

# A Mission for Lung Health

November 2024



ASTHMA+  
LUNG UK

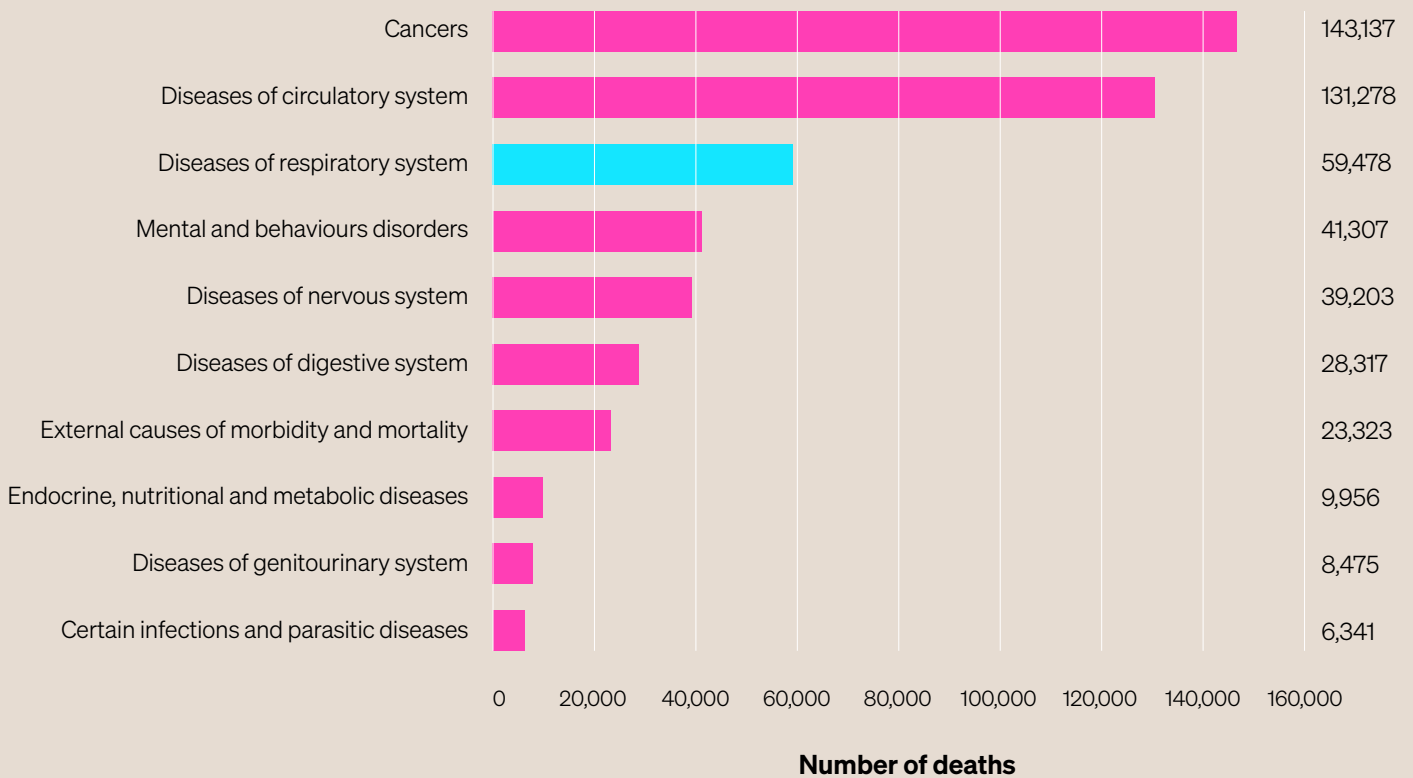
**The new government has identified three essential shifts needed to save the NHS. Getting respiratory care right will help the government achieve its goals.**

**1. Sickness Prevention**

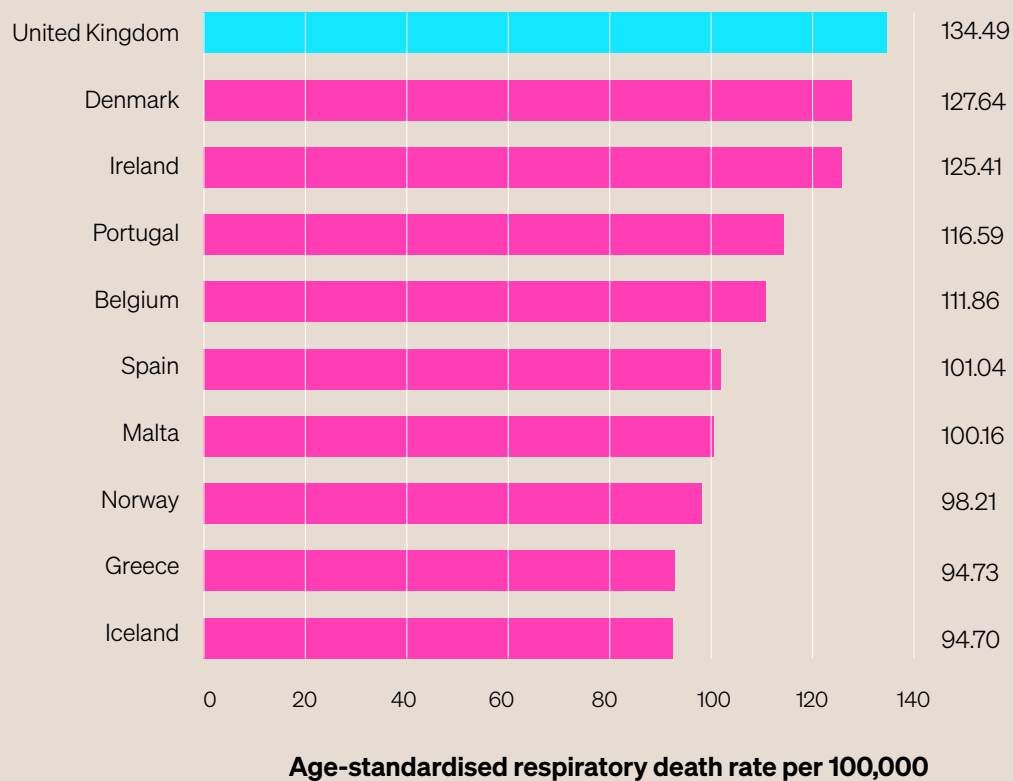
**2. Hospital Community Care**

**3. Analogue Digital**

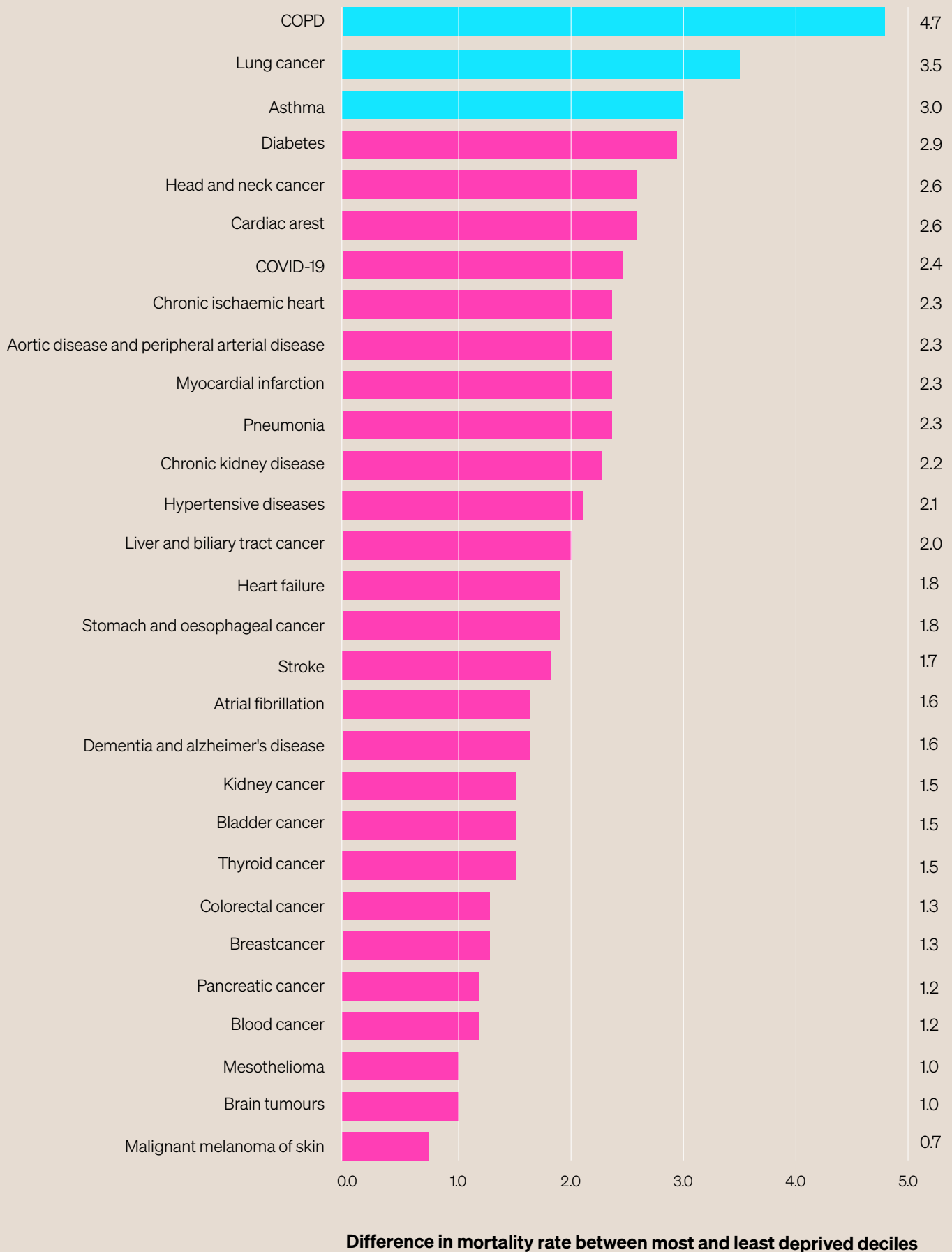
## Respiratory conditions are England's third biggest killer<sup>1</sup>



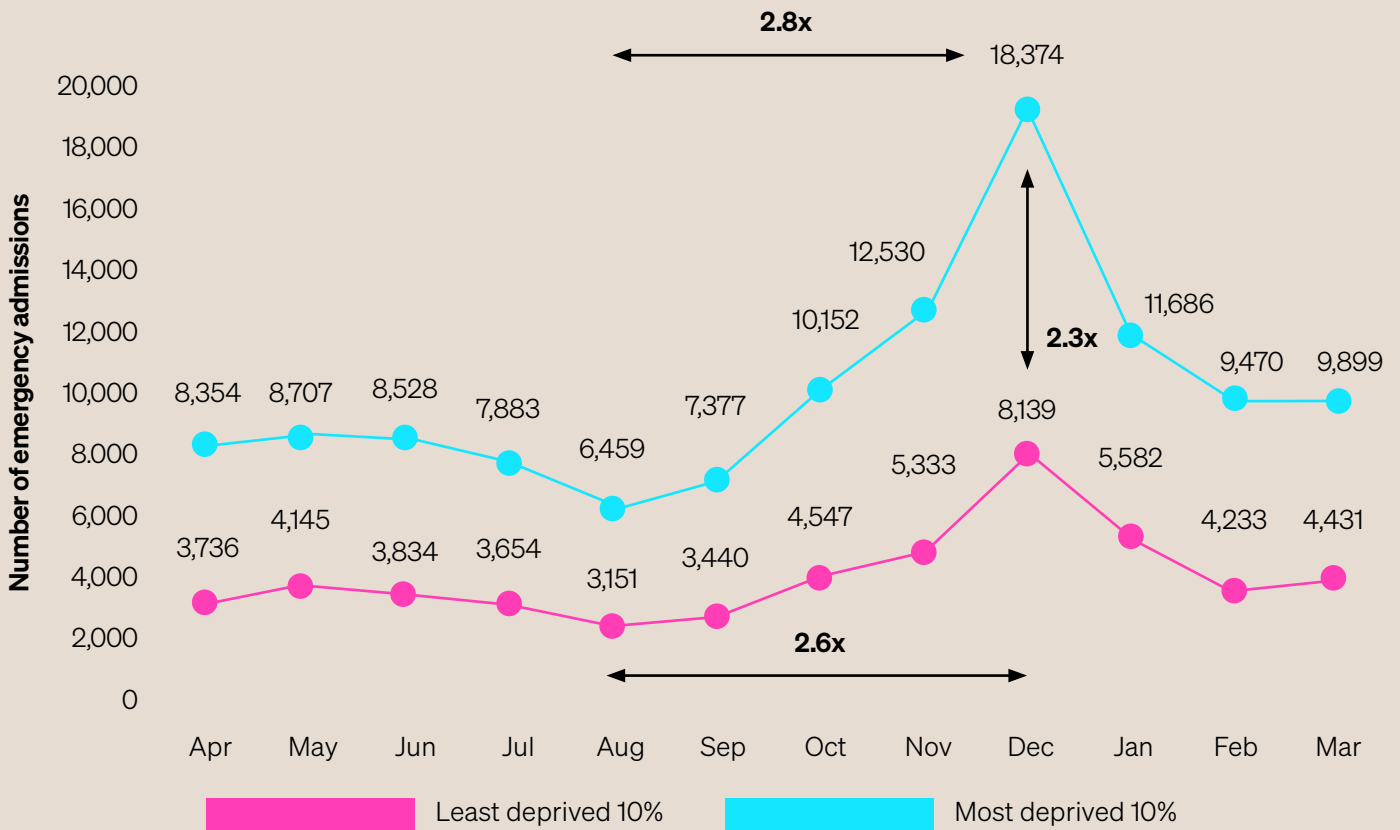
## We have the worst death rate for lung conditions in Europe<sup>2</sup>



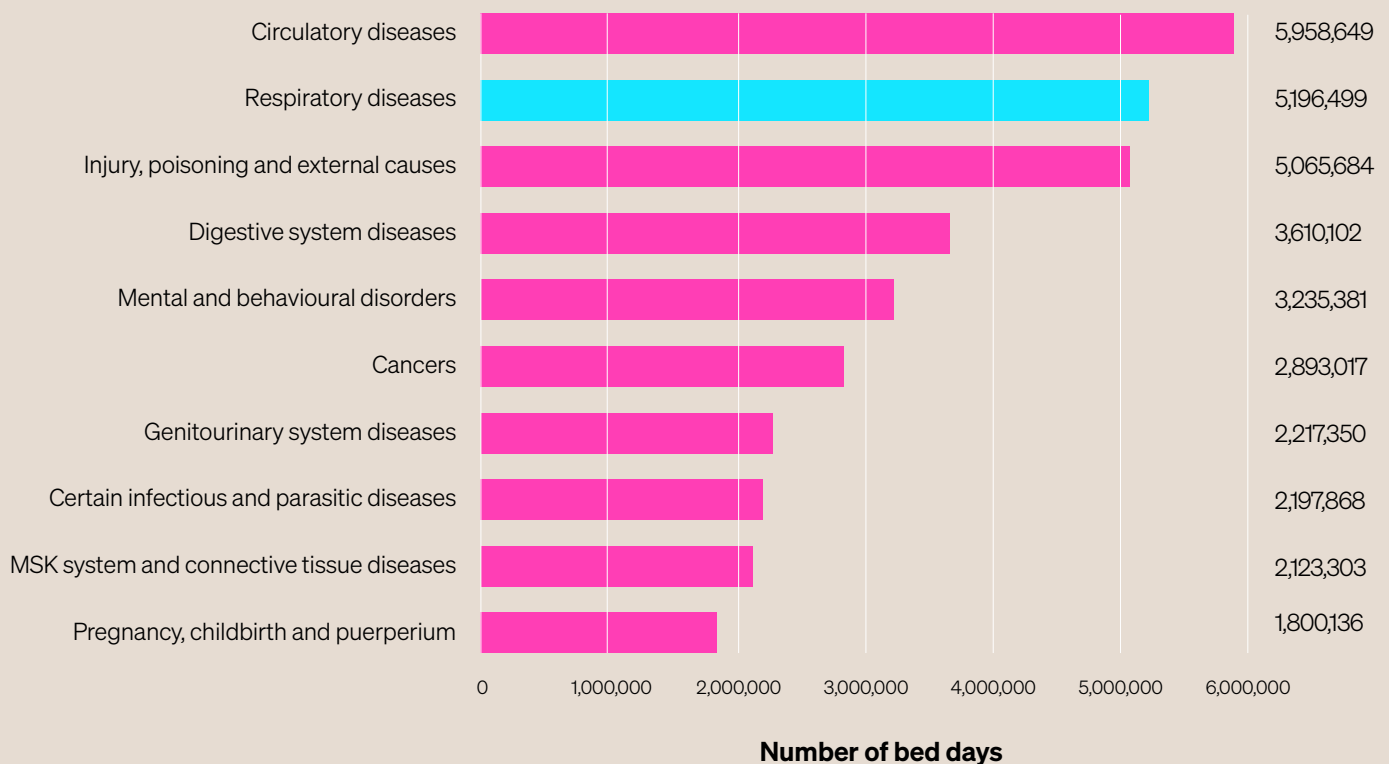
# Respiratory conditions have a bigger gap in mortality rate between the rich and poor than any other major condition<sup>3</sup>



# Respiratory conditions are the leading driver of hospital admissions and winter NHS pressures<sup>4</sup>



# Respiratory conditions are the second leading contributor to NHS bed days<sup>5</sup>



# 1. Sickness Prevention

**To move the NHS from sickness to prevention, the government should:**

- Tackle the toxic air pollution that kills 43,000 people every year, by establishing strong clean air targets in line with the World Health Organization to protect those most at risk.
- Prevent lung conditions by introducing a levy on tobacco companies to pay for a Smokefree Fund, ring-fenced for smoking cessation services, alongside the measures in the Tobacco and Vapes Bill to create a 'smokefree generation'.
- Develop a cross-departmental national strategy to fix cold and mouldy homes that are killing people.

# 2. Hospital Community Care

**To move care from hospitals to communities, the government should**

- Keep patients well and out of hospital, particularly in the winter months, by delivering good year-round basic care in the community, including annual reviews, vaccinations, and pulmonary rehabilitation, to all those with lung conditions.
- Prioritise the diagnosis of respiratory patients by providing a spirometry recovery fund of £40 million over the next two years, with more funding to those ICSs experiencing higher levels of deprivation.
- Implement national minimum standards for ICSs as a fundamental part of the new 10-year NHS plan to ensure that all major respiratory conditions are diagnosed and treated effectively, with under-performing ICSs held to account.

# 3. Analogue Digital

**To move from an analogue to a digital system, the government should:**

- Transform lung health research by committing funding and leadership to enable life-saving breakthroughs in how we diagnose and treat lung conditions.
- Improve data collection and analysis across the care pathway to bring together primary and secondary data, and make high quality, publicly available data which will help ICSs target care where it is needed and ensure accountability.
- Support ICSs to deliver proactive care facilitated by the roll out of digital tools, to keep patients well within the community and out of hospital, especially over winter.

# Improving the nation's health and supporting the government's growth mission.

People with lung conditions are often the most vulnerable in our society and they deserve better from the NHS. But in addressing their needs, we have the opportunity to support the government's desire to drive economic growth. We can enable people to live healthier lives and improve their economic opportunities. The government also has the opportunity to capitalise on the UK's world leading expertise in lung health and the potential for technology and pharma innovation to fully utilise our health data assets. Preventing, treating, and managing lung health is a global health problem, with massive unmet need. In prioritising respiratory research and innovation, and with relatively small investments, we could all gain from improved lung health in the UK.



# Sickness Prevention

1

**Tackle the toxic air pollution that kills 43,000 people every year, by establishing strong clean air targets in line with the World Health Organization to protect those most at risk.**

Up to 43,000 premature deaths per year are linked to air pollution in the UK<sup>6</sup>, and air pollution is associated with a wide range of health problems, including lung disease, heart disease, stroke, and cancer. People living with lung conditions continue to tell us how scared they are to go outside when air pollution levels are high due to the impact it can have on their condition, leaving them fighting for breath. Unfairly, it is those least responsible for air pollution who are often the most exposed, with evidence showing that exposure to air pollution is disproportionately experienced by people living on lower incomes and from ethnic minority backgrounds<sup>7 8</sup>.

There are no safe levels of air pollution. In 2021, the World Health Organization (WHO) updated its global air quality guidelines to reflect new evidence on the health impacts of air pollution. Governments must work towards these targets to protect everyone's health. The current limits set by the UK government's 2021 Environment Act fall short of what is needed and allow for levels above those recommended by the WHO. Many UK towns and cities have areas which breach legal limits of nitrogen dioxide (NO<sub>2</sub>), mainly due to road transport.

**Up to 43,000 premature deaths per year are linked to air pollution in the UK.**

The upcoming review of the Clean Air Strategy offers an opportunity to set a new level of ambition for targets on multiple pollutants including PM<sub>2.5</sub> and NO<sub>2</sub>, the two pollutants most dangerous to human health. The new government should look to align future targets with the latest WHO guidelines to ensure that in the longer term, we are moving towards a society where people are able to breathe clean air with healthy lungs.

More immediately, there should also be a commitment to bring forward our current target for PM<sub>2.5</sub> (10µg/m<sup>3</sup> by 2040) to 2030 to ensure that another generation is not left breathing dangerously toxic air.

By establishing strong clean air targets, the new government will protect those most vulnerable from the damaging effects of air quality. If the new 10-year NHS plan is to deliver a truly prevention-led NHS, it must include plans to tackle air pollution. A cross-departmental approach between DHSC, DEFRA and OHID is essential to tackle this in a holistic way that prioritises those most vulnerable to the harmful impacts of air pollution.



## 2

### **Prevent lung conditions by introducing a levy on tobacco companies to pay for a Smokefree Fund, ring-fenced for smoking cessation services, alongside the measures in the Tobacco and Vapes Bill to create a ‘smokefree generation’.**

Smoking remains the biggest cause of preventable illness and death in the UK<sup>9</sup>. It is estimated to cause one in five cancer deaths<sup>10</sup> and is recognised as a leading cause of lung conditions including Chronic Obstructive Pulmonary Disease (COPD), pneumonia, and obstructive sleep apnoea. Half of the difference in life expectancy between the least and most deprived in society is due to smoking<sup>11</sup>.

The groundbreaking Tobacco and Vapes Bill will, over time, prevent many thousands of unnecessary illnesses and deaths. But the government must do more to support the 6 million people<sup>12</sup> who currently smoke to give up for good.

In 2023, smoking cost the UK economy £93 billion, while only £8.4 billion was raised from tobacco taxes<sup>13</sup>. It is reasonable to expect such a harmful industry to pay for the damage it is creating through a levy on their products. As such, the new government must implement a levy on the tobacco industry to create a Smokefree Fund.

A Smokefree Fund would raise an estimated £700 million a year<sup>14</sup>. If adequately ringfenced for much needed smoking and nicotine cessation services, this long-term funding would have a transformational impact. Making smoking obsolete in England would lift 2.6 million adults and 1 million children out of poverty<sup>15</sup>, and help to reverse the 4.4 fold increase in sickness days lost due to respiratory conditions that the economy has faced in the past five years<sup>16</sup>.

## 3

### **Develop a cross-departmental national strategy to fix cold and mouldy homes that are killing people.**

Currently, 8 million people in England live in 3.7 million dangerous homes that are cold and in need of repair. These conditions can cause, and worsen, lung conditions <sup>17 18 19 20</sup>. That’s because respiratory infections can thrive in colder temperatures and poorly ventilated, damp environments. Long-term exposure to colder temperatures, damp and mould can also affect the immune response, hampering the body’s ability to fight off respiratory infections.

Housing is a well-established social determinant of health<sup>21</sup>, and although the recently introduced Renters’ Rights Bill will help to protect renters, it will not improve the quality of the country’s worst homes as a preventative strategy to help protect the nation’s health.

Almost one in four homes (21%) in the private rented sector fail the decent homes standard compared to around one in seven owner-occupied (14%) and one in ten (10%) socially rented homes<sup>22</sup>. This poor quality housing is severely damaging the health of millions of children, adults, and pensioners – and leading to huge costs and strain on the NHS.

Not only will a cross-departmental national strategy to fix unsafe homes prevent lung conditions from developing, it will ensure those living with a lung condition can stay warm and well at home and reduce their risk of exacerbation, particularly during winter. This strategy would also have economic benefits. Work by the Safe Homes Now campaign, of which Asthma + Lung UK is a member, found that investing just £625 million a year in home improvement could improve the quality of 520,000 homes a year, create 100,000 new jobs, save the NHS £1 billion a year and create potential health benefits of £19 billion<sup>23</sup>.



“There are traffic jams around here every day. Moving out of this area would cost me so much – I just couldn’t afford it.”

**Nikki-Leigh lives near to Birmingham’s notorious ‘Spaghetti Junction’, which more than 200,000 vehicles pass through every day. She is really concerned about the harmful effects of air pollution because five members of her family – including herself and her 14-year-old daughter – have been diagnosed with asthma. Her daughter Niah’s asthma has got worse in recent years. She has had several asthma attacks and has needed to take her reliever inhaler more often:**

*“I have definitely thought about the impact that air pollution might be having on Niah’s asthma because of where we live. You can see it in the sky sometimes. There are traffic jams around here every day. But we live where we live. Moving out of this area would cost me so much – I just couldn’t afford it.”*

**Niah has to be hyper-aware of pollution levels near her home, and the dangerous impact they might have on her health:**

*“My asthma does hold me back sometimes, especially if I’ve got a cold. I can’t do stuff. I can’t even walk up the stairs without being out of breath. I’m more aware of the impact that traffic fumes have on my asthma now that I’m at secondary school. The area where I catch the bus to school is very highly polluted. I do notice that I don’t seem to cough as much during the school holidays.”*

**Tackling toxic air pollution by establishing strong clean air targets would change the lives of people like Nikki-Leigh and Niah:**

*“I think urgent action should be taken to reduce air pollution because I want my child to live a long, healthy life. I don’t want it to affect the choices that Niah decides to make for her future. If she chooses to do something that’s physical and her asthma’s holding her back, I will think to myself about where we lived. I do think about my child’s future and even my own. I think about the statistics for life expectancy when you live in high pollution areas. As a parent, you feel like it’s your responsibility to keep your child healthy and safe. But there’s nothing I can do. However much I would love to move, it’s just not a viable option at the moment.”*

## 4

**Keep patients well and out of hospital, particularly in the winter months, by delivering good year-round basic care in the community, including annual reviews, vaccinations, and pulmonary rehabilitation, to all those with lung conditions.**

Delivered at scale, basic care, including annual reviews, vaccinations, and pulmonary rehabilitation, has the potential to enhance quality of life, reduce hospitalisations, improve healthy life expectancy, and alleviate winter pressures on the NHS.

We know from our annual *Life with a lung condition* survey that patients who receive the ‘five fundamentals’ of COPD care as recommended by NICE [offer treatment and support to stop smoking; offer pneumococcal and influenza vaccinations; co-develop a personalised self-management plan; offer pulmonary rehabilitation if indicated; and optimise treatment for comorbidities]<sup>24</sup> report fewer exacerbations and are better able to self-manage their condition. However, only 9% of our respondents actually received all five aspects, with a shocking 41% receiving just one fundamental or less<sup>25</sup>.

For people living with asthma, annual asthma reviews that include an inhaler technique check and written action plan are evidenced to reduce exacerbations and mortality, decrease oral corticosteroid use and the need for unscheduled healthcare<sup>26</sup>. Yet in our *Life with a lung condition* survey, 70% of respondents with asthma told us that they were not receiving these three aspects of basic care<sup>27</sup>.

### **Analysis by Asthma + Lung UK and PwC on the cost savings of delivering annual reviews with an inhaler technique check found:**

- Savings of £7 million a year across England, achieved as a result of patients gaining control over their condition.
- £244 million savings would be achieved in indirect costs such as improved productivity as this patient group become more economically active as a result of better health.
- Providing basic care would lead to a reduction in unscheduled visits to primary and emergency care, and a 70% reduction in hospital bed days amongst people with asthma, with almost half of this reduction in bed days likely to occur over the winter months<sup>28</sup>.

Good quality basic care should be available to everyone. Increasing access to pulmonary rehabilitation for all those eligible would result in £142.6 million of direct NHS savings related to reduced exacerbations, as well as a reduction of 194,000 bed days, 66,000 of which would be saved over the winter period. In addition, this would result in productivity saving of just under £4.8 million as a result of those with better controlled COPD becoming more economically active<sup>29</sup>.

Vaccinations are well-established as a cost-effective preventative intervention, and ensuring all those who need a respiratory vaccination receive one will help to reduce the 4.8 million working days that are lost in the UK due to seasonal flu every year<sup>30</sup>.

To see these results, sufficient resourcing of primary care to have the appropriately trained staff to deliver good basic respiratory care is necessary. Implementation of the NHS England (NHSE) Workforce Plan will help to meet this need. The upcoming review of the Quality and Outcomes Framework (QOF), a primary care incentive-based funding mechanism, should be used as an opportunity to redesign how incentives could work better for respiratory patients and services, lead improvement of these metrics at the integrated neighborhood team level, and improve the provision of quality basic care for respiratory patients.



## **Prioritise the diagnosis of respiratory patients by providing a spirometry recovery fund of £40 million over the next two years, with more funding to those ICSs experiencing higher levels of deprivation.**

1.7 million people are living with COPD in the UK, but around 600,000 of those are living undiagnosed. This is due to huge backlogs and geographical inequalities to accessing spirometry – a basic diagnostic test. Spirometry used to be provided in primary care but inadequate funding and workforce challenges are leaving people without proper care and treatment, permanent damage to health, and unnecessary hospital admissions. This inability to diagnose those with lung conditions in an accurate and timely manner is a serious failure in need of a serious solution.

Providing a spirometry recovery fund of £40 million over two years would ensure primary care finally has ringfenced money for this specific purpose, which will allow providers to upskill the necessary staff and commission services to meet demand and deal with the backlog.

**1.7 million people are living with COPD in the UK, but around 600,000 of those are living undiagnosed.**

Recent NHSE spirometry commissioning standards list spirometry test prices up to £56.88 per test. At this cost, £40 million over two years would deliver 703,234 tests. This would lead to a significant reduction in the backlog of people waiting for tests and embed spirometry in primary care again.

This recovery fund would bring significant system level benefits and savings. Work by Asthma + Lung UK and PwC found that expanding the availability of spirometry testing to just 50% of eligible patients could result in just over £80 million in direct NHS cost savings related to reduced exacerbations<sup>31</sup>. This could also result in a reduction of 85,474 hospital bed days (of which 29,061 would be winter bed days) and produce £2.4 million in productivity savings<sup>32</sup>.

Given that those from the poorest communities are 4.7 times more likely to die from COPD than those in the richest<sup>33</sup>, we recommend prioritising this funding to those areas experiencing higher levels of deprivation to ensure they have the resources to support those most in need.

# 6

## **Implement national minimum standards for ICSs as a fundamental part of the new 10-year NHS plan to ensure that all major respiratory conditions are diagnosed and treated effectively, with under-performing ICSs held to account.**

Lord Darzi's investigation into the state of the NHS found that patients are often being failed by the bodies that are created to provide care: ICSs. But currently local health systems are not being held accountable for their outcomes, or how they provide key services. A lack of transparency about what they are expected to deliver has led to patchy care and a postcode lottery of service delivery<sup>34 35</sup>.

To rectify this, the new 10-year NHS plan should lay out national minimum standards for ICSs covering all relevant services needed to diagnose and treat respiratory conditions.

### **These minimum standards should:**

- Ensure that all ICSs provide respiratory diagnostics at capacity to meet local need and monitor waiting times for these tests.
- Ensure good levels of basic care, for everyone with a long-term lung condition, prioritising those with greatest risk of being admitted to hospital.
- Ensure follow-up care post-discharge from hospital is consistently delivered, to minimise the chances of readmission.
- Incentivise local systems, including primary, secondary, social and community care, to collaborate effectively in order to keep those with lung conditions well year-round and minimise avoidable admissions.
- Commit to a national diagnosis target for lung conditions to make sure no one waits more than six weeks for a diagnostic test and to halve waiting lists by 2028, bringing lung disease in line with other major disease areas.

These minimum standards, and associated data for tracking them, should be used as an accountability mechanism for ICSs. The new 10-year NHS plan should outline the formal channels the government will use to monitor ICS outcomes and take action where they are falling short.



**“ If the doctors had done something about it as soon as possible, then I feel like it could have prevented a lot of the things that I had to go through. ”**

**Rae, a teacher based in Coventry, lives with bronchiectasis. Bronchiectasis causes the airways to widen and become inflamed with thick phlegm. People living with bronchiectasis often have a cough, experience breathlessness, and can face repeated chest infections. Despite managing her condition well as an adult, Rae had to fight to get an accurate diagnosis when she was younger:**

*“I was about 10, and always very out of breath, coughed up a lot of phlegm and when I would take part in exercise, my chest felt really painful and tight. My parents took me to my local GP who diagnosed me with asthma. But my cough was persistent, and my condition got much worse - my mum had to be very persistent and kept taking me back to my GP. After a few years, I was eventually seen by a specialist who ran lots of tests on me and then diagnosed me with bronchiectasis. I'd never had asthma.”*

**At the age of 12, Rae finally got the diagnosis she needed. But being a teenager with a chronic lung condition also came with challenges:**

*“If the doctors had done something about it as soon as possible, then I feel like it could have prevented a lot of the things that I had to go through. I was in hospital quite a lot. And I remember there were times I'd have different nurses coming in and out, different doctors coming in and out, it was frightening. And at secondary school, I didn't know how to go about explaining my lung condition to my friends because I felt very embarrassed. I'd go to the toilet and have to spit my sputum out because I felt so embarrassed. And during prayers, I would hold my breath, I didn't want people to hear the rattling in my lungs.”*

**For patients to self-manage their condition well, they need to understand their condition. But this is being missed due to capacity issues within the NHS and deprioritisation. Rae wants to see the NHS support people with lung conditions better:**

*“Doctors tend to say, ‘this is what you have’, and then they give you a leaflet, and then that's it. I remember by the look on my mum's face that she didn't know what it meant when I got my diagnosis. I hope that by giving the NHS the resources they need, they would provide better patient education, and support the whole family. It wasn't just me that's going through it; it was my whole family that was affected, and I was too young to explain it.”*

*“I also wish things were done a lot sooner; reducing waiting lists to see specialists and get an accurate diagnosis. That would have helped me out a lot. I could have managed my symptoms better and understood my medication a lot more.”*

# Analogue Digital

7

## **Transform lung health research by committing funding and leadership to enable life-saving breakthroughs in how we diagnose and treat lung conditions.**

The UK currently spends £70 million annually on lung research, which amounts to less than 2.5% of the £2.8 billion invested in health research each year<sup>36</sup>. As a result, people living with lung conditions are being left behind. The therapeutic approach for COPD hasn't changed in more than 30 years, there is no cure for idiopathic pulmonary fibrosis (IPF) which has a worse prognosis than some cancers (3-5 years), and there are currently no licenced treatments for bronchiectasis. There were 44% fewer patients recruited to clinical trials from 2017-2021<sup>37</sup>, indicative of the considerable issues with clinical trial accessibility and industry leaders leaving the UK.

**The UK currently spends £70 million annually on lung research, which amounts to less than 2.5% of the £2.8 billion invested in health research each year.**

Investing in lung health research would reap considerable rewards for the UK economy. Research by the charity and PwC found that increasing investment in respiratory research to a total of £721 million over a seven-year period would contribute £851 million to the economy by 2030<sup>38</sup>, and lead to an additional £699 million in wider private sector investments<sup>39</sup>. Research can enable more efficient diagnostics and better treatments thereby reduce waiting lists and keep people out of hospital. Investing now in respiratory research will help to tackle the big challenges the NHS faces in the long term.

### **To kickstart a transformation in UK respiratory research and development, Asthma + Lung UK is advocating for three investments that build on existing infrastructure over the coming years:**

- An investment of £50 million over five years into the Centre for Applied Respiratory Research Implementation and Innovation to leverage the UK's data assets to drastically reduce winter pressures and tackle health inequalities.
- Using the UK's greatest health asset – data – to drive a revolution in lung health and industry innovation. A £15 million investment to allow lung fitness measurements to be included at baseline within Our Future Health will allow a greater understanding of how respiratory diseases develop over time and how they can be prevented. Tech and pharma advances in the UK could unlock an enormous multibillion pound global market where there is massive unmet need in lung health.
- The creation of an NIHR Respiratory Clinical Trial Accelerator to resolve the current problem of vastly underrecruited respiratory clinical trials and development of new life-changing and life-saving treatments. The UK has the potential to be a powerhouse in global respiratory research supporting economic growth.



## **Improve data collection and analysis across the care pathway to bring together primary and secondary data, and make high quality, publicly available data which will help ICSs target care where it is needed and ensure accountability.**

Compared to other long term health conditions, respiratory data availability significantly lags behind<sup>40</sup>, with particular data gaps in primary care and diagnostic services which do not exist in cardiovascular disease, diabetes and cancer<sup>41</sup>.

Without meaningful data, serious gaps in care provision can be missed. For example, we cannot say with certainty how many people have received a spirometry test to diagnose their COPD or had an annual review for their asthma in a given year as this data is not publicly available. Further data gaps exist when looking at the quality of service delivery and this means opportunities to optimise care for the patient and the NHS are not taken, for example, stratifying patients at risk of exacerbation to prevent hospital admissions in winter.

Ensuring all data collected is available in a single NHS England platform for easy cross-linkage and analysis is essential. This platform needs to be publicly available to all so that ICS performance can be monitored and areas that are falling behind identified and supported to improve.

By ensuring this data is collected and published in a timely manner, near real time analysis will be possible, making the health system more able to react to a changing environment. Including more demographic information in a secure and anonymous way will also enable a better understanding and ability to address health inequalities.

Population health management will be one of the main benefits of better access to data: better data can facilitate the identification of individuals in primary care with features of disease e.g. symptoms suggestive of asthma or COPD, but who don't yet have a diagnosis. Better data will help to identify patients at rising risk of poor outcomes, and should be used to provide them with evidence-based interventions personalised to their condition. Better data (on e.g. hospital admissions, exacerbations, prescriptions overuse/underuse) could allow the continuous monitoring of all patients and identification of those in need of more support. And better data can guide clinicians to implement guidelines and support risk stratification of patients.





## **Support ICSs to deliver proactive care facilitated by the roll out of digital tools to keep patients well within the community and out of hospital, especially over winter.**

The government should support ICSs to deliver proactive care, and prevent lung conditions worsening, by rolling out digital tools across the health service. By using digital tools to focus on secondary prevention, exacerbations and flare ups can be prevented, people living with lung conditions can be kept well and economically active, and NHS resources can be saved, particularly in winter through reduced hospital admissions.

Digital tools can facilitate proactive care by identifying patients most at risk of exacerbations or hospital admissions, so that additional support can be delivered, symptoms can be managed, the risk of exacerbation reduced, and hopefully the need for emergency hospital care avoided.

Digital disease monitoring tools can monitor disease progression and predict exacerbation or deteriorating symptoms, thereby flagging to the patient or healthcare professional that intervention is needed to keep them well. Ideally, these can be delivered through passive monitoring that doesn't require data input and can be built into everyday technologies like mobile phones<sup>42</sup>.

### **Digital tools can facilitate proactive care by identifying patients most at risk of exacerbations or hospital admissions.**

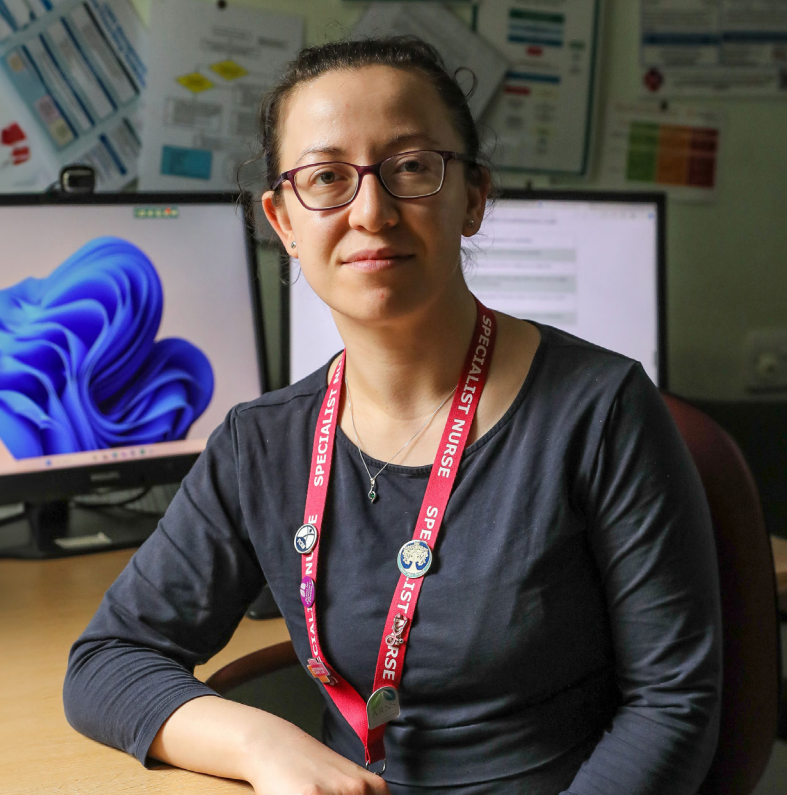
Artificial intelligence has the potential to play a key role in speeding up the diagnosis of respiratory diseases and freeing up capacity of healthcare professionals. For example, new AI-driven software solutions have shown early promise in reducing the time needed by healthcare professionals for interpretation of spirometry results<sup>43 44</sup>.

Other practical digital tools for patients can transform proactive care. Smart inhalers can help ensure that patients reliably administer their medication in a timely manner and monitor adherence over the course of treatment. Self-management apps can enhance patient-healthcare practitioner communications to improve the management of lung disease and reduce the incidence of exacerbations and A&E admissions<sup>45</sup>. Indeed, expanding uptake of an existing respiratory self-management app could result in the avoidance of 410,000 sick days per year across the UK<sup>46</sup>.

Digital pulmonary rehabilitation products, recently approved by NICE for use in the NHS as further evidence is collected, can enable a wider variety of people access to this effective, and cost saving, COPD treatment<sup>47</sup>.

Virtual wards can enable those with respiratory infections such as pneumonia, and those who have had a COPD exacerbation, to be cared for and monitored at home, thereby relieving the NHS of pressures, particularly during winter.

Work to break down the barriers to digital tool roll out, such as complicated procurement and support for clinicians<sup>48</sup>, is already underway<sup>49</sup>. However, the new 10-year NHS plan must consider how to overcome these barriers by reducing the time it takes for innovative treatments to reach patients, and supporting the Accelerated Access Collaborative product pipeline, the Clinical Entrepreneur training programme and the NHS Innovation Service.



**“ We have found a new way to risk stratify patients – we find the patients who need the most support and bring them in for review first. ”**

**Maria is a Clinical Respiratory Nurse Specialist in Southampton. She has worked in respiratory medicine since qualifying as a registered nurse in 2010.**

*“From doing an annual review and going through inhaler technique, to helping more complex patients manage their condition, I can explain what patients need to do and why. Doing those little things make a big difference and I find it very rewarding. Patients really appreciate when you give them the time to go through all these things with them.”*

**Despite loving her job, Maria sometimes finds it hard working in the NHS, particularly during winter.**

*“The winter is the busiest time, and where I work, the demand is increasing every year. There is a lot more urgent care needed and we have to focus on saving a patient when something has gone wrong rather than preventing it happening in the first place. It's so busy you feel like you're not necessarily giving the best quality care to patients. It's simply about trying to get more people through the door. And that's tough, it's stressful, and I'm often really tired.”*

**She also recognises the impact this is having on her patients.**

*“Most of the time patients struggle to access the GP. They need the time and the care to understand their lung disease, and to be able to access respiratory specialists in primary care. Accessibility is a big issue for my patients.”*

**Through her work as a nurse, and as an Asthma + Lung UK Respiratory Champion, Maria has changed respiratory care in her local area.**

*“Surgeries in the area used to bring patients in for review based on their birthday, but we have found a new way of risk stratifying them – we find the patients who need the most support and bring them in for review first. This has allowed us to get to patients before it's too late and they're in hospital – but we need more sustainable funding for primary care.”*

*“We also need to get the right patient to the right healthcare professional at the right time. Preventing them getting worse, but utilising NHS services better, for example, a well-controlled asthma patient could have their inhaler technique check done by a community pharmacist, freeing up my time as a Respiratory Nurse Specialist for more complicated patients.”*

*“If these changes could be rolled out across the country, it would make a huge difference.”*

# Recommendations

## 1. Sickness Prevention

**To reform the NHS from sickness to prevention, the government should:**

- Tackle the toxic air pollution that kills 43,000 people every year, by establishing strong clean air targets in line with the World Health Organization to protect those most at risk.
- Prevent lung conditions by introducing a levy on tobacco companies to pay for a Smokefree Fund, ring-fenced for smoking cessation services, alongside the measures in the Tobacco and Vapes Bill to create a 'smokefree generation'.
- Develop a cross-departmental national strategy to fix cold and mouldy homes that are killing people.

## 2. Hospital Community Care

**To move care from hospitals to communities, the government should:**

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- Prioritise the diagnosis of respiratory patients by providing a spirometry recovery fund of £40 million over the next two years, with more funding to those ICSs experiencing higher levels of deprivation.
- Implement national minimum standards for ICSs as a fundamental part of the new 10-year NHS plan to ensure that all major respiratory conditions are diagnosed and treated effectively, with under-performing ICSs held to account.

## 3. Analogue Digital

**To drive forward an analogue to digital system, the government should :**

- Transform lung health research by committing funding and leadership to enable life-saving breakthroughs in how we diagnose and treat lung conditions.
- Improve data collection and analysis across the care pathway to bring together primary and secondary data, and make high quality, publicly available data which will help ICSs target care where it is needed and ensure accountability.
- Support ICSs to deliver proactive care facilitated by the roll out of digital tools, to keep patients well within the community and out of hospital, especially over winter.

# Appendix 1: Data sources

## Life with a lung condition survey 2024

The *Life with a lung condition* 2024 was conducted between January and March 2024, gathering responses from 12,700 individuals across the UK. The survey was promoted through our mailing list, website, and both organic and paid social media channels. It covered a wide range of topics related to living with a lung condition.

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