

Top priorities for respiratory-focused primary healthcare service provision in the COVID era

The necessary restrictions imposed by the COVID-19 pandemic have created a backlog of patients in primary care who have perhaps delayed coming forward with respiratory health concerns, whose respiratory condition has worsened during lockdown and those whose assessment or treatment has been delayed. As we emerge from this seismic shift in primary healthcare provision, there is an urgent need to work through this backlog of patients. In this article we bring together our top priorities to help service managers support healthcare practitioners (HCPs) providing respiratory healthcare to prioritise their time and efforts to ensure that patients are evaluated, diagnosed and, where necessary, started on treatment to manage their respiratory disease.



Encourage HCPs to focus on identifying patients with asthma or COPD most at risk for exacerbation

This will help to initially focus care provision on the sickest or most in need patients and prioritise them for a face-to-face appointment. Practice-level IT systems and IT leads can be used to identify patients who meet any of the criteria listed in Table 1 for priority review. If you have access to local risk stratification software, consider running it across an Integrated Care System and pooling resources when you have identified your at-risk patients.



Support HCPs to restart spirometry and to focus on accurate diagnosis of respiratory symptoms

The hold on spirometry in the primary care setting has created a backlog of patients awaiting confirmatory evaluation of a provisional diagnosis. As spirometry services can now be restarted in primary care, they should be prioritised to ensure provisional diagnoses are confirmed or ruled out and that patients are receiving the appropriate therapy. HCPs should continue to take a pragmatic approach to the assessment and diagnosis of patients presenting with respiratory symptoms while the COVID-19 virus remains in widespread circulation.

Table 1: Red flags among patients with asthma or COPD

Red flags among patients with asthma	Red flags among patients with COPD
1. Using ≥ 4 reliever inhalers in the past year	1. Requiring ≥ 2 courses of oral steroids and/or antibiotics in last year
2. Using $< 60\%$ prescribed maintenance therapy in the last year	2. Been to the emergency department or out-of-hours care at all in the last year
3. Requiring ≥ 2 courses of oral steroids in the last year	3. Seen by the ambulance service at all in the last year
4. Eosinophil count > 400	4. Admitted to acute hospital care at all in the last year
5. Been to the emergency department or out-of-hours care at all in the last year	5. Current smokers
6. Seen by the ambulance service at all in the last year	6. Medical Research Council (MRC) score ≥ 4
7. Admitted to acute hospital care at all in the last year	
8. Current smokers	

Additional resources:

- Guidance for the Resumption and Continuation of Urgent and Elective Outpatient Respiratory Services. Available at: <https://www.brit-thoracic.org.uk/covid-19/covid-19-resumption-and-continuation-of-respiratory-services/#restarting-spirometry/>
- PCRS guidance on Risk Minimization in Spirometry Re-start which includes the Spirometry in Primary Care: Guidance on Reinstating spirometry in England. Available at: <https://www.pcrs-uk.org/sites/pcrs-uk.org/files/ReinstatingSpirometry270421.pdf>
- Improving the Quality of Diagnostic Spirometry in Adults. Available at: <https://respiratoryacademy.co.uk/resources/improving-quality-diagnostic-spirometry-adults-2/>
- The Diagnostic Work-Up of Patients Presenting with Respiratory Symptoms during the COVID-19 Pandemic. Available at: <https://www.pcrs-uk.org/resource/diagnostic-work-patient-presenting-respiratory-symptoms-during-covid-19-pandemic>

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Encourage and equip HCPs to be vigilant for other potential respiratory diagnoses such as lung cancer

Another casualty of COVID-19 has been the presentation and identification of patients with potential lung cancer. There is increasing evidence from secondary care that patients with lung cancer are presenting as emergencies and, moreover, presenting with more advanced disease. Be aware of the common presenting symptoms of lung cancer – cough, shortness of breath and chest pains – and ensure that there are processes in place to review patients with such symptoms that do not resolve after 3 weeks and who do not have a diagnosis of COVID-19. Make sure you know the process for referral for suspected cancer and are able to confidently implement this where appropriate to do so.

Additional resources:

The UK Lung Cancer Coalition provide a series of documents with a range of best practice recommendations on service development and delivery including:

- Early Diagnosis Matters – <https://www.uklcc.org.uk/wp-content/uploads/2020/01/UKLCC-ED-Matters-FINAL.pdf>
- COVID-19 Matters – <https://www.uklcc.org.uk/wp-content/uploads/2020/10/UKLCC-COVID-19-Matters-Report-Oct-2020.pdf>
- Access Matters – <https://www.uklcc.org.uk/wp-content/uploads/2020/01/UKLCC-Access-Matters-FINAL-1.pdf>

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Encourage and support the use of group consultations to reach more patients

Another way in which we can tackle the backlog of patients is by adopting Respiratory Group Consultations for patients with the same or similar diagnoses. These consultations can be useful to deliver education and support to groups of patients and to encourage peer support between patients facing the same challenges. While ideally delivered face to face, group consultations can be delivered virtually when national restrictions apply. Sessions typically last 60–90 minutes, with up to 10 patients joining the virtual session at the same time and supported by a trained group consultations facilitator, who remains with the patients for the duration of the session. A clinician (i.e. doctor, nurse, pharmacist) can deliver advice to the group for part of the session as well as 1:1 consultations when required.

Additional resources:

Useful resources for understanding and implementing group consultations can be found at:

- <https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/2-4-group-consultations-evidence-summary-etc>.

Listen to Dr Rupa Joshi describe how she has set up group virtual consultations in her practice. Available at: <https://vimeo.com/462115242/db3b675b5d>.

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Continue to ensure patients are offered smoking cessation support

People who smoke tobacco have worse outcomes when they acquire respiratory infection and that includes COVID-19.¹ Continue to ensure staff are trained in offering Very Brief Advice and are encouraged to do so at every opportunity. Ensure all staff are aware of local smoking cessation services.

Additional resources:

- Free online training on VBA is available through the National Centre for Smoking Cessation and Training (https://elearning.ncsct.co.uk/vba-stage_1) and through the MedThority website (<https://www.medthority.com/very-brief-advice-for-tobacco-dependency-learning-zone/>).
- PCRS provides a comprehensive range of tools to support those working in primary care to learn skills to help provide smoking cessation support including case studies demonstrating how smoking cessation support can be incorporated into a regular consultation – see <https://www.pcrs-uk.org/resource/tobacco-dependency-pragmatic-guide>.

See also the PCRS guide to the Role of E-cigarettes in smoking cessation. Available at: <https://www.pcrs-uk.org/sites/pcrs-uk.org/files/pcru/articles/2019-Autumn-Issue-18-RoleofECigs.pdf>.

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Promote the provision and uptake of pulmonary rehabilitation services

National lockdowns and shielding for patients most at risk for severe COVID-19 disease has likely exacerbated the deconditioning of patients with respiratory disease, a situation exacerbated by the lack of face-to-face pulmonary rehabilitation (PR) and the challenges of delivering such a service remotely. PR is a proven cost-effective intervention for patients with COPD with improvements in both exercise tolerance and quality of life for those who complete such programmes, with benefits lasting up to one year following completion. As such, the provision and uptake of PR should now be prioritised. There is emerging evidence that PR benefits the post COVID-19 patient.² Encourage HCPs to consider opportunities to refer suitable patients to local PR services or local exercise programmes commissioned via the Local Authority or on offer by other local groups. Where face-to-face services remain unavailable, ensure HCPs are aware of resources that can be recommended to patients to enable them to self-manage at home using home exercises and educational materials.^{3,4}

Additional resources:

See the Primary Care Respiratory Society resources to support the uptake of PR services:

- <https://www.pcrs-uk.org/resource/tips-encouraging-activity-gateway-good-respiratory-health>
- <https://www.pcrs-uk.org/resource/top-tips-communicating-benefits-pulmonary-rehabilitation-patients>
- <https://www.pcrs-uk.org/resource/business-case-cardiopulmonary-rehabilitation-service>

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Support HCPs in optimising regular respiratory review consultations

Making the most of every clinical consultation is vital at this time when direct patient contacts are reduced owing to COVID-19. Support HCPs to optimise routine clinical reviews by encouraging a systematic, structured approach that captures the red flags that may indicate poor disease control and risk for exacerbation. Encourage HCPs to review patient records prior to routine reviews to identify any red flags for exacerbation (see Priority One).

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Utilise the expertise of your community pharmacy colleagues

The last 18 months has brought up significant changes in the way we work and interact with our patients, allowing many innovations which previously were considered aspirational. Integrating community pharmacy into the respiratory pathways around improving self-management and prevention and optimising some of the newer services such as the Discharge Medicines Service (DMS) for people discharged from hospital, the New Medicines Service and the Structured Medication Review is an opportunity clinicians and their patients simply cannot afford to miss (Pharmaceutical Services Negotiating Committee 2021).⁴ Community pharmacies are the most accessible and inclusive part of the healthcare service, both for the supply of medicines and medical advice. During the COVID-19 pandemic, community pharmacies successfully helped to deliver vaccinations and supported the distribution of lateral flow tests, demonstrating their potential lies far beyond dispensing medication. Community pharmacy teams are already involved in the delivery of respiratory-focused services, ranging from inhaler technique reviews and supporting asthma reviews^{5,6} to a holistic COPD support service.^{7,8} Although the number of commissioned services is low, the outcomes are encouraging.⁹

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Get 'Winter Ready' by encouraging vaccination at every opportunity

Now is a great opportunity to plan for Winter 2021 so that the new-found confidence in immunisation can translate into increasing the number of eligible patients receiving the flu vaccine. In the years leading up to the COVID-19 pandemic, vaccination against flu among many at-risk groups struggled to achieve 50%. While the rates of influenza cases in the 2020/2021 season were lower than usual, likely as a result of the national lockdowns, we can, of course, expect our usual winter respiratory viruses to return. Now is a good time to start to prepare for the Winter 2021 flu season, reminding all at-risk patients (and HCPs) of the importance of flu vaccination and preparing for any potential programme of COVID-19 booster vaccinations.

Additional resources:

- See the suite of PCRS *Get Winter Wrapped* resources. Available at: <https://www.pcrs-uk.org/resource/winter-wrapped>.
- See the PCRS article prepared by Ren Lawlor on flu vaccination including strategies to increase vaccine uptake. Available at: <https://www.pcrs-uk.org/resource/influenza>.

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