

FIRST STEPS HOW READY IS YOUR PRACTICE?

The following questions are intended to be used as a checklist to prompt discussion and review the way COPD is managed within your practice. It is hoped that these questions will highlight your 'state of readiness' for the forthcoming UK National Strategy for COPD. These questions could be used as part of a COPD educational meeting to prompt debate. Alternatively, they could be used to identify areas within your practice that may benefit from review.

Prevalence of COPD

- 1. Do you know the prevalence of COPD in your practice?**
- 2. Do you know how it compares with the regional and national prevalence?**

Supporting Information:

- Currently it is estimated that 3.7 million people have COPD in the UK.
- However, only 900,000 are currently diagnosed and receiving treatment.
- 2.8million people remain unaware they have the disease.
- COPD is the 5th biggest killer disease in the UK.¹

The estimated average national prevalence from the Quality Outcome Framework Data is 1.5% however there is considerable variation around the UK between SHAs (0.9-2.3%) and between PCTs (0.7 – 2.9%).

Information at a national, local and practice level is available on the NHS information Centre website (<http://www.ic.nhs.uk>)

Diagnosing COPD

How is a diagnosis of COPD confirmed within your practice?

Supporting Information:

A diagnosis of COPD is made on the basis of history, examination and confirmation by spirometry of airflow obstruction.

It is recommended by GOLD² and ATS/ ERS³ that post bronchodilatory spirometry in undertaken. In addition it is currently a requirement to satisfy the requirements of the Quality Outcome Framework (QOF). However the current recommendation from NICE is that reversibility is no longer routinely recommended in the diagnosis of COPD⁴. These differing views can be confusing for practitioners within primary care. The recommendation by the Spirometry Standards document is that it is good practice to include post bronchodilator testing particularly in newly diagnosed patients⁵.

Another area of debate relates to the level of FEV₁ reversibility following bronchodilation that constitutes a significant clinical improvement. The lack of clarity can cause confusion within primary care. Currently NICE recommend a significant bronchodilatory response as > 400ml for considering a diagnosis of asthma. However, some feel this level is too high, and that many asthmatic patients may not be diagnosed as a result. In patients with a history suggesting asthma, a change of > 200mls and an FEV₁ increase of 12% may confirm the diagnosis.⁵⁻⁷

Use of a COPD Template to provide structured care

- 1. Have you recently used a COPD template and was it useful for identifying need?**
- 2. Have you recently reviewed the READ codes that are being used in your practice?**
- 3. Does your COPD template capture all the necessary information needed to provide a structured COPD programme of care?**

Supporting Information:

Gathering the right information through the use of a template enables resources to be targeted to specific areas of need. For example, when inviting patients in for a COPD review those with more severe COPD and frequent exacerbations may benefit from seeing a member of the clinical team with more COPD experience. A patient with mild COPD, no recent exacerbations and on minimal inhaled medication, could see a member of the team with less COPD experience. By targeting the more severe COPD patients to the most experienced team members both patient and clinician feel confident that every aspect of their care is being addressed. It is important that any health care professional involved in COPD management has undertaken an appropriate educational course to ensure they are competent to manage the complexities of this disease.

Click [here](#) for more information on providers of respiratory education.

An example of a COPD Template can be found at http://www.gpiag.org/news/copd_template2.php

Templates can be used to gather information to highlight patients who need to be reviewed sooner. For example, those with FEV₁ < 50% and 2 exacerbations - are they on the recommended inhaled medication of a combination of LABA and inhaled corticosteroid therapy?

Information gathered on the COPD template can be broken down into essential information (linked to QOF) and desirable information.

Some of the information required can be seen as essential for a practice to achieve its QOF targets. Additional parameters on a template allow for more sophisticated care / recall systems and may be used for improving quality of care in LES / DES initiatives.

A list of useful Read Codes to include in a COPD Template

COPD Clinic Template with relevant Read Codes (As at 24/8/2009)

Prompt	Read Code	Picklist
Respiratory disease monitoring	663..	6631. Initial respiratory assessment 66YL. COPD follow-up 9N4W.DNA – COPD clinic
Tobacco Consumption*	137..	
Date ceased smoking	137T.	
Cigarette Pack Years	137g.	
Smoking Cessation Advice*	8CAL.	
Cough Symptom	171..	
Breathlessness*	173..	MRC Breathlessness Scale: Grade 1: 173H Grade 2: 173I Grade 3: 173J Grade 4: 173K Grade 5: 173L
O/E Height	229..	
O/E Weight	22A..	
Body Mass Index	22K..	
Forced expired volume in 1 second*	339O.	
Forced vital capacity – FVC	3396.	
Percent predicted FEV ₁	339S.	
Spirometry	5882.	
Inhaler technique observed	6637. 663I.	663H. Inhaler technique – good Inhaler technique – poor
Pulse Oximetry monitoring	8A44.	
Oxygen Therapy	877.. 8771.	6639. Home Oxygen Supply Oxygen Therapy
COPD with acute exacerbation, unspecified.	H3y1.	Enter number of exacerbations in last year – free text
Admit COPD emergency	8H2R.	
Flu Vaccine*	65E	
Pneumococcal Vaccine	6572.	
Quality of life assessment completed	3894.	AQ20
Hospital anxiety and depression scale	388J.	
COPD self-management plan given	66YI.	
Pulmonary rehabilitation	8FA..	
Medical review done	8B3V.	
COPD Annual Review Done*	66YM	
*Required by QOF		

COPD Register

- 1. Is your COPD register up to date and accurate?**
- 2. Do you regularly review the COPD and asthma registers to support you in the identification of patients requiring a review?**

Supporting Information:

It is worth reviewing the asthma and COPD registers to identify patients who may have been misdiagnosed with either asthma or COPD.

It is useful to identify those patients over 35 who smoke or are ex-smokers on the asthma register. They run an increased risk of COPD and should be reviewed.

Check how many people on your COPD register have an FEV₁ > 80% and FEV₁/FVC > 70 %. These criteria do not meet the diagnostic criteria for obstructive airways disease and therefore their diagnosis should be reviewed.

Check how many COPD patients are on a single inhaled corticosteroid inhaler. Confirm there is a recorded indication for its use? Does this meet the criteria for inhaled corticosteroids as recommended by NICE⁴?

Your Practice Team and Teamwork

These questions are aimed at helping to identify learning needs and organisational issues.

- 1. Is there a lead GP and/ or Nurse for COPD in your practice?**
- 2. What is the level of COPD knowledge within your team?**
- 3. Is there a need to review the educational needs within your team?**
- 4. Does the team meet to discuss complex cases and review care for those COPD patients who have multiple needs?**
- 5. When COPD patients are reviewed do they get directed to clinical staff with knowledge of COPD?**
- 6. Do the reception team (who make the appointments) know which clinical staff review COPD patients?**
- 7. What links are there with secondary care and other respiratory interested groups?**
- 8. Is someone in the practice trained to perform diagnostic quality spirometry? If not, where is the practice spirometry performed?**

Supporting Information:

Q1 - It may be useful to identify a clinical lead for COPD to inspire ongoing COPD developments within your practice. This can be shared by several clinicians. Many practices opt for a Lead GP and Lead Nurse in Respiratory Care. It is useful to remember that key to their role is the dissemination of information and delegation of roles within the team.

Q2 & 3 - Key to the development of any successful COPD strategy is to assess the skills and knowledge of the team. This process should be seen as non-threatening and part of an ongoing process of improving COPD care within your practice. It is important that any clinician managing COPD patients is competent to manage the complexities of COPD and recognises when there is a need to refer on to specialist services.

There are many groups who provide educational events, programmes and courses. The GPIAG provides a list of educational providers who provide respiratory education in the UK. Click [here](#) for more information.

Q4 & 5 - Each team member has different skills to offer patients with COPD and the key is to get the patient to the right person for their particular health needs. This may be, for example, the dietician, smoking cessation advisor, nurse or GP. The key is for everyone to have an awareness of the skills of each member of the team and refer appropriately.

Q6 - It is important that the reception team are aware of the team members who review COPD patients. It is more productive for patient and clinician to ensure the patient sees the more appropriate member of the team. As reception is the first point of contact it is vital they are aware of this information.

Q7 - It is well recognised that key to well managed care is good, well established communication links between primary and secondary care. However, is not always easy and recognising the challenges is key to ongoing partnerships. One way to build good communication is through the use of self management plans which the patient can take into hospital to share information. BLF has an excellent, comprehensive self management booklet

(http://www.lunguk.org/supportingyou/Publications/copd_self_management_plan.htm

) but other shortened COPD self management plans are available

(http://www.gpiag.org/resources/copd_guidelinebooklet_final.pdf)

and are often produced at a local level.

See the GPIAG Opinion Sheet 11 – [Self Management of COPD in Primary Care](#), March 2007

Q8. Accurate confirmation of diagnosis of COPD (and Asthma) requires appropriately trained personnel in performing diagnostic quality spirometry. There are a number of training courses available in the UK. See the GPIAG Spirometry Standards document for more information. (7) <http://dx.doi.org/10.4104/pcrj.2009.00054>

Clinical guidelines

- 1. Is the practice using a recognised guideline that is readily available to the whole team?**

Supporting Information:

Guidelines can be cumbersome and, at times can be difficult to access during a consultation. It is therefore important the practice adopts a guideline and also a quick reference guide which can aid decisions. The NICE guideline published in 2004 is the

accepted key reference for the UK but may be adapted for local use⁴. In addition to the NICE guideline on COPD there are helpful international guidelines particularly the Global Strategy for the Diagnosis, Management and Prevention of COPD².

There are a variety of tools available to assess disability and quality of life. One example of a disability tool is the Medical Research Council (MRC) Dyspnoea Score which provides a useful way to classify patient's breathlessness⁴:

MRC Dyspnoea Score	
Grade degree of breathlessness related to activities:	
Grade 1	Not troubled by breathlessness except on strenuous exercise
Grade 2	Short of breath when hurrying or walking up a slight hill
Grade 3	Walks slower than contemporaries on a level because of breathlessness, or has to stop for breath when walking at own pace
Grade 4	Stops for breath after walking about 100m or after a few minutes on the level
Grade 5	Too breathless to leave the house or breathless when dressing or undressing

See further information within other GPIAG resources including

- Opinion Sheet 1 – [Spirometry](#), September 2004
- Opinion Sheet 7 – [Palliative care for people with COPD](#), September 2006
- Opinion Sheet 8 - [Home oxygen therapy](#), November 2006
- Opinion Sheet 13 – [The management of stable COPD in primary care](#), January 2007
- Opinion Sheet 16 – [The management of exacerbations of COPD in primary care](#), December 2007
- The [GPIAG Spirometry Standards document](#).
<http://dx.doi.org/10.4104/pcrj.2009.00054>

Spirometry

- 1. Who in the team has been trained and is competent in performing spirometry?**
- 2. Who in the team is trained and competent to interpret spirometry reports?**
- 3. Is there a system in place to ensure that the machine is serviced and calibrated and the readings verified?**
- 4. Is there an system in place to ensure the machine is disinfected as per manufacturers and local trust guidelines?**

Supporting Information:

Spirometry is an important test to confirm a diagnosis of COPD in conjunction with a careful clinical history and examination. In order to meet the NICE recommendations it is vital that robust policy and procedures are in place for access to diagnostic

quality spirometry within your practice. The main factors to consider are the following recommendations from the NICE 2004 guidelines⁴:

- 'All health care professionals managing COPD should have access to spirometry and be competent in the interpretation of results'.
- 'Any health care worker who has undergone appropriate training and keeps his/her skills up to date can perform spirometry'

We recognise that not all training is the same but support the notion of well trained health care professionals who have maintained their knowledge and skills making robust clinical diagnoses using well maintained spirometry.

Education and training organisations in the UK:

The following organisations offer spirometry courses approved by the ARTP resulting in the award of the ARTP/BTS Certificate

- ARTP/BTS spirometry courses and assessment www.artpweb2.f9.co.uk
- Education for Health www.educationforhealth.org.uk
- Primary Care Training Centre www.primarycaretraining.co.uk

Spirometry courses also available from:

- Respiratory Education UK www.respiratoryeduc.com
- Various spirometry manufacturers provide training but ideally these courses should be accredited by an appropriate body

Spirometry Standards and buying equipment:

- The GPIAG in association with the Association of Respiratory Technology & Physiology (ARTP) and Education for Health have published proposed standards for diagnostic spirometry in primary care⁷. See <http://dx.doi.org/10.4104/pcrj.2009.00054>
- If a practice is considering purchasing a spirometry a useful guide is the Centre for Evidence Based Purchasing. Spirometry Buyers Guide (PASA): NHS Purchasing and Support Agency 2009 www.pasa.nhs.uk/pasa/Doc.aspx?Path=%5BMN%5D%5BSP%5D/NHSprocurement/CEP/CEP08055.pdf

Patient Information

1. **What information is given to COPD patients about their condition?**
2. **Does every healthcare professional within your practice use the same information?**
3. **Are patients given self management plans?**
4. **Are patients given contact numbers for whom to call if their symptoms change and they need advice?**

Supporting Information:

It is recognised that patients frequently forget what has been discussed in consultations. It is imperative that they have user friendly information about their

disease and how it is going to be managed. The British Lung Foundation has a variety of appropriate leaflets and the EMIS Mentor programme and <http://www.patient.co.uk/> has a variety of resources which are patient friendly, appropriate and accurate. Many local trusts and PCOs also have information.

Referral Pathway

Are you aware of the resources and services that are available in your area and the referral criteria for these?

Supporting Information:

Key to assessing your readiness for the COPD National Strategy is identifying which resources/services you can refer to within either primary or secondary care.

It would be useful to review the following, including a review of the referral criteria for each resource/service:

- Pulmonary rehabilitation
- Smoking cessation
- Oxygen assessment
- Citizens Advice Bureau
- Dietician
- Occupational therapy
- Intermediate Care
- Psychology Services
- Hospital specialist support
- COPD community service Domiciliary Respiratory Physiotherapy

In addition, it is useful to find out what may have changed within a particular service/organisation which could influence referral.

End of Life Care

- 1. Do you have a list of people with severe COPD who are included in your GOLD Standards Framework clinical discussions?**
- 2. Do you have systems to notify out of hours, emergency services of the advanced care wishes of people with advanced COPD?**

Supporting information:

There is increased recognition that people with severe COPD have as many symptoms as those with cancer, yet often the severity of their condition is not recognised and they do not have the end of life discussions that people with cancer do.

It may be useful to consider which patients could be identified for End of Life care. There are several key contributing factors that can alert a clinician to a patient's increased risk of mortality. These include: $FEV_1 < 30\%$ predicted, history of two exacerbations requiring hospital admission, MRC 5, low BMI, a history of established respiratory failure or prior non-invasive ventilation.

An end of life care DVD has been produced by IMPRESS (GPIAG / BTS) which covers many of the important issues relating to end of life care.
<http://www.impressresp.com/PatientPublicengagement/LivingandDyingwithCOPDDVD.aspx>

References

1. British Lung Foundation: Invisible Lives. Chronic obstructive pulmonary disease (COPD) - finding the missing millions. London: BLF, 2007
www.lunguk.org/Resources/British%20Lung%20Foundation/Migrated%20Resources/Documents/Invisible%20Lives%20report.pdf
2. National Institutes of Health NHLBI. Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2008. Available from URL:<http://goldcopd.com>
3. Miller MR, Hankinson J, Brusasco V et al, Standardisation of spirometry. *Eur Resp. Journal* 2005; **26**(2) 319-38. <http://dx.doi.org/10.1183/09031936.05.00034805>
4. National Institute of Health and Clinical Excellence (NICE). National clinical guideline: Management of chronic obstructive pulmonary disease in adults in primary and secondary care. *Thorax* 2004;59 (suppl.1) S1-232. Available www.nice.org.uk (Last accessed 24/8/2009)
5. Miller MR, Crapo R, Hankinson J, Brusasco V, Burgos F, Casaburi R, et al. General considerations for lung function testing. *Eur Resp J.* 2005 July 1, 2005;26 (1):153-61
6. Pellegrino R, Veigi G, Brusasco V, Crapo RO, Burgos F, Casaburi R, et al. Interpretation of strategies for lung function tests. *Eur Resp J.* 2005 November 1, 2005;26(5):948 -68
7. Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes S, Small I. Diagnostic Spirometry in Primary Care: Proposed standards for general practice compliant with American Thoracic Society and European Respiratory Society recommendations. A General Practice Airways Group (GPIAG)¹ document, in association with the Association for Respiratory Technology & Physiology (ARTP)² and Education for Health³ 1 www.gpiag.org 2 www.artp.org 3 www.educationforhealth.org.uk. *Prim Care Resp J* 2009;**18**(3):130-147
Available from: URL: <http://dx.doi.org/10.4104/pcrj.2009.00054>

©PCRS-UK

The Primary Care Respiratory Society, formerly known as the *General Practice Airways Group*, is a registered charity (Charity No: 1098117) and a company limited by guarantee registered in England (Company No: 4298947)

VAT Registration Number: 866 1543 09

Registered offices: 2 Wellington Place, Leeds, LS1 4AP

Address for correspondence: PCRS-UK, Smithy House, Waterbeck, Lockerbie, DG11 3EY

Telephone: +44 (0)121 351 4455 **Facsimile:** +44 (0) 121 336 1914 **Email:** info@pcrs-uk.org **Website:** <http://www.pcrs-uk.org>

The Primary Care Respiratory Society UK is grateful to its corporate supporters including Allen & Hanburys, AstraZeneca UK Ltd, Boehringer Ingelheim Ltd / Pfizer Ltd, Chiesi Ltd, MSD UK, Napp Pharmaceuticals, Nycomed UK Ltd, Pfizer Vaccines and, Teva UK Limited for their financial support which supports the core activities of the Charity and allows the PCRS-UK to make its services either freely available or at greatly reduced rates to its members.