1. **Introductions and apologies for absence**
   Anne Ritchie welcomed everyone to the initial meeting of the Spirometry and Training Sub Group and introduced everyone round the table.

2. **Remit**
   Anne Ritchie introduced the remit and comments from the Core Group minutes were tabled.

   It was agreed that two service and training issues need to be covered.
   1. Spirometry specifically
   2. General COPD

   It is clear that the model for delivery of the diagnostic service must be agreed first then the training required to deliver it can be developed.

   The Group will then go on to develop the training required for the clinical management of COPD throughout the pathway. This will link with the training to implement the COPD booklet being developed by the guidelines group.

   The remit will be amended and recirculated to the Group.

**Hospital based spirometry**
Alastair Innes noted that Spirometry service in Lothian is behind other parts of Scotland and it must be done by fully trained staff. He described the service in the West of Scotland/Glasgow. He met with Roger Carter recently to discuss this. Trained physiologists rotate through hospitals and 12 sites within the community. Glasgow does 5000 diagnostic Spirometry tests for newly referred patients per year with 3 additional trained physiologists. They do 2 sessions per day, 4 days a week and spend one day on scheduling. Lanarkshire is starting up a similar service.
In order to meet capacity challenges, it was agreed that the high quality service would focus on first diagnostic referrals. Follow up Spirometry could be done in GP practices.

With regard to staffing, Jill MacLeod suggested that instead of requiring a 4 year training program to reach Band 5, you could recruit trainees and have them do 2 years of training to reach Band 4, and then they will be able to work within the community.

A possible model and costs for the whole of Lothian based on Glasgow was put forward by Alastair.

£60,000 staffing costs – 3 people at Band 4
£5,000 – overhead for report generation
£5,000 – other recurring consumables
£17-20,000 – non recurring cost for start up and equipment.

The current service at WGH/RIE has 13.3 wte physiologists and 1 wte at SJH. They offer 60 slots per month at WGH and 40 slots per month at RIE for GP access. They experience quite high DNA rates of about 20-25%. Ninian suggested these should be for diagnostic Spirometry only and not for follow up. There is no GP service at SJH for the 180,000 population that is serviced by that hospital and lack of physical space to provide a service. It is agreed that diagnostic spirometry should only be done by a trained physiologist. Reports should be in GP friendly language providing guidance on the meaning of Spirometry results.

It was agreed to put together a business case in time for the Lothian planning cycle. The deadline is 3 October 2008 but a draft is needed sooner, in September. AR, AI, NH, JM have agreed to work on this. Financial expertise will be sought. The case will include the problems with the status quo and the benefits of a redesigned service.

To support the case, AI will obtain a copy of the Glasgow business case. AR will obtain Lanarkshire’s business case.

Andy Robson will do a mini audit to see how many new cases arise each year. JC suggested we gather data to find out if admissions are inappropriate as a result of poor spirometry to back up the business case and also to make clear an approximate cost of money saved by taking this model forward. AI suggested looking at the Healthy Scotland Initiative for funding. If funding does not become available, we will need to add value and release efficiency. Too often people end up on prescriptions or exercise routines they don’t need due to faulty diagnosis.

**Community based spirometry**

Concerning general Spirometry in the community, the service review done by Innes Gentles had shown patchy results. Rose Bryan will forward the study report to the MCN Office. Shena Black noted that the spirometry done in GP practices is of variable quality and some are not safe. She sees a real need for standards to be put in place.
and asks what should be done in these practices with regards to the routine reviews and how to up-skill the staff.

AR wants the spirometry course at Queen Margaret’s University to be the minimum training requirement and she wants to see more GP’s attending. AI thinks there is not enough practical experience within this course. AB spoke of bidding for backfill money for training and AR believes this will make a big difference and is needed to backfill to train trainers and may be needed also for GPs. JC will contact David Blaney at NHS Education Scotland to talk about Scottish training and core competencies. JC said that British Heart Foundation has a model for heart failure which has worked well. A nurse goes around to every GP to discuss the issues with them and education is tailored to fit each practice. NH will explore pharmaceutical industry funding for this. NH said we need to make the case to GPs of why COPD is important and that they really do need proper training to be able to perform and interpret spirometry correctly. We will need to explain to them how it will enhance their care.

3. Date of Next Meeting
   Wednesday 29 October, 12:30-13:30, Seminar Room 5, MEC, WGH