Respiratory Managed Clinical Network

NHS Lothian

Respiratory MCN Core Group Meeting

Approved Minutes

Date: **Wednesday 5th February 2020**
Time: **10am – 12pm**
Venue: **Forth Suite, Chest Heart & Stroke Scotland, Rosebery House, Edinburgh**

Present:	Gourab Choudhury (Chair)	Clinical Lead, Respiratory MCN
	Elspeth Christie (Co-chair)	Clinical Lead, Respiratory MCN
	Ximena Recabarren	Clinical Lead MCN Subgroup, Bronchiectasis
	Claire Yerramasu	Advanced Physiotherapist
	Frieda Cadogan	Respiratory MCN Co-ordinator
	Crichton Ramsay	Clinical Director, Respiratory Services
	Katie Johnston	Primary Care Pharmacist
	Laura Groom	Physiotherapist, Community Respiratory Team
	Jill Adams	Physiotherapist, REACT response team, WL
	Shena Brown	Respiratory Facilitator, West Lothian
	Alexis Rumbles	Team Lead, Acute, Smoking Cessation
	Kim Bracher	Respiratory Nurse Specialist, RIE
	Jo Pilarska	Physiotherapist, East Lothian Community Hospital
	Donald Noble	Respiratory Consultant, St John's Hospital
	Allan White	Respiratory Advisor, Chest Heart & Stroke Scotland
	Katherine Byrne	Policy Manager, Chest Heart & Stroke Scotland
	Stephen Doohan	Clinical Team Leader/SR Paramedic, SAS
	Tom Mackay	Clinical Lead, Sleep Medicine
	Laura Jess	Specialist Nurse, Sleep Services
	Kenneth MacLeod	Paediatric Respiratory Consultant
	Ann McMurray	Respiratory Nurse Specialist, RHSC
	Susan McNarry	Physiotherapist, Pulmonary Rehabilitation
Apologies:	Frank Toner	British Lung Foundation
	Alyson Cumming	Programme Manager, Respiratory MCN
	Tracey Bradshaw	Clinical Lead, Asthma
	Luke Daines	Clinical Lead, Public Health/Innovation
	Nik Hirani	Clinical Lead, ILD
	Allan Cowie	Director of Services, Chest Heart & Stroke Scotland
	Dorothy Keith	Patient Representative
	Karen Gray	Smokefree Lothian Service Manager
	Jill MacLeod	Senior Chief Respiratory Physiologist
	Robyne Henderson	Acting Area Service Manager, Clinical Lead SAS
In Attendance:	Rachael Bell	Management Trainee, Strategic Planning
	Leanne Swadel	Programme Manager, Midlothian H&SCP
	Kim Turnbull	Bronchiectasis Nurse Specialist
	Orla Prowse	Service Lead, CRT and PR

1.	**Apologies**	
	Apologies were noted as above.	
2	**Welcome & Apologies**	

	The chair welcomed everyone to the meeting and introductions were made around the table.	
3	**Minute of the Previous Meeting – 20th November 2019**	
	The minutes from the previous meeting on 20th November 2019 were recorded as an accurate record.	
4.	**Respiratory Care Action Plan for Scotland Consultation**	
	The consultation was circulated as part of the meeting papers and a discussion took place during the meeting with the following points being highlighted: • There was some concern highlighted around the lack of patient involvement in the development of the plan, however this has now been addressed. British Lung Foundation (BLF) and Chest, Heart and Stroke Scotland (CHSS) met with the Scottish Government and a focus group is being held in Glasgow in two weeks. There is a link available to an online survey which will be circulated to the group. Responses will be sent to the Scottish Government and the outcome from the focus group event will help inform the CHSS response. • In relation to Smoking Cessation, Robbie Preece and Alexis Rumbles will give feedback to MCN, as mentioned throughout the document and will meet up to discuss in more detail to see if there is enough clarity around the issues raised. In relation to data for the service the team will attend a future meeting to present for each site. There are still some issues around Champix not being used as efficiently as it should be. This is currently stocked in Pharmacy and there is a need for clinics to have access to this sooner and there is a need to understand the challenges around the prescribing of this. It was also confirmed that each ward on the RIE and WGH site now stock nicotine patches as this was not previously the case. • The group agreed that there is important to have access to data around quit rate etc for plan. Dermott Gorman, Public Health Consultant and Alexis Rumbles will speak to the Clinical Director for TRAK to add a question around vaping and for patients quit date etc. • Need to add vaping to the action plan as there is now some evidence available around the short term toxic effects of vaping. Further information will be requested from the Public Health Pharmacy Consultant on guidance around this and will feed this back to the group. • Priority 1 – no commitment stated. All areas have this included except Prevention. • Performance indicators are very vague and there is not enough information to be able to measure improvement around quality of care and milestones. This is essential to include. • Air quality – NICE advice available to healthcare professionals on outdoor quality of air but not indoors. There needs to be some guidance around for example the burning of candle's around children under the age of one and aerosols and other things that can trigger an exacerbation. Anne McMurray will circulate the NICE document currently available for information. • Weight management – there is currently only funding for diabetes but no commitment around low BMI for respiratory patients. Losing weight and gaining weight is equally important in respiratory conditions. • Priority 2 (page 15) – This section is fine and includes early and accurate	

diagnosis which is good and health training for professionals.

- Pulmonary Rehabilitation (page 16) – Positives are that they have included some data from CHSS. Need clarity around how we measure improvement rates and what the targets are over 5 years for improvement. Also need clarity from Scottish Government around additional funding and resources required for improvement.
  - It was also noted that accreditation has been mentioned but information is vague with definition required and details on how this can be done. Also need some information around additional funding and resources required.
  - No mention of disease specific here although this is mentioned later on within the document. Not enough information around commitment and what is meant by support. Need to clarify if this is financial support. There is also mention that "we will design pathways". Need clarity around who will be doing this. Clarity is also required around definitions and resources and baseline data would be good.
  - Could include examples of good practice from pulmonary rehab.
- Mental Health (page 17) – There is not much detail here which is important to include. There needs to be more information on what exactly needs to be done and clarity around what the measures are and markers for success. Document mentions respiratory condition that affects mental health, however this is different to the group of patients who have mental health issues as well as a respiratory condition and document does not address this.
- Transition from child and young people services to adult services (page 18) –This section is vague and needs to include transition process for primary care and not just clinics. There is a need to recognise that the majority of young people with asthma only have contact with health professionals in primary care. Important to include process for adolescents moving to adult services and not just children. The focus is only on asthma whereas other areas of the document focus on general respiratory conditions. Clarity needed around all other associated area with chronic respiratory disease and not just medical management side for asthma.
- Palliative Care (page 19) – The group was content with this section and agree it is important to include information around palliative care. This is also mentioned in the sub-group sections. It has also included information around Anticipatory Care Planning which is good.
- Person centred and self-management (page 20/21) – A steer around the signposting of patients is important to include and the thoughts of patients needs to be incorporated into the document. The Patient Activation Measure (PAM) audit that is being done in Lothian should provide us with some sense of patients understanding of their self management. There also needs to be some clarity on measures and what needs to be done around patient understanding. Perhaps a steering committee would be a good proposal.
  - Anticipatory care Plans – national programme was embedded in 2018 which sits in commitment on how this is sustained and not stopped after embedded in the system. There is a need to understand how to take this forward on an ongoing basis.

  - Document mentions tertiary service support but not peer to peer support which is important. There is a need to have peer support groups in all areas within respiratory medicine.
- Equal Access (page 22) – Equity is being achieved and the Scottish Atlas of Variation tool which is included is very good and has good data.
- Commitment 12 (page 23) – In relation to understanding gaps in prevalence it would be good to include some baseline data to have markers around deprivation and mortality.
- Workforce (page 24) – Good to include this but also need to add Allied Health Professionals in here as it just mentions nursing and medical staff. It may be useful to put together a steering group for each sub-specialty on a national basis.
  - Need clarification around number of staff required in each region for optimal service provision and a structured framework is required in order to deliver. Need to be clear around Physiotherapist and need to state this profession other than just Allied Health Professionals. Also good to be more specific around the independent prescribing skills that sit with physiotherapy. Good to also acknowledge AHP in the broader sense. Orla Prowse will feedback further comments on this.
  - There is due to be a lot of retirements with Specialist community nursing so need to clarify how the Scottish Government will address this.
  - Benchmark around workforce good.
  - Group content with the remainder of workforce section.
- Partial Equality Impact Assessment (EQIA) (page 28) – There are challenges around all of this for healthcare providers. There needs to be a national impact assessment before local impact assessment.
- Implementation (page 29) – There needs to be clarity around targets and timeframes and expectations from each health board.
  - Document mentions 'partners'. Need to clarify who these partners are.
- Asthma (page 35) – Tracey Bradshaw will need to comment more on this section. Kenny MacLeod commented that the information is very vague and not particularly helpful to healthcare professionals. Need to clarify who this information is addressed to i.e. patients, families, healthcare professionals etc.
  - Page 37 – Needs to be more elaboration with link to BTS guidelines for description of asthma. Should reference quality standards or BTS guidelines for all conditions (BTS first and then standards if no guidelines).
  - Could include section on standards of care.
  - In relation to Diagnostics, only Spirometry is mention and there are other options therefore this needs to be broader.
  - Ask Tracey Bradshaw, Kenny Macleod and Ann McMurray for feedback.
- Bronchiectasis (page 38) – This was discussion at the Bronchiectasis subgroup meeting in February.
  - In relation to High Resolution CT (HRCT), there is a need to understand this further. This was done previously in Lothian but stopped due to funding issues. Currently only being done in NHS Tayside.

- In relation to Specialist clinic, this is a good idea but difficult to put into practice.
- Physiotherapy – agree with chest clearance techniques and needs clarity around funding.
- No mention of IV antibiotic and people treated at home and benchmarks around bed days saved. Worth adding.
- Where is funding for all of this in general.
- Patient rep feedback raised concerns around lack of clarity around funding. Need to emphasise the importance of patient interaction and peer to peer support to encourage this. There is a need for a process around this and patient feedback is that there was disappointment that this was not included.
- App – exploration of this for Bronchiectasis and national level. Nothing in plan around this.
- Good aims but need more detail on resources. Physiotherapy is the main issue.
- Respiratory diagnostic hub sounds good but how are these developed. How would these be taken forward and what are the resources available for this, if any.
- There were concerns raised that no-one from Lothian was involved in the development of the Bronchiectasis section of the plan.
- Paediatric – causes missed some management strategies PCP.
- There needs to be more information around diagnosis. Bronchiectasis has different causes and CT does not deal with this. Needs more than CT.
- There is no differentiation between primary care and secondary care, however it is understood that a lot of this will be done within primary care. There are some concerns around how this is managed in primary care as normally done in secondary care. There needs to be more specific information around training for primary care for the best management of patients. Perhaps an education programme or primary care pathway for early phase 1 patients.
- Pulmonary Rehabilitation do not see a lot of Bronchiectasis patient, however there is evidence to suggest they would benefit from more targeted PR.
- Fungal lung disease – Comments from group initially were that it was not understood why this was under Bronchiectasis section. It was confirmed that there are longer term plans to deal with this in Lothian, with plans to increase services, therefore it does fit here. This is in the early stages. It would be good to have data and this will be explored further within Lothian. Could ask the Scottish Government about this.

- COPD (page 41) - More addressed as lot of work going on currently. PR mentioned. Suitable venue doesn't matter where this is. Who leads classes? One nurse led PR in tayside and now retired. All physio. NICE guidelines repeating PR unnecessary to mention here. Point they are trying to make is challenges of delivering PR as patients do not attend as lack of understanding of importance of PR. Need to look at how to address this. Not about venue. About challenges around how we deliver PR. Future – could we do different version of home rehabilitation example.
  - No information around oxygen therapy. Need ambulatory oxygen included also.

- Novel therapies in COPD available – e.g. in GOLD guidelines. GC will feed this back to SG to incorporate into future workforce plan.
- In relation to Spirometry in Primary and Secondary care, need to be careful around defining accreditation of this and who can do this. Need guidelines around who is doing spirometry.
- Good idea of long term goal of hubs but how will hubs differ from clinics? Would get echocardiogram at same time and specialist in situ. Is this respiratory or cardiac? Patient will get assessed and then patient put in right pathway. Come up with one centre where initial tests done quite quickly. CTAC centres has Feno and spirometry there. There is a need to diagnose early to get patient on right pathway. If it is done well it might have implication on early diagnosis. Could include exercise and smoking cessation. This needs to be explored further.
- Largely preventable mentioned – how is this done? Need to include this. Also need to look at who is at risk of developing COPD in future. GC will look into this and discuss with Alison McCallum to come up with joint recommendations. There is a Smokefree home initiative but Alison McCallum has more information on this around prevention.
- Long term management of patient not being able to access PR to improve self management. Specialist nurses mentioned but not physiotherapists for example. Physiotherapists are such an integral part of self management in the community.
- In relation to Vaccination, KJ advised that Lothian data is available and it would be good to get national data also. It was advised that GP practices get paid to get these patients in. Could trial with community pharmacists given through NHS to improve uptake. There is a lot of discussion currently ongoing to take this away from GP's. Would be good to incorporate our five year goal and what we would like to achieve in relation to numbers.
- Oxygen – process needs improved. Not reviewing people properly. Dolby can provide data but no oxygen service to support review. Some patients come in to clinic and to CRT so Elspeth Christie can get someone to review this. Could get baseline data and recommendations on how to do this in Lothian. – SB/EC
- Smoking cessation – Acute currently doing quality improvement and will include further information on this when they present at future meeting.
- There is no mention of consequences. There is also a mention of symptoms and diagnosis but no mention of mortality etc. Plan does not state what issues are. Nothing in any areas other than bronchiectasis. Need a separate section reinforcing why this is important and why we have the plan.
- Would be helpful to mention other drug use such as cannabis smokers. PR seeing patients who smoke cannabis. Recreational drug users and COPD – GC will assist FC with adding this.
- There is no mention of community based respiratory teams where these are implemented.
- Alpha 1 – This is a niche group and is a rare cause of COPD and is a different group to general COPD with different challenges. Discussions are taking place for the exploration of a national network.

- ILD (page 45) – This needs more clarity and milestones. Needs to include palliative care and Pulmonary Rehabilitation in more detail.
  - No mention of peer support and carers support which is very important along with ELTOT reviews. Mentions specialist nurses but not talked about ratios. What are Primary and Secondary care provisions and differences between both areas. Secondary care has more resources but very little in Primary care. There are currently only two ILD nurses across the whole of Scotland. Kim Bracher will draft some bullet points to include in feedback and send to FC.
  - Obstructive Sleep Apnoea Syndrome (page 48) – Overall it was thought this section was disappointing as very basic and it misses the impact of the service with metabolic issues being the driver in relation to problems.
  - Terminology in relation to sleep apnoea and references to it being a syndrome is not good in the wider context.
  - Good to have example of good practice included however targets are not realistic. Numbers are not achievable and are out of context.
  - Engagement with technology and industry good but not realistic. Tom Mackay meeting with Tom Fardon today and will feedback.
  - Plan does not mention children and treatment for ILD would be completely different. Kenny MacLeod has Lothian data and can provide this which would be good to include. Prevalence and causes.
  - Diagnostic hubs – who takes responsibility for these and it would be good to have an example of what the diagnostic hub will look like. Is this part of ETech centre. Looking at other specialities.
  - Impact consequences as recurring theme. Baseline data would be good. Does not target specifics and is to general and broad. Who is this aimed at? Needs to be two documents, one for healthcare professionals and one for patients/carers. Sub-specialties could write their own documents.
  - There is no mention of Scottish Ambulance Service and they are a big part of the pathway. SAS representative at meeting confirmed they have their own pathway which has been implemented nationally which would be good to include. This is to prevent admission and assessment in the community. Will send pathway to FC.
  - There is nothing included on pharmacy which is interlinked. The plan mentioned a few niche areas but nothing in detail.
  - Useful to illustrate services which would be local, national and secondary care. Struggle to get things off the ground due to size of health boards. Certain things should be managed at national level. Not detailed in everything but some examples. Lung volume reduction mentioned previously. Agreed Glasgow national and Edinburgh local but not mentioned here. Highlighted that some aspects that need national commitment.
  - Quality of life issues not mentioned anywhere and it would also be good to include any targets we want to include. Boards are trying to achieve this as best practice.
  - Good to include something around sustainability in relation to medicines such as inhalers. NHS Lothian has a sustainability

	strategy but should still be mentioned in plan.	
5.	**MCN Sub Group**	
	Asthma	
	Due to time constraints an update was not provided.	
	Bronchiectasis	
	Due to time constraints an update was not provided.	
	ILD	
	Due to time constraints an update was not provided.	
	COPD	
	Due to time constraints an update was not provided.	
	Sleep Services	
	Due to time constraints an update was not provided.	
6.	**Stop Smoking Service Referrals**	
	This was discussed within item 4 of the agenda.	
7.	**Midlothian CRT**	
	Claire Yerramasu and Lianne Swadel delivered a presentation to the group on the progress made with the development of Midlothian Community Respiratory Team (CRT) with the following points being highlighted: • The development of the service is to treat patients at home in partnership with Midlothian Health & Social Care Partnership and NHS Lothian to prevent hospital admissions and to support patients with exacerbation of condition. This should also enable patients to be discharged from hospital sooner. The estimate is a six day saving per admission avoidance. • There is a high amount of mixed disease in Midlothian due to mining in the area previously and there has been a 28% increase in diagnosis. • There have been issues around coding of the data and a solution to the problem is being looked at on an ongoing basis. This is sometimes challenging due to the relatively small team treating a large cohort of patients. Prevalence is increasing however admissions are not therefore there has been a large impact and this is supported by patient feedback on the positive difference the service has made. Patient Activation Measure (PAM) project will provide more data to demonstrate the impact of the service. • Year to Oct 19 had 131 admissions prevented resulting in approx 700 bed days saved. 4 bed days saved per facilitated discharge. • Strength in data when looking at specific patients. • GP Pilot has taken place at Pathhead Medical Practice. • Reduction in cohort of patient of 48.8%. • Positive comments received from patients around increasing knowledge of self management and confidence. • Looking at expanding CRT to look at weekend working. • Results show that all 5 practices involved in pilot have made marked improvement. The group was asked for any comments or questions.	

	Orla Prowse asked if CRT team is doing treatment at home professionally that could be done in hospital. A lot of patients self refer as not confident, however there is a follow up from CRT a week after their hospital visit. As they have this support when they go home, patients are less likely to go to hospital. The CRT is supported by the MERRIT team. Within Edinburgh a band 4 will be going out to anxious patients to do exacerbation exercises to encourage basic level of encouragement and confidence. West Lothian is already doing this with patients. They link in with Hospital at Home and this model works well. It was agreed that it would be good for all areas to collaborate on what work is being done in each area, to share learning. In East Lothian recruitment has taken place for a community led Physiotherapist and going forward this will be CRT focused.	
8.	**In-Check Device**	
	The group was given an update on a potential pilot study taking place in West Lothian around the use of the in-check inhalation airflow inhaler. There is a need to understand how well we are, as a service, assessing techniques. This needs to be done more from a primary care perspective through Hospital at Home and will be trialed in different areas. There are so many different devices available however service needs just one with infection control in place, for demonstration purposes. Pulmonary Rehabilitation currently use this as well as Midlothian and the devices can be ordered online. Lesley Berry will provide Shena Brown with the details on how to do this. Going forward it would be good to progress with a pan Lothian business case for uniformity.	
9.	**Research Study**	
	The group was given a brief overview of a pilot study that is taking place around the introduction of home IV antibiotics for patients. Funding has been secured for the project and should be underway over the next few weeks. By introducing the Vygon Accufuser pump, patients will avoid a normal two week stay in hospital. This will be done with the support of the Hospital at Home team and will be trialed with three patients. If successful this would result in a reduction in hospital stay and thus result in bed day savings. Feedback from the group was that this had previously been considered for CF patients however there was an issue around the need to involve the Hospital Sterilisation and Decontamination Unit (HSDU) service to load the antibiotic into the device. It was clarified that this was not required for the Vygon pump.	

	The group welcomed the update and look forward to an update on the outcome of the pilot.	
10.	**AOB**	
	The group was made aware of a patient centred quality improvement project that is being carried out in West Lothian, which is supported by the manager within the REACT team and the Quality Academy. This will focus on point of care foundation methodology and will involve patient focus groups to compare and contrast feedback regarding the current service and highlight any potential issues for change. This will be undertaken over the following few weeks and results/findings will be presented at a future MCN Core Group meeting.	
11.	**Date of Next Meeting**	
	13th May 2020, 10am – 12pm, Forth Suite, Chest Heart & Stroke Offices, Rosebery House, Edinburgh	