



SUMMER MEETING 2024



British
Thoracic
Society

Final Programme

THURSDAY 20 AND FRIDAY 21 JUNE 2024

**MANCHESTER CENTRAL CONVENTION COMPLEX
THE EXCHANGE SUITE, PETERSFIELD, 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 my absolute pleasure to welcome you back to Manchester and to Manchester Central Convention Complex.

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. BTS continues to provide an extensive programme of online education via our Short Courses, the vast majority of which remain online during 2024.

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 lecture.

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 and I am confident that we have a programme that delivers for the whole respiratory team.

Highlights include:

Mini short courses – one on asthma, including a controversial pro-con debate, and the other illustrating the journey of the patient receiving respiratory support from acute care to home. Two symposia in each of these topics provide a comprehensive and in-depth clinical learning opportunity.

Symposia in a broad range of topics from COPD to lung cancer, 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 continue, with two exciting categories: "Improving quality and excellence in patient care" and "Improvements in respiratory education and training". With these Abstract Prizes, we aim to highlight and share the excellent and successful work we know is being undertaken in respiratory medicine departments across the UK. Following a submission and refereeing process, the 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. The work will also be displayed as digital posters in the exhibition hall and on the conference App. The presentations will be judged on the day and prizes awarded to the overall winners.

Digital Posters – new for this year, a number of abstracts that were highly scored in the Abstract Prizes competition, will be displayed as digital posters on plasma screens in the exhibition hall and on the conference App.

The Clinical Grand Round is, 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.

This year's **Guest Lecture** will be given by Professor Havi Carel, Professor of Philosophy at the University of Bristol, who will speak on "Breathlessness and lung transplantation". This promises to be a fascinating presentation that will incorporate both a personal and philosophical perspective, exploring the first-person experience of breathlessness.

The **Physiology quiz** is always popular, with digital cases on the conference App and an interactive question-and-answer session during the programme.

The **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.

The **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 20 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!

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, learn, discuss and network.

I look forward to seeing you in Manchester.

Alison Armstrong
Chair, BTS Education and Training Committee



@BTSrespiratory

@AlisonArmstron

#BTSSummer2024

#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 2024. 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

Becton Dickinson (BD)

Broncus Medical Inc

Chiesi

Consilient Health (UK) Ltd

Fisher & Paykel Healthcare

GSK

Guardant Healthcare

Insmmed

It's Interventional Ltd

Kenvue

MSD

my mhealth Ltd

P3 Medical

pfm medical UK Ltd

Sanofi

Stirling Anglian Pharmaceuticals



PROGRAMME AT A GLANCE

THURSDAY 20 JUNE 2024

TIME	DETAILS	LOCATION
8.30am – 9.30am	Registration and refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. 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	Exchange Auditorium, lower level
9.30am – 11.00am <i>Slido voting</i>	Insights from the cough clinic	Exchange 8-10, upper level
9.30am – 11.00am <i>Slido voting</i>	Granulomatous lung diseases	Exchange 11, upper level
11.00am – 11.30am	Refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
11.30am – 1.00pm <i>Slido voting</i>	A masterclass on vaping: everything a respiratory professional should know	Exchange Auditorium, lower level
11.30am – 1.00pm <i>Slido voting</i>	Clinical grand round	Exchange 8-10, upper level
11.30am – 1.00pm	Digital approaches to the monitoring of respiratory disease	Exchange 11, upper level
1.00pm – 2.00pm	Lunch. Visit the exhibition stands and view the Abstract Prize digital posters. 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: Improvements in respiratory education and training	Exchange 11, upper level
2.30pm – 4.00pm	Mini short course part 1 – Asthma: the whole airway	Exchange Auditorium, lower level
2.30pm – 4.00pm	Hot topics in pulmonary vascular medicine	Exchange 8-10, upper level
2.30pm – 4.00pm	Spotlight on respiratory integrated care	Exchange 11, upper level
4.00pm – 4.30pm	Refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
4.30pm – 6.00pm	Mini short course part 2 – Asthma investigations masterclass and a pro-con debate	Exchange Auditorium, lower level
4.30pm – 6.00pm	Cystic fibrosis – known unknowns	Exchange 8-10, upper level
4.30pm – 6.00pm	Improving outcomes for patients with somnolence: CPAP and beyond	Exchange 11, upper level
6.00pm – 7.00pm	The BTS President's Reception and Award Presentations – <i>All welcome!</i>	Exchange Hall, lower level

PROGRAMME AT A GLANCE

FRIDAY 21 JUNE 2024

TIME	DETAILS	LOCATION
8.00am – 8.30am	Registration and refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Foyer and Exchange Hall, lower level
8.30am – 10.00am <i>Slido voting</i>	Pneumonia: prevention and best practice	Exchange Auditorium, lower level
8.30am – 10.00am	How can we take pulmonary rehabilitation forwards equitably?	Exchange 8-10, upper level
8.30am – 10.00am <i>Slido voting</i>	Occupational lung diseases: the patient perspective	Exchange 11, upper level
10.00am – 10.30am	Refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
10.30am – 12.00pm	Let's get things in order – COPD	Exchange Auditorium, lower level
10.30am – 11.00am	Abstract Prizes spoken session – Category: Improving quality and excellence in patient care	Exchange 11, upper level
11.05am – 12.00pm	Physiology quiz Q&A session	Exchange 8-10, upper level
12.05pm – 1.00pm	Guest Lecture – Breathlessness and lung transplantation <i>Including at 12.05pm presentation of the Abstract Prize award for "Improving quality and excellence in patient care"</i>	Exchange Auditorium, lower level
1.00pm – 2.00pm	Lunch. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App	Exchange Hall, lower level
2.00pm – 3.30pm <i>Slido voting</i>	Mini short course part 1 – The patient's journey receiving respiratory support, from acute care to home	Exchange Auditorium, lower level
2.00pm – 3.30pm <i>Slido voting</i>	Pleural disease – state of the art	Exchange 8-10, upper level
2.00pm – 3.30pm	Non-tuberculous mycobacterial (NTM) infection and disease	Exchange 11, upper level
3.30pm – 3.45pm	Refreshments. Visit the exhibition stands and view the Abstract Prize digital posters. Test yourself with the Physiology Quiz cases on the Summer Meeting App. <i>(Exhibition closes at 3.45pm)</i>	Exchange Hall, lower level
3.45pm – 5.15pm <i>Slido voting</i>	Mini short course part 2 – The patient's journey receiving respiratory support, from acute care to home	Exchange Auditorium, lower level
3.45pm – 5.15pm	Lung cancer – from tissue to treatment	Exchange 8-10, upper level
3.45pm – 5.15pm	Joint BTS/ARTP symposium – "Doctor, why am I breathless?"	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 be sent a website link to access video recordings of the symposia and guest lecture, which will be available to view until 20 September 2024.

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 App or website.

BTS SUMMER MEETING ABSTRACT PRIZES

The Summer Meeting Abstract Prizes have been short-listed in two categories – “Improving quality and excellence in patient care” and “Improvements in respiratory education and training”. 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 12 and 16). The 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 plasma 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 20 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 the Abstract Prizes 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 FREE WIFI**
- The portal page should load automatically
- If not, open your web browser and click: Login to Manchester Central's Free Wi-Fi
- Read and check the box to accept the terms and conditions, then click connect

CONTACT DETAILS IN MANCHESTER

BTS registration desk (19 to 21 June only): 07917 466 947.

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.

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: 147695. 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

Instructions for generating certificates will be sent to delegates after the event.

ACCOMMODATION

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

Website: miceconciierge.com/btssummer2024

Email: hello@miceconciierge.com

Tel: 01438 908 770

TWITTER



Increase your participation by Tweeting about the Summer Meeting using: **#BTSSummer2024**

DATES OF FUTURE BTS MEETINGS

Winter Meeting 2024

27 to 29 November, London

Summer Meeting 2025

19 and 20 June, Manchester

Winter Meeting 2025

26 to 28 November, London

BTS SHORT COURSE WEDNESDAY 19 JUNE

ACUTE NON-INVASIVE VENTILATION AND HOME MECHANICAL VENTILATION 2024: PRACTICAL COURSE

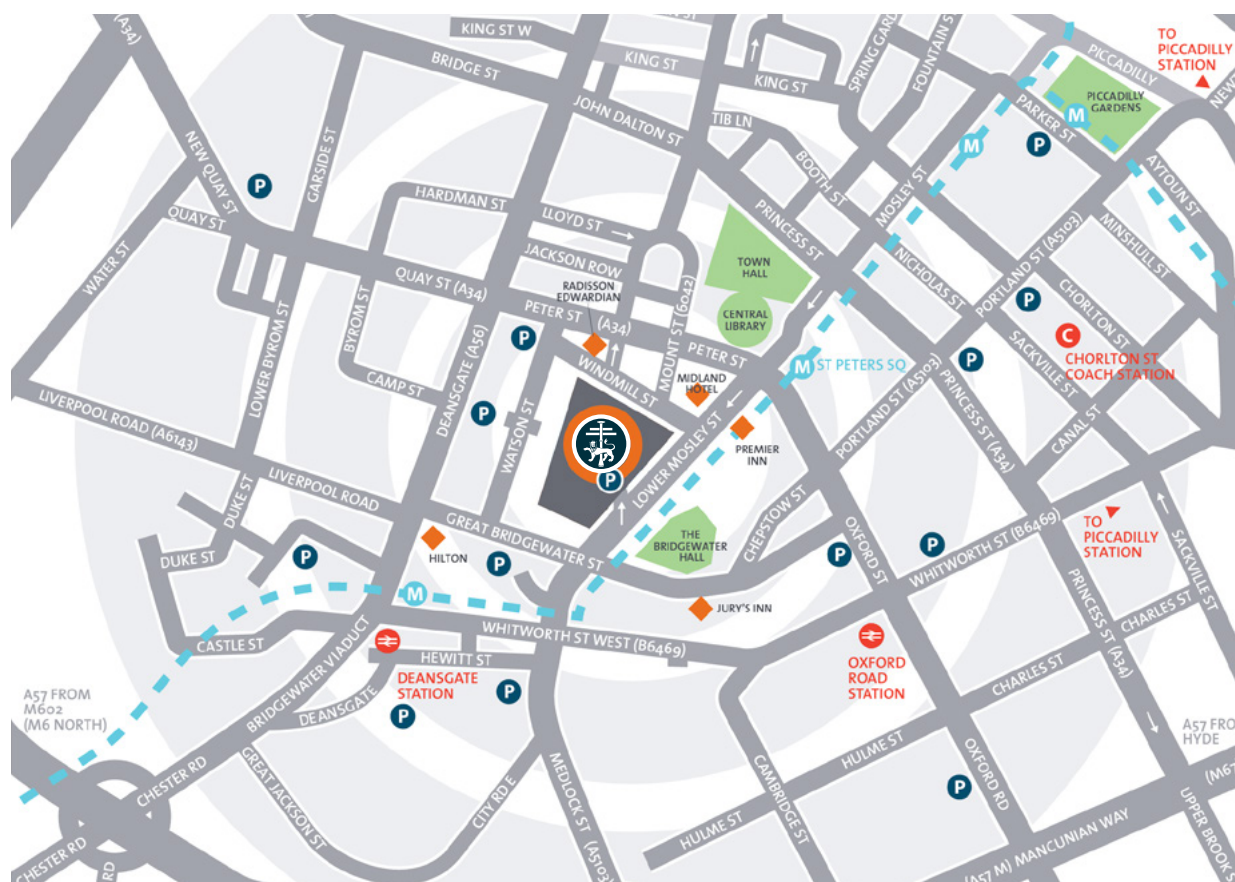
Venue: Crowne Plaza, Manchester City Centre

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:

[Courses in respiratory medicine](#)

TRAVELLING TO MANCHESTER



TRAVEL

A travel guide is available [here](#).

ON ARRIVAL IN MANCHESTER

Metroshuttle buses are free and link the city centre's main rail stations, shopping areas and businesses.

[Click here](#) for more information on routes.

The nearest **Metrolink** tram 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. 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/manchester-piccadilly

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**

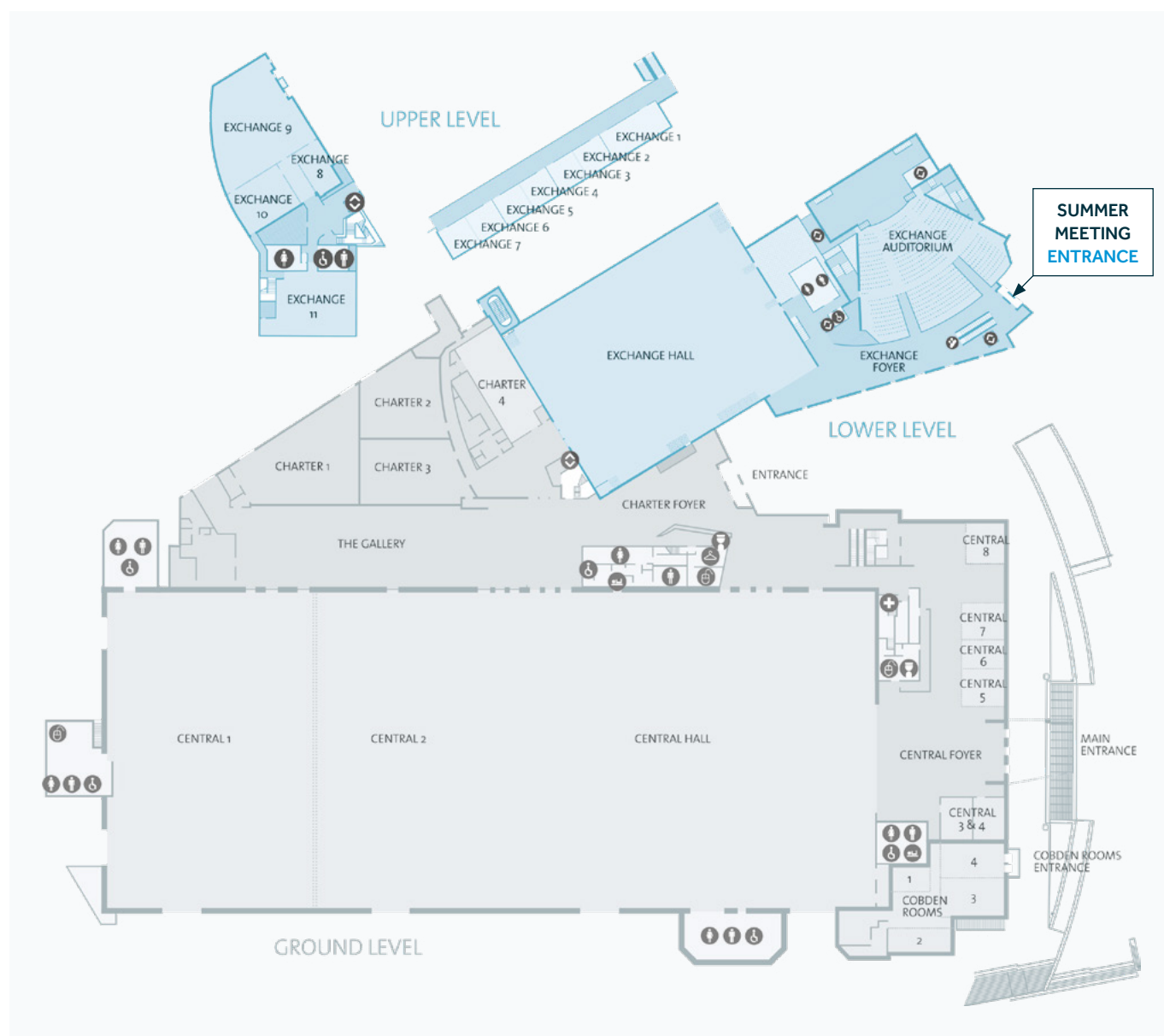
There is an NCP (National Car Park) directly below Manchester Central, which may be [booked here](#).

Participants may claim a discount by entering the discount code: **MCEXHIB14** (only valid when booked in advance)

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.

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 1, Upper 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 20 JUNE 2024

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

Chaired by: Mrs Alison Armstrong (Newcastle upon Tyne) and Dr Alanna Hare (London)

- | | |
|-------------------|---|
| 9.30am – 10.00am | Improving chest X-ray reporting – will AI help?
Dr Nick Woznitza (Canterbury and London) |
| 10.00am – 10.30am | Sustainability in healthcare: how things are both worse and better than you think
Dr Laura-Jane Smith (London) |
| 10.30am – 11.00am | What's new in bronchiectasis?
Professor Amelia Shoemark (Dundee) |

Learning objectives

- To become familiar with the role of AI in thoracic radiology and implications for clinical practice.
- Develop an awareness of the climate crisis on respiratory health and how we can develop sustainable respiratory care.
- To learn about the most recent bronchiectasis updates and develop an overview of the EMBARC journey, learning about the advantages of large clinical research networks for improving patient care.

Curriculum mapping

Generic Capabilities in Practice 1 – Able to function successfully within NHS organisational and management systems.
Speciality Capabilities in Practice 6 – Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

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

Exchange 8-10, upper level

INSIGHTS FROM THE COUGH CLINIC

Chaired by: Dr Paul Marsden (Manchester) and Mrs Claire Slinger (Preston)

- | | |
|---------|--|
| 9.30am | Understanding the cough reflex and new treatments in refractory/unexplained chronic cough (RUCC)
Dr Peter Cho (London) |
| 10.00am | How to approach and treat chronic cough: overview of the BTS Clinical Statement on Chronic Cough in Adults
Professor Jacky Smith (Manchester) |

- | | |
|---------|---|
| 10.30am | Cases from the cough clinic – an interactive panel discussion
Case presentations: Dr Samantha Decalmer (Salford) |
|---------|---|

Panel: Mrs Jennifer Butler (Northumbria), Dr Peter Cho (London), Ms Sarah Hennessey (Manchester) and Professor Jacky Smith (Manchester)

Learning outcomes

Gain an understanding of the mechanisms underlying RUCC and how these are targeted with novel therapies.

Understand the approach to the investigation and management of a patient attending clinic with chronic cough.

Understand the importance of a holistic MDT assessment of the individual with chronic cough.

Curriculum mapping

Specialist CiPs:

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

3.5: Presentations and conditions: Cough. Dyspnoea. Wheeze.

3.6: Practical procedures: Bronchoscopy

Slido voting may be in use in this session.

Exchange 11, upper level

GRANULOMATOUS LUNG DISEASES

Chaired by: Dr Fasihul Khan (Leicester) and Mariam Naqvi (London)

- | | |
|---------|--|
| 9.30am | Living with systemic pulmonary sarcoidosis – a patient experience
Paul Coates (SarcoidosisUK) |
| 9.35am | Taking a concise exposure history
Dr Ruth Wiggans (Manchester) |
| 10.00am | When, how and who to treat with granulomatous lung diseases
Professor Philip Molyneaux (London) |
| 10.25am | Drug-induced pneumonitis
Dr Nazia Chaudhuri (Londonderry) |

Learning outcomes

- To provide an insight into living with sarcoid through a shared patient experience.
- To provide an overview of obtaining a concise exposure history in suspected ILD.
- To discuss the role of immunosuppression and anti-fibrotics in hypersensitivity pneumonitis and sarcoid.
- When to suspect, diagnose and treat drug related causes of pneumonitis.

Curriculum mapping

Rare topics on the curriculum.

Slido voting may be in use in this session.

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

A MASTERCLASS ON VAPING: EVERYTHING A RESPIRATORY PROFESSIONAL SHOULD KNOW

Chaired by: Dr Zaheer Mangera (London) and Melanie Perry (NCSCT)

11.30am	How can vaping be used to support patients in stopping smoking? Professor Matthew Evison (Manchester)
12.00pm	Predicting the future impact of vaping: how worried should we be? Professor David Thickett (Birmingham)
12.30pm	Panel discussion: Is there a common ground the respiratory community can agree on with vaping? Professor Sanjay Agrawal (Leicester), Dr Sarah Brown (London), Professor Andy Bush (London), Professor Matthew Evison (Manchester), Dr Anant Patel (London), Melanie Perry (NCSCT), Professor David Thickett (Birmingham)

Learning outcomes

- To explore the current evidence-base around vaping as a tool to treat tobacco dependence.
- To help clinicians understand the BTS clinical statement and how to embed a patient centred pathway in their practice.
- To review and explore concerns held within the respiratory community about potential harms and risks associated with vaping.

Curriculum mapping

Crucially important in terms of supporting patients with tobacco dependency. It is an emerging area that future respiratory trainees must become experts in given the scale of vaping.

Slido voting may be in use in this session.

Exchange 8-10, upper level

CLINICAL GRAND ROUND

Judged by: Mrs Alison Armstrong (Newcastle upon Tyne), Amy Bendall (Cardiff), Dr Katharine Hurt (Worthing) and Dr Paul Walker (Liverpool)

11.30am	Hidden under COVID waves M Hardwick, A Wight. Wirral University Teaching Hospitals, Liverpool, UK
---------	--

12.00pm	Bilateral pleural effusion: is it a malignant pleural effusion, or not? A Elsheikh, B Iqbal, WM Chew, D Addala, A Saad, A Sundaralingam, R Hallifax, J Wrightson, NM Rahman. Oxford Respiratory Trials Unit and Oxford Centre for Respiratory Medicine, Oxford, UK
---------	---

12.30pm	Navigating diagnostic challenges in interstitial lung disease G Wisenfeld Paine. University Hospital Lewisham, London, UK
---------	--

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

DIGITAL APPROACHES TO THE MONITORING OF RESPIRATORY DISEASE

Chaired by: Mrs Aleksandra Gawlik-Lipinski (London) and Dr Lindsay Welch (Bournemouth)

11.30am	Monitoring to predict onset of exacerbation and reducing re-admission to hospital Maria Parsonage (North Cumbria)
12.00pm	Setting up virtual wards QIP – admission avoidance Emma Rickards (Liverpool)
12.30pm	Remote self-management in the context of digital inclusion Dr Emma Kinley (Liverpool) and Imogene Skene (London)

Learning outcomes

- To familiarise with digital tools allowing prediction of exacerbation of respiratory disease and the impact of digital exclusion on the outcomes.
- To explore ways to set up virtual ward.
- To improve awareness of available tools to allow patients self-monitoring and self-management.

Curriculum mapping

It is expected that consultants of the future will need to have the necessary skills to work in different and innovative ways. Technological advances have led to newer ways to screen for lung disease, to accurately diagnose diseases using a variety of investigational methods, to look for specific markers which will allow newer treatments to be used, and to interact with patients in different ways probably using digital methods.

1.00pm – 2.00pm

LUNCH BREAK

Exchange Hall, lower level

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

2.00pm – 2.30pm ABSTRACT PRIZES SPOKEN SESSION

Exchange 11, upper level

ABSTRACT CATEGORY: IMPROVEMENTS IN RESPIRATORY EDUCATION AND TRAINING

Submissions reviewed in advance and shortlisted abstracts judged on the day by: Mrs Alison Armstrong (Newcastle upon Tyne), Amy Bendall (Cardiff), Dr Odri Eneje (Cambridge), Dr Neeraj Shah (London)

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.

- 1) Providing effective respiratory care in patients with a learning disability or autism
S Stothard. South Tyneside and Sunderland Foundation Trust, Sunderland, UK
- 2) An eLearning module to drive improvement in inhaler technique reviews and inhaler sustainability
L Elsey, H Montgomery, J Watson, N Jones. Manchester University NHS Foundation Trust, UK
- 3) Innovative ways to improve patient education on inhaler technique
S Grant, S Khan. Calderdale Royal Hospital, Halifax, West Yorkshire
- 4) In-situ simulation: towards improved team cohesion and patient safety
S Masterson, L Gauslyte. Barts Health NHS Foundation Trust, London, UK
- 5) The introduction of a remote facilitated lung cancer MDT
¹M Hunt, ²J Hartley, ¹L Succony, ¹D Meek. ¹Royal Papworth Hospital NHS Foundation Trust, Cambridge, UK; ²Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK
- 6) Bite-sized is best: improving the appetite for and digestion of respiratory teaching on the ward
I Mechie, D Alderson, I Tang, W Flowers. Oxford University Hospitals NHS Foundation Trust, Oxford, UK

2.30pm – 4.00pm

SIMULTANEOUS SYMPOSIA

Exchange Auditorium, lower level

MINI SHORT COURSE – PART 1

ASTHMA: THE WHOLE AIRWAY

Chaired by: Dr Alexandra Nanzer (London) and Mrs Caroline Owen (Cambridge)

- | | |
|--------|---|
| 2.30pm | Managing co-morbid sino-nasal disease in the era of biologics
Mrs Archana Jaiswal (Manchester) |
|--------|---|

3.00pm

Laryngeal disease in the asthma clinic
Mrs Claire Slinger (Preston)

3.30pm

Should we, and can we, target the small airways in asthma?
Dr Rory Chan (Dundee)

Learning outcomes (for Parts 1 & 2)

- Understand the role of biologics and surgical intervention in managing sinonasal disease in patients with asthma.
- Understand the presentation of laryngeal disease in the asthma clinic: a comorbidity or an asthma mimic.
- Understand the impact of small airways dysfunction in asthma and severe asthma including pragmatic ways to measure and manage small airway disease.
- Understand the role and practical value of different investigations used by clinicians to diagnose and manage asthma: a masterclass.
- Consider the impact of smoking and underlying airway inflammation on phenotyping patients in the asthma clinic.

Curriculum mapping (for Parts 1 & 2)

- Managing all aspects of thoracic malignancy and advanced or terminal respiratory disease including diagnostic pathways and working with the MDT.
- Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease.
- Managing complex and unusual respiratory infection including contact tracing and public health (in particular, atypical pneumonia).
- Managing the service and patients with respiratory failure in multiple settings including hospital and in the community.
- Tertiary subspecialties interface: managing patients across the secondary and tertiary interface; in particular, patients with lung and heart transplants and pulmonary hypertension.
- Managing the use of drugs and therapeutic modalities specific to the practice of respiratory medicine.

Exchange 8-10, upper level

HOT TOPICS IN PULMONARY VASCULAR MEDICINE

Chaired by: Dr Colin Church (Glasgow) and Dr Joseph Newman (Cambridge)

2.30pm

Management of ILD-pulmonary hypertension: is it changing?
Professor John Wort (London)

3.00pm

How to interpret an echo for pulmonologists
Professor Daniel Augustine (Bath)

3.30pm

Do we really need to follow up patients with pulmonary embolism?
Prof Robin Condliffe (Sheffield)

Learning outcomes

- To understand the management of pulmonary hypertension in various forms of ILD, with focus on the data surrounding that of Treprostinil.
- Education of what is important when looking at an echo is lacking. This talk will address this and focus on key parameters that would facilitate greater understanding and earlier identification of patients with PH.
- Development of PE clinics has become more recognised – this talk will explore the key features that should be addressed in follow up.

Curriculum mapping

3.4 Specialty Capabilities in Practice

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

Exchange 11, upper level

SPOTLIGHT ON RESPIRATORY INTEGRATED CARE

Chaired by: Dr Sarah Elkin (London) and Jacqueline Pollington (Rotherham)

2.30pm	No more 'lift and shift': the BTS/PCRS position statement on respiratory integrated care Dr Alison Talbot-Smith (Wye Valley)
3.00pm	Educating practitioners to be respiratory integrated care specialists – what do we need to do differently? Catherine Ren Lawlor (London)
3.30pm	What does real integrated care look like? The Knowsley service Samantha Hayes (Knowsley)

Learning outcomes

- To understand what really is respiratory care integration rather than duplication or re-siting of respiratory services. To disseminate the BTS/PCRS position statement on integrated care.
- To reflect that integrated care has its own skill set and competencies and to examine how we should train future practitioners and what constitutes advanced training for new consultants.
- To highlight novel and innovative elements of a mature respiratory integrated care service, look at efficacy and outcome data and reflect the challenges to development and delivery.

Curriculum mapping

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

2.6 Managing a multi-disciplinary team including effective discharge planning.

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

Amongst multiple other generic and organisational competencies.

4.00pm – 4.30pm

REFRESHMENT BREAK

Exchange Hall, lower level

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

MINI SHORT COURSE – PART 2

ASTHMA INVESTIGATIONS MASTERCLASS AND A PRO-CON DEBATE

Chaired by: Dr Alexandra Nanzer (London) and Mrs Caroline Owen (Cambridge)

4.30pm	Spirometry, oscillometry and testing for bronchial hyper-responsiveness Professor Stephen Fowler (Manchester)
4.50pm	Measuring airway inflammation for the diagnosis and management of asthma Dr Ran Wang (Manchester)
5.10pm	The role of imaging in the asthma clinic Dr Nishanth Sivarasan (London)
5.30pm	Pro-con debate – “Is my patient an ex-smoker with severe asthma, or do they have eosinophilic COPD?” Dr Jessica Gates (London) and Dr Richard J Russell (Leicester)

Learning outcomes

See Part 1.

Curriculum mapping

See Part 1.

Exchange 8-10, upper level

CYSTIC FIBROSIS – KNOWN UNKNOWNNS

Chaired by: Tracey Daniels (York) and Dr Dawn Lau (Cardiff)

4.30pm	We are missing people with CF, but who, where and how? Dr Maya Desai (Birmingham)
5.00pm	What can we learn from CF about transition of care? Dr Steven Stirk (Cardiff) and Bethan Watkins (Cardiff)
5.40pm	What are the new and emerging treatments for CF? Professor Alexander Horsley (Manchester)

Learning outcomes

- To learn about the diagnosis of CF particularly in BAME groups and how therapy might be different.
- To understand the challenges and potential solutions of providing smooth high-quality transition of care from paediatric to adult services for young people with chronic respiratory problems.
- To understand new treatment modalities e.g., gene therapy and exposure to trial pipeline.

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.

Descriptors:

- Communicates effectively with clinical and other professional colleagues.
- Identifies and manages barriers to communication (e.g. cognitive impairment, speech and hearing problems, capacity issues).
- Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations.
- Shares decision making with children and young people.
- Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations.

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.

GPCs Domain 2: Professional skills

- Communication and interpersonal skills.

Exchange 11, upper level

IMPROVING OUTCOMES FOR PATIENTS WITH SOMNOLENCE: CPAP AND BEYOND

Chaired by: Dr Vicky Cooper (Salford) and Dr Sriram Iyer (Sheffield)

4.30pm	CPAP adherence – What works? What doesn't? What's new? Dr Amanda Sathyapala (London)
5.00pm	Weight loss in OSA – Are the new agents a game changer or are we missing the point? Professor Dan Cuthbertson (Liverpool)
5.30pm	When it's not OSA – The approach to the non-apnoeic patient with somnolence Dr Sonya Craig (Liverpool)

Learning outcomes

- To be updated on the evidence-based approach to improving CPAP adherence in patients with OSA, including technological innovations and horizon scanning.
- To be updated on the approach to treating obesity, including surgery and the role of the newest anti-obesity agents, in the OSA-NHS context.
- To understand the approach to the patient with hypersomnolence who doesn't have sleep apnoea.

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 team (e.g. physiotherapists, specialist nurses, palliative care team, pharmacists, physiologists and psychologists).

Clinical CiPs:

- 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.

6.00pm – 7.00pm

RECEPTION

Exchange Hall, lower level

THE BTS PRESIDENT'S RECEPTION AND AWARD PRESENTATIONS

All attendees are warmly invited to attend this social occasion, where the awards for the BTS Abstract Prizes and Clinical Grand Round will be presented.

PROGRAMME

FRIDAY 21 JUNE 2024

8.00am – 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

PNEUMONIA: PREVENTION AND BEST PRACTICE

Chaired by: Mrs Kiran Bidari (Derby) and Dr Jamilah Meghji (London)

8.30am	Can we get better at preventing pneumonia and acute respiratory infections? A vaccinology update Dr Catherine Hyams (Bristol)
9.00am	Hospital acquired pneumonia: a review and best practice Pearlene Antoine-Pitterson (Birmingham)
9.30am	Pneumonia and NCEPOD: what can we learn? Dr Mark Juniper (Swindon)

Learning outcomes

- What is the current state of the art in pneumonia prevention with vaccines, and how might this change in the future?
- How can I best identify and care for patients at risk of, or who have developed, hospital-acquired pneumonia?
- What can we learn from NCEPOD on improving outcomes for patients with community-acquired pneumonia?

Curriculum mapping

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

Relevance for Vaccines/Public Health

3. Managing complex and unusual respiratory infection including contact tracing and public health (in particular, atypical pneumonia)

- Shows awareness of broader aspects of pulmonary infections especially public health issues including notification and contact tracing of patients with specific infections.

Maps to Pulmonary Infections on the Section 3.5 Presentations and Conditions.

Slido voting may be in use in this session.

Exchange 8-10, upper level

HOW CAN WE TAKE PULMONARY REHABILITATION FORWARDS EQUITABLY?

Chaired by: Dr Enya Daynes (Leicester) and Professor William Man (London)

8.30am	How can we use the accreditation scheme to improve the wider delivery of PR across the UK and differing areas of deprivation and inequalities? Professor Maria Buxton (Hertfordshire)
9.00am	What do patients want from pulmonary rehabilitation and how can they help us improve delivery particularly to those with health inequalities? Dr Nicola Roberts (Edinburgh)
9.30am	Group singing on social prescription: how can this complement pulmonary rehabilitation for everyone? Dr Roisin Cahalan (Limerick)

Learning outcomes

- Understand the wider impact of the PRSAS programme.
- Raise awareness of how patients can feedback to rehab programmes and improve delivery of pulmonary rehabilitation.
- Highlight the role of social prescribing and how it can align with pulmonary rehabilitation in practice.

Curriculum mapping

The symposium provides wider knowledge around social prescribing, focuses on shared decision-making and highlights good practice (accreditation scheme).

Exchange 11, upper level

OCCUPATIONAL LUNG DISEASES: THE PATIENT PERSPECTIVE

Chaired by: Dr Hilary Tedd (Newcastle upon Tyne) and Samuel Wallbanks (Birmingham)

8.30am	Work-related asthma Dr Johanna Feary (London) and Dr Gareth Walters (Birmingham)
9.15am	Occupational interstitial lung disease Dr Christopher Huntley (Birmingham) and Dr Ruth Wiggins (Manchester)

Learning outcomes

- To identify key features of occupational asthma using the BTS clinical statement as a framework and including clinical history, the use of physiology and immunology in the diagnostic process and patient-centred management.
- To be aware of key aspects of occupational ILD including taking an exposure history, radiology and pathology and management strategies.
- To understand how a diagnosis of Occupational Lung Diseases may impact on how these differ from other respiratory diseases due to patient concerns around work, their livelihoods and compensation.

Curriculum mapping

5. Tertiary subspecialties interface: managing patients across the secondary and tertiary interface; in particular patients with lung and heart transplants and pulmonary hypertension.

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.

3.5 Presentations and conditions

For each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Symptoms: symptoms related to occupation.

Conditions/issues: occupational and environmental lung disease.

Slido voting may be in use in this session.

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

10.30am – 12.00pm SYMPOSIUM

LET'S GET THINGS IN ORDER – COPD

Chaired by: Mrs Elinor Bradley (Manchester) and Dr Steve Holmes (Shepton Mallet)

10.30am	Getting the diagnosis sorted right from the start Dr Steve Holmes (Shepton Mallet)
11.00am	Exacerbations – Let's stop being retrospective and move on Dr Sarah Sibley (Liverpool)
11.30am	Considerations in the frequent exacerbator and effect of multi-morbidity Dr Steve Holmes (Shepton Mallet)

Learning outcomes

- The need to establish diagnosis correctly from the start; the challenge of inadvertently mis-labelling the patient and the need to retrack if a patient labelled as COPD without the confirmatory diagnostics. How COPD diagnostics might pose new challenges in the era of lung cancer screening and setting up a service.
- Considering alternative approaches to COPD exacerbations – is there a role for intervening earlier with exacerbations? Can we be more pro-active in our approach to prevent the first exacerbation and certainly reduce risk of the second?
- Highlighting the role of multimorbidity and considering COPD within a multimorbidity strategy. Why multimorbidity is a respiratory clinicians role and how a co-morbidity may manifest as a COPD exacerbation or a co-morbidity worsen the risk of exacerbation.

Curriculum mapping

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

Managing medical problems in patients in other specialties and special cases.

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

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

10.30am – 11.00am ABSTRACT PRIZES SPOKEN SESSION

Exchange 11, upper level

ABSTRACT CATEGORY: IMPROVING QUALITY AND EXCELLENCE IN PATIENT CARE

Submissions reviewed in advance by: Lizzie Grillo (London), Dr Frances Grudzinska (Birmingham), Susanne Harkness (Newcastle upon Tyne), Dr George Hulston (London), Dr Mark Juniper (Swindon), Donna Peat (Preston), Dr Aravind Ponnuswamy (Liverpool) and Dr Stephen Scott (Chester)

Shortlisted abstracts judged on the day by: Lizzie Grillo (London), Dr Mark Juniper (Swindon), Donna Peat (Preston) and Dr Stephen Scott (Chester)

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.

- 1) Revamping our comfort food menu – a co-creational approach
R Kahai, S Gheewala, R Burton, N Matias, Y Smuts-Gardener, G Castelli. Royal Brompton Hospital, London, UK
- 2) Respiratory-led ultrasound-guided pleural biopsy service reduces hospital visits and waiting times
SP Tjong, J De Jesus, T Playle, S Vythilingam, K Nutkins, R Asciak. Portsmouth Hospitals University NHS Trust, Portsmouth, UK
- 3) Reducing time-to-initiation of biologic in patients with severe asthma
AS Bahra, D Sammut, S Saha, A Tyas. Sheffield Teaching Hospital, Sheffield, South Yorkshire
- 4) The impact of an ambulatory primary pneumothorax management pathway on healthcare care resource demand
T Macdonald, E Cox, L Johnson, E Harvey, R Asciak. Portsmouth Hospitals University NHS Trust, Portsmouth, UK
- 5) Interstitial lung disease-specific Fatigue and Breathlessness (FAB) programme pilot: a multi-disciplinary innovation
¹J Mandizha, ¹R Davies, ¹C Crook, ¹C Dean, ¹A Duckworth, ¹V Elworthy, ¹C Masey, ¹J Moss, ¹AR Paiva, ²AM Russell, ¹K Taylor, ¹M Gibbons, ¹S Lines. ¹Royal Devon University Healthcare NHS Foundation Trust, Exeter, UK; ²University of Exeter, Exeter, UK
- 6) "Train to Drain": a quality improvement project leading to a national educational resource to improve the confidence of doctors and nurses in managing patients with chest drains
B Iqbal, D Addala, S Guo, A Elsheikh, A Sundaralingam, R Hallifax, NM Rahman, J Wrightson. Oxford Pleural Unit, Oxford University Hospitals NHS Trust, Oxford, UK

11.05am – 12.00pm **SESSION**

Exchange 8-10, upper level

PHYSIOLOGY QUIZ Q&A LIVE SESSION

Chaired by: Joanna Purvis (Nuneaton) and Dr Karl Sylvester (Cambridge)

Cases presented by: Dr Vicky Moore (Coventry)

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.

12.05pm - 1.00pm **GUEST LECTURE**

Exchange Auditorium, lower level

BREATHLESSNESS AND LUNG TRANSPLANTATION

Guest lecturer: Professor Havi Carel (Bristol)

Introduced by: Dr Paul Walker (Liverpool)

Including at 12.05pm presentation of the Abstract Prize award for "Improving quality and excellence in patient care"

1.00pm – 2.00pm **LUNCH BREAK**

Exchange Hall, lower level

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

2.00pm – 3.30pm **SIMULTANEOUS SYMPOSIA**

Exchange Auditorium, lower level

MINI SHORT COURSE – PART 1

THE PATIENT'S JOURNEY RECEIVING RESPIRATORY SUPPORT, FROM ACUTE CARE TO HOME

Chaired by: Pearlene Antoine-Pitterson (Birmingham) and Dr Benjamin Jones (Cardiff)

2.00pm	Understanding nasal high flow from initiation, and weaning from high flow in emergency care Dr Murali Shyamsundar (Belfast)
2.30pm	The complex airway, sialorrhea and the challenges of weaning Dr Camilla Dawson (Birmingham)
3.00pm	Airway clearance: what does the future hold for our patients? Charlotte Massey (London)

Learning outcomes (for Parts 1 & 2)

- To gain further insight and understanding into how high flow is being utilised as a treatment technique across the healthcare environments. From patient selection, initiation, weaning and understanding why HFNC is effective in some patients and not in others.

- To follow the patient journey from front door services, critical care, management of the complex airway, weaning units and long-term support and care. Insight into the practicalities and challenges of weaning patients with complex ventilation needs and the role the MDT has to play in SWU.
- To ensure understanding of MDT involvement in the care of complex ventilation patients. To provide a first-hand personal experience from the MDT and the patients journey of how they felt during treatment. This will provide insight into any challenges or barriers to healthcare and highlight healthcare inequalities.

Curriculum mapping (for Parts 1 & 2)

Generic capabilities in practice

3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement.

3.3 Clinical capabilities in practice p18.

3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment.

5. Managing medical problems in patients in other specialties and special cases.

6. Managing a multi-disciplinary team including effective discharge planning.

3.4 Specialties in practice

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

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

Presentations and conditions

Respiratory failure in acute care exploring non-invasive ventilation and respiratory support.

Slido voting may be in use in this session.

Exchange 8-10, upper level

PLEURAL DISEASE – STATE OF THE ART

Chaired by: Dr Avinash Aujayeb (Northumbria) and Laura McNaughton (Glasgow)

2.00pm	Efficient diagnostics in pleural malignancy Professor Eleanor Mishra (Norwich)
2.30pm	Pneumothorax – what does the new evidence tell us? Dr Steven Walker (Bristol)
3.00pm	Mesothelioma – past, present and future Liz Darlison (Leicester)

Learning outcomes

- To understand the role of cytology and image guided biopsy in the investigation of a unilateral pleural effusion.
- To understand the equipoise in pneumothorax and the symptom-based approach of the BTS 2023 pleural guidance.
- To understand the recent developments in mesothelioma on top of BTS 2018 guidance.

Curriculum mapping

- Managing all aspects of thoracic malignancy and advanced or terminal respiratory disease, including diagnostic pathways and working with the MDT.
- Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions).

Slido voting may be in use in this session.

Exchange 11, upper level

NON-TUBERCULOUS MYCOBACTERIAL (NTM) INFECTION AND DISEASE

Chaired by: Dr Ronan Breen (Forth Valley) and Helen Dunning (Exeter)

2.00pm	What are non-tuberculous mycobacteria? How do we catch them and how do we kill them? The microbiology of NTM disease Dr Ian Laurenson (Edinburgh)
2.30pm	Better care for all: standards of care for NTM disease Dr Matthijs Backx (Cardiff)
3.00pm	Managing NTM disease: when to treat and what to use – Clinical cases and management dilemmas Christabelle Chen (London) and Dr Heinke Kunst (London)

Learning outcomes

- Understand what non-tuberculous mycobacteria are, how they cause human disease and what specific treatments are helpful.
- Knowledge of what good care for NTM disease in the NHS looks like and how this can be achieved.
- Understand complexity of clinical management of NTM disease, problems that can be encountered and options for management.

Curriculum mapping

CiP 2. Managing integrated respiratory medicine across the primary and secondary care interface including management of long-term disease: NTM infection is encountered in the management of multiple chronic respiratory conditions and delivery of NTM care will require development of robust integrated care services.

CiP 3. Managing complex and unusual respiratory infection including contact tracing and public health (in particular, atypical pneumonia).

CiP 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

THE PATIENT'S JOURNEY RECEIVING RESPIRATORY SUPPORT, FROM ACUTE CARE TO HOME

Chaired by: Pearlene Antoine-Pitterson (Birmingham) and Dr Benjamin Jones (Cardiff)

3.45pm	Transitioning the complex ventilation patient to a specialist weaning unit: appropriate selection and patient management Dr Rachel D'Oliveiro (Cambridge)
4.15pm	The intricacies of supporting end of life care in long term ventilated patients Debbie Field (London)
4.45pm	An MDT approach to respiratory support from hospital to home: a patient's journey Dawn Copeland (Southampton), Debbie Field (London), Dr Rachel D'Oliveiro (Cambridge) and Jane Rodger (Newcastle upon Tyne)

Learning outcomes

See Part 1.

Curriculum mapping

See Part 1.

Slido voting may be in use in this session.

Exchange 8-10, upper level

LUNG CANCER – FROM TISSUE TO TREATMENT

Chaired by: Dr Fraser Millar (Edinburgh) and Dr Alexandra Teagle (Edinburgh)

3.45pm	Making a tissue diagnosis in lung cancer Dr Haval Balata (Manchester)
4.15pm	Tissue requirements for modern molecular testing Dr Alexander Haragan (Liverpool)
4.45pm	New medical treatments for early and late-stage lung cancer Dr Martin Forster (London)

Learning outcomes

- Update on established tissue diagnostic techniques in lung cancer.
- To understand more novel techniques for the diagnosis of early-stage lung cancer.
- To understand the role of molecular pathology in lung cancer diagnostics.
- To appreciate the tissue sampling requirements to perform these tests.
- To understand the range of targeted medical therapies available in early and late-stage lung cancer.
- To understand the expanding role of immunotherapy in early and late-stage lung cancer

Curriculum mapping

Respiratory Speciality CiPs:

- 1) Managing all aspects of thoracic malignancy and advanced or terminal respiratory 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 11, upper level

JOINT BTS/ARTP SYMPOSIUM: "DOCTOR, WHY AM I BREATHLESS?"

Chaired by: Dr Martin Allen (Stoke on Trent) and Megan Beacham (Wolverhampton)

3.45pm	Living with asthma and ILD – patient perspectives
3.55pm	Making a diagnosis Mrs Amy Taylor-Gonzalez (London)
4.20pm	Normal basic tests, where next? Dr Joanna Shakespeare (Coventry)
4.45pm	Still breathless? Is the problem breathing pattern disorder? Mrs Lizzie Grillo (London)

Learning outcomes

- To understand how CDCs and direct GP access to lung function testing and interpretation can help with the diagnosis of a breathless patient.
- To recognise the other tests available to aid the diagnosis of breathlessness, what they assess and diagnostic outcomes.
- To be able to recognise breathing pattern disorders and management options.

Curriculum mapping

Generic CiPs

1. Able to successfully function within NHS organisational and management systems.
2. Able to deal with ethical and legal issues related to clinical practice.
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement.
4. Is focussed on patient safety and delivers effective quality improvement in patient.

Clinical CiPs (Internal Medicine)

3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment.
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions.

Respiratory Specialty CiPs

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

BIOGRAPHICAL DETAILS FOR SPEAKERS AND CHAIRS

Speakers and chairs are listed in alphabetical order, with summaries of presentations (where applicable) following each biography.

Professor Sanjay Agrawal is National Specialty Advisor for Tobacco Dependency at NHS England, RCP Special Advisor on Tobacco and a Consultant in Respiratory and Intensive Care Medicine at University Hospitals of Leicester NHS Trust. In 2023 he delivered the BTS Quality Improvement Programme in Tobacco Dependency and co-chaired the BTS Clinical Statement on the Medical Management of Tobacco Dependency published in 2024. Sanjay chairs the RCP Tobacco Advisory Group which recently published 'E-cigarettes and harm reduction: an evidence review', a comprehensive assessment of e-cigarette trends, safety, benefits, risks and regulation.

Pearlene Antoine-Pitterson is a Respiratory Physiotherapy Specialist with an interest in non-invasive ventilation. She has 13 years of experience in the NHS at University Hospitals Birmingham, working in acute care with respiratory patients with both complex ventilation requirements and respiratory physiotherapy needs, in her role of Acute NIV Lead Physiotherapist in Birmingham Heartlands Hospital. Alongside her clinical responsibilities, Pearlene has pursued academic interests including an NIHR MRes in Clinical Research and currently she is an Assistant Professor of Cardiorespiratory Physiotherapy at the University of Birmingham and Chair of the BTS Specialist Advisory Group on Critical Care and Respiratory Failure and Mechanical Ventilation.

Hospital acquired pneumonia: a review and best practice

Hospital acquired pneumonia (HAP) has an associated risk of mortality in both ventilator acquired pneumonia (VAP) and HAP. During this session, the main objective is to summarise the evidence surrounding best practice with regards to the management of HAP. There will be a focus on a multidisciplinary approach to the management of HAP with discussion on the practicable strategies for proactive and preventative approaches. There will be particular focus on non-pharmacological approaches.

Alison Armstrong is the Nurse Consultant within the regional North-East Assisted Ventilation Service, Royal Victoria Infirmary, Newcastle upon Tyne. She began her career within a neuro trauma intensive care setting and has now worked within the long-term ventilation service for over 20 years.

Alison is current Chair of the British Thoracic Society Education and Training Committee, and one of her main interests lies in education. She represents nursing on several groups nationally. Until recently she was Co-chair of the BTS Nurse Specialist Advisory Group. 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 16 years. The focus of this non-medical group is to promote the sharing of ideas which assists with the creation of new innovations and service improvement in this specialist area of practice.

Alison has been part of the group involved in developing the home mechanical ventilation medical curriculum and has led on the further development of this to provide a Long-Term Ventilation Educational Framework for multi-professional use.

She hosts flight assessment clinics for her long-term ventilation patients and recognises the importance of holidays, including airline travel, for this patient group. As a member of the British Thoracic Society, she has recently been involved in the development of a Clinical Statement for Managing Patients with Respiratory Diseases Planning Air Travel.

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.

Professor Dan Augustine is a Consultant Cardiologist at the Royal United Hospitals Bath and President of the British Society of Echocardiography (BSE). He specialises in cardiac imaging (echocardiography and cardiac MRI). Clinical and research interests include echocardiography in pulmonary hypertension and sports cardiology. He was lead author of the National Echocardiography Guidelines on the Assessment of Pulmonary Hypertension. He has authored and edited several textbooks including the Oxford Handbook of Echocardiography.

How to interpret an echo for pulmonologists

This presentation will summarise useful tips on echocardiography report interpretation in the assessment of pulmonary hypertension. We will review current guidelines, ways to differentiate pre- from post-capillary PH and novel techniques which may help to identify PH at an earlier stage. The talk is aimed at those with a primary interest in respiratory medicine, no prior echo knowledge is needed!

Avinash Aujayeb currently works as a Respiratory Medicine Consultant, Northumbria Healthcare NHS Foundation Trust. He is the Pleural Lead, Chair of the BTS Pleural Specialist Advisory Group and Secretary for the Pleural and Mediastinal Malignancies Group for the ERS. He has published widely on pleural disease, is PI for several trials and is a previous Mesothelioma UK Trustee.

Dr Matthijs Backx is a Consultant in Infectious Diseases and Medical Microbiology at the University Hospital of Wales, Cardiff. He is Clinical Lead for the Regional Mycology Reference Unit and the Wales Centre for Mycobacteria. Matt's interests include infection in the immunocompromised host and the diagnosis and management of fungal and mycobacterial disease.

Better care for all: standards of care for NTM disease

High-quality information on the management of NTM disease is limited, and clinicians may have little experience of providing care to people with this condition. Despite guidelines describing the recommended management being available, there is considerable variation in practice across the UK. A standard of care for NTM disease can help clinicians and services achieve the delivery of consistent, standardised, high-quality care, and so improve the experience for people with NTM disease.

Educational aims – Knowledge of what good care for NTM disease in the NHS looks like and how this can be achieved.

Dr Haval Balata is a Consultant Respiratory Physician based at Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, UK. He is also an Honorary Senior Lecturer at the School of Biological Sciences, University of Manchester, Manchester, UK.

Specialising in respiratory medicine and thoracic oncology, Dr Balata's clinical and research interests include the risk reduction, screening and early detection of lung cancer and interventional bronchoscopy. He has published on topics encompassing screening and early detection of lung cancer, diagnostic and treatment pathways as well as post-treatment risk-stratification and surveillance.

Dr Balata enjoys extensive involvement in the pioneering 'Manchester Lung Health Check' service for targeted lung cancer screening, having overseen the initial pilot study as part of his PhD thesis in 2016. He is now the active Responsible Clinician for two of the UK's largest 'Targeted Lung Health Check' programmes. His other roles include being the Clinical Lead for the Interventional Bronchoscopy Unit at Wythenshawe Hospital and Clinical Lead for the Regional Navigation Bronchoscopy Service.

Making a tissue diagnosis in lung cancer

This presentation will discuss the various methods of gaining tissue confirmation in lung cancer within established lung cancer diagnostic bundles, including image-guided biopsy and EBUS-TBNA, before focussing on the developing and novel methods of peripheral bronchoscopy, including navigation and robotic platforms. The aim of the session is to present the evidence base behind these diagnostic tests, as well as debating the 'pros and cons' of each when considering their implementation into NHS practice.

Megan Beacham completed her undergraduate degree in 2016 in Respiratory and Sleep Science, which started her career as a Registered Respiratory Physiologist at the Royal Wolverhampton NHS Trust. In 2019 she completed the Scientific Training Programme (STP), which gave her a Master's in Clinical Physiology, and she became a Registered Clinical Scientist. To date Megan continues her career as the Deputy Service Manager for Respiratory and Sleep Physiology at the Royal Wolverhampton NHS Trust. She is a member of the ARTP Sleep and Education Committee and Early Careers Ambassador.

Amy Bendall is a Chartered Physiotherapist and is a Senior Lecturer and the Professional Head 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.

Kiran Bidari is a Respiratory Infections Nurse Specialist at the Royal Derby Hospital and works as a Clinical Advisor at the NHS 111 Service as well. She has worked in various acute settings at three different NHS Trusts. Kiran also worked as a Rapid Response Nurse in the Community. She was on the NICE Committee in 2023 to formulate the NICE Guideline on Suspected Acute Respiratory Syndrome in Over 16s. Kiran also holds the role of Expert Adviser for the NICE Centre for Guidelines (CfG).

Elinor Bradley was first employed as a respiratory nurse in a busy North West teaching hospital. There, she developed her passion for respiratory medicine, specifically airways disease, joining a community and hospital-based COPD team. Within junior and senior Sister roles she supplemented her interest with a respiratory Master's degree and non-medical prescribing qualification, later leaving the service to complete the Advanced Clinical Practice Master's to become a Respiratory ACP.

Elinor now supports respiratory inpatient and outpatient services but maintains her interest in COPD via her own secondary care ACP led airways clinic. She sits on the BTS COPD Specialist Advisory Group.

Ronan Breen is currently a Consultant in Respiratory Medicine in Forth Valley Hospital in Scotland. His doctoral research was in TB and HIV at the Royal Free Hospital, London, with Marc Lipman. He was a Consultant at Guy's and St Thomas from 2007-2023 and was Lead for TB and NTM Infections. Ronan is the Vice-chair of NTM Network UK.

Dr Sarah Brown MD (Res) FRCPCH, is a Paediatric Respiratory Consultant, Lead for the Tertiary Respiratory Service at the Royal London Children's Hospital and Honorary Clinical Senior Lecturer at the Blizard Institute, Queen Mary University of London. She is active within the research community, holding both principal investigator and sub-investigator positions. She is Chair and Lead for the European Respiratory Society Task Force on Paediatric Neurodisability and Respiratory Morbidity, and a member of the Health Improvement Committee of the Royal College of Paediatrics and Child Health. She is a member of the British Paediatric Respiratory Society (BPRS) and has been involved in the development of the BPRS Statement on Youth Vaping.

Maria Buxton qualified in 1988 at King's College Hospital and then progressed through working mostly in London, but also USA and Australia. She joined Central Middlesex Hospital in 1997 as a Clinical Specialist, eventually becoming an Integrated Consultant Physiotherapist in 2005 with North West London Hospitals Trust, working across secondary and community care, with expertise in NIV, critical care, HOSAR, dysfunctional breathing and airways clearance as well as pulmonary rehabilitation.

Maria led on PR and later, home oxygen, with the London Respiratory Team from 2010, which later developed into the London Respiratory Network. As part of that, she helped to set up the London PR Provider Network, and the Home Oxygen Network. She was also involved in creating the CSP PRIME tool for PR commissioning.

Maria moved to Hertfordshire in 2018, as Consultant Respiratory Physiotherapist and Service Lead for the West Herts Community Respiratory Service under Central London Community Healthcare NHS Trust, which is one of the largest integrated community respiratory services in the UK, providing nine respiratory services.

She is the newly appointed Clinical Lead for the Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS), after having completed two years as their Quality Lead. In that role, she has led on assessor training, providing support to services on how to achieve accreditation, and has performed many service and site assessments as a Lead Assessor.

Dr Róisín Cahalan is an Associate Professor in Physiotherapy at the University of Limerick, teaching respiratory and cardiovascular physiotherapy. Her research areas of interest are dichotomised into interventions for chronic respiratory disease, and injury screening, surveillance and prevention in elite athletes and dancers. She is the founder of the SingStrong programme in Ireland.

Group singing on social prescription: how can this complement pulmonary rehabilitation for everyone?

This presentation will focus on the experience of working with a range of different respiratory cohorts including people with COPD, ILD, long COVID, and lung cancer. It will discuss the evidence behind singing for lung health and the physiological basis of the intervention. Research that we and others have conducted in this area will be briefly summarised. The benefits for practitioners and participants will be discussed, as well as some of the logistical and pragmatic considerations for setting up a group such as this, including cohort-specific issues. Alignment with the theme of equitable access to pulmonary rehabilitation will guide the talk.

Havi Carel is Professor of Philosophy at the University of Bristol, where she also teaches medical students. She has recently been awarded a £2.6m Wellcome Discovery Award, for a six year project on epistemic injustice in health care (EPIC). Details: <http://epicproject.info/>

In 2020 she completed a Wellcome Trust Senior Investigator Award, leading a five-year project, the Life of Breath (www.lifeofbreath.org). She was awarded the Health Humanities' Inspiration Award 2018 for her work on the project.

Havi won the IJPS 2021 PERITIA Prize for her paper 'When Institutional Opacity Meets Individual Vulnerability: Institutional Testimonial Injustice' (co-authored with Ian Kidd), published in the International Journal of Philosophical Studies. Her third monograph was published by Oxford University Press in 2016, entitled 'Phenomenology of Illness'. Havi was voted by students as a 'Best of Bristol' Lecturer in 2016 and was nominated for a teaching award three further times.

Havi is the author of 'Illness' (2008, 2013, 2018), shortlisted for the Wellcome Trust Book Prize, and of Life and Death in Freud and Heidegger (2006). She is the co-editor of 'Health, Illness and Disease' (2012) and of 'What Philosophy Is' (2004). She uses film in teaching and has co-edited a volume entitled 'New Takes in Film-Philosophy' (2010). She also co-edited a special issue of 'Philosophy on Human Experience and Nature' (2013).

Havi previously published on the embodied experience of illness, epistemic injustice in healthcare, vulnerability, wellbeing within illness, transformative experience, death, and on the experience of respiratory illness, in the Lancet, BMJ, Journal of Medicine and Philosophy, Journal of Medical Ethics, Journal of Applied Philosophy, and in edited collections.

In 2009–2011 Havi led an AHRC-funded project on the concepts of health, illness and disease. In 2011–2012 she was awarded a Leverhulme Fellowship for a project entitled 'The Lived Experience of Illness'. In 2012–2013 she held a British Academy Mid-Career Fellowship. <http://bristol.academia.edu/HaviCarel>
<http://www.bristol.ac.uk/school-of-arts/people/havi-h-carel/index.html>

Breathlessness and lung transplantation

This talk will explore what is unique and salient about both breathing and breathlessness from an experiential perspective. It will offer the distinction between normal and pathological breathlessness and characterise the latter as external, threatening and transformative. This presentation will also offer some thoughts on lung transplantation, thinking about it, as the philosopher JL Nancy said, as being 'sewn open'.

James D Chalmers is Asthma and Lung UK Chair of Respiratory Research at the University of Dundee and a Consultant Respiratory Physician. His clinical and research interests are in bronchiectasis and difficult respiratory infections. He is Chief Editor of the European Respiratory Journal, Chair of the European Bronchiectasis Registry and Chair of the Science and Research Committee of the British Thoracic Society.

What's new in bronchiectasis?

Bronchiectasis is a previously orphan disease which has experienced an increase in research and interest in recent years. The creation of large registries such as the European Bronchiectasis Registry (EMBARC) has helped to describe the characteristics of the patients, the underlying causes associated with bronchiectasis, the risk factors for disease progression and to describe current treatment patterns. An increasing number of randomised trials are taking place in bronchiectasis and have increased the evidence base for treatments such as inhaled antibiotics, macrolides and mucocactive drugs. This presentation will discuss the latest advances in the management of bronchiectasis.

Dr Rory Chan MBChB MRCP(UK) PhD, is an Honorary Consultant Respiratory Physician and Senior Clinical Lecturer at NHS Tayside and University of Dundee. His specialist area relates to precision medicine in severe asthma. He is also an Editorial Board Member at the journal CHEST.

Should we, and can we, target the small airways in asthma?

- To understand the utility of spirometry and airway oscillometry in fully characterising the small airway asthma phenotype.
- To summarise the existing evidence base for treating small airways dysfunction.

Dr Nazia Chaudhuri is an Interstitial Lung Disease (ILD) Specialist and Senior Clinical Fellow at the University of Ulster and Altnagelvin Hospital, Western Healthcare Trust, Londonderry, Northern Ireland (NI). She is lead of the NI ILD network.

Nazia is the Chair of the BTS ILD Registry and the Secretary of the European Respiratory Society (ERS) Idiopathic Interstitial Pneumonia Assembly. She is also a member of the Long Range Planning Committee for the ERS ILD Assembly.

Drug-induced pneumonitis

The presentation will highlight:

- How common is drug induced interstitial lung disease (DI-ILD)?
- The commonest causative agents of DI-ILD.
- Challenges and pitfalls of diagnosing DI-ILD.
- Use nitrofurantoin and immune check point inhibitors as examples.

Christabelle Chen is the Lead Respiratory Pharmacist for Barts Health NHS Trust and is the North-East London (NEL) Respiratory Network Medicines Optimisation Co-Lead.

She is a member of the British Thoracic Society (BTS) and contributes in a clinical advisory role to the BTS MDRTB Clinical Advisory Service and has recently joined the BTS Pharmacist Specialist Advisory Group. She also leads as Co-chair of NTM Network UK Pharmacists Subgroup.

Christabelle has been working as a respiratory pharmacist for the last 13 years with subspecialist experience and interest in TB, NTM, cystic fibrosis and asthma. She is an independent non-medical prescriber and passionate about developing innovative pharmacy led services and clinics within respiratory infections and severe asthma.

Managing NTM disease: when to treat and what to use – Clinical cases and management dilemmas (*joint presentation with Heinke Kunst*)

Managing NTM disease is complex with many patients being elderly, having pre-existing co-morbidities and on medications that will interact with NTM drug treatment. The cases discussed in this session will highlight how patient centred care with MDT involvement, support NTM treatment initiation with the aim to prevent clinical, microbiological and radiological disease progression. The session will also illustrate examples of the goals of NTM treatment such as symptom control, prevention of relapse and cure.

Dr Peter Cho is a Consultant in Respiratory Medicine at King's College Hospital NHSFT. He completed his PhD at King's College London, and his work provided novel insights into the role of cough inhibition mechanisms in the pathogenesis of chronic cough. His latest work focused on improving the assessment of the severity and impact of cough. Peter is currently leading a scientific study utilising network analysis to define phenotypes of cough for NEuroCOUGH, an ERS CRC funded Europe-wide cough registry.

Understanding the cough reflex and new treatments in refractory/unexplained chronic cough

Cough is such a common symptom but maybe it is time to start looking at it more as a disease. We will have a look at the physiology of cough, in particular refractory chronic cough (RCC). RCC is as its name implies and is persistent despite exhaustive investigations and treatment. We will aim to link physiology to areas that can be explored for treatment of RCC.

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 signalling in pulmonary vascular remodelling. He has a keen interest in both clinical and basic science research and is a principal investigator on several important clinical trials, including looking at novel anti-inflammatory strategies to treat pulmonary hypertension. His basic science research focuses on the interplay of inflammation and hypoxia on the pulmonary vascular cells particularly the pulmonary artery fibroblast.

Colin is one of three consultants in the Scottish Pulmonary Vascular Unit, which is the national referral centre for the Scottish population. This unit investigates and manages all patients in Scotland with pulmonary hypertension. He is also one of the principal clinicians involved in management of venous thromboembolic disease in the Queen Elizabeth University Hospital and is Secretary of the Glasgow Thrombosis Committee. Colin is involved in the planning force for the International Society of Heart and Lung Transplantation (ISHLT) and is Associate Editor for BMC Pulmonary Medicine. More recently he has become the Chair of the BTS Pulmonary Vascular Specialist Advisory Group. @acchurch1

Mr Paul D Coates BA (Hons) SW, has patient experience of chronic pulmonary sarcoidosis. He was diagnosed in 2007, following pneumonia and chronic cough, and a biopsy was taken and tested for granuloma.

Living with systemic pulmonary sarcoidosis – a patient experience

This presentation will explore how patient experience can help improve a patient prognosis and improve patient outcomes. It will look at support group involvement and self-care.

Dr Vicky Cooper is the Principal Clinical Scientist and Sleep and Acute Non-Invasive Ventilation Service Manager at Salford Royal Hospital. She first became interested in sleep medicine in 2000 as a post-doctoral research fellow at St James's University Hospital, Leeds, under the supervision of Dr Mark Elliott. Her research interests were in the relationship between obstructive sleep apnoea and hypertension. She also undertook research projects in a Mongolian singing technique for snoring and the effects of sleep apnoea on driving performance.

Current interests are in using lifestyle medicine to treat sleep disorders and she is currently studying for Accreditation Lifestyle Medicine.

Vicky was involved in the inaugural meeting of ARTP-Sleep in 2010 and soon after became the Editor of its biannual newsletter S-NEWS. In 2014 she became Co-chair of ARTP-Sleep and was Chair from January 2016 to 2018 before Co-Chairing again to support the incoming current Chair from 2018-2019.

Vicky has been involved in all levels of the Modernising Scientific Careers (MSC) from PTP to HSST including curriculum writing, teaching and candidate assessments. She has been involved in leading and teaching on ARTP, BSS and ISMC sleep courses and sits on the ARTP Sleep and BSS Education Sub-committees. Vicky is also the Lead for Sleep Teaching for the Scientific Training Programme (STP) at Manchester Metropolitan University. She is a member of the OSA Alliance and has worked on the Task and Finish Group for Standardising Optimal Sleep Pathways. Vicky is passionate about highlighting the profile of sleep professionals in the UK and improving education and training opportunities, as well as improving patient care.

Ms Dawn Copeland is a Band 7 Occupational Therapist working at University Hospital Southampton NHS Foundation Trust. She is based on the Respiratory High Dependency Unit however she works across the respiratory medical wards as required. Dawn has a specialist interest in complex respiratory discharge planning and promoting functional rehabilitation and independence.

Dr Sonya Craig is a Sleep and Respiratory Consultant working at University Hospital Aintree, Liverpool (LUHFT) where she is Lead Clinician for Sleep Medicine. She trained at Cambridge University and the Royal Brompton Hospital, London before completing an MD investigating cardiovascular risk and obstructive sleep apnoea (MOSAIC trial) with Professor John Stradling in Oxford. Her main research interests are vascular risk in OSA and the delivery of sleep medicine and care effectively and efficiently within the NHS. She is Co-chair of the OSA Alliance, ex-chair of the Sleep Specialist Advisory Group for BTS and has chaired the digital group for the Optimal Sleep Pathway Taskforce for NHSE. Her most recent publications are the results of the MERGE study published in *Lancet Respiratory* and a review of residual sleepiness in OSA (ERR 2022).

When it's not OSA – the approach to the non-apnoeic patient with somnolence

This presentation will cover how to assess patients who are still sleepy after CPAP therapy or who present with conditions not related to obstructive sleep apnoea. This is a practical guide and a step wise approach to these patients who may present in general respiratory clinics or specialist sleep clinics.

At the end of the session the attendee should be able to recognise common sleep disorders and will be able to arrange the appropriate diagnostic tests to investigate these conditions.

Tracey Daniels is the non-medical Clinical Lead at the York Hull Adult Cystic Fibrosis Centre, Clinical Lead for Innovation at Humber and North Yorkshire Integrated Care Board and a joint York St John University/York and Scarborough Teaching Hospitals Research Fellow. She is completing a PhD, within the CFHealthHub learning health system, which is focused on understanding the impact of co-adherence to inhaled therapies alongside CFTR modulators.

Liz Darlison MBE EN RN BSc MSc, has enjoyed 40 years of clinical practice at the University Hospitals of Leicester (UHL). In response to patient need in 2004, Liz established Mesothelioma UK, a national charity for mesothelioma. Currently she is a Consultant Nurse at UHL and is also CEO at Mesothelioma UK.

Mesothelioma – past, present and future

The UK has the highest incidence of mesothelioma in the world and despite previous predictions, the incidence continues to grow. A growing body of research supports concern about the number of people who develop mesothelioma following seemingly low levels of exposure. National campaign work is now very much focused on reducing exposure and removing asbestos completely.

New treatments, a portfolio of trials and civil compensation has expanded treatment options for patients. Mesothelioma UK has weathered a challenging few years to keep pace with meeting the UK's mesothelioma information and support needs.

Dr Camilla Dawson is a Consultant Speech and Language Therapist at the Queen Elizabeth Hospital in Birmingham, an Honorary Associate Professor at the University of Birmingham and a Professional Advisor for the Royal College of Speech and Language Therapists. She works clinically with patients with head and neck cancer and surgically altered airways. Camilla's clinical work and research focuses on adults with dysphagia and upper airway pathology, exploring a range of subjects from swallow physiology to the individual's perception and experience of their dysphagia.

The complex airway, sialorrhea and the challenges of weaning

This presentation will explore swallow physiology and its complex relationship with breathing and the anatomy of the upper airway. We will consider rehabilitation approaches to managing sialorrhea, with specific focus on patients with surgically altered airways. Finally, we will discuss extended surgical approaches to manage upper airway pathology and overarching concepts to optimise functional outcomes.

Dr Enya Daynes is a Senior Specialist Physiotherapist and Postdoctoral Researcher at the University Hospitals of Leicester NHS Trust. She is the current Co-chair of the BTS Pulmonary Rehabilitation Specialist Advisory Group and is involved with national activities such as the National Respiratory Audit Programme and Pulmonary Rehabilitation Services Accreditation Scheme. Clinically, Enya is a Specialist Physiotherapist in Pulmonary Rehabilitation, and lead for the Long COVID Rehabilitation Service. Her research explores the non-medical management of breathlessness, and she has recently led on a multicentre COVID rehabilitation trial.

Dr Samantha Decalmer is Consultant Respiratory Physician working in the Northern Care Alliance. She completed a PhD under the supervision of Professor Jacky Smith examining the phenotypes of patients presenting with chronic cough, with reference to the role of gastro-oesophageal reflux. She maintains a specialist interest in chronic cough and is a member of the North West Regional Cough MDT.

Insights from the cough clinic

Chronic cough is a common presentation in respiratory medicine and can be associated with significant physical, psychological and social sequelae for the patient. Cough can be associated with almost all respiratory conditions but can also occur without apparent lung disease. In this scenario, it can be difficult to diagnose and effectively treat. We will discuss a series of interesting cases, some common and some more unusual presentations, and the multidisciplinary approach to diagnosis and management.

Maya Desai has been a Consultant Respiratory Paediatrician at Birmingham Children's Hospital since 2002 and was previously Clinical Lead of the Paediatric CF Network, delivering care to around 300 children and young people with CF. She sits on the Executive Committee of the UK Cystic Fibrosis (CF) Medical Association, the Clinical Advisory Board of the Newborn Screening Programme for CF at NHSE and has been co-chair of the working group, currently revising the national CF standards of care document.

We are missing people with CF, but who, where and how?

The talk will cover the variability of presentation of cystic fibrosis in different ethnic groups and at different ages, and the impact of newborn screening on this. It will also look at different approaches to establishing a diagnosis and considerations of treatment options, which vary according to genotype.

Dr Rachel D'Oliveiro is a Consultant in Intensive Care and Respiratory Medicine at Royal Papworth Hospital, working within the Intensive Care Unit and Respiratory Support and Sleep Centre. Her clinical interests are in extracorporeal membrane oxygenation (ECMO), weaning, long term ventilation and sleep.

Transitioning the complex ventilation patient to a specialist weaning unit: appropriate selection and patient management

The aims of this presentation are to:

- Review the role of specialist weaning units, including the BTS and ICS Model of Care.
- Understand which patients benefit from transfer to a specialist weaning unit.
- Discuss approaches to weaning patients from invasive mechanical ventilation.

Mrs Helen Dunning graduated as a registered nurse in 2010, initially working in acute and emergency medicine at Royal Devon University Hospital (RDUH). She specialised as a respiratory nurse in 2014 where she focussed on supporting COPD patients between hospital and home. She subsequently moved on to work within sleep and ventilation, acute respiratory care, and COVID high-dependency areas.

Helen has been part of local service development, successfully establishing the Trust's Early Supported Discharge Service (ESD) for COPD patients, and the NIV Service for Chronic Respiratory and Neuromuscular Disorders. Her key interest is centred around respiratory infections, particularly those that are NTM related. She has recently been appointed Lead TB and Bronchiectasis Nurse for the Trust and is Co-chair of the NTM Network Nurse Interest Group.

Dr Odiri Eneje graduated from Imperial College School of Medicine, London and has an Intercollegiate 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 Master's 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.

Odiri is a Consultant in Respiratory Medicine at the Royal Papworth Hospital with a specialist interest in cystic fibrosis, complex lung infections and respiratory immunology. She is a member of the BTS Education and Training Committee.

Dr Johanna Feary is an Honorary Respiratory Consultant at Royal Brompton Hospital and Senior Clinical Research Fellow at the National Heart and Lung Institute, Imperial College London, a combination of roles that allow her to carry out clinical work and research as well as teaching. Her clinical interests include a broad range of occupational lung diseases and asthma. She is Chair of the British Thoracic Society Specialist Advisory Group on Occupational and Environmental Lung Disease and a member of the Group of Occupational Respiratory Disease Specialists (GORDS).

Debbie Field PhD MA (Dis) BSc(Hons) RN, is a Consultant Nurse in Home Mechanical Ventilation Outreach in the Royal Brompton Hospital Sleep and Ventilation Team.

She has been a nurse since 1979 and has seen many changes within nursing and healthcare. However, the essence and fundamental principle of nursing in any specialty has not changed; this is compassion we give to the patients we care for. At times it may go beneath the surface and get lost within the bureaucratic milieu, which is driven by protocols, evidence-based medicine, lack of imagination, nursing's obsession for professionalism and our healthcare's 'risk adverse' culture. Yet if compassion is valued, it puts the patient back into the centre of care allowing all healthcare practitioners to help and support the patient through their journey towards enablement and a quality of life for them.

This is what drives her passion for caring for patients who have complex ventilation needs in both the hospital and community setting.

For the past nine years, Debbie has been Consultant Lead for the Home Ventilation Community Outreach Team within the Sleep and Ventilation Service at the Royal Brompton and Harefield Hospitals. Our aim is to meet the needs of a unique group of patients who either require weaning from prolonged ventilation in other critical care units or have long term complex ventilation and tracheostomy needs and require support and care in the community. Setting up and developing such a service depends upon collaboration between hospitals and community, building partnerships and proactive pathways between the two ensuring effective communication. Above all making the patient the centre of care and enabling them to live their lives.

The intricacies of supporting end of life care in long term ventilated patients

This talk aims to try and understand and address the key concepts and nuances that impact the intricacies of supporting end of life care for patients who require long term ventilation. These include moral, ethical, philosophical, spiritual, institutional, psychosocial, medical and physiological concepts.

We hope to raise more questions than answers, generate thought and to open and stimulate discussion at the end of the talk and beyond. It will highlight the need for coordinated, collaborative, integrated, multi-professional holistic, individualised patient centred care. Demonstrating that end of life care will be a part of all our lives at some time along our own journey. We therefore need to encourage with our patients, early discussion, active listening and proactive integrated pathways of care to ensure the patient and their loved ones have a voice and the patient has a good and dignified death.

Stephen Fowler is a Professor of Respiratory Medicine at the University of Manchester and Honorary Consultant Physician at Manchester University NHS Foundation Trust. His clinical and research interests lie in the diagnosis, classification and management of airways disease, principally asthma and associated conditions such as inducible laryngeal obstruction and breathing pattern disorders. He is investigating novel non-invasive biomarkers for phenotyping inflammatory and infectious lung disease, through the detection and analysis of volatile molecules in exhaled breath.

Spirometry, oscillometry and testing for bronchial hyper-responsiveness

Determination of variable airflow obstruction is central to the diagnosis of asthma. In this session we will learn about classical and newer measures of airflow obstruction and their applications in the diagnosis and monitoring of asthma, in particular: (1) how to detect abnormal airflow resistance using spirometry and oscillometry; and (2) how to detect significant variability using bronchodilator reversibility testing and bronchial challenge testing.

Dr Jessica Gates is a Senior Clinical Asthma Fellow at Guy's and St Thomas' Hospitals Trust and a Respiratory Registrar in South London. She is currently undertaking her PhD in the field of severe eosinophilic asthma and is committed to helping improve care and treatment for people with asthma.

Pro-con debate – "Is my patient an ex-smoker with severe asthma, or do they have eosinophilic COPD?"

Jessica will be debating whether the patient is an ex-smoker with severe asthma versus having eosinophilic COPD.

Aleksandra Gawlik-Lipinski is Advanced Nurse and Paramedic Practitioner and PhD student at the University of Leicester. Aleks' research is focused on asthma mortality in children and she currently works in general practice as a respiratory ANP. She is NRAP (National Respiratory Audit Programme) Clinical Fellow for Children and Young People's Asthma at the Royal College of Physicians (RCP), Vice-Chair of the Association of Respiratory Nurses (ARNS) Research and Education Sub-Committee and a Co-chair of the BTS Nurse Specialist Advisory Group (SAG).

Dr Alexander Haragan is a pathologist based in Liverpool with a clinical and research interest in thoracic and molecular pathology. His main clinical and research interests are around targeted therapies for lung cancers, with his work focusing on the tumour immune microenvironment, protein-based biomarkers and antibody drug conjugates, as well as the use of digital pathology and AI to improve diagnostics and prediction of response to targeted therapies.

Graduating from the University of Aberdeen with his Medical Degree and First Class Honours in Biomedical Sciences, Dr Haragan also holds a Distinction Grade Master's in Pharmacogenomics, a PGCert in Molecular Pathology and has attained his PhD in Immuno-oncology and Clinical Pharmacology.

Tissue requirements for modern molecular testing

This talk will discuss how we in pathology handle different tissue specimens (e.g. EBUS aspirates, bronchial washings/brushings, pleural fluids and biopsies) in order to extract the most clinically relevant data and what an ideal full morphological and molecular outcome looks like. We will discuss the range of options available to manage challenging and limited specimens and highlight experiences where pathological and clinical specialties working closely has helped to optimise molecular testing outcomes.

Dr Allie Hare graduated in 1999 at Selwyn College, University of Cambridge and completed her postgraduate training at St Mary's, Imperial College London School of Medicine in 2002. She completed her Certificate of Completion of Training (CCT) in Respiratory and General Medicine in the North East Thames Deanery in 2015.

Dr Hare is a Consultant in Sleep and Ventilation at Royal Brompton Hospital, with responsibility for specialist clinics in sleep disorders and domiciliary ventilation. She is the Trust End-of-Life Clinical Lead and leads on medical education in respiratory medicine.

Dr Hare is President of the British Sleep Society and recently chaired a national programme on the review of outpatient sleep medicine pathways, from referral through diagnostics and timely treatment, working with GIRFT and NHSE.

Dr Hare is passionate about improving education and training, gaining a Master's in Clinical Education with Distinction from the Institute of Education. She has lectured extensively, authored several book chapters, and published a number of articles on both non-invasive ventilation and simulation-based education.

Dr Hare was appointed Chair of the British Thoracic Society Education and Training Committee in 2019 and was appointed Honorary Treasurer of BTS in 2024.

Samantha Hayes is a Consultant Respiratory Physiotherapist and has worked for an integrated community respiratory service for over 12 years. Sam is the Clinical Lead for Pulmonary Rehabilitation in Cheshire and Merseyside and is currently undertaking a PhD to develop a peer intervention to improve uptake in pulmonary rehabilitation.

What does real integrated care look like? The Knowsley service

This presentation will focus on the journey the Knowsley Community Respiratory Service has been on to develop into an integrated service. The session will look at outcome data of the service and its impact and will reflect on challenges to development and delivery of integrated care.

Sarah Hennessey is Lead Chronic Cough Specialist Nurse for the Manchester Chronic Cough Tertiary Service at Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, UK. In 2018, she set up and established the Chronic Cough Nursing Service. The Nursing Service won the Nursing Times Respiratory Team Award and Continence Care Team Award in 2022.

Her role includes undertaking nurse led clinics for chronic cough patients, providing assessment, advice and support with urinary incontinence, and regional MDT co-ordination. As part of Sarah's role, she is currently a nurse bronchoscopist and undertakes bronchoscopy on patients as part of their respiratory investigation work up.

Sarah has an extensive respiratory background having previously worked as a Specialist Practitioner in general practice and developing and taking an interest in respiratory care including asthma, COPD etc. Prior to this she worked in the community as a District Nurse, which she commenced following qualification as a Registered Nurse.

Sarah is currently the only nurse member of the BTS Chronic Cough Statement Group, where she has provided nursing input into current cough guidelines. She has published her work on the development of her role, continence promotion in chronic cough and nurse bronchoscopy training development in chronic cough in the Nursing Times journal and presented work at various conferences including ARNS, BTS and ERS. This work has seen her recently win three national nursing awards in respiratory and continence care.

Steve Holmes has worked for more than 35 years as a GP principal having had a respiratory interest for much of this period. He is currently on BTS Council and the Science and Research Committee as well as being a member of the BTS COPD Specialist Advisory Group. Steve is a Regional Clinical Lead for NHS England in the South West and Somerset ICB Respiratory Clinical Lead. He has more than 300 publications to his name and works closely with the Primary Care Respiratory Society, the International Primary Care Respiratory Group and the Royal College of General Practitioners.

He enjoys running (slowly) and playing guitar and piano (badly).

Considerations in the frequent exacerbator and effect of multi-morbidity

This presentation will look at the role of multimorbidity in the care of the people who are "frequent exacerbators" with COPD. It will cover clinical/holistic assessment of the patient and describe the evidence base and clinical presentation of co-morbidities in this group. It will cover how co-morbidities can manifest as "COPD exacerbations" and how these can be addressed, as well as highlighting patient learnt experiences influencing future health seeking behaviour.

Professor Alex Horsley is a Professor of Respiratory Medicine at the University of Manchester, Consultant at the Manchester Adult Cystic Fibrosis (CF) Centre, Director of the NIHR Manchester Clinical Research Facility, and until recently was chair of CF Trust Clinical Trials Accelerator Platform.

Alex has led over 25 trials of new therapies in CF since 2012 and has been national or global lead on trials of several new therapies, including transformative CFTR modulator drugs. His academic work encompasses lung physiology and imaging (as clinical and trial outcomes), and lung infection.

What are the new and emerging treatments for CF?

This presentation will review some of the new therapies that have transformed care in CF. It will look at the nature of the underlying defect, explaining how the new therapies work and the impact this has had on CF care. We will also consider why these are ineffective in a small proportion of those with CF and look at the next generation of genetic therapies that aim to correct the deficit in CF.

Dr Christopher Huntley is a Consultant Respiratory Physician at University Hospitals Birmingham NHS Foundation Trust and Honorary Clinical Tutor at the University of Birmingham. Dr Huntley specialises in interstitial and occupational lung disease, working in the Birmingham Regional Occupational Lung Disease Service. He is currently finishing a PhD on occupational exposures in sarcoidosis and has a clinical interest in exposure related and inflammatory interstitial lung diseases.

Dr Katharine Hurt is a Consultant Respiratory Physician at University Hospitals Sussex where she is the Clinical Lead for the Bronchiectasis and Complex Respiratory Infection Service.

She graduated in 2000 from the Royal Free and University College London Medical School. She became a consultant in 2012 after completing higher specialist training in respiratory and general medicine in the London South Thames deanery.

Dr Hurt is passionate about medical education and has several postgraduate and undergraduate roles. She is the Training Programme Director for Respiratory Medicine in Kent, Surrey and Sussex. Along with that she is also the Royal College of Physicians Specialist Advisor to the region.

Dr Hurt is also the Director of Student Support at the Brighton and Sussex Medical School and works to focus on supporting students living with illness and disability. She introduced a wellbeing committee and supported the introduction of suicide prevention training.

Dr Hurt was elected to the BTS Council in 2023 and sits on the Education and Training Committee.

Dr Benjamin Jones is a dual-trained Intensive Care and Respiratory Medicine Consultant working in both specialties in Cardiff. His clinical commitments and specialist interests include pleural disease (where he runs a pleural clinic), acute respiratory failure and diagnostics along with supporting the regional home invasive mechanical ventilation service and ITU follow-up clinic.

Dr Mark Juniper is a Consultant Respiratory Physician in Swindon and Medical Director at Health Innovation West of England. He is currently the Chair of the BTS Quality Improvement Committee. He was clinical co-ordinator for the recently published NCEPOD study of community acquired pneumonia, some of the results of this will be presented at the Summer Meeting.

Pneumonia and NCEPOD: what can we learn?

Results from the NCEPOD review of community acquired pneumonia (CAP) will be presented. The study revealed considerable room for improvement in some very basic aspects of clinical care. The presentation will include recommendations for improving hospital care for patients with CAP and ideas for local quality improvement activity.

Dr Fasi Khan serves as the Clinical Lead for Interstitial Lung Disease (ILD) in Leicester. His research focuses on evaluating biomarkers of progressive pulmonary fibrosis, and he leads the ongoing INJUSTIS study. He is a former member of the BTS ILD Specialist Advisory Group, and currently serves on the ILD Registry Steering Committee. He is actively involved with local educational initiatives, and various national ILD consortia.

Dr Emma Kinley is a Senior Lecturer at Liverpool John Moore's University and HCPC Registered Health Psychologist. She completed her PhD at the University of Edinburgh and Asthma UK Centre for Applied Research, exploring healthcare professional delivery of supported self-management and behaviour change/patient centred care for asthma. Emma also has experience as a Research Fellow in patient and public involvement in respiratory research.

Remote self-management in the context of digital inclusion
(joint presentation with Imogen Skene)

This presentation will explore both primary care and secondary care perspectives of remote asthma self-management in the context of digital inclusion. We will discuss a rapid realist review conducted to explore the clinical effectiveness, acceptability and safety of supported self-management delivery within remote primary care asthma consultations. We will also discuss; digital tools in the context of emergency care following an acute asthma exacerbation; the perspectives of adult patients on the role of digital tools used after an acute asthma exacerbation; and the role of digital tools in improving asthma management following discharge from emergency care.

Dr Heinke Kunst is a Reader in Respiratory Medicine at Queen Mary University and Honorary Consultant in Respiratory Medicine at Barts Health. Her main research interest is in translational research themes in tuberculosis, latent tuberculosis infection (LTBI), migrant health and non-tuberculous mycobacterial diseases.

She is the Lead for the NTM Service at Barts Health and has developed a multidisciplinary clinic with dedicated NTM nurse and pharmacy support.

Managing NTM disease: when to treat and what to use – Clinical cases and management dilemmas *(joint presentation with Christabelle Chen)*

Managing NTM disease is complex with many patients being elderly, having pre-existing co-morbidities and on medications that will interact with NTM drug treatment. The cases discussed in this session will highlight how patient centred care with MDT involvement, support NTM treatment initiation with the aim to prevent clinical, microbiological and radiological disease progression. The session will also illustrate examples of the goals of NTM treatment such as symptom control, prevention of relapse and cure.

Dr Dawn Lau works within a marvellous multidisciplinary team of the All Wales Adult Cystic Fibrosis Centre (AWACFC), as well as within the Non-CF Bronchiectasis Service as Consultant Chest and CF Physician at the Cardiff and Vale University Health Board. Another well-worn hat is involvement in medical education, and in this role she leads on the Undergraduate agenda within the Health Board, working closely with the Cardiff University School of Medicine.

When not in work-action, she enjoys jogging, food in the company of friends, and exploring new countries and cultures (and cuisine).

Professor William Man is Consultant Chest Physician and Professor of Respiratory Medicine at the Royal Brompton and Harefield Hospitals, Guy's and St Thomas' NHS Foundation Trust. He combines full-time NHS clinical practice with health services research, and is the Medical Lead for the Harefield Pulmonary Rehabilitation Service, which was the first clinical service to achieve national (PRSAS) accreditation. Professor Man is the current Co-Chair of the BTS Clinical Statement on Pulmonary Rehabilitation and the BTS Quality Standards for Pulmonary Rehabilitation.

Dr Zaheer Mangera qualified from UCL Medical School in 2006, undertaking specialist training in respiratory medicine from 2010 to 2017. He is now working as a Local Lung Cancer and Tobacco Dependency Service Lead. Previously, he was Chair of the British Thoracic Society Tobacco Dependency Specialist Advisory Group. Zaheer is Academic Lead for the Final Year MBBS Programme at UCL Medical School. His scope of work includes managing both acute and respiratory inpatients, alongside delivering a bronchoscopy/EBUS/pleural service.

Dr Paul Marsden is a Consultant Respiratory Physician at Manchester University NHS Foundation Trust, based at the North West Lung Centre, Wythenshawe Hospital, and Honorary Senior Lecturer at the University of Manchester. After undertaking a PhD in cough, asthma and airway inflammation, he completed training in the North West of England. He is Clinical Lead of the Manchester Cough Service and Lancashire/South Cumbria Cough Service based in Preston, which sees patients from across the UK and beyond. He has a research interest in chronic cough and contributed to the recently published BTS Clinical Statement.

Charlotte Massey is a Specialist Neuromuscular and Respiratory Physiotherapist specialising in neuromuscular respiratory impairment with a special interest in cough and secretion management. She has worked at the Neuromuscular Complex Care Centre based at University College Hospitals London, setting up a specialist cough and secretion clinic. She is currently an NIHR Clinical Doctoral Fellow at the Sheffield Institute for Translational Neuroscience (SITraN), University of Sheffield looking at harnessing technology to support cough and secretion management in motor neurone disease.

Airway clearance: what does the future hold for our patients?

Providing "the right care, at the right place, at the right time" (NHS Long Term Plan 2019). This presentation will discuss how we can support people living with long term neuromuscular diseases to access and utilise airway clearance devices to support them to live well with their condition. It will discuss current evidence, the experiences of patients and healthcare professionals and how we can look to harness technology to optimise airway clearance as we move into the future.

Laura McNaughton is currently working as a Pleural Clinical Nurse Specialist in the Pleural Disease Unit within the Queen Elizabeth University Hospital, Glasgow. She is a specialist in managing patients with pleural disease and has a specialist interest in pleural medicine, asbestos related conditions and mesothelioma. Laura has recently completed an MSc in Advanced Nursing Practice with focus on pleural and palliative disease. She recently sat on the BTS Pleural Specialist Advisory Group as the nurse representative and has been involved in developing the pleural nursing band framework.

Dr Fraser Millar is a Consultant Respiratory Physician working at the Royal Infirmary of Edinburgh. Dr Millar completed his clinical and research training in both London and Edinburgh, obtaining CCT in 2024. He has a clinical and research interest in early-stage lung cancer, bronchoscopy and novel early detection approaches.

Eleanor Mishra is Pleural Lead at the Norfolk and Norwich University Hospital NHS Foundation Trust, which provides image guided biopsy and advanced medical thoracoscopy. She is also Associate Professor in Translational and Clinical Medicine at the University of East Anglia, with research interests in diagnosis and management of pleural disease, breathlessness, biofilms and bacteriophages.

Efficient diagnostics in pleural malignancy

This presentation will use a case-based format to review key diagnostic tests in pleural malignancy (particularly cytology, thoracoscopy and image guided biopsy) with reference to the BTS Pleural Disease Guidelines and how and when to choose different diagnostic tests.

Phil Molyneaux is a Professor of Interstitial Lung Disease at Imperial College London and the Asthma and Lung UK Chair of Respiratory Research. He is a Consultant in Interstitial Lung Disease and the Director of the NIHR Cardiorespiratory Clinical Research Facility at the Royal Brompton Hospital. He runs an active clinical and translational research programme that oversees a team of basic scientists and clinical trial research staff.

When, how and who to treat with granulomatous lung diseases

This talk will aim to cover the evidence base and treatment options available for hypersensitivity pneumonitis and sarcoid, including the role of immunosuppression and anti-fibrotics. It will cover who and when to treat, monitoring strategies and highlight unmet needs with a focus on upcoming clinical trials and emerging data.

Dr Vicky Moore is a Clinical Scientist and Deputy Lead for Respiratory in the Respiratory and Sleep Sciences Department at University Hospitals Coventry and Warwickshire (UHCW) NHS Trust. 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. Vicky 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 Alexandra Nanzer PhD, is a Consultant Respiratory Physician at Guy's and St Thomas' Hospital, and a Senior Lecturer at King's College London, UK. She obtained her PhD in asthma immunology at the Peter Gorer Department of Immunobiology at King's College London.

Guy's Severe Asthma and Eosinophilic Lung Disease Centre is one of the largest centres of its kind in the UK with expertise in biologic therapies for patients with severe asthma, EGPA and associated eosinophilic lung diseases. Dr Nanzer leads the Regional Asthma Transition Service alongside paediatric colleagues in SE England and has a special interest in adolescent severe asthma.

Marium Naqvi is the Deputy ILD Clinical Lead and Highly Specialist ILD Pharmacist at Guy's and St Thomas' Hospital and Co-Chair of ILD-IN. She is the Project Lead at GSTT for the NHS Digital funded implementation of a home monitoring programme in patients with ILD.

Research interests include digitisation of the ILD patient pathway and service and workforce provision. Marium is supporting national initiatives to improve access to specialist care, develop care pathways, guidelines, and provide education and training. Marium is an independent prescriber who manages a complex patient cohort, including medication review, optimisation of therapies and managing the monitoring and supply of high risk and/or cost medicines.

Dr Joseph Newman is a British Heart Foundation Clinical Research Fellow at the Victor Phillip Dahdaleh Heart and Lung Research Institute at the University of Cambridge and the Pulmonary Vascular Disease Unit at Royal Papworth Hospital. Joe's research interests include the development and engagement of digital and decentralised endpoints for use in pulmonary hypertension trials. He is the trainee member of the BTS Specialist Advisory Group for Pulmonary Embolism and Other Pulmonary Vascular Diseases.

Caroline Owen is the Lead Nurse for the East of England Severe Asthma Network, based at Addenbrooke's Hospital in Cambridge. She started her career within intensive care nursing for 15 years before moving into respiratory medicine. She worked in the asthma, COPD and ILD teams before moving into caring for patients with severe asthma.

Caroline has developed a strong clinical network in the East of England covering 14 different trusts, supporting delivery of care to patients with severe asthma.

She has been integral in the development of patient pathways, supporting the patients' journey within the service and has shared her approach at several regional and national forums. Moving forwards, she is keen to embrace technology and has developed several short animation videos to support patient education.

She is a committee member of SANN, the Severe Asthma National Network, and hosts the National Severe Asthma Nurses Chat Forum.

Maria Parsonage qualified in 1995 and worked across respiratory medicine and critical care in her early career. With a strong interest in advanced practice, she became an ANP in 2002, completing her MSc in Clinical Nursing and non-medical prescribing qualification in 2005/2006. Maria has worked across boundaries as a Respiratory Consultant Nurse and Pleural Disease Specialist since 2016 and is the Pleural Clinical Lead and Virtual Ward Clinical Lead for North Cumbria.

Nationally, Maria is a GIRFT Virtual Ward Clinical Lead and the Vice Chair for the Association of Respiratory Nurses (ARNS). She has been involved in numerous work streams nationally for NICE, NHSE, BTS and the UK Pleural Society. She is the Taskforce for Lung Health, Workforce Committee Co-chair, she co-authored the BTS (2023) Pleural Disease Guidelines and sits on the Mesothelioma UK Clinical Expert Panel and BTS Pleural Procedures Training Standard groups.

Monitoring to predict onset of exacerbation and reducing re-admission to hospital

Evidence to support respiratory digital home monitoring and technology availability is increasing with the growth of virtual wards. Challenges lie within interoperability, data quality, health literacy and the effect of digital inequality. Digital home monitoring requires a dedicated workforce with key governance structures, equitable commissioning, a buy in from people living with respiratory disease and societal acceptance.

The aims of the session are to explore the safety and clinical effectiveness of predicting exacerbation and avoiding hospital admission.

Donna Peat is a qualified nurse with over 20 years' experience in critical care and acute medicine. She currently works as an Advanced Clinical Practitioner in Respiratory Services at Lancashire Teaching Hospitals. Within her role, she works as the Respiratory ACP Team Lead and Respiratory Virtual Ward Lead. Donna has a keen interest in improving the management of the acutely unwell patient within secondary care. She is particularly interested in addressing health inequalities within respiratory medicine 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.

Melanie Perry has a nursing background and has been working within tobacco control and smoking cessation for over 20 years. In this time, she has set up and led a hospital-based smoking cessation service and has presented and delivered local and national training within a variety of settings to health care professionals. She has worked alongside the British Thoracic Society supporting the NHSE Long Term Plan work and is currently a freelance expert trainer and inpatient consultant with the National Centre for Smoking Cessation and Training (NCSCT)

Jacqueline Pollington is a Respiratory Nurse Consultant and Clinical Lead for BreathingSpace in Rotherham. She has worked in respiratory care for 34 years. She has led service developments in community exacerbation management, difficult asthma, pulmonary rehabilitation, complex COPD and more recently, bronchiectasis.

Jacqui was Clinical Lead for South Yorks/Bassetlaw's QUIT programme and instrumental in the creation of educational materials for the regional rollout of the tobacco treatment programme.

She has a keen research interest and has been PI in several studies. Jacqui has a Master's degree in Advanced Nursing Practice.

Emma Rickards is a Consultant Respiratory Nurse at Liverpool Heart and Chest NHS Foundation Trust and Knowsley Community Respiratory Service. She works across both the community and hospital sector and is passionate about reducing health inequalities in respiratory care. Emma is the Acute Care Lead for the Association of Respiratory Nurses (ARNS).

Setting up virtual words QIP – admission avoidance

Background to presentation: experiences of implementing a virtual ward in an existing community respiratory service, and the opportunities of using point of care testing.

Dr Nicola Roberts is an Associate Professor within the School of Nursing and Social Care at Edinburgh Napier University. She teaches on a range of modules and programmes within the School of Health and Social Care. She supervises MSc dissertation and PhD students. She is a Health Services Researcher with an interest in the delivery of respiratory care. Nicola is also a Visiting Senior Lecturer at King's College.

Her current research focus is on two main areas. Firstly, upskilling healthcare staff and students to deliver respiratory care.

Recent work has focussed on how respiratory care is taught to pre-registration nursing students and how confident graduating students are about their respiratory clinical skills.

The second area of focus is on improving delivery of respiratory care within pulmonary rehabilitation, and recent work looks at how the educational component of pulmonary rehabilitation is delivered. She was a member of the Pulmonary Rehabilitation Clinical Statement Group at the British Thoracic Society.

Nicola is also a member of the American Thoracic Society (ATS) Conference Organising Committee for the Pulmonary Rehabilitation Assembly.

What do patients want from pulmonary rehabilitation and how can they help us improve delivery, particularly to those with health inequalities?

This presentation will explore what patients want from pulmonary rehabilitation and how this can be tailored to fit the different needs of the pulmonary rehabilitation population.

Learning outcomes: participants will be able to understand and apply some of the strategies discussed in this session.

Jane Rodger is an Advanced Nurse Practitioner in Home Ventilation at the Royal Victoria Infirmary, Newcastle upon Tyne. She qualified as a registered nurse in 1995 and started her career working on a combined ICU/CCU. In 2000 she changed roles to become a respiratory nurse specialist and helped to develop one of the first early supported discharge services for patients admitted with an acute exacerbation of COPD in the UK. During this time, she was also the nursing lead in developing the home ventilation service for Mid Yorkshire Hospitals NHS Trust in Wakefield, 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. She is currently developing the HOT-HMV nurse led clinic and a nasal high flow therapy service within the home ventilation team.

Dr Richard Russell has recently completed respiratory specialty training in Leicester. He undertook his PhD and an Academic Clinical Lectureship at Leicester University. He will shortly be taking up a consultant post in Sheffield. He has a specialist interest in airways disease and has published research in both asthma and COPD. He has been a contributing advisor on BMJ Best Practice articles on acute asthma and COPD exacerbation, and an expert panel member on the CHEST cough guidelines.

Pro-con debate – “Is my patient an ex-smoker with severe asthma, or do they have eosinophilic COPD?”

This presentation, as part of a pro-con debate, will discuss the features of the case that support the argument that the patient has eosinophilic COPD. It will outline the evidence underpinning eosinophilic COPD as an important clinical phenotype and discuss the implications this diagnosis has for the patient, and for the clinician considering investigation and management decisions. Finally, it will discuss possible future treatment options for eosinophilic COPD, and how these may overlap, or differ, from that of an ex-smoker with severe asthma.

Dr Amanda Sathyapala is a Senior Lecturer at Imperial College London and a Consultant Physician at Guy's and St Thomas' NHS Foundation Trust. Her research focusses on addressing the problem of poor patient adherence to CPAP. Her group have described six early patterns of behaviour that predict longer-term adherence to CPAP on which tailored management and interventions can be based and have developed interventions to improve CPAP adherence. She sits on the Executive Committee of the British Sleep Society (BSS) and co-leads the BSS's Research Committee. She is a member of an NIHR RfPB Grant Advisory Panel (London region).

CPAP adherence – What works? What doesn't? What's new?

The topics to be covered in this presentation will include:

- What works in improving CPAP adherence, and therefore what can be focussed on in your clinical practice?
- What doesn't improve CPAP adherence?
- What's new in the field and is anticipated in the near future?
- The patient's perspective of starting CPAP and how sleep services support the process of becoming adherent to CPAP.

Dr Stephen Scott works as a clinician at the Countess of Chester Hospital NHS Foundation Trust and is visiting Consultant at the Royal Liverpool University Hospital. He has a special interest in asthma, completing his PhD in the effect of weight loss in obese asthmatics. He is keen on quality improvement, has contributed to various national guidelines for asthma and has previously been a member of the BTS Standards of Care Committee amongst other roles. He also holds a Master's degree in Postgraduate Medical Education.

Steve is currently a member of the BTS Education and Training Committee and BTS Council member.

Dr Neeraj Shah is an ST7 Respiratory Registrar in South London, developing a specialist interest in chronic respiratory failure and long-term ventilation. He currently works at St George's Hospital. He has recently completed his doctoral studies at GSTT/KCL investigating mechanical insufflation-exsufflation therapy in patients with neuromuscular disease. He currently sits on the BTS Education and Training Committee, having recently handed over the role of President of the Respiratory Section at the Royal Society of Medicine, which he filled 2019-2023. He is an Army Reservist, currently serving as Second in Command of 335 Medical Evacuation Regiment.

Dr Joanna Shakespeare is a Consultant Clinical Scientist in Sleep and Ventilation at University Hospitals Coventry and Warwickshire NHS Trust, having worked as a Respiratory Physiologist/Scientist for 28 years. She spent 16 years as the Clinical Service Lead for the Respiratory and Sleep Sciences Department leading it to UKAS (IQIPS) accreditation in 2016.

Joanna is the Honorary Chair of the Association for Respiratory Technology and Physiology (ARTP). She is the Lead Editor for the NSHCS Scientific Training Programme (STP) Curriculum Review for Respiratory and Sleep. Joanna 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.

Normal basic tests, where next?

This presentation will discuss the role of cardiopulmonary exercise testing (CPET) in the assessment of the breathless patient whose routine diagnostic investigations are either normal or out of keeping with the patients' symptoms. It will look at how exercise testing can help differentiate from causes of breathlessness due to disorders of the heart, lungs and muscle.

Dr Sarah Sibley is a Consultant Respiratory Physician at Liverpool Heart and Chest Hospital and has been delivering integrated respiratory care for the local population in Cheshire and Merseyside for over 10 years. She is passionate about patient care and endeavours to improve respiratory care and outcomes for patients.

Sarah holds numerous leadership roles including: Clinical Lead for the NHSE Cheshire and Merseyside (C&M) Respiratory Clinical Network, Senior Responsible Officer for the C&M Respiratory Board, North West Clinical Lead for the NHSE Virtual Ward Programme and British Thoracic Society Integrated Care Lead.

Exacerbations – let's stop being retrospective and move on

A review of the evidence-based treatments of patients with COPD, a particular focus upon when to start treatments. Is it time to change our strategy for COPD care and prevent deterioration and be more proactive – a moment to pause and reflect. What can we learn from cardiology about primary prevention and secondary prevention?

Dr Nishanth Sivarasan is a Cardiothoracic Radiologist at Guy's and St Thomas' Hospital. He qualified from Imperial College London Medical School in 2013 as an academic award winner and entered radiology training at Guy's and St Thomas' Hospital, achieving the FRCR in 2018. Dr Sivarasan was appointed as the National Treasure Fellow at Royal Brompton Hospital from 2019-2021, completing subspecialty training in thoracic imaging. During this time, he was awarded an MD(res) from Imperial College London for his research on 'CT Morphological Phenotypes in Pulmonary Sarcoidosis'. Dr Sivarasan's clinical interests include imaging of interstitial lung disease, lung cancer, advanced COPD, severe respiratory failure and cardiovascular CT.

The role of imaging in the asthma clinic

An overview of the typical imaging findings in asthma, relevant complications and other eosinophilic lung diseases.

Imogen Skene is a PhD student at Queen Mary University of London and Co-Lead Research Nurse in Emergency Medicine at Barts Health NHS Trust. Her PhD focused on understanding the health beliefs and behaviours of adults presenting to the emergency department with a view to develop a medication optimisation intervention.

Remote self-management in the context of digital inclusion *(joint presentation with Emma Kinley)*

This presentation will explore both primary care and secondary care perspectives of remote asthma self-management in the context of digital inclusion. We will discuss a rapid realist review conducted to explore the clinical effectiveness, acceptability and safety of supported self-management delivery within remote primary care asthma consultations. We will also discuss: digital tools in the context of emergency care following an acute asthma exacerbation; the perspectives of adult patients on the role of digital tools used after an acute asthma exacerbation; and the role of digital tools in improving asthma management following discharge from emergency care.

Claire Slinger is a Consultant Speech and Language Therapist at Lancashire Teaching Hospitals NHS Trust, and a Professional Advisor to the Royal College of Speech and Language Therapists in the field of Adult Respiratory Care. She is a co-author of the RCSLT Position Paper on upper airway disorders, and the lead author of a Cochrane (Airways) review into speech therapy for chronic cough. She is currently a member of the BTS Cough Specialist Advisory Group.

Claire's areas of interest include assessment and management of inducible laryngeal obstruction (ILO) and chronic cough.

Claire is a Consultant SLT and Service Lead for Preston Complex Breathlessness (Airways) Multi-Disciplinary Team, Royal Preston Hospital, and is undertaking a NIHR research scholarship.

Laryngeal disease in the asthma clinic

- Gain an understanding of the type and aetiology of laryngeal presentations that may be seen in an asthma setting and their relevance.
- Highlight signs and symptoms to direct the clinician to suspect laryngeal dysfunction in an asthma clinic setting.

- Understand the approach to the assessment and management of a patient attending clinic with laryngeal dysfunction.
- Understand the importance of a holistic MDT assessment of the individual with co-existing asthma and laryngeal dysfunction.

Professor Jacky Smith is a Professor of Respiratory Medicine at the University of Manchester, an Honorary Consultant in Respiratory Medicine at Manchester University NHS Foundation Trust and the Director of the Manchester NIHR Clinical Research Facility. She set up and runs a multi-disciplinary team translating neurophysiological mechanisms in cough and facilitating the development of novel therapies. Her research is funded by a Wellcome Investigator Award, UKRI and the Manchester Biomedical Research Centre, for which she is Respiratory Theme Co-Lead. She led the development of a cough monitoring system that has changed the standards by which cough medicines are evaluated.

How to approach and treat chronic cough: overview of the BTS Clinical Statement on Chronic Cough in Adults

This presentation will summarise the new British Thoracic Society Clinical Statement on Chronic Cough in Adults, highlighting those aspects that have changed compared with previous guidance. It will aim to explain the terminology used to describe patients with chronic cough, including cough hypersensitivity, and describe the treatable traits approach to patient management.

Dr Laura-Jane Smith is a Respiratory and Internal Medicine Consultant at King's College Hospital, and certified Lifestyle Medicine Physician. Her subspecialty interests are in COPD and lung cancer. She qualified in 2006 and trained in Cambridge and London. During training, she took time out to undertake a clinical teaching fellowship at UCL Medical School and completed a Diploma in Clinical Education, and spent a year in research focusing on prognostication in severe COPD. She has written two books on respiratory medicine for doctors in training. LJ joined King's College Hospital as a Consultant in 2019. In recent years she has focused on social justice, health inequalities, air pollution and the health impacts of the climate crisis. She completed a Diploma in Lifestyle Medicine in 2021 and tries to apply a OneHealth approach to her clinical practice. She is the Clinical Lead for Sustainability at King's College Hospital, a member of MedAct, and Plant-Based Health Professionals. She is the first BTS Trustee for Sustainability.

Sustainability in healthcare – how things are both worse and better than you think

In this session LJ will provide an update on the latest data on the scale and pace of the climate crisis and its impact on human health. She will describe two possible futures, in which we either succeed or fail to act, highlighting what is at risk and what is to be gained by a just transition to a sustainable future. She will identify areas for immediate action for individuals and organisations (including the BTS), and how these are core to our work as respiratory health professionals. She will share examples of successful projects and actions, aiming to leave you with a sense of both urgency and agency.

Carol Stonham MBE, works at Gloucestershire ICB Respiratory Clinical Programme Group and is CYP Asthma Clinical Lead, following 26 years in nursing in general practice. Carol is also a Co-clinical Lead of the NHSE Southwest Respiratory Network.

She is past Executive Chair of PCRS – the first non-doctor and first female to take the chair. She is current Policy Lead for PCRS. Carol is a director of the UK Lung Cancer Coalition. She co-chairs the Lung Health Task Force Early and Accurate Diagnosis Group and is a member of the NHS Long Term Plan Breathlessness Diagnosis Group.

Carol received Queen's Nurse award in 2007 and in 2016 was awarded an MBE for Services to Nursing and Healthcare.

Getting the diagnosis sorted right from the start

COPD should be diagnosed early in the disease pathway allowing timely and appropriate pharmacological and non-pharmacological treatment to begin. This enables the patient to stay healthy for longer, to slow decline in lung function and prevent exacerbations and the complications that can follow.

This session will look at the ideal diagnostic pathway and the reason for variation from it. It will consider the barriers to timely diagnosis and potential solutions enabling a timely accurate diagnosis of COPD.

Dr Alison Talbot-Smith works as an Associate Specialist in Respiratory Medicine at Wye Valley NHS Trust, a rural District General Hospital that also provides community services. She previously worked as a Consultant in Public Health at Hereford PCT, a forward-thinking organisation that had a 'deep partnership arrangement' with the Local Authority. Subsequently, she became the Director of Service Transformation for Herefordshire GP Led Clinical Commissioning Group. As the national integration agenda progressed, she then became the STP Programme Manager and Director of Integrated Care System Development for Herefordshire and Worcestershire Integrated Care System (ICS).

No more 'lift and shift': the BTS/PCRS Position Statement on Respiratory Integrated Care

This session will outline the fundamentals of the recent BTS/PCRS Position Statement on Integrated Respiratory Care. It will discuss the underpinning policy drivers and goals, as well as the resources, relationships and new 'ways of working' needed for its effective delivery at both national and local level.

The session will not offer any 'one size fits all' solutions. Instead, it seeks to use the position statement as the beginning of a framework which respiratory practitioners can use to develop, implement, evaluate and evolve integrated respiratory care in their own 'patch'.

Amy Taylor-Gonzalez started her career in the Lung Function Laboratory at Royal Brompton Hospital in 2008 and became registered as a Respiratory and Sleep Clinical Scientist in 2015. She worked in clinical trials for new therapies to treat idiopathic pulmonary fibrosis (IPF) and her MSc dissertation focussed on equity of access to antifibrotic therapy using the current NICE policy. She worked at Barts Health leading the CPET service in cardiology, working alongside a team of 100 cardiac scientists.

It was here she recognised the importance of networking with other physiological scientists, in particular with patients suffering with chronic breathlessness. In 2018, Amy moved to Surrey and Sussex Healthcare to lead the Respiratory and Sleep Science Service and sought to resolve multiple pathway issues with patients referred to these services. In June 2022 she moved to NHS England as the Implementation Lead in the Physiological Science Transformation Programme.

Making a diagnosis

This presentation will focus on the adult breathlessness pathway which seeks to support an early and accurate diagnosis of the cause of chronic breathlessness in adults to ensure the best outcomes for patients and prevent unnecessary admissions into hospital.

Dr Hilary Tedd is a Respiratory Consultant working at the Royal Victoria Infirmary in Newcastle. She has a specialist interest in occupational lung disease and delivers specialist regional clinics in occupational lung diseases, along with working as part of the interstitial lung diseases MDT, providing specialist occupational input. She has a passion for teaching and training and is Training Programme Director for Respiratory Medicine for the North East and North Cumbria.

Professor David Thickett is Professor of Respiratory Medicine at the University of Birmingham. He is the Clinical Smoking Cessation Lead for University Hospitals Birmingham NHS Trust. His research interests include the molecular effects of cigarette and e-cigarette usage upon acute, perioperative and chronic inflammation. He is the Clinical Chief Investigator of the HTA funded ECAL trial comparing the effectiveness of e-cigarettes versus dual NRT in COPD patients.

Predicting the future impact of vaping: how worried should we be?

In this lecture we will discuss what is known about the potential harms that could be caused by e-cigarette use both short and long-term and put these in context with the effects of smoking. The challenge of studying e-cigarette toxicity will be outlined as well as the potential for interference by tobacco company funded bodies. The talk will specifically use potential for the development of COPD as a model for the discussion.

Dr Paul Walker is a Consultant Respiratory Physician in Liverpool University Hospitals Foundation NHS Trust and Sefton Integrated Community Respiratory Team. He is also Diagnostics Lead for Merseyside and Cheshire Respiratory Network. He is current Chair of the British Thoracic Society, having previously been Honorary Treasurer and Chair of the Education and Training Committee.

Paul's clinical interests are integrated care, bronchiectasis, COPD and pulmonary physiology and he is research active in these areas. He has a long-standing interest in health inequality, the impact of social deprivation on health outcomes and developing systems to increase access. This includes work looking at the presence of COPD and asthma in heroin and crack smokers.

Dr Steve Walker is an NIHR Consultant Senior Lecturer in Respiratory Medicine with a specialist interest in pleural disease, at the University of Bristol. His main research interest is the management of pneumothorax. He has published extensively and is leading several studies in the field. He is the Co-chair of the current European Respiratory Society (ERS) Guideline on Pneumothorax and on the Guideline Committee for the British Thoracic Society Pleural Disease Guidelines 2023. He is Co-chair of the ERS Pleural Clinical Research Collaborations.

Pneumothorax – what does the new evidence tell us?

Multiple recent practice changing trials and two new international guidelines on pneumothorax (BTS and ERS) have changed the landscape in pneumothorax management. This session will update the audience on recent evidence on conservative, ambulatory and surgical approaches and how they are reflected in guidelines.

Samuel Wallbanks is a graduate of the NHS Scientist Training Programme and works as a Clinical Scientist in Respiratory and Sleep across Birmingham Heartlands Hospital and Birmingham Chest Clinic. He leads in many aspects of physiology service delivery, including in education, lung function testing, cardiopulmonary exercise testing (CPET) and peak expiratory flow analysis. He works as part of the Occupational Lung Disease Service within Birmingham.

Gareth Walters is an NHS Consultant in Occupational Respiratory Medicine in Birmingham, and Honorary Senior Research Fellow at University of Birmingham. He leads the Birmingham Regional NHS Occupational Lung Disease Service and is a member of the Group of Occupational Respiratory Disease Specialists (GORDS-UK) and the Industrial Injuries Advisory Council. Gareth's research interests are in the occupational aspects of airways diseases and interstitial lung disease, as well as early case finding in work-related disease.

Dr Ran Wang is an NIHR Clinical Lecturer at University of Manchester with special interest in asthma diagnostics. She graduated from University of St Andrew's and Manchester (2012) and trained through the Integrated Clinical Academic Training Programme during her foundation and specialist training years. Having completed her PhD entitled "The impact of physiological variability on asthma diagnosis and management" earlier this year, she has been awarded the NIHR Clinical Lectureship to investigate the physiological and functional heterogeneity of asthma through computational modelling of novel physiological parameters and functional lung imaging.

Measuring airway inflammation for the diagnosis and management of asthma

The presentation will explore the roles of inflammatory biomarkers in asthma diagnosis and management. We will discuss the pros and cons of using each inflammatory biomarker in the clinical settings. The talk will focus on the diagnostic efficiency of inflammatory measures and accessibility/practicality of tests. Discrepancies amongst guidelines in regard to the use of these measures will also be discussed.

Bethan Watkins worked as a youth worker for over 10 years in the local authority, education sector and health, always supporting young people through different life transitions. She is currently studying to be a social worker at Cardiff University.

Dr Lindsay Welch is an Associate Professor in Nursing Practice at University Hospitals Dorset and Bournemouth University. This senior clinical academic role is concerned with the development of a research skilled, curious, and quality orientated nursing workforce within UHD, simultaneously conceptualising and developing the Breathing and Fundamental Respiratory Care Research Group within the Department of Nursing at Bournemouth University.

Lindsay's research, education, and enterprise activity are all centred around the concept of fundamental nursing care (including health inequalities, and inclusion health), respiratory nursing, respiratory diagnostics and the development and inclusion of technology in respiratory practice to disrupt traditional diagnostic pathways.

Dr Ruth Wiggins is a respiratory consultant with a clinical and academic interest in a range of occupational and environmental lung disease and in work-related health. Ruth splits her time as a consultant at North Manchester General Hospital and academic at the University of Manchester.

She is a member of the BTS Occupational and Environmental Lung Disease Specialist Advisory Group and of the Group of Occupational Respiratory Disease Specialists. Ruth was awarded a PhD from the University of Sheffield in 2020, which examined risk factors for occupational asthma in allergen exposed workers. Current research projects explore intersections between work and health including between health inequalities and occupational lung disease, analysing data from the national THOR occupational disease surveillance database, return to work in long-COVID, and silicosis in the UK.

Taking a concise exposure history (Granulomatous Lung Diseases)

This session will describe the epidemiology of occupational granulomatous lung disease, the main causes, and the occupational groups at risk. The session will cover some of the similarities and differences between occupational granulomatous lung disease and granulomatous lung disease without an occupational link. The session will equip the ILD practitioner with key questions to ask in taking a concise exposure history, and how to manage a patient where a potential occupational cause is suspected.

Occupational interstitial lung disease (Occupational Lung Diseases)

This session will provide a patient perspective on a diagnosis of occupational ILD. This session will use the patient voice to explain the risk factors, symptoms, diagnosis, and consequences of a diagnosis of occupational ILD. The session will highlight how delays in treatment can have a huge impact on patient outcomes, and why primary prevention for occupational lung disease is so important.

Professor S John Wort Following completion of a chemistry degree at the University of Oxford, Professor Wort studied medicine in London. He completed a PhD at Imperial College, London in 2002 investigating the role of endothelin-1 in autocrine regulation of vascular smooth muscle proliferation. He is a Consultant in Pulmonary Hypertension at the Royal Brompton Hospital and Professor of Practice at Imperial College, London. Research interests include the role of inflammation in pathogenesis of pulmonary vascular remodelling, congenital heart disease PAH and PH associated with chronic lung disease. He has recently completed his role as Chair of the National Pulmonary Hypertension Physicians' Committee in the UK.

Management of ILD-pulmonary hypertension: is it changing?

This presentation will summarise the current evidence for treatment of pulmonary hypertension (PH) associated with interstitial lung diseases (ILDs). Up to recently there has not been any hard evidence for the use of pulmonary vasodilators in this group of patients. However, the recent INCREASE study indicated a role for inhaled trepostinil, a prostanoid, in the management of ILD-PH, further supported by several follow-on studies. These will be reviewed as well as thoughts on implications for the future management of ILD-PH in the UK.

Nick Woznitza MBE is a Consultant Radiographer at University College London Hospital and Clinical Academic at Canterbury Christ Church University. His work is focused on the role of radiographers, including radiographer reporting, lung cancer and artificial intelligence. He was awarded an MBE in the 2022 New Year's Honours list for services to radiography.

Improving chest X-ray reporting – will AI help?

Artificial intelligence is being highlighted as the cure of all problems in healthcare. In particular, AI image interpretation of chest imaging has a plethora of available products. However, recent NICE guidance has failed to recommend routine use of AI for chest X-rays or non-screening chest CT. This session will:

- Provide context on chest X-ray reporting.
- Summarise the current available evidence on chest X-ray AI.
- Update on ongoing research on AI supporting chest X-ray reporting.

BTS ABSTRACT PRIZES – SHORTLISTED ABSTRACTS

CATEGORY: IMPROVEMENTS IN RESPIRATORY EDUCATION AND TRAINING

1 (RespEd)

Providing effective respiratory care in patients with a learning disability or autism

S Stothard. South Tyneside and Sunderland Foundation Trust, Sunderland, UK

Introduction

Respiratory disease is one of the leading causes of avoidable death of people with a learning disability in England. Patients with a learning disability, were being overlooked in their outpatient care. These patients were identified as high usage of emergency and out of hours services

Objective

- Patient involvement in managing their own respiratory disease.
- Personalised care planning, shared decision making
- Improve compliance
- Improve quality of life
- To reduce admissions / emergency services, in turn reducing the carbon footprint

Methods

The quality improvement tool PDSA was used. The adapted clinic is ran by the Respiratory Nurse. Longer appointment times and adjustments are made to address any sensory issues a patient may have. An accessible room is used and sensory lighting available. The first appointment is a 'fact finding' appointment, using the patient passport, to establish patient's preferences and understanding. Subsequent appointments involve developing an individualised asthma management plan, including materials such as easy read patient leaflets, self-management care plans, incentive peak flow, visual trigger aids, videos and messaging services.

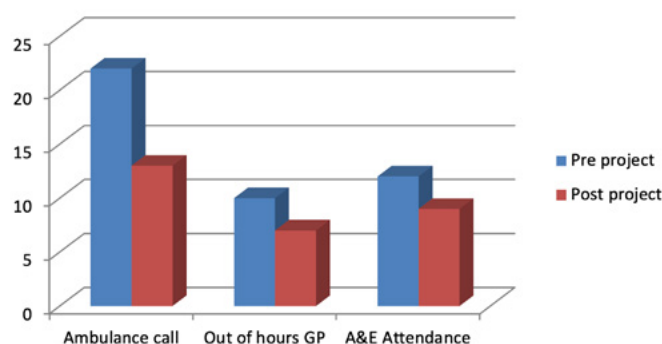
Results

There was found to be a 25% reduction in ED or out of hours services usage. 68% reduction in short acting beta agonist (SABA) use and 70% reduction in oral corticosteroid use over a 6-month period. Patient feedback via validated asthma questionnaires supported improved asthma control and quality of life for the patients. Improved engagement and concordance, greater understanding of self-management plan, knowing there was support available and the reasonable adjustments being made. Money savings were identified as over £2000 during the 6 months of the project. Carbon footprint reduced due to less hospital attendances and admissions and less SABA use.

Conclusion

The development of the service has made a significant impact on the quality of care given to this group of vulnerable patients. It has empowered and enabled them to manage their asthma, within the realms of their disability. Reasonable adjustments are a legal requirement to make sure health services are accessible to all patients. Through the work we have done, it has led to the delivery of personalised shared care.

Emergency Service Use Data



Service usage in 6 months

2 (RespEd)

An eLearning module to drive improvement in inhaler technique reviews and inhaler sustainability

L Elsey, H Montgomery, J Watson, N Jones. Manchester University NHS Foundation Trust, UK

Inhalers, particularly metered dose inhalers (MDIs) account for 3% of all carbon emissions produced by the NHS. Short acting beta agonist inhalers (SABA) are one of the largest contributors to the inhaler carbon footprint and are often overused due to poor inhaler technique with preventer inhalers and this leads to poor asthma control. In 2023, we carried out a survey on inhaler technique at our Trust of 77 staff members including Nurses, Pharmacists, Medical staff, and Physiotherapists. We found only 43% would check inhaler technique. Confidence in reviewing technique was low with only 44.2% of respondents scoring themselves 8 or above (10 being very confident). However, 75.3% of respondents believed that reviewing inhaler technique was very important (Fig. 1). In response we obtained national funding to develop an innovative eLearning package which could be undertaken by all levels of staff across the Trust. The eLearning introduces the effect that MDIs have on the environment, the importance of good inhaler technique to improve asthma control, how to effectively assess a patient's inhaler technique, lower carbon emission inhalers and options available to optimise patients' inhalers. We linked with the inhaler technique teaching resources available through the Asthma and Lung UK website.

Our key objectives were:

- To increase the knowledge and confidence of staff in reviewing inhaler technique.
- To ensure that patients admitted to the hospital receive an inhaler technique review and inhaler optimisation by a competent healthcare professional.

Since the launch we have had positive feedback from colleagues across a variety of disciplines and staff have completed the survey post completion of the training to assess the impact on confidence and knowledge.

The number of respondents who would now assess inhaler technique had increased to 96.7% (29 of 30 respondents). There was an increase of 39.2% of respondents (83.4% vs 44.2%) who would score themselves above 8 in terms of their confidence to assess inhaler technique. The results from the post implementation survey indicate a positive impact of the eLearning package. We are now looking at how we role this learning out further across the integrated care board.

3 (RespEd)

Innovative ways to improve patient education on inhaler technique

S Grant, S Khan. Calderdale Royal Hospital, Halifax, West Yorkshire

Background

The BTS recommends that inhaler technique should be part of standard practice during patient consultations. A good inhaler technique optimises drug delivery and can therefore reduce exacerbations and hospital admissions. Our project aims to promote better patient education and improve inhaler technique using a free and approved app.

Methodology

We prospectively collected data on 24 in-patients admitted to the respiratory ward with either an Asthma/ COPD exacerbation. Information gathering focused on demographics, use and type of inhaler, and exploring preferential modes of educational delivery (face to face, leaflets, online videos/apps). Patients were asked to rate their perceived confidence levels in terms of inhaler technique using a numerical scale. Inhaler technique was assessed before and after watching a video via the clinical app RightBreathe.

Results

The majority of patients (75%) were using an MDI, but very few alongside a spacer. Only half had been shown how to use their inhaler in the last 12 months. The majority were unable to use their inhaler correctly despite perceived confidence and some were unable to generate adequate inspiratory effort. Introduction of the free and approved app 'right breathe' helped to improve inhaler technique in almost all patients. Some patients had their type of inhaler changed to suit their abilities, with most switching from DPI to MDI and spacer with good effect. Many patients who used a spacer were unaware of the correct aftercare therefore we used this opportunity to educate them. Face-to-face education was the preferred method amongst many of our older patients, whereas online resources were appealing to the younger patient cohort.

Conclusion

Modern technology in the form of a clinical app should be considered for some and may have a useful role in the management of asthma and COPD patients. It has the advantage of being able to use it "anytime, anywhere" making it convenient as well as encouraging patient autonomy. We do not advocate replacing a face-to-face review but rather encourage usage of an online tool alongside more traditional methods. It is important to remember that a 'one-size fits all' approach to patient education does not exist and to tailor the approach according to the individual.

4 (RespEd)

In-situ simulation: towards improved team cohesion and patient safety

S Masterson, L Gauslyte. Barts Health NHS Foundation Trust, London, UK

Introduction

Simulation provides safe opportunities to develop technical and non-technical skills and has become a deeply engrained component of modern medical education.

In-situ simulation is delivered in an authentic clinical area. A key benefit of this approach is it's potential to uncover system-based vulnerabilities which can compromise patient safety – latent safety error. Their exposure provides opportunity to mitigate these threats.

We developed an innovative programme of in-situ simulation within the respiratory and acute medical departments of a busy district general hospital, aligned with wider patient safety improvement work.

Methods

We reviewed current evidence on the use of in-situ simulation. Scenarios were written focusing on acute respiratory conditions including acute asthma, COPD and deteriorating patients in these contexts. A structured debrief was led by trained faculty.

The in-situ simulations were rolled out monthly with feedback collected from participants and educational leads – medical and nursing. Following the sessions the faculty discussed and reported the uncovered latent strengths and errors to departmental leads.

Results

Between December 2022 and June 2023, 10 in-situ sessions were held with feedback collected from 8/10 (1 session poorly attended, 1 session used for clinical incident debrief) with a total of 51 MDT participants. Key themes identified as latent error were incomplete initial assessment and hesitancy to escalate.

Participants reported better understanding of escalation protocol and technical aspects of managing unwell patients and increased confidence in A to E assessment. Narrative feedback highlighted the value of the multiprofessional nature of the training. There had been recent high volume workforce turnover and in-situ simulation assisted in building the confidence of new recruits to escalate concerns.

Discussion

This project of in-situ simulation training provided opportunity to identify system level issues which were escalated to local safety leads and addressed through ongoing education work. We found it challenging to precisely quantify the impact when addressing latent threats, particularly when situated within a multifaceted patient safety improvement strategy.

In-situ simulation improves teamwork and for us it provided an opportunity for teams to bond and build participants' confidence in escalation of concerns which is essential for improving patient safety.

5 (RespEd)

The introduction of a remote facilitated lung cancer MDT

¹M Hunt, ²J Hartley, ¹L Succony, ¹D Meek. ¹Royal Papworth Hospital NHS Foundation Trust, Cambridge, UK; ²Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK

Multi-disciplinary team (MDT) meetings are an integral and important part of optimal care for patients with lung cancer. These meetings can provide a valuable educational opportunity. However, due to their size and complexity, medical students and trainees can struggle to engage fully and feel part of the management team.

The COVID-19 pandemic necessitated the development of novel teaching methods – at Royal Papworth Hospital we created the Remote Facilitated MDT. This utilised video-calling technology to allow medical students to observe a regional Thoracic Oncology MDT from afar. Following overwhelmingly positive feedback from students and facilitators, we have continued to implement and develop this innovative educational tool over the last three years. In its current form, a clinician and group of students meet face-to-face and remotely access a live MDT. The clinician will periodically mute the discussion to allow for questions, guided conversation and teaching, and will have access to the meeting to provide input and ask questions.

We have gathered three years of feedback from learners and facilitators. Both groups report increased satisfaction with their learning in this model compared to traditional MDT attendance. Students, who often report feeling overlooked and/or lost within an MDT meeting, find this bespoke facilitation and opportunity for questions helpful. Of 32 students sampled this year, 91% strongly agreed/agreed that it improved their understanding of thoracic oncology, and 81% strongly agreed/agreed that it improved their understanding of how an MDT functions. Moreover, clinicians – particularly trainees – find this session a valuable opportunity to develop their teaching skills, obtain Teaching Observation Assessments, and improve their own knowledge.

Through its three years of operation, the Remote Facilitated MDT has increasingly become part of the team culture, with a wider group of clinicians from all stages of training facilitating the session. This has led to the strengthening of the educational community of practice within the team, whilst easing pressures on clinicians attending the MDT itself.

We highlight how this innovative use of technology for medical education within MDT meetings could easily be implemented in other centres and to great effect.

What was good about this session? How did it compare to normal MDTs you have attended?

Having the registrar there to explain things really helped	It was good to discuss the cases in more detail and information more relevant for our clinical years.	Very good because it was slow paced
Very useful. Made it significantly easier to follow and understand	It was more relaxed, could ask questions.	It was nice to be able to discuss as it went along as we were in a separate room.
Very useful to have explanations as the MDT went	Extremely useful to have someone explain the key points from the meeting otherwise it is extremely difficult to follow	It was interesting to have the complicated MDT cases explained in private, instead of not being able to keep up at all
We can discuss and ask anything during the MDT. It is more effective when you have some idea of what is going on.	Better as had someone explaining	It was very useful to have an explained MDT meeting
Much more understandable than a normal MDT and felt more useful to attend	Very helpful to have someone explain what is going on at a more reasonable pace.	Better because we had a clinician explaining things I would not normally understand from an MDT
So much more useful than normal MDT - explained things in a way that made things more accessible and useful	Having someone help explain what was happening was very helpful, was able to understand more and learn	Great teaching, more useful than normal ones
Easier to follow		

Figure 1: Student Feedback from Academic Year 2023-2024

6 (RespEd)

Bite-sized is best: improving the appetite for and digestion of respiratory teaching on the ward

I Mechie, D Alderson, I Tang, W Flowers. Oxford University Hospitals NHS Foundation Trust, Oxford, UK

Introduction

Respiratory wards offer an unlimited supply of opportunities for applied learning. However, for junior doctors working in an ever-stretched NHS, attending formal teaching sessions can be challenging, and designing effective organised teaching programmes (part of respiratory training applications) even harder, especially attempting to include trainees from different specialty backgrounds (FY, GPVTS, IMT) with differing curricula and timetables. Creating an environment that is conducive to teaching and learning, through effective and flexible teaching strategies, is essential to create a meaningful teaching programme.

Methods

We conducted a two-cycle Quality Improvement Project using the Plan-Do-Study-Act framework. Cycle 1 involved: identifying key topics to create a comprehensive respiratory curriculum; and working with respiratory trainees, consultants, and junior doctors to create a timetable to deliver teaching. After evaluating efficacy at 3 months, and responding to feedback, in Cycle 2 a new 'Bite-Sized' teaching concept was created: with a dedicated learning flipchart and consultant support to encourage impromptu sessions of illustrated case-based teaching and learning through "clinical pearls". Contemporaneous anonymous feedback was collected using a Google form-linked QR code for individualised tutor feedback and to evaluate programme design.

Results

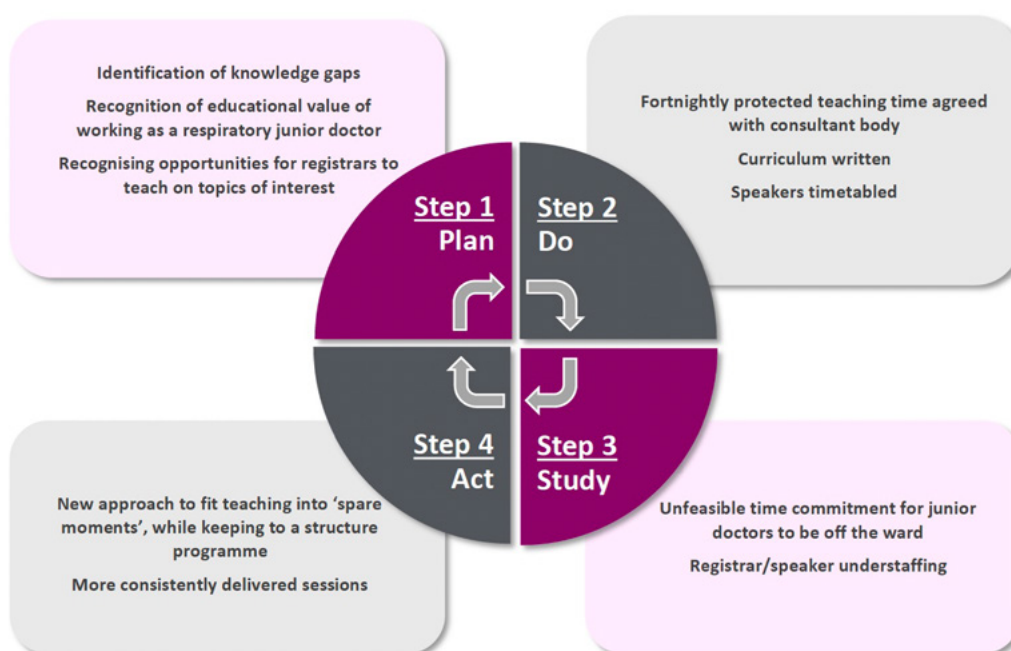
Analysis of qualitative feedback showed that after 3 months, despite high-quality comprehensive curriculum design and timetabling, the formal teaching sessions were not effective; with many sessions postponed due to staff shortages; interrupted or cancelled at short notice due to ward emergencies.

By contrast, the flipchart bite-sized teaching was able to work around the unpredictable ward environment; kept teaching clinically focused and highly relevant; and fostered an environment conducive to learning and teaching, involving FY1s to senior SpRs. Writing on the flipchart promoted active learning and having a physical record of teaching sessions on the flipcharts allowed for easy revisiting of topics to help with spaced learning and prompted discussion well after the initial teaching sessions.

Conclusion

Availability for teaching cannot be predicted; busy, dynamic ward environments demand flexibility in teaching. Where protected teaching time cannot be facilitated, novel teaching and learning methods can employ 'spare moments', utilising the rich clinical environment for effective learning and is more feasible than conventional timetabled teaching.

Figure 1: Summary of Plan Do Study Act Methodology



BTS ABSTRACT PRIZES – SHORTLISTED ABSTRACTS

CATEGORY: IMPROVING QUALITY AND EXCELLENCE IN PATIENT CARE

1 (IQ)

Revamping our comfort food menu – a co-creational approach

R Kahai, S Gheewala, R Burton, N Matias, Y Smuts-Gardener, G Castelli. Royal Brompton Hospital, London, UK

Introduction

Nourishing hospital food is important to help tackling malnutrition. Research has suggested that up to 60% of patients in respiratory wards are malnourished (Laaban et al., 1993). For patients who are nutritionally vulnerable, meals should be 800kcal and 27g of protein (British Dietetic Association (BDA), 2023). Royal Brompton Hospital offers a “call order menu” additional to regular menus to provide higher energy and protein options.

Aim

The aim of this project is to improve and update the call order menu via a co-creational approach with respiratory patients.

Method

We used the PDSA cycle. We took a three-pronged approach to change the menu. Patients were asked about their views on the menu and improvements (n=17). We asked our chefs what meals they were cooking off the menu. We looked at data from the electronic ordering system over a month to see what meals were being ordered. Once we created a new menu from the information collected, we looked at the difference in energy (kcal) and protein (g) between the two menus.

Results

Patients rated the old menu at 3.85/5. This menu met 51% of energy and 77% of protein guidelines. Qualitative themes from patient feedback included options for their likes of the current menu, dislikes and preferences of food choices when unwell. The diet chef reported they cook 8/18 of the menu options. The electronic system showed 7/18 options were ordered in July 2023. Based on this feedback, a new menu was created, differences are presented in table 1.

The new menu meets 126% of energy and 142% of protein guidelines.

Conclusion

The call order menu was updated to support patients meeting their nutritional needs whilst in hospital. The old menu did not meet the BDA guidelines, compared with the new menu. Food preferences and choice can be varied depending on culture, habits, and individual preferences. Through co-creation, we hope that we have included enough options on the menu to cater for majority of our respiratory patients to positively impact recovery.

Table 1 - Difference in nutrients between the old and new menus.

	Old menu	New menu	P-value
Energy (kcal) ± SD	408±228	1008±261	<0.001
Protein (g) ± SD	20.7±10.9	38.6±9.36	<0.001

2 (IQ)

Respiratory-led ultrasound-guided pleural biopsy service reduces hospital visits and waiting times

SP Tiong, J De Jesus, T Playle, S Vythilingam, K Nutkins, R Asciak. Portsmouth Hospitals University NHS Trust, Portsmouth, UK

Introduction

Previously, patients in our hospital underwent ultrasound guided pleural biopsies (USGB) solely by interventional radiology (IR) with delays dependent on IR availability. Patients who also needed therapeutic thoracentesis had to attend separate respiratory appointments for this. An USGB service by respiratory department was introduced in December 2021, aiming to shorten USGB waiting times, allowing concurrent diagnostic/therapeutic fluid aspiration.

We aimed to assess the outcomes and efficacy of this new service on waiting times and hospital visits.

Method

IR-USGB between January 2020 to December 2022 were compared with respiratory-USGB between December 2021 to December 2023. Since respiratory-USGB are only performed in the presence of pleural effusion, only patients with pleural effusion were included in this study to avoid data bias.

Time to biopsy was the interval between biopsy request date and biopsy-procedure date. The time to diagnosis was defined as the time between the referral date to the respiratory department, to date of the agreed diagnosis at multidisciplinary team meeting. Number of hospital visits per patient was calculated for this same period. Plan-Do-Study-Act (PDSA) methodology was adapted in this QIP which involved planning and launching this new service.

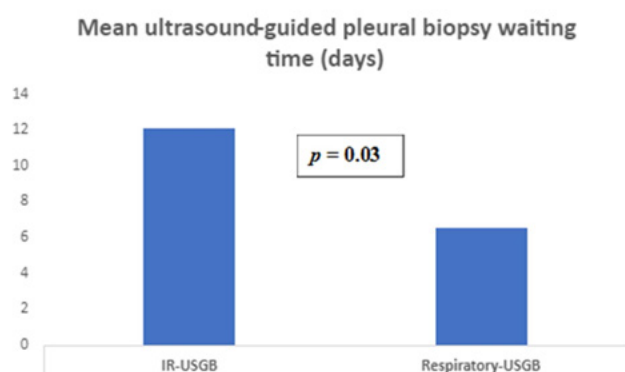
Results

There were 25 respiratory-USGB, diagnostic rate 21/25 (84%), and 42 IR-USGB. Respiratory-USGB was associated with shorter waiting time to biopsy (mean 6.55 (SD 6.01) vs 12.02 (SD 10.36) days for IR-USGB; $p=0.03$, Mann-Whitney-U), achieving shorter time to lung cancer or mesothelioma diagnosis (n=11/25 (44%), and n=17/42 (40.5%)) mean 32.3 (SD 18) vs 54.4 (SD 93) days ($p=0.62$, Mann-Whitney-U, Figure 1). All respiratory-USGB had concurrent pleural fluid aspiration (8/25 (32%) diagnostic, 17/25 (68%) diagnostic and therapeutic) vs 2/42 (4.8%) of IR-USGB had diagnostic pleural fluid aspiration ($p<0.0001$, Chi²). Respiratory-USGB required fewer hospital clinic appointments (mean 3 (SD 1.4) vs 3.6 (SD 1.6) from referral to diagnosis, $p=0.2$); 22/42 (52.4%) of IR-USGB needed additional therapeutic fluid aspiration appointment.

There were two cases of minor post-biopsy bleeding resolving with pressure for respiratory-USGB, and no major complications.

Conclusion

Respiratory-USGB significantly shortened time to biopsy and importantly decreased number of procedures per patient by combining biopsy with diagnostic/therapeutic fluid aspiration, reducing hospital appointments, with minimal complications risk and 84% diagnostic rate (vs 84% also stated in literature (Mei et al., 2020)).



3 (IQ)

Reducing time-to-initiation of biologic in patients with severe asthma

AS Bahra, D Sammut, S Saha, A Tyas. Sheffield Teaching Hospital, Sheffield, South Yorkshire

There are currently five approved asthma biologics with different criteria each needing multidisciplinary team (MDT) discussion and paperwork. Time-to-initiation of biologics at Sheffield Severe Asthma centre was higher than UK averages (Rupani et al., 2022).

Objective

To reduce time-to-initiation of biologic in patients with severe asthma.

Methods

Data retrieved from hospital severe asthma MDT records. Analysed using JASP Opensource statistical software (ver0.18.3).

Results

Baseline data between September 2021 and September 2022 was reviewed (n=36). On average it took 81 days from the clinic where a biologic was proposed to the MDT meeting and 96 days between the MDT meeting to the biologic being administered.

To improve this, we introduced (1) a biologics discussion form (BDF) to ensure all necessary criteria addressed before MDT, (2) a biologics co-ordinator role to facilitate paperwork and (3) prioritised biologics discussions in the MDT meeting.

We re-reviewed data between October 2022 and October 2023 (n=44). After the introduction of the above measures, it now took an average of 50 days from clinic to MDT meeting and 42 days from MDT meeting to biologic administration.

There was a reduction in the interval between clinic review and patient receiving the biologic (mean pre- 177 days vs post- 92 days, p=0.007). The mean time from clinic to MDT meeting was reduced (mean pre- 81 days vs post- 50 days, ns) with our intervention, as did the time to the patients receiving the first dose from MDT discussion (pre- 97 vs post- 42, p=0.019). Further analysis shows that the improvement lies in a reduction in the interval between MDT meeting and the submission of paperwork to the hospital team (mean pre- 40 days vs post- 15 days, p=0.043) or homecare team (mean pre- 23 days vs post- 5 days, p=0.021). In fact the mean number of days between submitted paperwork and first dose has increased slightly post-optimisation probably reflecting increased demand between the two time periods.

Overall, we have demonstrated a significant reduction in the time it takes for biologics to be initiated at our centre and have identified areas where further gains can be made.

Table: Mean time intervals (days) to initiation of biologic

	Pre-optimisation	Post-optimisation	p-Value
Clinic to 1 st dose	177	92	0.007
Clinic to MDT	81	50	0.138
MDT to 1 st dose	97	42	0.019
MDT to paperwork			
Hospital (n=44)	40	15	0.043
Homecare (n=34)	23	5	0.021
Paperwork to 1 st dose			
Hospital (n=44)	20	27	0.39
Homecare (n=34)	35	38	0.603

4 (IQ)

The impact of an ambulatory primary pneumothorax management pathway on healthcare care resource demand

T Macdonald, E Cox, L Johnson, E Harvey, R Asciak. Portsmouth Hospitals University NHS Trust, Portsmouth, UK

Introduction

Spontaneous pneumothoraces are a frequent cause for presentation to hospital and have traditionally been managed according to pneumothorax size and symptoms. The latest BTS guidelines released in 2023 have deemphasised the importance of pneumothorax size with respect to its management and switched the focus to the presence or absence of symptoms as well as recommending ambulatory conservative management or the use of pleural vents for appropriate patients. Implementation of the new BTS guidance promises improved patient choice and potential to avoid unnecessary inpatient stays.

Aims

To develop an ambulatory pneumothorax management pathway within our hospital in line with the 2023 BTS pleural guidelines, allowing for ambulatory conservative and pleural vent management of select patients with primary pneumothoraces thereby reducing healthcare resource demand.

Methods

An ambulatory primary pneumothorax management pathway was designed alongside stakeholders in the respiratory, emergency and acute medicine departments with education delivered to all teams. Data was gathered on the pneumothorax management modality (as a process measure) and length of hospital stay (as an outcome measure) prior to and after the introduction of the pathway.

Results

There was no significant difference in the demographics of the patient populations before and after the pathway (Table 1). Forty five (29.2%) patients with primary pneumothorax received ambulatory management (conservative management or needle aspiration) in the 18 months prior to the introduction of the pathway, compared with 10 (41.7%) after the introduction of the pathway of whom 12.5% had a pleural vent. Prior to the pathway, 52.2% of those suitable for ambulatory pneumothorax treatment were managed as an inpatient, compared with 9.1% after implementation ($p=0.03$, Table 1).

Discussion

The ambulatory pneumothorax pathway provides a framework by which patients have more choice in the management of their condition and a robust follow up framework for those managed outside of the hospital. Introducing an ambulatory primary pneumothorax pathway suitable for our local hospital set-up has led to significantly reduced hospital admissions. Further work is needed to fully embed this pathway in the normal practice of the emergency and respiratory departments to ensure that all options are provided to patients where possible.

Table 1 shows the comparison of data between patients with primary pneumothorax before and after the ambulatory pneumothorax management pathway was introduced in our hospital.

	18 month period prior to pathway implementation	5 month period following pathway implementation	p value and statistical test (p)
Presentations with spontaneous pneumothorax (n)	65	24	
Mean age in years (SD)	49.0 (23.2)	41.1 (22.0)	0.15 (T-test)
Male (n (%))	51 (78.5)	19 (79.2)	1 (Fisher exact)
Current/history of smoking (n (%))	46 (70.8)	18 (75.0)	1 (Fisher exact)
Admissions to hospital (n (%))	44 (67.7)	14 (58.3)	
Patients suitable for management under new ambulatory pneumothorax management pathway (n (%))	23 (35.4)	11 (45.9)	
Outpatient conservative management (n (%))	17 (26.2)	6 (25.0)	
Pleural vent (n (%))	0	3 (12.5)	
Needle aspiration and same day discharge from hospital (n (%))	2 (3.1)	1 (4.2)	
Total patients treated on an ambulatory basis (n (%))	19 (29.2)	10 (41.7)	
Patients admitted to hospital at presentation, who would have been suitable for ambulatory pneumothorax treatment under new pathway, (n (% of those suitable))	12 (52.2)	1 (9.1)	0.03 (Fisher exact)
Potentially avoidable bed-days in hospital (days)	29	9	

5 (IQ)

Interstitial lung disease-specific Fatigue and Breathlessness (FAB) programme pilot: a multi-disciplinary innovation

¹J Mandizha, ¹R Davies, ¹C Crook, ¹C Dean, ¹A Duckworth, ¹V Elworthy, ¹C Masey, ¹J Moss, ¹AR Paiva, ²AM Russell, ¹K Taylor, ¹M Gibbons, ¹S Lines. ¹Royal Devon University Healthcare NHS Foundation Trust, Exeter, UK; ²University of Exeter, Exeter, UK

Background

Interstitial Lung Disease (ILD) causes breathlessness, cough and fatigue. These symptoms impact quality of life and contribute to low mood and anxiety.

The Fatigue and Breathlessness (FAB) programme is used by acute NHS trusts and Hospices for people living with life-limiting conditions, predominantly cancer and heart failure. The course includes education and group discussion on managing breathlessness, panic and fatigue.

We explored the utility of the FAB programme for people living with ILD.

Methods

The course ran over 4 consecutive weeks, with 4-6 participants per group. Each two-hour session was led by an ILD-specialist Physiotherapist and ILD Clinical Nurse Specialist (CNS). The first 3 sessions focussed on managing breathlessness, fatigue and wellbeing. The final session focussed education on self-management of ILD, including healthy diet (with an ILD-specialist dietician), airway clearance and cough control.

Participants received a 1:1 session with the CNS to set personalised goals and explore individual health beliefs/behaviours. Cognitive Behavioural Therapy techniques were used where appropriate.

We report on participants' evaluation and outcome measures of the FAB programme, March 2023-February 2024.

Results

Participants included 25 patients (14 male; median age 75 years; range 41-83 years; 10=IPF, 5=CTD-ILD, 3=HP, 1=Sarcoidosis, 6=Other; FVC % predicted median: 79%; range: 49-118%).

Seventeen (68%) patients attended all four sessions, 2 (8%) attended three sessions, 5 (20%) attended two sessions and 1 (4%) attended one session. Commonly, absence was due to acute illness or concurrent appointments.

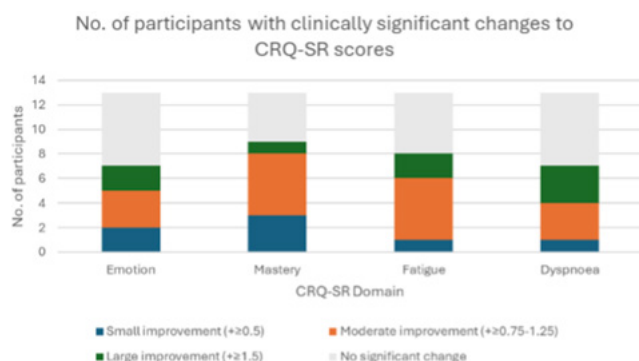
Thirteen patients completed the Chronic Respiratory Questionnaire (CRQ-SR) at arrival and the end of Week 4. Nine patients (69%) demonstrated clinically significant improvements in mastery domain scores, 8 (62%) in fatigue domain scores and 7 (54%) in emotion and dyspnoea domain scores. (Fig-1)

Twenty-five (100%) participants would recommend this programme to others.

Conclusion

The FAB programme was positively evaluated by participants. The CRQ-SR overall demonstrated improvements across all domains, particularly in mastery and fatigue.

Our pilot data demonstrates initial acceptability and effectiveness of an ILD-specific FAB programme. We will further explore the emotional impact and the range of outcome measures longitudinally in a larger cohort.



6 (IQ)

"Train to Drain": a quality improvement project leading to a national educational resource to improve the confidence of doctors and nurses in managing patients with chest drains

B Iqbal, D Addala, S Guo, A Elsheikh, A Sundaralingam, R Hallifax, NM Rahman, J Wrightson. Oxford Pleural Unit, Oxford University Hospitals NHS Trust, Oxford, UK

Introduction

Chest drain is a common procedure to drain pleural effusion in an acute hospital setting. A recent National Patient Safety Alert (NSPA) highlighted that inappropriate drainage of pleural effusion from chest drains can cause significant patient harm. However, there are limited educational resources available to train medical staff in the management of chest drains to improve patient safety.

Methods

We conducted a Quality Improvement Project (QIP) to improve the confidence of doctors and nurses in managing patients with chest drains in non-respiratory wards. A driver diagram was used to plan intervention i.e. regular teaching sessions for training of medical staff and a PDSA (Plan-Do-Study-Act) framework was employed to assess the impact in small group teaching. In the first PDSA cycle, significant issues of arranging teaching slots, frequency of teaching, retention of knowledge and staff turnover were identified raising concerns about the sustainability of this intervention. Discussions were conducted with key stakeholders to identify essential training areas in managing chest drains and to explore alternative teaching approaches. This led to the development of a sustainable educational resource comprising eight bite-sized videos providing focused learning for the identified training areas with the added advantage of on-demand learning (accessible on tiny.cc/chestdrain). The impact was assessed in a 2nd PDSA cycle using videos for medical staff teaching with pre- and post-teaching matched surveys.

Results

The surveys demonstrated an overall improvement in the confidence of medical staff in managing chest drains by using focused training videos (Fig.1a&b). Results for the safe drainage of pleural effusion, as highlighted in the NSPA alert, showed a similar trend. The videos have now been distributed nationally, as a freely accessible resource on YouTube, through the UK Pleural Society, the Royal College of Physicians and the respiratory programme directors with excellent feedback.

Conclusion

This QIP highlights the positive impact of targeted educational interventions for doctors and nurses to improve patient safety by using sustainable, cost-effective resources. With the national distribution of our educational videos, we hope to support the medical staff in all Trusts across the UK in delivering better care to patients with chest drains.

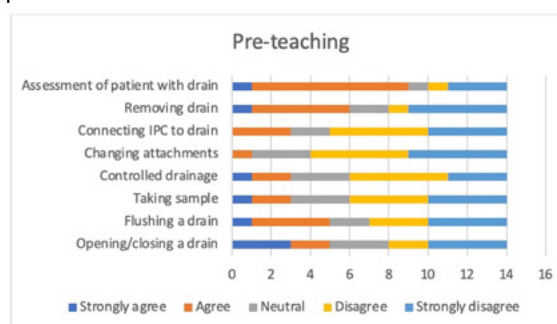


Fig.1a

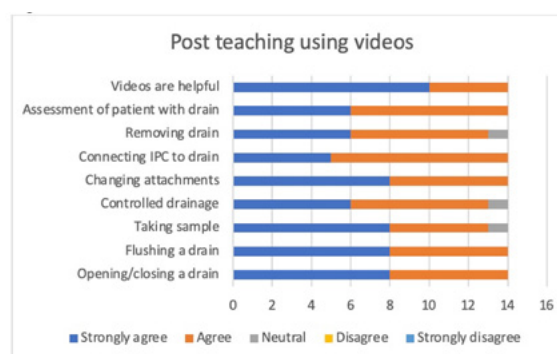


Fig.1b

BTS ABSTRACT PRIZES – DIGITAL POSTERS

D1

Assessment of cardiovascular disease risk factors in severe asthma clinic

S Childs, A Bahra, S Saha, D Sammut. Sheffield Teaching Hospitals, Sheffield, UK

Background

There is increasing evidence that asthma is associated with a higher risk of cardiovascular disease (CVD) morbidity and mortality. The severe asthma clinic can provide an opportunity to identify and address modifiable risk factors (RFs) for CVD.

Objective

To determine the prevalence of CVD RFs in patients attending a severe asthma clinic and whether these are being identified and addressed in clinic.

Methods

Patients who attended severe asthma clinic were surveyed for CVD RFs. The prevalence of modifiable RFs was determined and then clinic letters were reviewed to determine whether these RFs had been identified or acted upon. Patients were also asked regarding any previous medical input addressing these RFs from other sources.

RF deemed to be present if: current smoker, alcohol consumption >14units/week, Body Mass Index >25kg/m², activity levels less than NHS weekly recommendations, HBA1c >47mmol/mol,

QRISK3 >10% or abnormal lipid levels meeting local criteria for referral to lipid clinic, blood pressure >140mmHg systolic or >90mmHg diastolic on clinic measurement.

Results

- **Total modifiable RFs identified:** a total of 64 CVD RFs were identified on survey (survey total). 26/30 (87%) patients had ≥1 modifiable CVD RFs identified; 11/30 (37%) patients had ≥3.
- **CVD RFs identified in clinic:** 32 were identified in clinic (clinic total), which is 50% of survey total.
- **Actioned CVD RFs:** In clinic, 10 RFs were actioned (31% of the clinic total). There were 32 RFs not identified and therefore not actioned in clinic (50% of survey total). Out of survey total, 28 CVD RFs were newly identified, and had not been actioned previously, either in clinic or in primary care.

Discussion

The results suggest that we do not regularly screen for CVD RFs in the severe asthma clinic. Furthermore, even when RFs are identified, action may not be taken, or at least not documented as having been taken.

Future work would include raising awareness about the association of CVD and asthma within our service, identifying ways to facilitate patient access to services already in place once RFs identified and making this an integrated part of the severe asthma assessment.

Modifiable cardiovascular disease risk factor	Number of at risk patients identified:		Number of risk factor acted upon:		
	In survey	In clinic	In clinic	Previously (if not in clinic)	Never
Smoking	2	2	2	0	0
Alcohol	3	1	1	0	2
BMI	20	18	2	10	8
Activity level	14	6	4	4	6
HBA1c	5	0	0	3	2
Dyslipidaemia/QRISK 3	9	1	1	6	2
Blood pressure	11	4	0	3	8

Table 1: Number of modifiable cardiovascular disease risk factors identified on survey and in clinic. Number of risk factors acted on in clinic, actioned previously (e.g. in primary care) or never actioned.

D2

QIP project to improve pneumonia care at Wexham Park Hospital: importance of patient information leaflets

SJ Davis, B Howarth, G Esposito, N Kolath, S Menzies. Wexham Park Hospital, Slough, England

Introduction

Pneumonia imposes a substantial burden on healthcare, often resulting in prolonged hospital stays. This Quality Improvement Project aimed to enhance patient care and reduce lengths of stay through patient education and the use of patient information leaflets as suggested in BTS guidelines on pneumonia management (1).

Method

We surveyed 28 inpatients with a diagnosis of pneumonia at Wexham Park Hospital, focusing on their understanding of pneumonia. The main topics of the survey were modifiable risk factors, anxiety and whether they had received any written information. We subsequently designed and distributed a patient education leaflet on pneumonia and re-surveyed a separate cohort of inpatients to assess if understanding and anxiety had improved.

Results

Pre-leaflet distribution showed no patients were given any written information about pneumonia and 69% of patients understood their diagnosis of pneumonia 'not well'. Only 25% understood how long their symptoms would last, only 3.5% understood the follow-up to expect on discharge and 25% felt 'very anxious' about being diagnosed with pneumonia. Post-leaflet distribution 70% of patients understood their diagnosis 'fairly well' and 83% understood how long their symptoms would last. 90% understood the follow-up to expect on discharge and only 5% felt 'very anxious' about being diagnosed with pneumonia.

Conclusion

We have shown that the use of written information in the form of leaflets can improve patients' understanding of their diagnosis and reduce anxiety relating to pneumonia. We predict that due to improved education this would reduce length of stay and we would aim to do further data collection to ensure this is the case and that the on-going distribution of leaflets occurs. We are incorporating the leaflet into our electronic patient records and plan to ensure it is automatically attached to discharge summaries of patient who had a diagnosis of pneumonia.

References

- 1) W S Lim, S V Boudouin, R C George, A T Hill, C Jamieson, I Le Jeune, J T Macfarlane, R C Read, H J Roberts, M L Levy, M Wani, M A Woodhead, October 2009. Guidelines for the management of community acquired pneumonia in adults: update 2009. *Thorax*, Volume 64

D3

Developing standards of care for young people transitioning from paediatric ventilation services to adult ventilation services

¹E Gallagher, ²J Price, ³KAM Buchan. ¹University Hospitals Birmingham NHS Trust, Birmingham, England; ²Manchester University Hospitals NHS Trust, Manchester, England; ³University Hospitals Bristol and Weston NHS Trust, Bristol, England

Background

Transition from paediatric to adult services can be a complex and overwhelming time for young people (YP). If YP are not transitioned well it can lead to miscommunication, a disengagement with adult services and health consequences (NCEPOD, 2023). Home mechanical ventilation (HMV) services support patients from nocturnal HMV users, to patients dependent on invasive 24-hour ventilation. There is variability and inequality nationally how YP transition into adult HMV services. In September 2022, clinicians from the Specialists in Long-term Ventilation at Home (SiLVaH) network, created and led a task force focused on the purpose of developing minimum standards of care for YP transitioning from paediatric to adult HMV services. The standards were re-designed, using quality improvement (QI) principles through the continual improvement process with actions of repeated evaluation, feedback and systematic revision.

Method

A working party was set up from HMV providers, across paediatric and adult services. A review of the existing literature occurred and the Plan, Do, Study, Act (PDSA) process facilitated the standards development (NHS England and NHS improvement, 2023). These were re-designed following a qualitative survey to SiLVaH.

The standards were then analysed by professionals from HMV services and the feedback led to further revisions. The standards were reviewed and refined again by the SiLVaH network. Wider service teams were consulted and standards were presented to patient networks for feedback.

Results

Minimum standards of care were continually refined to improve the quality of care for patients on HMV transitioning to adult services through QI methodology of planning to design the standards and repeated, systematic review to improve them.

Conclusion

Using QI principles, clinicians from the SiLVaH network were able to develop national minimal standards to improve the equality and quality of care for transitioning YP with HMV.

References

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2023) The 'Inbetweeners' A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult services. https://www.ncepod.org.uk/2023transition/The%20Inbetweeners_summary%20report.pdf
- NHS England and NHS Improvement (2023) Plan, Do, Study, Act (PDSA) cycles and the model for improvement. <https://aqua.nhs.uk/wp-content/uploads/2023/07/qsir-pdsa-cycles-model-for-improvement.pdf>

D4

Evaluating the impact of the first dedicated occupational therapy service for interstitial lung disease patients: ILD-OT

CJ Gillespie, IA Forrest, C Rafique. Newcastle upon Tyne Hospitals Trust, Newcastle, UK

Background

Interstitial lung disease (ILD) encompasses various debilitating conditions characterised by lung inflammation and fibrosis, leading to dyspnoea, fatigue, weight loss and cough. Fibrosis in ILD is irreversible, and current treatment may not consistently slow disease progression. Increasing symptom burden leads to functional impairment, independence loss, and heightened risks of depression and anxiety. Guidelines recommend treatments target symptom relief and enhancing quality of life (QoL), however there is limited evidence exploring the role of occupational therapy (OT) for ILD patients.

Methods

This study presents findings from a mixed methods pilot, combining quantitative data and results of qualitative questionnaires (CARE Measure) over 10-months. Part of a larger 2-year service improvement project, exploring the need and impact of a dedicated OT (ILD-OT) integrating into an already established ILD multidisciplinary service. ILD-OT was available to all patients with a clinical frailty score (CFS) ≥ 4 (vulnerable).

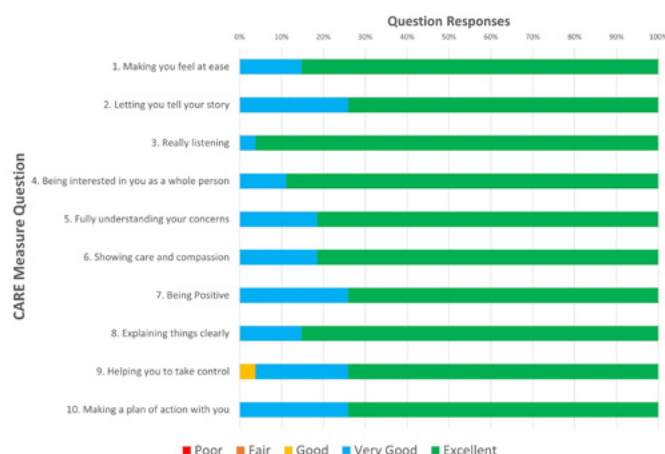
Results

ILD-OT input was provided to 119 patients, including holistic initial assessment, follow-ups, and future care discussions. Mean age at referral was 74 years, with a mean CFS of 4.7 (mild frailty). 716 ILD-OT led interventions were actioned, with 407 referrals made to other health care professionals promoting holistic patient care. CARE Measure results (figure 1) indicated high satisfaction, with 89% rating ILD-OT as 'Excellent'. 100% of respondents recommend ILD-OT input for fellow ILD patients. Notably, urgent ILD-OT interventions averted all but two hospital admissions out of 20 at risk.

Discussion

Studies exploring the impact of OT input for ILD patients is scarce compared to other chronic respiratory conditions. This scarcity emphasises the need for further research to better understand the potential benefits and optimal interventions for this specific population. This study provides valuable insights into this underexplored area of research.

The findings underscore the critical need for dedicated OT input and regular patient reviews for ILD management. As the disease progresses, interventions such as home environment modifications, exacerbation management, and prevention of hospital admissions are key to maintaining QoL. ILD-OT plays a vital role in addressing emotional and social challenges associated with the illness, whilst facilitating vital discussions surrounding future care within a supportive framework.



D5

Improving non-invasive ventilation documentation: the Non-Invasive Ventilation Passport

C Goodin, M Deakin, M Sovani. Nottingham University Hospitals NHS Trust, Nottingham, England

Background

Non-invasive ventilation (NIV) is the provision of ventilatory support in the form of positive pressure via the patient's upper airway using a mask or similar interface, indicated for acute hypercapnic respiratory failure.

Record keeping for patients on NIV at Nottingham University Hospitals was inconsistent. The initial NIV prescription was often not recorded, and changes poorly documented.

This was demonstrated in the Respiratory Support Unit (RSU) audit.

British Thoracic Society (BTS) guidelines for NIV suggest that rationale for commencing NIV and proposed settings should be clearly documented. Clinicians cannot effectively tailor changes if this information is not clearly recorded, which could lead to failure to rescue.

Aims

- Develop a comprehensive single document for recording NIV delivery
- Accurate prescription and titration
- Improve accuracy of data collection for audit
- Support data collection for current and future research projects

Objectives

- Clear record of initial NIV set-up on hospital admissions regardless of point of entry
- Clear record of NIV safety checks and safe transfer checklist
- Redesign the 24 hour NIV observation chart for consistent monitoring
- Clear record of any changes to ventilation prescription before discharge on domiciliary NIV
- Include supporting quick user guides

Design & Feedback

The design became increasingly more comprehensive. Reflected in the inclusion of:

- Supporting material, quick start guides and transfer safety documents
- Feedback on usability
- Significant improvement at initiation in the emergency department.
- NIV data can more easily be drawn to support active research trials

Lessons & Limitations

Several factors meant for a long timeline:

- Identification and engagement of key stakeholders
- Adapting to new ventilators meant further revisions were necessary
- Including the nursing team in the observation chart redesign and pilot helped the project gain traction

Conclusions

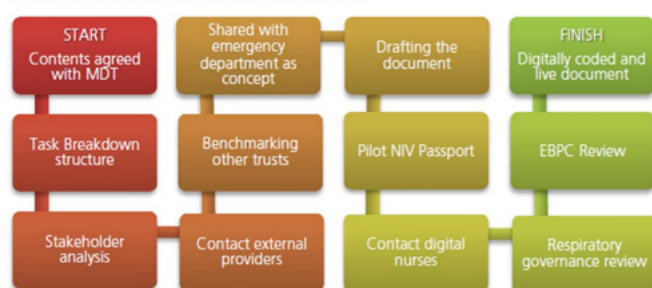
Understanding the step-by-step process after drafting the document was the biggest hurdle. See Fig.1

Timely review from implementation to audit improvement in documentation will be vital to ensure the document doesn't become dormant.

References

- BTS Reports: RSU: Guidance on development and implementation. 2021
- BTS Quality Standards for acute non-invasive ventilation in adults. BMJ 2018
- BTS/ICS guideline for the ventilatory management of acute hypercapnic respiratory failure. Thorax. 2016
- NCEPOD; 2017; Acute NIV: Inspiring Change

PROCESS TO IMPLEMENTATION



D6

Improving recognition and care of respiratory patients approaching end of life using the gold standards framework

L Higgins, D Morris. Salford Royal Hospital, Manchester, UK

The gold standards framework (GSF) is a tool used across the UK to help recognise patients approaching end of life.¹ It aims to promote proactive, coordinated advance care planning. The GSF has developed general and disease-specific indicators of decline, for example for patients with chronic obstructive pulmonary disease (COPD), which is a progressive condition with a high burden of morbidity and mortality.

Respiratory and palliative care teams at a Greater Manchester hospital noted that a consequence of the COVID-19 pandemic was reduced emphasis on management of chronic disease. An opportunity was identified to improve care of patients with advanced respiratory disease, with early involvement from multidisciplinary team members (MDT), including respiratory and palliative care clinicians, respiratory physiologists and specialist nurses.

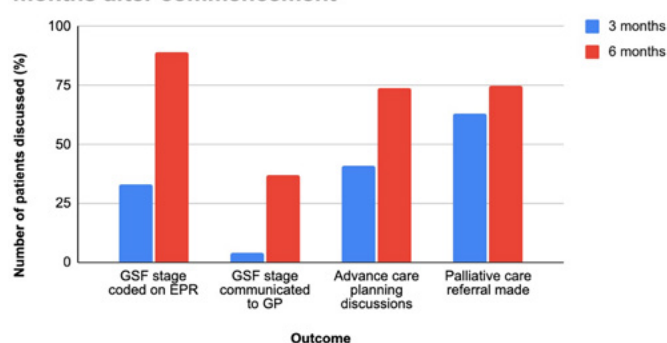
A weekly meeting had existed pre-pandemic and was re-established for MDT members to discuss respiratory inpatients. Data was collected to evaluate four outcomes for patients recognised as suitable for GSF: whether GSF stage was subsequently coded on the electronic patient record (EPR), whether this was communicated to GPs, if advance care planning discussions took place and if palliative care referral was made. Focus on these outcomes was intended to lead to improved coordination of individualised, holistic patient care.

The project was conducted in multiple small cycles. Data was studied regularly and actions implemented accordingly, including a clinician survey asking how the meeting could be improved, a departmental presentation and the creation of an EPR shortcut to record outcomes and provide prompts to complete suggested actions. Engaging the junior medical team was challenging, particularly following trainee rotation points, and was addressed at the three-month point with a teaching session and provision of written resources.

Across six months, all measured outcomes showed improvement, demonstrated in Figure 1. Staff engagement improved and the positive impact on patient care was acknowledged by the palliative team. 92% of team members felt that reintroducing the meeting improved patient outcomes.

1. Royal College of General Practitioners. Gold Standards Framework Proactive Identification Guidance. <https://www.goldstandardsframework.org.uk/cd-content/uploads/files/PIG/NEW%20PIG%20-%20%20%202020.1.17%20KT%20vs17.pdf> [Accessed 01 March 2024]

Figure 1: Outcomes from the GSF meeting at 3 and 6 months after commencement



D7

Audit on compliance of NICE guidelines for the indication of CTPA scans in the diagnosis of pulmonary embolism

RN Hook, R Perowne. South Tyneside and Sunderland Foundation Trust, South Shields, UK

Background

CT Pulmonary Angiograms (CTPA's) are gold-standard for diagnosis of Pulmonary Embolism (PE). Over-requesting can lead to unnecessary use of resources and radiation exposure to patients. NICE guideline [NG158] suggests use of a risk stratification tool: the 2-level Well's score and D-dimer blood test.

The first cycle assessed compliance to NICE guideline [NG158], showing Well's score documentation was low and d-dimers were requested inappropriately. The main change implemented was promotion of a Well's score proforma on the electronic notes system, before reassessing compliance in the second cycle.

Methods

The trust information team provided patients aged >18 years who underwent a CTPA requested within the Emergency Assessment Unit, A+E or Ambulatory Care at South Tyneside Hospital between 1st July-31st December 2021 for the first cycle (n=131), and 1st December 2022-31st March 2023 for the second cycle (n=139). Notes were analysed for a D-dimer result and documentation of a Well's score. CTPA's were split into the following groups:

1. D-dimer without available Well's score
2. No D-dimer, no available Well's score
3. Well's score ≤ 4 without positive D-dimer
4. Well's score >4 with D-Dimer
5. Well's score >4 without D-Dimer
6. Well's score ≤ 4 with positive D-Dimer

Groups 1-4 were not compliant with NICE guidelines. Groups 5-6 were compliant. CTPA's were sorted further into positive or negative categories.

Results

CTPA's requested in line with NICE guidelines improved from 19.1% in the first cycle to 41.1% in the second cycle. Compliance was higher for the negative CTPA category (45.7%) compared to the positive CTPA category (17.4%).

Documentation of Well's scores improved from 33.6% to 51%. However, this is not 100% as it should be.

Inappropriate D-dimer requests continued. 40% were taken without a documented Well's score and 9% were taken despite the Well's score being >4.5 .

CTPA's taken without a documented Well's score or D-dimer blood test improved from 17.5% to 9%.

Conclusion

Compliance to NICE Guidelines improved in the second cycle, however, there is still room for improvement as this is still less than 50%.

		Group 1: D-Dimer taken without available Well's score	Group 2: No D-dimer taken and no available Well's score	Group 3: Well's score >4 with D-Dimer	Group 4: Well's score ≤ 4 without D-Dimer	Group 5: Well's score ≤ 4 with D-Dimer	Group 6: Well's score >4 without D-dimer	Total
2nd cycle	Positive (PE Present)	9	4	5	1	4	0	23
	Negative (PE Not present)	46	9	6	2	49	4	116
1st cycle	Positive (PE Present)	5	2	3	0	2	0	12
	Negative (PE Not present)	59	21	15	1	20	3	119

Table 1: Number of CTPA scans allocated to each group in positive and negative categories for the first and second cycle

Specialist dietetic intervention in fibrotic interstitial lung diseases: a randomised controlled pilot trial

¹R Kahai, ²G Castelli, ³F Danzo, ⁴L Ferreira, ¹A Srirangan, ¹C Roberts, ¹C Stock, ¹S Bax, ¹R Hewitt, ¹M Kokosi, ¹P George, ¹F Chua, ¹V Kouranos, ¹P Molyneaux, ¹RG Jenkins, ¹A Wells, ¹G Korff, ¹E Renzoni. ¹Royal Brompton Hospital, London, UK; ²University of Padova, Padova, Italy; ³Luigi Sacco University Hospital, Milan, Italy; ⁴Unidade Local de Saude de Gaia e Espinho, Porto, Portugal

Introduction

Weight loss is associated with worse prognosis in interstitial lung disease (ILD) (Pugashetti et al., 2018; PMID:30072505). The impact of specialist dietetic care in ILD patients has not been evaluated.

Aim

To assess feasibility of specialist dietetic intervention in ILD patients by a randomised controlled pilot trial (NCT06016959). The primary outcome included feasibility of randomising a target of 40 malnourished ILD patients to a three-month dietetic intervention.

Methods

Inclusion criteria: between July 2023-January 2024, patients meeting at least one between:

1. body mass index (BMI) $\leq 20 \text{ kg/m}^2$ ($\leq 21 \text{ kg/m}^2$ if aged > 75)
2. unintentional weight loss $\geq 5\%$ of body weight, over previous year
3. unintentional weight loss $> 2 \text{ kg}$ if BMI normal, over previous year

Patients were randomised to a three-month specialist dietetic intervention or to control group receiving dietary leaflets.

Demographics, smoking history, comorbidities, antifibrotic treatment, and lung function tests were evaluated at baseline. All patients were asked to complete the following questionnaires: Patient-Generated Subjective Global Assessment (PG-SGA), King's Brief Interstitial Lung Disease (K-BILD), Gastrointestinal Symptom Rating Scale (GSRG), and Hospital Anxiety and Depression Scale (HADS). The Nutritics™ application (www.nutritics.com) was used to evaluate the total energy, carbohydrate, and protein intake from a self-reported 3-day food diary.

Results

Of the 128 ILD patients referred to the study, 24 patients were not eligible, 21 declined participation, 21 were unreachable, 20 did not return the consent form, and 2 replied after completion of target randomization. The primary outcome of feasibility was met, with 40 patients randomised, 19 in the active group, and 21 in the control group. As summarised in Table 1, the groups did not differ in baseline values, except for the K-BILD score, with the control group presenting worse quality of life, mainly driven by the psychological domain.

Conclusions

Specialist dietetic intervention in ILD patients was demonstrated to be feasible. The high number of referrals over only 7 months highlights the unmet need of dietetic input in this population. Complete data from this pilot trial will be available shortly and may suggest potential differences between specialist dietetic support versus dietary leaflets, allowing power calculations required to design a larger trial.

Table 1 – Baseline characteristics of the trial population, divided into active and control arms

	Total population (40)	Active (19)	Control (21)	p value
Female n - %	16 (40)	9 (47)	7 (33)	0.37
Age – years	74 (8.5)	71 (8)	76 (9)	0.39
Weight – kg	60.7 (18.1)	60.2 (19.4)	63.6 (18.1)	0.56
Weight loss (kg) over previous year - %	7.15 (7)	7.9 (4.9)	6.6 (9.4)	0.48
BMI	21.5 (4.55)	21 (4)	21.7 (4.7)	0.52
Smoking status				
Former n - %	21 (53)	10 (53)	11 (52)	0.99
Never n - %	19 (47)	9 (47)	10 (48)	
Pack years – n	12 (9.5)	10.8 (29)	12 (8)	0.70
Antifibrotic treatment				
None n - %	14 (35)	6 (32)	8 (38)	0.30
Nintedanib n - %	21 (53)	12 (63)	9 (43)	
Pirfenidone n - %	5 (12)	1 (5)	4 (19)	
Charlson Comorbidities Index	4 (2)	4 (1.5)	4 (2)	0.95
Baseline questionnaires				
PG-SGA	8 (8.5)	6 (7.5)	8.5 (9)	0.50
K-BILD Psychological	51.2 (28.4)	65.4 (27.8)	43.2 (17.3)	0.03
K-BILD Dyspnea	38.3 (25.5)	42.5 (23.1)	34 (25.5)	0.14
K-BILD Chest symptoms	65.6 (40.6)	68.8 (26.6)	53.1 (34.4)	0.09
K-BILD total	50.2 (29.3)	64.1 (22.1)	45.3 (18.8)	0.02
HADS Anxiety	6 (6.5)	5 (5)	8 (9.25)	0.23
HADS Depression	6 (7)	5 (6.5)	8 (7.25)	0.28
GRSS	1.97 (1.4)	1.87 (1.1)	2.23 (1.4)	0.23
Baseline Pulmonary Function Tests				
FVC%	70.3 (23.6)	73.4 (26.9)	69.8 (16.1)	0.53
FEV1 %	76.7 (18.4)	76.7 (16.4)	77.8 (21.2)	0.94
DLCO%	43.5 (16.3)	44.5 (14.6)	40 (16)	0.92
Baseline Diet Intake				
Kilocalories intake	1629 (486)	1657 (371)	1583 (545)	0.94
Protein intake	70.5 (25.8)	69 (24.5)	72 (22.5)	0.82
Carbohydrate intake	187 (64.3)	187 (57.5)	187 (72)	0.74

BMI – body mass index; DLCO – Lung Diffusion of Carbon Monoxide; FEV1 – Forced Expiratory Volume 1st second; FVC – Forced Vital Capacity; GSRS – Gastrointestinal Symptom Rating Scale; HADS – Hospital Anxiety and Depression Scale; K-BILD – King’s Brief Interstitial Lung Disease; PG-SGA – Patient-Generated Subjective Global Assessment; Data are expressed in Median and (IQR) or number and (percentage), chi-squared test and Mann Whitney U-Test were used to compare the two populations, as needed.

A quality improvement project evaluating oxygen use and improve oxygen prescribing within a busy district general hospital in England

¹M Kalaravy, ²C Gnanalingam, ³P Rai. ¹Medway Foundation Trust, Kent, UK; ²Barking, Havering and Redbridge Hospitals University NHS Trust, Barking, UK; ³East Kent Hospitals University NHS Foundation Trust, East Kent, UK

Background

Oxygen is the most commonly used emergency drug. If administered inappropriately, it can lead to patient harm, particularly in patients at risk of hypercapnic respiratory failure. BTS guidelines recommend all patients should have oxygen prescribed with target saturations specified, including those not presently requiring oxygen, in the event of unexpected clinical deterioration with hypoxaemia. Despite this, audits of oxygen prescription reveal persistently poor compliance. This audit surveyed the number of patients in a busy DGH with an oxygen prescription with specified target saturations, and whether these rates are acceptable compared to BTS guidelines.

Methods

Baseline data was collected from five wards, covering acute medicine, surgery, frailty, respiratory and A&E. Data collected included whether a patient was on oxygen, whether this was prescribed and whether target saturations were specified.

Three interventions were applied, over two years:

1. Delivery of presentations at Trust-wide inductions for doctors.
2. Direct ward-based support to doctors, through use of trained staff ('oxygen champions').
3. Presentations to emergency department doctors to encourage oxygen prescription at point of admission.

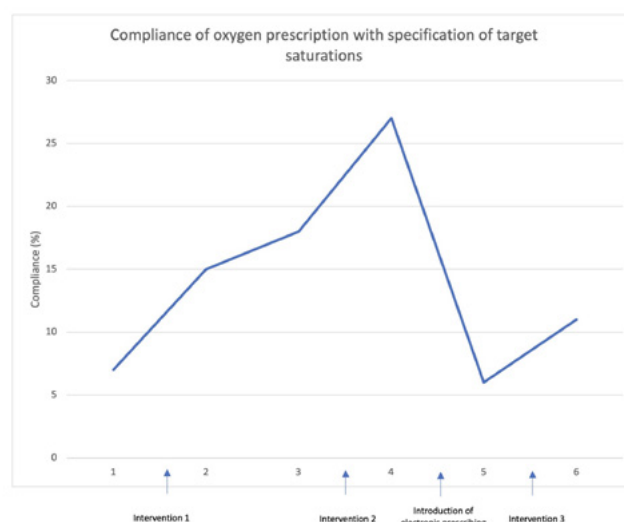
New baseline data was collected between interventions two and three due to introduction of electronic prescribing in the Trust.

Results

At baseline, 7% of hospital patients had oxygen prescribed with target saturations specified. Intervention 1 increased oxygen prescription with specification of target saturations from baseline (7%) to 15% (PDSA 1, May 2022). Intervention 2 increased compliance further from 18% to 27% (PDSA 2, September 2022). Trust-wide introduction of electronic prescribing after PDSA 2 drastically reduced compliance from 27% to 6%. Intervention 3 increased compliance from 6% to 11% (PDSA 3, January 2024).

Conclusions

PDSA 1 and PDSA 2 significantly improved oxygen prescription compliance. However, overall compliance was still not close to accepted standards as per BTS guidelines. Introduction of electronic prescribing negated any improvements seen. This is likely due to staff time constraints and entrenched oxygen prescribing behaviours, secondary to inadequate understanding of oxygen therapy roles and dangers. More data is needed to understand reasons for non-compliance. Implementing mandatory oxygen prescription in the electronic interface may align practice closer to BTS guidelines, enhancing adherence to accepted standards.



D10

Indwelling pleural catheter – patient satisfaction survey

H Khan, E Harvey, L Johnson, R Asciak. Queen Alexandra Hospital, Portsmouth, UK

Indwelling pleural catheters (IPCs) are used more frequently, placing increased burden on healthcare services and patients. Previously in our hospital, all patients had a clinic visit one month after IPC insertion. Community teams handling IPCs did not have formal management training. There was lack of documentation on IPC insertion/management as documentation was not digitalized. Changes were proposed to improve efficiency of the IPC service but whether these would translate to improved patient satisfaction was unknown.

Aim

To improve IPC service, focusing on patient-centred outcomes assessing effect on patient satisfaction.

Method

Changes included recruitment of a pleural specialist nurse, detailed patient information leaflet (including information about patients being trained to drain IPC themselves or with the help of relative/carer if they wished and contact details of our pleural specialist nurse), management course for hospital and community staff managing IPCs, digitalization of documentation, and patient-initiated follow-up (PIFU) pathway after IPC insertion instead of routine clinic visit.

A Likert Scale questionnaire was used to collect data before (2022) and after (2023) the changes. Results were converted into overall scores for satisfaction.

Results

There was one less clinic visit per patient with IPC (i.e. total 1-2 fewer pleural clinic appointments per week) through PIFU; there was improved staff confidence after IPC management course, improved communication between hospital/community IPC teams, improved IPC management documentation serving as audit tool to ensure standards are maintained.

Unsurprisingly, shortness of breath decreased after IPC insertion (VAS 73.9 before vs 21.7 after IPC, n=13 (n=1 missing VAS score data), p 0.005); VAS 79.9 before vs 21.3 after IPC for n=11 patients in the 'after group' (n=7 missing VAS score data), p <0.0001 (paired t-test).

However, the main aim was to see if these changes translated to improved patient satisfaction after changes were implemented. The results are shown in figure 1.

Conclusion

The IPC service changes reduced clinic visits, improved documentation, auditing of services, and improved communication between medical teams showing benefits for the healthcare service. They also led to improved patient-focused outcomes with improved patient satisfaction scores.



Figure showing the total overall scores obtained per question in the IPC patient satisfaction survey comparing the periods before (2022, n=14) and after (2023, n=18) IPC service changes were implemented.

D11

Junior training programme in thoracic ultrasound and basic pleural intervention – our experience

G King, M Mitchell, A Harries, A Ionescu. Aneurin Bevan University Health Board, Newport, UK

Introduction

In ABUHB we run a dedicated pleural teaching programme for junior doctors with the aim of meeting ARCP/training requirements. This includes pre-course e-learning, a simulation session on thoracic ultrasound and pleural procedures followed by attendance at pleural ambulatory sessions to gain clinical experience. We regularly collect feedback to assess how the programme is working and where it can be improved.

Method

Feedback via electronic multiple-choice form was collected post-simulation sessions. This compares candidate confidence in performing the various pleural procedures in both pre and post-simulation sessions in a single combined form. Questions ask the candidates to give a rating from 1-5 with 1 being the least useful or the least confident in a particular skill and 5 being the most.

Results

To date, we have 41 responses. Of these, the average rating was 4.85 in terms of the whole session and 4.66 for the ultrasound segment. Confidence levels for procedures went from 2.29 and 2.41 pre-course for pleural aspiration of effusion and pneumothorax respectively to 3.98 post-course. Similarly, for intercostal drain insertion for both effusion and pneumothorax, the rating went from 2.37 and 2.17 pre-course to 3.95 and 3.83 post-course respectively.

Conclusion

As the results above suggest the simulation sessions are found to be extremely useful by candidates and do, at least in the short term, increase the confidence they would feel in performing these procedures independently when necessary.

D12

A one stop shop, streamlining the diagnosis and management of chronic cough

¹J King, ²S Ludlow, ²S Hennessey, ²P Marsden, ²JA Smith, ²B Al-Shekkly. ¹University of Manchester, Manchester, UK; ²Manchester University NHS Foundation Trust, Manchester, UK

Background

Refractory and Unexplained Chronic Cough (RUCC) is a common condition that has frequent overlap with other treatable traits including nasal disease, gastro-oesophageal reflux disease (GORD), and asthma (1). Licenced drug therapies for RUCC are not available in the UK. Unlicensed treatments including morphine sulphate tablets and gabapentinoids often have associated stigma and intolerable side effects (2). Speech and language therapy (SLT) is an effective R/UCC (3). Combined with a diagnostic laryngoscopy, it supports with exclusion or management of other treatable traits.

Methods

We developed a multidisciplinary one stop clinic (OSC) where patients underwent spirometry, clinician history and examination and diagnostic laryngoscopy and initial treatment at first appointment. Demographics, co-morbidities and outcomes from 39 patients seen in OSC over a 4-month period October 2023-February 2024 to a paired number of medic led new patient clinic outcomes in the preceding 4 months retrospectively compared.

Results

Patients were predominantly female, with no significant difference in age, or prevalence of GORD, nasal disease, asthma, or bronchiectasis (table 1). Time to first appointment (weeks), median (IQR) and time to treatment (RTT) was significantly lower for OSC (8 (7-11) vs. 20 (16-25), p<0.001) and (8 (7-11) vs. 28 (22-34), p<0.001) respectively. Significantly more OSC patients had a laryngoscopy (34/39, 87% vs. 17/40 (42%), p=0.001) and a higher proportion of this group were treated with SLT (23/39, 59% vs. 16/40, 40%, p=0.117). The wait (median (IQR) for SLT was significantly lower in OSC (0 (0-0) vs. 13.5 (7.8-20) p<0.001). OSC patients were more likely to receive a diagnosis of CHS on the day (27/39, 69% vs. 23/40, 57.5%, p=0.223). They were also less likely to be prescribed antitussives (12/39, 69% vs 23/40, 57%, p=0.226).

Conclusion

Patients undergoing a OSC model had reduced RTT, increased access to laryngoscopy and are more likely to undergo nonpharmacological management for their cough, avoiding unlicensed antitussives in many cases. Same day spirometry and laryngoscopy aids with effective assessment and management of other treatable traits.

- 1) Parker et al. 2023
- 2) King et al. 2022
- 3) Ryan et al. 2010

Table 1. Comparison of Demographics, RTT (Time to Treatment) and Diagnosis in New vs. One Stop Clinic.

Features	New n=40	One stop n=39	P value
Age, Median IQR	59.5 (48.25-70.75)	65 (54-72)	0.402
Female sex, n (%)	26 (65)	27 (69)	0.593
Gastro-oesophageal reflux	12 (32.5)	11 (28.2)	0.678
Postnasal Drip	9 (22.5)	7 (17)	0.615
Asthma	9 (22.5)	12 (30.8)	0.406
Bronchiectasis	2 (5)	2(5)	0.958
Had a Laryngoscopy, n (%)	17/40 (42%)	34/39 (87%)	0.117
RTT	28 (22-34)	8 (7-11)	p<00.1
CHS, n (%)	23/40 (57.5%)	27/39 (69%)	0.226

D13

A quality improvement initiative to safely reduce unnecessary chest X-rays after elective lung resection and mediastinal surgery

¹JJ Law, ²M Calderwood, ²KH Lee, ²N McGonigle, ²R Beattie, ²M Jones, ²P Mhandu. ¹London School of Hygiene and Tropical Medicine, London, UK; ²Department of Thoracic Surgery, Belfast, UK

Background

Chest x rays (CXR) are routinely performed after elective thoracic surgery and commonly misperceived as low cost and low risk to patients. Existing literature demonstrate that routine CXR have limited impact in changing patient care. There is also limited understanding regarding the safety of withholding CXRs. Currently, no guidelines exist to guide best practice amongst thoracic surgery units globally.

Objectives and Methodology

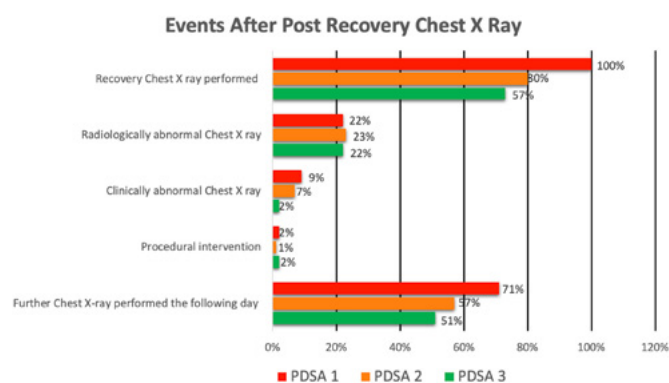
From June 2022 to September 2023, the department embarked on a 3-phase quality improvement initiative using the "plan-do-study-act" (PDSA) methodology to reduce recovery CXR(CXR performed in the Post Anaesthesia Care Unit) and daily CXR utilisation. Each cycle lasted 4 months and a total of 265 elective patient were monitored in this initiative. Main patient exclusion criteria included non-elective procedures, procedures without intraoperative chest drains, pleural surgeries and pneumonectomies. Preliminary audit results derived from 112 patients identified an excessive mean daily rate CXR of 1.25 ± 0.8 CXRs per patient per day. Interventions included MDT focused education, standardization of CXR ordering practises via departmental guidelines and feedback gathering during clinical governance. Postoperative outcomes and other healthcare quality metrics were examined to safeguard patient safety throughout this initiative. Cost saving was estimated using NIHR Costing Tool (iCT).

Results

From PDSA cycle 1 to 3, the mean daily rate of CXR was successfully reduced from 1.25 ± 0.8 to 0.8 ± 0.3 while recovery CXRs utilisation reduced from 100%(112), 87%(70) to 73%(48). Patient characteristics and operative data were similar between pre and post-intervention cohorts. There was no difference in postoperative complications classed Clavien-Dindo ≥ 3 (13% vs 14%, $p=0.53$), hospital length of stay (7 ± 6 vs 7 ± 13 days, $p=0.65$), return to theatre (7% vs 6%, $p=0.86$), readmission within 30 days (6% vs 6%, $p=0.86$) and death within 30 days (1% vs 1%, $p=0.85$) before and after intervention. Conservative estimate of cost saved was GBP 66,300 per year. Additionally, each cycle demonstrated that only 2-3% of routine recovery CXR led to actual changes in patient care in the form of procedural intervention (Figure 1).

Conclusion

Routine CXR utilisation after elective thoracic surgery can be reduced safely and systematically. Further PDSA cycles are still undergoing within our institution to sustain this patient-benefiting and NHS cost saving initiative.



D14

Multidisciplinary management of cough hypersensitivity within a one stop assessment clinic

¹S Ludlow, ¹J King, ¹B AIShekilly, ¹S Hennessey, ¹P Marsden, ²J Smith. ¹Manchester University NHS Foundation Trust, Manchester, UK; ²University of Manchester, Manchester, UK

Introduction

Cough Hypersensitivity (CHS) is characterised by increased neural responsivity to a range of stimuli that affect the airways. The Manchester Cough clinic is a tertiary service established to assist with diagnosis and management of CHS. Currently there are long waits for important diagnostic test such as laryngoscopy and spirometry, which can delay treatment. We set up a 'one stop' assessment clinic to reduce visits, patient travel, and shorten time to diagnosis/treatment.

Aim

To evaluate clinical outcomes and patient satisfaction in attending a multidisciplinary (MDT) cough 'one stop' clinic.

Method

Demographic data and clinical outcomes were collected from the Manchester cough 'one stop' clinic over 4 months (October 2023-January 2024). During the assessment, patients were assessed by a specialist nurse, speech and language therapist (SLT) and respiratory physician. Spirometry, bloods and laryngoscopy (if indicated) were completed during the visit. A patient satisfaction survey was emailed to patients following their visit.

Results

Of 39 patients [27 female, mean (SD) age 62 (12) years], 34 (87%) had laryngoscopy on the day, with 30 (88%) having features consistent with CHS and 8 (24%) receiving an additional diagnosis of Inducible Laryngeal Obstruction (ILO). Twenty-seven (69%) were diagnosed with CHS on the day, 6 (15%) treated for other conditions, and 6 sent for additional investigations. By comparison, only 57.5% of patients were diagnosed with CHS on first appointment prior 'one stop' initiation, with no same day laryngoscopy available.

Of the 27 diagnosed with CHS, 15 (55%) were referred for SLT alone, 4 (15%) prescribed antitussives alone, and 8 (30%) were referred for joint SLT and antitussives. Decisions on treatments were patient led after receiving guidance from the doctors. Of the 12 patients who were prescribed antitussives, 11 (92%) were started on morphine, and one (8%) on pregabalin.

All patients were 'very satisfied' (80%) or 'somewhat satisfied' (20%) with the visit. Most felt the length of the appointment was 'just right' (87%). The distance travelled was average (range) 30 (5-100) miles.

Conclusion

A one stop assessment clinic for CHS allows faster diagnostic and treatment pathways to be established, reduces clinic wait times, with high patient satisfaction.

Figure: Word Cloud capturing patient feedback from the one stop assessment clinic



D15

Respiratory virtual wards can reduce hospital length of stay: an update over two years

P Natarajan, R Whelan, L Loewenthal, J Martinovic, D Ward, V Smith. Kingston Hospital NHS Foundation Trust, London, UK

Introduction

The Kingston and Richmond Respiratory Virtual Ward (VW) based at KHFT has been running since 2022. With respiratory-related admissions increasing annually, novel ways of delivering patient care are needed^[1]. VWs provide hospital treatment at home for patients who would otherwise need longer hospital admission.

Aims

To increase use of our VW to reduce overall hospital length of stay (LoS)

Methods

VW patients with asthma exacerbations from 01/2022-12/2023 were analysed.

Demographics, asthma severity, treatments, Hospital/VW LoS and 30/90-Day Outcomes were recorded.

Treatments offered by the VW included nebulisers, oxygen and monitoring.

Patients had to meet our specific inclusion criteria to be eligible to the VW:

- Improving clinical trajectory
- No previous asthma-related ICU admissions
- VTE and sepsis excluded
- No life-threatening asthma

Results

125 patients were admitted to VW over the 24-month period with asthma exacerbations. There was a 55% increase in admissions from 2022 to 2023 (49 vs 76 admissions) (Figure.1).

Most VW patients were classed as mild exacerbations (82.6% in 2022, 71.1% in 2023) with the rest classed as moderate and severe.

Home nebulisers continued to be the most used VW treatment (69.4% in 2022, 78.9% in 2023).

In 2022, average hospital LoS for our asthma patients managed on VW was 4.2 days, followed by a VW LoS of 12 days. In 2023, hospital LoS and VW LoS was reduced to 3.5 days and 8 days on average respectively.

On review of 90-day outcomes, 14.3% of VW patients in 2022 and 9.2% of VW patients in 2023 were readmitted with asthma-related issues. This reduction may be related to increased interventions patients received while on VW, such as advice and medication changes (10.2% in 2022 vs 42.1% in 2023).

Conclusion

Increased use of the VW has been associated with reduced hospital LoS. There has been a reduction in VW asthma readmissions which may be due to increased use of VW therapeutic interventions.

Our data indicates that use of VW in acute asthma exacerbations can be safe and effective with appropriate patient selection and monitoring. We will continue to evaluate our data on this.

- 1) Allen. Respiratory Medicine: GIRFT Programme National Specialty Report (2021)



Figure 1: Asthma admissions to Kingston and Richmond Respiratory Virtual Ward

D16

Effect of an integrated care system on waiting times for patients with fibrotic-ILD

¹C Plum, ¹T Gatheral, ²S Weinberg, ³R Mountain. ¹University Hospitals Morecambe Bay NHS Trust, Lancaster, UK; ²Manchester University NHS Foundation Trust, Manchester, UK; ³Lancaster Medical School, Lancaster University, Lancaster, UK

Background

Strategies to address diagnostic delay in patients with fibrotic ILD (fILD) is essential. This analysis reviews the impact of a local integrated care system (the Morecambe Bay Respiratory Network [MBRN]) on time from referral to: investigations, initial clinic appointment, and treatment, for patients with fILD.

Method

This is a retrospective cohort analysis of referrals to the ILD clinic at University Hospitals Morecambe Bay (UHMB) NHS trust by GPs (General Practitioners). Dates of referral, initial diagnostic tests, initial ILD appointment and starting treatment were collected. Time from referral to each outcome was compared between MBRN and non-MBRN GPs.

Results

Analysis included 70 patients in the MBRN group and 73 in the non-MBRN group. Mean time to initial Computer Tomography (CT) chest scan from referral in the MBRN and non-MBRN group was -44.5 and 48.4 days respectively (p -value<0.0001). Mean time to initial Lung Function Test (LFT) from referral in the MBRN and non-MBRN group was 39.0 and 94.8 days respectively (p -value<0.0001). The median (interquartile range [IQR]) time from referral to ILD clinic in the MBRN and non-MBRN group was 76 (40-139.5) and 178 (74-310.5) days respectively. The median (IQR) time from referral to decision to commence antifibrotics, if eligible, in the MBRN and non-MBRN group was 96 (57-138) and 157 (109.5-240) days respectively.

Conclusion

Integrated care through the MBRN significantly shortened completion of key diagnostic investigations in fILD. Seeking ways to improve timely diagnosis and management for these patients is key to access disease modifying therapy and provide early supportive care.

D17

Safer delivery of oxygen: improving staff confidence and accuracy when using ball-float flow meters and Venturi valves for the delivery of oxygen

M Sambrook Smith, V Wells, L Hartmann, Q Tang. Poole Hospital, University Hospital Dorset, Poole, UK

Introduction

Errors in oxygen prescribing, delivery and titration can be dangerous and costly to both the patient and the trust. A preliminary audit in our trust showed that for each patient the oxygen flow rate delivered could vary by up to 1L/min depending on the staff member. Our project aimed to improve the consistency and accuracy of oxygen delivered to inpatients in acute medical settings. We aimed to improve the confidence and accuracy of clinical staff using ball-float flow meters and venturi valves. The overall intention of this project is to reduce usage of unnecessary oxygen, thus ensuring sustainable and safe practices whilst also saving the trust money.

Methods

We used the PDSA improvement model. We collected data on multiple variables (e.g demographic data, confidence assessments and skills assessments) using paper-based questionnaires delivered to staff over three different acute medical wards. Confidence was assessed using a 5-point Likert scale and assessed factors such as reading off from flow meters, physically adjusting flow meters and adjusting oxygen to match target saturations. The skills based assessment was measured using case studies and graded according to correct answers. PDSA cycles were run sequentially with interventions delivered in between each cycle.

Results

Cycle 1 and 2 data covered a wide variety of staff (ie. therapy tech, physios, nurses, doctors, students, ANPs). Only 73% of clinical staff members were correctly reading the flow rate of oxygen from the ball-bearing. Staff felt most confident physically adjusting the flow meters and least confident adjusting oxygen flow rates to match target saturations and when using venturi valves. We presented these results at clinical governance meetings and peer-to-peer teaching sessions. We have updated our oxygen e-learning module, arranged intranet updates and safety announcements. The third PDSA cycle is on-going.

Despite the acute medical wards (including respiratory ward) being a key place for oxygen delivery - there is a discrepancy between confidence and skill. Nurses, doctors and HCAs all require more on-going training about the safe delivery of oxygen. Further data collection and interventions are needed in other areas of our hospital (e.g. surgical units) to ensure consistency amongst all wards.

A new “Lung Health Check” service for patients with substance misuse disorder in the North East of England

R Thompson, S Bourke, J Steer, L Dismore. Northumbria Healthcare NHS Foundation Trust, Newcastle, England

Background

Substance misuse disorder is associated with high rates of lung disease and poor engagement with healthcare. North East England has high rates of substance misuse disorder. Many socio-economic barriers to diagnosis and treatment in this population exist.

Intervention

A ‘one-stop’ Lung Health Check clinic was established and provided within addiction service premises to diagnose, educate and treat patients with lung disease. Attendance, diagnoses, and treatments provided were captured. Qualitative interviews were conducted to understand service user’s experiences of healthcare services and the Lung Health Check clinic. Processes were continually refined based on results.

Patients were identified using an adapted COPD screening tool, administered by their addiction service keyworkers. Clinic personnel are: Respiratory Physician, Nurse Specialist, Physical Health Nurses, Senior Peer Support Worker, Physiologist, and Clinical Psychologist. In addition to diagnosis and education, the clinic provides medications, prescriptions, respiratory vaccinations, smoking cessation therapy, referral for pulmonary rehabilitation, further investigation and follow up as required. Service users are incentivised with a £5 food voucher and transportation.

Results

Twelve clinics between May 2023 and February 2024: 68 patients seen with 80.9% of new patient appointments attended. Those attending had high symptom burden (mean CAT score 27) and high rates of ED attendance and hospital admission in the preceding year (168 and 42 respectively).

Among attendees 51 (75%) received a new diagnosis of lung disease or intervention for an existing condition. COPD or asthma was found in 46 (68%) and this was a new diagnosis in 32 (70%). Of those with respiratory disease 48 of 51 (94%) received or advised treatment including vaccination, pulmonary rehabilitation or physical activity promotion, smoking cessation or change in oral or inhaled therapy.

Patients reported several barriers to accessing healthcare: travel costs; difficulty booking appointments; concern of being stigmatised. Service users were positive about: the clinic being in a familiar, supportive environment; feeling listened to; and education around their condition.

Conclusion

The Northumbria “Lung Health Check” shows promise as a model to better diagnose and treat this ‘hard to reach population’. The clinic model removes many of the barriers that patients previously perceived and is well received.

Tobacco dependence treatment for inpatient smokers – technology-enabled improvement project

F Vivian, K Michalakakis, M Ullah, S Kasim, C Newey, K Louison, L Baker. Lewisham and Greenwich NHS Trust, London, UK

Introduction

Smoking is a leading cause of preventable morbidity and mortality. Opportunistic tobacco dependence treatment for inpatient smokers is a cost-effective public health intervention^[1]. The Ottawa model involves assessing smoking status for all inpatients and providing smokers with nicotine replacement therapy (NRT) and specialist counselling. In the 2021 British Thoracic Society tobacco dependence audit, our trust, consisting of two acute hospital sites, performed below the national average on these elements.

Aims

A multi-disciplinary team was established aiming to increase the proportion of inpatient smokers that:

- 1) receive NRT
- 2) are seen by the tobacco dependence team (TDT)

Method

Weekly data on NRT prescriptions and TDT reviews were collated from the electronic patient record (EPR). Quality improvement methodology was utilised to deliver changes and assess their impact in three phases:

- 1) Training of staff
- 2) Introduction of a standardised NRT order-set with automatic TDT referral
- 3) Introduction of a mandatory smoking status assessment within admission documentation. This generated an EPR report of inpatient smokers for the TDT.

Results

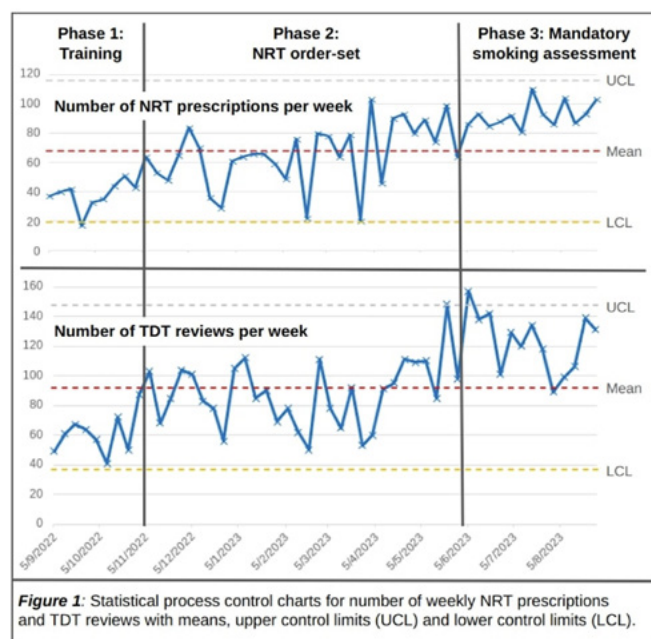
The number of smokers prescribed NRT and seen by the TDT increased through each phase of the project and doubled by its conclusion [Figure 1]. However, there was a possible trend of improvement independent of the interventions and the variance of both metrics was high.

Conclusion

This project demonstrated serial improvements in delivery of tobacco dependence treatment. Leveraging the EPR enabled the capture of key metrics to assess the impact of our interventions. Intervening with technological changes led to wide-reaching and sustainable change. The ability for the TDT to identify smokers from the mandatory smoking assessment has transformed their workflow. They now identify most patients via the EPR, rather than by laborious in-person screening. The new system also provides additional metrics that are being utilised to assess ongoing iterative improvement with greater data quality. This technology-enabled, data-led approach to improvement, which could be replicated elsewhere, is increasing the reach of tobacco dependence treatment, saving lives.

References

[1] Evison M, et al. Health economic analysis for the 'CURE Project' pilot: a hospital-based tobacco dependency treatment service in Greater Manchester. *BMJ Open Respiratory Research*. 2021 Dec;8(1):e001105.



D20

Developing an interface approach to standardise COPD reviews: a digital co-design and service improvement project

E Walker, C Levey, A Taylor, J Anderson, C Carlin. Queen Elizabeth University Hospital, Glasgow, Scotland

Introduction

Chronic obstructive pulmonary disease (COPD) is a common, preventable respiratory disease that is the third leading cause of death worldwide. Opportunities to optimise core patient management are often missed resulting in clinical deterioration and unscheduled care events. Developing co-designed digital solutions that capture structured COPD reviews and support service delivery across the primary-secondary care interface offers the opportunity to improve uptake of value-based interventions and transform pathways to enhance proactive care delivery.

Methods

NHS Greater Glasgow and Clyde (NHSGG&C) are undertaking a prospective service improvement project to optimise multidisciplinary care delivery to the COPD population, comprised of asynchronous secondary care triage of a data-driven patient cohort, pharmacy team-led education sessions and 1:1 patient-tailored primary care reviews. This collaborative framework establishes a foundation for ongoing digital transformation of COPD care, and supports professional development within the MDT.

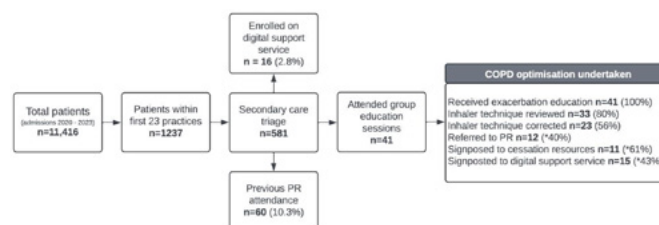
Results

11,416 patients across 436 general practices were identified as having a COPD-related hospital admission within NHSGG&C between October 2020 and September 2023. Initial implementation has focused on 23 GP practices, with results shown in Figure 1. Clinical details and data capture are currently hosted on a co-designed electronic template. Initial triage data highlighted low levels of previous attendance at pulmonary rehabilitation and underutilisation of established digital self-management tools, as well as addressable smoking behaviours.

Review of published data has allowed development of a projected value algorithm that will be implemented as part of service evaluations to infer predicted benefits from these care optimisations on patient mortality, hospital readmission rates, and healthcare-associated cost savings.

Conclusion

Preliminary findings from this digital transformation initiative confirm substantial addressable care quality gaps in the access and utilisation of non-pharmacological interventions for patients with COPD. It is anticipated that the evolving co-design of assistive digital tools and extension of this interface collaborative working will address these inequalities, improve clinical outcomes and provide a platform for further improvements in delivery of high-value care. The addition of AI-driven insights and risk prediction models has the potential to offer patient risk stratification and targeted decision-support features that would augment service evolution and optimise pathway efficiencies.



D21

Evaluating the use of medical thoracoscopy for the diagnostic accuracy for suspected malignant pleural effusion

J Wylie, P Chohan, A Varghese, M Chaudri, A Azam. Russells Hall Hospital, Dudley, UK

Background

Day case medical thoracoscopy (MT) with indwelling pleural catheter insertion (IPC) is used increasingly in the evaluation and management of patients with undiagnosed pleural effusion.

Objective

We aimed to review the role of MT in a district general hospital, examining the diagnostic accuracy for malignancy, the rate of complications and the 30-day post procedure admission rate.

Methods

A retrospective observational analysis was performed looking at all MTs performed between November 2021 and May 2023 at Russells Hall Hospital, UK. All procedures performed for suspected malignancy were included in the analysis.

Results

A total of 33 MTs were performed with 23 IPCs inserted during the procedure. Of these, 100% had prior pleural fluid analysis for cytology. 76% (25/33) of these were negative and 21% (7/33) were indeterminate for source of primary. MT was able to reach a definitive diagnosis of malignancy in 73% (24/33) of cases.

There were 9/33 (27%) procedure related complications: pneumothorax (3), trapped lung (2), cough (2), and surgical emphysema (2). The majority of cases were performed as day-case (81%) with 6/33 (18%) already inpatients at the time of their MT. 11% (3/33) required admission within 30 days of the procedure: 1 for observation post-sedation, 1 for poor IPC drainage and 1 for breathlessness requiring IPC insertion.

Conclusion

The use of MT significantly increased the diagnostic accuracy for malignancy, enabling the primary source to be identified in 73% of cases versus 3% with pleural fluid cytology alone. We demonstrated the ability to perform this procedure safely in a day case setting with minimal complications and hospital admission rates.

EXHIBITORS' INFORMATION

ACTION FOR PULMONARY FIBROSIS

Stand number: 36

Action for Pulmonary Fibrosis is a people-driven charity. We are here for you.

Our four themes

1. Support

To advocate for people living with PF and to provide support to improve their quality of life and to develop collaborative partnerships to help fund people-focused support programmes.

2. Research

To support research into improved outcomes and greater understanding of the disease and to champion research programmes.

3. Education

To undertake targeted awareness raising of the disease, amongst the medical profession, decision-makers and the wider public.

4. Campaigning

To proactively target parliamentarians, NHS and policymakers and to represent patient interests with NICE and the NHS and to target symptom recognition in primary care for prompt diagnosis.

Email: info@actionpf.org

Phone: +44 (0)1733 839 642

<https://actionpf.org>

ASSOCIATION FOR RESPIRATORY TECHNOLOGY AND PHYSIOLOGY

Stand number: C

The Association for Respiratory Technology and 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

Phone: +44 (0)1543 442 141

<http://www.artp.org.uk>

ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN RESPIRATORY CARE

Stand number: D

The Association of Chartered Physiotherapists in Respiratory Care (ACPRC) 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 is taking 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 stakeholders. Special interest groups, we also aim to publish two peer reviewed journals a year and are a member of crossref.

<https://www.acprc.org.uk>

ASSOCIATION OF RESPIRATORY NURSES

Stand number: B

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.

ARNS influences respiratory policy by collaborating with other respiratory organisations and sends representation to the Department of Health (DoH), NICE and other NHS initiatives that involve respiratory care, policy and practice.

ARNS supports its members by fostering networking with other respiratory specialists and organisations. ARNS encourages research by providing bursaries to its members. ARNS encourages and promotes new respiratory initiatives that improve respiratory care for patients. ARNS is run by nurses for nurses. Associate membership is offered to allied health professionals and those working in a non-clinical environment who are involved in respiratory care.

Email: info@arns.co.uk

Phone: +44 (0)1543 442 198

<https://arns.co.uk>

ASTHMA AND LUNG UK

Stand number: 14

Asthma + Lung UK is the only charity in the UK fighting for everyone with a lung condition, aiming for a world where everyone can breathe with healthy lungs. We fund cutting-edge research and provide advice and support via our dedicated Helpline and WhatsApp service for the 12 million people who will get a lung condition during their lifetime. We provide in person and virtual support groups for our beneficiaries and also campaign for clean air and for better NHS diagnosis and treatment. For further information visit asthmaandlung.org.uk

<https://asthmaandlung.org.uk>

ASTRAZENECA

Stand numbers: 3 & 12

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 our website and follow us on Twitter @AstraZenecaUK.

Email: riexternalengagementteam@astrazeneca.com
<http://www.astrazeneca.co.uk>

BD

Stand number: 2

BD is one of the largest global medical technology companies in the world and is advancing the world of health by improving medical discovery, diagnostics and the delivery of care. The company supports the heroes on the frontlines of health care by developing innovative technology, services and solutions that help advance both clinical therapy for patients and clinical process for health care providers. BD and its more than 70,000 employees have a passion and commitment to help enhance the safety and efficiency of clinicians' care delivery process, enable laboratory scientists to accurately detect disease and advance researchers' capabilities to develop the next generation of diagnostics and therapeutics. BD has a presence in virtually every country and partners with organisations around the world to address some of the most challenging global health issues. By working in close collaboration with customers, BD can help enhance outcomes, lower costs, increase efficiencies, improve safety and expand access to health care.

Email: daniel.sime@bd.com
Phone: +44(0) 7595 895 302

<https://www.bd.com/en-uk>

BRITISH THORACIC SOCIETY

Stand number: A

The British Thoracic Society (BTS) is the leading professional society for respiratory medicine in the UK, with over 4,500 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
<http://www.brit-thoracic.org.uk>

BRONCUS MEDICAL

Stand number: 1

As a leader in the diagnosis and treatment of lung disease, Broncus Medical continues to partner with clinicians from around the world to answer the biggest challenges in pulmonary medicine through innovative solutions.

The Archimedes system is a next generation virtual bronchoscopic navigation system developed from years of experience and clinical feedback. Archimedes integrates CT, pattern recognition software and fused fluoroscopy to provide real-time airway navigation and Bronchoscopic Trans-Parenchymal Nodule Access (BTPNA). The technology combines state-of-the-art nodule, vessel and airway mapping features along with virtual pathway guidance to ensure a safe and efficient airway or BTPNA procedure. The proprietary software and design allows for the use of any bronchoscope and existing off the shelf tools during airway navigation and a simple access kit for BTPNA.

Bronchoscopic Thermal Vapor Ablation® (InterVapor® or BTVA®) is a non-surgical and non-implant therapy developed for emphysema. BTVA is a simple, quick, and non-invasive procedure that typically takes less than 15 minutes and can be performed under light sedation. Vapor is delivered through a catheter to the most diseased segments of the lung. The vapor ablates the diseased tissue and the body removes the ablated tissue through the natural healing process. In patients with severe emphysema, vapor ablation of the most diseased segments of the lung may result in clinically meaningful improvement in breathing by increasing pulmonary function.

Email: ftam@broncus.com
Phone: +44 (0)7526 179 788
<https://www.broncus.com>

CHIESI

Stand numbers: 6, 7, 8 & 9

Based in Parma, Italy, Chiesi Farmaceutici is an international research-focused biopharmaceuticals group with over 85 years' experience in the pharmaceutical sector operating in 30 countries, employing around 6,000 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.

<https://www.chiesi.uk.com>

CONSILIENT HEALTH (UK) LTD

Stand number: 19

Consilient Health, a well-established pharmaceutical company founded in 2005, 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 our website for details.

UK-SH-79(1)a(2) January 2024

Email: info@consilienthealth.com

<https://www.consilienthealth.com>

FISHER & PAYKEL

Stand number: 20

More than 50 years ago, Fisher & Paykel Healthcare created a device to deliver humidified air and oxygen to hospital patients. That device developed into a full range of innovative products and therapies that are today used in the treatment of around 14 million patients in more than 120 countries. Throughout the years, the company focus has been on therapies that change clinical practice, resulting in world-leading products such as Airvo™ and Optiflow™.

Email: liane.elderfield@fphcare.co.uk

Phone: +44 (0)1628 678 407

<http://fphcare.com>

GSK

Stand numbers: 15, 16, 27 & 28

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

Email: customercontactuk@gsk.com

Phone: +44 (0)20 8047 5000

<https://www.gsk.com/en-gb>

GUARDANT HEALTH

Stand number: 17

Guardant Health is a leading precision oncology company focused on helping conquer cancer globally through use of its proprietary blood tests, vast data sets, and advanced analytics.

The Guardant360 liquid biopsy comprehensive genomic profiling test is the leading, analytically and clinically validated liquid biopsy assay that effectively detects the four main classes of genomic alterations in 74 well-documented cancer genes, thereby enabling clinicians to identify candidates for targeted therapies and to avoid treatments which are less likely to be effective. 6,7,8,9 Guardant360 was the first liquid biopsy to receive FDA approval on August 9th, 2020 and it is also CE marked. It is indicated for all advanced solid tumours, both in first line and at progression and is a companion diagnostic for Tagrisso (Osimertinib). Guardant360 includes most guideline recommended genomic biomarkers, in line with those included on the National Genomic Test Directory, and has a very fast turnaround time, with an average of 7 days from sample receipt in the laboratory to issuing of the report. The test is performed in a single CLIA certified and CAP and ISO15189 accredited central laboratory in Redwood. Since being introduced, Guardant360 has become widely adopted in clinical practice and there are now more than 220 peer-reviewed publications, over 60 of which describe the outcomes achieved when patients are treated in line with their molecular tumour profile identified through Guardant360. The test has been used by over 9,000 oncologists, with more than 180,000 tests performed to date.

<https://guardanthhealth.eu>

INSMED

Stand number: 24

Insmmed is a global biopharmaceutical company on a mission to transform the lives of patients with serious & rare diseases. At Insmmed, the needs of patients serve as our compass point when setting priorities for the company and weighing difficult decisions. In everything we do, we put patients first.

Email: aisha.ahmed@insmed.com

IT'S INTERVENTIONAL

Stand number: 18

It's Interventional is an SME based in Sheffield. Our aim is to be different in an increasingly undifferentiated world. We select proven, clinically effective medical devices and are proud to continue our support of the BTS Summer Meeting. Formally UK Medical, we introduced the concept of IPC into the UK in 2006, our focus for this event will be The Aspira™ Drainage System. Aspira™ is the natural evolution of IPC and provides new methods of catheter implant, as well as innovative home drainage options designed to improve patient comfort and quality of life. The It's Interventional 'In-Home' service, serves to facilitate a seamless transition into the community and ensure continuity of care for all patients. Product innovation and the highest levels of service & support are central in ensuring your Aspira patients receive the best possible healthcare - why not put us to the test?

Please visit us at stand no: 18 or visit itsinterventional.com for more information on Aspira™.

Email: hello@itsinterventional.com

Phone: +44 (0)114 268 8880

<https://itsinterventional.com>

KENVUE

Stand number: 21

Nicorette® (nicotine) has been at the forefront of Nicotine Replacement Therapy (NRT) innovation for more than 40 years, and now has a wide range of smoking cessation products including gum, lozenge, patch, inhalator and sprays. In 2023, Nicorette® QuickMist Mouthspray became the first and only medicinal aid licensed for vaping cessation. Visit our stand for HCP resources and tools.

[Click here](#) for Nicorette® prescribing information.

Adverse events should be reported. Reporting forms and information can be found at <https://yellowcard.mhra.gov.uk>. Adverse events should also be reported to McNeil Products Limited on 0808 238 9999.

References: 1. Nicorette QuickMist 1mg/spray Mouthspray SmPc

Email: academyplusuk@kenvue.com

Phone: 0808 238 9783

<https://academy-plus.co.uk>

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.

Email: corporateaffairsuk@msd.com

Phone: +44 (0)208 1548 000

<https://msd-uk.com>

MYMHEALTH

Stand number: 29

Our mission is to change healthcare forever by empowering patients and clinical teams to manage long term conditions (Asthma, Diabetes, COPD and Heart Disease) using digital therapeutics. The platforms are designed to support medicines optimisation, patient initiated follow up and medication compliance. We aim to provide patient centred standardised care with an emphasis on promoting digital and health literacy. The apps promote healthy living and provide support through education, mindfulness and exercise. my mhealth's digital therapeutics have been prescribed to over 130,000 patients. Real world and clinical trial evidence demonstrate the efficacy of my mhealth's digital interventions www.mymhealth.com. We are delighted to announce our myCOPD product has been recommended by NICE - National Institute for Health and Care Excellence as a digital support tool for pulmonary rehabilitation (PR) programmes for adults with chronic obstructive pulmonary disease (COPD). Receiving this recognition by NICE as part of their 'Early Value Assessment' (EVA) program highlights our commitment to enhancing COPD care. Many of our NHS partners have already embraced the evaluation and deployment of myCOPD at scale, and made advanced digital care for pulmonary rehabilitation a reality.

Email: sales@mymhealth.com

Phone: +44 (0)1202 299 583

<https://mymhealth.com>

THE NATIONAL ASPERGILLOSIS CENTRE (MANCHESTER)

Stand number: 34

Aspergillosis is a group of serious conditions caused by *Aspergillus* mould, including acute infections (IPA), chronic infections (CPA) and allergic conditions (ABPA, SAFS). The National Aspergillosis Centre (Manchester) is an NHS highly-specialised service that accepts referrals from across the UK. We have dedicated funding to diagnose and treat CPA patients, with support from our team of specialist nurses, pharmacists, physiotherapists, radiologists and patient support staff.

- **Refer a patient or join our MDT**
- Find out more about our **team and services**
- **Submit a sample to our on-site mycology reference laboratory** (Aspergillus PCR, susceptibility testing, sequencing, BDG, galactomannan, therapeutic drug monitoring)
- **Access free patient support groups and information activities** that are open to all UK aspergillosis patients (i.e. no referral is needed)
- **Join our Aspergillosis clinicians mailing list** for updates on the latest diagnostics, treatments, events, training/CPD and clinical trials

Phone: +44 (0)161 291 5866

<https://mft.nhs.uk/wythenshawe/services/respiratory-and-allergy/national-aspergillosis-centre>

OSA ALLIANCE/HMViP

Stand number: 30

The Home Mechanical Ventilation in Partnership (HMViP) is a multi-disciplinary group made up of members from across the home ventilation clinical community including patients and carers, and the healthcare profession, consisting of nurses, consultants, respiratory physiotherapists and physiologists, all of whom have significant experience in home mechanical ventilation (HMV). The group is dedicated to improving education and awareness of HMV to support both patients and fellow healthcare professionals.

Contact: Gillian Gibbons, Secretariat, HMViP

Email: gillian@wychwoodcommunications.com

Phone: +44 (0)7795 342 804

<https://hmvip.co.uk>

P3 MEDICAL

Stand number: 23

P3 Medical is a UK-based company specializing in the development and manufacture of innovative single-use medical devices. Our cutting-edge technology and skilled workforce enable us to provide superior quality products to our clients worldwide. All our products are manufactured in the UK, ensuring stringent quality control and adherence to international standards. We strive to deliver excellence in every aspect of our business, from product development to customer service. Our goal is to provide innovative solutions that enhance patient care, reduce healthcare costs, and improve clinical outcomes. We are committed to delivering value to our clients and ensuring their satisfaction through continuous improvement and innovation.

Email: info@p3medical.com

Phone: +44 (0)1179 728 888

<http://www.p3-medical.com/UK>

PFM MEDICAL

Stand number: 25

pfm medical UK Limited is the UK subsidiary of pfm medical gmbh.

Located in the Cheshire countryside, we are committed to supplying high quality products to the NHS, private hospitals, research and development centres, laboratories and all other care services.

We have been established since 2007 and have a strong team of clinical sales consultants and expert support staff.

Email: uk@pfmmmedical.com

Phone: +44 (0) 1625 875 388

<https://pfmmmedical.co.uk>

PRSAS

Stand number: 13

The Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) is an accreditation programme designed to support pulmonary rehabilitation services to improve quality of care. Accreditation of a service provides assurance to patients, referrers, and commissioners of high-quality service delivery.

Delivered by the Royal College of Physicians, the programme evaluates the service against a set of standards developed with multi-professional input and in accordance with national guidelines.

The accreditation programme is delivered across Scotland, England, Wales, and Northern Ireland. In 2024, NHS England released commissioning standards for pulmonary rehabilitation services. This guidance stated the goal for all patients to receive quality assured pulmonary rehabilitation from an accredited service or a service actively working towards accreditation.

Email: Pulmrehab@rcp.ac.uk

Phone: 020 3075 1407

<https://www.prsas.org/Default.aspx>

ROYAL BROMPTON AND HAREFIELD HOSPITALS

Stand number: 35

Royal Brompton and Harefield Hospitals are internationally recognised as centres of innovation and clinical excellence in heart and lung care.

Our team is not just a group of professionals; we are a collective force committed to advancing medical frontiers. From our accomplished doctors and dedicated nurses to our specialised imaging experts, each member contributes to a legacy of excellence.

Imagine a world where medical innovation takes centre stage. Here, our experts are not simply practitioners – they are architects of transformative procedures. Whether it is developing a ground-breaking minimally invasive heart procedure or introducing innovative methods for diagnosing complex lung conditions, our team stands at the forefront of cutting-edge clinical research.

Education is at the core of our mission. As a leading global medical training centre, we are driven to share our knowledge. Our commitment extends to healthcare professionals worldwide, elevating the standard of patient care globally.

What sets us apart? Our strategic partnerships with academic centres such as Imperial College London, Brunel University London and King's Health Partners. These collaborations position us uniquely, providing access to international clinical research trials and the latest treatments and surgical techniques.

Envision enhancing your career in this dynamic environment. Our dedicated training platform offers a range of resources – from insightful online Expert Talks to comprehensive courses, Fellowships, and Observerships. Join us, and learn from the world's leading experts, propelling your career to new heights.

At Royal Brompton and Harefield Hospitals, we invite you to be a part of something extraordinary. Discover a world where expertise meets passion, and where every day brings new possibilities in the realm of heart and lung care.

Email: rbhh-education@rbht.nhs.uk

<https://www.rbhh-education.co.uk>

SANOFI

Stand numbers: 10 & 11

We 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 potentially life-saving vaccine protection to millions of people globally, while putting sustainability and social responsibility at the centre of our ambitions.

<https://sanofi.com/en>

STIRLING ANGLIAN PHARMACEUTICALS

Stand number: 4

Based in the UK, Stirling Anglian is committed to medicines optimisation. It has sourced and developed a portfolio of medicines to help the NHS curb waste – across a range of conditions that currently place unnecessary and avoidable pressure on NHS resources. At a time when there is such pressure on the NHS to reduce costs, we believe we offer a real and practical solution.

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.

Email: info@stirlinganglianpharmaceuticals.com

Phone: +44 (0)345 527 0680

<https://www.stirlinganglianpharmaceuticals.com>

SWORD-THOR

Stand number: 33

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 and evidence 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 randomly allocated month per year and are offered opportunities to collaborate with THOR on research projects as well as receiving quarterly newsletters and annual reports on THOR data.

For more information please visit our website or contact Laura Byrne (Research Administrator for SWORD) via email

Email: laura.byrne@manchester.ac.uk

<http://www.coeh.man.ac.uk/u/sword>

TOFS

Stand number: 31

Tracheo-Oesophageal Fistula Support (TOFS) is an active support group for those born with oesophageal atresia/tracheo-oesophageal fistula (OA/TOF) and associated conditions. Once considered a paediatric illness, it's now evident that those born with OA/TOF may have respiratory issues throughout life. TOFS wants to engage with respiratory doctors for adults, with the aim of improving care for anyone born with these conditions so that they may live life unlimited.

Chronic respiratory issues that OA/TOF patients may face include:

- Chronic cough
- Bronchomalacia
- Tracheomalacia
- Pneumonia
- Bronchiectasis
- Asthma
- Aspiration
- Sleep disruption

TOFS has recently published a management handbook for health professionals. Please visit our stand to find out more.

Email: info@tofs.org.uk

Phone: +44 (0)115 961 3092

<https://www.tofs.org.uk>

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 subscription renewals 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.



British Thoracic Society

The British Thoracic Society is a Company Limited by Guarantee. Registered in England and Wales with number 1645201. Registered Office: 17 Doughty Street, London, WC1N 2PL • The British Thoracic Society is a Charity registered in England and Wales with number 285174, and registered in Scotland with number SC041209

www.brit-thoracic.org.uk