NHS FIFE RESPIRATORY MANAGED CLINICAL NETWORK

ANNUAL REPORT
2013-2014

Approval Record

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<tr>
<td>Dr Colin Selby &amp; Gill Dennes, Fife Respiratory MCN Clinical Leads</td>
<td>02 April 2014</td>
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EXECUTIVE SUMMARY

This is the fourth annual report of the Fife Respiratory Managed Clinical Network (MCN). The purpose of the MCN is to improve the health and wellbeing 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 2013-2014 has been:

- The local implementation and monitoring of national guidelines on oxygen prescribing and delivery;
- Ongoing education sessions;
- Working with the Heart Disease Managed Clinical Network and Heart Failure Clinic to casefind undiagnosed COPD patients;
- Review and updating of the COPD and Asthma Resource Packs available on the Dunfermline and West Fife CHP and NHS Fife websites;
- Provision of training to support Primary Care Emergency Service (PCES) clinicians in managing complex care patients (Acute Asthma) in a community setting;
- Re-focussing of the Children & Young People’s Asthma Sub Group;

This report highlights the work of the NHS Fife Respiratory Managed Clinical Network between 01 April 2013 and 31 March 2014.

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

This is the fourth Annual Report of the Fife Respiratory Managed Clinical Network [MCN] and covers the period 01 April 2013 to 31 March 2014.

The purpose of this report is to:

- Provide an overview of the work undertaken within the Fife Respiratory MCN in 2013-2014;
- Highlight progress within 2013-2014 relative to the Annual Work Plan;
- Highlight the focus for 2014-2015 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.’

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1 Scottish Executive Letter, Strengthening the Role of Managed Clinical Networks, HDL (2007) 21
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\textsuperscript{2} 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.

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\textsuperscript{1}, 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’\textsuperscript{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 Fife Respiratory MCN Annual Workplans reflects these quality ambitions.

\textsuperscript{2} Excluding lung cancer which is covered by the South East Scotland Cancer Network [SCAN]
\textsuperscript{3} Scottish Government CEL 29 (2012), Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy, July 2012
3 OVERVIEW OF WORK UNDERTAKEN BY THE FIFE RESPIRATORY MCN DURING 2013-2014

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 five times between 01 April 2013 and 31 March 2014. 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 – including GP representation, 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 COPD, Fife Respiratory MCN and Fife Heart Disease (HD) MCN, with assistance from the Tuesday Heart Failure Clinic commenced a 12 month Spirometry Screening pilot in January 2013.

A simple hand-held screening spirometer (COPD6), measuring FEV1, was used by Nursing Auxiliaries to screen patients attending the Tuesday Heart Failure Clinic at Victoria Hospital, Kirkcaldy. Patients showing an FEV1 <85% are seen, on the same day, by the Pulmonary Function lab for post-bronchodilator spirometry. If COPD is indicated, Dr Francis, Cardiac Consultant, includes 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. The completed checklists are returned to the Respiratory MCN where a non-patient identifiable register of results is kept. To date:

- 139 patients were seen within the Tuesday Heart Failure clinic
- 96 of those patients were tested using the handheld COPD6 spirometers
- 36 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 Primary Care.

Those patients who did not undergo spirometry screening either declined or identified

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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
themselves against one of the exclusion criteria.

A report of the pilot is available from the MCN Coordinator.

3.1.2 COPD & Asthma Information Systems

The Fife Respiratory MCN aims 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.

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 are designed to aid data collection during COPD and Asthma review appointments.

Both the EMIS and VISION templates are due to be reviewed in line with current guidelines prior to widespread roll out across all Fife GP Practices. These templates will be optional but it is hoped as many GP Practices as possible will use these templates as part of their standard patient reviews.

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 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 4a5; ‘Pulmonary Rehabilitation is available within the NHS Board to people with COPD’ and NICE Clinical Guideline 1016; ‘Pulmonary Rehabilitation should be made available to all appropriate people with COPD including those who have had a recent hospitalisation for an acute exacerbation’

Since the initial pilot in 2008, the Pulmonary Rehabilitation service has relied on short-term and yearly funding.

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
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.

Following completion of the survey by 11 NHS Boards, six priorities / measures of success were identified. A further two optional priorities / measures of success were also identified.

NHS Boards were then asked to anonymously benchmark themselves against the six (or eight) measures of success, which will provide the National Advisory Group with the opportunity to consider emerging themes from locally identified challenges, risks and barriers to implementation, and will inform the development of local and national asthma improvement plans to drive forward implementation.

Fife Respiratory MCN, with input from Clinicians, completed the self assessment. This will influence the work around Asthma within the Fife Respiratory MCN annual workplan. Further feedback / guidance from the National Advisory Group is awaited.

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. Under the new National Service, equipment and supplies are delivered directly to patients by Dolby-Vivisol.

During 2013/14 there have been concerns and incidents around GP access to emergency oxygen supplies in the ‘in hours’ periods. Fife Respiratory MCN will continue to liaise with, Pharmacy, GP and Specialist Service colleagues to agree provision of access to emergency oxygen supplies and guidance around the use of this.

3.1.6 COPD and Asthma Resource Pack Updates

The COPD and Asthma resources are reviewed and updated yearly, to ensure the information available to clinicians and public members remains relevant, appropriate and up-to-date.

3.1.7 Bronchiectasis

Bronchiectasis was included in the Respiratory MCN Annual Workplan for the first time in 2013/2014. To date, an electronic Bronchiectasis Self Management Action Plan has been produced and an education session on this condition was delivered.

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7 SIGN/BTS British guideline on the management of asthma. Asthma Priorities: influencing the agenda, February 2013
3.1.8 Sleep Apnoea

Sleep Hygiene Measures and a Sleep Pathway Guideline for Primary Care Referrals have been produced and are available via the DWF CHP and NHS Fife websites.

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

The Children & Young People’s (C&YP) Asthma Sub Group is a multidisciplinary 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.

To ensure the group was functioning effectively and making the best use of the time and knowledge that members were bringing to the group, Organisational Development facilitated a one-off meeting to discuss the purpose and way forward for the C&YP Asthma Sub Group.

As such, the Group focussed on the functioning of the Group during 2013/2014 and will take forward the actions from the workplan during 2014/2015.

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.

The main focus of the Education Sub Group during 2013/2014 was:

3.3.1 Training Needs Analysis

An online survey was undertaken. The aim of the survey was to engage with all healthcare professionals across Fife who had a remit or interest in respiratory care, to identify training and education needs in relation to respiratory care. This information would then be used to inform and develop training and education that specifically meets local requirements.

Unfortunately the response rate for the survey was relatively low – 28%, and it is of note that the majority of respondents work within the Dunfermline & West Fife CHP area, which is where the Fife Respiratory MCN is hosted.

The Education Sub Group will take forward the recommendations from the survey report.

3.3.2 Provision of Education

During 2013/2014, the Fife Respiratory MCN provided education sessions as detailed in Appendix B.
3.4 **Fife Respiratory MCN Palliative Care Sub Group**

Following discussions at the Education Sub Group around the gap in education provision for non-cancer palliative care, a Palliative Care Sub Group was convened. The group will take forward education and learning packages within this area.

3.5 **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. Chaired and coordinated by the public members, the Group leads on supporting the Patient Focus Public Involvement agenda in relation to Respiratory care in Fife.

For their first piece of work, the Patient Sub Group decided to focus initially on ‘equality of treatment of patients throughout Fife’. This concern had been raised at previous Chest Voices Scotland focus groups. The Patient Sub Group was aware that the Respiratory MCN had produced and distributed COPD Action Plans for self management to GP Practices across Fife and wanted to know how widespread the implementation had been. A short questionnaire was produced and distributed to fellow patients via members’ respective BreatheEasy Groups.

The Group received 31 replies covering 25 GP surgeries. The results of the survey indicated that the provision of Self Management Action Plans is not consistently applied throughout Fife with 15 responders have received an action plan for self management of their condition but 16 did not. The survey also indicated there was a surgery where there were patients with and without an action plan.

A report of the survey is available from the Patient Sub Group.

3.6 **Communication, Involvement and Awareness Raising**

3.6.1 **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.

3.6.2 **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.
3.6.3 My Lungs, My Life website

Chest Heart & Stroke Scotland (CHSS) are in the process of developing a national online resource – ‘My Lungs, My Life’. NHS Fife input to the steering group for this has been via the Clinical Lead (Primary Care). CHSS also held focus groups and the Fife Respiratory MCN Patient & Carer Sub Group participated in these giving input to the initial subjects to be included.

3.6.4 National Respiratory Prescribing Guidance

As a result of the successful completion of the Respiratory Bundle (2011-2012), Fiona Eastop, Primary Care Development Pharmacist (Representative on the MCN), was invited by the National Advisory Group (NAG) for Respiratory MCNs to attend a national meeting (February 2013) to discuss a national prescribing strategy and share the methods and results of the Fife Respiratory Bundle.

Fiona Eastop was then approached to write the national strategy on behalf of the QuEEST team. The Fife Respiratory MCN was invited to comment on the draft strategy during the developmental process and one year on, the final draft has been circulated to the Respiratory NAG for approval.

4 PROGRESS AGAINST FIFE RESPIRATORY MCN ANNUAL WORKPLAN 2013-2014

The Fife Respiratory MCN Steering Group and Sub Groups worked to the agreed annual workplan during 2013/2014. 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 2014/2015 Annual Workplan.

5 FOCUS FOR 2014/2015

The Fife Respiratory MCN will focus on the following key priorities during 2014-2015:

- Palliative Care Education, eLearning Package and Study Day
- C&YP Asthma actions
- National Review of Asthma Deaths
- Home Oxygen service local guidance and protocols
- Populate Bronchiectasis section on website
- MCN Endorsement

The annual workplan for 2014-2015 is attached at appendix D.
6 **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:

**HIS / BTS / SIGN Guidelines**

In 2013/2014, the Fife Respiratory MCN submitted a self assessment against the BTS/SIGN Asthma Priorities Action Plan

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

7 **SUMMARY**

During 2013-2014, the Fife Respiratory MCN has continued to expand and has focussed on a number of key areas, including: local implementation and monitoring of national guidelines on oxygen prescribing and delivery; Spirometry, Bronchiectasis and Acute Asthma education sessions; joint working with the Heart Disease MCN and Heart Failure Clinic to casefind new cases of COPD; piloting EMIS and VISION patient review templates; self assessment against SIGN / BTS Asthma Priorities Action Plan and re-focussing of the Children & Young People’s Asthma Sub Group.
## Communication & Reporting Plan

This plan outlines the Fife Respiratory MCN’s stakeholders, what it communicates with them and how this communication takes place.

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<thead>
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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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| Public, Service users and carers | ➢ Updates on the work of the MCN ➢ Seek local feedback and informed input to the work of the MCN | Inform, engage & consult with BreatheEasy support groups in Fife. This is a two way process, the MCN welcomes proactive engagement from all its stakeholders.  
The MCN Steering Group has two service user representatives, including representation from the Patient & Carer Sub Group. The Children & Young People’s Asthma sub group has a service user/carer representative.  
Using a variety of means (web / working & sub groups / people’s panel, PPF) to reach as many people as possible.  
Steering Group minutes, annual work plan and annual report will be posted on the NHS Fife website. |
| Voluntary sector | ➢ Updates on the work of the MCN ➢ Seek sector feedback and informed input to the work of the MCN | The three national groups (Asthma UK, BLF & 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. |
| National Advisory Group of Respiratory MCNs | ➢ Updates on the work of the Fife MCN ➢ Obtain information on work of MCNs throughout Scotland ➢ Share learning ➢ Guidance on national initiatives and guideline implementation | Quarterly meeting attended by a Clinical Lead and / or MCN Coordinator.  
Email contact with Chair of the National Advisory Group.  
Learning Forums and events  
Respiratory Knowledge Network |
| Healthcare Improvement Scotland | ➢ Dissemination and review of local and national guidelines / projects / quality improvement activity | Electronically  
Timescales as requested |
<table>
<thead>
<tr>
<th>Internal Stakeholders</th>
<th>What is to be communicated</th>
<th>Methods and frequency of communication</th>
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| Fife Respiratory MCN Steering group        | ➢ Annual report and work plans presented to the D&WF CHP Clinical Governance Group for approval  
➢ Update of MCN progress/status          | Bi-monthly Steering Group meetings, which includes internal and external stakeholders.                       |
|                                            | ➢ Update and review of participation in both local and national quality improvement activity |                                                                                                         |
|                                            | ➢ Risks and local service delivery issues                                                 |                                                                                                         |
| D&WF CHP Clinical Governance Group         | ➢ Un-resolvable risks and local service delivery issues escalated the D&WF CHP Clinical Governance Group via the MCN Coordinator > these will then be further escalated to D&WF CHP Management Team > NHS Fife Clinical Governance > 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                         | ➢ Updates on the work of the MCN                                                          | Bi-monthly General Practice & Primary Care Clinical Group - Primary Care Clinical Lead & MCN Coordinator are members of this Group. |
| NHS Fife Clinical Governance Committee     | ➢ Seek local feedback and input to the work of the MCN                                    |                                                                                                         |
| D&WF General Practice & Primary Care Clinical Group | ➢ Updates on the work of the MCN                                                          | Weekly meetings. Secondary Care Clinical Lead member of group                                          |
|                                            | ➢ Seek local feedback and input to the work of the MCN                                    |                                                                                                         |
| Respiratory Consultants meeting (weekly)   | ➢ Development and awareness of resources/processes to support clinical practice            | Resources available on website                                                                         |
| General Practice and LMC                   | ➢ ADTCs approval will be sought on any new resources which mention medications/devices or processes impacting on pharmacy. | GP representation on MCN SG and Sub Groups > links with LMC                                             |
| Area Drugs and Therapeutics Committee (ADTC)| ➢ Updates which involve changes to medication references.                                  | Quarterly / bi-annual update newsletter (TBC)                                                          |
# RESPIRATORY EDUCATION DELIVERED IN 2013/2014

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<td>Lorna Stewart</td>
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<td>Gill Dennes, Anne McKean &amp; Gaynor Black</td>
<td>Practical Spirometry</td>
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<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>
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<td>09/05/2013</td>
<td>June James</td>
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<td>Dr Tom Hartung</td>
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<td>Dr Anirrudhan &amp; Dr Fairnbairn</td>
<td>Acute Asthma</td>
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<td>Gill Dennes &amp; Heather Sheddon</td>
<td>Practical Spirometry in Primary Care: Getting it Right Every Time</td>
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</tbody>
</table>
## 1. Clear Management Arrangements and Leadership of the MCN

### a) Refresh role and remit [annually]

- **anticipated outcome(s):** Unity of purpose and direction of the MCN and Involvement of multidisciplinary colleagues
- **person responsible:** MCN Coordinator
- **target / objective:** Role & Remit reviewed and agreed by December 2013
- **core principle:** CEL 29: 8.2; 8.5; 8.6; 16; 19
  HDL 21: 3; 10.1
  QAP: 1
  QA: 2
- **RAG status:** Orange

### b) Identify / agree Clinical Leadership for 2014 onwards

- **anticipated outcome(s):** Continuation of current Lead Clinicians / new Lead Clinician(s)
- **person responsible:** MCN Steering Group
- **target / objective:** Continued clear clinical leadership and responsibility for the functioning of the MCN
- **core principle:** CEL 29: 8.1
  HDL 21: 10.1 & 24
  QAP: 1
  QA: 2
- **RAG status:** Orange

### c) Complete annual report including progress within Quality Assurance Programme

- **anticipated outcome(s):** Unity of purpose and direction of the MCN. Update stakeholders with progress made against agreed actions / priorities. Progress and adherence to various clinical standards.
- **person responsible:** MCN Coordinator
- **target / objective:** 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
- **core principle:** CEL 29: 8.1; 38
  HDL 21: 10.1, 10.7 & 33
  QAP: 1
  QA: 2
- **RAG status:** Green

## 2. Involvement & Partnership Working

### a) internet and intranet web presence

- **anticipated outcome(s):** Clinicians and patients have access to information and resources
- **person responsible:** MCN Coordinator
- **target / objective:** 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.
- **core principle:** CEL 29: 8.6
  HDL 21: 35
  QA: 1 & 2
- **RAG status:** Green

### Key:

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

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**Appendix C**

**Respiratory MCN 2013-14 Work plan - Final Draft**

The following work plan is treated as a ‘live’ document.
### 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

### c) Working with other MCNs
- Work with HD MCN to Casefind undiagnosed COPD patients

#### MCN Coordinator; MCN Clinical Leads
- Casefind undiagnosed COPD patients

(See 3c below)

### d) Primary Care Review Templates
- To support Clinicians with patient reviews.
  
  [HIS COPD Clinical Standards 1&3; Asthma Priorities Measurements 2&6; SIGN Asthma Priorities 3&4]

#### MCN Coordinator
- COPD pilot / roll out Vision & EMIS
- Asthma pilot / roll out Vision & EMIS

#### CEL 29: 19
- HDL: 35
- QA: 2

<table>
<thead>
<tr>
<th>Patient sub group undertook survey of use / distribution of COPD Action plans in relation to Chest Voices concerns of “equality of treatment of patients throughout Fife”. Report of findings available. AGM held December 2013. Group reviewing work plan. Group chaired and coordinated by members. Education provided (see 7a below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirometry results collated to Aug 2013. Cases of undiagnosed COPD identified. 12 month pilot period ended Jan 2014 Database of collated results.</td>
</tr>
</tbody>
</table>
### 3. COPD

#### a) Local Priorities from HIS Clinical Standards Self Assessment

<table>
<thead>
<tr>
<th>Clinical Standards</th>
<th>MCN Clinical Leads; MCN Coordinator</th>
<th>CEL 29: 8.4</th>
<th>HDL: 10.4; 12 QA: 1&amp;2</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are diagnosed earlier, reduced emergency admissions and length of stay. Identify areas of focus from self assessment.</td>
<td>- Review / update self-assessment&lt;br&gt;- Review current working in line with National Benchmark&lt;br&gt;- ‘developing’ = casefinding; palliative care services&lt;br&gt;- ‘implementing’ = diagnosis &amp; periodic review of COPD; oxygen therapy&lt;br&gt;- ‘monitoring’ = home support, intermediate care &amp; supported discharge services</td>
<td>Casfinding pilot Palliative Care SG formed. COPD templates for EMIS Oxygen local guidelines in draft</td>
<td></td>
</tr>
</tbody>
</table>

#### b) Review and update COPD Resource Pack [annually]

<table>
<thead>
<tr>
<th>Supporting clinicians. Supporting patient self management</th>
<th>Resource Contributors; MCN Coordinator</th>
<th>HDL: 10.4; 15 &amp; 35 QA: 1&amp;2</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To provide high quality, up to date information</td>
<td>All sections reviewed and updated 2013.</td>
<td></td>
</tr>
</tbody>
</table>

#### c) Casefinding

<table>
<thead>
<tr>
<th>12 month pilot to identify undiagnosed COPD patients (HIS Clinical Standard 2: People with COPD are diagnosed in the early stages of the disease)</th>
<th>MCN Coordinator; HF Clinic Nursing Auxiliaries; LF Nurses, Cardiac Consultant</th>
<th>CEL 29: 17 QA: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Facilitate earlier diagnosis&lt;br&gt;- Earlier diagnosis to help maintain quality of life for longer&lt;br&gt;- Maintain database of non-patient identifiable results.&lt;br&gt;- Review pilot after 6 months</td>
<td>Forms received to Aug 2013. Results input to database. From Aug 2013, staffing and time constraints within Pulmonary Function &gt; impacting Dr Francis clinic appts. 12 month pilot complete</td>
<td></td>
</tr>
</tbody>
</table>

#### d) Support smoking cessation

<table>
<thead>
<tr>
<th>Enhance / support continued smoking cessation</th>
<th>Smoking cessation colleagues</th>
<th>QA: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enhance use of smoking cessation support and improve diagnosis&lt;br&gt;- Pilot of COPD6 screening (lungs age info) to support stop smoking attempts</td>
<td>6 month pilot extended to 12 month pilot. Report of pilot available from Smoking Cessation. Showed increase at 4 week quit rates but no increase at 3 month quit rates.</td>
<td></td>
</tr>
</tbody>
</table>

**GREEN**
### 3. Continuation of Pulmonary Rehabilitation Programme

**e)** 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.

**HDL:** 10.9; 15; 20
**HEAT:** 7+
**QA:** 1,2 & 3

Ongoing – year on year funding.

### f) Telepod pilot

Support good quality proactive clinical care using technological advances

**MCN Coordinator NHS 24 E-Health**

- Demonstrate reduction in COPD hospital admissions

**HDL:** 35
**QA:** 1,2 & 3

### 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

**CEL 29:** 8.6

Evening session for Primary Care Emergency Service Clinicians on Acute Asthma.
Palliative Care learning packages being discussed.
### 4. ASTHMA

<table>
<thead>
<tr>
<th></th>
<th><strong>a) Review and update the Asthma Resource Pack [annually]</strong></th>
<th><strong>Supporting clinicians.</strong> Support patient self management</th>
<th><strong>Resource Contributors:</strong> MCN Coordinator;</th>
<th><strong>To provide high quality, up to date information.</strong></th>
<th><strong>HDL:</strong> 10.4; 15 &amp; 35 <strong>QA:</strong> 1&amp;2</th>
<th>All sections reviewed and updated in 2013.</th>
<th><strong>GREEN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>b) Review paediatric detailed patient care pathway</strong></td>
<td><strong>To ensure delivery of highest standard of evidence-based care across Fife</strong></td>
<td><strong>Chair C&amp;YP Asthma Sub Group</strong></td>
<td><strong>Identify gaps in current service provision / patient journey e.g. referral routes &amp; criteria</strong>&lt;br&gt;<strong>Review actions identified as part of mapping exercise (2012)</strong>&lt;br&gt;<strong>Link to Integrated Care Pathway – show where, why and how various services are involved along the pathway</strong></td>
<td><strong>HDL:</strong> 10.2; 15</td>
<td><strong>RED</strong></td>
<td></td>
</tr>
</tbody>
</table>
|  | **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**<br>**BTS paediatric management of asthma** | **HDL:** 10.2; 15 **QA:** 1 | Diagnosis & Management Flowcharts issued to each GP Practice in Fife and available on the website. **GREEN**<br>**GREEN**

All Practices were offered the opportunity to partake in a facilitated ‘Asthma Roadshow’ to raise awareness of the flowcharts, encourage discussion and increase knowledge of paediatric asthma – no takers.
| 4. CONT. | d) Self Assessment against SIGN / BTS Asthma Priorities action plan | Contribute to National Advisory Group benchmark / Scotland-wide picture | MCN Coordinator; C&YP Asthma Sub Group; MCN Steering Group | ● Review current activities against asthma priorities / standards and self assess current level | CEL 29: 8.4 HDL: 10.4 QA: 1&2 | Review template complete for Primary Care and adult & paediatric Secondary Care. | GREEN |
| | e) Structured discharge process from Secondary to Primary Care | To ensure paediatric patients discharged from Secondary Care are known to Primary Care and agreed care plan in place | C&YP Asthma Sub Group | ● Establish link and communication process with Primary Care prior to patient discharge | CEL 29: 19; 41 HDL: 15 QA: 1, 2, & 3 | CEL 29: 19; 41 HDL: 15 QA: 1, 2, & 3 | RED |
| | f) Structured referral template for Primary Care | To aid appropriate referrals / triage | C&YP Asthma Sub Group Chair | ● Based on Diagnosis & Management flowchart ● Electronic referral | CEL 29: 19; 41 HDL: 15 | CEL 29: 19; 41 HDL: 15 QA: 1 | RED |
| | g) Communication from Primary to Secondary Care | To ensure Secondary Care are kept informed of paediatric patient follow-up reviews following a hospital admission | Paediatric Asthma Specialist Nurse; PC Lead Clinician | ● Share information on Primary Care reviews ● Electronic transfer of information | CEL 29: 19; 41 HDL: 15 QA: 1 | CEL 29: 19; 41 HDL: 15 QA: 1 | RED |
| | h) Clarify timeframe of ‘regular’ reviews | To clarify meaning of ‘regular’ to allow best practice for Primary Care | C&YP Asthma Sub Group | ● Allow best practice across Fife | | | RED |
|   | i) Pre-school review of inhaler needs | Children may no longer need inhaler when starting Primary or Secondary School [Asthma Priorities Measurement 7] | 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 | QA: 2 |
|---|---|---|---|---|
| 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  
Pharmacy audit.  
GP patient system review templates  
GP patient system review templates |
| k) Asthma Education | To provide education in line with SIGN & Asthma priorities [Asthma Priorities Measurement 5&7; SIGN Asthma Priority 2] | 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 | CEL 29: 8.7  
HDL 10.8  
Acute Asthma session provided to PCES. |
<table>
<thead>
<tr>
<th></th>
<th>BRONCHIECAT ASIS</th>
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<tbody>
<tr>
<td></td>
<td>5. a) Review BTS Quality Standards for Clinically Significant Bronchiectasis for Adults</td>
<td>Improve standards of care for people with bronchiectasis. Measurable markers of good practice. <em>BTS Quality Standards for Clinical Significant Bronchiectasis in Adults; July 2012, Vol.4 No.1 2012</em></td>
<td>MCN Clinical Leads; MCN Coordinator; MCN Steering Group</td>
<td>• Review current practice / gaps  • 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</td>
</tr>
</tbody>
</table>

|   | SLEEP APNOEA | a) Review and disseminate local guidelines | Improved referral patterns | Clinical Lead (secondary care) | • Guidelines for awareness and protocols  • Reduction in redirected referrals.  |


|   |   |   |   |   |   | GREEN  |

|   |   |   |   |   |   | GREEN  |
## 7. EDUCATION

| a) Agree programme of education for the year ahead |
| 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

### PLT:
- Interpreting Spirometry
- Bronchiectasis
- Evening Sessions:
  - Acute Asthma
  - Practical Spirometry

Self assessments completed for interpreting spirometry

- TNA completed.

### Pulmonary Rehab (Dr Chinn)

- Pharmacy (Fiona Eastop)

- Palliative Care being taken forward by newly formed Palliative Care Sub Group

- Acute Asthma session to PCES

---

## 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

- Review of seretide 250 evohaler prescribing – practices piloted stepping down in asthma to formulary choice Fostair.
### 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 co-ordinated 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 | OoH contingency process in place.  
Still concerns and issues around GP access to emergency O2 ‘in hours’ for palliative patients not known to specialist service. Meeting to be set up to discuss way forward.  
Local guidelines and flowchart in draft.  
Clinical (national guidance & scenarios) and patient info available on Oxygen section of website. |

- **17** action areas have been completed [green] within the financial year 2013/2014. Some of these actions will continue, as standing actions, on the 2014/15 Work Plan
- **6** action areas are currently still in progress [orange]:
  - Action 1a: Refresh role & remit
  - Action 1b) Identify/ agree Clinical Leadership for 2014
  - Action 2d: Primary Care Review Templates – pilots completed on EMIS and VISION templates. Still be rolled out. Templates required reviewing in 2014 prior to full roll out.
  - Action 4j: Priorities from the SIGN 101 Guideline review - some work on this is ongoing e.g. Primary Care review templates.
  - Action 4k:Asthma education
  - Action 9a: Support and Monitor the new National Home Oxygen supply service
- **7** actions remain outstanding [red]:
  - Action 3f: Telepod pilot to support good quality proactive clinical care using technological advances.
  - Action 4e: Structured discharge process from Secondary Care to Primary Care
  - Action 4f: Structured referral template for Primary Care
  - Action 4g: Communication from Primary to Secondary Care
  - Action 4h: Clarify timeframe of ‘regular’ reviews
  - Action 4i: Pre-school review of inhaler techniques
# FIFE RESPIRATORY MCN WORK PLAN 2014-2015
*(the following work plan is treated as a “live” document)*

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Purpose</th>
<th>Person Responsible</th>
<th>Target / Objective</th>
<th>Core Principle</th>
<th>Progress to Date</th>
<th>RAG status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a) Refresh role and remit [annually]</td>
<td>Unity of purpose and direction of the MCN. Involvement of multidisciplinary colleagues.</td>
<td>MCN Coordinator</td>
<td>Role &amp; Remit reviewed and agreed</td>
<td>CEL 29: 8.2; 8.5; 8.6; 16; 19 HDL 21: 3; 10.1 QAP: 1 QA: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Clinical Leadership</td>
<td>Primary Care and Secondary Care Lead Clinicians to drive forward the work of the MCN</td>
<td>MCN Steering Group</td>
<td>Clear clinical leadership and responsibility for the functioning of the MCN</td>
<td>CEL 29: 8.1 HDL 21: 10.1 &amp; 24 QAP: 1 QA: 2</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>c) Annual Report</td>
<td>Unity of purpose and direction of the MCN. Update stakeholders with progress made against agreed actions / priorities. Progress and adherence to various clinical standards and local and national guidance.</td>
<td>MCN Coordinator</td>
<td>Continuous improvement in the quality of service provided by the MCN. Highlight work achieved against previous year’s workplan / objectives. Set out focus / workplan for coming year</td>
<td>CEL 29: 8.1; 38 HDL 21: 10.1, 10.7 &amp; 33</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>d) MCN Endorsement</td>
<td>Endorsement of MCN by NHS Fife Board</td>
<td>MCN Coordinator; MCN Clinical Leads</td>
<td>Continuous improvement. Provide assurance to NHS Fife Board. 3-yearly assessment</td>
<td>HDL 21: 10.1, 10.7 &amp; 33 QAP: 1 QA: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area</td>
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</tbody>
</table>
|      | 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 website resources.  
• Website presence  
• Encourage use of website as a resource / knowledge network. | CEL 29: 8.6  
HDL 21: 35  
QA: 1&2 |            |
|      | b)     | MCN Patient Sub Group | Patient focus approach.  
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 | • To support the work of Patient Sub Group and help progress work within their action / workplan and comment / input on any issues identified. | CEL 29: 8.6; 32  
HDL 21: 31  
QA: 3 |            |
|      | c)     | Working with other MCNs | Establish links and joint working with the other MCN's in Fife.  
Joint working with National Respiratory Group / other Board Respiratory MCNs | MCN Coordinator; MCN Clinical Leads | • Share ideas & education resources  
• | Self management event |            |
|      | d)     | Primary Care Review Templates | To support Clinicians with patient reviews.  
[HIS COPD Clinical Standards 1&3; Asthma Priorities Measurements 2&6; SIGN Asthma Priorities 3&4] | MCN Clinical Lead (PC) and MCN Coordinator | • COPD and Asthma templates available to all GP Practices in Fife  
• Review templates in line with changes to guidelines | CEL 29: 19  
HDL: 35  
QA: 2 |            |
<p>|      | e)     | Health Inequalities Team | Detect Cancer Early – Lung Health initiative. | | • Raise awareness of referral guidelines with GPs/Primary Care. | |            |</p>
<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Purpose</th>
<th>Person Responsible</th>
<th>Target / Objective</th>
<th>Core Principle</th>
<th>Progress to Date</th>
<th>RAG status</th>
</tr>
</thead>
</table>
| 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. | MCN Clinical Leads; MCN Coordinator               | • Take forward areas of focus from self assessment:  
  ✓ ‘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) 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          | QA: 3                                                        |                  |            |
|                           | d) Pulmonary Rehabilitation Programme                                  | Pulmonary Rehab is available to patients with COPD. Equitable access. | 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 | HDL: 10.9; 15; 20  
HEAT: 7+  
QA: 1,2 &3                                      |                  |            |
|                           | f) Telepod pilot                                                       | Support good quality proactive clinical care using technological advances | MCN Coordinator NHS24 E-Health                   | • Demonstrate reduction in COPD hospital admissions                                   | HDL: 35  
QA: 1,2&3                                      |                  |            |
<table>
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<tr>
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<tbody>
<tr>
<td>COPD CONT...</td>
<td>g) Complex Care</td>
<td>People with complex care receive care in a community setting (HIS Clinical Standard 6: People with COPD have access to home support services)</td>
<td>TBC</td>
<td>• Supporting clinicians managing complex cases in a community setting</td>
<td>CEL 29: 8.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Review and update the Asthma Resource Pack [annually]</td>
<td>Supporting clinicians. Support patient self management</td>
<td>Resource Contributors; MCN Coordinator; Chair C&amp;YP Asthma Sub Group</td>
<td>• To provide high quality, up to date information.</td>
<td>HDL: 10.4; 15 &amp; 35 QA: 1&amp;2</td>
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<td></td>
<td>b) Review paediatric detailed patient care pathway</td>
<td>To ensure delivery of highest standard of evidence-based care across Fife</td>
<td>Chair C&amp;YP Asthma Sub Group</td>
<td>• Identify gaps in current service provision / patient journey e.g. referral routes &amp; 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</td>
<td>HDL: 10.2; 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) 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 self assessment against national benchmark • Take forward identified priorities / areas of focus</td>
<td>CEL 29: 8.4 HDL: 10.4 QA: 1&amp;2</td>
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<tr>
<td>d) 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>
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<td>e) 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 • Electronic referral</td>
<td>CEL 29: 19; 41 HDL: 15</td>
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<td>f) 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 • Electronic transfer of information</td>
<td>CEL 29: 19; 41 HDL:15 QA: 1</td>
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<td>g) Clarify timeframe of ‘regular’ reviews</td>
<td>To clarify meaning of ‘regular’ to allow best practice for Primary Care</td>
<td>C&amp;YP Asthma Sub Group</td>
<td>• Allow best practice across Fife</td>
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| h) 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 | QA: 2 |
| i) 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 |
| j) 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 | CEL 29: 8.7  
 HDL 10.8 |
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<tr>
<td>5. BRONCHIECATIS</td>
<td>a) Review BTS Quality Standards for Clinically Significant Bronchiectasis for Adults</td>
<td>Improve standards of care for people with bronchiectasis. Measurable markers of good practice. <em>BTS Quality Standards for Clinical Significant Bronchiectasis in Adults; July 2012, Vol.4 No.1 2012</em></td>
<td>MCN Clinical Leads; MCN Coordinator; MCN Steering Group</td>
<td>• Review current practice / gaps  • Education  • Promote use of self management plan  • Section / resources on website e.g. management of condition – patient and clinician; exacerbations; airway clearance techniques; pharmacological management  • Pulmonary rehab referral</td>
<td>CEL 29: 8.4  HDL: 10.4  BTS QA: 1&amp;2</td>
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<td>6. PULMONARY FIBROSIS</td>
<td>a) Review NICE guidelines for Idiopathic Pulmonary Fibrosis</td>
<td>Improve standards of care for people with Idiopathic Pulmonary Fibrosis</td>
<td>MCN Clinical Leads, MCN Steering Group, MCN Coordinator</td>
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<td>7. SLEEP APNOEA</td>
<td>a) Sleep referrals &amp; guidelines</td>
<td>Improved referral patterns</td>
<td>Clinical Lead (secondary care)</td>
<td>• Guidelines for awareness and protocols  • Reduction in redirected referrals.</td>
<td>CEL 29: 8.6  HDL: 15  QA: 1</td>
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| 8. EDUCATION | a) Programme of education for the year ahead                          | Planned programme of targeted education                                | Chair Education Sub Group; MCN Coordinator | • Ensure equitable access to evidence-based education.  
• Raise awareness of education available  
• Raise awareness of MCN  
• e-Learning opportunities explored  
• Asthma education (see area 4k above)  
• MCN study day                       | CEL 29: 8.7  
QAP 8  
HDL 10.8                  |                |                                                                      |                                        |                                    |
|        | b) Interpreting & Practical Spirometry                                | Support clinicians to update knowledge and skills.                      | Education Sub Group                      | • Competencies maintained via self assessment or education session.                 |                |                 |            |
| 9. PHARMACY | a) Support enhanced prescribing practice                              | Best Practice in prescribing is supported                               | MCN Pharmacy members                     | • Pharmacy / GP Prescribing projects                                               | CEL 29: 8.8  
HDL: 10.9       |                |                                                                      |                                        |                                    |
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| 10. 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 co-ordinated 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 for access to emergency oxygen during In-hours period for patients not known to a specialist service  
• Ensure GPs are aware of referral pathways and criteria  
• Information resources on website | CEL 29: 12  
HDL: 15  
QA: 1&2 | | |