



# **ABMU RESPIRATORY DELIVERY PLAN 2014 – 2017**

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## 1. BACKGROUND AND CONTEXT

“Together for Health – a Respiratory Health Delivery Plan” was published in April 2014 and provides a framework for action by health boards and NHS trusts working together with their partners. It sets out the Welsh Government’s expectations for the planning and delivery of high-quality person-centred care for anyone affected by a respiratory condition.

For each theme it sets out:

- Delivery expectations for the management of respiratory conditions
- Specific priorities for 2014-17
- Responsibility to develop and deliver actions to achieve the specific priorities
- Potential assurance measures

### **The vision**

Our vision is for people of all ages to be encouraged to value good lung health, to be aware of the dangers of smoking and, take personal responsibility for their lifestyle 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.

Our aim is for Wales to have low incidence for lung disease and improved health care outcomes. We will use the following indicators to measure success:

- 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

### **The Drivers:**

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 and respiratory diseases cause one in seven (15%) of all deaths in Wales. Moreover, the *Welsh Health Survey 2012*, which includes lifestyle information, reveals a smoking prevalence in Wales of 23% and a prevalence of overweight and obese adults of 59%. Both smoking and obesity are major contributory factors to the levels of respiratory disease. Improving the respiratory health of the population in Wales is a major challenge for health care providers and a key opportunity to improve the lives of patients and their families.

Improvements in respiratory health care have not been achieved equally for all people and substantial differences in service provision can be found between communities. Levels of respiratory disease in areas of social deprivation are of particular concern and improved outcomes in respiratory health also need to be delivered equitably.

Focus now needs to be on providing services which make the most effective use of resources, whilst measurably impacting upon the quality of life for areas of population with particularly poor lung health.

### **What do we want to achieve?**

The all-Wales Delivery Plan sets out action to improve outcomes between now and 2017. It focuses on meeting population need, tackling variation in access to services and reducing inequalities across six themes:

- Preventing poor respiratory health
- Detecting respiratory disease quickly
- Delivering fast, effective treatment and care
- Supporting people living with lung disease
- Improving information
- Targeting research

## 2 ORGANISATIONAL PROFILE

Abertawe Bro Morgannwg University Health Board, launched on 1<sup>st</sup> October 2009, combines the former Abertawe Bro Morgannwg University NHS Trust (previously Bro Morgannwg NHS Trust and Swansea NHS Trust) and the three Local Health Boards; Bridgend, Neath Port Talbot and Swansea.

Acute, intermediate, primary, community care and mental health services are integrated into the one Abertawe Bro Morgannwg University Health Board (ABMU-HB). Services continue to be delivered across a network of primary care practices, Community Clinics, Health Centres and a number of Community Hospitals, supported by three main acute hospitals - Morriston, Princess of Wales and Singleton. The overall Health Board allocation is in the region of £1billion, and we have a staffing complement of over 17,000.

The ABMU-HB provides services to a population of 600,000 people, primarily serving the populations of Swansea, Bridgend, Neath Port Talbot, the Western Vale of Glamorgan and their respective communities. In addition, Morriston provides a large range of regional and sub-regional services, including Cardio-Thoracic Surgery, Intensive Care, Renal Medicine, Neurology and the Welsh Burns and Plastic Surgery Unit.

There are Respiratory Services at all 4 Hospitals within ABMU-HB. Acute in-patient services are currently based at 3 acute hospital sites: Morriston, Singleton and Princess of Wales (Bridgend) Hospitals. Outpatient clinics and bronchoscopy are also provided at Neath Port Talbot Hospital.

There are currently eleven Respiratory Consultants in post (10.5 Whole Time Equivalent):

Morriston Hospital:	Dr NK Harrison (Associate Professor) (0.3 NHS) Dr EN Evans Dr D Vardill (0.5 MH IP 0.5 NPTH OP) Dr M Shetty (0.6 MH IP 0.4 NPTH OP)
Singleton Hospital:	Dr S Packham Dr RS Finn Dr G Davies (Clinical Associate Professor) (0.6 NHS) Vacant Post (part time)
Neath Port Talbot Hospital:	OP clinics (Dr Vardill & Dr Shetty)
Princess of Wales Hospital:	Dr M Sevenoaks Dr J Banks Dr Jacqueline Woolley (0.8) Dr Emma Watkins (0.8)

The ABMU Respiratory Delivery Plan (2014 -2017) is made up by two operational plans. They are the Swansea-Neath delivery plan and a Bridgend delivery plan. Both of the documents are displayed separately in this plan (the Swansea-Neath delivery plan as Section A and the Bridgend delivery plan as Section B).

# SECTION A

## Swansea /Neath Port Talbot Respiratory Delivery Plan (2014 – 2017)

The Respiratory Teams in Swansea and Neath Port Talbot are expected to work collaboratively to provide a high quality service across the area. The vision for the near future includes a single acute site for medical admissions and inpatient work, with day-case, ambulatory and outpatient services at Morriston, Singleton & Neath Port Talbot Hospitals.

Sub-specialist interests at Morriston Hospital including Lung Cancer, Endobronchial Therapies, Interstitial Lung Disease, Cough and Pleural Disease. The Swansea and Neath Port Talbot Lung Cancer MDT is based at Morriston Hospital. Cancer clinics are then run in each of the 3 hospitals supported by the 3 Lung Cancer Specialist Nurses. There is also a weekly specialist Interstitial Lung Disease clinic.

Morriston Hospital has a designated respiratory ward of 27 beds and operates a ward-based system for acute admissions. A dedicated Non-Invasive Ventilation unit within the Respiratory Ward is under development. Junior staff consist of two Specialist Registrars in Respiratory and General Medicine, three CMT's, one ACCS, one GPVTS and three FP1's. There is a weekly endobronchial ultrasound (EBUS), interventional bronchoscopy list and radiology meeting and a monthly Thoracic Pathology meeting.

Sub-specialist interests at Singleton Hospital include Difficult Asthma and Allergy, Domiciliary Non-invasive ventilation, Lung Cancer and Pleural Disease. There is a monthly Difficult Asthma Clinic and quarterly Joint Immunology and Allergy Clinic. Singleton Hospital has a designated respiratory ward of 30 beds and operates a ward-based system for acute admissions. The sleep unit has inpatient Visi-lab sleep facilities as well as home Embletta and oximetry monitoring. Currently acute non-invasive ventilation is undertaken in the four bedded high dependency unit. Junior staff consist of one Honorary Respiratory Registrar, two Specialist Registrars in Respiratory and General Medicine, two CMT's, one academic FP2, and three FP1's.

There is ward based thoracic ultrasound available on the Morriston and Singleton sites. Endobronchial Ultrasound has recently begun and Medical Thoracoscopy services will begin shortly.

There are no acute inpatient respiratory services at Neath Port Talbot Hospital. All admissions are through Morriston and Singleton Hospitals. The General Medicine department at Morriston Hospital admits all medical patients referred from the Emergency Department. All General Practice medical referrals are admitted directly to Singleton Hospital. An average of 25 - 30 medical admissions are assessed on each site during a 24 hour period. In the near future all acute inpatient work will be centred at Morriston Hospital.

Swansea is the Regional Lung Cancer Centre with Thoracic Surgery, Endobronchial Therapies and Palliative Care based at Morriston, and Radiotherapy and Chemotherapy services in a dedicated new Oncology Centre at Singleton Hospital.

There is a well-equipped Lung Function Laboratory operating across Swansea with two body boxes (Morriston Hospital), dosimeter for bronchial challenge testing and equipment for

Cardio-Pulmonary Exercise Testing. There are full radiology services including CT, MRI and nuclear medicine. PET scanning is currently undertaken in Cardiff.

The Respiratory Service in Swansea (Morrison & Singleton Hospitals combined) is currently supported by a team of 4.9 WTE Respiratory Nurse Specialists, 1.8 WTE Lung Cancer Nurse Specialists, 3 WTE Respiratory Clinical Physiologists in Morrison and 2.2 WTE's in Singleton and 1.6 WTE Specialist Respiratory Physiotherapists.

The Respiratory Service in Neath Port Talbot is currently supported by of 3.8 WTE Respiratory Nurse Specialists, 1.0 WTE Lung Cancer Nurse Specialist, 0.8 WTE Respiratory Clinical Physiologist and 0.7 WTE Specialist Respiratory Physiotherapist.

The Respiratory Services for Swansea and Neath Port Talbot include:

- Acute medical admissions at MH and SH
- Medical inpatients under care of respiratory team at MH and SH (Respiratory beds: MH 27 and SH 30 – with additional outliers)
- Review of IP referrals
- Ad hoc Respiratory Nurse review of MAU / AGPU patients
- Respiratory nurse review of inpatients on the wards
- Weekly bronchoscopy list at all 3 sites (urgent IP only at SH)
- General respiratory and sub-specialty clinics at all 3 sites
- Allied Health Professional (AHP) clinics at all 3 sites
- Lung cancer MDT recently merged at MH
- Respiratory physiology diagnostics at all 3 sites
- CPAP and domiciliary NIV service at MH, SH & NPTH (CPAP only at NPTH)
- Nebuliser service
- TB contact tracing and screening
- Bronchiectasis sputum service
- Pulmonary Rehabilitation across multiple sites
- AHP community visits
- Ad hoc daycase patient reviews and pleural aspiration at MH & SH
- Daycase patients for eg lung biopsy, omalizumab injections.
- Junior doctor supervision, training and teaching
- Medical student supervision and teaching

We provide respiratory services to a local population with the following incidence of:

- Asthma
- COPD
- Bronchiectasis
- Pulmonary fibrosis
- Sleep apnoea

Respiratory Services activity in Swansea and Neath Port Talbot (2013-4) is as follows:

## 2.1 INPATIENT ACTIVITY

### Respiratory Emergency Admissions:

Hospital	2013/14 Fin year Total
MORRISTON HOSPITAL	3788
SINGLETON HOSPITAL	1744
<b>Grand Total</b>	<b>5532</b>

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

### All Emergency Consultant Episodes – Respiratory Consultants:

Consultant	2013/14 Fin year Total
DAVIES, DR G A	501
EVANS, DR EN	1219
FINN, DR RS	1094
HARRISON, DR NK	515
PACKHAM, DR S	1067
VARDILL, DR DAVID	1410
<b>Grand Total</b>	<b>5826</b>

### Asthma Emergency Admissions

Hospital	2013/14 Total
MORRISTON HOSPITAL	176
SINGLETON HOSPITAL	97
<b>Grand Total</b>	<b>273</b>

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

### COPD Emergency Admissions

Hospital	2013/14 Total
MORRISTON HOSPITAL	493
SINGLETON HOSPITAL	367
<b>Grand Total</b>	<b>860</b>

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

### **Pulmonary Fibrosis Emergency Admissions**

Hospital	2013/14 Total
MORRISTON HOSPITAL	14
SINGLETON HOSPITAL	3
<b>Grand Total</b>	<b>17</b>

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

### **Lung Cancer Emergency Admissions**

Hospital	2013/14 Total
MORRISTON HOSPITAL	99
NPT HOSPITAL	13
SINGLETON HOSPITAL	128
Grand Total	240

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

### **Pleural Effusion Emergency Admissions**

Hospital	2013/14 Total
MORRISTON HOSPITAL	92
NPT HOSPITAL	9
SINGLETON HOSPITAL	83
<b>Grand Total</b>	<b>184</b>

(These figures are based on primary diagnosis. Numbers dependant on coding completion levels)

## 2.2 OUTPATIENT ACTIVITY

### Morrison & Singleton Hospital

New OP Attendances	2013/14 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	2014/15 Total	Grand Total
DAVIES, DR GA	139	6	18	13	7	19	63	202
EVANS, DR EN	330	30	33	35	35	38	171	501
FINN, DR RS	250	22	14	3	0	0	39	289
HARRISON, DR N.K.	219	24	20	16	30	21	111	330
PACKHAM, DR S	338	29	40	47	54	25	195	533
<b>Grand Total</b>	<b>1276</b>	<b>111</b>	<b>125</b>	<b>114</b>	<b>126</b>	<b>103</b>	<b>579</b>	<b>1855</b>
Fup OP Attendances	2013/14 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	2014/15 Total	Grand Total
DAVIES, DR GA	360	21	28	24	29	3	105	465
EVANS, DR EN	879	59	44	39	51	21	214	1093
FINN, DR RS	429	31	24	31	15	11	112	541
HARRISON, DR N.K.	2217	183	207	178	213	189	970	3187
PACKHAM, DR S	1068	72	66	122	44	17	321	1389
<b>Grand Total</b>	<b>4953</b>	<b>366</b>	<b>369</b>	<b>394</b>	<b>352</b>	<b>241</b>	<b>1722</b>	<b>6675</b>

(These numbers will include activity generated by independent nurses and multi-professionals which is attributed to an overarching Consultant. Waiting list initiative activity is also included).

### Neath Port Talbot Hospital

New OP Attendances	2013/14 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	2014/15 Total	Grand Total
EBEJER, DR MJ	437	36	29	17	17	22	121	558
VARDILL, DR DAVID	279	19	25	32	26	9	111	390
POOLED ACTIVITY	48	4	9	7	14	4	38	86
<b>Grand Total</b>	<b>764</b>	<b>59</b>	<b>63</b>	<b>56</b>	<b>57</b>	<b>35</b>	<b>270</b>	<b>1034</b>

Fup OP Attendances	2013/14 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	2014/15 Total	Grand Total
EBEJER, DR MJ	1638	74	73	44	68	64	323	1961
VARDILL, DR DAVID	612	27	26	30	25	22	130	742
POOLED ACTIVITY	205	80	105	103	124	62	474	679
<b>Grand Total</b>	<b>2455</b>	<b>181</b>	<b>204</b>	<b>177</b>	<b>217</b>	<b>148</b>	<b>927</b>	<b>3382</b>

(These numbers will include activity generated by independent nurses and multi-professionals which is attributed to an overarching Consultant. Waiting list initiative activity is also included).

## 2.3 CT GUIDED LUNG BIOPSIES

	2013/14	2014/15	Grand Total
NPT Hospital	26	0	26
Singleton Hospital	24	13	37
Morrison Hospital	31	12	43
<b>Grand Total</b>	<b>81</b>	<b>25</b>	<b>106</b>

(Radiology Data)

## 2.4 BRONCHOSCOPIES

Inpatients	2013/14	2014/15	Grand Total
NPT Hospital	1	0	1
Singleton Hospital	13	6	19
Morrison Hospital	20	20	40
<b>Grand Total</b>	<b>34</b>	<b>26</b>	<b>60</b>

(2014/15 activity up to August)

Day Case	2013/14	2014/15	Grand Total
NPT Hospital	69	51	120
Singleton Hospital	0	0	0
Morrison Hospital	115	21	136
<b>Grand Total</b>	<b>184</b>	<b>72</b>	<b>256</b>

(2014/15 activity up to August)

## ADDITIONAL RESPIRATORY ACTIVITY

- 29 patients have undergone EBUS in MH between April 2014 and September 2014.
- 119 patients completed pulmonary rehabilitation
- Approximately 1000 patients on nebulised therapy
- Approximately 1000 patients on home oxygen
- Approximately 200 patients on domiciliary Non-Invasive Ventilation

### Respiratory Physiology Activity 2013-4

Respiratory	NPTH	MORR	SING
Sleep study	72	320	997
CPET		364	
CPAP issue	79	75	237
CPAP Fup	339	560	1077
Spirometry	641	OP 1860 IP 600	633

See Appendix 1 for detailed breakdown of NPTH activity

There are intentions to expand the CPET service in Morriston Hospital to meet increasing demand. There is also a recognised increase in the number of referrals from neuromuscular clinics (locally and regionally). An increased establishment of Respiratory Physiologists will be essential in managing this workload.

Within the Swansea locality there is a heavy reliance on the Chronic Disease Nurses picking up the follow-up and community support of specialist respiratory patients. This is currently being reviewed.

### 3.0 Overview of local health need and challenges to respiratory services

Particularly challenging issues include:

- Multiple sites and historically small, separate departments
- Multiple acute sites and inpatient work
- Respiratory conditions account for largest proportion of acute medical admissions
- Poor access to diagnostics
- Poor access to quality ambulatory care (current service not adequately staffed /resourced / housed)
- Understaffed consultant body
- Understaffed respiratory allied health professionals
- High levels locally of smoking, obesity, poor fitness and deprivation Ageing population
- Increasing demand on inpatient and outpatient services

All services within ABMU-HB are undergoing reconfiguration as a result of the South Wales Programme and the Changing for the Better programme. This is also in the wake of the RCP's Future Hospitals Commission, seven day working and the Andrews Report.

Respiratory Physicians across the UK have traditionally made a significant contribution to the acute general medical in-take in district general hospitals because respiratory conditions such as COPD, pneumonia, asthma and lung cancer all commonly present as acute medical emergencies. However, the juxtaposition of expertise of a number of disciplines allied to respiratory medicine on the *same site* are common to Respiratory 'Centres of Excellence' the world over. These are:

- Thoracic Surgery
- Intensive Care
- Cardiology
- Thoracic histopathology
- Cardiothoracic Radiology

Morrison Hospital is the only centre in Wales where all these services exist on one site. It is thus uniquely placed to serve as a Cardio-Thoracic Centre of Excellence for West Wales and a 'hub' for Respiratory Services across ABMU-LHB.

We propose a whole service change for Respiratory in Swansea and Neath Port Talbot. Our vision is that the Respiratory Service for Swansea and Neath Port Talbot would be based at Morrison Hospital. This would serve as the hub for services delivered in the other hospitals and community. Currently the service is understaffed, particularly at Consultant and Allied Health Professional staff levels, and is struggling to maintain these services. The difficulties are compounded by splitting **all** services, across **all** 3 sites.

With a single hub and improved staffing levels, including appropriate AHP and administrative support, we would be able to develop innovative and robust services for our growing population. The services we could offer would be centred on several elements:

- Inpatient – emergency and elective, including urgent cases
- Outpatient Clinics - hot slots, sub-specialty, MDT, nurse-led, physio-led
- Daycase / Ambulatory Care – bronchoscopy, EBUS, lung biopsy, thoracoscopy, pleural aspiration, omalizumab etc
- Other outpatient / community services – early discharge, admission avoidance, pulmonary rehabilitation, home visits

## **Inpatient Services – Emergency and Elective**

The Respiratory Consultants would continue to support the acute general medical intake through the acute hub at Morriston Hospital. We propose having a Respiratory on call day per week, with the Respiratory Consultants rotating through that slot internally. Weekends would be covered by each consultant as per the general medical on call rota.

The Respiratory ward(s) and outliers would be covered by 2-4 Respiratory Consultants of the Month (max 20-25 patients each as per RCP guidance). The Respiratory Physicians will rotate on and off the wards according to an internal departmental rota. Initially this will be on a 5 day basis, increasing to 7 day working when staffing levels allow.

The On Wards Consultants will deliver:

- Daily board and ward round which improves patient care, experience and length of stay
- Twice daily review of the acute NIV beds which are high dependency. This improves care and allows better use of the beds with increased throughput
- Daily review of respiratory patients in the CDU / MAU, pulling patients through to the respiratory ward as necessary
- Daily review of respiratory referrals from other wards such as ITU, surgery, other medical etc
- daily identification and review of patients with COPD suitable for early supported discharge with the Respiratory Team
- Daily identification and review of patients with bronchiectasis suitable for early discharge with home IV antibiotics with CRT
- Supervise IP pleural procedures with bedside thoracic ultrasound allowing adherence to national guidance, better care for patients and better training for trainees
- Supervise short stay semi-elective cases for medical thoracoscopy and indwelling pleural catheters
- Internally cover the weekday on call and post take ward round
- Supervise students and trainees on the wards
- Reduced outpatient commitment

Such a strong consultant presence on the wards has several advantages. Good inpatient care requires daily senior review with time for regular discussion with patients and their carers / relatives. This not only improves care but reduces informal unhappiness / issues and formal complaints. A strong consultant presence on the ward also improves communication between all members of the wider ward team along with supervision, training and teaching of junior and student staff.

The Off Wards Consultants will deliver:

- Bronchoscopy – diagnostic and therapeutic
- Daycase pleural procedures including indwelling pleural catheters
- Ambulatory care – omalizumab, lung biopsy
- MDT case management of outpatients under early discharge scheme or nurse / AHP led clinic review
- Virtual clinics
- Email advice for GPs
- Telephone advice to GPs
- Outpatient referrals triaged by consultant into most appropriate pathway
- Hot slots in clinic for rapid review / admission avoidance
- Subspecialty and MDT clinics
- General respiratory clinics
- Support pulmonary rehabilitation

- Supervise students and trainees in clinics and ambulatory care
- Educational supervision
- Teaching of both medical students and junior doctors
- Ongoing commitment to audit, quality improvement projects and research

These commitments are likely to be divided into separate periods of rotation eg

- General Respiratory clinics with urgent slots / Virtual clinics / Telephone and email advice for GPs / Support for AHPs with case meetings
- Ambulatory care / Bronchoscopy / Daycase procedures / Hot slot review for admission avoidance
- Teaching / supervision
- Research

The Respiratory Consultants will also rotate through a cover period, which will allow annual leave to be taken without significantly reducing or compromising either inpatient or outpatient activity.

All consultants (on and off wards) will attend:

- Weekly respiratory department meeting
- Weekly respiratory radiology meeting
- Weekly general medical case presentation meeting
- Monthly respiratory business meeting
- Monthly respiratory pathology meeting

The Respiratory Consultants will develop and lead on sub-specialty conditions such as

- Acute Respiratory Illness
- Asthma and Allergy
- Bronchiectasis
- COPD
- Domiciliary NIV
- ILD
- Lung cancer
- Oxygen
- Pleural disease
- Pulmonary Rehabilitation
- Sleep
- Smoking Cessation
- Tuberculosis

This allows our service to meet quality standards by the development of inpatient guidelines, ambulatory care guidelines, sub-specialty outpatient clinics (including MDT and joint specialty clinics), and the development of AHP led clinics under consultant supervision. All of which not only improve patient care and experience but also reduce length of stay, avoid admission, streamline OP review and free-up consultant outpatient clinic capacity.

The wider Respiratory Team including Respiratory Nurse Specialists, Respiratory Physiotherapists and Respiratory Physiologists would be able to offer enhanced services with some additional investment. These services would improve patient care and experience whilst reducing costs through improving patient and population health, improving patient self management, reducing referrals to secondary care, avoiding admission to hospital and reducing length of stay.

## **Outpatient Clinics**

Some outpatient activity would be maintained during On Wards rotation, but at a reduced level to maintain availability for troubleshooting on the wards. The Outpatient Clinics maintained should be urgent subspecialty work only.

Off Wards Consultants would offer an enhanced range of outpatient services. All outpatient referrals would be reviewed by a respiratory consultant and allocated to the most appropriate clinical pathway eg. USC cancer, urgent review (within 2 weeks), subspecialty MDT clinics, ambulatory care review, AHP clinic review. This would ensure that patients are seen by the most appropriate person, first time.

### *Subspecialty Clinics*

These would be developed by the sub-specialty lead consultant. The Lung Cancer Multidisciplinary clinic at Morriston is an excellent example of a subspecialty MDT clinic. This allows comprehensive assessment by the specialist MDT with swift diagnostic and treatment strategies. There is also the ability for patients to be reviewed by different members of the MDT according to need.

There are also Difficult Asthma, Allergy and ILD clinics currently running.

There are a number of other subspecialty clinics which would be beneficial in terms of improving patient care and experience whilst streamlining the service eg

- Sleep Disordered Breathing – this would fit with the new pathway developed for ABMU. At present there is an Initial consultant review, then when stable, transferring to a Physiologist led clinic with consultant input as required. There is scope to increase the number of complex patients undergoing an initial review by a physiologist.
- Domicillary NIV – a multidisciplinary clinic with Respiratory Consultant, Nurse and Physiologist. There is also a need to develop a joint Neurology and Respiratory MDT clinic for those with neuromuscular weakness eg MND.
- COPD – for complex patients who may require domicillary NIV, lung volume reduction surgery or transplantation.
- Bronchiectasis – Initially Consultant review with Respiratory Nurse and physiotherapist, then when stable, transferring to a Physiotherapist led clinic with consultant input as required. There will also be strong links to ambulatory care for the insertion of mid-lines and initiation of IV antibiotics which would then transfer to CRT for the duration of the home IV antibiotic course.
- Pleural Disease – This pathway will need to run in close conjunction with ambulatory care to allow both diagnostic and therapeutic aspiration. In addition to ongoing pathway development, thoracoscopy equipment has been purchased to further develop this service.
- Tuberculosis – will require a Consultant clinic for diagnosis, initiation and completion of therapy. A Respiratory Nurse Specialist led clinic currently performs interim review and contact tracing. However, the addition of a nurse led screening and contact tracing clinic, particularly for new immigrants and all university students from endemic countries, would allow faster identification and monitoring of new patients. Especially those at high risk of MDR TB.

### *General Respiratory*

With the sub-specialty clinics seeing patients with particular pathology, the general respiratory clinics could be manned on a rotational basis. These clinics could offer urgent slots for patients who do not obviously fit into a subspecialty clinic urgent slot. Patients are likely to be reviewed and worked up in this clinic. Once a diagnosis has been achieved, patients are then either discharged back to primary care or transferred to a specialty clinic.

### **Daycase / Ambulatory Care / Hot Slot Admission Avoidance**

The pleural clinic would run in conjunction with ambulatory care, allowing diagnostic and therapeutic aspiration. Some patients would then benefit from direct referral for therapeutic aspiration eg patients with a known malignant pleural effusion. Indwelling pleural catheters could also be inserted if there are appropriate facilities.

Other ambulatory care procedures include lung biopsy, omalizumab injections, complex domiciliary NIV review, cytotoxic infusions etc.

Bronchoscopy and EBUS is offered as a daycase procedure. The Morriston list will predominantly be for EBUS and therapeutic endobronchial procedures and the NPTH list will be for diagnostic bronchoscopy.

Medical thoracoscopy is likely to remain a short stay procedure initially, but with experience some patients may be suitable for daycase.

It may also be prudent to run admission avoidance clinics / reviews from the ambulatory care unit. A large number of these patients are likely to be low risk pneumonia, low risk PE, exacerbation of COPD and pleural effusions. However, a number of such patients are likely to require admission therefore the best site for review remains debatable at present. These may be pathways for future development once the service is more developed.

### **Other Outpatient / Community Services**

#### *Pulmonary Rehabilitation*

Apart from flu vaccination and smoking cessation, pulmonary rehabilitation is the most cost effective treatment for COPD. With increased staffing of both nurses and physio's, we could offer pulmonary rehabilitation to more patients. This would include milder cases, to try and keep healthy, and acute rehab post admission to try and regain fitness. These programmes would feed into the National Exercise Referral Scheme to continue the improvement and maintain fitness in the long term.

There is also increasing evidence that pulmonary rehabilitation is cost effective for other chronic respiratory conditions such as ILD, chronic asthma and bronchiectasis.

#### *Admission Avoidance*

With a further increase in staffing, the Early Discharge Scheme could offer admission avoidance. Obviously the greatest benefits would come when the service can be staffed for 7 day working. Again this would also benefit from close working with CRT for social support. The Chronic Conditions Management team will continue to work closely with GP's/OOH's with regard to admission avoidance.

#### *Link nurse for A&E / AGPU / MAU*

The benefit of this is close links between the emergency front door and the specialist respiratory service. This ensures that patients get specialist input quickly, either from immediate review or appropriate outpatient / daycase review. This in turn improves patient care and experience, reduces length of stay and can avoid admission completely.

#### *Sub-specialty Respiratory Nurses*

We already have Lung Cancer Specialist Nurses, an Oxygen Lead Nurse, an ILD Lead Nurse and are recruiting a Pleural Specialist Nurse. We also require Lead TB (particularly in view of the recent MDR TB cases), Sleep, NIV, Difficult Asthma and COPD Nurses.

### *Tuberculosis*

We currently have 2 cases of multi-drug resistant tuberculosis (MDR TB), which have highlighted the deficiencies in our service. These cases have been costly in terms of both time and resource. Best practice advocates a lead consultant and specialist nurse. Other services in Wales also offer screening to all new university students from endemic areas. This would have potentially allowed earlier identification of our current MDR TB cases, thus reducing the public health exposure and allowing earlier treatment. Swansea is also now a refugee centre city, which will increase the number of people from countries with endemic tuberculosis and high risk for multi-drug resistant tuberculosis.

### **Pleural Disease**

The pleural disease service will be developed (in secondary care) to enhance care provide to patients across the Swansea and Neath Locality. This commitment is underlined by the recent purchase of thoracoscopy equipment which will deliver improved diagnostic and therapeutic care to patients with pleural disease. Further work is ongoing to develop the clinical strategy for this service.

### **Pharmacy**

An increased number of respiratory consultants, each with sub-speciality responsibility, will allow closer collaboration and joint working with pharmacy, which will no doubt improve the consistency, quality and safety of prescribing within ABMUHB, whilst also helping to constrain and reduce costs to the organisation.

We will look to develop initiatives to help ensure common prescribing patterns for respiratory diseases in both secondary and primary care. This will include production of protocols and guidelines for different respiratory diseases, linked with training and education of junior doctors, nurses etc. and colleagues in primary care, and improved education of patients e.g. this may be based on our work and experience gained with the COPD 'bundles' and thus extrapolated to other common respiratory conditions.

#### **4. SUMMARY OF THE PLAN - THE PRIORITIES FOR 2014–17**

Following the completion of the key findings have been incorporated into our delivery plan for respiratory health. This delivery plan includes actions against each of the 2017 milestones within the Welsh Government's Respiratory Health Delivery Plan (2014).

##### **Preventing poor respiratory health**

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

##### ***Our key challenges are:***

###### Smoking

- Reduction in the prevalence of adult smoking to 20% by 2016 and 16% by 2020

###### Vaccination Programme

- Ensure >75% of target populations receive appropriate vaccinations

###### Obesity and Fitness

- More people pursue a healthy diet and achieve a healthy weight

##### ***Our priorities for 2014 – 17 are:***

###### Smoking

- Work with a broad range of partners (Public Health Wales, the community stop smoking service 'Stop Smoking Wales', community pharmacists, GPs and secondary care) to deliver local strategies and services to prevent smoking, offer support for those wishing to quit and achieve the Tier 1 target on smoking cessation
- Work with Public Health Wales and regularly review, plan and deliver the smoking cessation programmes recommended in the Tobacco Action Plan (2011) ensuring appropriate data collection for monitoring success
- Ensure smoking cessation services comply with best practice
- Ensure sufficient capacity and workforce to be able to deliver the actions and outcomes of the Tobacco Control Action Plan for Wales (2011)

###### Vaccination Programme

- Raise awareness and implement local immunization policies

###### Obesity and Fitness

- Work with a broad range of partners (Public Health Wales, community teams, community pharmacists, GPs and secondary care) to deliver local strategies and services to prevent obesity and offer support for those wishing to diet and exercise
- Ensure timely referral to dietetic support
- Ensure timely referral to the National Exercise Referral Scheme (NERS), designed to increase the long-term adherence in physical activity of patients.

## **Detecting respiratory disease quickly**

Lung disease is detected promptly and early on in its development

### ***Our key challenges are:***

- People over-35 who smoke are offered spirometry and signposted to smoking cessation support and made aware of the consequences of continuing to smoke on their health and possible future treatment
- At-risk groups who present with persistent respiratory symptoms receive appropriate diagnostic tests and are signposted to support and treatment as required

### ***Our solutions are:***

- 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 minimize disease progression
- Increase awareness by primary care, schools and the general public of the symptoms of lung disease

### ***Our priorities for 2014 – 17 are:***

- Identify at-risk groups
- Offer at-risk groups who present with persistent respiratory symptoms appropriate diagnostic tests (e.g. chest X-rays and spirometry), delivered by appropriately trained staff
- Offer spirometry to the over-35 age group who smoke, delivered by Association for Respiratory Technology and Physiology (ARTP) accredited staff within primary and secondary care
- Validate and improve reporting and interpretation of spirometry results

## **Delivering fast, effective treatment and care**

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

### ***Our key challenges are:***

For patients with:

- Asthma and Allergy
- Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis
- Interstitial Lung Disease
- Sleep-Disordered Breathing
- Acute Respiratory Illness
- Pleural Disease – Work is ongoing to establish the necessary actions to develop the Pleural Disease Service in Swansea & Neath.

We will deliver:

- A reduction in number of unscheduled attendances and re-attendances to hospital, and average length of stay
- Increased access for patients to community-based teams able to manage individuals closer to home across relevant disease groups
- Patient information about their condition, which is easy to access, relevant and easy to understand
- Referral to pulmonary rehabilitation (PR) for patients with MRC breathless score of 3 or greater
- Management through a Multi Disciplinary Team (MDT) that works to national guidelines for patients diagnoses with ILD
- Achieve, and maintain, compliance with patient referrals for treatment targets (RTT)

Our patients will experience:

- Prompt and appropriate access to clinically and cost-effective treatment in primary and secondary care, including smoking cessation services
- 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 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

### ***Our solutions are:***

#### **Asthma and Allergy**

We will provide a high quality, well co-ordinated and efficient service which delivers the NICE Asthma Quality Standards:

1. People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
2. Adults with new onset asthma are assessed for occupational causes.
3. People with asthma receive a written personalised action plan.
4. People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
5. People with asthma receive a structured review at least annually.
6. People with asthma who present with respiratory symptoms receive an assessment of their asthma control.

7. People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
8. People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
9. People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.
10. People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.
11. There should be a designated named clinician for asthma in every hospital and gp practice.
12. People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

### **Chronic Obstructive Pulmonary Disease (COPD)**

We will provide a high quality, well co-ordinated and efficient service which delivers the NICE COPD Quality Standards:

1. People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
2. People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.
3. People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
4. People with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and co morbidities.
5. People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
6. People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
7. People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.
8. People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
9. People with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.
10. People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.
11. People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.
12. People admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.
13. People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

## **Bronchiectasis**

We will provide a high quality, well co-ordinated and efficient service which delivers the BTS Non-CF Bronchiectasis in Adults Quality Standards:

1. People with a clinical diagnosis of bronchiectasis have the diagnosis confirmed by CT chest (using 1mm slices).
2. People with bronchiectasis are taught appropriate airway clearance techniques by a specialist respiratory physiotherapist and advised of the frequency and duration with which these should be carried out.
3. People with bronchiectasis have sputum bacteriology culture when clinically stable recorded at least once each year.
4. Sputum is sent for bacterial culture at the start of an exacerbation before starting antibiotics. Empirical antibiotic therapy to start as soon as feasible and not await the sputum culture results.
5. People with bronchiectasis to attend pulmonary rehabilitation if they have breathlessness affecting their activities of daily living.
6. People with bronchiectasis receiving intravenous antibiotic therapy to have an objective evaluation of the efficacy of their treatment and the result recorded.
7. Services for people with bronchiectasis to include provision of nebulised prophylactic antibiotics for suitable patients supervised by a respiratory specialist.
8. People with bronchiectasis to be investigated for allergic bronchopulmonary aspergillosis (ABPA), common variable immunodeficiency (CVID) and cystic fibrosis (latter if indicated) as these are specific treatable causes.
9. People with bronchiectasis to have an individualised written self-management plan.
10. People with bronchiectasis who meet the criteria for continuing secondary care to be managed by a multidisciplinary team led by a Respiratory physician.
11. Services for people with bronchiectasis to include provision of home intravenous antibiotic therapy for exacerbations in selected patients.

## **Interstitial Lung Disease**

We will provide a high quality, well co-ordinated and efficient service which delivers the NICE Idiopathic Pulmonary Fibrosis Quality Standards (in consultation):

1. People with suspected idiopathic pulmonary fibrosis are diagnosed only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.
2. People with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them and if they wish their families and carers.
3. People with idiopathic pulmonary fibrosis are assessed for oxygen therapy if they are breathless at rest or on exertion, or have been admitted to hospital because of idiopathic pulmonary fibrosis.
4. People with idiopathic pulmonary fibrosis who are suitable are offered pulmonary rehabilitation that includes exercise and educational components tailored to their needs.
5. People with idiopathic pulmonary fibrosis, and their families and carers, have access to the full range of services offered by palliative care teams.

## **Sleep-Disordered Breathing**

We will provide a high quality, well co-ordinated and efficient service which delivers appropriate treatment to patients with sleep disordered breathing, core components of which include (Impress March 2009 Service Specification):

1. Initial assessment of patients referred from primary or secondary care, including evaluation of the primary problem, differential diagnosis and relevant comorbidity

2. Availability of an experienced specialist multidisciplinary team, comprising medical, nursing and scientific or technical specialists
3. Ready access to facilities for investigation of possible Obstructive Sleep Apnoea Syndrome (OSAS) on a domiciliary and/or in-patient basis
4. Availability of, or reasonable access to, facilities for more detailed sleep investigation as required
5. Facilities, equipment and experienced personnel necessary to initiate Continuous Positive Airways Pressure (CPAP) treatment
6. Personnel and facilities to provide necessary support and training for patients commencing CPAP therapy
7. Availability of a wide range of interfaces to allow provision of the most appropriate CPAP machine and interface, plus humidifier if required
8. Regular monitoring and follow-up of patients
9. Open access for CPAP-related problems or telephone help and support line, 9-5/Mon-Fri
10. Provision of replacement machines and parts as required
11. Monitoring of patient compliance, symptoms and side-effects of treatment
12. Onward referral for more specialised investigation where clinically appropriate
13. Reporting to the patient's registered GP and secondary care specialist(s) following each patient contact (other than parts provision)
14. Providing advice and reports for other agencies e.g. occupational health services and DVLA regarding medical fitness for work and driving
15. A database of patients receiving CPAP, to include equipment type, interface, settings, service history and compliance
16. Providing advice and recommendations on alternative or adjunctive treatment e.g. weight reduction, mandibular advancement devices
17. Close liaison or integration with services which share similar expertise and technology (e.g. long term domiciliary NIV)
18. Ready access to, and cooperation with, clinical services dealing with the common comorbidity of OSAS (obesity, diabetes, cardiovascular disease, ENT conditions, etc)
19. Obtaining data on patient related outcome measures (PROMs) in accordance with agreed audit criteria and providing reports for monitoring and informing service development decisions

### **Acute Respiratory Illness**

Acute respiratory illnesses are common and include community-acquired pneumonia, acute exacerbations of COPD, asthma attacks and a number of less common conditions, which together represent a major demand on primary and hospital care.

We will provide a high quality, well co-ordinated and efficient service which delivers appropriate treatment to patients with acute respiratory illness, core components of which include:

1. Adherence to NICE / BTS Quality Standards and Clinical Guidelines
2. Daily Respiratory Consultant review of respiratory patients on the acute medical admission unit
3. Daily Respiratory Consultant review of patients on the specialty respiratory ward
4. Ward based non-invasive ventilation with twice daily Respiratory Consultant review
5. Early discharge schemes
6. Home IV antibiotics for appropriate patients eg bronchiectasis
7. Admission avoidance initiatives including;
  - a. Specialist telephone / email advice
  - b. Specialist Hot clinic review
  - c. Specialist ambulatory care review and treatment
8. Appropriate GP / Specialist review after discharge

9. Subspecialty clinics to ensure high quality outpatient specialist review
10. Written self management plans for patients presenting with a chronic respiratory condition

***Our priorities for 2014 – 17 are:***

- Develop enhanced discharge and follow-up schemes to facilitate, when appropriate, quicker discharge from hospital and community support to reduce risk of re-admissions
- Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions and allergic disorders
- Audit data on treatment steps, concordance with treatment and chronic respiratory condition self-management plans to support the development of improved service delivery
- All patients attending hospital with a respiratory illness to have a discharge letter delivered to the GP within 24 hours, or by the next working day
- Ensure the implementation of NICE and British Thoracic Society (BTS) treatment guidelines for respiratory conditions in both primary and secondary care services through a defined pathway of care
- Develop recognised MDT-led Pulmonary Rehabilitation Programs (PRP) that address local needs and responds to the recommendations of National Clinical Audit<sup>1</sup>
- Develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations
- Ensure that adequate levels of physiotherapy services are established to provide and teach the breathing and lung drainage techniques that are essential to patients with bronchiectasis
- Ensure that, as with lung cancer, patients with ILDs are managed through a MDT framework and have access to specialist nursing support for appropriate conditions
- Ensure that pathways for the investigation of sleep-disordered breathing are established to assess and treat patients with OSAHS within established RTT
- Undertake a population needs assessment and review current levels of service for sleep-disordered breathing against the recommendations of the *Strategy Document for Sleep Disordered Breathing Services in Wales 2010*<sup>2</sup>
- Develop initiatives with community leads to promote the management of acute respiratory conditions in the patient's home and intermediate care, where appropriate

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<sup>1</sup> The National COPD Audit Programme will include pulmonary rehabilitation snapshot audits.

<sup>2</sup> *Strategy Document for Sleep Disordered Breathing Services in Wales 2010* was issued jointly to LHBs by the Welsh Government and the Respiratory National Specialist Advisory Group in February 2011.

- Develop pathways to address acute conditions across an enhanced primary-secondary care interface and to manage them where appropriate in the community setting
- Develop local hospital and community pathways to improve and facilitate the patient's journey from admission to returning home or to an intermediate care facility

### **Supporting people living with lung disease**

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

#### ***Our key challenges are:***

- All patients with chronic respiratory conditions to have an agreed self-management plan
- Increase the proportion of qualifying patients who have accessed support groups and palliative care services
- All respiratory patients receive relevant key measurements for their condition annually as set out in NICE and British Thoracic Society treatment guidelines
- Increased number of advanced directives of patients with advanced chronic lung disease
- All patients with advanced disease to be offered palliative and end-of-life support
- Services available as locally as possible

#### ***Our solutions are:***

- 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 and is reviewed regularly
- 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

### ***Our priorities for 2014 – 17 are:***

- Ensure that all people with chronic respiratory conditions have a personalised self-management plan in place within three months of diagnosis
- Ensure that all respiratory patients have the necessary key measurements taken annually to identify early decline in disease and facilitate appropriate interventions
- Support the development of, and encourage referral to, patient groups such as Breathe Easy
- Ensure adequate and equitable access to palliative care services, including respite care, for patients with respiratory disease in the end-stages of their illness
- Utilise appropriate referral to the NERS scheme to support people with respiratory conditions increase their long-term adherence to physical activity

### **Improving information**

#### ***Our key challenges are:***

- Patients need clear information, that is easy to understand and which allows them to make decisions about their care and treatment, and the possible consequences for their treatment if positive steps in self management are not undertaken. Information should be provided at the point of diagnosis and may include a self-management plan. It should be in the language of choice of the patient and should be updated or added-to as their disease progresses.
- Health professionals need information on the respiratory health needs of their local population and how well the NHS is operating. Information should be accessible in both primary and secondary care to facilitate seamless care.
- Clinicians should provide clear and thorough notes and timely transfer of care information, thus ensuring that information is of high-quality and supports optimal levels of care for patients.
- Service planners need information for the clinical management of patients in order to drive continuous improvements to services. This requires the recording of both clinical and performance data by Local Health Boards.
- The public, NHS Wales, the third sector and Welsh Government need information on the identified outcomes that result from NHS care.

These data sets need to link better across all providers with more real time data on clinical outcomes in order to support effective clinical care.

#### ***Our solutions are:***

- Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions, in a variety of languages and formats including ABMU on YouTube
- Signpost patients, and carers, to other relevant information sources such as patient support groups and appropriate internet sites

- Provide the public with information about our services and how they perform
- Regular audit of clinical notes to ensure appropriate standards
- Develop electronic clinical notes
- Implement, use and develop the Welsh Clinical Portal
- Continue to use and develop the GP portal, further improving communication and use of shared resources between primary and secondary care services
- Increase the use of electronic transfer of care forms to improve communication between teams, particularly between primary and secondary care
- Continue to use and develop clinical dashboards eg for unscheduled care
- Continue to use and develop performance scorecards
- Continue to use and develop clinical benchmarking tools including condition specific analysis
- Continue to develop the ABMU internet and intranet sites to inform the public and staff
- Continue to work with NWIS, Public Health Wales and Welsh Government to ensure data collected is used to inform service change which delivers high quality care

***Our priorities for 2014 – 17 are:***

- Record and use information provided by Public Health Wales and Welsh Government sources to guide service review and development
- Ensure outcome data and information from local and primary care services are collected and used to facilitate development
- To use data and information collected so as to reflect service provision and outcomes and to report such progress annually
- Report progress against local delivery plan milestones on their website

In order to ensure we are achieving our objectives, we will measure our performance against the following population indicators and NHS assurance measures, as outlined in the Respiratory Delivery Plan.

**Population Outcome Indicators:**

- Reduce the prevalence of adult smoking to 20% by 2016 and 16% by 2020
- Incidence of 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

### **NHS Assurance Measures:**

- 5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks
- % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis
- % 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
- % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan
- % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework
- People with asthma and COPD: number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)
- % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care

### **Targeting research**

#### ***Our key challenges are:***

- An increased number of respiratory trials run within Wales
- An increased number of respiratory patients recruited to clinical trials

#### ***Our solutions are:***

- Strengthen and develop our close links with Swansea University and the clinical trials units
- Strengthen and develop our links with other universities and clinical trials units
- Continue to develop clinical trials networks with links to the whole of the UK and internationally
- Encourage the development of clinical academics within ABMU
- Increase awareness of clinical trials recruiting within ABMU

#### ***Our priorities for 2014 – 17 are:***

- Welsh Government and its partners, working with stakeholder researchers, to lead and co-ordinate development and co-operation through a respiratory framework
- Encourage more respiratory patients to participate in research activity

## **5.0 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 each health board's annual report on respiratory services. They will be calculated on behalf of the NHS annually at both a national and local population level.

Health board's delivery plans and their milestones will be reviewed and updated annually.

The outcomes to measure success against the key deliverables of this plan are also laid out in the Action Plan (which follows).

## ACTION PLAN 2014 – 2015

Preventing poor respiratory health					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Smoking	<p>Work with a broad range of partners (Public Health Wales, the community stop smoking service 'Stop Smoking Wales', community pharmacists, GPs and secondary care) to deliver local strategies and services to prevent smoking, offer support for those wishing to quit and achieve the Tier 1 target on smoking cessation</p> <p>Work with Public Health Wales and regularly review, plan and deliver the smoking cessation programmes recommended in the Tobacco Action Plan (2011) ensuring appropriate data collection for monitoring success</p> <p>Ensure smoking cessation services comply with best practice</p> <p>Ensure sufficient capacity and workforce to be able to deliver the actions and outcomes of the Tobacco Control Action Plan for Wales (2011)</p> <p>Link with Localities and PHW on the update of the Community Pharmacy Level 3 Smoking Cessation programme to assess impact and effectiveness.</p>	<p>Reduction in the prevalence of adult smoking to 20% by 2016 and 16% by 2020</p> <p>5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks</p>	<p>Poor public engagement with smoking cessation services</p> <p>Insufficient capacity in smoking cessation services</p>	2016	<p>Public Health Wales</p> <p>Stop Smoking Wales</p> <p>Chronic Conditions Mgmt Team</p> <p>Community Pharmacy Smoking Cessation Service</p>
Vaccination	Raise awareness and implement local immunization policies	Ensure >75% of target populations receive appropriate vaccinations	Poor public engagement	2015	Pharmacy & Operational
Obesity	<p>Work with a broad range of partners to deliver local strategies and services to prevent obesity and offer support for those wishing to diet and exercise</p> <p>Ensure timely referral to dietetic support</p>	More people pursue a healthy diet and achieve a healthy weight	<p>Poor public engagement</p> <p>Need for education and training of staff</p> <p>Lack of capacity in dietetics</p>	2016	TBC

Fitness	<p>Work with a broad range of partners to deliver local strategies and services to encourage improved fitness and offer support for those wishing to exercise</p> <p>Ensure timely referral to the National Exercise Referral Scheme (NERS), designed to increase the long-term adherence in physical activity of patients.</p>	More people regularly exercise and improve their fitness	<p>Poor public engagement</p> <p>Need for education and training of staff</p> <p>Lack of capacity in NERS</p>	2016	TBC
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Detecting respiratory disease quickly					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Public Awareness and Education	<p>Work with a broad range of partners to deliver local strategies and services to increase awareness of chronic respiratory conditions such as asthma, COPD etc</p> <p>More accessible information and support services for respiratory health provided through local delivery channels</p> <p>People at risk of developing a chronic respiratory condition have access to information and services to prevent or minimize disease progression. Raise awareness of the Healthy City Directory for Third Sector organizations who can provide appropriate support and advice.</p>	<p>Greater awareness by primary care, schools and the general public of the symptoms of chronic respiratory conditions</p> <p>People with a chronic respiratory condition have an improved understanding of symptoms and treatment</p> <p>People with a chronic respiratory condition access appropriate services closer to home</p>	<p>Lack of sufficient time and resource to provide effective public awareness campaigns regarding symptoms, conditions and services</p> <p>Lack of time and resource to educate partners and develop appropriate strategies</p>	2016	<p>Chronic Conditions Management Team</p> <p>Respiratory Clinical Lead</p>
At risk groups	<p>Identify at risk groups. Link to the Prismatic pilot and any work undertaken with MSDi.</p> <p>At risk groups who present with asthma symptoms receive appropriate diagnostic tests and are signposted to support and treatment as required</p> <p>Offer spirometry to the over-35 age group who smoke delivered by Association for Respiratory Technology and Physiology (ARTP) accredited staff within primary and secondary care</p>	<p>People with chronic respiratory conditions are diagnosed earlier with milder symptoms</p> <p>Initially increase the incidence of COPD per 100,000 population as the “missing millions” are diagnosed</p> <p>In the long term, reduce the incidence of COPD per 100,000 population</p>	<p>Poor identification of at risk groups</p> <p>Lack of time and resource to educate and train staff</p> <p>Resource to ensure all GP practices have a spirometer and appropriately trained staff</p>	2016	Medical Director

Diagnostic Tests	Diagnostic tests are delivered by appropriately trained staff (Association for Respiratory Technology and Physiology (ARTP) accredited staff within primary and secondary care)  Validate and improve reporting and interpretation of spirometry results	Improve the quality and accuracy of spirometry tests and results	Lack of time and resource to educate and train staff within primary care		Locality Practice Nurse Facilitators  Alex Perkins
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Delivering fast, effective treatment and care					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Asthma	<p>Patients with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance</p> <p>Adults with new onset asthma are assessed for occupational causes</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions and allergic disorders</p> <p>Patients with asthma receive a written personalised action plan</p> <p>Patients with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment</p> <p>Patients with asthma receive a structured review at least annually</p> <p>Patients with asthma who present with respiratory symptoms receive an assessment of their asthma control</p> <p>Patients with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation</p>	<p>Improved patient and carers awareness of asthma and allergy symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter/ transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Split site acute working</p>	All by 2017	Dr Gwyneth Davies

	<p>Patients aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation</p> <p>Patients admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge</p> <p>All patients attending hospital with acute asthma to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Patients who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment</p> <p>Patients with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service</p> <p>Patients with difficult asthma are offered pulmonary rehabilitation if appropriate</p> <p>Patients with advanced and optimally treated asthma receive appropriate palliative and end of life care</p> <p>Audit data against NICE Asthma Quality Standards on treatment steps, and patient concordance with treatment and asthma self-management plans, to support the development of improved service delivery</p>	<p>pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Reduction in unscheduled hospital admissions for asthma per 100,000 population</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE Asthma Quality Standards</p> <p>Improved patient satisfaction</p>			
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<p>Chronic Obstructive Pulmonary Disease (COPD)</p>	<p>Patients with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.</p> <p>Patients with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions</p> <p>Patients with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.</p> <p>Patients with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and co morbidities.</p> <p>Patients with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.</p> <p>Develop recognised MDT-led Pulmonary Rehabilitation Programs (PRP) that address local needs and responds to the recommendations of National Clinical Audit<sup>3</sup></p> <p>Develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations</p>	<p>Improved patient and carers awareness of COPD symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with COPD who smoke are offered smoking cessation and successfully stop smoking</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Lack of training of ward based respiratory nursing staff in non-invasive ventilation</p> <p>Split site acute working</p>	<p>All by 2017</p>	<p>Dr David Vardill</p>
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<sup>3</sup> The National COPD Audit Programme will include pulmonary rehabilitation snapshot audits.

	<p>Patients who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.</p> <p>Patients with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.</p> <p>Patients with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.</p> <p>Patients admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.</p> <p>Patients admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.</p> <p>All patients attending hospital with acute COPD to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Patients admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.</p> <p>Patients with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.</p>	<p>programme</p> <p>Increase % of patients with COPD attending PRP post acute exacerbation</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Increased % of patients with COPD receiving appropriate home oxygen therapy</p> <p>Reduction in unscheduled hospital admissions for COPD per 100,000 population</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients receiving appropriate ward based NIV</p> <p>Increased % of patients with COPD being assessed and appropriately discharged with a specialist early discharge scheme</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with</p>			
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	<p>Audit data on NICE COPD Quality Standards treatment steps, and patient concordance with treatment and COPD self-management plans, to support the development of improved service delivery</p> <p>Ensure the implementation of NICE guidelines for COPD in both primary and secondary care services through a defined pathway of care</p>	<p>advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE COPD Quality Standards</p> <p>Improved patient satisfaction</p>			
Bronchiectasis	<p>Patients with a clinical diagnosis of bronchiectasis have the diagnosis confirmed by CT chest (using 1mm slices).</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions</p> <p>Patients with bronchiectasis to have an individualised written self-management plan.</p> <p>Patients with bronchiectasis are taught appropriate airway clearance techniques by a specialist respiratory physiotherapist and advised of the frequency and duration with which these should be carried out.</p> <p>Ensure that adequate levels of physiotherapy services are established to provide and teach the breathing and lung drainage techniques that are essential to patients with bronchiectasis</p> <p>Patients with bronchiectasis have sputum bacteriology culture when clinically stable recorded at least once each year (sputum surveillance)</p> <p>Sputum is sent for bacterial culture at the start of an exacerbation before starting antibiotics. Empirical antibiotic therapy to start as soon as feasible and not await the sputum culture results.</p>	<p>Improved patient and carers awareness of bronchiectasis symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with bronchiectasis are taught appropriate breathing and lung drainage techniques by a specialist physiotherapist</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Split site acute working</p>	All by 2017	Dr David Vardill

	<p>Patients with bronchiectasis to attend pulmonary rehabilitation if they have breathlessness affecting their activities of daily living.</p> <p>Patients with bronchiectasis receiving intravenous antibiotic therapy to have an objective evaluation of the efficacy of their treatment and the result recorded.</p> <p>Services for people with bronchiectasis to include provision of nebulised prophylactic antibiotics for suitable patients supervised by a respiratory specialist.</p> <p>Patients with bronchiectasis to be investigated for allergic bronchopulmonary aspergillosis (ABPA), common variable immunodeficiency (CVID) and cystic fibrosis (latter if indicated) as these are specific treatable causes.</p> <p>Patients with bronchiectasis who meet the criteria for continuing secondary care to be managed by a multidisciplinary team led by a Respiratory physician.</p> <p>Services for people with bronchiectasis to include provision of home intravenous antibiotic therapy for exacerbations in selected patients.</p> <p>All patients attending hospital with an acute exacerbation of bronchiectasis to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p>	<p>Increased % of patients have sputum surveillance performed</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients with bronchiectasis being assessed and appropriately discharged with a specialist early discharge scheme for home IV antibiotics</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease</p>			
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		<p>receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE Bronchiectasis Quality Standards</p> <p>Improved patient satisfaction</p>			
Interstitial Lung Disease	<p>Patients with suspected idiopathic pulmonary fibrosis are diagnosed only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions</p> <p>Patients with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them and if they wish their families and carers.</p> <p>Patients with idiopathic pulmonary fibrosis are assessed for oxygen therapy if they are breathless at rest or on exertion, or have been admitted to hospital because of idiopathic pulmonary fibrosis.</p> <p>Patients with idiopathic pulmonary fibrosis who are suitable are offered pulmonary rehabilitation that includes exercise and educational components tailored to their needs.</p> <p>Patients with idiopathic pulmonary fibrosis, and their families and carers, have access to the full range of services offered by palliative care teams.</p> <p>Audit data on treatment steps and concordance with treatment to support the development of improved service delivery</p> <p>All patients attending hospital with an acute deterioration to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p>	<p>Improved patient and carers awareness of ILD symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increased % of people with difficult and complex respiratory conditions being</p>		All by 2017	Dr Harrison Kim

	<p>Develop enhanced discharge and follow-up schemes to facilitate, when appropriate, quicker discharge from hospital and community support to reduce risk of re-admissions</p> <p>Ensure the implementation of NICE / BTS guidelines for ILD in both primary and secondary care services through a defined pathway of care</p>	<p>managed through an appropriate MDT framework</p> <p>Increased % of patients with ILD receiving appropriate home oxygen therapy</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE ILD Quality Standards</p> <p>Improved patient satisfaction</p>			
Sleep-Disordered Breathing	<p>Initial assessment of patients referred from primary or secondary care, including evaluation of the primary problem, differential diagnosis and relevant comorbidity – including physiologist led clinic</p> <p>Availability of an experienced specialist multidisciplinary team, comprising medical, nursing and scientific or technical specialists</p> <p>Ready access to facilities for investigation of possible Obstructive Sleep Apnoea Syndrome (OSAS) on a domiciliary and/or in-patient basis</p> <p>Availability of, or reasonable access to, facilities for more detailed sleep investigation as required</p>	<p>Improved patient and carers awareness of sleep apnoea symptoms and treatment</p> <p>Physiologist led clinic would reduce pressure on consultant clinic and increase capacity for the increasing demand</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> </ul>	All by 2016	Dr Stuart Packham

	<p>Facilities, equipment and experienced personnel necessary to initiate Continuous Positive Airways Pressure (CPAP) treatment</p> <p>Personnel and facilities to provide necessary support and training for patients commencing CPAP therapy</p> <p>Availability of a wide range of interfaces to allow provision of the most appropriate CPAP machine and interface, plus humidifier if required</p> <p>Regular monitoring and follow-up of patients Open access for CPAP-related problems or telephone help and support line, 9-5/Mon-Fri</p> <p>Provision of replacement machines and parts as required</p> <p>Monitoring of patient compliance, symptoms and side-effects of treatment</p> <p>Onward referral for more specialised investigation where clinically appropriate</p> <p>Reporting to the patient's registered GP and secondary care specialist(s) following each patient contact (other than parts provision)</p> <p>Providing advice and reports for other agencies e.g. occupational health services and DVLA regarding medical fitness for work and driving</p> <p>A database of patients receiving CPAP, to include equipment type, interface, settings, service history and compliance</p> <p>Providing advice and recommendations on alternative or adjunctive treatment e.g. weight reduction, mandibular advancement devices</p>	<p>Increased % of patients with sleep disordered breathing receiving appropriate CPAP treatment within recommended timeframes</p> <p>Improved compliance with CPAP treatment</p> <p>Reduction in road traffic accidents attributable to sleep disordered breathing</p> <p>Improved patient satisfaction</p>			
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	<p>Close liaison or integration with services which share similar expertise and technology (e.g. long term domiciliary NIV)</p> <p>Ready access to, and cooperation with, clinical services dealing with the common co morbidity of OSAS (obesity, diabetes, cardiovascular disease, ENT conditions, etc)</p> <p>Obtaining data on patient related outcome measures (PROMs) in accordance with agreed audit criteria and providing reports for monitoring and informing service development decisions</p> <p>Ensure that pathways for the investigation of sleep-disordered breathing are established to assess and treat patients with OSAHS within established RTT</p> <p>Undertake a population needs assessment and review current levels of service for sleep-disordered breathing against the recommendations of the <i>Strategy Document for Sleep Disordered Breathing Services in Wales 2010</i><sup>4</sup></p>				
Acute Respiratory Illness	<p>Develop initiatives with community leads to promote the management of acute respiratory conditions in the patient's home and intermediate care, where appropriate</p> <p>Develop pathways to address acute conditions across an enhanced primary-secondary care interface and to manage them where appropriate in the community setting</p> <p>Develop local hospital and community pathways to improve and facilitate the patient's journey from admission to returning home or to an intermediate care facility</p>	<p>Improved patient and carers awareness of respiratory illness symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community</li> </ul>	All by 2017	<p>Public Health Wales</p> <p>GPs</p> <p>Community Pharmacies</p> <p>Third Sector organisations</p> <p>Dr Rhian Finn</p>

<sup>4</sup> *Strategy Document for Sleep Disordered Breathing Services in Wales 2010* was issued jointly to LHBs by the Welsh Government and the Respiratory National Specialist Advisory Group in February 2011.

	<p><i>The above initiatives would include:</i></p> <p>Ensure the implementation of NICE / BTS guidelines for ILD in both primary and secondary care services through a defined pathway of care</p> <p>Audit data of adherence to NICE / BTS Quality Standards and Clinical Guidelines</p> <p>Daily Respiratory Consultant review of respiratory patients on the acute medical admission unit</p> <p>Daily Respiratory Consultant / CNS review of patients on the specialty respiratory ward</p> <p>Ward based smoking cessation brief interventions</p> <p>Ward based non-invasive ventilation with twice daily Respiratory Consultant review</p> <p>Early discharge schemes</p> <p>Develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations</p> <p>Home IV antibiotics for appropriate patients eg bronchiectasis</p> <p>Admission avoidance initiatives including;</p> <ul style="list-style-type: none"> <li>• Specialist telephone / email advice</li> <li>• Specialist Hot clinic review</li> <li>• Specialist ambulatory care review and treatment</li> </ul> <p>Appropriate GP / Specialist review after discharge</p> <p>Appropriate review at specialist condition MDT</p> <p>Subspecialty clinics to ensure high quality outpatient specialist review</p> <p>Written self management plans for patients presenting with a chronic respiratory condition</p>	<p>their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients who smoke are offered smoking cessation and successfully stop smoking</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increase % of patients with COPD attending PRP post acute exacerbation</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Increased % of patients with COPD receiving appropriate home oxygen therapy</p> <p>Reduction in unscheduled hospital admissions for</p>	<p>teams</p> <ul style="list-style-type: none"> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Split site acute working</p> <p>Further development and capacity in ambulatory care</p> <p>Further development and capacity for Hot clinic slots</p>		
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		<p>COPD per 100,000 population</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients receiving appropriate ward based NIV</p> <p>Increased % of patients with COPD being assessed and appropriately discharged with a specialist early discharge scheme</p> <p>Increased use of ambulatory care</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE / BTS Respiratory Quality Standards</p> <p>Improved patient satisfaction</p>			
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Supporting people living with lung disease					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Self Management Plans	<p>Ensure that all people with chronic respiratory conditions have a personalised self-management plan in place within three months of diagnosis</p> <p>People with chronic respiratory conditions have an agreed, personalised self-management plan, which is co-produced with all relevant healthcare professionals and is reviewed regularly</p>	<p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Regular review of self management plans</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> </ul>	2016	GP & Disease Specific Leads (secondary care)
Annual Review	Ensure that all respiratory patients have the necessary key measurements taken annually to identify early decline in disease and facilitate appropriate interventions	<p>All respiratory patients receive relevant key measurements for their condition annually as set out in NICE and British Thoracic Society treatment guidelines</p> <p>Increased number of advanced directives of patients with advanced chronic lung disease</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory</li> </ul>	2016	Appropriate Clinician

			physiologists <ul style="list-style-type: none"> <li>• Respiratory Consultants</li> </ul> FUNB list and clinic capacity		
Patient Support Groups	Support the development of, and encourage referral to, patient groups such as Breathe Easy	Increased number and /or membership of patient support groups	Poor public engagement	2015	Appropriate Clinician
Palliative Care	<p>Ensure adequate and equitable access to palliative care services, including respite care, for patients with respiratory disease in the end-stages of their illness</p> <p>Link to work being undertaken by GP practices via Cluster Network Plans and the End of Life Care pathway audits</p>	<p>Increased number of advanced directives of patients with advanced chronic lung disease</p> <p>All patients with advanced disease to be offered palliative and end-of-life support</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative care team</li> </ul>	2017	Appropriate Clinician
National Exercise Referral Scheme (NERS)	Utilise appropriate referral to the NERS scheme to support people with respiratory conditions increase their long-term adherence to physical activity	Increased referral to NERS	<p>Poor public engagement</p> <p>Lack of education regarding NERS in primary and secondary care</p> <p>Capacity in NERS</p>	2016	Appropriate Clinician

<p>Integrated Care</p>	<p>Services available as locally as possible</p> <p>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</p> <p>Access to, and care and support from, co-ordinated and seamless primary, secondary and community services</p> <p>More accessible educational and support services for smoking cessation provided through local pharmacies</p> <p>Working with the Localities and Public Health Wales to assess the effectiveness of the Level 3 Smoking Cessation service when implemented</p> <p>Access to support in maintaining a healthy lifestyle from healthcare professionals with training in behavioural change techniques</p>	<p>Improved care (improving population outcomes and NHS assurance indicators)</p> <p>Improved patient satisfaction</p> <p>Increased rates of smoking cessation</p> <p>Increased rates of people maintaining a healthy lifestyle</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Split site acute working</p>	<p>2017</p>	<p>Primary care</p> <p>Disease Specific Leads</p>
<p>Education</p>	<p>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</p>	<p>Improved patient knowledge and self management</p> <p>Improved control of respiratory condition</p> <p>Reduction in inappropriate access of emergency services</p>			<p>Public Health Wales</p> <p>Third Sector</p>

Improving information					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Patient Education and Self Management	<p>Patients will be given clear information, that is easy to understand and which allows them to make decisions about their care and treatment, and the possible consequences for their treatment if positive steps in self management are not undertaken.</p> <p>Information will be provided at the point of diagnosis and may include a self-management plan. It will be in the language of choice of the patient and will be updated or added-to as their disease progresses.</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions, in a variety of languages and formats including ABMU on YouTube</p> <p>Signpost patients, and carers, to other relevant information sources such as patient support groups and appropriate internet sites</p> <p>Continue to develop the ABMU internet and intranet sites to inform the public and staff</p>	<p>Improved patient knowledge and self management</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Improved control of respiratory condition</p> <p>Reduction in inappropriate access of emergency services</p> <p>Reduced number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS) for patients with asthma and COPD</p>	<p>Public not engaged</p> <p>Poor lines of communication</p> <p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p>	2017	<p>Public Health Wales</p> <p>Third Sector</p> <p>ABMU Communications team</p> <p>Secondary Care: Disease Specific Leads</p>
Clinical Notes and Transfer of Care Information	<p>Clinicians will provide clear and thorough notes and timely transfer of care information, thus ensuring that information is of high-quality and supports optimal levels of care for patients (Discharge Summaries etc).</p> <p>Audit data on clinical notes</p> <p>In conjunction with NWIS, develop an electronic patient record that is accessible from community, primary and secondary care</p>	<p>All patients attending hospital with acute respiratory illness will have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Improved legibility, timeliness and accuracy of clinical notes</p> <p>Improved communication between community, primary and secondary care</p>	<p>Poor clinician engagement</p> <p>IT infrastructure / support</p>	2017	Locality Performance Team

<p>Integrated care</p>	<p>Implement, use and develop the Welsh Clinical Portal</p> <p>Continue to use and develop the GP portal, further improving communication and use of shared resources between primary and secondary care services</p> <p>Increase the use of electronic transfer of care forms to improve communication between teams, particularly between primary and secondary care</p> <p>Continue to use and develop clinical dashboards eg for unscheduled care</p> <p>Continue to use and develop performance scorecards</p> <p>Continue to use and develop clinical benchmarking tools including condition specific analysis</p> <p>Continue to develop the ABMU internet and intranet sites to inform the public and staff</p> <p>Continue to work with NWIS, Public Health Wales and Welsh Government to ensure data collected is used to inform service change which delivers high quality care</p> <p>Ensure outcome data and information from local and primary care services are collected and used to facilitate development</p> <p>To use data and information collected so as to reflect service provision and outcomes and to report such progress annually</p> <p>Report progress against local delivery plan milestones on the website</p>	<p>Improved care (improving population outcomes and NHS assurance indicators)</p> <p>All patients attending hospital with acute respiratory illness will have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Improved communication between patients and staff</p> <p>Improved communication between community , primary and secondary care services</p> <p>Improved performance against benchmarking</p> <p>Improved data for service design</p>	<p>IT and informatics infrastructure / support</p> <p>Poor clinician engagement</p> <p>Lack of time and resource to collect and then use the data for service development</p>	<p>2017</p>	<p>Gareth Barbour</p>
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Targeting research					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Welsh Research	<p>Welsh Government and its partners, working with stakeholder researchers, to lead and co-ordinate development and co-operation through a respiratory framework</p> <p>Strengthen and develop our close links with Swansea University and the clinical trials units</p> <p>Strengthen and develop our links with other universities and clinical trials units</p> <p>Continue to develop clinical trials networks with links to the whole of the UK and internationally</p> <p>Encourage the development of clinical academics within ABMU</p> <p>Increase awareness of clinical trials recruiting within ABMU</p>	An increased number of respiratory trials run within Wales	<p>Lack of Clinical Academics</p> <p>Lack of funding</p> <p>Lack of time within job plans</p> <p>Lack of infrastructure</p>	2017	Dr Kim Harrison and Dr Gwyneth Davies
Welsh Participants	<p>Encourage more respiratory patients to participate in research activity</p> <p>Increase awareness of clinical trials recruiting within ABMU</p>	An increased number of respiratory patients recruited to clinical trials	<p>Lack of clinician awareness of trials recruiting</p> <p>Lack of patient awareness</p>	2015	Dr Kim Harrison and Dr Gwyneth Davies

# SECTION B

## Bridgend Respiratory Delivery Plan (2014 – 2017)

The Princess of Wales Hospital has a designated respiratory ward of 23 beds and operates a ward-based system for acute admissions which includes Non-Invasive Ventilation (NIV) patients. The respiratory service is led by a team of 3.6 WTE Consultants. Junior staff consists of two Specialist Registrars in Respiratory and General Medicine, one CMT, one GPVTS, two FP2's and one FP1.

There is a well-equipped Lung Function Laboratory operating within the Princess of Wales Hospital, dosimeter for bronchial challenge testing and equipment for Cardio-Pulmonary Exercise Testing. There are full radiology services including CT, MRI and nuclear medicine. PET scanning is currently undertaken in Cardiff.

The Respiratory Service in Bridgend is currently supported by a team of 2 WTE Respiratory Nurse Practitioners and 4 WTE Respiratory Clinical Nurse Specialists. The CNS's provide the Early Discharge Scheme and Pulmonary Rehabilitation as well as other respiratory services (Oxygen, NIV, asthma etc.), 1 WTE Lung Cancer Nurse Specialists, 1 WTE Respiratory Clinical Physiologists, 1 WTE Specialist Respiratory Physiotherapist.

The Respiratory Services for the Princess of Wales Hospital include:

- Acute medical admissions
- Medical inpatients under care of respiratory team
- Review of IP referrals
- Ad hoc Respiratory Nurse review of AMU patients
- Respiratory nurse review of inpatients on the wards
- Weekly bronchoscopy list
- General respiratory and sub-specialty clinics
- Weekly Lung cancer MDT meetings
- Respiratory physiology diagnostics
- CPAP and domiciliary NIV service
- Pulmonary Rehabilitation
- Junior doctor supervision, training and teaching
- Medical student supervision and teaching

### **Overview of local health need and challenges to respiratory services**

The hospital continues to work towards full compliance with the All Wales Respiratory Delivery plan and is in the process of establishing a Respiratory Planning and Delivery Group, locally, chaired by Dr. Jackie Woolley, Consultant in Respiratory Medicine. In addition clinical leads have been appointed for the following:

- Lung cancer
- Smoking cessation
- Chronic diseases
- COPD
- Pulmonary Rehabilitation

- Interstitial Lung Disease
- TB
- MIA
- Bronchiectasis
- Sleep Apnoea
- Obesity
- Thoracoscopy
- Pleural Disease
- Difficult asthma
- NIV & Domi-NIV

In order to ensure progress towards the implementation of the Respiratory Delivery Plan, a number of multi-disciplinary meetings have been held which have agreed the following key areas for service improvement for the next three years:

- Enhancing nursing and therapy services for the community, including chronic disease management and further development of domiciliary NIV services.
- Developing closer working relationships with generic primary and community care colleagues.
- Developing alternative pathways to hospital admission.
- Supporting the acute medical intake with rapid access to specialist advice and outpatient clinic hot slots.
- Developing specialist outpatient clinics such as difficult asthma.

### 3. RESPIRATORY SERVICE ACTIVITY

#### 3.1 OUTPATIENT ACTIVITY

##### Princess of Wales Hospital

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	2014/15	Grand Total
New OP Attendance	780	73	70	72	91	52	128	82	568	1348
Fup OP Attendances	1531	113	132	109	153	86	125	143	861	2392

(These numbers will include activity generated by independent nurses and multi-professionals which is attributed to an overarching Consultant. Waiting list initiative activity is also included).

#### 3.2 CT GUIDED LUNG BIOPSIES

	2013/14	2014/15	Grand Total
PoW Hospital	46	17	63
<b>Grand Total</b>	<b>46</b>	<b>17</b>	<b>63</b>

(Radiology Data)

### 3.3 BRONCHOSCOPIES

In-Patients	2013/14	2014/15	Grand Total
PoW Hospital	24	13	37
<b>Grand Total</b>	<b>24</b>	<b>13</b>	<b>37</b>

(2014/15 activity up to September 2014)

Day Cases	2013/14	2014/15	Grand Total
PoW Hospital	119	50	169
<b>Grand Total</b>	<b>119</b>	<b>50</b>	<b>169</b>

(2014/15 activity up to September 2014)

### 3.4 RESPIRATORY PHYSIOLOGY ACTIVITY 2013-4

Test	Number
APAP issue	172
Sleep Study	113
ON SpO2	384
CPAP issue	100
CPAP compliance check	363
CPAP problems	236
Spirometry	85
RFT (spiro, Tlco, static vol)	1052
Reversibility (including RFT)	131
Manitol challenge	5
Arterial blood gas sample	3.
Cardio-pulmonary exercise test	20
Flight test	7
OSA clinic	235
<b>TOTAL</b>	<b>2906</b>

### 3.5 Inpatient Activity

There were a total of 3895 FCEs (Finished Consultant Episodes) with a primary coded respiratory diagnosis in 2013/14. Further work will be undertaken to break down the activity into sub-specialties to fully understand the demand profile currently.

## 5. SUMMARY OF THE PLAN - THE PRIORITIES FOR 2014/17

This delivery plan includes actions against each of the 2017 milestones within the Welsh Government's Respiratory Health Delivery Plan (April 2014).

### 5.1 Preventing poor respiratory health

### **Our key challenges are:**

#### **Smoking**

- Reduction in the prevalence of adult smoking to 20% by 2016 and 16% by 2020.

#### **Vaccination Programme**

- Ensure >75% of target populations receive appropriate vaccinations.

#### **Obesity and Fitness**

- More people pursue a healthy diet and achieve a healthy weight.

### **Our priorities for 2014 – 17 are:**

#### **Smoking**

- Ensure that all incidental opportunities to counsel against smoking and provide information about Smoking Cessation services are taken.

#### **Vaccination Programme**

- Raise awareness of local immunisation policies.

#### **Obesity and Fitness**

- Work with a broad range of partners (Public Health Wales, community teams, community pharmacists and GPs) to deliver local strategies and services to prevent obesity and offer support for those wishing to diet and exercise.
- Ensure timely referral to the National Exercise Referral Scheme (NERS), designed to increase the long-term adherence in physical activity of patients.

## **5.2 Detecting respiratory disease quickly**

### **Our key challenges are:**

- People over-35 who smoke are offered spirometry and signposted to smoking cessation support and made aware of the consequences of continuing to smoke on their health and possible future treatment.
- At-risk groups who present with persistent respiratory symptoms receive appropriate diagnostic tests and are signposted to support and treatment as required.

### **Our solutions are:**

- 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.
- Increase awareness by primary care, schools and the general public of the symptoms of lung disease.

### **Our priorities for 2014/17 are:**

- Provide primary care with advice on identifying at-risk groups.
- Ensure primary care can access for at-risk groups who present with persistent respiratory symptoms appropriate diagnostic tests (e.g. chest X-rays and spirometry), delivered by appropriately trained staff.

### **5.3 Delivering fast, effective treatment and care**

#### **Our key challenges are:**

For patients with:

- Asthma and Allergy
- Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis
- Interstitial Lung Disease
- Sleep-Disordered Breathing
- Acute Respiratory Illness
- Pleural Disease

We will deliver:

- A reduction in number of unscheduled attendances and re-attendances to hospital, and average length of stay.
- Increased access for patients to community-based teams able to manage individuals closer to home across relevant disease groups.
- Patient information about their condition, which is easy to access, relevant and easy to understand.
- Referral to pulmonary rehabilitation (PR) for patients with MRC breathless score of 3 or greater.
- Management through a Multi Disciplinary Team (MDT) that works to national guidelines for patients diagnoses with ILD.
- Achieve, and maintain, compliance with patient referrals for treatment targets (RTT).

Our patients will experience:

- Prompt and appropriate access to clinically and cost-effective treatment in primary and secondary care, including smoking cessation services.
- 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 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.

### **Our solutions are:**

#### **Asthma and Allergy**

We will aim to provide a secondary care service planned in conjunction with and providing support to primary care to ensure that the population has access to a high quality, well co-ordinated and efficient service which delivers the NICE Asthma Quality Standards:

- People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
- Adults with new onset asthma are assessed for occupational causes.
- People with asthma receive a written personalised action plan.
- People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
- People with asthma receive a structured review at least annually.
- People with asthma who present with respiratory symptoms receive an assessment of their asthma control.
- People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
- People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
- People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.
- People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.
- There should be a designated named clinician for asthma in every hospital and GP practice.
- People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

## **Chronic Obstructive Pulmonary Disease (COPD)**

We will aim to provide a secondary care service planned in conjunction with and providing support to primary care to ensure that the population has access to a high quality, well co-ordinated and efficient service which delivers the NICE COPD Quality Standards:

1. People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
2. People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.
3. People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
4. People with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and co morbidities.
5. People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
6. People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
7. People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.
8. People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
9. People with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.
10. People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.
11. People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.
12. People admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.
13. People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

## **Bronchiectasis**

We will aim to provide a secondary care service planned in conjunction with and providing support to primary care to ensure that the population has access to a high quality, well co-ordinated and efficient service which delivers the BTS Non-CF Bronchiectasis in Adults Quality Standards:

1. People with a clinical diagnosis of bronchiectasis have the diagnosis confirmed by CT chest (using 1mm slices).
2. People with bronchiectasis are taught appropriate airway clearance techniques by a specialist respiratory physiotherapist and advised of the frequency and duration with which these should be carried out.
3. People with bronchiectasis have sputum bacteriology culture when clinically stable recorded at least once each year.
4. Sputum is sent for bacterial culture at the start of an exacerbation before starting antibiotics. Empirical antibiotic therapy to start as soon as feasible and not await the sputum culture results.
5. People with bronchiectasis to attend pulmonary rehabilitation if they have breathlessness affecting their activities of daily living.
6. People with bronchiectasis receiving intravenous antibiotic therapy to have an objective evaluation of the efficacy of their treatment and the result recorded.
7. Services for people with bronchiectasis to include provision of nebulised prophylactic antibiotics for suitable patients supervised by a respiratory specialist.
8. People with bronchiectasis to be investigated for allergic bronchopulmonary aspergillosis (ABPA), common variable immunodeficiency (CVID) and cystic fibrosis (latter if indicated) as these are specific treatable causes.
9. People with bronchiectasis to have an individualised written self-management plan.
10. People with bronchiectasis who meet the criteria for continuing secondary care to be managed by a multidisciplinary team led by a Respiratory physician.
11. Services for people with bronchiectasis to include provision of home intravenous antibiotic therapy for exacerbations in selected patients.

## **Interstitial Lung Disease**

We will aim to provide a secondary care service planned in conjunction with and providing support to primary care to ensure that the population has access to a high quality, well co-ordinated and efficient service which delivers the NICE Idiopathic Pulmonary Fibrosis Quality Standards (in consultation):

1. People with suspected idiopathic pulmonary fibrosis are diagnosed only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.
2. People with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them and if they wish their families and carers.

3. People with idiopathic pulmonary fibrosis are assessed for oxygen therapy if they are breathless at rest or on exertion, or have been admitted to hospital because of idiopathic pulmonary fibrosis.
4. People with idiopathic pulmonary fibrosis who are suitable are offered pulmonary rehabilitation that includes exercise and educational components tailored to their needs.
5. People with idiopathic pulmonary fibrosis, and their families and carers, have access to the full range of services offered by palliative care teams.

### **Sleep-Disordered Breathing**

We will aim to provide a high quality, well co-ordinated and efficient service which delivers appropriate treatment to patients with sleep disordered breathing, core components of which include (Impress March 2009 Service Specification):

1. Initial assessment of patients referred from primary or secondary care, including evaluation of the primary problem, differential diagnosis and relevant co-morbidity.
2. Availability of an experienced specialist multidisciplinary team, comprising medical, nursing and scientific or technical specialists.
3. Ready access to facilities for investigation of possible Obstructive Sleep Apnoea Syndrome (OSAS) on a domiciliary and/or in-patient basis.
4. Availability of, or reasonable access to, facilities for more detailed sleep investigation as required.
5. Facilities, equipment and experienced personnel necessary to initiate Continuous Positive Airways Pressure (CPAP) treatment.
6. Personnel and facilities to provide necessary support and training for patients commencing CPAP therapy.
7. Availability of a wide range of interfaces to allow provision of the most appropriate CPAP machine and interface, plus humidifier if required.
8. Regular monitoring and follow-up of patients.
9. Open access for CPAP-related problems or telephone help and support line, 9-5/Mon-Fri.
10. Provision of replacement machines and parts as required.
11. Monitoring of patient compliance, symptoms and side-effects of treatment.
12. Onward referral for more specialised investigation where clinically appropriate.
13. Reporting to the patient's registered GP and secondary care specialist(s) following each patient contact (other than parts provision).

14. Providing advice and reports for other agencies e.g. occupational health services and DVLA regarding medical fitness for work and driving.
15. A database of patients receiving CPAP, to include equipment type, interface, settings, service history and compliance.
16. Providing advice and recommendations on alternative or adjunctive treatment e.g. weight reduction, mandibular advancement devices.
17. Close liaison or integration with services which share similar expertise and technology (e.g. long term domiciliary NIV).
18. Ready access to, and cooperation with, clinical services dealing with the common co morbidity of OSAS (obesity, diabetes, cardiovascular disease, ENT conditions, etc).
19. Obtaining data on patient related outcome measures (PROMs) in accordance with agreed audit criteria and providing reports for monitoring and informing service development decisions.

### **Acute Respiratory Illness**

Acute respiratory illnesses are common and include community-acquired pneumonia, acute exacerbations of COPD, asthma attacks and a number of less common conditions, which together represent a major demand on primary and hospital care.

We will aim to provide a high quality, well co-ordinated and efficient service which delivers appropriate treatment to patients with acute respiratory illness, core components of which include:

1. Adherence to NICE / BTS Quality Standards and Clinical Guidelines.
2. Daily Respiratory Consultant review of respiratory patients on the acute medical admission unit.
3. Daily Respiratory Consultant review of patients on the specialty respiratory ward.
4. Ward based non-invasive ventilation with twice daily Respiratory Consultant review.
5. Early discharge schemes.
6. Home IV antibiotics for appropriate patients eg bronchiectasis.
7. Admission avoidance initiatives including;
  - a. Specialist telephone / email advice
  - b. Specialist Hot clinic review
  - c. Specialist ambulatory care review and treatment
8. Appropriate GP / Specialist review after discharge.
9. Subspecialty clinics to ensure high quality outpatient specialist review.
10. Written self management plans for patients presenting with a chronic respiratory condition.

### **Our priorities for 2014/17 are:**

- Develop enhanced discharge and follow-up schemes to facilitate, when appropriate, quicker discharge from hospital and community support to reduce risk of re-admissions.
- Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions and allergic disorders.
- Audit data on treatment steps, concordance with treatment and chronic respiratory condition self-management plans to support the development of improved service delivery.
- All patients attending hospital with a respiratory illness to have a discharge letter delivered to the GP within 24 hours, or by the next working day.
- Ensure the implementation of NICE and British Thoracic Society (BTS) treatment guidelines for respiratory conditions in secondary care services through a defined pathway of care.
- Further develop recognised MDT-led Pulmonary Rehabilitation Programs (PRP) that address local needs and responds to the recommendations of National Clinical Audit<sup>5</sup>.
- Further develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations.
- Ensure that adequate levels of physiotherapy services are established to provide and teach the breathing and lung drainage techniques that are essential to patients with bronchiectasis.
- Ensure that, as with lung cancer, patients with ILDs are managed through a MDT framework and have access to specialist nursing support for appropriate conditions.
- Ensure that pathways for the investigation of sleep-disordered breathing are established to assess and treat patients with OSAHS within established RTT.
- Jointly develop initiatives with community leads to promote the management of acute respiratory conditions in the patient's home and intermediate care, where appropriate.
- Jointly develop pathways to address acute conditions across an enhanced primary-secondary care interface and to manage them where appropriate in the community setting.
- Jointly develop local hospital and community pathways to improve and facilitate the patient's journey from admission to returning home or to an intermediate care facility.

### **5.4 Supporting people living with lung disease**

#### **Our key challenges are:**

- All patients with chronic respiratory conditions to have an agreed self-management plan.

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<sup>5</sup> The National COPD Audit Programme will include pulmonary rehabilitation snapshot audits.

- Increase the proportion of qualifying patients who have accessed support groups and palliative care services.
- All respiratory patients receive relevant key measurements for their condition annually as set out in NICE and British Thoracic Society treatment guidelines.
- Increased number of advanced directives of patients with advanced chronic lung disease.
- All patients with advanced disease to be offered palliative and end-of-life support.
- Services available as locally as possible.

**Our solutions are:**

- 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 and is reviewed regularly.
- 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.

**Our priorities for 2014/17 are to support primary and community care services to :**

- Ensure that all people with chronic respiratory conditions have a personalised self-management plan in place within three months of diagnosis.
- Ensure that all respiratory patients have the necessary key measurements taken annually to identify early decline in disease and facilitate appropriate interventions.
- Support the development of, and encourage referral to, patient groups such as Breathe Easy.
- Ensure adequate and equitable access to palliative care services, including respite care, for patients with respiratory disease in the end-stages of their illness.
- Utilise appropriate referral to the NERS scheme to support people with respiratory conditions increase their long-term adherence to physical activity.

## **6. Improving information**

### **Our key challenges are:**

- Patients need clear information, that is easy to understand and which allows them to make decisions about their care and treatment, and the possible consequences for their treatment if positive steps in self management are not undertaken. Information should be provided at the point of diagnosis and may include a self-management plan. It should be in the language of choice of the patient and should be updated or added-to as their disease progresses.
- Health professionals need information on the respiratory health needs of their local population and how well the NHS is operating. Information should be accessible in both primary and secondary care to facilitate seamless care.
- Clinicians should provide clear and thorough notes and timely transfer of care information, thus ensuring that information is of high-quality and supports optimal levels of care for patients.
- Service planners need information for the clinical management of patients in order to drive continuous improvements to services. This requires the recording of both clinical and performance data by Local Health Boards.
- The public, NHS Wales, the third sector and Welsh Government need information on the identified outcomes that result from NHS care.

These data sets need to link better across all providers with more real time data on clinical outcomes in order to support effective clinical care.

### **Our solutions are:**

- Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions, in a variety of languages and formats including ABMU on YouTube.
- Signpost patients, and carers, to other relevant information sources such as patient support groups and appropriate internet sites.
- Provide the public with information about our services and how they perform.
- Regular audit of clinical notes to ensure appropriate standards.
- Develop electronic clinical notes.
- Implement, use and develop the Welsh Clinical Portal.
- Continue to use and develop the GP portal, further improving communication and use of shared resources between primary and secondary care services.
- Ensure the sustained and increased use of electronic transfer of care forms to improve communication between teams, particularly between primary and secondary care.

- Continue to use and develop clinical dashboards eg for unscheduled care.
- Continue to use and develop performance scorecards.
- Continue to use and develop clinical benchmarking tools including condition specific analysis.
- Continue to develop the ABMU internet and intranet sites to inform the public and staff.
- Continue to work with NWIS, Public Health Wales and Welsh Government to ensure data collected is used to inform service change which delivers high quality care.

**Our priorities for 2014/17 are:**

- Record and use information provided by Public Health Wales and Welsh Government sources to guide service review and development.
- Ensure outcome data and information from local and primary care services are collected and used to facilitate development, as well as secondary care.
- To use data and information collected so as to reflect service provision and outcomes and to report such progress annually.
- Report progress against local delivery plan milestones on the Health Board website

In order to ensure we are achieving our objectives, we will measure our performance against the following population indicators and NHS assurance measures, as outlined in the Respiratory Delivery Plan.

**Population Outcome Indicators:**

- Reduce the prevalence of adult smoking to 20% by 2016 and 16% by 2020.
- Incidence of 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.

**NHS Assurance Measures:**

- 5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks.
- % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis.
- % 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.
- % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan.

- % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework.
- People with asthma and COPD: number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS).
- % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care.

## **7. Targeting research**

### **Our key challenges are:**

- An increased number of respiratory trials run within Wales.
- An increased number of respiratory patients recruited to clinical trials.

### **Our solutions are:**

- Strengthen and develop our links with other universities and clinical trials units.
- Continue to develop clinical trials networks with links to the whole of the UK and internationally.
- Encourage the development of clinical academics within ABMU.
- Increase awareness of clinical trials recruiting within ABMU.

### **Our priorities for 2014/17 are:**

- Welsh Government and its partners, working with stakeholder researchers, to lead and co-ordinate development and co-operation through a respiratory framework.
- Encourage more respiratory patients to participate in research activity.

## **8. 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 each health board's annual report on respiratory services. They will be calculated on behalf of the NHS annually at both a national and local population level.

Health board's delivery plans and their milestones will be reviewed and updated annually.

## **9. ACTION PLAN**

Please note that the actions and outcomes outlined in the tables below do not cover the whole range contained within the narrative or in the National Respiratory Delivery Plan; this section of the plan focuses primarily on secondary care actions and outcomes that measured by secondary care. The outcomes in italics are measured at population level not within the secondary care sector.

## ACTION PLAN 2014 – 2015 (Secondary Care)

<b>Preventing poor respiratory health</b>					
<b>Priority</b>	<b>Actions</b>	<b>Expected outcome</b>	<b>Risks to delivery</b>	<b>Timescales</b>	<b>Lead</b>
Smoking	Ensure that all incidental opportunities to counsel against smoking and provide information about Smoking Cessation services are taken.	<i>Reduction in the prevalence of adult smoking to 20% by 2016 and 16% by 2020.</i>  <i>5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks.</i>	Poor public engagement with smoking cessation services.	2016	<i>Primary care</i>
Vaccination	Raise awareness of local immunisation policies.	<i>Ensure &gt;75% of target populations receive appropriate vaccinations</i>	Poor public engagement	2015	<i>Primary care</i>
Obesity & Fitness	Work with a broad range of partners to deliver local strategies and services to prevent obesity, improve fitness and offer support for those wishing to diet and exercise.  Ensure timely referral to the National Exercise Referral Scheme (NERS), designed to increase the long-term adherence in physical activity of patients.	<i>More people pursue a healthy diet and achieve a healthy weight</i>	Poor public engagement  Need for education and training of staff  Lack of capacity in dietetics	2016	TBC

Detecting respiratory disease quickly					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
At risk groups	<p>Provide primary care with advice on identifying at-risk groups.</p> <p>Ensure primary care can access for at-risk groups who present with persistent respiratory symptoms appropriate diagnostic tests (e.g. chest X-rays and spirometry), delivered by appropriately trained staff.</p>	<i>People with chronic respiratory conditions are diagnosed earlier with milder symptoms.</i>	Lack of time and resource to educate and train staff	2016	TBC

Delivering fast, effective treatment and care					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Asthma	<p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions and allergic disorders.</p> <p>Patients with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.</p> <p>Patients with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.</p> <p>Patients aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.</p>	<p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter/ transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory</li> </ul>	All by 2017	Dr Jackie Woolley

	<p>Patients admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.</p> <p>All patients attending hospital with acute asthma to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Patients with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service</p> <p>Patients with difficult asthma are offered pulmonary rehabilitation if appropriate.</p> <p>Patients with advanced and optimally treated asthma receive appropriate palliative and end of life care.</p> <p>Audit data against NICE Asthma Quality Standards on treatment steps, and patient concordance with treatment and asthma self-management plans, to support the development of improved service delivery.</p>	<p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p><i>Reduction in unscheduled hospital admissions for asthma per 100,000 population</i></p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p><i>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</i></p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE Asthma Quality Standards</p> <p>Improved patient satisfaction</p>	<p>physiologists</p> <ul style="list-style-type: none"> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul>		
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<p>Chronic Obstructive Pulmonary Disease (COPD)</p>	<p>Patients with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.</p> <p>Patients with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and co morbidities.</p> <p>Develop recognised MDT-led Pulmonary Rehabilitation Programs (PRP) that address local needs and responds to the recommendations of National Clinical Audit.</p> <p>Develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations.</p> <p>Patients who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.</p> <p>Patients with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.</p>	<p>Improved patient and carers awareness of COPD symptoms and treatment</p> <p><i>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</i></p> <p><i>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</i></p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with COPD who smoke are offered smoking cessation and successfully stop smoking</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increase % of patients with COPD attending PRP post acute exacerbation</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Lack of training of ward based respiratory nursing staff in non-invasive ventilation</p>	<p>All by 2017</p>	<p>Dr John Banks</p>
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	<p>Patients with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.</p> <p>Patients admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.</p> <p>Patients admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.</p> <p>All patients attending hospital with acute COPD to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Patients admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.</p> <p>Patients with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.</p> <p>Audit data on NICE COPD Quality Standards treatment steps, and patient concordance with treatment and COPD self-management plans, to support the development of improved service delivery</p> <p>Ensure the implementation of NICE guidelines for COPD in both primary and secondary care services through a defined pathway of care</p>	<p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Increased % of patients with COPD receiving appropriate home oxygen therapy</p> <p>Reduction in unscheduled hospital admissions for COPD per 100,000 population</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients receiving appropriate ward based NIV</p> <p>Increased % of patients with COPD being assessed and appropriately discharged with a specialist early discharge scheme</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE COPD Quality Standards</p> <p>Improved patient satisfaction</p>			
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Bronchiectasis	<p>Patients with a clinical diagnosis of bronchiectasis have the diagnosis confirmed by CT chest (using 1mm slices).</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions.</p> <p>Patients with bronchiectasis are taught appropriate airway clearance techniques by a specialist respiratory physiotherapist and advised of the frequency and duration with which these should be carried out.</p> <p>Ensure that adequate levels of physiotherapy services are established to provide and teach the breathing and lung drainage techniques that are essential to patients with bronchiectasis.</p> <p>Patients with bronchiectasis have sputum bacteriology culture when clinically stable recorded at least once each year (sputum surveillance).</p> <p>Sputum is sent for bacterial culture at the start of an exacerbation before starting antibiotics. Empirical antibiotic therapy to start as soon as feasible and not await the sputum culture results.</p> <p>Patients with bronchiectasis to attend pulmonary rehabilitation if they have breathlessness affecting their activities of daily living.</p> <p>Patients with bronchiectasis receiving intravenous antibiotic therapy to have an objective evaluation of the efficacy of their treatment and the result recorded.</p> <p>Services for people with bronchiectasis to include provision of nebulised prophylactic</p>	<p>Improved patient and carers awareness of bronchiectasis symptoms and treatment</p> <p>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with bronchiectasis are taught appropriate breathing and lung drainage techniques by a specialist physiotherapist</p> <p>Increased % of patients have sputum surveillance performed</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul>	All by 2017	Dr John Banks
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	<p>antibiotics for suitable patients supervised by a respiratory specialist.</p> <p>Patients with bronchiectasis to be investigated for allergic bronchopulmonary aspergillosis (ABPA), common variable immunodeficiency (CVID) and cystic fibrosis (latter if indicated) as these are specific treatable causes.</p> <p>Patients with bronchiectasis who meet the criteria for continuing secondary care to be managed by a multidisciplinary team led by a Respiratory physician.</p> <p>Services for people with bronchiectasis to include provision of home intravenous antibiotic therapy for exacerbations in selected patients.</p> <p>All patients attending hospital with an acute exacerbation of bronchiectasis to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p>	<p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients with bronchiectasis being assessed and appropriately discharged with a specialist early discharge scheme for home IV antibiotics</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE Bronchiectasis Quality Standards</p> <p>Improved patient satisfaction</p>			
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<p>Interstitial Lung Disease</p>	<p>Patients with suspected idiopathic pulmonary fibrosis are diagnosed only with the consensus of a multidisciplinary team with expertise in interstitial lung disease. Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions</p> <p>Patients with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them and if they wish their families and carers.</p> <p>Patients with idiopathic pulmonary fibrosis are assessed for oxygen therapy if they are breathless at rest or on exertion, or have been admitted to hospital because of idiopathic pulmonary fibrosis.</p> <p>Patients with idiopathic pulmonary fibrosis who are suitable are offered pulmonary rehabilitation that includes exercise and educational components tailored to their needs.</p> <p>Patients with idiopathic pulmonary fibrosis, and their families and carers, have access to the full range of services offered by palliative care teams.</p> <p>Audit data on treatment steps and concordance with treatment to support the development of improved service delivery</p> <p>All patients attending hospital with an acute deterioration to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Develop enhanced discharge and follow-up schemes to facilitate, when appropriate, quicker discharge from hospital and community support to reduce risk of re-admissions</p>	<p>Improved patient and carers awareness of ILD symptoms and treatment</p> <p><i>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</i></p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter delivered to the GP within 24 hours, or by the next working day</p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Increased % of patients with ILD receiving appropriate home oxygen therapy</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p>		<p>All by 2017</p>	<p>Dr John Banks</p>
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Ensure the implementation of NICE / BTS guidelines for ILD in both primary and secondary care services through a defined pathway of care

Improved audit results against NICE ILD Quality Standards

Improved patient satisfaction

<p>Sleep-Disordered Breathing</p>	<p>Initial assessment of patients referred from primary or secondary care, including evaluation of the primary problem, differential diagnosis and relevant co-morbidity – including physiologist led clinic.</p> <p>Availability of an experienced specialist multidisciplinary team, comprising medical, nursing and scientific or technical specialists.</p> <p>Ready access to facilities for investigation of possible Obstructive Sleep Apnoea Syndrome (OSAS) on a domiciliary and/or in-patient basis.</p> <p>Availability of, or reasonable access to, facilities for more detailed sleep investigation as required.</p> <p>Facilities, equipment and experienced personnel necessary to initiate Continuous Positive Airways Pressure (CPAP) treatment.</p> <p>Personnel and facilities to provide necessary support and training for patients commencing CPAP therapy.</p> <p>Availability of a wide range of interfaces to allow provision of the most appropriate CPAP machine and interface, plus humidifier if required.</p> <p>Regular monitoring and follow-up of patients Open access for CPAP-related problems or telephone help and support line, 9-5/Mon-Fri.</p> <p>Provision of replacement machines and parts as required.</p> <p>Monitoring of patient compliance, symptoms and side-effects of treatment.</p>	<p>Improved patient and carers awareness of sleep apnoea symptoms and treatment</p> <p>Physiologist led clinic would reduce pressure on consultant clinic and increase capacity for the increasing demand</p> <p>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p> <p>Increased % of patients with sleep disordered breathing receiving appropriate CPAP treatment within recommended timeframes</p> <p>Improved compliance with CPAP treatment</p> <p><i>Reduction in road traffic accidents attributable to sleep disordered breathing</i></p> <p>Improved patient satisfaction</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> </ul>	<p>All by 2016</p>	<p>Dr Emma Watkins</p>
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	<p>Onward referral for more specialised investigation where clinically appropriate.</p> <p>Reporting to the patient's registered GP and secondary care specialist(s) following each patient contact (other than parts provision).</p> <p>Providing advice and reports for other agencies e.g. occupational health services and DVLA regarding medical fitness for work and driving.</p> <p>A database of patients receiving CPAP, to include equipment type, interface, settings, service history and compliance.</p> <p>Providing advice and recommendations on alternative or adjunctive treatment e.g. weight reduction, mandibular advancement devices.</p> <p>Close liaison or integration with services which share similar expertise and technology (e.g. long term domiciliary NIV).</p> <p>Ready access to, and cooperation with, clinical services dealing with the common co morbidity of OSAS (obesity, diabetes, cardiovascular disease, ENT conditions, etc).</p> <p>Obtaining data on patient related outcome measures (PROMs) in accordance with agreed audit criteria and providing reports for monitoring and informing service development decisions.</p> <p>Ensure that pathways for the investigation of sleep-disordered breathing are established to assess and treat patients with OSAHS within established RTT.</p> <p>Undertake a population needs assessment and review current levels of service for sleep-disordered breathing against the</p>				
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recommendations of the *Strategy Document for Sleep Disordered Breathing Services in Wales 2010*.

<p>Acute Respiratory Illness</p>	<p>Develop initiatives with community leads to promote the management of acute respiratory conditions in the patient's home and intermediate care, where appropriate.</p> <p>Develop pathways to address acute conditions across an enhanced primary-secondary care interface and to manage them where appropriate in the community setting.</p> <p>Develop local hospital and community pathways to improve and facilitate the patient's journey from admission to returning home or to an intermediate care facility.</p> <p><i>The above initiatives would include:</i></p> <p>Ensure the implementation of NICE / BTS guidelines for ILD in both primary and secondary care services through a defined pathway of care.</p> <p>Audit data of adherence to NICE / BTS Quality Standards and Clinical Guidelines.</p> <p>Daily Respiratory Consultant review of respiratory patients on the acute medical admission unit.</p> <p>Daily Respiratory Consultant / CNS review of patients on the specialty respiratory ward.</p> <p>Ward based smoking cessation brief interventions.</p> <p>Ward based non-invasive ventilation with twice daily Respiratory Consultant review.</p> <p>Early discharge schemes.</p> <p>Develop Pulmonary Rehabilitation Programs (PRP) for patients admitted with acute exacerbations.</p>	<p>Improved patient and carers awareness of respiratory illness symptoms and treatment</p> <p><i>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</i></p> <p>Increased % of people with diagnosed lung disease supported in the community by appropriate healthcare professionals addressing their action plan</p> <p>Increased % of patients admitted to hospital with an acute exacerbation to have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p><i>Increased % of patients who smoke are offered smoking cessation and successfully stop smoking</i></p> <p>Increased % of patients with significant breathlessness (MRC 3 or greater) who have been referred for a pulmonary rehabilitation programme close to where they live, and increased % of referrals who have successfully completed the programme</p> <p>Increase % of patients with COPD attending PRP post acute exacerbation</p> <p>Increased % of people with difficult and complex respiratory conditions being managed through an appropriate MDT framework</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Poor junior doctor engagement with prompt completion of transfer of care forms</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul> <p>Further development and capacity in ambulatory care</p> <p>Further development and capacity for Hot clinic slots</p>	<p>All by 2017</p>	<p>Public Health Wales</p> <p>GPs</p> <p>Community Pharmacies</p> <p>Third Sector organisations</p> <p>Dr John Banks</p>
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	<p>Home IV antibiotics for appropriate patients eg bronchiectasis.</p> <p>Admission avoidance initiatives including;</p> <ul style="list-style-type: none"> <li>• Specialist telephone / email advice</li> <li>• Specialist Hot clinic review</li> <li>• Specialist ambulatory care review and treatment</li> </ul> <p>Appropriate GP / Specialist review after discharge.</p> <p>Appropriate review at specialist condition MDT.</p> <p>Subspecialty clinics to ensure high quality outpatient specialist review.</p> <p>Written self management plans for patients presenting with a chronic respiratory condition.</p>	<p>Increased % of patients with COPD receiving appropriate home oxygen therapy</p> <p>Reduction in unscheduled hospital admissions for COPD per 100,000 population</p> <p>Reduction in number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS)</p> <p>Increased % of patients receiving appropriate ward based NIV</p> <p>Increased % of patients with COPD being assessed and appropriately discharged with a specialist early discharge scheme</p> <p>Increased use of ambulatory care</p> <p><i>Reduction in disease and age group specific mortality rates under age 75 per 100,000 population</i></p> <p>Increased % of patients with advanced and optimally treated respiratory disease receiving appropriate palliative and end-of-life care</p> <p>Improved audit results against NICE / BTS Respiratory Quality Standards</p> <p>Improved patient satisfaction</p>			
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### Supporting people living with lung disease

Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Self Management Plans	People with chronic respiratory conditions have an agreed, personalised self-management plan, which is co-produced with all relevant healthcare professionals and is reviewed regularly.	<p><i>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</i></p> <p><i>Regular review of self management plans</i></p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> </ul>	2016	GP & Disease Specific Leads (secondary care)

Annual Review	Ensure that all respiratory patients have the necessary key measurements taken annually to identify early decline in disease and facilitate appropriate interventions.	<p>All respiratory patients receive relevant key measurements for their condition annually as set out in NICE and British Thoracic Society treatment guidelines</p> <p>Increased number of advanced directives of patients with advanced chronic lung disease</p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> </ul> <p>FUNB list and clinic capacity</p>	2016	Appropriate Clinician
Patient Support Groups	Support the development of, and encourage referral to, patient groups such as Breathe Easy.	<i>Increased number and /or membership of patient support groups</i>	Poor public engagement	2015	Appropriate Clinician

Palliative Care	<p>Ensure adequate and equitable access to palliative care services, including respite care, for patients with respiratory disease in the end-stages of their illness.</p> <p>Link to work being undertaken by GP practices via Cluster Network Plans and the End of Life Care pathway audits</p>	<p><i>Increased number of advanced directives of patients with advanced chronic lung disease</i></p> <p><i>All patients with advanced disease to be offered palliative and end-of-life support</i></p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative care team</li> </ul>	2017	Appropriate Clinician
National Exercise Referral Scheme (NERS)	Utilise appropriate referral to the NERS scheme to support people with respiratory conditions increase their long-term adherence to physical activity.	<i>Increased referral to NERS</i>	<p>Poor public engagement</p> <p>Lack of education regarding NERS in primary and secondary care</p> <p>Capacity in NERS</p>	2016	Appropriate Clinician

Integrated Care	<p>Services available as locally as possible</p> <p>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,</p> <p>Access to, and care and support from, co-ordinated and seamless primary, secondary and community services</p> <p>Working with the Localities and Public Health Wales to assess the effectiveness of the Level 3 Smoking Cessation service when implemented,</p>	<p><i>Improved care (improving population outcomes and NHS assurance indicators)</i></p> <p>Improved patient satisfaction</p> <p><i>Increased rates of smoking cessation</i></p> <p><i>Increased rates of people maintaining a healthy lifestyle</i></p>	<p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p> <p>Insufficient staff time / capacity in</p> <ul style="list-style-type: none"> <li>• Primary care</li> <li>• Community teams</li> <li>• Respiratory specialist nurses</li> <li>• Respiratory physiotherapists</li> <li>• Respiratory physiologists</li> <li>• Respiratory Consultants</li> <li>• Palliative Care</li> </ul>	2017	<p>Primary care</p> <p>Disease Specific Leads</p>
Education	<p>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</p>	<p><i>Improved patient knowledge and self management</i></p> <p><i>Improved control of respiratory condition</i></p> <p>Reduction in inappropriate access of emergency services</p>			<p>Public Health Wales</p> <p>Third Sector</p>

Improving information					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Patient Education and Self Management	<p>Information, that is easy to understand and which allows them to make decisions about the care and treatment, and the possible consequences for their treatment if positive steps in self management are not undertaken.</p> <p>Information will be provided at the point of diagnosis and may include a self-management plan. It will be in the language of choice of the patient and will be updated or added-to as their disease progresses.</p> <p>Provide patients, and carers, with relevant, appropriate and adequate information about their respiratory conditions, in a variety of languages and formats including ABMU on YouTube.</p> <p>Signpost patients, and carers, to other relevant information sources such as patient support groups and appropriate internet sites.</p> <p>Continue to develop the ABMU internet and intranet sites to inform the public and staff.</p>	<p><i>Improved patient knowledge and self management</i></p> <p><i>Increased % of people with a chronic respiratory condition receiving a written self-management plan within 3 months of diagnosis</i></p> <p><i>Improved control of respiratory condition</i></p> <p>Reduction in inappropriate access of emergency services</p> <p>Reduced number of unscheduled attendances and re-attendances to hospital and average length of stay (ALOS) for patients with asthma and COPD</p>	<p>Public not engaged</p> <p>Poor lines of communication</p> <p>Lack of time and resource to educate and train staff within the community, primary and secondary care</p>	2017	<p>Public Health Wales</p> <p>Third Sector</p> <p>ABMU Communications team</p> <p>Secondary Care: Disease Specific Leads</p>

<p>Clinical Notes and Transfer of Care Information</p>	<p>Clinicians will provide clear and thorough notes and timely transfer of care information, thus ensuring that information is of high-quality and supports optimal levels of care for patients (Discharge Summaries etc).</p> <p>Audit data on clinical notes .</p> <p>In conjunction with NWIS, develop an electronic patient record that is accessible from community, primary and secondary care.</p>	<p>All patients attending hospital with acute respiratory illness will have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Improved legibility, timeliness and accuracy of clinical notes</p> <p>Improved communication between community, primary and secondary care</p>	<p>Poor clinician engagement</p> <p>IT infrastructure / support</p>	<p>2017</p>	<p>Dr Jackie Woolley, Lead Consultant</p>
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<p>Integrated care</p>	<p>Implement, use and develop the Welsh Clinical Portal.</p> <p>Continue to use and develop the GP portal, further improving communication and use of shared resources between primary and secondary care services.</p> <p>Increase the use of electronic transfer of care forms to improve communication between teams, particularly between primary and secondary care.</p> <p>Continue to use and develop clinical dashboards eg for unscheduled care.</p> <p>Continue to use and develop performance scorecards.</p> <p>Continue to use and develop clinical benchmarking tools including condition specific analysis.</p> <p>Continue to develop the ABMU internet and intranet sites to inform the public and staff.</p> <p>Continue to work with NWIS, Public Health Wales and Welsh Government to ensure data collected is used to inform service change which delivers high quality care.</p> <p>Ensure outcome data and information from local and primary care services are collected and used to facilitate development.</p> <p>To use data and information collected so as to reflect service provision and outcomes and to report such progress annually.</p>	<p>Improved care (improving population outcomes and NHS assurance indicators)</p> <p>All patients attending hospital with acute respiratory illness will have a discharge letter / transfer of care form delivered to the GP within 24 hours, or by the next working day</p> <p>Improved communication between patients and staff</p> <p>Improved communication between community , primary and secondary care services</p> <p>Improved performance against benchmarking</p> <p>Improved data for service design</p>	<p>IT and informatics infrastructure / support</p> <p>Poor clinician engagement</p> <p>Lack of time and resource to collect and then use the data for service development</p>	<p>2017</p>	
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Report progress against local delivery plan milestones on the website.

Targeting research					
Priority	Actions	Expected outcome	Risks to delivery	Timescales	Lead
Welsh Research	<p>Welsh Government and its partners, working with stakeholder researchers, to lead and co-ordinate development and co-operation through a respiratory framework.</p> <p>Strengthen and develop our close links with Universities and the clinical trials units</p> <p>Continue to develop clinical trials networks with links to the whole of the UK and internationally.</p> <p>Encourage the development of clinical academics within ABMU.</p> <p>Increase awareness of clinical trials recruiting within ABMU.</p>	An increased number of respiratory trials run within Wales	<p>Lack of Clinical Academics</p> <p>Lack of funding</p> <p>Lack of time within job plans</p> <p>Lack of infrastructure</p>	2017	TBC
Welsh Participants	<p>Encourage more respiratory patients to participate in research activity.</p> <p>Increase awareness of clinical trials recruiting within ABMU.</p>	An increased number of respiratory patients recruited to clinical trials	<p>Lack of clinician awareness of trials recruiting</p> <p>Lack of patient awareness</p>	2015	