

National Audit of Primary Care Organisations Service Provision for COPD patients

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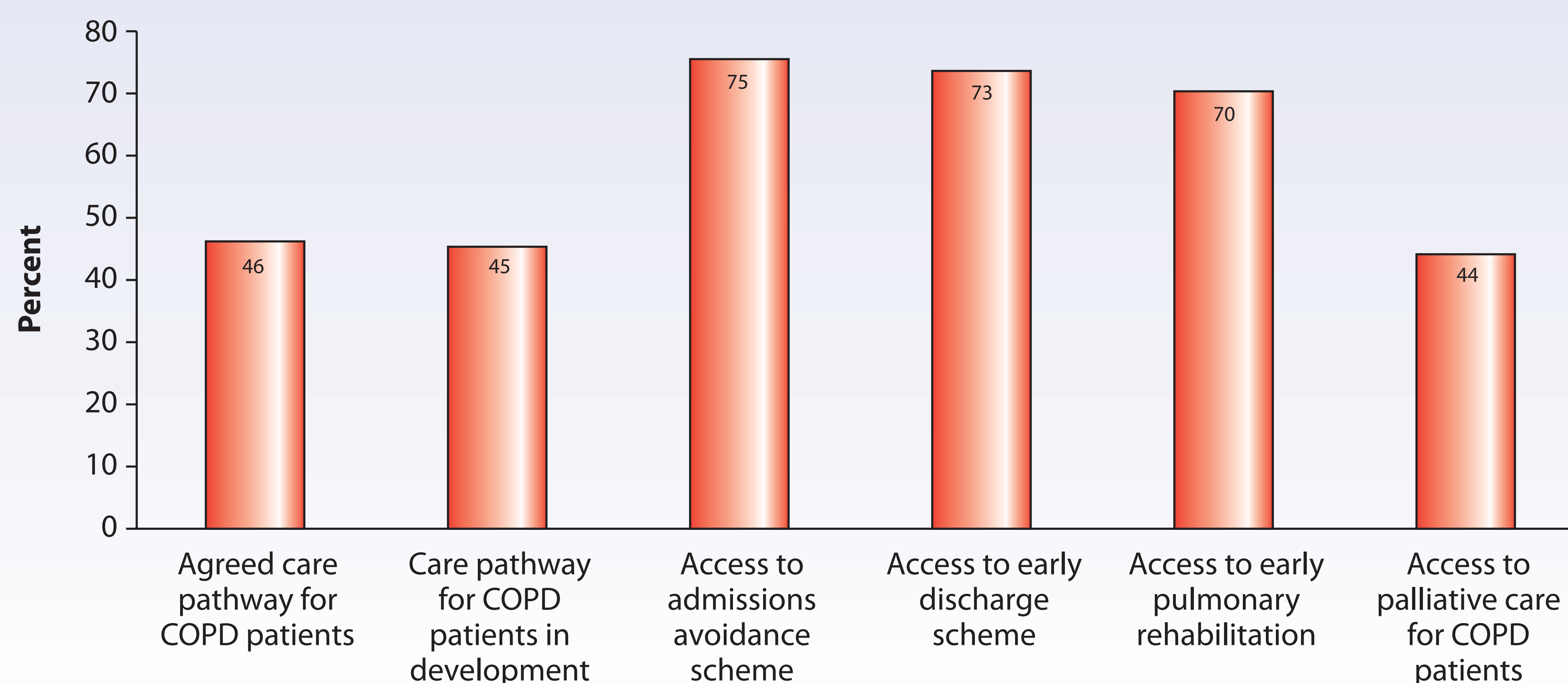
Background

In 2008, for the first time, an organisational survey of United Kingdom NHS Primary Care Organisations (PCOs) was undertaken, with participating PCOs completing a cross-sectional paper-based questionnaire about the resources and organisation of care for people with COPD in their locality. The person nominated to complete the questionnaire was to have an understanding of the local COPD services: for example, a Commissioner, Service Manager or Clinical Governance team member. The project team at CEEU worked closely with this person during the audit period.

Results

- Responses were received from 73% (141/192) of PCOs.
- We noted a wide range of job roles amongst staff tasked with developing COPD services (111 different job roles amongst 156 individuals).
- 86% (119/139) of PCOs reported they had a defined group responsible for developing new COPD services
- 50% (70/140) of PCOs had a written plan for these developments (a further 39% aiming to produce one)
- Future service development plans (in the 50% with a plan) included; Pulmonary rehabilitation 97%, Early discharge scheme 90%, Admissions avoidance 93%, Palliative Care 78%.

Reported service availability in PCO's



Key Messages

- PCOs demonstrated a high level of participation in this national audit of services for people with COPD
- PCOs commonly have COPD development groups, although it is unclear how these translate their administrative activity into delivery of care as only 46% of PCOs have an agreed COPD care pathway. This may reflect the developmental stage of such groups as 90% of the remainder have plans to develop pathways.
- The majority of PCOs provide Community Pulmonary Rehabilitation, Early Discharge and Admission Avoidance Schemes.
- Only 44% of PCOs report formal palliative care arrangements for patients with COPD. Of the PCOs that had written agreed plans for developing their COPD services, 22% were not planning to consider palliative care services as part of these developments.
- There is a wide range of staff, with very variable job titles, apparently responsible for developing COPD services within PCOs.

Conclusions

- **Further prospective audits of outcomes as well as economic benefit are undertaken as Community COPD services develop or emerge.**
- **Schemes involving case management and admission avoidance in particular should be subject to high quality evaluation including peer review**
- **There is a significant gap in the provision of palliative care for patients with COPD, despite evidence of effective interventions that are not being currently commissioned. We recommend PCO service improvement plans contain a mandatory consideration of end of life care services for patients with COPD.**
- **There should be a mechanism to exchange service developments and evidenced data between PCOs in order to avoid repetition and maximise the benefit of these changes to patients and local health economies.**
- **We recommend the good practice reported by PCOs in developing multidisciplinary services that cross sector and service boundaries.**

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