



THE FIVE YEAR FORWARD VIEW

NINE PRIORITIES FOR RESPIRATORY HEALTH

NINE NATIONAL MUST-DOs: WHERE DOES RESPIRATORY HEALTH FIT IN?

The Five Year Forward View proposes a significant remodelling of healthcare services, with a view to focusing on public health and illness prevention. As part of this, nine national areas of priority were identified, and commissioning of services and systems over the next few years is likely to focus on meeting these priorities. Respiratory conditions are not specifically mentioned as a disease priority in the Forward View; however, opportunities to focus on respiratory care can be found within each of the nine listed priorities.

The nine priorities were first described in 2015, in *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21*, and later expanded and refined in the *2017–19 NHS Operational Planning and Contracting Guidance*.

This report represents the views of the Primary Care Respiratory Academy Commissioning Platform faculty, and is based on current evidence and consensus.

1. SUSTAINABILITY TRANSFORMATION PLANS (STPs)

Priority:

- Implement agreed STP milestones.
- Achieve agreed trajectories against STP core metrics.

Opportunities for respiratory care:

There is a high burden of disease from respiratory conditions in many Clinical Commissioning Groups (CCGs); conditions such as chronic obstructive pulmonary disease (COPD) cause high levels of early mortality, ill health and healthcare resource utilisation. For many local areas, respiratory care will therefore be a key priority to focus on in STPs as progress towards metrics, such as reducing emergency admissions or avoidable deaths, can only be achieved by addressing the conditions responsible.

Meeting the needs of respiratory patients in the current system requires developing a workforce in ways that can transfer across to the achievement of objectives in other disease areas. For example, encouraging integration of care for breathless patients can only be achieved through increased collaborative working between providers (including vertical integration of care), flexible working, joint education, training and establishing strong links with local educational establishments. All of these workforce initiatives are crucial to delivering STP objectives, regardless of the disease area.

2. FINANCE

Priority:

- Achieve local and national system financial control totals.
- Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiency.

Opportunities for respiratory care:

'Demand growth' here refers to the predicted rise in healthcare utilisation and costs for COPD and asthma over the coming years. Demand reduction measures specifically suggested by the Forward View include:

- *Supporting self-care and prevention:* Self-care, as defined by the Department of Health, includes self-management of long-term conditions. Self-management in respiratory disease is crucial to achieving good disease control, improving health-related quality of life and reducing avoidable hospital admissions and healthcare overuse.
- *Medicines optimisation:* Over-prescription is common in asthma and COPD, with many patients receiving inappropriate or superfluous inhaled corticosteroid therapy. Optimising and personalising pharmacotherapy for these patients could not only reduce costs but may also reduce the risk of serious sequelae, such as pneumonia in those with COPD, thereby improving patient outcomes. Furthermore, checking inhaler technique before stepping up pharmacotherapy in a patient with poorly controlled asthma is a simple step, with the possibility to improve outcomes at no extra cost.

Likewise, suggested provider efficiency measures include implementing new models of acute service provision and better integrating community services. This could include carousel-style clinics for patients with respiratory conditions (similar to the MISSION clinics, pioneered in Wessex), or enhanced care homes.

Central to demand reduction and efficiency is the role of accurate and early diagnosis. Appropriate diagnosis, not only of respiratory disease (including review of those patients with an existing diagnosis, to confirm the diagnosis accuracy), but also of its comorbidities, will support the efficient use of healthcare resources.

3. PRIMARY CARE

Priority:

- Implement the General Practice Forward View, including the plans for Practice Transformational Support, and the 10 high-impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including increasing the numbers of doctors, pharmacists and therapists in general practice, investing in training practice staff and stimulating the use of online consultation systems.
- Extend and improve access.
- Support general practice at scale and the expansion of multispecialty community providers (MCPs) or primary and acute care services (PACs).

Opportunities for respiratory care:

The General Practice Forward View features '10 high-impact actions', many of which include obvious links to respiratory care:

- *Active signposting:* To interventions that attend to the social determinants of ill health usually provided by local authority colleagues including tobacco dependency, physical activity and healthy eating services.
- *Developing the team:* For example, nurse-led breathlessness clinics are now commonplace. Ensure this workforce is supported with the best training and consider how pharmacists and physician assistants would also add value to these services.
- *Partnership working:* Improving links between general practice and secondary care respiratory services, between primary care respiratory leads and generalist staff, and between GPs, nurses, pharmacists and allied healthcare professionals, can all improve the patient experience of respiratory care.
- *Supporting self-care:* The evidence for use of personalised action plans in asthma in reducing admissions and attacks is now well established and can save lives. COPD care is complex, so individualised and supported self-management is key, and evidence continues to develop in this area.
- *Social prescribing:* Many areas are now introducing community services providing social support to people with long-term health conditions; linking patients to these services can improve their self-management and quality of life, while reducing costs to the CCG. Community-based support such as peer support groups can enable and empower patients to look after themselves and one another.

4. URGENT AND EMERGENCY CARE

Priority:

- Deliver standards for A&E wait times and ambulance response times.
- Meet the four priority standards for seven-day hospital services.
- Implement the Urgent and Emergency Care Review.
- Reduce the proportion of ambulance 999 calls that result in avoidable transportation to A&E.
- Prepare for the waiting time standard for urgent care for mental health crises.

Opportunities for respiratory care:

'Acute care' is often used to mean pre-hospital and secondary emergency services, but primary care has a key role in the urgent and emergent care of acutely ill patients, both through referring patients to urgent secondary care and through managing long-term conditions. There is evidence that teaching patients self-management skills reduces the number of unplanned hospital admissions for asthma and COPD. Improving control of respiratory conditions could reduce the risk of patients needing emergency treatment for acute exacerbations of such conditions, thereby reducing pressures on the emergency care system. People with breathlessness represent a significant proportion of people who call an ambulance, with figures above 10% of all London Ambulance Service activity in London. Of these people who call, 90% get transferred to A&E. Are there opportunities to use non-emergency services or assessment protocols (for example, by rapidly triaging respiratory patients attending A&E and redirecting them to primary or community care if appropriate) to help with this A&E burden?

5. REFERRAL TO TREATMENT TIMES AND ELECTIVE CARE

Priority:

- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment.
- Deliver patient choice of first outpatient appointment and achieve 100% of use of e-referrals.
- Streamline elective care pathways.
- Implement the national maternity services review, Better Births.

Opportunities for respiratory care:

Streamlining care pathways within respiratory care is key to improving the patient experience; with conditions such as COPD needing a multidisciplinary approach to treatment, and a significant proportion of patients with COPD having comorbidities, patients can become frustrated if they are required to attend multiple appointments with multiple healthcare providers. Rationalising this process may require a rethink of existing outpatient services – for example, the MISSION system allows patients to be seen by multiple multidisciplinary specialists in a single appointment, reducing the number of referrals needed and the number of appointments for patients to attend.

6. CANCER

Priority:

- Implement the cancer taskforce report.
- Deliver the NHS Constitution cancer standards.
- Improve one-year survival rates; increase the proportion of cancers diagnosed at stage one and stage two; reduce the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow-up pathways for breast cancer patients; prepare to roll these out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned.

Opportunities for respiratory care:

Patients with COPD are at increased risk of lung cancer compared with the general population. Targeted or stratified screening programmes, and increased awareness among primary care clinicians of 'red-flag' symptoms that suggest malignancy, may contribute to improved survival rates among such patients.

7. MENTAL HEALTH

Priority:

- Deliver the implementation plan in full for the Five Year Forward View for Mental Health.
- Ensure delivery of the mental health access and quality standards.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and prepare for NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out-of-area placements for non-specialist acute care.

Opportunities for respiratory care:

People with a long-standing mental health problem are twice as likely to smoke as those with no mental health problem, and smoking is a major cause of physical ill health and early death in these patients. The reverse situation is also true – people with long-term physical illnesses suffer more complications if they also develop mental health problems and this comorbidity can increase the cost of care by an average of 45%.

The Mental Health Five-Year Forward View recommends that smoking cessation programmes should be made available to everyone with a severe mental illness, noting that there is a particularly low uptake of information, assessment and interventions related to physical activity, smoking and cancer among these patients. People with schizophrenia and bipolar disease are represented seven times more in the population with COPD than in the general population. Making a lung health check a routine part of the annual physical health check should be considered for people with severe mental illness.



8. PEOPLE WITH LEARNING DISABILITIES

Priority:

- Deliver Transforming Care Partnership plans with local government partners.
- Reduce inpatient bed capacity.
- Improve access to healthcare for people with learning disabilities.
- Reduce premature mortality by improving access to healthcare services, and education and training of staff, and by making necessary reasonable adjustments.

Opportunities for respiratory care:

Improving access to respiratory care, and by extension reducing premature mortality from respiratory conditions, may require critically assessing services to ensure patients with a learning disability and respiratory disease are still able to access annual reviews, and that information regarding their condition and medication is provided in a manner they can understand. People with learning disabilities may also smoke tobacco, but this may be overlooked during their health checks. Consider lung health and exhaled carbon monoxide testing in physical health checks for all patients, including those with learning disabilities.

9. IMPROVING QUALITY IN ORGANISATIONS

Priority:

- Implement plans to improve quality of care.
- Measure and improve efficient use of staffing resources.
- Participate in the annual publication of findings from reviews of deaths, the annual publication of avoidable death rates, and actions taken to reduce deaths.

Opportunities for respiratory care:

The National Review of Asthma Deaths in 2015 identified a number of areas where quality of care could be improved to reduce asthma mortality, such as proactive identification of patients using excessive quantities of short-acting reliever inhalers. Similarly, the Royal College of Physicians 2014–2015 audit of COPD diagnosis and treatment in primary care also offered several recommendations on improving service provision. These lists of recommendations may provide a useful foundation for adapting or developing new processes with the aim of reducing avoidable mortality from respiratory conditions.

Finally, the Forward View specifically aims to ‘tackle health inequalities’ and to ‘close the health and wellbeing gap’. In few other areas of healthcare are the effects of social inequality so starkly seen as in respiratory care. The Burden of Lung Disease report by the British Thoracic Society in 2006 estimated that social inequality caused a higher proportion of deaths in respiratory disease than in any other disease area, with 44% of respiratory deaths associated with social class inequalities. Men aged 20–64 years in unskilled manual occupations are 14 times more likely to die from COPD than men of similar ages working in professional roles. Addressing healthcare inequalities due to social factors cannot be achieved without specific attention to respiratory care.

