Respiratory Health Strategy for Halton 2015 – 2020

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

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Foreword

Sadly the impact of respiratory disease has no bounds – from the school child with asthma who wakens in the night and is unable to compete with his peers to the elderly COPD patient with recurrent exacerbations and subsequent admissions. Their suffering is devastating for them and their families and there is a real risk of premature death. The impact of exacerbations and poor control places a further burden on the resources of an already stretched NHS.

There are many excellent therapies and guidance but still the basics of delivering evidence-based and personalised care remains essential for effective timely intervention for these respiratory patients.

This strategy will attempt to fully integrate health and social care aspects on respiratory care and encourage a more equitable service across the Borough incorporating primary, secondary and community services. It will empower local health care & other professionals to deliver the best possible care through better organisation, use of evidence-based care, improved self-management, prevention strategies and appropriate effective therapies and interventions.

The CCG, local authority and health and community partners should all be proud to participate in the initiative to improve the health and social well-being of all respiratory patients and their carers in Halton.

Dr Chris Woodforde, Respiratory Lead GP for NHS Halton CCG

People in Halton, on average, live shorter lives than people in many other parts of the country. Respiratory disease is the third leading cause of death after circulatory disease and cancer. There are significant health inequality in respiratory diseases, people in the most deprived communities in Halton, are twice more likely to die from a respiratory illness than the general Halton population.

Smoking and tobacco smoke is a cause of many respiratory problems and is linked to deprivation, but this is not the only link; working conditions, poor housing, fuel poverty and lifestyle are all associated with respiratory disease and more greatly affect people in poorer communities. Only when all organisations and partners are working together with a single strategic vision, and across all sectors, can we deliver a full range of services to reduce the impact respiratory illness has on the people of Halton. Ensuring that we improve opportunities to delay or prevent the development of respiratory conditions, improve access to appropriate good quality health services, and support people with respiratory problems, and their carers, to confidently manage their condition(s) and achieve the best possible quality of life, are key outcomes of this strategy.

Eileen O'Meara, Director of Public Health, Halton Borough Council

Executive Summary

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer. There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking, all of which are addressed within the scope of the strategy.

The strategy presents a vision for respiratory health in Halton:

Our vision is:

to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

In order to achieve the vision, the strategy identifies a set of aims across the treatment and condition pathways to improve respiratory health for the people of Halton, identifying the key issues and concerns for each strategic area, identifying the current provision and gaps and making recommendations for action against each. There are numerous recommendations identified in detail at the end of the document which will help achieve the following stated aims:

I. **Prevent respiratory ill health**

II. **Earlier detection of respiratory diseases**

III. **Primary Care and Community based support**

IV. **High Quality Hospital Services**

V. **Promoting Self Care and Independence**

The recommendations will inform the Respiratory Action Plan which will be overseen and monitored by the Respiratory Health Strategy Group in order to assess progress and analyse overall outcomes.

Contents

Strategic Context

Scope of the strategy

This strategy will address the key issues around respiratory health in Halton, it will address a spectrum of respiratory illnesses, causes, treatments and outcomes. While this strategy will aim to provide a broad picture, it cannot address every aspect of respiratory ill health within the one document, a number of related issues are covered in other local Strategic documents, for example, A Cancer Strategy for Halton, 2014-2019[1],identifies specific issues and actions around lung cancer ; A Housing Strategy for Halton , 2013-2018[2] identifies the issues around warm, healthy homes which also impact upon respiratory health; Halton Health and Wellbeing Strategy 2013-2016[3] also provides detailed activity and needs around certain lifestyle issues such as smoking cessation, to which this document will refer.

The Respiratory Strategy for Halton will identify the major respiratory health issues affecting the population of Halton and sets out how Health and Social Care organisations in Halton will deliver on its responsibility to meet the needs of people at risk of developing, or affected by, a wide variety of acute and chronic lung conditions. This is a significant challenge, for individuals and their carers and the whole Health and Social Care.

While the strategy cannot cover the full extent of potential lung and respiratory conditions it will focus on conditions which cause the most significant problems for local people and where illness may be preventable or amenable to treatment and where local action could significantly improve outcomes. The strategy will include the conditions: Chronic Obstructive Pulmonary Disease (COPD); Asthma; Pneumonia; Lung cancer; sleep disordered breathing; Interstitial Lung disorders; bronchiectasis; potentially work related lung disorders and other associated conditions.

Why Do We Need A Halton Respiratory Health Strategy?

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

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[1] http://www4.halton.gov.uk/Pages/health/PDF/health/HWB/ACancerStrategyforHalton.pdf last accessed 3.12.14

[2] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/housing/Halton_Housing_Strategy_2013-18.pdf last accessed 3.12.14

[3] http://www3.halton.gov.uk/Pages/health/PDF/health/Halton_Health_and_Wellbeing_Strategy.pdf last accessed 3.12.14

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

The 2014 Halton Respiratory Health Profile[4] details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are in line with the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

In addition, the incidence and mortality from cancer is higher in Halton than in many other parts of the country. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers)[5] and incidence fluctuates unequally across the Borough. While the incidence amongst men has seen a decline since the early 1990s, the incident rate amongst women continues to increase (increasing by 15.43 cancers per 100,000 population, from 1993-95 to 2009-11). Lung cancer represents a significant burden of respiratory illness for the population of Halton.

Halton has high rates of smoking. In 2014, 22.6% of the adult population smoked compared to an England average of 19.5%[6]. Other data suggests that the Smoking rate within Halton may be 30%, and up to 38% in some age groups (the NHS Merseyside Lifestyle Survey identifies that 38% of 25-34 year olds smoke). The rate of smoking related deaths was 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse

[4] http://www3.halton.gov.uk/Pages/health/PDF/health/RespiratoryHealthProfile.pdf
[5] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/General_Cancer_Profile_2013.pdf
[6] Halton health profile 2014 http://www.apho.org.uk/resource/item.aspx?RID=142121

than the England average smoking related death rate of 292 (per 100,000 population). Smoking results in considerable respiratory health problems and exacerbates existing conditioned resulting in increases in secondary care usage and poorer outcomes for patients. Halton also has a considerably higher proportion of women smoking at the time of delivery, with 18.9% of women smoking at delivery compared to 12.7% across England (2012/13). Smoking during pregnancy has considerable consequence to the growth and development of the child, not least a significantly greater likelihood of the child developing severe asthma in childhood and later life.

The treatment and management of people with respiratory conditions represent a significant challenge on current health and social care systems:

- 547 Children aged under 16 years of age presented at Whiston Accident and Emergency in 2013, 56% (305) of these were due to 'difficulty breathing'. 254 of those attending with difficulty breathing (83%) were subsequently admitted.
- CHIMAT data indicates 88 asthma admissions in 2013/2014 across Warrington & St Helens and Knowsley Hospitals.
- The proportion of people dying from respiratory disease in Halton is higher than the North West average and is significantly higher than the England average.
- Fewer people within Halton with existing respiratory illnesses are protecting themselves from the complications of flu. 89.8% of COPD patients received their annual seasonal flu vaccination compared to 92.7% across England as a whole.
- Adult Social Care records show 572 individuals registered with Care First who have asthma or COPD.
- In 2014/15, Halton CCG spend just over £3.4 million on prescribing for respiratory health. This is approximately 15% of the total prescribing spend for Halton CCG.
- The overall spend on respiratory services, prescribed drugs and patient activity for 2013/14 has been estimated to be £5.8 million within Halton.

Our Vision & Aims

We want to improve the respiratory health and well-being of people in Halton, and reduce the impact that respiratory conditions have on people and services across Halton.

Our vision is:

to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

In order to achieve our vision, this strategy aims to;

VI. **Prevent respiratory ill health**
Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

VII. **Earlier detection of respiratory diseases**
Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

VIII. **Primary Care and Community based support**
Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

IX. **High Quality Hospital Services**
Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

X. **Promoting Self Care and Independence**
Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

The strategy will inform the development of a comprehensive action plan to oversee the delivery of actions to enable the achievement of the identified aims within the Strategy. The Strategy and Action plan will be overseen by the Respiratory Health Group. The multidisciplinary Respiratory Health Group will oversee and receive assurance from all partners with regards performance towards achieving the action plan objectives and outcomes. The Respiratory Health Strategy Group is accountable to Halton Clinical Commissioning Group's Service Development Committee, a multiagency group consisting of a range of health, public health, social care and voluntary sector providers.

The action plan will be reviewed at least annually and refreshed as required.

Achieving the Aims

i. Preventing respiratory ill health

Health education and disease prevention activities should inform everyday lifestyle choices for the population of Halton. Motivating people to be aware of and take action to reduce their risks of developing respiratory ill health must remain a key focus of activity within this strategy.

Smoking

In Halton:

The average smoking rate in Halton is now the same as the national average at 18.4%

Up to 30% of adults smoke in deprived areas, significantly higher than the Halton Average (18.4%)

19% of pregnant women smoke at the time of delivery, significantly worse than the England average (12%)

There are 416 smoking related deaths per 100,000 over 35 population per year, compared to 292 as an England Average[7]

Reducing the prevalence of smoking will have the greatest impact upon respiratory disease prevention. Improving access to smoking cessation services and encouraging long term quit rates would have a significant impact on reducing prevalence of a variety of respiratory disease, including COPD, lung cancer, adult and childhood asthma amongst others. Increasing work within schools and youth settings and identifying innovative and best practice techniques to prevent young people taking up the habit of smoking will help limit future impacts of respiratory ill health. There is increasing evidence that young people may be using e-cigarettes as a gateway to smoking. Targeting activities towards limiting the increasing usage of e-cigarettes, and working across agencies to limit access and lobby for legislative change could help prevent people in Halton becoming smokers in the near future.

Current data on smoking prevalence varies, with the national Lifestyle survey suggesting that smoking in Halton is the same rate as the national average but other local surveys suggest that as many as 30% of the local population (in the most deprived areas) may smoke.

[7] Halton Health Profile 2014, Public health England http://www.apho.org.uk/resource/item.aspx?RID=142121

Vaccination

In Halton:

In 2013/14, against a national target of 75%

- 73.5% of those 65 years old and over received their annual flu vaccination
- 51.9% of those under 65 but at risk received a flu vaccination
- 38.3% of pregnant women received a flu vaccination

71.2% of those 65 and over had received a Pneumococcal vaccine (national average 68.9%, 2013/14)

Uptake of childhood vaccinations is generally good, with the Halton average uptake for Pneumococcal and Pertussis vaccines by 12 months and Hib vaccine by 24months being above the 95% national target (although there is wider practice level variation)

Next to clean water and sanitation, vaccination is the most effective public health intervention of all time. Vaccinations can prevent respiratory illnesses.

Promoting and improving the uptake of appropriate vaccination programs (Influenza and Pneumococcal) amongst our target populations is essential to reduce in the burden of respiratory illness caused by influenza and pneumococcal infections amongst the most vulnerable people in our communities (the very young, older people and those with existing chronic health conditions). Achieving recommended uptake of influenza and Pneumococcal vaccination (at least 75% uptake amongst all people over 65, those under 65 with an existing health condition, and pregnant women, and achieving a 90% uptake amongst those with COPD), would make a significant contribution to reducing the number of excess winter deaths in Halton.

The uptake of primary Immunisations in childhood is good. Across Halton as a whole, the uptake of primary immunisations including those preventing respiratory diseases Pneumococcal disease, Pertussis (whooping cough) and Haemophilus Influenzae type B (Hib) were above the national target of 95%. There is some variation across GP practices, with some practices reporting 88.9% while others achieved 100% uptakes. Halton Council are working closely with Public Health England to ensure that we maximize opportunities to increase vaccination coverage across Halton.

Obesity

In Halton:

There is a higher percentage of obese adults than the England average.

35.2% of adults in Halton are obese (England average 23%).

Levels of obesity in year 6 children are similar to the national average (20.4% in Halton compared to the England average 19.1%).

Obesity can have a very serious negative impact on the respiratory system, significantly reducing respiratory health. Some of the health effects of obesity on respiratory system include diseases like:-

- Exertion dyspnoea – severe breathlessness as a result of only minor physical activity. This is a common feature among people who are obese.
- Obstructive sleep apnoea syndrome (OSA) – This condition leads to closing or narrowing of the airways during sleep leading to snoring, repeated waking and lack of adequate and restful sleep.
- COPD - a group of lung diseases that block airflow and make breathing difficult. Emphysema and chronic bronchitis are the two most common conditions.
- Asthma – Obese patients are more at risk of asthma exacerbations. The prevalence of asthma is around 38% higher in overweight patients and by 92% in obese patients. Obese patients with asthma also get more acute attacks, need more asthma medication, need more frequent visits to the emergency department (ED), and have more hospital admissions than non-obese patients with asthma.
- Pulmonary embolism – This is a serious condition where a blood clot gets lodged in the blood vessels of the lungs leading to a life threatening medical emergency. Pulmonary embolism may lead to failure and death.

Respiratory illnesses for which obesity can represent a significant cause have a great impact upon the health of people in Halton and the health services across Halton. There are estimated to be 1328 adults with moderate to severe Sleep apnoea.[8] The cost of treating all people with moderate to severe OSA would be £1,092,406 per year. In 2013-14, there were 180 emergency admissions as a result of COPD across Halton. In the same time there were 43 emergency admissions for adults aged 45-74 years of age as a result of asthma.

Encouraging people to lose weight and maintain a healthy weight through a healthy balanced diet and regular exercise is the only way in which the population of health on can stay within a healthy weight range and reduce the likelihood of obesity related respiratory ill health. Halton has a number of services to promote healthy lifestyles, diet and exercise. Current programmes range from interventions in Schools (Food and nutrition awareness, cooking skills, exercise programmes) to Adult Fresh Start programmes to encourage healthy weight loss, provide healthy food skills and supporting regular exercise programmes and opportunities across the Borough and we

[8] British Lung Foundation 2015 OSA Calculator

need to work across partner agencies and the public to a greater extent to ensure that everyone has an equal opportunity to benefit from the services available.

Drugs

In Halton

According to the North West Mental Wellbeing Survey 2012/13

A local schools survey suggests that approximately 5 % of secondary school children had used cannabis in the previous year, which is generally lower than national trends.

In a sample of 500 adults aged 16 and over in Halton 11.3% reported cannabis use

Cannabis use is associated with longer-term damage to the respiratory tract, with an increased risk of chronic bronchitis, asthma and potentially lung cancer. There is also a reported association between cannabis smoking and an increased risk of developing infectious lung diseases such as tuberculosis and Legionnaires disease.

Education to reduce the levels of cannabis use, and prevent young people from using cannabis could help to reduce rates of chronic bronchitis and asthma.

Housing

In Halton

In 2012, 4841 households (9.2% of all households) were in fuel poverty, spending more than 10% of their household income on heating costs. This is not distributed evenly, in some areas within Halton, as much as 26% of households in privately rented accommodation are in fuel poverty.

Halton has seen a general increase in Excess Winter mortality over recent years (although the most recent data is lower than). Nationally, respiratory diseases account for the second highest proportion (32%) of excess winter deaths[9]. Cold homes are a considerable contributor to the excess deaths resulting from respiratory illnesses (particularly exacerbations of COPD) and fuel poverty is a significant cause of cold homes. Damp living conditions are also a major cause of respiratory illness, ranging from allergy to mould resulting in significant rhinitis, wheeze, coughs and exacerbations of asthma and COPD, to increased rates of infections ranging from flu like symptoms to significant lung damage.

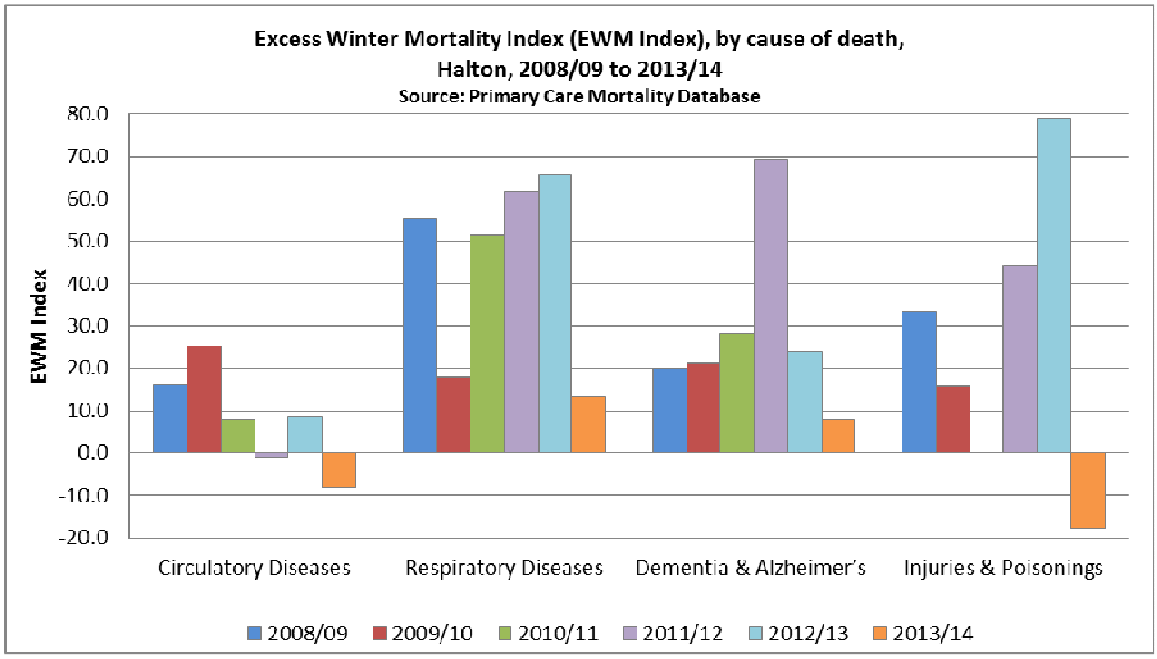
Fuel poverty and cold homes can have severe and life-long effects on children. Studies show that long-term exposure to a cold home can increase hospital admission rates for children and increase the severity and frequency of asthmatic

[9] Office for National Statistics (2010). Statistical bulletin *http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2010-11--provisional--and-2009-10--final-/index.html*

symptoms. Children in cold homes are more than twice as likely to suffer from breathing problems and children in damp and mouldy homes are up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared to those with warm, dry homes.[10] During 2013-14 there were 82 emergency admissions for asthma in children under the age of 14.

Figure 1 shows the proportion of Excess Winter deaths attributable to different causes, in Halton from 2008 – 2014. This shows that respiratory disease generally account for the highest proportion of these deaths,

Figure1: Excess Winter Mortality Index, by cause of death, Halton 2008/09 to 2013/14



During 2011/12 to 2013/14, of all emergency admissions for lower respiratory tract infections in 0-18 year olds, 81.5% were for those under 1 year of age (the England average was 70%) and 79% of these were for acute bronchiolitis. Bronchiolitis can be best prevented by good hygiene and living conditions. Children who are exposed to passive smoking, can suffer more severely with bronchiolitis.

Halton Housing strategy 2013-18 identifies key actions around developing the affordable warmth strategy and promoting energy efficiency and green deals to help

[10] Fact-file: Families and fuel poverty ; Association for the conservation of energy, February 2013 http://www.ukace.org/wp-content/uploads/2013/02/ACE-and-EBR-fact-file-2012-02-Families-and-fuel-poverty.pdf

reduce the local burden, although further multidisciplinary and health involvement would benefit the development and promotion of these interventions.

Environment

In Halton:

Air quality as a whole has improved in Halton over the previous decades.

There are 2 Air Quality Management Areas which regularly exceed recommended emissions levels which can affect health. These are a result of high density traffic flow and congestion.

The environment that we live in can have a great impact upon our respiratory health, both indoor and outdoor environmental factors, predominantly air quality, can significantly influence our chances of experiencing good respiratory health. Breathing fine particles (those produced through burning), high levels of gases such as nitrogen oxide and sulphur dioxide, and low level ozone can all irritate the lungs. In the short term they can cause breathlessness, and exacerbate symptoms of asthma and COPD. In the long term they could lead to reduced lung function, initiation of asthma, and cause scaring and damage to the lung or causes some forms of Interstitial lung disease (a range of conditions which include most commonly Idiopathic pulmonary fibrosis).

Indoor environment

Our indoor environment plays a significant role on our health, particularly so for young children who may spend considerable amounts of their time indoors. Indoor environmental tobacco smoke is the main indoor environmental pollutant to affect peoples, especially children's, respiratory health. Passive smoking is breathing in the smoke from someone else's tobacco. Passive smoking can be either secondary of tertiary; secondary smoking is exposure to smoke from other peoples cigarettes, and tertiary smoking is exposure to residual smoke on persons, clothing and furniture etc. as a result of smoking). The predominant source of passive smoke exposure in children is smoking in the home by parents. The best way to prevent passive smoking in the home is therefore to reduce the prevalence of smoking among parents and would-be parents.[11]

Passive smoking can have a significant impact on health, increasing the likelihood of recurrent lower and upper respiratory infections, recurrent pneumonia, development and worsening of asthma, as well as a significant cause of lung cancer in smokers and none smokers:

[11] Passive smoking and children. Royal College of Physicians 2010.

- Smoking by the mother increases the risk of lower respiratory infections in children by about 60%, and smoking by any household member increases the risk by over 50%. Most of this increase is due to an effect on bronchiolitis, which is about 2.5 times more likely to occur in children whose mothers smoke[12]
- Secondary smoking increases the risk of wheezing at all ages. Again, the effect is strongest for amongst children whose mothers smoke, with increases in risk of 65% to 77% according to the age of the child. The risk of asthma is increased by household smoking by about 50%.[13]

Other indoor environmental factors which can impact upon respiratory health include:

- Mould - Poor quality damp housing and lack of ventilation in humid places such as kitchens and bathroom can lead to the growth of mould. There are many types of mould, many of which harmless, but some people can have allergic reactions to mould or mould spores which can lead to rrespiratory symptoms including persistent sneezing, eye irritation, rhinitis (runny nose), coughing and wheezing, which can be worse in children.
- Pets – fur and feathered pets are sources of allergies. Some people are allergic to certain proteins and substances found in the skin or some secretions (saliva etc) from some animals. Pet allergies can lead to long term rhinitis, coughing and wheezing. Identifying the source of the respiratory ill health can be difficult to detect and can develop even when pets have been present for a long time.
- Dust – dust can harbour mites. Faeces from dust mites are also a very common allergen that can be a significant contributor to the development of asthma and/or triggering asthmatic attacks. Mites accumulate in or on surfaces that accumulate human skin cells or sweat etc. They also thrive in conditions of high humidity and temperature. They accumulate in bedding, pillows, mattresses, carpets and furniture. People are exposed by inhalation and can result in allergic respiratory symptoms as well as asthma.

Ensuring that the environment is clear of potential allergens, when there is a known or likely link (family history) is key to preventing poor respiratory health, and removing/ limiting contact with potential allergy sources where a respiratory allergy symptoms are present is key to preventing ongoing or worsening conditions.

Outdoor environment

[12] Cook DG, Strachan, DP. Health effects of passive smoking
[13] Parental smoking and prevalence of respiratory symptoms and asthma in school age children. *Thorax*1997;52:1081–94.

Outdoor Air pollution is also a key determinant of respiratory health. There are several kind of pollutants which affect health, and are of major concern, these are pollutants for which there are national and international criteria to monitor their levels and limit the impact that they have upon health. The council has a responsibility to regularly monitor, review and assess air quality as part of the Environmental Act (1995) and national Air Quality Strategy.

The Committee on Medical Effects of Air Pollution (COMEAP) estimated that air pollution accounts of 29,000 deaths nationwide every year[14]. The most recent COMEAP Report looks at the proportion of deaths in a local area that can be attributable to particulate pollution. The proportion of deaths attributable to long term exposure to manmade particulate air pollution in Halton is 5.5%, while this still represents a fraction of deaths for which preventive action must be sought, it is reassuring that Halton has no greater risk than many other areas of the country. The average attributable risk across England is 5.6%.[15]

Halton is an industrial area, with a long history of industrial processes. It has had historically poorer air quality than other areas of the country. However, with the reduction in industrial manufacturing, cleaner technologies and closer processes monitoring and permitted processes has significantly improved air quality in Halton over the decades. Halton currently collects data on air quality across the borough to regularly assess air quality. Halton is generally well within national Criterial levels for common air pollutants (particulates, Sulphur dioxide, nitrogen dioxide). However, there are 2 areas which have been identified as Air Quality Management Areas (AQMA) where nitrogen dioxide are above Air quality objective levels, both these areas are in Widnes Town Centre and are associated with high volume traffic flows.

Halton Borough Council in partnership with other agencies is working towards improving transport options, increasing sustainable transport options, cleaner technologies, assessing traffic routes and active travel options (walking and cycling etc.)

Actions for Prevention

Smoking

- Increase the number of people attending Smoking Cessation Services in Halton
- Reduce the proportion of people smoking in Halton

Vaccination

[14] The Mortality Effects of Long Term Exposure to Particulate Air Pollution in the UK. COMEAP Dec 2010

[15] Estimating Local Mortality Burdens Associated with Particulate Air Pollution. PHE, COMEAP April 2014

● Increase the uptake of flu vaccination amongst at risk groups, to achieve national target

● Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity

● Improve uptake to lifestyle advice across the borough

● Increase the proportion of people taking regular daily exercise in Halton

Drugs

● Improve education and awareness of the impacts of cannabis use, especially preventing young people from starting to use cannabis.

Housing

● Increase access to grants and equipment to increase energy efficiency in

People's homes

● Continue to work across the private rented sector to improve housing standards

Environment

● Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport

● Identify opportunities to further improve air quality across Halton

ii. Earlier detection of respiratory diseases

In Halton:

43.1% of lung cancers are detected at early stage 1 and 2.

One and five year survival from lung cancer is higher than regionally and nationally.

2.6% of the population have COPD, but there is a possible 0.79% we don't know about.

Failing to treat the estimated 1328 people in Halton who have Sleep Apnoea could increase NHS costs, social care costs and accidents locally.

Early diagnosis of lung disease delivers significant benefits, particularly in such conditions as asthma, COPD, and lung cancer. There is a need for greater public awareness of the symptoms of such lung diseases, of the risks posed by smoking and by any delay in diagnosing smoking-related lung conditions such as lung cancer and COPD to encourage people to recognise early indications that there may be a problem and to seek medical attention early. In addition, there is a requirement to ensure that primary care are fully aware of the early symptoms of specific conditions and explore appropriate diagnostic tests, and referrals early.

Whilst prevention of ill health remains the primary long term focus to safeguard respiratory health in to the future, significant improvements in health outcomes and mortality can only be made by earlier diagnosis and interventions for respiratory illnesses. There are a number of respiratory conditions that have early signs and symptoms, that can be diagnosed early, or that are more frequently diagnosed late and opportunities may exist for earlier diagnosis. Such conditions include

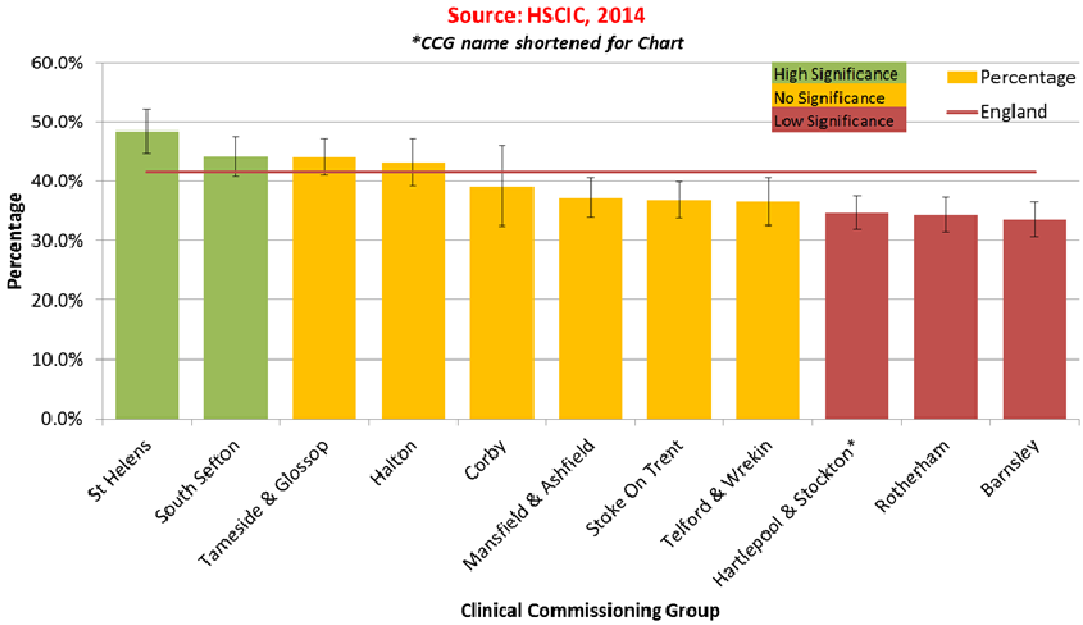
Lung cancer

In Halton, 43.1% of lung cancers were detected at an early stage (stage 1 and 2), where the cancer is much more treatable, has generally had less opportunity to spread and leads to much better outcomes for the patient. This is slightly higher than the England average early diagnosis and is significantly higher than many of comparable Clinical Commissioning Group (CCG) areas as seen on **Figure 2**.

People with lung cancer normally present with common respiratory symptoms (cough, coughing blood and breathlessness). These patients are nearly always seen by a respiratory physician for diagnosis before referral to oncologists and many are admitted as an emergency because the correct diagnosis is not made. This means

that we should put emphasis on early and accurate diagnosis of any unusual respiratory symptoms.

Figure 2: Percentage of lung cancers diagnosed at stage 1 and 2 for Halton and Statistically similar CCGs



Halton has been running a Get Checked public awareness campaign since 2008 which raises awareness about the early symptoms of cancer to the public. From 2008 to date, 'Get checked', in combination with other national awareness initiatives such as Be Clear on Cancer have increased the volume of fast track GP referrals year on year for suspicious breast, bowel and lung cancer symptoms by 24% with an associated increase of cancer diagnosis of 19%. The continuation of the Halton Get Checked campaign and further innovations in delivery are required to further increase awareness of signs and symptoms of lung cancer. These approaches should be backed up with a system approach to ensure that 2 week wait referrals are made appropriately, that system capacity is able to meet any increase in demand in terms of urgent referrals, diagnostics, and treatment and rehabilitation pathways.

COPD

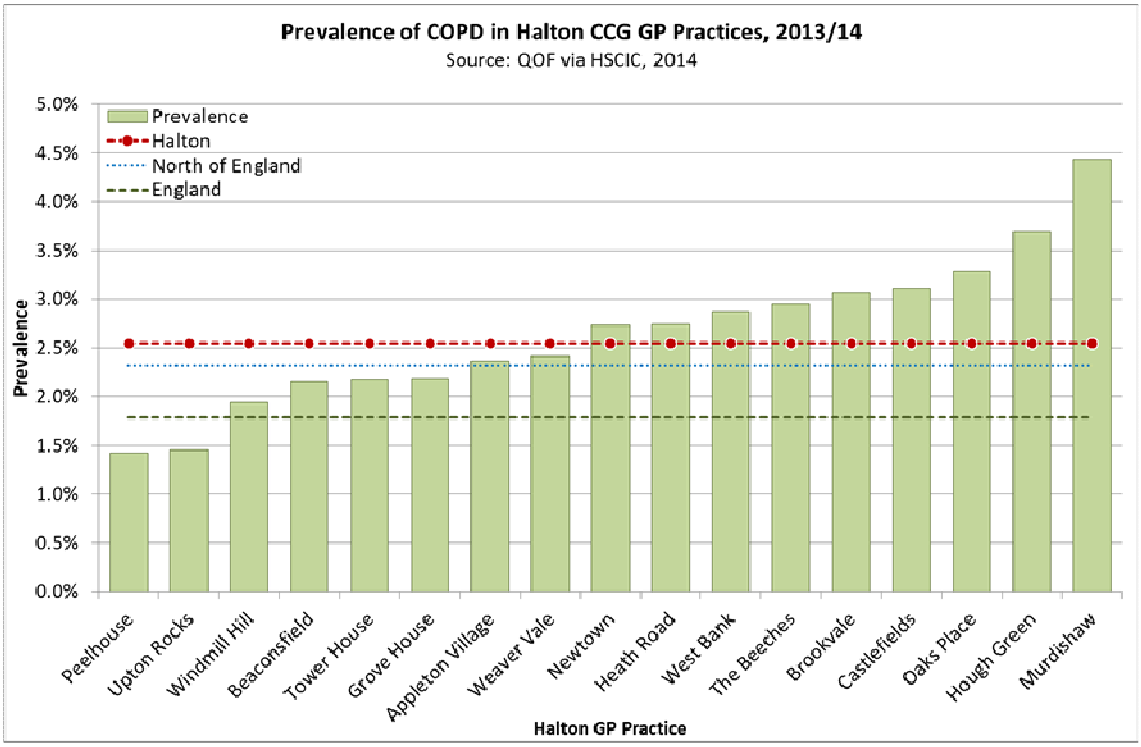
In Halton it is estimated that 3,916 residents over the age of 16 had COPD as of 2010, which is predicted to rise to 4,420 by 2020. The biggest increase is predicted to be in the 65 plus age group.

It is a requirement of the GP contract that practices hold a register of all patients with COPD, data for 2012/13 indicates that 3,210 patients who are registered with practices in Halton have COPD. This represents 2.6% of the registered population.

The prevalence of COPD varies considerably by practice, with some practices experiencing higher than average rates of COPD, and other considerably lower.

Figure 3 below shows the practice variation in COPD prevalence ranging from 1.4% to 4.4% prevalence across the practices.

Figure 3: Prevalence of COPD in Halton CCG GP practices 203/14



Estimates have been made of the number of people that would be expected to have COPD, based on the demographics within the Borough, and these suggest that 3207 people (3.39% of the population)[16] would have COPD. The difference between expected and actual registered cases of COPD suggests that there is a proportion of the population who have undiagnosed COPD. There have been improvements in case finding since 2009/10 closing the gap between the modelled estimated number of people with COPD and those of GP disease registers. But it is important that we continue to actively identify those with undiagnosed COPD. Early diagnosis and treatment initiation for COPD can markedly slow down decline in lung function provide patients with an opportunity to enjoy an active life for longer. Improving public awareness of COPD, including what good respiratory health looks like and signs and symptoms of possible COPD, in addition to wider community, high quality spirometry to assess lung function will help to identify possible COPD patients to enable more rapid diagnosis and earlier treatment plans.

[16] COPD Prevalence Estimates Dec 2011, East of England Public Health Observatory http://www.apho.org.uk/resource/item.aspx?RID=111122

Interstitial lung diseases

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung.

Due to the variety of the illness that comprise ILD, there is no single early diagnosis tool or single set of signs and symptoms, although shortness of breath especially with relatively minor exertion is one common feature. A number of the most common ILD can be related to occupational or environmental factors, and therefore, it is important that a full personal and work history is taken within primary care when a patient presents with breathing problems. In addition, it is also important to ensure that the population are aware of the potential risks so that those who may be in higher risk groups, coal workers, farmers etc. are aware of possible signs and symptoms and encouraged to present early to health services.

Obstructive Sleep Apnoea (OSA)

Due to the risk factors and profile of those who develop OSA, it is possible to predict the likely proportion of a local population who are likely to have OSA. Based on the British Lung Foundation OSA calculator, 1328 people (1.06% of the population) will have OSA. By assessing predicted rates within a population, against known rates, it would possible to identify how many people are likely to have the condition, but remain undiagnosed. However, there are no accurate data on the actual local prevalence of OSA. Locally we need to ensure that we are aware of the population rates of OSA.

The British Lung Foundation estimates that cost of not treating all those with moderate to severe OSA will cost the local health and social care economy will be over £109,000 more per year than the cost of actually treating all people with moderate to severe OSA. In addition, identifying and treating all those with moderate to severe OSA could prevent 157 road traffic accidents every year.

People with symptoms, abnormal tests or screening results should have these addressed locally and/or where appropriate, should be referred for further assessment and management when lung disease is suspected or confirmed.

Spirometry, oxygen saturation measurement and chest radiology are important investigations widely available in both primary and secondary care practice. They can be used to identify at risk groups within case finding strategies which can be most effectively undertaken in local community settings and we must ensure that local spirometry services are robust and accessible.

People with Learning Disability

The Confidential Inquiry into the Premature Death of People with Learning Disability found the most prevalent immediate cause of death in people with learning disabilities was respiratory disorders, followed by heart and circulatory disorders. The report highlights that these deaths are most likely to be amenable to health care interventions. The most common respiratory illness associated with premature death in people with Learning Disability was usually pneumonia.[17]

15.5% of the general population develop respiratory disease and 17% of those die from it. By comparison, 19.8% of people with a learning disability develop the disease but about 50% of these die from it.

Actions for early detection

Cancer

- Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer
- Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

COPD

- Encourage improved and early case finding to facilitate better management and treatment access
- Develop and implement a Borough wide, inclusive community spirometry service

ILD

- Ensure risk markers are identified on patient records, known risk occupations etc

OSA

- Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability

- Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.
- People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

[17] Confidential Inquiry into premature deaths of people wioth Learning Disability (CIPOLD) 2013 http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

XI. Primary Care and Community based support

In Halton

- GP practices perform slightly better than the England average for all but 1 clinical indicator for asthma
- GP practices perform slightly better than the England average for all but 1 clinical indicator for COPD
- There is a higher rate of emergency admissions for bronchiolitis than the England average.

Conditions affecting respiratory health are numerous, varied and often complex, requiring a multidisciplinary approach to identification and management offered by many different providers. The route of these approaches invariably lies within primary care. Ensuring that primary care, and the community health approaches are robust and effective will improve outcomes for patients and minimise the health system burden resulting from respiratory ill health.

There are a number of lung conditions where improvements in the delivery of effective primary care and community support care can result in high impact changes to the respiratory health of people in Halton.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can in the short-term lead to potentially life-threatening exacerbations and in the long-term to irreversible damage to the lungs.

To ensure high quality diagnosis and treatment, it is key that appropriate services are commissioned that enable all practitioners and services to meet the NICE Quality Standards 25 for asthma. The 10 quality statements which will improve care and treatment for people with asthma are:

Statement 1	People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
Statement 2	Adults with new onset asthma are assessed for occupational causes.
Statement 3	People with asthma receive a written personalised action plan.

Statement 4	People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
Statement 5	People with asthma receive a structured review at least annually.
Statement 6	People with asthma who present with respiratory symptoms receive an assessment of their asthma control.
Statement 7	People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
Statement 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.
Statement 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.
Statement 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.
Statement 11	People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

Most people with asthma are managed within primary care. However, some people will require hospital admission. In some instances, increased hospital admissions may result for poor management of the condition which can result in inadequate response and management of exacerbations.

The GP contract requires that practices closely monitor diagnosis, assessment of control and smoking status in young people. For 2012/13, **figure 4** shows that Halton Practices performed better than the England average for asthma diagnosis and assessments of control, but below the national average for recording of smoking status.

Figure 4: Achievement against asthma clinical indicators, 2012/13

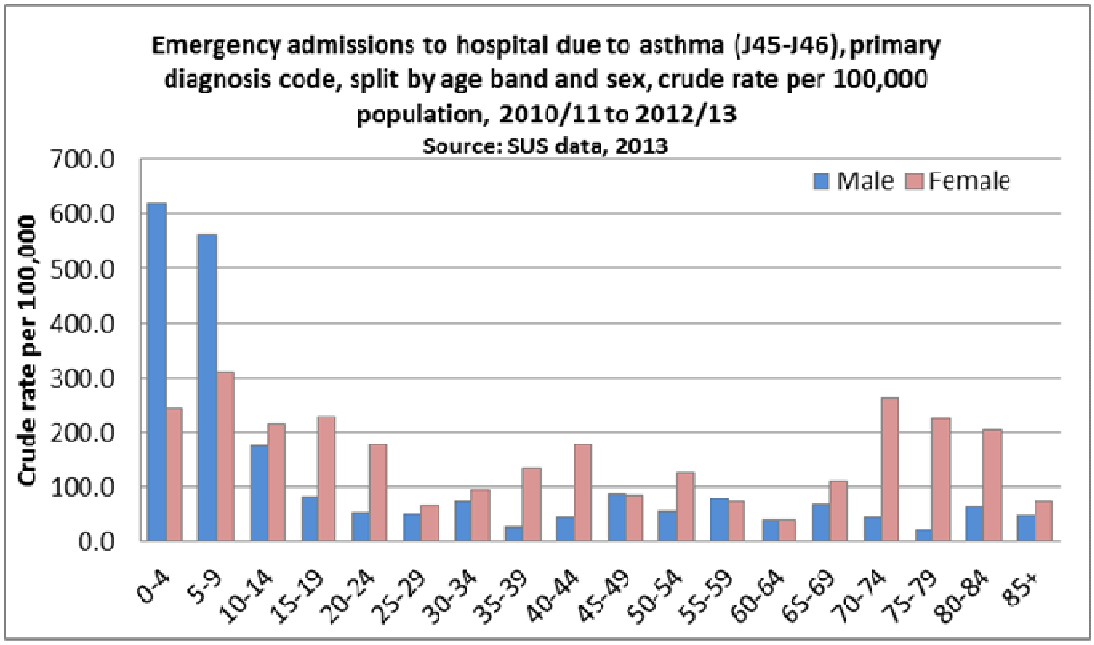
Practice Code	Practice Name	ASTHMA08	ASTHMA09	ASTHMA10
N81011	Beaconsfield	82.6%	79.3%	85.1%
N81019	Castlefields	95.9%	73.4%	87.5%
N81035	Appleton Village	83.1%	71.1%	100.0%
N81037	Beeches	85.5%	62.3%	75.6%

N81045	Peelhouse	89.0%	78.9%	89.4%
N81054	Weaver Vale	94.9%	81.9%	86.8%
N81057	Tower House	97.5%	90.7%	95.7%
N81064	Newtown	82.2%	78.0%	88.5%
N81066	Grove House	95.6%	74.5%	85.5%
N81072	Murdishaw	94.4%	77.2%	87.5%
N81096	Brookvale	81.9%	76.7%	87.5%
N81119	Hough Green	98.1%	74.2%	100.0%
N81618	Heath Road	91.9%	62.1%	100.0%
N81619	Oaks Place	94.0%	75.0%	90.0%
N81625	West Bank	91.4%	89.4%	84.6%
N81651	Upton Rocks	82.8%	78.3%	100.0%
Y02512	Windmill Hill	87.5%	77.9%	83.3%
Halton CCG		**90.5%**	**76.1%**	**88.9%**
Merseyside Area Team		**87.4%**	**76.4%**	**90.6%**
North of England		**87.8%**	**75.4%**	**89.6%**
England		**87.6%**	**74.8%**	**89.3%**

ASTHMA08: The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility
ASTHMA09: The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions
ASTHMA10: The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months

Effective primary care and case management is key to preventing exacerbations and preventing hospital admissions. **Figure 5** shows that the highest rate of admissions is for the 0-9 age groups, this could be admissions as a result of first diagnosis or where management systems are not yet in place, however, for older age group, effective management is more likely to be in place and close monitoring and engagement with primary care and community could potentially reduce emergency admissions.

Figure 5: shows the emergency admissions by age group for Asthma from 2010/11 to 2012/13.



Smoking cessation is an important part of ensuring good respiratory health, for people with asthma (and COPD) it is even more vital that they receive high level support to quit smoking to improve treatment out comes and limit potential serious exacerbations. All people who are on the asthma (and COPD) registers in practice should also have smoking status recorded, and regular (repeated as necessary) offers to engage with smoking cessation services. Encouraging practices to benchmark smoking status and set reduction targets for smoking in these practice populations can have a significant effect on ongoing symptom management.

COPD

COPD is a chronic progressive disease of the airways associated with high morbidity and mortality. It is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient and community support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery. As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease.

Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission.

Non-invasive ventilation is cost effective and improves outcomes for selected patients. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

NICE COPD Quality Standards 10 identifies 13 key statements that will improve care and management for patients with COPD, that we must endure appropriate services are commissioned locally and that clinicians are able to meet these standards to maximise care and treatment for COPD patients in Halton. The statements are:

Statement 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.
Statement 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.
Statement 3	People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
Statement 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 comorbidities.
Statement 5	People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
Statement 6	People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
Statement 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.
Statement 8	People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
Statement 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.

Statement 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.

Statement 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.

Statement 12 People admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.

Statement 13 People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

The GP contract requires practices to manage patients in line with best practice. For COPD this relates to diagnosis, recording of FEV1 (maximal amount of air you can forcefully exhale in one second), influenza vaccination and an assessment of the level of breathlessness a patient is experiencing. For 2012/13, Halton practices showed better than the national average performance on all but one factor. The percentage of COPD patients who received a flu vaccination was below the England average (**Figure 6**).

Figure 6: Achievement against COPD clinical indicators, 2012/13

Practice Code	Practice Name	COPD08	COPD10	COPD13	COPD15
N81011	Beaconsfield	96.9%	89.4%	92.1%	100.0%
N81019	Castlefields	96.6%	87.6%	96.4%	97.2%
N81035	Appleton Village	88.9%	80.5%	97.0%	97.2%
N81037	Beeches	97.1%	85.0%	90.8%	90.0%
N81045	Peelhouse	93.0%	90.0%	91.3%	86.2%
N81054	Weaver Vale	87.4%	95.1%	93.3%	90.0%
N81057	Tower House	97.4%	98.4%	98.6%	100.0%
N81064	Newtown	31.9%	88.1%	96.0%	91.7%
N81066	Grove House	90.6%	93.2%	91.1%	87.5%

N81072	Murdishaw	94.0%	89.1%	97.4%	98.8%
N81096	Brookvale	96.3%	80.9%	90.1%	90.9%
N81119	Hough Green	81.5%	93.9%	94.6%	88.9%
N81618	Heath Road	92.7%	95.1%	95.0%	88.9%
N81619	Oaks Place	94.9%	94.0%	92.0%	85.7%
N81625	West Bank	94.5%	95.6%	97.1%	85.7%
N81651	Upton Rocks	97.6%	92.7%	93.0%	83.3%
Y02512	Windmill Hill	85.7%	87.5%	92.5%	100.0%
Halton CCG		**89.8%**	**89.4%**	**94.2%**	**93.6%**
Merseyside Area Team		**92.4%**	**82.8%**	**91.0%**	**92.0%**
North of England		**92.7%**	**87.9%**	**91.1%**	**91.3%**
England		**92.7%**	**88.4%**	**91.1%**	**91.3%**

COPD08: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
COPD10: The percentage of patients with COPD with a record of FEV1 in the preceding 15 months
COPD13: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months
COPD15: The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry

COPD is a rare condition before the age of 40. Most people who develop the condition are managed within primary care. However, some people will develop exacerbations of the condition or they may be undiagnosed, which can result in an emergency (unplanned) admission to hospital. **Figure 7** shows the data for 2010/11 to 2012/13 which show that admissions rise from the age 45 onwards for both males and females but that the rate of admissions is generally higher for men than for women.

A number of people with COPD are admitted on more than one occasion during a single year. Research suggests that there are nearly half a million 'frequent flyers' in the United Kingdom and that they cost the health service approximately £2.3 billion a year (2003-4 figures). Assessing the numbers of re-admissions or frequent flyers, does not indicate that the hospital admissions are unnecessary, but we need to

understand the data to ensure that primary care and patient management are maximised to prevent these repeated admissions.

Figure 7: Emergency admissions due to COPD for 2010/2011 to 2012/13

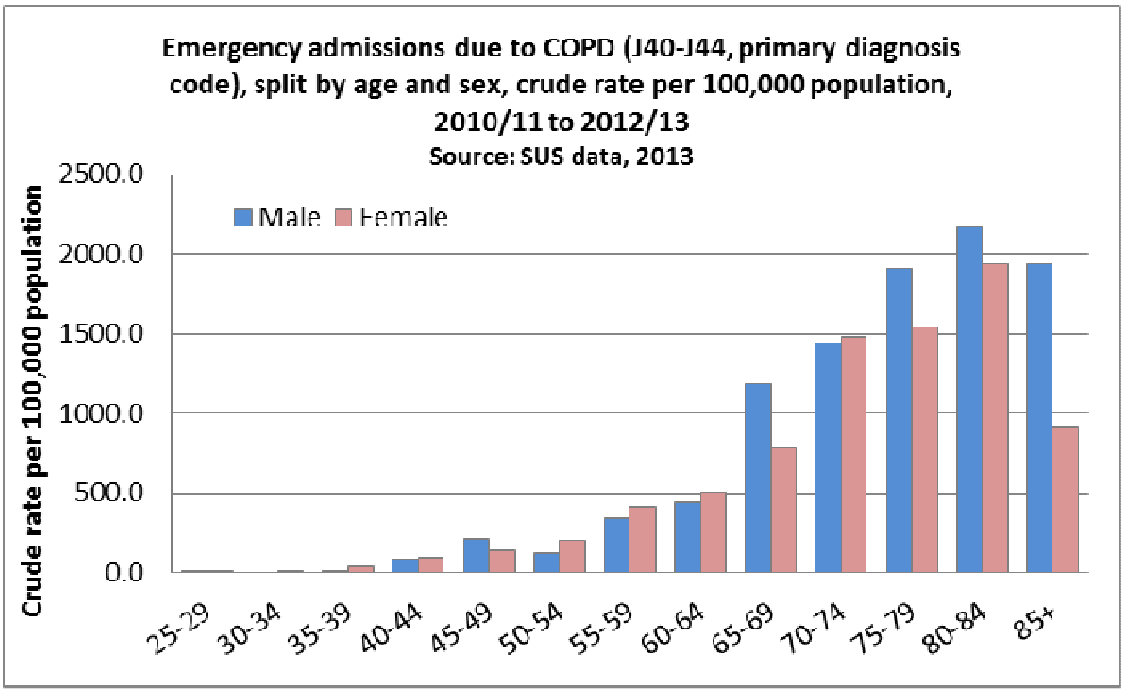
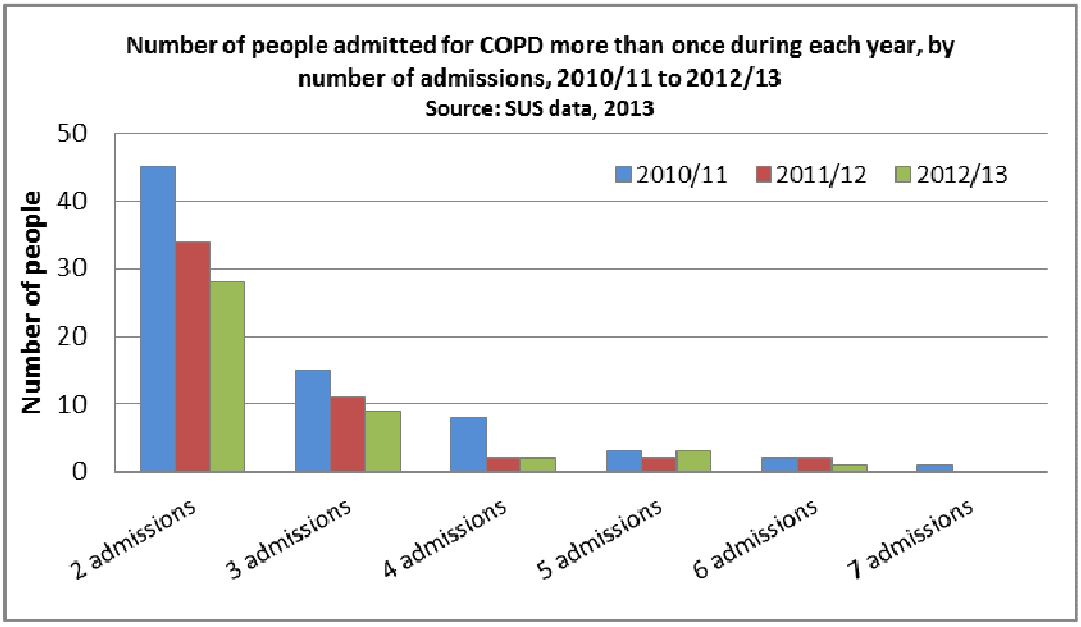


Figure 8 shows the number of patients admitted more than once during a year from 2010/11 to 2012/13. In Halton, most people who were admitted more than once were admitted either 2 or 3 times, with very few people being admitted more than this.

Figure 8: Number of people admitted for COPD more than once in a year



During 2012/13 there were over 100 readmissions due to COPD, however, the number, and percentage of total COPD admissions, has decreased from 2010/11.

	2010/11	2011/12	2012/13
Total number of admissions	452	331	358
Number of readmissions	201	131	112
Percent	44.5%	39.6%	31.3%

Halton Rapid Response Respiratory Team provide services for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and OSA. It provides an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

Halton Rapid Response Respiratory Team

About this service

The Team offer an award winning service for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and obstructive sleep apnoea.

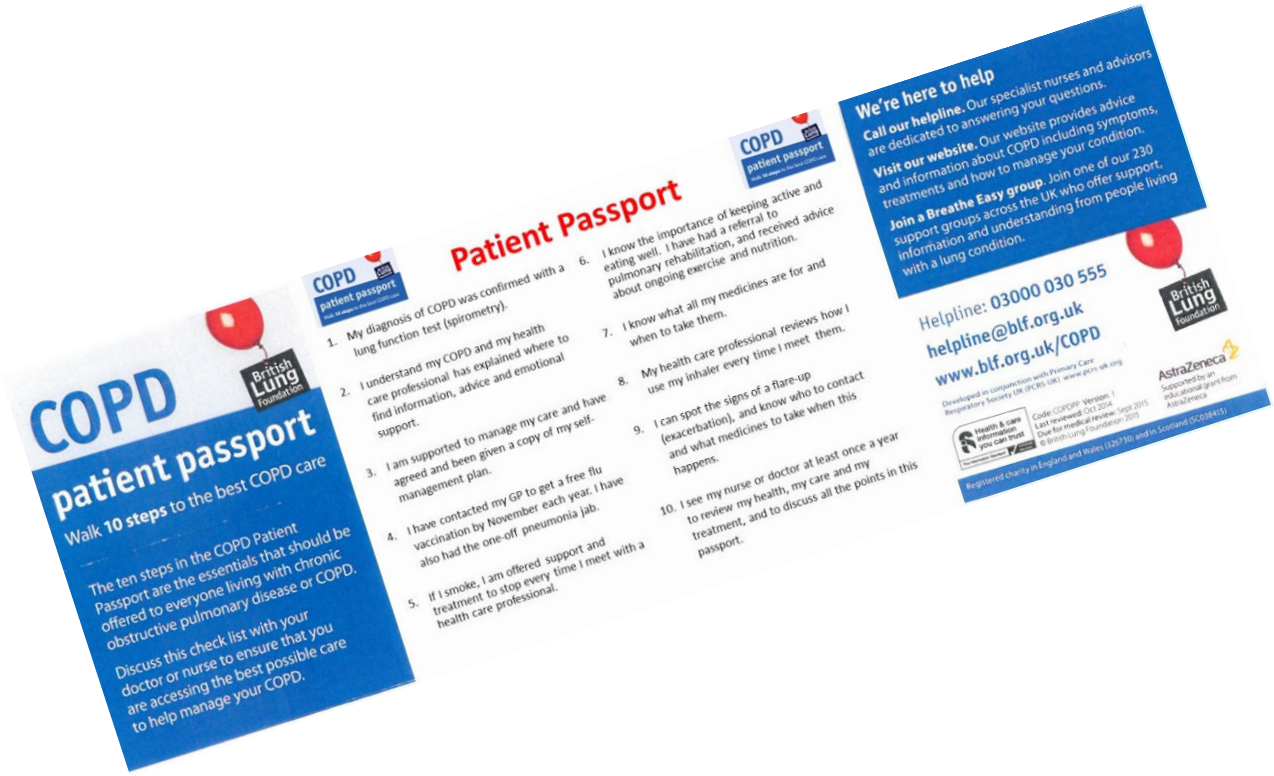
The Team aim is to provide an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

The team can be accessed by referral from the GP or hospital and will undertake an assessment to of what you need. Available services and information include:

- Respiratory assessment in your own home
- Pulmonary Rehabilitation
- Long-term Oxygen Therapy
- Ambulatory Oxygen clinics
- Nurse Led Clinics
- Physiotherapy led clinics

Patients are referred to the team either by the GP or the hospital with an aim to seeing each patient the same day or within 24 hours for advice, assessment, support, intervention and supported discharge.

British Lung Foundation's COPD Patient Passport, available through practices and Breathe Easy Groups, helps patients with COPD identify if they are getting the right care and support.



Bronchiectasis

Bronchiectasis is a condition characterised by chronic sputum production and a increased likelihood of developing frequent lung infections, often requiring hospital admission.

There is often pre-existing COPD. People with a suspected diagnosis of bronchiectasis should have the diagnosis confirmed by chest CT (computed tomography).

There has been a steady rise in the number of emergency admissions involving bronchiectasis over the last few years, from 62 in 2011/12, 92 in 2012/13 to 121 in 2013/14. The causes of this are unknown. Primary care management of patients and early identification and treatment of infections could prevent admissions. Physiotherapy has a major role in the management of bronchiectasis and self-help to enable patients to manage signs and symptoms better, helping to reduce infections and hospital admissions.

Halton Oxygen Assessment Service for Long Term Oxygen Therapy

Halton oxygen assessment service was formed in January 2009, following the introduction of the NICE COPD guidelines which recommended that all oxygen assessments should be completed in secondary care.

The service is run by **Senior Respiratory Nurse Specialists**. Our service is based with the Respiratory team at Halton General Hospital in block 4. Our working hours are **Monday-Friday 8.30am to 6.30pm,** our direct telephone number during these hours is **01928 753165.** We are also available on **Bank Holidays** and **weekends** from **8.30am to 6.30pm** on **01928 714567** - please ask for on call staff.

Our initial aim is to provide an up to date assessment for the people who are already on oxygen therapy so that they know what their oxygen needs are. As the service becomes more established and more funding becomes available we are hoping to expand the service and take open referrals. At this time we are limited to completing assessments on individuals with respiratory diseases, unfortunately there is no capacity for the assessment of cardiac related breathlessness at this time.

Referral criteria: Individuals should be considered for oxygen assessment if their oxygen saturations are <92% at rest on room air. To complete the oxygen assessment the individual needs to be stable (i.e. 6 weeks post exacerbation/chest infection).

Interstitial Lung Disease

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung. It is known that some ILDs are caused by cigarette smoke and others may occur as a reaction to medication and yet others occur in association with diseases such as rheumatoid arthritis. Finally, ILDs need to be distinguished from other lung conditions which they sometimes mimic.

Idiopathic pulmonary fibrosis (IPF), the commonest ILD, has shown a greatly increased prevalence over the past 20 years although local prevalence data is not easy to determine as a result of the range of conditions that could be included under the ILD definition.

NICE Quality Standard 79 identifies the set of 5 key statements which will improve the quality and standard for care for people with ILD, these should be adopted locally to ensure best quality of care for patients in Halton.

Statement 1	People are diagnosed with idiopathic pulmonary fibrosis only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.
Statement 2	People with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them.
Statement 3	People with idiopathic pulmonary fibrosis have an assessment for home and ambulatory oxygen therapy at each follow up appointment

	and before they leave hospital following an exacerbation of the disease.
Statement 4	Pulmonary rehabilitation programmes provide services that are designed specifically for idiopathic pulmonary fibrosis.
Statement 5	People with idiopathic pulmonary fibrosis and their families and carers have access to services that meet their palliative care needs.

Hospital admissions for ILD increase with age. **Figure 9** shows the admissions per 5 year age group for the period 2011/12 to 2013/14. The higher rates of admission amongst men are likely to reflect the work related nature of some forms of ILD, but the crude rates represent a significant burden on secondary care capacity.

The number of emergency admissions per year for ILD (**Figure 10**) has increased in the last few years. An assessment is needed to identify if this increase is as a result of increasing prevalence. There is also a need to assess if community and primary care management and services achieve quality standards locally to prevent emergency admissions.

Figure 9: Admissions by 5 year age band and sex, 2011/12 to 2013/14

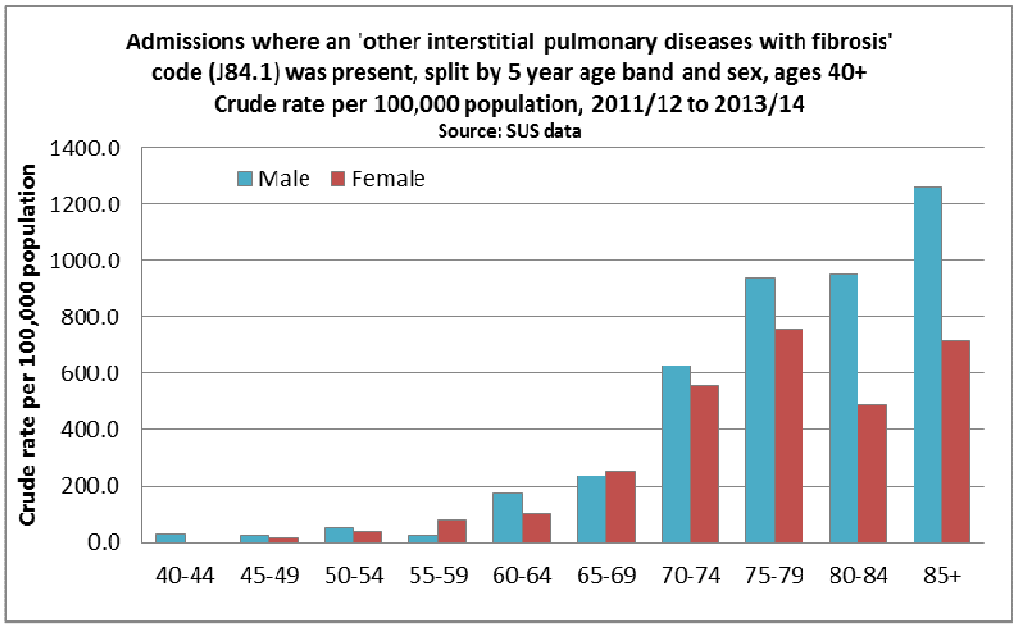


Figure 10: Number of admissions by year

Year	Elective	Emergency
2011/12	31	68
2012/13	33	95
2013/14	21	150

The median survival for IPF is just three years – a prognosis that is worse than many cancers. Lung transplantation is the only treatment proven to improve survival in some forms of ILD.

Ambulatory oxygen therapy (AOT) assessment

AOT allows the patient to leave the home and improves daily activities and quality of life.

The purpose of a formal **AOT assessment** is to:

1. Determine if the patient has evidence of exercise desaturation, which is defined as a 4% drop in SaO2 below 90%.
2. To determine the appropriate flow rate to correct exercise desaturation.
3. To see if an oxygen conserving device is appropriate for that particular patient

Who qualifies for AOT?

Ambulatory Oxygen only indicated in a number of conditions. There are 3 grades of patients who qualify for AOT.

- **Group 1**. On Long Term Oxygen Therapy with low activity level. This group **do not** usually require a **formal** AOT assessment. There flow rate is usually set to their Long Term Oxygen Therapy flow rate.

- **Group 2**. On Long Term Oxygen Therapy but are active.

- **Group 3**. Not on Long Term Oxygen Therapy but demonstrate exercise oxygen desaturation. In this group AOT should be considered only if there is evidence of improvement in exercise tolerance and dyspnoea and the Patient is motivated to use it.

Sleep-Disordered Breathing

Identification and diagnosis of Obstructive Sleep Apnoea is a key challenge. Once diagnoses has been made promotion and provision of lifestyle advice including assessment of weight and measures of obesity, with primary care support and access to community weight management service, smoking cessation and exercise provides a primary approach to reduction in symptoms. Halton Health Improvement Team are able to provide a wide range of lifestyle interventions which would improve outcomes for people with OSA, from diet and exercise based weight management to smoking cessation services and can receive referrals directly from primary care.

Bronchiolitis

Bronchiolitis usually presents with cough with increased work of breathing and it often affects a child's ability to feed. Symptoms are usually mild and might only last for a few days, but in some cases the disease can cause severe illness. There are several individual and environmental risk factors that can put children with bronchiolitis at increased risk of severe illness.

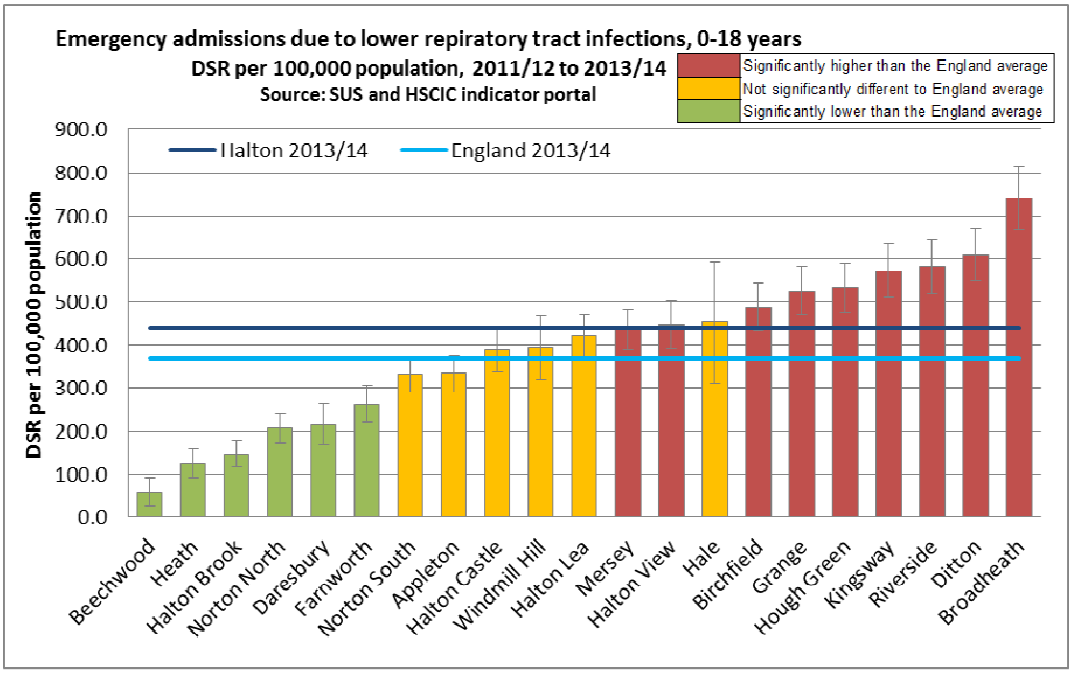
Most children with bronchiolitis present in primary care to a GP. The diagnosis of bronchiolitis is based on clinical assessment showing the presence of various characteristic symptoms and signs. Although bronchiolitis can usually be managed at home, approximately 3% of affected children are admitted to hospital. In 2011/2012 in England there were 30,451 secondary care admissions for the management of bronchiolitis.

The management of bronchiolitis depends on the severity of the illness. In most children bronchiolitis can be managed at home by parents or carers. In mild or moderate cases treatments that improve feeding and reduce the work of breathing could be beneficial. A range of treatments have been trialled, including: inhaled bronchodilators; inhaled corticosteroids; systemic corticosteroids; antibiotics.

Children in Halton are admitted as an emergency admission for lower respiratory tract infections (of which bronchiolitis is the most common) at a higher rate than the England average, and there is significant variation in the rate of admission across different wards within the Borough, which suggests that there could potentially be variations in the primary care management for children with respiratory infections. **Figure 11** shows the variation in emergency admission rate for lower respiratory tract infections for 0-18 year olds between 2011/12 to 2013/14 by ward across Halton. There is little correlation between the variations and the levels of local deprivation, or known lifestyle factors to explain the pattern in variation, which could suggest a potential primary care link (although the data is not presented by practice)

There are 6 wards with significantly higher admission rate for lower respiratory tract infections than the Halton average, and 9 wards are significantly higher than the England average emergency admission rate. During 2011/12 to 2013/14, 81.5% of all emergency admissions in Halton for lower respiratory tract infections were for children under 1 year of age, 79% of these were for acute bronchiolitis; for the rest of England this was 70%.

Figure 11: Emergency Admission due to lower respiratory tract infection in children 2011/12 to 2013/14



NICE are due to publish Guidance for the Diagnosis and Management of Bronchiolitis in Children in May 2015. This guidance needs to be assessed against local services provision and pathways to ensure that local case management and care follow the best practice guidance.

Actions for Primary Care and community based support

General

- Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.
- Pro Active Care programme Local Enhanced Service (2014/15)
- Review provision of pulmonary rehabilitation across Halton
- Establish integrated delivery of respiratory services across Halton
- Improve prescribing of respiratory medication across primary care

Asthma and COPD

- Implement standardised COPD and Asthma template across primary and secondary case
- Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.

● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD

● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

OSA

● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.

● Review the pathway for people with OSA

Bronchiolitis

● Rapid review (and application) of NICE Guidance when it is released in May 2015

● Review cause for practice variations in admissions for bronchiolitis across Halton practices

iii. High Quality Hospital Services

Conditions that affect respiratory health are numerous. They are often varied and often complex and need a multidisciplinary approach to treatment and management. In terms of ensuring appropriate high quality hospital services are available, this document will identify were improvements in the delivery can result in high impact changes for respiratory health conditions.

Nurse Led Clinic

The **respiratory nurses** at Halton and Warrington Hospitals run nurse led clinics. These are done in conjunction with **Respiratory Consultants** and are in parallel to their clinics. If the nurse feels the patient is not responding to treatment or needs further advice, they can discuss the patient with the consultant.

Types of patients seen in the clinics are;

- Medication review and optimisation of medication
- Trial of nebuliser
- Post discharge
- To review pulmonary function tests
- To review post discharge
- Review medication change
- To assist in diagnosis, such as asthma
- General monitoring of patients
- Prior to pulmonary rehabilitation
- Following pulmonary rehabilitation
- Following rapid response respiratory team input
- Request from consultant
- GP requests

The clinics run on **Tuesday mornings**, in the Delemere Centre, Halton and **Thursday afternoons**, clinic A, Halton. **Monday afternoon**, OPD clinic Warrington.

Patients can be referred to the clinic by letter to the respiratory nurse, Block 4, Halton General Hospital or respiratory support team, A7/A8 corridor, Warrington Hospital.

Patients cannot self-refer to the clinic, this must be done by a health professional.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can worsen and in the short-term lead to potentially life threatening symptoms, but in the longer term can lead to irreversible damage to the lungs

Once a diagnosis of asthma has been achieved, information about asthma which is relevant, easy to understand and in an accessible format should be provided to the patient and their family. Those diagnosed should all be provided with an individual asthma management plan including relevant contacts and what to do in the event that their asthma becomes uncontrolled, including training in inhaler technique to support effective self-management strategies for the condition. All patients with asthma will receive treatment appropriate to the severity of their Illness.

With regard to children there is a multidisciplinary asthma pathway in place at St Helens & Knowsley Acute Hospital Trust for children who present at A&E, which incorporates issuing of self-management plans. Follow ups take place with the GP. At Warrington & Halton Hospitals Foundation Trust there is a similar A&E Pathway, which incorporates issuing of an Asthma/Wheeze Management Plan. Follow ups take place in an asthma clinic at Springfield Medical. Asthma UK self-management plans have also been made available to all GP practices for use in annual reviews to ensure those children who do not attend secondary care services also have the choice for robust self- management.

COPD

COPD is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery.

As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease. Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

Lung Cancer

Liverpool Heart and Chest Hospital is the local specialist unit for Lung Cancer. It is essential that decisions are made efficiently as a patient identified in primary care, or via a local hospital will often need to be referred to a different provider for specialist treatment.

Timeliness of referrals between trusts for cancer treatments is monitored on a regular basis in line with national cancer waiting time targets. This process allows the identification of any recurrent issues in relation to cancer pathways and allows multidisciplinary discussion to take place to work towards improving them.

From April 2013, diagnostic imaging has been unbundled from the Outpatient tariff (PbR Guidance 13/14), which includes; Magnetic resonance imaging (MRI) scans, Computerised tomography scans (CT), Dexa scans, Contrast fluoroscopy procedures, Non-obstetric ultrasounds, Nuclear medicine and simple echocardiograms. There is local commitment (from the CCG) to working with healthcare providers to explore options for direct access, in particularly direct GP access to diagnostics that will aid with the diagnosis of lung cancer including MRI, ultrasound and chest X-Ray.

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. Together these represent a major demand on primary and particularly hospital care.

We need to ensure that we have adequate primary and community provision in place so that we can maximise admission avoidance wherever possible and ensure people can be treated successfully in the community and at home. From secondary care, we need to ensure that early assessment and discharge schemes can be effectively utilised to reduce delays in effective treatment and subsequently the length of hospital stay, thus optimising the use of hospital beds and reducing the considerable costs of such conditions.

Actions for High Quality Hospital Services

General

- Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
- Review current arrangements regarding Halton adult residents admitted to Whiston Hospital with respiratory health problems

- Review current arrangements regarding Halton children & young people admitted to Halton and Warrington Hospitals and ST Helens and Knowlsey Hospitals with respiratory health problems
- Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

iv. Promoting Self Care and Independence

Improving health outcomes for people with respiratory disease not only requires appropriate medical interventions but also enhanced communication, knowledge, skills, and the development of a therapeutic alliance between the patients and the healthcare professional. All patients with respiratory disease and/or their carers should strive to become better informed. Every effort should be made to equip patients, carers and families with the necessary knowledge and skills to improve decision making and thereby improve outcomes.

Education is key to improving awareness of respiratory disorders and associated symptoms, helping achieve an earlier diagnosis and improved self-management.

Having confident and informed respiratory patients at the centre of the decision-making processes will allow them to take ownership of their conditions leading to fewer unplanned primary care consultations, reductions in visits to outpatient departments, reduced hospital admissions and reduced length of stays in hospital.

Individuals with chronic lung disease benefit greatly from a multidisciplinary approach to care and gain the most benefit from this care if delivered in the community, closer to home. This ensures that individuals have two key elements of care: physical and psychological support. These are important, when living with such chronic disease, to help the individual cope with distressing symptoms such as breathlessness, as well as ensuring that respiratory infections are treated earlier to prevent worsening structural damage to the lungs. Professionals involved in supporting individuals with respiratory conditions should be trained in techniques which build self-sufficiency in their clients and address health related behaviours such as smoking and obesity. Pulmonary rehabilitation provides many aspects of this care and should be available locally for all patients with chronic lung disease.

Pulmonary Rehabilitation

Pulmonary rehabilitation is a programme of exercise and education for people with long-term chest problems designed to help patients manage breathlessness due to respiratory conditions. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. The service in Halton is provided by Warrington and Halton NHS Foundation Trust's Rapid Respiratory Team. The programme runs twice weekly for 6 weeks. Each session comprises of 1 hour of individualised exercise and 1 hour of education. Each person receives a resource pack on completion with all aspects of education topics included and encouragement for people to continue with exercises at home after they have completed the course in order to maintain the benefits it produces. There are a number of ongoing exercise classes arranged for pulmonary rehabilitation patients the Halton Health Improvement Team.

- Between March 2012 and December 2013, 420 patients attended Pulmonary Rehabilitation in Halton. 69% at Halton Hospital and 31% at Ditton Community Centre.
- The largest referrers were GPs, Respiratory Consultant (Halton) and respiratory physiotherapists. Of the GPs, Castlefields, Weavervale and Grove House referred the most patients.
- Of those that attended; 171 patients completed at least 9 of the 12 sessions, 64 patients partially completed (<9 sessions), 49 did not attend and 101 were unable to attend due to illness.
- As of June 2015 there were 22 people waiting for an appointment for assessment with a waiting time to assessment of 10 weeks. The service currently sees around 17% of people with respiratory illnesses.

Pulmonary rehabilitation

The programme

Pulmonary rehabilitation is an exercise and educational programme designed to help patients manage breathlessness due to respiratory conditions such as COPD. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. For more detailed information about pulmonary rehabilitation there are links to the NHS Choices and British Lung Foundation Websites below.

We run a six-week programme which patients attend twice weekly for two hours. Classes will run every Monday and Friday in Runcorn and Tuesday and Thursday in Widnes.

Pulmonary rehabilitation is available both in Widnes and Runcorn; all sessions are in the afternoon.

Who should be referred?

Patients with a diagnosed respiratory condition with symptomatic breathlessness do well on this course.

Expert Patient programme

The Expert Patients Programme (EPP) is a self-management programme for people living with a chronic (long-term) condition. The aim is to support people by:

- increasing their confidence

- improving their quality of life
- helping them manage their condition more effectively

Local Authority Public Health have just commissioned an extension of the Expert patient programme which will encourage people to live healthy active lives, better manager their own conditions and be able to be more involved in decision making around their care.

Asthma

The children's multidisciplinary asthma pathway at St Helens and Knowsley Acute Trust and Warrington & Halton Hospitals Foundation Trust for children presenting at A&E incorporates self-management plans and guidance on self-care. School nurses also signpost parents/carers to access their GP/Practice nurse for appropriate asthma management as necessary.

Lung cancer

The Runcorn and Widnes Cancer Support Group has been providing numerous support services for a number of years ranging from basic information, to caravan breaks, it offers support and information on the whole range of cancers including lung cancer. Funding for the service has been agreed collaboratively between the CCG, Halton Borough Council and Public Health going forward and the service will continue to receive referrals from a variety of health professionals across the locality including GP's and social services and explore ways to raise awareness of the service across Halton.

Integrated Breathe Easy Project

The British Lung Foundation's Nesta-funded 'Integrated Breathe Easy project' aims to increase self-care opportunities for people affected by respiratory illness. Halton Clinical Commissioning Group is working in partnership with BLF to support the development of two new groups (Widnes and Runcorn). The groups provide peer support and access to a wide range of information that enhances and supports wellbeing. The groups are part of a national project seeking to establish the value of group-delivered self-care due to report in June 2016.

Breathe Easy Widnes	**Breathe Easy Runcorn**
Where: Ditton Community Centre, Dundalk Road, Widnes, WA8 8DF **Date:** First Tuesday of each month **Time:** 12.30pm to 2pm	**Where:** Palacefields Community Centre, The Uplands, Runcorn, WA7 2UA **Date:** Second Wednesday of each month **Time:** 12.00pm to 1.30pm

Patients, Friends, family or carers are welcome to just turn up
There is usually a respiratory healthcare professional in attendance

Breathe Easy groups provide support and information for people living with a lung condition, and for those who look after them.

Groups hold regular meetings, usually monthly, where people can meet and talk to others, share their experiences and learn from each other. Regular speakers can also share information about living with their condition and coping with the emotional aspects of having a lung condition.

They also raise awareness locally about lung conditions, their group and the BLF.

Breathe Easy Case study

"When I returned from Australia I found that I was unable to walk my dogs, walk up slopes or even bend down without getting out of breath. I then caught flu which also affected my chest quite badly. I visited my practice nurse who gave me spirometry and informed me my lung age was 80. I was prescribed an inhaler and told to come back in 4 weeks. My flu got worse. Two weeks later I collapsed and ended up in hospital. I was prescribed antibiotics. I felt down as I used to be so active. Four weeks later when I saw my nurse again she gave me the BLF COPD leaflet and told me that I had COPD. I went home and cried and felt really down again. I read the leaflet which really helped but I still felt panicky. I then went on to the BLF website and found out that there was a Breathe Easy group in Runcorn and the next meeting was imminent. I went along to the Breathe Easy group meeting and haven't looked back. I found BLF information including the BLF COPD passport available and it was so good to meet and chat to other members who have the same condition as me. They gave me advice and tips at that meeting. I took a copy of the COPD passport away and went with my daughter to see my GP who went through each step and explained what it meant. At the next Breathe Easy meeting the community respiratory nurse talked to us about inhalers and inhaler technique. I realised that I had been using mine incorrectly and the nurse showed me how to use it properly. When I visit the chemist they sometimes call me in to ask me about my medications and I had been prescribed a new inhaler. We tried to work out how to use it but I realised that I had been using it incorrectly until the nurse showed me at the Breathe Easy meeting. Next time I am at the chemist I am going to tell them the correct way. I am also waiting to go on a course of pulmonary rehabilitation which I am looking forward to. Sometimes I still feel down but I can honestly say that since joining the Breathe Easy group I have felt so much better and it has changed my life; I know that it is not the end. I have also joined other local groups and realise that I can lead a full life."

Actions for Promoting Self-care and Independence

- Develop a range of interventions to support self-management
- Improve the feedback of patients and carers on their experiences of respiratory services
- Further develop and expand the Expert Patients Programme

Recommendations

There are key actions to be considered in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton that are highlighted at the end of each chapter. These actions form the key recommendations of this strategy and are summarised below:

I. Prevent respiratory ill health

Smoking

● Increase the number of people attending Smoking Cessation Services in Halton
● Reduce the proportion of people smoking in Halton

Vaccination

● Increase the uptake of flu vaccination amongst at risk groups, to achieve national target
● Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity

● Improve access and uptake to lifestyle advice across the borough
● Increase the proportion of people taking regular daily exercise in Halton

Drugs

● Improve education and awareness of the impacts of cannabis use especially preventing young people from starting to use cannabis.

Housing

● Increase access to grants and equipment to increase energy efficiency in People's homes
● Continue to work across the private rented sector to improve housing standards

Environment

● Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport
● Identify opportunities to further improve air quality across Halton

II. Earlier detection of respiratory diseases

Cancer

● Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer
● Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

Chronic Obstructive Pulmonary Disease

● Encourage improved and early case finding to facilitate better management and treatment access

● Develop and implement a Borough wide, inclusive community spirometry service

Interstitial Lung Disease

● Ensure risk markers are identified on patient records, known risk occupations etc

Obstructive Sleep Apnoea

● Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability

● Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.

● People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

III. Primary Care and Community based support

General

● Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.

● Pro Active Care programme Local Enhanced Service (2014/15)

● Review provision of pulmonary rehabilitation across Halton

● Establish integrated delivery of respiratory services across Halton

● Improve prescribing, in line with guidance[18], of respiratory medication across primary care

Asthma and COPD

● Implement standardised COPD and Asthma template across primary and secondary case

● Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.

● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD

● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

[18] Pan Mersey Area Prescribing Committee Guidelines http://www.panmerseyapc.nhs.uk/guidelines.html

OSA

● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.
● Review the pathway for people with OSA

Bronchiolitis

● Rapid review (and application) of NICE Guidance when it is released in May 2015
● Review cause for practice variations in admissions for bronchiolitis across Halton practices

IV. High Quality Hospital Services

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● Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
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● Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

V. Promoting Self Care and Independence

General

● Develop a range of interventions to support self-management
● Improve the feedback of patients and carers on their experiences of respiratory services
● Further develop and expand the Expert Patients Programme

The recommendations will be translated in to the Respiratory Action Plan and progressed assessed against these, and current actions by the Respiratory Health Group

How Will We Know Strategy Is Successful?

By 2020 this strategy will have;

I. Embedded respiratory health into a range of preventive programmes and be seeing a decline in prevalence of a number of key preventable respiratory illnesses.
II. Improvements in smoking quit rates and increase number of people referred to smoking cessation services.

III. Increased uptake of flu vaccination amongst those with existing respiratory conditions and amongst those with other on term health conditions, including those with learning disability, to mitigate the effects of flu on general respiratory health.
IV. Improved awareness within the general population of factors that prevent and protect against respiratory ill health, enable earlier identification of problems and health seeking behaviours.
V. Improved the recognition, diagnosis and management of a variety of respiratory illnesses (including COPD, asthma, lung cancer) within primary care.
VI. Developed a range of interventions and support to enable individuals and their carers to better 'self–manage' their respiratory condition.
VII. Involved more individuals and their carers in the planning and quality assurance of respiratory health services.
VIII. Improved the pathways between primary, acute, residential, nursing and social care for individuals and their carers.

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Many thanks to the Halton Respiratory Strategy Group, and other colleagues who have contributed to the development of the strategy.

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Document Summary

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Respiratory Strategy for Halton 2015 – 2020,

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