RESPIRATORY SERVICES DELIVERY PLAN

2014 – 2017

October 2014

EXECUTIVE SUMMARY

One in seven adults (14%) in Wales reports being treated for a respiratory condition. However the Welsh Health Survey 2012/13 suggested that within Cwm Taf 16% of adults were being treated for a respiratory illness. Latest QOF data shows that 19,738 individuals are registered as having Asthma (a prevalence of 6.5%), and 2.67% of our population are registered as having COPD (8,122).

The national Respiratory Delivery Plan for Wales was published in April 2014 and provides a framework for action by Local Health Boards (LHBs) and NHS Trusts. In response to the document Cwm Taf University Health Board's Respiratory Planning and Delivery Group (RPDG) has developed a local Respiratory Delivery Plan, which sets out the UHB's response to the actions within the national document. The Plan covers five lung conditions including, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Bronchiectasis, Interstitial Lung Disease, Sleep-Disordered Breathing and Acute Respiratory Care.

There are a number of local drivers for improving Respiratory care. These include the prevalence of respiratory diseases locally, outcomes for our population, the growing demand on our services in the context of a difficult financial climate and issues in relation to equity of service provision. In response the RPDG has established four sub groups which are taking forward agreed priorities for the first year of the Plan. The rationale being that a focussed approach on smaller number of priorities is likely to achieve more progress. In September 2015 the RPDG will then review progress and identify the next round of priorities for year two of the plan.

The four sub groups established to drive implementation of the plan are as follows:

1. Preventing poor respiratory health.
2. Early detection.
3. Prompt effective treatment.
4. Patient education and support services.

The University Health Board acknowledges the challenges it faces in implementing the vision for respiratory services and these are detailed within the plan. Progress and performance against the national outcomes and assurance measures will be monitored by the Executive Board and reported to the Board annually.

1. BACKGROUND AND CONTEXT

The national Respiratory Delivery Plan for Wales was published in April 2014 and provides a framework for action by Local Health Boards (LHBs) and NHS Trusts. It sets out the Welsh Government's (WG) expectations of the NHS in Wales to tackle lung diseases in adults and young people wherever they live in Wales and whatever their circumstances. The Plan sets out how the NHS will deliver on its responsibility to meet the needs of people at risk of developing, or affected by, a wide variety of acute and chronic lung conditions. This is a significant challenge, for individuals and their carers and the Welsh NHS.

The context within which the University Health Board currently operates will impact on our ability to deliver against the national plan. We face many challenges within the coming years with growth in our population need, increased costs and significant resource constraints. The next three years will be particularly challenging with further real terms reductions in resource allocations over this period. This will present the most significant challenge of this type that the University Health Board has faced to date. In taking forward our local plan we must therefore look for new and innovative approaches to tackling respiratory diseases and meeting the needs of our local population. This will require different ways of working, a more collaborative approach across primary and secondary care services and the development of integrated services with our Local Authority and Third Sector partners.

2. VISION

The vision for Wales is for people of all ages to be encouraged to value good lung health, to be aware of the dangers of smoking and, take be supported to make llifestyle choices to reduce the risk of acquiring a respiratory condition and maximise the benefit of any treatment. Where problems with lung health occur, individuals can expect early and accurate diagnosis and effective treatment so the quality of their life can be optimised.

As recognised in the national Respiratory Delivery Plan much of the ongoing care and support for people with long term conditions can be provided by primary and community services at or close to home. The University Health Board's three year integrated plan "Cwm Taf Cares" outlines our vision that as an organisation we are committed to delivering:

Prevent ill health, protect good health and promote better health by providing services as locally as possible and reducing the need for hospital inpatient care wherever possible.

We will apply this vision within respiratory services ensuring that as a UHB working with our partners we do all we can to raise awareness of the risk factors associated with developing respiratory diseases, provide timely access to services within primary care and the community and ensure our specialist services focus on those patients with most complex conditions.

The Plan covers five lung conditions including, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Bronchiectasis, Interstitial Lung Disease, Sleep-Disordered Breathing and Acute Respiratory Care. As recognised in the national Respiratory Delivery Plan, lung cancer services are out with the scope of this document and are covered within the organisation's Cancer Delivery Plan. The UHB's End of Life Care Delivery Plan also holds relevance in the development and delivery of respiratory services. Whilst this document references some of the key actions to be taken forward within end of life care specifically for people with a respiratory condition, the End of Life Care Delivery Plan provides in more detail the UHB's vision for end of life care services in Cwm Taf.

3. OUR DRIVERS

Tackling the development of respiratory disease is an organisational priority for a number of reasons as detailed below:

Prevalence

Health Statistics Wales 2013 makes clear the magnitude of respiratory conditions nationally. One in seven adults (14%) in Wales reports being treated for a respiratory condition. However within Cwm Taf the Welsh Health Survey 2012/13 suggested that 16% of adults were being treated for a Respiratory illness.

Rates of asthma in Wales are amongst the highest in the world. More than 314,000 people with the condition live in Wales (1 in 10 adults), including 59,000 children (1 in 9 children). In 2011-2012 across Wales there were 3,349 children and young people admitted to hospital including 58 deaths. Wales has the highest proportion of children under 14 years being admitted to hospital for asthma in the UK (Asthma UK 2014).

Within Cwm Taf 19,738 individuals are registered as having Asthma (a prevalence of 6.5%). In relation to COPD, 2.67% of our population are registered as having the condition (8,122).

Outcomes

Respiratory disease is a very common cause of death, severe acute illness, A&E attendance and a major cause of emergency hospital admissions. Chronic Obstructive Pulmonary Disease is generally the most frequent cause of an emergency admission to hospital.

In November 2013 the UHB undertook a point prevalence study which demonstrated the impact of respiratory conditions on our services. The most common reason for admission was found to be COPD or shortness of breath (caveat that shortness of breath symptoms can relate to other conditions e.g. heart failure). 64 individuals were inpatients with a respiratory condition/symptom which represented 9% of total inpatients on that day. 47 of those individuals were aged 70 or over. 6 people were readmitted within 4 months.

Of the 64 individuals, 11 sadly passed away in hospital and 2 died following discharge. Respiratory diseases cause one in seven (15%) of all deaths in Wales. Increases in deaths from respiratory disease are one of the main causes of excess winter mortality (in the winter of 2007/08, the excess winter mortality index compared to summer months for respiratory diseases was 42 per cent in Wales). Sudden very cold spells, poor-condition and energy-inefficient housing, poverty and low income, lack of central heating, and increasing fuel costs play an important part in excess winter mortality (and emergency admission) risk. The highest rate of excess winter deaths relate to people aged 85 or over.

Expenditure

In 2012-13 Cwm Taf University Health Board spent £42.7m on respiratory services (7.65% of our total expenditure) which equated to £145.2 per head of population - higher than the Welsh average of £117.7.

Given the level of expenditure within Cwm Taf and the increasing financial constraints impacting on the organisation, there is a need to identify how we allocate our resources differently with the aim of improving the outcomes for those with respiratory conditions as detailed above.

Equity of Service Provision

One of the University Health Board's key priorities for 2014-15 is to reduce health inequity. In relation to this plan, section four below details the variation in outcomes across Cwm Taf for people with respiratory disease.

We are also aware that access to some of our services does vary across primary care and hospital sites (for example the provision of the Respiratory Local Enhanced Service (LES), breathlessness clinics, bronchiectasis service and Pulmonary Rehabilitation). This is of key concern to the Respiratory Planning and Delivery Group which the implementation of this plan over the next three years will need to address.

4. ORGANISATIONAL PROFILE

Organisational Overview

Population Profile

Cwm Taf University Health Board provides services to the 289,400 residents of Merthyr Tydfil & Rhondda Cynon Taff. Almost 81% of the population live in Rhondda Cynon Taff Local Authority and the remaining 19% in the boundaries of Merthyr Tydfil. The University Health Board's catchment population increases to 330,000 when including patient flow from the Upper Rhymney Valley, South Powys, North Cardiff and the Western Vale.

It has long been recognised that Cwm Taf University Health Board serves the most deprived population within the Welsh boundaries. This has been evidenced in the lower life and health expectancy of its residents, coupled with the historical issue of a higher percentage of single handed General Practices with corresponding larger list sizes, which results in a higher level of dependency on Cwm Taf's acute unscheduled care services.

The University Health Board is developing plans for a long term programme based on the Inverse Care Law to increase healthy life expectancy by five years by 2023. The programme is designed to reduce health inequalities through the targeted provision of highly integrated disease preventing and health promoting primary care and community focussed services.

Overview of local health need and challenges to respiratory services

Smoking, obesity and vaccination rates are the key focus for reducing the incidence of respiratory disease and ensuring individuals maintain as healthy lifestyle as possible.

- **Smoking** - The proportion of the population aged 16 and over who smoke, although improving, remains higher at 26% than the Welsh average of 23%. In Cwm Taf as a whole over one in four people smoke, contributing to around 630 deaths per year.
- **Overweight and obesity** - around 64% of adults in Cwm Taf are either overweight or obese, with 26% classed as obese. Improving diet and physical activity are essential to reducing the high proportions of people who are overweight or obese.
- **Immunisations** - Uptake of seasonal influenza vaccine in people aged 65 years and over increased to 66.3% in Cwm Taf during 2013/14 period. Uptake within the under 65 year olds at risk group also increased to 51.9%, which is the same as the Welsh average. There is no reportable programme on pneumococcal vaccine, so we have to rely on vaccine usage figures only, we do not know the proportion of the population at risk who have received this vaccine.

The UHB is aware that Cwm Taf has the highest prevalence of respiratory disease in Wales, according to primary care data. For those individuals:

- Merthyr Tydfil has a very high emergency hospital admission rate for residents aged 75 and under. It is one of the highest rates in Wales.
- The respiratory mortality rates for Merthyr Tydfil and Rhondda Cynon Taf are the highest in Wales. The rate increases sharply moving from the least deprived to the most deprived small areas within them.
- Increases in deaths from respiratory disease are one of the the main causes of excess winter mortality.
- Sudden very cold spells, poor-condition and energy-inefficient housing, poverty and low income, lack of central heating, and increasing fuel costs play an important part in excess winter mortality (and emergency admission) risk. The highest rate of excess winter deaths relate to people aged 85 or over.

<u>Service Profile</u>

Services for individuals with a respiratory condition are provided across primary and secondary care dependent on age, type and complexity of the individual's condition. The services currently delivered within Cwm Taf are detailed below.

Preventative Services

- Smoking Cessation.
- Community weight management.
- Flu and Pneumococcal vaccination programmes.

Primary Care and Community Services

- Annual COPD / Asthma QOF Reviews.
- Respiratory Local Enhanced Service.
- Home oxygen service.
- Shared care clinics.
- Community Pharmacies (Inhaler technique, medicines use reviews etc).
- Pulmonary Rehabilitation.
- @Home services for the frail elderly (who may also have a respiratory condition).

Secondary care paediatric services

- Consultant led chest clinic.
- Consultant led allergy clinic.
- Shared care CF clinic.
- Nurse led asthma/allergy clinic.
- Nurse led TB service.
- Nurse led Oxygen service neonates/paediatrics.
- Nurse led Omalizumab clinic as required.
- Nurse led Pulivizumab clinic.
- Nurse led Influenza vaccine clinic for high risk allergy patients.
- Nurse led Asthma clinics in primary care as required.

Secondary care adult services

- Support to primary care and community services e.g. advisory, educational.
- General respiratory outpatient clinics.
- Sleep apnoea outpatient clinics.
- Asthma outpatient clinics.
- Bronchiectasis outpatient clinic.
- ILD (interstitial lung disease) outpatient clinics.
- Breathlessness outpatient clinic.
- Nurse-led TB service.
- Acute admission with appropriate in-hospital supported discharge planning with links to primary care and community services.
- Palliative Care including chronic NIV (non-invasive ventilation) clinics.
- Pulmonary Rehabilitation.

Performance Profile

The following provides an overview of the UHB's performance, activity and demand on services across primary, community and secondary care.

Tier One Targets

The following three tier one targets are critical to the preventative agenda.

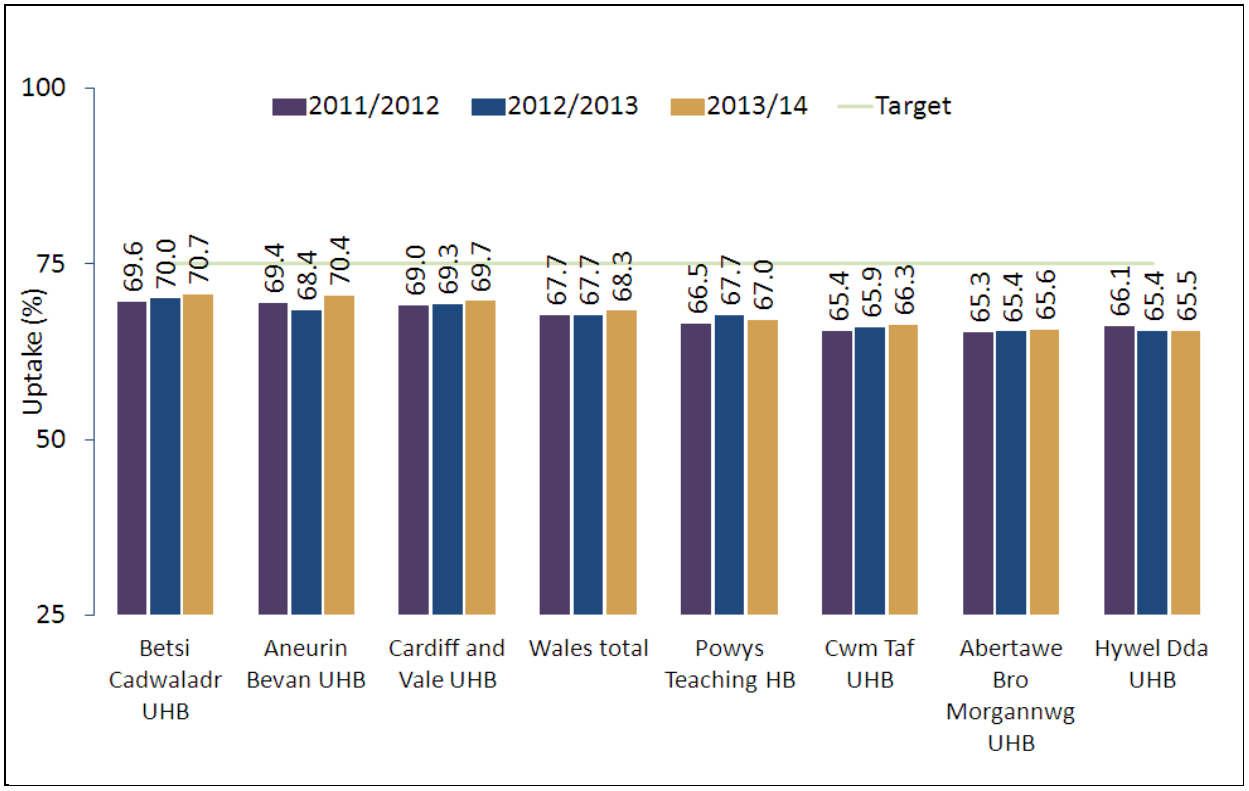
95% vaccination of all children to age 4 with all scheduled vaccines

Vaccination of all children to age 4 with all scheduled vaccines:	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
% uptake rates of MMR at age 2 (95% target)	96.0%	94.7%	93.7%	95.9%	97.7%	98.6%	97.4%	97.5%
% uptake rates of MMR at age 5 (95% target)	96.3%	96.7%	96.2%	96.4%	97.6%	98.7%	97.4%	98.1%
% uptake rates of MMR at age 5 (2 doses) (95 % target)	91.3%	91.2%	90.0%	92.0%	93.4%	94.5%	92.3%	92.7%
% uptake rates of 5 in 1 vaccine at age 1 (95% target)	97.4%	97.0%	97.1%	97.5%	97.5%	96.6%	98.4%	97.5%
% uptake rates of 4 in 1 vaccine at age 5 (95% target)	93.2%	92.2%	88.9%	93.7%	93.5%	95.1%	93.5%	96.2%
% uptake rates of HPV 1 dose for girls at age 12-13 (90% target)	93.2%	94.0%	92.8%	92.8%	93.3%	93.7%	92.8%	93.7%
Tier 1 composite target, up to date in schedule by four years of age				86.3%	88.8%	89.7%	89.9%	91.2%

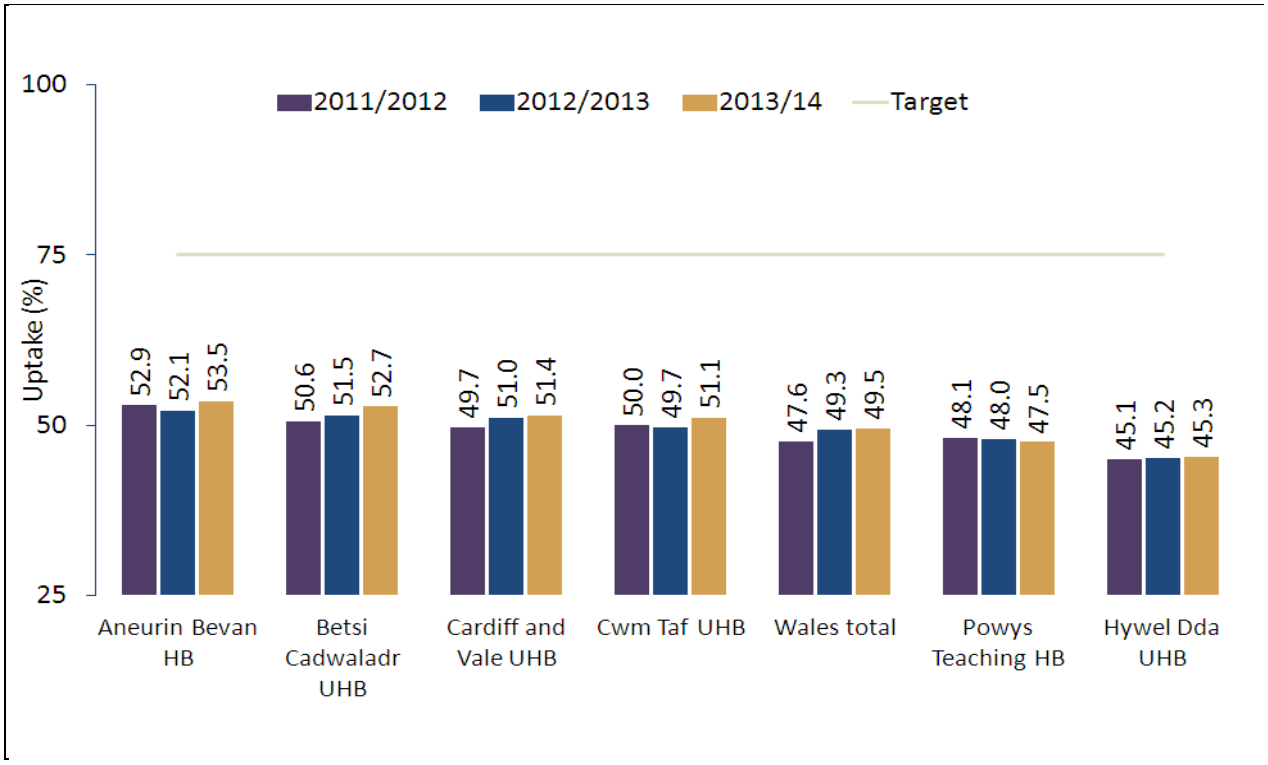
75% uptake of influenza vaccination among:

- **65 years and over**
- **Under 65s in at risk groups**

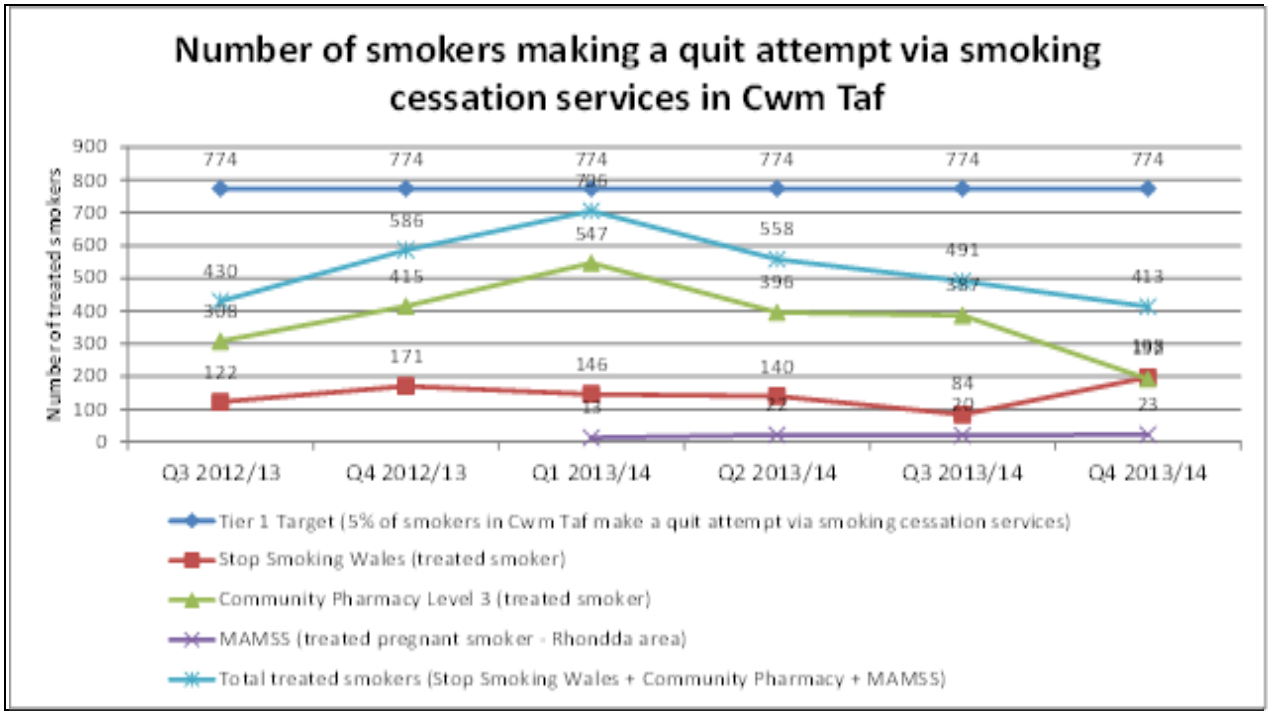
Patients aged 65 years and older



Under 65 at risk



5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quite rate at 4 weeks



Primary Care

Traditionally there is very little data available which demonstrates the breadth of activity undertaken within primary care and there are no specific performance targets which relate to the delivery of services for respiratory patients in this setting. The UHB has been working collaboratively with GlaxoSmithLine and local GP Practices on the management of COPD in primary care. One of the products is a detailed audit of the number of patients receiving key measurements as per QOF and NICE guidelines which will be available later in the year. This information will support individual practices in focussing on improving patient outcomes in their practice.

Currently there are 21 of 47 Practices in Cwm Taf providing the Respiratory Local Enhanced Service.

Inpatient Services

The information below outlines the impact of respiratory disease on hospital services during 2013/14.

COPD

Spells & Average Length of Stay				
	Spells	Spells w/proc	Average Pre-Op LoS	Average LoS
Total	1220	6	8.7	7.4
Elective	2			0
Non-Elective	1218	6	8.7	7.5

Readmissions within 28 Days			
	Discharges Subsequently Readmitted	Total Discharges	Readmission Rate
Total	281	1220	23.00%
Non-Elective	281	1218	23.10%
Elective	0	2	0.00%

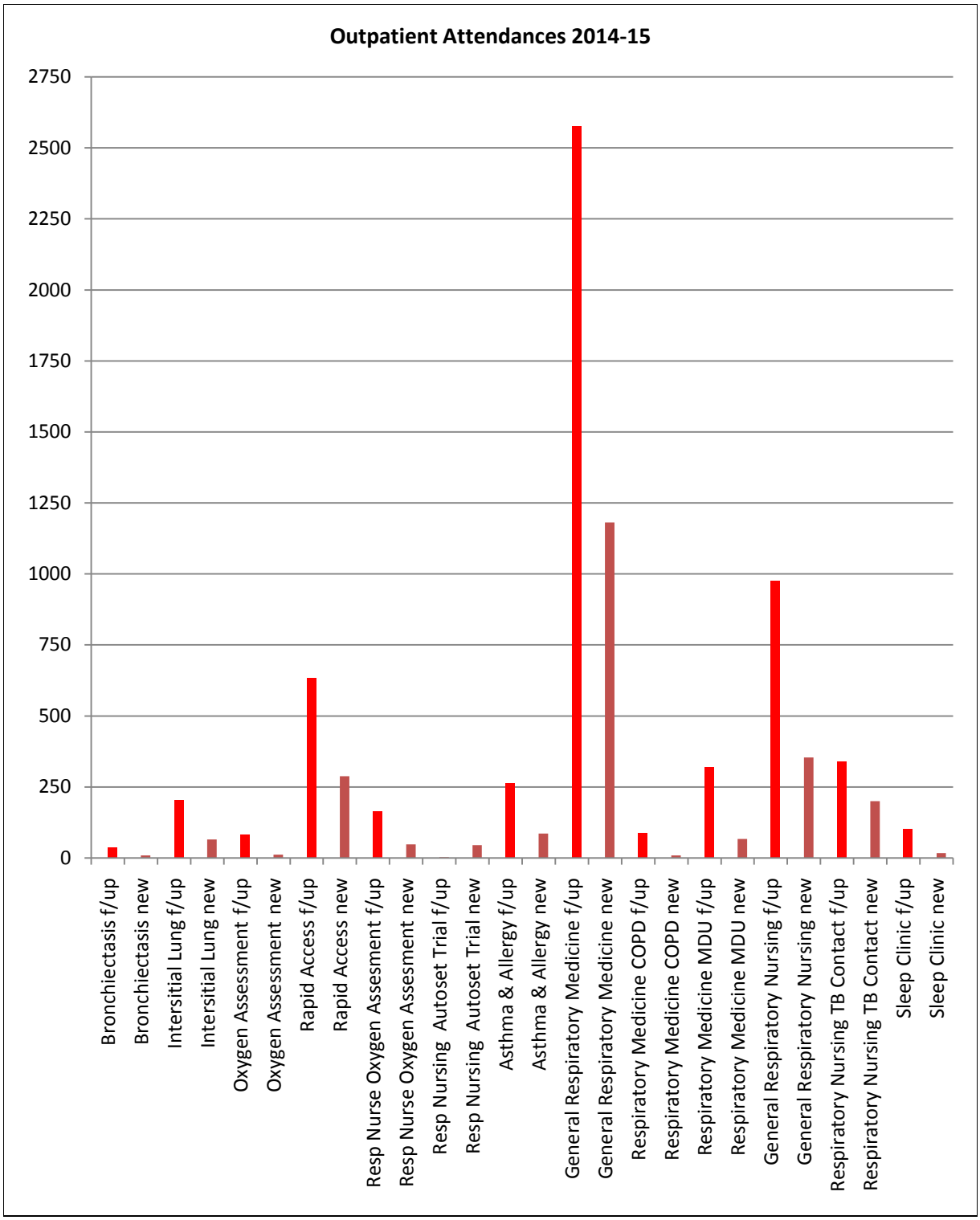
Asthma

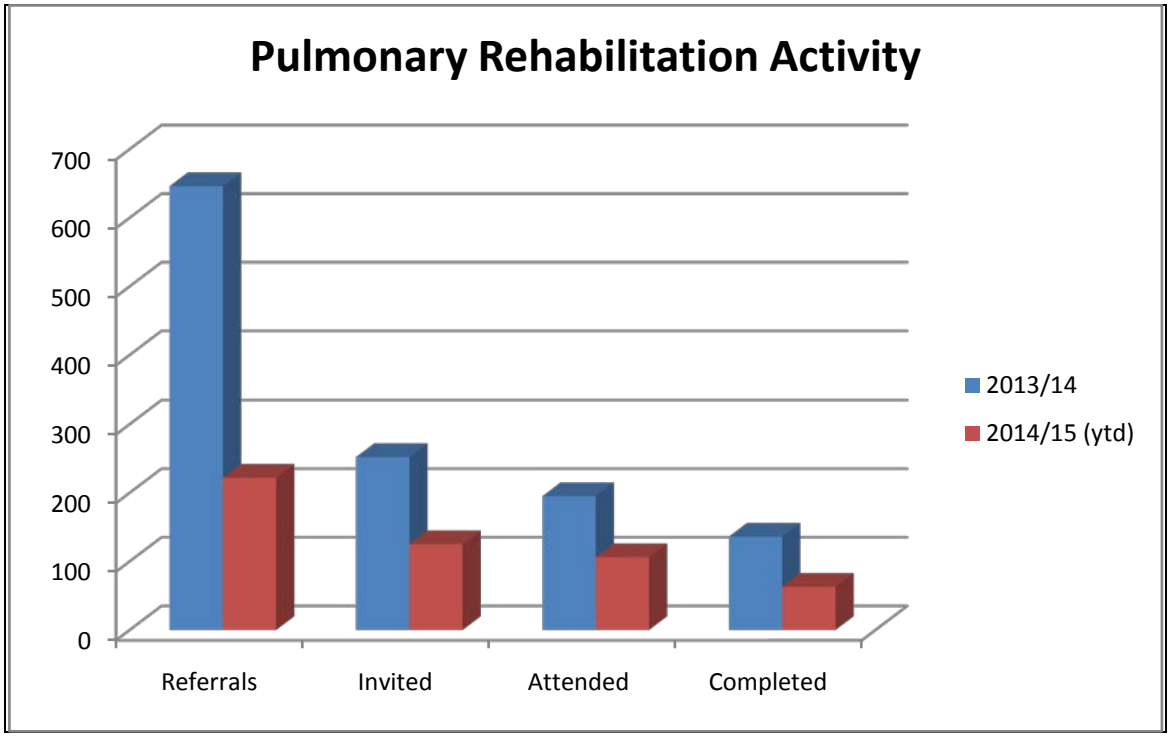
Spells & Average Length of Stay				
	Spells	Spells w/proc	Average Pre-Op LoS	Average LoS
Total	393	1	0	2.5
Elective	1			0
Non-Elective	392	1	0	2.5

Readmissions within 28 Days			
	Discharges Subsequently Readmitted	Total Discharges	Readmission Rate
Total	41	393	10.40%
Non-Elective	41	392	10.50%
Elective	0	1	0.00%

Outpatient Services

There are a number of sub-specialty outpatient services within respiratory care. Below is a summary of the outpatient attendances across our hospital / community sites in 2013-14 split by new and follow-up.


Outpatient Attendances 2014-15
2750
2500
2250
2000
1750
1500
1250
1000
750
500
250
0
Bronchiectasis f/up
Bronchiectasis new
Intersitial Lung f/up
Intersitial Lung new
Oxygen Assessment f/up
Oxygen Assessment new
Rapid Access f/up
Rapid Access new
Resp Nurse Oxygen Assesment f/up
Resp Nurse Oxygen Assesment new
Resp Nursing Autoset Trial f/up
Resp Nursing Autoset Trial new
Asthma & Allergy f/up
Asthma & Allergy new
General Respiratory Medicine f/up
General Respiratory Medicine new
Respiratory Medicine COPD f/up
Respiratory Medicine COPD new
Respiratory Medicine MDU f/up
Respiratory Medicine MDU new
General Respiratory Nursing f/up
General Respiratory Nursing new
Respiratory Nursing TB Contact f/up
Respiratory Nursing TB Contact new
Sleep Clinic f/up
Sleep Clinic new

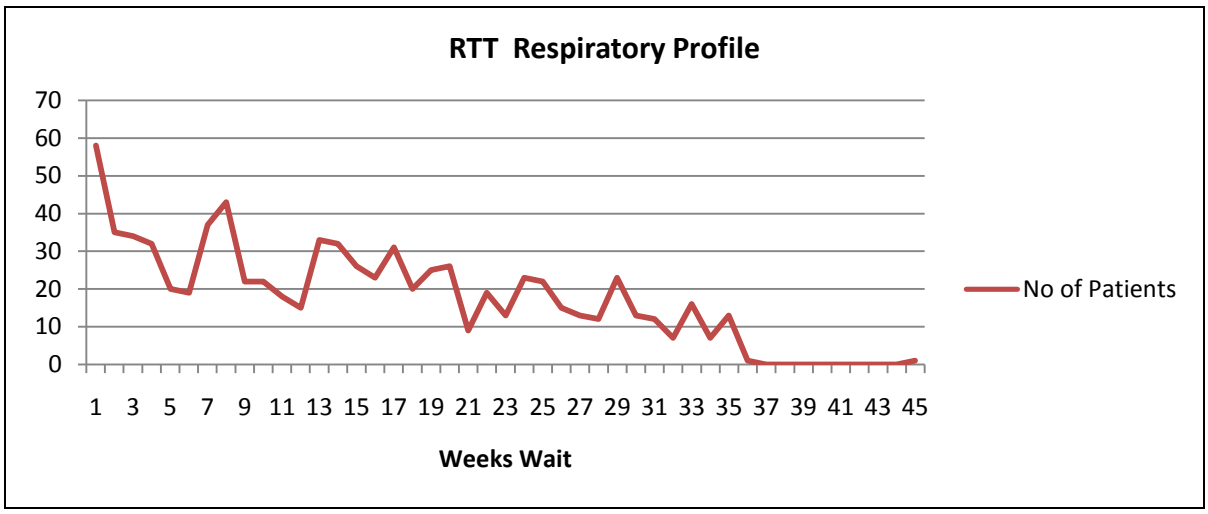


RTT

The target relating to referral to treatment times in Wales aims to ensure timely access to planned services. This is assessed using figures for patients waiting to start treatment at the end of the month:

- 95 per cent of patients waiting less than 26 weeks from referral to treatment; and
- 100 per cent of patients (not treated within 26 weeks) treated within a maximum of 36 weeks.

The profile below highlights that there are currently 790 patients waiting for a first outpatient appointment and their anticipated waiting time, with all patients expected to be seen within 36 weeks.



5. SUMMARY OF THE PLAN - THE PRIORITIES FOR 2014–15

Cwm Taf University Health Board has established a Respiratory Planning and Delivery Group (RPDG) to oversee the implementation of the Respiratory Health Delivery Plan. The aim of the group is to ensure where possible we take action to prevent or reduce the prevalence of respiratory disease and provide the best possible care for those living with a respiratory condition. The RPDG is the UHB's principle vehicle for the planning and development of respiratory services in Cwm Taf. It will be responsible for overseeing the implementation of this plan and providing regular reports on progress to the Executive Board and Health Board.

The national Respiratory Delivery Plan outlines the Respiratory health care experience that people can expect by 2017 (as detailed in ***Annex 1***). The respiratory team within Cwm Taf are keen to ensure that patient experience and outcomes are at the centre of what we do as an organisation. Therefore our priorities for the coming 12 months have been developed from the gaps we have identified within our services that should be addressed if we are to aspire to delivering this experience for our citizens.

We have consolidated the range of actions within the Respiratory Delivery Plan in to four key priority areas with a nominated UHB lead for each:

1. Preventing poor respiratory health – Angela Jones
2. Early detection – Fiona Wood
3. Prompt effective treatment – Dr Paul Neill, Neil Cooper
4. Patient education and support services – Tracy Jones, Rhian Williams

Whilst the timeframe for the national plan is three years, our local plan is focussed on the organisation's key priorities for implementation over the next twelve months (to September 2015). The plan will then be reviewed annually to identify progress made against the priorities and identify the priorities for the forthcoming year to ensure delivery of the national plan aligned to the identified timescales where possible.

Preventing poor respiratory health

Our key challenges are:

- Reduce smoking prevalence rates to 16% by 2020. Currently 26% of people within Cwm Taf are smokers.
- Increase the rates of treated smokers in line with the Tier 1 target.

- Increase the vaccination rate to 75% in line with the Tier 1 target.

Our solutions are:

- Reduce the uptake of tobacco use, especially amongst children and young people.
- Reduce smoking prevalence levels.
- Reduce exposure to second-hand smoke.
- Multi-agency collaboration to increase vaccination uptake rates.

Our priorities for 2014 – 15 are:

- Increase referrals to smoking cessation services and subsequent smoking cessation rates.
- Improve awareness of the benefits of not smoking and of the availability of smoking cessation services.
- Raise awareness of the harm caused by tobacco among children and young people.
- Embed the Cwm Taf UHB Smoke Free Environment Policy and associated action plan.
- Increase the number of people with a respiratory condition and their carers who receive an annual flu and pneumococcal vaccination.
- Raise awareness of the impact of housing on respiratory health.

The anticipated outcomes are:

- Reduction in smoking prevalence.
- Increase in the number of smokers who quit.
- Increase in flu and pneumococcal vaccinations for those in the “at-risk” group.

Early detection

Our key challenges are:

- One in eight people over 35 has COPD that has not been properly identified or diagnosed. (DOH 2013)

Our solutions are:

- People over 35 who smoke and at-risk groups with persistent respiratory symptoms should receive appropriate and timely diagnostic tests such as spirometry.

Our priorities for 2014 – 15 are:

- Ensure all patients are accurately diagnosed with COPD or Asthma.

- Improve access to timely assessment for patients with symptoms of lung disease.

The anticipated outcomes are:

- A consistently high standard of spirometry testing throughout Cwm Taf.
- An up to date and accurate record of staff competencies in relation to spirometry.

Prompt effective treatment

Our key challenges are:

- The poor respiratory health of our population creates great demand for our services.
- Equity of access to outpatient services for patients with bronchiectasis or breathlessness.
- Ability to meet referral to treatment time targets (RTT).
- Availability of sub-specialty services e.g. Asthma, ILD etc.
- Ability to deliver necessary inpatient case management for COPD and Asthma.
- Consistency and timeliness of follow-up following discharge.
- High readmission rates for COPD.

Our solutions are:

- Support for primary care to meet the needs of our population.
- Improving the interface between primary care, community services and secondary care.
- Where appropriate provide alternatives to hospital admission.
- Ensure all patients with a respiratory condition receive appropriate specialist care when admitted to hospital.
- Enhanced support and information for patients.

Our priorities for 2014 – 15 are:

- Agree a whole system service model for COPD.
- Continue to work collaboratively with primary care colleagues to ensure patients with respiratory conditions receive the best possible care.
- Raise awareness of self management techniques.
- Ensure that people with a respiratory condition receive the most appropriate treatment, advice and support on diagnosis.
- Ensure all patients with a respiratory condition when admitted to hospital are admitted under a respiratory team, preferably on a respiratory ward.
- Ensure all patients have an agreed discharge plan in place and have access to the necessary services within primary care and the community.
- Ensure adequate and equitable access to end of life care.

- Ensure the UHB delivers against the required performance targets.

The anticipated outcomes are:

- A reduction in avoidable admissions and re-admissions to hospital.
- Release more professional time in respiratory outpatient clinics to look at developing specialist services e.g. breathlessness and bronchiectasis clinic.
- All patients with advanced disease are offered appropriate end of life support.
- Patients have access to prompt diagnosis and treatment, achieved by maintaining compliance with patient referrals for treatment targets (RTT).

Patient education and support services

Our key challenges are:

- Consistency of information provided on managing your condition and support services available. In particular for newly diagnosed patients to better understand the condition they have and how it may affect them.
- Not all patients with COPD or Asthma have self management plans and where appropriate access to rescue packs.
- Equity of access to Pulmonary Rehabilitation services across Cwm Taf.

Our solutions are:

- All patients eligible for Pulmonary Rehabilitation and want to participate in a programme have timely access to this service.
- Availability of alternative education and exercise programmes to Pulmonary Rehabilitation for those patients for whom Pulmonary Rehabilitation is not appropriate.
- Suitable transport facilities in place to enable patients to access programmes within the community.

Our priorities for 2014 – 15 are:

- Improve information available to patients and their carers to ensure patients are aware of their diagnosis, treatment plan and self management techniques.
- Explore the potential for enhancing the role of Breathe Easy Support Groups across Cwm Taf.
- Ensure equity of access to Pulmonary Rehabilitation and other forms of education, support and exercise e.g. National Exercise on Referral Scheme (NERS).

The anticipated outcomes are:

- All patients with a chronic respiratory condition have an agreed self management plan and a greater understanding amongst patients of their diagnosis and its correct management.
- An increase in the number of patients able to participate in education, support and exercise programmes both suitable to their needs and in a timely manner (including Pulmonary Rehabilitation, Breathe Easy and NERS).
- All people affected by a respiratory condition receive information about their condition which is easy to access, relevant and easy to understand.
- Establishment of new breathe easy groups and an increase in the number of people attending.

Services for Children and Young People

The UHB is currently awaiting the publication of the Paediatric section of the national Respiratory Delivery Plan. Following publication the Respiratory Planning and Delivery Group will consider this in detail to identify action required. However there are a number of local priorities already identified as detailed below.

Our key challenges are:

- Numbers of young people smoking or exposed to passive smoking.
- Knowledge and experience of the management of respiratory conditions within primary care.

Our solutions are:

- Improved education and training.
- Closer working across professions and agencies.
- Integrated pathways.
- Development of new roles.

Our priorities for 2014 – 15 are:

- Reduce the number of children exposed to passive smoking, and reduce the number of teenagers smoking.
- More focus on health promotion/education sessions in schools.
- Establishing better working relationships between primary care and paediatric team.

The anticipated outcomes are:

- Reduction in the incidence of respiratory disease.
- High quality, equitable and sustainable services available to children and young people with a respiratory condition across Cwm Taf.

Annex 2 outlines the priorities above and the action required to deliver these in year one.

6. PERFORMANCE MEASURES / MANAGEMENT

The Welsh Government's Respiratory Health Delivery Plan (2014) contained an outline description of the national metrics that health boards will need to consider. Progress against these NHS outcomes and assurance measures will form the basis of our annual report on respiratory services.

At an All Wales level the following indicators will be used to monitor progress:

- A reduction in prevalence of smoking as per the Tobacco Control Action Plan for Wales.
- Incidence of Chronic Obstructive Pulmonary Disease (COPD) per 100,000 population.
- Unscheduled hospital admissions for both asthma and COPD per 100,000 population.
- Disease and age group specific mortality rates under age 75 per 100,000 population.

These are outlined in more detail in ***Annex 3***.

7. FINANCIAL ASSESSMENT

In light of the current financial context within which the UHB is operating the Respiratory Planning and Delivery Group and the leads for each of the priority sub groups are conscious that service improvement proposals will need robust cost benefit analyses with a clear assessment of expected outcomes. A number of the proposed actions within this plan will require further scoping and subsequently a financial appraisal to assess how the development can be funded (e.g. invest to save) and provide assurances that the service / initiative will release resources elsewhere within the system.

8. MONITORING IMPLEMENTATION

The University Health Board will report progress against the local delivery plan milestones to the Executive Board and Board at least annually and to the public via our website.

Annex 1

The respiratory health care experience

This describes the characteristics of the services expected by 2017.

Experience 1 - People are aware of and are supported in minimising their risk of lung disease through healthy lifestyle choices and medication where appropriate.

- More people are informed and aware of the risks to their respiratory health from smoking.
- More people are aware of the benefits of not taking up smoking and of the availability of smoking cessation services for those who wish to give up.
- Smoking cessation services, including pharmacological means, are easier to access and are more co-ordinated and systematic.
- More people pursue a healthy diet and achieve a healthy weight.

Experience 2 – Lung disease is detected promptly and early on in its development.

- Easier and wider access to effective primary care spirometry.
- More accessible information and support services for respiratory health provided through local delivery channels.
- People at risk of developing respiratory disease have access to information and services to prevent or minimise disease progression.
- Greater awareness by primary care, schools and the general public of the symptoms of lung disease.

Experience 3 - People with lung disease receive prompt effective treatment and care so they have the best possible chance of living a long and healthy life.

- Prompt and appropriate access to clinically and cost-effective treatment in primary and secondary care, including smoking cessation services.
- People experience well co-ordinated services which are compliant with national standards and guidelines and available as locally as possible.
- Seamless, integrated care with all healthcare sectors – primary, secondary, intermediate and voluntary, being potentially involved in patient management and at an appropriate time.

- Equity of care outcomes in people with respiratory disease.
- Respiratory health care is delivered by a motivated, highly educated and accredited healthcare professional workforce.
- Timely access to appropriate, specialist, multidisciplinary teams with care tailored to individual patient's needs.

Experience 4 - People are placed at the heart of respiratory care with their individual needs identified and met so they feel well supported, informed and able to manage the effects of their lung disease.

- Services are available as locally as possible.
- The psychological, social and clinical needs of people with respiratory disease are assessed, agreed and recorded in a shared management plan with services designed around meeting those needs.
- People are empowered through access to education and information to understand their respiratory condition, what care to expect, what to look out for, what to do and which service to access if problems arise.
- People with chronic respiratory conditions have an agreed, personalised self-management-plan, which is co-produced with all relevant healthcare professionals.
- Access to, and care and support from, co-ordinated and seamless primary, secondary and community services.
- More accessible educational and support services for smoking cessation provided through local pharmacies.
- Access to support in maintaining a healthy lifestyle from healthcare professionals with training in behavioural change techniques.

Annex 2

ACTION PLAN 2014 – 2015

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
1: Increase referrals to smoking cessation services and subsequent smoking cessation rates (further detail available within "Smoke Free Cwm Taf Strategic Action Plan"). 1a: Improve smoking cessation support for in patients, including onward referral to cessation services.	Identify and train smoking champions in secondary care settings. Implement referral pathways for patients who wish to quit smoking. Provide quarterly feedback on referral to referrers. Liaise with pharmacy to ensure adequate therapeutic options available.	Smoking champions established on all wards. Referral pathways implemented on all wards.	Recruitment of champions.	Resource packs for champions provided by public health.	Year 1	Respiratory specialist nurses/Angela Jones/ Stop Smoking Wales Stop Smoking Wales

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
1b: Improve smoking cessation support for house bound patients, including onward referral to cessation services.	Identify and train HCAs in brief intervention. Implement referral pathways for patients who wish to quit smoking. Provide quarterly feedback on referral to referrers.	Number of HCAs trained in BI.	Recruitment of HCAs.	Resource packs for HCAs provided by public health.	September 2015	Mair Thomas
1c: Motivate known smokers to quit or change behaviour through coaching and signposting to community support.	Train HCAs to provide coaching in General Practice.	Increased numbers of treated smokers and quit rates as defined by the Tier 1 target.	Ability to recruit sufficient HCAs.	Inverse Care Programme.	September 2015	Primary Care / Public Health
1d: Increase the number of community pharmacies providing smoking	Train staff to provide smoking cessation services. Provide resources. Monitor progress and report against Tier 1 target to	70 community pharmacies, delivering level 2. 60 community pharmacies, delivering level 3.	-Ongoing funding. -Non engagement.	Cwm Taf HB Public Health (CO monitors).	March 2015	Emma Hinks

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
cessation services at level 3 and 2 (currently 40).	Welsh Government.					
1e: Improve access to pharmacological treatment via Community Pharmacy smoking cessation services.	Develop a protocol and PGD for the supply of Varenicline. Train pharmacists.	Varenicline available via level 2 and 3 community pharmacies in Cwm Taf.	-Ongoing funding. -Non engagement.	Cwm Taf Health Board.	Year 1	Medicines Management Practice Unit / Emma Hinks
1f: Provide Brief Intervention training for community pharmacy staff engaged in NHS smoking cessation services.	Enable community pharmacy staff to access the NHS e-learning platform which provides access to the SSW e-learning package.	All pharmacy staff able to access online e-learning in smoking cessation brief interview.	IT connectivity barriers.	Public Health Wales.	Year 1	Medicines Management Practice Unit / Emma Hinks
1g: Provide support for pregnant smokers to quit smoking	Extend the MAMSS (Models for Access to Maternal Smoking Cessation Support) programme from Rhondda area to include Taff Ely and Cynon Valley.	Improved referral route for support. Number of treated smokers and CO validated quits reported to Welsh Government.	Engagement of pregnant smokers.	Fframwaith.	Year 1	Maternity Services Angela Jones
2: Improve awareness of the benefits of not	Actions Co-ordinate local action in support of national smoking	At least one campaign/awareness event run in 11	Multi agency organisation.	Local Public Health Team.	September 2015	Angela Jones Communities

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
smoking and of the availability of smoking cessation services.	cessation and respiratory campaigns No Smoking Day (March 2015). Stoptober (October 2014). Don't be the 1 (October 2014). World COPD Day (November 2014). Work with the British Lung Foundation to identify opportunities to work collaboratively across Wales to raise awareness of the benefits of quitting smoking and how to access smoking cessation services.	Communities First settings, 77 Community pharmacies and CTHB hospital sites. Consistent messaging across Wales.		As yet not identified.	June 2015	First Clusters Stop Smoking Wales Community Pharmacy Ward champions HCAs Angela Jones / Chris Mulholland
	Implement All Wales MECC (Making Every Contact Count) approach in Cwm Taf.	Empower staff working in health services, and potentially wider afield to recognise the role they have in preventing illness and supporting behaviour change.	Competing time priorities/non engagement.	To be confirmed.	Dependent upon all Wales delivery timescales.	Public Health Wales

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
3: Raise awareness of the harm caused by tobacco among children and young people.	Pilot a whole school approach to tackling tobacco in secondary and primary education settings.	Uptake of programme within two identified schools.	Competing time priorities/non engagement.	Local Public Health Team.	September 2014	Angela Jones Education settings School Nurses Youth services
4: Embed the Cwm Taf University Health Board's Smoke Free Environment Policy and associated action plan	Establish a routine monthly walkabout of sites by all senior staff in the health board. Progress work relating to litter enforcement officers, in conjunction with local authority. Canvass staff groups to participate in Stop Smoking Wales clinics or community pharmacy smoking cessation support.	Compliance with policy.	Lack of supporting legislation.	No additional funding required.	September 2014	Cwm Taf Smoke Free Environment Policy Maintenance Group
5: Increase the number of people with respiratory conditions and their carers who receive a flu and pnuemoccoal vaccination.	Take forward all the actions in the Cwm Taf Flu Action plan.	Increased uptake towards the 75% target.	Practices will often only target as many patients as they have purchased vaccine for, not, the 75% level.	Funding is in place to deliver.	January 2015	Jane Williams / Nicola John

	Preventing poor respiratory health					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	Regular engagement with primary care.	Increased uptake, no target is set.	More difficult to achieve as this is not an annual programme, and data is not fed back to practices.	Funding in place to deliver.	Ongoing	Jane Williams / Nicola John
6: Raise awareness of the impact of housing on respiratory health.	Joint action across Cwm Taf including primary and community care, registered social landlords and Local Authorities to educate householders to prevent mould growth and support staff training.	Reduction in condensation mould growth in households and associated asthma attacks / exacerbations of other respiratory conditions.	Multi agency agreement as a priority.	Within existing organisational structure.	September 2015	Claire Williams
7: Implement "Healthy Weights, Healthy Valleys"  Healthy Weight Healthy Valleys Strate	As outlined within the strategy.	As outlined within the strategy.	As outlined within the strategy.	As outlined within the strategy.	As outlined within the strategy.	Angela Jones

	Early detection					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
Ensure all patients are accurately diagnosed with COPD or Asthma.	Undertake Spirometry audit in primary care to review: -Competencies -Interpretation of results -Equipment	Up to date information will be available on the practice of Spirometry in Primary Care together with the competency levels / training needs of staff involved in its use.	-Time management -Non engagement of Primary Care staff.	No additional funding required.	March 2015	Louise Walby
	Identify any deficits/inconsistencies in terms of spirometry practice.	Ability to target training / support to Practices.	-Time management -Non engagement of Primary Care staff.	No additional funding required.	March 2015	Louise Walby
	Identify whether existing clinical protocols and procedures are fit for purpose.	Up to date information will be available on current protocols and procedures and whether there is a need to revise documentation.	-Time management -Non engagement of Primary Care staff.	No additional funding required.	March 2015	Louise Walby
	Take forward the recommendations identified as part of the evaluation of the Cwm Taf COPD Joint Working Project.	Dependent upon recommendations.	Dependent upon recommendations.	Dependent upon recommendations.	February 2015	Julie Scudamore

	Early detection					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
Improve access to timely assessment for patients with symptoms of lung disease.	Identify the most appropriate model for timely assessment and accurate diagnosis of patients with symptoms of lung disease.	Patients with COPD and Asthma will be assessed in a timely and accurate manner.	Agreement on appropriate model.	To be determined once model agreed.	March 2015	Dr Sadiyah Hand / Dr Paul Neill / Prof Jonathan Richards

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
Agree a Cwm Taf whole system model for COPD.	Members of the RPDG to agree the service model required for COPD management in Cwm Taf.	-Clear vision to work towards. -Agreed pathways in place. -Reduction in preventable hospital admissions.	-Agreement and sign up required across all professions. -Potentially additional resources required to deliver agreed model (requires scoping once agreed).	To be determined once model and associated implementation plan agreed.	January 2015 – agreement on the model. Implementation – to be determined.	Dr Paul Neill / Professor Jonathan Richards
Continue to work collaboratively with primary care colleagues to ensure patients with Respiratory conditions receive the best possible care.	Use the recommendations from the "Together for Health" COPD project to inform next phase of facilitative work with primary care practices.	- All Respiratory patients receive relevant key measurements for their condition annually as set out in the NICE and British Thoracic Society treatment guidelines.	-Sign up / engagement from primary care.	Any funding required will become clearer once recommendations available. Potential impact on Respiratory LES (e.g. expansion in number of practices providing the LES).	Recommendations to be presented 16th October.	Julie Scudamore / Louise Walby
	Cwm Taf is the Lead Health Board in Wales in development and implementation of a range of interventions to improve quality, safety	-Improved medication reviews. -Improved clinical management. -Improved patient and staff education.	None identified at this stage.	No funding requirements identified at this stage.	Ongoing	Professor Jonathan Richards

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	and cost effectiveness under the Prudent Prescribing Initiative. Respiratory Conditions are a key component of this work that will involve general practice teams, community pharmacies, Local Government and Voluntary Agencies.					
Raise awareness of self management techniques.	Encourage all primary care practices to issue rescue packs where appropriate.	Reduction in acute exacerbations. Reduction in admissions to hospital.	Dependent on sign up from Primary Care and willingness to prescribe rescue packs.	Potential impact on prescribing budget.	Ongoing	Louise Walby / Professor Jonathan Richards
	Raise awareness amongst patients of rescue packs and the benefits of commencing treatment early.	Reduction in acute exacerbations. Reduction in admissions to hospital.	Dependent on sign up from Primary Care and willingness to prescribe rescue packs.	Potential impact on prescribing budget.	Ongoing	All healthcare professionals involved in delivering Respiratory services
Ensure that people with a respiratory condition receive the most appropriate treatment, advice and support on	Agree "Cwm Taf" best practice template for paediatrics and adults for use in primary care.	Best practice templates will be available for primary care staff.	-Time management. -Conflicting priorities / non engagement by key staff to develop templates.	To be determined following agreement of template.	September 2015	Prof Jonathan Richards / Louise Walby / Dr Paul Neill

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
diagnosis.	Evaluate admission avoidance looking at available models and develop Cwm Taf approach to encompass primary, community and secondary care and include ambulance services and innovative technologies e.g. telehealth.	Reduction in avoidable emergency admissions for people with Respiratory disease. Care closer to home. Improved multi-disciplinary working.	-Admission avoidance schemes often difficult to evidence. -Potentially resource intensive (staff and financial).	To be confirmed once model agreed.	September 2015	Dr Paul Neill / Rhian Williams
	UHB to provide support to national programme to Welsh Government and NWIS in development of an IT system which enables the sharing of patient's information and data between primary and secondary care.	Improved communication across the primary / secondary care interface. More timely availability of information.	Dependent on national timescales.	Welsh Government	To be confirmed by Welsh Government.	Welsh Government
Ensure all patients with a Respiratory condition receive appropriate specialist care when admitted to hospital.	Ensure all patients with a respiratory condition when admitted to hospital are admitted to a respiratory ward or where this is not possible admitted under the care of the respiratory team.	Patients with a respiratory condition requiring admission will receive standardised specialist care.	Achievement of this action is dependent on wider patient flow work within the organisation to ensure sufficient inpatient capacity available on	No additional funding required.	September 2015	Dr Sadiyah Hand / Dr Paul Neill

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
			identified Respiratory wards.			
	Inpatient Case management looking at appropriate discontinuation of O2, appropriate switch from nebuliser to inhaled therapy, optimisation of inhaler technique, prescription of NRT, appropriate on-ward physio and O.T. input, aiming at likely discharge by 5-6 days.	-Reduction in length of stay. -Delivery of high quality standardised care.	Non engagement from key staff within the multi-disciplinary team.	No additional funding required.	September 2015	Rhian Williams
Ensure all patients have an agreed discharge plan in place and have access to the necessary services within primary care and the community.	Ensure all inpatients reviewed 2-3 days before discharge, and given advice on medication including: • inhaler technique, • smoking cessation advice with signposting / referral to on-going cessation support, • pulmonary rehab advice and referral if agreeable • advice to contact their	All respiratory patients discharged from hospital will have an increased awareness of support services available and where appropriate these services will be offered.	Potential for demand to outweigh current capacity within education/exercise services e.g. Pulmonary Rehabilitation.	To be determined	September 2015	Dr Sadiyah Hand / Dr Paul Neill

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	GP about the possibility of an antibiotic /steroid rescue pack, • a self-management plan.					
	Standardise advice and information to all patients on discharge via an agreed discharge plan.	Improved quality and timeliness of information received by patients to support self management.	None identified.	To be taken forward within existing resources.	September 2015	Rhian Williams
	Develop a form of communication with primary and/or community care so that follow-up in 2-4 weeks can be organised, (the period when another exacerbation is likely to occur).	All respiratory patients discharged from hospital will have a timely follow up in the appropriate setting.	-Capacity within primary care to facilitate follow-up within 2-4 weeks. -Engagement from GP practices due to other competing priorities.	Further development of this proposal will identify whether additional resources are required.	January 2015	Paul Neill / Prof Jonathan Richards
	Establish multidisciplinary quality improvement programme at RGH to test impact of targeted interventions e.g. rescue packs, inhaler technique etc.	Reduction in emergency admissions to hospital for patients who have been admitted with an exacerbation three or more times within the last twelve months.	Capacity to deliver within existing roles.	None identified as required at this stage.	September 2015	Caroline Craven / Owain Jones / Nominated Respiratory Nurse Specialist

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	Nominated Prescribing Adviser to act as a link between primary and secondary care.	Link to be established between primary and secondary care.	-Staff resource. -Time management. -Non engagement of staff. -Number of competing priorities.	No funding required.	March 2015	Caroline Craven
	To continue to develop and further roll out a service to Care Homes specifically undertaking Medication reviews.	Service to be rolled out to Care Homes in Taff Ely and Rhondda.	-Staff resource -Number of competing priorities for primary care staff.	Funding already in place.	September 2015	Caroline Craven
Ensure adequate and equitable access to end of life care.	Explore ways in which the Respiratory and Palliative Care teams ensure that core palliative care issues are being met e.g. control of common symptoms, screening for depression/anxiety, welfare/benefits/DS1500 etc., and advance care planning.	Appropriate support in place for patients at end of life.	Capacity of palliative care team.	None identified at present.	December 2014	Dr Paul Neill / Dr Ian Back
Ensure the UHB delivers against the required performance targets.	Review the current outpatient and diagnostics model. To include: • Condition specific access e.g. bronch-iectasis,	Patients have timely access to treatment.	Capacity within team to undertake the review. Further risks may be identified on completion of the	To be determined once review completed.	March 2015	Neil Cooper / Dr Paul Neill

	Prompt effective treatment					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	dysfunctional breathing and anxiety related dyspnoea. • Multi-disciplinary support available.		review.			
	Ensure adequate provision of investigation; basic, and more specialised e.g. home partial polysomnography for obstructive sleep apnoea.	Timely diagnosis and initiation of treatment.	Potentially requires additional investment in diagnostics.	To be determined.	June 2015	Neil Cooper
	Support for the development in Wales of tertiary services from tertiary centres for conditions either needing specialist investigations or treatment, or for tertiary specialist advice e.g. complex sleep problems and pulmonary hypertension.	Improved clinical outcomes.	Requires national approach. Impact on commissioning budgets.	To be determined.	Ongoing	Respiratory Consultants

	Patient education and support services					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
Improve information available to patients and their carers to ensure patients are aware of their diagnosis, treatment plan and self management techniques.	Review information available for newly diagnosed patients.	Enhanced awareness of respiratory disease diagnosis and its implications amongst newly diagnosed patients.	Time constraints / other priorities.	To be confirmed following review of information currently available.	January 2015	Rhian Williams / Chris Mulholland
	Map all available sources of support, education and information for patients with a respiratory condition.	UHB has a clear understanding of services available, referral routes, demand and current capacity. Menu of education, exercise and information support developed. Any gaps in provision identified.	Demand out weighing capacity (e.g. Pulmonary Rehabilitation as currently provided).	To be confirmed following completion of mapping exercise.	January 2015	Rhian Williams / Tracy Jones
	Develop a standardised self management plan to be used across Cwm Taf Health Board.	Use of unified self management plan throughout Cwm Taf.	Non engagement in primary care due to competing other priorities.	No additional funding	September 2015	Rhian Williams Janis Downs
Explore the potential for enhancing the role of Breathe Easy Support Groups across Cwm Taf.	Identify link member of staff for local group.	Improved communication between third sector and UHB and patients and UHB staff.	None identified.	None required.	October 2014	Rhian Williams
	Raise awareness of	-Improved peer	Non engagement	No additional	September	Rhian

	Patient education and support services					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Funding**	**Timescales**	**Lead**
	Breathe Easy Groups amongst health care professionals. Explore the potential for establishing additional Breathe Easy Groups in Cwm Taf. Use the Breathe Easy Groups as a model for expanding peer support available for patients with a Respiratory condition within Cwm Taf.	support for patients. -Better utilisation of support services. -Development of new groups with in Cwm Taf	from the public.	funding required.	2015	Williams / Derek Cummings / Chris Mulholland
Ensure equity of access to Pulmonary Rehabilitation and other forms of education, support and exercise e.g. National Exercise on Referral Scheme (NERS).	Undertake demand and capacity exercise for Pulmonary Rehabilitation.	Increased access to services available.	Demand will outweigh capacity of Pulmonary Rehabilitation if current model maintained.	To be determined.	January 2015	Tracy Jones/Nicola Giannoulis

Annex 3

Population Outcome Indicators and NHS Assurance Measures

Our population outcomes are:

1. People, through smoking prevention measures and smoking-cessation have minimal or no risk of developing smoking-related lung disease.

2. People have a minimised risk of developing other respiratory disease and where it occurs an improved chance of living a long and healthy life.

We will use the following outcome indicators to measure and track how well we are doing over time.

As we want to reduce inequalities in health, we will also examine how well we are reducing the gap between the most and least deprived parts of Wales and between age groups.

OUTCOME INDICATOR: Reduce the prevalence of adult smoking to 20% by 2016 and 16% by 2020

Population Group
Adults resident in Wales (aged 16+)

Rationale
These represent various age groups of people with, or at risk of developing, respiratory disease and it is closely associated with previous and current smoking. It is an indicator of effective health promotion, prevention, patient empowerment and smoking cessation service effectiveness.

OUTCOME INDICATOR: Incidence of COPD per 100,000 population

Population Group
People 35 years or older resident in Wales

Rationale
This is the largest group of people with respiratory disease and it is closely associated with previous and current smoking. It is an indicator of effective health promotion, prevention, patient empowerment and service effectiveness.

OUTCOME INDICATOR: Unscheduled hospital admissions for both asthma and COPD per 100,000 population

Population Group
People of all ages resident in Wales, including child age groups for asthma

Rationale
This is the population marker for the long-term successful management of these conditions in primary, secondary and community care. It is a marker of effective multidisciplinary pathways, patient empowerment and service effectiveness.

Admission rates across deprivation quintiles are used here to describe any variation in outcome for people with these conditions. Admission rates for asthma need to include variation of outcomes for childhood age groups.

OUTCOME INDICATOR: Disease and age group specific mortality rates under age 75 per 100,000 population

Population Group
People resident in Wales

Rationale
This is a marker of effective health promotion, prevention, patient empowerment and service effectiveness.

Excess deaths are experienced in COPD particularly, but also in asthma, interstitial lung disease and OSAHS. To reflect the effectiveness of the service in delivering effective care, all these groups are required to be assessed. The other important group, those with lung cancer, is addressed in the Cancer National Plan.

Mortality rates across deprivation quintiles are used here to describe any variation in outcome for people with these conditions.

NHS Assurance Measures

The following NHS Assurance Measures have been identified to measure how people receiving NHS respiratory care are better off as a result improved services. Where not currently available, these will be developed and form the basis of Local Health Boards' annual reports on respiratory care.

Some NHS services aim to reduce risk factors associated with respiratory disease such as the number of people who smoke or

who are obese. NHS Assurance Measures for those services are not included here as they are set out in *Programme for Government* and in the Welsh Government's Performance Level Agreement with Public Health Wales NHS Trust.

ASSURANCE MEASURE: 5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks

What experience does this relate to?

Experience 1 – People are aware of and are supported in minimizing their risk of lung disease through healthy lifestyle choices and medication where appropriate.

Experience 2 – Lung disease is detected promptly and early on in its development.

Patient Group

Smokers of all ages.

Rationale

We need to identify people at-risk for smoking-related lung conditions and detect any early disease in primary care through means of assessment and spirometry. We need to identify those people with smoking-related diseases in secondary care in order to provide smoking-cessation advice and support. Smoking cessation in such patients is highly cost-effective.

This is a marker of effective self-care through patient education and empowerment, and effective NHS monitoring of people who smoke for complications and early disease.

ASSURANCE MEASURE: % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis

What experience does this relate to?

Experience 4 - People are placed at the heart of respiratory care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of their lung disease.

Patient Group

People newly diagnosed with a chronic respiratory condition.

Rationale

People of all ages newly diagnosed with lung disease who receive structured education about their lung condition are more likely to be empowered and able to manage the effects of it and to stay healthy and out of hospital.

ASSURANCE MEASURE: % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and the % of referrals who have successfully completed the programme.

What experience does this relate to?

Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

Experience 4 - People are placed at the heart of respiratory health care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of respiratory disease.

Patient Group

People of all ages diagnosed with the relevant conditions namely, COPD, bronchiectasis, ILD, in whom such programmes are known to be of benefit.

Rationale

This is a marker of prompt effective care through patient education and empowerment leading to a better quality of life from locally-based treatment and support.

ASSURANCE MEASURE: % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan

What experience does this relate to?

Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

Experience 4 - People are placed at the heart of respiratory health care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of lung disease.

Patient Group

People of all ages diagnosed with respiratory disease.

Rationale
This is a marker of effective community-based and self-care through patient education and empowerment, and effective NHS monitoring of people with respiratory disease for complications, progression or exacerbations.

ASSURANCE MEASURE: % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework.

What experience does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

Experience 4 - People are placed at the heart of respiratory health care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of lung disease.

Patient Group
People of all ages diagnosed with severe bronchiectasis, ILD, difficult asthma, complex sleep-disordered breathing conditions.

Rationale
This is a marker of effective MDT networks working to national guidelines and effective NHS monitoring of people with complex and difficult lung conditions at risk of complications.

ASSURANCE MEASURE: People with asthma and COPD: number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS).

What experience does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

Experience 4 - People are placed at the heart of respiratory health care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of lung disease.

Patient Group
People of all ages with a diagnosis of asthma and >35 years old with a diagnosis of COPD.

Rationale

We want to keep people with asthma and COPD well-controlled, healthy and out of hospital. This depends on the provision of personal care plans (PCPs) and the establishing of enhanced follow-up schemes post-discharge and pulmonary rehabilitation. The number of hospital admissions, re-admissions and ALOS are markers for these.

ASSURANCE MEASURE: % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care.

What experience does this relate to?

Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

Experience 4 - People are placed at the heart of respiratory care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of lung disease.

Patient Group

People of all ages with advanced and terminal lung disease.

Rationale

This is a marker of the effective and timely access to appropriate and specialist MDTs with care tailored to the individual and that care being locally delivered.