Staffordshire and Stoke-on-Trent Integrated Care System

All Age Respiratory Strategy, 2025-2030

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Foreword

We are proud to introduce the All Age Respiratory Strategy 2025–2030 for Staffordshire and Stoke-on-Trent Integrated Care System (ICS). This strategy represents a significant milestone in our collective commitment to improving respiratory care for people of all ages from our communities.

The current NHS Long Term Plan identifies respiratory disease as a key clinical priority for better care, and this strategy outlines our shared vision across the ICS to enable high-quality, patient-centred respiratory care. The strategy captures the evolving health and care landscape, including new approaches and innovations, as well as the implications of national policy and local developments.

In developing this strategy, we have engaged extensively with partners across the health and care system, as well as with individuals and communities who bring invaluable lived experience. Their insights and perspectives have shaped the strategy's priorities and provided assurance that it reflects the needs and aspirations of Staffordshire and Stoke-on-Trent's diverse population. We extend our thanks to all who contributed to this effort; your voices have been essential in helping us design a strategy that is ambitious, inclusive, and grounded in real-world experience.

Delivering this strategy will require genuine and sustained collaboration. The ICS is committed to fostering stronger partnerships between health, care, local government, voluntary, and community organisations - as well as with the people we serve.

Foreword *continued*

The ambitions set out in this strategy are bold, but we are confident they are achievable with the shared dedication of our system partners. By working together, we can create a future where respiratory patients of all ages are supported with the highest standards of care.

Thank you for your commitment and collaboration as we move forward together.

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Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) Non-Executive Chair.

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Introduction

Respiratory diseases affect one in five people in England and are the third biggest cause of death in the country. They are a key contributor to hospital admissions generally and to admissions over the winter months in particular. Mortality from respiratory diseases is patterned on deprivation and contributes to the gap in healthy life expectancy seen between the richest and the poorest. As such chronic obstructive pulmonary disease (COPD) features as a focus area in the CORE20PLUS program for adults and asthma in the programme for children. Chronic respiratory diseases are also identified as a target for action in the NHS Major Conditions Strategy. The annual economic burden on the NHS of respiratory diseases is £11 billion.

The NHS Long Term Plan and the more recent report produced by Professor Lord Darzi emphasise the importance of prevention and a shift to care in the community. This is especially important in respiratory diseases where smoking causes 45% percent of the Disability-Adjusted Life-Year (DALY) burden. Addressing respiratory disease also benefits from integrated approaches across integrated care systems (ICS), with important roles for communities, local authorities, the voluntary sector, social care and healthcare.

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) Joint Forward Plan and Integrated Care Partnership Strategy demonstrated that better, personalised management of long term conditions is needed to improve outcomes, improve patient experience and reduce demands on services.

The scope of this strategy includes asthma, COPD and pneumonia in people of all ages across the Staffordshire and Stoke-on-Trent ICS.

This strategy has been developed after undertaking an extensive examination of the data, speaking to colleagues and seeking the views of patients and carers. We will describe our enablers, our interactions with other portfolios of work and our disease specific aims.

There is excellent work happening in the ICB to address respiratory diseases, but we still have high admissions, high readmissions and high mortality. So, we need to find different ways of working for the benefit of our populations.

Ambition

Children, young people and adults of all backgrounds, identities and abilities can breathe freely and live healthy, independent lives.

The views of patients and carers

Two focus groups were attended and 108 people completed an online survey. The main themes include:

Prevention:

- almost all smokers have considered stopping. Usually for health reasons
- some have managed without support. Others would like more support
- encouragement and information from healthcare was important

Asthma and COPD:

- confidence in managing stable disease and exacerbations is helped with education, clinical support (including specialists) and experience
- half the people found annual reviews helpful. Others would prefer a more holistic approach and flexible delivery options
- most people seek help from GPs first
- personal action plans are valued

Systems:

- early diagnosis of asthma, COPD and pneumonia is valued
- better communication at the interfaces is needed
- easier access to people with the right skills and equipment is needed
- acknowledgement of multimorbidity is needed
- flexibility of delivery is needed
- more holistic discharge planning is needed

The views of providers and professionals

Two provider and professional workshops were held. Attendees (36 in total) included representatives from primary care, community care, local authority, medicines management, secondary care and voluntary sector representatives. One-to-one discussions were held with consultants, community and acute respiratory nurses, allied health professionals (AHP) leads, the medicines management team, care home leads and voluntary sector representatives. Several important themes emerged:

Improved communication is needed:

- this can be facilitated by a shared electronic record
- teams should be able to meet in person to develop stronger relationships

Equitable access to services is essential:

- those who are housebound, living in care homes or in rural areas are forgotten
- there is inequitable access to community respiratory nursing and smoking cessation services
- there is inequitable access to specialist review after hospital admissions

Holistic, integrated care should be prioritised:

- loneliness, housing, nutrition and psychological wellbeing impact on disease outcomes
- there are many models of integrated care and multidisciplinary team working and these should be explored
- continuity of care is important

Interactions and interfaces

The ICS Long Term Conditions Strategy describes how the ICS has identified a series of priority portfolio areas for service and quality improvement. Portfolios include:

- Urgent and Emergency Care (UEC)
- Planned Care, Cancer and Diagnostics
- Mental Health, Learning Disabilities and Autism
- Children and Young People (CYP)
- Primary Care
- Community Transformation

This strategy falls under the Community Transformation portfolio. Clinical Improvement Groups (CIGs) within the Community Transformation portfolio are tasked to deliver an improvement plan for their disease area. We have worked closely with partners in primary care, community care, secondary care and local authorities to develop this strategy. Within the Community Transformation portfolio there are overlaps with healthy ageing and frailty, cardiovascular disease, diabetes and end of life workstreams.

Enablers

At an ICS level there are several factors which enable better development and delivery of the objectives outlined in this strategy.

Integrated care:

- this means people receive the care they need at the time that they need it, delivered by those who are qualified to deliver it
- it reduces variation, improves outcomes and is preferred by patients
- it includes admission and discharge pathways

Workforce development:

- all staff should have access to opportunities to increase their knowledge, confidence and skills
- this will allow expansion of skills to meet different needs without changing job roles
- this should include those working in the voluntary and care sectors

Greater use of digital and data tools:

- shared electronic records to enable smoother communication and transitions
- better coding practices make data more reliable
- data can be used to identify need and offer targeted care

Prevention

Objective: We will make prevention a core activity in all services and care settings regardless of disease severity.

Rationale:

- prevention activities are important for all respiratory conditions. The ICB has higher rates of COPD than its peers and the highest rates of admissions due to pneumonia in the country
- 45% of the (disability-adjusted life years) DALY burden of all chronic respiratory diseases is attributable to smoking
- there are nearly 100,000 smokers in the ICS area. Rates are higher in areas of deprivation. Smoking, both active and passive, is problematic for all respiratory conditions
- comorbidities are common in patients with COPD. Preventing multimorbidity and increasing resilience are both important to improve quality of life and clinical outcomes
- healthy lifestyle choices even, if started late in life, can prevent long term illnesses and reverse their effects
- early detection of cancer, respiratory and cardiometabolic disorders can prevent underlying multimorbidity and significantly reduce negative impacts

- preventing infections reduces the risk of pneumonia, flu and covid which may be particularly deleterious in those with respiratory conditions. Vaccines and warm homes can prevent pneumonia. There is good uptake of the pneumococcal vaccine but poorer uptake of the flu vaccine in those most at risk in the ICS area. Within the ICS there are some areas with the worst fuel poverty in the country
- local data shows that there are high levels of inactivity and alcohol-related admissions and poor levels of fruit and vegetable intake and health literacy
- some localities in the ICS area have poor air quality which can contribute to asthma exacerbations
- Asthma, COPD and pneumonia outcomes are patterned on deprivation. And pneumonia outcomes are worse in those with learning disabilities. So, equity and guarding against inequalities is important in prevention and treatment decisions

Targets:

- support the development of an ICS Prevention Strategy by 2027
- to meet national targets for existing large-scale screening and prevention programmes for those who are eligible (e.g. NHS Health Checks and cancer screening)
- to meet national targets for flu, pneumococcal, COVID-19 and RSV vaccines in those at risk
- increase training for and delivery of Making Every Contact Count (MECC), Five Ways to Wellbeing and Patients Know Best for all public facing staff in clinical and non-clinical roles
- embed smoking cessation services into all clinical settings by 2030
- meet the government target of an adult smoking prevalence of 5% or less by 2030
- improve awareness of the importance of indoor air quality, especially around smoking in the home
- decrease the proportion of adults consuming more than the recommended amounts of alcohol
- increase the proportion of adults engaging in physical activity both before and after diagnoses are made
- increase the proportion of adults eating a healthier diet
- work with system partners to reduce fuel poverty and improve housing quality
- support all partners to achieve national green targets

Asthma and COPD

Education, psychological support, nutritional support, social care, managing multimorbidity

Early diagnosis

Objective: All children, young people and adults will have equitable access to respiratory diagnostic services in the community.

Rationale:

- early diagnosis improves outcomes and symptom control in asthma and COPD
- diagnostic guidelines recommend the use of spirometry and fractional exhaled nitric oxide (FeNO) testing
- some service users report long delays in getting investigation and treatment
- there is uneven distribution across the ICS of community diagnostic services for asthma and COPD

Targets:

- to ensure that adults, children and young people have timely access to spirometry and FeNO, as appropriate, by the end of 2025
- move to proactive identification of COPD across the ICB in at risk groups using digital tools as they become available

Management of stable disease I – empowering patients

Objective: All patients with asthma and/or COPD are empowered to manage their own or disease.

Rationale:

- patient education in asthma and COPD can improve symptom control, disease outcomes and general wellbeing
- the evidence base for both diseases suggests that patient activation (that is having the knowledge, confidence and skills to manage own health) and health literacy are important
- behavioural science evidence suggests that multipronged approaches are needed to embed new knowledge and behaviour. Regular review of information from both healthcare staff and peers is helpful
- personal action plans can improve quality of life and reduce hospital admissions for adults and reduce mortality in children and young people. Producing an action plan is part of an annual asthma review, but there is little information locally or nationally about how many adult patients have and use their action plans. Parents and carers of children and young people in the ICB report that they find personal action plans useful and reassuring
- service users report that they have found the support from voluntary sector groups valuable, that they wish they had information earlier and that written action plans are useful
- empowerment approaches will need to be adaptive to changes in age and lifestyle. Providers report that the transition between children's and adult services can be challenging. The evidence suggests that co-ordinated planning which starts early and includes the young person, their family and their GP offers the best chance for a smooth transition

Targets:

- to include data about presence of personal action plans in respiratory dashboards by 2025
- to ensure that 50% of patients with asthma and COPD have a personal action plan by 2027 and 80% by 2030
- to ensure that action plans are reviewed annually and after exacerbations
- to explore the possibility of group sessions to reinforce key messages
- to enable patient engagement with voluntary sector local support groups by providing information at diagnosis and annual reviews
- to evaluate both processes and impact of the Asthma Champions programme for children and young people with asthma by 2025
- to develop an ICS-wide approach to smooth the transition between children's and adult services following national guidelines once they are released

Management of stable disease II – being equitable and effective

Objective: System partners are enabled to deliver equitable, high quality, primary and community care for all people living with asthma and COPD

Rationale:

- annual asthma and COPD reviews are an incentivised action. Good quality annual reviews improve outcomes, and in children and young people can reduce death. The coverage and quality of annual reviews is variable across the ICB. The proportion of eligible patients receiving asthma reviews ranges from 50% to 98% per practice. The range for COPD is 45% to 100%. Service users and professionals report varied quality of reviews
- service users and practitioners value community respiratory teams. There is evidence that community respiratory teams improve outcomes and reduce admissions. There are areas of the ICB where there is no access to community respiratory support
- pulmonary rehabilitation is one of the most effective and cost-effective interventions to reduce deterioration, exacerbations and admissions for people living with COPD. There is variability in referral and attendance to pulmonary rehabilitation across the ICB
- optimised inhaler use reduces exacerbations, the need for emergency care and mortality in asthma. It also enables the NHS to meet its carbon promise and is cost-effective
- newly developed ICB asthma and COPD guidelines offer an opportunity to reinforce practitioner facing educational material
- multimorbidity increases the risk from asthma and COPD and can make each condition more challenging to control

Targets:

- to identify support needs of practices to complete annual reviews
- to improve the quality of asthma and COPD annual reviews by developing a minimum standard for each by the end of 2025
- to co-ordinate annual reviews for those with multimorbidity
- to refresh practitioner-facing educational materials by the end of 2025
- to achieve children and young people's asthma tier training for public-facing staff at a level appropriate for their role as per contract targets
- to develop a business case for equitable access to community respiratory support by the end of 2025
- to ensure equitable access to community respiratory nursing services by the end of 2028
- to work with patients to understand barriers for attending pulmonary rehabilitation (PR)
- ensure 70% of patients enrolled for PR go on to complete the programme and have a discharge assessment
- to work with the medicines management team to deliver annual targets
- to ensure that the right patient is on the right medication
- to review access to home oxygen services and ensure that this access is equitable by 2028

Exacerbations

Objective: Exacerbations of asthma and COPD are reduced in frequency and managed early with appropriate use of community and secondary care services

Rationale:

- exacerbations, especially if frequent, indicate poor disease control. This in turn risks damage to the lungs and strain on other body systems
- early identification of exacerbations can enable treatment at home with relatively little lung damage
- management of an exacerbation includes review of regular medication and taking steps to prevent further exacerbations
- suboptimal identification and management of exacerbations increases the risk of admissions, readmissions and mortality
- Stoke-on-Trent has high rates of admissions and mortality from asthma and COPD
- the whole ICB has high rates of readmissions following an admission with asthma or COPD
- service users report that post-discharge communication with primary care and patients' needs to be improved
- most asthma deaths are preventable
- early identification and management of exacerbations contributes to demand management efforts

Targets

- improve early detection and treatment of exacerbations through patient and practitioner education
- continue to develop admission avoidance support for those well enough to be managed at home
- ensure that all patients admitted with asthma or COPD are reviewed by clinician with specialist respiratory skills
- develop a respiratory virtual ward for both step-up and step-down activities
- to ensure that there is clear communication about primary and secondary care follow up after an exacerbation
- provide open access to community services for named patients most in need
- ensure appropriate community or primary care follow up for patients seen in out of hours or hospital settings within two days

Stepping up care

Objective: All those requiring secondary care specialist input receive this in a timely and equitable manner

Rationale:

- SSOT ICB has the longest waiting lists for respiratory outpatient services in the country and waits are increasing. Reviewing referral letters, addressing causes for missed appointments, improving coding practices and improving access to community diagnostic services can all help to reduce waiting lists. The latter is already mentioned in this strategy
- NHS England supports the use of biologic agents for severe asthma. These require assessment in specialist clinics. A current pilot has shown that the service is effective and welcomed by patients

Targets

- to reduce waiting times for outpatient appointments such that SSOT is line with demographic peers by 2027
- explore the option for waiting well initiatives in respiratory care
- ensure equitable access to biologic agents for severe asthma once pilot studies have been evaluated

Complex disease

Objective: All patients with complex disease are managed by multi-disciplinary teams

Rationale:

- complexity can be brought about by respiratory disease, multimorbidity or social circumstances
- NICE (National Institute for Health and Care Excellence) guidelines recommend that patients with complex asthma and COPD be managed using a multidisciplinary team (MDT) approach. This should include nutritional, psychological and physical input alongside respiratory input. Early anticipatory care discussions are also encouraged
- where service users have had access to MDTs, they have valued the holistic nature of the assessment and the time given to them
- prevention remains important even at this stage of the disease
- children and young people, those who are housebound and those living in care facilities may also need MDT input

Targets

- Develop a population health management approach to systematically identify patients who will benefit from an MDT approach
- develop integrated MDTs to offer holistic management
- integrate frailty, respiratory and cardiovascular MDTs where needed
- ensure equitable access to MDTs

Palliative and End of Life Care

Objective: People living with asthma and COPD will have access to compassionate care at the end of their lives, or when symptom control is needed.

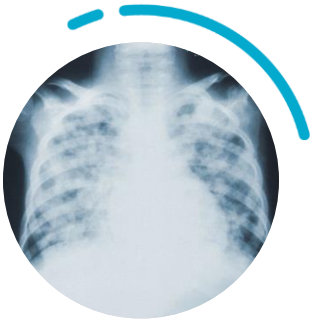
Rationale:

- death is inevitable. There are tools to help identify those most at risk of death
- local data shows that there are high rates of admissions in the last three months before death. These may be preventable with proper anticipatory care discussions
- Palliative care may be needed for symptom control in cancer and non-cancer patients, including those living with respiratory disorders. Access to palliative care should not be restricted to the end of life only

Targets

- to support the development of ICB Palliative and End of Life Strategy
- to provide education and support to clinical staff in identification of those nearing the end of life
- to collect data about death in preferred place

Pneumonia



Pneumonia pathway redevelopment

Objective: All people with pneumonia are identified and treated promptly

Objective: All people admitted with pneumonia are offered appropriate discharge support to prevent readmissions.

Rationale:

- compared to our demographic peers, SSOT has the second-highest A&E (accident and emergency) attendance rates for acute lower respiratory tract infections
- mortality where influenza or pneumonia are one of the contributing causes is significantly higher in SSOT than in England
- SSOT ICB has the highest readmission rates following an admission with pneumonia in the country
- Pneumonia admissions are a key driver of winter pressures
- service users report variable experience of getting an early diagnosis
- service users report varied discharge experiences
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has outlined key steps to reduce death due to pneumonia

Targets

- to implement a new integrated pneumonia pathway covering primary care, intermediate services and acute trusts by winter 2025/26
- to implement holistic discharge processes which include assessment of the home environment, information for community services and the patient by winter 2024/25
- to provide health care providers with reminders about pneumonia guidelines before winter every year
- to develop the infrastructure for pneumonia expertise with one specialist pneumonia nurse per 400 admissions
- to agree standardised coding practices around pneumonia for primary and secondary care by 2028

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