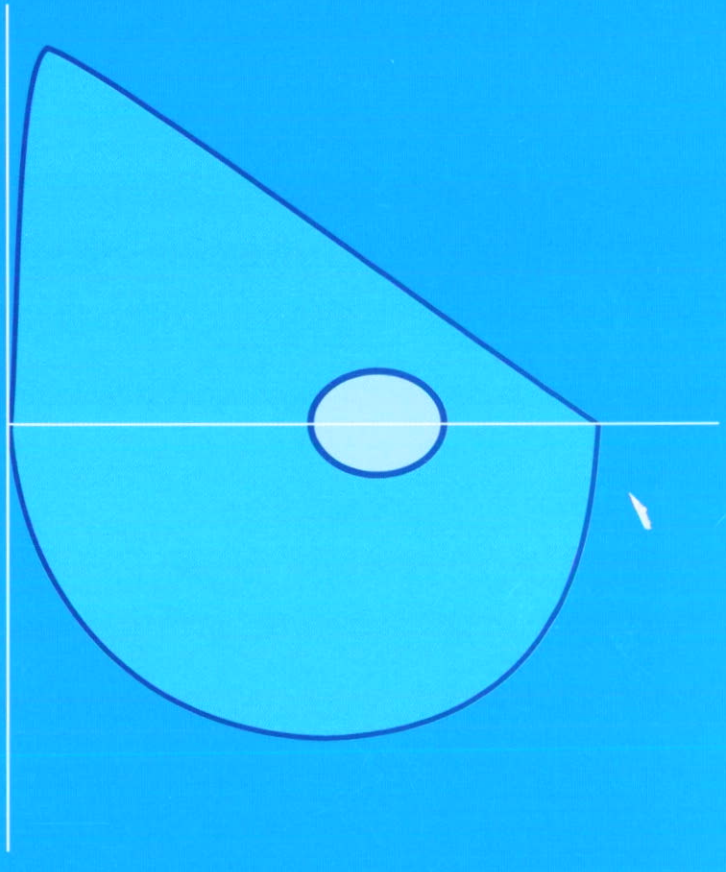
Vol. 6 No. 1 Feb. 2005

Inspire



www.artp.org.uk

The Official Journal of the Association for Respiratory Technology & Physiology

Inspire

The Official Journal of The Association for Respiratory Technology and Physiology

ISSN No. 1473-3781 ***Registered Charity No. 2900907***

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FIRST WORD

I suppose I should start this column by introducing myself. About two months ago I received a telephone call from our esteemed Chairperson which started as follows: ".....The answer to the following question is "yes".....". Two minutes later I put the telephone down as the newly installed Editor of Inspire. That man could sell ice-cream to polar bears. Some of you already have the misfortune of knowing me, and I have no doubt the rest of you will get to over the next few months. I have worked as a Clinical Scientist in the Respiratory Function Service in Edinburgh for nearly ten years now, after spending the previous eight years in London engaged in research, into a variety of obscure areas of respiratory physiology. I am looking forward to the challenge of preparing the Journal for publication, but I haven't done anything like this before so I hope you will bear with me while I find my feet. I must thank Gill Butcher for her endless patience in answering my increasingly frantic emails over the last few weeks asking her how to put a Journal together. I will be making a few changes to the style of Inspire over the next few months, but nothing too drastic. I hope you will like them, but if you don't please let me know – I do have a thick skin. This is your Journal – if there is anything you would like to see in it that is not there already, just let me know – my contact details will be at the end of the column.

As I write this I am still recovering from the jetlag resulting in flying back to Edinburgh from Birmingham, where I was at the Heads of Department meeting. It was nice to see so many of you there – I hope you found the meeting as inspiring (sorry!) as I did.

This issue of Inspire should reach you just before the 2005 Annual Conference in Glasgow. Christine Downie and I have prepared a Rough Guide to the city, which we hope will come in handy for those of you making the trek north.

Regards,

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THE ERS SPIROMETRY TENT

by Dr Brendan Cooper, Chair, ARTP

It all seemed a good idea at the time. Spend two days in George Square in a tent in the centre of Glasgow and measure spirometry as part of a huge PR campaign on behalf of the ERS. At last the communication machine between BTS and ARTP swung into action. Volunteers were offered free ERS registration in return for two sessions measuring Glaswegians in the heart (or was it lungs?) of their home. (A week later the same tent hosted the Whisky Festival – talk about getting your timing wrong!) Many showed interest and after several attempts Sheila Edwards at BTS had a rota up and running.

Most of us flew up the day before to attend the excellent Primary Care Conference which offered lively debate, some nonsense about "quantity over quality" in spirometry from a Dutch GP and a chance to sample the genteel Friday nightlife in Sauchiehall Street.

Ah yes, Sauchiehall Street, that beautiful tree-lined wide, boulevard with pavement cafes, street theatre, were sophisticated couples strolling arm-in-arm discuss the arts, philosophy and meaning of life……! O.K. we stepped over the teenage junkies who begged for cash and hurled abuse that would make your alveoli curl. Even younger gangs of girls arm-in-arm seven across, marched along, midriffs in full sail with piercings and designer everything, singing the latest "hip hop bop til ye drop" offering, kicking Tennents lager cans to death before stopping the traffic and teetering across the road in a gaggle of laughter. To be honest it wasn't that shocking – it reminded me of Liverpool, Newcastle or any other city centre on a Friday night, but because it was Glasgow, it was a bit more extreme, it had energy, life and an air of outrageousness – it was fabulous.

After breakfast the next morning we gathered in the Spirometry Tent, a large white marquee, which by 9.15 on Saturday morning already had a queue outside it. Hang on! It's Saturday morning? (a) What are people doing up at 9.15? (b) Why are they in town (high risk of shopping or spending money, etc.) and (c) why did they want to perform spirometry?

The local press took some pictures and the odd TV and radio reporter collected some human interest feature on Hamish Mc Togglewinky, who'd hiked backwards from Tomintoul with his pet shrimp called McBert in a jam-jar on his head. With 10 booths available (ARTP manned 6 of them) and the doors were opened.

What followed was a frantic physiological jamboree of inspired expiration! In the first hour over 50 spirometry tests were performed. We weren't counting, but ARTP did the bulk of those!) Ten minutes into the session the first drunk attended. Not bad, 10.10 on a Saturday!

The stories that came out over the two days were both funny and tragic. One chap pinned the supporting doctor down for 40 minutes because he had been diagnosed with lung cancer 4 days before. An eighty four year old had become concerned about his breathlessness on exertion – when he went mountaineering on his own! A seventy four year old lady was delighted she was above her predicted range and confirmed she would continue ice skating as usual!!

The spirometers we used were open flow measuring devices. One chap blew so hard that his single tooth on a plate flew out of the device and hit the wall of the tent with a loud "sphut". Without blinking an eye, he walked across, picked it up wiped it on his coat popped it back in and continued the tests. The operator recalled later how she could barely keep her face straight and pretend nothing had happened.

It was a privilege to meet the people of Glasgow, and indeed beyond Glasgow. One couple caught the train from Edinburgh especially for the tent because they had seen it on the news! People worried about their results and ARTP staff and others were on hand to explain the results and put their minds at rest. No such pampering for the smokers! I asked one punter if he was prepared to work all his life and then give up his whole pension to me? His reply involved a few "f"s and "b"s, but he appreciated my point when I explained about his obviously heavy smoking habit.

Most people accepted the good advice. In 2 days over 1000 tests were performed to excellent standards. The data is yet to be analysed and downloaded, but it was estimated that about 40-50% had abnormal lung function (figures to be confirmed).

George Square is a fairly unique place. One local drunk was very perturbed that the benches that he patrolled, were taken up with people in ERS sweatshirts, eating lunchboxes and enjoying the warm September sun. At one stage he took his shoes and socks off to rail at the world in his bare feet. On Sunday morning a young drunk was sitting up asleep on another bench with a Rizla paper in one hand and some "baccy" in the other – frozen in a drunken stupor. (come to think of it …. had I seen him at ARTP functions before?).

So was it all worth it? Well, I had the easy job, "being on hand" and doing the odd spirometry, but the ARTP and nurse grafters who did a fabulous job all seemed to enjoy the experience immensely. Yes it was hard work but it raised the profile of COPD and showed that mass spirometry performed by experts to be possible, useful and practical in this Public Relations environment. Even more, it showed to me that we **could** sell mass spirometry in the High St in a similar way on behalf of the NHS. It required good organisation, experienced, trained experts and the back up of a physician and a smoking cessation service.

Although hard work, spirometry can be fun. We all ought to think about using spirometry in public as the "shop-window" of our profession. Raising awareness and our professional profile may help the public realise how important we are to screening public health.

Below is a list of all those who participated. On behalf of ARTP and the profession everywhere – **THANK YOU**.

Thanks to the following people for donating time to staff the ERS Spirometry Tent:

Cath Billings
Gaynor Black
Sue Charlesworth
Sarah Dempsey
Isobel Dundas
Donna MacFarlane
Georgina Martin
Clare Newall
Barbara Oatway
Lindsey Paddison
Maggie Freer
Sue Gray
Kay Holt
Nick John
Adrian Kendrick
Jane Leyshon
Julie Lloyd
Jo Riley
June Roberts
Joanna Shakespeare
Ruth Stearn
James Stockley
Jenny Till
Arlene Wishart

"ON THE BLOWER"

By Alan Moore, Nigel Clayton and Brendan Cooper

Do you have a leak?

How often do you check the condition of the rolling seal inside your spirometer? Like all rubber products, latex will deteriorate with time and small holes can develop within the rolling seal. Even the smallest hole will increase the FRC measurement when using helium dilution. Steve Webb at Ferraris Respiratory recommends that the seal should be inspected at the annual preventative maintenance visit and replaced every two years. (NC)

MHRA Medical Device Alert Ref MDA/2004/052

An alert was released on 1 December to all users of Precision Medical mouth pressure meters. When reassembling the meter following decontamination it is important that the clips retaining the circular one-way diaphragm valve are present and securely fitted. If not there is the possibility that loose components may be inhaled by the patient when performing the Maximum Inspiratory Pressure (MIP) measurement.

Please note the MHRA report does not specify which model is being referred to as not all of them feature the removable diaphragm assembly. (NC)

BREAS PV10 update

Breas have released new internal software which can be downloaded from PC to Flash RAM which is claimed to solve the pressure resetting problem which resulted in the Medicines and Healthcare products Regulatory Agency (MHRA) issuing a safety bulletin following pressure from ARTP. Users can either perform this upgrade themselves using a simple piece of software and a serial cable connection supplied by Vital Signs or the devices can be returned to Vital Signs for upgrading. Contact Vital Signs direct for further details. (AM)

Radiometer acquired by Danaher.

In September Radiometer announced that they had been acquired by a company based in the United States. The Danaher Corporation designs, manufactures, and markets industrial and consumer products throughout the world.

Radiometer was established back in 1935 when they made measuring instruments for the radio industry. In 1954 Radiometer collaborated with Dr Poul Astrup to develop the world's first acid-base measuring equipment. In 1959 the Astrup trolley was introduced, allowing hospitals to make measurements of PO_2, pH and PCO_2.

I can remember using this instrument when I first started working at Wythenshawe Hospital many years ago. A blood gas measurement, including manual calculation of PCO_2, base and bicarbonate, would take between ten and fifteen minutes to complete. All electrodes were calibrated manually and the results displayed on what could best be described as a large voltmeter. In 1973 Radiometer introduced the worlds first fully automated blood gas analyser. This was a joy to use compared to the technology of the 1950's.

Since then Radiometer have gone from strength to strength and have just announced the release of the ABL 800 flex series of blood gas / electrolyte analysers. Based on the 700 series it now features a faster processor, improved software, built in bar code reader and all models come with built in automatic quality control.

Radiometer have assured me that customers should not notice any change in the quality of service. Let's hope that Danaher allow Radiometer to continue building their illustrious history for many more years to come. (NC)

Profile Respiratory Systems acquired by Respironics.

Yet another takeover in the respiratory market. For the last fifteen years Profile have been selling the Respironics range of sleep and ventilation products throughout the UK. Profile must have been doing a good job as Respironics has now decided to buy them out.

I have been informed that the products and staff will not change and the company will still trade as Profile Respiratory Systems Ltd. Contact numbers and address also remain unchanged. (NC)

Centralised spirometry from Vitalograph

Vitalograph have just released "Centralised Spirometry", a software package aimed at centres performing clinical trials. It enables spirometry data to be transmitted to a data management site for expert quality review and feedback. By encrypting the data it allows secure patient data transmission via the internet. One aspect of the software that I like is that it forces the testing site to calibrate the spirometer daily. It also stores all test data (good and bad) so that the management site can assess the test quality performed by the trial centre.

I can see another possible use for this software between primary care and secondary care. With the introduction of the General Medical Services (GMS) contract, more and

more spirometry will be performed in primary care. To ensure data quality and report quality, some primary care trusts are asking if they can send their data over to the local lung function laboratory for review. This would seem like an ideal application for this type of software. (NC)

Izzy Wizzy lets get VISI

Stowood have just announced the release of the Visi-3 sleep system. Competitively priced, this is a full sleep screening system which does not require EEG. New features of the latest system include a microphone calibrated in dB, an oximeter using Masimo technology, airflow by pressure and wireless digital video. (NC)

Micro Medical Super Spiro and Spida Expert

The latest version of the Super Spiro spirometer is now on the market. With data storage of 32MB it allows up to 2500 complete test sessions to be stored. The colour screen now features touch screen icons to simplify use.

Micro Medical has also released the latest version of Spida software. This is an interpretation and diagnostic spirometry software package which automatically assesses the quality and reproducibility of the spirometry test. Sounds ideal for use in primary care and is compatible with all Micro Medical spirometers. I wonder if it will log daily verification data? (NC)

Somno screen updates

S-med have just released the latest version of software for the Somnoscreen sleep system. Many new additional features have been added including remote monitoring from any internet/intranet PC (where security allows), CPAP analysis module for calculating TV/MV/BF and a new portable version designed to run from a notebook. This software upgrade is available free of charge to all current users of the system (other manufacturers please take note). (NC)

New from Ferraris

Ferraris have now launched the Collins Eagle modular PFT system in the UK and the revised CPL software has some impressive features, particularly the report generator.

Also new on the market is a portable spirometer – the KoKo Legend. Ferraris are also the first company in the UK to have an electronic monitoring spirometer available by GP prescription via FP10.

Ferraris now offer a P.A.S.A. (Purchasing and Supplies Agency) approved leasing scheme. (AM)

News from Viasys

The next generation of VMax systems is now shipping into the UK. VMax Encore is a single module which, in addition to existing tests, offers IOS and APS as options. Both VMax and Jaeger systems now have new 32 bit software interfaces. A new portable spirometer, Flowscreen II which is based on a Hewlett Packard Deskjet Printer will be shipping into the UK in the New Year. The display screen and keyboard are fitted into the lid of the printer and patient data is stored on Compact Flash cards and is importable into both VMax and Jaeger databases. Also shipping shortly is the Somnostar Pro software which delivers a common software platform for Jaeger and SensorMedics sleep systems. (AM)

If you are using the original Vmax legacy system and considering a PC upgrade to Windows XP – BEWARE! The original Vmax software will not run under XP. Whilst upgrades were provided free of charge under older operating systems, Viasys have decided to charge for the XP upgrade. On the surface I have not noticed any significant benefits provided by the new software, however I'm sure Viasys will beg to differ. (NC) A report on our meeting with Viasys follows "On The Blower".

News from Pulmolink

Again, innovation is at the forefront and Pulmolink now have available a portable spirometry system from Medisoft which is Bluetooth enabled; i.e. no cables between pneumotachograph and PC.

No doubt we will see a "rash" of Bluetooth enabled devices hitting the market place within the next 12 months, followed shortly by devices which will be able to take advantage of wireless networking capabilities within departments. Exciting times indeed ! AM

In the last edition of *Inspire* I mentioned that Shielder Medical had entered the filtration market in the UK. These filters are competitively priced and are now available through Pulmolink. (NC)

And finally.....

ARTP Watchdog has had a good year working not only with manufacturers, but also with MHRA. ARTP advisors have produced two safety bulletins (one on the Precision Medical mouth pressure meter and one on the Breas 102 CPAP device problems) with the MHRA. This advice was helpful to both manufacturers and users. This healthy partnership continues as we try to inform manufacturers and users of changes and problems that arise from time to time. The ARTP Manufacturers Liaison Committee is considering plans for the ARTP Equipment Users Survey sometime in 2005. Like the J.D. Power surveys of new cars we will try to capture the leaders and laggers in sales, service and good practice in lung function equipment. (BC)

It looks like the ARTP Chairman's Thank You speech at the Conference Dinner is going to be more difficult this year without any Morgan Medical representatives present. I have been browsing the Ferraris brochures and found not a trace of the Morgan name at all now – although I recognised the "patient" in the wheelchair as none other than Roy Kernahan, that stalwart of Morgan days. But who knows which company will receive the banter this year. Have you all really been receiving a good service from every company? Let us know! (BC)

If you have an issue with quality of service provided by any company please contact the Manufacturers Liaison Committee either via the ARTP Administration address (on inside front cover of *Inspire*) or by email to watchdog@artp.org.uk. Nigel can be contacted by telephone on 0161 291 2406 and Alan on 0121 507 4098. It is only with your help that we can hope to improve the quality of service provided to us by manufacturers throughout the UK.

Manufacturers Liaison meets with Viasys Healthcare, December 2004

By Nigel Clayton, ARTP Manufacturer's Liaison Officer

Following on from our meeting with Ferraris in August, ARTP Manufacturers Liaison have now met with Viasys to discuss important issues regarding quality of service and training.

Brendan and myself met with Mahboob Raja (International Group President, Viasys Healthcare) to discuss the new structure of the company and how it aims to improve the quality of service provided to our members. Raja filled us in with details regarding the restructuring of the company over the last three years and explained that Warwick is now the international operations centre for the company.

The number of service engineers serving the UK was our main cause for concern. Just four respiratory engineers serve the whole of the UK with backup from two critical care engineers. Feedback regarding the time taken to respond to equipment breakdown was the main concern voiced by the membership and would suggest that the number of engineers is too low to provide the quality of service which we and our patients expect.

Raja would not be drawn on this issue, however he did state that a customer relation management system (CRM) was due to be introduced early in the New Year to log all customer calls and allow Viasys to closely monitor all call response times. This system will be released globally and will allow the CEO to check all aspects of service quality throughout the world. Manufacturers liaison would welcome as much feedback as possible from the ARTP membership relating to the quality and efficiency of service provided once this system is in place.

Training was next on the agenda. We requested that Viasys provide a full one-day training package with all major equipment purchases. A product specialist rather than the installation engineer should deliver the training. Raja acknowledged that this was a reasonable request however he did not know how many training specialists were available in the UK. Raja stated that training could also be provided at the Viasys training centre based in Warwick.

We then discussed training programmes which may be delivered from the training centre in Warwick involving specialists from within the ARTP. The training centre could be utilised to offer postgraduate training in specialist areas of respiratory physiology such as exercise physiology, body plethysmography, oscillometry etc. Raja took this on board and stated that Viasys would be keen to be involved in such an initiative.

Towards the end of the meeting Raja stated that he wishes to establish a forum with other manufacturers in the respiratory field to discuss such issues as database platforms. This is relevant to us all with the implementation of the Electronic Patient Record due to be rolled out in the not too distant future.

We asked about future developments within the company. Trade secrets were not forthcoming, however Raja did state that Viasys are investing more in obstructive sleep apnoea therapy and further consolidating the Jaeger/Viasys software and hardware platforms. Research and development are also to be centralised.

DATES FOR YOUR DIARY

February 24th – 26th
ARTP Annual Conference, Thistle Hotel, Glasgow

April 8th & 9th
Joint ARTP/ARTI Meeting, Cork

April 2005 (date to be confirmed)
ARTP Scottish Forum Spring Meeting, Aberdeen

June 28th –30th
COPD 5, Birmingham International Conference Centre.
www.copdconferences.org

30th June – 1st July
British Thoracic Society Summer Meeting, Newcastle.

GLASGOW – A ROUGH GUIDE

by Andy Robson (Editor, Inspire) and Christine Downie (Scottish Forum Secretary)

After five years of subtle persuasion (!) the Scottish members of the ARTP have managed to bring the ARTP Annual Conference north of the border. As a result we feel that we need to make sure that members enjoy this Conference as much as possible, so that we will find it easier to bring the Conference back! Glasgow is a fantastic city, and you are guaranteed to have a good time. To help you on your way we have put together a quick guide to the Dear, Green Place.

A little bit of history

There has been a settlement on the banks of the Clyde since the early 6th Century when St Kentigern set up a religious community somewhere in the vicinity of the current site of Glasgow University. Glasgow received a Royal Charter in 1175 and after that the place really started to develop. There has always been a strong association with the sea and Glasgow in addition to developing as a major port, there has been a long tradition of shipbuilding, especially after the Industrial revolution. Glasgow suffered badly during the Depression of the 1930's but since the late 1970's the city has reinvented itself into the modern, vibrant city it is today.

Getting there

The Conference is based in the Thistle Hotel, which has the great convenience of being in the heart of the city. It is easily accessible by road, rail and air. If you are coming by train, it's likely you will arrive at Glasgow Central, which is only a short taxi ride from the Thistle. If you are flying in, make sure you are coming into Glasgow International airport, which is on the outskirts of the city rather than Glasgow Prestwick, which is actually closer to Belfast than Glasgow. There is an Airport Link bus from International about every 15-20 minutes, which will drop you at Buchanan Street Bus Station, which is only a short walk from the Thistle. If you do end up at Prestwick there are a couple of buses, which take about 90 minutes to get into the heart of the city or a train, which takes about 45 minutes. Both train and bus services are fairly frequent (at least hourly).

Outside the Hotel

Of course, the main reason for coming to Glasgow is to attend the Conference, but all work and no play…….. For retail therapy, the nearest place will be the Buchanan Galleries, a vast shopping mall about 10 minutes walk from the hotel. There are plenty other shops on Buchanan Street and Sauchiehall Street – enough for even the dedicated shopaholic. Anybody interested in the Art Deco period should head for the Willow Tea Rooms at 217 Sauchiehall Street (it's on the first floor, above a shop). The rooms were decorated and furnished by Charles Rennie Macintosh, Glasgows' foremost designer of the early 20th Century. What you see is actually a reconstruction of the original rooms, which were closed for nearly 50 years. Those of you after a cultural hit could try the Royal Concert Hall on Killermont Street or the magnificent Burrell Collection in Pollok Park – it's a bit of a trek, but worth it.

Parliamo Glasgow?

Glaswegians have their own language – part Scots, part Gaelic, part Martian. Here are a few useful expressions, with their translations:

Weather

The rainzcummindooninbuckets	It is raining very heavily at present.
Saffnoo	The rain has now stopped.
Rainzoanagain	It has started to rain again.
Saffykolraday	It is very cold today.
Rasunzoot (rarely heard)	The sun has come out.
Swaarmthaday (never heard)	It is warm today.

At the Gala Dinner

Dyewaantyereyesback?	Please don't stare at me.
Gonnigeez……..	Please may I have a …….
Jiwanni dance?	Would you like to dance?
Wherzalavvi	Could you direct me to the washroom please?

At the AGM

Maheidsburstin	I have a bit of a headache
Jiwaantacuplasprin?	Would you like some painkillers?
Moanfuracoaffy	Dr Coopers' introduction seems to be longer than ever -would you like to join me for a small latte?
AhmdeeingeezaBruquick	I am really feeling quite queasy. Could I have some Irn Bru* please.

** Barr's Irn Bru is the best know restorative after a few shandys too many. It is available over the counter without a prescription.*

WORLD COPD DAY 2004

World COPD day 2004 was used by the British Lung Foundation (BLF) to raise awareness of the symptoms of COPD, promotion of spirometry as a diagnostic tool for the identification of COPD and also to promote BLF activities related to COPD.

The first such event was held in 2003 and was not exactly the success that was envisioned. A number of Superdrug pharmacists had been trained (apparently) how to perform spirometry and were offering this as a free service to anybody who cared to turn up. As you may remember, this ruffled a few feathers within the ARTP and as a result, the ARTP became involved in the preparation for the 2004 event at a much earlier stage.

Superdrug pharmacies were again involved in the event and a number of their pharmacists were given spirometry training by members of the ARTP. Interestingly, in feedback from the pharmacists after the event many of them stated that they had enjoyed the training and some claimed that they would be willing to offer spirometry as part of their routine services (this may open up a whole new can of worms however…). Out of the 20 participating stores, some were very quiet with little interest in the additional services available but most were kept busy throughout the event. In some areas there was little local media exposure and this probably helped keep numbers low. (As you will see from Brendan Cooper's article on the ERS Spirometry Tent in Glasgow, good publicity works wonders in these events – Ed.). Anybody who was tested and was found to have abnormal results were given a letter and advised to contact their GP's for further investigation. Of the 20 stores reporting one in Croydon had a significantly higher rate of abnormal tests compared to other store locations. Is the population of Southwest London really in such bad shape?

On the whole, the 2004 World COPD Day events were much more sucessful than in 2003. A number of local Breathe Easy groups (local BLF member groups) were involved in manning information stalls and a large number of BLF information leaflets were handed out. The event will be repeated in 2005 and it offers another opportunity for the ARTP and it's members to publicise the profession as a whole. More information on the plans for World COPD Day 2005 will be released throughout the year – keep your eyes peeled!

A POLL OF VOLUNTARY REGISTRATION IN RESPIRATORY DEPARTMENTS

by Keith Butterfield, Vice Chair, ARTP

At the National Heads of Department Meeting at the Telford conference in January great concern was expressed at, what appeared to be, the poor take-up rate for voluntary registration. This register has been open for over 3 years and despite much publicity there still seemed to be less than half the practitioners expected on the register.

When the network group facilitators met later that day this was discussed at length and it was decided that a national poll may answer some of the questions. This was carried out via the Regional Network over May to August 04 – though this is not strictly a snapshot of a single point in time the numbers being processed as new registrants over this period would not affect this overall picture too much.

Departments providing a respiratory service were polled and were not asked to make a distinction between whether the individual practitioners role was purely respiratory; hence the figures presented here will include some single speciality cardiology practitioners.

Complete coverage of all UK departments was not achieved, however 183 of the estimated 248 labs in the UK were included comprising 817 MTO grade practitioners. There was no return from the North West region otherwise all regions managed to poll all, or nearly all, of the departments in their area. The 2003 ARTP Survey estimated that there are currently approximately 967 MTO posts in respiratory labs.

Results

Of the 817 practitioners polled 370 (45%) reported that they were already on the RCCP voluntary register. By measuring themselves against the basic criteria *(Table 1)* 163 (20%) of those who were not on the register were eligible to apply and 254 (31%) declared that they were not eligible. The status of 30 (4%) practitioners was unknown.

Of the 254 considered ineligible, 188 (74%) had less than 4 years experience and so must still be in a training post or gaining experience. 52 (21%) were ineligible by reason of having <6 years experience - these people would therefore not have the relevant qualifications specified by RCCP and would have to apply under the 'grand-parenting' route. 14 (5%) only performed a limited range of procedures these were however mainly ATO's.

When the 163 who could apply but were not yet on the register were asked 38 (24%) said that they had already applied. 108 (66%) said that they intended to apply. 17 (10%) did not intend to apply.

There was no registered practitioner in 40 (22%) of the 183 labs polled.

Discussion

It would appear that the original concern that less than half of respiratory practitioners had registered was not well founded. Among those practitioners polled, 70% of those eligible to apply for voluntary registration have already done so with a further 7% already in the process of applying. The vast majority of the others that are eligible expressed an intention to apply; predicting that RCCP can expect at least 108 further applications from respiratory or cardio-respiratory labs.

The lack of a definite cut off date for the formal changeover was quoted as a reason for delaying application - "we're just going to wait to see what happens".

The main reason for ineligibility is lack of clinical experience with three quarters of those having less than 4 years, implying that nearly 30% of the workforce are still 'earning their wings'!

The main reasons given by those not intending to apply, even though eligible, was that they were close to retirement. Some of the more honest said they didn't want to register as they didn't see why after years of service they now have to justify doing their job on paper. One department reasoned; "Our Trust probably won't do anything about it because they still need technicians to work. If none of us register then we will all be in the same boat. What are they going to do, close the whole department?!" In response to this it should be noted that the Department of Health recently issued a statement/warning to trust Chief Execs about employing non-registered Biomedical Scientists so it is expected that the same sort of pressure will be applied to all registerable staff in future.

The fact that over a fifth of labs did not have a single registered practitioner is a worrying statistic. In future, under state registration, it should be expected that each respiratory lab is under the lead of a registered practitioner in clinical physiology. This statistic may have been a result of lack of urgency due registration currently only being voluntary but maybe, despite the copious publicity by the professional bodies, the message has still not reached some labs. Hopefully this poll will have, at least, alerted the majority of labs.

About Registration

There does *still* seem to be a little confusion regarding cardio-respiratory practitioners with people from different regions reporting in the survey that while they are already on the voluntary register following either a cardiology or respiratory application they also intend to make an application for registration in the other speciality. This is not necessary. RCCP Registration covers practice in any Clinical Physiology discipline regardless of the discipline under which you originally applied. Of course, this does not automatically make you competent to perform any CP procedure without appropriate training. As a comparable example a registered nurse (though qualified and having core nursing knowledge and experience) would have to undertake further training to specialise in something like Intensive Therapy.

As has been stated many times before; if you are eligible to apply the easiest, and cheapest, route to state registration will be to get on the RCCP voluntary register prior to it transferring to the Health Professions Council.

Some people are hoping that RCCP will change the 'goal posts' to enable more people to register before the deadline. RCCP made it's submission to HPC and it is on the basis of that submission that recommendation has been made to parliament that Clinical Physiologists be granted registration status. It is therefore not possible for RCCP to relax the criteria. Unfortunately anyone who does not meet the criteria before the deadline (the actual date of which depends on the legal process) will have to apply under whatever criteria HPC declare for grand-parenting after the register has transferred. The criteria for this may be different to those currently applied by RCCP. Beyond a certain date (currently expected to be 2007) the ONLY access route to registration will be via the Clinical Physiology Degree.

Table 1: Assessment of eligibility

Their work encompasses 'Full' PFT's (or an equivalent range of procedures if working in a multi-disciplinary dept) and one of two sets of time criteria...

a) 4 Year Route – would have ONC/HTEC in MPPM or Degree in a relevant subject PLUS ARTP Part 1 or NVQ3.

or

b) 6 Year Route (aka Grandparenting) – would just need to document relevant experience/competence and need have no academic qualifications whatsoever.

Do bear in mind that it takes time for RCCP to process an application and you need to get yours in as soon as you are eligible to ensure you don't get caught up in the last minute rush & confusion of the transfer to HPC.

A good way to keep up with progress on national issues it to make sure your department is represented at regional 'network' group meetings where you can discuss issues with your peers and, if necessary, the group facilitators can feedback your questions and/or worries via the ARTP.

Table 2: Data collected

- Total No. of Physiologist Staff in the Dept
- No. already Registered
- No. deemed Not Eligible
- No. who could be Eligible

Reasons given for not being on the register yet ...

- Not enough experience (< 4 years)
  – probably still studying/gaining experience
- Not enough experience (< 6 years)
  – would have no relevant academic qualifications
- Not performing the full range of procedures

Not on the register yet but who are eligible to apply ...

Table 3: Regional uptake of registration

Region	n=	Registered	Not eligible	Could	Unknown
Trent	47	63.8%	23.4%	12.8%	
Scotland Lothians & North	37	56.8%	27.0%	13.5%	2.7%
West Midlands	108	53.7%	30.6%	15.7%	
Eastern	29	51.7%	34.5%	13.8%	
Scotland West	51	51.0%	37.2%	9.8%	2%
South Wales	124	50.4%	21.6%	27.2%	
South West	53	49.1%	45.3%	5.7%	
Yorkshire	146	46.6%	25.3%	9.6%	18.5%
South	36	44.0%	27.8%	27.8%	
South East	24	37.5%	41.7%	16.7%	4.2%
London	100	37.0%	42.0%	21.0%	
Northern Ireland	19	31.6%	15.8%	27.8%	
Northern	52	30.8%	21.2%	48.1%	
North Wales	17	29.4%	41.2%	29.4%	
North West	No data				
National	843	43.9%	30.1%	19.3%	3.6%

MINUTES OF THE HEADS OF DEPARTMENT MEETING, ON 17th DECEMBER 2004 AT THE POSTGRADUATE CENTRE, QUEEN ELIZABETH HOSPITAL, BIRMINGHAM

By Jane Caldwell, ARTP Honorary Secretary

Brendan Cooper, Chair of the ARTP, welcomed 74 delegates to the Heads of Departments (H of D's) Meeting; He thanked the organisers for the meeting, reviewed the aims and acknowledged the delegates attendance to this meeting, which this year had been separated from the annual conference. The importance that H of D's were informed about professional issues & major changes, was stressed.

(PowerPoint presentations from the meeting are available on the ARTP Website, member's only section under Gallery, Meetings).

The meeting commenced with a review of the feedback from last year's conference at Telford which overall was very positive despite problems with the venue, specifically with accommodation, catering and accessibility. The conference for 2005 will be on 24th –26th February at the *Thistle Hotel, Glasgow* and has an excellent programme, which includes: sleep, working with Primary Trust Care; paediatric testing and the popular lunchtime workshops and poster presentations (full program available on the ARTP website under 'Education').

Dr Cooper then gave acknowledgements to all those representatives who had supported the ARTP throughout the year and he stressed that the ARTP needed volunteers from the membership to help achieve the substantial tasks ahead. Specific acknowledgements included: **Gina Martin & Julie McWilliam**, ARTP Representatives on the RCCP. Brendan also thanked Julie who was stepping down as representative and would be replaced by **Claire Hill (Walsall)**. The **National Occupational Standards (NOS) group** representatives and specifically **Jo Shakespeare (Birmingham QE)** who had performed a huge task in enabling the NOS standards to be pushed forward to meet deadline demands. The **Education Committee**, specifically **Angela Evans (Stoke)** who had unfortunately had to step down recently as Education Chair. Brendan thanked Angela for her efforts over the year and confirmed that Angela would still be involved with Education, within the Spirometry Sub Group. The Spirometry Sub group led by **Cheryl Roberts (Sheffield)** and supported by **Sally Holgate (EBS)** were also acknowledged for their superb efforts and achievements.

Acknowledgements were given to those **ARTP Members** who had supported the **World COPD day** and the **Health Care Scientist Awareness Week (HCSAW)**, with specific mention of **Damian Muncaster (Homerton Hospital, London)** who had been heavily involved with the HCSAW and had also recently joined the ARTP Executive as Public Relations Officer. Further acknowledgements were given to **Pat Mitchell, (Liverpool)** BTS/ARTP Meeting Point Representative at the ATS Meeting, **Adrian Kendrick (Bristol)** ERS Section 9.1 Representative and **Angela Evans (Stoke)** and **Keith Butterfield (Dudley)** as ARTP/BTS liaison Representatives. Dr Roger Carter was thanked for continuing to act as ARTP

Scottish Forum Co-ordinator.

Dr Cooper made specific mention of the support given by **Jackie Hutchinson** and the staff of **EBS Ltd** over the year and finally he thanked all members of the **ARTP Executive Committee** and confirmed that the Executive Committee was inclusive and not exclusive and that anyone wishing to join the committee was very welcome and that all help or support would be gratefully received.

At this point **Keith Butterfield, Vice Chair of ARTP Executive,** acknowledged Dr Brendan Cooper's own commitments and input for all the ARTP work he personally undertook and formally thanked Brendan on behalf of all the ARTP members which the H of D's re-iterated by a round of applause.

Dr Cooper then gave a brief resumé of the day's programme. Then some direct questions were asked of the H of D's regarding accommodation for students and bursaries. *The H of D's were asked if they preferred courses to be booked with or without accommodation.* ***Majority stated that they would like ARTP HQ to book accommodation with the courses.*** *The H of D's were asked if accommodation should be standard hotel type or inexpensive university accommodation.* ***Majority stated it should be university type.*** The H of D's were then asked *why they felt that members were not applying for the bursaries to attend the ARTP conferences.*

Comments included: **Gina Martin (Leeds)** felt it was often difficult trying to motivate and find the time as H of D to encourage and support staff members to apply. **Nigel Clayton (Manchester)** thought that the bursary flyers should state "if you cannot afford to send your staff on a course/meeting then why not apply for a bursary to attend?" The H of D's were then asked *why they felt that practitioners were not joining the ARTP as members?* No direct comments were received on this other than **DD Vara (Leicester)** who asked why we couldn't have joint membership for ARTP & RCCP. Brendan explained that being a member of a professional body was not compulsory and therefore at this stage it was not feasible.

The second presentation of the day was from the **Education Group Committee** members: **Julie Lloyd (Sutton Coldfield)** Acting Vice Chair of Education. Julie gave a brief resume' of last year's examination outcomes compared to the previous years. **Clare Newall (Birmingham QE)** then gave an update on the RCCP PEBEG group, followed by **Joanna Shakespeare (Birmingham QE)** with an update on National Occupational Standards (NOS). Volunteers were requested to help with all the substantial forthcoming tasks that the Education Committee had to face in the near future

Rod Lane (GOSH, London) gave the next presentation on an Update on the ARTP Regional Groups. Rod took this opportunity to thank all the Regional Group leads and then he discussed the pros and cons of regional groups. Questions from the floor following this presentation included one from **Janet Stocks (GOSH, London)** enquiring whether video conferencing would be a way of linking up departments in the future for meetings. Brendan stated that he felt this might be available in the future and currently took part in teleconferencing for some meetings and found this very useful

Keith Butterfield (Dudley) gave the next presentation on the ARTP Surveys. Following this presentation Keith urged H of D's to complete the next survey due in 2005.No questions were received following this presentation.

Gina Martin (Leeds) gave the next presentation on an Update on Statutory Regulation, including current figures on voluntary RCCP register and future HCS register (anticipated to take over possibly be late 2005 or early 2006). Gina took this opportunity to emphasise to the audience that it is vital that respiratory practitioners register ASAP as applications are currently taking between 2 and 6 months to review and process. Questions were then taken from delegates: **Rod Lane (GOSH, London)** asked if the BSc + 6 years route was still available, which Gina confirmed was correct and suggested that anyone in this category should perhaps take the ARTP Part 1 and along with a relevant BSc would be able to apply earlier to the voluntary register; i.e. after 4 years. **Barbara Thornley (Stockport)** asked if part time workers had to have equivalent whole time years, which Gina confirmed was the case.

Pat Mitchell (Aintree Hospital, Liverpool) worked through the current situation on the Agenda for Change process, which had been accepted from 1st October 2004. Pat concluded her presentation by thanking the early implementer sites for their support and feedback. No questions were received following this presentation

Damian Muncaster (Homerton, London) gave feedback on Healthcare Scientists Awareness Week, which informed the delegates what events had taken place throughout the country. Damien took questions, which included: **Gina Martin (Leeds)** asking, once the profile had been raised, how we could access this funding for extra HCS staff into departmental budgets? **Gloria Holbrook (Abergavenny)** stated that she had recently come across a Dept of Health leaflet, which she felt although it raised the profile described a Physiologist's role in an inappropriate way and **Liz Martindale, (Oldham)** asked when the dates for the HCS week were next year.

Damian & Brendan stated that the only way we could make a difference is by being involved and continually raising the profile, providing accurate information, being challenging and being at the heart of things. A show of hands confirmed that approximately half of the delegates were involved with, or was a member of, their own Trust's HCS committee which was acknowledged as very promising as HCS representation will encourage our involvement with local issues, service planning & delivery. This coming year's HSC Awareness week would be 14th to 18th November 2005.

Brendan Cooper (Birmingham QE) gave the next presentation on Taking Services Closer to Patients, which focused on working in liaison with PCT and looking at new ways of working.

After lunch the H of D's meeting commenced with **Brendan's** introduction to the presentation on Working Groups, an Overview & Progress. Each working group representative gave feedback on their group's current progress:

- Keith Butterfield (Dudley) — Quality Assurance
  (including feedback on regional progress with the National QA Scheme)
- Nigel Clayton (Manchester) — Testing Facilities
- Julie Lloyd — Staffing Levels
- Jo Shakespeare (Birmingham QE) — Staff Training and Development
- Martin Bucknell (Bromley) — Department Size and Space
- Alan Moore (Birmingham City) — Department Budgets

Questions from the audience from: **Mike Nash (Wales), Ana McPoland (Cheshire), Barbara Thornley (Cheshire), Gina Martin (Leeds) and Alan Moore (Birmingham City)** following this presentation, including questions on types of tests recommended to be performed at basic, intermediate and advanced centres and effects of other professionals running or leading some services, i.e. Nurses or Physiotherapists; when would the results from the working groups be available; equipment differences during QA monitoring; and specific funding issues. Keith confirmed that each working group would acknowledge these comments, as at this stage standards had not been set in stone. It was again stressed that volunteers were needed to help with the working groups and anyone interested should contact ARTP HQ or a Committee member.

Dr Brendan Cooper gave the final presentation of the day on Clinical Scientists, which included the role and remit of a scientist compared to the physiologist.

Questions following this section from **Gina Martin (Leeds) Alan Moore (Birmingham City) and John Griffiths (Kidderminster)** included issues on the use of "consultant" in the title; differences in the two types of roles; and research and development aspects.

At this stage of the meeting Brendan then introduced the surprise guest speaker, **Professor Sue Hill, Chief Scientific Officer from the Department of Health** and his took this opportunity to thank Sue on behalf of the delegates for her relentless efforts she has given to promote HCS. Sue took questions from the audience, which had been raised earlier during the meeting: **Gloria Holbrook (Abergavenny)** raised the issue again of the leaflet describing the physiologist's role, which she felt was inappropriate. Sue acknowledged that some information was inaccurate and that we should all aim to raise our profiles & provide correct information to relevant sources. She suggested that we subscribe to the *CSO Bulletin*, which half the audience confirmed that they had access to already.

Gina Martin (Leeds) informed Sue that following the HCSAW they had had massive interest & enquires from people wanting to join the profession but her Trust had stated that there is no funding to train such people. Sue stated that the Workforce Development Confederations were the ones who had the monies for this training. She stated that it was therefore important that we access and communicate with the WDC's and also link with the PCT's to ensure that delivery plans for services include HCS needs. She also stated that in the future PCT's might recognise services via block tariff contracting directly with physiology departments, which may improve access to monies. She explained that the future NHS would focus on getting patients through the patient pathway in a co-ordinated and different way, with HCS working along side other Health Care Professional's including PCT's to improve the patient experience. **Linda Lukehurst (Liverpool)** raised the issue previously raised at last year H of D's meeting, regarding her being unable to access the HCS forum at her Trust. Other comments from the audience were also received in this vein. *(Half the audience had access to a forum but half still did not).* Sue explained that the infrastructure would happen but was slow to take off in some areas, but the Strategic Health Authorities would expect and monitor that such a forum exists at each Trust in the future. **Alan Moore (Birmingham City)** raised the issue of some recent funding restrictions within the Midlands area and Sue confirmed that an urgent meeting had been proposed to address this issue. Sue concluded her session by encouraging all H of D's to take an active part in the future development of the HCS in anyway that they could.

Brendan Cooper, Chair of ARTP, concluded the afternoon sessions by thanking all the speakers for their presentations and for the delegates' attendance. He stressed that help was needed and urged the silent 92 MTO4's and 17 MTO5's to get actively involved with the ARTP to meet the demands ahead for the profession. Finally Dr Cooper expressed good wishes to all the delegates for the forthcoming holiday period on behalf of all the Executive Committee members. The H of D's meeting closed at around 4.45pm

Further information can be obtained by visiting the ARTP website at www.artp.org.uk were the H of D Meetings Powerpoint presentations can be accessed in the members only section.

GRAPEVINE

This is the place for news of promotions, retirals, members moving to new jobs etc. Obviously as this is the first time the column has run I don't have a lot of news to pass on I'm relying on you to keep me informed. If there is anything you want to see in this spot, send an email to inspire@artp.org.uk Ed.

Congratulations to **Vicky Zgardzinski**, who has moved from Raigmore Hospital in Inverness to take up an MTO4 post in Newcastle. *(Having known Vicky for the last ten years I'm sure she can show the Geordies how to party!)* Congratulations also go to **Keith Butterfield**, Vice-Chair of the ARTP who has left Dudley for the tranquility of Dorset County Hospital.

ASSOCIATION FOR RESPIRATORY TECHNOLOGY & PHYSIOLOGY

INCOME & EXPENDITURE ACCOUNT

YEAR ENDED 31st MARCH 2004

	2004 £	2003 £
INCOME		
Members Subscriptions	24,167	21,012
Courses	25,241	29,648
Sale of Handbook & Merchandise	2,000	250
Advertising - Inspire Newsletter	1,400	1,700
Circulation of Job Vacancies	29,100	23,985
Candidate fees - ARTP/BTS National Assessments	9,375	6,650
Deposit Account & Building Society Interest	1,004	644
Spiro Training	3,280	1,020
Scottish Forum	1,300	1,680
Other Income	220	2,248
	97,086	88,837
EXPENDITURE		
Committee Costs	3,274	2,855
Courses & Meetings	31,631	12,786
Scottish Forum		886
Spiro Training	411	33
National Assessment	3,693	3,534
Bank Charges	118	218
Postage, Stationery, Telephone, Fax & Internet	12,190	11,697
Travel & Subsistence	5,386	996
Printing Costs - Newsletter & Job Vacancies	4,016	4,768
Bursaries	500	1,000
Storage	178	360
Sundry Expenses	1,759	984
Accountants Fees	813	587
Professional Issues	7,082	651
Administrators Costs	21,276	13,018
Depreciation of Fixed Assests	197	263
	92,522	54,636
EXCESS OF INCOME OVER EXPENSES	**4,564**	**34,201**

ASSOCIATION FOR RESPIRATORY TECHNOLOGY & PHYSIOLOGY

(TRADING ACCOUNT)

INCOME & EXPENDITURE ACCOUNT

YEAR ENDED 31st MARCH 2004

		2004 £		2003 £
RECEIPTS		176,931		133,455
EXPENSES				
Accommodation & Venue	90,384		74,546	
Catering	27,609			
Printing & Stationery	7,020		3,054	
Bank Charges	772		647	
Equipment Hire	5,216		5,150	
Marketing & Promotions	7,141		1,327	
Conference Entertainment	1,268		2,230	
Travel & Speakers Expenses	6,422		4,562	
Sundry Expenses	232		501	
Accountants Fees	350		250	
Administation Costs and Staff Wages	20,422		16,481	
Bursary	188		1,588	
Insurance	1,223		966	
Advertising			420	
Depreciation	571		511	
		168,818		112,233
EXCESS OF INCOME OVER EXPENDITURE		**8,113**		**21,222**

REGISTRATION COUNCIL CLINICAL PHYSIOLOGISTS (RCCP) UPDATE

By Gina Martin, RCCP Respiratory Physiology Representative

The Remit of the RCCP was to form an overarching structure to represent 6 independent professional bodies i.e.:- respiratory physiology, cardiology, audiology, gastrointestinal physiology, hearing therapy and neurophysiology within the Physiological Science branch of Health Care Scientists for regulation of practice.

This allowed us as Clinical Physiologists to apply to the Health Professions Council (HPC) for regulation.

In September 2004 the HPC recommended the profession for regulation to the Secretary of State for Health, this was agreed.

We are now in to the second part of the process where the Department of Health have started to draft the legislation and consultation document, this is a complex process which it is hoped will be completed by the end of 2005.

By the end of this year we will therefore be moving towards statutory regulation. Once a statutory register has been opened, previous arrangements by the RCCP will no longer apply i.e. registration, grand parenting and fitness to practice. There will be a three year transitional period. This will be to enable individuals to complete their training or to gain an approved qualification in the interim period. Grand parenting will be left open during this period (though the criteria will be different) and the standards of proficiency will be set by the HPC.

The entry route from 2005 will be:-

- BSc in Clinical Physiology or equivalent
- PLUS your professional exams ARTP Part1 / ARTP Part 2
- A minimum of 4 years experience is required for all entry routes.

International applicants who wish to practice clinical physiology in the UK will have their training experience assessed against the same HPC standards as the BSc has been designed to meet.

The RCCP voluntary registration will continue to operate as a registration council until the register transfers to the HPC. We will accept applications until this time.

However, I must emphasise to everyone that although applications can be processed within two months of receipt, some applications take much longer, frequently in excess of six months, due to problems related to the applicant's form or to the sheer volume of applications being processed.

I THEREFORE URGE EVERYONE WHO IS ELIGIBLE TO APPLY NOW.

Guidance to support the regulation of current trainees.

Those who entered training in 2001 and are due to complete in 2005, (before the opening of the statutory register), will need an ONC/D plus the professional body examination ARTP Part 1.

Entering training between 2002-04, these trainees will complete training no later than 2006, 2007& 2008 respectively. Will need a minimum requirement of HNC/D plus professional body examinations, some of which may only be available through modules in the degree programme, together with a total of 4 years supervised training.

Entering training from 2005. The only approved qualification will be the BSc in Clinical Physiology or equivalent plus Part 1 & Part 2 of our professional ARTP exams.

If there are any questions please look on the RCCP website (www.rccp.co.uk). Or you may contact me (by email for preference):-

Georgina Martin

Respiratory RCCP Representative

Telephone: 0113 2064865

georgina.martin@leedsth.nhs.uk

E-MAIL FORUM DIGEST

For the benefit of those members who do not yet have access to the E-mail forum here is a synopsis of some of the messages and discussions that have been 'posted' between 24/03/2004 and 31/08/2004.

Tony Parkes kicked off this session with his hunt for the source of a 'garlicy/sweaty/oniony' smell during TLCO measurement. According to several esteemed sources it's not just a 'fishy' tale but is due to Acetylene (give me good old CO any day).

Once again the subject of Infection Control Nurses raised its head, this time their insistence that Volmatic devices should be disposed of after each patient (Trefor Watts). A sensible attitude was recommended by Adrian Kendrick and Alan Moore (in a forceful manner) based around Adrian's paper in Resp. Med (Infection control of lung function equipment: a practical approach. Respiratory Medicine (2003) 97, 1163-1179) and Alan's suggestion of producing a risk assessment. Brendan Cooper stated that the ARTP were putting together a working group to look at this issue and guidelines will be produced (in conjunction with the BTS) later this year. The discussion then turned to the question of static build-up due to regular cleaning (Mark Townsend). This mostly occurs if the devices are polished dry (Julie Lloyd), but is greatly reduced by correct handling (Lesley Lowe) as described in the paper 'Washing plastic spacers in household detergent reduces electrostatic charge and greatly improves delivery'. Pierart F, Wildhaber JH, Vrancken I, Devadason SG, Le Souef PN. Eur Respir J. 1999 Mar;13(3):673-8).

Angela Evans started a long discussion about the new linear European scale that will begin to appear on peak flow meters from 01/09/04. After the more 'venerable' members had gotten over their reminiscences (when we were young etc.) it was decided that labs should try to take the lead in promoting awareness of the change around hospitals and PCT's and highlight its potential ramifications. To this end Jo Montgomery provided an excellent web site for reference www.peakflow.com.

Vicky Cooper queried an inconsistency between calculated paediatric predicted values using the equations published in the 2nd edition of the ARTP handbook. Adrian Kendrick replied (sheepishly) that there was actually a typo in the TLCO equation " in the Height to the 4th power there should be one less zero ie 1.5287 x 10 -6 and not 10-7 as stated."

Anna Clapham asked for guidance on the diagnostic value of tests on patients with pulmonary haemorrhage and/or Goodpastures Syndrome without baseline values. Adrian Kendrick and Andy Robson agreed that whilst baseline readings would be advantageous, the TLCO still provided useful diagnostic information during a haemorrhage, in particular the changes in KCO. They stated that "as a rule of thumb a value for KCO >2.0 was a good indicator of an active haemorrhage." (NB : Authors Note – values above 2 are normal in the paediatric population)

Carla Waygood asked for advice about deviations in TLCO measurements in physiological controls and how often it is necessary to recalculate the range. Kevin Hogben outlined the variables involved, inspired volume, breath hold time and the ratio of inspired to expired gases and how each can highlight a problems such as subject effort, mechanical problems or changes in cardiac output. Brendan Cooper stated that "in normal healthy non-smoking individuals the change in TLCO with age is less than the normal variation (<0.5 SI Units) in the measurement" and so the range calculated from 50 measurements should be fine for 2 to 3 years.

Still on the tack of TLCO, Cathy Hammond inquired about the effect of sub maximal inspirations on the measurement and whether a correction factor can be applied to the results. Both Brendan Cooper and Derek Cramer thought, that whilst it did exist, the use of a correction factor was dodgy. Furthermore Kevin Hogben produced a detailed working out of the problem and how it could affect the results. However I'm afraid I got lost after the 2nd page of calculations so I will leave it up to each reader to study the original e-mail.

SCOTTISH FORUM AUTUMN MEETING AND AGM

By Christine Downie, Scottish Forum Secretary

The autumn meeting of the Scottish Forum was held at The New Edinburgh Royal Infirmary on Friday 5th November. Thirty-one delegates were present, representing thirteen labs. The meeting was chaired by Scottish Forum Co-ordinator, Dr Roger Carter. ARTP Chair Dr Brendan Cooper had left his home well before dawn in order to come to the meeting as well.
The first presentation was given by Roger and was about setting up an outreach spirometry service in Glasgow. The service seems to be a victim of it's own success as it now has a long waiting list in one of the areas served. The presentation gave us a useful insight into the pitfalls in setting up this type of service, the costs involved and the level of input required to keep it on track.

The next presentation was about interventional bronchoscopy and was given by Dr Mark Cotton from Glasgow Royal Infirmary. This was an extremely interesting presentation which was punctuated by video clips showing tumours being removed using diathermy via the bronchoscope. A good insight into procedures we wouldn't normally see.

Dr Andy Robson gave the next presentation, which was an update on the diagnosis and management of patients with hyperventilation. He talked us through the protocol used in Edinburgh, the referral patterns and the treatment options available. Andy also told us of his personal theory about mouth breathing being implicated in hyperventilation and the use of the "SNOT 20" questionnaire (apparently this does exist!). We look forward to hearing if he can prove his theory!

The morning session was concluded by Jill Lenney from Edinburgh, telling us about a new protocol devised to assess patients in need of ambulatory oxygen. The protocol was simple and is something which could easily be adapted by those of us who have a treadmill in our departments.

Lunch was kindly provided by Ferraris Respiratory Europe.

The afternoon session started with the AGM of the Forum, with Dr Brendan Cooper acting as chairman.
The sitting office bearers were re-elected as follows:

Co-ordinator	Dr Roger Carter
Secretary	Christine Downie
West of Scotland	Anne Stevenson
East of Scotland	Barbara Oatway

Vicki Zgardzinski who has been the North of Scotland Rep since the beginning of the Forum is leaving Scotland to take up an MTO4 post in Newcastle. Joyce Leys from Aberdeen Royal Infirmary was unanimously elected as the new North of Scotland rep.

Roger then updated us on the financial position of the Forum. At present we have a healthy balance in the ARTP accounts. A proposal was put forward to use some of this money by offering bursaries for Scottish Forum members to attend meetings. The pay back for this is to agree to make a presentation at a Scottish Forum meeting.
This idea will be developed and will be available very soon.

We were then updated on the national QA scheme.
The West of Scotland have completed the feedback and have 2 volunteers to visit departments. When a 3rd volunteer is found, a pilot testing day will be arranged.
The North of Scotland have to organise a testing day for the 2 hospitals involved. Now Vicki has left, A volunteer is required from Inverness. The East of Scotland are slightly further behind and there is a major problem here regarding volunteers. Roger urged those present to consider being a test subject for the scheme.

The next subject on the agenda was training.
Meetings have been taking place with Stow College and Caledonian University to get the degree course up and running in Scotland. This now looks as if it could happen in 2006, with the first 2 years of the course undertaken at Stow with the next 2 years and specialist options at Caledonian. There will be a need to provide training in Scotland to cover the syllabus for ARTP parts 1 & 2.

Roger reported what had been discussed at a meeting of the Scottish Forum for Healthcare Science in August. As health is a devolved issue, it is necessary to devise a Scottish strategy for developing Healthcare science as a profession. Roger is involved in this group and will keep us informed regarding developments.

It was agreed that the next Forum meeting would be held in April at Aberdeen Royal Infirmary.

Following the AGM, Brendan brought us up to date with national issues including the status of the BTS/ARTP spirometry certificate. He encouraged more labs to come forward to be accredited as training centres. We were told of working groups, which the ARTP have set up to produce guidelines for all aspects of a respiratory function service from staffing levels to department size. He informed us of the latest on the national assessments, state registration and the ARTP/BTS liaison committee.

The Forum graciously accepted his grovelling apology for the lack of editions of Inspire this year and welcomed Andy Robson as the new Editor – gau'n yersel' Andy! *(I'm blushing now – Ed)* Brendan finished with a preview of the Conference programme – lets make sure there's a huge Scottish presence and maybe it will come up north again in less than 10 years!

DECLARATION OF INTERESTS BY MEMBERS OF THE ARTP EXECUTIVE COMMITTEE AND SUB-COMMITTEE MEMBERS

The following members hereby state that they have obtained interests, which are declarable during the financial year 1st April 2002 to 31st March 2003:

Dr Brendan Cooper

Dr Adrian Kendrick

Mr Nigel Clayton

Mrs Julie Lloyd

Mrs Pat Mitchell

Mrs Jane Caldwell

Mr Keith Buterfield

Dr Rod Lane

Mrs Angela Evans

The following members hereby state that they have obtained interests, which are declarable during the financial year 1st April 2003 to 31st March 2004:

Dr Brendan Cooper

Dr Adrian Kendrick

Mr Nigel Clayton

Mrs Julie Lloyd

Mrs Pat Mitchell

Mrs Jane Caldwell

Mr Keith Buterfield

Dr Rod Lane

Mrs Angela Evans

Mrs Georgina Martin

Mr Alan Moore

Mrs Leslie Lowe

Mr Trefor Watts

Dr Roger Carter.

Interests that are declarable include:

Payments from commercial companies for professional services, i.e. teaching.

Sponsorship, gifts or ex gracia payments.

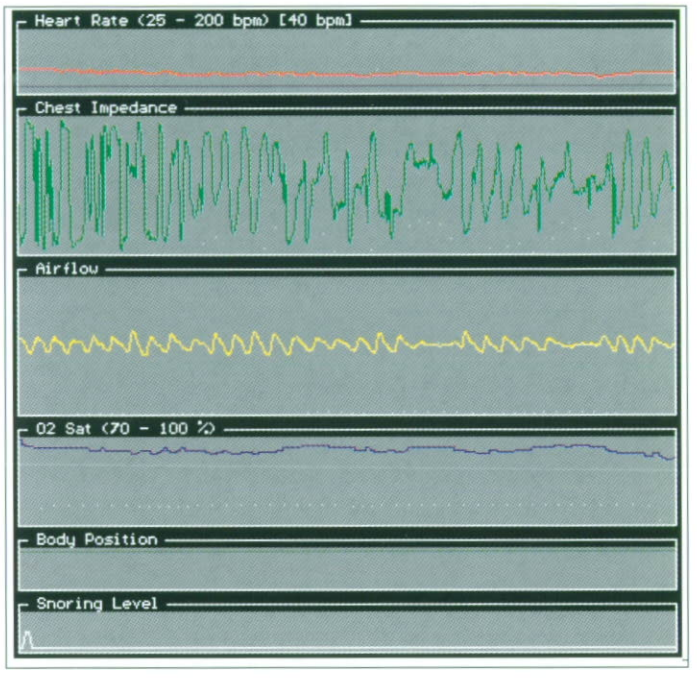
Consultancy agreements with outside organisations.

Specific details of declarations of interests for specific Executive members can be, if necessary obtained by writing to Jane Caldwell, Honorary Secretary of the ARTP stating what is required and the purpose of the request.

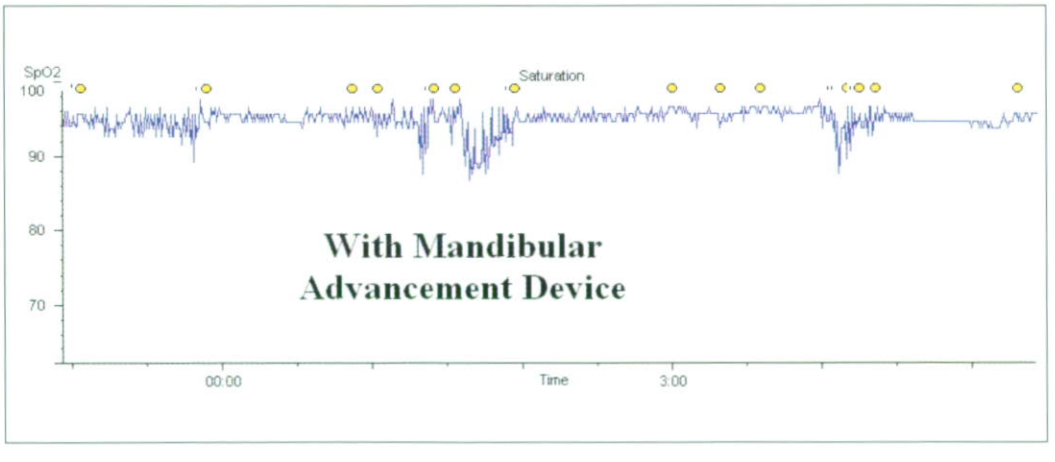
ERRATUM
Case Study – Obstructive Sleep Apnoea with Another form of Treatment

Harry Patel, Dudley Group of Hospitals NHS Trust

An error in the last issue of Inspire resulted in the incorrect post-treatment figures being printed. The Editor apologises to readers and especially to Mr Patel for the mix-up, which was entirely his fault. The correct figures are shown below.



Five minute tracing of Mr. PM's limited polysomnogram study with mandibular advancement device in place.



Mr. PM's simple pulse oximetry trace showing improvement in oxygen saturation with mandibular advancement device in place.

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Printed by Parker and Son (Printers) Ltd, 70 Guild Street, Burton upon Trent, Staffordshire DE14 1NE
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