



FIRST STEPS QUICK TIPS/HOW TO GET STARTED

Quick Tips aims to give you some key, practical first steps to reviewing the way you manage COPD within your practice, in preparation for the impending COPD National Strategy. This is intended to be used in conjunction with 'How Ready is Your Practice', which expands on the key points below with further references, and may be used by an individual or a team reviewing the management of COPD.

1. **Consider a COPD diagnosis in any patient over 35 who is a smoker or ex-smoker with:**
 - **Breathlessness on exertion**
 - **Chronic cough**
 - **Regular sputum production**
 - **Frequent chest infections or bouts of 'winter bronchitis'**
 - **Wheeze**
 - **Severe asthma with limited reversibility**

Supporting Information:

COPD is underdiagnosed and estimates suggest that the true prevalence is four times the national figure. Patients presenting with COPD symptoms may be misdiagnosed with asthma, heart disease or simply attributed to getting older or less fit. COPD could be identified opportunistically by testing symptomatic smokers, or via practice computer searches.

2. **Check your COPD template and ensure the READ codes are capturing the necessary information**

Supporting Information:

We provide [here](#) (and see page 2) a list of all 'desirable' Read codes. This can be used to develop an 'essential' list in developing practice templates which will include the QOF requirements (correct as at 24/8/2009)

COPD Clinic Template with relevant Read Codes (correct 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 FEV1	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**

3. Review your Asthma Register and identify those patients over 35 who are smokers/ ex- smokers, and assess for COPD

Supporting Information:

It may be useful to identify those patients over 35 who smoke or are ex-smokers on the asthma register. These patients may be at increased risk of COPD and should undergo spirometry testing if they are symptomatic.

Refer to the papers in the PCRJ:

IPCRG Screening¹: <http://dx.doi.org/10.4104/pcrj.2009.00055>

IPCRG Guidelines on diagnosis²: <http://dx.doi.org/10.1016/j.pcrj.2005.10.004>

4. Smoking cessation: rapid intervention to assess interest and provision of good information will aid smoking cessation

Supporting Information:

Ensure that smoking cessation information is accessible in the waiting room and utilise all resources in the locality offering smoking cessation. Consider training up health care assistants and receptionists as smoking cessation advisors to free up some practice nurse time.

Remember to ask patients if they want help stopping and support those that do:

- Do you smoke?
- Would you like to stop?
 - If yes refer and/or give assistance in-house. If no, ask these questions at the next review.

Resource: GPIAG Opinion Sheet 17 'Managing Smoking Cessation in Primary Care'

http://www.gpiag.org/opinions/smokingcessation_final.pdf

5. Review which health care workers in the practice can perform spirometry and interpret the results competently.

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 spirometry within your practice. The main factors to consider are the following recommendations from the NICE 2004 guidelines³:

- 'All health care professional 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'

Systems should be in place in practices to ensure quality control of spirometry testing performed on their patients. This role could be undertaken by commissioners or practice respiratory leads.

Resource:

GPIAG Spirometry Standards document⁴: <http://dx.doi.org/10.4104/pcrj.2009.00054>

6. Identify a core COPD team within the practice

Supporting Information:

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.

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.

References

- 1) Price D, Crockett A, Arne M, Garbe B, Jones R, Kaplan A, Langhammer A, Willaims S, Yawn BP. Spirometry in primary care case-identification, diagnosis and management of COPD. *Primary Care Respiratory Journal* 2009; 18(3): 216-223.
<http://dx.doi.org/10.4104/pcrj.2009.00055>
- 2) Levy ML, Fletcher M, Price DB, Hausen T, Halbert RJ, Yawn BP. International Primary Care Respiratory Group (IPCRG) Guidelines: Diagnosis of respiratory diseases in primary care. *Primary Care Respiratory Journal* 2006;**15(1)**: 20-34.
<http://dx.doi.org/10.1016/j.pcrj.2005.10.004> (Last accessed on 24/8/2009)
- 3) 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 (accessed 24/8/2009)
- 4) 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>

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