First meeting of the Cross Party Group on Lung Health
CR4 Scottish Parliament
1st November 2016 5.30pm-7pm

MINUTES

In attendance:
Emma Harper MSP
Mark Ruskell MSP
Anas Sarwar MSP
Maree Todd MSP

Jill Adams	Chest Heart & Stroke Scotland
Allison Brisbane	ASH Scotland
Katherine Byrne	Chest Heart & Stroke Scotland
Michelle Duffy	NHS Highland
Tom Fardon	Scottish Thoracic Society; Clinical lead Tayside MCN
Irene Johnstone	British Lung Foundation Scotland
Elaine Mackay	Greater Glasgow & Clyde Health Board
Linda McLeod	Breatheasy Clackmannanshire
Phyllis Murphie	NHS Dumfries & Galloway
Mark O'Donnell	Chest Heart & Stroke Scotland
Adam Osprey	Community Pharmacy Scotland
Krisnah Poinasamy	Asthma UK
Gordon Thomson	Braveheart
Claire Shanks	British Lung Foundation Scotland
Lorna Stevenson	Chest Heart & Stroke Scotland

Apologies:
Alex Cole-Hamilton MSP
Alexander Burnett MSP
Iain Small, National Advisory Group
George Chalmers, Greater Glasgow & Clyde Health Board

1. **Election of Office Bearers**

- Emma Harper MSP was nominated as Convener by Anas Sarwar MSP, and seconded by Mark Ruskell MSP.
- Emma Harper nominated Chest Heart & Stroke Scotland, and British Lung Foundation Scotland, as co-Secretariat for the group. Mark Ruskell seconded.

2. **Lung Health in Scotland: Irene Johnstone, Head of British Lung Foundation Scotland**

- In 2015 BLF published RHON, an epidemiological study which compared statistics about lung disease from across the UK. The report looked at how many people in the UK are affected by each of the major lung diseases and how the figures vary by age, gender, region and standard of living. It also reveals the impact lung disease has on health services, such as hospital admissions and bed-days. The report found that the incidence of some lung conditions was much higher that had been previously reported, and there has been an unacceptable lack of progress made.

- National Registers of Scotland statistics show the proportion of deaths from respiratory system diseases (for example pneumonia or chronic obstructive pulmonary disease) has increased from 11 per cent of all deaths in 1980-82 to 13 per cent of all deaths in 2015.

- In 2015 the number of deaths from respiratory system diseases (7,669) was greater than the number from coronary heart disease (7,142) for the first time. Urban Scotland, particularly around Glasgow, has the highest lung disease mortality rates in Britain – for instance, your chances of dying from lung disease in Glasgow City is nearly twice that of nearby Stirling, and nearly triple that of places like Kensington and Chelsea in London.

- Historic smoking rates are the biggest factor in this, and the impact of heavy industry is also a significant factor – tellingly, Scotland has higher rates of less common lung conditions such as pneumoconiosis, which are usually caused by inhaling dusts and chemicals in the workplace. Various parts of Scotland, notably those with a history of shipbuilding, also have high rates of the asbestos-related cancer mesothelioma.

- Scotland also has among the highest rates in the UK of conditions such as asthma, sarcoidosis and idiopathic pulmonary fibrosis (IPF) – the reasons for this are less clear, as we don't know what causes these conditions. Since 2004, Scotland has had the 3rd highest number of COPD diagnoses of the 12 UK regions.

- Key messages from a recent round-table meeting of representatives from Scotland's respiratory/academic/public and social care community were:

    i. We have the will but we don't have the way...(evidenced by the exemplary practice and research)
    ii. We need more genuine engagement from Government

iii. We need a stronger partnership in respiratory health that should include amongst others public health, pharmacy and informatics
iv. We need support to implement and develop value based services and or stronger value based propositions.
v. Lung Health not long disease must be the focus (prevention /education eg air pollution/ environmental policy decisions)

- Dr George Chalmers posed the question, "Who is looking after Scotland's lungs?" A key role of the new Cross Party Group will be to help address that.

3. **Why we need a Cross-Party Group on Lung Health: Mark O'Donnell, Chief Executive Chest Heart & Stroke Scotland**

- The scale of the resource challenges for the NHS caused by respiratory illness are stark, with 100,000 hospital admissions and half a million bed-days as a consequence of respiratory conditions. The integration of health and social care creates the conditions to bring about real change – and must drive improvements on managing lung health.

- Inequalities in tackling respiratory illness are enormous, with uneven provision of investment and prioritisation across Scotland.

- The new group needs to focus on what action can be taken, both individually and collectively in order to influence change.

4. **Group discussion**

Members were invited to comment on the proposed Aims, Objectives, and Outcomes for the Group.

- A draft National Respiratory Quality Improvement Plan has been developed by Phyllis Murphie and Iain Small. The plan includes a focus on primary prevention, pulmonary rehabilitation, and access to care. The draft framework needs input from Scottish Government's Health Department, and the CPG will provide a forum to help with this. It was noted that a dedicated Respiratory Taskforce should complement this.

- Developing an Improvement Plan would support the ambition for Lung Health to become a National Clinical Priority for the Scottish Government. (IJ)

- The issue of the cost to the NHS from respiratory conditions could be added to the aims of the CPG. (M O'D) [Note – added to Objective III]

- The aims of the Battle for Breath report should be at the centre of the CPG's work. (PM)

- The group can help demonstrate to Scottish Government how we can support change, there are examples of successful work across the country (eg Community Respiratory Teams in Glasgow and Dundee) but these need to be replicated. Need to focus on key themes, not individual conditions. (IJ)

- The group's objectives should include the need to influence the NHS in identifying waste and disinvesting in treatments which are proven to be ineffective. (GT)

- The group needs to increase political awareness by being clear about what it will do, and be solution-focused. (KP)

- Important to note the Scottish Government has moved away from single health issues as priorities towards issues such as health improvement, multi-morbidities etc, and so there may be resistance to respiratory disease becoming a National Clinical Priority. A National Taskforce with high-level leadership would underpin delivery of a Lung Improvement Plan. (M O'D)

- Purpose of group to help position lung health as an equal partner with other health issues such as stroke and heart disease. (M O'D)

- Important to firstly articulate the compelling need for this prioritisation, and also learn from other areas where there has been successful improvement, such as tackling heart disease. (IJ)

Discussion then focused on some key emerging themes:

<u>Efficiency and equity of services</u>

- Cost of respiratory disease to NHS is critical, bed-days are cheap compared with expense of drugs, some of which are prescribed unnecessarily and proved to be ineffective yet the NHS finds difficult to disinvest in at a national level. Some Health Boards have been effective. (TF)

- Interventions like smoking cessation or pulmonary rehabilitation are highly cost effective in tackling COPD but are not equally available across Scotland. (PM)

- Importance of national action to tackle local variation in practice. (MD)

Coordination of services

- Research into lung disease needs to be better coordinated across Scotland. There are challenges because of the relatively small scale of some diseases. A coordinated national network is needed which identifies where expertise is sited. (TF)

Prevention and protection

- Scotland currently has no occupational lung specialists, unlike England which has local centres, and needs a national centre. Issues around exposure to harmful substances in the workplace are therefore not tackled here. (TF)

- Important to widen the debate around health promotion and healthier lifestyles, to include air quality, smoking, targeting areas where inequalities lie. (MR)

- Importance of acknowledging the harmful impact of second hand smoking, both in causing and exacerbating conditions. 48% of people living with illness or disability are smokers. A culture change is still needed. New legislation about smoking in the perimeter of hospitals, and preventing smoking in cars (comes into force on December 5th) (AB)

Digital optimisation, informatics and data

- ISD Scotland's data could be used to support people in making decisions about their care – not just for NHS. (IJ)

- Importance of telemedicine and for rehab (PM)

5. **Next steps**

- Important that Primary Care is fully represented in membership of the CPG. GPs are spending as much as a third of their time on patients with respiratory illnesses. Also important the membership has representation from Health Improvement Scotland and those dealing with health inequalities.

- Members need to target where they can influence and lobby to bring about improvements. (M O'D)

- EH noted the new Air Quality sub-group of the Environment Committee, and the scope for her to take issues to that group. As a member of the Health & Sport Committee, she can also drive forward messages about the issue of lung health.

- To reflect the Scottish Government's approach, the CPG should look for opportunities to have joint meetings with relevant CPGs, and seek involvement of Ministers or senior officials. (MR)

- Possible outputs from each meeting include reports produced each time for lobbying and wider messaging purposes. Meetings need to be action-focused where possible.

- Following formal registration of the CPG, aim to hold 4 meetings over an initial 12 month period (approximately January/February, April/May, September, December).

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