SUMMER MEETING 2025

British Thoracic Society

Final Programme

THURSDAY 19 AND FRIDAY 20 JUNE

**MANCHESTER CENTRAL CONVENTION COMPLEX,
THE EXCHANGE SUITE, PETERSFIELD, MANCHESTER, M2 3GX**

Conference Information
Speakers' Details
Presentation Summaries
Abstract Prizes
Exhibitor Information

Please see our website: **brit-thoracic.org.uk**

Better lung health for all

WELCOME TO THE SUMMER MEETING

It is a great pleasure to present the programme for the British Thoracic Society Summer Meeting, which will be returning to Manchester and the Manchester Central Convention Complex again for 2025.

The Summer Meeting will be onsite only, as this event emphasises the value of meeting colleagues, sharing experiences and having those one-to-one interactions that can sometimes be missed from online events.

After the event, all delegates who have attended the Meeting will be sent a website link to access video recordings of the main sessions and guest lectures. We recognise the value of online education, and we will continue to deliver the majority of our extensive programme of Short Courses online.

As always, the Summer Meeting provides a comprehensive, clinically grounded programme, delivering a wide range of topics. The speakers are chosen carefully to ensure the wider MDT is fully represented. I am confident that we have a programme that once again delivers for the whole respiratory team.

Highlights this year include:

- **Mini short courses**
- **Symposia**
- **Abstract Prizes**
- **Clinical Grand Round**
- **Guest Lecture**
- **Physiology quiz**
- **Exhibition**
- And new for 2025, our **Lunchtime Sessions**

All delegates are invited to the **President's Reception** in the conference centre at 6.00pm on Thursday 19 June, where prizes will be awarded for the Abstract Prizes and Clinical Grand Round. This is a perfect opportunity to catch up and network with your colleagues from around the country too!

In my role as Chair of the BTS Education and Training Committee, I continue to be a strong advocate for ensuring the entire respiratory workforce is represented in programme development and delivery of education and events within the Society, and I hope that the Summer Meeting reflects this.

I am certain the programme will contain plenty to interest and stimulate all delegates. We invite all those who deliver care to respiratory patients to attend this event so we can learn, discuss and network together.

I look forward to seeing you in Manchester.

Alison Armstrong
Chair, BTS Education and Training Committee

@BTSrespiratory @AlisonArmstron
#BTSSummer2025 #RespisBest

THANK YOU

The British Thoracic Society gratefully acknowledges sponsorship from the under listed companies, through the purchase of exhibition space at the Summer Meeting 2025. None of them have had any input into the programme content or the planning of the conference. Furthermore, the Society does not allow any sponsored symposia at this event, within the programme or associated in any way with it:

AstraZeneca
BD
Broncus Medical, Inc.
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Consilient Health (UK) Ltd
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HealthNet Homecare
ICU Medical
Insmed
Love Medical Ltd
MSD
NIOX Group Plc
Pharming UK Ltd
Richard Wolf UK Ltd
Roche UK
Sanofi & Regeneron
STADA, Thornton and Ross
Stirling Anglian Pharmaceuticals
Vapotherm

This year's highlights

Mini short courses

We have two short courses on offer this year, one on lung cancer, which will include a mini-MDT panel discussion where clinical cases will be presented and audience participation is encouraged, and the other, an in-depth insight of pleural services and procedures. Two symposia in each of these topics provide a comprehensive and in-depth clinical learning opportunity.

Symposia

A broad range of topics from asthma to TB, including content which is relevant to all members of the respiratory team. To aid trainee delegates, the programme has been mapped to the respiratory curriculum.

Abstract Prizes

Abstract Prizes continue with a broader all-encompassing category this year that invites abstracts, "...that are providing measured improvements to patient care and that highlight multi-professional projects (big and small)." We know teams are using QI methodology to change practice, and respiratory teams lead in developing innovative integrated care solutions; with these Abstract Prizes, we aim to highlight and share the excellent and successful work being undertaken in respiratory medicine departments across the UK. Following a submission and refereeing process, the twelve short-listed abstracts will be presented in two spoken sessions, one on each day, so please go along and support the authors and share good practice. Additional work will also be displayed as digital posters in the exhibition hall and on the conference App. The short-listed presentations will be judged on the day and prizes awarded to the overall winners.

Clinical Grand Round

As ever, an important part of the programme, where three finalists will battle it out under the scrutiny of a judging panel and audience. Please do support this session, go along and listen to the challenging cases and pose equally challenging questions to the presenters. An overall winner will be chosen at the end of the session and will receive a prestigious prize.

Guest Lecture

This year's Guest Lecture will be given by Professor James Hull, Consultant Respiratory Physician, at the Royal Brompton and Harefield Hospital. Professor Hull will speak on, "In search of marginal gains – when elite sport meets respiratory health". This promises to be a fascinating presentation that will incorporate Professor Hull's world-leading research on exercise physiology and respiratory health with elite athletes.

Physiology quiz

The Physiology Quiz is always an extremely popular part of the conference, with digital cases on the conference app and a question-and-answer session during the programme facilitated by our expert panel of respiratory physiologists.

Exhibition

Make the most of this great opportunity to meet up with industry colleagues and hear directly about the latest pharmaceutical evidence and innovative investigative and therapeutic equipment. Do also stop by the BTS stand, say hello to the team and use this area to meet fellow professionals, network and share ideas.

Lunchtime Sessions

New for 2025, are our Lunchtime Sessions. One of which will be aimed at trainee delegates who might be looking at the next stage in their career and approaching Consultant roles, and the other, following the success of our Women in Respiratory session at the 2024 Winter Meeting, we are delighted to be showcasing another open to all session at the Summer Meeting where you can share your views and experiences.

President's Reception

All delegates are warmly invited to this informal social event, which will be held in the conference centre at 6.00pm on Thursday 19 June, and where prizes will be awarded for the Abstract Prizes and Clinical Grand Round. This is a perfect opportunity to catch up and network with your colleagues from around the country too!

PROGRAMME AT A GLANCE
THURSDAY 19 JUNE 2025

TIME	DETAILS	LOCATION
8.30am – 9.30am	**Registration and refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Foyer and Exchange Hall, lower level
9.30am – 11.00am	Year in Review: The evolving landscape of Respiratory Care	Exchange Auditorium, lower level
9.30am – 11.00am *Slido voting*	This isn't going to hurt: talking about tobacco dependence	Exchange 8-10, upper level
9.30am – 11.00am	Screening for and managing OSA in high-risk groups - what is the evidence, what is the reality?	Exchange 11, upper level
11.00am – 11.30am	**Refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
11.30am – 1.00pm *Slido voting*	Mini short course: Part 1 - Insights from the pleural clinic	Exchange Auditorium, lower level
11.30am – 1.00pm *Slido voting*	Clinical Grand Round	Exchange 8-10, upper level
11.30am – 1.00pm *Slido voting*	Practical solutions to occupational and environmental lung diseases	Exchange 11, upper level
1.00pm – 1.45pm *Slido voting*	Lunchtime session: Approaching consultant? Everything you need to know!	Exchange 8-10, upper level
1.00pm – 2.30pm	**Lunch.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
2.00pm – 2.30pm	Abstract Prizes spoken session Category: Innovation and education: a passport to learning (IE1 - IE6)	Exchange 11, upper level
2.30pm – 4.00pm	Mini short course: Part 2 - The ins and outs of pleural procedures	Exchange Auditorium, lower level
2.30pm – 4.00pm	Inhaler devices: the art and the science	Exchange 8-10, upper level
2.30pm – 4.00pm *Slido voting*	What needs to be fixed in bronchiectasis care in 2025?	Exchange 11, upper level
4.00pm – 4.30pm	**Refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
4.30pm – 6.00pm	Joint BTS/BSACI Symposium: More to asthma than steroids and biologics	Exchange Auditorium, lower level
4.30pm – 6.00pm *Slido voting*	Pneumonia: when to think about zebras	Exchange 8-10, upper level
4.30pm – 6.00pm *Slido voting*	Chronic cough: the what, the when, and the how	Exchange 11, upper level
6.00pm – 7.00pm	The BTS President's Reception and Award Presentations – *All welcome!*	Exchange Hall, lower level

PROGRAMME AT A GLANCE
FRIDAY 20 JUNE 2025

TIME	DETAILS	LOCATION
8.00am – 8.30am	**Registration and refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Foyer and Exchange Hall, lower level
8.30am – 10.00am	COPD care now and in the future: using NRAP to show the way	Exchange Auditorium, lower level
8.30am – 10.00am *Slido voting*	STAG Education Symposium: Excellence in respiratory training	Exchange 8-10, upper level
8.30am – 10.00am *Slido voting*	Enhancing the journey of the respiratory patient with the use of data	Exchange 11, upper level
10.00am – 10.30am	**Refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
10.30am – 12.00pm	'Getting it right first time' for UK TB elimination	Exchange Auditorium, lower level
10.30am – 11.00am	Abstract Prizes spoken session Category: Local improvements driving patient care forward (QI1 - QI6)	Exchange 11, upper level
11.05am – 12.00pm *Slido voting*	Physiology quiz Q&A session	Exchange 8-10, upper level
12.10pm – 1.00pm	**Guest Lecture: In search of marginal gains – when elite sport meets respiratory health** *Including presentation of the Abstract Prize award for "Local improvements driving patient care forward"*	Exchange Auditorium, lower level
1.00pm – 1.45pm *Slido voting*	Lunchtime session: Women in Respiratory	Exchange 8-10, upper level
1.00pm – 2.30pm	**Lunch.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
2.00pm – 3.30pm	Mini short course: Part 1 - Lung cancer: Novel diagnostics and management of advanced disease	Exchange Auditorium, lower level
2.00pm – 3.30pm	Case based studies from healthcare scientist led services	Exchange 8-10, upper level
2.00pm – 3.30pm *Slido voting*	Cystic fibrosis: lessons learnt of relevance to respiratory teams	Exchange 11, Upper Level
3.30pm – 3.45pm	**Refreshments.** Visit the exhibition stands and view the digital poster screens. Test yourself with the Physiology Quiz cases on the Summer Meeting App. *(Exhibition closes at 3.45pm)*	Exchange Hall, lower level
3.45pm – 5.15pm	Mini short course: Part 2 - Lung cancer mini-MDT	Exchange Auditorium, lower level
3.45pm – 5.15pm *Slido voting*	What is changing in pulmonary vascular medicine?	Exchange 8-10, upper level
3.45pm – 5.15pm	Management of advanced ILD	Exchange 11, upper level

MEETING INFORMATION

THE VENUE

Manchester Central Convention Complex, The Exchange Suite, Petersfield, Manchester, M2 3GX

Please enter via the dedicated EXCHANGE entrance, located on street level to the right of the main entrance. Registration will be located in the Exchange Foyer, Lower Level.

Manchester Central is in the heart of Manchester.
Further information and directions may be found **here**

FACILITIES AT THE VENUE

A multi-faith prayer room is located on the ground floor, close to the cloakroom. Additional space is available in Exchange 5, along with a quiet room for nursing mothers in Exchange 4, both on the upper level.

CLOAKROOM

A free of charge, staffed cloakroom is available on site on the ground floor.

SECURITY

Please keep valuables with you at all times, especially mobile phones and laptops. Neither BTS nor the venue can be held responsible for the disappearance of personal items while delegates are attending the conference.

FINAL PROGRAMME & CONFERENCE APP

The final programme will be available as a PDF only, available to download from the **BTS website** or on the conference App.

As well as the programme, the App will contain lots of useful information about the Meeting.

We recommend that you download the BTS Events/Summer Meeting App to your phone/tablet before arriving at the venue.

CONFERENCE SESSIONS

The conference sessions will be held in the Exchange Auditorium on the lower level, and in Exchange 8-10 and Exchange 11, both on the upper level.

After the event, all registered delegates will have access to video recordings of the symposia and guest lecture via the Summer Meeting App. These will be available to view until 19 September 2025.

Q&A

In all conference sessions, delegates may ask questions either in the traditional way using the microphones available in the rooms, or via the Q&A section of the conference App. **We recommend that you download the BTS Events/Summer Meeting App to your phone/tablet before arriving at the venue.**

VOTING/POLLING IN SESSIONS

In some sessions, speakers will include questions and scenarios on which delegates may vote. This will be done via the Slido App.

Sessions where polling is included are highlighted in the programme and a participation code will be projected on screen at the start of the session, to enable delegates to join in.

Access to Slido is via the Conference App or directly on the Slido website / App.

BTS SUMMER MEETING ABSTRACT PRIZES

The Summer Meeting Abstract Prizes have been short-listed in two categories – "Innovation and education: a passport to learning" and "Local improvements driving patient care forward". The short-listed abstracts will be on view in digital format in the exhibition area on the ground floor and on the conference App. The work will also be presented in two spoken sessions in Exchange 11 (upper level) (please see pages 14 and 18). The short-listed posters and presentations will be judged on the day and prizes will be awarded to the overall winners.

Additional digital posters will also be available to view on the conference App and on the digital poster screens in the exhibition area, where authors will be available during the breaks to answer any questions.

EXHIBITION

Please take time to visit the exhibition and charity/association stands located in Exchange Hall. BTS is very grateful to all exhibitors for their support of the Summer Meeting.

PHYSIOLOGY QUIZ

The Physiology Quiz is available as digital cases on the conference App, with an interactive question-and-answer session in Exchange 8-10 (upper level) on Friday morning. BTS is very grateful to Dr Vicky Moore and Respiratory and Sleep Sciences, University Hospitals Coventry and Warwickshire NHS Trust for organising the quiz.

REFRESHMENTS

All refreshments will be served in Exchange Hall, lower level.

CONFERENCE RECEPTION AND AWARD PRESENTATIONS

On Thursday 19 June from 6.00pm, all participants are warmly invited to join us in the exhibition area for an informal reception with wine, beer, soft drinks and nibbles. Presentations will be made to the finalists participating in the Abstract Prize category "Innovation and education: a passport to learning", and Clinical Grand Round. The reception will end at 7.00pm to enable participants to enjoy the many restaurants and social activities that Manchester has to offer.

MEET THE BTS TEAM

The BTS stand in Exchange Hall will provide a focal point for delegates to meet, network and share ideas. Members of the BTS and Respiratory Futures teams will be available on the stand during the breaks.

INTERNET ACCESS

Wireless internet access is available free of charge throughout the venue and may be accessed as follows:

- Check your Wi-Fi is on
- Connect to the wireless network named: **_MCCC WIFI wireless network**
- The portal page should load automatically, if not open it in a web browser
- Click: Manchester Central Free Wi-Fi
- Read and check the box to accept the terms and conditions, then click connect

CONTACT DETAILS IN MANCHESTER

BTS registration desk: 020 7831 8778 (option 3 for booking queries / option 4 for finance enquiries).
Or email: bookings@brit-thoracic.org.uk

Venue website: www.manchestercentral.co.uk

CONFERENCE BAGS

As part of the Society's ambition to be more environmentally-friendly and to reduce paper use and wastage, re-useable conference bags will be available onsite, but they will not be packed with literature. Instead, please use the Summer Meeting App or visit the BTS website for updates to the programme, company literature and other useful information about the Meeting: BTS website

CPD APPROVAL

The BTS Summer Meeting has been approved by the Federation of the Royal Colleges of Physicians of the UK for 12 category 1 (external) CPD credits (6 per day) with CPD code: 151073. We will automatically register all eligible delegates for CPD when they register for the Meeting.

NURSING AND MIDWIFERY COUNCIL REVALIDATION

By attending the Summer Meeting, it will be possible for nurses to demonstrate CPD and write reflective accounts to support their revalidation. These relate to the NMC Code for Professional Standards of Practice and Behaviour for Nurses and Midwives, including:

- what you learnt from the sessions;
- how you will change or improve your practice as a result;
- how this is relevant to the Code – prioritising people, practising effectively, preserving safety or promoting professionalism and trust.

A reflective accounts form is available on page 47 of this document. Revalidate booklet

CHARTERED SOCIETY OF PHYSIOTHERAPISTS CPD

The Summer Meeting should be suitable for inclusion in the portfolios of respiratory physiotherapists, being part of a programme of education offered by the British Thoracic Society. Details of the CSP ePortfolio are available here

ATTENDANCE CERTIFICATES

Attendance certificates will be sent via email to all registered delegates who attended the event.

ACCOMMODATION

For last-minute hotel bookings or queries, please contact MICE Concierge:

Website: www.miceconciergeme.com/bts-summer-2025

Email: hello@miceconcierge.com

Tel: 01438 908 770

SOCIAL MEDIA

Increase your participation by posting about the Summer Meeting using: **#BTSSummer2025**

DATES OF FUTURE BTS MEETINGS

Winter Meeting 2025
26 to 28 November, London

Summer Meeting 2026
9 and 10 July, Manchester

Winter Meeting 2026
25 to 27 November, London

BTS SHORT COURSE

PLEURAL DISEASE & MESOTHELIOMA FOR SPECIALIST NURSES 2025

Wednesday 18 June

Venue: Lowry Hotel, Manchester City Centre

Please note, this is NOT the same venue as the Summer Meeting.

ACUTE NON-INVASIVE VENTILATION & HOME MECHANICAL VENTILATION 2025 - PRACTICAL COURSE

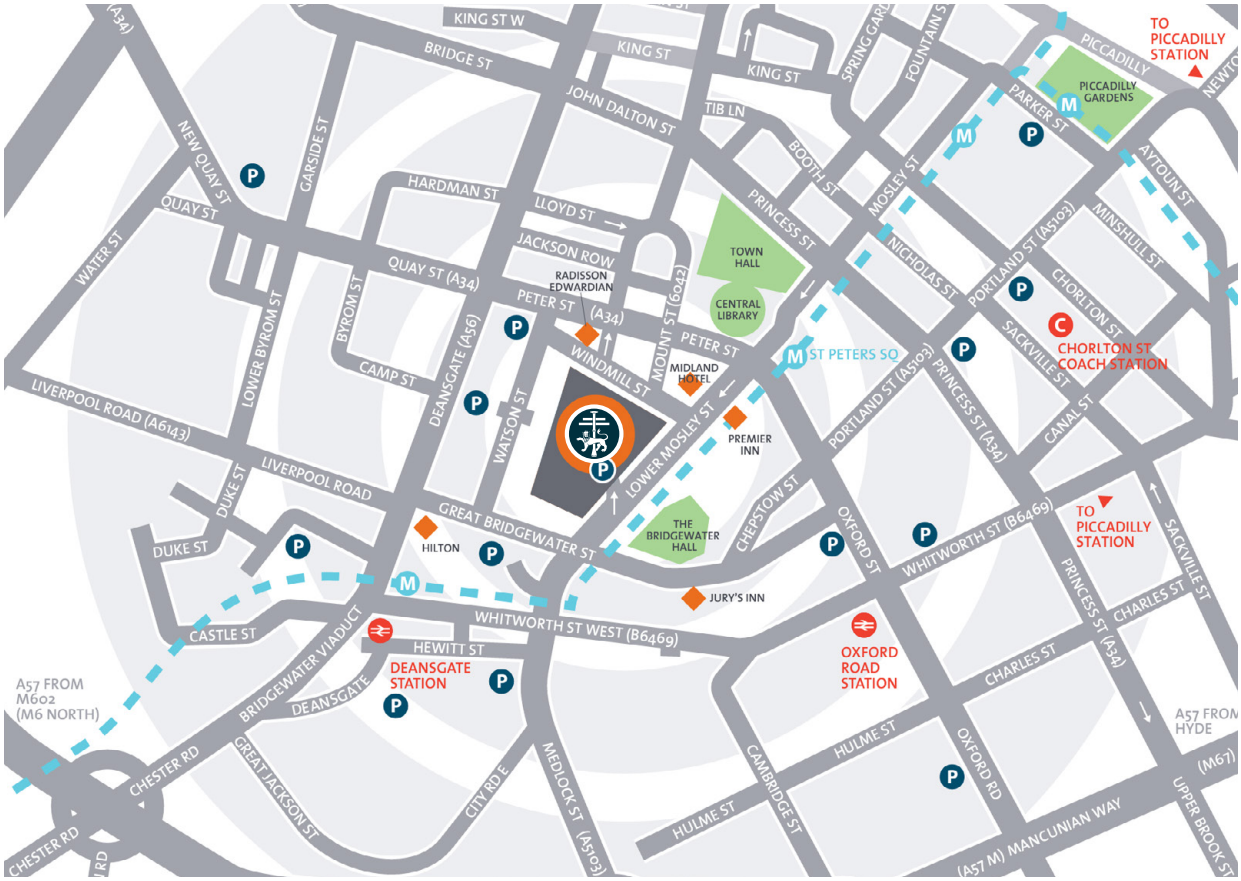
Wednesday 18 June

Venue: Lowry Hotel, Manchester City Centre

Please note, this is NOT the same venue as the Summer Meeting.

For last-minute information, please see the Short Courses page of the website

TRAVELLING TO MANCHESTER



TRAVEL

A travel guide is available **here.**

ON ARRIVAL IN MANCHESTER

Free Bus services (via the Bee Network) link the city centre's main rail stations, shopping areas and businesses, all free of charge.

Click here for more information on routes.

The nearest **Metrolink** stop to Manchester Central is St Peter's Square and is just a few minutes away on foot. Metrolink runs every few minutes from early morning until late in the evening.

You don't need a timetable, just turn up, buy your ticket and the next Metrolink will be along shortly. However, the network is currently being expanded so please do check your route before travelling. Routes and further information can be found on the **Metrolink website.**

There is a dedicated **taxi rank** at the front of the venue for pickups and drop offs. Black cab taxis are readily available at Manchester Airport and at Piccadilly and Victoria train stations. Find out more at **tfgm.com** or phone Traveline on **0871 200 22 33.**

BY TRAIN

Manchester has direct connections to most major UK cities and it takes a little over two hours to reach Manchester from London. Services arrive at Piccadilly or Victoria stations where passengers can connect with Metrolink trams for easy access to the city centre. Manchester Central is a 20-minute walk from Piccadilly Station or five minutes by taxi. Alternatively, catch a connecting train to Oxford Road Station, just a five-minute walk from Manchester Central.

Further information on train services can be found at:

www.avantiwestcoast.co.uk

www.nationalrail.co.uk

www.tpexpress.co.uk

www.northernrailway.co.uk/stations/MAN

BY CAR

Manchester is at the heart of a comprehensive motorway network. Manchester's M60 orbital motorway provides easy access from north, south, east and west. If using a Satnav, follow the postcode: **M2 3GX**

There is an NCP (National Car Park) directly below Manchester Central, which may be **booked here.**

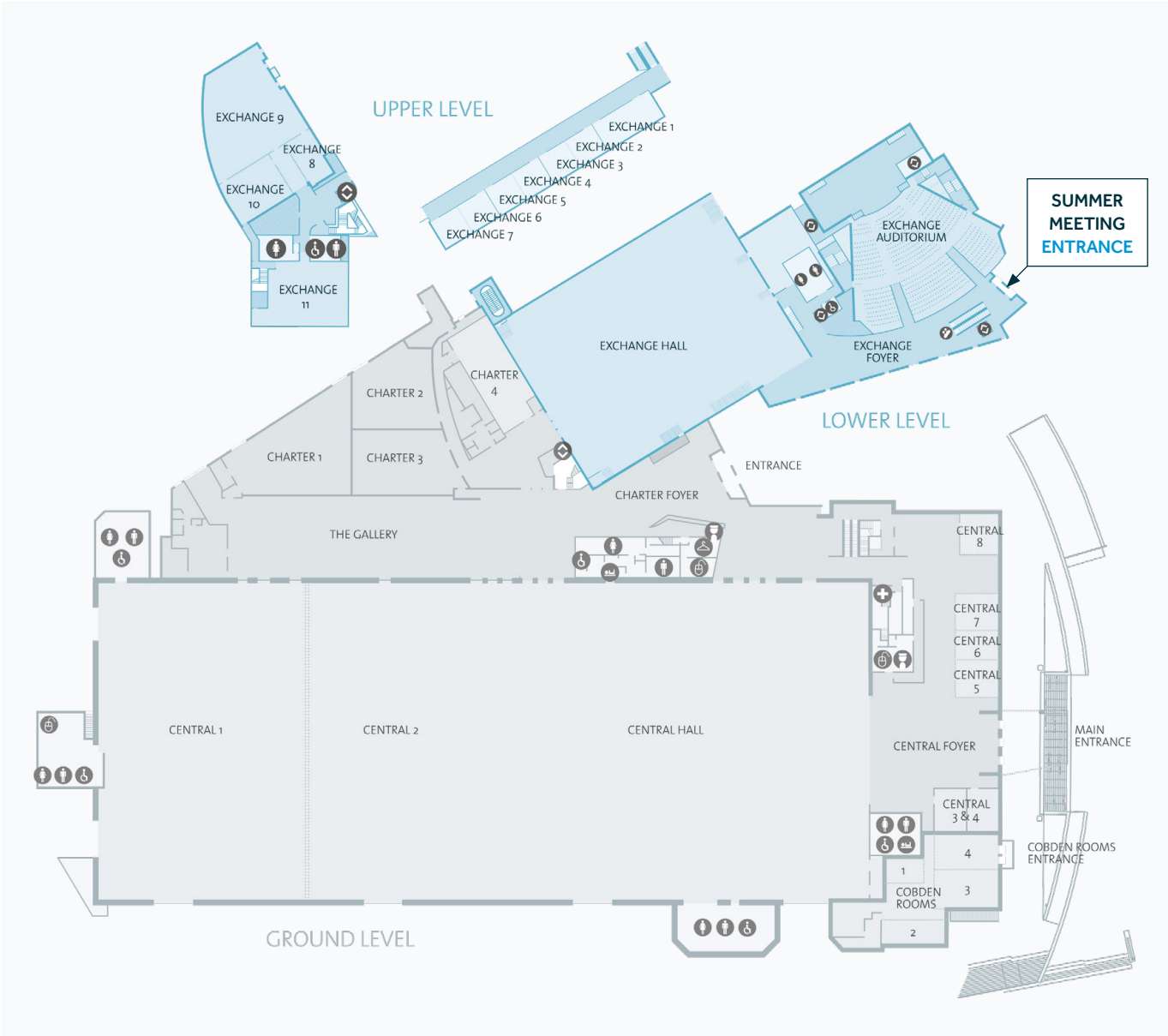
Participants may claim a discount when booking ahead by entering the discount code: **MCEXHIB16** for £16 rate.

VISIT MANCHESTER

Visit the Meet in Manchester website for further information on transport, what to see and do in Manchester, running routes and offers and discounts for delegates.

Meet in Manchester website

FINDING YOUR WAY AROUND THE VENUE



Key

- TOILETS
- ORGANISERS' OFFICE
- FIRST AID
- ESCALATORS
- LIFT
- CONCIERGE
- CLOAKROOM
- BABY CHANGE

Entrance:
Exchange Suite, Windmill Street

Cloakroom:
Exchange Foyer, ground level

BTS registration:
Exchange Foyer, lower level

Exhibition and catering:
Exchange Hall, lower level

Conference rooms:
Exchange Auditorium, lower level
Exchange 8-10, upper level
Exchange 11, upper level

Abstract Prize & digital poster screens:
Exchange Hall, lower level

Speakers' preview room:
Exchange Foyer, lower level

Private meeting rooms:
Exchange 2-3, 6 & 7, upper level

Prayer room:
Lower Foyer, ground level and Exchange 5, upper level

Nursing mothers' room:
Exchange 4, upper level

PROGRAMME
THURSDAY 19 JUNE 2025

8.30am – 9.30am **REGISTRATION** and refreshments

Exchange Foyer & Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

9.30am – 11.00am **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

YEAR IN REVIEW: THE EVOLVING LANDSCAPE OF RESPIRATORY CARE

Chaired by:	Mrs Alison Armstrong (Newcastle upon Tyne) Dr Charlotte Addy (Cardiff)
9.30am -	RSUs interaction between RSUs and ICUs, future pathways, triple accreditation Dr Dhruv Parekh (Birmingham)
10.00am -	Nursing and allied health professional workforce issues and changing landscape (mapping the respiratory nurse specialist workforce) Dr Kate Lippiett (Southampton)
10.30am -	Where is integrated care in 2025? Dr Daryl Freeman (Norfolk)

Learning outcomes:

- To understand the changing landscape of care for patients with respiratory failure within respiratory and critical care settings.
- To consider how training in respiratory and critical care has changed and will evolve in future to reflect this changing landscape of care.
- To highlight past, present and future issues affecting the non-medical respiratory workforce and discuss how this impacts the whole respiratory community, with a focus on respiratory nursing.
- To review the evolution of integrated care services for people with respiratory disease.

Curriculum mapping:

Generic Capabilities in Practice 1: Able to function successfully within NHS organisational and management systems.

- Demonstrates engagement in career planning.

Speciality Capabilities in Practice 2: Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.

- Understands how to set up integrated respiratory services (including relevant NHS structures, business cases, commissioning, tendering processes).
- Demonstrates practical application of "Hospital at Home" and admission avoidance systems.
- Works in partnership with the Respiratory Multi-disciplinary team (e.g. physiotherapists, specialist nurses, palliative care team, pharmacists, physiologists and psychologists).

Speciality Capabilities in Practice 4: Managing the service and patients with respiratory failure in multiple settings including hospital and in the community.

- Demonstrate an understanding of the role of the respiratory physician in the management of critically ill patients.
- Show recognition of patients who will and will not benefit from intensive care or from care in an HDU.
- Demonstrate knowledge and skill in managing oxygen therapy in the acute and domiciliary setting.
- Demonstrate understanding of, and the skills required to provide non-invasive ventilation for acute and acute or chronic respiratory failure in hospital.

Exchange 8-10, upper level

THIS ISN'T GOING TO HURT: TALKING ABOUT TOBACCO DEPENDENCE

Chaired by:	Ms Jacqui Pollington (Rotherham) Dr Rachel Penfold (Liverpool)
9.30am -	What every HCP in training needs to know about addiction, from pathology to socioeconomics Professor Sanjay Agrawal (Leicester)
10.00am -	Confident prescribing in tobacco dependence including swap to stop Mr Darshan Negandhi (London)
10.30am -	The science behind the conversation – talking to people about harm reduction in the context of multiple health problems including mental health problems Professor Caitlin Notley (Norwich)

Learning outcomes:

- To have a greater understanding of the pathology of addiction, the socioeconomic cause, effect and wider consequences.
- To confidently discuss and prescribe treatment for tobacco dependence.
- To develop communication skills to confidently navigate a conversation on the treatment of tobacco dependence.

Curriculum mapping:

- Respiratory specialty Capabilities in Practice 6: managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.
- Clinical Capabilities in Practice 2: managing the acute care of patients within a medical specialty service.
- Clinical Capabilities in Practice 4: managing patients in an outpatient clinic, ambulatory or community setting, including management of LTCs.
- Generic Capabilities in Practice 3: communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgment.

Exchange 11, upper level

SCREENING FOR AND MANAGING OSA IN HIGH-RISK GROUPS: WHAT IS THE EVIDENCE, WHAT IS THE REALITY?

Chaired by:	Dr Tim Quinnell (Cambridge) Dr Lizzie Hill (Bristol)
9.30am -	COPD-OSA overlap syndrome: is there a case for screening and if so, who? Dr Sophie West (Newcastle upon Tyne) Ms Trish Matharu (Coventry and Warwickshire)
10.00am -	Hypoglossal nerve stimulation: Presentation of complex cases. Evidence to date, 1st UK centre experience, national access, referral criteria Professor Joerg Steier (London)
10.30am -	Pre-operative screening for OSA: What are the risks of surgery? Does diagnosis/treatment help? Critical appraisal of new guidance Dr Philippa Graff-Baker (Leicester)

Learning outcomes:

- To understand the current evidence for the potential impacts of coexistent OSA on outcomes in COPD, in order to guide the clinical approach. To be aware of the aims and scope of the EPIC-OSA trial.
- To understand the evidence supporting the role of hypoglossal nerve stimulation (HNS) and to be updated on the early experience of the first UK centre. To understand referral criteria and national options for accessing this emerging treatment for patients.
- To be briefed on the latest guidance on pre-operative OSA screening, including a critical appraisal of supporting evidence, in order to inform the development and delivery of real-life clinical services.

Curriculum mapping:

Generic Capabilities in Practice:

- Able to function successfully within NHS organisational and management systems.
- Able to deal with ethical and legal issues related to clinical practice.

Speciality Capabilities in Practice:

- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.
- Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Works in partnership with the Respiratory Multi-disciplinary in Practice team (e.g. physiotherapists, specialist nurses, palliative care team, pharmacists, physiologists and psychologists).

Clinical Capabilities in Practice:

- Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions.

3.5 presentations and conditions – Sleep related breathing disorders

4.1 Training programme – 11. Continuous Positive Airway Pressure (CPAP): At ST7 trainees will be independent in the use of CPAP to manage obstructive sleep apnoea.

11.00am – 11.30am **REFRESHMENT BREAK**

Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

11.30am – 1.00pm **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

MINI SHORT COURSE: PART 1
INSIGHTS FROM THE PLEURAL CLINIC

Chaired by:	Miss Hannah Collins (Cambridge) Mrs Jennifer Rees (Wythenshawe, Manchester)
11.30am -	Setting up the perfect pleural service in line with GIRFT recommendations and BTS standards Dr Avinash Aujayeb (Northumbria)
12.00pm -	How to integrate the new pleural training standards into practice Dr Andrew Stanton (Newcastle upon Tyne)
12.30pm -	Cases from the pleural clinic – an interactive panel discussion Dr Rakesh Panchal (Leicester)

Learning outcomes:

- To develop a pleural service which can be income generating, safe and line up to the wider NHS plan.
- To develop an understanding of the pleural procedure training standards and provide a safe service.
- To develop knowledge around novel management of non-expandable lung and biochemically discordant effusions.

Curriculum mapping:

- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.
- Practical procedural skills.

Exchange 8-10, upper level

CLINICAL GRAND ROUND

Judged by:	Mrs Alison Armstrong (Newcastle upon Tyne), Ms Amy Bendall (Cardiff), Dr Ayesha Kumar (Liverpool) and Dr Richard Russell (London and Hampshire)
11.30am -	Pulmonary syphilis - a lung cancer mimic? EJ Comben, S Hussain
12.00pm -	Refractory airway diseases: is there something peculiar going on? SP Tiong, R Cowburn, T Playle, L Wardle, M Quint, K Adeniji, T Jones
12.30pm -	"Hypoxia, hunches and the online pharmacy. a case of rethinking assumptions?" NH Hare, AT Talwar

Session overview:

The above three finalists, selected after evaluation of a host of submissions, will present interesting clinical scenarios, highlighting diagnostic dilemmas and complex management decisions. A winner will be chosen after the session and announced at the President's Reception.

Slido voting will be in use in this session.

Exchange 11, upper level

PRACTICAL SOLUTIONS TO OCCUPATIONAL AND ENVIRONMENTAL LUNG DISEASES

Chaired by:	Ms Tamanna Kabir (London) Dr Huda Badri (Wythenshawe, Manchester)
11.30am -	How to talk to your patients about environmental exposures and respiratory health Professor Ian Sinha (Liverpool) Dr Alice Lee (Liverpool)
12.00pm -	Work and health inequalities – what do I need to know and how can I help my patients? Dr Ruth Wiggans (Manchester)
12.30pm -	What occupational lung diseases am I missing and how does this impact on my patient? Dr Chris Barber (Sheffield)

Learning outcomes:

- To understand key questions for respiratory patients about their indoor and outdoor environment, and potential solutions that can help improve outcomes.
- To understand the interplay between work and other social factors and specifically how work reinforces and reflects social gradients of health.
- To be able to identify common occupational lung diseases and understand how they can be missed, and to understand the potential issues with wrongly attributing a disease to work.

Curriculum mapping:

3.4 Specialty Capabilities in Practice.

2. Respiratory medicine.

- Demonstrates expertise in the management of airway disease and provides guidance to non-respiratory specialists.
- Understands impact of air pollution in lung disease and contributes to measures to improve air quality.

5. Tertiary subspecialities.

- Demonstrates ability to consider the diagnosis of pulmonary hypertension, occupational lung disease, allergy, severe asthma, cystic fibrosis, interstitial lung diseases and other orphan lung diseases.
- Knowledge of diagnostic criteria for rare lung diseases.

Generic Capabilities in Practice.

- Communication and interpersonal skills.
- Dealing with complexity and uncertainty.
- Clinical skills.

3.5 Presentations and conditions.

- Symptoms related to environment.
- Symptoms related to occupation.
- Occupational and environmental lung disease.

1.00pm – 2.30pm **LUNCH BREAK**

Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

1.00pm – 1.45pm **LUNCH TIME SESSION**

Exchange 8-10, upper level

APPROACHING CONSULTANT? EVERYTHING YOU NEED TO KNOW!

Chaired by:	Dr Abigail MacKintosh (Shrewsbury) Dr Aaron Braddy-Green (London)
1.00pm -	Getting the consultant job – where to find jobs, writing your application and preparing for interview Dr Shaun Thein (Birmingham)
1.15pm -	The bits training doesn't teach you: the consultant contract, job planning and flexible working Dr Sophie West (Newcastle upon Tyne)
1.30pm -	Developing as a consultant: setting up a new service, developing external roles and management opportunities Dr Emma Crawford (Telford)

Learning outcomes:

- A clear understanding of where to go to find Consultant job adverts and what to expect from the application and interview process.
- How to negotiate a job plan that suits you and your department taking into consideration flexible working options. How does the Consultant Contract work and how is it different to the Junior Doctor Contract.
- How do you set up a new service if this is part of your new Consultant role. What sort of opportunities are there outside of the immediate clinical job and how do you feed these into your job plan.

Curriculum mapping:

Generic Capabilities in Practice:

- 1 - Able to successfully function within NHS organisational and management systems.

2.00pm – 2.30pm **ABSTRACT PRIZES SPOKEN SESSION**

Exchange 11, upper level

ABSTRACT CATEGORY: INNOVATION AND EDUCATION: A PASSPORT TO LEARNING (IE1 - IE6)

Shortlisted abstracts judged on the day by:
Dr Charlotte Addy (Cardiff)
Mrs Alison Armstrong (Newcastle upon Tyne)
Dr Gareth Hughes (Bolton)
Dr Odiri Eneje (Cambridge)

The six shortlisted abstracts will be presented during this session, with the associated digital posters on display in the exhibition hall and on the conference App.

IE1. "This isn't even taught in GP" - Improving medical student's understanding of COPD management in a GP setting through simulation-based learning.
L Moreton, C Hood, K Stevens, A Manzar, G Hope

IE2. Iatrogenic haemoptysis – hope for the best or prepare for the worst?
S Galbraith, V Sobolewska, J Roberts, E McCorry, N Faulkner, A Talbot, S Giavedoni

IE3. Enhancing patient care through interprofessional simulation: a collaborative approach to team-based healthcare.
V Sobolewska, P Prabhu, R Bramah

IE4. Broadcasting success: enhancing medical education using 'Near Me' and peer learning.
V Sobolewska, S Galbraith, K McLaren

IE5. The evolution of the Lung Nodule Navigator: developing a new service and improving patient pathways through a bespoke training programme.
AF Falolu, JY Yates, YD Duong, CR Ridgeon, JP Park, AM Moore, AS Sykes, GG Ghidoni, RB Benamore, FG Gleeson, AT Talwar

IE6. Improving pleural procedural competency for non-respiratory trainees: a four-stage approach.
S J Davis, Z Manji, J Asis, S Power.

2.30pm – 4.00pm **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

MINI SHORT COURSE: PART 2 THE INS AND OUTS OF PLEURAL PROCEDURES

Chaired by:	Miss Hannah Collins (Cambridge) Mrs Jennifer Rees (Wythenshawe, Manchester)
2.30pm -	Chest drains – the why, what, when and how? Dr Dinesh Addala (Oxford)
3.00pm -	Indwelling pleural catheters – a patient centred approach? Ms Maria Parsonage (Carlisle)
3.30pm -	Medical thoracoscopy and image guided biopsy – the why, what, when and how? Dr Joseph Mackenzie (Fife)

Learning outcomes:

- To develop a sound understanding of the mechanics behind chest drains, their various indications and safety considerations.
- To develop an understanding of IPC complications and how to treat them, and to make sure that the insertion of an IPC is a truly patient centred decision.
- To develop knowledge around medical thoracoscopy, its indications, as well as the recent evidence around service provision and anaesthesia.

Curriculum mapping:

- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.
- Practical procedural skills.

Exchange 8-10, upper level

INHALER DEVICES: THE ART AND THE SCIENCE

Chaired by:	Ms Gráinne d'Ancona (London) Ms Helena Cummings (Hull)
2.30pm -	Balancing inhaler options – how to work with patients to choose the best sustainable device Professor Anna Murphy (Leicester)
3.00pm -	Inhaler monitoring technology – what does it add and where is it going? Professor Richard Costello (Dublin)
3.30pm -	New inhaler technologies: a look inside Professor Ben Forbes (London)

Learning outcomes:

- Be able to assess and agree upon the best inhaler device for a patient.
- Appreciate the inhaler technology available to support best outcomes for patients.
- Understand the science behind lung drug delivery, why this is important and how it is evolving.

Curriculum mapping:

Inhaler use is the commonest intervention in respiratory medicine with over 80 million devices dispensed every year. This means it is essential for clinicians to develop the critical appraisal skills, and the expertise required to use shared decision making to choose the correct device for an individual and help them use it optimally. Unfortunately, most healthcare professionals are not consistently and competently able to assess inhaler technique or needs, so we want this session to equip the audience with good medical practice (particularly around patient safety and safeguarding vulnerable groups) and an awareness of support beyond inhaler technique checking.

Exchange 11, upper level

WHAT NEEDS TO BE FIXED IN BRONCHIECTASIS CARE IN 2025?

Chaired by: Mrs Pamela Vaughn (Glasgow)
Dr Fiona Mosgrove (Aberdeen)

2.30pm - What does good bronchiectasis care look like according to guidelines/best practice?
Video clip of patient speaker

2.40pm - What does good bronchiectasis care look like according to guidelines/best practice?
Professor Anthony de Soyza (Newcastle upon Tyne)

3.00pm - MDT care for bronchiectasis in the UK; current issues, opportunities and challenges and role expansion
Mr Paul McCallion (Newcastle upon Tyne)
Miss Rachel Daly (Manchester)

3.30pm - Burden of disease: guideline compliance and challenges; QI opportunities
Professor Adam Hill (Edinburgh)

Learning outcomes:

- Understanding of patient care and guideline needs in bronchiectasis.
- Recognition of MDT approach and service delivery challenges/opportunities.
- Understanding of health inequalities/variations in care.

Curriculum mapping:

Generic Capabilities in Practice:

- Able to successfully function within NHS organisational and management system.

Clinical Capabilities in Practice (Internal Medicine):

- Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions.

Capabilities in Practice in respiratory specialty:

- Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

4.00pm – 4.30pm REFRESHMENT BREAK

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

4.30pm – 6.00pm SIMULTANEOUS SYMPOSIA

Exchange Auditorium, lower level

JOINT BTS/BSACI SYMPOSIUM: MORE TO ASTHMA THAN STEROIDS AND BIOLOGICS

Chaired by: Dr Shamsa Naveed (Leicester)
Mrs Lynn Elsey (Wythenshawe, Manchester)

4.30pm - Transition of young people with severe asthma: how, when, where
Dr Alexandra Nanzer-Kelly (London)
Miss Jodie Lam (London)

5.00pm - Allergen immunotherapy: is there a role for this in asthma management?
Dr Natasha Gunawardana (London)

5.30pm - Obesity and asthma: more than 'just steroids'
Professor Timothy Hinks (Oxford)

Learning outcomes:

- Understand the need for, and importance of, a transition service for young people with severe asthma and the challenges and successes of such a service.
- Understand the place for allergen immunotherapy for the treatment of asthma and the mechanisms and indications for allergen-specific immunotherapy.
- Understand the physiological and immunological links between obesity and asthma and the role and impact of treatment strategies.

Curriculum mapping:

- Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions.
- Managing a multi-disciplinary team.
- Tertiary subspecialties interface: managing patients across the secondary and tertiary interface.
- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 8-10, upper level

PNEUMONIA: WHEN TO THINK ABOUT ZEBRAS

Chaired by: Dr Caroline Baxter (Wythenshawe, Manchester)
Ms Aneeka Chavda (London)

4.30pm - Difficult to treat pneumonia: who, where, what
Professor Wei Shen Lim (Nottingham)

5.00pm - Aspergillus lung disease in specific hosts: transplantation, immunocompromised and beyond Professor Jeremy Brown (London)

5.30pm - Trainee case presentation– Complex pulmonary infection with resistant organisms
Dr Meera Mehta (London)

Learning outcomes:

- Awareness of complex pulmonary infections unique to different populations and patient specific conditions exploring interplay between infection and the host environment. The speakers will provide insight as to potential reasons behind the complexity such as the host response, multi-drug-resistant organisms, treatment duration, complications and other comorbidities. Diagnostics and treatment must be personalised as one size does not fit all.

- MDT approach in challenging pulmonary infection cases and the role and value of different MDT member contributions. How to systematically approach these cases and formulate outcomes.
- Reinforced understanding of the aspergillus lung disease guidelines.
- Exploring newer emerging diagnostics and therapies in complex pulmonary infections.

Curriculum mapping:

- Managing complex and unusual respiratory infection including contact tracing and public health (atypical pneumonia).
- Tertiary subspecialties interface managing patients across the secondary and tertiary interface; such as the National Aspergillosis Centre and centres with complex pulmonary infection teams. Also, interdisciplinary communication and review of patient referred from other specialities such as haematology. Working closely with physiotherapy and other speciality teams in the acute and chronic settings.
- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 11, upper level

CHRONIC COUGH: THE WHAT, THE WHEN, AND THE HOW

Chaired by:	Dr Sabrina Zulficar (Oxford) Miss Bethany Tidmarsh (Preston)
4.30pm -	How to assess cough (including assessment of severity and impact of cough) in a clinic setting Professor Surinder Birring (London)
5.00pm -	Pharmacological management of chronic cough: the what, the when, and the how Dr Jenny King (Manchester)
5.30pm -	Speech therapy for chronic cough: the what, the when, and the how Mrs Claire Slinger (Preston)

Learning outcomes:

- To learn about the clinical assessment and management of chronic cough, and reference to the BTS clinical statement on chronic cough in a clinical setting. To reflect and understand the impact of chronic cough on health-related quality of life and how this can be addressed in a clinical setting.
- To understand further the range of pharmacological agents for treatment of chronic cough. Which treatments are currently available, and when/how to incorporate them, as well as exploring the mechanisms of action and new drugs for chronic cough and how these can be incorporated into a management plan.
- To learn and further understand the clinical and research base of speech therapy management of chronic cough, and how this can be incorporated into an MDT approach. Approaches in secondary as well as tertiary care will be covered, as well as the patient perspective.

Curriculum mapping:

- Promoting the knowledge and skills to look after patients who present with common lung diseases including chronic cough.
- Recognising the need for full respiratory assessment to review for sinister causes of chronic cough.
- Focus on multi-disciplinary assessment and management, including complex and long-term presentations.
- Knowledge of clinical skill and assessment methodologies for respiratory assessment of patient, including knowledge of appropriate physiology and investigations required in the assessment of patients with all common lung diseases. These include lung function testing, radiological techniques presenting with chronic cough in secondary or tertiary setting, and links with primary care settings, as well as the wider MDT.
- Working across secondary and tertiary-level services.
- Knowledge of the use of drugs and therapeutic modalities specific to respiratory medicine.
- Knowledge of use of clinical guidelines in practice.
- Dealing with complexity and uncertainty.
- Formulating diagnostic and management plans.
- Highlighting clinical reasoning behind diagnostic and clinical management decisions.
- Management of comorbidities in outpatient clinic, ambulatory or community setting.

6.00pm – 7.00pm **THE BTS PRESIDENT'S RECEPTION AND AWARD PRESENTATIONS**

Exchange Hall, lower level

All attendees are warmly invited to attend this social occasion, where the awards for the BTS Abstract Prize category "Innovation and education: a passport to learning" and Clinical Grand Round will be presented.

Presented by: Professor Nick Maskell (Bristol)

PROGRAMME
FRIDAY 20 JUNE 2025

08.00am – 8.30am **REGISTRATION** and refreshments.

Exchange Foyer & Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

8.30am- 10.00am **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

COPD CARE NOW AND IN THE FUTURE: USING NRAP TO SHOW THE WAY

Chaired by:	Professor Tom Wilkinson (Southampton) Mrs Ola Howell (Oxford)
8.30am -	What does COPD care look like now in the UK, and what are the opportunities to shape high value care in the biologics era? Dr Neil Greening (Leicester)
9.00am -	NRAP Healthcare Improvement Programme Dr Yueqi-Ge (London) Dr Ravijyot Saggu (London) Lucy O'Donoghue (Nuneaton)
9.30am -	Improving care in COPD by example Dr Hannah Burke (Southampton)

Learning outcomes:

- To understand high value therapies for COPD and how they fit into disease management.
- How national audit and quality improvement can lead to improved outcomes for patients with COPD and improve services.
- How delivery of COPD care can be delivered in innovative ways and across integrated care.

Curriculum mapping:

Category 3: Safety and quality:

- 4. Is focussed on patient safety and delivers effective quality improvement in patient care.

Category 4: Wider professional practice:

- 5. Carrying out research and managing data appropriately.

4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions).

2. Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.

Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 8-10, upper level

STAG EDUCATION SYMPOSIUM: EXCELLENCE IN RESPIRATORY TRAINING

Chaired by:	Dr Abigail MacKintosh (Shrewsbury) Dr Charlotte Addy (Cardiff)
8.30am -	Respiratory training in the North East – sharing best practice Dr Hilary Tedd (Newcastle upon Tyne)
9.00am -	Advanced Practice in Respiratory: building a workforce for the future Mr Andy Lee (Nottingham)
9.30am -	What does the future hold for respiratory education? Dr Gerrard Phillips (Dorset) Dr Catherine Rowan (Leeds)

Learning outcomes:

- Understand how high-quality respiratory education and training can be delivered in the resource-limited NHS environment.
- Highlight new ways of expanding the workforce.
- Consider how respiratory careers may evolve over the next decade and what skills current trainees and AHPs may wish to acquire should they plan to be involved in leading this.

Curriculum mapping:

- Generic Capabilities in Practice 6: Acting as a clinical teacher and clinical supervisor.

Exchange 11, upper level

ENHANCING THE JOURNEY OF THE RESPIRATORY PATIENT WITH THE USE OF DATA

Chaired by:	Dr Natalie Harper (Dorset) Miss Padmavathi Parthasarathy (Leicester)
8.30am -	SNOMED codes – How can we identify patients with severe asthma and improve their access to biological therapy? Ms Mariana Fernandes (London) Ms Cris Roxas (London)
9.00am -	Audit data – how the NRAP Audit helps to inform areas for improvement and conduct QIP. Practical advice and good practice examples from around the UK. Mrs Aleksandra Gawlik-Lipinski (Leicester)
9.30am -	How can technology help you to improve your patients' care and make your life easier? The solutions implemented in Dorset Dr William McConnell (Dorset)

Learning outcomes:

- To familiarise with the SNOMED codes, see example on how to use them in QIP to identify patients eligible for biological treatment.
- To learn how to improve patients' experience and journey in the NHS through the use of National Respiratory Audit Data.
- To explore ways of utilising technology and electronic systems in respiratory practice.

Curriculum mapping:

Clinical Capabilities in Practice in internal medicines:

- Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions).
- Managing a multi-disciplinary team including effective discharge planning.

Capabilities in Practice in respiratory medicine:

- Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.
- Tertiary subspecialties interface: managing patients across the secondary and tertiary interface.

10.00am – 10.30am **REFRESHMENT BREAK**

Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

10.30am – 12.00pm **SIMULTANEOUS SESSIONS**

Exchange Auditorium, lower level

'GETTING IT RIGHT FIRST TIME' FOR UK TB ELIMINATION

Chaired by:	Dr James Brown (London) Mrs Tracey Langham (London)
10.30am -	TB on the rise – why is it happening and what can we do? Dr Lauren Ahyow (London)
11.00am -	Improving TB care: the GIRFT TB review Dr Martin Allen (Stoke-on-Trent)
11.30am -	Case studies – the public health impact of missed and delayed TB diagnoses Dr Martin Dedicoat (Birmingham) Ms Hanna Kaur (Birmingham)

Learning outcomes:

- Update on TB epidemiology and awareness of rising caseload across the UK with emphasis on some of the factors driving this.
- Outcome of 2024 GIRFT review and key recommendations from the National Report to improve and future proof TB services.
- Understand factors leading to diagnostic and patient delays in recognising TB, including in vulnerable groups, and the implications on TB transmission illustrated by clinical cases.

Curriculum mapping:

TB cases continue to rise but trainees in low burden areas frequently feel that they lack exposure to TB and experience to manage it. Feedback from trainees is frequently the need for better TB learning resources. This symposium delivers training that overlaps the following Generic and Specialty Capabilities in Practice of the Respiratory Curriculum:

Generic Capabilities in Practice:

- 4. Is focussed on patient safety and delivers effective quality improvement in patient care.

Specialty Capabilities in Practice:

- 2. Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
  - Works in partnership with the Respiratory Multi-disciplinary team (e.g. physiotherapists, specialist nurses, palliative care team, pharmacists, physiologists and psychologists).
- 3. Managing complex and unusual respiratory infection including contact tracing and public health (in particular atypical pneumonia).
  - Demonstrates accurate diagnosis of patients presenting with pulmonary infections including interpretation of clinical features, investigations and laboratory results.
  - Shows awareness of broader aspects of pulmonary infections especially public health issues including notification and contact tracing of patients with specific infections.

10.30am – 11.00am **ABSTRACT PRIZES SPOKEN SESSION**

Exchange 11, upper level

ABSTRACT CATEGORY: LOCAL IMPROVEMENTS DRIVING PATIENT CARE FORWARD (QI1 - QI6)

Shortlisted abstracts judged on the day by:
Dr Nazia Chaudhuri (Derry/Londonderry)
Ms Lizzie Grillo (London)
Dr Andrew Molyneux (Nottingham)
Mrs Donna Peat (Preston)

The six shortlisted abstracts will be presented during this session, with the associated digital posters on display in the exhibition hall and on the conference App.

QI1. Clearing the air: enhancing the delivery of nicotine replacement therapy in a district general hospital, a quality improvement project.
H Oluwarounke, P Morgan, C Henwood, G Yeo, J Britz, R Campbell, A Williamson, M O'Malley, M Greer, R Bhatia, J Wilson, E Robinson, R Haque, P Sivagangan, A Barnes, B Eldridge, D Lodge

QI2. Breathlessness pathway pilot: providing a streamlined process for diagnosis and management.
S Richards, E Fraser, E Tucker, Y Markova, A Cogle, P Swan, C Evans, N Reeder, J Alberts, S Gadhia, I Sadler, J Park

QI3. Co-production in the redesign of the national outpatient sleep pathway: a narrative and lessons for the future.
N Read, M Baker, A Hare

QI4. Improving management of pleural infection: implementation of a regional pathway based on the 2023 BTS guidelines on pleural disease.
R Watson, J Heaton

QI5. Introducing an ambulatory pleural effusion pathway at Whiston Hospital – a quality improvement project.
A Berry, R Early, J Heaton

QI6. Large group CPAP setup is feasible and effective.
WAMP Jayasiri, B Marsh, T Harris, M Babe, C Dobson, H Stevens, D Embury, T Joseph, K Allmond, R Evans, C Turnbull, A Nickol

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11.05 – 12.00pm **PHYSIOLOGY QUIZ Q&A LIVE SESSION**

Exchange 8-10, upper level

Chaired by: Miss Helen Purcell (Basingstoke and North Hampshire)
and Ms Joanna Purvis (Nuneaton)

Cases presented by: Dr Vicky Moore (Coventry and Warwickshire)

Physiology Quiz organised by Dr Vicky Moore and Respiratory and Sleep Sciences, University Hospitals Coventry and Warwickshire NHS Trust.

Join this session where colleagues will discuss the Physiology Quiz cases and answer questions from delegates, and take part in live voting.

Delegates will be able to access the Physiology Quiz cases on the conference App throughout both days of the Meeting, with answers available during this live session.

12.10pm – 1.00pm **GUEST LECTURE**

Exchange Auditorium, lower level

IN SEARCH OF MARGINAL GAINS – WHEN ELITE SPORT MEETS RESPIRATORY HEALTH

Guest lecturer: Professor James Hull (London)

Introduced by: Dr Richard Russell (London and Hampshire)

Including at 12.10pm presentation of the Abstract Prize award for "Local improvements driving patient care forward"

1.00pm – 2.30pm **LUNCH BREAK**

Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App.

1.00pm – 1.45pm **LUNCH TIME SESSION**

Exchange 8-10, upper level

WOMEN IN RESPIRATORY

Chaired by: Dr Rachael Moses OBE (London)
Dr Hilary Tedd (Newcastle upon Tyne)

The Society is committed to encouraging and supporting women working in all roles across the multi-professional respiratory team. We feel we are making good progress as an organisation with increasing numbers of women now engaging in membership and leadership roles, as well as being active participants in our education events, but we know more can and should be done.

This open session is offered to all delegates, as a way of hearing your views and experiences on how women working in respiratory healthcare can be actively and appropriately supported.

We are developing a dedicated space on Respiratory Futures and will showcase this during the session.

A very important component of the session will be the chance to network with colleagues.

2.00pm – 3.30pm **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

MINI SHORT COURSE: PART 1
LUNG CANCER: NOVEL DIAGNOSTICS AND MANAGEMENT OF ADVANCED DISEASE

Chaired by: Ms Karen Peplow (Manchester)
Dr Giorgios Tsaknis (Kettering)

2.00pm - Robotic bronchoscopy – where does it fit into the diagnostic pathway?
Dr Justin Garner (Watford)

2.30pm - ctDNA and liquid biopsies – how do they fit into the lung cancer pathway? Do we need tissue biopsies anymore?
Dr Jason Adhikaree (Nottingham)

3.00pm - Palliation and management of breathlessness in lung cancer
Dr Ricky Thakrar (London)

Learning outcomes:

- To understand the role of robotic bronchoscopy in the earlier diagnosis (and treatment) of lung nodules/lesions. To use case examples to show where robotic bronchoscopy may fit and discuss other navigational techniques and highlight the differences.
- To explore the role of circulating tumour DNA and liquid biopsy and how they fit into the management of advanced lung cancer, alongside clinical case examples. To examine what the role of tissue biopsy is and how it fits in with liquid biopsy.
- To cover the range of new treatments now available for breathlessness in cancer, including management of central airway obstruction, focussing on endobronchial intervention.

Curriculum mapping:

3.2 Generic Capabilities in Practice.

- Category 3: Safety and quality.

4. Is focussed on patient safety and delivers effective quality improvement in patient care.

3.3 Clinical Capabilities in Practice.

8. Managing end of life and applying palliative care skills.

3.4 Specialty Capabilities in Practice.

- Managing all aspects of thoracic malignancy and terminal disease including diagnostic pathways and working with the MDT.

6. Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 8-10, upper level

CASE BASED STUDIES FROM HEALTHCARE SCIENTIST LED SERVICES

Chaired by: Dr Joanna Shakespeare (Coventry)
Dr Karl Sylvester (Cambridge)

2.00pm - Acute NIV – introducing the role of the HCS in delivering an acute NIV service, focus on cases and how the knowledge and skills of a HCS can benefit acute NIV services
Miss Helen Purcell (London)

2.30pm - Cardiopulmonary Exercise Testing – discussing the benefits of a scientist led CPET service, example case studies illustrating the role of CPET in managing the breathless patient
Mr Chris Harding (Cambridge)

3.00pm - Sleep Clinics – How can HCS support sleep clinics, highlighting the role of the consultant grade HCS in the delivery of a sleep clinic with a focus on case studies
Dr Gillian Twigg (London)

Learning outcomes:

- The role of physiological investigations in the diagnosis and management of a range of conditions.
- How members of the wider MDT can support the assessment and treatment of respiratory and sleep patients in both the acute and chronic setting.
- Awareness of the quality assured scientist led services being delivered currently and how these can be utilised to enhance patient care.

Curriculum mapping:

It will map with the following Capabilities in Practice:

- Appropriately selects, manages and interprets investigations.
- Recognises need to liaise with specialty services and refer where appropriate.
- Works in partnership with the Respiratory Multi-disciplinary team (e.g. physiotherapists, specialist nurses, palliative care team, pharmacists, physiologists and psychologists).
- Demonstrate understanding of and the skills required to provide non-invasive ventilation for acute and acute or chronic respiratory failure in hospital.
- Demonstrate understanding of and the skills needed to provide non-invasive ventilation for chronic respiratory failure in the community.
- CPET: Have knowledge of the principles and theoretical basis. Some trainees may gain practical experience in the procedure (optional).

Exchange 11, upper level

CYSTIC FIBROSIS: LESSONS LEARNT OF RELEVANCE TO RESPIRATORY TEAMS

Chaired by: Mrs Catherine Brown (Birmingham)
Professor Daniel Peckham (Leeds)

2.00pm - Remote care and adherence in Respiratory Medicine: lessons learnt from CF
Ms Tracey Daniels (York)

2.30pm - Ageing and metabolic syndromes in CF – does this help shape care for other lung diseases?
Dr Freddy Frost (Liverpool)

3.00pm - Navigating the psychosocial challenges of CF: should we be doing more to support people with chronic respiratory disease
Dr Rachel Massey-Chase (London)

Learning outcomes:

- To understand service design and adherence challenges in chronic respiratory disease.
- To learn about chronic respiratory disease, ageing and cardiovascular risk.
- To learn about the psychosocial challenges of CF and chronic respiratory disease.

Curriculum mapping:

- Generic Capabilities in Practice 1 – Able to function successfully within NHS organisational and management systems.
- Generic Capabilities in Practice 2 – Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement.
- Speciality Capabilities in Practice 2 – Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Speciality Capabilities in Practice 6 – Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

3.30pm – 3.45pm **REFRESHMENT BREAK**

Exchange Hall, lower level

Visit the exhibition stands and view the Abstract Prize digital poster screens and Physiology Quiz on the App. (Exhibition closes at 3.45pm).

3.45pm – 5.15pm **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

MINI SHORT COURSE: PART 2
LUNG CANCER MINI-MDT

Chaired by: Professor Matthew Evison (Manchester)
Dr Liz Fuller (Newcastle upon Tyne)

Case presentations by:
Dr Fraser Millar (Edinburgh)
Dr Kay Por Yip (Wythenshawe, Manchester)

MDT Panel:
Surgeon: Mr Luigi Ventura (Sheffield)
Respiratory Physician: Dr Anna Bibby (Bristol)
Lung cancer nurse specialist: Ms Karen Peplow (Manchester)
Radiologist: Dr Rachel Benamore (Oxford)
Clinical/medical oncologist: Dr Jason Adhikaree (Nottingham)

3.45pm - Case 1: A case of stage 3 disease looking at the role of neoadjuvant chemoimmunotherapy and surgery

4.07pm - Case 2: Stage 4 disease looking at advances in treatment/targeted therapy

4.29pm - Case 3: An early-stage lung cancer/nodule case discussing the diagnostic challenges/ management options

4.52pm - Case 4: A case of oligometastatic disease- looking at what may be treated

Learning outcomes:

Clinical cases will be presented. The expert panel will discuss the clinical options; using clinical research publications and national audit data to help inform discussions and management decisions. Interactive audience participation will be encouraged using voting during the case discussions.

Curriculum mapping:

3.2 Generic Capabilities in Practice.

- Category 3: Safety and quality.
- 4. Is focussed on patient safety and delivers effective quality improvement in patient care.

3.3 Clinical Capabilities in Practice.

8. Managing end of life and applying palliative care skills.

3.4 Specialty Capabilities in Practice.

- Managing all aspects of thoracic malignancy and terminal disease including diagnostic pathways and working with the MDT.

6. Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 8-10, upper level

WHAT IS CHANGING IN PULMONARY VASCULAR MEDICINE?

Chaired by: Dr Colin Church (Glasgow)
Dr Frankie Varian (Sheffield)

3.45pm - How should we manage acute pulmonary embolism?
Professor Luke Howard (London)

4.15pm - The clinical approach to pulmonary arteriovenous malformations
Professor Claire Shovlin (London)

4.45pm - What's new in pulmonary hypertension: update from the World Symposium 2024
Dr Neil Hamilton (Sheffield)

Learning outcomes:

- This will explore the use of PERT teams in guiding management decisions on PE and explore the mechanical techniques that are now evolving in this area.
- The diagnosis and management of pulmonary AVM is very difficult. It is less common so education is required as all respiratory physicians will see them. Management with interventional embolisation will be discussed.
- This talk will explore the new updates to PH including diagnosis, management and prognosis. This is based on the output from the World Symposium in 2024.

Curriculum mapping:

3.4 Speciality Capabilities in Practice.

- Point 2 -Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Point 5 - Tertiary subspecialties interface: managing patients across the secondary and tertiary interface; in particular patients with lung and heart transplants and pulmonary hypertension.
- Point 6 - Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 11, upper level

MANAGEMENT OF ADVANCED ILD

Chaired by: Dr Sabrina Bajwah (London)
Dr Nazia Chaudhuri (Derry/Londonderry)

3.45pm - Lung transplantation for ILD: how has it evolved?
Dr Gerard Meachery (Newcastle upon Tyne)

4.15pm - Oxygen via high flow nasal cannula for patients with advanced ILD: from hospital to home
Mrs Jane Rodger (Newcastle upon Tyne)

4.45pm - Palliative care in ILD – what is current best practice?
Dr Anne-Marie Bourke (Newcastle upon Tyne)

Learning outcomes:

- Advanced ILD has emerged as the most common indication for lung transplantation globally yet represents a treatment option in only a small proportion of patients with advanced ILD.
- This symposium will explore how lung transplantation for ILD has evolved over recent decades as a treatment option for patients with advanced ILD.
- To gain an understanding of the indications for use of oxygen via HFNC and the role it plays for patients in advanced ILD. The role of oxygen via HFNC is a novel concept in the care of patients with advanced ILD. This symposium will also explore the role of oxygen delivered via HFNC in patients with advanced ILD who are either waiting for lung transplantation or to help facilitate care from hospital to home.
- To understand current best practice and evidence-based guidelines for managing symptoms in advanced ILD. This introduces the upcoming BTS statement for 'Palliative care in ILD'.

Curriculum mapping:

- Tertiary subspecialties interface: managing patients across the secondary and tertiary interface; in particular patients with lung and heart transplants and pulmonary hypertension.
- Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Managing end of life and palliative care skills.

SPEAKER BIOGRAPHIES & PRESENTATION SUMMARIES

Dr Dinesh Addala is a NIHR Doctoral Research Fellow and Respiratory Registrar at Oxford University Hospitals. His publications and specialist research interests include malignant pleural effusion, pleural infection and thoracic ultrasound. His doctoral research, based at the Oxford Respiratory Trials Unit, focuses on trials assessing early diagnosis and treatment in malignant pleural effusion using contrast ultrasound, direct to biopsy strategies and early IPC insertion (STREAMLINE).

Dr Addala is a member of the ERS Taskforce for Ultrasound Guided Respiratory Intervention and faculty for the ERS thoracic ultrasound and pleural postgraduate courses.

Chest drains – the why, what, when and how?

This talk will highlight the key principles and strategies in the interventional management of commonly encountered pleural conditions, including pneumothorax, pleural infection, malignant pleural effusion and the undiagnosed pleural effusion. Real-life clinical scenarios will be discussed and the evidence, guidelines and future directions of management will be covered.

Dr Charlotte Addy is a self confessed Sputumologist. She is a respiratory physician based in Cardiff, with specialist interests in Cystic Fibrosis and Bronchiectasis. She's been privileged enough to work in England, Northern Ireland and Wales, in both NHS and academic roles.

She has research interests in lung infection, inflammation and biomarkers. She is part of the CF Trust Clinical Trials Accelerator Programme and European CF Society Clinical Trials Network (ECFS-CTN). She is co-chairing the CF Trust Antimicrobial guideline group, sits on the ECFS Standards of Care Committee and helped write the recent ECFS Standards of Care.

She has keen interests in service development, education, training and workforce planning. She is a member of BTS Council, the BTS Education and Training Committee, Training Programme Director for South Wales and a member of the SAC. She is a Clinical Senior Lecturer at Cardiff University Medical School. She also chairs the Taskforce for Lung Health Workforce group and has just taken on a new challenge, co-hosting the new Respiratory Futures podcast.

Dr Jason Adhikaree qualified from Imperial College, London in 2008 and completed his Specialist Registrar Training and a NIHR academic clinical fellowship in Nottingham University Hospitals Trust in 2020. In this period he also received an MRC Clinical Training Research Fellowship grant and completed his PhD in 2019, which focussed on reversing dysfunctional dendritic cells in cancer. He is currently a Clinical Associate Professor and Honorary Medical Oncology Consultant at University of Nottingham specialising in thoracic malignancies. He currently resides on the British Oncology Thoracic Group Steering Committee and leads the Community of Practice Genomics Group in Lung Cancer aiming to improve genomic education.

ctDNA and liquid biopsies – how do they fit into the lung cancer pathway? Do we need tissue biopsies anymore?

The ctDNA pilot has had excellent UK uptake recognising the need for rapid genomic results for patients with lung cancer. This has highlighted the need for the MDT to increase their understanding of genomic test results, particularly since this is often requested under a respiratory consultant code on the diagnostic pathway. Here we discuss the advantages, challenges and limitations of ctDNA use in clinical practice.

Professor Sanjay Agrawal is a Consultant in Respiratory and Intensive Care Medicine in Leicester and the National Specialty Advisor for Tobacco Dependency at NHS England. Over the years Sanjay has supported the BTS national tobacco audit, delivered quality improvement collaboratives on tobacco dependency treatment pathways and produced several reports on different facets of tobacco control as Chair of the Royal College of Physicians Tobacco Advisory Group.

What every HCP in training needs to know about addiction, from pathology to socioeconomics

During this session we will review the physiologic basis of addiction and its drivers that include socioeconomic factors, commercial determinants, intersectionality and phenotypes and how this knowledge can be used to address treatment and break the cycle of addiction.

Dr Martin Allen is a Consultant Physician based at the University Hospital of North Staffordshire where he has had a major interest in respiratory and sleep medicine, developing and delivering sleep medicine, TB, COPD and ventilation services. Much of this clinical work is underpinned by physiological science and his previous research. He has fulfilled a variety of management and transformational roles within the hospital, including CD and Medicine Divisional Head, redesigning acute medicine.

Over the last several years Martin has held a variety of national roles including: chairing the expert working group on respiratory coding for NHSE; sitting on and chairing the Respiratory CRG; contributing to the Respiratory Long Term Plan, where he led on early diagnosis and pneumonia. Previously he was the National Clinical Director then the National Speciality Advisor (NSA) for Respiratory Medicine. He is the GIRFT National Clinical Lead for Respiratory Medicine where he is currently reviewing tuberculosis services in England and Scotland. For the last three years Martin has been the NSA for Physiological Science.

Improving TB care: the GIRFT TB review

Tuberculosis has seen a resurgence over recent years, with changing patterns of disease. As part of the TB Action Plan, it was recognised a GIRFT review of TB services would be helpful. This was commissioned by NHSE for England with a subsequent commission from NHS Scotland to review TB services. The reviews have been completed and national reports written.

The presentation will discuss the methodology of the reviews, the key findings and highlight the recommendations for improving care, while also contrasting the different findings between England and Scotland.

Key outcomes:

- Recognise the increasing but changing patterns of tuberculosis
- Review the resources that are available and those that are needed to deliver a TB service
- Highlight process for making change happen in TB care

Mrs Alison Armstrong is the Nurse Consultant within the regional North-East Assisted Ventilation Service. She is also the current Chair of the BTS Education and Training Committee, and one of her main interests lies in education. She is also Chair of HMViP; a collaboration of clinicians and patients to provide support and education to those receiving and using home mechanical ventilation. She has been the host of the Specialists in Long-term Ventilation at Home (SiLVaH) national network for the last 17 years.

Alison has an MSc in Practice Development and is an independent prescriber. She is passionate about promoting independence and ensuring an enhanced quality of life for her complex patient group.

Dr Avinash Aujayeb is the local pleural lead at Northumbria Healthcare NHS Foundation Trust, and the service has been selected as a GIRFT exemplar. He is very research active and published extensively on pleural disease. He is the current BTS Pleural SAG Chair.

Setting up the perfect pleural service in line with GIRFT recommendations and BTS standards

Pleural services are essential in respiratory medicine, and when properly funded and managed can have a number of benefits. This talk will go through some exemplar services, talk about coding for pleural disease and doing the right procedure in the right setting, whilst achieving the best outcomes for patients

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Dr Huda Badri is Respiratory Consultant and Clinical Academic with special interest in occupational lung disease, chronic cough and asthma. She was awarded a PhD in airway neurophysiology (role of GABAb in the cough reflex) in 2018. She is a member of the Group of Occupational Respiratory Disease Specialists and spends 50% of her time as an NHS consultant at the regional occupational lung disease service in North Manchester General Hospital and 50% as a clinical academic. Her research interests are in airway neurophysiology and the effects of indoor and outdoor pollutants on respiratory disease including chronic cough and occupational lung diseases. Her research is funded by the NW Lung Charity, Wellcome/UoM Perera Fellowship and most recently an NIHR personal award.

Dr Sabrina Bajwah is a Clinical Reader at King's College London and Consultant in Palliative Medicine. Dr Bajwah was a member of the NICE Quality Standards Committee for IPF and a member of the BTS Emergency Oxygen Guideline Group and IPF clinical and research advisory committees. She has published guidance for the European Respiratory Society on management ILD palliative care needs and American Thoracic Society on Patient Centred Outcomes in ILD. She runs the first and largest ILD palliative care clinic in the UK, whilst continuing to drive forward respiratory palliative care research nationally and internationally.

Dr Chris Barber is a Respiratory Consultant with a clinical and research interest in occupational lung disease. His time is split between NHS clinical work in Sheffield and HSE sessions at the Centre for Workplace Health in Buxton.

He is a member of the Group of Occupational Respiratory Disease Specialists (GORDS), and former chair of the BTS Occupational and Environmental Lung Disease Specialist Advisory Group. He has previously chaired the BTS groups that produced the Clinical Statement on Occupational Asthma and the Position Statement on Air Quality and Lung Health.

What occupational lung diseases am I missing and how does this impact on my patient?

This talk aims to provide guidance for when to consider common forms of occupational lung disease, and will discuss the benefits of early recognition. The talk will also cover the adverse outcomes of misattributing respiratory disease to work.

Dr Caroline Baxter is a Consultant Respiratory Physician at Manchester University Hospital Foundation Trust where she is the Divisional Medical Director for Respiratory and Thoracic Services. She has a specialist interest in bronchiectasis and complex lung infection, including pulmonary aspergillosis. She has led the development of UK National Aspergillosis Centre since 2019, which holds an international reputation for patient care, research, and education. Her PhD focused on the molecular detection of aspergillus in sputum samples which has since led to the UKs first accredited pyrosequencing assay to detect genetic antifungal resistance mechanisms. She has continued an active portfolio of research in lung infection working both for the South Manchester Bronchiectasis Service and the Medicines Evaluation Unit, an early phase accredited clinical trial unit in Manchester.

Dr Rachel Benamore qualified in medicine from Cambridge University. She undertook her radiology training in Leicester and spent a year as a fellow in thoracic radiology in Toronto, Canada. She is an author of over 30 peer-reviewed papers and two book chapters. She has been a Consultant Thoracic Radiologist at Oxford University Hospitals since 2006. She is currently Thoracic Radiology Lead in Oxford and frequently lectures nationally.

Ms Amy Bendall is a Chartered Physiotherapist and a Senior Lecturer and the Professional Accountability Lead for Physiotherapy in the School of Healthcare Sciences, Cardiff University. She was the Journal Editor and committee member of the Association of Chartered Physiotherapists in Respiratory Care (ACPRC) from 2017-2024 and currently represents the ACPRC on the BTS Education and Training Committee.

Dr Anna Bibby is an Associate Professor in Respiratory Medicine at the University of Bristol and Respiratory Consultant at North Bristol NHS Trust. She is Clinical Director for the Somerset Wiltshire Avon and Gloucester Lung Cancer Screening Service, and holds an NIHR Advanced Fellowship focussed on optimising screening effectiveness. She completed her PhD in mesothelioma in 2020 and is Chief Investigator for the ASSESS-meso study - the world's first, multicentre, prospective mesothelioma cohort.

Professor Surinder Birring is Professor of Respiratory Medicine and Consultant Respiratory Physician at King's College Hospital, London. His research focuses on the assessment and treatment of cough and the development of patient reported outcome measures. He has published over 300 papers, reviews and book chapters and is author of American, British and European cough clinical guidelines. He chairs the Scientific Committee of the European NeuroCough registry. He has been the chief investigator of numerous multi-centre clinical trials. His team developed the widely used quality of life questionnaires LCQ, KBILD, KSQ, CHQ and BHQ. Professor Birring is also co-developer of the Leicester Cough Monitor device. He was elected Fellow of the European Respiratory Society in 2023.

How to assess cough (including assessment of severity and impact of cough) in a clinic setting

Chronic cough is a common condition referred for outpatient management. It's profound effect on quality of life is often the reason why patients seek medical attention. In some patients, treatment of comorbid conditions such as asthma, reflux and rhinitis may be helpful but in many the cough remains refractory. Most patients have an underlying hypersensitive cough reflex that is the focus of ongoing research and novel therapies.

This presentation will focus on the clinical assessment with particular reference to the recent BTS clinical statement on cough. The concept of identifying treatable traits will be discussed. Tools to assess the frequency, severity and impact of cough will be reviewed. The importance of earlier recognition of patients with cough hypersensitivity or refractory cough will be emphasised to minimise the number of investigations patients undergo.

Dr Anne-Marie Bourke is a Consultant in Palliative Care Medicine at the Newcastle upon Tyne Hospitals NHS Foundation Trust. She has an interest in the palliative care of interstitial lung disease (ILD) and established an embedded palliative care service in the regional ILD clinic in 2016. As part of this role she was on the supervising team of a qualitative research project examining the experience of end of life care for people with ILD. Anne-Marie also has an interest in clinical ethics and holds a master's degree in Medical Ethics and Law.

Palliative care in ILD – what is current best practice?

A presentation delivered by a consultant who has embedded a palliative care service into a regional interstitial lung disease clinic. The session will cover approaches to symptom management in advanced interstitial lung disease. Practice points will include (1) how to discuss non pharmacological strategies for breathlessness management and (2) how to start advance care planning conversations in a busy clinic setting. The talk will also include the patient perspective drawing on the research study "Critically examining the end of life care of people with interstitial lung disease: views of patients, families and healthcare professionals."

Dr Aaron Braddy-Green graduated from Barts and The London School of Medicine and Dentistry in 2014. He completed an Academic Foundation Programme in Medical Education at the University of Sheffield before receiving an NIHR Academic Clinical Fellowship in Respiratory Medicine in 2018. Currently a Clinical Research Fellow at Imperial College London, he is pursuing a PhD under Professor Wisia Wedzicha and Dr. James Allinson, investigating early COPD pathophysiology. He also serves on the BTS Education and Training Committee and the Specialty Trainee Advisory Group.

Mrs Catherine Brown For 15 years, Catherine has specialised in cystic fibrosis as a physiotherapist at the West Midlands Adult CF Centre. She is a previous chair of the ACPCF and led its Independent Prescribing group. She currently represents physiotherapy on the BTS CF Specialist Advisory Group.

Catherine is a co-author of a Cochrane review of nebuliser devices in CF, the European CF Society Standards of Care, and the CF Trust's Antibiotic Standards of Care. She is currently co-editing the 2025 update of the CF Trust Standards of Care and Good Clinical Practice in Physiotherapy Management of CF.

Dr James Brown is a Respiratory Consultant at the Royal Free Hospital in London. He has a special interest in respiratory infection including tuberculosis and non-tuberculous mycobacterial disease and is a member of the BTS MDR-TB Clinical Advice Service, and recently sat on the BTS Tuberculosis Specialty Advisory Group.

Professor Jeremy Brown is an Academic Respiratory Consultant at University College London where he leads a team investigating the pathogenesis of bacterial pneumonia, including host immunity and vaccine development. In addition, he conducts translational research into patients with bronchiectasis and pneumonia. He has a subspecialty interest in lung infection, including bronchiectasis, ABPA, aspergillosis, and pneumonia in immunocompromised patients. He is co-head of the UCL Respiratory Department. Since 2018 he has been a member of the UK Joint Committee on Vaccination and Immunisations, contributing to national decisions on vaccine policy for multiple pathogens including COVID, *S. pneumoniae*, influenza, and RSV. He co-chairs the British Thoracic Society clinical statement committee for chronic *Aspergillus* lung disease.

***Aspergillus* lung disease in specific hosts: transplantation, immunocompromised and beyond**

Exposure to inhaled spores of *Aspergillus* species is ubiquitous but usually only leads to disease when there is an impaired immune response. The clinical pattern and speed of progression of *Aspergillus* infections is broad, and this is partially dependent on the type and extent of any underlying immune defects. Using case presentations linked to the recent British Thoracic Society Clinical Statement on *Aspergillus*-related chronic lung disease this lecture will summarise the main patterns of infection caused by *Aspergillus*, the interpretation of the different diagnostic tests within a given clinical context, and the potential treatment approaches.

Dr Hannah Burke is a Consultant Respiratory Physician at University Hospital Southampton NHS Foundation Trust, specialising in integrated COPD care. A dedicated clinician and researcher, she was awarded a Wellcome Trust funded PhD exploring the mechanisms underlying exacerbations in COPD in 2021. Committed to improving patient outcomes, Dr Burke leads the *"Optimise for Winter"* community COPD programme, a competitively funded initiative designed to enhance access to care and reduce hospital admissions. She also plays a key role in several national steering groups focused on advancing COPD care quality and policy.

Improving care in COPD by example

A review of the latest NRAP COPD clinical audit findings, with a deep dive into key performance indicator 6 - the delivery of the discharge bundle (KPI 6). We will highlight areas of good and poor practice and look at regional variability and how this might link to other patient outcome data such as mortality. We will explore the possible factors which may explain poor performance in delivery of COPD care. We will also present data on local initiatives to identify patients in the community who are at risk of exacerbation and admission to hospital and how this might be implemented at scale.

Dr Nazia Chaudhuri is a Respiratory Physician with a specialist interest in interstitial lung disease (ILD). She is Senior Clinical Lecturer at Ulster University and is lead of the Northern Ireland ILD network. She is Chair of the British Thoracic Society (BTS) ILD Registry Working Group and was Chair of the BTS Interstitial and Rare Lung Disease Specialist Advisory Group from Nov 2020 to 2023. She is also a member of the European Respiratory Society (ERS) ILD Long Range Planning Committee, an ERS ILD mentor and has just been appointed as the Secretary of the ERS Idiopathic Interstitial Pneumonia ILD Assembly. She is on the Irish Thoracic Society council and ILD working group. She is a trustee of the patient charity Pulmonary Fibrosis Northern Ireland (PFNI) and the NI Rare Disease Partnership.

Ms Aneeka Chavda is the senior lead pharmacist for Infection at Imperial College Healthcare NHS Trust. She is a committee member of the UK Clinical Pharmacy Association Infection Group and is a member of the British Thoracic Society Multi-Drug Resistant Tuberculosis Clinical Advice Service. Postgraduate education includes an MSc in Pharmacy Practice, a non-medical independent prescribing status and is currently a healthcare leadership fellow. Aneeka has particular interests' data-driven improvements in antimicrobial stewardship and the drug management of multidrug resistant tuberculosis.

Dr Colin Church is a Consultant in Pulmonary Vascular and Respiratory Medicine. He trained in Glasgow, Cambridge, Papworth and Sydney. He has completed a PhD in understanding the basic mechanisms of inflammatory signaling in pulmonary vascular remodeling. He has a keen interest in both clinical and basic science research and has been a principal investigator on a number of important clinical trials including looking at novel anti-inflammatory strategies to treat pulmonary hypertension. His interest also lies in the overlap between cardiovascular diseases and respiratory diseases especially airways diseases and fibrotic lung diseases and he is currently on a number of steering committees for the management of pulmonary hypertension in fibrotic lung diseases.

He is one of the members of the UK collaborative PH Cohort group which has informed better understanding of the proteomic, genomic and metabolomic pathology of pulmonary hypertension.

He is one of three consultants in the Scottish Pulmonary Vascular Unit which is the national referral centre for the Scottish population. He is Chair of the British Thoracic Society Specialist Advisory Group on pulmonary vascular disease and sits on the International Society for Heart and Lung Transplantation Education Oversight Committee. He was an associate editor for Journal Heart and Lung Transplantation and BMC Pulmonary Medicine.

Miss Hannah Collins is a Pleural Nurse Specialist at Addenbrooke's Hospital, Cambridge, with eight years of experience managing patients with pleural disease across acute and palliative settings. She is interested in integrating advanced nursing practice within pleural medicine and is currently completing her MSc in Advanced Nursing Practice. In addition to her clinical role, Hannah is CRN-funded to support pleural research and contributes to several ongoing studies. She is a core member of the NHS England Rare Disease Collaborative Network for Familial Pneumothorax and is a nursing representative on both the BTS Pleural Diseases Specialist Advisory Group and the UK Pleural Society.

Professor Richard Costello is a Professor of Respiratory Medicine in Respiratory Medicine at the RCSI and Consultant Respiratory Physician. He trained at Beaumont Hospital Dublin and later at the Johns Hopkins University Hospital, Baltimore, USA.

Professionally, he served as Chair of Education at the European Respiratory Society and previously served the Royal College of Physicians as Vice President, as well as roles as Director of Research and National Specialist Director of Training in Respiratory Medicine.

Academically, his work is focused on studying how digital technology can be used to optimise outcomes in patients with respiratory disease. He has published over 180 research papers and he holds five patents and is the founder of a spin-out company Phyxiom.

Inhaler monitoring technology – what does it add and where is it going?

Professor Costello will outline the clinical need for digital monitoring of inhalers, provide clinical evidence of their usefulness and cost effectiveness. The talk will also highlight how these technologies can be implemented into clinical practise in a severe asthma and COPD service.

Dr Emma Crawford is a Consultant Physician in Respiratory and General Medicine at the Princess Royal Hospital in Telford, Shropshire. She is an undergraduate tutor at Keele University Medical School and is the Programme Director for the lung cancer screening programme in Shropshire, Telford and Wrekin. She was the clinical lead for lung cancer within her hospital trust for seven years and maintains a specialist clinical interest in the diagnosis and management of people with lung cancer.

Developing as a consultant: setting up a new service, developing external roles and management opportunities

This presentation will explore some of the opportunities available to new and prospective consultants to augment their core job plan including roles in clinical service development, management and education. This introductory overview seeks to offer delegates some insights into how to consider and approach these opportunities. It will draw on personal experience to offer practical tips to support delegates to be confident and successful in developing this rewarding area of their portfolio.

Ms Helena Cummings is a Senior Respiratory Nurse Specialist who leads the severe asthma service in Hull and East Riding and supports the regional network across HNY. Additionally, she works as an independent ACP in primary care, providing expert respiratory support, education, and mentorship.

Committed to service development, Helena chairs the PCRS Service Development Committee and sits on committees within ARNS and SANN driving national respiratory improvements. She is a dedicated educator, sharing expertise across multiple platforms and founding the Humber Respiratory Champions Network to mentor emerging leaders in respiratory care.

Research is another key focus; Helena has participated in numerous studies and advocates for embedding research into clinical practice. Her unwavering enthusiasm for respiratory health drives her ongoing pursuit of optimal respiratory care.

Ms Gráinne d'Ancona is the Consultant Pharmacist for Respiratory Medicine at Guy's and St Thomas' NHS Foundation Trust and a senior lecturer at King's College London. She has contributed to national guidelines and training programmes, was a clinical champion for the asthma biologics rapid uptake programme of the NHSE Accelerated Access Collaborative and holds several national committee seats, most notably on the NHSE & NHSI Inhaler Sustainability Delivery Board, the RCP National Respiratory Audit Programme, and chairs the BTS Pharmacist Specialist Advisory Group. An advocate for integrated respiratory care and value-based interventions, her clinical roles include optimising care for patients with severe asthma, COPD, ILD and sleep disorders, in the hospital setting and also through virtual clinics in general practice. Her particular area of academic interest is medicines optimisation.

Miss Rachel Daly is the Lead Nurse and Deputy Service Lead for the Manchester Airways Service at the Northwest Lung Centre, Manchester University NHS Foundation Trust. She manages patients with inducible laryngeal obstruction, complex breathlessness and difficult to control asthma.

Rachel is a non-medical nurse prescriber and has a BA Hons in Respiratory Care. She has attended numerous national conferences presenting her work. Rachel is currently the only complex breathlessness specialist nurse and is leading the way in this field. She is an active member of the Northwest Severe Asthma Network and an elected member of the British Thoracic Society (BTS) Bronchiectasis Specialist Advisory Group, the Association of Respiratory Nurse Specialists (ARNS) committee as bronchiectasis lead and nurse representative for the European Respiratory Society(ERS) taskforce for transition in bronchiectasis.

MDT care for bronchiectasis in the UK; current issues, opportunities and challenges and role expansion

The talk will be delivered by Rachel Daly (nurse specialist) and Paul McCallion (specialist physiotherapist) who will emphasize the importance of MDT collaboration in caring for patients with bronchiectasis. They will highlight historic nursing and physiotherapy roles and how these roles have adapted and expanded in current practice. Learning points will include how development and expansion of roles can lead to better patient care, challenges and barriers to best practice will be explored, whist thinking about future opportunities and implementing effective collaboration in the workforce to improve bronchiectasis care.

Ms Tracey Daniels is the Non-Medical Clinical Lead at the York Hull Adult Cystic Fibrosis Centre, Clinical Lead for Innovation at the Humber and North Yorkshire Integrated Care Board and a joint York St John University/York and Scarborough Teaching Hospitals Research Fellow. She has worked with people with cystic fibrosis for over twenty years in four cystic fibrosis centres across the UK. Tracey is completing a PhD which is delivering the National Efficacy-Effectiveness CFTR Modulator Optimisation (NEEMO) programme. This focuses on using electronic data capture to understand the impact of co-adherence to inhaled therapies alongside CFTR modulators.

Remote care and adherence in respiratory medicine: lessons learnt from CF

You may be using remote care and virtual monitoring and be interested in what others are doing to use these technologies to optimise care and to support adherence. Or you may see virtual monitoring as a bit big brother; something we had to use during the initial Covid response but a relief to go back to usual care models. Even if these technologies and processes aren't things we as clinicians decide to reach for, it's likely that we will find them firmly in the toolboxes of people managing their long-term conditions. This session will describe the potential of these tools in our clinical and research toolbox and describe new opportunities to monitor health status, to understand and support adherence, and to deliver personalised care.

Dr Martin Dedicoat is a Consultant Infectious Diseases Physician at University Hospitals Birmingham. He is Clinical Lead for the Birmingham and Solihull Tuberculosis Service.

He also works for the UKHSA National TB Unit and National Mycobacterial Reference Service. He is currently Chair of the MDRTB Clinical Advice Service.

Case studies – the public health impact of missed and delayed TB diagnoses

Examples of the impact of delayed TB diagnosis will be presented. Ways to try and improve pathways will be presented.

Professor Anthony De-Soyza is an Academic Clinician / Physician-Researcher and an Honorary Consultant Physician at Newcastle upon Tyne Hospitals NHS Foundation Trust. His interests are in translational gaps particularly in bronchiectasis and COPD. Tony works with a fabulous MDT team of physios, nurses, microbiology, radiology and immunology in Newcastle looking after nearly 1000 adults with bronchiectasis. He has led a successful bid for an MRC Partnership grant in a multicentre approach to bronchiectasis and has set up the UK national registry in bronchiectasis "BRONCH-UK" 2014-2017 with further funding from the US COPD foundation. Tony also holds several NIHR HTA grants.

What does good bronchiectasis care look like according to guidelines/best practice?

- Highlight learning points from setting up a service
- MDT team working top tips
- Ensuring guideline compliance
- Experience of NHS management and business case development linked to patient safety and quality
- Embedding research into practice

Mrs Lynn Elsey is a Consultant Respiratory Pharmacist at Manchester University NHS Foundation Trust with a clinical interest in severe asthma. Lynn is currently undertaking a PhD exploring the impact of digital inhaler monitoring on adherence in asthma at the University of Manchester. She is also a member of the British Thoracic Society (BTS) Respiratory Pharmacist Specialist Advisory Group, represents the BTS on the Taskforce for Lung Health Treatment working group and is the pharmacist committee member on the NICE/BTS/SIGN asthma guidelines. She has an interest in sustainability and is a co-lead for the Centre for Sustainable Health Respiratory Sustainability Network.

Dr Odiri Eneje graduated from Imperial College School of Medicine, London and has an intercalated Bachelor of Science degree in Management. During her many years of specialist training, she completed the diploma of tropical medicine and hygiene before spending time working in rural South Africa looking after patients with complex lung infections. She has completed a Masters in Clinical Education at University College London, and has an educational interest in the use of simulation based training in medical training. Her PhD studies investigated the role of inflammation in cystic fibrosis. She is a Consultant in Respiratory Medicine at the Royal Papworth Hospital with a specialist interest in cystic fibrosis, complex lung infections and respiratory immunology.

Professor Matthew Evison qualified from Manchester University Medical School in 2004. He undertook specialist training in Respiratory Medicine 2008-2014 including a two-year fellowship in Thoracic Oncology at Wythenshawe Hospital, Manchester University NHS Foundation Trust, completing an MD degree in lung cancer diagnostics. Matthew was appointed as a Consultant in Respiratory Medicine (Thoracic Oncology) at Wythenshawe Hospital in 2014, and then Clinical Director for Lung Cancer for Greater Manchester Cancer from 2017-2023. Professor Evison was later appointed as Associate Medical Director for the Greater Manchester Cancer Alliance in 2023, and Clinical Lead for the Greater Manchester regional tobacco control programme 'Making Smoking History'. He is also a member of the British Thoracic Society Lung Cancer & Mesothelioma Specialist Advisory Group (SAG) and a Member of the British Thoracic Oncology Group Steering Committee. Matthew is also MASHC Honorary Clinical Chair, Faculty of Biology, Medicine & Health, University of Manchester.

Ms Mariana Fernandes is a Clinical Nurse Specialist at Guy's Severe Asthma Centre with a strong background in respiratory medicine. Her experience spans from working on a respiratory ward to intensive care before specialising in severe asthma care. A non-medical prescriber since 2020, she completed a MSc in Advanced Clinical Practice in 2024. Passionate about supporting patients with asthma, she serves as a vital link between patients and the multidisciplinary team, including primary care and other specialties. Mariana is committed to sharing best practices and continuously learning from colleagues to enhance patient care and outcomes.

SNOMED codes – How can we identify patients with severe asthma and improve their access to biological therapy?

The presentation explores how accurate clinical coding can improve outcomes for respiratory patients. A key focus is on understanding SNOMED codes, their role in identifying patients with severe asthma, and ensuring timely access to biological therapies. The session will highlight the importance of correct coding, the potential implications for patient care and healthcare finances when coding is inaccurate, and practical strategies for improving clinical coding. By leveraging structured data, clinicians can enhance disease identification, optimise treatment pathways, and improve patient outcomes in severe asthma care.

Professor Ben Forbes is Professor of Pharmaceutics with over 25 years of experience in inhaled medicines research at King's College London, where he has been Head of the Institute of Pharmaceutical Science since 2019. He has a BPharm from King's College London (1987) and a Ph.D. in Drug Delivery from Strathclyde University (1996). He is a pioneer in Inhalation Biopharmaceutics with interests in inhaled medicine formulation and the development of techniques to study respiratory drug transport, metabolism and inhalation toxicology.

New inhaler technologies: a look inside

This presentation explores the evolving landscape of orally inhaled drug products and the key factors driving change in this field. It will highlight the emergence of novel aerosolization technologies developed in response to clinical and regulatory needs. Attendees will gain insight into both the opportunities and technical challenges involved in reformulating inhaled medications, as well as the scientific principles underlying these innovations. From a scientific perspective, the talk will illustrate how advancing technology is not only ensuring continuity of inhaled therapies for asthma and COPD, but also opening new possibilities for delivering treatments for a broader range of diseases.

Dr Daryl Freeman is an associate Clinical Director with Norfolk Community Health and Care, the main provider of community care in Norfolk and Waveney. The role entails care of our frail in patients. Daryl is also one of two medical leads for the step-up community based virtual wards running across the entire Norfolk and Waveney footprint.

Following the formation of the ICB and its clinical work-streams, Daryl is the ICB Respiratory Clinical Adviser, working alongside other clinicians and managers to try to integrate respiratory care. The role aims to improve care for patients with respiratory disease in Norfolk and Waveney and meet the ambitions of NHSE by bringing care out of the acute setting and addressing health inequalities. This role entails being an active member of the East of England Respiratory Clinical Network.

Daryl is a keen member of the Primary Care Respiratory Society and is currently a member of the Service Development, Policy and Executive committees and is pleased to have been recently appointed as a Director to the UKLCC.

Daryl loves country life and is a keen walker and horsewoman and lives in rural Norfolk with her two dogs, two horses and long-suffering advanced paramedic partner.

Where is integrated care in 2025?

The presentation will discuss which regions have integrated respiratory services (IRS) and those which do not. In addition, the benefits and the barriers to setting up an IRS.

In particular the difficulties faced by those regions which have never had an integrated respiratory service focussing on ICB and NHS structure barriers, local objectives and objections and how these can be overcome. An overview of how services are provided – and by whom and how their priorities differ, from admission avoidance to earlier interventions (so called left shift) and how each structure benefits the patients and NHS as a whole.

Dr Freddy Frost is a Consultant Respiratory Physician at Liverpool Heart and Chest Hospital NHS Foundation Trust and Senior Lecturer at University of Liverpool. His clinical and research interests focus on aspects of complex lung infection the epidemiology of lung infection, the effects of antibiotics on the lung microbiome and multimorbidity implication including cardiometabolic comorbidities.

Ageing and metabolic syndromes in CF – does this help shape care for other lung diseases?

In this talk, Dr Frost will cover:

1. What is known about increasing multimorbidity in ageing CF patients?
2. What challenges this presents to the CF multidisciplinary team?
3. How these challenges are relevant to other lung diseases?

Dr Liz Fuller is a Consultant Respiratory Physician at Newcastle Hospitals NHS Foundation Trust and an Honorary Senior Lecturer at the University of Newcastle. In addition she is the Clinical Lead for Lung Cancer Screening for the Northern Cancer Alliance. Her research interests are lung cancer screening, early diagnosis and health inequalities of lung cancer. She is a member of the British Thoracic Society Lung Cancer and Mesothelioma Specialist Advisory Group and Lung Cancer Clinical Expert Group.

Dr Justin Garner qualified from Imperial College School of Medicine in 2008. He trained as a respiratory specialist in the Northwest Thames deanery and completed his PhD in Interventional Bronchoscopy under Professors Pallav Shah and Omar Usmani in 2020.

He has worked as a Consultant Respiratory Physician at the Royal Brompton Hospital since October 2021 in the Department of Lung Cancer and Interventional Bronchoscopy.

Dr Justin Garner has specialist expertise in:

- Management of lung cancer and pulmonary nodules (including robotic-assisted navigation bronchoscopy)
- Lung volume reduction (e.g., endobronchial valves) and novel interventional therapies for chronic obstructive pulmonary disease (COPD)
- Bronchial thermoplasty for severe asthma
- Transbronchial cryo-excision biopsy for interstitial lung disease
- General diagnostic and interventional bronchoscopy

His research interests include small airways disease, inflammatory biomarkers, and medical device innovation (ResearchGate).

Robotic bronchoscopy – where does it fit into the diagnostic pathway?

This presentation provides an overview of robotic-assisted bronchoscopy and how this is proving to be a game-changing technology for the management of peripheral pulmonary nodules.

Mrs Aleksandra Gawlik-Lipinski, an Advanced Nurse Practitioner and Independent Nurse Consultant, is a PhD Candidate at the University of Leicester, focusing her research on asthma mortality trends and predictors of asthma-related deaths in children. During her 18 years of healthcare experience, Aleks was involved in clinical practice, research, leadership, education, and policy shaping. She has spent the past nine years working clinically in general practice, specialising in respiratory medicine.

In addition to her clinical and academic roles, Aleks serves as a Clinical Fellow for Children and Young People's Asthma and as a Healthcare Improvement Coach for the National Respiratory Audit Programme (NRAP) at the Royal College of Physicians. She also holds leadership positions as Vice-Chair of the Association of Respiratory Nurse Specialists (ARNS) Research and Education Sub-Committee, Co-Chair of the British Thoracic Society (BTS) Nurse Specialist Advisory Group, and Co-Chair of the BTS Statement on the management of cough in children.

Audit data – how the NRAP Audit helps to inform areas for improvement and conduct QIP. Practical advice and good practice examples from around the UK.

Session outline:

1. What is NRAP and what data is available
2. How to identify areas for improvement (using an example of CYP or adult asthma data)
3. How to conduct a QIP in a nutshell, including a good practice repository

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Dr Yueqi Ge is a Respiratory Registrar in North West London currently out of programme for research (OOP-R) as a Clinical Research Fellow at the Royal Marsden Hospital. She joined the National Respiratory Audit Programme (NRAP) as Healthcare Improvement Fellow in summer 2024 working alongside Professor Alice Turner to develop and deliver NRAP healthcare improvement strategies.

NRAP Healthcare Improvement Programme

By the end of the session attendees will:

- Understand the role of the national respiratory audit programme (NRAP) in healthcare improvement
- Be able to describe the improvement support offered through health coaches and communities of practice
- Understand the value of teamwork in supporting improvement
- This session will delve into how NRAP supports healthcare improvement systematically. You'll hear from a multi professional team outlining:
- An overview of the NRAP health improvement programme and NRAP fellow role
- The role of coaches supporting teams to deliver respiratory health improvement
- Examples of real-world projects undertaken to improve respiratory care and outcomes including showcase of an out-patient collaborative project enabling patient optimisation prior to pulmonary rehab to improve uptake, completion rates and patient experience.

Dr Philippa Graff-Baker is a Consultant in Anaesthesia and Sleep Medicine at the University Hospitals of Leicester NHS Trust, and is also Lead Clinician for Sleep Medicine. Philippa is also Clinical Lead for high risk assessment hepatobiliary surgery and Anaesthetic Lead for enhanced recovery programme hepatobiliary surgery.

Pre-operative screening for OSA: What are the risks of surgery? Does diagnosis/treatment help? Critical appraisal of new guidance

To outline perioperative risk, the perioperative journey, the physiological factors that influence perioperative outcomes and how OSA contributes to this picture. Latest evidence and guidance.

Lizzie Grillo is an Advanced Physiotherapist at Guy's and St Thomas's Hospital (Royal Brompton Hospital) and is completing a PhD as an NIHR Research Fellow with Imperial College London. She has over 15 years of experience working in chronic disease and has a special interest in airway clearance, breathlessness, and breathing pattern assessment. Her PhD aims to look further at BPD assessment and develop our understanding of the utility of the Breathing Pattern Assessment Tool (BPAT).

She has published several articles in this area and supported guideline development with the British Thoracic Society. She is a member of the Association of Chartered Physiotherapists in Respiratory Care (ACPRC) and was a previous chair of this group. Additionally, she supports the Physiotherapy for Breathing Pattern special interest group in delivering their study days.

Dr Natasha Gunawardana is a Consultant in Adult Allergy at Cambridge University Hospital since 2023. She completed her allergy training in London at the Royal Brompton Hospital and Guy's and St Thomas's Hospital prior to moving to Cambridge. She has special interests in drug allergy, aeroallergen allergy and food allergy. She is the current British Society of Allergy and Clinical Immunology Adolescent and Young Adult Committee adult chair and previously held the role of Joint Scientific Programme Lead for the annual conference in 2023 and 2024. She is currently also a faculty member in the Imperial College London Allergy Msc.

Allergen immunotherapy: is there a role for this in asthma management?

Aeroallergen immunotherapy leads to a long-term modification of the underlying immune response in allergic asthma with clinical benefits that persist long after treatment has ended. Recent real-world data has confirmed the efficacy and safety of immunotherapy in asthma patients and in addition shows benefits in reducing respiratory tract infections. Recent GINA guidance has incorporated the use to house dust mite (HDM) immunotherapy in the treatment pathways for HDM – allergic asthmatics. There is the potential to further modify aeroallergen immunotherapy by the use of adjuvants and in combination with biologics to potentially improve both safety and efficacy in allergic asthma.

Dr Neil Hamilton is Consultant Pharmacist and Clinical Pharmacy Research Lead at Sheffield Teaching Hospitals, currently managing over 2100 patients on targeted PH therapies. Neil is an independent prescriber and has developed a specialist interest in pulmonary vascular diseases since 2003. In addition to his local role, Neil is the current Chairman of PH Professionals; the UK group of allied healthcare professionals involved in the care of patients with PH. He is also the PH Pharmacist on NHS England's Specialist Respiratory Clinical Reference Group.

What's new in pulmonary hypertension: update from the world

The update from the 7th World Symposium on Pulmonary Hypertension will include:

- Headline changes in practice from the 7th World Symposium 2024
- Diagnosis and classification of pulmonary hypertension
- Current guidelines for treatment of pulmonary hypertension
- Managing patients with cardiac and respiratory co-morbidities
- New and exciting treatments, focussing on sotatercept.

Mr Chris Harding is Chief Respiratory Physiologist and CPET Service Lead for Cambridge University Hospitals. He has been working in respiratory physiology for 11 years following a BSc in Sport and Exercise Science from the University of Bedfordshire.

Cardiopulmonary exercise testing – discussing the benefits of a scientist led CPET service, example case studies illustrating the role of CPET in managing the breathless patient

This presentation aims to demonstrate how, using real case studies, a scientist-led cardiopulmonary exercise test service can be used in the diagnosis and treatment of patients with unexplained breathlessness. By assessing, via CPET, how exercise ability is provided by the cardiovascular, respiratory and metabolic systems this talk aims to show how this overview can be used to highlight causes for symptomatic patients that are not always reflected from individual system assessments.

Dr Natalie Harper currently works as a Respiratory Consultant Nurse in Dorset running nurse led respiratory clinics in three community hospitals and an acute hospital covering a range of respiratory conditions.

Natalie completed her BSc Hons in Respiratory Care in 2012. She continued along the education path completing her MSc in advanced practice in 2016 and her Doctorate of Professional Practice in 2024.

In 2019 Natalie was awarded the title of Queens Nurse in recognition of her commitment to high standards of patient care and continually improving practice. At present she works with National organisations such as, UKIG, BTS SAG for nurses, Asthma + Lung UK Council of Healthcare Professionals and the RCP on the National Asthma Audit.

Professor Adam Hill is an Honorary Consultant Chest Physician at the Royal Infirmary of Edinburgh, Professor of Respiratory Medicine, University of Edinburgh, and Dean of Post Graduate Medicine, NHS Education for Scotland. He is actively involved in clinical and translational research in respiratory infection, chaired the revision of the British Thoracic Society Bronchiectasis Guidelines and Quality Standards, and is currently Chair of the BTS Standards of Care Committee.

Burden of disease: guideline compliance and challenges; QI opportunities

There is a significant bronchiectasis burden affecting about 0.5% of the population in high income countries. The BTS guidelines have been helpful in providing stepwise management for patients with bronchiectasis and the quality standards created aim to improve respiratory care for bronchiectasis on a national level. Audits have highlighted, however, that much work is needed. This session will highlight key areas for improvement and represent ideal opportunities for quality improvement work.

Dr Lizzie Hill is a Clinical Scientist with over 20 years' experience of working with adults and children with sleep disorders in clinical and research settings. She is currently a Senior Lecturer in Sleep Physiology at the University of the West of England (UWE Bristol), where she leads the PGCert Sleep Medicine programme, commissioned and funded by NHS England to address the skills gaps in clinical sleep services (https://courses.uwe.ac.uk/C9P100/sleep-medicine). Lizzie gained her PhD by research at The University of Edinburgh in 2016, examining prevalence and treatment of obstructive sleep apnoea in adults with Down syndrome. She is a Society Rep for The Physiological Society, Past President of the European Society of Sleep Technologists and previously served as the Education Lead of the British Sleep Society.

Professor Timothy Hinks is a Group Leader at Oxford University, where his group researches the immunology of airways diseases and airways infections. After training at Cambridge and Oxford, and predoctoral research into TB immunology he undertook a PhD in Southampton on T cell responses in asthma, with subsequent postdoctoral research in Melbourne studying pulmonary MAIT cells. In 2017 he established his group at Oxford focusing on the role of asthma immunology using bronchoscopies, single cell and spatial technologies. As an Honorary Consultant and Associate Professor he co-leads the Severe Asthma Service at the John Radcliffe Hospital.

Obesity and asthma: more than 'just steroids'

Obesity affects one third of severe asthma, and drives a quarter of hospital asthma admissions, more than smoking, GORD, rhinosinusitis, anxiety and depression combined. Maternal obesity increases asthma risk in children by 15-30%. Obesity is also associated with late onset asthma. Mechanisms include physical restriction of lung function, induction of airway hyper-responsiveness, systemic IL-6 mediated inflammation, and effects on inflammasome, surfactant protein and steroid-responsiveness. Over-use of beta agonists and systemic steroids must be minimised. Patients require lifestyle interventions, and bariatric surgery if possible. The advent of GLP1-receptor agonists will likely make ORA the most important treatable trait after type 2 inflammation.

Mrs Ola (Aleksandra) Howell is an NIHR Clinical Academic Doctoral Fellow at the University of Oxford, researching the use of COPD rescue packs. A pharmacist with 15 years of experience, she is also an Independent Prescriber and Advanced Clinical Practitioner. Ola has worked across primary, secondary and tertiary care, led NHS health innovation projects and is a visiting lecturer. She is a member of the BTS COPD Specialist Advisory Group and the PCRS Policy Forum.

Dr Gareth Hughes is a Consultant in Intensive Care and Respiratory Medicine at Bolton NHS Foundation Trust where he is the Subspecialty Lead for ILD and the Director of Medical Education. He is a Senior Lecturer at the University of Manchester and the University of Greater Manchester involved with teaching medical students and advanced clinical practitioners. He has undertaken further postgraduate studies in workplace based postgraduate medical education and health care ethics and law. Dr Hughes is actively engaged in clinical research and has experience as a principal investigator and co-investigator in a range of phase 2 - 3 clinical trials covering respiratory and critical care medicine.

Professor (Hon.) James Hull PhD FRCP FACSM is a respiratory physician at the Royal Brompton Hospital and leads a sports pulmonology service at the Institute of Sport, Exercise and Health (ISEH), UCL, London. His clinical and research interests are centred on helping athletic individuals overcome sports-related respiratory issues. He is an advisor to the International Olympic Committee, UK Sports Institute and Team GB and several elite sporting organisations, include EF Pro cycling.

In search of marginal gains - when elite sport meets respiratory health

In this presentation, Prof. (Hon.) James Hull will consider and discuss the interface between sport and respiratory health. He will describe the potential (bidirectional) translational benefits of considering how sporting organisations optimise health and how we can use this approach to help provide best care, citing examples from his work within elite sporting organisations.

Ms Tamanna Kabir is a Clinical Nurse Specialist in Occupational Lung Disease at the Royal Brompton Hospital, London. She works with patients and the multidisciplinary team to run a weekly occupational lung disease clinic for patients. She carries out nursing assessments including allergy and lung function testing, and also provides education and training for both patients and colleagues in occupational lung disease. Tamanna has a background in community nursing, communications in the charity sector, and a previous undergraduate degree in Psychology.

Ms Hanna Kaur is the TB Lead Nurse for Birmingham and Solihull TB Service. She has been working in TB since 2008. During this period, she has also worked in London.

Her background is intensive care nursing and occupational health. Hanna is currently undertaking some work round health inequalities.

Case studies – the public health impact of missed and delayed TB diagnoses

Case study to discuss the implications, in terms of public health impact and delay in commencing treatment.

Aim: to understand the impact delays have upon treatment starting and contact tracing.

Dr Jenny King is a Specialty Trainee in Respiratory Medicine in the North West of England. She has recently completed her PhD in the field of chronic cough at the University of Manchester and Manchester University NHS Foundation Trust. Her PhD focussed on mechanisms of cough in lung diseases including Idiopathic pulmonary fibrosis, chronic obstructive pulmonary disease and asthma. She has also set up a patient support group for patients with chronic cough at Manchester University NHS Foundation Trust.

Pharmacological management of chronic cough: the what, the when, and the how

This presentation will focus on the treatable traits approach to managing patients with Chronic Cough. We will discuss the practical application of the BTS Clinical Statement on Chronic Cough in Adults and discuss the evidence base behind these recommendations. There will also be an update on new drug development in Chronic Cough. At the end of the session attendees should have a clear understanding of how and when to use, monitor and stop different pharmacological treatments in Chronic Cough patients.

Dr Ayesha Kumar is a Consultant Respiratory Physician in Liverpool University Hospitals Foundation Trust. Dr Kumar completed her CCT in August 2023 after training in both Manchester and Liverpool. She now works as a respiratory physician with a subspeciality interest is in sleep and ventilation. Dr Kumar is currently a member of the BTS Education and Training Committee.

Miss Jodie Lam is a Clinical Nurse Specialist and Lead Nurse for the Adolescent Transition Clinic at Guy's Hospital Severe Asthma Centre, where she leads a dedicated adolescent clinic for young adults with asthma aged 16-24 years old. She has previously worked in acute medicine and respiratory research and has always had a keen interest in respiratory medicine. She is currently working towards her masters in Advanced Clinical Practice at King's College London.

Transition of young people with severe asthma: how, when, where

The ever-changing societal landscape and multi-faceted psychological aspects of adolescence contribute to the complexity of managing any long-term illness. Asthma is the most prevalent chronic respiratory disease both in children and adults. Adolescents are not simply older children and do not automatically transform into independent adults, nor do they become proficient in self-management of their condition overnight. Adolescence is a high-risk time for many people with asthma, with increased risk of asthma-related morbidity and mortality.

Recognising adolescents and young adults as a distinct patient population with unique healthcare needs and risks is critical when developing a service. Young people's unique perspectives and experiences require us to design healthcare services that are flexible, reactive and multidisciplinary. This session will highlight how such services develop and grow.

Mrs Tracey Langham qualified as a nurse in 1991 and began her career on a respiratory ward at the Royal Berkshire NHS Foundation Trust. In 1998, she transitioned to the respiratory outpatient department, where her interest in tuberculosis (TB) care began. She progressed to Lead TB Nurse, overseeing clinical services and outpatient care. Tracey completed a master's degree in advanced practice, including non-medical prescribing, and contributed to the development of nurse-led TB screening and treatment clinics. In 2021, she joined the UKHSA National TB Unit where she continues to work as the Lead Nurse, supporting the TB workforce and delivering the TB Action Plan for England.

Dr Alice Lee is a paediatric respiratory GRID trainee and PhD student in the North West.

Her research interests are primarily around child poverty, respiratory health inequalities, and place-based interventions. As part of Dr Lee's PhD she co-designed and managed the Respiratory Parent Champions in the Community programme with Liverpool City Council Children's Centres.

How to talk to your patients about environmental exposures and respiratory health

This session will focus on practical communication strategies to help clinicians talk to patients and families about environmental exposures and respiratory health. Featuring Dr Lee in conversation with Professor Sinha, who developed the UK's first clean air clinic, the session will include insights from parent champions and case examples.

Topics include discussing environmental risks, engaging with landlords and housing agencies, and supporting families to reduce harmful exposures. Educational aims are to improve clinician confidence, enhance person-centred care, and highlight the clinician's role in addressing environmental risk factors and advocating for healthier living conditions.

Mr Andy Lee is Specialty Lead ACP in Nottingham having started his training post in 2015. There is currently a team of 14 qualified and trainee ACPs working across multiple inpatient areas. He started his career as a HCA in 2002 at Stoke Mandeville Hospital in Buckinghamshire before starting his Nurse training at De Montfort University in 2004. Andy began his clinical career on a vascular surgery ward before moving to a respiratory and cardiology admissions unit. Prior to starting his MSc in Advanced Clinical Practice Andy worked as a Critical Care Outreach Nurse across all three hospitals in Leicester.

Andy is passionate about workforce development and in particular training and retention of staff from ward nurses through to specialist nurses and beyond.

Advanced practice in respiratory: building a workforce for the future

The presentation will aim to highlight the growing numbers of advanced practitioners within respiratory medicine from the beginnings through to where it is moving in the future. It will cover the BTS career framework for advanced practitioners, RCP/NHSE capabilities in practice document along with a discussion around roles currently filled by advanced practitioners across England.

Professor Wei Shen Lim is Consultant Respiratory Physician at Nottingham University Hospitals NHS Trust and Honorary Professor of Medicine, University of Nottingham. His research activities are in the field of acute respiratory infections, including pneumonia, pneumococcal infections and influenza. He is Chair of the Acute Respiratory Infections National Research Strategy Group, NIHR Respiratory Translational Research Collaboration. He developed the CURB65 severity scoring tool for community acquired pneumonia and co-led the evaluation of Dexamethasone for COVID-19 in the RECOVERY Trial.

Difficult to treat pneumonia: who, where, what

This presentation will discuss potential approaches to the management of a patient with pneumonia who does not respond to treatment as might be expected.

Dr Kate Lippiett (BA (Hons), MSc, RGN, PhD) is a nurse academic with a joint role. First, as Senior Research and Knowledge Mobilisation Fellow at the University of Southampton/NIHR Applied Research Collaborative Wessex. Second, as a Clinical Research Fellow in Primary Care for NHS England South West.

Nursing and allied health professional workforce issues and changing landscape (mapping the respiratory nurse specialist workforce)

This presentation will set out the issues that the mapping of the respiratory nurse specialist workforce is intended to address: a lack of understanding of respiratory nurses capabilities; problems with recruiting and retaining respiratory nurses and inconsistency in financial remuneration. It will highlight how it aligns with the Association of Respiratory Nurses' research strategy and existing initiatives such as the COPD audit. It will set out plans for the mapping and future steps.

Dr Joe Mackenzie is a Consultant in Respiratory Medicine working in NHS Fife, predominantly at Victoria Hospital Kirkcaldy. Subspecialty interests include pleural disease and lung cancer. He is part of a pleural service providing weekly thoracoscopy lists and pleural clinics, and also has a regular ultrasound-guided biopsy list to support the lung cancer service. He qualified with an MBChB in Medicine from Aberdeen in 2007, and undertook specialty training in Respiratory Medicine in the Northeast of England, before moving to Fife to take up a consultant post in 2016. Interests outside work include running, football, cycling and climbing.

Medical thoracoscopy and image guided biopsy – the why, what, when and how?

Have you ever wondered about the optimal route to a diagnosis for your patient with pleural disease, but been too afraid to ask? Then this talk is for you! This talk will explain how thoracoscopy and image guided biopsy are performed, with a discussion of the "pros" and "cons" of each approach, and where they fit in the diagnostic pathway. There will also be discussion of day-case thoracoscopy and intra-pleural anaesthesia.

Dr Abigail MacKintosh is a Respiratory Registrar training in the West Midlands Deanery. She graduated from the University of Birmingham in 2013 and has been a registrar since 2018. In July 2023 she took up the role of Chair for the BTS Speciality Trainee Advisory Group. Dr MacKintosh has a particular interest in education and training, and during her time in this role would like to get trainees across the country connected and sharing areas of good practice to improve everyone's training.

Professor Nick Maskell undertook his DM thesis on pleural diseases in Oxford prior to taking up a consultant post at North Bristol NHS Trust in 2003. He was awarded a national Walport Senior Lecturer award in 2005 and joined University of Bristol. His research interests include clinical trials in pleural infection, pneumothorax, pleural malignancy, mesothelioma and patient safety during pleural procedures. He leads the Academic Respiratory Unit (ARU) at the University of Bristol and the Respiratory theme of the Bristol BRC. He is an NIHR senior investigator and currently the Chief Investigator for a number of NIHR multi-centre randomised controlled trials. His current H-index is 70 with over 280 peer reviewed publications and 24000 citations. He is part of the faculty of the newly developed ERS thoracic ultrasound certified training programme. He co-chaired the 2018 BTS mesothelioma guidelines, the 2019 ERS malignant pleural effusion taskforce statement, the 2023 BTS pleural disease guidelines, 2024 ERS pneumothorax guidelines. Nick is the Chairman of the Board of Trustees for Mesothelioma UK and President for the British Thoracic Society.

Dr Rachel Massey-Chase has been the Lead Clinical Psychologist in the Adult CF Centre at King's College Hospital since 2012. The service currently cares for 300 CF patients across the South East of England. Rachel is an active member of the CF community, she is co-chair of the UK Psychosocial Professionals in CF (UKPPCF) Group and has previously presented at both the European and North American CF conferences in addition to regularly collaborating with the Cystic Fibrosis Trust.

Navigating the psychosocial challenges of CF: should we be doing more to support people with chronic respiratory disease?

Clinical psychology has been a core, embedded member of the multidisciplinary team for the care of cystic fibrosis patients for many years. This presentation will explore the psychosocial challenges facing patients with CF (both in terms of mental health and health management difficulties) and how services have evolved to meet these needs. We will discuss the recently published guidelines for UK clinical psychology services in cystic fibrosis and reflect on transferable learning for other respiratory services.

Ms Trish Matharu graduated as a Respiratory Physiologist from Swansea University in 2011, attaining a clinical role at University Hospitals of Coventry and Warwickshire (UHCW). She is Deputy Head of Service, where she leads the Sleep Service at UHCW. In 2016, Trish attained HCPC registration as a Clinical Scientist and currently holds a place on the Higher Specialist Scientist Training (HSST) programme. Trish is Editor of the Association for Respiratory Technology and Physiology (ARTP) Newsletter for Sleep Sciences, SNEWS. Her area of interest within sleep sciences includes narcolepsy and idiopathic hypersomnolence. Trish also guest lectures for Swansea University on the topic of polysomnography.

COPD-OSA overlap syndrome: is there a case for screening and if so, who?

This session will aim to address the question is there a case for screening patients with COPD/OSA syndrome and if so, who? The content will address COPD/OSA overlap as a syndrome and its presentation amongst patients. The presentation will explore the use of sleep studies when diagnosing this condition. Evidence around screening tools will be discussed, evaluating what is currently being used and if it is effective. On diagnosis of COPD/OSA overlap syndrome, treatment currently used will be explored and adherence to treatment reviewed.

Mr Paul McCallion is an Advanced Respiratory Medicine Physiotherapist with a specialist interest in bronchiectasis and research. He is the Clinical Lead for the Newcastle upon Tyne Hospitals NHS Foundation Trust Physiotherapy Respiratory Outpatient Service. Paul is also a current NIHR PhD Fellow - his PhD is looking into the use of Shared Decision Making to support patients with their Airway Clearance Techniques in bronchiectasis. Paul holds the Long-Term Conditions role for the Association of Chartered Physiotherapists in Respiratory Care in the UK (www.acprc.org.uk).

MDT care for bronchiectasis in the UK; current issues, opportunities and challenges and role expansion

The talk will be delivered by Rachel Daly (nurse specialist) and Paul McCallion (specialist physiotherapist) who will emphasize the importance of MDT collaboration in caring for patients with bronchiectasis. They will highlight historic nursing and physiotherapy roles and how these roles have adapted and expanded in current practice. Learning points will include how development and expansion of roles can lead to better patient care, challenges and barriers to best practice will be explored, whist thinking about future opportunities and implementing effective collaboration in the workforce to improve bronchiectasis care.

Dr Will McConnell has been a Consultant Respiratory Physician at Dorset County Hospital since 2001, having trained in Oxford and Wessex. His main areas of respiratory interest are in asthma and COPD and integrated respiratory care, and he has developed a population health management database of asthma and COPD patients in Dorset. He leads the Dorset Respiratory Clinical Network and is one of the clinical co-leads of the South West Respiratory Network.

How can technology help you to improve your patients' care and make your life easier? The solutions implemented in Dorset

Dr McConnell will present how he has supported the development of the Dorset Intelligence and Insight Service Respiratory database to enable the respiratory population beyond the hospital to be managed more pro-actively. Attendees will learn how this approach can be used to optimise preventative care, ensure that the right people are seen by specialist care and assess the impact of population interventions on health outcomes.

Dr Gerard Meachery is a Consultant in Respiratory and Transplant Medicine and Joint Director of the Cardiothoracic Transplant programme based at the Freeman Hospital in Newcastle Upon Tyne, UK. He is member of the UK Cardiothoracic Advisory Group (CTAG) and President of the Freeman Heart & Lung Transplant Patient Association (FHLTA). He has focused on building strong national and international training and educational partnerships and is an Honorary Associate Professor for the RCSI UCD Medical Campus (RUMC) in Penang, Malaysia. His interests focus on service improvements, clinical lung transplant outcomes, supporting clinical trials in CLAD and medical education.

Lung transplantation for ILD: how has it evolved?

1. Understand the indications for lung transplantation in ILD patients, including timing and criteria for referral.
2. Outlining key factors and evaluation of prognostic factors that inform MDT clinical decision making in ILD and lung transplantation outcomes.
3. Knowledge application through case-based examples.
4. The importance of monitoring and managing the ILD patient on a lung transplant waiting list.
5. Key factors in managing the post-lung transplant patient in an acute setting.
6. Review developments of novel approaches to deal with the continued lack of suitable donor organs.

Dr Meera Mehta is a Respiratory Registrar at Imperial College NHS Trust, with a specialist interest in complex pulmonary infection. She has completed her PhD investigating the non-lytic escape of mycobacterium tuberculosis from macrophages.

Trainee case presentation – Complex pulmonary infection with resistant organisms

Invasive fungal lung infection (IFI) is poorly recognised and often diagnosed late. There is a rapidly expanding body of immunosuppressed patients, as well as those on long term antifungal therapy; as respiratory physicians, we are likely to be involved in an increasing number of these cases. We present one such case that highlights the clinical and diagnostic complexities in IFI, and how we might better recognise and approach the diagnosis. We also discuss management options to improve outcomes in these difficult to treat diseases with high mortality and morbidity.

Dr Fraser Millar is a Respiratory Consultant at the Royal Infirmary of Edinburgh and Honorary Senior Clinical Lecturer at the University of Edinburgh. Dr Millar completed his early training in London before moving to Edinburgh to continue his research and clinical speciality training. He has a clinical and research interest in early-stage lung cancer, interventional pulmonology and novel early detection approaches.

Dr Andrew Molyneux is a Consultant Respiratory Physician, Sherwood Forest Hospitals. He trained and did his PhD in Health Services Research in Nottingham and the East Midlands. He has been a consultant for 21 years with interests in sleep/NIV and COPD/asthma. Andy's interest in QI and patient safety, particularly in the delivery of acute NIV, stems from his involvement in NCEPOD Inspiring Change. He has worked with NICE, chairing the COPD and Melanoma Guideline Committees, and Co-Chairing the BTS/NICE/SIGN Asthma Guideline Committee, and is the current Chair of the BTS Quality Improvement Committee.

Dr Vicky Moore is a Clinical Scientist and Deputy Lead for Respiratory in the Respiratory and Sleep Sciences Department at University Hospital Coventry and Warwickshire (UHCW). Her specialist interests include asthma and occupational asthma, causal agent identification, specific and non-specific challenge testing, lung function testing and CPET. She is a keen researcher in these areas. She runs clinics in occupational asthma at UHCW and with the team at the Birmingham Chest Clinic. She completed her PhD in this area in 2010. She is the current ARTP/BTS rep and before this was the ARTP Education Chair. She is also a member of the ERS spirometry group. She is passionate about supporting training and education in respiratory physiology.

Dr Rachael Moses OBE is a Consultant Physiotherapist who specialises in critical care and respiratory medicine. Rachael has been fortunate to hold a number of leadership positions over the years and is an active humanitarian aid worker. Rachael is very proud to have been as appointed the 4th female BTS President and is hopeful to see more women in senior leadership positions within the society.

Dr Fiona Mosgrove is a GPwSI respiratory medicine working in Aberdeen. She works clinically as a GP and as part of the difficult asthma clinic in Aberdeen Royal Infirmary. She is currently undertaking her PhD, part time, in Bronchiectasis. She sits on the ACT on COPD working group in Scotland and the Education Committee for the Primary Care Respiratory Society.

Professor Anna Murphy is Professor of Pharmacy Practice at De Montfort University, Leicester and a Consultant Respiratory Pharmacist at University Hospitals of Leicester NHS Trust. With over 25 years' experience in respiratory medicine, Anna has contributed to national guidelines, sits on the BTS Council and Workforce committees, and co-chairs the Medicines Optimisation group for the Taskforce for Lung Health. She is author of Asthma-in-Focus and creator of the "7-Steps to Success" inhaler education materials. Her research focuses on improving respiratory care, education, and medicines adherence.

Balancing inhaler options – how to work with patients to choose the best sustainable device

This presentation explores how to balance clinical effectiveness, patient needs, and environmental impact when choosing inhaler devices. It aims to equip healthcare professionals with the knowledge and skills to compare different inhaler types, understand their sustainability profiles, and engage patients in shared decision-making. Emphasis is placed on practical approaches to assessing patient ability and inhaler technique, as well as strategies for supporting appropriate switching when needed. By the end, participants will be better prepared to make informed, patient-centred, and environmentally responsible inhaler choices in clinical practice.

Dr Alexandra Nanzer is a Consultant Respiratory Physician at Guy's Severe Asthma Centre and an Adjunct Senior Lecturer at King's College London where she obtained a PhD in asthma immunology at the Peter Gorer Department of Immunobiology at King's College London, supported by Asthma UK. She has a special interest in adolescent asthma, and she leads the regional Asthma Transition Service together with paediatric teams in South East England. She has developed a large specialist, multi-disciplinary clinic for adolescents and young adults with asthma at Guy's and she has spoken and published on transitioning asthma care at national and international events including editing of a Monograph book series for the European Respiratory Society on Transition of Care in Respiratory Medicine.

Transition of young people with severe asthma: how, when, where

The ever-changing societal landscape and multi-faceted psychological aspects of adolescence contribute to the complexity of managing any long-term illness. Asthma is the most prevalent chronic respiratory disease both in children and adults. Adolescents are not simply older children and do not automatically transform into independent adults, nor do they become proficient in self-management of their condition overnight. Adolescence is a high-risk time for many people with asthma, with increased risk of asthma-related morbidity and mortality.

Recognising adolescents and young adults as a distinct patient population with unique healthcare needs and risks is critical when developing a service. Young people's unique perspectives and experiences require us to design healthcare services that are flexible, reactive and multidisciplinary. This session will highlight how such services develop and grow.

Dr Shamsa Naveed is a Respiratory Consultant and Severe Asthma Lead in University Hospitals of Leicester. Her research interests are medication compliance (and its effect on asthma control) and mechanisms of airway remodelling in airway disease. She chairs regional Severe Asthma MDT in East Midlands region and regularly takes part in training and up-skilling of primary and secondary care asthma teams.

Mr Darshan Negandhi is an adept PCN and community pharmacist, and possesses a profound understanding of the evolving landscape of primary and community care. His insights into the shifting workloads are pivotal for pharmacists striving to meet the objectives outlined in the NHS Long Term Plan and the GP Recovery Plan.

With a firm belief in the transformative potential of Pharmacy First services, Darshan sees these as foundational to a clinical future that aligns with the rigorous training pharmacists undergo. He envisions these services as a stepping stone to broaden the scope of pharmacists' knowledge and expertise.

As a Superintendent Pharmacist and the Director of an independent pharmacy, Darshan's commitment extends beyond his administrative duties. He is passionate about postgraduate education and takes great satisfaction in imparting knowledge through teaching. For Darshan, it's about channelling his passion into a purposeful direction, shaping the future of pharmacy with every endeavour and delivering patient outcomes.

Confident prescribing in tobacco dependence including swap to stop

This presentation is an educational session designed to equip healthcare professionals with the knowledge and confidence to support patients in stopping smoking using evidence-based pharmacological and behavioural strategies. The presentation covers the physiology of nicotine addiction, first-line treatments (NRT, varenicline, bupropion, cytisinicline), and introduces the 'Swap to Stop' approach, highlighting the role of e-cigarettes under NICE guidance. It emphasizes personalised care, prescribing algorithms, and motivational interviewing, with special focus on populations such as pregnant individuals and those with mental health conditions. The aim is to enhance clinical confidence in offering comprehensive tobacco dependence support.

Professor Caitlin Notley leads the Public Health Research Department and the Addiction Research Group at the University of East Anglia. She is a social scientist, with research expertise in clinical trials and applied mixed methods. Her particular areas of expertise are tobacco smoking cessation, relapse prevention and harm reduction. She is Editor-in-Chief for the journal 'Nicotine and Tobacco Research', co-chairs the Cancer Research UK E-Cigarette Research Forum, and is also an author of the Cochrane 'E-cigarettes for smoking cessation' living systematic review.

The science behind the conversation – talking to people about harm reduction in the context of multiple health problems including mental health problems

This presentation will discuss the evidence on supporting people to switch away from smoking tobacco, recognising that people have complex lives and often present with multiple physical and mental health comorbidities, so may not be actively considering smoking cessation. The presentation will aim to demonstrate how to have effective conversations drawing on training resources developed for the 'cessation of smoking in the emergency department' (COSTED) trial. Theory and evidence underpinning approaches will be emphasised and signposting to training resources will be included.

Miss Lucy O'Donoghue is currently employed at George Eliot Hospital NHS Trust as a Principal Physiotherapist in Respiratory. She leads the Pulmonary Rehabilitation and Outpatient Respiratory Physiotherapy service across North Warwickshire. She has been working in respiratory care for 10 years.

NRAP Healthcare Improvement Programme

By the end of the session attendees will:

- Understand the role of the national respiratory audit programme (NRAP) in healthcare improvement
- Be able to describe the improvement support offered through health coaches and communities of practice
- Understand the value of teamwork in supporting improvement
- This session will delve into how NRAP supports healthcare improvement systematically. You'll hear from a multi professional team outlining:
- An overview of the NRAP health improvement programme and NRAP fellow role
- The role of coaches supporting teams to deliver respiratory health improvement
- Examples of real-world projects undertaken to improve respiratory care and outcomes including showcase of an out-patient collaborative project enabling patient optimisation prior to pulmonary rehab to improve uptake, completion rates and patient experience.

Dr Rakesh Panchal is a Consultant Respiratory Physician at the University Hospitals of Leicester NHS Trust in the UK. He has a specialist interest in pleural diseases and interventional bronchoscopy for which he is the Lead Clinician. Dr Panchal is a member of the Institute for Lung Health and plays an active role in both undergraduate and postgraduate education. He is an Honorary Associate Professor in Respiratory Sciences and Medical Education at the University of Leicester, a College Tutor for the Royal College of Physicians (RCP) London and the East Midlands RCP/BTS Regional Specialty Advisor for Respiratory Medicine. Dr Panchal is a principal investigator on a number of pleural research trials. Dr Panchal has been invited to speak and host practical courses both locally and internationally and offers a popular Interventional Pulmonology Fellowship that has trained people from the UK, Europe, Australia and New Zealand.

Ms Maria Parsonage currently works in North Cumbria as a Respiratory Consultant Nurse and has specialised in pleural disease for almost 20 years. She is the Pleural Lead for NCIC and has a passion for developing equitable pleural services across North Cumbria after relocating from the Wirral in 2023. She has co-authored the National Patient Safety Alert (2020) Deterioration due to rapid offload of pleural effusion fluid from chest drains, the British Thoracic Society (2023) Pleural Disease Guidelines and Pleural Procedures Training Standards (pending publication 2025) and sits on the Mesothelioma UK clinical expert panel. Maria is the Secretary of the European Respiratory Society (ERS) Thoracic Oncology Assembly 11 and the Chair of the Association of Respiratory Nurses (ARNS).

Indwelling pleural catheters – a patient centred approach?

Indwelling pleural catheters (IPC) are a highly effective intervention when it comes to managing symptoms such as breathlessness, anorexia and fatigue associated with the burden of pleural disease. For many, quality of life is vastly improved. However, shared decision making is vital to ensure patients understand how to navigate potential difficulties as well as the benefits of IPC's when taking consent.

Miss Padmavathi (Padma) Parthasarathy is an Advanced Nurse Practitioner in Acute Respiratory Medicine at University Hospitals of Leicester NHS Trust. She began her nursing career in India and has worked in the United Kingdom since 2000, building a diverse clinical portfolio spanning surgery, orthopaedics, high dependency care, critical care, emergency medicine, respiratory care, and clinical research.

She completed her MSc in Advanced Clinical Practice in 2016 and developed a specialist interest in respiratory medicine during her work in critical care and critical care outreach. Her clinical focus is on the management of patients with acute respiratory conditions, and she is currently based within the acute respiratory admissions unit.

Padma is committed to advancing high-quality, evidence-based care and is actively engaged in clinical education and service development. She delivers regular multidisciplinary teaching, leads local quality improvement initiatives, and supports professional development within her team. She previously completed a three-year term on the British Thoracic Society (BTS) Standards of Care Committee, contributing to national guidance and quality standards.

She currently serves as a member of the BTS Education and Training Committee and Co-Chair of the BTS Nurse Specialist Advisory Group. A strong advocate for the advancement of the ACP role in respiratory medicine, Padma is Vice-Chair of the Respiratory ACP Network and was a key contributor to the development of the national Respiratory ACP Curriculum, now available through Health Education England.

Mrs Donna Peat is an Advanced Clinical Practitioner working at Lancashire Teaching Hospitals NHS Foundation Trust, with over 20 years' experience in critical care and acute medicine. Donna currently works as the Respiratory ACP team lead and Respiratory virtual ward clinical lead. Her clinical role focuses on the acute management of patients presenting with a respiratory condition with a focus on acute asthma and COPD. Donna has a keen interest in improving the management of the acutely unwell patient within secondary care and exploring ways in which patient care can be transformed utilising quality improvement methodology to streamline pathways and provide healthcare that is accessible to all.

Professor Daniel Peckham is Professor of Respiratory Medicine and Deputy Director of the Leeds Institute of Medical Research at the University of Leeds. He is the Clinical Lead for the Regional Leeds Adult Cystic Fibrosis, Primary Ciliary Dyskinesia and Bronchiectasis Services. Daniel pioneered the design and implementation of chronic disease electronic patient records and established a strong base for clinical and basic research in cystic fibrosis. Active research programs focus on CF-related inflammation, CFTR modulators, gut dysbiosis, cancer, drug allergy, big data, electronic patient records and clinical trials. He is passionate about education and was the founding Director of Education for the European Cystic Fibrosis Society.

Dr Rachel Penfold is an ST7 Respiratory Registrar in Merseyside, having worked across the region for the last 14 years. She completed a Masters in Humanitarian Studies from the Liverpool School of Tropical Medicine and this fuelled her interests in health and social inequality. She has experience as a Clinical Fellow in Integrated Care and would like to work further in population health, COPD and diagnostic services. She currently sits on the BTS SAG for Tobacco Dependence.

Ms Karen Peplow is a Macmillan Lung Cancer Matron working within the Lung Cancer Directorate at Wythenshawe Hospital, Manchester Foundation Trust. Karen has worked as Clinical Nurse Specialist within both lung cancer and palliative care for 30 years. Her current role is supporting the clinical nurse specialist teams delivering care and support to lung cancer patients and families across the pathway from pre diagnosis, through surgery and SACT into survivorship and supportive and palliative care. Within this role Karen has specific focus on education and training for the lung cancer workforce, aiming to equip and enthuse staff which then promotes the highest standard of care to the patients. Karen has particular interest in communication skills training and also works alongside the Ruth Strauss Foundation delivering training related to supporting patients in talking to their children.

Dr Gerrard Phillips

What does the future hold for respiratory education?

Postgraduate medical training is experiencing huge challenges. This session aims to explore the current issues faced in respiratory higher specialty training and consider how we might fix them in future. The session will include a consultant and registrar perspective.

Ms Jacqui Pollington RGN BSc MHSc is a Respiratory Nurse Consultant And Clinical Lead for the Community Respiratory Service at BreathingSpace, in Rotherham, South Yorkshire. Qualified for over 30 years, she has had the privilege of leading service developments in the management of airways diseases including PR, exacerbation management and LTOT. She was Clinical Lead for South Yorkshire's QUIT programme and has a particular interest in the treatment of tobacco dependence. She is Chair of the BTS Specialist Advisory Group on Tobacco Dependence.

Ms Helen Purcell has worked in respiratory physiology for almost 20 years both clinically and in a research capacity. She is currently the Chief Respiratory Physiologist at UCLH, heading up the lung function, sleep, ventilation and CPET services within the Trust. She has been an advocate for exams and training throughout her professional career, supporting local PTP and STP trainees, running several ARTP courses, as well as being the current ARTP Education Chair.

Acute NIV – introducing the role of the HCS in delivering an acute NIV service, focus on cases and how the knowledge and skills of a HCS can benefit acute NIV services

To highlight the benefit of having physiologist/HCS led services within the acute, inpatient setting resulting in better patient outcomes in both the short term, in relation to BTS audit criteria, and the longer term for continuity of care.

Ms Joanna Purvis is a Trainee Consultant Clinical Scientist specialising in respiratory and sleep physiology. She is the Clinical Service Lead for Physiological Services at George Eliot Hospital NHS Trust in Nuneaton, Warwickshire. With a strong focus on service innovation and quality, Joanna leads the Clinical Scientist–led breathlessness pathway and plays a key role in developing streamlined diagnostic services, including the Community Diagnostic Centre's breathlessness service.

Her specialist interests include cardiopulmonary exercise testing and the advancement of integrated diagnostic pathways aimed at improving patient outcomes and access to care. She currently serves as Vice Chair of the Standards Committee for the Association for Respiratory Technology and Physiology (ARTP), contributing to the development and implementation of best practice guidelines within the field.

Dr Tim Quinnell has worked at Royal Papworth Hospital, Cambridge since 2004 and has led one of the UK's largest sleep and ventilation centres since 2021. He specialises in respiratory and non-respiratory sleep disorders, domiciliary noninvasive ventilation and weaning from invasive ventilation. His MD was on genetic and electrophysiological aspects of narcolepsy. He was Chief Investigator for the NIHR Trial of Mandibular Advancement Devices in OSA and now leads an NIHR trial of combination therapy in OSA. He is current Chair of the BTS Sleep SAG. Dr Quinnell is actively engaged in providing and developing multidisciplinary sleep medicine education.

Mrs Jennifer Rees is the senior, Band 7 Specialist Pleural Nurse at Wythenshawe Hospital, Manchester University NHS Foundation Trust. Wythenshawe Hospital provides tertiary referral, regional pleural service providing the breadth of pleural diagnostics and therapeutics and is the regional mesothelioma centre and MDT for Greater Manchester. She is the nurse representative on the British Thoracic Society Pleural Specialist Advisory Group and the UK Pleural Society Board. She has been part of the team that has developed numerous projects such as My Pleural Effusion Journey decision support website for patients with malignant pleural effusions and the Greater Manchester Single Queue Diagnostics programme for local anaesthetic thoracoscopy.

Mrs Jane Rodger qualified as a registered nurse in 1995 and started her career working on a combined ICU/ CCU. In 2000 she became a respiratory nurse specialist. During this time, she was the nursing lead in developing the home ventilation service for Mid Yorkshire Hospitals NHS Trust, which is where she developed her passion for home ventilation. She is also a non-medical prescriber.

In 2018 Jane joined the North East Assisted Ventilation Service based in Newcastle upon Tyne as Senior Nurse Specialist and Operational Lead. In May 2024 she became an advanced nurse practitioner. During this time Jane has developed a HOT-HMV nurse led clinic and has a passion for high flow therapy at home developing a high flow therapy service within the home ventilation team. She is currently exploring the role of high flow therapy in patients with interstitial lung disease (ILD).

Oxygen via high flow nasal cannula for patients with advanced ILD: from hospital to home

This presentation will explore the role of high flow therapy for patients with advanced ILD, with a focus on provision of high flow therapy at home. It includes a patient pathway from hospital to home, managing patient and carer expectations and training on high flow therapy devices. The presentation will also inform of the patient and carer experience of high flow therapy at home provided by a regional home ventilation service.

Dr Catherine Rowan is an ST7 Respiratory Registrar in West Yorkshire. She is currently working at Mid Yorkshire Teaching NHS Trust. She has an interest in medical education and has organised several regional training programmes including Yorkshire general medicine teaching and collaborated with Northern deanery during the COVID-19 pandemic to set up virtual SCE teaching. She has been a member of the RCP Resident Doctors Committee (RDC) since July 2022 and in September 2025 she was appointed co-chair. In this role she has contributed to the RCP 'Next generation' work stream and advocated for resident doctors at a national level in issues such as recruitment, study budget and the balance of specialty and generalist training.

What does the future hold for respiratory education?

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Ms Cris Roxas, an Asthma Advanced Nurse Practitioner at Guy's and St. Thomas' Hospital, trained at the same institution and graduated from King's College London in 2009. She holds the Associateship of King's College Award, a Master's in Advanced Nursing Practice, and is a non-medical prescriber. As Governance Lead for Respiratory and Lead Asthma Nurse at a nationally commissioned Severe Asthma Centre, she also runs a regional asthma nurses network. A member of the BTS Nursing Specialist Advisory Group and KHP Respiratory and Allergy CAG Nursing Executive, Cris is passionate about improving asthma care and advancing nursing practice through education and leadership.

SNOMED codes – How can we identify patients with severe asthma and improve their access to biological therapy?

The presentation explores how accurate clinical coding can improve outcomes for respiratory patients. A key focus is on understanding SNOMED codes, their role in identifying patients with severe asthma, and ensuring timely access to biological therapies. The session will highlight the importance of correct coding, the potential implications for patient care and healthcare finances when coding is inaccurate, and practical strategies for improving clinical coding. By leveraging structured data, clinicians can enhance disease identification, optimise treatment pathways, and improve patient outcomes in severe asthma care.

Dr Richard Russell is a Clinical Reader at KCL London, the Head of the Peter Gorer Department of Immunobiology, and a Respiratory Consultant at Southern Health NHS Foundation Trust. He is the Clinical Director of the West Hampshire Integrated Respiratory Service, looking after COPD and asthma for 2.5 million people.

His PhD at Imperial College was as a British Lung Foundation Research Fellow under the supervision of Professor Peter Barnes. The research focussed on the basic mechanisms of COPD and disease progression in a population of smokers in primary care, and this is a continuing area of study as an Honorary Senior Lecturer at Imperial.

Dr Russell has just joined KCL from the University of Oxford where his research was focussed on COPD exacerbations, mechanisms of lung damage as well as phenotypes of all airways disease. He is a founder shareholder of Albus Health, a spin off company looking at remote patient monitoring. He is an advisor for three other European spin off companies with diverse interests. Where others see obstructions, Dr Russell looks for ways around, over or under. He leads clinical, research and health delivery teams with this campaigning approach.

Dr Russell has interests in obstructive lung disease, particularly pathophysiology of COPD and how patients should be cared for across the primary/secondary care interface. He is the Chair of the British Thoracic Society and is active in Asthma+Lung UK.

Dr Russell is the founding Editor of the International Journal of COPD (impact Factor 3.6), and is keen to increase the global awareness of COPD and provide a platform for scientific developments from across the world.

He was recently the Respiratory Director for NHS England SE region and Hampshire and Isle of Wight ICB.

Dr Ravijyot Saggu is an Honorary Clinical Lecturer. She was Chief Pharmaceutical Officer's Clinical Fellow ('21/'22 at NHSE) and recent Medicines Optimisation Lead in a community trust.

Ravijyot is Chair of the UK Clinical Pharmacy Association Respiratory Committee and has been part of national/European guideline and working groups (NICE/BTS/ERS/Greener Practice asthma QI toolkit/BTS Sustainability position statement). She sits on a range of committees including NHSE Sustainability board/Respiratory clinical reference group with various publications

She is a coach (including for NRAP), NICE Associate and council member for ALUK. She is passionate about sustainable, personalised, holistic care for patients and population health to reduce health inequalities.

NRAP Healthcare Improvement Programme

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- Understand the value of teamwork in supporting improvement

This session will delve into how NRAP supports healthcare improvement systematically. You'll hear from a multi professional team outlining:

- An overview of the NRAP health improvement programme and NRAP fellow role
- The role of coaches supporting teams to deliver respiratory health improvement
- Examples of real-world projects undertaken to improve respiratory care and outcomes including showcase of an out-patient collaborative project enabling patient optimisation prior to pulmonary rehab to improve uptake, completion rates and patient experience.

Dr Joanna Shakespeare is a Consultant Clinical Scientist in Sleep and Ventilation at University Hospitals Coventry and Warwickshire, having worked as a Respiratory Physiologist/ Scientist for 30 years.

Joanna is the Honorary Chair of the Association for Respiratory Technology and Physiology (ARTP). She regularly teaches on lung function and cardiopulmonary exercise testing (CPET) and is a faculty member for the ARTP CPET course, the UCLA/ Cambridge CPET course and the ERS advanced clinical exercise testing course. Her specialist interests include cardiopulmonary exercise testing and non-invasive ventilation in both the acute and domiciliary settings.

Professor Claire Shovlin is Professor of Practice (Clinical and Molecular Medicine) at Imperial College London: https://profiles.imperial.ac.uk/c.shovlin. Since 1999, she has personally reviewed >3,000 people with pulmonary arteriovenous malformations (PAVMs) and hereditary haemorrhagic telangiectasia (HHT). Over 100 Shovlin-led papers include ten detailing 150-700 consecutive PAVM patients; landmark reviews (AJRCCM, Thorax) and guidance from national/international committees she chaired.

However, despite 26 papers cited >100 times, and knowledge generation for seven preventable PAVM complications (brain abscess; ischaemic stroke; migraines; misunderstood hypoxaemia; maternal death in pregnancy; delayed MR scans; inappropriate lifestyle limitations), only obstetric evidence has translated into routine care. She seeks to change this.

The clinical approach to pulmonary arteriovenous malformations

This presentation will use proven methods to educate attendees so that they can deliver better care for the people with pulmonary AVMs who are referred to local respiratory clinics for screening, or management after radiological diagnosis, whether respiratory symptoms are present or absent. With pulmonary AVMs estimated to affect 1 in 2,600 of the population (>25,000 people in the UK), educational aims are for attendees to understand how to prevent strokes that will affect the majority of patients, **why** they need to have PAVM-specific knowledge regarding oxygen levels; and **what** extra information is needed to optimise life-long health.

Professor Ian Sinha is Consultant Respiratory Paediatrician at Alder Hey Children's Hospital. Professor Sinha is also Honorary Professor of Child Health at the University of Liverpool, and National Respiratory Audit Programme Paediatric Clinical Lead. He is also NHSE North West CYP Asthma Clinical Lead

How to talk to your patients about environmental exposures and respiratory health

This session will focus on practical communication strategies to help clinicians talk to patients and families about environmental exposures and respiratory health. Featuring Dr Lee in conversation with Professor Sinha, who developed the UK's first clean air clinic, the session will include insights from parent champions and case examples. Topics include discussing environmental risks, engaging with landlords and housing agencies, and supporting families to reduce harmful exposures. Educational aims are to improve clinician confidence, enhance person-centred care, and highlight the clinician's role in addressing environmental risk factors and advocating for healthier living conditions.

Mrs Claire Slinger is Consultant Speech and Language Therapist, Lancashire Teaching Hospitals NHS Trust, and Professional Advisor to Royal College of Speech and Language Therapists (Field of Adult Respiratory care). Co-author RCSLT Position Paper Upper Airway disorders. Lead author of a Cochrane (Airways) review into speech therapy for chronic cough. Current Chair of the BTS Cough Specialist Advisory Group.

Areas of interest include assessment and management of Inducible Laryngeal Obstruction (ILO) and Chronic Cough, as well as an interest in MDT upper airway assessment to support patients who have upper airway issues tolerating mechanical insufflation-exsufflation and/or non-invasive ventilation. Currently investigating the utility of non-invasive tools to assess laryngeal dysfunction.

Currently working as Consultant SLT and Service Lead for Preston Complex Breathlessness (Airways) Multi-Disciplinary Team, Lancashire Chest Centre, Royal Preston Hospital, Lancashire Teaching Hospitals Trust.

Speech therapy for chronic cough: the what, the when, and the how

This session aims to provide a practical overview of non-pharmacological intervention for chronic cough, including assessment, differential diagnosis and management strategies, as well as timing of interventions, patient selection and working with the MDT. An examination of the evidence base for non-pharmacological interventions will underpin the session.

Dr Andrew Stanton trained in Glasgow and Oxford and spent nine years as a Consultant in Swindon before moving to Newcastle in 2019. Here he is Lead for Pleural Diseases and also contributes to the severe asthma and lung cancer services. Dr Stanton has contributed to several BTS initiatives in pleural disease including the 2023 Pleural Diseases Guideline. He retains a strong interest in undergraduate and postgraduate training and after developing BTS Training Standards in thoracic ultrasound has been co-chair of the BTS Pleural Procedural Training Standards Group.

How to integrate the new pleural training standards into practice

This session will discuss the principles and content of upcoming Pleural Procedural Training Standards, which hopefully will be published by the time of the BTS Summer Meeting. It will be targeted to the multidisciplinary audience and will highlight how to make these standards an effective vehicle for learning in pleural procedural training and how to integrate them within the existing e-portfolio structure.

Professor Joerg Steier trained at the University of Leipzig and completed his MD thesis on pulmonary hypertension, gaining international experience in Switzerland and the USA. His respiratory training at the Western German Lung Centre in Essen led to a European Respiratory Society fellowship in London, where he completed his PhD on sleep-disordered breathing at King's College London. He is Consultant at Guy's & St Thomas' NHS Foundation Trust's Lane Fox Unit and the Sleep Disorders Centre. As Professor of Respiratory and Sleep Medicine at King's College London, he has developed patented technology and established global collaborations. He served as President of the British Sleep Society (2019-2023) and is the Immediate Past President.

Hypoglossal nerve stimulation: presentation of complex cases. Evidence to date, 1st UK centre experience, national access, referral criteria

The presentation aims to provide healthcare professionals with comprehensive knowledge of hypoglossal nerve stimulation (HGNS) for obstructive sleep apnoea (OSA) through:

1. Understanding the principles and mechanism of action of HGNS therapy
2. Analysing real-world complex cases from Guy's & St Thomas' NHS Foundation Trust's pioneering experience as the first UK centre
3. Critically evaluating current clinical evidence supporting HGNS effectiveness and safety
4. Familiarising attendees with NHS patient selection criteria and referral pathways
5. Developing competency in identifying suitable candidates for HGNS therapy
6. Understanding post-implantation care and optimisation of treatment outcomes

Dr Karl Sylvester is Consultant Healthcare Scientist at Cambridge University Hospitals and Royal Papworth Hospital NHS Foundation Trusts. Part of this role involves clinical oversight of the breathlessness pathway at the Cambridgeshire and Peterborough Community Diagnostic Centre's. He is a Fellow of the Academy of Healthcare Science. He has served as honorary Chair of the Association for Respiratory Technology and Physiology (ARTP) and Chair of Group 9.1 at the European Respiratory Society, a group which represents respiratory and sleep scientists from across Europe. His specialist interest is the performance and interpretation of cardio-pulmonary exercise testing. He is Faculty Lead for the ARTP's annual CPET course, the BTS/ARTP Physiology Course and Faculty Director for the UCLA/Cambridge CPET course. Dr Sylvester initially joined Cambridge University Hospitals after completing a PhD investigating respiratory complications in patients with sickle cell disease.

Dr Hilary Tedd is a Respiratory Consultant at the Royal Victoria Infirmary, Newcastle upon Tyne NHS Foundation Trust, with a specialist interest in home ventilation and occupational lung disease. She is passionate about improving post-graduate education and has been Returning to Training Lead for the School of Medicine since 2019 and TPD in Respiratory Medicine since 2022, for the North East and North Cumbria.

Respiratory training in the North East – sharing best practice

This talk will look at areas of good practice around post graduate medical education in respiratory medicine, as a result of lessons learned from training in the North East and North Cumbria which consistently scores very highly in the GMC training survey for resident doctor satisfaction. Specific areas that will be covered include improving induction processes into higher speciality training, supporting residents with different requirements such as International Medical Graduates and residents working flexibly, supporting trainee well-being and promoting high quality education within the region.

Dr Ricky Thakrar (MBBS MRCP PhD) is a Consultant Chest Physician at University College London Hospital NHS Foundation Trust and an Honorary Associate Professor in the Division of Medicine at University College London. He has clinical expertise in advanced diagnostic and therapeutic bronchoscopy procedures, employing a wide range of techniques including rigid bronchoscopy, laser resection, airway stenting, cryotherapy, and brachytherapy. Notably, he recently established one of the UK's first robotic-assisted bronchoscopy clinical services. Dr Thakrar is the principal investigator of several lung cancer clinical trials and has successfully secured both clinical trial and innovation grant funding in bronchoscopy.

Palliation and management of breathlessness in lung cancer

Explore the role of interventional bronchoscopy in the management of malignant central airway obstruction (MCAO), focusing techniques for palliation and airway restoration. The talk will cover procedural approaches such as laser therapy, cryotherapy, stenting, and electrocautery, emphasising their indications, benefits, and limitations. Through case-based discussion and evidence-based insights, attendees will gain a comprehensive understanding of patient selection, procedural techniques, and patient outcomes.

- Recognise the clinical significance of malignant central airway obstruction (MCAO) in lung cancer and its impact on patient outcomes
- Identify suitable patients with MCAO who would benefit from interventional bronchoscopy and understand referral pathways
- Understand the range of available bronchoscopic techniques, distinguishing between those used for intraluminal and extraluminal disease
- Evaluate the effectiveness of different bronchoscopic interventions in symptom relief, airway patency, and overall patient prognosis
- Develop a practical approach to integrating interventional bronchoscopy into multidisciplinary lung cancer management

Dr Shaun Thein is a Respiratory Physician at Sandwell and West Birmingham NHS Trust and Honorary Associate Clinical Professor at the University of Birmingham. He is on the BTS Council and Workforce and Service Development Committee. He has an interest in interstitial lung disease and research into the effects of social inequality on health outcomes. In addition, he leads the ILD service at SWBH.

Getting the consultant job – where to find jobs, writing your application and preparing for interview

This talk aims to highlight the process for applying for a consultant job, application writing, preparing for interview and job planning. This will be beneficial for final year trainees, but may also be of interest for those who are applying for posts at other grades. Specific topics were taken from the BTS trainee survey.

Miss Bethany Tidmarsh is a Specialist Respiratory SLT and qualified from Newcastle University in 2015. She has been working in tertiary asthma and airways services for a number of years, including Wythenshawe Complex Breathlessness Service and The Royal Brompton Hospital. Specialist areas of interest include laryngeal dysfunction, ILO and chronic cough.

Dr George Tsaknis is a Consultant in Respiratory Medicine and Clinical Lead for Lung Cancer at Kettering General Hospital, Clinical Director of the Lung Cancer Screening Programme in Northamptonshire, Co-Chair of the Lung ECAG and Lung Cancer ODN in East Midlands, member of the Lung Cancer and Mesothelioma SAG for the British Thoracic Society, and Honorary Senior Lecturer in Respiratory Sciences, University of Leicester.

Dr Gillian Twigg is a Consultant Clinical Scientist and Sub-specialty Lead for Sleep at Imperial College Healthcare NHS Trust. She gained her PhD in 2008, specialising in neuroanatomical changes and cognitive function in patients with obstructive sleep apnoea, before moving into clinical practice. She underwent a programme on specialist training via the Higher Specialist Scientist Training programme, leading to the award of Doctor of Clinical Science and eligibility for consultant practice in 2022. Her specialist clinical role involves history taking and test interpretation in a range of respiratory and non-respiratory sleep disorders.

Sleep Clinics – How can HCS support sleep clinics, highlighting the role of the consultant grade HCS in the delivery of a sleep clinic with a focus on case studies

Many NHS services are struggling to meet the rising demand for specialist sleep services. The concept of physiology-led sleep services is not new, but prevailing models of physician-led care and reluctance to change the status quo means that decision-makers may be slow to recognise the untapped resources in front of them. With little to no formal sleep training for consultant medics, many services find themselves struggling to replace the gaps in expertise left when self-taught experts in the field retire. The aim of this talk is to illustrate with clinical cases, how a consultant clinical scientist can help to deliver sleep services, working autonomously to diagnose and treat a range of sleep disorders.

Dr Frances Varian is an Academic Cardiology Registrar and BRC Clinical Research Fellow currently pursuing a PhD in pulmonary hypertension. Based in Sheffield, she is co-investigator for a multicentre, randomised controlled trial utilising digital and remote implanted technologies. She has a special interest in patient-reported outcome measures and has been developing these for robust health-related quality of life endpoints in pulmonary hypertension research. She also has a strong interest in sustainability and serves as a British Cardiovascular Society (BCS) Sustainability Committee representative, presenting internationally on sustainable practices in clinical trial design.

Mrs Pamela Vaughn is a Principal Physiotherapist in Respiratory Medicine in the North of Glasgow, with over three decades of experience in the field. She qualified in Glasgow, where she began her career and quickly developed a passion for respiratory care. In 1992, she was the sole physiotherapist involved in the establishment of the West of Scotland Adult Cystic Fibrosis Unit and was a founding member of the Association of Chartered Physiotherapists in Cystic Fibrosis.

Her career includes time spent working in the United States, after which she returned to Glasgow to further her clinical and academic focus on respiratory medicine. Pamela has been an independent prescriber since 2013 and holds advanced practice qualifications. She runs autonomous outpatient clinics with a specialist focus on bronchiectasis, airway clearance, chronic cough, and breathing pattern disorders.

Pamela has played an active role in national guideline development through her involvement in several British Thoracic Society Guideline Groups. She currently serves on the Bronchiectasis Specialist Advisory Group and is an expert member of the West of Scotland Research Ethics Committee. Her academic contributions include journal publications and a forthcoming student handbook.

Mr Luigi Ventura is a Consultant Thoracic Surgeon at the Sheffield Teaching Hospital NHS Foundation Trust.

He has developed his experience in thoracic surgery, having served in various roles across Italy, China, and the UK.

Mr Ventura has been a clinical fellow at the Shanghai Chest Hospital (Shanghai, China) and St. Bartholomew's Hospital (London, UK), where he developed his skills in minimally invasive techniques, specifically video-assisted and robotic-assisted thoracic surgery (VATS & RATS).

He is a member of multiple international committees, including the Screening & Early Detection Committee and the Staging and Prognostic Factors Group (SPFG) for the International Association for the Study of Lung Cancer (IASLC). He is also a Pleural Disease Working Group member for the European Society of Thoracic Surgeons (ESTS) and an Education Committee Member for the International Thymic Malignancy Interest Group (ITMIG).

Mr Ventura's clinical expertise is complemented by his commitment to education and research in thoracic oncology and thoracic surgery.

Dr Sophie West is a Respiratory Consultant in Newcastle upon Tyne, Lead of the Regional Sleep Service and Board Chair of the Cardiothoracic Clinical Board. Her clinical and research interests are in best treatments for obstructive sleep apnoea and its associated conditions. She has sat on specialist committees for NICE: NG202 Obstructive Sleep Apnoea-Hypopnoea Syndrome and Obesity Hypoventilation Syndrome Guideline, 2021 and DAP70 Automated home testing devices for diagnosing OSAHS, 2024. Dr West is an active member of the OSA Alliance, a multi-professional group who facilitate clinical excellence with all in OSA and work to improve access to OSA-related care and professional education and resource.

COPD-OSA overlap syndrome: is there a case for screening and if so who?

In this talk, we will review the symptoms and diagnosis of chronic obstructive pulmonary disease-obstructive sleep apnoea (COPD-OSA) overlap syndrome.

We will discuss the estimated prevalence of this condition (up to 67% in patients with COPD), and the increased rate of COPD exacerbations compared to patients with similar severity COPD without OSA, along with what interventions are indicated and where research is needed, including the EPIC-OSA trial. We will consider screening for COPD-OSA overlap syndrome and how this might be approached.

Dr Ruth Wiggans is a Consultant Respiratory Physician with an interest in occupational and environmental lung diseases. Her PhD research focused on occupational asthma in allergen exposed workers. Her clinical practice centres around the care of people with occupational and environmental lung disease with a particular interest in occupational interstitial lung disease. Research interests include addressing health inequity in workplaces, designing and evaluating interventions to support healthier work, and using data for monitoring occupational and environmental disease in particular from the THOR scheme. She is a member of BTS Specialist Advisory Group for Occupational and Environmental Lung Diseases and of the Group of Occupational Respiratory Disease Specialists.

Work and health inequalities – what do I need to know and how can I help my patients?

Workplace exposures contribute significantly to the global burden of respiratory disease. The distribution of occupational lung disease is not equal among populations: poverty, education, sex/gender and ethnicity all contribute to the risks. This session aims to:

1. Demonstrate how work and employment reflect and reinforce social gradients of health.
2. Explain how OLDs can intersect with other social determinants of health, resulting in worse outcomes for those affected.
3. Show how workplaces can present a unique sphere in which to intervene to improve respiratory health outcomes.

Professor Tom Wilkinson is Professor of Respiratory Medicine at the University of Southampton, Faculty of Medicine, Associate Dean of the Faculty of Medicine and Honorary Consultant at University Hospitals Southampton. He trained at the University of Cambridge and the Royal London School of Medicine and completed his PhD at UCL studying disease mechanisms driving exacerbations of COPD.

He is Lead of the Southampton COPD Research Group, the Respiratory Theme of the NIHR Southampton Biomedical Research Centre and Senior Clinical Lead of the National Respiratory Audit Programme. His research seeks to improve outcomes for patients with chronic lung disease. He has published over 200 peer reviewed papers and reviews in this field. In 2023 he was appointed as an NIHR Senior Investigator in recognition of his national contribution to respiratory medicine.

Dr Kay Por Yip is a Senior Clinical Fellow at the Department of Thoracic Oncology in Wythenshawe Hospital, Manchester. He had previously completed a PhD in 2022 and subsequently an academic clinical lectureship at the University of Birmingham in which he was actively participating at the lung cancer and airways disease research. Having completed his lectureship and respiratory specialty training in the West Midlands Deanery in 2024, he is currently undertaking a post-CCT fellowship in lung cancer and pleural disease in Wythenshawe Hospital.

Lung cancer mini-MDT: case presentations

These series of lung cancer cases will aim to highlight the complexities of lung cancer diagnosis and management including holistic care. There will be four clinical cases discussed with each covering different aspects of lung cancer care. The aim is to utilise an MDT approach backed up by clinical trials and national audit data to help inform discussion regarding diagnosis and management decisions. An interactive audience participation is encouraged during these sessions to stimulate informative discussions.

Dr Sabrina Zulfikar is a final year Respiratory Registrar in Bristol. Prior to this, she was a Clinical Research Fellow in Interstitial Lung Disease in Oxford, undertaking an MD exploring non-invasive methods of prognosticating interstitial lung diseases. She was a member of the BTS Cough Specialist Advisory Group from 2021 to 2024.

BTS ABSTRACT PRIZES – SHORTLISTED ABSTRACTS

CATEGORY: INNOVATION AND EDUCATION: A PASSPORT TO LEARNING (IE1 - IE6)

IE1

"This isn't even taught in GP" - Improving medical student's understanding of COPD management in a GP setting through simulation-based learning.

[1]L Moreton, [1]C Hood, [1]K Stevens, [1]A Manzar, [1]G Hope. [1]Barts Health NHS Trust, London, United Kingdom.

Background

Chronic Obstructive Pulmonary Disease (COPD) is reported to affect approximately three million people in the United Kingdom and is the second most common cause of emergency admissions to hospital. Furthermore, approximately 1.4 million general practice (GP) consultations per year are due to COPD. Effective initial management of acute exacerbations is essential for optimising patient outcomes. However, medical students often have limited exposure to managing an acute COPD exacerbation in a GP setting. To address this gap, we developed a simulation-based scenario designed to enhance the student's ability to recognise and manage COPD in the community prior to hospital transfer.

Methods

Two hundred and forty final year medical students participated in a high-fidelity simulation replicating an acute COPD exacerbation within a community setting over a six-month period. The scenario required the students to assess the patient, initiate appropriate management and coordinate an ambulance transfer to secondary care. The simulation was followed by a detailed debriefing session, incorporating reflective learning and feedback from the simulation facilitators. Students were also asked to complete feedback following the session. Thematic analysis was used to review and identify themes from the student feedback forms.

Results

Preliminary findings suggest the students were more aware of the limited resources within a GP setting following this simulated learning. Students felt more confident to initiate management and liaise with the emergency services following this session. Furthermore, students indicated this was their first time using oxygen cylinders, hence improving understanding of oxygen therapy. The qualitative feedback highlighted the importance of immersive learning in reinforcing theoretical knowledge and understanding.

Conclusion

Simulation is widely used for secondary care-based scenarios, however, few sessions involve situations in a community setting. This simulation project highlights the importance of integrating primary care emergency scenarios into undergraduate training to enhance student preparedness for real-world clinical situations. Further training should be completed with undergraduates aiming to address the gap in knowledge regarding patient transfers and oxygen therapy.

IE2

Iatrogenic Haemoptysis – hope for the best or prepare for the worst?

[1]S Galbraith, [1]V Sobolewska, [1]J Roberts, [1]E McCorry, [2]N Faulkner, [2]A Talbot, [2]S Giavedoni. [1]Medical Education Directorate, NHS Lothian, Edinburgh, United Kingdom; [2]NHS Lothian, Edinburgh, United Kingdom.

Bleeding during bronchoscopy is a potentially fatal complication. Being a high acuity, low occurrence event, bronchoscopy teams have limited training opportunities in managing this emergency. The BTS Quality Standards for Flexible Bronchoscopy state departments must maintain safety and operator performance. We argue, without adequate training in complication management, patient safety is at risk. Adverse events require team collaboration and combined decision-making, communication and technical skills for which simulation-based education, an underutilised tool in respiratory medicine, is an effective teaching modality.[1] We employed simulation training to prepare bronchoscopy teams in our organisation to manage iatrogenic haemoptysis. Interprofessional learning, where learners from different professions learn with, from and about one another, enhances the learner experience whilst reflecting the reality of the clinical environment.[2] We incorporated this strategy, optimising the learning quality whilst strengthening the intervention's accessibility.

A national survey of respiratory registrars demonstrated 52% of respondents sought further training in bronchoscopy complication management. Our response involved designing an in-situ, interprofessional simulation for iatrogenic haemoptysis (Fig.1), requiring collaboration with technicians, content experts and bronchoscopy nurses. Respiratory trainees (n=8) and bronchoscopy nurses (n=8) were invited to partake in the simulation. Four sessions were delivered in total, each with two participants from each profession. A qualitative approach was taken to conduct a descriptive phenomenological study. Data collection involved audio-recording debriefings and analysis of transcriptions employed Braun & Clarke's reflexive thematic analysis.

Results demonstrated situational awareness, task prioritisation, escalation and self-efficacy were all themes within the construct of preparedness with evaluation confirming these were effectively addressed during the intervention.

Through the application of simulation methodology, we provide novel evidence demonstrating that in-situ, interprofessional simulation is effective for enhancing bronchoscopy team members' preparedness to manage iatrogenic haemoptysis. This is a transferable, reproducible intervention we wish to share with international simulation teams to improve the safety of patients undergoing bronchoscopy.

1. New ML, Amass T, Neumeier A, Huie TJ. Massive hemoptysis simulation curriculum improves performance. Chest.2024;165:645-52.

2. Freeth D, Savin-Baden M, Thistlethwaite J. Interprofessional education. In: Swannick T, Forrest K, O'Brien C, editors. Understanding medical education: evidence, theory and practice. 3rd ed. Oxford: John Wiley & Sons; 2019.p.191-206.

IE2 - Figure 1

IE3

Enhancing patient care through interprofessional simulation: a collaborative approach to team-based healthcare.

[1]V Sobolewska, [2]P Prabhu, [2]R Bramah. [1]Medical Education Directorate, NHS Lothian, Edinburgh, United Kingdom; [2]NHS Lothian, Edinburgh, United Kingdom.

Interprofessional education is being increasingly integrated into healthcare settings, often through the use of simulation-based learning. Our respiratory inpatient ward is staffed by frequently rotating resident doctors and nursing staff with variable experience. Effective teamwork is essential for maintaining patient safety, and educational interventions that foster professional collaboration can enhance this.[1] The introduction of interprofessional facilitation and co-debriefing has been shown to improve collaboration within healthcare teams, thereby adding value to interprofessional education.[2]

Fourteen sessions were delivered addressing common clinical presentations on the respiratory ward including acute respiratory failure, severe asthma exacerbations, mucous plugging and chest drain complications. Participants included one clinical support worker, one staff nurse, one foundation year one doctor and one middle grade doctor, with other team members observing. A local faculty development session was organised to support an interprofessional facilitation model and to encourage interprofessional co-debriefing. Faculty included registrars, resident doctors and senior charge nurses.

Anonymous pre and post simulation feedback was collected from the participants. 85% felt more prepared to manage an acutely unwell patient (with 69% pre session). 89% reported feeling comfortable working as part of the inpatient multidisciplinary team, an improvement of 23% pre session. Senior charge nurses and a resident doctor had the opportunity to progress from having no prior experience in simulation facilitation to leading sessions, co-debriefing and contributing to the design of future scenarios.

We conclude that interprofessional educational interventions like this one can significantly enhance teamwork on the ward, leading to improve patient care and safety. This model is highly transferrable and we would advocate for its adoption by teams globally. The integration of interprofessional facilitation and co-debriefing clearly fosters enhanced teamwork, collaboration and individual professional development as educators. Future work will focus on evaluating the effectiveness of interprofessional co-debriefing for both participants and faculty.

References

1. Stockert B, Ohtake. PJ A national survey on the use of immersive simulation for interprofessional education in physical therapist education programme. Simulation in Healthcare Journal of the Society for Simulation in Healthcare 2017;12(5):298-303. doi.org/10.1097/SIH.0000000000000231
2. Holmes C, Mellanby E. Debriefing strategies for interprofessional simulation: a qualitative study. Advances in Simulation 2022. doi.org/10.1186/s41077-022-00214-3

IE4

Broadcasting success: enhancing medical education using 'Near Me' and peer learning.

[1]V Sobolewska, [1]S Galbraith, [2]K McLaren. [1]Medical Education Directorate, NHS Lothian, Edinburgh, United Kingdom; [2]NHS Lothian, Edinburgh, United Kingdom.

Increasing numbers of medical students worldwide presents significant challenges to the ongoing delivery of high-quality education.[1] Our local respiratory module for Year 6 medical students experienced a 50% increase for the academic year 2023-24, a trend that is expected to continue. In response to this growing demand, innovative educational strategies are required to sustain high-quality education. To address this challenge, we implemented a novel intervention using the 'Near Me' system (usually reserved for delivery of remote healthcare) in an educational setting, complemented by peer learning. Peer learning, an evidence-based educational approach,[2] fosters collaboration and supports learning in contexts where capacity constraints are prominent.

Respiratory outpatients were invited to participate in the teaching clinics. In contrast to traditional outpatient experience where students observe the consultant, two year six medical students led the consultation with supervision from a respiratory consultant. Six peers observed via 'Near Me'. A facilitated debrief with all learners was led by trained educators with experience in respiratory medicine. The discussions focussed on the primary/secondary care interface and common respiratory conditions encountered in the secondary care setting.

Seven clinics were delivered, with fourteen patients and thirty-nine students. Anonymous feedback revealed 95% of students valued this teaching experience, with 44% appreciating the opportunity for collaborative learning and 51% reporting a positive peer learning experience. All patients expressed a willingness to participate again. Feedback was used to inform future iterations of the intervention to improve efficacy and optimise resource implementation.

Through incorporation of technology, peer learning and facilitation, we enhanced the traditional outpatient experience for undergraduate learners whilst addressing the increasing burden on health-profession education. This is a scalable, transferable solution across all healthcare professions that should be implemented by organisations globally to provide a sustainable solution to the growing demand for high-quality education.

References

1. Hays RB, McKinley RK, Sen Gupta TK. Twelve tips for expanding undergraduate clinical teaching capacity. Medical Teacher. 2018; 31(3):271-274. doi.org/10.1080/0142159X.2018.1429587
2. Markowski M, Bower H, Essex R, Yearley C. Peer learning and collaborative placement models in health care: a systematic review and qualitative synthesis of the literature. Journal of Clinical Nursing. 2021; 30 (11):1519-1541. doi.org/10.1111/jocn.15661

IE5

The Evolution of the Lung Nodule Navigator: Developing a New Service and Improving Patient Pathways through a Bespoke Training Programme

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Background

In 2022 we developed a dedicated incidental pulmonary nodule (IPN) service which is now led by two specialist nurse navigators (SSNs). Data presented after 6 months of the project showed significant improvements in patient management and timely investigation for growing nodules as well as improvements in patient safety. [1] [2]

At the start of their journey, the SSNs had no prior knowledge about the management of IPNs. This prompted the leading clinicians to design a novel educational package using a web-based clinical simulation platform to teach the SSNs about lung nodule management, risk stratification, volumetry measurements and then structured CT scan reporting.

The navigators also received weekly teaching sessions with a thoracic radiologist and respiratory physician. As their confidence improved the navigators progressed to acting as first readers and reporting CT scans from the outset.

In this abstract we present data demonstrating the learning and progression of the SSN's in IPN management.

Methods

The SSNs were trained in stages.

Stage 1 comprised a teaching, then training (58 clinical vignettes) and an assessment module with 111 cases.

Stage 2 involved a first reader reporting trial for confirming identification of nodules with benign morphology and assessing for IPN growth.

The radiologist scored the SSN's recommendations on an agreement scale of 1-5.

Results

The results of the Stage 1 training and then the Stage 2 reporting trial are shown in Table 1.

Conclusion

This work demonstrates that investing time to train specialist nurses can have a significant impact on the development of a service and ultimately more efficient patient care. The reporting trial will form part of audit and continuing professional development for the SSNs.

By sharing this work, we hope to show how a safe and effective IPN service model can be developed using a bespoke education package which can provide a standard for training and assessment in this area.

References

[1] Lung Cancer 178 (2023)

[2] Lung Cancer 190 (2024)

IE5 - Table 1 summarises the progression in learning by the SSNs

Stage 1: IPN Education Package Training and Assessment (n=2 SSNs)		
Correct Solid Nodule Categorisation	First attempt Mean Score (baseline knowledge)	Second Attempt Mean Score (post training module)
Training module (58 cases)	79.5%	97%
Assessment module (111 cases)	75.6%	98%
Confidence in IPN assessment (VAS 1-10 with increasing confidence as score increases)	3	7

Stage 2: CT Scan Reporting Trial
N=2 SSNs

1. *Major disagreement: serious interpretative discrepancy, high probability of significant clinical impact.*
2. *Moderate disagreement, moderate interpretative discrepancy with the potential to significantly impact on patient care.*
3. *Minor disagreement, an inaccuracy which may require amendment but will not significantly impact on patient care.*
4. *Trivial disagreements, no potential clinical consequence and no change required.*
5. *Perfect report*

	Trial 1 (October 2024) **n= 28 cases**		**Trial 2 (February 2025)** **n= 27 cases**	
Thoracic Radiologist agreement with SSN risk stratification and management of IPN (VAS 1-5 with increasing agreement as score increases)	**Agreement Score**	**No. of Cases**	**Agreement Score**	**No. of Cases**
	1	**0**	**1**	**0**
	2	**2**	**2**	**0**
	3	**6**	**3**	**4**
	4	**1**	**4**	**2**
	5	**19**	**5**	**21**

Mann-Whitney U Test yielded a value of U = 330.50 with a p-value = 0.3107.
The independent T-test showed a t-value of -1.26 with a p-value = 0.2150.

IE6

Improving Pleural Procedural Competency for Non-Respiratory Trainees: A Four-Stage Approach

[1]SJ Davis, [1]Z Manji, [1]J Asis, [1]S Power. [1]Wexham Park Hospital, Slough, United Kingdom.

Introduction

In both Internal Medicine Training (IMT) stage 1 and Internal Medicine Stage 2, trainees are required to be competent to perform pleural aspirates unsupervised. This is often challenging due to staffing shortages, limited scheduled teaching and lack of appropriate supervisors. We aimed to develop a programme to improve access to pleural procedures in a structured and safe environment, ensuring patient safety was maintained.

Method

We implemented a four-stage pleural teaching programme consisting of: (1) pre-course material, (2) lecture-based teaching, (3) a simulation session with hands-on ultrasound experience and (4) a senior respiratory trainee-led pleural clinic. Trainees were required to complete each stage before progressing. We used participant survey to assess educational benefit, confidence and competence.

Results

A pre-course survey showed 25% of trainees did not feel confident they would achieve their training requirement for pleural procedures. 18.5% were unable to perform a pleural aspirate. Following the simulation session 92% felt confident they would achieve their training requirement and 46% felt they could perform a pleural aspirate with limited supervision. No trainees reported being unable to perform the procedure. After the pleural clinic, 100% felt confident they would achieve their training requirement, 40% of trainees were able to perform pleural aspirates independently.

Discussion

We have shown that a structured approach to pleural teaching can provide a beneficial teaching experience for medical trainees to safety improve their confidence and competence, while not compromising on patient safety. We feel this structured approach could be adapted to be used at other hospitals to enhance procedural training.

BTS ABSTRACT PRIZES – SHORTLISTED ABSTRACTS
CATEGORY: LOCAL IMPROVEMENTS DRIVING PATIENT CARE FORWARD (QI1 - QI6)

QI1

Clearing the Air: Enhancing the Delivery of Nicotine Replacement Therapy in a District General Hospital, a Quality Improvement Project

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Background

Nicotine Replacement Therapy (NRT) should be available within two hours of hospital admission for current smokers. In our District General Hospital, we recognised that there were numerous barriers preventing inpatients from receiving NRT including identification of current smokers, knowledge of NRT products amongst prescribers, and availability of NRT for administration.

Methods

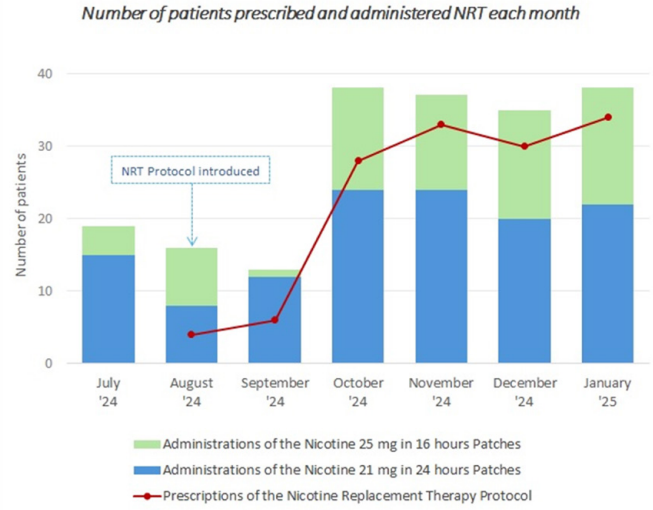
Using the British Thoracic Society Clinical Statement on Tobacco Dependency as a framework, we employed Quality Improvement Methodology to implement a number of changes aimed at increasing the number of NRT prescriptions and administrations for inpatients with tobacco dependency. This included a mandatory electronic assessment of smoking status on admission by nursing staff; the introduction of a simplified electronic NRT prescription protocol; working with pharmacy staff to improve stock of NRT across all wards in the hospital; and educational events for prescribers and nursing staff.

Results

The number of current smokers identified on admission through an electronic smoking assessment has increased by 28%, from 74 to 95 each month. The number of patients prescribed NRT through the electronic protocol has increased from 4 to 34 monthly. The introduction of the NRT prescribing protocol has led to an overall increase in the number of NRT prescriptions each month. Additionally, the increased availability of NRT products throughout the hospital has led to a 50% rise in the number of patients receiving NRT patches, from 19 to 38 per month, particularly the high-dose (25 mg over 16 hours) patches. This improvement has been sustained.

Conclusion

A multi-faceted approach has resulted in a significant increase in the prescribing, availability and administration of Nicotine Replacement Therapy for inpatients with tobacco dependency in our District General Hospital. Further improvements are planned as part of this ongoing project, including electronic referrals to a Tobacco Dependency Advisor and nurse-led administration of NRT.



QI2

Breathlessness Pathway Pilot: providing a streamlined process for diagnosis and management

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Background

The government has prioritised elective recovery in the NHS. Patients typically wait months for appointments and tests are often performed at different times and places leading to fragmented care and delayed diagnoses. Patients with diseases such as COPD and ILD are often identified late despite presenting with symptoms years beforehand. This is exacerbated by health inequalities. Early diagnosis through easier access to clinical pathways is essential for improving outcomes and reducing health and social care costs and has been highlighted as a NHSE priority. To address this, we set up a 'one-stop-shop' Breathlessness Pathway Pilot at the Oxford Community Diagnostic Centre (CDC) to provide investigations, diagnosis and management advice at a single visit in a location convenient and accessible to patients.

Pathway implementation

We selected 8 GP practices, focusing on areas of higher social deprivation. We designed an easy-to-use proforma for GPs to refer patients with breathlessness for >8 weeks where the diagnosis was unclear.

On the day of the appointment, patients undergo 'Tier 1' investigations (lung function tests, chest x-ray, ECG, bloods) and then are reviewed by respiratory physician and physiotherapist working side-by-side. Patients typically receive a diagnosis on the day alongside intervention, management and signposting advice.

Outcomes

We compared patients in the pilot to a control group of breathless patients who received standard care via a conventional respiratory outpatient appointment. A health economic analysis was performed via Health Innovation Oxford and Thames Valley.

The table summarises the clinical outcomes, carbon footprint, and costs per patient from GP visits to prescriptions for the breathlessness pilot and standard care groups. The costs for an expected cohort of 288 patients seen in the breathlessness pathway per year are also estimated.

Conclusions

Data from this Breathlessness Pathway Pilot demonstrates:

- Improved rate of diagnosis at first visit (90% vs 52%)
- Reduced requirement for follow-up appointments
- Reduced secondary care encounters ("touchpoints") with resultant reduction in healthcare costs
- Improved sustainability with a per patient reduction in carbon emissions
- Overall reduction in costs per patient with a potential system saving of £64,500 per annum.

Outcomes	Breathlessness Pilot Pathway group (n= 125)	Standard Care group seen in Respiratory Clinic (n = 23)	
Clear diagnosis at first visit	112 (90%)	12 (52%)	
"Touchpoints" per patient	2.1	4.1 (3.7 excluding physiotherapy)	
Follow up appointments per patients	0.23	1.04	
Emissions per patient (4.8 $kgCO_2$)	14.51	39.4	
Emissions attributed to travel ($kgCO_2$)	8.67	23.52	
Costs per patient	**£ per patient in pilot pathway**	**£ per patient standard care**	**Difference in £ per patient**
GP visits	99.0	152.2	53.2
Breathlessness pathway clinic cost (pilot group)	448.8	0	-448.8
Respiratory clinic cost -new appointment and follow-up	23.2	398.4	375.2
Test costs	584.6	626.7	42.1
Additional service support (Cardiology, A&E etc)	136.0	301.8	165.8
Reduction in prescription costs (inhalers)	0	36.4	36.4
Total	**1,291.6**	**1,515.5**	**223.9**
Costs for 288 patients (estimated number seen in Breathlessness Pathway per year)	**Total Annual Cost (£000s)**	**Total Annual Cost (£000s)**	**Total Annual Saving (£000s)**
Total	**372.0**	**436.5**	**64.5**

QI3

Co-production in the redesign of the national outpatient sleep pathway: a narrative and lessons for the future

[1]N Read, [2]M Baker, [1]A Hare. [1]Royal Brompton Hospital, Kings Health Partnership, London, United Kingdom; [2]Hypersomnolence UK, Manchester, United Kingdom.

Introduction

Effective and meaningful patient involvement within service re-design is integral to ensuring that services deliver improved outcomes for patients.

Methodology

Co-production provides opportunity for meaningful patient-centred change. This project involved experience-based co-design (1) of a national sleep service outpatient pathway between healthcare professionals from across the multiprofessional team, working together with patients with lived experience of sleep disorders.

Outcomes

We successfully produced a clinical pathway designed with and for patients which places patient needs front and centre (2). The pathway has been endorsed and published by the BTS, British Sleep Society and ARTP and we believe it will improve patient experience and clinical outcomes important to both patients and clinicians. We explore the implications and challenges of co-production for service design and reflect on the experience of both clinicians and patients involved in the project.

Discussion

Patient involvement in service re-design is crucial to deliver effective services and sustained improvements in healthcare outcomes. Our co-production experience demonstrates that this model is feasible and associated with positive experiences for both patients and clinicians.

Collaborative service design also raises challenges. Poor health can compromise the ability of patients to engage. In our experience, providing practical support and time to ensure the patient voice is heard throughout is key. Patient organisations allow for representation of more diverse patient groups, but some groups remain under-represented in these conversations, for example those with learning disabilities or social disadvantage, in whom healthcare outcomes remain disproportionately poor. We found that co-production requires skilled communication and comprehensive understanding of the complex ways in healthcare systems shape and constrain co-productive interactions between healthcare professionals and patients.

Conclusions

A well-designed improvement programme should, and can, embed patient expertise alongside that of clinicians in true partnership, to improve quality and access to services for all. Co-production of services with patients can ensure new healthcare systems are responsive and agile and support collaboration with service users towards improved healthcare outcomes.

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QI4

Improving management of pleural infection: implementation of a regional pathway based on the 2023 BTS guidelines on pleural disease

[1]R Watson, [1]J Heaton. [1]Mersey and West Lancashire Teaching Hospitals NHS Trust, Prescot, United Kingdom.

Background

Pleural infection, including empyema (pus in the pleural space) and complex parapneumonic effusion (CPPE), are associated with high morbidity and mortality, with a 20% mortality rate in adult inpatients. The 2023 British Thoracic Society (BTS) guidelines on pleural disease provide evidence-based recommendations for managing pleural infection, including the optimal timing for intercostal drain (ICD) insertion, referral for video-assisted thoracoscopic surgery (VATS), and the use of intra-pleural enzyme therapy (IET).

Objectives

- Design a local Trust pathway for managing pleural infection based on the 2023 BTS guidelines.
- Collaborate with neighbouring NHS Trusts to establish a regional pathway and referral system to the regional cardiothoracic surgery centre.
- Collect and compare data on patient management before and after implementing the new pathway.

Methods

Data was initially collected from August 2023 to February 2024 on 18 patients with pleural infection who had an ICD inserted.

From February 2024, a management pathway was implemented, including a written protocol on timing of ICD, clinical reassessment at 48 hours, and a decision tool for VATS referral or IET. A proforma for documenting the 48-hour reassessment in patient notes was introduced. Additional data was collected from March to September 2024 after the pathway's implementation.

Results

Comparing two groups, the first (August 2023–February 2024) included 18 patients, while the second (March–September 2024) had 12 patients. In the first group, the mortality rate was 28% (N=5). In contrast, there were no fatalities in the second group.

Key improvements after the pathway's introduction included reduced length of stay (15.1 vs. 19.8 days), faster ICD insertion (0.5 vs. 1 day), quicker surgical referrals (3 vs. 4 days), and earlier IET initiation (2 vs. 4.4 days). The percentage of appropriate patients referred for surgery increased from 63% to 83%, with a higher acceptance rate (60% vs. 40%).

Conclusions

The new pathway has improved the timeliness of evidence-based treatment for pleural infection, aligning with BTS recommendations. Close collaboration with the regional cardiothoracic centre has allowed for regional pathway implementation. Future work will expand data collection at a regional level to further assess its impact.

QI5

Introducing an Ambulatory Pleural Effusion Pathway at Whiston Hospital – A Quality Improvement Project

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Background

A 3-month audit of all inpatient pleural referrals found only 27% of patients meeting criteria for appropriate ambulatory care were discharged to ambulatory pleural clinic. The patients that were not ambulated had an average 3.5-day inpatient stay compared to less than 1 day for those ambulated.

SMART Aim

By July 2024, 100% of eligible pleural effusion patients are discharged home and ambulated to outpatient pleural clinic via newly implemented pleural referral pathway.

Methods

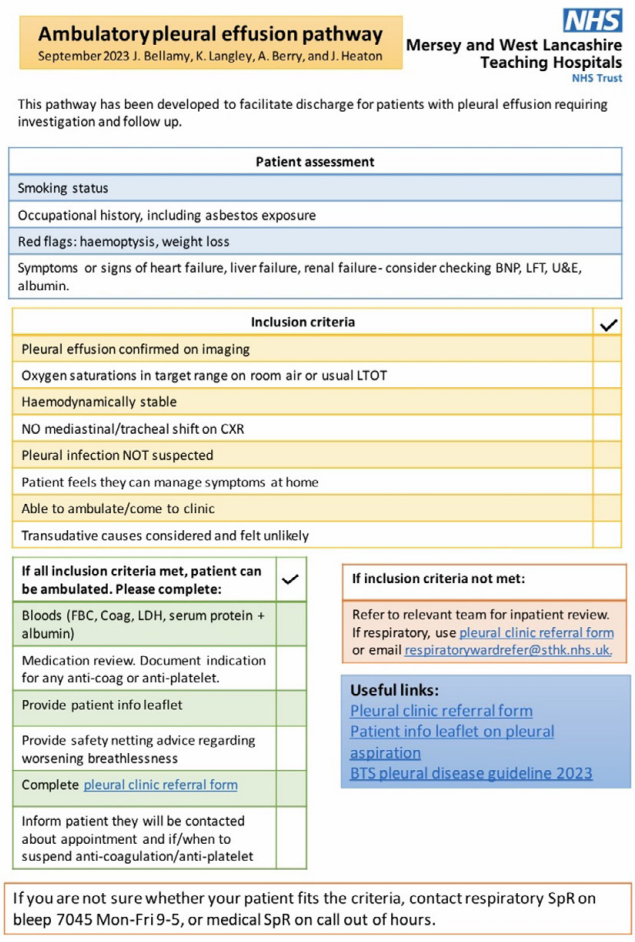
A Plan-Do-Study-Act approach was used over two quality improvement cycles from August 2023 to March 2024. A new ambulatory pleural effusion pathway and online referral form was designed, locally approved and published by the respiratory department in cooperation with the acute and emergency medical teams. Strict inclusion/exclusion criteria were chosen to limit the number of referrals caused by clear transudative processes and to set safe parameters for ambulation (fig 1). Prospective data collection was performed to monitor SMART aim attainment and to monitor balancing measures (readmissions and complications).

Results

Cycle 1 interventions included implementing and advertising the new pathway. This was achieved through trust wide email/ poster advertising and "ground-level" promotion from ED and AMU leaders. This resulted in 80% of patients being appropriately ambulated over three months. Surveys of ED and medical doctors/ANPs found relatively low use/awareness/confidence in the using the pathway at 33%, 67% and 75% respectively. Cycle 2 focused on targeted education strategies for key identified stakeholders: ED/SDEC/AMU resident doctors and ANPs. Focus groups were utilised to inform changes to the online referral process to improve useability. Data from Cycle 2 found 100% (17/17) of patients with pleural effusion were successfully ambulated to pleural clinic via the ambulatory pathway.

Conclusions

The SMART aim was achieved with 100% of suitable patients ambulated via the new pathway and an estimated 2.5 bed days per patient saved. With an average 4 patients per month this saves 10 bed days per month – this small but significant saving could potentially have an impact on bed pressure and overall patient experience.



Ambulatory pleural effusion pathway

September 2023 J. Bellamy, K. Langley, A. Berry, and J. Heaton

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

This pathway has been developed to facilitate discharge for patients with pleural effusion requiring investigation and follow up.

Patient assessment
Smoking status
Occupational history, including asbestos exposure
Red flags: haemoptysis, weight loss
Symptoms or signs of heart failure, liver failure, renal failure- consider checking BNP, LFT, U&E, albumin.

Inclusion criteria	✓
Pleural effusion confirmed on imaging	
Oxygen saturations in target range on room air or usual LTOT	
Haemodynamically stable	
NO mediastinal/tracheal shift on CXR	
Pleural infection NOT suspected	
Patient feels they can manage symptoms at home	
Able to ambulate/come to clinic	
Transudative causes considered and felt unlikely	

If all inclusion criteria met, patient can be ambulated. Please complete:	✓
Bloods (FBC, Coag, LDH, serum protein + albumin)	
Medication review. Document indication for any anti-coag or anti-platelet.	
Provide patient info leaflet	
Provide safety netting advice regarding worsening breathlessness	
Complete pleural clinic referral form	
Inform patient they will be contacted about appointment and if/when to suspend anti-coagulation/anti-platelet	

If inclusion criteria not met:

Refer to relevant team for inpatient review. If respiratory, use pleural clinic referral form or email respiratorywardrefer@sthk.nhs.uk.

Useful links:

Pleural clinic referral form

Patient info leaflet on pleural aspiration

BTS pleural disease guideline 2023

If you are not sure whether your patient fits the criteria, contact respiratory SpR on bleep 7045 Mon-Fri 9-5, or medical SpR on call out of hours.

QI6

Large group CPAP setup is feasible and effective.

[1]WAMP Jayasiri, [1]B Marsh, [1]T Harris, [1]M Babe, [1]C Dobson, [1]H Stevens, [1]D Embury, [1]T Joseph, [1]K Allmond, [1]R Evans, [1]C Turnbull, [1]A Nickol. [1]Oxford University Hospitals NHS Trust, Oxford, United Kingdom.

Introduction

The Oxford Sleep Unit demand for CPAP set-up is 40/ week. Our traditional small-group CPAP setups (4–6 patients per 1.5-hour session) provide insufficient capacity to meet this, resulting in long waiting times. To address this, we piloted large-group setup (25 patients per session) following a pre-consultation, auditing objective and subjective outcome measures. In another sleep centre, this model reduced wait times whilst maintaining good CPAP adherence [1].

Method

Data was collected between October and December 2024. Two large-group sessions were held, with consideration of suitability. A matched small-group cohort was used for comparison. Satisfaction surveys were distributed and patients and/ or their data reviewed at 1-month.

Results

Forty-six patients underwent large-group set-up and 35 small-group setups. Patient characteristics were similar (see Table). At the preliminary 1-month follow-up, high CPAP adherence (>4 hrs/ night for > 70% of days) was 40% in the small group and non-inferior at 56.5% in the large group, with average usage of 3.2(0.7-6.4) and 5.5(0.4-6.9) hours per night, respectively. Both groups had clinically meaningful reductions in the ESS at the 1-month follow-up. The median fall in ESS at 1-month follow-up was 6.0 (1.0–9.0) in the large group and 9.0 (4.6–12.0) in the small group.

Satisfaction surveys were positive in both groups, with 100% willing to use and recommend the service. While the small group rated the venue slightly better and the large group reported lower hearing clarity, both found the service accessible and expressed strong satisfaction.

Conclusion

This audit shows that the large-group setup is feasible, and as effective as the small-group setup, with similar CPAP compliance, reductions in ESS, and high patient satisfaction. Implementing the large-group approach more widely could enhance CPAP set-up capacity.

References

1. Hughes R, Grant K, Williams-Allen C, *et al* P32 Compliance and patient satisfaction in large group face to face initiation consultations for CPAP *Thorax* 2023;**78:**A125-A126.

QI6 - Table 1 Baseline patient characteristics

Characteristic	Small Group (n=35)	Large Group (n=46)
Age (years)	47.9 ± 13.1	52.6 ± 11.9
Sex -Male -Female	 24 (68.6%) 11 (31.4%)	 30 (65.2%) 16 (34.7%)
Ethnicity among patients who declared -White British	 26 (83.9%)	 25 (83.3%)
OSA severity -Mild -Moderate -Severe	 6 (17.1%) 15 (42.9%) 14 (40%)	 14 (30.4%) 17 (36.9%) 15 (32.6%)
OSA severity -AHI (/hr) -4% ODI (/hr)	 27.5 (15.5-55) 23.5 (14.5-120.5)	 21 (12.5–35) 20 (13.5–29.3)
Pre CPAP ESS (out of 24)	12.7 ± 5.5	11.1 ± 4.8

Data are expressed as mean±SD, median (first quartile, third quartile) or number (percentage), as appropriate.

AHI, Apnoea–Hypopnoea Index; BMI, body mass index; CPAP, Continuous Positive Airway Pressure; ESS, Epworth Sleepiness score; ODI, Oxygen Desaturation Index ≥4%, OSA, Obstructive Sleep Apnoea

BTS ABSTRACT PRIZES – DIGITAL POSTERS (DP1 - DP34)

DP1

Respiratory Virtual Wards are a safe and effective way of managing asthma exacerbations in a step-down setting

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The Kingston and Richmond (KRFT) Respiratory Virtual Ward (VW) has been operational since 2022. The multi-disciplinary team (MDT) consists of physiotherapists, nurses, a pharmacist and a respiratory consultant. With increasing pressures on conventional hospital bed-spaces, it is vital to foster management strategies which alleviate these pressures, while providing safe and effective care. In this update, we report on the safety profile and effectiveness of our Virtual Ward in the management of acute asthma.

We conducted a retrospective analysis of patients onboarded to the VW for management of acute asthma as a step-down following hospital admission between February 2022 and October 2024. Inclusion criteria were as follows: established asthma diagnosis, improving clinical trajectory, exclusion of other diagnoses (VTE, sepsis), no previous ITU admission for asthma, and respiratory consultant or registrar approval. A total of 187 patients were onboarded. 134 (72%) were classified as having a mild exacerbation, with 46 (25%) moderate and 7 (4%) severe.

Strategies to avoid re-admission involved an MDT approach. 40(22%) patients underwent medication changes, 30 (16%) received specialist advice, 9 (5%) were reviewed by a team member in an ambulatory hospital setting. 140 (75%) underwent nebuliser wean, 5 (3%) underwent oxygen weaning, and 65 (35%) required no intervention aside from monitoring.

Outcomes were assessed at 30 and 90 days (figure 1). At 30 days, 19 (10%) patients required re-admission to a conventional ward. At 90 days, a further 10 (6%) patients required re-admission. Of the 29 re-admissions, 14 (48%) were directly related to asthma management, 7.5% of the total cohort. Of these 14 readmissions, only 7 were clinically worse than initial presentation, with one requiring admission to ITU. On ITU they required no level 2 care other than monitoring.

Two patients died within the follow-up period. One died from aspiration pneumonia after re-admission. The other died from heart failure after taking their own discharge from the service. There were no deaths related directly to asthma.

Our data demonstrates that with specific inclusion criteria, the virtual ward MDT at KRFT has been able to provide safe and effective management for acute asthma patients, while alleviating conventional bed-space pressures.

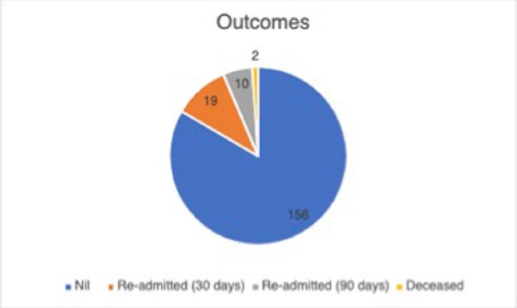


Figure 1: Patient outcomes

Nil – not re-admitted or deceased within the 90-day follow-up period
Re-admitted (30 days) - re-admitted within the initial 30-day follow-up period
Re-admitted (90 days) - re-admitted within the 90-day follow-up period but after the first 30 days.
Deceased – died within the 90-day follow-up period

DP2

In-Situ Simulation for pleural procedures: improving MDT working and patient care

[1]S J Davis, [1]S Power. [1]Wexham Park Hospital, Slough, United Kingdom.

Introduction

Complications arising from pleural procedures, though rare, can present significant challenges in patient management. The absence of the primary pleural operator at the time of such complications often leads to situations where a resident doctor or nurse, who may have limited experience, is responsible for managing the unwell patient. By implementing regular in-situ simulations coupled with debriefing, we aim to enhance the team's ability to recognise and manage potential complications from pleural procedures. This initiative also strives to improve multidisciplinary team (MDT) collaboration.

Method

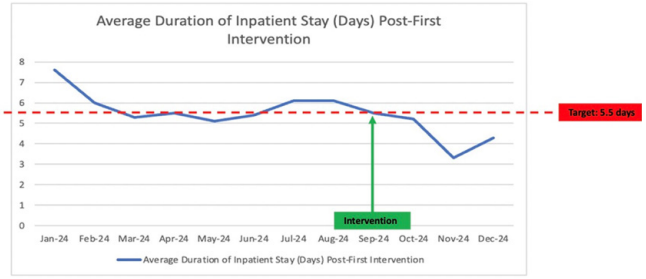
We set up a regular in-situ simulation with scenarios based on complications of pleural procedure: tension pneumothorax, post procedure bleed, surgical emphysema and re-expansion pulmonary oedema. This involved a 15-minute simulation followed by a 15-minute de-brief and took place on the respiratory HDU. Present for the simulations were a general internal medicine (GIM) registrar, respiratory resident doctor and ward respiratory nurse, all of which had it embedded in their rota to ensure attendance was possible. We surveyed the participants pre and post the simulation session

Results

Pre simulation survey revealed 40% of participants were not confident in their knowledge of what the possible complications of pleural procedures were and how to manage these. 50% of participants rated the MDT working on the ward as average or poor. Post simulation survey revealed an improvement in confident in managing pleural procedures complications, with 40% being very confident. 70% rated MDT working as being excellent post the session.

Discussion

We have shown that by setting up a regular in-situ simulation for complications of pleural procedure we can improve doctors and nurses confident in managing them and in turn improve the MDT working. We would hope this would lead to improved patient care should when these complications occur. We aim to incorporate a similar structure of in-situ simulation throughout the trust as part of training for internal medicine doctors.



DP3

Improving the Efficiency of Discharges on Respiratory Ward by Adapting the Daily Multi-Disciplinary Team Meeting

[1]FP Paterson, [1]RL Leckie, [1]RH Hammond, [1]LS Smith, [1]AT Tynan. [1]Ninewells Hospital, Dundee, Scotland.

The aim of this QI Project was to shorten the length of inpatient stay on the respiratory ward by improving the process and efficiency of the daily multidisciplinary team (MDT) meeting.

Prior to September 2024, the respiratory ward had a long established, daily MDT meeting attended by a wide range of colleagues. The setting for the MDT meeting prior to September 2024 (and during initial data collection) was in a private procedure room within the respiratory ward. All patients on the ward were individually discussed amongst the team. Factors discussed were to clarify their current medical issues including likely length of time until patient would be medically fit for discharge, social barriers to discharge and if rehabilitation would be required and, if so, likely duration. The intention of this daily MDT was to optimise the patient discharge process and ensure patients are discharged safely without unnecessary delays.

The previous set-up of the MDT meeting was discussed amongst the team and strategies considered to optimise the process. This QI project changed the MDT meeting format completely following these discussions and introduced a Discharge Whiteboard for all colleagues to use. This encompassed a wide range of factors including requirement for MDT colleague input, patient locality, transport issues and planned discharge date. The location of the meeting was also moved and the number of colleagues attending was reduced to optimize use of colleagues time.

Following implementation of the new MDT set up - data was recollected to demonstrate if average length of inpatient stays had reduced post intervention. The results demonstrated that the average stay had reduced from an average of 5.9 days to 4.3 days post-intervention. A target of 5.5 days of average inpatient stay is set by the Hospital Discharge Team and data collected post-intervention consistently bettered this target.

Anonymous feedback from MDT colleagues following implementation of the new MDT format was also met with overwhelmingly positive feedback with future interventions planned to continue to optimize this process.

The PDSA (Plan, Do, Study, Act) QI methodology was utilized for this QI Project.

DP4

Improving follow up imaging practices for patients with community-acquired pneumonia

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Introduction

The incidence of lung cancer in patients presenting to hospital with community acquired pneumonia (CAP) is variably reported at 1-10%. The British Thoracic Society guidelines for the management of CAP recommend that high-risk patients (aged >50 and current or ex-smokers) with consolidation on a chest x-ray should be followed up with a 6-week repeat x-ray to ensure resolution of changes and to exclude an underlying malignancy.

Initial audit data in our local Respiratory Department showed 41% of patients were not followed up with repeat imaging, either because imaging was not arranged or because patients did not attend.

The aim of this quality improvement project (QIP) was to increase the number of patients who were successfully followed up.

Methods

QIP methodology was utilised to design a series of interventions for this third cycle audit. These interventions included: a patient information sheet with the date and location of the chest x-ray; a reminder on the doctors' handover proforma; a poster in the Doctors' Office; and an update made to the standard of practice for CAP discharges within the trust.

A prospective audit cycle was conducted to analyse the number of patients discharged with a pneumonia by the respiratory team across a 2-month period through discharge code collation.

Results

97 patients had discharge codes for CAP. Of these, 83 met the inclusion criteria for analysis. 31 (37.3%) patients meeting the inclusion criteria were deemed unsuitable for follow up. 11 (13.2%) of these had alternative imaging requested and 11 (13.2%) were excluded due to death. Of the remaining 52 patients, 47 (90.4%) had x-rays requested by the hospital and 34 (72.3%) of these attended their planned follow up. Only 5 (6.0%) patients were incorrectly not followed up.

Conclusion

Concurrent successful interventions have demonstrated an improvement in patient care. Before this QIP, 41% of patients were incorrectly not followed up, whereas in this third audit cycle only 6.0% of eligible patients did not have x-rays booked on discharge. With the increasing incidence of lung cancer in the wider population this should have a positive impact on early detection and treatment of underlying lung malignancies.

DP5

The Role of PET-CT in Sarcoidosis: Evaluating Its Impact on Clinical Decision-Making

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Background

Sarcoidosis is a heterogeneous disease with variable clinical manifestations. While guidelines suggest PET-CT imaging should be used only in highly selected cases to address diagnostic uncertainty, real-world clinical experience has driven the widespread use of PET-CT, particularly for assessing disease activity and guiding treatment decisions.

This audit aimed to evaluate the indications for PET-CT in sarcoidosis and assess how frequently it influences clinical management.

Methodology

This audit was conducted at a tertiary sarcoidosis referral unit. It included all adult sarcoidosis patients undergoing FDG-PET-CT scans as part of routine clinical care from January 2019 until December 2024. Clinical, demographic and radiographic data were extracted from electronic health records. Medians and interquartile ranges (IQRs) were reported for non-normally distributed data.

Results

A total of 292 FDG-PET-CT scans from 163 patients were identified. Of the cohort, 52.1% were male and the median age at diagnosis was 49 years (IQR: 41–57). Lung involvement was present in 76.1% at presentation and 82.2% had biopsy-confirmed disease. Pre-PET-CT, 44.8% of patients were on prednisolone (median dose: 7.5 mg daily), 32.5% on methotrexate (median dose: 15 mg weekly), and 4.9% on infliximab.

Patients underwent a median of 1 PET-CT scan (range: 1-7), 26.0% of scans were cardiac suppressed. The median age at PET-CT was 55 years. Indications for PET-CT included assessment of disease activity in patients with known sarcoidosis (75.3%) and diagnostic work-up (19.5%). 5.1% were performed for unrelated reasons.

PET-CT findings changed clinical management in 50% of cases, leading to initiation of prednisolone in 14.0% of cases (median starting dose: 20 mg daily) and an increased dose in 20.9%. Methotrexate was initiated in 12.3% of cases and increased in 15.1% (median dose: 20 mg weekly) and infliximab was initiated in 1.4%.

Conclusion

PET-CT is frequently utilised in the management of sarcoidosis, largely driven by clinical experience. In this audit, PET-CT was predominantly used for assessing disease activity and had a measurable impact on treatment decisions, particularly in guiding corticosteroid and immunosuppressant adjustments. Understanding the indications for PET-CT and its influence on management can inform the development of future guidelines to optimise its role in sarcoidosis care.

DP6

Tezepelumab: Bridging the Gap in Asthma Control for Biologic-Experienced Patients

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Background

Tezepelumab, approved in 2022, is a monoclonal antibody targeting thymic stromal lymphopoietin (TSLP) for severe asthma management. Unlike other biologics, it is effective regardless of biomarkers like eosinophil count or fractional exhaled nitric oxide (FeNO), offering an option for patients uncontrolled on biomarker-specific biologics.

Objective

To assess the impact of Tezepelumab on asthma control in biologic-experienced patients who remained poorly controlled despite treatment and were switched to Tezepelumab following multidisciplinary team (MDT) review.

Methods

A retrospective analysis was conducted on 19 patients from a difficult asthma clinic previously treated with monoclonal antibodies (Omalizumab: 10, Benralizumab: 3, Mepolizumab: 6). 15 patients had eosinophilic or eosinophilic atopic asthma, and 5 had atopic asthma. Clinical parameters were assessed before and 12 months after Tezepelumab initiation.

Results

At 12 months, the annual exacerbation rate (AER) decreased from 7.19 to 2.4 ± 1.37 ($p = 0.0018$). Eosinophil counts reduced from 500 to 160 ± 90 cells/μL ($p = 0.0001$), and ACQ-6 scores improved from 3.0 to 1.9 ± 0.41 ($p = 0.0134$). Hospital admissions declined from 1.3 to 0.47 ± 0.67 (not significant). Maintenance corticosteroid dose decreased from 6.6 mg/day to 4.5 ± 1.95 mg/day (not significant). Total IgE decreased from 739 kU/L to 412 ± 296 kU/L (not significant). FEV_1 increased from 2.17 L/min to 2.44 ± 0.27 L/min, and FeNO reduced from 39 ppb to 22 ± 8.98 ppb.

Conclusion

Tezepelumab significantly improved asthma control by reducing exacerbation rates and ACQ-6 scores. However, its suboptimal effect on hospital admissions and oral corticosteroid reduction may reflect patient cohort complexity, including comorbidities such as inducible laryngeal obstruction (ILO)/vocal cord dysfunction (VCD), mental health conditions, high BMI, and adrenal suppression. These findings highlight the need for further real-world studies to better understand Tezepelumab's role in this challenging population.

DP7

Riding the spiral COPD storm; DECAF and NIVO scores.

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[1]Frimley Park Hospital, Camberley, United Kingdom;
[2]Southampton General Hospital, Southampton, United Kingdom;
[3]Norwegian University of Science and Technology, Trondheim, Norway.

Introduction

COPD exacerbations are the second most frequent cause of acute hospital admissions in the UK(1). Due to our aging population, COPD prevalence is predicted to rise by 40% in England by 2030, despite falling smoking rates. Timely specialist review and prompt initiation of non-invasive ventilation (NIV) remain suboptimal. Risk stratification tools, such as the DECAF (Dyspnoea, Eosinopenia, Consolidation, Acidaemia, and Atrial Fibrillation) and NIVO (NIV Outcome) scores, have been shown to correlate with in-hospital mortality risk and can guide clinical management.

Methods

This retrospective observational study assessed NIV requirements, in-patient mortality, and readmission rates at 30 and 90 days in COPD patients admitted with exacerbations. DECAF scores were calculated for all patients, and NIVO scores were calculated specifically for those requiring NIV. Patients lacking objective COPD diagnoses or those with terminal illnesses (prognosis less than 12 months) were excluded. Data analysis was performed using Cochran-Armitage tests for categorical trends and Kruskal-Wallis tests for continuous data.

Results

The study analysed data from 89 patients. DECAF scoring classified 56% of patients as low-risk, 23% as intermediate, and 23% as high-risk. High DECAF scores significantly correlated with increased NIV requirement (45%) ($p<0.01$) and in-hospital mortality (40%) ($p<0.01$). Patients with high DECAF scores also demonstrated significantly elevated readmission rates, with 78% readmitted within 30 days ($p<0.01$) and 55% within 90 days (p 0.025). Of those requiring NIV, half had medium-risk NIVO scores, and two patients with high NIVO scores required escalation to mechanical ventilation following NIV failure. Length of hospital stay although showed positive correlation with DECAF score on observational data, was not statistically significant (0.243).

Conclusion

The DECAF and NIVO scores reliably predict mortality and clinical outcomes, supporting clinical decision-making to prevent readmissions or suitability for escalation vs palliation. Utilization of these objective scoring tools enhances communication with patients and their families regarding prognosis and management plans. Further exploration is required to create effective models for interventions using these scores to assess if they improve patient outcomes or readmission rates. However, these scores should complement clinical judgment rather than replace it, ensuring optimal patient-centred care.

1) 1. Office for National Statistics. Population estimates. Available from:

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

DP8

Improving inhaler technique following asthma and COPD admissions using an MDT and digital approach: a quality improvement project based in a district general with a deprived local population

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Introduction

Chronic obstructive pulmonary disease (COPD) and asthma exacerbations carry a high re-admission and mortality risk which could be ameliorated with optimised inhaler therapy [1]. Our respiratory department faces several barriers to effective assessment of inhaler technique. Post-pandemic, a surgical ward was repurposed into a respiratory ward creating gaps in nursing skillset. The lack of funding for an asthma/COPD specialist nurse further stretches resources. Additionally, our local population experiences high levels of deprivation and limited primary care engagement. Hospital admission is therefore a vital opportunity for optimisation of chronic disease in this population.

National Respiratory Audit Data 2022/23 showed just 20% of patients admitted to our hospital had their inhaler technique checked. The aim of this quality improvement project was to ensure all patients admitted to our respiratory ward with a COPD or asthma exacerbation receive an inhaler technique review.

Methods

This project was designed against SQUIRE 2.0 guidelines and registered on Datix. Patients included were discharged alive from an adult respiratory ward with coded diagnoses of asthma or COPD exacerbation over a one-month period. Data collection was repeated every 3 months. Interventions were introduced sequentially and included: a digital documentation tool (Figure 1); a class-based teaching session designed using UK Inhaler Standards [1]; a bedside teaching session; and MDT feedback from respiratory doctors, nurses, and pharmacists.

Results

At baseline (March 2024), 9% of patients had inhaler technique checked. Following introduction of a digital documentation tool, this remained the same. Class-based teaching for nursing staff improved this to 26%, and after bedside teaching, proportion increased to 33%. Of 26 patients reviewed, 10 had their inhaler changed, or a spacer added, due to poor technique.

Conclusion

While the number of patients having their inhaler technique checked modestly increased, additional improvements are necessary. One constraint identified on staff feedback surveys was confidence and awareness of when to undertake the review. This could be addressed with creation of a competency-based assessment, senior role-modelling, and appointment of a dedicated nurse specialist in asthma/COPD.

[1] UK Inhaler Standards and Competency Document, 2019. UK Inhaler Group and the Taskforce for Lung Health Medicines Optimisation

DP8 - Figure 1

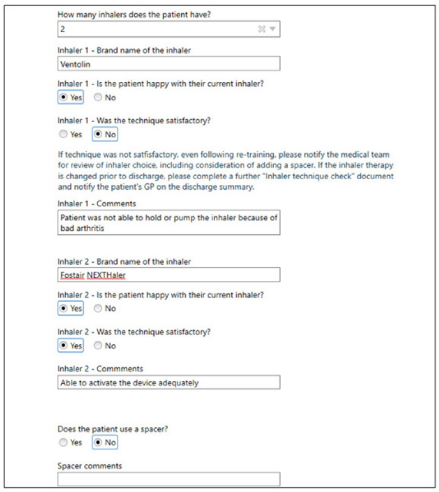

Figure 1 Digital Documentation Tool: The 'Inhaler Technique Check' is a dedicated note-type in the electronic patient record. The design was optimised for simplicity and clarity based on MDT feedback. The form will provide tailored feedback depending on user selection, for example, if the user selects 'No' to 'Is the patient happy with their current inhaler?', a pop-up will appear that reads: 'If the patient is not happy with their current inhaler, please notify the medical team for review of inhaler choice before proceeding to check technique'.

DP9

Green inhalers: can we persuade patients and clinicians in secondary care to make the switch?

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Introduction and Objectives

Metered Dose Inhalers (MDIs), comprising mainly short-acting beta-agonists (SABAs), contribute to 3% of the carbon footprint of the NHS. Despite patient preference for low-carbon inhalers and the potential for significant reduction in carbon emissions, few are prescribed a low-carbon alternative such as a dry powder inhaler (DPI). This quality improvement project aimed to increase the proportion of hospital inpatients with asthma or COPD prescribed a SABA DPI where appropriate and improve clinician knowledge and confidence in discussing the environmental impact of inhalers with patients.

Method

Over a six-month period, data was collected from inpatients with COPD or asthma on two respiratory wards as part of two PDSA cycles, analysed using run charts. Interventions included education sessions for junior doctors focused on 1) enhancing knowledge, 2) improving confidence in holding discussions with patients regarding switching and 3) appropriate inhaler selection and technique. Further interventions targeted changes to the electronic prescribing system, mandating inhaler brand selection and promoting DPI usage.

Results

The median percentage of patients prescribed a SABA DPI post-PDSA 2 compared to baseline decreased on one ward (12.5 to 9.1) and increased on the other (28.8 to 33.3), falling short of targets. Both wards showed a reduction in prescribing a generic SABA MDI (66.7 to 50% and 85.7 to 84.7 % respectively), representing a higher proportion of patients being prescribed a named, lowest carbon-footprint SABA MDI. Median number switched to a DPI during admission improved from 0 pre-intervention to 0.5 and 2 respectively post-PDSA 2.

Clinician confidence improved from a mean score of 4.6 to 8.3 out of 10 after education sessions.

Conclusions

Variability of results and unsatisfactory improvement in DPI prescription overall likely reflects ineffective interventions and a lack of causal relationship between interventions and results. Barriers included clinician time (related to workload pressures), availability of patient information resources and engagement of stakeholders such as specialist nurses and pharmacists. Production of a patient information leaflet and involvement of the whole MDT will likely improve results in future cycles.

References

1. British Thoracic Society, 2024. *Position Statement. Sustainability and the Environment: Climate Change & Lung Health*

DP10

Non-Invasive Ventilation in Medical Patients

[1]R Haider, [1]L Pitchford, [1]A Bandyopadhyay, [1]O Aldroubi, [1]R Sarwari, [1]I Sau. [1]Walsall Manor Hospital, Walsall, United Kingdom.

Background

Prompt initiation of non-invasive ventilation (NIV) is crucial in patients presenting with acute exacerbations of COPD complicated by acute hypercapnic respiratory failure as it reduces mortality and shortens the length of hospital stay (Lightowler, 2003; Plant, 2000).

British Thoracic Society recommends the door-to-mask time to be less than 2 hours, and timely arterial blood gases to monitor the effectiveness of treatment. However, national data (2018) showed poor compliance with this guidance.

Our project aimed to assess the timely initiation of non-invasive ventilation, probe into the factors leading to any delays, and improve compliance through staff education.

Methodology

We carried out a two-cycle Quality Improvement Project. Retrospective data was obtained for a six-month period (n=20), assessing factors contributing to any delays in NIV initiation, and if response to treatment using arterial blood gases at 1 and 4 hours was monitored adequately. Since front-door clinicians make the bulk of decisions pertaining to non-invasive ventilation, we surveyed Registrars in the Emergency Department and General Medicine to find out how confident they felt about initiating, titrating, and weaning off NIV. We also asked front-door clinicians about the challenges they encounter leading to delays in timely initiation, and organized a series of hands-on NIV training sessions for Registrars and Consultants. Subsequently, we completed a second cycle (n=15) to see the results of our interventions.

Results

Our results showed remarkable improvement - the proportion of patients commenced on NIV within two hours increased from 25% to 54%. Education of front-door clinicians reduced the delay in decision-making from 42% in Cycle 1 to 25% in Cycle 2. Resource limitation remained a limiting factor contributing to half the delays. The proportion of patients being monitored with one- and four-hour ABGs remarkably increased (33% to 83% and 8% to 67% respectively). Clinical outcomes remained favourable.

Conclusion

Early recognition and timely initiation of non-invasive ventilation are vital to improving patients' outcomes. However, medical registrars in other specialties do not receive any relevant training. Enhancing education and clinical confidence with hands-on practical training of front-door clinicians is vital to service improvement and providing our patients with the best possible care.

DP11

Expanding the Role of Respiratory Consultants in Ultrasound-Guided Core Biopsies of Lymph Nodes: A Service Improvement Initiative

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Background

Core biopsies of lymph nodes are a crucial diagnostic tool in respiratory medicine, particularly for conditions such as malignancy and tuberculosis. Traditionally, these procedures are performed by radiologists, which can lead to delays in diagnosis due to service demands. This study evaluates the impact of a respiratory consultant-led ultrasound-guided core biopsy service on diagnostic efficiency and patient outcomes.

Methods

Between September 2023 and February 2025, 10 patients underwent ultrasound-guided core biopsies of lymph nodes performed by a respiratory consultant who received training from a radiologist. Biopsy sites included the supraclavicular fossa (n=7), axillary lymph node (n=2), and pleural lining (n=1). The primary outcome was the diagnostic yield, defined as a biopsy result providing a definitive diagnosis. The time from referral to biopsy was also assessed.

Results

A definitive diagnosis was obtained in 9 out of 10 cases (90% diagnostic yield). The pathological findings included small cell lung cancer, NSCLC, mantle cell lymphoma, malignant melanoma and Mycobacterium tuberculosis.

The Radiology biospy service had an average waiting time of 2-3 weeks, extending to 4 weeks during holidays. Our service had an average referral to biopsy time of 1 week, significantly expediting the diagnostic process. No major complications were reported.

Conclusion

This study demonstrates the feasibility and effectiveness of a respiratory consultant-led core biopsy service following targeted radiology training. The initiative has improved diagnostic efficiency while maintaining a high diagnostic yield. These findings support the expansion of respiratory consultant involvement in ultrasound-guided lymph node biopsies to enhance patient care and streamline diagnostic pathways.

DP12

Streamlining Primary Care Referrals to the Sleep-Disordered Breathing Pathway at a District General Hospital

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Background

Obstructive Sleep Apnoea (OSA) causes daytime sleepiness and reduced quality-of-life. Increased demand and referrals to the Sleep-Disordered Breathing (SDB) pathway suggest significant numbers of affected individuals. The NICE-approved STOP-Bang criteria can identify suspected OSA patients. Through auditing primary care referrals to the SDB pathway, we identified missing records of high-risk occupation (e.g. pilots) screening, Epworth-Sleepiness-Score (ESS) and STOP-Bang scores. These missing data hinder triaging of suspected OSA patients.

Aim

Improve completeness of suspected OSA referrals from primary care by incorporating high-risk occupation, ESS and STOP-Bang scores into a standardised referral form to the SDB pathway. We aim to increase reported STOP-Bang scores from 3.33% to 80.0%, and high-risk occupation screening from 20.0% to 80.0% by April 2025.

Methods

After baseline data collection of 30 consecutive suspected OSA patients from primary care referrals, we liaised with the primary care lead for Digital Health to develop a standardised primary care referral form for our Plan-Do-Study-Act (PDSA) Cycle 1 intervention. This included specific sections to record high-risk occupation screening, ESS, and STOP-Bang score. We repeated the 30-patient data collection after our form went live to primary care providers and analysed pre- and post-intervention results, using a quasi-experimental approach. Similar methods will be used for PDSA Cycle 2.

Results

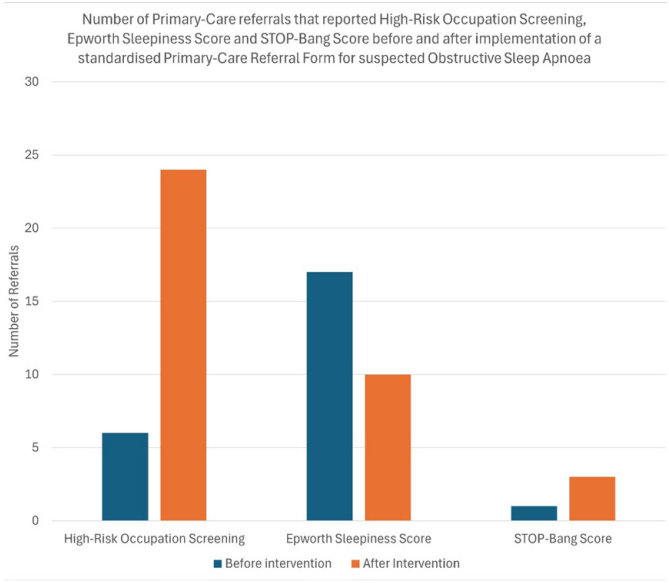
Results following PDSA Cycle 1:

- STOP-Bang Score reporting increased from 3.33% to 10.0% (p=1.000).
- Recording of patient neck circumference within the STOP-Bang Score was often omitted, preventing total scoring.
- High-risk occupation reporting increased from 20.0% to 80.0% (p=0.075).
- ESS reporting decreased from 56.6% to 33.3% (p=0.705).

Discussion/Conclusion

Baseline audit data showed that information within primary care referrals was inconsistent. Making concise changes to the referral form, with primary care collaboration, has improved data-completeness of referrals to the SDB pathway. This may facilitate better triaging and prioritising of high-risk patients for expedited assessment and management. For the PDSA Cycle 2 intervention, the edited referral form includes:

- The score for each constituent question within the STOP-Bang score to facilitate easier totalling.
- Clarification of the neck circumference question, e.g., using the length of a pencil as a comparator for measurement.
- Adding constituent questions of the ESS.



DP13

Evaluating the Impact of Precision Medicine in Biologic Therapy for Severe Asthma

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Background

Biologic therapies have revolutionised severe asthma treatment by targeting specific inflammatory pathways. Precision medicine enables individualised care, but some patients require biologic switching due to inadequate efficacy, side effects, or disease progression. This study explores the impact of biologic transitions on clinical outcomes and biomarker responses to refine therapeutic strategies.

Objective

To assess the effectiveness of biologic switching in severe asthma, optimising treatment response, minimising adverse effects, and adapting to evolving phenotype/endotype.

Methodology

This retrospective study analysed 86 patients (46 males, 40 females) from a severe asthma centre, who switched biologics between July 2020 and July 2024. Data included demographics, reasons for switching, biomarker levels before and after the switch, and clinical outcomes at 16 and 32 weeks.

Results

Biologic switching was driven by uncontrolled exacerbations, side effects (rash, arthralgia, nephropathy, migraine), and patient preference. Exacerbations decreased from a mean of 4.8 ± 0.43 to 1.4 ± 0.32 at 16 weeks, with a slight increase to 1.8 ± 0.35 at 32 weeks ($p<0.0001$). ACQ-6 scores improved from 2.91 ± 0.18 to 1.85 ± 0.25 at 16 weeks, then rose to 2.36 ± 0.29 at 32 weeks. Eosinophil count decreased from 250 ± 30 to 150 ± 60 at 16 weeks, reaching 120 ± 40 at 32 weeks. FeNO levels dropped from 63 ± 7 ppb to 47 ± 6 ppb at 16 weeks, reaching 39 ± 5 ppb at 32 weeks.

Conclusion

Biologic switching, whether within the same or different drug class, in patients with inadequate response to previous biologics, significantly reduces exacerbations and improves asthma control. Timely intervention and strategic biologic selection are crucial for optimising long-term management of severe asthma.

DP14

Reinterpreting pulmonary function tests: The clinical impact of shifting from race-specific to race-neutral reference equations

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Pulmonary Function Testing (PFT) interpretation compares actual measurements with predicted values derived from a global dataset of healthy non-smokers. While race and ethnicity have historically informed these interpretations, their use is increasingly questioned due to their potential to perpetuate health disparities. To standardise PFT interpretation, the Global Lung Function Initiative (GLI) developed race-specific reference equations (2012), but limitations were recognised. In 2022, GLI introduced race-neutral equations. This study evaluates the impact of transitioning from race-specific to race-neutral equations on PFT interpretations in a local patient sample.

PFT data from 5716 patients aged 18-95 were reanalysed using GLI global 2022 race-neutral and compared to the existing GLI 2012 race-specific reference equations. Results were stratified by self-reported ethnicity (White, Black, and Other/Mixed) to assess clinical implications.

The mean difference in FEV1 Z-scores between race-specific and race-neutral reference equations was -0.31 [LOA: 0.08; -0.71] in the white cohort, 0.53 (LOA: 0.93; 0.13) in the black cohort, and -0.06 (LOA: 0.36; -0.49) in the Other/Mixed cohort. Race-neutral equations resulted in lower FEV1 Z-scores in Black individuals than race-specific equations, whereas in White individuals, they produced slightly higher FEV1 Z-scores. Minimal differences were observed in the Other/Mixed cohort.

Race-neutral equations increased the prevalence of lung function impairment by 1.9% in the White cohort, 11% in the Black cohort, and 0.65% in the Other/Mixed cohort. Applying race-neutral equations increased obstruction prevalence by 3.5% in the White cohort, with minimal changes in the Black and Other/Mixed cohorts. Restriction prevalence increased by 10.9% in the Black cohort but decreased by 4.6% and 3.2% in the White and Other/Mixed cohorts, respectively. Obstruction severity changed in 9.2% of White, 8% of Black, and 7.8% of Other/Mixed individuals. Overall, 8.1% of patients had interpretation changes from race-specific to race-neutral equations.

The adoption of GLI Global 2022 race-neutral reference equations will significantly impact spirometry interpretation, particularly in Black individuals. Clear communication with clinical teams is essential to ensure awareness of these changes and their implications. While the shift to race-neutral equations represents progress, further research, especially in non-white cohorts, is needed to fully evaluate its clinical impact.

DP14 - Table 1: Prevalence of Obstruction, Restriction, Mixed/Non-Specific, and Impairment

Group	Category	GLI 2012 Race-specific (n)	GLI 2012 Race-specific (%)	GLI Global 2022 Race-neutral (n)	GLI Global 2022 Race-neutral (%)	% Change
White	Obstruction	1007	20.7%	1175	24.2%	+3.5%
	Restriction*	765	15.7%	541	11.1%	-4.6%
	Mixed/Non-Specific	270	5.6%	208	4.3%	-1.3%
	Impairment**	1834	37.7%	1924	39.6%	+1.9%
Black	Obstruction	25	13.1%	21	10.9%	-1.2%
	Restriction*	32	16.8%	53	27.7%	+10.9%
	Mixed/Non-Specific	8	4.2%	12	6.3%	+2.1%
	Impairment**	65	34.0%	86	45.0%	+11.0%
Other/Mixed	Obstruction	90	13.6%	86	13.0%	-0.6%
	Restriction*	204	30.8%	183	27.6%	-3.2%
	Mixed/Non-Specific	45	6.8%	37	5.6%	-1.2%
	Impairment**	302	45.6%	306	46.25%	+0.65%

*Suggestion of restriction, lung volumes needed to confirm.

**Impairment = Obstruction, Restriction or Mixed/Non-Specific.

DP15

The Cost and QALY Impact of Penicillin Allergy in Individuals With COPD- A Model-based Economic Evaluation

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Background

COPD is a common condition characterised by persistent respiratory symptoms and airflow obstruction. It affects around 2% of the population and is a leading cause of hospitalisation and deaths in the UK. Penicillin allergy (PenA) affects about 10% of the population and has important consequences for infection frequency, hospitalisation and mortality in these patients. There are no estimates of the cost and quality of life years (QALY) impact of having PenA in COPD patients.

Methods

A Markov decision model was developed to compare the costs and QALYs accrued by COPD patients aged 60yrs with and without PenA respectively over a period of 20 years. Data inputs were derived mainly from published literature. One-way and probabilistic sensitivity analyses were performed to account for data uncertainty. Discounted costs and QALYs were calculated using a UK NHS perspective.

Results

COPD patients with PenA costed an additional £2,833 and lost 0.6 QALYs over the model duration compared with those without PenA. Given that 1.4 million individuals are affected by COPD in the UK, the annual excess cost of a PenA label to the UK health economy is around £18.6 million with a loss of 4200 QALYs. The costs are higher if only individuals with severe COPD are considered in the model. The findings of the base case estimation remained stable under multiple one-way sensitivity analyses. Probabilistic sensitivity analysis showed that PenA was the more costly option 96% of the time and always resulted in a QALY loss.

Conclusions

PenA label carries considerable cost and QALY consequences for individuals with COPD. There is a need for strong antibiotic stewardship and to look closely at allergy labelling and de-labelling practices to reduce costs for the health service and to improve outcomes for these individuals.

DP16 - Abstract withdrawn

DP17

Enhancing Patient Preparedness in Outpatient Pleural Clinic Appointments: The Impact of an Informational Leaflet

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Introduction

The Pleural Clinic provides follow-up for patients who have previously been admitted for pleural procedures or surveillance. However, many patients attending the clinic are uncertain about what to expect during their visit, the necessary preparations, or the medications they may need to stop prior to any interventions. This lack of awareness can lead to patient anxiety and confusion.

This study aims to improve patient knowledge and preparedness by providing a dedicated informational leaflet to patients before their clinic appointment. The leaflet covers key topics such as what to expect during the visit, instructions on medications to stop (if relevant), and the risks and benefits of procedures.

Method

To assess patients' existing knowledge about the pleural clinic, a survey (Survey 1) was conducted with 30 randomly selected patients. The survey aimed to identify gaps in understanding regarding the clinic's processes and necessary preparations for pleural interventions. Based on the survey results, an informational leaflet was developed. This leaflet provides essential details about the pleural clinic, including:

- Expectations for the clinic visit
- Instructions on any medications that may need to be stopped before the appointment
- Information on the risks and benefits of pleural procedures

The leaflet is sent to patients alongside their appointment letter, allowing them time to review the information before their visit.

Results

Survey 1 findings indicated that most patients had limited knowledge about what to expect during their clinic appointment and the necessary preparations, such as medication adjustments. Survey 2, currently ongoing, aims to assess the leaflet's effectiveness in improving patient understanding. Preliminary feedback suggests that patients find the leaflet informative and beneficial in reducing uncertainty about their visit.

Discussion

The results highlight a significant knowledge gap, contributing to patient anxiety. Implementing an informational leaflet is a promising step toward improving patient education and preparedness. Early results suggest this intervention enhances the patient experience. Future steps include refining the leaflet based on feedback, expanding the study, and assessing long-term effects on patient satisfaction. Addressing these gaps ensures patients feel more confident and prepared, ultimately improving care quality and outcomes.

DP18

Evaluating the impact of a very severe OSA clinical assessment service (CAS) model on patient waiting times and sleep clinic workload

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Introduction

Delays in sleep clinic access prolong CPAP initiation for sleep-disordered breathing. This study evaluates a streamlined CAS model where consultants review referrals, limited sleep study results, and patient questionnaires to triage individuals directly to physiologist-led CPAP initiation.

Methods

Retrospective analysis of 91 patients who underwent sleep studies (July15-Oct 24, 2024). Demographics, sleep study results, and referral pathways to CPAP or clinician consultation were analysed.

Results

Mean patient age: 50 years (24-85). Mean AHI: 79 (severe OSA). Mean SpO2: 89.3%.

63 patients were referred directly to CPAP, with an average waiting time of 74 days; 28 patients required a clinician review first, with mean wait of 101 days.

Fifty-nine percent were identified to need CBG check before CPAP initiation; None had a PaCO2 >7 kPa.

Discussion

Direct referral to CPAP significantly reduced waiting times by 27 days, allowing earlier treatment for patients with severe OSA. Given the high AHI in this cohort, timely intervention is crucial to prevent complications associated with untreated OSA.

The identification of patients requiring CBG testing before CPAP also ensures appropriate screening for ventilatory failure, which may otherwise be missed in routine care. Notably, none of the patients assessed had PaCO2 >7 kPa, supporting the feasibility of this approach in identifying suitable candidates for CPAP without unnecessary delays.

Conclusion

The CAS model significantly shortens CPAP initiation time, reduces sleep clinic burden, and maintains clinical efficacy. By integrating limited diagnostics with expert assessment, this approach facilitates timely treatment initiation and improves efficiency in managing severe sleep-disordered breathing.

DP19

Oxygen prescribing made safer: A QIP for sustained prescribing compliance

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Background

Oxygen is the most commonly-used emergency drug but remains under-prescribed despite BTS guidelines, putting patients at risk of harm—especially those at-risk of hypercapnic respiratory failure. Previous cycles of this QIP (presented at the 2024 BTS Summer Conference) aimed to improve compliance but led to only transient improvements. This study continues this QIP with PDSA cycles 4 and 5, identifying oxygen prescribing barriers and implementing an intervention to achieve sustained compliance improvements.

Methods

PDSA 4: An anonymous questionnaire was distributed to clinicians to explore oxygen prescribing barriers. The questionnaire collected quantitative and qualitative data using Likert scales and open-ended questions to assess clinician understanding, adherence, and perceived barriers.

PDSA 5: Baseline data were collected from five wards, including acute medicine, surgery, frailty, respiratory, and A&E, focusing on whether oxygen was administered, prescribed, and whether target saturations were specified. We implemented a mandatory 'hardstop' oxygen prescription into the electronic patient record (EPR), requiring clinicians to prescribe oxygen and specify target saturations at admission.

Results

Questionnaire key findings (PDSA 4, n=15)

- **Perceptions:** 33.3% of clinicians believed oxygen should always be prescribed, whilst 25% felt oxygen should never require a prescription. Many viewed oxygen as separate from other medications, contributing to poor prescribing compliance.
- **Time constraints:** 83.3% cited limited clinical time to prescribe oxygen
- **Prescribing challenges:** 41.7% found EPR difficult to use
- **Lack of training:** 41.7% reported insufficient training, with 50% unaware of BTS guidelines
- **Nursing practice influence:** 70% noted nurses administer oxygen without a prescription, reinforcing the perception that prescribing is unnecessary, while 41.7% relied on nursing staff for oxygen management.

Intervention impact (PDSA 5): Compliance increased from 10% (baseline) to 99% one week after implementing the mandatory 'hardstop', remaining at 99% after six weeks.

Conclusion

This QIP highlights clinicians' limited understanding of when to prescribe oxygen, its necessity, and BTS guidelines, identifying inefficient workflows and inadequate training as key barriers. The mandatory prescription intervention produced consistent, sustained compliance in line with BTS standards. However, ongoing education is essential. We recommend a national BTS-led campaign to effectively standardise practices and address prescribing barriers.

DP19 - Figure 1

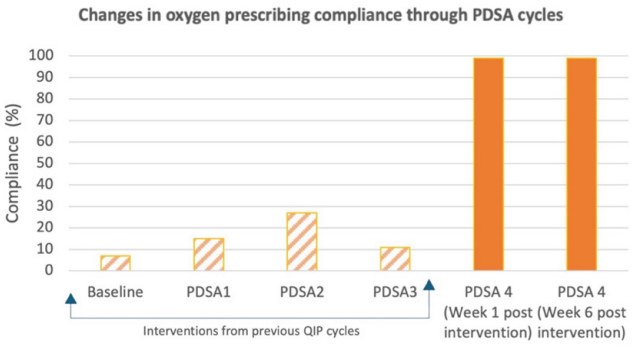

Figure showing earlier PDSA cycles (1–3) produced only minor, transient improvements in oxygen prescribing compliance. The mandatory oxygen 'hardstop' prescription (PDSA 4) led to a significant, sustained increase in compliance, maintaining near-complete adherence well beyond the intervention period.

DP20

Rethinking Urgent Home Oxygen Orders: Can We Improve?

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Introduction

Long-term oxygen therapy is important when prescribed appropriately. The British Thoracic Society (BTS) have published guidelines which outline such scenarios[1]. A Home Oxygen Order Form (HOOF) is required for oxygen prescription. At the discretion of the clinician completing this, oxygen can be delivered within time frames ranging from; 4 hourly (urgent) to 3 business days (routine). The NHS incurs an additional cost for each urgent HOOF.

Aim

There are valid logistical situations where urgent HOOFs can benefit a patient. However, we identified that one service provider was among the top three highest prescribers of urgent HOOFs in the East of England region. This audit was to identify if this reflected genuine patient needs or inefficiencies.

Methods

Data was collected retrospectively from the oxygen provider for patients prescribed urgent HOOFs from May-July 2024. From the hospital records, we audited the date of urgent HOOF requests and patient discharge. Where possible, we evaluated the indication and reason for delays and compared this against recommended BTS criteria.

Results

Figure 1 shows the 28 prescriptions for urgent HOOFs placed from May-July 2024 by specialty.

Discussion

Areas of good practice identified

- The respiratory team measured ABGs, documented targets and indication for oxygen

Areas of poor practice identified

- None of the palliative prescriptions under other specialties followed the BTS guidance; they did not have an underlying respiratory pathology and were not hypoxic.
- Saturations were above oxygen targets and no ABG was documented for one patient coded with COPD

Conclusion

Urgent HOOFs prescribed by the respiratory service were appropriate and followed BTS guidance, whereas those prescribed from other specialties did not follow recommended guidance and the indications were not clear. Addressing this may have the potential to improve clinical practice and be cost saving.

Looking to the future, a gatekeeping process may be considered to ensure that urgent HOOFs are only requested for patients who meet criteria and need.

References

1. British Thoracic Society guidelines for home oxygen use in adults: accredited by NICE (2015)

DP20 - Figure 1

Indication	Specialty	
	Respiratory	Other Medical Teams
Unclear (requested by Hospital at Home)	5	0
Palliative	4	13
Other respiratory pathology	3	1
LTOT	2	0
Total	**14**	**14**

DP21

Resuscitating Respiratory Journal Club

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Introduction

The crisis in UK clinical academic training threatens the NHS's ability to deliver research and innovation. Respiratory clinicians need to maintain skills in critical appraisal and evidence-based medicine, even outside of formal academic pathways. Journal clubs, while valuable, often compete with service pressures.

Methods

A respiratory journal club was relaunched post-pandemic, organized by a designated respiratory registrar. Papers were selected by a resident doctor or medical student, and discussions were chaired by a respiratory consultant. Time and location were varied, rotating through different days and times to maximize attendance. Formal feedback was obtained in 2024 via an online questionnaire.

Results

Between 7th September 2021 and 11th February 2025, 94 papers were discussed across 86 journal clubs, chaired by 12 consultants across Addenbrooke's and Royal Papworth. Attendees included respiratory doctors, pharmacists, physiotherapists, trainee ACPs, and pleural nurse specialists, with a peak weekly attendance of 18 clinicians. The most popular subspecialties were infection (including COVID-19) (n=21), COPD (n=17), and ILD (n=12). The most frequently selected journals were *Thorax* (n=18), *NEJM* (n=17), and *Lancet Respiratory Medicine* (n=14). Feedback was completed by junior doctors (n=12) and consultants (n=3). All presenters found the experience "useful" or "extremely useful".

83% (n=10) of resident doctor respondents felt their knowledge of evidence-based respiratory medicine improved, and 75% (n=9) felt their appraisal skills improved. Qualitative feedback included "In 4 years of training, this is a unique educational opportunity" and "Thank you for organising!!! Very useful and a nice break from ward work". Attendance challenges included clinical activity (n=5) and rota/staffing issues (n=5).

Discussion

This journal club demonstrates sustained engagement and positive feedback, particularly from IMTs, highlighting its value in developing critical appraisal and evidence-based practice. The range of subspecialties and high-impact journals suggest relevance to diverse respiratory clinicians. While the small feedback sample is a limitation, consistent attendance and positive comments support its success. Attendance challenges underscore competition with service pressures, but flexible scheduling mitigated these. Respiratory departments should consider replicating this model, potentially using hybrid formats or multi-site collaboration. Further research could explore the journal club's long-term impact on clinical practice and patient outcomes.

DP22

Endobronchial Ultrasound Audit in Irish Tertiary centre

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Background

Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is a key diagnostic tool for sampling enlarged mediastinal and hilar lymph nodes, with a sensitivity of at least 88% for staging lung cancer. This audit aimed to evaluate whether the EBUS yield at University Hospital Limerick aligns with international standards.

Methods

This retrospective study analysed the results of EBUS procedures performed at a tertiary center from January 2024 to December 2024. We assessed whether the EBUS tissue samples were sufficient for diagnosis, classifying the procedure as successful if it yielded adequate lymph node tissue. Samples deemed "inadequate" or "non-diagnostic" on cytopathology reports were considered unsuccessful. The British Thoracic Society (BTS) Quality Standards for Flexible Bronchoscopy (2014) served as the standard for comparison. We also subclassified pathology results into benign and malignant categories. Additionally, we noted the frequency of repeated EBUS-TBNA procedures.

Results

Out of 373 lymph node samples, 265 (71%) were adequate. Of the 163 EBUS procedures performed, 119 (73%) were diagnostic. 19% of total EBUS procedures (31 out of 163) were positive for malignancy, 1.2% (2 out of 163) for lymphoma, and 79.8% were benign. 14% (23 out of 163) of EBUS procedures in 2024 were repeated from the previous year or within the same year.

Conclusions

The diagnostic yield of EBUS-TBNA for pulmonary pathology at University Hospital Limerick was 73%, compared to the BTS standard of 88% for lung cancer staging. Potential root causes for the lower yield were identified, including the lack of rapid on-site evaluation, inconsistencies in the number of passes, and insufficient formal documentation. Training improvements are necessary to enhance diagnostic yields and sensitivity for detecting both intra- and extra-pulmonary pathology.

DP23

It's Not Easy Going Green – Challenges and Successes in Implementing Lower Carbon Footprint Inhalers

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Introduction

Inhalers make up 3% of the NHS's greenhouse emissions, but Dry Powder Inhalers (DPIs) can have a carbon footprint between 20-30 times less than their equivalent Metered Dose Inhalers (MDIs). The UK lags significantly behind the rest of Europe in its use of DPI.[1]

At our Trust, a Green Inhalers Action Group was formed in 2021 with the aim of reducing new prescriptions of MDIs, in line NHS net-zero policy. The action group included consultant and resident doctors, pharmacists and sustainability officers.

Methods

Using a Plan-Do-Study-Act methodology we implemented several key interventions. Including teaching sessions for pharmacists and doctors, changing of inhalers stock, electronic prescribing and developing powerplans to encourage DPIs.

Data was collected on the total and type of inhalers prescribed across the Trust between April 2020 and late 2024. Over 100,000 inhalers were prescribed across this period.

Results

For salbutamol inhalers specifically there has been a significant increase in the proportion of DPIs prescribed with an over 1400% increase (from 0.3% to 4.6%). However, overall total prescriptions of MDI's remain high (between 71-77% of all inhalers).

Conclusion

Our findings underscore the necessity of a multifaceted approach that includes key stakeholders to drive change. By combining education with MDT engagement and technological solutions we were able to demonstrate improvements overtime.

Nevertheless, achieving persistent change has proved difficult, in part due to the challenge of the transient nature of resident doctors training, with frequent rotations leading to a limited institutional memory.

There is cause for optimism though. Salbutamol has consistently made up more than half of inhalers prescribed at our trust. With new NICE/BTS/SIGN guidance salbutamol should no longer be prescribed as first line in asthma. The new first line is a low dose ICS/formoterol combination inhaler. This presents a huge opportunity to change clinical practice in a way that benefits patients and the environment.

Reference

1. Janson C, Henderson R, Löfdahl M, Hedberg M, Sharma R, Wilkinson AJK. Carbon footprint impact of the choice of inhalers for asthma and COPD. Thorax. 2020 Jan;75(1):82-84. doi: 10.1136/thoraxjnl-2019-213744. Epub 2019 Nov 7. PMID: 31699805; PMCID: PMC6929707.

DP24

Real World Treatment Outcome of Exercise-Induced Laryngeal Obstruction (EILO) Using Breathing Pattern Optimisation and Biphasic Technique: A Service Evaluation

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Introduction

Exercise-induced laryngeal obstruction (EILO) is a laryngeal dysfunction characterised by partial occlusion of the glottis or supraglottic structures during high-intensity exercise, resulting in respiratory distress such as exertional breathlessness and inspiratory wheeze. It is frequently misdiagnosed as differential diagnoses, i.e. asthma. This service evaluation aims to investigate the patient outcomes of the current treatment approaches for diagnosed EILO in a respiratory specialist centre in the United Kingdom, including the utilisation of breathing pattern optimisation and laryngeal control techniques, with the goal to guide clinicians in developing standardised treatment approaches for EILO in the future.

Methods

Patients that have an EILO diagnosis following a continuous laryngoscopy during exercise (CLE) in 2023 and received physiotherapy are included. Patient data was retrospectively collected as part of routine care from the electronic medical record, including the Exercise-induced laryngeal obstruction dyspnoea index (EILODI), Breathing Pattern Assessment Tool (BPAT), Nijmegen Questionnaire (NQ) and Dyspnoea 12 (D12) pre- and post-interventions. Statistical analysis was performed using STATA.

Results

36 patients were diagnosed with EILO. However full data sets were only available for 5 patients (80% Female, age range 20-63). 2 patients achieved the minimal clinically important difference (MCID) in EILODI, and overall demonstrating a mean improvement of 35% (figure 1.). All 5 patients reached normalised values in BPAT, with a mean improvement of 82.6% (figure 1.). There is a mean improvement of 27% in the NQ (figure 1.), with all 5 patients having pre-treatment scores below the threshold indicative of hyperventilation. 2 patients achieved established MCID in D12, with an overall 24.9% mean improvement (figure 1.).

Conclusion

Although the available sample size is relatively small, overall positive trends were noted, with the mean EILODI and D12 scores achieving MCID, and BPAT scores of all patients have returned to normalised values, indicating potential clinical effectiveness. The service evaluation shows that further research with a larger sample size is required to establish a more robust analysis of the treatment effects, as the current analysis is limited by data loss and small patient numbers.

DP24 - Figure 1

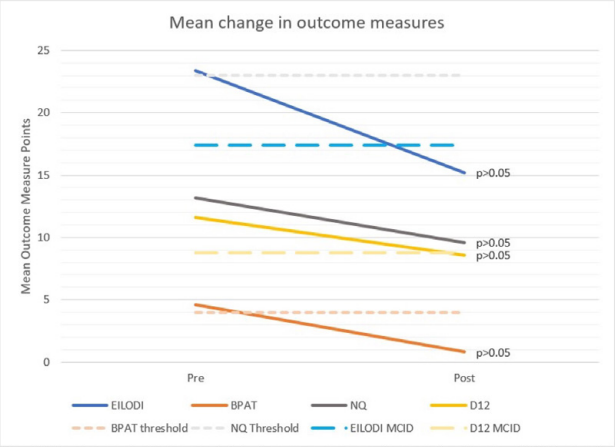

Figure 1. *Mean changes of points in each selected outcome measures comparing pre- and post-treatment. EILODI = Exercise-induced laryngeal obstruction dyspnoea index; BPAT = Breathing Pattern Assessment Tool; NQ = Nijmegen Questionnaire; D12 = Dyspnoea-12; MCID = Minimal clinically important difference. BPAT threshold of >= 4 is indicative for positive dysfunctional breathing with the sensitivity of 0.92 and specificity of 0.75. NQ threshold of >=23 is indicative for hyperventilation syndrome. EILODI MCID is established at 6. D12 MCID is established at 2.83.*

DP25

Reduction of Exacerbations According to Type 2 Inflammatory Biomarkers With Dupilumab Treatment in Patients with Chronic Obstructive Pulmonary Disease (COPD)

[1]S Couillard, [2]R Wysoczanski, [3]S Ramakrishnan, [4]ID Pavord, [5,6]Y Çolak, [7]R Buhl, [8]G Deslée, [9]D Bauer, [10]M Soliman, [9]J Heble. [1]University of Sherbrooke, Quebec, Canada; [2]Sanofi, Berkshire, United Kingdom; [3]Institute for Respiratory Health, University of Western Australia, Perth, WA, Australia; [4]Respiratory Medicine Unit, Nuffield Department of Medicine, University of Oxford, Oxford, UK; [5]Copenhagen University Hospital – Herlev and Gentofte, Copenhagen, Denmark; [6]University of Copenhagen, Copenhagen, Denmark; [7]Mainz University Hospital, Mainz, Germany; [8]INSERM U1250, University Hospital of Reims, Reims, France; [9]Sanofi, Bridgewater, NJ, USA; [10]Regeneron Pharmaceuticals Inc., Tarrytown, New York, USA.

Rationale

Dupilumab, a human monoclonal antibody, blocks interleukin-4/13 signaling, key and central drivers of Type 2 (T2) inflammation. In BOREAS and NOTUS, add-on dupilumab reduced moderate-or-severe exacerbation rates and T2 biomarkers, and improved lung function in COPD and T2 inflammation. Safety was consistent with the known dupilumab profile. This post hoc analysis of BOREAS and NOTUS explored the predictive baseline blood eosinophil counts (BEC) and fractional exhaled nitric oxide (FeNO), for response to dupilumab treatment in patients with COPD and T2 inflammation.

Methods

BOREAS (NCT03930732) and NOTUS (NCT04456673), Phase 3, randomized, placebo-controlled trials, enrolled 1874 patients (40–85 years) with moderate-to-severe COPD and T2 inflammation (screening BEC ≥300 cells/mL) on triple therapy [inhaled corticosteroids, long-acting β2-agonists, and long-acting muscarinic antagonists]. Patients received dupilumab 300 mg q2w or placebo for 52 weeks. The annualized moderate-or-severe exacerbation rates over a range of T2 biomarkers was evaluated using a negative binominal model and a first-degree fractional polynomial transformation of the biomarker as a continuous variable, and the biomarker-by-treatment interaction.

Results

Reductions in annual exacerbation rates were observed over a range of baseline BEC (estimate [95% CI] – dupilumab: 0.57 [0.51, 0.63] for 300 cells/mL to 0.58 [0.51, 0.65] for 900 cells/mL; placebo: 0.81 [0.73, 0.89] for 300 cells/mL to 0.81 [0.73, 0.89] for 900 cells/mL).

Reduction in treatment rate ratio for exacerbations was observed with increasing baseline FeNO levels from 0.69 (0.60, 0.80) (FeNO ≥20 ppb) to 0.56 (0.46, 0.69) (FeNO ≥40 ppb), indicating a significant predictive value (*P*=0.006) for treatment by baseline FeNO interaction unlike baseline BEC (*P*=0.087). Reductions in annual exacerbation rates were also observed regardless of baseline IgE levels (estimate [95% CI] – dupilumab: 0.56 [0.50, 0.63] for IgE 100 IU/mL to 0.53 [0.44, 0.63] for IgE 1,000 IU/mL; placebo: 0.82 [0.74, 0.90] for IgE 100 IU/mL to 0.78 [0.67, 0.92] for IgE 1,000 IU/mL).

Conclusion

In BOREAS and NOTUS, dupilumab reduced exacerbations compared to placebo independently of baseline BEC and IgE. Baseline FeNO levels were associated with a greater response to dupilumab, implying utility to manage T2 inflammatory COPD.

DP26

Working Towards Sustainability in Respiratory Medicine

[1]H Sathyavan, [1]S Sezhian. [1]King's College London, London, United Kingdom.

Background

Climate change is one of the greatest health challenges of this century. In England, the National Health Service (NHS) produced between 3% and 4% of greenhouse gas emissions. Therefore, better environmental sustainability within healthcare is vital, especially in regards to respiratory medicine. [1] The chest drain procedure is one example, where an evaluation of its carbon footprint may inform environmentally sustainable practices. This project aims to map the chest drainage procedure, quantify its carbon footprint, and offer a means to mitigate its environmental impact.

Method

The chest drainage procedure was evaluated for its carbon footprint firstly by mapping the key components: room energy usage, equipment used, and waste disposal. The carbon footprint was calculated using the SusQI framework, provided by the Centre for Sustainable Healthcare (CSH). [2] For each piece of equipment, its emission factor was multiplied by the price of the product, and the quantity used. Energy usage emissions were calculated by multiplying the associated emission factor by the energy usage of the room. Similarly, waste disposal emissions were calculated by multiplying the estimated weight of waste by the associated emission factor.

Results

The total carbon footprint of a single chest drain procedure was calculated to be 62.8kgCO2e, which translates to an estimated 19,600kgCO2e per year. The procedural component contributed to the largest share of the carbon emissions at 40.4kgCO2e, comprising 64% of the total carbon footprint. The chest drain kit alone contributed 31.4kgCO2e - equivalent to 78% of the procedure component (*Table 1*).

Conclusion

This study highlights areas for intervention such as streamlining chest drain kits, finding lower carbon alternatives for single use items and implementing robust recycling policies. Life cycle assessments of the equipment are essential to bridge existing gaps within the literature. Incorporating the carbon footprint of the production of equipment, and its transportation would allow for hospitals to make greener choices and strive towards a more sustainable NHS.

References:

1. NHS England. Delivering a "Net Zero" National Health Service [Internet]. 2022 Jul. Available from: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf
2. Centre for Sustainable Healthcare. Measuring Impact Carbon Footprinting [Internet]. Centre for Sustainable Healthcare; 2024. Available from: https://www.susqi.org/measuring-impact

DP26 - Table 1: Carbon Impact of Chest Drain Procedure by Category

Component of Pathway	Carbon Footprint (kgCO2e)
PPE	
Gown	0.308
Sterile Gloves	0.040
Prep	
18G needle	0.043
21G needle	0.043
25G needle	0.043
Chloraprep swabs	10.062
10ml syringe	0.031
50ml syringe	0.167
Sterile drapes	0.777
Procedure	
12fg Chest drain kit	31.356
Tubing and Closed system drain	3.332
Chest drainage bottle	5.701
Sterile swabs	0.048
Ultrasound Equipment	
Ultrasound probe cover	0.148
Ultrasound gel packet	0.428
Closing Equipment	
Sutures	0.932
Dressing	0.401
Cleaning	
Tristel pre clean wipe	1.440
Tristel sporicidal wipe	2.955
Tristel rinse wipe	1.440
Energy Usage	2.617
Waste Disposal	
Sharps bin	0.215
Orange infectious bin	0.285
General waste	0.011
Total Carbon Footprint of a Chest Drain Procedure	62.822

DP27

Reducing Healthcare Utilization in an Indwelling Pleural Catheter Cohort: A Quality Improvement Project

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Introduction

Care of indwelling pleural catheters (IPCs) frequently poses challenges to patients and caregivers. In the Singapore health system, caregivers or patients need to self-care for their IPC. Difficulty with draining and lack of confidence in managing the catheter often result in repeated healthcare visits, negating the benefits of the IPC. We sought to reduce healthcare utilization by the following nurse-led interventions: 1) training community nurses to complete caregiver training in the patient's home and 2) standardizing IPC care education of the caregiver and patient prior to discharge.

Intervention

The specialist pleural nurse carried out the training. The intervention commenced in January 2021 and the community nurses began home visits in September 2021. Once completing caregiver training, patients would be discharged from the community nursing service.

Outcomes

We measured median hospital length of stay during the IPC insertion and healthcare visits within 90 days after IPC insertion for catheter-related issues. To measure utilization of the community service, number of phone calls and home visits performed were recorded. Both emergency department visits and respiratory clinic visits accounted for healthcare visits.

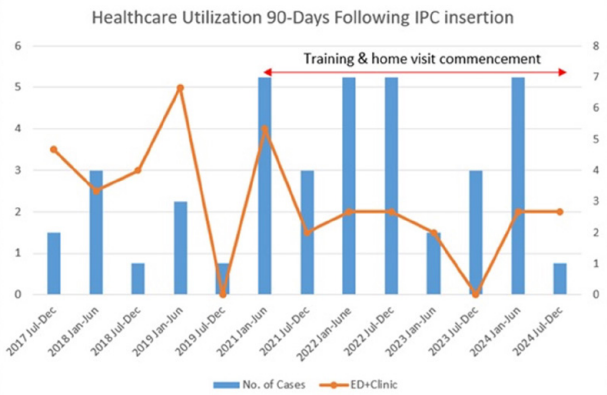
Results

50 IPCs have been inserted since the start of IPC service in July 2017 til December 2024. 29 patients were referred for community nursing, and 26 patients were enrolled. No IPCs were inserted in 2020. There was no change in overall median hospital length of stay comparing pre and post intervention, with the median number of days being 4 days. The median number of healthcare visits in the 90 days following IPC insertion decreased from 3.5 to 2 after the intervention. The median number of nursing telephone call follow up required was 3.5 calls, and 2 home visits.

Conclusion

The implementation of standardized training for caregivers and community nurses resulted in a sustained reduction in emergency and clinic visits but has increased workload for community nursing. Further research into the cost effectiveness of this intervention is ongoing.

DP27 - Figure 1



DP28

Assessing cardiovascular disease risk and risk reduction using statin therapy amongst patients admitted with acute exacerbation of COPD – a role for QRISK3?

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Background

Chronic obstructive pulmonary disease (COPD) is one of the commonest adult respiratory conditions in the UK and is associated with an increased risk of cardiovascular diseases (CVD) including myocardial infarction and stroke[1]. As such, it is prudent to be proactive in assessing and controlling CVD risk factors in COPD patients. Data also demonstrate an increased risk of cardiovascular events following an acute exacerbation of COPD (AECOPD), further highlighting the need for aggressive CVD risk reduction. QRISK3 is a risk assessment tool intended for use in primary care in patients without established CVD to assess ten-year risk of myocardial infarction or stroke[2]. A QRISK3 score ≥10% indicates statin therapy for CVD primary prevention should be considered.

Methods

We retrospectively assessed 100 patients admitted with AECOPD between November 2024 and January 2025, assessing their CVD risk using QRISK3 and whether they were prescribed lipid-lowering therapy (LLT).

Results

Of the 100 patients studied (age range 40-93 years, median age 75 years, 42 male:58 female), mean QRISK3 score was 30.0% (range 1.2%-74.0%, SD 16.0%). Of the 88 patients (88%) with a QRISK3 score ≥10% (suggesting statin therapy is indicated), only 41 patients (46.5%) were prescribed LLT. 53 of 100 patients were on anti-hypertension medication and 28 patients were current smokers, the remainder either ex-smokers (67) or never-smokers (5).

Discussion/Conclusion

The importance of CVD risk reduction in COPD patients should not be overlooked. That less than half of patients where LLT would be indicated were on such treatment implies potential for improvement. Attendances with AECOPD could be viewed as a chance to optimise CVD risk as part of a holistic COPD assessment. QRISK3 can be useful for identifying COPD patients with higher CVD risk and the upcoming QR4 tool will likely be even more useful as it includes COPD in the algorithm.

References

1. Finkelstein J, Cha E, Scharf SM. Chronic obstructive pulmonary disease as an independent risk factor for cardiovascular morbidity. *Int J Chron Obstruct Pulmon Dis*. 2009;4:337-49

2. NICE NG238 Cardiovascular disease: risk assessment and reduction, including lipid modification (2023). Available at: https://www.nice.org.uk/guidance/ng238 (accessed 03 March 2025)

DP29

Hospital Admission Outcomes in Chronic Obstructive Pulmonary Disease (COPD) Patients with Home Mechanical Ventilation

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Background

UK HOT-HMV trial has led to widespread HMV use, however clinical practice varies and benefit is still on debate.

Aim

To evaluate outcomes of local COPD patients on HMV versus those without who presented with acute decompensated type II respiratory failure (T2RF) to Respiratory Support Unit (RSU).

Methods

40 COPD patients with or without HMV pre-admission who were admitted to RSU with acute decompensated T2RF between 1/12/2022 to 10/6/2023 were included in this retrospective study. Data was collected using Aperture and ICE and statistically analysed using Microsoft Excel.

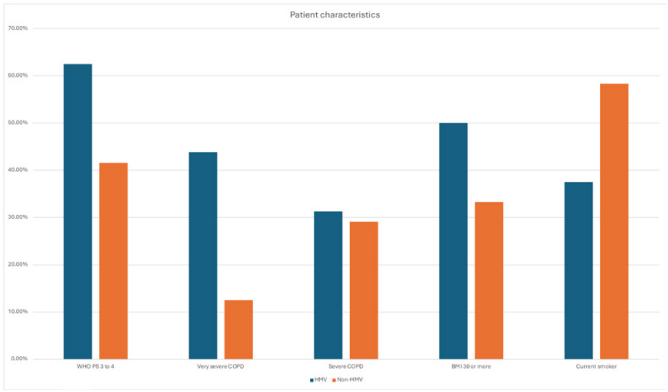
Results

16 patients was on HMV pre-admission. We have 20 males and 20 females, with mean age of 71. There was no difference between the 2 groups (HMV vs non-HMV) in pre-admission arterial blood gas pH and pCO2. Most patients in HMV group had very severe to severe COPD. WHO PS>3 and high BMI. In HMV group, 69% had good HMV compliance defined by usage of 5 hours or more overnight, 93.7% are prescribed with IPAP>20cmH2O with mean 24.5cmH2O. HMV group has better inpatient survival whilst non-HMV group has shorter inpatient stay and less readmission rate.

Conclusion

HMV use with good compliance and high IPAP pressure improves inpatient survival during acute exacerbation with T2RF in severe COPD patients. Routine screening for obesity-related breathing disorder may help identify appropriate COPD patients for HMV.

DP29 - Figure 1



DP30

Beyond the Bottleneck: Improving Clerking and Senior Review in Acute Cardio-Respiratory Admissions

[1]M Jones, [1]W Chua, [1]C Kerr, [1]K Vanham, [1]D Cristea-Nicoara. [1]Glenfield Hospital, Leicester, UK.

Background

Our hospital has a dedicated 46-bed cardio-respiratory admissions unit, receiving referrals from the emergency department (ED), bed bureau, and direct 999 admissions. During peak winter periods, patient demand increases significantly, with over 100 new admissions per day. In 2024, the unit managed 23,041 patients. This surge in activity led to prolonged waiting times, delayed clinical decision-making, and declining staff morale.

Methods

A structured improvement process using Six Sigma and Plan-Do-Study-Act (PDSA) methodology was initiated in November and remains ongoing. Thematic analysis of MDT interviews identified key areas for intervention.

Key performance indicators (KPIs) included:

- The percentage of patients clerked within 4 hours, in line with RCP guidance (Royal College of Physicians, 2018).
- The percentage of patients reviewed by a registrar or consultant within 6 hours.
- The percentage of patients receiving a consultant review within 14 hours, as per NHS seven-day service standards (NHS England, 2022).

Interventions were implemented in phases:

1. Increased medical staffing to enhance clerking capacity and senior decision-making (RCP, 2018).
2. Reorganisation of the unit into two discrete areas, each managed by a dedicated team.
3. Future plans include additional clerking spaces and electronic patient notes.

Results

Pre-intervention, the median percentage of patients clerked within 4 hours was 64.3%, increasing to 65.85% and 73.25% after interventions.

- Senior review within 6 hours improved from 79.4% to 83.3% and 87.25%.
- Consultant review within 14 hours increased from 73.1% to 75.65% and 77.05%.

Learning Points

A well-resourced admissions unit remains critical for safe and effective patient care. Reorganising the unit and increasing staffing in line with RCP recommendations improved timely decision-making during peak demand. Increased senior presence enhanced team leadership and efficiency. Further work is needed to optimise patient pathways and assess staff burnout.

References

- NHS England (2022) Seven-day service clinical standards.
- Royal College of Physicians (2018) Guidance on safe medical staffing.

DP31

Lessons In Asthma - improving the management of respiratory conditions in a primary school setting

[1]D M Edwards, [1]L-J Whelan-Hughes, [1]H Wang. [1]South Pembrokeshire Cluster, Pembrokeshire, Wales.

Problem

The UK has one of the highest prevalence, emergency admission and death rates for childhood asthma in Europe.

Two thirds of school aged asthmatics will have an asthma attack in school.

NRAD (2014) highlighted that in children, poor perception of risk, poor prescribing and poor management were important avoidable factors in 70% deaths. Recent reports and audits support this.

If we don't change how we do it, we cannot expect different results.

Plan

Encourage patient participation by conducting the reviews in a child-friendly environment (their primary school) with read/write access to the surgery PMR.

Target primary school pupils with a blue inhaler.

Run session on vaping/smoking for older pupils.

Write local policy to allow schools to hold an emergency reliever.

Expand pilot to all primary schools in Pembrokeshire.

Aims

Address NRAD recommendations.

Educate and empower pupils, parents and teachers to self-manage their condition.

Give pupils an inhaler and regime they could and would use.

Stop unnecessary medication.

Improve quantitative and qualitative measures.

Every school to have an emergency reliever.

Outline

Group education sessions with staff and parents of target group.

- Diagnosis,
    - NB we coded as
        - Viral Induced Wheeze or Multi-trigger wheeze in under 6 age group
        - Suspected asthma or asthma in 6 to 11 year olds
- pathophysiology,
- good control,
- action/use of medication,
- adherence,
- inhaler technique,
- recognising/safely managing worsening symptoms

One-to-one review (parents present)

- diagnosis explanation
- condition assessment (C-ACT)
- physical examination
- treatment optimisation
    - following All Wales or NICE guidelines
    - we were mindful of the green agenda and changed most 6+ children to a DPI
- education – condition/medication/inhaler technique/ worsening symptoms
- asthma & pre-school wheeze action plan for every pupil seen
    - school also had copy
- Plan going forward.

Findings

Pupils/parents unclear about diagnosis meaning.

Understanding of condition and medication was poor.

Few had asthma action plan.

Outcomes

- improved quantitative outcomes
    - 70% reported a clinically important difference in C-ACT
    - Adherence & inhaler technique
    - 100% PAAP digital/written issued
- improved qualitative outcomes (from feedback forms)
- emergency reliever policy adopted

Conclusion

Changing the setting and structure of the review has led to improved outcomes.

DP31 - Figure 1

Milford Haven, Fishguard, Pembroke & Haverfordwest School Clusters			
Number of pupils seen		380	
NB total number of pupils as above, not all the pupils fitted into all the criteria for the data collected. The percentages below are calculated using the pupils eligible for each criterion rather than the total number seen.			
History – past 2 years			
Attended OOH/A&E	Prescribed antibiotics for chest	Prescribed OCS for chest	Prescribed either antibiotics or OCS
114 (30%)	203 (53%)	157 (41%)	235 (62%)
Asthma review in primary or secondary care in last 12 months (pupils with an existing asthma or suspected asthma diagnosis only)			
Existing asthma or suspected asthma diagnosis		Respiratory review documented in notes	
153		105 (69% of 153)	
Exposure to second-hand smoke			
Passive Smokers	60	Parents referred to SC	4 (7%)
Adherence, SABA use and inhaler technique			
Adherence less than 80% in pupils with ICS past 12 months	Pupils prescribed 4 or more SABA in past 12 months	Pupils with 1 or more critical errors in inhaler technique	
99 (43% of 230)	57 (20% of 285)	98 (54% of 181)	
Childhood Asthma Control Test data (C-ACT)			
C-ACT < 20 at initial consultation		C-ACT improvement of 2 or more at second consultation	
154 (51% of 302)		115 (69% of 167)	
Treatment			
Change to treatment according to guidelines		Change to DPI (aged 6 and over)	
210 (68% of 308)		119 (45% of 263)	
Diagnosis			
Change to diagnosis		119 (41%)	
Diagnosis after second consultation			
No respiratory issues	Viral wheeze	Multi-trigger wheeze	Suspected asthma	Asthma
114	39	26	41	150
Secondary Care			
Referred to secondary care		Already under secondary/tertiary care	
21 (6%)		33 (9%)	

DP32 - Abstract withdrawn

DP33

Quality Improvement Project (QIP): Enhancing Compliance with CAP Management Guidelines

[1]NSZ Zinna, [1]TZ Zaman. [1]Sandwell and West Birmingham NHS Trust, Birmingham, United Kingdom.

Background

CAP is one of the leading causes of hospital admissions and is associated with increased mortality and morbidity. The British Thoracic Society (BTS) provides guidelines, referred to as the Pneumonia Care Bundle (PCB), for the management of CAP in hospitals. These include four key elements: assessment of oxygenation, severity of pneumonia, radiological diagnosis and administration of appropriate antibiotics, all within 4 hours of presentation.

Methods

This QIP aimed to improve compliance with the PCB, specifically adherence to the antibiotic guidelines. We planned a multi-media educational campaign to include a poster and a short educational video which were distributed via the weekly communication bulletins, the intranet and during resident doctors' teaching sessions. Two Plan-Do-Study-Act cycles were conducted and compliance with each element of the PCB was measured. Statistical analyses were undertaken to compare patient outcomes which include length of stay (LOS), 30-day mortality and rate of readmissions.

Results

Baseline measurement revealed that 29% of patients admitted with CAP received appropriate antibiotics as per local guidelines and overall, only 10% of patients received all four elements of the PCB. Post-intervention, compliance with the bundle varied. However, there was a statistically significant improvement in adherence to the antibiotic guidelines (29% vs. 58%; $p<0.01$). This was further associated with a statistically significant reduction in LOS ($p<0.01$), decreasing by almost a half from a mean of 7.75 days (SD ±6.69 days) pre-intervention to 3.95 days (SD ±2.53 days) post-intervention.

Conclusion

At baseline, adherence to antibiotic guidelines was suboptimal. After intervention via a multi-media educational approach, we successfully delivered a sustained improvement, which also positively impacted other patient outcomes. To our knowledge, this QIP is one of the few pieces of evidence that demonstrates the impact of appropriate antibiotic prescribing on patient outcomes for CAP. However, there is room for improvement in adherence to other elements of the PCB. Our next step is to embed the educational programme into regular induction training for resident doctors and develop an electronic interface to reinforce CAP guidelines and streamline management.

DP33 - Table 1: Comparison of demographics and secondary outcomes between pre- and post-intervention

	Pre-intervention (n=40)	Post-intervention (n=36)
Age, median (IQR)	74 (± 15.75)	74.5 (± 12.50)
Male, n (%)	19 (48%)	19 (53%)
High severity score (3 or more), n (%)	14 (35%)	15 (42%)
Length of stay in days, mean (SD)	7.75 (±6.69)	3.95 (± 2.53) p<0.01
Readmission, n (%) *excluded patients who passed away	4/35 (11%)	7/30 (23%)
30-day Mortality, n (%)	5 (13%)	6 (17%)

DP34

SMART ASTHMA in ED: Optimising asthma care in the emergency department (ED) through improved prescribing practice and use of the BTS asthma 4 bundle.

[1]F Cheema, [1]K Roy. [1]University College London Hospital, London, United Kingdom.

Background

The BTS asthma 4 bundle issued following an adult asthma exacerbation (AE) incorporates 4 high impact actions: (i) medication review, (ii) personalised asthma-action-plan, (iii) tobacco dependence advice and (iv) clinical review within four weeks. The aim is to reduce risk of further AE and readmission. Implementation of the bundle in ED may be challenging due to time constraints and unfamiliarity with new asthma guidelines. BTS/SIGN/NICE guidelines (2024) recommend maintenance and reliever therapy (MART) as the first line management of asthma; however, many clinicians may be more familiar with prescribing inhaled corticosteroid (ICS) alongside Salbutamol. This QI project facilitated better asthma care in ED using a SmartPhrase (ready-made electronic patient record (EPR) template) supported by teaching and training programmes.

Methods

Audit of care for those discharged from ED in October 2024 with a primary diagnosis of AE was compared to March 2025, after development and implementation of a SmartPhrase (figure 1), delivery of a tailored ED training programme and accessible digital resource with QR codes linking to information around inhaler technique, smoking cessation and the Myhealth asthma app.

Results

We focussed on ED as many patients are discharged without ICS treatment and only prescribed oral steroids, leading to further readmissions and increased mortality. Of 54 patients, 9 were discharged without an ICS inhaler and were only given Salbutamol. Only 2 patients were newly prescribed an ICS - these were both ICS only inhalers (not containing LABA) alongside salbutamol, rather than a MART regime. None of those on ICS were changed to MART. Smoking cessation advice was only provided to one out of nine current smokers, and over a quarter of encounters had no follow-up.

Conclusion

Better care starting in ED is important as these patients often have difficult disease compounded by poor adherence to treatment and do not attend clinic visits. As they are most at risk of death, it is vital to take the opportunity to make the most of this encounter by ensuring management is optimised. Digital tools may enhance this care pathway delivering care in a simple streamlined approach in already pressured areas in the NHS.

EXHIBITORS' INFORMATION

ACTION FOR PULMONARY FIBROSIS

Stand number: I

APF is a national UK charity. We bring people together to drive change so more people affected by pulmonary fibrosis (or lung scarring) can live well for longer. People living with lung scarring, their loved ones and the professionals caring for them are at the heart of everything we do.

We provide expert support, information, education, help a growing network of support groups and raise awareness of pulmonary fibrosis. We collaborate to drive change that improves health and care and we provide vital resources to researchers, bringing hope for new and future treatments for this devastating disease.

ASSOCIATION FOR RESPIRATORY TECHNOLOGY & PHYSIOLOGY (ARTP)

Stand number: E

The Association for Respiratory Technology & Physiology (ARTP) are the professional society focused on physiological measurement and interpretation within the field of respiratory medicine for the UK. We work alongside partner organisations and societies to produce position papers, national guidelines and standards for good practice. Our primary focus is the performance of respiratory/sleep physiological measurement, and the delivery of lung function and sleep services.

Email: admin@artp.org.uk

Website: www.artp.org.uk

ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN RESPIRATORY CARE (ACPRC)

Stand number: D

The Association of Chartered Physiotherapists in Respiratory Care promotes health and best practice in respiratory physiotherapy for the benefit of all. With over 1800 members the ACPRC is the largest national body of Physiotherapists interested in all aspects of Respiratory Care.

Connecting with our members is at the heart of our organisation, and in addition to our ACPRC Conference which took place in April 2025 we also engage with members via:

- Regular short courses
- Monthly e-Newsletters with latest updates for our members
- Dedicated social media pages via Facebook, Instagram and X with regular updates, opportunities to network, access to a high number of followers and links to key resources
- A website that is packed with resources and also contains subspecialty networks such as the UK ECMO Physiotherapy network www.acprc.org.uk
- Support with publishing your research
- Education grants

Furthermore, we support the development of National Guidelines related to cardio-respiratory care and are key stakeholders in many professional networks and special interest groups. We also aim to publish two peer reviewed journals a year and are a member of crossref.

ASSOCIATION OF RESPIRATORY NURSES (ARNS)

Stand number: F

The Association of Respiratory Nurses (ARNS) was established in 1997 as a nursing forum to champion the specialty respiratory nursing community, promote excellence in practice, and influence respiratory health policy.

ARNS also works to influence the direction of respiratory nursing care.

ASTRAZENECA

Stand number: 3

AstraZeneca is a global, science-led biopharmaceutical company that focuses on the discovery, development, and commercialisation of prescription medicines in Oncology, Rare Diseases, and BioPharmaceuticals, including Cardiovascular, Renal & Metabolism, and Respiratory & Immunology. AstraZeneca operates in over 100 countries and its medicines are used by millions of patients worldwide.

With a proud 100-year heritage in advancing UK science, today AstraZeneca is the UK's leading biopharmaceutical company. The company is based in five different locations across the UK, with its global headquarters in Cambridge. In the UK, around 8,700 employees work in research and development, manufacturing, supply, sales, and marketing. We supply around 36 different medicines to the NHS.

For more information, please visit **www.astrazeneca.co.uk** and follow us on Twitter @AstraZenecaUK

BD

Stand number: 17

BD is a global medical technology company that is advancing the world of health by improving medical discovery, diagnostics and the delivery of care.

BD leads in patient and health care worker safety and the technologies that enable medical research and clinical laboratories. The company provides innovative solutions that help advance medical research and genomics, enhance the diagnosis of infectious disease and cancer, improve medication management, promote infection prevention, equip surgical and interventional procedures and support the management of diabetes.

BD Interventional - Peripheral Intervention focuses on being at the forefront of developing innovative medical devices that solve the challenges of healthcare professionals and improving the quality of patients' lives. We are committed to pursuing technological innovations that offer superior clinical benefits while helping to reduce overall health care costs.

BRITISH THORACIC SOCIETY

Stand number: A

The British Thoracic Society (BTS) is the leading professional society for respiratory medicine in the UK, with over 4,800 members. BTS supports respiratory professionals to deliver the best-quality healthcare to people with respiratory diseases.

The Society's vision is 'Better Lung Health for all' and BTS aims to:

- influence the provision of the optimum respiratory workforce and the development of services that promote sustainable solutions and reduce health inequalities
- educate professionals to advance knowledge and share learning in the prevention, diagnosis and treatment of lung disease
- support all members of the respiratory team to improve standards of care

Each year BTS hosts two conferences, the Summer Meeting in June and the Winter Meeting in November. The Summer Meeting focuses on education, training developments and opportunities within respiratory health, while the Winter Meeting focuses on science and research. BTS conferences remain internationally renowned celebrations of respiratory medicine and healthcare, relevant to the UK and globally.

Email: bts@brit-thoracic.org.uk

Phone: +44 (0)207 831 8778

Website: www.brit-thoracic.org.uk

BRONCUS MEDICAL, INC.

Stand number: 12

Broncus Medical, Inc. is a publicly listed company based in San Jose, CA.

The company's mission is to deliver navigation, diagnostic, and therapeutic technologies to treat patients with lung disease. Archimedes® Virtual Bronchoscopic Navigation System supports bronchoscopic procedures and to quickly and accurately navigate to tumors in the lungs. The Archimedes™ system supports a comprehensive lung access platform, including BTPNA (Bronchoscopic Trans-Parenchymal Nodule Access), which combines state-of-the-art nodule, vessel, and airway mapping, pathway guidance, and intra-operative fluoroscopy imaging — allowing for previously impossible biopsy and therapeutic access to virtually any location in the lung.

CHIESI

Stand numbers: 6, 7, 8, 9

Headquartered in Parma, Italy, Chiesi Farmaceutici is an international research-oriented biopharmaceuticals group with over 85 years' experience in the pharmaceutical sector with 31 affiliates worldwide, employing over 7,000 people.

Chiesi develops and markets innovative therapeutic solutions in respiratory health, rare diseases, and specialty care. The company's mission is to improve people's quality of life and act responsibly towards both the community and the environment.

As a certified B Corp since 2019, Chiesi is part of a global community of businesses that meet high standards of social and environmental impact. Chiesi Limited is headquartered in Manchester employing over 400 people.

CIPLA

Stand number: 15

Cipla has been developing respiratory medicines for patients for more than 40 years and we are the second largest global manufacturer of respiratory inhalers, committed to becoming a global leader in respiratory care.

We have a range of high-quality respiratory products, designed with similar instructions and features to the market-leading originator brands.

At Cipla, we have priced our range to be more sustainable and affordable so more NHS patients can receive optimal care. We are dedicated to minimising our environmental footprint in support of the NHS goal of becoming carbon net zero by 2040.

CONSILIENT HEALTH

Stand number: 14

Consilient Health, a well-established pharmaceutical company founded in 2005.

Consilient Health is dedicated to addressing unmet clinical needs while ensuring quality and savings for the NHS. With a strong focus on bone health, women's health, and urology, we extend our commitment to innovative solutions for ADHD and smoking cessation.

Visit **www.consilienthealth.com** for details.

ENERGY SYSTEMS CATAPULT

Stand number: H

Exhibitor Energy Systems Catapult is an innovation accelerator helping to transform the UK's energy system to achieve Net Zero.

Our Warm Home Prescription® service tackles the health impacts of cold homes by providing energy credits, tailored advice, and support accessing funding for long-term improvements. 79% of recipients reported better physical health, 70% noted mental health improvements, and 93% placed greater importance on staying warm.

"This is the first winter I haven't been admitted to hospital with breathing problems. I was warm and cosy for the first time in the last 4 years". - previous Warm Home Prescription® participant

GSK

Stand numbers: 18, 19, 24, 25

GSK are a global biopharma company with a purpose to unite science, technology and talent to get ahead of disease together.

We aim to positively impact the health of 2.5 billion people by the end of 2030. Our bold ambitions for patients are reflected in new commitments to growth and a step-change in performance.

NP-GB-RS-COCO-230002 | January 2024

HEALTHNET HOMECARE

Stand number: 22

HealthNet Homecare is a leading UK homecare provider, delivering specialist clinical services and medication directly to patients in their homes. With a strong focus on respiratory care, we partner with the NHS and pharmaceutical companies to improve patient outcomes through flexible, scalable, and technology-enabled solutions. Our highly trained team ensures seamless transitions, robust patient support, and continuity of care, even at scale. HealthNet is committed to innovation, quality, and making treatment more accessible, helping patients live healthier, more independent lives.

ICU MEDICAL

Stand number: 13

ICU Medical is a global leader offering clinically essential products and solutions that connect patients with caregivers through life-enhancing, innovative technology. Our robust portfolio features products for infusion therapy, emergency medicine, general and regional anesthesia, homecare, NICU/PICU, oncology, pain management, and respiratory care.

INSMED

Stand number: 21

Insmed is a global biopharmaceutical company on a mission to transform the lives of patients with serious and rare diseases. We are powered by purpose, a purpose to serve patients and their families with unwavering dedication. A purpose to find solutions where there were none before. A purpose to do what's right, even when it isn't easy.

A biotech company that empowers great people to deliver with a profound sense of urgency and compassion, life-altering therapies to small patient populations experiencing big health problems, transforming the lives of patients living with serious and rare diseases.

At Insmed, we are powered by our shared sense of purpose to serve patients. We don't always have a defined play book, but we operate with passion and creativity to find the best path forward. We take pride in our ability to challenge the status quo. Team members are comfortable operating outside their traditional roles and comfort zones, using what we already know to uncover what we don't.

LOVE MEDICAL

Stand number: 33

Love Medical has successfully worked with over 50 customer sites across the UK since being established in 2008, with a combined industry experience of over 35 years.

Maintaining a strong relationship with customers past the point of sale and providing ongoing support, training and product development is at the core of Love Medicals values**.**

Our range of products covers:

- Cardiopulmonary Exercise Testing (CPET)
- Pulmonary Function Testing (PFT)
- Prehabilitation
- ECG
- Exercise ErgometersStirling Anglian Pharmaceuticals

MSD

Stand number: 5

At MSD, known as Merck & Co., Inc., Rahway, NJ, USA in the United States and Canada, we are unified around our purpose: We use the power of leading-edge science to save and improve lives around the world.

For more than a century, we've been at the forefront of research, bringing forward medicines, vaccines and innovative health solutions for the world's most challenging diseases.

GB-NON-11119 | March 2025

NATIONAL ASPERGILLOSIS CENTRE

Stand number: G

The National Aspergillosis Centre (based at Wythenshawe Hospital, Manchester University NHS Foundation Trust) is a highly specialised service for managing chronic pulmonary aspergillosis (CPA). We accept referrals and requests for advice & guidance (or remote MDT) from consultants across the UK.

Our centre has an on-site mycology reference laboratory as well as specialist nurses, pharmacists and physiotherapists. We also run free patient support groups via Teams and Facebook (no referral needed).

Visit **www.aspergillosis.org** to learn more about our services or to find information about CPA and ABPA

Feb 1st = #WorldAspergillosisDay

NIOX GROUP PLC

Stand number: 2

NIOX Group plc is the global leader in FeNO testing, with a strong reputation for innovation and excellence in the development of medical devices for the diagnosis and management of asthma. With NIOX VERO®, healthcare professionals have a reliable and non-invasive tool to help them better diagnose and manage asthma. NIOX VERO® provides accurate and reliable results, allowing healthcare professionals to make informed decisions about the diagnosis and management of asthma. It is easy to use, and can be used in a variety of settings, including clinics, hospitals, and primary care settings.

PHARMING UK LTD

Stand number: 28

Pharming is a global biopharmaceutical company dedicated to transforming the lives of patients with rare, debilitating, and life threatening diseases. Pharming is commercializing and developing an innovative portfolio of protein replacement therapies and precision medicines to serve the unserved rare disease patient.

PULMONARY REHABILITATION SERVICES ACCREDITATION SCHEME (PRSAS)

Stand number: B

The Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS), developed by the Royal College of Physicians, supports services to deliver high-quality, patient-centred pulmonary rehabilitation.

PRSAS promotes quality improvement through highlighting areas of best practice and areas for change, encouraging the continued development of the clinical service

RICHARD WOLF UK LTD

Stand number: 4

Richard Wolf is a leading manufacturer of technologies for endoscopic diagnosis and therapy.

Since 1906, we have delivered solutions that enhance surgical results, improve patient outcomes, and pave the way for new, groundbreaking procedures. From the earliest stages of R&D to the moment one of our instruments is shipped to a facility, we are driven by the spirit of excellence. Crafted in Germany, our products are designed for a broad range of minimally invasive specialities and shaped by an ongoing dialogue with leading surgeons. Richard Wolf technologies are known around the world for their reliability and exceptional quality.

ROCHE UK

Stand number: 16

At Roche UK, we focus our energy and investment in developing tests and treatments that change lives and give us more quality time with the people we love. And, together with others, we're aiming to solve healthcare's greatest challenges; helping to achieve better results by connecting early diagnosis to targeted treatment and ongoing support.

Healthcare matters to all of us. That's why we work hard to ensure that all our new medicines are made available to those who need them through the NHS - wherever they live, whatever their circumstances.

That's what makes us who we are. That's what makes us Roche UK. For more information, please visit **www.roche.co.uk**

SANOFI & REGENERON (MEDICAL AND COMMERCIAL STANDS)

Stand numbers: 10, 11 and 34, 35

Sanofi are an innovative global healthcare company, driven by one purpose: we chase the miracles of science to improve people's lives. Our team, across the world, is dedicated to transforming the practice of medicine by working to turn the impossible into the possible. We provide potentially life-changing treatment options and life-saving vaccine protection to millions of people globally, while putting sustainability and social responsibility at the centre of our ambitions.

Regeneron is a leading biotechnology company that invents, develops and commercialises life-transforming medicines for people with serious diseases. Founded and led by physician-scientists, our unique ability to repeatedly and consistently translate science into medicine has led to numerous approved treatments and product candidates in development, most of which were homegrown in our laboratories.

STADA, THORNTON & ROSS

Stand numbers: 20, 23

Thornton & Ross, part of the STADA group, focuses on caring for people's health through a broad portfolio including generics, biosimilars and non-prescription consumer healthcare products as a trusted partner supplying the NHS. STADA sells its products in more than 120 countries, employing over 12,000 people worldwide.

STIRLING ANGLIAN PHARMACEUTICALS

Stand number: 1

Founded in 2013, Stirling Anglian Pharmaceuticals is a UK based pharmaceutical company, and part of the Kelso Pharma Group.

Stirling Anglian is completely committed to improving patient care and medicines optimisation.

We have sourced and developed a portfolio of high quality, patient-centric medicines designed to benefit health outcomes and help the NHS curb waste. We work closely with stakeholders across the NHS to identify real-world problems and develop value-based solutions that support the delivery of efficient and cost-effective healthcare. By addressing patient compliance issues, we offer real and practical solutions to waste management and supply these at the lowest possible cost.

SWORD-THOR

Stand number: C

The Surveillance of Work-related & Occupational Respiratory Disease (SWORD) is the longest running constituent scheme of The Health and Occupation Research (THOR) network. THOR is the main source of data used by HSE to develop and evaluate policy around occupational respiratory disease.

Since 1989 SWORD has collected over 29,000 cases of work-related respiratory disease from respiratory consultants across the UK. Participating consultants report to SWORD on a monthly basis or for one random month per year and are offered opportunities to collaborate with THOR on research as well as receiving quarterly and annual reports.

For more information visit our website
www.coeh.man.ac.uk/u/sword

or contact Laura Byrne via email
laura.byrne@manchester.ac.uk

VAPOTHERM

Stand number: 26

Vapotherm are a global medical technology company focused on the development and promotion of our proprietary High Velocity Therapy products that are clinically indicated for patients of all ages suffering from respiratory distress caused by a range of pathologies including: asthma, bronchitis, CHF, COPD, dyspnoea and pneumonia or following prolonged mechanical ventilation.

Our High Velocity Therapy delivers non-invasive ventilatory support by providing heated, humidified, and oxygenated air at a high velocity to patients through a comfortable small-bore nasal interface.

Our Precision Flow and HVT 2.0 systems are clinically validated alternatives to, and address many limitations of, the current standard of care for the treatment of undifferentiated respiratory distress in a hospital setting. Randomised controlled trials have shown high velocity therapy to be non-inferior to NiPPV in preventing intubation for spontaneously breathing patients, from premature babies in the NICU to hypercapnic COPD patients experiencing moderate to severe acute exacerbations in the Emergency Department and the ICU.

JOIN BTS NOW!

We welcome applications for membership from all who work in respiratory healthcare in all settings in medicine and other professions who share our ambition to improve standards of care for people with respiratory diseases and to support those who provide that care.

Member benefits include:

- Access to our highly regarded journal, Thorax (some categories of membership only)
- Excellent delegate discounts to our short courses and annual Summer and Winter Meetings
- Free access to Thoracic Ultrasound Online Learning Resources
- UK based BTS members receive a heavily discounted membership rate for the European Respiratory Society, and full access to ERS member benefits
- The opportunity to become involved in our work via an annual call for volunteers to stand for election for one of our Committees, Specialist Advisory Groups or Guideline Groups
- Discounted author submission fee for papers accepted by BMJ Open Respiratory Research

Members pay a 12-month subscription which is renewable on 1 July. Members who join between 1 August and 30 April will pay a pro rata sum of the membership rates. Members who join between 1 May to 31 July will pay the costs as outlined on the website, which covers their membership until the end of June the following calendar year.

We offer a discount for members who are on maternity/paternity leave or sick leave for three months or longer.

Membership of the Society is not open to persons who are, or have been, full or part-time employees of, or paid consultants to, the tobacco industry at any time during the previous 10 years.

For further information, membership categories, rates, or to join online, please visit our website at:

www.brit-thoracic.org.uk/about-us/join-now

Alternatively, speak to one of the team on the BTS stand during the Summer Meeting.

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