Developing effective services for people with COPD

In terms of health care resources, chronic obstructive pulmonary disease (COPD) has long been the poor relation of other respiratory conditions such as asthma and lung cancer. However, over the last 10 years health professionals have recognised the importance of COPD and its cost to society and have been motivated to provide an improved service for patients. The first guidelines for the management of COPD were published by the British Thoracic Society in 1997. The Global Initiative for Chronic Obstructive Lung Disease followed this document with its Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (2001).

There have been major developments in the services and treatment options for patients with COPD. With the increasing health and economic burden of this chronic lung disease, hospital at home schemes have been developed to meet the needs of the patients and also to reduce the need for lengthy hospital stays. Different styles of service provision have emerged and results from randomised control studies of ‘hospital at home’ services have demonstrated their effectiveness with no increase in morbidity, mortality or readmission rate (Colton et al, 2000).

Primary care Primary care initiatives for people with COPD range from nurse-led COPD clinics for diagnosis, assessment and management of the disease, to nurse-led smoking cessation clinics. Smoking cessation remains the most important intervention in modifying the rate of decline in lung function and is cost effective. Primary care trusts also employ respiratory nurse specialists to help GPs to identify patients with COPD as early as possible, and assist with the management, support and education of these patients.

Pulmonary rehabilitation Pulmonary rehabilitation services led by nurses and/or physiotherapists has brought about improvements in functional status and quality of life for COPD patients. This is achieved through increased exercise capacity and a reduction in the sensation of breathlessness.

Observational studies (Foglio et al, 1999; Stewart et al, 2001) have suggested that patients who participate in rehabilitation (as inpatients and outpatients) have a reduced frequency of exacerbations. Unfortunately, there are few centres that provide pulmonary rehabilitation so it is still important to discuss with patients the merits of regular exercise and provide them with leaflets and advice concerning exercise and lifestyle.

Developments in drug therapy Long-acting inhaled beta_2 agonists such as salmeterol and formoterol, which have a duration of action of 12 hours, have been shown to improve symptoms, exercise capacity and health status in patients with COPD. In a large multi-centre study Calverley et al (2003) showed that combination therapies of long-acting inhaled beta_2 agonists and corticosteroids produce better control of symptoms and lung function while reducing the frequency of exacerbations and the use of rescue medication. Tiotropium, a new generation antimuscarinic agent is the latest long-acting once-daily drug and has been shown to have benefits in symptom relief (Casaburi et al, 2002).

Effects of respiratory disease Respiratory nurses develop an understanding of the physical, psychological and social impact COPD has on the patient and his or her carers through the regular contact, monitoring and treatment of patients.

Respiratory nurses working in primary and secondary care use their core nursing skills to address, support and utilise other services such as social workers, physiotherapists, occupational therapists and district nurses. There may be times when additional help can be provided by the palliative care and support team and this is highlighted in the article on p46.

Government policy Respiratory diseases are not on the government’s targets for action. In contrast with coronary heart disease, cancer, older people, mental health and paediatric intensive care, there is no national service framework for respiratory disease. Fortunately, in Bridging the Gap (2003) the Respiratory Alliance warns primary care trusts that concentrating mainly on NHS priorities may distort clinical practice, resulting in ‘disease discrimination’ where patients with ‘non-priority’ diseases lose out. Bridging the Gap is the first comprehensive document that aims to help primary care trusts to commission and deliver quality allergy and respiratory care.

It states that primary care trusts can improve patient care and reduce both emergency hospital admissions and use of health care funding. It offers a comprehensive checklist for health service providers summarising services they should provide to meet reasonable patient expectations.

This important document supports The NHS Plan in that it aims to provide the people of Britain with a health service fit for the 21st century, a health service designed around the patient. It will be interesting to see whether purchasers of health care services take heed.