Guidelines for improving care in respiratory disease in the UK

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More than eight million people in the UK have respiratory conditions and one in four people die from them. We appear to be facing a major paradox with regard to the management of respiratory disease in the UK. Although we have a wide range of diagnostic tests and effective treatments at our disposal, we do not appear to be making any impact on the morbidity and mortality of respiratory disease. Respiratory disease needs to be moved onto the ‘must do’ agenda.

A national service framework is urgently required for respiratory disease. A shocking report published in 2003 by the European Respiratory Society revealed that in the European Union only countries of the former Soviet Union, Kyrgyzstan, Kazakhstan and Turkmenistan, have more deaths than the UK from lung cancer, asthma, pneumonia, and chronic obstructive pulmonary disease (COPD). Deaths from lung disease in the UK are twice the EU average (Box 1). According to the ERS’s European Lung White Book, more people in the UK suffer from asthma than anywhere else in Europe. Up to 13 per cent of people in the UK have the condition.

The impact of respiratory disease

Diseases of the respiratory tract have a major impact on morbidity and mortality (World Health Organization, 2001). In the UK over eight million people have respiratory conditions and one in four people die from them. Respiratory conditions account for more deaths each year than coronary heart disease.

Respiratory disease results in a significant demand on NHS resources. It costs the NHS more than any other disease area. The demand is particularly high on primary care. There are estimated to be 38 million consultations each year in primary care for respiratory disease and almost 18 per cent of all GP emergency consultations are for respiratory disease (Office for National Statistics, 2000). A staggering 31 per cent of all people and two thirds of children under five years old visit their GP at least once a year because of a respiratory condition. For an average primary care trust this equates to nearly 16,000 consultations a year at a cost of almost £2.5m (National Respiratory Training Centre, 2002).

Asthma and COPD activity in particular account for a sizeable proportion of this. Although there are fewer patients with COPD, the annual cost of treating the condition is considerably higher than the cost for asthma. On average, patients admitted to hospital with COPD stay in hospital over three times longer (10.3 days) than those admitted with asthma (Department of Health, 2004).

We appear to be facing a major paradox with regard to the management of respiratory disease in the UK. On the one hand, we have better knowledge about the pathophysiology and causes of diseases than ever before and have a wider range of diagnostic tests and more effective treatments at our disposal. The aetiology is probably multifactorial and includes:

- The burden of the disease in itself;
- Too many competing ‘must do’ priorities for an overstretched NHS;
- Failure of health professionals to follow evidence-based clinical guidelines;
- Lack of education of health professionals, patients, and the public.

A national service framework

Despite these stark facts, the government has not yet been shamed into producing a national service framework (NSF) for respiratory disease. The DoH firmly believes that NSFs raise the standards of health care and reduce unacceptable variations, and from the improvements made in the management of coronary heart disease since the implementation of its NSF, this would appear to be true. But why then is work on an NSF for respiratory disease still neglected?

One of the unfortunate by-products of an NSF driven by the NHS is that it perpetuates a health service with ‘disease specific’ priorities. Asthma UK’s audit (2001), suggested that asthma would not be deemed a local priority in most primary care organisations until it was a government priority and therefore a ‘must do’. It is inevitable that conditions deemed by the government as priorities, or those with the most effective lobbyists, receive the greatest attention. However, it remains unclear how a disease reaches the level of ‘priority’. The assumption is that there must be irrevocable epidemiological and economic evidence that the status quo is unacceptable,
and there are known interventions that would improve the situation. Much of this evidence is already available in the context of respiratory care.

**Current standards**

Studies within primary care have shown that considerable improvements for patients with respiratory disease can be achieved with adherence to clinical guidelines, specialist training for health care professionals, and structured care with systematic reviews (Asthma UK, 2004; O’Reilly et al, 2001). The new general medical services contract (MSC) targets both asthma and COPD within the quality framework. Indeed, there are a significant number of ‘points’ to be rewarded, which equate to the generation of financial income. Optimists will see this leading to a reappraisal of these diseases in primary care and ultimately to clinical improvements. Pessimists will see this as doing very little to improve outcomes, as the exercise becomes one purely of ‘ticking boxes’ and regurgitating statistics into a computer.

In secondary care, it is vital that there are sufficient numbers of respiratory specialists, both doctors and nurses, to deliver high-quality services. NSFs in themselves will not necessarily improve standards of care. What will ultimately improve care are well-trained clinicians with sufficient access to resources, particularly time. There are national and international guidelines on most aspects of respiratory disease (British Thoracic Society/Scottish Intercollegiate Guidelines Network, 2004), so it is not the clinical standards that need to be rewritten; it is the government drive and support that is woefully lacking.

The new COPD guidelines developed by the National Collaborating Centre for Chronic Conditions and published by the National Institute for Clinical Excellence and the British Thoracic Society (2004) highlights clearly what needs to be put in place for improving the care of patients with COPD. After examining all the published literature, the guidelines highlight seven key priorities for improvement. It is refreshing that these cover not just the obvious with regard to diagnosis and therapeutic interventions, but also issues related to prevention and delivery of care. The need for both pulmonary rehabilitation and multidisciplinary working are emphasised.

Asthma UK has produced a patients’ charter, which promotes the basic right of people with asthma to:

- Have easy access to a doctor or nurse who has had specific asthma training;
- Have their asthma quickly and accurately diagnosed, with referral to a specialist if necessary;
- Discuss and agree a personal asthma action plan with their doctor or nurse;
- Have their asthma reviewed at least once a year.

The various well-respected guidelines in respiratory care need to be implemented across the whole NHS and used as a vehicle for commissioning and contracting, and for the delivery of services. The guidelines already have the intellectual support of many clinicians at the coalface both in primary and secondary care. The impetus can be maximised by exploiting clinical governance and training of all health professionals.

**Conclusion**

Despite the enthusiasm of many clinicians to improve respiratory disease it is questionable whether major inroads can be achieved without diktats from above. The admirable work of patient-based charities such as Asthma UK and the British Lung Foundation has raised awareness among the public and campaigns on behalf of patients with respiratory disease. Shifting respiratory disease onto the ‘must do’ agenda is what the government needs to do to address the UK’s poor performance.