GMS Contract 2017/18

CND 012W

National Clinical Priority D: Chronic Obstructive Pulmonary Disease (COPD)

COPD Pathway

The COPD QP pathway has been developed to try to improve COPD care within the context of the framework embedded within QOF following recently published national guidance on best practice namely “Quality Standard 10 – COPD” (NICE) and “An Outcomes Strategy for COPD and Asthma” (Dept. of Health – England).

- COPD remains the fifth most common cause of death in England and Wales, accounting for more than 28,000 deaths in 2005 and is the second largest cause of emergency admission in the UK
- One in eight (13,000) emergency admissions to hospital are related to COPD.
- One fifth (21%) of bed days used for respiratory disease treatment are due to chronic obstructive lung disease, such that COPD accounts for more than one million 'bed days' each year in hospitals in the UK.
- There are around 835,000 people currently diagnosed with COPD in the UK and an estimated 2,200,000 people with COPD who remain undiagnosed, which is equivalent to 13% of the Population of England aged 35 and over.4
- COPD is often associated with other conditions that also need assessment and effective interventions in a holistic care approach e.g. about 40% of people with COPD also have heart disease, and significant numbers have depression and/or anxiety disorder.

Extract from COPD national audit (p14)
There should be better coding and recording of COPD consultations, prescribing and referrals.
a. As patient access to personal health records improves and patients’ involvement in their own care becomes an expected norm, there will be opportunities to support people with COPD to ‘know their numbers’ or, in other words, to understand why their spirometry test is consistent with COPD.
They should be able to record quality of life assessments, their ability and confidence to use
inhalers and their understanding of how to help themselves through access to and involvement with self-care documentation and action plans.
b. Much of the variation seen in the data suggests variance in electronic coding. In order to link datasets across the system in the future, we ask the wider system (whether through development of the Systematised Nomenclature of Medicine coding system or other activity) to make standard recording templates available to ensure that the right things are recorded and that health professionals can spend more time with patients by avoiding the time spent on duplicate entries or manual entry. Health boards and clusters of GP surgeries should consider the use of a standardised set of codes and templates.

National Clinical Priority D- COPD

Aim: By 31st March 2018, there will be higher percentage of accurate coding and recording of COPD consultations, and more appropriate prescribing and referrals, with the improvements being measured by the practice and shared with the cluster.

- **Step One**: **Reflection on National Clinical Audit:**
  - The contractor will review their individual National COPD Audit outcomes and consider any action points arising from this review either for
    - action within the practice **or**
    - discussion with the cluster **or**
    - for feeding back to HB (e.g. where gaps in service provision identified or resources needed to address problems identified).

    NB – where a practice did not engage in the previous years national COPD audit then reviewing the overall Welsh or HB achievement is acceptable for this year, however the practice must participate in the National COPD audit in this contractual year.

- **Step Two: Review Spirometry Results:**
  - The contractor will review the spirometry results of patients on their COPD register to ensure accurate diagnostic coding (using a national COPD template if available)

    1. If the diagnosis has been made on clinical grounds rather than through spirometry then these patients identified to undergo spirometry
    2. Patients with confirmed spirometry showing an FEV/FVC ratio of 0.2-0.7 (or 20% -70%) will be confirmed as having COPD. No further work required on this patient cohort.
    3. Those patients with a spirometry that does not confirm COPD to have their records reviewed and a clinical review to facilitate change to medication, READ coding, record updating, other diagnostics (if appropriate) and onward referral (if appropriate)

- **Step Three: Collate Outcomes of review and share learning**
  - The practice to collate outcomes of this review:
    i.e. % correct diagnoses, incorrect diagnoses (and brief outlines of subsequent actions taken) and themes from their review of their individual COPD audit data.
  - This data to then be discussed at cluster level together with review of QOF data extraction and other allied issues relating to the whole COPD pathway to identify further actions required across whole pathway. The collated findings across the cluster network to then be referenced in the annual cluster end of year review.