National COPD Policy Action Plan

An action plan to improve outcomes for people living with COPD in the UK.

JOINT STAKEHOLDER NATIONAL COPD POLICY ACTION PLAN

This action plan was developed in partnership with the Primary Care Respiratory Society, the British Lung Foundation, the Association of Respiratory Nurse Specialists, the Association of Chartered Physiotherapists in Respiratory Care and the National Pharmacy Association, supported by ACT on COPD secretariat, MHP Communications. The ACT on COPD secretariat was initiated and funded by AstraZeneca.

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Foreword

COPD is the fifth most common cause of death in the UK, causing nearly 30,000 deaths every year in England alone.[1]

Despite this disease burden, Chronic Obstructive Pulmonary Disease (COPD) does not receive adequate recognition and prioritisation. Even though national ambitions exist, including those within the NHS Long Term Plan and the Government's Life Sciences Vision, to reduce the number of people who die prematurely from respiratory conditions, the system is not currently fully equipped to meet these ambitions.

Representing a diverse, multi-disciplinary, respiratory community – the Primary Care Respiratory Society, the British Lung Foundation, the Association of Respiratory Nurse Specialists, the Association of Chartered Physiotherapists in Respiratory Care and the National Pharmacy Association – are calling on clinicians and policymakers to take urgent action for policy and system reform to drive improvements in the outcomes of people living with COPD.

We have developed a joint National COPD policy action plan which calls out priority ambitions for policy reform. This plan is based on input gathered from UK based clinicians, policymakers and professional bodies, and also builds upon existing work, for example, the Taskforce for Lung Health's five-year plan for lung health, which outlined recommendations to enable earlier diagnosis through breathlessness pathways and case finding for COPD,[1] and the Primary Care Respiratory Society's critical work to call for greener healthcare through improved patient management,[2] to name a few.

We need to work together as an entire COPD community to reduce morbidity and premature mortality from COPD. As well as outlining our ambitions for reform, this plan includes actions that we can all take to get us there; whether that's through calling for national policy change, playing a part in the prioritisation of initiatives at a system level or changing practice at a grassroot level.

Together, it is time, to act on COPD.

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[1] https://www.blf.org.uk/taskforce/plan/recommendations
[2] https://www.pcrs-uk.org/sites/pcrs-uk.org/files/White-Paper-Greener-Respiratory-Healthcare-20201118.pdf

*The ACT on COPD National Working Group is a group of 20 clinicians and patient advocacy group representatives from across the UK, convened and funded by AstraZeneca.

The unmet need in COPD

Chronic Obstructive Pulmonary Disease (COPD) is the fifth most common cause of death in the UK, causing nearly 30,000 deaths every year in England alone.[1] However if best practice was applied, one quarter of these deaths could be avoided.[2]

Pauline, 73, was diagnosed with COPD at the age of 55

1.2 million people are estimated to have COPD within the UK.[3] However, almost two thirds of the estimated COPD population are thought to be undiagnosed[3] and, for those who are diagnosed, they often only receive a diagnosis after the disease has progressed, leaving them at greater risk of early mortality.

Over 70% of people living with COPD will experience at least one exacerbation (also known as 'flare ups') within three years of diagnosis.[4] A single COPD exacerbation can result in lung damage,[5,6] have a detrimental impact on quality of life,[7] and increase the risk of death.[8]

Furthermore, the damage from exacerbations goes beyond the lungs – even moderate exacerbations can increase the risk of cardiovascular events, such as myocardial infarction or stroke.[9] Despite this, significant clinical inertia exists, leaving many patients under treated and at greater risk of further disease progression. For example, one third of patients (33.3%) are not reviewed by a respiratory team within 24 hours of hospital admission, leaving them more likely to spend longer in hospital and at greater risk of mortality.[10] Similarly, 38% of patients remain under treated post hospital discharge.[11]

Adding to the stark reality of COPD care in the UK, the outcomes for people living with COPD will differ depending on who the patient is and where they live. Respiratory mortality is seven times higher in the most socioeconomically deprived areas in England compared to the least deprived areas.[12]

As a result, COPD places a significant burden on our healthcare systems and society. Within the UK, COPD is the second largest cause of emergency hospital admissions, with the overall burden of COPD costing the NHS £1.9 billion a year.[13,14]

This policy action plan is driven by insight from those working on the ground and from policymakers to capture three ambitions and policy recommendations that we believe will ultimately **drive morbidity and mortality reduction for people living with the condition across the UK**.

Elina, 33, was diagnosed with COPD when she was 26

Our ambition for change

National ambitions, including those contained within the NHS Long Term Plan and the Government's Life Sciences Vision, exist to reduce the number of people who die prematurely from respiratory conditions, however the UK health system is not currently fully equipped to meet these ambitions. Aligning to these ambitions and the expectations set out within the Global COPD Patient Charter,[15] we are calling for the system to commit to activities to drive morbidity and mortality reduction in COPD, focusing on the following three priorities:

1

Accelerate early and accurate diagnosis

Patients with symptoms of COPD are identified and encouraged to present to healthcare services and healthcare professionals have the knowledge to identify symptoms and the tools to provide an accurate assessment for timely diagnosis.

2

Reduce clinical inertia and focus on prevention

Proactive management of patients to prevent and reduce future risk of exacerbations, disease progression, and mortality.

3

Minimise health inequality and variation in care

People living with COPD have equal access to the right care and treatment no matter who they are or where they live.

1 | **Accelerate early and accurate diagnosis –** the need for change

Our ambition

Patients with symptoms of COPD identified and encouraged to present to healthcare services and healthcare professionals have the knowledge to identify symptoms and the tools to help provide an accurate assessment for timely diagnosis.

It is estimated that **2 million people are living with undiagnosed COPD within the UK**.[16]

Many COPD patients remain undiagnosed until the disease has progressed, as a result of lack of presentation to healthcare services and inadequate tools for diagnosis.

Although spirometry guidance exists, the **guidance is often contradictory** resulting in care variation and the risk of patients leaving hospital without a COPD diagnosis.[17,18]

Further efforts are also needed to raise awareness of COPD and identify potential COPD patients via case-finding.

For example, NHS Lung Health Checks only view COPD as an 'incidental finding' and Integrated Care Systems (ICSs) lack clear guidance on how and when to refer to primary care for accurate and timely diagnosis.[19,20]

Our recommendations

NATIONAL

- **NICE Quality Standard adapted** to include clearer guidance on criteria for targeted case finding (e.g. risk factors and history) and when to offer spirometry, including within secondary care (e.g. post exacerbation vs. pre hospital discharge)
- **NHS England (NHSE) to reintroduce spirometry into lung health checks** and to include COPD within target screening population with clear criteria for eligibility. Spirometry must be performed by a suitably qualified clinician and with safe procedures in place post COVID-19
- **NHS health checks** (for patients 55+) **equipped with the guidance and tools to recognise the symptoms of COPD** and diagnose opportunistically or, where appropriate, refer to diagnostic hub for diagnosis
- **NHS England (NHSE) explore incentives to accelerate targeted case finding for COPD** e.g., through funding initiatives such as the Primary Care Network Contract Directed Enhanced Service (PCN DES) to accelerate targeted case finding for COPD amongst patients who present to primary care, with potential to secure new Quality and Outcomes Framework (QOF) incentive

REGIONAL (I.E. INTEGRATED CARE SYSTEMS)

- **Integrated Care Systems to develop a strategy on targeted case finding** amongst patients who present to primary care, including clear criteria for staff outlining specific risk factors and history, and clear steps to address workload challenges (e.g., training and/ or commissioning specific case finding teams)
- **Integrated Care Systems to commission diagnostic hubs**, once established, to act as a referral point for wide range of breathlessness symptoms to improve opportunistic detection of COPD and other respiratory / CVD conditions. These hubs should include spirometry and clinicians qualified to diagnose COPD

GRASSROOT CHANGES TO CLINICAL PRACTICE

- **Healthcare professionals can share available resources** with colleagues and patients on the risk factors and early symptoms of COPD (utilising guidance from member bodies)
- **Practices can encourage multidisciplinary collaboration** to support identification of misdiagnosed COPD patients
- **Practices can introduce system flags for identification of 'at-risk' patients** already presenting to healthcare services
- **Community pharmacists can identify and encourage patients to present to healthcare services**, including lung health checks, and conduct spirometry tests for at-risk patients

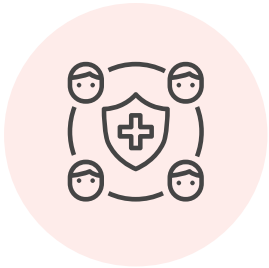
2 | **Reduce clinical inertia and focus on prevention –** the need for change

Our ambition

Proactive management of patients to **prevent and reduce** future risk of exacerbations, disease progression, and mortality.

Despite the burden that COPD places on both patients and society, significant clinical inertia exists. Due to existing treatment guidelines, too often we wait for patients to get worse or exacerbate before we optimise their treatment – this is a failure-based approach.[21]

Even within this, there are additional missed opportunities for treatment optimisation.[22,23] For example, exacerbations of COPD are often under reported, with 40% of patients taking no immediate action when having an exacerbation,[24] and patients are remaining under treated even following hospitalisation[11] leaving them at greater risk of disease progression and readmission.[25,26]



The need to optimally treat patients (both pharmacologically and non-pharmacologically) to reduce the risk of exacerbations and hospitalisation has been recognised in global and local strategies; including GOLD, the NHS Long Term Plan and the NHS system priorities for 2021/22.[18,27,28] However, more needs to be done to ensure the system is set up to enable a proactive, preventative approach for COPD management.

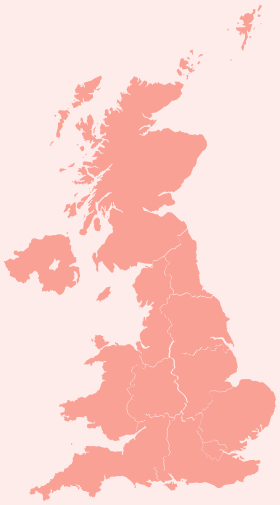
Patients should be reviewed annually as per current recommendations.[29] However this is not being met, with over a fifth (22%) of patients not receiving a review in 2019/20[30] and there is also significant variation in the quality of these reviews. In addition, guidance needs to be extended to ensure these reviews are accelerated, for both patients at increased risk of exacerbations and also following an exacerbation, as an opportunity for treatment optimisation. In particular, more needs to be done post severe, or hospitalised, exacerbations to prevent short- and long-term reoccurrence and readmission. The reason accelerating reviews at this point is so crucial is that these patients are at a significantly increased risk of readmission or even death – approximately 40% of patients with exacerbations are re-admitted or die within 90 days of discharge.[31]

Equally, ambitions to deliver greener healthcare need to be balanced against the role of treatment optimisation and improved patient outcomes in reducing the environmental footprint of care.

Our recommendations

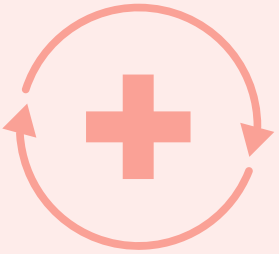
NATIONAL

- **NICE Quality Standard adapted** to include:
  - A focus on conducting a proactive and structured review with clear guidance on who from the multidisciplinary team can conduct each review, minimum set of standards for review and the action to be taken following a review (e.g. initiate treatment review, referral to non-pharmacological services):
    - For patients with an increased risk of exacerbations with clear guidance on the population targeted
    - Urgently following any exacerbation, within one month whether in community or in hospital, and following repeat prescription of antibiotics / oral corticosteroids (OCS)
  - Source guidance on discharge care bundles
- **Updated PCN DES** to include requirements for proactive and structured review for the following populations of COPD patients:
  - For COPD patients with an increased risk of exacerbations with clear guidance on the population targeted (based on National Asthma and COPD Audit Programme – NACAP)
  - Urgently following any COPD exacerbation, within one month, and following repeat prescription of antibiotics / OCS / excess short-acting beta agonists (SABA)
- **Greener policies continue to protect the contribution of shared decision making with patients** (e.g. around inhaler choice) and recognise the role of improved patient outcomes in reducing the environmental footprint of care.



REGIONAL (I.E., INTEGRATED CARE SYSTEMS)

- **Integrated Care System strategy on proactive management of COPD exacerbations**, including on:
  - Identification of patients at risk of exacerbation (utilising digital health solutions where appropriate)
  - Selective criteria for rescue pack use, pulling through advice from member bodies
- **Integrated Care Systems prioritise importance of tackling 90-day readmissions** within their strategies (e.g. incentivising partnerships between primary and secondary care, implementation of national discharge bundle guidance)



GRASSROOT CHANGES TO CLINICAL PRACTICE

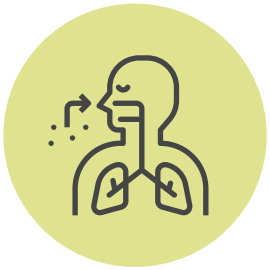
- **Healthcare professionals can share resources** with colleagues and patients on recognising exacerbation risk (utilising guidance from member bodies), and share resources with patients on the importance of reporting exacerbations
- **Healthcare professionals can deliver prompt referral** to non-pharmacological therapy (including treating tobacco dependency and pulmonary rehabilitation) for patients
- **Practices can set-up searches of clinical systems and remove rescue packs as an option for repeat prescription service** following discussion with patients
- **Community pharmacists can identify poor medication adherence and provide tailored support to patients** to support the usage of their medication (including treating tobacco dependency, checking and coaching inhaler technique)

3 | **Minimise health inequality and variation in care –** the need for change

Our ambition

People living with COPD have equal access to the right care and treatment no matter who they are or where they live.

Accelerating diagnosis and reducing clinical inertia will go some way to minimising health inequalities across the UK in COPD, however additional targeted measures are needed to focus activity in areas of the greatest unmet need.



Respiratory conditions, including COPD, are major contributors to widening health inequalities in the UK. For example, respiratory mortality is seven times higher in the most socioeconomically deprived areas in England[12] compared to the least deprived areas and mortality rates for COPD are 4.5 times higher in the areas with the highest number of COPD deaths compared to the lowest (values ranged from 26.8 to 120.8 per 100,000 population).[32]

It is not surprising that tackling health inequalities is a priority by both the UK Government and NHSE&I, and whilst there are planned initiatives such as the "Core20PLUS5" initiative for 2021-22,[33] more needs to be done to ensure COPD is not overlooked as one of the major chronic respiratory conditions driving health inequality across the UK.

Our recommendations

NATIONAL

- **NHSE and DHSC prioritise the improvement of COPD outcomes** (aligned with existing public health outcome framework) in line with existing Long Term Plan, post COVID-19 health inequality and Core20PLUS5 ambitions to target existing and new funding
- **Updated NHS oversight metrics** to include COPD specific metrics to ensure ICSs are prioritising COPD outcomes (aligned with existing public health outcome framework) and allocated targeted support to deliver best practice care

REGIONAL (I.E., INTEGRATED CARE SYSTEMS)

- **Integrated Care Systems identify worst-performing PCNs and Trusts** performing below the national target based on COPD outcomes and support to implement targeted measures at place level to improve COPD outcomes (e.g. aligned with the recommendations made by NHS RightCare and AHSN)

GRASSROOT CHANGES TO CLINICAL PRACTICE

- **Healthcare professionals can consider tailored support** for patients based on potential inequalities, including a mix of telehealth and face-to-face appointments
- **Healthcare professionals can record relevant characteristics in patient records and accelerate access to preventative programmes** for patients who have been identified at greatest risk of poor health outcomes (utilising guidance from member bodies)
- **General practices and community pharmacists can prioritise smoking cessation services**, particularly in areas with high prevalence of smoking and support the usage of medication (including checking and coaching inhaler technique)

Our action plan

With the prioritisation of reducing mortality in respiratory disease as a key mission for the UK Government, this is a clear moment in time to instigate change and put forward detailed measures to achieve this goal.

WE INVITE YOU TO JOIN US TO ACT:

1

Join us in our national efforts to reach national policy stakeholders, such as NHSE&I, NICE, DHSC and the CQC to call for national policy reform contact us by e-mailing

ACTonCOPD@mhpc.com.

2

Schedule meetings within your local Integrated Care System leads to discuss how to implement regional changes.

3

At a grassroot level, work with colleagues within your practice to explore opportunities to implement changes to address this report's three ambitions.

SHARING BEST PRACTICE:

Share best practice on how you have implemented changes to address this report's three ambitions by e-mailing

ACTonCOPD@mhpc.com.

Let us know if your organisation has any feedback on how to implement the plan by e-mailing:
ACTonCOPD@mhpc.com

For more information or resources on COPD practice, please visit:

- https://www.blf.org.uk/
- https://arns.co.uk/
- https://www.acprc.org.uk/
- https://www.npa.co.uk/
- https://www.pcrs-uk.org/
- https://www.astrazeneca.com/

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