

Major Conditions Strategy Submissions: chronic respiratory disease June 2023

Question: In your opinion, which of these areas would you like to see prioritised for CRD?

- Getting diagnosis quicker
- Stopping or delaying progression of CRD through clinical interventions for individuals at high risk (secondary prevention)
- Improving non-urgent and long-term treatment and care to support management of CRD

Question: How can we better support local areas to diagnose more people at an earlier stage?

The number of people with a diagnosis of COPD has increased by 27% in the last decade and asthma is the most common respiratory disease in the UK.

Respiratory disease such as COPD and asthma can co-exist with upper airway disorders. Where people have coexisting chronic respiratory disease and upper airways disorder, they demonstrate greater healthcare use by more than a third, compared to those with chronic respiratory disease only (Murphy et al, 2020).

This can have an economic burden and impact upon quality of life:

- Between 24% and 53% of patients with severe asthma have Inducible Laryngeal Obstruction, which is between two and four million people in the UK (joint European Respiratory Society and European Laryngological Society guidance)
- Respiratory conditions such as asthma can lead to chronic cough. Cough presents a considerable financial burden, with acute cough costing approximately £979 million in the UK, including £875 million in loss of productivity and £104 million in healthcare costs.

Symptoms and triggers of upper airway disorders can mimic lower respiratory disease making it difficult to differentiate between the two. Misdiagnosis of upper airway disorders or chronic respiratory disease is common and increases costs to the wider health system, including through:

- Over-prescription of medication, some of which is inappropriate.
- Inappropriate hospital admissions.
- Excessive medical assessments.
- Inappropriate hospital reviews.
- Prolonged hospital stays.
- Avoidable patient and family distress.

National service provision to diagnose and assess this population is scarce, meaning many people experience extended care pathways, misdiagnosis, long waiting times and are prescribed unnecessary medications. The limited access to specialist care results in poor experience and sub-optimal outcomes.

A whole multidisciplinary team approach is needed to ensure correct diagnosis and for longer term management and support. The NHS England Severe Specification for Asthma, for children and adults, identifies a 'need for a speech and language therapists within the severe asthma multi-disciplinary team'. However, provision is a postcode lottery.

Where speech and language therapists work within a multidisciplinary team of respiratory experts, including doctors, nurses, lung physiologists and clinical psychologists, they improve accurate diagnosis, offer timely and appropriate intervention and support people to live well. Reference: Case study 6: <https://www.ahpnw.nhs.uk/media/1150/case-studies-cvd.pdf> . This specialist respiratory MDT model needs to be available in more areas to end the regional variation in access to services.

Respiratory function testing facilities need to be available. Pulmonary physiology tests, such as spirometry, are essential for accurate diagnosis. For some, a spirometry test is vital to rule out respiratory disease, so an alternative cause for

breathlessness can be found. For others it leads to accurate diagnosis and then appropriate treatment to manage symptoms. There is a backlog of patients waiting for respiratory physiology services.

Question: How can we better support and provide treatment for people after a diagnosis?

Where people have both chronic respiratory disease such as COPD and asthma along with an upper airway disorders they demonstrate greater healthcare use by more than a third, compared to those with chronic respiratory disease only (Murphy et al, 2020).

Due to the lack of national provision to diagnose and assess this population, many people experience extended care pathways, misdiagnosis, long waiting times and are prescribed unnecessary medications. The limited access to specialist care results in poor experience and sub-optimal outcomes.

A whole multidisciplinary team approach is needed for longer term management and support. The NHS England Severe Specification for Asthma, for children and adults, identifies a 'need for a speech and language therapists within the severe asthma multi-disciplinary team'. However, provision is a postcode lottery.

Every person has a right to have access to vital and life saving speech and language therapy for their communication, voice and swallowing needs, as well as having their physical needs met. Speech and language therapy in the NHS is not a "nice to have". People need to access and receive speech and language therapy appropriate to their condition that is not allocated via a post-code lottery.

Investment in the respiratory workforce, including speech and language therapists, is needed. Where speech and language therapists work within a multidisciplinary team of respiratory experts, including doctors, nurses, lung physiologists and clinical psychologists, they improve accurate diagnosis, offer timely and appropriate intervention and support people to live well. Reference: Case study 6:

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Evidence shows that nonpharmacological treatment approaches can improve/eliminate symptoms. The British Thoracic Society's guidelines for asthma management recommend controlling asthma using 'the lowest possible doses of medication'. The James Lind Alliance Priority Setting Partnerships promotes a need to 'explore the role of complementary therapies for asthma management, including breathing exercises'.

The remit of speech and language therapists working in respiratory services is both broad and specialised. Speech and language therapists are required to manage patients with multiple and complex comorbidities and work across different MDT teams. The speech and language therapy workforce has the skills to contribute across a patient's clinical journey through assessment, differential diagnosis, management planning, treatment and discharge. Structured rehabilitation programmes from speech and language therapists include breathing strategies, throat and upper body relaxation exercises, giving advice on how to maintain a healthy larynx, behaviour change techniques and offering psychological support.

Accessing and understanding health messages and advice

- Messaging is not always accessible and inclusive for people who communicate differently or with difficulty. If information and communication is inaccessible people cannot follow the advice because they do not understand what is being said and what they are meant to do.
This includes advice across all areas of living well and self-management, for example uptake and adherence to guidance on healthy eating, physical exercise as per the CMO guidelines, falls prevention, smoking cessation and vaccines.
- This variation needs to be addressed and tailored written communications provided.
- Gaining timely access to healthcare services often requires a high level of health literacy. Older people and people with cognitive and communication

difficulties often have lower levels of health literacy and as a result have less understanding of, and insight into, managing and maintaining their own health.

Question: How can we better enable health and social care teams to deliver person-centred and joined-up services?

Specialist respiratory services include a number of multi disciplinary professionals including, speech and language therapists, clinical psychologists, lung physiologists, nursing staff and physicians, with the primary aim of providing timely and effective treatment and support. Reference: Case study 6:

<https://www.ahpnw.nhs.uk/media/1150/case-studies-cvd.pdf> . This specialist respiratory MDT model needs to be available in more areas to end the regional variation in access to services.

National service provision to diagnose and assess this population is scarce, meaning many people experience extended care pathways, misdiagnosis, long waiting times and are prescribed unnecessary medications. The limited access to specialist care results in poor experience and sub-optimal outcomes. Investment in the entire respiratory multidisciplinary team is needed.