NHS FIFE RESPIRATORY
MANAGED CLINICAL NETWORK

ANNUAL REPORT
2012-2013

Approval Record

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<td>Dr Colin Selby &amp; Gill Dennes, Fife Respiratory MCN Clinical Leads</td>
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EXECUTIVE SUMMARY

This is the third annual report of the Fife Respiratory Managed Clinical Network (MCN). The purpose of the MCN is to improve the health and well-being of people with respiratory conditions and to coordinate the best integrated services across professional and service boundaries. In order to achieve our objectives, the Fife Respiratory MCN has continued to support and extend the knowledge and skills of clinicians in the primary, community and acute sectors, develop local guidance and integrate national guidance, and collaborate with the wider community and service users.

The main focus of the Fife Respiratory MCN in 2012-2013 has been:

- The local implementation and monitoring of national guidelines on oxygen prescribing and delivery;
- Ongoing education sessions;
- Self assessment against Healthcare Improvement Scotland COPD Clinical Standards;
- Development of a Detailed Paediatric Asthma Patient Care Pathway;
- Development of a Children’s Asthma Diagnosis & Management Flowchart

This report highlights the work of the NHS Fife Respiratory Managed Clinical Network between 01 April 2012 and 31 March 2013.

Dr Colin Selby, Respiratory Consultant, and Gill Dennes, Practice Nurse
NHS Fife Respiratory Managed Clinical Network Lead Clinicians
1. **INTRODUCTION**

This is the third Annual Report of the Fife Respiratory Managed Clinical Network [MCN] and covers the period 01 April 2012 to 31 March 2013.

The purpose of this report is to:

- Provide an overview of the work undertaken within the Fife Respiratory MCN in 2012-2013;
- Highlight progress within 2012-2013 relative to the Annual Work Plan;
- Highlight the focus for 2013-2014 including the Annual Work Plan;
- Highlight work in line with evidence-based standards.

2. **BACKGROUND**

2.1 **Fife Respiratory Managed Clinical Network [MCN]**

Fife Respiratory MCN Structure & Governance

Hosted by Dunfermline & West Fife Community Health Partnership [D&WF CHP] on behalf of the three Fife CHPs and accountable via the D&WF CHP Clinical Director, the Fife Respiratory MCN was established in January 2010 with the aim of ‘consistency and quality of service throughout the care pathway, and the bringing of service user and provider views to the service planning process, to aid the fundamental Delivering for Health aim of developing services which are truly person-centred, delivered locally wherever possible but specialised where need be.’

The role of the Fife Respiratory MCN is to improve the health and wellbeing of the people of Fife (children and adults) with respiratory disease by co-ordinating the provision and development of the best possible integrated care across service and professional boundaries and supporting evidence-based quality improvements by working with health care professionals in respiratory care to enhance the care pathway for the people of Fife.

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1 Scottish Executive Letter, Strengthening the Role of Managed Clinical Networks, HDL (2007) 21
2 Excluding lung cancer which is covered by the South East Scotland Cancer Network [SCAN]
The Fife Respiratory MCN continues to be led by two Lead Clinicians – Gill Dennes, Practice Nurse, representing Primary Care; and Dr Colin Selby, Respiratory Consultant, representing Secondary Care and an MCN Coordinator. The MCN has created a forum for:

- Sharing ideas and best practice;
- Identifying solutions and methods of improvement;
- Initiating planning and delivery of a Respiratory education programme;
- Supporting patients, carers and professionals across Fife.

2.2 Communication and Reporting

In line with the Scottish Executive Letter HDL (2007) 21, the Fife Respiratory MCN reports through local management arrangements via the Fife Respiratory MCN Steering Group and D&WF CHP Clinical Governance Group reporting structures. This includes:

- MCN work plan presented and approved on an annual basis;
- MCN annual report presented and approved on an annual basis;
- Progress against any agreed national or local standards;
- Minutes of MCN Steering Group meetings for information.

The Fife Respiratory MCN has an approved communication plan which outlines the MCNs stakeholders, areas and methods of communication. This is detailed in Appendix A

In July 2012, the Scottish Government issued CEL29 (2012) ‘Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy’3, which re-emphasised the importance of close links between MCNs and appropriate planning, delivery, improvement and governance functions of Boards in achieving the three Quality Ambitions: Safe, Effective and Person-centred. The Annual Workplan for 2013-2014 reflects these quality ambitions.

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3 Scottish Government CEL 29 (2012), Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy, July 2012
OVERVIEW OF WORK UNDERTAKEN BY THE FIFE RESPIRATORY MCN DURING 2012-2013

3.1 Fife Respiratory MCN and Steering Group

The Fife Respiratory MCN Steering Group, as the executive group of the MCN, is responsible for defining the strategic direction, agreeing the annual work plans, overseeing the work of the sub-groups, and formal decision making and reporting on the work of the MCN. The Fife Respiratory MCN Steering Group met seven times between 01 April 2012 and 31 March 2013. The Group is chaired by the Lead Clinicians on a rotational basis and membership includes: the MCN Lead Clinicians, MCN Coordinator, and representatives from each of the three CHPs, Secondary Care [Acute], paediatric service, public health, pharmacy, AHP and voluntary and service-users / carers.

The main focus of the MCN and the Steering Group during this period has been:

3.1.1 COPD Casefinding

In line with the Fife Respiratory MCN’s role to support best practice from a sound evidence base, one of the standards within the Quality Improvement Scotland COPD Clinical Standards [March 2010] relates to a strategy and implementation plan to identify people with undiagnosed COPD.

Recognising that people with Ischemic Heart Disease / Heart Failure have a high probability of also having COPD⁴, Fife Respiratory MCN held discussions with Fife Heart Disease (HD) MCN to propose a Spirometry Screening pilot.

A simple hand-held screening spirometer (COPD6), measuring FEV1, will be used by Nursing Auxiliaries to screen patients attending the Tuesday Cardiac Clinic at Victoria Hospital, Kirkcaldy. Patients with an FEV1 <85% will be seen, on the same day, by the Pulmonary Function lab for post-bronchodilator spirometry. If COPD is indicated, Dr Francis, Cardiac Consultant, will include reference of this in his letter to the patient’s GP.

The Respiratory and HD MCNs agreed a checklist, including contraindications, to be used for the recording of results. Training on the use of the COPD6 screening spirometers and guidance on discussing the checklist with patients was provided to Cardiac Clinic Nursing Auxiliaries. The completed checklists are returned to the Respiratory MCN where a register of results is kept. To date:

- 62 patients have been offered spirometry within the Cardiac clinic
- 46 of those patients were tested using the handheld COPD6 spirometers
- 21 of those patients had an FEV1 reading less than 85% and were referred for further post-bronchodilator spirometry
- A total of 7 have been diagnosed with COPD and will be monitored within the Primary Care setting / GP practice

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⁴ Diagnostic and Therapeutic Challenges in Patients With Coexistent Chronic Obstructive Pulmonary Disease and Chronic Heart Failure, Thierry H. Le Jemtel MD, Margherita Padeletti MD, Sanja Jelic MD, Journal of the American College of Cardiology Volume 49, Issue 2, 16 January 2007, Pages 171-180
Those patients who did not undergo spirometry screening either declined or identified themselves against one of the exclusion criteria.

### 3.1.2 COPD & Asthma Information Systems

The Fife Respiratory MCN has been seeking to support the use of single information systems across Primary Care and potentially Secondary Care to support achievement of clinical standards in practice; facilitate the simple aggregation of data to shape and inform the work of the MCN; and thereby, support improved outcomes for service users.

As such, the Fife Respiratory MCN, in conjunction with NHS Fife Primary Care IT, developed COPD and Asthma templates for the EMIS and Vision systems that are in use within General Practices across Fife. The templates were designed to aid data collection during COPD and Asthma review appointments.

The EMIS COPD and Asthma templates were piloted during 2012-2013: four Practices in Glenrothes & North East Fife CHP; two Practices in Kirkcaldy & Levenmouth CHP and three Practices in Dunfermline & West Fife CHP. Comments received will be considered and amended templates will be rolled out Fife-wide for full use during 2013-2014.

The Vision COPD and Asthma templates will be piloted within volunteer Practices during 2013-2014.

The templates have been developed to support adherence to QIS COPD Clinical Standards and SIGN 101 Management of Asthma Guidelines including, in particular: monitoring children in Primary Care and structured reviews [audit percentage of patients receiving action plans and audit asthma outcomes in relevant sub groups of the population.

### 3.1.3 Pulmonary Rehabilitation

Pulmonary Rehabilitation is an individually tailored, multi-disciplinary (Rehabilitation Physiotherapist, Technical Instructor, Pharmacist, Respiratory-trained Practice Nurse and Carers Trust) intervention for symptomatic patients, which is integrated into their overall care. Pulmonary Rehabilitation aims to reduce symptoms, improve overall functional performance, reduce healthcare utilisation and health care costs. This is in line with Quality Improvement Scotland COPD Clinical Standard 4a\(^5\): ‘Pulmonary Rehabilitation is available within the NHS Board to people with COPD’ and NICE Clinical Guideline 101\(^6\): ‘Pulmonary Rehabilitation should be made available to all appropriate people with COPD including those who have had a recent hospitalisation for an acute exacerbation’

Established initially as a Fife-wide 18-month pilot in 2008, funded by the Scottish Enhanced Services Programme (SESP), the eight-week programme includes a structured exercise and education programme designed to help patients improve control of their condition. Further fixed-term SESP funding was secured to allow full roll-out of the programme.

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\(^5\) NHS QIS Chronic Obstructive Pulmonary Disease Clinical Standards, March 2011  
\(^6\) NHS NICE Chronic Obstructive Pulmonary Disease – Management of chronic obstructive pulmonary disease in patients in primary and secondary care, Quick Reference Guide, June 2010
A review of the Community Pulmonary Rehabilitation service delivery was undertaken by the Physiotherapy department in 2011/2012 to facilitate the implementation of a streamlined service provision that was equitable across Fife with regard to access, quality and standardisation of intervention and cost. A saving of £35,000 was realised. Following the cessation of Scottish Enhanced Services Programme (SESP) funding in March 2012, a further one-year funding was considered and approved by the Primary Medical Service – Primary Care (PMS-PC).

During 2012, the Fife Respiratory MCN, Fife Physiotherapy Service and Fife Respiratory MCN Patient / Carer Sub Group worked on producing a paper to support ongoing funding. The funding bid was considered at the PMS-PC Group in January 2013, with a further one year’s funding (April 2013-March 2014) approved.

Ongoing funding opportunities and provision of the service will continue to be explored and discussed during 2013/2014.

3.1.4 Asthma Priorities: Influencing the Agenda

Following the launch of the revised BTS/SIGN British Guideline on the Management of Asthma (May 2011), a collaborative approach to support local implementation was agreed in partnership with the National Advisory Group for Respiratory MCNs.

Boards across Scotland were asked to submit their top five priorities from a list of eleven and regional events were held to allow the opportunity to discuss the priorities in detail and identify measures of success against the national benchmark.

This work will continue during 2013/2014.

3.1.5 Home Oxygen Service

During 2012/2013, NHS Fife transitioned to the new National Home Oxygen Service. The aim of the service is to have a single standard across Scotland and to ensure best practice in prescribing oxygen for all patients. As a result, GPs are no longer able to prescribe oxygen to be dispensed at a Community Pharmacy. Under the new National Service, equipment and supplies are delivered directly to patients by Dolby-Vivisol. Fife Pharmacy and Fife Respiratory MCN took a lead role in progressing and monitoring the transition. The move to a national supplier provides the opportunity to ensure that each patient is receiving the most appropriate care. It will ensure that future prescribing is safe and effective and support a more appropriate and efficient service. Relevant Secondary Care services now have designated ‘authorised prescribers’ for completion of the Scottish Home Oxygen Order Forms (SHOOF).

The Fife Respiratory MCN are producing guidance for Primary and Secondary Care colleagues regarding the provision of Home Oxygen during both the ‘in-hours’ and ‘out of hours’ periods. A referral flowchart is also being produced to aid Primary Care Clinicians in determining if referral for oxygen assessment is clinically appropriate and advice if emergency access to home oxygen is deemed appropriate,
3.1.6  **COPD and Asthma Resource Pack Updates**

To ensure the information contained within the COPD and Asthma Resource Packs, available on the D&WF CHP website, is as up-to-date as possible, all resource pack contributors were asked to review and update their relevant sections. Each section will be reviewed / updated / confirmed on an ongoing annual basis.

3.1.7  **COPD Standards: Self Assessment**

Following a request by the National Advisory Group (NAG) for Respiratory MCNs, Fife Respiratory MCN completed a self assessment of current practices against the standards outlined in the Healthcare Improvement Scotland Clinical Standards for COPD. Anonymised submissions would then be used by the NAG to provide an overall picture of compliance against the standards and identify any recurrent themes that need to be considered by the Group.

3.1.8  **Role & Remit**

The Role and Remit of the Fife Respiratory MCN Steering Group was reviewed, updated and agreed for the coming year. The Fife Respiratory MCN Steering Group also agreed the continuation of current Clinical Leadership through 2013/2014.

3.2  **Fife Respiratory MCN Children & Young People’s Asthma Sub Group**

The Children & Young People’s Asthma Sub Group is a standing group of the Fife Respiratory MCN which takes a lead on the consideration and development of best practice in relation to Asthma care and support within Fife. This Group is chaired by the Lead Clinician for Children’s Services [Consultant Paediatrician] and membership includes representation from Primary Care [GP and Practice Nurse], Paediatric Asthma Nurse Specialist, Adult Respiratory Consultant, Community Paediatrician, Community Nursing [Public Health Nursing], Primary and Secondary Care Pharmacy, Charge Nurse Children’s Ward, MCN Coordinator, Education Service and service user representation. This Group has met twice during 2012-2013 focussing on:

3.2.1  **Detailed Patient Care Pathway**

The Children & Young People’s Asthma Sub Group have developed a detailed patient / care pathway for children with Asthma. This included a multi-disciplinary meeting [including service-user and their parent] to map out the current pathway, use of resources, clinical input & patient journey.

3.2.2  **Children’s Asthma Diagnosis & Management Flowchart**

The Fife Respiratory MCN developed a flowchart, in line with SIGN guidelines, to aid Primary Care clinicians to diagnose and manage children’s asthma, and to provide guidance for appropriate referral to the Paediatric Respiratory Service. These flowcharts were circulated to all Practices across Fife.

To raise awareness of the flowchart and encourage discussions around appropriate British Thoracic Society management of paediatric asthma, Practices have been offered educational ‘Asthma Roadshow’ information sessions. These will be facilitated by the Paediatric Asthma Specialist Nurse and Respiratory MCN Clinical Lead
3.3 Fife Respiratory MCN Education Sub Group

The Fife Respiratory MCN Education Sub Group is a working group which leads on supporting the development of skills and knowledge to support best practice in relation to respiratory care in Fife. This Group is chaired by the Anticipatory Care Nurse, DWF CHP, and membership of this group includes: Primary Care [GP & Practice Nurse representatives], District Nursing and Secondary Care representatives and Protected Learning Time Coordinators. The Education Sub Group met three times during 2012 and 2013.

The main focus of the Education Sub Group during this period has been:

3.3.1 Education Catalogue

One of the key roles of the Fife Respiratory MCN, as outlined in the Scottish Executive HDL (2007) letter, is to facilitate training and education opportunities for all staff who work with patients with respiratory disease. To this end, the Education Sub Group developed an Education Catalogue which aims to provide a comprehensive overview of the training and education that is available to staff within NHS Fife delivered by NHS Fife staff on behalf of the Fife Respiratory MCN. The Education Catalogue was shared with General Practices, Primary Care Teams and Protected Learning Time [PLT] Coordinators across Fife as an educational resource from which specific / required areas of education and development can be requested for PLT or in-house Practice-based sessions. Each of the individual workshops meet specific eKSF dimension(s).

3.3.2 Education Input to Protected Learning Time (PLT) Sessions

During 2012/2013, the Fife Respiratory MCN provided a number of education sessions as detailed in Appendix B.

3.4 Fife Respiratory MCN Patient / Carer Sub Group

The Patient / Carer Sub Group of the Fife Respiratory MCN is a working group of patients and carers, which will lead on supporting the Patient Focus Public Involvement agenda in relation to Respiratory care in Fife.

The Group was established in July 2012 and, to date, have:

- Agreed chairmanship and administration of the Group
- Agreed their Role and Remit
- Provided input to the Pulmonary Rehabilitation Funding paper
- Agreed the focus / priority areas for 2013/2014
3.5 Communication, Involvement and Awareness Raising

3.5.1 Website Resources

The Fife Respiratory MCN continues to update the Respiratory sections on the D&WF CHP website. The pages provide background on the work of the MCN, the COPD and Asthma Resource Packs, Clinical Guidelines, Education Resources and MCN Steering Group meeting minutes. This resource is for clinicians and patient / public members. The respiratory section also includes links to partner organisations and support groups.

Links to the Fife Respiratory MCN from Glenrothes & North East Fife CHP website, the new NHS Fife website and NHS Fife Intranet have been established.

3.5.2 Champions Of Self Management In Care (COSMIC) Workshop

Members of the three Fife BreatheEasy Groups and the three Fife CHP Public Partnership Forum Registers of Interest were invited to attend a ‘Champions Of Self Management In Care’ (COSMIC) workshop facilitated by Chest Heart & Stroke Scotland. The aims of the COSMIC workshop were to enable participants to understand:

- Self management and the broad range of what it involves
- The various roles of professionals, family and community in relation to self management and the support available to those living with a long term condition
- Health economics at a basic level
- The role of targets and single outcome agreements in the allocation of funds within the health and social care and to be able to include them in putting forward a business case for self management
- The role of a Self Management Champion
- Know where to get support to access resources
- Identify issues, linked to self management, which need to be addressed and present these in a logical order.

Two half-day sessions were organised (one in Dunfermline and one in Kirkcaldy) with a total of 17 members attending over the two days.

3.5.3 Public / Service-User & Voluntary Group Involvement

The Fife Respiratory MCN Steering Group has two service-user representatives and the Asthma Children & Young People’s Asthma Sub Group has a service-user/carer representative. The three National voluntary sector Respiratory Groups [Asthma UK, British Lung Foundation and Chest Heart & Stroke Scotland] and local BreatheEasy support groups attend the Steering Group meetings.

The Fife Respiratory MCN aims to work with active support groups, public members, service-users/carers and voluntary groups to inform, engage and support involvement in the work of the MCN. This is achieved using established communication channels e.g. meeting minutes and website, and individual CHP Public Partnership Forums [PPFs].
4 PROGRESS AGAINST FIFE RESPIRATORY MCN ANNUAL WORKPLAN 2012-2013

The Fife Respiratory MCN Steering Group and Sub Groups worked to the agreed annual workplan during 2012-2013. The updated workplan is available in Appendix C. Particular areas of progress are highlighted in the previous sections above. Priorities / actions not fully achieved during 2012-2013 will be carried forward and incorporated into the 2013-2014 Annual Workplan.

5 FOCUS FOR 2013-2014

The Fife Respiratory MCN will focus on the following key priorities during 2013-2014:

1. EMIS & VISION templates
2. Asthma [Young People]:
   - Asthma in adolescents including: diagnosis and assessment; risk factors; long term outlook and entry into the workplace / career choices
   - Supporting the management of acute asthma [in reducing referrals to acute assessment units.
   - Asthma Priorities / Action Plan self assessment
3. Asthma [Adults]:
   - Management of acute asthma in Primary Care.
   - Asthma Priorities / Action Plan self assessment
4. COPD
   - Case finding pilot with Cardiac MCN
   - Telepod Pilot
5. Home Oxygen – NHS Fife guidelines and referral flowchart for Primary Care
6. Bronchiectasis
   - Development of local guidelines
   - Development of a Self Management Action Plan

The annual workplan for 2013-2014 is attached at appendix D.
WORKING TO EVIDENCE-BASED STANDARDS

All materials recommended by the Fife Respiratory MCN have been developed from sound evidence-based guidelines e.g. British Thoracic Society [BTS], Scottish Intercollegiate Guidelines Network [SIGN], National Institute for Health & Clinical Excellence [NICE] and Healthcare Improvement Scotland [HIS] including:

COPD & Asthma Resource Packs

Guidance materials developed by the Fife Respiratory MCN take the form of Resource Packs providing simple, easy to follow guidance to support clinicians as they work with patients throughout the patient pathways.

COPD & Asthma QIS Clinical Standards

The Fife Respiratory MCN COPD work has been guided by the QIS Clinical Standards for COPD, and likewise, the work of the Children & Young People’s Asthma Group has centred on the QIS Clinical Standards for Asthma for services for children and young people.

Practical and Interpreting Spirometry Workshops

Spirometry is the key to effective diagnosis of COPD and supports ongoing quality management of respiratory conditions. Both the Practical and Interpreting Spirometry workshops were developed in response to Scotland-wide standards and meets the NHS QIS Clinical Standards:

for Practical Spirometry

- 3a.4: staff carrying out spirometry testing are trained and their competency assessed;
- 3a.5: the competence of staff carrying out spirometry testing is maintained;

for Interpreting Spirometry

- 3a.6: staff interpreting spirometry test results are trained and their competency assessed;
- 3a.7: the competence of staff interpreting spirometry results is maintained

The MCN has:

- submitted self assessment against the QIS/HIS COPD Clinical Standards.
- Begun to self assess against the BTS/SIGN Asthma Priorities Action Plan
- Continue to seek endorsement in line with HIS Quality Assurance Programme and CEL 29.

The Fife Respiratory MCN will continue to ensure ongoing work, guidance materials and training resources are in line with national and / or local evidence-based standards and will work in partnership with the National Advisory Group for Respiratory MCNs in Scotland.
SUMMARY

During 2012-2013, the Fife Respiratory MCN has continued to evolve and has focussed on a number of key areas, including: involvement in the changes to the national provision of Home Oxygen Services; updating the COPD and Asthma Resource Packs; securing funding to continue the Community Pulmonary Rehabilitation Service and developing a Diagnosis & Management Flowchart for Primary Care relating to Children’s Asthma.
Communication planning and reporting schedules
This plan outlines the MCNs stakeholders, what it communicates with them and how this communication takes place.

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<th>External Stakeholders</th>
<th>What is to be communicated</th>
<th>Methods and frequency of communication</th>
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<tr>
<td><strong>Public, Service users and carers</strong></td>
<td>- Updates on the work of the MCN</td>
<td>There are a number of active support groups in Fife with a wide range of members: we will work with them to consult, inform and involve service users. This is a two way process, the MCN welcomes proactive engagement from all its stakeholders. The MCN Steering Group has two service user representatives. Asthma sub group has a service user/carer representative. Using a variety of means (web/groups/people’s panel, PPF etc) to reach as many people as possible. Steering group minutes, annual work plan and annual report will be posted on the website.</td>
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<td>- Seek local feedback and informed input to the work of the MCN</td>
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<td><strong>Voluntary sector</strong></td>
<td>- Updates on the work of the MCN</td>
<td>The three national groups (Asthma UK, BLF &amp; CHSS) are included in the steering group circulation – owing to their commitments it is hoped that at least one group is able to attend each meeting.</td>
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<td>- Seek sector feedback and informed input to the work of the MCN</td>
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<td><strong>National Advisory Group of Respiratory MCNs</strong></td>
<td>- Updates on the work of the Fife MCN</td>
<td>Quarterly meeting attended by a Clinical Lead and MCN manager</td>
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<td>- Obtain information on work of MCNs throughout Scotland</td>
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<td>- Share learning (consideration being given to the NAG acting as a peer forum for considering progress against QIS COPD Clinical Standards)</td>
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<td><strong>Healthcare Improvement Scotland</strong></td>
<td>• as required</td>
<td>- to meet reporting timescales for the review and dissemination of local and national Clinical Governance information -this may also include update on the progress and specific status of individual projects</td>
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<tr>
<td>Internal Stakeholders</td>
<td>What is to be communicated</td>
<td>Methods and frequency of communication</td>
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| Steering group                         | -the MCN will produce an annual report and MCN work plan. This will be presented to the D&WF CHP Clinical Governance Group for their approval as agreed  
  ● update of MCN progress/status  
  ● update and review of participation in both local and national quality improvement activity  
  ● review and disseminate MCN clinical governance activity  
  -to be an escalation point for issue resolution  
  -update the D&WF CHP Clinical Governance Group on MCN activity and progress/status of individual projects where required  
  -the MCN should try to resolve any risks/issues locally  
  -risks/issues which cannot be resolved locally are                                                                 | -the steering group meets every two months and includes all stakeholders  
  -scheduled update as specified within the approved MCN action plan to meet the reporting timescales for the review and dissemination of local and national clinical effectiveness information as defined in the D&WF CHP Clinical Governance Reporting Schedule  
  -annual MCN Action Plan as defined in the D&WF CHP Clinical Governance Reporting Schedule  
  -annual MCN report  
  -this may include update on progress on the specific status of individual projects                                                                                                 |
| D&WF CHP Clinical Governance Group     | -escalated to the D&WF CHP Clinical Governance Group via the MCN Manager  
  -the D&WF CHP Clinical Governance Group must then escalate un-resolvable risks/issues to the D&WF CHP Management Team for escalation and if necessary to the NHS Fife Clinical Governance Steering Group/ CHP Committee | -minutes from the MCN Steering Group to be included for noting on the D&WF CHP Clinical Governance Group Agenda as a standing item |
| D&WF CHP Committee/ Fife Clinical Governance Committee | -Updates on the work of the MCN  
  -Seek local feedback and input to the work of the MCN                                                                                                                   | Primary Care Clinical Lead member of Localities Group                                                                                              |
| D&WF Localities Group (quarterly)      | -Updates on the work of the MCN  
  -Seek local feedback and input to the work of the MCN                                                                                                                   | Secondary Care Clinical Lead member of group                                                                                                      |
| Respiratory Consultants meeting (weekly)| -Updates on the work of the MCN  
  -Seek local feedback and input to the work of the MCN                                                                                                                   | -Resources available on website  
  -communication regarding new resources and updates forwarded to all practices  
  -LMC included in approval processes for new resources and consulted on programmes/projects                                                                 |
<p>| General Practice and LMC               | -Development and awareness of resources/processes to support clinical practice                                                                                                                                              | -Resources to be forwarded to DATC secretary with cover paper following liaison with ADTC secretary. |
| Area Drugs and Therapeutics Committee  | ADTCs approval will be sought of any new resources including mention of medications/devices or processes impacting on pharmacy. Updates would only require similar approval where changes are made to medication references.   |                                                                                                       |</p>
<table>
<thead>
<tr>
<th>DATE DELIVERED</th>
<th>FACILITATOR</th>
<th>TOPIC</th>
<th>PURPOSE</th>
<th>AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>03/05/2012</td>
<td>Gill Dennes &amp; Dr Selby</td>
<td>COPD, Acute Exacerbations &amp; Oxygen Inhaler Technique for Asthma &amp; COPD</td>
<td>Ad hoc</td>
<td>Hospital at Home Team, DWF CHP</td>
</tr>
<tr>
<td>31/05/2012</td>
<td>Gill Dennes</td>
<td></td>
<td></td>
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<tr>
<td>JUNE</td>
<td></td>
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<tr>
<td>14/06/2012</td>
<td>Gill Dennes</td>
<td>COPD Update</td>
<td>Ad hoc</td>
<td>District/Practice Nurses, Leven, K&amp;L CHP</td>
</tr>
<tr>
<td>28/06/2012</td>
<td>Carole Smith &amp; Gayle White, Lorna Stewart &amp; Dr Priyadharshan</td>
<td>Pulmonary Rehab</td>
<td>Peer-training</td>
<td>DWF CHP [including H@H &amp; K&amp;L CHP]</td>
</tr>
<tr>
<td>28/06/2012</td>
<td>Carole Smith &amp; Gayle White, Lorna Stewart &amp; Dr Priyadharshan</td>
<td>Palliative Care</td>
<td>PLT</td>
<td>DWF CHP [including H@H &amp; K&amp;L CHP]</td>
</tr>
<tr>
<td>SEPTEMBER</td>
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</tr>
<tr>
<td>04/09/2012</td>
<td>Anne McKean (&amp; Dr Hilary Maddox)</td>
<td>The Challenges of Chronic Illness Management in Adolescents</td>
<td>PLT Conference</td>
<td>DWF CHP Conference</td>
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<tr>
<td>OCTOBER</td>
<td></td>
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<tr>
<td>10/10/2012</td>
<td>Gill Dennes</td>
<td>Using the COPD-6 Handheld Spirometry Screening Tool</td>
<td>Peer-training</td>
<td>DWF Stop Smoking Team</td>
</tr>
<tr>
<td>11/10/2012</td>
<td>Gill Dennes</td>
<td>Using the COPD-6 Handheld Spirometry Screening Tool</td>
<td>Peer-training</td>
<td>K&amp;L Stop Smoking Team</td>
</tr>
<tr>
<td>NOVEMBER</td>
<td></td>
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<tr>
<td>07/11/2012</td>
<td>Dr Hartung</td>
<td>Interpreting Spirometry Readings</td>
<td>PLT</td>
<td>Fife-wide</td>
</tr>
<tr>
<td>29/11/2012</td>
<td>Gill Dennes, Heather Sheddon</td>
<td>Practical Spirometry in Primary Care: Getting it Right Every Time</td>
<td>Evening Session</td>
<td>D&amp;WF CHP</td>
</tr>
<tr>
<td>FEBRUARY</td>
<td></td>
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<tr>
<td>07/02/2013</td>
<td>Lorna Stewart</td>
<td>Palliative Care</td>
<td>PLT</td>
<td>GNEF</td>
</tr>
<tr>
<td>07/02/2013</td>
<td>Gill Dennes, Anne McKea</td>
<td>Practical Spirometry</td>
<td>PLT</td>
<td>Fife-wide</td>
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<tr>
<td>MARCH</td>
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<tr>
<td>22/03/2013</td>
<td>Gill Dennes</td>
<td>COPD</td>
<td>Ad-hoc / Practice Request - Lunchtime session</td>
<td>Bennochy MP (K&amp;L)</td>
</tr>
</tbody>
</table>
## Respiratory MCN 2012-13 Work plan - Final Draft

The following work plan is treated as a 'live' document.

### Key:
- **Green:** Work on track and completed
- **Orange:** Work on track not yet completed
- **Red:** Work not on track and not completed

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action</th>
<th>Anticipated Outcome(s)</th>
<th>Person Responsible</th>
<th>Target / Objective</th>
<th>Risks</th>
<th>Core Principle</th>
<th>Progress to Date</th>
<th>RAG status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Clear management arrangements and leadership of the MCN</td>
<td>a) Refresh role and remit [annually]</td>
<td>Unity of purpose and direction of the MCN</td>
<td>MCN Coordinator</td>
<td>Role &amp; Remit reviewed and agreed December 2012</td>
<td>HDL: 10.1 QAP: 1</td>
<td>Approved by MCN January 2012.</td>
<td>G</td>
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<tr>
<td></td>
<td></td>
<td>b) Identify / agree Clinical Leadership for 2013 onwards</td>
<td>Continuation of current Lead Clinicians / new Lead Clinician(s)</td>
<td>D&amp;WF CHP</td>
<td>Continued clear clinical leadership and responsibility for the functioning of the MCN</td>
<td>HDL: 10.1 &amp; 24 QAP: 1</td>
<td>MCN SG confirmed Gill Dennes and Dr Selby to continue with Leadership into 2013.</td>
<td>G</td>
</tr>
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</table>

### Progress to Date:
- May: QAP informal submission to CG 15/05/12. July: QAP approval by CG. Annual Report 2011/2012 approved by:
  - MCN SG April & June 2012
  - Clinical Governance Jan 2013
<table>
<thead>
<tr>
<th>Priority</th>
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<th>Risks</th>
<th>Core Principle</th>
<th>Progress to Date</th>
<th>RAG status</th>
</tr>
</thead>
</table>
| 2. | a) Internet and Intranet Webs presence | People have access to information and resources | MCN Coordinator | ● Ensure all information is kept up-to-date.  
● Continued utilisation of DWF CHP website resource.  
● Information on NHS Fife Intranet & internet / web-link to DWF CHP site  
● Information / link on GNEF CHP website | Out of date information is not updated timely and therefore available to clinicians / public members | HDL: 35 | April/May: COPD section updated on DWF website.  
June: Link on GNEF to DWF Respiratory section | G |
|  | b) Equip people to support their involvement | Peoples’ skills, knowledge and abilities are used appropriately and for the benefit of the MCN | MCN Coordinator | ● Chest Voices Programme | HDL: 10.5 & 31 | April: Info sent to schools & nurseries re Asthma Aware online resources pilot [Asthma UK and Education for Scotland]  
Sept: Two COSMIC sessions (25th & 26th). 17 attendees in total. Facilitated by CHSS. | G |
|  | c) MCN Patient Sub Group | Patient focus approach | [TBC] | To take forward actions from Chest Voices and public / patient consultation / engagement exercises | HDL: 31 | May: LCK discussed with LE.  
July: LCK met with NC to discuss.  
Oct: 1st meeting 08/10, R&R proposed, chair & admin agreed. 2nd meeting 22/10 – PR Case for Change drafted. | G |
<table>
<thead>
<tr>
<th>Priority</th>
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<th>Target / Objective</th>
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<th>Progress to Date</th>
<th>RAG status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. COPD</td>
<td>a) Local Priorities from QIS Clinical Standards</td>
<td>Clinical Standards are met: People are diagnosed earlier, reduced emergency admissions and length of stay.</td>
<td>MCN</td>
<td>• Review / update self-assessment as appropriate</td>
<td>HDL: 10.4</td>
<td>June: NAG template [not as indepth as QIS]. To be completed and shared with NAG in Nov. July: COPD templates pilot for EMIS practices. Oct: - draft self assessment discussed and agreed. Nov: submitted to NAG. National Benchmark discussed at NAG and MCN SG Nov.</td>
<td></td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>b) Review and update COPD Resource Pack [annually]</td>
<td>Supporting clinicians and patient self management</td>
<td>MCN Coordinator; Resource Contributors</td>
<td>• To provide high quality information</td>
<td>HDL: 10.4; 15 &amp; 35</td>
<td>May: all sections reviewed, updated and uploaded.</td>
<td></td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>c) Casefinding</td>
<td>Identify undiagnosed COPD</td>
<td>MCN Coordinator / Cardiac Rehab MCN</td>
<td>• Facilitate earlier diagnosis • Earlier diagnosis to help maintain quality of life for longer • Support practices to populate their COPD register and improving the opportunity for care planning.</td>
<td></td>
<td>May: Meeting arranged with Dr Francis, Lynne Garvey, CS &amp; GD to agree protocol &amp; training – 18/07/12. Nov: Discussed further with L Garvey Dec: Meeting with Cardiac OPD Charge Nurse to discuss further. Process and feedback agreed Jan: Pilot began in Tuesday Cardiac Outpatient clinic. Pilot to run for 12 months</td>
<td></td>
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<tr>
<td></td>
<td>d) Support smoking cessation</td>
<td>Enhance / support continued smoking cessation</td>
<td>Smoking cessation colleagues</td>
<td>• Enhance use of smoking cessation support and improve diagnosis</td>
<td></td>
<td>July: Meeting with CR &amp; KG to discuss training Oct: Training on use of COPD6 &amp; contraindications checklist given to K&amp;L and DWF Teams. Process for feeding back to MCN agreed.</td>
<td></td>
<td>G</td>
</tr>
</tbody>
</table>
| e) Continuation of Pulmonary Rehabilitation Programme | Preferred model of delivery; equitable access | Pulmonary Rehab Team / Service Managers | ● Access to an evidence-based programme.  
● Active Options 2 programme for maintenance classes | 2013-2014 funding | HDL: 4&9  
HEAT: 7+ | Oct: Update meeting on Active Options 2 progress.  
Nov: Paper, prepared by MCN, Physio & Patient SG, submitted to Dr Kilpatrick for taking to PMS-MG / SMT-PC. Deferred to Jan 2013 SMT-PC meeting.  
Jan: Information session planned by FSLT re AO2. Funding for PR for 013/2014 granted.  
Feb: PLT session planned for 07/02/13 |
|----------------|-----------------|---------------------------------|-----------------|-----------------|-----------------|-----------------|
June: meeting with SB, CS, HS, LS, LB & Tunstall reps. Issues with roll-out prior to Sept [home oxygen changes] |
| g) Complex Care | People with complex care receiving care in a community setting | TBC | ● Supporting clinicians managing complex cases in a community setting | April 2012: informal chat with H@H Team.  
Arranged two educational sessions: 1) COPD presentation & acute exacerbations and oxygen 03/05/2012; and 2) Inhaler Technique for Asthma & COPD 31/05/2012.  
Jun: PR & Palliative Care education session at PLT (DWF incl K&L)  
Nov: Palliative care peer education session to Pharmacy.  
Feb: PR & Palliative Care education session at PLT (GNEF) | | |
### 4. Asthma

#### a) Review and update the Asthma Resource Pack
- **Supporting Outcome(s):** Supporting clinicians and patient self management
- **Person Responsible:** MCN Coordinator; Resource Contributors
- **Target / Objective:**
  - To provide high quality information
- **Risks:** HDL: 10.4; 15 & 35
- **Core Principle:** Jun: Sections updated and uploaded to website.
- **Progress to Date:**
  - **RAG status:** G

#### b) Develop a detailed patient care pathway for children & young people
- **Supporting Outcome(s):** Clear understanding of HCP roles and the routes between services
- **Person Responsible:** Chair Asthma Sub Group
- **Target / Objective:**
  - Detailed overview of patients’ journey.
  - Timeline with information at every event relating to treatment.
  - Can be used for patient information and / or planning of services.
- **Risks:** HDL: 15; 26 BoC
- **Core Principle:** May: MDT met 30/05/12 to take forward. Session facilitated by Strategic Change. Initial pathway mapped and actions recorded. June: pathway shared with colleagues for comment. Oct: updated pathway discussed at MCN SG.
- **Progress to Date:**
  - **RAG status:** G

#### c) Support compliance with SIGN Guidance on the Management of Asthma
- **Supporting Outcome(s):** Compliance with guidelines to support clinical excellence
- **Person Responsible:** Clinical Leads
- **Target / Objective:**
  - Five priorities identified from SIGN Guideline review
  1. Oxygen driven nebulisers/face masks etc.
  2. Asthma patient education & self management
  3. Monitoring children in PC
  4. Audit percentage of patients receiving asthma action plans
  5. Monitoring airway response – induced sputum eosinophil.
- **Risks:** HDL: 10.4 SIGN 101
- **Core Principle:** May: Involvement in ‘Asthma Priorities: Influencing the Agenda’ event. Fife info submitted and schools presentation. MCN to take forward recommendations from NAG [event feedback report]. (Priority 2) May: Audit of nebulisers etc – GD emailed M Vass (priority 1) July: Asthma templates pilot within EMIS practices Sept: Adolescent Asthma session at DWF conference ISD info at C&YP SG
- **Progress to Date:**
  - **RAG status:** O
<table>
<thead>
<tr>
<th>Priority</th>
<th>Action</th>
<th>Anticipated Outcome(s)</th>
<th>Person Responsible</th>
<th>Target / Objective</th>
<th>Risks</th>
<th>Core Principle</th>
<th>Progress to Date</th>
</tr>
</thead>
</table>
| 5. Sleep Apnoea | a) Review and disseminate local guidelines | Improved referral patterns | Clinical Lead (secondary care) | • Guidelines for awareness and protocols  
• Reduction in redirected referrals. | | | |
| | | | | | | | |
| 6. Education | a) Maintain the Education Catalogue | Clear outline of education available via the MCN | Chair Education Sub Group | • Ensure wide range of education available | Facilitator time | QAP: 8 | July: approved at Sub Group meeting.  
Oct: approved at MCN SG  
Nov: circulated to Fife PMs and PLT Leads. |
| | b) Agree programme of education for the year ahead | Planned programme of targeted education | Chair Education Sub Group | • Ensure equitable access to education | Facilitator time | QAP: 8 | May: Request for information session from Fife Carers Centre. LS and CS to provide.  
[date?]  
May: GD providing COPD & Inhaler technique education session to Leven PC Nurses.  
June: Pul Rehab and Palliative Care session at DWF [incl K&L] PLT  
Nov: Interpreting Spirometry Fife-wide PLT session.  
Nov: Practical Spirometry evening session (DWF) |
<table>
<thead>
<tr>
<th>Priority</th>
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<tbody>
<tr>
<td>7.</td>
<td>c) Identify areas to enhance prescribing practice</td>
<td>Best Practice in prescribing is supported</td>
<td>MCN Pharmacy members</td>
<td>Continue to support the Respiratory Bundle project</td>
<td></td>
<td></td>
<td>Aug: presentation at NAG meeting. Sept: poster at NAG Learning Forum Oct: SMC approval of Flutiform</td>
<td>G</td>
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<tr>
<td>8.</td>
<td>a) Support the process changes required to enable the implementation of national provision.</td>
<td>Support clinical excellence by working to a nationally agreed guidance.</td>
<td>Clinical Lead (Secondary Care)</td>
<td>Transfer of patients using cylinders to concentrators • Ensure patients are informed • Ensure GPs are informed and are aware of the national and local guidance • Local guidance for palliative care • Local contingencies in place</td>
<td>QAP: 9</td>
<td></td>
<td>May: 1) Background info sent to LDMT &amp; request for signatories list (not required for LD). 2) update requested from paediatrics [Dr Ainsworth]. May: Letters sent to GPs and Pharmacies. Info on website. June: Article in DWF newsletter. Discussed at MCN SG. July: meeting with pharmacy</td>
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<td></td>
<td></td>
<td>Authorised signatories list – signatures received sent to HFS. Palliative Care O/S. Local contingency in place for access to oxygen cylinders at six pharmacies across Fife until end March 2013. Local contingency being worked through for access to emergency home oxygen during ‘in-hours’ period.</td>
<td>O</td>
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</tbody>
</table>
19 action areas have been completed [green] within the financial year 2012/2013. Some of these actions will continue, as standing actions, on the 2013/14 Work Plan.

5 action areas are currently still in progress [orange]:

- The Quality Assurance Programme (now to be known as endorsement) is still in progress - this will continue to be progressed during 2013/2014;
- Casefinding to identify undiagnosed COPD - pilot began in Jan 2013 and will run for 12 months;
- Complex Care: people with complex care receiving care in a community setting – education sessions to community staff and DWF CHP Hospital at Home team. Will need to be rolled out to K&L and G&NEF Hospital at Home teams once up and running;
- Support compliance with SIGN Guidance on the Management of Asthma: compliance with guidelines to support clinical excellence – self assessment against the guidelines was completed and priorities identified. Priorities to be taken forward during 2013/2014;
- Support the process changes required to enable the implementation of national provision of home oxygen – local contingencies continue to be discussed.

2 actions remain outstanding [red]:

- Telepod pilot to support good quality proactive clinical care using technological advances – the implementation of this was put back during 2012/2013 due to the implementation of the National Home Oxygen Service and the demands this would place on the Respiratory service / nurses;
- Sleep Apnoea: local guidelines to support and improve referral patterns – to be progressed during 2013/2014.
### 1. Clear management arrangements and leadership of the MCN

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Anticipated Outcome(s)</th>
<th>Person Responsible</th>
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<th>Core Principle</th>
<th>Progress to Date</th>
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<tbody>
<tr>
<td></td>
<td>a)</td>
<td>Refresh role and remit [annually]</td>
<td>Unity of purpose and direction of the MCN</td>
<td>Role &amp; Remit reviewed and agreed by December 2013</td>
<td>CEL 29: 8.2; 8.5; 8.6; 16; 19; HDL 21: 3; 10.1; QAP: 1; QA: 2</td>
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<tr>
<td></td>
<td></td>
<td>Involvement of multidisciplinary colleagues</td>
<td>MCN Coordinator</td>
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</table>

|      | b)     | Identify / agree Clinical Leadership for 2014 onwards | Continuation of current Lead Clinicians / new Lead Clinician(s) | Continued clear clinical leadership and responsibility for the functioning of the MCN | CEL 29: 8.1; HDL 21: 10.1 & 24; QAP: 1; QA: 2 | | |
|      |        | | MCN Steering Group | | | | |

|      | c)     | Complete annual report including progress within Quality Assurance Programme | Unity of purpose and direction of the MCN. Update stakeholders with progress made against agreed actions / priorities. Progress and adherence to various clinical standards. | Annual Report against work / objectives for 2012/2013; Progress report on MCN performance and achievements in relation to the QAP; Continuous improvement in the quality of service provided by the MCN; Endorsement of MCN by Board / peers | CEL 29: 8.1; 38; HDL 21: 10.1, 10.7 & 33; QAP: 1; QA: 2 | | |
### 2. Involvement & Partnership Working

| **a) Internet and Intranet Web presence** | Clinicians and patients have access to information and resources | **MCN Coordinator** | - Ensure all information is kept up-to-date.  
- Continued utilisation of DWF CHP website resource.  
- Information on NHS Fife Intranet & internet / web-link to DWF CHP site  
- DWF CHP website will migrate to NHS Fife website before March 2014 – ensure information is up to date for migration. | CEL 29: 8.6  
HDL 21: 35  
QA: 1&2 |
|---|---|---|---|---|
| **b) MCN Patient Sub Group** | Patient focus approach.  
Involve public partners in decision making.  
Support patient sub group to take forward actions from Chest Voices programme and action plans.  
Equip people to support their involvement: Peoples’ skills, knowledge and abilities are used appropriately and for the benefit of the MCN | **MCN Coordinator / MCN Patient Sub Group** | - Check progress of issues identified at 2011 Chest Voices event.  
- Take forward outstanding actions from 2011 Chest Voices event  
- Actions identified from 2013 Patient Sub Group meeting:  
  - BreatheEasy Groups to audit members: do they receive annual review; do they have COPD action plan  
  - Evidence gathering to support Pulmonary Rehab funding bids  
  - Providing information about conditions to patients | CEL 29: 8.6; 32  
HDL 21: 31  
QA: 3 |
| **c) Working with other MCNs** | Work with Cardiac MCN to Casefind undiagnosed COPD patients | **MCN Coordinator; MCN Clinical Leads** | (see Target 3c below) | |
| 3. COPD | a) Local Priorities from HIS Clinical Standards Self Assessment | Clinical Standards are met: People are diagnosed earlier, reduced emergency admissions and length of stay. Identify areas of focus from self assessment | MCN Clinical Leads; MCN Coordinator | • Review / update self-assessment  
• Review current working in line with National Benchmark  
• ‘developing’ = casefinding; palliative care services  
• ‘implementing’ = diagnosis & periodic review of COPD; oxygen therapy  
• ‘monitoring’ = home support, intermediate care & supported discharge services | CEL 29: 8.4  
HDL: 10.4; 12  
QA: 1&2 |
| --- | --- | --- | --- | --- |
| | b) Review and update COPD Resource Pack [annually] | Supporting clinicians. Supporting patient self management | Resource Contributors; MCN Coordinator | • To provide high quality, up to date information | HDL: 10.4; 15 & 35  
QA: 1&2 |
| | c) Casefinding | 12 month pilot to identify undiagnosed COPD patients  
(HIS Clinical Standard 2: People with COPD are diagnosed in the early stages of the disease) | MCN Coordinator; HF Clinic Nursing Auxiliaries; LF Nurses, Cardiac Consultant | • Facilitate earlier diagnosis  
• Earlier diagnosis to help maintain quality of life for longer  
• Support practices to populate their COPD register and improving the opportunity for care planning.  
• Maintain database of non-patient identifiable results.  
• Review pilot after 6 months | CEL 29: 17  
QA: 3 |
### 3. COPD (cont)

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| **d)** Support smoking cessation | Enhance / support continued smoking cessation | Smoking cessation colleagues | Enhance use of smoking cessation support and improve diagnosis  
Pilot of COPD6 screening (lung age info) to support stop smoking attempts |
| **e)** Continuation of Pulmonary Rehabilitation Programme | Pulmonary Rehab is available to patients with COPD.  
QOF NM47: The percentage of patients with COPD and MRC Dyspnoea scale ≥3 at any time in the preceding 15 months with a subsequent record of an offer of referral to a PR programme.  
Equitable access.  
(HIS Clinical Standard 4: Pulmonary Rehabilitation is available within the NHS Board to people with COPD; & Quality Outcomes Framework 2013/14) | MCN Clinical Leads; MCN Coordinator; MCN Education Sub Group; MCN Patient Sub Group | Raise awareness to Practices of access to evidence-based programme.  
Raise awareness and encourage referrals to Active Options 2 programme for maintenance classes  
Gather ongoing evidence to support 2014/15 funding bid. |
| **f)** Telepod pilot | Support good quality proactive clinical care using technological advances | TBC | Demonstrate reduction in COPD hospital admissions |
| **g)** Complex Care | People with complex care receive care in a community setting  
(HIS Clinical Standard 6: People with COPD have access to home support services) | TBC | Supporting clinicians managing complex cases in a community setting |

QA: 3  
HDL: 10.9; 15; 20  
HEAT: 7+  
QA: 1,2 &3  
CEL 29: 8.6
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<tr>
<th></th>
<th>4. Asthma</th>
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<tbody>
<tr>
<td>a)</td>
<td>Review and update the Asthma Resource Pack [annually]</td>
<td>Supporting clinicians. Support patient self management</td>
<td>Resource Contributors; MCN Coordinator;</td>
<td>● To provide high quality, up to date information.</td>
<td>HDL: 10.4; 15 &amp; 35 QA: 1&amp;2</td>
</tr>
</tbody>
</table>
| b) | Review paediatric detailed patient care pathway | To ensure delivery of highest standard of evidence-based care across Fife | Chair C&YP Asthma Sub Group | ● Identify gaps in current service provision / patient journey e.g. referral routes & criteria  
● Review actions identified as part of mapping exercise (2012)  
● Link to Integrated Care Pathway – show where, why and how various services are involved along the pathway | HDL: 10.2; 15 |
| c) | Diagnosis & Management Flowchart | To aid Primary Care Clinicians in diagnosing and managing asthma in children and supporting appropriate referral to specialist Respiratory service | MCN Lead Clinician (PC); Paediatric Asthma Specialist Nurse; Chair C&YP Asthma Sub Group | ● Roadshow / awareness raising / education to Practices  
● BTS paediatric management of asthma | HDL: 10.2; 15 QA: 1 |
<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Responsible Parties</th>
<th>Objectives</th>
<th>References</th>
</tr>
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<tbody>
<tr>
<td><strong>d)</strong> Self Assessment against SIGN / BTS Asthma Priorities action plan</td>
<td>Contribute to National Advisory Group benchmark / Scotland-wide picture</td>
<td>MCN Coordinator; C&amp;YP Asthma Sub Group; MCN Steering Group</td>
<td>• Review current activities against asthma priorities / standards and self assess current level</td>
<td>CEL 29: 8.4; HDL: 10.4; QA: 1&amp;2</td>
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<td><strong>e)</strong> Structured discharge process from Secondary to Primary Care</td>
<td>To ensure paediatric patients discharged from Secondary Care are known to Primary Care and agreed care plan in place</td>
<td>C&amp;YP Asthma Sub Group</td>
<td>• Establish link and communication process with Primary Care prior to patient discharge</td>
<td>CEL 29: 19; 41; HDL: 15; QA: 1,2&amp;3</td>
</tr>
<tr>
<td><strong>f)</strong> Structured referral template for Primary Care</td>
<td>To aid appropriate referrals / triage</td>
<td>C&amp;YP Asthma Sub Group Chair</td>
<td>• Based on Diagnosis &amp; Management flowchart&lt;br&gt;• Electronic referral</td>
<td>CEL 29: 19; 41; HDL: 15</td>
</tr>
<tr>
<td><strong>g)</strong> Communication from Primary to Secondary Care</td>
<td>To ensure Secondary Care are kept informed of paediatric patient follow-up reviews following a hospital admission</td>
<td>Paediatric Asthma Specialist Nurse; PC Lead Clinician</td>
<td>• Share information on Primary Care reviews&lt;br&gt;• Electronic transfer of information</td>
<td>CEL 29: 19; 41; HDL: 15; QA: 1</td>
</tr>
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### Asthma (cont)

<table>
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<tr>
<th>h) Clarify timeframe of ‘regular’ reviews</th>
<th>To clarify meaning of ‘regular’ to allow best practice for Primary Care</th>
<th>C&amp;YP Asthma Sub Group</th>
<th>• Allow best practice across Fife</th>
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</table>
| i) Pre-school review of inhaler needs | Children may no longer need inhaler when starting Primary or Secondary School | C&YP Asthma Sub Group | • To review children prior to starting Primary and Secondary School to establish if inhaler is still required  
• Linked to SIGN 101 priority 3 |
| [Asthma Priorities Measurement 7]       |                                                                         |                       |                                  |
| j) Priorities from the SIGN 101 Guideline review | Take forward priorities outlined in SIGN 101 guideline review | C&YP Asthma Sub Group; MCN SG | • Priority 1: Oxygen driven nebulisers / face masks available in Primary Care  
• Priority 2: Asthma patient education and self management  
• Priority 3: Monitoring children in Primary Care, including symptom control and RCGP 3 questions  
• Priority 4: Asthma audits, including action plans  
• Priority 5: Monitoring airway response |
|                                         |                                                                         |                       | CEL 29: 8.4  
HDL: 10.4  
SIGN 101  
QA: 1 & 2 |
| k) Asthma Education                      | To provide education in line with SIGN & Asthma priorities | C&YP Asthma Sub Group; Education Sub Group | • Individual self management / care plans completed in partnership with schools  
• Input to school healthcare plans  
• Managing acute exacerbations  
• Paediatric / Adolescent Asthma  
• Psychological factors of asthma |
| [Asthma Priorities Measurement 5 & 7; SIGN Asthma Priority 2] |                                                                         |                       | CEL 29: 8.7  
HDL 10.8 |
- Educational opportunities / gaps  
- Self management plan / action plan for patients.  
- Section / resources on website e.g. management of condition – patient and clinician; exacerbations; airway clearance techniques; pharmacological management  
- Pulmonary rehab referral | CEL 29: 8.4  
HDL: 10.4  
BTS QA: 1&2 |
|---|---|---|---|---|
| 6. Sleep Apnoea | Improved referral patterns | Clinical Lead (secondary care) | - Guidelines for awareness and protocols  
- Reduction in redirected referrals. | CEL 29: 8.6  
HDL: 15  
QA: 1 |
| 7. Education | Planned programme of targeted education  
*[Asthma Priorities Measurement 5; SIGN Asthma Priority 2]* | Chair Education Sub Group | - Ensure equitable access to evidence-based education.  
- Undertake Training Needs Analysis to determine:  
  - areas of focus  
  - preferred delivery method  
- Raise awareness of education available  
- Raise awareness of MCN  
- Education to Patient Sub Group  
- e-Learning opportunities explored  
- Asthma education (see area 4k above) | CEL 29: 8.7  
QAP 8  
HDL 10.8  
Apr13: 24 clinicians on Spirometry register contacted to advise yearly Interpreting Spirometry assessment due by 3rd May. This is being done via self assessment submissions. Dr Hartung to mark. Certificates will be issued.
8. **Pharmacy**

**a) Support enhanced prescribing practice**
Best Practice in prescribing is supported

MCN Pharmacy members

- Flutiform and Genuair savings opportunities
- National Respiratory Prescribing SLWG recommendations

CEL 29: 8.8
HDL: 10.9

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9. **National Home Oxygen Service**

**a) Support & monitor the new National supply service**
Support clinical excellence by working to nationally agreed guidance.

[HIS COPD Clinical Standard 5: There is an effective and coordinated domiciliary oxygen therapy service provided by the NHS and people with an exacerbation of COPD have access to oxygen therapy and supportive ventilation where clinically indicated.]

Clinical Lead; Specialist Services; MCN Coordinator

- Local contingencies in place: In-hours; out of hours; palliative care; neurology
- Ensure GPs are aware of referral pathways and criteria
- Information resources on website

CEL 29: 12
HDL: 15
QA: 1&2