

Respiratory Leadership Programme

Leadership skills enable respiratory nurse to raise standards of care



Fran Robinson talks to **Deirdre Siddaway** Respiratory Specialist Nurse, Suffolk

When Deirdre Siddaway came up against some obstacles while trying to improve respiratory care it was the PCRS-UK Respiratory Clinical Leadership programme that gave her the support she needed to succeed.

Deirdre, a respiratory nurse specialist in Suffolk, was instrumental in persuading her CCG to commission a 6-month integrated care pilot to improve the management of respiratory patients in primary care.

But she had to overcome a number of challenges along the way.

Deirdre first tried raising her idea for improving standards of care at local CCG meetings. She spoke to the CCG Chair and the official responsible for medicines management.

It was only after she learned about stakeholder mapping at a respiratory leaders' workshop that she realised she had been approaching the wrong people. She explains: "The workshop taught me to identify who the local key players were that could help me to drive my idea forward. I was able to work out who might be an advocate, who could help with funding and who would be interested in commissioning services. I also understood how to avoid the 'blockers', people who will prevent the project from progressing."

She says the workshops helped her to find the levers to encourage the right people to listen to her idea and to engage those who were influential.

She also learned the importance of aligning the aims of her project with those of the CCG. This meant looking at the CCG's

five-year plan which identified avoiding hospital admissions and cost-effective prescribing were a priority. "Respiratory conditions weren't specifically mentioned but they fitted within that umbrella," recalls Deirdre.

The project began to move forward when Deirdre identified a respiratory consultant at her local hospital who was involved in setting up a respiratory taskforce. She also found the CCG official responsible for long-term conditions was supportive.

Other valuable backing came from people she met at the respiratory leaders' workshops who had worked on and achieved success with similar projects. "I was able to use a lot of their ideas and their levers to engage the CCG. One of the delegates had launched a similar project across a very large CCG with a similar demography and geography to mine and they were happy to share with me virtually everything that they had done. This included the way they had worked out their figures, the savings that could be achieved and the potential improvement that could be gained in patient outcomes. I was able to take that to the CCG and say this is how it could work," says Deirdre.

With the hospital consultant on board, the project began to take shape. However, Deirdre recalls that during the process of developing the project with secondary care there were at least half a dozen frustrating meetings where hospital managers talked about the issues that were important to them and were concerned about ring fencing their own pools of money. She was initially the only representative from primary care. However, influencing

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The PCRS-UK Respiratory Clinical Leadership programme offers a rolling three-year programme of workshops to help give you the tools, knowledge and skills to drive improvements for patients with respiratory disease in your area. We run two residential workshops each year which are free of charge to members of PCRS-UK. Each workshop is a stand-alone event with a focus on hot clinical topics and policy or guidance changes, teaching essential professional skills such as understanding your team or your own leadership style, as well as one or more relevant management techniques such as making a business case, mapping your stakeholders, pitching your case for change or evaluating data.

The programme also facilitates an active network discussion group through which participants share dilemmas, ideas, best practice and solutions.

The next workshop is to be held on 9 and 10 November 2018 at the University of Birmingham and the title is 'Utilising Patients' Feedback for Service Evaluation: Patient-Centred Outcomes Based Care'.

For more details see <https://www.pcrs-uk.org/event/november-2018>

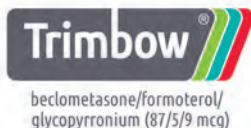
Prescribing Information

Trimbow 87/5/9 Pressurised Metered Dose Inhaler (pMDI) Prescribing Information

Please refer to the full Summary of Product Characteristics (SPC) before prescribing.

Presentation: Each Trimbow 87/5/9 pMDI delivered dose contains 87micrograms (mcg) of beclometasone dipropionate (BDP), 5mcg of formoterol fumarate dihydrate (formoterol) and 9mcg of glycopyrronium. This is equivalent to a metered dose of 100mcg BDP, 6mcg formoterol and 10mcg glycopyrronium. **Indications:** Maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) not adequately treated by a combination of an inhaled corticosteroid (ICS) and a long-acting beta₂-agonist (for effects on symptoms control and prevention of exacerbations see section 5.1 of SPC). **Dosage and administration:** For inhalation in adult patients (≥18 years), 2 inhalations twice daily (bd). Can be used with the AeroChamber Plus[®] spacer device. BDP in Trimbow is characterised by an extrafine particle size distribution which results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Trimbow are equivalent to 250mcg of BDP in a non-extrafine formulation). **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not for acute use in treatment of acute episodes of bronchospasm or to treat COPD exacerbation. Discontinue immediately if hypersensitivity or paradoxical bronchospasm. **Deterioration of disease:** Trimbow should not be stopped abruptly. **Cardiovascular effects:** Use with caution in patients with cardiac arrhythmias, aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, occlusive vascular diseases, arterial hypertension and aneurysm. Caution should also be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 450 milliseconds for males, or > 470 milliseconds for females) either congenital or induced by medicinal products. Trimbow should not be administered for at least 12 hours before the start of anaesthesia as there is a risk of cardiac arrhythmias. Caution in patients with thyrotoxicosis, diabetes mellitus, phaeochromocytoma and untreated hypokalaemia. Increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods, but are less likely than with oral steroids. These include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation, decrease in bone mineral density, cataract, glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. Potentially serious hypokalaemia may result from beta₂-agonist therapy. Formoterol may cause a rise in blood glucose levels. Glycopyrronium should be used with caution in patients with narrow-angle glaucoma, prostatic hyperplasia or urinary retention. Use in patients with severe hepatic or renal impairment should only be considered if benefit outweighs the risk. **Interactions:** Since glycopyrronium is eliminated via renal route, potential drug interactions could occur with medicinal products affecting renal excretion mechanisms (e.g. with cimetidine (an inhibitor of OCT2 and MATE1 transporters in the kidney) co-administration, glycopyrronium showed a slight decrease in renal excretion (20%) and a limited increase in total systemic exposure (16%). Possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded and therefore caution and appropriate monitoring is advised. **Related to formoterol:** Non-cardioselective beta-blockers (including eye drops) should be avoided. Concomitant administration of other beta-adrenergic drugs may have potentially additive effects. Concomitant treatment with quinidine, disopyramide, procainamide, antihistamines, monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants and phenothiazines can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards beta₂-sympathomimetics. Hypertensive reactions may occur following co-administration with MAOIs including drugs with similar properties (e.g. furazolidone, procabazine). Risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Concomitant treatment with xanthine derivatives, steroids or diuretics may potentiate a possible hypokalaemic effect of beta₂-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. **Related to glycopyrronium:** Co-administration with other anticholinergic-containing medicinal products is not recommended. **Excipients:** Presence of ethanol may cause potential interaction in sensitive patients taking metronidazole or disulfiram. **Fertility, pregnancy and lactation:** Should only be used during pregnancy if the expected benefits outweigh the potential risks. Children born to mothers receiving substantial doses should be observed for adrenal suppression. Glucocorticoids and metabolites are excreted in human milk. It is unknown whether formoterol or glycopyrronium (including their metabolites) pass into human breast-milk but they have been detected in the milk of lactating animals. Anticholinergic agents like glycopyrronium could suppress lactation. A risk/benefit decision should be taken to discontinue therapy in the mother or discontinue breastfeeding. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from therapy. **Effects on driving and operating machinery:** None or negligible. **Side effects:** *Common:* pneumonia (in COPD patients), pharyngitis, oral candidiasis, urinary tract infection, nasopharyngitis, headache, dysphonia. *Uncommon:* influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, sinusitis, rhinitis, gastroenteritis, vulvovaginal candidiasis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, dysgeusia, hyposensitivity, otosalginitis, atrial fibrillation, electrocardiogram QT prolonged, tachycardia, tachyarrhythmia, palpitations, hyperaemia, flushing, cough, productive cough, throat irritation, epistaxis, diarrhoea, dry mouth, dysphagia, nausea, dyspepsia, burning sensation of the lips, dental caries, rash, urticaria, pruritus, hyperhidrosis, muscle spasms, myalgia, pain in extremity, musculoskeletal chest pain, dysuria, urinary retention, fatigue, asthenia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased, blood cortisol decreased. *Rare:* Lower respiratory tract infection (fungal), hypersensitivity reactions, including erythema, lips, face, eyes and pharyngeal oedema, decreased appetite, insomnia, hypersomnia, angina pectoris (stable and unstable), ventricular extrasystoles, nodal rhythm, sinus bradycardia, blood extravasation, hypertension, paradoxical bronchospasm, oropharyngeal pain, angioedema, nephritis, blood pressure increased, blood pressure decreased. *Very rare:* thrombocytopenia, adrenal suppression, glaucoma, cataract, dyspnoea, growth retardation, peripheral oedema, bone density decreased. *Unknown frequency:* psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (Refer to SPC for full list of side effects). **Legal category:** POM Packs and price: £44.50 1x120 actuations. **Marketing authorisation No:** EU/1/17/1208/002 **UK Distributor:** Chiesi Limited, 333 Styal Road, Manchester, M22 5LG. **Date of preparation:** Jun 2017. 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skills, managing conflict and project planning techniques and tips she learned at the respiratory leaders' workshops all helped her to progress the scheme.

Eventually the meetings were scaled down to involve only the key players and a 6-month pilot was launched.

The project

The pilot was established to improve the respiratory patient pathway between primary and secondary care, reduce outpatient appointment waiting times (at that time between 12 and 16 weeks) and enable cost-effective prescribing.

It involved:

- Deirdre and a respiratory consultant went into 15 practices to work alongside and train and upskill primary care staff
- A full-time respiratory nurse specialist in hospital, assessing patients prior to discharge and liaising with primary care
- An agreement was put in place to ensure that practices would see patients within 48 hours of discharge from hospital
- A treatment pathway for management of asthma and COPD was established and rolled out, resulting in savings in prescribing spend
- A self-management plan for asthma and COPD was produced for use across the CCG
- Breathless patients with symptoms of anxiety were given access to an Improving Access to Psychological Therapies Service
- The number of places for pulmonary rehabilitation were trebled and filled

Feedback shows that healthcare professionals are now more confident about managing patients in primary care and are less likely to refer unwell patients to secondary care.

For various reasons the pilot didn't continue beyond the 6 months, but Deirdre says the additional training and resources that were introduced have left a legacy of improved care.

"I was very disappointed that the pilot came to an end. However, I do feel that I was able to raise the profile of respiratory care in my area, gain the support of local practices and make a difference to a wider group of patients beyond my own practice."

"This project has been the high point of my career so far. I could not have got it off the ground without the skills I gained from the respiratory leaders' programme."