National Respiratory Audit Programme (NRAP)

COPD secondary care audit - Frequently asked questions (FAQs)
Version 1.0: October 2023

There are also guidance documents available for the technical aspects of the web tool, including how to import data in bulk.

Contents

This contents page is navigable. Please click on any of the below headings and subheadings to take you to the relevant section of the FAQ document.

General information

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- **What are the contact details for the COPD audit team?**
  - You can contact us at 020 3075 1526, or copd@rcp.ac.uk. Our help desk is open from 9am – 5pm, from Monday to Friday.
  - Our addresses are
    - London: The National Asthma and COPD Audit Programme, The Royal College of Physicians, 11 St Andrew's Place, Regent's Park, London, NW1 4LE.
    - Liverpool: The National Asthma and COPD Audit Programme, The Royal College of Physicians, 2 Paddington Village, Liverpool, L7 3FA.

- **Where can I find previous reports and general information about the COPD secondary care audit?**
  - Information about the secondary care audit (including previous reports and methodology) can be found at https://www.rcp.ac.uk/projects/copd-secondary-care-workstream

- **What resources are available for the audit and where can I download them from?**
  - The following resources are available: datasets, data collection sheet, guidance documents (including guidance on importing), patient information sheet, and patient information poster.
  - These are available on the NRAP's website: The National Respiratory Audit Programme (NRAP) | RCP London

- **Does the audit programme have a Twitter account?**
  - Yes, it does. The team posts updates regularly, so please do follow us, our twitter handle is @nrapaudit.

- **Can I obtain a participation certificate in exchange for helping with my local audit?**
  - Yes. If you would like participation certificates to recognise your contribution to the audit, please contact your local audit lead so that they can request a certificate for you from the audit team.

- **Is there information explaining the audit available for patients?**
  - Patient information documentation (poster and leaflet) are available to download from our website: Patient involvement and support | RCP London

- **Does this audit collect patient identifiable data?**
  - This audit has Section 251 approval from the Health Research Authority Confidentiality Advisory Group (reference number: 23/CAG/0045). This allows identifiable data to be collected and processed without patient consent. However, if a patient informs you that they **do not wish to be included in the audit**, please make this clear in the patient's notes and **do not enter their data** into the audit.
  - If you would like more information about our information governance, please see our information governance FAQs on our website (https://www.rcp.ac.uk/projects/outputs/support-service-teams-copd).
  - Please note that the data is anonymised post collection and we will never publish information that could be used to identify you.

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Using the web tool
Login and registration

- **Where can I find the COPD web tool?**
  - It can be found at this website: www.nrap.org.uk. Please click on 'visit' under the COPD workstream tile.

- **Do I have a login for the web tool?**
  - If you were registered, you should have received an email from helpdesk@crownaudit.org. This may have gone through to your junk mail.
  - The email will contain your username, and details on how to reset your password.
  - If you have not received this email, but believe that you should have, please contact the webtool team.

- **How do I register more users on the web tool?**
  - If you have your login for the web tool, you can create new logins for your colleagues.
  - Once you are logged in, please follow the last option on the top menu bar 'Support', then select 'New user' from the left-hand menu that appears and follow the instructions.
  - If you are the lead for the audit at your hospital, then you can approve new user requests.
  - If you are not the lead, the lead will need to approve the new user request. The lead will automatically be sent an approval request via email.
  - Once the request has been approved, an email will be sent to your colleague, asking them to complete the login process.
  - Please be careful when entering in names, telephone numbers and especially email addresses, when creating new accounts. Errors will mean that the account will have to be deleted and started again.

Viewing patient records

- **Can I view the patient records entered for my hospital?**
  - Yes. By selecting 'Patients' from the menu bar, you will be able to view which patients have been entered onto the web tool.

- **What is an 'Artemis ID'?**
  - This is a code automatically assigned to every patient entered on the web tool, which serves to anonymise the data. It is presented as a long sequence of letters and numbers such as, 5C920511992C579832C378DF34B8AFBB. Please use this if you wish to discuss particular patient records with either the NRAP audit team or Crown.
  - **Please do not, under any circumstances, send/provide NHS numbers to any member of the NRAP audit team.**

- **Can I search through the patient record list by NHS number?**
  - Yes, there is a search box where you can search by NHS number. It is likely that you will see the same NHS number multiple times as patient readmissions are entered as separate records. Duplicates are

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automatically captured by the web tool using a combination of patient's NHS number, date of birth, admission date, and postcode.

Deletion of patient records

- **What do I do if I have entered the same patient twice?**
  - If you attempt to validate or save a record which has already been entered (i.e. the NHS number, date of birth, gender and date of admission match), the web tool will flag this up and you will not be able to save the duplicate.

- **I want to delete a patient record, what do I do?**
  - Click on the record you wish to delete
  - Click "Edit" in the top right hand corner
  - Click "Delete"
  - In the pop-up box that appears, select your reason for deleting the record, tick "confirm deletion" and then click "Delete"
  - The record will appear in your deleted records list (this list won't appear until you have deleted a record)

Adding/removing custom fields

- **How can I add in/remove custom fields?**
  - If you wish to add in custom fields to your dataset, then please select 'Custom fields' from the top menu bar once you are logged into the web tool and follow the instructions on the left-hand bar.
  - You can request to delete a custom field only if there is no data stored against it. If there is data against the custom field, but you still wish to remove it, you are able to 'disable' for local use.
  - To disable a custom field, select 'Custom fields' from the top menu bar, then click on the name of the field you wish to disable. Click on the 'Edit' button in the top right-hand corner and then select 'No' for 'Include this field in your records?'
  - Please note that custom fields cannot be imported. Please refer to the separate import guidance documents (available on the web tool and on our website) for more information.

Importing and exporting data

- **Can I upload/import patient data in bulk?**
  - Yes, you can bulk upload data in a suitably formatted .csv file.
  - Guidance on how to format these files is available on both the web tool's 'Downloads' page at www.nrap.org.uk (available to select from the top menu bar of the homepage of the audit once you are logged in) or alternatively you can contact the NRAP audit team or our webtool provider here helpdesk@crownaudit.org for more information.

- **In the importing specification document, which of the columns provide details of acceptable response options for the questions?**

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- Column H provides acceptable responses, as do columns I and J. We offer three types of data for imports as each have their merits and limitations:
  - Column H is a 'short-code' - typically a single character, (but not always), letter or number or both, e.g.: 'F' for 'Female'. The code is not always obvious (i.e. does not necessarily map clearly to the data item), but hard to get wrong and most external systems can support this coded form.
  - Column I is the full 'dataset' phrase - typically more than one word with possibly some punctuation characters included. This format is very 'readable' but hard to get exactly right, suffers from spelling mistakes, punctuation errors, character set and word substitution issues. Many external systems struggle to deal with these long descriptive phrases and concatenations of multiple phrases.
  - Column J is an 'import only' reduced 'keyword' phrase - typically a single word without punctuation. This is a compromise to balance brevity with readability between the minimalist codes (in column H) and expansive dataset phrases (in column I). The 'keyword' is easy to get right, has an obvious meaning and is compatible with most external systems.

- **In the importing specification document question 10.4 is multiple choice. How should the responses to this question be formatted?**
  - When multiple choice responses are required, we typically recommend using the semi-colon as the main separator. If your system cannot support the semi-colon character, you can also use: | ^ & * _ # @ + characters.

- **Can I export the clinical data for my own hospital?**
  - Yes. Once you are logged into the web tool, select 'Exports' from the menu bar and then follow the instructions to export your site level data as a .csv file.

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Clinical audit

Data entry deadlines

- **When did the COPD clinical audit start?**
  - For England and Wales, data collection started on Wednesday 1 February 2017 at 8am. Data collection started in Scotland on Thursday 1 November 2018 at 8am and finished on 6 November 2020. Data collection for all audits runs (or ran) continuously.

- **Are there any deadlines for entering data?**
  - There are data entry deadlines which align with the COPD Best Practice Tariff (BPT) and other reports* we produce. These are listed in the table below:

COPD

Deadline date	Patients discharged
10 November 2023	1 April 2023 – 30 September 2023
9 February 2024	1 October 2023 – 31 December 2023
10 May 2024	1 January 2024 – 31 March 2024
9 August 2024	1 April 2024 – 30 June 2024
15 November 2024	1 July 2024 – 30 September 2024
14 February 2025	1 October 2024 – 31 December 2024
16 May 2025	1 January 2025 – 31 March 2025
15 August 2025	1 April 2025 – 30 June 2025
14 November 2025	1 July 2025 – 30 September 2025
13 February 2026	1 October 2025 – 31 December 2025
15 May 2026	1 January 2026 – 31 March 2026

- **Can I have an extension on the above deadlines?**
  - Unfortunately, we cannot offer extensions on the above deadlines under any circumstances.
  - We recommend that hospitals allow enough time to screen for, and apply if necessary, national data optout preferences from 31 July 2022.

- **How many cases should we be entering?**
  - All patients admitted with an acute exacerbation of COPD should be included. Please note that we are not auditing patients for whom COPD is a comorbidity, but only those where COPD is their primary diagnosis.

- **Are draft records included in any of the COPD audit reporting?**
  - No, draft records are not included in any COPD audit reporting. Please ensure all records are saved fully prior to data entry deadlines.

Best Practice Tariff (BPT)

COPD BPT was reintroduced in April 2023.

- **What are the COPD Best Practice Tariff metrics?**
  - The conditions are that, at a trust level, 60% of all patients admitted with an exacerbation of COPD must have both:
    - Received a review from a member of the respiratory team within 24 hours of admission, **and**
    - Received a COPD discharge bundle, or the components thereof.
  - For more information about the COPD BPT please refer to the information on our resources website, or visit the NHS Improvement website, https://www.england.nhs.uk/wp-content/uploads/2022/12/23-25NHSPS_Annex-DpC-Best-practice-tariffs.pdf

- **How will commissioners be able to see whether my trust has achieved BPT?**
  - After each quarter ends, a commissioner's report will be produced showing whether each participating trust reached BPT for that quarter.
  - The BPT commissioner report for the current quarter can be accessed by going to www.nrap.org.uk and selecting the 'Reports' button from the COPD secondary care box.
  - This is a publicly available report, and all future quarterly reports will be hosted in the same place.

- **Can I add commentary to the national commissioner's report to provide more background as to why my Trust did/did not reach the BPT?**
  - You cannot add any commentary to the national commissioner's report and we are not able to add this for you. You will need to contact your commissioner in these circumstances.

- **Can I see which patients have received both BPT indicators?**
  - You can check which patients in your hospital's cohort have met the tariff indicators on a monthly basis. This can be found by logging into the web tool (www.nrap.org.uk) and selecting the 'Visit' link from the COPD tile. Once logged in select 'Reports' from the top menu, and then selecting 'BPT data check' from the left-hand menu.

Eligibility criteria

- **What if a patient develops an acute exacerbation of COPD whilst already admitted for a different reason (e.g. a patient originally admitted with a hip fracture experiences an acute exacerbation of COPD (AECOPD) 3 days into their stay)?**
  - You should only include patients that were originally admitted due to an AECOPD. Please discount patients that develop an exacerbation whilst already admitted for an alternative issue.

- **What are the inclusion criteria for the clinical audit?**
  - Include patients:
    - who are 35 years and over on the date of admission,
    - who have been admitted* to hospital adult services,
    - who have a primary diagnosis of COPD exacerbation,

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- where an initial, or unclear, diagnosis is revised to an acute exacerbation of chronic obstructive pulmonary disease (AECOPD).

*Where admission is an episode in which a patient with an AECOPD is admitted to a ward and stayed in hospital for 4 hours or more (this includes Emergency Medicine Centres, Medical Admission Units, Clinical Decision Units, short stay wards or similar, but excludes patients treated transiently before discharge from the Emergency Department (ED)).

Please refer to the quick guide below for specific ICD-10* codes and positions eligible for inclusion in the COPD clinical audit.

Fig. 1: Patients with the following ICD-10 codes and positions in the first episode of care are eligible for inclusion in the audit:

Inclusion criteria codes and positions:

1st position	2nd position
J44.0 – COPD with acute lower respiratory infection	Any code
J44.1 – COPD with acute exacerbation	Any code
J44.8 – other specified COPD	Any code
J44.9 – COPD unspecified	Any code
J43.9 - emphysema	Any code
J22 – unspecified acute lower respiratory infection	J44.0 or J44.1 or J44.8 or J44.9 or J43.9
R06.0 – dyspnoea (shortness of breath)	J44.0 or J44.1 or J44.8 or J44.9 or J43.9
J96.0 – acute respiratory failure	J44.0 or J44.1 or J44.8 or J44.9 or J43.9
J96.1 – chronic respiratory failure	J44.0 or J44.1 or J44.8 or J44.9 or J43.9
J96.9 – respiratory failure	J44.0 or J44.1 or J44.8 or J44.9 or J43.9
J10.1 – influenza due to other identified influenza virus with other respiratory manifestations	J44.0 or J44.1 or J44.8 or J44.9 or J43.9

Retrospectively identifying patients who have been miscoded:
To ensure that all eligible patients are included in the audit, NRAP recommends that if resources allow, clinical leads should periodically review patient lists. If any patients have been miscoded, and their correct code is shown in fig. 1 in the necessary first or second position, they should retrospectively be included in the audit.

*For more information on how inclusion criteria were determined, please refer to paper *Recording of hospitalizations for acute exacerbations of COPD in UK electronic health care records*. Clin Epidemiol 8: 771-782. Available here.

- **How do I identify cases for inclusion?**
  - If there is doubt over the inclusion or exclusion of an individual case, it is reasonable to check with the clinician leading the audit at your site.

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- o We suggest that cases should be identified prospectively.

- **What are the exclusion criteria for the clinical audit?**
  - o Exclude patients:
    - in whom an initial diagnosis of an AECOPD is revised to an alternative at a later stage,
    - who have had a stay in hospital of less than 4 hours (who would be classed as a non-admission)
    - with COPD who are being managed for pneumonia, not AECOPD*.

*This would usually mean the presence of consolidation on a chest x-ray.

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Clinical audit dataset

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Inclusion criteria

- **Which audit (COPD or AA) do I enter a patient with mixed airways disease in?**
  - This is a clinical decision and is entirely up to the local team. As per clinical advice, the data inputter should come to the clinical decision, whether the reason for admission is for asthma or COPD.
  - If it is due to asthma then they should be inputted in the asthma audit. If it is due to a deterioration in COPD then the record should be entered in the COPD audit.
  - If there is a genuine reason to be unable to differentiate then they should be excluded from the audit.

- **A patient has COPD and is also covid positive, do I include the patient data in the COPD audit?**
  - Please refer to the position of the ICD-10 codes as per the inclusion criteria specified in the dataset or on page 8 of the COPD FAQ's document.
  - If Covid is the primary diagnosis with COPD in the second position, the admission should not be included because the audit is specifically for acute exacerbations of COPD and we do not want to include patients with Covid who coincidentally also have COPD.

- **If someone has got AECOPD on discharge summary but their treatment in hospital is for pneumonia and states they were treated for pneumonia. Do we include this in the COPD audit?**
  - No. Our exclusion criteria state 'that people with COPD who are being managed for pneumonia, not AECOPD' should be excluded.

Admission data

- **How do I answer question '*Time of admission to the unit'?***
  - This refers to the time that it was decided that the patient would be admitted (regardless of how long the patient may have subsequently spent in A&E before being admitted to a ward). This can be any ward and does not have to be a respiratory ward. This can be the same time that the patient left A&E if this is the only information available in the patient notes.
- It doesn't matter if the patient is subsequently moved to a respiratory/more appropriate ward; the time entered here should still reflect the time of the decision to admit the patient.
- **A patient was not admitted within 72 hours of arrival and the system will not allow me to enter the admission date/time, how do I record this?**
  - Enter the admission date/time as exactly 72 hours after arrival. Note that this may impact the time from admission to respiratory review. To record the actual admission date/time and / or reason for not admitting within 72 hours, add custom fields to the dataset (see page 4).

- **Why does the system not allow an admission date/time more than 48 hours after arrival to be entered into the system?**
  - As of 1st June 2023, the 72-hour limit was included because the majority of patients should/will be admitted within 72 hours of arrival at hospital.

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Respiratory specialist review

- **A patient was assessed by a respiratory specialist in A&E before the decision to admit was made. Does this mean that I can answer 'yes' to the question 'Was the patient reviewed by a member of the respiratory team during their admission'?**
  - o Yes, you can record these reviews if they occur in A&E, but you will only be able to record respiratory review time after the time of arrival. In these cases simply enter the date and time of arrival or within 1 hour of arrival for the respiratory review.

- **Can advanced nurse practitioners who regularly manage respiratory patients be included as members of the respiratory team regarding specialist review?**
  - o This would be at the discretion of the local respiratory lead. If a member of staff is deemed competent, has had appropriate training and is working as part of a wider respiratory team, then this should, in theory, be acceptable; however the local team should decide this.

- **A patient doesn't have a time recorded in their notes for first review by a member of the respiratory team, how do I answer this question in this instance?**
  - o As time to respiratory review is one of the COPD BPT criteria, it is essential that a time is recorded. If you cannot find a time, we suggest asking a member of the clinical team and referring to the notes where possible. We also advise reminding the local team, of the importance of recording the correct time, and recommending they incorporate it going forward.

- **For patients who are less severely unwell, we sometimes discharge them within 24 hours under an early supported discharge scheme. This means that they will usually not have had a respiratory review but will have been seen by a consultant (non-respiratory). Could this count as a respiratory review?**
  - o In these circumstances, you should tick 'no' for respiratory review. A review by a member of the respiratory team is important, as it means the patient is more likely to receive the correct interventions.

- **What about patients admitted to the ICU? They are not seen be a respiratory specialist within 24 hours but are clearly receiving specialist care?**
  - o 'No' should be selected if a patient has only been seen by a non-respiratory staff member. This includes patients admitted to ICU who are receiving non-respiratory specialist care.

Non-invasive Ventilation (NIV)

- **The patient wasn't decompensated on arrival, but did require NIV later during the admission, how do I record this, given that the target is within 2 hours of arrival?**
  - o NRAP recommend that all people admitted with an AECOPD and require NIV, receive it within 120 minutes of arrival at hospital.
  - o If a patient was not decompensated on arrival but did require NIV later during their admission, we recommend that you add a custom field to the dataset to record why NIV wasn't given within 2 hours. Eg "If the patient did not receive NIV within 2 hours of arrival, please give the reason." This will not be

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included NRAP's national reporting outputs but will be useful for your service's internal performance review.

Spirometry

- **The only spirometry data available is over a year old, can I still enter this?**
  - o The web tool validation is set so that it will accept any date on or after the patients 35th birthday.
  - o Please ensure that you are entering the most recent reading that can be found for each patient. The most recent reading should be preferably only a year old. If the result is over a year old. Please conduct a spirometry test for the patient to confirm their COPD diagnosis once again.
  - o If you have any questions regarding spirometry date, please contact the audit team (contact details on the first page and at the bottom of this document).

- **Where would I find the FEV1% predicted value to answer question 8.1 in the COPD clinical dataset?**
  - o This information is commonly found on a spirometer/spirometry result print out.

- **What do you enter if no spirometry is available - don't we report the KPI as % of cases with FEV1% recorded?**
  - o If there is no spirometry available, please select 'Not recorded. Although this may reflect negatively on your service's performance (eg % of cases with FEV1% recorded), remember that the purpose of the audit is to drive QI at a local level.
  - o We recommend that you add a custom field to the dataset to flag that spirometry is not available. This will not be included NACAP's national reporting outputs but will be useful for your service's internal performance review.

- **How do I calculate the FEV1/FVC ratio?**
  - o FEV1/FVC ratio can be calculated by dividing the FEV1 by the FVC.
  - o If you only have the ratio recorded as a percentage, please divide this figure by a 100 to convert it to a decimal.

Smoking status

- **If a patient uses only e-cigarettes but has never smoked cigarettes, how should I record their smoking status?**
  - o Please record this patient as 'Never smoked and current vaper'.

- **If a patient has recently quit smoking cigarettes, how should I record their smoking status?**
  - If the patient stopped smoking at least 4 weeks prior to the admission, please enter 'Ex-smoker'.
  - If the patient has stopped within 4 weeks, mark as a 'Current smoker'.

- **If a patient regularly smokes a substance other than tobacco (e.g. cannabis), how should I record their smoking status?**
  - o Regular smokers of any substance (i.e. including cannabis or heroin) should also be counted as current smokers.

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Discharge & discharge bundles

- **What date of discharge do I enter if the patient is discharged onto another hospital, an early discharge scheme, hospital at home or community COPD scheme?**
  - Please enter the date of discharge from your hospital and not the scheme.

- **A patient was readmitted soon after their previous discharge, do we need to issue another discharge bundle even if they received one less than a few weeks before?**
  - Please only select 'Yes' if a discharge bundle has been completed for the **current admission.**
  - We recommend that a discharge bundle is completed for every admission to ensure the patient remains aware of the correct inhaler technique and medication use, smoking cessation options, pulmonary rehabilitation and follow-up arrangement. Arrangements may not have changed if the time to readmission was short. It is particularly important to optimise care for those with frequent admissions and, in addition to the standard interventions on the bundle, consideration of co-morbidities and social support will be equally important.

- **Do the items from the discharge bundle have to be given to the patient at discharge to count as being issued?**
  - Not necessarily. If the patient has received the necessary required items during the course of their admission and this has been checked at discharge, then this will count as having received a full discharge bundle.

- **To achieve the BPT an organisation needs to demonstrate they have completed a discharge bundle (BTS or equivalent if alternative version is used.) Do all elements of the bundle need to be completed?**
  - It is recommended that all elements would be completed however if they weren't, or an alternative was included in your organisation's particular bundle that was different from the BTS this is acceptable and you would not be penalised for this.

- **How do I record it if a patient is offered elements of the discharge bundle, such as referral to smoking cessation or pulmonary rehabilitation, but declines?**
  - If the patient has been offered smoking cessation, asked and/or been provided with the necessary information they need to make/request the follow up/PR referral appointment(s) themselves within the recommended timeframe, please select that the component was completed.

- **What should I do in situations where the patient self-discharges (against the advice of the medical team), and so therefore we have not been able to provide a full discharge bundle?**
  - In an occasion where a patient has self-discharged, and therefore the team have not physically been able to provide a discharge bundle, please select 'Self-discharge' at the question 'Was a discharge bundle completed for this admission?'.

- **How should I enter a patient that dies during admission into the web tool?**
  - In the occasion where the patient has died during admission, please enter their date of death into the questions 'Date of discharge/death'. In this circumstance you would not need to complete the

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discharge bundle or discharge elements of good practice questions, these would automatically grey out on the web tool and disallow data entry.

- **What if elements of a discharge bundle have been considered but deemed unsuitable for a patient?**
  - Please select 'No' if items are considered, but not received because they are deemed unsuitable. You may wish to add in a custom field identifying the reasons why. This will not be included in NRAP's national reporting outputs but will be useful for your service's internal performance review.

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