**Summary of key findings and recommendations from ‘Time to take a breath’ – primary care COPD audit report in Wales**

**FINDINGS**

**Poor standards of diagnosis or inconsistent coding?**

* Only 19.7% of people on the COPD registers had an electronic record of the post bronchodilator FEV1/FVC ratio, which is necessary for diagnosing COPD.
* 63% of patients on the COPD register had a record of an x-ray around the time of diagnosis, which NICE recommends for all COPD diagnoses to exclude co-morbidities.
* In people who had a record of post-bronchodilator spirometry, only 26.9% had a value that was consistent with a diagnosis of COPD. Therefore, the data extraction from Wales provided confidence in the quality of COPD diagnosis in only 14.4% of people on the COPD register. This was in sharp contrast to the QOF data in Wales, which shows practices recorded an assessment of breathlessness in over 90% of cases. In conclusion, at best 42% of the COPD registered population and at worst 85.6% will require diagnostic re-evaluation to confirm COPD (depending on whether a wider range of codes was used as the basis of analysis or only the most appropriate code).
* There is considerable variation in data accuracy and coding across practices, particularly for diagnosis.

**Under-use of high value interventions means patients are missing out on optimal care**

* Many highly effective treatments supported by good evidence are available to manage COPD. Many of these are being used, but there is also evidence that effective interventions are being under-used, and harmful or ineffective treatments over-used.
* In COPD patients recorded as being current smokers, almost 75% had been referred to stop smoking service. However, only 10.8% of current smokers had received any pharmacotherapy to help them quit.
* Approximately one in five people on the COPD register were not recorded as having had the influenza vaccine in 2014/15.
* Two thirds of patients with an MRC breathlessness score making them eligible for pulmonary rehabilitation had never actually been referred to pulmonary rehabilitation
* It is likely that the number of people on oxygen treatment is under-recorded – only 0.4% of people on COPD registers had a record of receiving oxygen.
* There is undoubtedly a need for greater clarification about what should be recorded during a routine COPD review and how this should be recorded.

**Discrepancies between coding in notes and QOF results means people with more serious disease may not be getting the care they need**

* The number of COPD patients with an MRC breathlessness score recorded in the audit year was 58.2%. A breathlessness score is important for planning care and for detecting worsening of COPD.
* In only 10.8% of patients with COPD was an exacerbation coded in 2013-14, which is almost certainly an under-recording. There was wide variation between Health Boards, with the lowest recording 6.9% vs 13.5% for the highest.
* Over 15% of COPD patients on COPD registers were exception-reported in QOF
* Considerable discrepancies emerged between the high level of achievement of regular reviews reported for QOF, while the individual components of review were not coded in records.

**RECOMMENDATIONS**

**A diagnosis of COPD should be made accurately and early. If the diagnosis is incorrect, any subsequent treatment will be of no value.**

* People who have breathlessness and/or cough that does not go away or frequent ‘chest infections’ should have access to health professionals who have been trained to know what to do and have the resources to reach a diagnosis in a timely way.
* Spirometry is fundamental to a diagnosis of COPD and patients should be assured that their test has been performed and interpreted in the right way.
* Trained and competent health workers should offer patients with a risk factor and symptoms suggestive of COPD a comprehensive and structured assessment
* Clinical symptoms, risk factors and evidence of post-bronchodilator airways obstruction are all essential factors when making a diagnosis.
* People at risk of COPD are at higher risk of lung cancer and chest x-ray is an essential part of the breathlessness assessment and diagnosis of COPD

**People with COPD should be offered interventions according to value-based medicine principles – which includes flu vaccination, help to overcome tobacco dependency and pulmonary rehabilitation.**

* Tobacco dependence treatment is safe, well-tolerated and effective at prolonging life: It reduces flare ups and has a wider impact on health. However, it is underused. Health professionals who treat people with COPD should be trained to have the right conversation; to know how to assess dependency’ and to feel confident and have the resource to treat it.
* Flu vaccination is effective and safe but underused in people with COPD. System leaders should identify where variation exists and ensure that people with COPD have the best information to make the right decision for them.
* Anyone with MRC breathlessness score 3 or more should be offered and encouraged to do pulmonary rehabilitation by their primary care health professional and have timely and easy access to an appropriate provider of this evidence-based therapy.
* Health professionals providing inhaler therapy for COPD should have up-to-date knowledge about what devices are available and ensure that people are able to use their devices (NICE CG101); are offered optimal bronchodilator medication (NICE GCG101). They should ensure that safety of long-term, high-dose inhaled steroids is discussed. (NICE CG101)

**People with severe disease (categorised according to the extent of airflow limitation) should be identified for optimal therapy. COPD encompasses a broad spectrum of conditions and health statuses and a personalised approach is essential.**

* People having frequent exacerbations of COPD need to be identified as they are at higher risk of an accelerated decline in their condition and may require specialist review both to manage symptoms and to slow decline. The recording the ‘number of exacerbations in the last year’ allows this group to be better identified by practices and prioritised.
* Long-term oxygen therapy is a life prolonging intervention for people with COPD who have hypoxia. When primary care professionals detect low oxygen saturation in the primary care setting, patients should be referred to a suitable assessment and review service. Primary care should record the use of oxygen on patient notes as they would for any other long-term medication to ensure timely review for assessment of safety and effectiveness.

**There should be better coding and recording of COPD consultations, prescribing and referrals.**

* 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.
* Much of the variation seen in the data suggests variance in electronic coding. In order to link datasets across the system in 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 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.