NCP Respiratory Team

Clinical Lead:
Prof. Breda Cushen

Adult Resp GP Lead:
Dr Shane Mc Keogh

Programme Manager:
Susan Curtis
susan.curtis@hse.ie

NCP Respiratory

https://www.hse.ie/eng/about/who/cspd/ncps/ncpr/

Spring Newsletter 2025

Welcome to the Spring Update from NCP Respiratory!

It is an honour to represent you all as the clinical lead for the National Clinical Programme Respiratory (COPD and Asthma). It is such an exciting time to be working in the management of COPD and asthma. In recent years, there have been substantial changes in how we approach and manage patients with these conditions and we can finally offer this group patient-centred, and individualised care. We should be proud of the leading role Ireland is taking in improving access to early diagnosis and intervention for COPD and asthma patients nationwide. The Chronic Disease Management (CDM) programme, run by our GP colleagues is supporting people with COPD and asthma by offering 6-monthly disease specific review. While only established 5 years ago, CDM has already demonstrated improvements in cardiac and metabolic indices at a population level. I have no doubt that in time we will also see improvements in respiratory outcomes.

The success of CDM would not be possible without the work of community-based and acute respiratory specialist teams working together to deliver specialist multidisciplinary clinical care. There are currently 26 specialist respiratory teams working in the community. Diagnostic spirometry is available at 17 community sites, and pulmonary rehabilitation is established in each RHA. In this issue of the newsletter, the fantastic work being done by Dr Junaid Khan and his team in providing comprehensive community-based care to patients in the midlands region is highlighted. The support and collaboration of Dr Khan's colleagues, and wider MDT, in Mullingar Regional Hospital and local community, have been fundamental to allowing him to develop a truly integrated service.

As a new feature of the newsletter, I want to highlight innovative work taking place around the country. In this issue, you will read about a pilot project between the National Ambulance Service and COPD Outreach teams. By working together across the community and hospital we hope to ensure patients can access appropriate exacerbation care at home without having to attend a hospital emergency department.

The supports now available to patients with COPD and asthma have been expanded further by partnerships with the patient advocacy groups, COPD Support Ireland, the Asthma Society of Ireland and the Alpha 1 Foundation Ireland. In the partnerships section of this newsletter, there is a focus on the Asthma Adviceline and the essential services it offers to patients.

Finally it would be remiss of me not mention the challenges that must be overcome to ensure that the vision for improved chronic care for COPD and asthma patients is achieved. The loss of funding for 40% of respiratory community posts, in addition to the loss of acute posts, is a huge barrier to the successful implementation of enhanced community care. As NCP Lead, I have made it my priority to advocate for the restoration of posts by demonstrating the breadth of work that you are all doing nationwide and its impact.

- A Day in the life… of an Integrated Respiratory Consultant -

Dr Junaid Khan
Mullingar Regional Hospital & Longford/Westmeath Hub

L-R Fionae O'Brien (Business Manager), Majella Murray (Senior Physiologist), Kate Plunkett (Clinical Specialist Physiotherapist), Ciara Gill (COPD Outreach CNS), Rosie Hassett (Respiratory CNS), Junaid Khan (Consultant)

I started in Mullingar Regional Hospital towards the end of January 2024 and am grateful for the immense help and support given to me from the outset by my two colleagues in Respiratory Medicine (Dr Mark Sheehy and Dr Senan Glynn).

Since the pandemic, demand for routine respiratory medicine OPD has increased substantially; Mullingar hospital/CHO8 is no different. When I commenced in post, Mullingar had a 26-month respiratory medicine OPD waiting list. I noticed however that the PFT waitlist was much shorter at 12-months and that most of those waiting for an OPD appointment had already had PFTs performed. I saw this as a great starting point for me to establish the community-based clinical service, whilst also an opportunity to contribute to shortening the hospital OPD wait-time for patients; I could see those who had already had diagnostic lung function, give them a diagnosis, initiate treatment and if well, discharge to our GP colleagues for follow-up every 6 months in the chronic disease management program. Those with an uncertain diagnosis, or who were not suitable to be discharged to the GP could remain under my care in the hospital as part of my 50% acute hospital commitment.

Whilst we suspected that the majority of patients on our waiting list were those with possible Asthma or COPD, we couldn't say that for everyone. Hence I began the daunting task of screening all the Healthlink referrals for a historic or potential diagnosis of airway disease. I confirmed the patient was still on the waitlist, ruled out any other potential diagnoses as best as I could from the information provided, and ensured that referrals for each area were put into chronological order from time of referral receipt with a tick box for diagnostics (PFTs and CXR).

Useful Websites:

Integrated Chronic Disease

https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/

Integrated Respiratory Care Videos:
https://www.youtube.com/playlist?list=PLsQK32cdMW_zhtp-jH7_dBEI9No2J_zZT

HSE Change resources

https://www.hse.ie/eng/staff/resources/changeguide/#:~:text=The%20Health%20Service%20Change%20Guide,to%20support%20managers%20and%20staff

Referrals were subsequently divided by address into the 3 regions covered by the RIC team (Longford, Mullingar, and Athlone). I was grateful when I received much needed administration support, which has continued to be vital for the operation of the RIC service.

Three satellite clinics were established in Camlin Healthcare Hub Longford and the Primary Care Centre Athlone, from which I run clinics on a rotational basis depending on demand, and the Primary Care Centre Mullingar where I hold a weekly clinic. I also see patients weekly at Mullingar hospital. I tend to see low risk patients in community as the support and access to investigations is more limited. I started seeing patients with the RIC team, and now one year later, the hospital respiratory OPD waiting time has reduced by 92% to 2 months.

Along with the respiratory consultant clinic we run a consultant-GP virtual clinic, respiratory specialist nurse led clinic, physiotherapy clinic, pulmonary rehabilitation, GP direct access spirometry, and hold weekly multidisciplinary team (MDT) meetings where all patients seen by the team are discussed. In addition to my community work, I participate in the hospitals rapid access lung cancer service, respiratory consults, inpatient work, bronchoscopy, and attend educational activities. I have also led the transition of patients in the area prescribed oxygen, to a new oxygen provider. This included chart reviews, patient engagements, and MDT meetings. I plan to establish a dedicated oxygen clinic which is an absolute necessity for the patients in this region.
Once every 4-6 weeks there is a hospital consultants meeting with local GPs where there is a clinical presentation followed by informal chat to explore how we can improve the hospital-community interface.

The RIC MDT and I are very proud of the service we run, but there are challenges. We do not have a full complement of staff (1 CNS, 1 physiotherapist, 1 physiologist), out of a required 6.5 WTE, and therefore the service is vulnerable during times of sickness or leave. Additionally, this leaves us with limited capacity for service evaluation, research and other important activities. With only 1 physiotherapist, we are finding it increasingly difficult to deliver the pulmonary rehabilitation program. We are very grateful to community physiotherapists in the Mullingar region, the community respiratory nurse, and the COPD Outreach CNS from the hospital who are assisting in the delivery of pulmonary rehabilitation whilst we work towards a more permanent solution.

It's fair to say that the working life of an Integrated Care Consultant is different from that of a fully hospital-based Consultant. Mine also differs from integrated care consultants in other hospitals and other specialties. An added challenge for me has been the fact that this is my first Consultant job. I have found that having a good relationship with local colleagues, speaking with senior colleagues in other hospitals/CHO's, and knowing the requirements of your area/hospital, have made it easier for me to establish an efficient integrated service.

National Ambulance Service

- Respiratory Innovation -
COPD Outreach/ National Ambulance Service project

In 2025, three COPD Outreach teams will join forces with the National Ambulance Service (NAS) on a pilot project designed to provide early specialist intervention for COPD patients experiencing exacerbations in their home. The aim of this project is to limit dependence on emergency department services by providing expert respiratory care in the home.

One-fifth of acute hospital presentations with respiratory disease are in patients with COPD, of whom an estimated 25% can be managed at home by a specialist COPD Outreach team.

This pilot project will combine the expertise of a Community Paramedic (CP) with advanced training in the identification and management of acute exacerbations of airways disease, and that of COPD Outreach teams.

Consenting COPD patients who suspect they are having an exacerbation of COPD, can contact NAS and request review by a CP. Alternately the COPD Outreach team can directly ask for CP review of a patient who has contacted the service in the patient's home.

The CP will assess the patient in the home, and if appropriate, initiate treatment for them at home with further follow-up care by the COPD Outreach team.

This collaborative community and hospital services approach to COPD care has proven successful in other jurisdictions. The pilot is expected to run over the course of 2025, with the first site due to launch in the coming weeks.

If you would like to know more about this pilot project please contact Susan Curtis directly.

- Good News Update -

In 2024, the number of respiratory patients referred directly by their GP to the community hubs doubled. As well as seeing direct GP referrals, all of our RIC consultant colleagues continue to remove suitable patients from the acute hospital waitlists. In 2024, an average of 250 patients/consultant* were redirected to hub clinics and removed from hospital OPD waiting lists.

**Data extrapolated from 2024 Modernised Care Pathway activity report*

- Patient Partnership -
Asthma Society of Ireland

Asthma Adviceline (1800 44 54 64) - Enhancing Patient Support
A free call back service providing 30-minute consults with an asthma expert, supported by the National Clinical Programme and the HSE.

The Asthma Adviceline aims to improve the health of people with asthma, reduce unscheduled healthcare, and empower patients by delivering comprehensive asthma education, and self-management advice and support.
Managing asthma effectively requires a collaborative approach, ensuring patients receive timely and expert guidance. This multidisciplinary service supports patients by providing continuity of care beyond clinic appointments, and improving access to timely expert advice. As part of our commitment to integrated respiratory care, **respiratory HCPs can now refer patients directly to the Asthma Adviceline** for professional advice and support. Additionally patients can continue to self-refer to the Adviceline.

Expert advice to help your patients
The Asthma Adviceline is staffed by qualified asthma nurses knowledgeable in mild, moderate and severe asthma, with a background in primary, secondary and tertiary care. Patients can also access chest physiotherapy and exercise advice through senior physiotherapy consultation if needed.

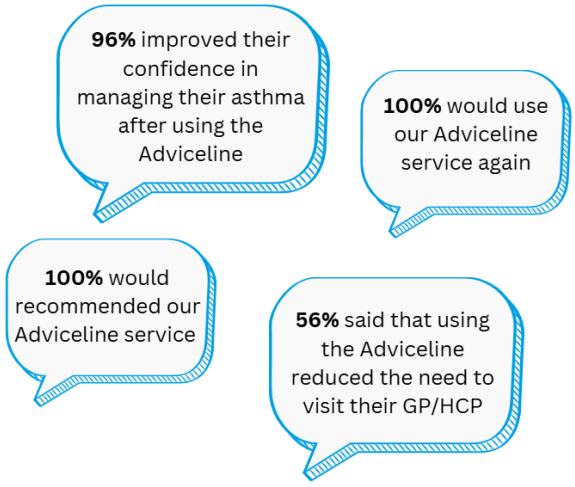
Who to refer?
Stable patients who require education and advice on:

- Symptom management
- Identification of triggers
- Identification of exacerbation and initiating a personalised action plan
- Medication and adherence education
- Lifestyle and exercise advice
- Airway clearance techniques
- Breathing control techniques

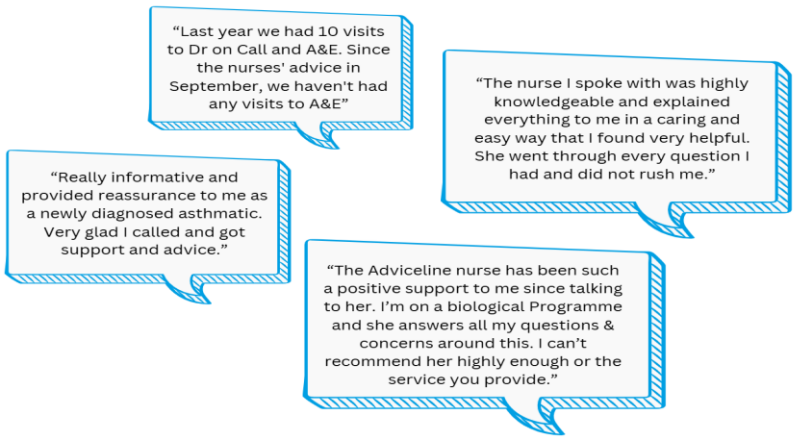
Phone support is complemented by the sign-posting of patients to further expert online and written resources.

How to refer
HCP and patient self-referrals can be made at:
https://www.asthma.ie/patient-e-referral
or you can scan the QR code:
Once referral form completed, the Asthma Society will contact the patient to schedule a consultation with an asthma nurse or physiotherapist.
Phone referrals can also be made at 1800 44 54 64.
What patients say about the Asthma Adviceline:

At the Asthma Society we strive to demonstrate the effectiveness of our service. This is done through surveys and testimonials. At the end of a call, we ask for feedback on the service given. Our Adviceline surveys show



Some testimonials



WhatsApp Nurse Messaging Service 0860590132

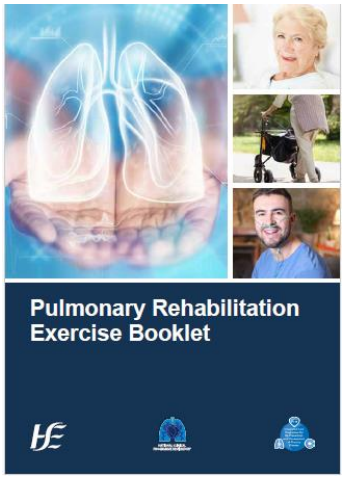
The WhatsApp nurse messaging service is a secure convenient and confidential way of allowing patients to ask questions about their asthma and receive guidance from trained nurses without having a full consultation. Videos on inhaler technique, infographics and webinars can be shared with the patient that they can then keep on their phone and share with others.

If you have any questions about the Asthma Adviceline/WhatsApp services or if you would like further information, please do not hesitate to contact.

mary.mcdonald@asthmasociety.ie reception@asthma.ie

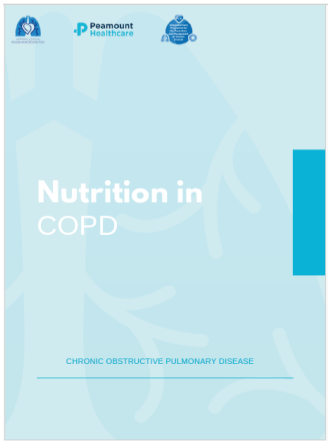
New NCP Respiratory Resources

Pulmonary Rehabilitation Exercise Booklet



A group of Clinical Specialist Physiotherapists Pulmonary Rehabilitation Coordinators identified the need for a specific exercise booklet for patients to use at home during and after their pulmonary rehabilitation course. NCP Respiratory worked with this group to develop and design this booklet. **Resource available here**.

COPD and Nutrition Leaflet



A new booklet on Nutrition in COPD has been developed by Peamount Healthcare's Nutrition and Dietetic Department in collaboration with the National Clinical Programme Respiratory. **The booklet is available here.**

Dates for your Diary

- Technology & Transformation "Better Together" Conference Venue: Conference Centre Dublin - April 25th
- "Spark Summit" Venue: Conference Centre Dublin - June 11th
- European Respiratory Society Congress Amsterdam - Sept 28-Oct 1
- ITS conference Galway – Nov 20-22nd
- GOLD COPD conference, Online registration– Nov 12-13th

Awareness Dates

- World Asthma Day – May 6th
- World Lung Day – Sept 25th
- World COPD Day – Nov 19th
- Alpha-1 Awareness month – Nov

Do You Know-

Accessing Attend Anywhere

What is Attend Anywhere?

Attend Anywhere is an application that facilitates video consultations, approved by the HSE and available to all staff and teams across the organisation, to provide 1:1 consultations and group education sessions (up to 250 participants).

What are the benefits of telehealth (video consultations)?

1. **Improving equity of access to health services**

   The introduction of telehealth services can reduce barriers faced by vulnerable populations' i.e.

   - Less mobile patients: may minimise logistical concerns for accessing healthcare services.
   - Regional patients: This cohort may experience increased time, travel and costs previously associated with accessing equivalent in-person services.

2. **Enhance health workforce effectiveness**

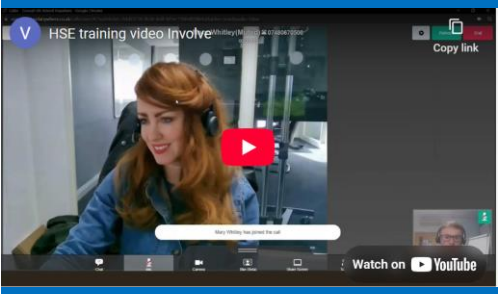
   Introducing telehealth services has the potential to enhance productivity

   - Enhanced clinical productivity i.e. minimise travel requirements for off-site services.
   - Opportunity for increased flexibility for workers.
   - Increased access to care i.e. utilises video consultations to support Wait List Management

3. **Improvement in patient experience & engagement**

   The opportunity to deliver telehealth capabilities as an integrated service embeds flexibility.

   - Initial patient feedback from the ECC Telehealth roll-out, showed high satisfaction with video consultations; particularly the increased accessibility and associated time savings benefits experienced by patients.
   - Increased engagement across multiple age groups may result in reserving in-person services for those who require face to face consultations.
   - Ease and flexibility of video consultations; early data suggests that video consultations may result in a reduction of DNA rates.



What are the use cases for Attend Anywhere?

Attend Anywhere can be broadly utilised for various clinical use cases:

1. **Follow Up Appointments**

   Many ECC services are embracing the use of video consultations, particularly for follow-up appointments. This approach allows clinicians to hold an initial face-to-face consultation, during which they evaluate whether a patient's follow-up needs can be appropriately addressed through a video consultation. This ensures continuity of care while offering added convenience for patients. A range of low face to face requirement consultations, may be appropriate for video consultations including:

   - Medication Review
   - Inhaler Technique Review
   - Handover of test results

2. **Initial Appointments**

   Attend Anywhere can be effectively utilised for initial appointments, particularly as a strategy to support Waitlist Management:

   - CD Wexford's Cardiology service has identified the use of video consultations as a pathway to support their Waitlist Management. Patients are identified based on various factors including:
     - Patients presenting with non-complex conditions resulting in low face to face consultation requirement
     - Patients with transport or logistical issues accessing physical services (identified on referral information)
     - Previous / recent interaction with service (to be included for future identification)

3. **Multidisciplinary Team Meetings**

   Attend Anywhere has been trialled in the use of multidisciplinary collaboration, to connect in with external healthcare providers i.e. General Practitioner, to discuss nominated patients. Benefits of this include:

   - Ability to utilise a single platform across the service
   - Attend Anywhere complies with GDPR requirements
   - Introducing Attend Anywhere as a core tool for delivering multidisciplinary style meetings further fosters familiarity of the system across the service
   - Ability to connect with internal and external healthcare providers with ease for case management discussions.

4. **Group Education Delivery**

   Attend Anywhere has the ability to facilitate group education style healthcare services (up to 250 participants) and has additional functionality to support this i.e. use of breakout rooms etc. This may be of use for programmes such as Virtual Pulmonary Rehabilitation Programme.

How do teams access Attend Anywhere?

There is currently support from the National ECC Programme to implement Attend Anywhere across ECC services, the support includes:

- Opportunities and Process Mapping
- Demo and training of the system
- Documentation support
- Editable templates
- Shared learning
- Go-Live Support

Several resources and guides that teams can use are available on the ECC Hub on HSELand.

To sign into your account and locate the hub, click here.
For further information please email: ECCMetrics@hse.ie

Attend Anywhere Training Sessions with eHealth

1:1 Training - second Tuesday of every month at 1-2pm - Link here
Group Training - third Tuesday of every month at 1-2pm - Link here