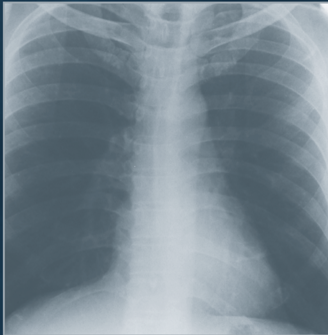
National COPD Audit Programme



COPD: Who cares?

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Resources and organisation of care in acute NHS units in England and Wales 2014

National organisational audit
Executive summary
November 2014

Prepared by:

Royal College of Physicians

British Thoracic Society

In partnership with:

Royal College of General Practitioners

Commissioned by:

Working in wider partnership with:

The Royal College of Physicians
The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. The RCP provides physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing 30,000 fellows and members worldwide, the RCP advises and works with government, patients, allied healthcare professionals and the public to improve health and healthcare.

The Clinical Effectiveness and Evaluation Unit (CEEU) of the RCP runs projects that aim to improve healthcare in line with the best evidence for clinical practice: national comparative clinical audits, the measurement of clinical and patient outcomes, clinical change management and guideline development. All of the RCP's work is carried out in collaboration with relevant specialist societies, patient groups and NHS bodies. The CEEU is self-funding, securing commissions and grants from various organisations including the Department of Health and charities such as the Health Foundation.

The British Thoracic Society
The British Thoracic Society (BTS) was formed in 1982 by the amalgamation of the British Thoracic and Tuberculosis Association and the Thoracic Society, but their roots go back as far as the 1920s. The BTS is a registered charity and a company limited by guarantee. The Society's statutory objectives are: 'the relief of sickness and the preservation and protection of public health by promoting the best standards of care for patients with respiratory and associated disorders, advancing knowledge about their causes, prevention and treatment and promoting the prevention of respiratory disorders'. Members include doctors, nurses, respiratory physiotherapists, scientists and other professionals with an interest in respiratory disease. In September 2014, the BTS had 2,950 members. All members join because they share an interest in the BTS's main charitable objective, which is to improve the care of people with respiratory disorders.

Healthcare Quality Improvement Partnership (HQIP)
The National COPD Audit Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme (NCA). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP holds the contract to manage and develop the NCA Programme, comprising more than 30 clinical audits that cover care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual audits, also funded by the Health Department of the Scottish Government, DHSSPS Northern Ireland and the Channel Islands.

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Foreword

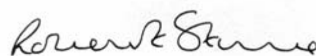
National audits of chronic obstructive pulmonary disease (COPD) have been undertaken in 1997, 2003 and 2008, and now in 2014. The first three rounds revealed individual areas of excellence and good practice, but also notable variations in the organisation and delivery of COPD services when assessed against published standards. These variations led to the National COPD Resources and Outcomes Project (NCROP), which paired high-performing units with those achieving less well, to share learning and managerial skills in the hope that this would drive change. The variations were also one of the drivers behind the development of the National Outcomes Strategy for COPD and the NICE quality standards for COPD care.

The seismic period between 2008 and 2014 has seen publication of the National Outcomes Strategy for COPD, further NICE guidance for COPD, significant organisational change within the NHS and the launch of a new NHS plan. There has been a major drive to improve the management of medical admissions, with most acute hospitals having invested heavily in the appointment of acute physicians to bolster their admissions processes. Within the changing NHS environment, there continues to be an inexorable rise in medical admissions, including many frail and elderly patients, for whom we have the challenge of delivering evidence-based, cost-effective, patient-centred care alongside an ever-sharpening focus on budgets.

Against this backdrop, and in the knowledge that COPD has continued to form a major part of the admission workload for acute trusts, the Healthcare Quality Improvement Partnership (HQIP) commissioned the 2014 COPD audit as part of its ongoing programme of national audits. This is a hugely important development for respiratory care, and it is essential that organisations do not see the audit merely as a data collection exercise but that they instead take the findings and embed them within their improvement programmes to drive up quality.

It is a testament to the dedication and professionalism of respiratory teams across England and Wales that recruitment and participation in this audit have been so comprehensive. Asking units to undertake a major organisational survey alongside an audit of all cases of acute COPD exacerbation admitted over the busiest 3 months of the year was always going to prove challenging, and we pay tribute to colleagues across the professional spectrum who have provided data that, for the first time, will be publicly available and comparable.

We are conscious that this report presents some tough messages, but we ask you to consider two questions as you study it: firstly, is it acceptable in the 21st century that patient experience should be so variable, and that some units do not provide evidence-based care? Secondly, is it time for chief executives and clinical leads to ask: ‘Does my unit provide the level of organisation and resources for COPD patients that I would be proud of if that patient were me, my friend or a member of my family?’



Professor Mike Roberts, National COPD Audit Programme Clinical Lead

Dr Robert Stone, Secondary Care Audit Workstream Clinical Lead

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Executive summary

This report presents results from the National Chronic Obstructive Pulmonary Disease (COPD) Secondary Care Audit 2014: Resources and organisation of care in acute units in England and Wales. The National COPD Audit Programme, of which this organisational audit forms a part, aims to provide a comprehensive view of COPD patient care and services across the patient pathway in England and Wales. A further report, due to be published in February 2015, will detail the results of the National Secondary Care COPD Clinical Audit 2014.

Summary of recommendations

These recommendations are directed with equal weight towards commissioners and providers, as they are relevant to both good clinical practice and the commissioning of COPD services. We suggest that they are discussed carefully at trust/CCG board level and within local respiratory programme groups.

- Patients admitted with COPD exacerbation should receive a respiratory specialist opinion within 24 hours.
- Patients with COPD exacerbation who need onward hospital care after their stay on the medical admissions unit should be managed in a respiratory ward.
- All patients requiring non-invasive ventilation (NIV) should have access to level 2 care.
- Respiratory wards should be staffed to run at least one of the level 2 beds, the number being dependent upon demand and size of the hospital, in which NIV can be administered according to accepted clinical guidelines.
- Intensive care unit (ICU) outreach services should be available 24 hours, 7 days a week.
- All hospitals/units should have a fully-funded and resourced smoking cessation programme delivered by dedicated smoking cessation practitioners.
- All hospitals/units should make spirometry results accessible from every computer desktop; there should be a data sharing agreement between primary and secondary care that allows general practice spirometry data to be made universally available.
- Post-discharge pulmonary rehabilitation services should be available within 4 weeks of referral.
- Each unit should nominate a respiratory clinical lead for discharge care and integrating services, this individual having designated time to improve the uptake of discharge bundles, improve the quality of discharge information and work collaboratively with colleagues in primary care to improve integrated pathways for COPD.
- Acute and community providers, primary care, patient groups and commissioners should work collaboratively via local respiratory programme groups to improve coordinated care and formalise COPD pathways; respiratory specialists should take a lead in this process, forming such groups if they do not exist at present.

Chronic obstructive pulmonary disease (COPD) is common, usually progressive and is a leading cause of mortality and morbidity globally. The World Health Organization (WHO) (1) estimates that COPD is responsible for 5% of annual deaths. Whilst 835,000 people in the UK have been diagnosed with the disease, it is estimated a further 2 million may be unidentified (2). COPD kills about 25,000 people per annum in England and Wales, is the fifth biggest killer in the UK and the only major cause of death on the increase (2, 3). It is a common cause of hospital admission and a major burden on primary care services. COPD causes progressive breathlessness with cough and wheeze, punctuated by exacerbations (flare-ups) that may lead to hospital admission. It associates with increasing frailty and a number of comorbidities.

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In 2014, after 17 years of national audit, it is clear the organisation of care and the resources allocated to people with COPD still varies unacceptably across the NHS hospitals of England and Wales. Two patients who have the same condition and an equivalent level of severity and comorbidities may receive totally different standards of care, dependent upon the organisation and resources available within the hospitals to which they are admitted. In one hospital they will be seen early by a respiratory specialist, be admitted under a specialist team and discharged into an integrated COPD pathway within the community. In another they will be admitted, managed and discharged without ever benefitting from such care.

The key finding from this audit is that whilst some specialty resources available for better COPD care have improved since the 2008 round, many patients are still unable to access them; either the model of hospital care does not provide for specialty input to COPD patients or it is unavailable 7 days a week.

There have however been some notable improvements in resource that do have the potential to affect patient care in a positive way: there has been an increase in respiratory consultant numbers, there is better availability of palliative care, there are more supported discharge services and the organisation of NIV has improved. Pockets of excellence continue but there remains unacceptable variation in the organisation and delivery of COPD services when assessed against key standards. Significantly, this variation occurs on a backdrop of a 22% rise in median emergency medical admissions since 2008, with COPD admissions having risen by 13%. Although the number of respiratory consultants has increased from a median of three to four per unit, reflecting the drive to consultant-delivered care, access to key members of the wider multidisciplinary (MDT) team, notably respiratory specialist nurses, has declined. Access to specialist respiratory review is markedly reduced on non-respiratory wards and there is a major gap in service delivery out of hours and at weekends. The availability of smoking cessation services (a key treatment for COPD), access to spirometry results and post-discharge pulmonary rehabilitation is inadequate.

Our recommendations for service change are intended to improve care for COPD patients across each of the NHS domains. We believe they will help to reduce respiratory deaths and also benefit the wider delivery of respiratory and integrated services. The over-riding message, above all else, is that COPD patients admitted with exacerbation should be cared for by an MDT of respiratory specialists on a respiratory ward; the service should be organised and resourced to provide that care 7 days a week. The respiratory ward should be staffed to run at least one level 2 bed where NIV can be administered. Hospitals that are unable to provide NIV, or undertake it to a satisfactory standard, should not be admitting patients with acute exacerbation of COPD.

We also propose that greater emphasis be given to improving processes for managing COPD around discharge and beyond; respiratory specialists should take an active role in leading this activity, in helping to develop interface services and advising, via formally agreed structures that link into local clinical commissioning groups (CCGs), on the development or regular updating of care pathways for the disease. We hope this will embed better commissioning of COPD services.

We believe these recommendations, taken as a whole, will lead not only to further improvements in care but also reduce the variation in organisation and resource that has been so evident after each round of national audit to date.

'All patients requiring admission with acute exacerbation of COPD should be cared for by a respiratory specialist in a respiratory ward.'

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For further information on the overall audit programme or any of the workstreams, please see our website or contact the national COPD team directly:

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We also have a quarterly newsletter, so please send us your email address and contact details if you would like to join the mailing list.

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