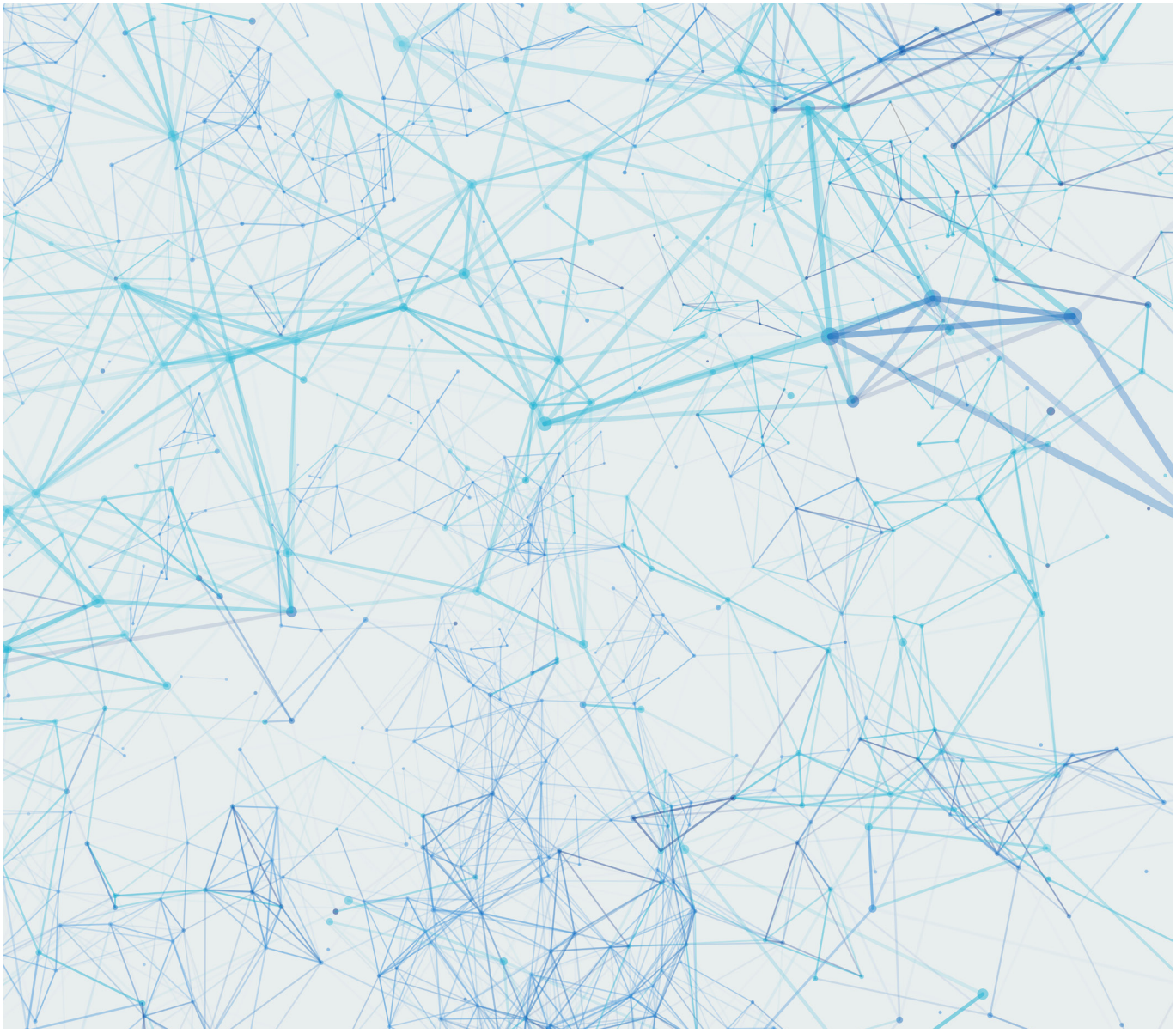
sanofi

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

COPD Pathway Review Report

Leicester, Leicestershire and Rutland Integrated Care Board



COPD Pathway Review Report produced as an outcome of a collaborative working project between Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and Sanofi.

Contents

1.0 Introduction

This report presents the outcomes of the review of the COPD pathway within Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB).

The ICB considered that the mapping of collective services within the COPD pathway could help to improve current service provision by identifying priority areas to focus on to deliver improvements in outcomes. The review was undertaken through a collaborative working partnership between Leicester, Leicestershire and Rutland Integrated Care Board & Sanofi which was conducted between June 2025 and February 2026. The review was undertaken with input from representatives from primary care, University Hospitals of Leicester, Leicestershire Partnership Trust, University of Leicester and Leicester, Leicestershire and Rutland ICB.

The conclusions of the review and recommendations were informed by scrutiny of local data and interviews with key clinicians and stakeholders. In addition, the voices of people with COPD was taken from the Leicester contribution to the national COPD voices report (as outlined in Section 5.0 below) and informed the recommendations of this review.

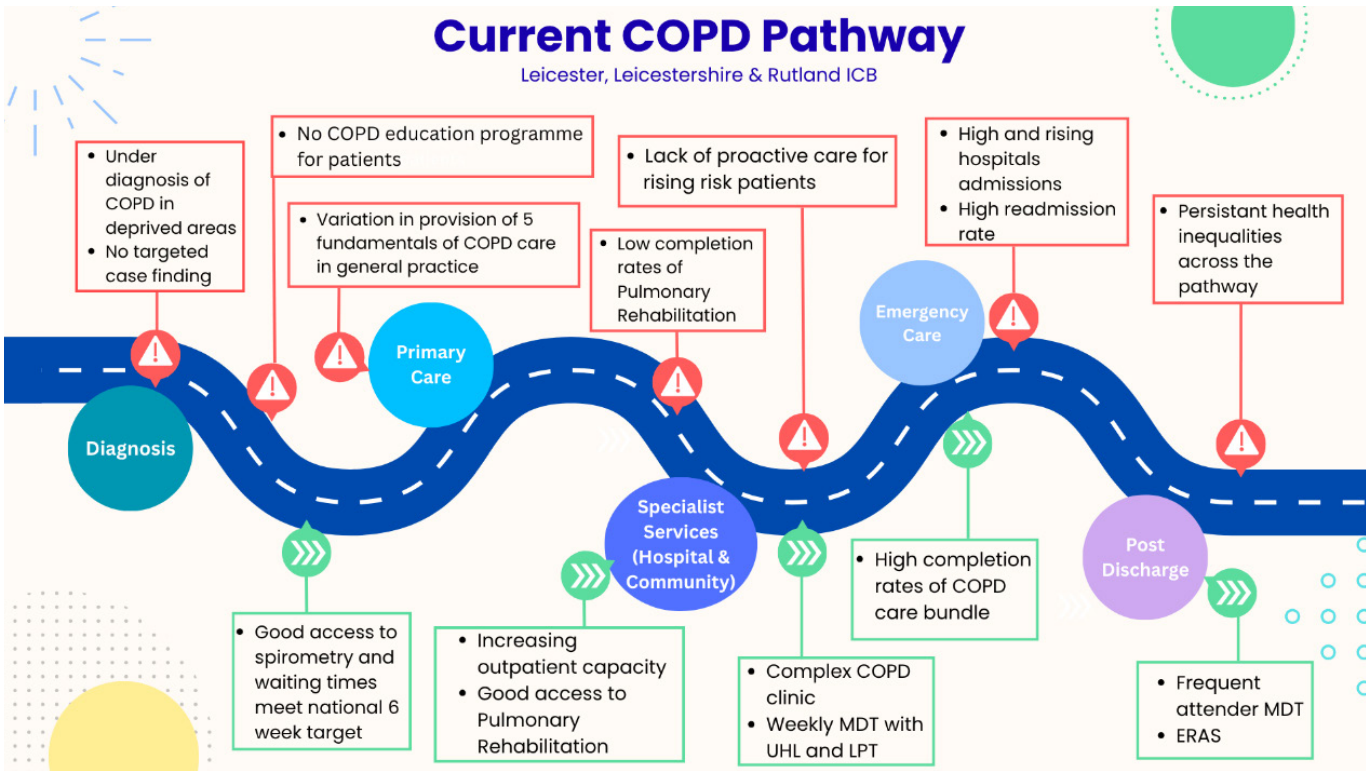
2.0 Executive Summary

This review of the Chronic Obstructive Pulmonary Disease (COPD) pathway across Leicester, Leicestershire and Rutland (LLR) has identified a system with strengths in hospital and community respiratory services but also significant weaknesses and unwarranted variation elsewhere in the care pathway that contribute to poor outcomes, high hospital utilisation, and marked health inequalities particularly for people living in areas of high deprivation. All parts of the system including primary, community and secondary care are all responsible for improving outcomes, reducing hospital attendances and improving health inequity.

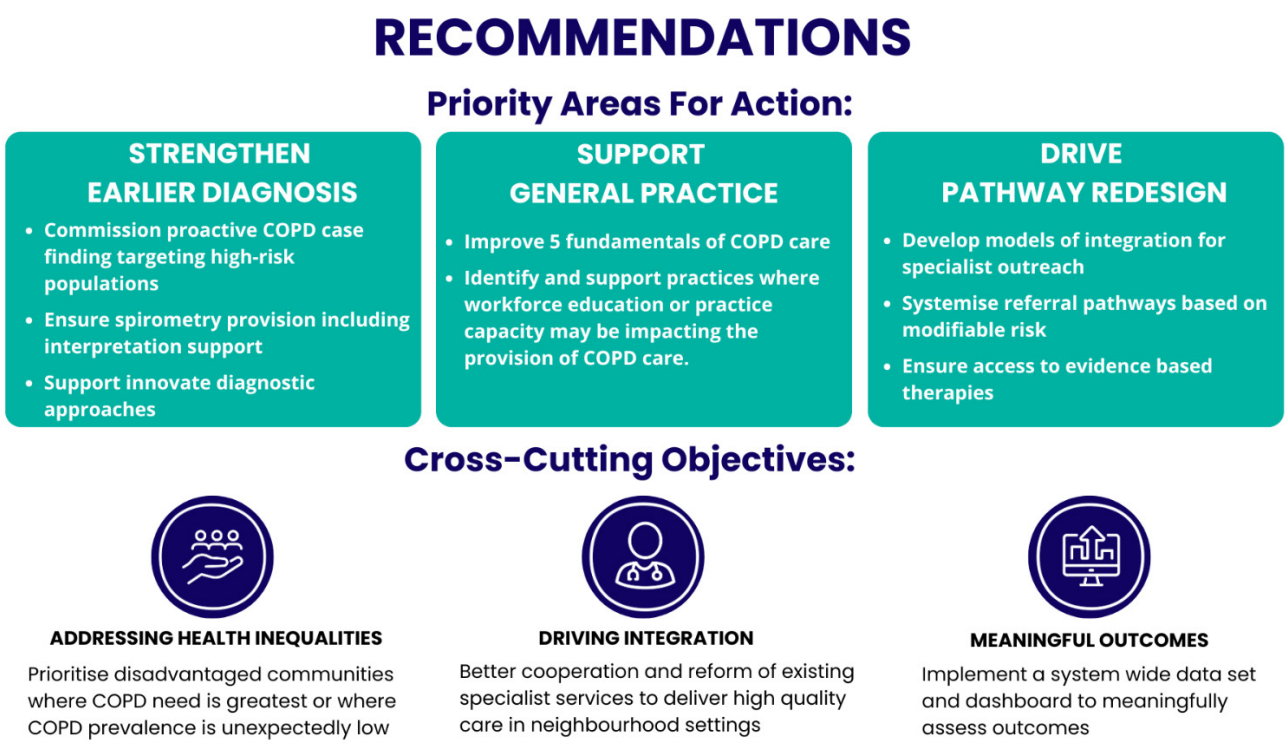
The review found that whilst secondary and community services perform well against national benchmarks, particularly once patients are engaged with specialist care, LLR ICB is a national outlier for COPD non-elective admissions. This could be related to late diagnosis and lack of specialist input to intervene early to address modifiable variation in primary care access and quality of care, and inequitable access to key therapeutic interventions. Overall care for people with COPD is insufficiently proactive with a lack of investment in prevention measures early during the natural history of the condition. Addressing these upstream gaps offers the greatest opportunity to improve outcomes, reduce admissions, and deliver better value for the system.

People with COPD who attended the engagement session held in Leicester as part of the national COPD Voices programme led by Kings College London (Report published in April 2025) found that people with COPD in Leicester face significant delays in diagnosis and lack of information provided about COPD at time of diagnosis, difficulties in accessing GPs, specialist services and pulmonary rehabilitation and experience poor communication between different healthcare providers and inadequate follow-up post hospital discharge.

The detailed findings from the review of the COPD pathway are outlined in Appendix 1. The infographic below summarises the COPD patient pathway and outlines what is working well and what are the key challenges and opportunities for improvement across the pathway.



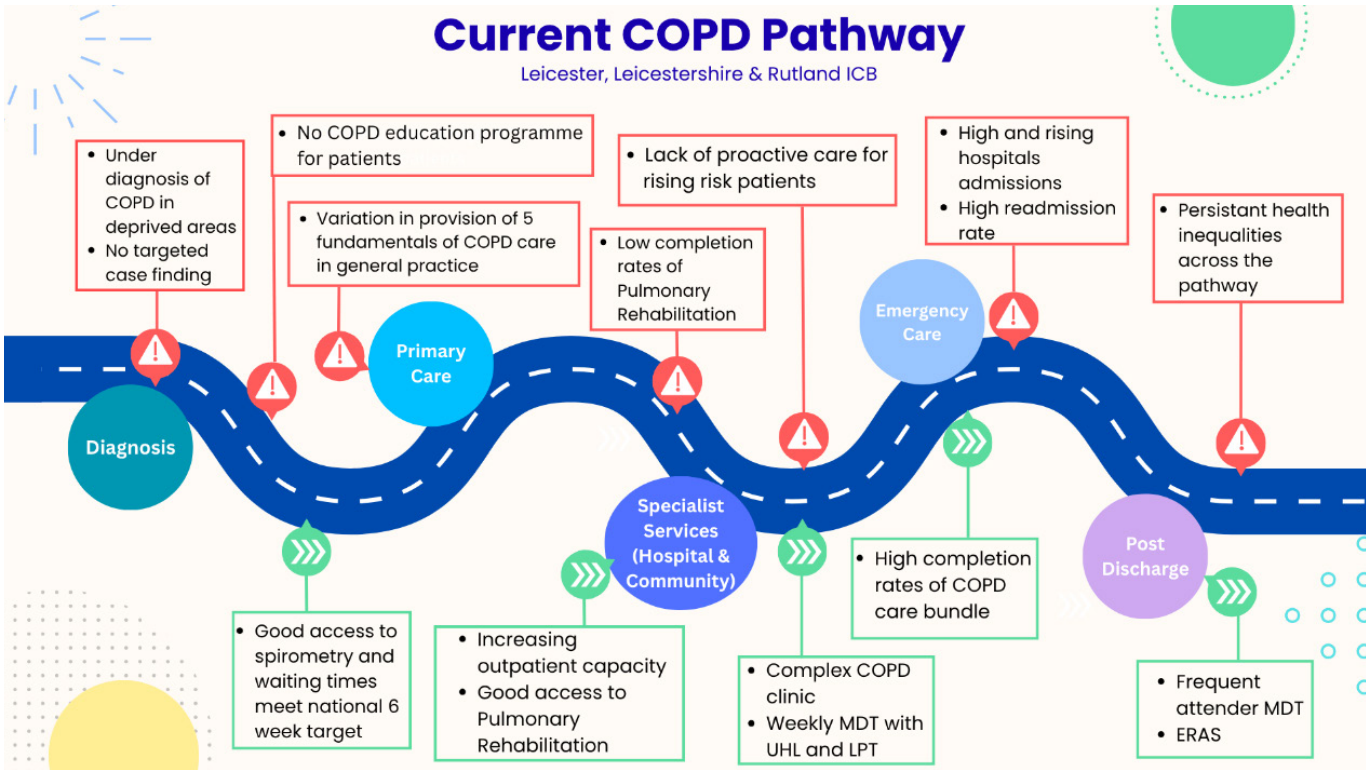
A summary of the recommendations to address the key challenges and opportunities for improvement is outlined in the infographic below. Fuller details are provided in Section 4.0 below.



We call upon all the system partners within Leicester, Leicestershire and Rutland to commit to these recommendations and join us in tackling these challenges head-on. Together, we can deliver real change for the people with COPD within Leicester, Leicestershire and Rutland.

3.0 Overview of the current COPD Pathway

The detailed findings from the review of the COPD pathway are outlined in Appendix 1. The infographic and sections below summarises the COPD patient pathway and outlines what is working well and what are the key challenges and opportunities for improvement across the pathway.



3.1 What is working well?

LLR has several notable strengths that provide a solid foundation for pathway improvement:

Timely access to quality assured spirometry, supported through a Local Enhanced Scheme and multiple delivery routes (primary care, PCNs, CDCs and UHL), with waiting times now below the national 6-week target.

Excellent provision of pulmonary rehabilitation, with a wide range of delivery models (face-to-face, home-based and online) and a good local spread of access to PR across the ICB, improving enrolment rates, and marked reductions in waiting times. LLR now performs above the England average for timely access to pulmonary rehabilitation within 90 days of referral.

High-performing specialist hospital COPD nursing services, concentrated at Glenfield Hospital, with top-quartile performance in the National Respiratory Audit Programme, strong delivery of discharge bundles, and excellent post-discharge nurse follow-up.

A well-resourced Community Respiratory Service, providing care locally for people with COPD including specialist clinics, admission avoidance (ERAS), frequent attender MDTs, and close integration with hospital COPD services.

Strong collaboration between providers, including regular COPD MDTs spanning hospital and community services, and improving coordination of post-admission care.

Primary care provision of **annual COPD reviews** for people with COPD within the ICB is above the England average but there is significant variation across GP practices.

3.2 Key challenges and opportunities for improvement

However, the review highlights several critical weaknesses that limit the overall impact of the pathway:

Under-diagnosis of COPD, particularly in deprived communities and high-risk groups, with a 1.57% COPD prevalence in LLR which is significantly below both the England average 1.89% and estimated prevalence of 2.6%. Diagnostic rates do not follow the expected deprivation gradient.

Unexplained variation in the provision of the five fundamentals of COPD care in general practice. This includes provision of annual reviews, referrals to pulmonary rehabilitation, smoking cessation support, uptake of influenza and pneumococcal vaccinations, and optimisation of treatment.

Absence of a commissioned structured education and self-management programme for people with COPD, outside of pulmonary rehabilitation.

High and rising hospital admission rates, LLR had a COPD non-elective admission rate of 157 per 1,000 COPD population compared to an England average of 108 with LLR ICB having the second highest admission rate across the 42 ICBs. COPD non-elective admissions have increased by 11% in the 2 years between 2022-23 and 2024-25. It should be noted that not all hospital admissions and readmissions are preventable. This indicates insufficient proactive and preventative care upstream and a need for a targeted focus to address modifiable risk. Further work is required to understand how COPD hospital admissions via Assessment Unit attendance are being coded as zero length of stay and the contribution this is making to the increase in COPD admissions.

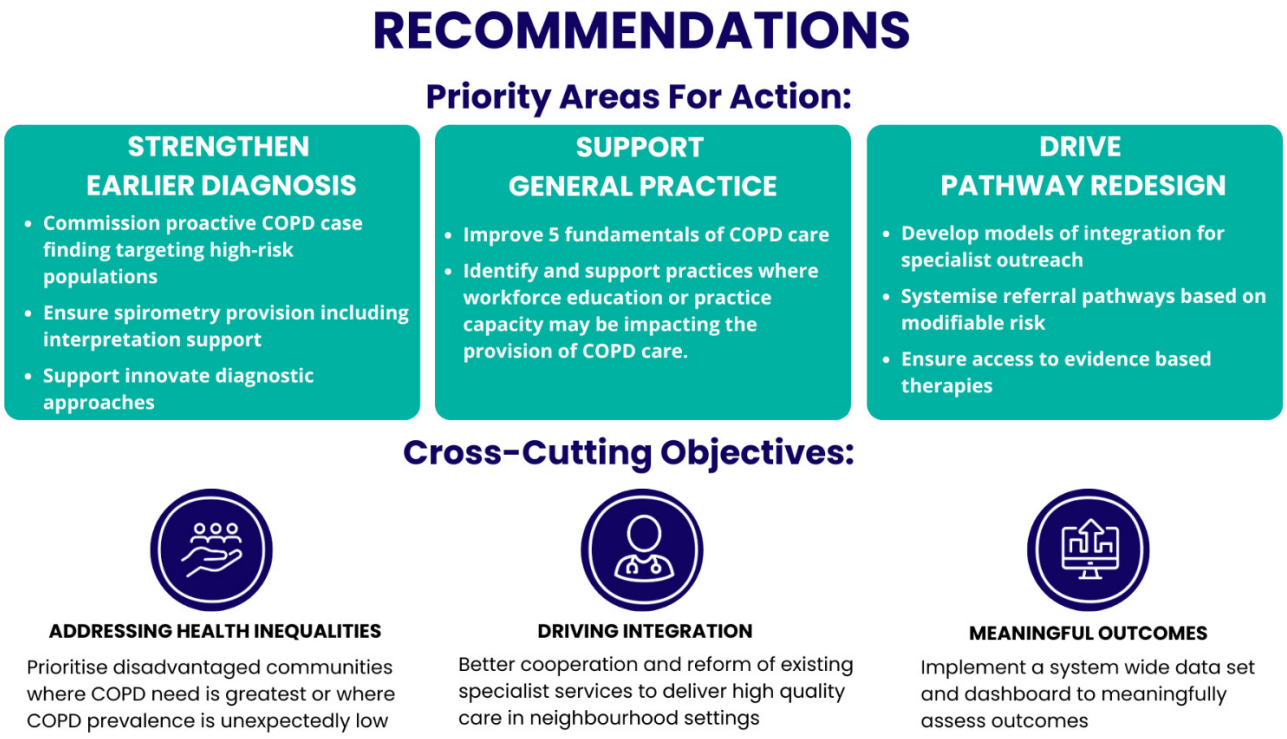
Lack of systematic risk stratification and proactive case management, despite clear evidence that a significant proportion of admissions are driven by a smaller cohort of patients with repeated exacerbations. This includes lack of identification in primary care of COPD patients with 'rising risk' who require additional input from primary care and/or specialist COPD services to optimise management and address these risks. In addition, there is a need to implement systematic identification of patients with modifiable risk especially for exacerbations given the new therapeutic landscape with the recent publication of NICE guidance on biologic therapy.

Persistent health inequalities were identified by the review including poorer diagnosis rates, higher hospital admissions and admissions at a younger age and poorer outcomes amongst the deprived population. Addressing these inequalities offers the greatest opportunity for clinical impact. Additional interventions should be targeted towards those in deprived populations as this is likely to deliver the highest gains in addressing inequities in access to care and improving health outcomes and therefore be most cost effective.

The current primary care and provider **outcome metrics** do not give a rounded indication of the quality of services or the impact on patients.

4.0 Recommendations

To address the above gaps and improve outcomes, we have identified priority areas for improvement and recommend actions that the ICB and provider partners should take to deliver these objectives. These recommendations are in line with the ICB's strategic priorities and the NHS 10 year plan in that they focus on enhancing COPD care provided in communities, shifts the focus of care to longer term prevention and streamlines pathways using data driven stratification for rising modifiable risk. We identify three priority areas for action - Strengthening Early Diagnosis, Supporting Primary Care and Pathway Redesign. We also identify key cross-cutting objectives that will ensure impact of these actions; prioritising disadvantaged/ underserved communities where we have identified gaps in COPD care, driving efficiency and cost effectiveness through better integration of existing services and ensuring impact and effectiveness is robustly measured by recording meaningful outcomes.



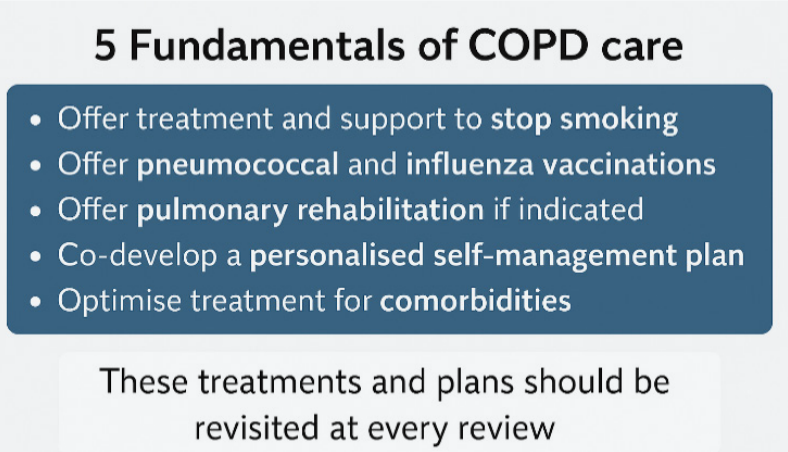
Priority areas for action:

1. Strengthen Earlier Diagnosis

- Commission and incentivise proactive COPD case finding targeting high-risk but low prevalence populations (e.g. smokers and ex-smokers aged ≥40, deprived communities, ethnic minority groups, people with substance misuse, those attending lung cancer screening with significant emphysema but no diagnosis of COPD). Earlier detection will improve optimisation of care and reduce disease progression and rate of exacerbation by addressing modifiable risk.
- Ensure spirometry provision includes interpretation support (from provider partners where needed), with a focus on practices where current provision is inadequate (e.g. some parts of Leicester City). Consider achieving this by separate payments for performance and interpretation of spirometry withing existing contract arrangements.
- Support adoption of innovative diagnostic approaches (for example incorporation of AI supported quality assurance and interpretation of spirometry) where evidence supports benefit. This will improve the quality and quantity of spirometry provision in primary care, improving access closer to home.

2. Support General Practice

- Implement approaches to support General Practice to deliver the **five fundamentals of COPD care** to the whole COPD population equitably. These interventions are proven to improve outcomes in COPD (including improving mortality and reducing risk of unscheduled hospitalisation). This may be achieved through incentivisation for general practice or delivery of care by other partners where appropriate (e.g. the LPT community respiratory service) through a "Making Every Contact Count" approach.
- Identify and support practices where **workforce education or practice capacity** may be impacting the provision of COPD care. Consider commissioning measures to protect GP and practice nurse time to deliver high quality COPD care and to drive integrated specialist MDT support for practices where this need is greatest.



3. Drive Pathway Redesign

- Develop and facilitate **models of integration** that deliver specialist multidisciplinary expertise from UHL and LPT to support patient care and drive knowledge mobilisation in general practice. This will increase earlier access to specialist therapies to improve outcomes. Similar integration models for CKD and Cardiometabolic disease are being implemented across LLR and should be commissioned for COPD.
- **Systematise referral pathways** to specialist and community respiratory services based on modifiable risk rather than ad hoc referral. Incorporate data driven approaches to identify and "pull" COPD patients with 'rising risk' (frequent exacerbations, repeated oral corticosteroid use or deteriorating symptom control) into specialist services to ensure earlier **access to evidence based therapies** where need is greatest (for example Novel Biologic Drug Therapies, antibiotic prophylaxis, and other exacerbation preventions strategies). The resource requirements to assess and administer novel biologic drug therapies within LLR have been identified.
- Encourage **provider partners** (LPT and UHL) to deliver care in line with this integration model. Consultants and other members of the specialist COPD MDT at UHL should be supported to deliver care within neighbourhoods in line with the UHL clinical strategy.

Cross-Cutting Objectives:

1. Addressing Health Inequalities

It is clear from our data analysis that outcomes and care for people with COPD across LLR are unequal. The underlying reasons for this inequality are complex, and we recognise that care provision and outcome may not be correlated. We suggest our recommendations above should be targeted where data suggests COPD need is greatest (for example socioeconomically deprived communities) or where COPD prevalence is unexpectedly low (for example ethnic minority communities). Likewise identifying where care provision is under-resourced (especially in primary care) will ensure greatest increment in outcomes and return on investment.

2. Driving Integration

Our analysis of service provision for people with COPD identifies several strengths in local services but also unexplained variation in care and outcomes. Addressing these deficiencies when resources are constrained requires closer integration of these services. We urge commissioners and providers to consider how the recommendations above can be delivered through better cooperation and reform of existing UHL and LPT COPD pathways and in particular how such integration can deliver high quality care in neighbourhood settings as outlined in the NHS 10 year plan.

3. Meaningful Outcomes

In scrutinising outcome data for COPD, it was clear that available indices are insufficient to derive a clear picture of the quality of care. For example, raw hospitalisation data do not reliably distinguish avoidable and non-avoidable admissions and Quality & Outcomes Framework indices themselves do not provide an assessment of the quality of annual COPD reviews. Given that COPD care is aimed at improving quality of life, patient related outcome or experience measures are absent. Our recommendations are centred on ensuring the equitable provision of evidence based interventions in COPD which have been shown to reduce disease burden and healthcare utilisation. We urge the implementation of a system wide dataset and dashboard that would meaningfully assess the provision of these interventions over an appropriate time period.

5.0 Voices of local people with COPD

In April 2025, the national COPD Voices Report was published by Kings College London which captures the lived experience of people with COPD and carers. The report highlights systemic issues in diagnosis, management, and access to care, and proposes a framework for transforming COPD services and recommendations for improving care. An engagement session was held with people with COPD in Leicester which fed into the outputs in the overall report and generated a Leicester specific report. A summary of the key issues raised by people with COPD in Leicester is provided below. Many of these issues identified by people with COPD in Leicester mirror the key findings from the review of the COPD Pathway in particular delays in diagnosis, access to care and support and exacerbation experiences and recovery.

The report concludes that people with COPD and their carers experience inequitable healthcare access and an urgent need for more comprehensive, patient-centred care. One of the most critical issues is the delay in accurate diagnosis and lack of information provided about COPD. Many people with COPD report not being diagnosed for years which impacts treatment effectiveness but also leaves them feeling frustrated and unsupported. People with COPD consistently report difficulties accessing services that are essential to managing their condition, including GP appointments, specialist care, and pulmonary rehabilitation. They also experience poor communication between different healthcare providers and inadequate follow-up after hospital discharge. Many people advocate for better support in managing exacerbations at home with prompt access to intervention where necessary to reduce hospital admissions and improve quality of life.

Summary of COPD Voices Leicester Report

1. Diagnosis & Information Gaps

- **Inadequate information at diagnosis** — all but one participant felt the information they received about COPD was insufficient.
- **Delayed or incidental diagnosis** — one patient only discovered their COPD diagnosis through a health insurance application, having never been informed by their GP.
- **Language barriers** — verbal and written information was not available in patients' languages (e.g., Gujarati), and some English medical terms have no direct translation.
- **Lack of culturally sensitive care** — healthcare providers often did not understand cultural nuances, and translators were rarely available at appointments.

2. Access to Care & Support

- **GP access severely impacted post-COVID** — patients reported difficulty getting through by phone, long waits (3–6 weeks), and often seeing locums or nurses rather than their GP.
- **Self-management barriers** — patients who cannot read, write, or speak English struggled with basic tasks like using inhalers correctly.
- **Digital exclusion** — assumptions that all patients can access online tools; when patients said they couldn't, no alternatives were offered.
- **Support groups at risk** — valued groups like Breathe Easy were seen as therapeutic, but language barriers and funding concerns threatened access.

3. Exacerbation Experiences & Recovery

- **Confusion around rescue packs** — inconsistent policies, with some patients told packs were being discontinued.
- **Unnecessary hospital admissions** — language barriers led to 999 calls and hospital admissions that could have been avoided (e.g., panic attacks mistaken for exacerbations)
- **Poor hospital-to-GP communication** — discharge information was frequently not uploaded to patient records, resulting in no post-discharge follow-up.

4. Awareness of Treatment Options

- **Zero awareness of biologic treatments** — not a single attendee knew about biologics until the focus group discussion.
- **Enthusiasm for research participation** — patients expressed strong interest in trying new treatments and joining clinical trials.

5. Mental Health Toll

- **Anxiety, panic attacks, and depression** — universally reported as a consequence of COPD and breathlessness.
- **Carer mental health overlooked** — carers described feeling unsupported, isolated, and overwhelmed.
- **Shocking care decisions without consent** — one family discovered a DNR order placed on a relative's notes without their knowledge.
- **Lack of centralised information** — carer support organisations were described as essential but inaccessible due to poor information provision.

6.0 COPD Pathway Review Methodology

The methodology used within the review of the COPD Pathway included:

- Reviewing population health data for people with COPD in LLR including access to treatment and clinical outcomes where available. Variations in care across the ICB footprint were also assessed.
- Undertaking a deep dive and review of COPD services/pathways within LLR through the analysis of available data on activity and performance within primary care, community and hospital services,
- Development of proposals to improve the COPD pathway and services to enhance the care for people with COPD.

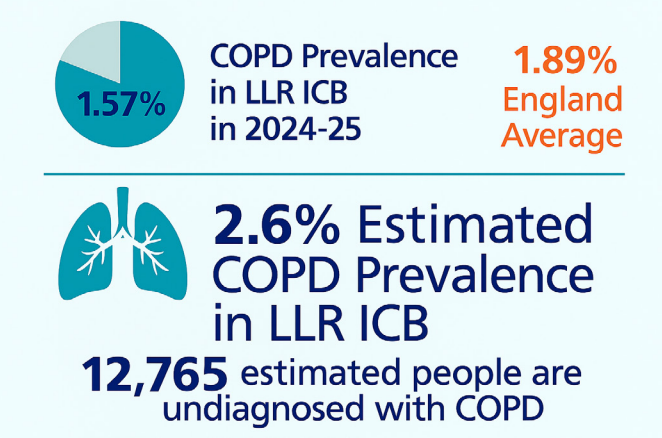
The review was co-ordinated by a Project Steering Group made up of clinical stakeholders involved in the COPD pathway along with commissioners from the ICB leading on COPD and long term conditions. Membership of the Steering Group is outlined in Appendix 2.

Interviews were held with 15 clinical and manager stakeholders to review the pathway. The outcome of the interviews has been recorded in the Visio pathway map shown in Appendix 3. The pathway map alongside the activity and population health data analysis were discussed at the Project Steering Group and were used to inform the key findings from the review of the current COPD pathway and to identify the priorities areas to be addressed and the recommendations contained within this report.

Appendix 1

Key findings from the COPD Pathway Review

1.0 COPD Diagnosis



Current position

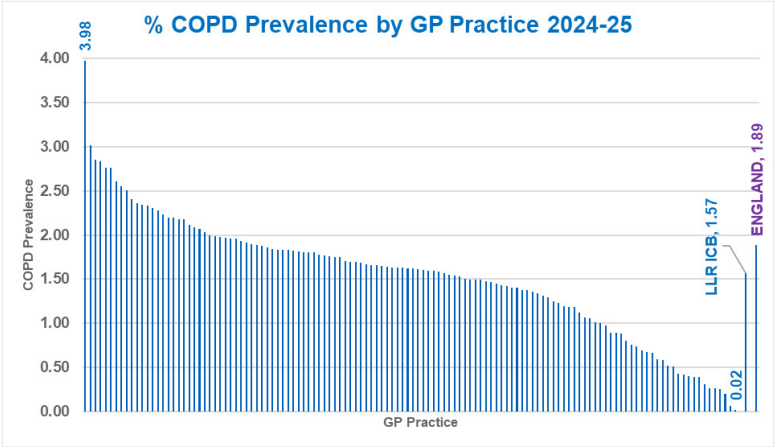
19,329 people within LLR ICB had a diagnosis of COPD recorded in primary care in March 2025. COPD prevalence in LLR ICB was 1.57% in March 2025 which is significantly lower than the England average of 1.89%. The number of people diagnosed with COPD increased by 360 between 2023-24 and 2024-25. This is a 1.90% increase which is lower than the England average of 3.52%. (QOF data 2024-25)

The expected COPD prevalence in LLR ICB is **2.6%**, meaning that there may be **12,765** people with COPD who are currently undiagnosed. (Source: Model Health System)

Diagnosis of COPD is still frequently made during hospital admission following acute exacerbation, suggesting there may have been opportunities for earlier detection in the community. People with COPD who attended the COPD Voices session in Leicester identified delays in diagnosis as a gap.

The steering group considered that the under diagnosis of COPD is due to a range of issues including historical poor access to spirometry testing in primary care, long waiting times for spirometry tests in secondary care, lack of incentives for primary care to case find for COPD amongst high risk populations as well as patients not presenting to primary care particularly within deprived communities.

There is marked variation in prevalence between GP practices, including those serving highly deprived populations, where recorded COPD prevalence ranges from 3.89% to as low as 0.06% (excluding University practices).



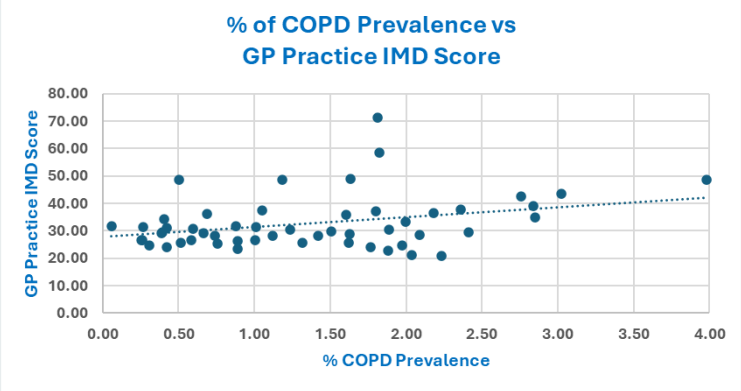
COPD diagnosis by deprivation - Comparison of COPD prevalence against IMD score for all GP practices did not show a correlation between COPD prevalence and Index of Multiple Deprivation (IMD) score. A higher IMD score means that the GP practice serves a population in an area that is relatively more deprived compared to other practices. When this analysis focused on those practices with an IMD Score above the average of 20.76 there was a stronger correlation between IMD score and COPD prevalence. There was significant variation in COPD prevalence across the 20 practices with the highest IMD scores ranging from 3.89% to 0.06% and some of the GP practices with the highest IMD scores have a lower than expected COPD prevalence. Therefore, the expected gradient of higher prevalence in areas of greater deprivation is not consistently observed, suggesting missed opportunities for earlier diagnosis.

There is evidence to support the under diagnosis of COPD within deprived populations despite higher hospital utilisation from people from the most deprived populations.

COPD diagnosis in other high risk groups - There is a significantly lower diagnosis rate of COPD amongst the non-white populations. The steering group recognised that COPD may be under-recognised and diagnosed in non-white populations but also acknowledged uncertainties relating to the accuracy of coding of ethnicity in primary care systems, variable rates of smoking prevalence, and potential variations in susceptibility to COPD in these populations.

Respiratory Clinicians on the Project Steering Group reported that they are seeing an increase in the number of people who are drug users presenting to the specialist respiratory service with a diagnosis of COPD. They reported that the diagnosis of COPD in this patient group is occurring at a much earlier age than the general population and have greater earlier progression of their disease.

COPD prevalence and smoking correlation - Comparison of COPD prevalence with smoking prevalence within GP practices shows a strong correlation between COPD prevalence and smoking prevalence. However, several GP practices with a high smoking prevalence have a lower than expected COPD prevalence, indicating potential under diagnosis of COPD. This is a potential area for intervention and proactive case finding to improve the diagnosis of COPD. There is also an opportunity to target those attending lung cancer screening with significant emphysema but no diagnosis of COPD.



Access to spirometry has improved considerably within LLR over the past 2 years through the Local Enhanced Scheme and multiple providers with waiting times now below the national target of 6 weeks. However, provision remains uneven, particularly in Leicester City where only 31% of practices provide spirometry and utilise hospital spirometry. In addition, the provision of interpretation of spirometry results by providers is inconsistent.

What is working well?

- Improved capacity and timeliness of spirometry across the system
- Multiple access points, including primary care, PCNs, CDCs and University Hospitals Leicester
- Reduced waiting times for spirometry to below the national target of 6 weeks.

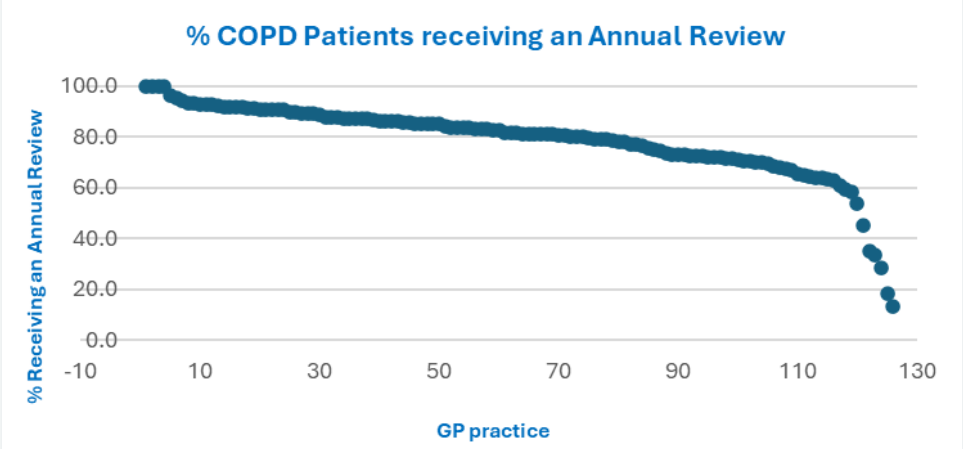
Key challenges and opportunities for improvement

- Lack of systematic, proactive case finding in areas with lower than expected COPD prevalence and in areas of higher deprivation.
- Co-ordinate access to spirometry for those attending lung cancer screening with significant emphysema but no diagnosis of COPD.
- There is variation in support for spirometry interpretation with some primary care providers providing both spirometry and interpretation and some not providing interpretation.
- Duplication of diagnostics in primary care and secondary care due to information systems not talking to each other.

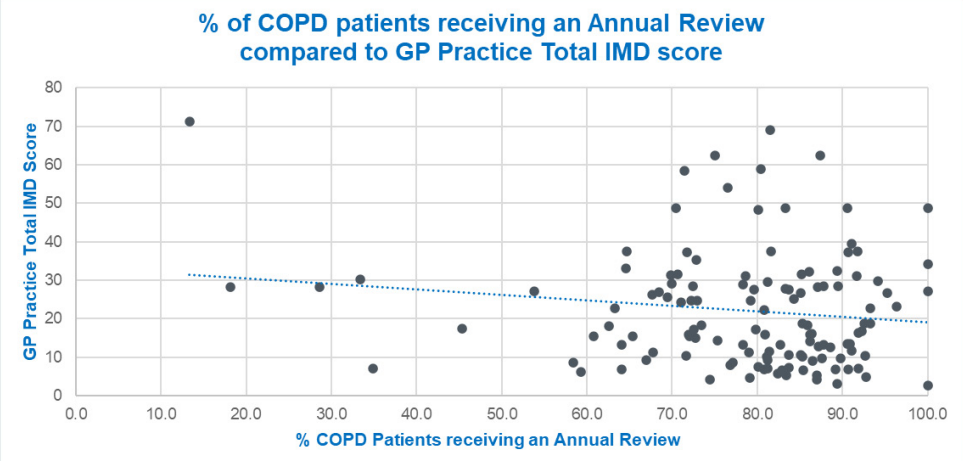
2.0 Primary Care Management of COPD

Current position

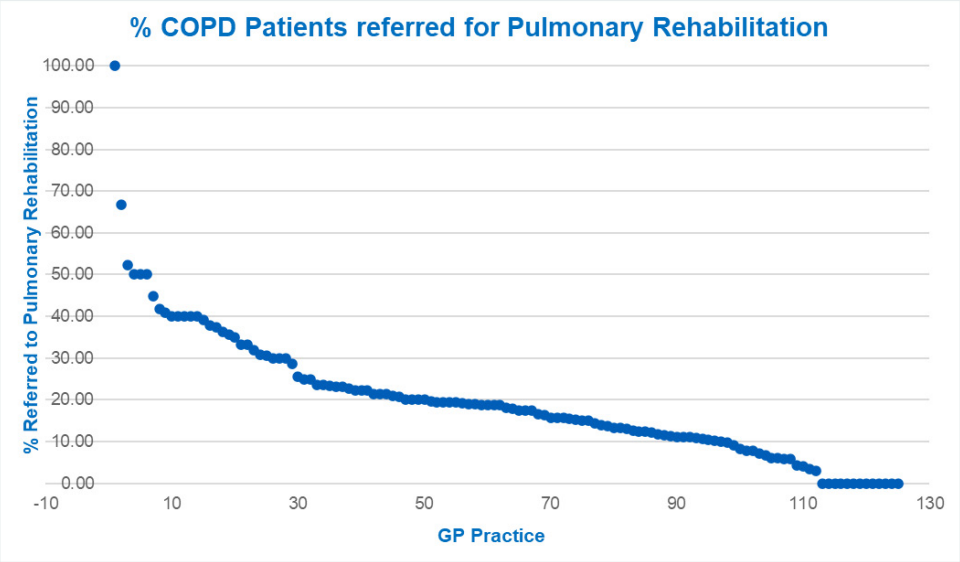
In 2024-25, 77.3% of COPD patients had an annual review within last 12 months in LLR ICB which was slightly above England average of 76.4% (Data source QOF 2024-25 - this data is based on those patients who received the intervention and excludes those patients who have been excluded through Personalised Adjustments). Whilst the overall annual review rates are slightly above the England average, there is wide variation at practice level, with lower performance observed in more deprived areas.



The graph below shows the % of COPD patients receiving an annual review compared to the Total IMD Score for the GP practice. This shows that there is a weak negative correlation (r = -0.208) between IMD and annual reviews with practices in more deprived areas (higher IMD) tending to have lower annual review rates. This may be due to the known challenges in providing proactive care reviews to a deprived population who tend to have a more reactive approach to healthcare utilisation.



The chart below shows that referral rates to pulmonary rehabilitation for people with COPD with an MRC scale of 3 and above also vary across GP practices. (Data source QOF 2024-25 - this data is based on those patients who received the intervention and excludes those patients who have been excluded through Personalised Adjustments)



The stakeholder interviews identified gaps in workforce capacity, skills and confidence in COPD management within primary care. There were limited incentives within QOF in 2024-25 for COPD management and this has been reduced further in 2025-26 with the pulmonary rehabilitation measure being removed which now leaves the annual review as the only measure. The current national QOF framework provides limited support for proactive, high-quality COPD care, and access to specialist input is reactive and referral-dependent rather than systematic and needs-based.

What is working well?

- Completion of annual reviews are above England average but there is significant variation across GP practices.

Key challenges and opportunities for improvement

- Inconsistent delivery of the five fundamentals of COPD care.
- Variable referral rates from GP practices to pulmonary rehabilitation.
- Limited structured support and education for primary care teams was identified through stakeholder interviews. LPT are commissioned to provide this, and further action is required by them working within neighbourhood teams to improve provision.
- Lack of commissioned proactive identification and proactive management of patients with 'rising' risk.

3.0 Five fundamentals of COPD care

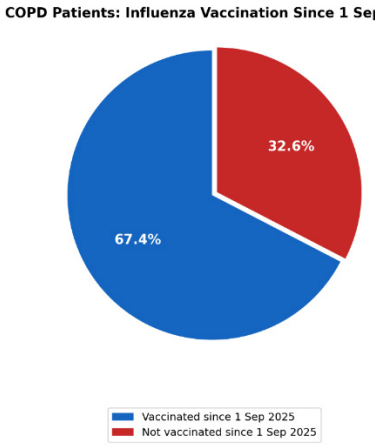
3.1 Vaccinations

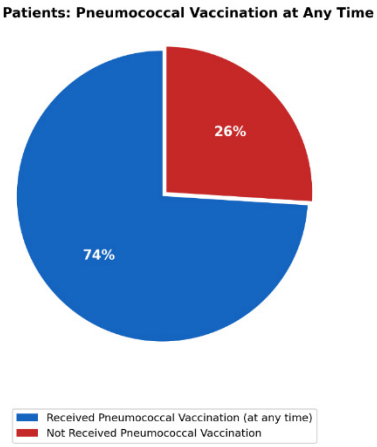
For individuals with compromised lung function, a common respiratory infection can quickly escalate into severe exacerbation, leading to hospitalisation or permanent lung damage. Vaccinations function as a primary shield to prevent these complications. By preventing common infections like the flu and pneumonia, patients can avoid the sudden worsening of symptoms that leads to hospitalisation.

Current position

General Practice provide the bulk of vaccinations who invite eligible patients for vaccination. In addition, there are some vaccinations provided by pharmacies.

An analysis of uptake of vaccinations for the population with COPD in February 2026 showed that 67.4% of patients with COPD had received an influenza vaccination since 1st September 2025 and 74% had received a pneumococcal vaccination at any time.





What is working well?

- 88.2% of the COPD population had been invited for an influenza vaccination in 2025 but there is still work to do to encourage further uptake.
- 6 GP practices (5%) had achieved over 80% flu vaccinations for the COPD population.
- 53 GP practices (42%) had achieved over 80% pneumococcal vaccination at any time for the COPD population.

Key challenges and opportunities for improvement

- 6,439 patients with COPD (32.6%) have not received an influenza vaccination between 1 Sept 2025 and February 2026.
- 5,106 patients with COPD (26%) have never had a pneumococcal vaccine.
- There is unexplained variation across GP practices in the proportion of patients receiving an influenza vaccination since 1st September 2025 and for pneumococcal vaccination at any time – see tables below:

% COPD Patients who have received an Influenza vaccination since 01 Sept 2025	GP practices within LLR ICB		
	Lowest	Highest	Average
	20.2%	83.3%	67.4%

% COPD patients who have had Pneumococcal vaccine at any time	GP practices within LLR ICB		
	Lowest	Highest	Average
	21.0%	90.7%	74.0%

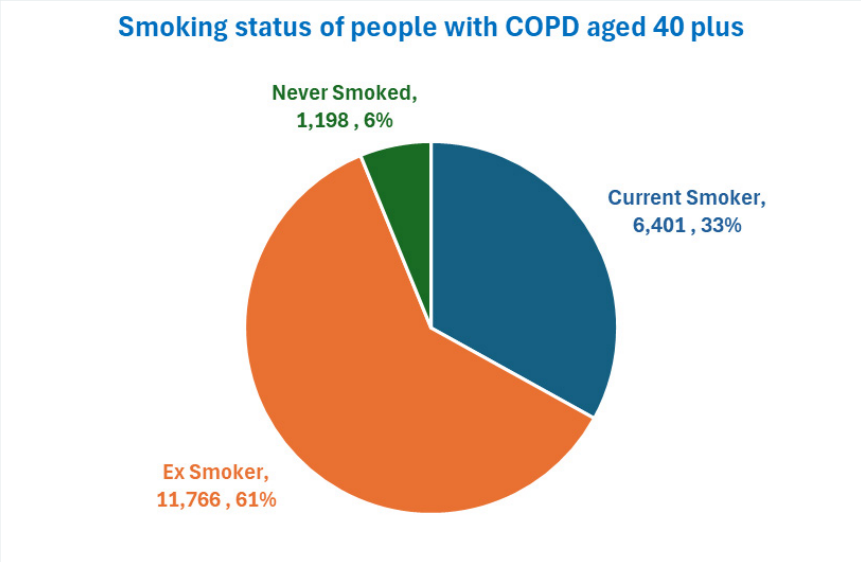
Recommendations

- Ensure that vaccination is discussed (and offered where possible) at each touchpoint for the patient as well as sending invitations out from the registered GP. Community and secondary care clinicians should discuss and promote vaccination and opportunities for delivering vaccines in community and secondary care settings should be explored.
- Improving vaccination uptake for the COPD population should be a key focus of neighbourhood work.

3.2 Stop Smoking

Current position

Data from primary care in April 2026 shows that 33% of people with COPD aged 40 plus are current smokers and 61% are ex-smokers and 6% never smoked.



LLR ICB have given a commitment to recurrent funding of in-hospital smoking cessation services across the 3 acute hospital sites and Mental Health to encourage and support patients admitted to hospital who smoke to stop smoking. There is a strong Tobacco Dependency Service in the hospital with up to 400 patients per month accessing Tobacco Dependency Advisers. This includes associated prescribing of 12 week supply of prescriptions medications. Work is undertaken by the Tobacco Dependency Service to upskill hospital staff around opportunities to encourage patients to stop smoking. There is a linked referral pathway into the Community Stop Smoking Services. Patients are referred out into the community stop smoking service in the community funded by the Local Authorities.

Within Hospitals there is also Tobacco Dependency Adviser input into some OutPatient Clinics for example Cardiology.

There is a plan to link smoking cessation with the Targeted Lung Health Screening Programme to be implemented in 2026-27. This will provide real time access to stop smoking support. Patients with incidental findings from lung health screening will be used as a vehicle to offer further smoking cessation input.

What is working well?

- Provision of smoking cessation support for people admitted to Hospitals.
- Provision of 12 week supply of prescription medications on discharge from hospital.

Key challenges and opportunities for improvement

- Stakeholder interviews identified the lack of access to smoking cessation services alongside hospital respiratory clinics as a gap in the pathway.
- An enhanced focus by Neighbourhood Teams on increasing the uptake of smoking cessation to increase smoking cessation rates amongst the COPD population.

3.3 Pulmonary Rehabilitation and Self-Management

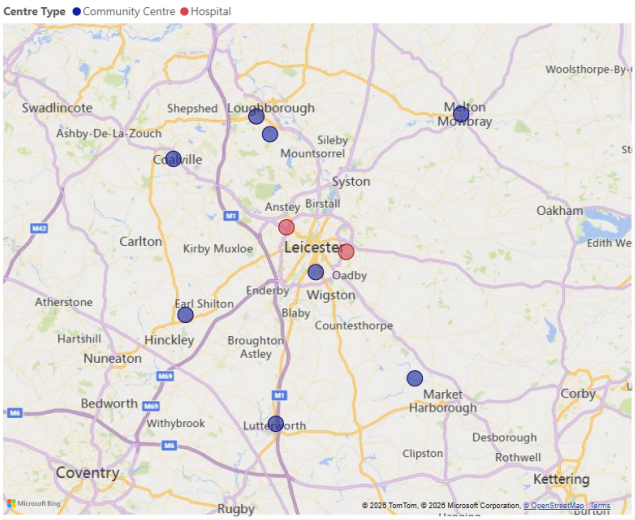
The British Thoracic Society (BTS) Guideline for PR in adults, published in 2013, highlights the benefits of PR, including improved exercise capacity and health-related quality of life (HRQOL) in patients with chronic obstructive pulmonary disease (COPD). PR is one of the most cost-effective interventions for adults with COPD and has been shown to improve HRQOL to a greater extent than bronchodilator therapy.

Current position

Pulmonary rehabilitation provision in LLR is a clear strength with good capacity and multiple delivery models providing patients with a choice of face to face, home based and on-line programmes together with improving uptake and reduced waiting times.

Provision - Data from NRAP shows that there were 2,160 pulmonary rehabilitation cases (places) provided in 2024-25 with 1,136 cases provided by Leicestershire Partnership Trust and 1,024 provided by University Hospitals of Leicester. LLR ICB had a good level of provision of pulmonary rehabilitation in 2024-25 (as recorded on NRAP data) with 171 pulmonary rehabilitation cases per 100,000 total population compared to an ICB average of 77.

Pulmonary rehabilitation is provided in Glenfield Hospital and Leicester General Hospital and 8 community venues which provides a good spread of availability and access to PR for people with COPD in LLR. PR is largely provided in group sessions with an individualised programme of exercise and education for people with COPD. In addition, UHL provides alternative programmes in the form of a home based guided manual programme for pulmonary rehabilitation as well as an on-line programme (www.i-impact.co.uk) and LPT provide a home based programme. This provides choice for people with COPD on the type of programme they would like to access.



The pulmonary rehabilitation programme provided by LPT is incorporated within the Breathlessness Rehabilitation service which is an individualised programme of exercise and education for people with chronic respiratory disease and heart failure. UHL also provide a Breathlessness Programme for people with chronic respiratory disease and heart failure.

Referrals - Data from LPT shows that referrals for pulmonary rehabilitation have increased from 1,522 in 2023-24 to 1,860. Of the referrals to PR within LPT, 424 in 2023-24 were from the acute hospital (hospital discharges and outpatient clinics) which increased to 716 in 2024-25. Data from UHL shows that 1,429 referrals for pulmonary rehabilitation in 2023-24 and 1,444 in 2024-25. Within UHL, 25% of the referrals to pulmonary rehabilitation come directly from primary care with the remaining coming from the specialist hospital service.

Data on pulmonary rehabilitation referral from GP practices was included in the QOF for 2024-25 (but is no longer a QOF measure). Data for 2024-25 shows that 27.7% of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, had a subsequent referral to a pulmonary rehabilitation programme (this data is based on those patients who received the intervention and excludes those patients who have been excluded through Personalised Adjustments). This is above the England average of 19.0%. However, the level of referral rates from GP practices is variable ranging from 0% to 100%.

Both BTS and NICE guidance on pulmonary rehabilitation recommends that 'patients hospitalised for acute exacerbation of COPD (AECOPD) should be offered pulmonary rehabilitation at hospital discharge'. Data provided by UHL shows an increasing level of referral to pulmonary rehabilitation post hospital admission and this has increased from 15% in 2023-24 to 22% in 2024-25 which has been achieved through improved completion of the COPD Care Bundle by the COPD Nursing Team at UHL. This is significantly above the national level of only 4% of people in the NRAP audit were referred to PR from secondary care services following AECOPD.

Uptake - Data from the PR programme provided by University Hospitals of Leicester shows that the proportion of people with COPD referred to pulmonary rehabilitation who subsequently enrol on the programme has increased from 53% in 2023-24 to 65% in 2024-25.

The table below provides data on assessment, enrolment and completion of the UHL programme by all respiratory patients referred to pulmonary rehabilitation (this includes patients with COPD and other respiratory conditions).

% of patients referred to the UHL PR Programme (All Respiratory Patients)		
	2023-24	2024-25
Completed Assessment	**85%**	**83%**
Enrolment post assessment	**85%**	**78%**
Completion post enrolment	**57%**	**56%**

The table below provides data from LPT on the Breathlessness Programme on the proportion of people referred who had assessments completed and enrolled and completed the programme. The proportion who have completed assessments has increased between 2023-24 and 2024-25, whilst both enrolment and completion has slightly decreased. This data is for the overall Breathlessness Programme and not just for people with COPD attending the programme. (Data includes patients with a chronic respiratory disease, a diagnosis of heart failure and/or diagnosis of long COVID).

% of patients referred to the LPT Breathlessness Programme (All Respiratory Patients)		
	2023-24	2024-25
Completed Assessment	**61%**	**68%**
Enrolment post assessment	**76%**	**74%**
Completion post enrolment	**66%**	**60%**

Waiting times - The NRAP healthcare quality improvement goal is for 70% of patients to start a PR programme within 90 days of referral, and 70% of patients with acute exacerbation of COPD (AECOPD) to start within 30 days of referral by May 2026. The table below shows that the percentage of patients who started pulmonary rehabilitation within 90 days of referral within LLR has significantly improved between 2024-25 and 2025-26 and is now above the England average.

% starting Pulmonary Rehabilitation within 90 days of referral for patients with Stable COPD		
	2023-24	2024-25
Leicestershire Partnership Trust	**35.7%**	**84.9%**
University Hospitals Leicester	**32.5%**	**82.0%**
England	**63.8%**	**71.0%**

The current average waiting time is 8 weeks to access the PR rolling programme within LPT and is currently 4 weeks for the PR programmes within UHL. The average waiting times for PR provided by LPT have reduced from 24 weeks in 2023-24, to 16 weeks in 2024-25 and to 8 weeks in 2025-26. The average waiting times for PR provided by UHL have reduced from 16 weeks in 2023-24 to 12 weeks in 2024-25 and to 4 weeks in 2025-26.

Completion - The completion rate for pulmonary rehabilitation for people with COPD provided by UHL and LPT are shown in the table below for 2023-24 and 2024-25 (this is the percentage of people enrolled on the programme who completed it which is defined as patients who completed 8 or more sessions out of 12). The completion rates for pulmonary rehabilitation in LLR are lower than the national average of 69% achieved in 2023-24. (Data Source - NRAP report "Catching our breath" published in 2025).

% who completed Pulmonary Rehabilitation		
	2023-24	**2024-25**
Leicestershire Partnership Trust	**Not available**	**63%**
University Hospitals Leicester	**57%**	**56%**
England	**63.8%**	**71.0%**

Pulmonary rehabilitation and deprivation. Work undertaken by UHL to address health inequalities included an analysis of data relating to those who declined or dropped out of pulmonary rehabilitation and compared this to areas of deprivation. This found that:

- More deprived groups are more likely to decline the offer of pulmonary rehabilitation, to not attend the assessment appointment and to not start the programme.
- More deprived groups are less likely to complete Pulmonary Rehabilitation due to higher DNA rates and higher did not start.
- However, more deprived groups are less likely to drop out of Pulmonary Rehabilitation once they commence the programme.
- More deprived groups see lower levels of improvement in exercise capacity.

The results of this analysis were used by UHL to develop an action plan to tackle lower uptake and completion of the pulmonary rehabilitation programme. This analysis suggests that lowering of DNA rates and supporting patients to start rehabilitation from the most deprived areas are key areas to focus on to improve completion of Pulmonary Rehabilitation for people in deprived groups.

Structured Education Programme - Outside of pulmonary rehabilitation, there is no commissioned structured education or self-management programme for people with COPD either nationally or locally.

What is working well?

- Good level of provision of PR compared to other ICBs.
- Wide choice of PR formats.
- Increasing post-admission referral rates to pulmonary rehabilitation from secondary care.
- Improving uptake and reduced waiting times to commence pulmonary rehabilitation.

Key challenges and opportunities for improvement

- Variable levels of referral from primary care to pulmonary rehabilitation.
- Stakeholder interviews identified a lack of awareness and advocacy for pulmonary rehabilitation amongst staff in primary care. However, rather than expect all staff to know about pulmonary rehabilitation we should reframe how patients enter the pathway by changing how we proactively find and invite people into the service.
- There is some duplication of referrals between UHL and LPT but the services are working together to address this. There is the opportunity to consider how better integration of the two services could avoid differences in waiting times and reduce duplication and improve value for money.
- Completion rates are below national average.
- There are cultural and practical barriers for some populations in accessing pulmonary rehabilitation e.g. South Asian women.
- There is no nationally or locally commissioned structured education programme for people with COPD. Patients who uptake pulmonary rehabilitation will have access to education as part of the programme but not all patients are offered or uptake pulmonary rehabilitation.

Specific recommendations for Pulmonary Rehabilitation

- Implement measures to increase referral rates from low referring practices including in reach from PR services to general practice to "pull" in patients. This would also help with knowledge mobilisation about pulmonary rehabilitation within primary care.
- Provision of a standardised education programme at point of diagnosis.
- Support continued participation by providers in the National Respiratory Audit Programme and accreditation of PR programmes.
- Ensure that if demand for PR is driven up, that sufficient PR capacity is commissioned to meet the additional demand.

4.0 Community Respiratory Service

Current position

LLR benefits from well- resourced Community Respiratory Service. LPT provide a range of respiratory services in the community which supports the management of people with COPD in the community including:

- Enhanced Respiratory clinics in community locations providing specialist nurse/physio input for patients with COPD.
- Respiratory Assessment Service (ERAS) which supports admission avoidance and supported discharge for patients who have an exacerbation of COPD.
- Frequent Attenders Pathway which supports admission avoidance for patients who frequently attend hospital for exacerbations of COPD.
- A monthly MDT to discuss high risk COPD patients with UHL specialist teams including: UHL nurses, LPT nurses, consultants, mental health, county and city care coordinators/ social prescribers.
- The service did provide the Virtual Ward for high risk COPD patients providing step down and earlier supported discharge from hospital but also included step-up of patients to avoid hospital admission following referral from community respiratory nurses, GP or ambulance. However, following a recent review of the service by the ICB this service was decommissioned as it was not able to demonstrate that patients on the virtual ward were of high enough acuity and there was not an impact upon length of stay.

Staffing resource:

The staffing within Community Respiratory Specialist Service is as follows:

- 1.0 WTE Band 7 Team Lead (no caseload)
- 1.0 WTE Band 7 Clinical Team Lead (0.5 WTE caseload)
- 9.0 WTE Band 7 Respiratory Nurse Specialists
- 2.4 WTE Band 6 Respiratory Nurse Specialists
- 2.58 WTE Band 3 Health Care Assistants.

Activity data:

Activity data is provided below for the Community Respiratory Service:

- Clinical contacts - CHS Respiratory Specialist Service excluding Virtual Wards - 8,316 in 2024-25.
- Enhanced Respiratory Assessment Service (ERAS) - 533 COPD referrals in 2024-25.
- Frequent Attenders Pathway - 151 referrals from June 2024.

What is working well?

- Hospital and community integration through weekly MDT.

Key challenges and opportunities for improvement

- Limited systematic pull-through from primary care based on risk.
- Lack of clear outcome measures by which community respiratory services are commissioned.

5.0 UHL COPD Services – Elective Pathway

The hospital COPD specialist service provides specialist outpatient and inpatient services including general respiratory and Complex COPD clinics. Activity has increased steadily over recent years, reflecting rising demand. DNAs and cancellations have reduced, and integration between hospital and community teams is improving through shared MDTs.

Staffing resource:

The COPD specialist nurses provide support for patients being discharged from hospital following an acute exacerbation of COPD and the delivery of the discharge bundle as well as providing input to the COPD outpatient clinics and pulmonary rehabilitation provision.

The Respiratory Nurse staffing within UHL is as follows:

- 0.8 WTE Band 7 Clinical Team Lead (0.5 WTE caseload)
- 4.4 WTE Band 6.

The Consultant staffing within UHL is as follows:

- 5 Consultants and
- 1 Integrated Care Consultant.

Delivery to the COPD OutPatient clinic is 4 PAs weekly for direct clinical care. The Consultants also contribute to a once weekly COPD MDT with academic and clinical trainees as extra alongside COPD Specialist Nurses and the LPT Community Respiratory Team.

OutPatient Activity:

Data on General Respiratory Clinic and Complex COPD Clinic attendances shows that outpatient attendances have increased over the last 3 years:

- General Respiratory Clinic attendances for all respiratory conditions has increased from 3,471 in 2022-23 to 3,916 in 2023-24 and 4,460 in 2024-25.
- Complex COPD Clinic attendances has increased from 1,036 in 2022-23 to 1,355 in 2023-24 and 1,397 in 2024-25.

In addition, the proportion of DNAs and 'On The Day Cancellations' for General Respiratory Clinics have reduced from 17.5% in 2022-23 to 13.2% in 2024-25 and for the Complex COPD clinic from 30.7% in 2022-23 to 18.5% in 2024-25.

Access to Advanced Therapies:

The hospital specialist service provides the range of NICE approved and evidence based specialist COPD therapies (including specialist led prescribing (e.g. Roflumilast, Azithromycin), identification for patients suitable for surgical procedures (Lung Volume Reduction) and home ventilation for respiratory failure.

Lung Volume Reduction Surgery - 70 procedures per year across South East Midlands with a higher case load of assessment and MDT discussion as a proportion are unsuitable for LVR.

Long Term Oxygen Therapy (LTOT) – the number of patients on LTOT has decreased from 363 in October 2020 to 295 in August 2025. This is despite an increase in COPD population over this period.

Biologic Treatment - On 26th March, NICE published a positive NICE Technology Appraisal (TA) for the first biologic for the treatment of patients with moderate to severe COPD. (Reference - Dupilumab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils [ID6235]. NICE. 26 March 2026). Other biologics are expected to be considered by NICE in 2026.

As part of the review of the COPD Pathway meetings were undertaken with clinical stakeholders to review and identify the service delivery requirements to introduce appropriate advanced therapies for people with COPD. The outcome of this is presented in Appendix 5

What is working well?

- Growing outpatient capacity with improving attendance rates.
- Strong hospital and community service integration.
- Access to specialist therapies and advanced interventions through the Complex COPD clinic and COPD MDT.

Key challenges and opportunities for improvement

- Limited systematic pull-through from primary care based on risk.
- Lack of clear outcome measures by which hospital COPD services are commissioned.
- Opportunity to target biologic treatments to the COPD population with the highest risk of hospital admission to reduce exacerbations and A&E attendances and hospital admissions. There is a need to develop the COPD biologic service at UHL which requires additional staff to implement the service.

6.0 UHL COPD Services – Non-Elective Pathway

Current position:

The non-elective care pathway for people with COPD and other respiratory conditions is focussed on Glenfield Hospital with only those patients with high frailty score being admitted to Leicester Royal Infirmary.

COPD Care in Hospital:

Glenfield Hospital were in top quartile of performance on KPIs for hospital COPD care within the National Respiratory Audit Programme with Leicestershire Royal Infirmary in the bottom quartile. *(Data Source: NRAP COPD Benchmark)* The lower performance at Leicestershire Royal Infirmary is due to the Respiratory Specialty Service and Team being focused on Glenfield with no in reach to Leicester Royal. There are also more frailty patients in Leicester Royal Infirmary due to a cut off clinical frailty score of 7 at Glenfield.

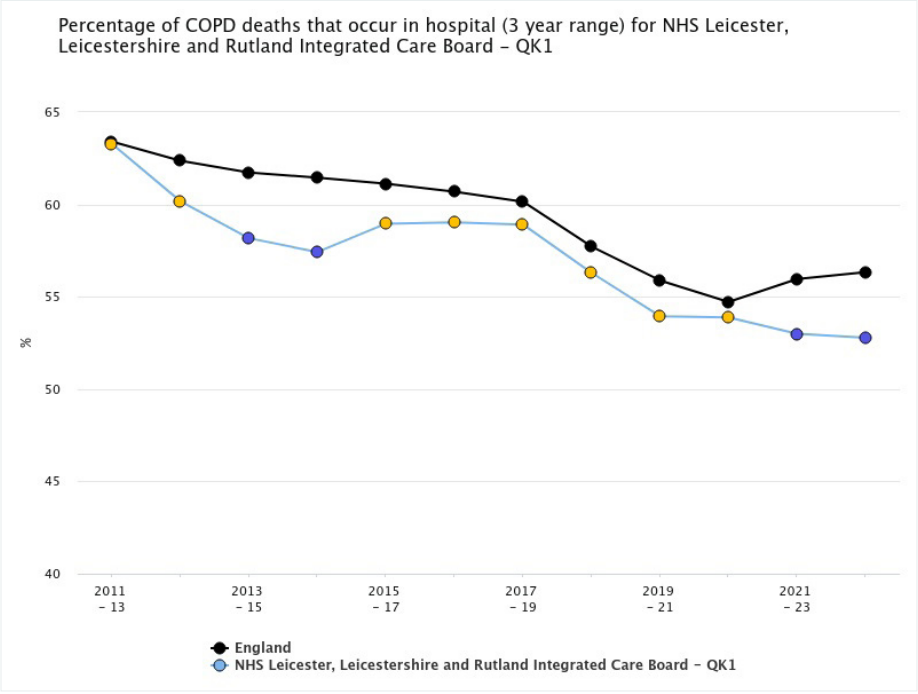
Organization	Cases	KPI 1: NIV within 2 hours %	KPI 2: Oxygen target saturation %	KPI 3: Spirometry available %	KPI 4: Smoking therapy %	KPI 5: 24 hour respiratory review %	KPI 6: Discharge bundle %
> University Hospitals of Leicester NHS Trust	1,622	27.8	100	66.3	59.8	71.1	55.8
Glenfield Hospital	1,277	27.8	100	77.5	69.2	90.1	69.7
Leicester Royal Infirmary	345	0	100	24.9	1.3	0.9	0.6
All audit data	**70,526**	**21.2**	**98.1**	**52.9**	**63**	**63.5**	**33.9**

Follow-Up after Hospital Discharge:

Data from UHL shows a high proportion of patients with a confirmed diagnosis of COPD are receiving follow-up from after hospital admission with 90% in 2023-24 and 97% in 2024-25. The UHL COPD Nurse team provide the follow up post discharge usually. However, this will change in 2026 with some of the follow up calls being completed by the community respiratory team.

In-Hospital mortality:

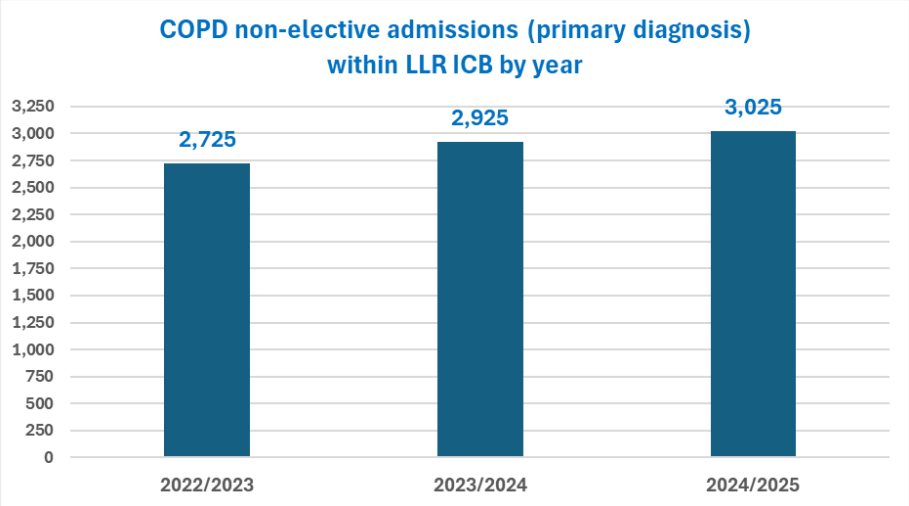
The chart below shows that the percentage of COPD deaths in LLR ICB that occur in hospital (3 year range) is below the England average. The steering group considered that hospital mortality will be affected by the quality of hospital care together with acuity thresholds for admission. The latter can reflect the capability of primary care to deliver proactive care for COPD and manage lower acuity exacerbations in out of hospital settings.



(Source: OHID, based on Office for National Statistics data. Accessed through Fingertips \| Department of Health and Social Care 20 April 2026)

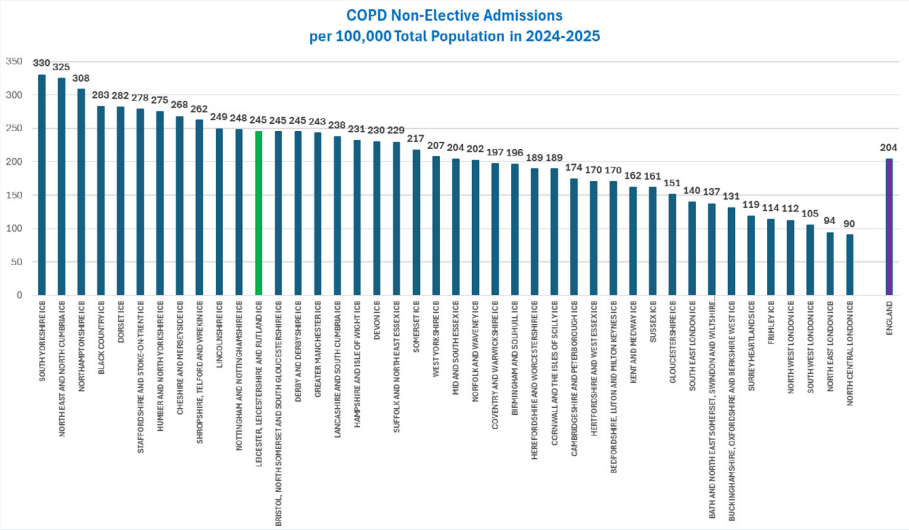
COPD non-elective hospital admissions:

COPD non-elective admissions (primary diagnosis) have increased by 11% in LLR ICB over the past 2 years from 2,725 in 2022-23 to 3,025 in 2024-25. *(Data Source: Hospital Episodes Statistics (HES) database produced by NHS Digital and sourced from CorEvitas' Vantage Tool)*

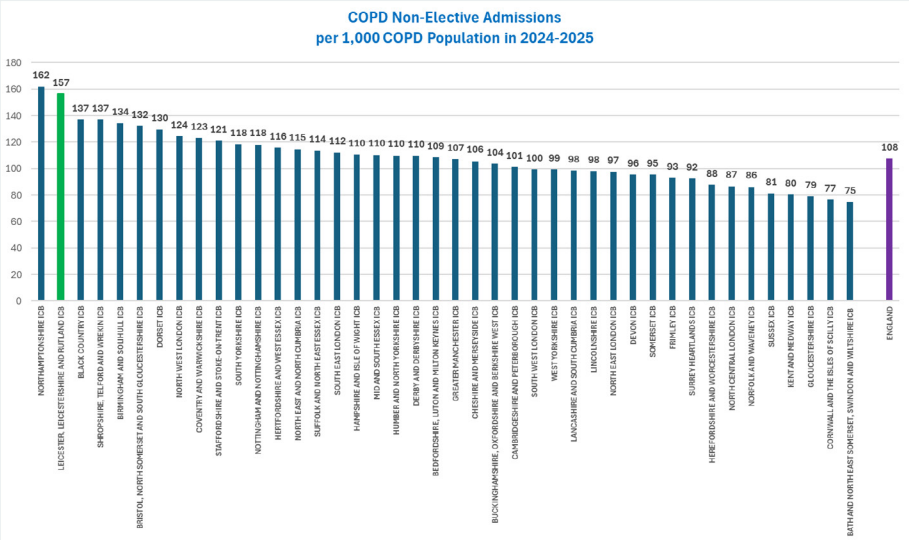


The cost of COPD non-elective admissions at HRG tariff cost in 2024-25 was **£7,676,521**. (*Data Source: HES data 2024-25 at NHS Tariff price)*

LLR ICB had a COPD non-elective admission rate (primary diagnosis) in 2024-25 of **245 per 100,000 Total Population** compared to an England average of 204 which was 12th highest of the 42 ICBs.



LLR had a COPD non-elective admission rate (primary diagnosis) in 2024-25 of **157 per 1,000 COPD Population** compared to an England average of 108 with LLR ICB which was the 2nd highest admission rate across the 42 ICBs. This suggests that in those diagnosed with COPD there is a higher admission rate.



The majority of COPD non-elective admissions in 2024-25 were to hospitals within the ICB geography and is broken down as follows:

- Glenfield Hospital: 73.9%
- Leicester Royal Infirmary: 17.3%
- Other hospitals outside LLR: 8.8%.

The split in COPD admissions between Glenfield Hospital and Leicester Royal reflects the concentration of specialist respiratory services and the admission intake at Glenfield Hospital with only COPD patients with a high frailty index being admitted to Leicester Royal Infirmary.

Bed Days and Length of Stay:

COPD admissions in 2024-25 accounted for a total of **17,146 bed days** and an **average length of stay of 5.66 days** across all hospitals which is above the England average of 5.49 days. The average length of stay in 2024-25 was 4.61 days at Glenfield Hospital and 7.64 days at Leicester Royal Infirmary. This reflects the frailer population with a greater level of co-morbidities admitted to Leicester Royal necessitating a longer length of stay.

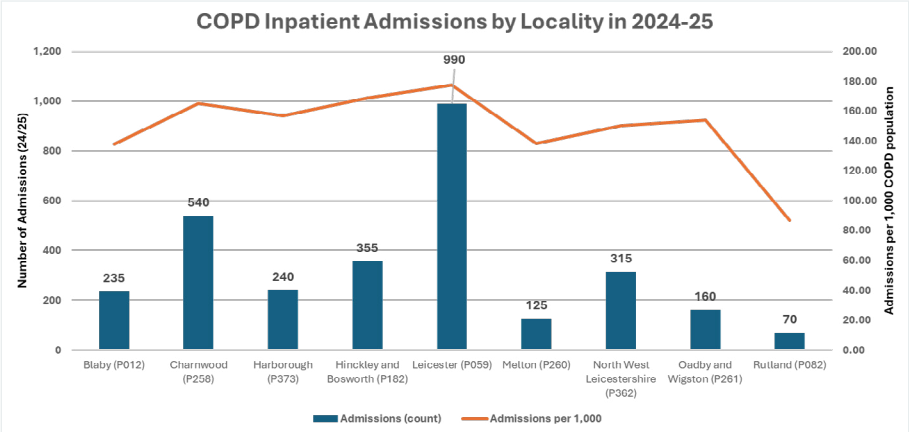
Analysis of COPD admissions by length of stay over the 3 years (2023-23, 2023-24 & 2024-25) at Glenfield Hospital shows that:

- Zero day admissions are increasing annually.
- One day admissions remain the same.
- Admissions with a 2–6 days LOS have increased annually, and the increase was most significant in COPD admissions lasting 6 days or more.

There was no significant change in admissions in zero and one day COPD admissions at Leicester Royal Infirmary over the 3 year period (2023-23, 2023-24 & 2024-25).

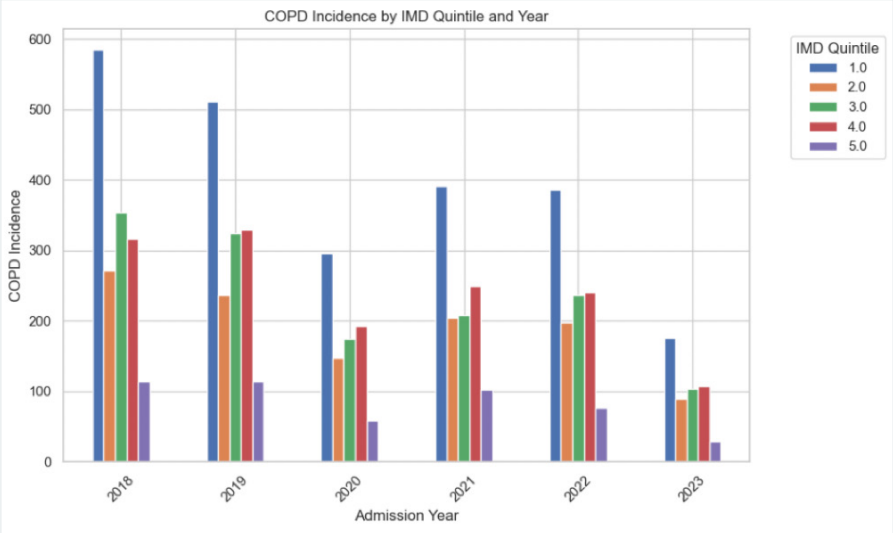
Admissions by Locality:

The chart below shows that the greatest number of COPD admissions and the highest COPD admission rate per 1,000 COPD population in 2024-25 are in the Leicester and Charnwood localities. *(Source: HES and QOF data)*

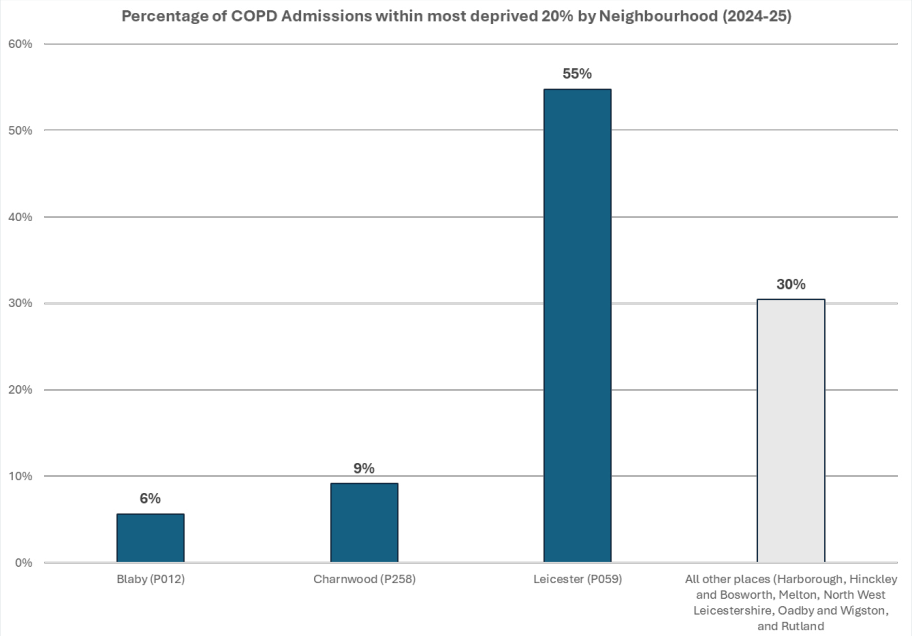


Admissions by deprivation:

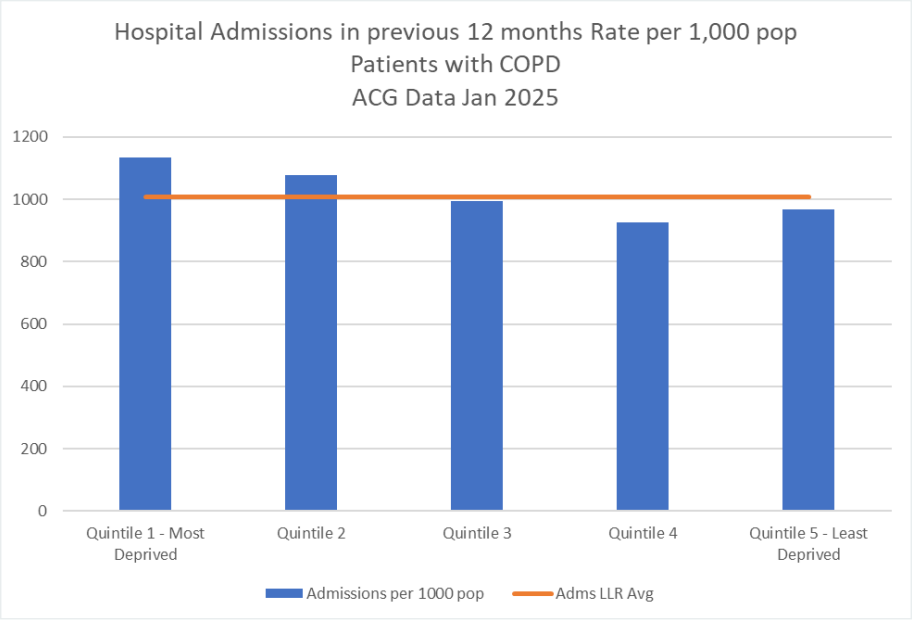
An analysis of COPD admissions between 2016 to 2023 by deprivation using the UHL COPD Health Inequalities Minimum Dataset showed that admissions disproportionately affect people from the most deprived populations. The analysis showed that the majority of COPD incident admissions (first admission in a year) are from people within the highest deprivation quintile.



Further analysis of COPD admissions found that the majority of COPD admissions for people from the most deprived population were within the following neighbourhoods - 55% Leicester, 9% Charnwood and 6% Blaby with all other neighbourhoods accounting for the remaining 30%. This analysis of COPD admissions also showed that people from the most deprived quintile are also admitted to hospital with COPD at a younger age.



An analysis of COPD non-elective admissions undertaken in January 2025 using the ACG Tool shows an admission rate of 1,008 admissions per COPD 1,000 COPD population in the previous 12 months. The highest admission rate is in the most deprived population with a rate of 1,135 per 1,000. There is a deprivation gradient, with rates decreasing in each quintile of deprivation between quintile 1 and 4. However rates in quintile 5 show an increase when compared with quintile 4.



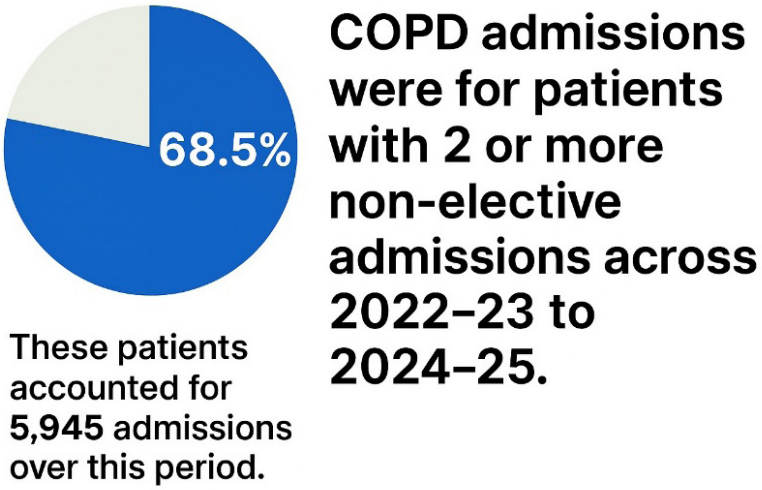
Admissions by ethnicity:

The majority of COPD admissions are from White population followed by Asian/Asian British. However, the White population has a COPD admission rate seven times higher than the Asian/Asian British population. In the 2021 Census the proportion of people who identified their ethnic group within the "Asian, Asian British or Asian Welsh" category was 43.4% in Leicester City, 20.2% in Leicestershire County and 1.5% in Rutland. The proportion who people who identified their ethnic group within the "White" category was 94.8% in Rutland, 71.6% in Leicestershire County and 40.9% in Leicester City.

Readmissions:

In 2024-25, COPD non-elective hospital readmission within 30 days was 13% compared to the England average of 14% and readmission within 90 days was 25% compared to the England average of 24%.

68.5% of the total COPD non-elective hospital admissions in the 3 year period of 2022-23, 2023-24 and 2024-25 were for patients who had 2 or more admissions. This accounted for a total of 5,945 hospital admissions. *(Data Source: Hospital Episodes Statistics (HES) database produced by NHS Digital and sourced from CorEvitas' Vantage Tool)*



Data from Model Health System and Getting it Right First Time Report:

Data on respiratory expenditure from the Model Health System and Getting It Right First Time (GIRFT) has identified opportunities to improve cost effectiveness across respiratory disease in LLR including for COPD. The respiratory expenditure data showed:

- The total indicative secondary care spend for respiratory was £51 million for patients with COPD in the 12 months previous to January 2025. This is for secondary care activity for all causes not just COPD and includes admissions, ED attendances and outpatients. This represents 9% of LLR's indicative secondary healthcare spend.
- COPD patients consume an average of £2,451 per head of secondary care expenditure per year which is five times more than average patients of £472 per patient. Deprivation drives higher costs with the most deprived quintile having the highest secondary care expenditure of £2,631 per head.
- 30-day readmission rate in respiratory overall was 25.0% which is higher than the national benchmark of 20% but below the Peer median of 25.1%.
- Non-elective bed days per 1,000 population for respiratory conditions is among the highest nationally (8th position out of 42 ICBs).
- There is an overall efficiency opportunity of £7.2 million across non-elective admissions, A&E, outpatients and primary care prescribing.

Although the above opportunities are **across respiratory not just COPD**, data from the COPD pathway review has identified that the COPD non-elective admission rate per 100,000 Total population and per 1,000 COPD Population in LLR ICB is above the England average suggesting that there is an opportunity to improve efficiency and reduce costs.

What is working well?

- Strong delivery of COPD care bundle in-hospital.
- High rate of nurse follow-up post hospital discharge.
- Lower than average in-hospital mortality.

Key challenges and opportunities for improvement

- COPD hospital admissions have risen by 11% within LLR ICB in the last 2 years. This compares to a 5.7% increase in total population and 6.7% increase in population diagnosed with COPD in the last 2 years within LLR ICB.
- COPD non-elective admission rates per 100,000 Total Population and per 1,000 COPD population are higher than the England average suggesting room for improvement in upstream care.
- Leicester and Charnwood have the highest COPD admission rates per 1,000 COPD population.
- Hospital admissions for COPD disproportionately affect people from the most deprived populations.
- Bed day utilisation is high and while 30 and 90 day readmission rates are close to national averages, the absolute volume of readmissions creates significant system pressure and cost.
- There is a high proportion of the patients admitted to hospital with COPD (53%) who have had 2 or more hospital admissions within the last 3 years.

Appendix 2

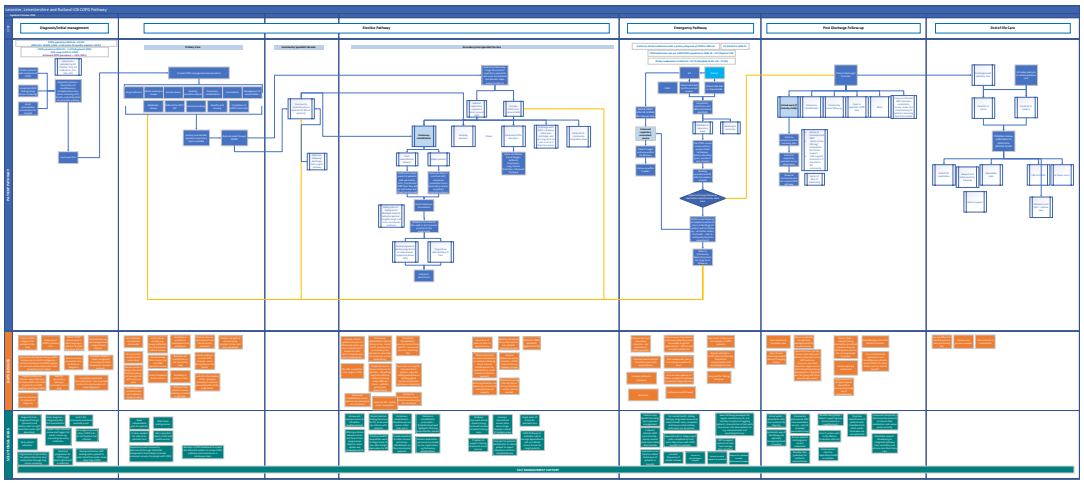
Membership of the COPD Pathway Review Steering Group

Name and Role
Professor Michael Steiner, Deputy Chief Medical Officer, LLR ICB
Dr Louise Ryan, GP & Clinical Lead for Respiratory, LLR ICB
Dr Rahul Patel, Consultant Respiratory Physician, University Hospitals of Leicester
Dr Neil Greening, Associate Professor at the University of Leicester and Honorary Consultant Respiratory Physician at Leicester's Glenfield Hospital
Dr Ire Valero-Sanchez, Integrated Consultant Respiratory Physician, University Hospitals of Leicester
Mark Pierce, Population Health Lead, LLR ICB
Dr Tom Ward, Clinical Lecturer, University of Leicester
Professor Manish Pareek, Development Centre for Population Health
Professor Anna Murphy, Consultant Respiratory Pharmacist, University Hospitals of Leicester
Jade Atkin, Long Term Conditions Lead, LLR ICB
Priyanka Lillie, Long Term Conditions Project Manager, LLR ICB
Kristen Dy, Respiratory Team Lead, Leicestershire Partnerships NHS Trust
Poppy Burrows, Respiratory Service, Respiratory Team Lead, Leicestershire Partnership NHS Trust
Michael Kensington, Respiratory Specialist Physiotherapist & Respiratory Team Clinical Lead, Leicestershire Partnership NHS Trust
Alison Shaw, Cardio-Respiratory Service Lead, Leicestershire Partnerships NHS Trust
Nikki Gardiner, Clinical Nurse Manager for Cardio-respiratory Rehabilitation, COPD Nursing Team and Home Oxygen Service, University Hospitals of Leicester
Lisa Clinch, COPD Specialist Nurse, University Hospitals of Leicester
Emma Chaplin, Clinical Lead Pulmonary & COVID Rehabilitation, University Hospitals of Leicester
Martin Cassidy, Programme Manager – NHS Partnerships, Sanofi
Alison Trundle, Regional Engagement & Access Manager, Sanofi
Georgia Rogers, NHS Engagement & Access Apprentice, Sanofi

Appendix 3

Leicester, Leicestershire & Rutland ICB – Current COPD Pathway Visio Map

Please zoom in to view the Pathway.



Appendix 4

Requirements for COPD Biologics Service

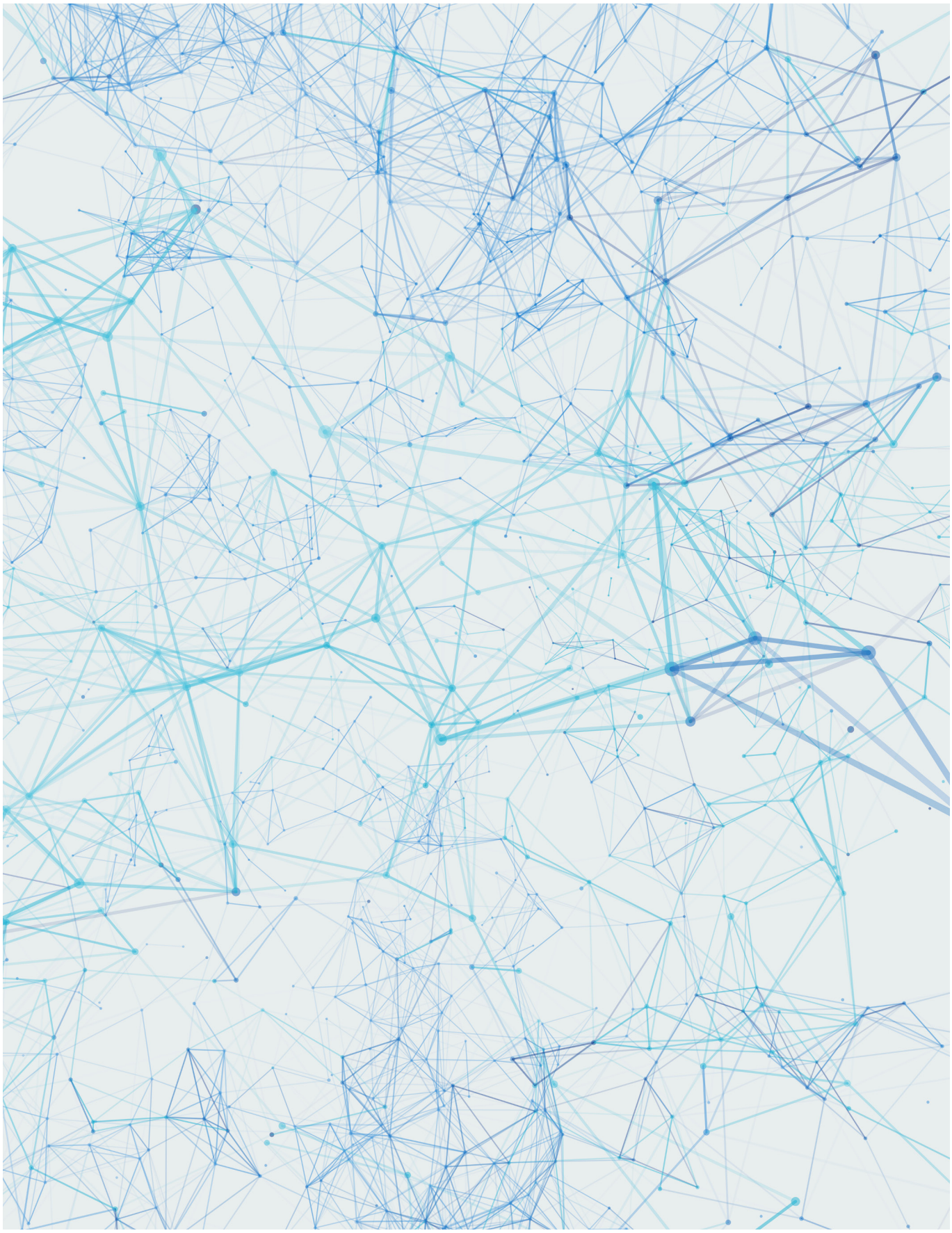
As part of the review of the COPD Pathway meetings were undertaken with clinical stakeholders to review and identify the service delivery requirements to introduce appropriate advanced therapies for people with COPD.

This identified the following requirements:

- In relation to biologics as with other advanced therapies (Lung Volume Reduction, Home NIV) there is a requirement for patients to be seen by a COPD Specialist and MDT discussion.
- Within the current COPD pathway there is a Complex COPD clinic (weekly Mondays 9.00 to 12.30) where patients can be considered for advanced therapies such as biologics. However, there is a need to set up a separate COPD Biologics MDT to discuss patients being considered for a biologic treatment and to decide on appropriateness of treatment.
- It is proposed that the first 1 or 2 doses would be delivered in Hospital by the specialist team at least at the outset. In the long term there is a potential to use homecare for initiation.
- With the planned strategic development of neighbourhood delivery models within the NHS that this could support more local provision of biologics. The opportunity to reduce the number of visits to hospital required for biologic initiation and follow-up. With the national direction of travel with more specialists moving out into the community this has the potential to prevent patients having to attend hospital for every review/decision.
- On-going monitoring and review could be a mix of hospital and community delivery with interim reviews (3 and 6 monthly) undertaken by the neighbourhood teams and the decision to continue a biologic treatment at 12 months being undertaken in the hospital service. In the long term more stable patients could be managed through the neighbourhood/community teams.
- Additional staff are required to implement a COPD biologics service within UHL including additional Nurse Specialist (0.4 WTE, Band 6), Pharmacist (0.5 WTE, Band 8a), Homecare Pharmacy Technician (0.5 WTE, Band 5) and Biologics & Biologics MDT Co-ordinator (1.0 WTE, Band 3).

sanofi

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board



COPD Pathway Review Report produced as an outcome of a collaborative working project between Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and Sanofi.