COPD Commissioning Toolkit

A Resource for Commissioners

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Foreword

The Outcomes Strategy for COPD and Asthma showed the Government's commitment to improving services for people with respiratory disease, and providing high-quality care that is safe, effective and responsive to the needs of individuals.

This was supported by the NHS Companion Document that set out how the NHS can deliver against the Outcomes Strategy, the NICE Quality Standard for COPD, and the NHS Outcomes Framework. The Companion Document set out the key areas for improving the quality of care for people with COPD, including using quality-assured spirometry and assessment, providing pulmonary rehabilitation, carrying out home oxygen assessment and review, and managing exacerbations.

There is strong evidence that these interventions help to reduce mortality, improve quality of life and recovery, improve patient experience and improve patient safety – so are relevant to all give domains of the NHS Outcomes Framework.

We know from the National COPD Audit and other research that the provision, quality and take-up of these services is variable across England.

This COPD Commissioning Toolkit forms another key part of the suite of tools and resources aimed at supporting implementation of the Outcomes Strategy.

This Toolkit offers the NHS in England support to make a step change in the commissioning of these services for people with COPD. This document sets out the case for change, including evidence and research showing how these services can improve outcomes. Also in the Toolkit are clear and evidenced service specifications, supported by two costing tools. These will enable both commissioners and provider organisations to understand what is required, and from whom, and to critically to assess whether what is being provided will lead to high quality outcomes, and meet peoples' needs and expectations. We would urge colleagues in the NHS to use the Toolkit to make a real difference to the lives of people with COPD.

We would like to thank everybody who has been involved in developing the COPD Commissioning Toolkit. In particular, we would like to thank the many commissioners, healthcare professionals and their representative bodies who have given their time and expertise freely and willingly.

Meeting the challenge set out in the Outcomes Strategy for COPD and Asthma will require all those working in the NHS to break down barriers and be true partners in care. Success will require joint planning and working between commissioners and providers, professional groups, patient groups, people with COPD and asthma and their carers. Its success will also depend on clinical leadership and engagement to develop local ownership and a shared sense of purpose.

Professor Sue Hill and Dr Robert Winter
Joint National Clinical Directors for Respiratory Disease

Introduction

The COPD Commissioning Toolkit

The COPD Commissioning Toolkit aims to make it easier to commission better services for people with COPD by bringing together the clinical, financial and commercial aspects of commissioning in one place. Much of the hard work has already been done in developing these best practice specifications and costing tools.

The COPD Commissioning Toolkit supports the delivery of the Outcomes Strategy for COPD and Asthma, and the NHS Companion Document to the Outcomes Strategy. It has been developed in consultation with a large number of commissioners, health and social care experts, patients and their carers. Thanks goes to all those people listed in Annex 1 who helped put this Toolkit together.

The COPD Commissioning Toolkit is being issued as part of the suite of tools and resources to help to implement the Outcomes Strategy and NHS Companion Document. The Commissioning Toolkit is not mandatory but designed to help implement existing guidelines and can be amended according to local needs. The overriding objective is to drive up standards and improve outcomes and the quality COPD services.

What is COPD?

Chronic obstructive pulmonary disease (COPD) describes lung damage that is gradual in onset and that results in progressive airflow limitation. This lung damage, when fully established, is irreversible and, if it is not identified and treated early, leads to disability and eventually death. The principal cause of COPD is smoking. Other factors include workplace exposure, genetic make-up and general environmental pollution.

The main symptoms of COPD are shortness of breath and reduced exercise ability, together with a cough and production of phlegm, which may get worse at certain times of the year. COPD is a progressive illness, and the likelihood of people dying as a result of COPD increases with age. It is not curable, but it is treatable. Its progress can be halted and can be managed to minimise the burden it imposes.

The impact of COPD in England – why do we need to act to improve outcomes?

- COPD causes around 23,000 deaths in England each year – that's one person every 20 minutes. Death rates from diseases of the respiratory system in the UK are higher than both the European average and the European Union (EU) average.

- Three million people in England have COPD, but only just under a million have been diagnosed with the disease.

- 10% of people with COPD are only diagnosed when they present to hospital as an emergency.

- The total annual cost of COPD to the NHS is over £800 million.

- It costs the NHS nearly ten times more to treat severe COPD than mild disease.

- The rate of lung function decline is faster in the earlier stages of the disease which can be modified by treatment.

- COPD is the second most common cause of emergency admission to hospital. Some areas in England see four times as many emergency admissions due to COPD than other areas.

- Around a third of those admitted to hospital as a result of their COPD are readmitted within a month of discharge. Readmission rates vary by up to five times in different parts of the country.

- The annual cost of lost productivity to employers and the economy because of COPD has been put at £3.8 billion. Some 25% of people with COPD are prevented from working due to the disease.

- If the whole NHS were to deliver services in line with the best around 7,500 lives could be saved each year.

The case for change

The national context

The NHS is aspiring to excellence and the best possible outcomes for people in a future which is patient-centred, clinically-led and focussed on the needs of the local population.

The NHS Outcomes Framework

In the new NHS architecture, the NHS Outcomes Framework will be used to provide a national-level overview of how well the NHS is performing, to act as an accountability mechanism between the Secretary of State and the NHS Commissioning Board (NHSCB), and as a catalyst for quality improvement through the NHS.

The NHS Outcomes Framework includes a specific indicator on respiratory disease in Domain One on preventing people from dying prematurely: 'Under 75 mortality rate from respiratory disease'. This indicator is also shared with the Public Health Outcomes Framework, and will help to assess how well public health and NHS services are doing in reducing deaths and improving outcomes in respiratory disease.

Domains Two and Three of the NHS Outcomes Framework, on improving the quality of life for people with long-term conditions, and recovery from episodes of ill health, will also help to assess whether high-quality care and outcomes are being achieved for people with COPD.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

An Outcomes Strategy for COPD and Asthma and the NHS Companion Document

An Outcomes Strategy for COPD and Asthma and the subsequent NHS Companion Document to the Strategy are designed to support the NHS in improving outcomes for people with COPD against the indicators in the NHS Outcomes Framework.

The Outcomes Strategy recognises the need to move away from the largely reactive episodic care based in hospitals to systematic, pro-active and patient centred approach. This should be rooted in the primary care setting but underpinned by a multi-disciplinary approach to the management of COPD. It is recognised that success will require joint planning and working between commissioners and providers, professional groups, the third sector and people with COPD and their carers.

The NHS Companion Document describes what the NHS specifically can do to help meet the objectives in the Outcomes Strategy. The document clearly shows which are the relevant indicators for COPD and for asthma in each domain of the NHS Outcomes Framework, and describes the key interventions and actions that commissioners and providers can take to improve outcomes in that area.

An Outcomes Strategy for COPD and Asthma:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128428.pdf

NHS Companion Document to the Outcomes Strategy for COPD and Asthma: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134001.pdf

NICE Clinical Guideline for COPD

NICE published an updated guideline on the *Management of chronic obstructive pulmonary disease in adults in primary and secondary care* in 2010.

The guideline sets out recommendations for the treatment and care of people with COPD. Among the key priorities for implementation in the 2010 update are those on sppirometry, pulmonary rehabilitation and managing exacerbations.

http://www.nice.org.uk/nicemedia/live/13029/49397/49397.pdf

NICE Quality Standard for COPD

The NICE Quality Standard for COPD provides a set of clear statements describing high quality care, with associated measures, within the scope adopted. There are quality statements in the Quality Standard on providing spirometry, pulmonary rehabilitation, managing exacerbations, and providing home oxygen assessment and review.

http://www.nice.org.uk/media/714/EC/COPDQualityStandard.pdf

The case for spirometry and assessment

Making a diagnosis of COPD relies on clinical judgement, based on history, physical examination and confirmation of the presence of airflow obstruction using quality-assured diagnostic spirometry.

Spirometry is the test that measures exhaled volume and/or flow against time from a maximum intake of breath. It can detect the presence of airflow obstruction in the lung, as well as the degree of reversibility achieved with bronchodilator treatment.

Why is earlier and accurate diagnosis (via quality-assured spirometry) important for improving outcomes?

- 2.1m people are living with undiagnosed COPD – an estimated 70% of the total number of people with COPD.
- Of the undiagnosed population, the majority have mild or moderate disease, but a significant minority have severe COPD.
- Those who are diagnosed are often diagnosed relatively late (in the moderate or severe stages of the disease). Late or under diagnosis has been shown to have a strong association with hospital admission for exacerbations.
- The 10-year survival rate following diagnosis is relatively low (about 50%).

- If people remain undiagnosed until they are severely disabled by the condition, or are admitted to hospital as an emergency, the benefits of treatment to the individual are greatly reduced and the costs to the healthcare system greatly increased.

- Over 25% of people with a diagnostic label of COPD have been wrongly diagnosed, usually because of poorly-performed spirometry.

- There is strong evidence that many people with COPD consult their GP repeatedly with respiratory symptoms before COPD is diagnosed. In a recent study, over half had been to their GP with symptoms on two or more occasions in the two years prior to diagnosis, and of these around a third had received multiple prescriptions for oral steroids and/or antibiotics. These patients had also recorded more inpatient hospitalisations over the four years prior to diagnosis.

The case for pulmonary rehabilitation

Pulmonary rehabilitation programmes are multi-component, multi-disciplinary interventions, which are tailored to the individual patient's needs. They should incorporate physical training, disease education, and nutritional, psychological and behavioural interventions.

Why is pulmonary rehabilitation important for improving outcomes?

- A recent study showed that providing pulmonary rehabilitation after discharge from hospital can reduce readmissions within three months from a third to just 7% of patients.[1] Pulmonary rehabilitation is the only intervention to date shown to impact readmission rates in this way.

- Pulmonary rehabilitation has also been shown to improve health-related quality of life in COPD patients after suffering an exacerbation (e.g. dyspnoea, fatigue, and patient control over the disease).[2]

- It is substantially below the NICE threshold for cost effectiveness, at only £2,000-£8,000/QALY.

- It has also been shown to be cost-saving. One recent study showed an overall cost saving of £152 per patient per pulmonary rehabilitation programme.[3]

The case for managing exacerbations

Even when a diagnosis is made, and if proactive care measures are in place, it is inevitable that a proportion of people with COPD will experience episodes of acute exacerbations. COPD exacerbations are associated with worse quality of life, faster disease progression and increased mortality. Some people with COPD are prone to frequent exacerbations, defined as requiring two or more courses of antibiotics and/or corticosteroids in a 12-month period.

Why is managing exacerbations important for improving outcomes?

- Prompt treatment at the onset of exacerbation symptoms has been shown to improve outcomes.[iv] It can result in less lung damage, faster recovery and fewer admissions (and subsequent readmissions) to hospital.

- Outcomes have been shown to be improved in hospitals where specialist respiratory physicians are present,[v] however a recent audit showed that only 50% of people admitted with an acute episode of COPD were under a respiratory team at the time of discharge from hospital.[vi]

- There is also evidence that increasing the frequency of consultant ward rounds, for example changing from twice weekly to twice daily, reduces average length of stay by half with no increase in mortality or readmissions.[vii]

- Early discharge schemes or hospital at home can prevent hospital readmissions.[viii]

The case for home oxygen assessment and review

The home oxygen service provides around 85,000 people in England with oxygen therapy within their own homes, of whom around 60% have COPD.

Assessment and review services ensure that when home oxygen is prescribed, it is appropriate to the needs of the patient as established by thorough assessment and regular review.

Why is home oxygen assessment and review important for improving outcomes?

- Long-term oxygen therapy in appropriate individuals can improve survival rates by around 40%.

- At the same time 30% of people on home oxygen therapy currently derive no clinical benefit from it.

- In a recent study, at least 15,000 people nationally were found to have no recorded oxygen usage in a six-month period, at a cost of £13m per annum.

- Conversely, 20% of people with COPD would benefit from home oxygen therapy but do not get it.

- The total annual cost of the service in England is approximately £120m. PCTs that have introduced a review of their oxygen registers, coupled with the introduction of a formal assessment service, have reduced their annual spend by up to 20%. If the scale of savings were replicated across England, it is estimated that they could amount to between £10-20m of savings a year.

Annex 1: People who helped in the development of the Toolkit

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