# NHS Fife Respiratory Managed Clinical Network

## Annual Report

**2015-2016**

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EXECUTIVE SUMMARY

This is the sixth 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 2015-2016 has been:

- Delivering an afternoon study day focussing on Palliative Care within Respiratory Disease
- Finalising an online (LearnPro) module focusing on Non Malignant Palliative Care in Respiratory Disease
- Adapting and localising a Spirometry learning module on the LearnPro platform
- Self assessment against the recommendations from the National Review of Asthma Deaths report
- Delivering asthma education to individual General Practices linked to the recommendations outlined in the National Review of Asthma Deaths report
- Review of Fife Formulary Chapter 3 (respiratory medicine) in line with new devices, compounds and preparations
- Review and update of the Asthma Resource Pack available on the NHS Fife website
- Supporting Stop Smoking colleagues to use the COPD6 handheld spirometry screening devices to encourage patients to stop smoking
- Working with colleagues from NHS Lothian Respiratory MCN in relation to proposed changes to the referral criteria for the Obstructive Sleep Apnoea Hypopnoea Syndrome Service
- Continuing to use electronic newsletters as a means of wider communication and updating on various issues and items of interest

The Respiratory MCN was also delighted to receive a nomination in the 2015 Staff Achievement Awards in the Innovation Category.

This report highlights the work of the NHS Fife Respiratory Managed Clinical Network between 01 April 2015 and 31 March 2016.

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

This is the sixth Annual Report of the Fife Respiratory Managed Clinical Network [MCN] and covers the period 01 April 2015 to 31 March 2016.

The purpose of this report is to:

- Provide an overview of the work undertaken within the Fife Respiratory MCN in 2015-2016;
- Highlight progress within 2015-2016 relative to the Annual Work Plan;
- Highlight the focus for 2016-2017 including the Annual Work Plan;
- Highlight work in line with evidence-based standards.

2. BACKGROUND

2.1 Fife Respiratory Managed Clinical Network [MCN]

Hosted by Dunfermline & West Fife Community Services [formerly known as Community Health Partnership] on behalf of the three Fife Community Services and accountable via the D&WF 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

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Originator: MCN Coordinator Page 5 of 31
The role of the Fife Respiratory MCN is to improve the health and well-being of the people of Fife (children and adults) with respiratory disease\(^2\) 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 guided by two Lead Clinicians – Gill Dennes, Advanced Nurse Practitioner, representing Primary Care; and Dr Colin Selby, Respiratory Consultant, representing Secondary Care and Lorraine Cooper-King, MCN Coordinator. The MCN provides a forum for:

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

2.2 Communication and Reporting

In line with the Scottish Executive Letter HDL (2007) 21\(^1\), the Fife Respiratory MCN reports through local management arrangements via the Fife Respiratory MCN Steering Group and D&WF Community Services 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 available on the NHS Fife website.

The Fife Respiratory MCN has a communication and reporting plan which outlines the MCN’s stakeholders, areas and methods of communication and reporting arrangements. 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 Fife Respiratory MCN Annual Workplans reflects these quality ambitions.

\( ^2 \) Excluding lung cancer which is covered by the South East Scotland Cancer Network [SCAN]

\( ^3 \) 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 2015-2016

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 2015 and 31 March 2016. The Group is chaired by the Lead Clinicians on a rotational basis and membership includes: the MCN Lead Clinicians, MCN Coordinator, General Practitioner, Anticipatory Care Nurse, Respiratory Specialist Nurses, Paediatric Asthma Nurse Specialist, primary and secondary care Pharmacists, Community Respiratory Physiotherapists, Stop Smoking service, Education representative and Breathe Easy Support Group representative.

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

3.1.1 National Review of Asthma Deaths (NRAD)

Fife Respiratory MCN received a copy of a self assessment template, developed by Dumfries & Galloway Respiratory MCN, for capturing current progress / status against the NRAD recommendations.

The MCN issued a letter to all General Practices in Fife requesting voluntary feedback. A total of 21 out of 58 practices returned completed feedback templates. Secondary care feedback was also received.

Key points identified from the Fife NRAD self assessment includes:

- **Identified respiratory lead within General Practice**: 20 out of the 21 practices confirmed the practice has an identified respiratory lead; 14 GPs and 10 Practice Nurses / Nurse Practitioners
- **Proactive method for identifying those who fail to attend for regular asthma reviews**: barriers to achieving this included time management in contacting patients, poor response to recall if patient condition is stable, and encouraging people who feel they do not need to be reviewed. This may impact on the practice’s efforts to support parents, carers and children to manage their asthma, medications and recognise when their asthma is poorly controlled.
- **Patients issued with asthma action plans**: feedback highlighted the use of personal asthma action plans was variable, with the main barriers being time constraints in completing the plans and patient acceptance and understanding of the plans.
- **Managing acute asthma within general practice**: practices who replied advised of effective systems of triage / urgent appointment availability; appropriate equipment and clinical skills.
- **Proactive method for identifying those who fail to attend for regular asthma reviews**: a variety of methods were reported for identifying and managing higher risk asthma patients, including the previous audit of high SABA prescribing (as outlined in the 2014-2015 annual report)

Following on from this, Practices were offered targeted education to support the management of asthma patients within Primary Care (detailed below).
3.1.2 Asthma Education Roadshow

In line with the NRAD recommendations and barriers to achieving these, as identified from the feedback from practices, Gill Dennes, Lead Clinician and Anne McKean, Paediatric Asthma Nurse Specialist, developed and delivered targeted education to support the management of asthma patients within Primary Care.

Between October 2015 and end of March 2016, six asthma education sessions were delivered, with a further three delivered in April and May 2016.

The interactive education sessions allowed discussion about both adult and children with asthma, and Practices were given the opportunity to prioritise the areas of discussion, depending on need, prior to the session:

- Child scenario; including discussion of paediatric asthma management
- Adult scenario; including 1st and 2nd line treatments
- BTS stepwise approach
- Fife Formulary
- Benefits for stepping up and down treatment
- Adrenal suppression
- Asthma review

Evaluation responses are still being collated, however, initial feedback has been positive.

3.1.3 Asthma Review Letters

NICE Quality Standard (QS25)\(^4\) states people with asthma should receive a structured review at least annually.

The National Review of Asthma Deaths (NRAD) found no evidence that an annual review had taken place in general practice in the year preceding death for 84 out of the 195 people who died.

All patients on the QOF register should be offered an annual review. In many practices, the asthma review letters are generated automatically and after three failed appointments the patient is then exempted until the next year.

The MCN were concerned that some children may be missing their review appointments as a result of the failure of their parent / guardian to bring them to their review.

To assist practices to overcome the challenges of children not attending for an annual review of their asthma, and where there may be wider wellbeing concerns, the MCN developed template letters of an escalating nature, which were available to Practices to use should they wish to do so. The letters make reference to possible notification to the child’s named person if the child is not brought to their appointment / contact from the parent / guardian in relation to the appointment.

\(^4\) MCN Annual Report 2015-2016 Version 1.0 Last Updated 07 October 2016
3.1.4 Paediatric Case Discussion following Cause for Concern cases in Secondary Care

The MCN were made aware of concerns within the secondary care paediatric service, following a number of admissions to the High Dependency Unit (HDU) of children not previously known to secondary care.

The MCN were presented with a report highlighting children admitted to paediatric HDU with a history of wheeze / asthma; 55 admissions in 2014 and 50 admissions in 2015. Drilled down information highlighted that for 14 children in 2014 and 19 children in 2015, this was their first or second presentation to secondary care.

Furthermore, two children (one in 2014 and one 2015) required ventilation. These children were of primary school age.

Three cause for concern cases were progressed (one in 2014 and two in 2015); two of which have been escalated to the children being placed on the ‘at risk’ register due to wider wellbeing concerns.

Following a significant event review within the paediatric service of one of the reported cause for concern cases – a six year old girl with two HDU admissions in two years for severe exacerbation of asthma. The MCN were advised the cause for concern was due to a number of factors:

- Failure to attend both secondary care (Discharge Clinic) and primary care (GP) appointments, presenting a real risk to the child’s health as no professional involvement in care management
- Over-use of reliever medication but under-use of preventer medication
- Poor school attendance

As part of the SEA, a number of lessons learned / changes have been implemented, including:

- Discharge planning meetings are arranged prior to discharge for second HDU admission to formulate a plan of care to keep the child safe
- Parents are provided with an arranged follow up appointment for the Discharge Clinic before the child is discharged from HDU / Ward. This allows a ‘red flag’ warning if the child / family does not attend, as eradicates uncertainty if family have or have not received the appointment through the post in time.

Further discussions at the MCN meeting agreed discussions are still ongoing regarding the role of the named person and how services would link with the named person; risk assessment tools are available on the intranet which helps to focus thoughts and concerns and gives advice on how to act / share / escalate as appropriate; and healthcare professionals can request child wellbeing meetings with social work and all health professionals involved in the care of the child.

A future issue of the MCN newsletter will focus on child wellbeing in relation to missed appointments.

3.1.5 Idiopathic Pulmonary Fibrosis

The MCN supported one of the Respiratory Consultants in asking General Practices to assist in identifying numbers of patients in Fife with Idiopathic Pulmonary Fibrosis.
The SBAR case was initially presented to the Local Medical Committee (LMC), who agreed the request could be sent to General Practices.

The prevalence data will be used to inform future service delivery. The deadline for responses was 30th April 2016. The MCN will request further updates during 2016-2017.

### 3.1.6 Home Oxygen Smoking Policy

Following the publication of the British Thoracic Society *Guidelines for Home Oxygen Use in Adults*, the Respiratory National Advisory Group asked Board MCNs to consider developing local policies with regards to installation and withdrawal of oxygen from patients who continue to smoke.

Information shared by the Respiratory Nurse Specialists was adapted into:

1. Local Protocol for Oxygen Therapy
2. Long Term Oxygen Therapy Patient Consent and Smoking Agreement
3. Home Oxygen Therapy Patient Information Leaflet

The patient consent form and information leaflet were shared with the MCN Patient / Carer Sub Group and BreatheEasy Support Groups for comment. These documents were also processed through West Division Community Services Clinical and Care Governance Group and the readability tool.

Work to promote and share the protocol, consent form and patient information leaflet will be taken forward in 2016-2017.

### 3.1.7 Fife Formulary Review

In September 2015, a review was undertaken of Chapter 3 (Respiratory) of the Fife Formulary. A number of changes were proposed and later accepted by the Area Drugs and Therapeutics Committee.

Including changes to recommended 1st and 2nd line medication choices, the supporting appendices were also amended:

- Appendices 3B-3E were renamed from Preferred Asthma Inhaler Devices to Asthma Treatment in adults, adolescents, children 5-12 years and children under 5 years.
- Appendix 3F – Guidance on Management of COPD Inhaled Therapy – significant changes were made to reflect emphasis to differentiate between treating symptoms or exacerbations, and includes all updated formulary choices.

### 3.1.8 My Lungs My Life website

Fife Respiratory MCN supported Chest Heart & Stroke Scotland with the promotion of a new website for Respiratory patients in Scotland. Launched in June 2015, the comprehensive, free to use website is split into three sections: people living with COPD, adults living with asthma and parents / guardians of children with asthma. The website also includes inhaler technique videos.
3.1.9 Prescribing Support Nurse

The Respiratory MCN worked with primary care Pharmacy Prescribing colleagues to develop a post outline for a new Respiratory Prescribing Support Nurse post.

This is post will be an 18 month contact, and will help to support both the Respiratory MCN and Primary Care Pharmacy Prescribing Team to increase formulary adherence / prescribing strategies and promote the national and local prescribing strategies.

The Respiratory Prescribing Support Nurse will: act as a link between practices, pharmacy and primary care prescribing; undertake prescribing review clinics (including home visits); provide education to support changes in clinical practice; support and provide mentoring to Practice Nurses and GPs; and work in partnership with the Respiratory MCN by attending meetings; supporting delivery of education; and raise the profile of MCN guidelines and protocols.

Post holders will take up post during 2016-2017.

3.1.10 Obstructive Sleep Apnoea Hypopnoea Syndrome Service (OSAHS)

NHS Fife refers the majority of patients experiencing sleep disorder to the NHS Lothian OSAHS service. The Lothian OSAHS service receives approximately 2500 referrals per year; 43% of all referrals coming from Fife, Forth Valley and the Borders.

NHS Lothian developed plans focussed on improving the service and efficient triaging processes. The outcome is stricter criteria around weight reduction, smoking cessation and alcohol consumption.

There is no major change to the service currently provided to Fife patients. However, referrals will need to evidence patient commitment and motivational lifestyle / behavioural changes.

NHS Lothian Respiratory MCN liaised with Fife Respiratory MCN from the early stages of service discussions within Lothian.

Changes to the referral / protocol, communication letter to GPs and referral flowcharts have been submitted to Fife LMC for consideration prior to wider circulation to Fife General Practices.

3.1.11 Pulmonary Rehabilitation / Active Options

Pulmonary Rehabilitation is an evidence-based exercise and education programme for people living with long term respiratory conditions, mainly Chronic Obstructive Pulmonary Disease (COPD). In Dunfermline & West Fife the service is provided by Community Respiratory Physiotherapists working within the Integrated Care Assessment and Support Service (ICASS).

A questionnaire was sent out to patients who had completed a Pulmonary Rehabilitation class in the preceding year and who had agreed to being referred to a follow-on Active Options2 class (run by Fife Sports and Leisure Trust).

45 questionnaires were sent out, and 23 were returned; giving a response rate of 51.1%
From the 23 returned questionnaires,

- 12 people advised they had attended, and were still attending the Active Options2 (AO2) class
- 4 people reported never attending the AO2 follow on class.
- 7 people started the classes but did not continue attending

The patients were asked additional questions, including what they enjoyed about the class; what they had found beneficial; if they had received information about the class before they attended; and, most importantly for the service, what could the service have done to prepare the patient better / help them to make the transition from a health class to a leisure class. In relation to the last question, the responses received included:

- You have been most helpful
- It was for me a good transition
- Maybe stress that it is not supervised to the same extent as pulmonary rehab.
  Keep up the good work!

The analysis of the responses was shared with the Active Options managers, and the general consensus was that those who go to the classes enjoy them and continue to go. However, there are a number of people who do not engage with the follow-on option after referral. The Community Respiratory Physiotherapy service are working towards making sure the patients are well informed about what is involved in the classes and the difference between the AO2 classes and the pulmonary rehabilitation class they have recently completed.

### 3.1.12 National Advisory Group

The Fife Respiratory MCN continues to engage with, and attend meetings of the National Advisory Group (NAG).

### 3.2 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 of healthcare professionals to support best practice in relation to respiratory care in Fife.

#### 3.2.1 Provision of Education

During 2015/2016, the Fife Respiratory MCN provided a number of education sessions as detailed in Appendix B, including practical spirometry, inhaler technique and the asthma education roadshows. All education is delivered using in-house venues and trainers.

Although training has been provided during 2015/2016, provision of training in 2016/2017 will become increasing difficult. The previous cohort of Spirometry Trainers have all now left post, leaving just one member – Gill Dennes. Providing the same level of education by only one trainer will not be sustainable. No funding is available to allow additional trainers to be recruited or to provide back fill to allow time out of Practice to deliver training for the MCN.
3.2.2 Palliative Care within Respiratory Disease: Study Day

In partnership with NHS Fife Practice & Professional Development Unit, a study afternoon was organised for registered health and social care practitioners on the subject of palliative care within respiratory disease. The event took place in April 2015.

The informative and interactive afternoon discussed palliative care issues relating to non-malignant respiratory disease. The afternoon offered the following topic areas:

- Ceiling of Treatment and Anticipatory Care Planning in Respiratory Conditions
- Loss and Adjustment in COPD: A Psychological Perspective
- Management of Breathlessness and Opioids
- Non-Malignant Respiratory Palliative Care elearning module

We were fortunate to have Professor Robin Taylor, Respiratory Consultant at Wishaw General, NHS Lanarkshire, join us for the afternoon. Prof Taylor presented the session on Ceiling of Treatment and Anticipatory Care Planning in Respiratory Conditions. Prof Taylor presented the moving video diary of a patient with end stage COPD, whom he cared for when working in Australia. The video-diary aims to highlight the importance of ‘A Good Death’.

A total of 43 delegates attended the day and provided good evaluation feedback. As part of the evaluation, delegates were asked what was the ‘most useful part of the workshop’. Responses included:

- 1st session – ceiling of treatment rather than DNACPR
- The taboo of dying – talking about death
- End of life conversations
- Anticipatory care planning; recognising palliative care in non-malignant conditions

The full evaluation report is available to view on the Respiratory MCN website.

3.2.3 Non-Malignant Respiratory Palliative Care eLearning

During 2015-2016, the content for the Non-Malignant Respiratory Palliative Care elearning module, on the LearnPro platform, was finalised. The MCN were grateful to the reviewers, both from within NHS Fife and out-with NHS Fife, who took the time to review and comment on the learning.

The elearning was launched on the live LearnPro platform in April 2016.

3.2.4 Spirometry eLearning

Gill Dennes, Lead Clinician has continued to work on amending and localising the Spirometry elearning package, which was shared by NHS Lothian for Board MCNs to adapt and use as appropriate.
3.2.5 Scottish Allergy Respiratory Academy (SARA) Video Conference

Fife were fortunate to be able to video conference into the Scottish Allergy Respiratory Academy’s ‘Treating the Breathless Patient’ education event in September 2015. This allowed eleven Practice Nurses across Fife to access this learning without the additional time out of practice to travel to Glasgow where the session was being held.

The MCN hopes to take advantage of more of these opportunities.

3.3 Fife Respiratory MCN Palliative Care Sub Group

Following identification of a gap in available learning around non-malignant palliative care, the Palliative Care Sub Group worked hard during 2015/2016 to fine tune the content in the learning package.

Recognising end of life in respiratory conditions is challenging. Through the learning package, Fife Respiratory MCN aims to provide healthcare professionals with an overview of why palliative care in respiratory conditions is important, prognostic indicators and triggers for palliative care, recognition of end of life, managing palliative respiratory conditions, approaching difficult conversations about palliative and end of life issues and care planning.

As outlined above, the elearning package was finalised during 2015-2016, and launched in April 2016.

Lorna Stewart, Anticipatory Care Nurse and Chair of the Palliative Care Sub Group, presented the elearning package to a national meeting of the Scottish Palliative Care Forum. Interest was expressed by other Boards to use / access this learning.

The Palliative Care Sub Group was a short life working group, with the remit of developing learning / education around non-malignant respiratory palliative care. The learning is now available on the LearnPro platform, therefore this group has now disbanded.

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. Chair ed and coordinated by patient members, the Group leads on supporting the Patient Focus Public Involvement agenda in relation to Respiratory care in Fife. The Group has now been meeting for three years.

The Group unfortunately lost two members who sadly passed away during 2015-2016, and two members moved out of the area, though the Group hopes to welcome them back at a meeting in the near future.

The Group has continued to focus efforts on increasing awareness of the group and encouraging new members to join. The Group hosted an information stand at the main reception of VHK on 16th June 2016. Although no new members were recruited to the Group as a result of this, Group members did engage with a number of people interested in finding out more about their condition / relative’s condition. Information and signposting to resources / support groups was provided to these people.
The Group has just recently agreed their workplan for the year ahead, and will be again focussing efforts on increasing awareness and membership to the Group. This will be done by outreach to existing community and support groups. The Group also plans to engage with the NHS Tayside Respiratory MCN Patient Group in 2016-2017.

The MCN also has close links with the local BreatheEasy Support Groups. The Coordinator for the Dunfermline and Kirkcaldy Groups attends the MCN Steering Group meetings as the link and feed back for the three BreatheEasy Support Groups.

The BreatheEasy Support Groups arrange for clinical speakers to attend their meetings; Gill Dennes is due to attend the June 2016 meeting.

3.5 Communication, Involvement and Awareness Raising

The Respiratory MCN Coordinator continues to share learning opportunities and documents for consultation with members of the Steering Group, Patient / Carer Group and other service health professionals as appropriate.

3.5.1 Website Resources

The Fife Respiratory MCN continues to regularly update the Respiratory sections on the NHS Fife website: www.nhsfife.org/respiratorymcn.

3.5.2 Information Stand

The Respiratory MCN Coordinator joined members from the Patient / Carer Group at their stand in the VHK in June 2016.

3.5.3 MCN Update Newsletters

The Fife Respiratory MCN continued to produce and share newsletters during 2015-2016.

The newsletters are distributed electronically to all NHS Fife via the Dispatches feature and are available on the Respiratory MCN section of the website.

4 PROGRESS AGAINST FIFE RESPIRATORY MCN ANNUAL WORKPLAN 2015-2016

The Fife Respiratory MCN Steering Group and Sup Groups worked to the agreed annual workplan during 2015/2016. The updated workplan is available in Appendix C. Particular areas of progress are highlighted in the previous sections above.
FOCUS FOR 2016/2017

The Fife Respiratory MCN will focus on the following key priorities during 2016-2017:

- Implement the National Respiratory Improvement Plan [pending National Advisory Group / Scottish Government guidance]. The 2016-2017 has been formatted to reflect the current draft National Respiratory Improvement Plan
- Joint MCN Study Day focussing on the long term conditions journey / managing patients with complex co-morbidities
- Education provision of Interpreting Spirometry – need to identify consultant who can deliver this training
- Education provision of Practical Spirometry, or any other respiratory education, will be difficult; no available trainers or budget
- Ensuring best practice in COPD / asthma / Bronchiectasis post QOF GP contract e.g. annual reviews
- Increasing referrals to, and patient uptake of, Pulmonary Rehabilitation programmes

The annual workplan for 2016-2017 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], Global Initiative for Asthma [GINA], and Healthcare Improvement Scotland [HIS] including:

6.1 **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.

6.2 **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.

6.3 **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.
6.4 **HIS / BTS / SIGN Guidelines**

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 2015-2016, the Fife Respiratory MCN has focussed on a number of key areas, including finalising two elearning modules; reviewing and updating the Fife Formulary, related appendices and communicating the changes; providing targeted education on asthma linked to the recommendations from the National Review of Asthma Deaths.
## 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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<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 the Patient Sub Group and 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; one from BreatheEasy Kirkcaldy/Dunfermline and one from the Patient & Carer Sub Group [currently vacant].  
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.  
MCN Manager’s Network.  
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>
</tr>
</thead>
</table>
| Fife Respiratory MCN Steering group                     | - Annual report and work plans presented to the D&WF 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 | Agreement reporting timescales for the review and dissemination of local and national clinical effectiveness info/guidelines as defined in the D&WF Clinical Governance Reporting Schedule / Business Programme |
|                                                         | - Risks and local service delivery issues                                                | Annual report including current and forthcoming year’s workplan as defined in the D&WF Clinical Governance Reporting Schedule / Business Programme |
| D&WF Clinical Governance Group                          |                                                                                         | Bi-monthly General Practice & Primary Care Clinical Group - Primary Care Clinical Lead & MCN Coordinator are members of this Group. |
| NHS Fife Clinical Governance Committee                  | - Un-resolvable risks and local service delivery issues                                  | Ad hoc as required                                                                                     |
| 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                                  | Resources available on website                                                                        |
| Respiratory Consultants meeting (weekly)                 |                                                                                         | GP representation on MCN SG and Sub Groups >                                                        |
|                                                         |                                                                                         | Link with LMC [currently vacant]                                                                       |
|                                                         |                                                                                         | Update newsletter                                                                                     |
| General Practice and LMC                                | - Updates on the work of the MCN                                                         | Resources to be forwarded to ADTC secretary with cover paper following liaison with ADTC secretary as required. |
|                                                         | - Seek local feedback and input to the work of the MCN                                  |                                                                                                         |
| Area Drugs and Therapeutics Committee (ADTC)            | - ADTCs approval will be sought on any new resources which mention medications/devices or processes impacting on pharmacy. |                                                                                                         |
|                                                         | - Updates which involve changes to medication references                                 |                                                                                                         |
## RESPIRATORY EDUCATION DELIVERED IN 2015/2016

<table>
<thead>
<tr>
<th>DATE DELIVERED</th>
<th>FACILITATOR</th>
<th>TOPIC</th>
<th>PURPOSE</th>
<th>AREA</th>
<th>VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR 28/04/2015</td>
<td>Various + PPDU</td>
<td>Non-malignant Palliative Care</td>
<td>Study Day</td>
<td>Fife-wide</td>
<td>QMH</td>
</tr>
<tr>
<td>MAY 07/05/2015</td>
<td>Gill Dennes</td>
<td>Practical Spirometry</td>
<td>Ad-hoc / competence</td>
<td>Fife-wide</td>
<td>Linburn Road</td>
</tr>
<tr>
<td>19/05/2015</td>
<td>Gill Dennes</td>
<td>Respiratory Drugs &amp; Inhalers</td>
<td>Pharmacy internal education</td>
<td>Fife-wide</td>
<td>QMH</td>
</tr>
<tr>
<td>SEPT 08/09/2015</td>
<td>Gillian Hunt &amp; Gill Dennes</td>
<td>Treating the Breathless Patient - SARA Conference</td>
<td>Video-conference</td>
<td>Fife-wide</td>
<td>Cardenden HC</td>
</tr>
<tr>
<td>OCT 29/10/2015</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>Valleyfield</td>
</tr>
<tr>
<td>NOV 12/11/2015</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>Adamson Hospital</td>
</tr>
<tr>
<td>26/11/2015</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>Muiredge</td>
</tr>
<tr>
<td>DEC 03/12/2015</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>New Park</td>
</tr>
<tr>
<td>10/12/2015</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>New Park</td>
</tr>
<tr>
<td>17/12/2015</td>
<td>Gill Dennes &amp; Heather Sheddon</td>
<td>Practical Spirometry</td>
<td>Ad-hoc / competence</td>
<td>Fife-wide</td>
<td>Leven Health Centre</td>
</tr>
<tr>
<td>JAN 14/01/2016</td>
<td>Gill Dennes &amp; Anne McKean</td>
<td>Asthma Education Roadshow</td>
<td>NRAD</td>
<td>Fife-wide</td>
<td>Cos Lane Medical Practice</td>
</tr>
<tr>
<td>FEB 10/02/2016</td>
<td>Heather Sheddon</td>
<td>Practical Spirometry</td>
<td>1:1 (Racheal Cunningham)</td>
<td>Fife-wide</td>
<td>Wallsgreen</td>
</tr>
<tr>
<td>11/02/2016</td>
<td>Gill Dennes</td>
<td>COPD6 Spirometry Screening</td>
<td>Update Training</td>
<td>Fife-wide</td>
<td>Lynebank Hospital</td>
</tr>
</tbody>
</table>
### Respiratory MCN 2015-16 Work plan - Final Draft

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>
</table>
| a) Refresh role and remit [annually] | Unity of purpose and direction of the MCN  
Involvement of multidisciplinary colleagues | MCN Coordinator | • Role & Remit reviewed and agreed | CEL 29: 8.2; 8.5; 8.6; 16; 19  
HDL 21: 3; 10.1  
QAP: 1  
QA: 2 | Review and refresh due March 2016 (although earlier refresh may be required in line with H&SC / IJB structures.  
April 2016: R&R not yet updated-still awaiting confirmation of placing in new structures. | O |
| b) Clinical Leadership | Primary Care and Secondary Care Lead Clinicians to drive forward the work of the MCN | MCN Steering Group | • Clear clinical leadership and responsibility for the functioning of the MCN | CEL 29: 8.1  
HDL 21: 10.1 & 24  
QAP: 1  
QA: 2 | Review in line with Role and Remit  
April 2016: as above | O |
| c) Annual Report | 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. | MCN Coordinator | • 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 | CEL 29: 8.1; 38  
HDL 21: 10.1, 10.7 & 33  
QAP: SA3 | Annual Report Apr14-Mar15  
Aug 2015: Circulated with MCN Agenda 05/08/2015.  
No comments received following this.  
Nov 2015: Presented to Clinical Governance - approved | G |
<table>
<thead>
<tr>
<th>Area</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a)</td>
<td>internet and intranet web presence</td>
<td>Clinicians and patients have access to information and resources</td>
<td>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</td>
<td>CEL 29: 8.6 HDL 21: 35 QA: 1&amp;2 QAP: SA1</td>
<td>Regularly updated as and when new pages added / information changes as appropriate.</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>MCN Patient / Carer Group</td>
<td>Patient focus approach. Equip people to support their involvement: Peoples’ skills, knowledge and abilities are used appropriately and for the benefit of the MCN</td>
<td>MCN Coordinator / MCN Patient / Carer Group • To support the work of Patient / Carer Group and help progress work within their action / workplan and comment / input on any issues identified. • Assist and support Patient / Carer Group with recruitment of new members / raising awareness of the Group</td>
<td>CEL 29: 8.6; 32 HDL 21: 31 QA: 3 QAP: SA2 &amp; CP6</td>
<td>June 2015: Information stand at VHK foyer. Group information shared with physios, ward and general practices. Info shared ad hoc as opportunities arise</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>c)</td>
<td>Working with other MCNs</td>
<td>Establish links and joint working with the other MCN’s in Fife. Joint working with National Respiratory Group / other Board Respiratory MCNs</td>
<td>MCN Coordinator; MCN Clinical Leads • Share ideas &amp; education resources Managing complex conditions: ➢ Increase joint working with 3rd sector ➢ Explore joint ACP with other MCNs ➢ Explore supporting good management of multiple long term conditions through joint MCN projects</td>
<td>QAP: SA1,3&amp;4 Many Conditions, One Life</td>
<td>April 2016: Joint working beginning – collaborative study day; Health Promoting Health Service</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>d)</td>
<td>Primary Care Review Templates</td>
<td>To support Clinicians with patient reviews. [HIS COPD Clinical Standards 1&amp;3; Asthma Priorities Measurements 2&amp;6; SIGN Asthma Priorities 3&amp;4]</td>
<td>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</td>
<td>CEL 29: 19 HDL: 35 QA: 2</td>
<td>May 2015: EMIS templates circulated to relevant practices</td>
<td>G</td>
</tr>
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<td>Area</td>
<td>Action</td>
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<tr>
<td>INVOLVEMENT &amp; PARTNERSHIP WORKING – cont.</td>
<td>e) Public Health / Health Inequalities</td>
<td>To liaise with Public Health to promote resources / campaigns to raise awareness of Respiratory disease.</td>
<td></td>
<td>• Encourage attendance at MCN SG meetings to identify areas of joint working</td>
<td>QAP: SA1 &amp; CP5&amp;6</td>
<td>June 2015: Info stand at VHK foyer – MCN, COPD casefind, My Lungs My Life, Patient SG. Coordinator attends Health Promoting Health Service Group No PH rep attendance at MCN</td>
<td>R</td>
</tr>
</tbody>
</table>
| | | 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 | Non Malignant Respiratory Palliative Care elearning package. Home oxygen – contract awarded to Dolby for next five years. Portal allows for analysis of prescribing by Board / patient. | G |
| | | 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 | Aug 2015: agreed at meeting (05/08/15) to review two-yearly. Next review due 2016. Sept 2015: ACPs added. Develop into e-learning package | G |
| | | 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 | Continued links with smoking cessation service. Rep on SG. Update training provided on COPD6 screening. | G |

**COPD**

<table>
<thead>
<tr>
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<th>Progress to Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>b) Review and update COPD Resource Pack [annually]</td>
<td>Supporting clinicians. Supporting patient self management</td>
<td></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>
<td>Aug 2015: agreed at meeting (05/08/15) to review two-yearly. Next review due 2016. Sept 2015: ACPs added. Develop into e-learning package</td>
<td>G</td>
</tr>
</tbody>
</table>
| 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 | Continued links with smoking cessation service. Rep on SG. Update training provided on COPD6 screening. | G |
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</thead>
<tbody>
<tr>
<td>d) Complex Care</td>
<td>People with complex care receive care in a community setting <em>(HIS Clinical Standard 6: People with COPD have access to home support services)</em></td>
<td>TBC</td>
<td>• Supporting clinicians managing complex cases in a community setting</td>
<td>CEL 29: 8.6; QAP: SA2,3&amp;4</td>
<td>April 2015: Palliative care elearning and study day. Scope common areas for joint working with other MCNs – multiple conditions. Tobacco Strategy stakeholders event.</td>
<td>G</td>
</tr>
<tr>
<td>e) COPD Self Management / Action Plans</td>
<td>To help patients to self manage their condition</td>
<td>MCN SG</td>
<td>• To ensure all patients receive a COPD Action Plan at annual review</td>
<td>QAP: SA1&amp;2 &amp; CP6&amp;9</td>
<td>June 2015: Action plan reviewed and updated. Continued to promote use via newsletters, education sessions and Patient SG.</td>
<td>G</td>
</tr>
<tr>
<td><strong>4. ASTHMA</strong></td>
<td></td>
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</tr>
<tr>
<td>a) Review and update the Asthma Resource Pack [bi-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 QAP: SA1</td>
<td>Review undertaken June-Sept 2015. All sections re-uploaded to web. Develop into elearning.</td>
<td>G</td>
</tr>
<tr>
<td>b) Paediatric patient care pathways / flowcharts</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 QAP: SA2&amp;3 &amp;CP2&amp;6</td>
<td>Diagnosis &amp; Management flowchart: article in newsletter (July/Aug) – no comments received. Reviewed and updated at Oct 2015 SG. Patient Pathway: to review once HV/SN representation on SG – still to be taken forward.</td>
<td>G</td>
</tr>
<tr>
<td>Area</td>
<td>Action</td>
<td>Purpose</td>
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<tr>
<td></td>
<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>
<td>Communication letter sent by Secondary to GP Practices. Informal links exist between Primary and Secondary Care</td>
</tr>
<tr>
<td></td>
<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>
<td>[Action removed]</td>
</tr>
<tr>
<td></td>
<td>f) Pre-school review of inhaler needs</td>
<td>Children may no longer need inhaler when starting Primary or Secondary School</td>
<td>C&amp;YP Asthma Sub Group</td>
<td>• To review children prior to starting Primary and Secondary School to establish if inhaler is still required • Linked to SIGN 101 priority 3</td>
<td>QA: 2</td>
<td>Discussions on omalizumab planned for Jun 16.</td>
</tr>
<tr>
<td></td>
<td>g) Complex care</td>
<td></td>
<td></td>
<td>• Models for delivering Omalizumab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Action</td>
<td>Purpose</td>
<td>Person Responsible</td>
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</tbody>
</table>
| 5. | BRONCHIECTASIS | a) Provide clinician and patient resources | Improve standards of care for people with bronchiectasis. Measurable markers of good practice. *BTS Quality Standards for Clinical Significant Bronchiectasis in Adults; July 2012, Vol.4 No.1 2012* | MCN Clinical Leads; MCN Coordinator; MCN Steering Group | • Review current practice / gaps from self assessment work  
• 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 | CEL 29:  
8.4 
HDL: 10.4 
BTS QA: 1&2 | Bronchiectasis self management action plan promoted. | O |
| 6. | PULMONARY FIBROSIS | a) Provide clinician and patient resources | Improve standards of care for people with Idiopathic Pulmonary Fibrosis | MCN Clinical Leads, MCN Steering Group, MCN Coordinator | • Review current provision / gaps from self assessment work | QAP: SA1 | March 2016  
Supported RespiratoryClinician with submission to LMC / request to Practices to identify patients diagnosed with IPF. This internal study is aimed to estimate the prevalence and burden of IPF in Fife. | R |
| 7. | SLEEP APNOEA | a) Review service provision in Fife / tertiary service | Improved referral patterns | Clinical Lead (secondary care) | • Review referral process | CEL 29:  
8.6 
HDL: 15 
QA: 1 | Fife pathway reviewed in line with changes to Lothian referral / service.  
Lothian changes went live Apr16. Information to go to Fife LMC Apr/May16 | O |
<table>
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<tr>
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</table>
| 8. EDUCATION | a) Programme of education for the year ahead | Planned programme of targeted education  
[Asthma Priorities Measurement 5; SIGN Asthma Priority 2] | 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  
• MCN study day  
• Palliative Care  
• Asthma Training  
• Bronchiectasis  
• Allergy  
• Pulmonary Fibrosis  
• Respiratory Resource Updates (COPD & Asthma) | CEL 29: 8.7  
QAP 8  
HDL 10.8 | No education input to June PLT. No further PLT dates for 2015.  
Apr 2015: MNRPC study day  
May 2015: Practical Spirometry  
May 2015: Respiratory Drugs and Inhalers  
Sept 2015: SARA VC-Treating the Breathless Patient  
Oct 2015-Mar 2016: six asthma education sessions  
Dec 2015: Practical Spirometry  
Feb 2016: Practical Spirometry and COPD6 screening  
Elearning: Non-malignant Respiratory Palliative Care, Spirometry, (yet to be finalised and go-live) | G |
|  | b) Interpreting & Practical Spirometry | Support clinicians to update knowledge and skills. | Education Sub Group | • Competencies maintained via self assessment or education session. | QAP: CP8 | LearnPro module – being adapted from Lothian package.  
Nov 2015: Ad hoc practical spirometry session delivered in Levenmouth area.  
Three practical spirometry sessions delivered during 2015-2016.  
Intrepreting spirometry provision to be discussed 2016 | O |
### Area: PHARMACY

#### a) Support enhanced prescribing practice

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>9. PHARMACY</td>
<td>a)</td>
<td>Support enhanced prescribing practice</td>
<td>MCN Pharmacy members</td>
<td>• Pharmacy / GP prescribing projects</td>
<td>CEL 29: 8.8 HDL: 10.9</td>
<td>Respiratory Bundle Prescribing Support Nurse Ongoing as opportunities arise</td>
<td>G</td>
</tr>
</tbody>
</table>

#### KEY

- **GREEN**: Work on track and completed
- **ORANGE**: Work on track not yet completed
- **RED**: Work not on track and not completed

- 14 action areas have been completed [green] within the financial year 2015/2016.
- 7 action areas are currently still in progress [orange]:
  - Action 1a) & b) Refresh of role and remit and Clinical Leadership – to be reviewed / amended in line with new H&SCP structure arrangements once confirmed
  - Action 2c) Working with other MCNs – no opportunities arose in 2015/16. New MCN Managers now in post for the three vascular MCNs. Work has begun planning a joint education session for later in 2016
  - Action 4d) Structured discharge process from Secondary Care to Primary Care: communication letter in place. However, communication from Primary to Secondary Care via informal links only
  - Action 5a) Bronchiectasis – resources for website outstanding
  - Action 7a) Sleep Apnoea – awaiting approval from LMC to communicate changes
  - Action 8b) Interpreting Spirometry – unable to provide interpreting spirometry training due to consultant vacancy

- 5 actions remain outstanding [red]:
  - Action 2e) Public Health – no public health representation / input to MCN
  - Action 4f) Pre-school review of inhaler needs
  - Action 4g) Complex care
  - Action 6a) Pulmonary Fibrosis – provide clinician and patient resources
<table>
<thead>
<tr>
<th>Expected Benefit</th>
<th>Aim</th>
<th>Areas of Focus / Action</th>
<th>Core Principles</th>
<th>Evidence / Progress</th>
<th>Status</th>
</tr>
</thead>
</table>
| 1. Prevention of Respiratory conditions | Recognise higher incidence amongst ‘deprived’ groups to ensure focus on prevention activities in these areas | • Health promotion champions  
• Focus on high risk groups  
• Focus on inequalities central to all health promotion activities  
• Focus on public health smoking prevention programs and encouraging smoking cessation in smokers  
• Early years support for parents  
• Engaging with wider health improvement work | SA1: Improving Health | | |
| 2. Diagnosis of Respiratory conditions | Patients receive the right diagnosis in a timely and equitable manner | • Case finding programme to identify undiagnosed patients  
• Promote and support use of respiratory diagnostic pathways  
• Consistent and accurate diagnostic testing through sustainable model of education and training  
• Coding of diagnosis and IT support | SA1: Improving Health  
SA2: Patient Experience  
SA3: Planning for Service Delivery  
SA4: Delivery & Efficiency  
CP4: Evidence base | | |
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<th>Assessment Measure</th>
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| 3. Treatment of Respiratory conditions | Patients with respiratory conditions receive the right treatment, administered by skilled staff | • Improve ability to prescribe according to prescribing strategy  
• Links with prescribing support team  
• Best practice in prescribing  
• Support long term management of patients with respiratory conditions e.g. use of non-pharmacological interventions  
• Emergency care pathways | SA2: Patient Experience  
SA4: Delivery & Efficiency  
CEL29: 8.8  
HDL: 10.9  
CP8: Education & Training | | |
| 4. Person-centred care | People with respiratory conditions are able to safely and effectively self-manage their condition | • Encourage completion of self management action plans  
• Patient review clinics [post QOF]. Encourage annual reviews / recall via Cluster working  
• Support patients to self manage their condition  
• Encourage / increase referral and uptake of Pulmonary Rehab  
• Understanding of patient experience and treatment / management choices  
• Optimise use of Community Pharmacies at point of prescription collection  
• Health Promoting Health Service pathways  
• Mindful of health literacy  
• Promoting benefits of anticipatory care plans | SA2: Patient Experience  
SA4: Delivery & Efficiency  
CP6: Patient-focused approach  
CP8: Education & Training | | |
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| 5. Journey of care for those with complex comorbidities                         | Improve the journey of care for patients with respiratory and complex co-morbidities | • Enhanced diagnostic pathways  
• Reducing and managing exacerbations across the primary and secondary care journey  
• Collaborative working with other Fife MNCs  
• Supporting clinicians to manage complex cases in a community setting | SA2: Patient & Staff Experience  
SA3: Planning for service improvement  
SA4: Delivery & Efficiency  
CP5: Multidisciplinary MCN  
CEL29: 8.6 |                                     |                                   |
| 6. Multidisciplinary approach (including Palliative Care)                        | Support patients and carers with respiratory conditions to live longer, healthier lives out-with the hospital environment | • Links to palliative and end of life care networks  
• Early supported discharge and access to home support services e.g. anticipatory care service  
• Anticipatory care plans  
• Develop links with social care / H&SCP | SA2: Patient Experience  
SA4: Delivery & Efficiency  
CP5: Multidisciplinary MCN |                                     |                                   |
| 7. Education and Training                                                       | Provision of appropriate education and training                                      | • Portfolio of educational opportunities  
• Targeted approach to patient groups: diagnosis; post-admission; elderly patients; children & young people  
• Education for wider community groups | SA2: Patient & Staff Experience  
CP8: Education & Training  
CEL29: 8.7  
HDL: 10.8 |                                     |                                   |