Editorial

I shall be leaving North Bristol Lung Centre (NBLC) at the end of March 2012 after over 30 years working in Bristol, so it is interesting to reflect on how much we have developed, particularly in recent years.

When I started my Consultant post in the early 80s I was the only trained fibre optic bronchoscopist in Bristol. There were four consultants covering BRI, Frenchay, Ham Green, and Southmead Hospitals. Now there are seven consultants at NBLC and at the BRI there are six full time and four part time consultants. The Central Health Clinic at Tower Hill where we all did two clinics a week and ran an open access chest x-ray reporting service, closed in 1988 and Ham Green Hospital moved to Southmead in 1991.

One of the “jewels in our crown” has clearly been our admission avoidance “Hot Clinic”. This was originally developed at the suggestion of Professor Millar in 1996 long before the two week wait system and its success was reported in the national press. Unfortunately, the PCT at the time felt unable to fund it and so it was abandoned until the formation of NBLC in 2006. It is a very popular service with our primary care colleagues who use it frequently and last year our audit suggests that we saved over 700 admissions, quite apart from providing a senior opinion and rapid investigation service for the 1200 patients who will be referred this year.

NBLC has usually been at the forefront of developments and was one of the first in the region to obtain an oximeter(!), develop non-invasive ventilation and, more recently, medical thoracoscopy and indwelling pleural catheter insertion, (Nick Maskell), endobronchial ultrasound (Andrew Medford), and other interventional bronchoscopic techniques including auto fluorescence. We have developed specialist clinics in bronchiectasis (David Smith), interstitial lung disease (Ann Millar), and tuberculosis where we are fortunate to have considerable experience and expertise in TB (James Calvert and Begonia Bovill). James is also the south west regional lead for COPD. Our lung cancer service is led by Martin Plummeridge and is the busiest in the Southwest region with around 225 new cases annually. Martin also runs our Difficult Asthma clinic. Our famous pulmonary rehabilitation service (LEEP) at Frenchay was one of the first in the country and has been the source of very valuable research over the years, demonstrating the benefits of pulmonary rehabilitation, led initially by Roger White and more recently David Smith.

We also have 12 specialist nurses with expertise in rapid discharge, oxygen assessment, biological treatments for asthma, and interstitial lung disease. Led by our two academic colleagues we have a very creditable research profile. (See our presentation and publication list at the end of this report).

In the future we look forward to moving into our new hospital in the Spring of 2014, where hopefully we will have rapid access to a PET scanner, will be a recognised interstitial lung disease centre, and will also develop our interventional bronchoscopy role. We have exciting plans for developing early specialist review in the medical admissions unit and extending our admission avoidance Hot Clinic. More extensive use of consultant-led community clinics and telemedicine should also help reduce the number of emergency admissions. Following a recent, very successful, meeting with our colleagues at the BRI, we intend to have a much closer working relationship across the city in respiratory medicine, developing our mutual areas of expertise for the benefit of our patients in this part of the region. The future for NBLC certainly looks very exciting and appears to be well set for whatever challenges face us.

John Harvey
Wards

G ward (now operating on C Ward), like all areas, has had a very busy year and believe that we have achieved and maintained our high standards of care throughout that time. D Ward, in association with Corrine and Catherine, our senior respiratory physiotherapists, and G Ward senior staff, provide NIV training for the Trust.

The year was full of challenges, some anticipated and some not. We had an exceptionally difficult time with HDU patients but prevailed and eventually achieved safe discharges.

The changing face of Southmead continues to encroach on all our daily lives. The building work outside G ward’s back door is getting ever closer and higher. We shall soon be issued with yellow hard hats and asked to join in!

A change in working practices has also brought its own challenges and we endeavour to keep on top of these and be adaptable. We appear to be expanding our services more and more within the limited space that we have, but are pleased to be able to contribute to the great service provided by the whole Team.

Nursing staff, in particular, continue to improve their knowledge, education and skills by attending and completing post registration courses to enable them to enhance their practice within Respiratory Medicine. We are also rising to the challenge of managing the future skill mix and are encouraging our Health Care Assistants to increase their skills and train towards higher grades, supported by trained nurses. This is still felt to be an important aspect of day to day management of all staff and we continue to encourage everyone to attend as much as they can for the benefits of patient care and job satisfaction. They should all be congratulated for their achievements particularly as most of the work is done in their own time.

There have been several personnel changes with staff moving around within the service. This has enabled us to keep skills within the Department as well as giving staff the opportunity to gain different experiences. Some staff have moved away from Southmead altogether, and are still sorely missed. There are yet others who are expanding the population and who may well become our future!

As a team, we would wish to continue to provide a great service for the coming year and anticipate the new changes for the immediate future to be a challenge we will relish.

Interstitial lung disease at NBLC

The Interstitial lung disease service at North Bristol Lung Centre continues to develop.

Professor Ann Millar now provides a specialist ILD clinic in addition to a combine connective tissue / lung disease clinic in collaboration with Dr Harsha Gunawardena, consultant rheumatologist. These clinics are supported by lung physiology and the specialist respiratory nurse team, in particular Heather Lamb, enabling the provision of a “one-stop clinic” with consideration of oxygen therapy and liaison with the community and palliative care teams.

There is a now an active multi-disciplinary team meeting with radiology and pathology expertise which attracts referrals from the entire South Western region. There are more than 250 patients on our database and this is increasing exponentially. This is enabling us to support these patients in a more holistic manner. We are hoping to be at the forefront of care delivery for these patients as novel forms of therapy come on line.

Lung Function Unit

The well-established lung function unit continues to build on its success during the year. In addition to the standard lung function tests the unit also provides sleep studies, mannitol challenge testing, hyperventilation provocation studies, skin prick allergy testing, muscle testing, flight assessment and more recently, induced sputum analysis.

The unit continues to contribute both to the teaching of medical students and other health
professionals as well as being involved in a number of research projects.

The unit has seen an increase in the number of patients seen, approximately 4000 patients attended for testing during last year alone.

Although most of the patients originate from respiratory referrals we also see patients from other specialities including neurology, cardiology and ENT. Tests requested can range from simple spirometry for pre-op assessment to full muscle and diaphragmatic testing for patients with neuromuscular disease.

We are now joined by Mel from Musgrove Park, Taunton and Annette from Cardiology NBT – both bringing valuable experience into the department.

Jason Viner, Head of Physiology

**NBLC Hot Clinic**

Originally started by us 15 years ago, but then suspended when the PCT withdrew funding, it was reinstated in October 2006 as part of the service re-organisation for respiratory medicine in North Bristol. Its main focus has been as an admission-avoidance clinic.

Our Hot Clinic operates 5 days a week from 9am until late afternoon, with the last faxed referral being accepted in the early afternoon.

An analysis of our cases over a 3-year period shows us that the mean age is 63 (range 18 to 96!), with a male/female ratio of 45/55%. 2/3 are seen by a consultant and over ¾ are seen the same or next day. Until the end of 2011 we have seen over this period approximately 1700 patients, most of whom are threatening admission. In 2011 897 attended our Hot Clinic which saved an estimated 717 admissions. In 2012 we are heading for over 1200 patients which should save over 900 admissions this year.

The feedback we get back from our colleagues in primary care is extremely positive and we are proud of the service that we are offering.


**External Roles**

**James Calvert**

James Calvert was appointed as Respiratory Lead for the South West Strategic Health Authority in November 2010. Since being appointed he has taken a lead in developing care bundles in partnership with the British Thoracic Society. He has also been involved in the establishment of a South West Multidisciplinary network for COPD – activities associated with this have included development of a data dash board for the South West Public Health Observatory and organisation of two team building days in the South West to assist clinical teams in developing commissioning strategies for COPD. Over the next year he will be working with the pharmacy leads in the South West to develop appropriate training for pharmacists engaging in asthma medicine use reviews to improve patient compliance and practice in long term conditions management in asthma.

Professional & Organisational Standards Committee of the BTS
BTS Bronchiectasis Quality Standards
Trust COPD Discharge Audit.
Deputy Medical Director of NBT

**A.B. Millar**

Appointed as member of NICE IPF guidelines group
Awarded PHD studentship by Novartis
Invited speaker RCP of Ireland. Biological therapies in lung disease.
Invited speaker: Sheffield “managing difficult lung disease in the real world” conference.
Sarcoidosis

**David Smith**

Academy Dean, Bristol North Academy, University of Bristol
Training Programme Director, Respiratory Medicine, Peninsular and Severn Deaneries
Member of Specialty Workforce Committee, British Thoracic Society
Member of British Thoracic Society
Member of Standards of Care Committee, British Thoracic Society
Specialist of Advisory Committee for Respiratory Medicine, Joint Royal College of Physicians Training Board
PACES Examiner, Royal College of Physicians

Dr Andrew Medford
BTS Specialist Advisory Group: Interventional Bronchoscopy
Editorial Board for Thoracic Cancer and Respiration
MRCP Part 1 Question Reviewer

Dr Nick Maskell
Now an Associate Editor for Thorax
Editorial Board to British Journal of Hospital Medicine
Member of British Thoracic Society
Vertical Theme Lead for CAPS – Bristol Medical School
Royal College of Physicians Respiratory Exit Exam Writing Group

Martin Plummeridge
Avon, Somerset and Wiltshire Cancer Services.
Lung Cancer Site Specific Group
Member SW Regional Health Authority Acute Trust End of Life Care network
Royal College of Physicians national Asthma Deaths Audit

Pleural research
Bristol pleural CTU continues to expand and is currently coordinating/delivering 6 UK-CRN trials in the field of pleural disease. We are currently the leading respiratory centre in the UK in terms of the number of active pleural RCT trials being conducted.

The pleural research team currently comprises of Dr Nick Maskell consultant and research lead, Dr Amelia Dunscombe research clinical fellow, Dr Rahul Bhatnager research clinical fellow, Natalie Zahan pleural research nurse and Joanna Strickland research administrator.

Recent grants for pleural research include
TAPPS trial – Nov 2011 (3 years) NIHR - HTA £640,000 Poudrage vs Slurry talc pleurodesis in malignant pleural effusions. 6 centre study. Due to start in March 2012. 220 patients.
SMART – Sept 2011 (3 years) NIHR-fpb £242,000 Prophylactic Radiotherapy for mesothelioma 15 centres – Started recruitment December 2011 3/204 patients to date
IPC-STOP trial – August 2011 Industry sponsored - Care Fusion Indwelling pleural catheters and out-patient pleurodesis £140,000

Forthcoming Publications
Chest radiology – Editor of this book with M Darby and A Edey (in press)
ABC of pleural disease – Joint editor of this book (in press)
Pleural disease – book chapter for Medicine International A Dunscombe and NA Maskell (in press)
Chapter in decision support in medicine E book Malignant pleural effusion A Dunscombe and N Maskell (in press)
Iatrogenic pleural complications – Current Respiratory Care Reports A Dunscombe and NA Maskell (in press)

Pleural service and pleural trials unit
We continue to offer a reactive patient centred pleural service that offers a weekly pleural out-patient clinic, thoracoscopy and indwelling pleural catheter service. In addition to this we see any acute pleural problem the next day in the HOT clinic.

Audit data from the national BTS pleural disease audit 2011 put NBT in the top 5% of hospitals in the UK for its low complication rate and short length of stay for pleural problems

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Frenchay Hospital, LEEP holds two sessions of exercise and education each week over a 7 week program and also hosts a follow-up exercise class for graduates from the main course. This January the program is changing format to a rolling program which will allow patients to drop in and out at any point within the cycle. This will increase the numbers of patients we treat and allow us to begin to offer PR to patients straight after an exacerbation. We have continued to publish our experiences, with a full scientific paper and a further abstract over the last year. Approximately 100 patients each year go through our programme.

Publications


Medford ARL. Endobronchial Ultrasound: what is it and when should it be used? *Clin Med* 2010 10(5): 458-63.


Medford ARL, Edey AJ. A challenging case on the evening medical take (quiz case). *West Engl Med J* 2011 100(3):


Medford ARL. The utility of thoracic ultrasound (TUS) before local anaesthetic video-assisted thoracoscopy (LAVAT) in patients with suspected pleural malignancy. *J Clin Ultrasound* 2010 38: 222-5.


Bibby AC & Maskell, NA. ‘Pleural procedures: intercostal chest drains and indwelling pleural catheters’, *Br J Hosp Med (Lond)*, 72(6), (pp. 331-335), 2011.

Bucknall CE & Maskell, NA. ‘Recognising the importance of national respiratory audits’, *Thorax*, 66(6), (pp. 460-461), 2011.


Rahman NM & Maskell, NA. ‘Pleural infection on the increase but with a better evidence base to inform clinical care’, *Thorax*, 66(8), (pp. 649-650), 2011.


Hooper, CE, Lee YCG & Maskell, NA. ‘Setting up a specialist pleural disease service’, *Respirology*, 15(7), (pp. 1028-1036), 2010.


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Maskell, NA. ‘New directions in thoracoscopy: is the future fluorescent?’,* Respiration*, 80(3), (pp. 188-189), 2010.

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Medford ARL, Smith DL. Impact of centralisation of specialist services on sister hospital specialty opinion demand and consultant job plans. Clinical Medicine 2008;8,4:4-5.


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Maskell N, Millar AB Oxford Desk Reference of Respiratory Medicine (Editor and Sole Chapter author, Usual interstitial pneumonitis, Pulmonary manifestations of connective tissue disorders and Acute Respiratory Distress Syndrome ) Oxford University Press (2009)


Vascular endothelial growth factor receptor and co-receptor expression in human acute respiratory distress syndrome Andrew R.L. Medford, Nassif B.N. Ibrahim, Ann B. Millar. 

The role of IREB2 and transforming growth factor beta-1 genetic variants in COPD: a replication case-control study BMC Medical Sally L Chappell, Leslie Daly, Juzer Lotya, Aiman Alsaegh, Tamar Guetta-Baranes, Josep Roca, Roberto Rabinovich, Kevin Morgan, Ann B Millar, Seamus C Donnelly, Vera Keatings, William MacNee, Jan Stolk, Pieter S Hiemstra, Massimo Miniati, Simonetta Monti, Clare M O’Connor and Noor Kalsheker. 
*Genetics,* 12:24 (14 Feb 2011)

*Thorax* (2010); 65 (Suppl:2) ii17-ii30.

Master of Science in Medical Leadership and Management and its’ role in the current NHS. Bateman K, Barratt S and Harvey J
*Clinical Medicine* (2010); no 5, 477-479.

**Presentations**

2009: Royal College of Physicians ILD and the elderly

2010: Royal College of Physicians Red lights in Respiratory Medicine

Assessment of Hyperventilation Syndrome provocation testing and the Nijmegen score 
*American Thoracic Society 2010. Viner J, Harvey JE.*

A prospective observational trial examining the diagnostic utility of serum and pleural fluid procalcitonin in the initial investigation of unilateral pleural effusions 
*British Thoracic Society. 2010. Hooper C, Maskell NAM and Harvey JE*

Is serum n-terminal pro b type natriuretic peptide (nt-probnp) measurement useful in the investigation of unilateral pleural effusions? – a prospective observational study. A prospective observational trial examining the diagnostic utility of serum and pleural fluid 
*British Thoracic Society 2010. Hooper C, Maskell NAM and Harvey JE.*

*ERS 2010*

Bakere H, Sandrey V, Barr S, Smith DL. Long term maintenance following pulmonary rehabilitation (PR); effect on physical, emotional and educational outcomes. 
*ERS 2010*

Evaluating the impact of a rapid access respiratory clinic on the provision of care for patients with COPD – presented at the ERS 2010 (S. Barrett, J. Calvert)
