Dear Colleagues,

Re: Spirometry in General Practice

The new QOF targets for 2021/22 require us to perform spirometry for the diagnosis of asthma and COPD

Asthma:

AST006. The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or

2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1st April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration

COPD:

COPD009. The contractor establishes and maintains a register of:

1. Patients with a clinical diagnosis of COPD before 1 April 2021 and

2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and

3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry (based on NM169)

Since the beginning of the coronavirus pandemic, practices have ceased to offer spirometry to patients due to safety concerns.

The Association for Respiratory Technology and Physiology (ARTP) and the Primary Care Respiratory Society have put together guidelines for risk minimisation in spirometry restart. Here is the link for the documents https://www.artp.org.uk/write/MediaUploads/Standards/COVID19/ARTP_PCRS_spiro_re-start_FINAL2.pdf

Key points

- Spirometry is **not** an aerosol generating procedure (AGP), however, spirometry generated cough has the potential to generate aerosol droplets.
- Pre-screening considerations should always be undertaken to reduce risk

    - pre-attendance questionnaire to screen for symptoms of covid or contacts.
    - Pre-visit negative lateral flow or PCR testing

- Spirometry should not be performed on anyone with symptoms of respiratory tract infection. The approach should be in-line with local infection control procedures.

- Personal Protective Equipment (PPE)
    - consisting of gloves, apron, visor and Type IIR (surgical) mask.
    - a perspex screen between patient and operator offers additional protection.
- Equipment
    - All tests must be performed using a single use antibacterial antiviral filter.
    - Surface cleaning materials should be used to clean the equipment and all areas that have come in to contact with the patient.
- Ensure good air circulation
    - Open windows or use of extractor fans.
    - You may also consider using high-efficiency particulate air (HEPA) fan/filtration systems to help enhance air cleaning in areas frequently inhabited by persons with higher likelihood of COVID-19 and/or increased risk of getting COVID-19.
- Consider the staff member performing spirometry
    - Consider their vaccination status
    - Individual risk assessment should be undertaken if they are deemed high risk
- Given that the greatest risk is from the coughing patient
    - The patient should be pre-counselled about what actions to take if they need to cough.
        - try to stay on the mouthpiece / testing device if possible and cough into the bacterial/viral filter.
        - If they feel they need to come off the device to cough, they should have a surgical facemask in immediate proximity that is placed over the mouth immediately following completion of the
        - In some cases the use of a face shield may be easier for the patient or the use of adapted screen may be considered.
- Performing spirometry
    - **Individuals who have a** productive cough after a deep or forced airway expiratory manoeuvres, are likely to expose any individual in close proximity (i.e., the clinician performing the test) to a greater degree of risk. To circumvent the need for this type of manoeuvre, in individuals where clinicians are concerned there is likely to be a heightened risk of infective cough, **it is recommended to undertake a relaxed or slow vital capacity manoeuvre followed by a 1-2 second expiratory manoeuvre to obtain the forced expiratory volume in one second (FEV1).**

- **Low effort procedures that are not likely to cause coughing with deep expectoration (e.g., rate control exhalation during FeNO and CO monitoring), should not be considered to be a high risk.**

Patient:

- Is there a history of cough-inducing lung disease? If so, the procedure should be considered akin to an 'induced sputum procedure', and thus must be approached with a higher degree of caution.
- Whilst it is accepted that it can often be difficult to predict who may or may not cough during a procedure, individuals with a history of regular sputum production (e.g., individuals with bronchiectasis) should be classified in this category.
- Patients with distinct immune vulnerability (e.g., individuals post-transplant or who are immunosuppressed) should also be considered at increased risk. Procedures to protect them should be discussed with local clinical leads (e.g., local transplant team) and may include testing them at the start of a day or using a 'cold' testing room if possible.

Prioritising

The guidelines suggest prioritising patients for whom diagnostic spirometry will potentially impact their treatment pathway or determine their onward care.

- Spirometry to confirm diagnosis is valuable but not an immediate priority
  Routine spirometry is of low priority and annual spirometry is no longer a QOF requirement

We will be providing further guidance on how we will support practices to ensure correct diagnosis, if you do not have accredited HCPs at present.

Accreditation

Moving forward we will need to ensure that those performing the spirometry test and interpreting the results are accredited and we will have to look at how best this can be provided for patients in city and hackney to align with practices within NEL and as recommended by the London respiratory network and NHS England.

It is recommended that spirometry is undertaken and interpreted by an accredited HCP and we have funded places for individuals to do this. Accreditation requires the HCP to perform and interpret a number of spirometry results which has not been possible over the last 18 months. For those that attended the training in 2019 are now able to proceed with either level 1 or level 2 accreditation. We will be providing more information on this in the next couple of weeks.

Kind regards,
Chandra Sarkar and Hetal Dhruve (Joint Clinical Leads for Respiratory, City and Hackney CCG)