

Excerpt from the COPD National Strategy - Quality and productivity challenge

33. Alongside the commitment to increase frontline NHS funding in line with inflation, we have also set out the quality and productivity challenge the NHS needs to meet. Demand for services is increasing and there are areas where we could increase the quality, efficiency and value for money of services, as well as improve outcomes for people with the disease. *High Quality Care for All* (the Next Stage Review of the NHS, published in 2008) and the local visions developed by strategic health authorities (SHAs) that accompanied it set an ambitious goal of putting quality at the heart of the NHS by making it its organising principle.
34. As the NHS Chief Executive has set out, we are required to deliver £15–£20 billion in efficiency savings over the three-year period from 2011. We therefore need to use our growth in 2010/11 to put into effect the changes that we know will deliver the most benefits to patients in the future. This will be tough, but it is possible. We need a relentless focus on three things to make this possible: first, improving quality while improving productivity, using innovation and prevention to drive and connect them; second, having local clinicians and managers working together across boundaries to spot the opportunities and manage the change; and third, to act now for the benefit of the long term.
35. The challenge is therefore to ensure that we continue to provide high-quality services during a period in which growth in expenditure on the NHS will be restricted despite increased demand.
36. Many of the measures recommended in the strategy are designed to support the NHS to meet the quality and productivity challenge, either by identifying where resources might be released or by improving understanding of the key interventions that have greatest effect.
37. A phased approach to implementation of the recommendations in the strategy, and ensuring appropriate management of those with moderate and severe COPD, will mean ensuring that those people whose COPD has already been diagnosed have a correct diagnosis, and are managed according to the most cost-effective and evidence-based interventions. More specifically, this will be ensured by taking action to:

- review those people who are on both the COPD and asthma registers;
- review home oxygen registers; and
- work with NHS Improvement, as part of their Lung Programme, to:
 - reduce the number of hospital admissions for COPD;
 - reduce length of stay for people with COPD, where appropriate;
 - develop cost-effective models of chronic disease management by the introduction of regular review, use of care plans and secondary prevention for those with COPD; and
 - reduce admission rates for asthma to at least the current national average.
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38. In future years, implementation will include reviewing all those on the GP-held registers with COPD and asthma, developing wider programmes of prevention and identification to ensure the long-term sustainability of services by stopping people getting COPD, and finding those people who have the milder stage of COPD to stop them progressing in severity.

39. In five years' time, the NHS will need to have more services closer to home. There will need to be much less variation, with defined National Institute for Health and Clinical Excellence (NICE) quality standards and patient pathways. Some of this will require new ways of organising services to deliver care. Convenience for the system too often takes precedence over convenience for people with COPD and asthma. There is still too much variation in the quality and safety of care. Too much care is organised in hospitals, which best practice shows could be better organised in community settings. Care provided by different professionals and organisations also needs to be better integrated around people with COPD and asthma.

40. Because of the magnitude of the burden of asthma we have also included a chapter on the condition within the national strategy for COPD. This chapter highlights where there are synergies in the approach to the diagnosis and care of these two conditions and where there are differences. We will also undertake further work to determine where, out of the estimated £1 billion of expenditure on asthma, further efficiencies could be made.