This report is intended for UK Healthcare Professionals (HCPs) and Other Relevant Decision Makers (ORDMs).

GSK

System Leaders Forum 2026

Collaborating today to improve healthcare tomorrow

A white paper report

This summary report was produced by HSJ Information, and was commissioned and fully funded by GSK.

NP-GB-CAU-BKLT-260001 | June 2026

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Contents

The views expressed in this report are those of the participants and not necessarily those of GSK.

Foreword

Professor Michael G Crooks
Professor of Respiratory Medicine,
NHS Humber Health Partnership
and University of Hull

As a respiratory physician, I see every day how breathlessness affects people's lives. It limits mobility, independence, work, sleep, relationships and confidence. It can also be a stark marker of wider inequalities, with respiratory diseases disproportionately affecting those from more deprived communities. Respiratory disease is the third biggest cause of death in England, and respiratory conditions remain the leading cause of emergency hospital admissions in England. Asthma and COPD alone are estimated to carry an annual economic burden of approximately £4.9 billion to the NHS, with £3 billion and £1.9 billion for asthma and COPD, respectively. COPD affects around 3 million people in the UK, yet more than half of those living with the condition are thought to be undiagnosed. These are not abstract statistics. They represent people who may only come to the attention of the NHS when they are already in crisis.

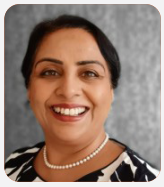
That is why this event was so important. It brought together clinicians, system leaders, patient representatives, charities and industry partners to ask a practical question: how do we move respiratory care from a reactive, hospital-centred model to one that finds people earlier, intervenes sooner, and supports them better in the community? The discussions were clear that incremental improvement is no longer enough. We need earlier and more accurate diagnosis, better use of data to identify people at risk, more consistent optimisation of treatment, improved access to pulmonary rehabilitation, smoking cessation and vaccination, and stronger neighbourhood models that join up primary care, community services, hospital specialists, local authorities and the voluntary sector.

I was particularly struck by the afternoon pitch session. It introduced a new and energising dynamic into the conversation. Rather than simply restating the burden, participants had to design credible, investable models of care that could be tested, scaled and sustained. The proposed solutions focused on practical priorities: risk stratification in primary care, community respiratory hubs, outreach into underserved neighbourhoods, virtual wards, digitally enabled COPD care bundles and respiratory champions embedded in primary care networks. The format created momentum because it asked people to think not only about what should change, but how it could be delivered, funded and measured.

For senior leaders across the health and social care system, the message is clear. Respiratory care represents a significant system performance challenge, with important implications for health inequalities and population health. If NHS partners and industry can work together transparently, with shared priorities and strong governance, there is real potential to strengthen data capability, redesign pathways, generate evidence, support implementation and scale what already works.

This report captures both the urgency and the opportunity. The next step is to turn ambition into delivery, so that people with respiratory disease are diagnosed earlier, consistently treated to a high standard, and supported to live well.

Chairs' Statement



Jyotika Singh
Senior Principal Consultant,
HSJ Information

It was a privilege to chair this forum and to help shape this report, which captures an important and timely discussion on the future of respiratory care. The discussion reinforced the need for stronger system-wide collaboration to address rising demand, unwarranted variation and persistent health inequalities.

What stood out to me was the shared ambition to move beyond fragmented, reactive care towards a more proactive model, with earlier diagnosis, population health management, better use of data and more consistent pathways. The innovation pitch discussions gave delegates valuable headspace and practical tools to develop solutions, build confidence and think about how to take ideas back into their own organisations.

Meaningful transformation will require clinical leadership, aligned commissioning, patient involvement and purposeful partnership with industry, in line with NHS priorities and the Life Sciences Sector Plan. The call to action is clear: improving respiratory care depends on shared accountability, scalable innovation and sustained collaboration.

Manu Sharma
Head of Market Access,
GSK

In my role as Head of Market Access at GSK, I have the opportunity to work closely with NHS leaders and see the significant pressures they are facing as they strive to deliver better patient outcomes while navigating financial constraints, rising operational demand and ongoing system change. For many leaders, the task can feel increasingly difficult: improving patient care while operating in an uncertain and dynamic environment.

Respiratory disease helps bring these challenges into the spotlight. It affects one in five people and continues to drive avoidable admissions and health inequalities. In the year ending March 2024, there were around 120,000 emergency admissions for COPD in England, a 9% increase on the previous year. Behind these figures are patients whose care could potentially be more proactive, integrated and equitable.

That is why this inaugural System Leaders Forum matters. It creates space for senior NHS leaders to step back from immediate pressures and envision what a more sustainable model of respiratory care could look like. It also provides an opportunity to explore how strategic commissioning, service delegation and the emerging 10-Year Health Plan can support practical transformation on the ground.

At GSK, we recognise that industry has a responsibility to engage with the NHS in a way that is focused on shared priorities. Market access is not only about enabling access to medicines. It is also about understanding the wider service barriers that sit across pathways and working with the NHS to support optimal patient care.

Through collaborative working, respiratory transformation initiatives and forums such as this, there are opportunities to support improvements in patient care and service delivery. My hope is that this report captures not only the scale of the challenge, but also the ambition, ideas and partnerships that may contribute to a more sustainable and equitable future for respiratory care across the UK.

Executive summary

There remain significant gaps in meeting the needs of people with respiratory disease. Fragmented service delivery and inconsistency of care across England remain key barriers to service improvement.

The problems:

- Respiratory conditions are the leading cause of emergency hospital admissions in England. COPD is a chronic, progressive condition driving significant burden on patients, the NHS, and the economy.
- More than half of people with COPD are undiagnosed; those who are diagnosed sometimes receive suboptimal care, fuelling potentially preventable exacerbations, A&E attendances, and hospital admissions.
- Early diagnosis and prevention represent key opportunities for impact, yet many patients experience challenges in accessing timely diagnosis and may feel unprepared when their condition deteriorates.

The solutions:

- Incremental change is no longer enough. A unified vision and genuine system-level collaboration are needed, with patients at the heart of everything through meaningful co-design and engagement with patient groups which is essential, not optional.
- Integrated pathways must move from concept to delivery, with neighbourhood teams, commissioners, providers, and the voluntary sector aligning around a single respiratory pathway, with improving population health and reducing health inequalities an explicit priority throughout.
- Post-acute care offers quick and significant gains in outcomes and should not be overlooked.
- Community pharmacy remains underutilised in some areas of respiratory care and has the potential to play a greater role, including through the expanding role of independent prescribers.
- Better use of data and population health management, including identifying undiagnosed patients, targeting high-risk cohorts, and managing exacerbations proactively can support improved respiratory outcomes. These approaches may be facilitated by improved system-wide data sharing and, where appropriate, by collaborative NHS-industry partnerships.
- Many of the components needed already exist. Delivering impact will depend on navigating the system to unlock resource, foster new ways of working, and scale what is proven.

Ultimately, the forum message was simple: system performance depends not only on getting the fundamentals right and delivering them consistently at scale, but also on rethinking pathways, roles and technologies to meet rising respiratory demand through timely diagnosis, prevention and innovative care.

Background

In March 2026, a panel of healthcare professionals (HCPs) with expertise in respiratory disease, system leaders, and patient representatives from the charities COPD Voices and Asthma + Lung UK convened at a non-promotional discussion forum initiated and fully funded by GSK and delivered with HSJ Information.

The aim of the forum was to discuss the burden of respiratory care on healthcare systems and how respiratory conditions are prioritised and managed in practice in order to identify new models and care pathways.

Objectives

- Gain insight into the burden of respiratory care for COPD and other respiratory disease on healthcare systems
- Understand the roles of ICBs in shaping integrated respiratory pathways
- Understand how respiratory care is prioritised among other priorities
- Understand how respiratory care is aligned with population health management

- Explore innovative models of care
- Discuss commissioning levers and practical steps to support service improvement
- Identify enablers and measures of success and key performance indicators
- Discuss how to develop the workforce to implement the strategy
- Discuss what a new model of care could look like, focusing on care delivered closer to home

Reflecting the views of the forum, this white paper has been developed by HSJ Information with the support of Jemma Carter and Kieran Brown. The report was funded by GSK, who reviewed the report for accuracy.

Expert speakers and discussion leads

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Introduction

Clinical perspective

Respiratory disease is the third biggest cause of death in England[1]

Respiratory conditions are the leading cause of emergency hospital admissions in England,[2] and asthma and chronic obstructive pulmonary disease (COPD) alone have an annual economic burden on the NHS in the UK of approximately £4.9 billion.[3]

COPD is a chronic and progressive condition, driving morbidity and mortality

It is estimated that 392 million people globally have COPD, which is reported to affect around 3 million people in the UK.[4,5,6] More than half of people with COPD are estimated to be undiagnosed.[7] Patients reduce their physical activity early in the disease course, even before they are diagnosed with COPD.[8]

COPD exacerbations are associated with patient, economic and environmental burden

For patients, COPD exacerbations drive disease progression and have significant associated mortality.[9,10]

Lung conditions and COPD specifically also have direct costs to the NHS, with COPD exacerbation-related healthcare resource utilisation a major driver of direct costs.[11,12]

Many COPD patients have their first exacerbation before diagnosis[13] and people with COPD often experience variation in access to optimal care

COPD patients often struggle to access a diagnosis and feel unprepared for their first exacerbation and their early experiences can impact future behaviour.[14]

'For about two weeks I'd been struggling with my breathing…and then one day I just hit the floor, couldn't breathe. They rushed me into [the emergency department]. I wasn't prepared for hospital, no.'

'I did not expect it [exacerbation]; I just expected to slowly get worse.'

Patient quotes are illustrative of individual experiences and may not be representative of all people living with COPD.

More than two-thirds of patients with newly diagnosed COPD had healthcare events consistent with COPD during the five years prior to COPD diagnosis, including probable exacerbation events.[13]

Prevention, diagnosis, treatment and reducing inequalities and inequities all offer opportunities for improvement in the management of COPD and other respiratory conditions.

Patient perspective

The Life with a Lung Condition 2025 survey undertaken by Asthma + Lung UK found that people face serious challenges in terms of their health and getting the care they need[15]

Almost 1 in 4 waited ≥ 5 years for COPD diagnosis[22]

Almost 1 in 8 waited ≥ 10 years for COPD diagnosis[22]

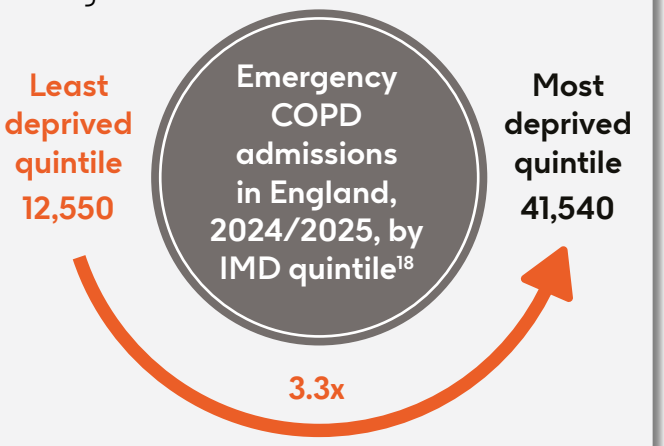
Only 9% received good basic care and support[15]

Five of the 15 highest mortality inequalities in England during 2021–2023 related to respiratory conditions[16]

People with respiratory conditions face some of the starkest inequalities in mortality, with these conditions showing among the widest differences in death rates between the most and least deprived communities.[16]

Across the country, respiratory admissions and death vary considerably between regions[17]

Inequities exist in access to diagnosis, quality of care, and outcomes in England. A clear north–south divide is seen, with the bottom 10 ICSs for respiratory admissions and death rates predominantly in the north of England.[17]

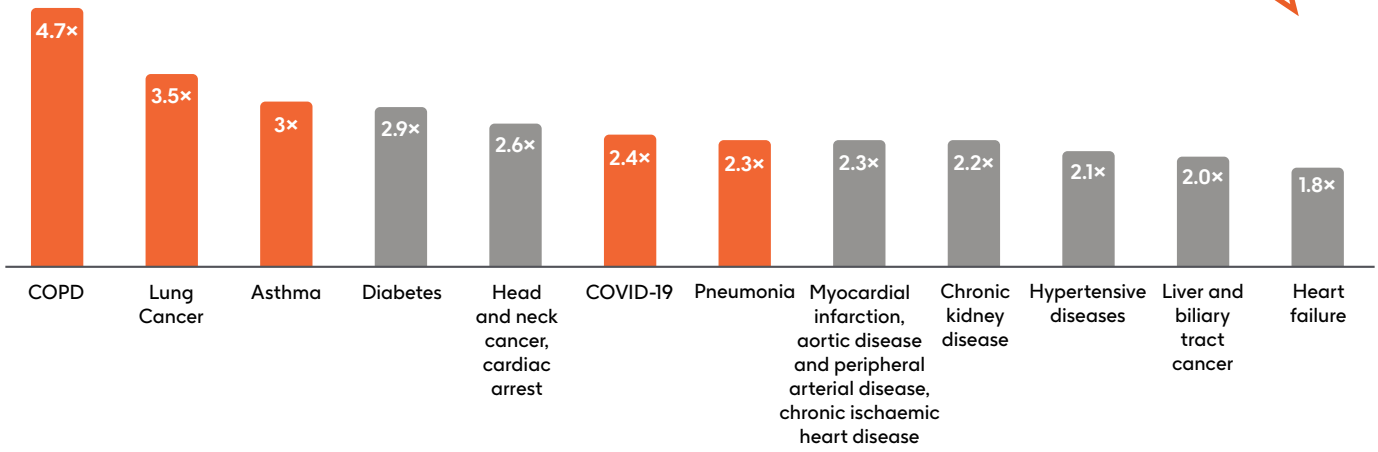


"Of the many indignities associated with being poor, or relatively so, having increased risk of chronic obstructive pulmonary disease or dying of lung cancer or pneumonia are among the worst."

"The tragedy of it is that we know quite a bit about what to do to prevent this needless suffering."

Sir Michael Marmot

Highest mortality inequalities between most deprived areas and least deprived areas[16]



Setting the vision: strategic direction for respiratory care

Summary

A medium-term commissioning model for respiratory care should invest upstream in prevention, early community diagnosis, optimisation of treatment options throughout the pathway, including for advanced treatments in line with national and local guidelines. This model should use integrated data and risk stratification to target those most at risk, aiming to reduce inequalities, emergency attendances and hospital admissions.

Change needs to be driven through quality improvement and neighbourhood working, with strong clinical, commissioning and GP leadership and a consistent, personalised, proactive model of care that recognises patients as key managers of their condition.

Throughout, the focus must remain on what matters to people, using optimism and cross-system partnerships to make every contact count and deliver joined-up, place-based care that empowers patients.

The discussion painted a picture of a respiratory system that needs to shift its centre of gravity away from reacting to crises and towards proactively preventing them. Rather than commissioning activity in a narrow sense, the emphasis was on commissioning for better patient outcomes while ensuring equity of access. This will require ensuring patients get the right treatment, including advanced treatments where appropriate, in line with local and national guidelines, at the right time at the right place, and contributing to addressing health inequalities by increasing diagnostic capacity and focussing it in geographical areas and community services with the greatest need (e.g. drug and alcohol services, outreach services, and non-health/non-traditional community settings).

Preventative measures

Early, accurate diagnosis

Interventions with potential to improve outcomes

- Increasing diagnostic capacity, focusing on geographical areas and community services with the greatest need
- Improving adherence to treatment plans
- Improving timely access to appropriate treatments, including advanced therapies and pulmonary rehabilitation

Make the diagnosis, start the treatment, improve the outcome, prevent admission and readmission

The concept behind the 10 Year Health Plan for England's three shifts[19] is that by finding people earlier in the course of their disease, more proactive and personalised intervention, and a stronger focus on prevention, the system can reduce the overall burden of respiratory illness and tackle stark inequalities in who gets access to, and benefits from, care. Over time, this should translate into a reduction in the acute care burden, through fewer emergency department (ED) attendances and hospital admissions.

Underpinning this is a population health approach that uses data not simply to describe problems but to actively target solutions. Integration of information across primary and secondary care – including prescribing patterns, admissions, and use of pulmonary rehabilitation – allows systems to identify which patients and communities are most at risk. Alongside this, proxy indicators such as rescue pack use, vaccination uptake, deprivation quintile, and smoking status can flag people on a trajectory towards poorer outcomes. The aim is to move from a passive, reactive model to one where risk stratification and proactive care are the norm, allowing resources to be focused where they can have the greatest impact and where inequalities are currently widest.

Driving better neighbourhood health

Delivering this change is not just a technical exercise; it requires a conscious quality improvement mindset and new ways of working at neighbourhood level. The panel highlighted models where specialist respiratory teams reach out into general practice, helping to train and upskill primary care HCPs, identify priority patients, and run multidisciplinary team (MDT) reviews – for example, using frameworks like the COPD OPTIMISE approach.[20] These MDTs then co-design care plans, implement evidence-based, high-value interventions, and ensure care is aligned to latest best practice. Neighbourhood working becomes the method through which changes are tested, refined and embedded rather than relying solely on top-down directives.

The OPTIMISE approach[20]

- **O**ptimal treatment
- **P**ulmonary rehabilitation
- **T**obacco dependence services
- **I**nhaler technique
- **M**aximising vaccination coverage
- **I**ncreasing physical activity
- **S**upport for psychosocial wellbeing
- **E**ducation & self-management

None of this happens without the right leadership. Respiratory clinical leaders have a critical role in championing new models of care and engaging with neighbourhood and population health teams. Commissioning leaders, in turn, need to unlock investment, develop compelling business cases, and align incentives with the outcomes the system is trying to achieve. Most care for COPD takes place in primary care, and GP leaders sit at the interface, helping to bring general practice with them, shaping local key performance indicators (KPIs), and making sure any additional asks of primary care are matched with the right support and resources. Together, these leadership roles create the conditions for sustained improvement. However, with ICBs merging, some leadership roles in primary care are being lost or diluted – potentially weakening primary care representation at system level at a time when a stronger presence is needed.

From the patient's perspective, the ideal model of care is not defined by organisational structures but by how it feels and what it delivers. The panel cautioned against thinking

there is a single 'patient voice' that can be leveraged for the system's purposes. There is no one voice, and the point of all this work is not to comply with policy priorities or chase targets but to deliver better outcomes and experiences for patients. That means resisting the pull of jargon and shifting initiatives, and instead staying grounded in what matters to patients – both in terms of the ends (health and quality of life) and the means (how care is delivered and relationships are built).

Ideal model of care: the patient perspective

Consistent

- Reliable access
- Consistent standards of care

Proactive

- Earlier diagnosis and identification of those at risk
- Self-management plans and action plans
- Proactive monitoring and post-exacerbation reviews

Personalised

- Care tailored to
  - individual circumstances
  - goals • preferences

Empowering patients

- The patient is a key manager of the condition and must be:
  - informed • supported • empowered

Respiratory care needs a confident and constructive narrative. While the field has too often been overlooked, focusing only on risks weakening momentum. Practical optimism, grounded in clear solutions, could potentially be more likely to secure attention, investment and support. At the heart of this should be a nationally led prevention strategy, with smoking cessation as a core priority across respiratory care and wider population health. This will require a clear government framework, sustainable funding and shared accountability across departments.

There is already a strong foundation of dedicated professionals, effective local models and significant potential for improved outcomes. A suggested next step is to get colleagues outside the respiratory world excited about this agenda and to make every community contact count, whether in general practice, community clinics or pharmacies. Neighbourhood working between the NHS, local authorities and the voluntary sector should become routine, with stop-smoking services protected as essential provision and a focus on service provision to communities with the greatest need to address health inequities. Alongside action on wider determinants such as housing and isolation, and workforce development to support consistent standards, this would help create a joined-up place-based system supporting improved respiratory outcomes and addressing health inequalities.

Key practical priorities

Make every contact count

- Upskill all community healthcare professionals (including pharmacy teams)
- Early, accurate community-based diagnosis is essential
- Consistent interventions: tobacco dependence treatment, vaccination, antimicrobial stewardship, personalised self-management

Ensure patients have access to the right treatments at the right time

- Developing clinician confidence and competencies to develop treatment plans with patients
- Improving timely access to appropriate treatment, including advanced therapies where in line with local and national guidelines, and using levers such as patient-initiated follow-up (PIFU) to reduce the burden in secondary care and reserve capacity for patients with the greatest clinical need

Embed neighbourhood partnerships as 'business as usual'

- Integrate NHS, local authority, and Voluntary Community and Social Enterprise (VCSE)
- Deliver place-based, joined-up care focused on outcomes, not organisational silos
- Ensure consistent quality across neighbourhoods

Tackle wider determinants and empower patients

- Reduce unwarranted variation and ensure consistent, holistic neighbourhood-level care
- Collaborate with local authorities to address housing, isolation, and other social factors alongside clinical care
- Support patients to be active partners in managing their health

Standardise high-quality care via workforce development

Use frameworks like Primary Care Respiratory Society's 'Fit to Care'

Making it happen: from strategy to implementation through service delegation

Summary

Strategic investment in respiratory care is increasingly being driven by a system-wide, 'single team' approach that uses respiratory as a population health priority and a practical testbed for integrated care.

Linked datasets are enabling more proactive, targeted interventions by MDTs for those at highest risk of disease progression, while respiratory pathways themselves are being used as an 'amplifier' to build relationships with local authorities and reach communities with poorer engagement, including low vaccination uptake. Progress is measured through a blend of hard operational metrics and softer but critical outcomes around patient experience and the psychological impact of living with chronic respiratory disease.

A potential enabler of system-level improvement is early, creative collaboration with financial colleagues to address stranded costs and design funding and partnership models, ensuring that clinical transformation is matched by sustainable financial architecture. Where barriers limit effective collaboration, non-promotional NHS–industry partnerships may support specific initiatives aligned with local priorities.

Strategic investment in respiratory care is increasingly being shaped by a focus on system-level activities rather than isolated programmes from single organisations. This can be described as a 'single team' approach, where partners across acute, community, primary care and local authority services see themselves as part of one integrated respiratory offer rather than a narrow clinical silo.

Targets for improvement

- Improve population health
- Manage demand on urgent care
- Strengthen foundations of integrated care model

A central enabler of this approach is more sophisticated use of data. Data-driven AI targeting of high-risk patients could be used to identify undiagnosed patients, as COPD prevalence in England is only 1.9%[21] but estimated to be around 10% globally.[5] Linked datasets are used to move away from reactive, episodic care and towards proactive, population-based management of respiratory risk. By combining information across care settings, systems can pinpoint individuals and groups at higher risk of deterioration or hospital admission. MDTs can then direct their time and resources towards those who are most likely to benefit from earlier, targeted intervention. In this way, investment decisions are increasingly guided by where the data shows the greatest opportunity for impact.

Key areas of focus

- Optimise medication
- Support self-management
- Tackle environmental triggers
- Direct patients to community support

Respiratory is also being used as an 'amplifier' across the wider system. Because respiratory conditions are so prevalent and cut across age, deprivation and comorbidities, they provide a powerful lens through which to build relationships and capability. Work on respiratory pathways can open doors to collaboration with local authorities around housing, air quality, smoking cessation and social support and can help systems reach communities that have been historically harder to engage. For example, respiratory vaccination campaigns or review clinics can become a route into neighbourhoods with low vaccination uptake more generally, creating a channel for broader preventive and engagement work.

Respiratory investment is judged not only by its direct clinical effects but also by how well it helps to strengthen the wider integrated care ecosystem.

Systems use a mix of operational, clinical and experiential measures to assess progress and define success. A major focus remains on tackling seasonal spikes in unplanned respiratory care, which can place significant pressure on urgent and emergency services. Innovative models such as virtual hospitals support safe discharge and ongoing monitoring at home, with the goal of improving patient experience and freeing up bed capacity.

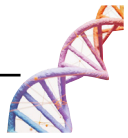
Potential key performance indications could include

- Fewer emergency admissions
- Fewer prolonged hospital stays
- Reduced readmission rates

However, the story is not purely about flow and capacity. Chronic respiratory disease carries a substantial psychological and emotional burden, and measures of patient experience should be core indicators not secondary considerations. This includes listening to patients' accounts of anxiety, social isolation, and the day-to-day realities of breathlessness and then ensuring pathways are designed to respond to these needs. This may mean integrating psychological support into respiratory services or strengthening peer support and community-based offers.

Rather than treating finance as a late-stage gatekeeper, the suggestion was to move towards including them as genuine partners in design

To accelerate system-level improvement, one of the most practical lessons has been the importance of engaging finance colleagues early and constructively. This is crucial when trying to address the 'stranded cost' problem – where improvements in one part of the system



(e.g. reduced admissions) do not immediately translate into cashable savings, because fixed costs remain. By working together from the outset, clinical, operational and financial leaders can explore more creative solutions. For example, neighbourhood-based care models supported by charitable funding allow systems to shift resources closer to communities, build neighbourhood MDTs and support more proactive, relational forms of care, while managing financial risk in a planned, transparent way.

Where internal barriers to this collaboration still exist at subnational system levels, NHS-industry collaboration may support sustainable transformation that aligns with local commissioner priorities such as targeting areas of deprivation and improving overall population health.

Sustainable respiratory transformation depends as much on how services are funded as on clinical innovation. When finance, data, clinical leadership and community partnerships are aligned, respiratory becomes a priority area of need and a powerful proving ground for integrated care at scale.

Key practical priorities

System-wide, "single team" approach	• Respiratory is testbed for integrated care • Focus on a joined-up, system-wide model as the foundation for strategy and investment
Effective use of linked data and targeted interventions	• Increasing use of linked datasets to support identification of high-risk individuals with respiratory conditions • Data then drives targeted MDT interventions, rather than generic or blanket approaches
Respiratory as a system "amplifier"	• Respiratory work is used to build wider system capability and relationships (e.g., with local authorities) • Respiratory is a route to reach underserved communities, such as those with low vaccination uptake, and to deepen cross-sector collaboration
Early and creative collaboration with finance	• Engage finance colleagues early when designing respiratory programmes • Work together on innovative approaches to the 'stranded cost' problem (e.g., using novel funding or partnership models) • Financial design is treated as integral to service redesign, not an afterthought
Collaborations with external organisations	• Charities to ensure that the patient voice comes through • Health Innovation Networks (HINs) and research facilities to ensure consideration of future burdens • Partnerships with industry may help address local population needs

Showcasing successful respiratory care transformation – a case study from Greater Manchester (GM)

Greater Manchester ICB developed a transformation project as part of the Respiratory Transformation Partnership (RTP)– a national initiative to try different ways of working to provide better pathways

The opportunity

Greater Manchester ICB identified a number of issues with respiratory care in the area. A service redesign was developed to test whether early identification, optimisation and appropriate treatment would prevent admissions.

Issues described by GM ICB in the case study

- Most high-risk patients did not have a COPD diagnosis
- One third of patients seen in ED due to COPD or asthma not registered with GP
- Spirometry not commissioned in primary care → No consistency across primary care practices
- Quality assurance - when undertaken - was suboptimal →
  - No clear diagnosis
  - No clear optimisation of inhalers
  - Patients with repeated infections and/or exacerbations not coded, optimised, or treated properly

The innovation

The project included three of the 14 primary care networks (PCNs) in Manchester – each with their own district general hospital (DGH), complexity and variation in deprivation.
The transformation team engaged with the PCNs' clinical directors, GPs, consultants and community respiratory teams (CRTs). Each PCN used a one-stop MDT community clinic to:

- OPTIMISE patients (see page 10)
- deliver wraparound care and management, including virtual reviews
- bring GP and secondary care closer together through joint working between CRTs, GPs with a respiratory interest, and respiratory consultants
- share understanding of roles across the patient journey

Potential benefits

System benefits

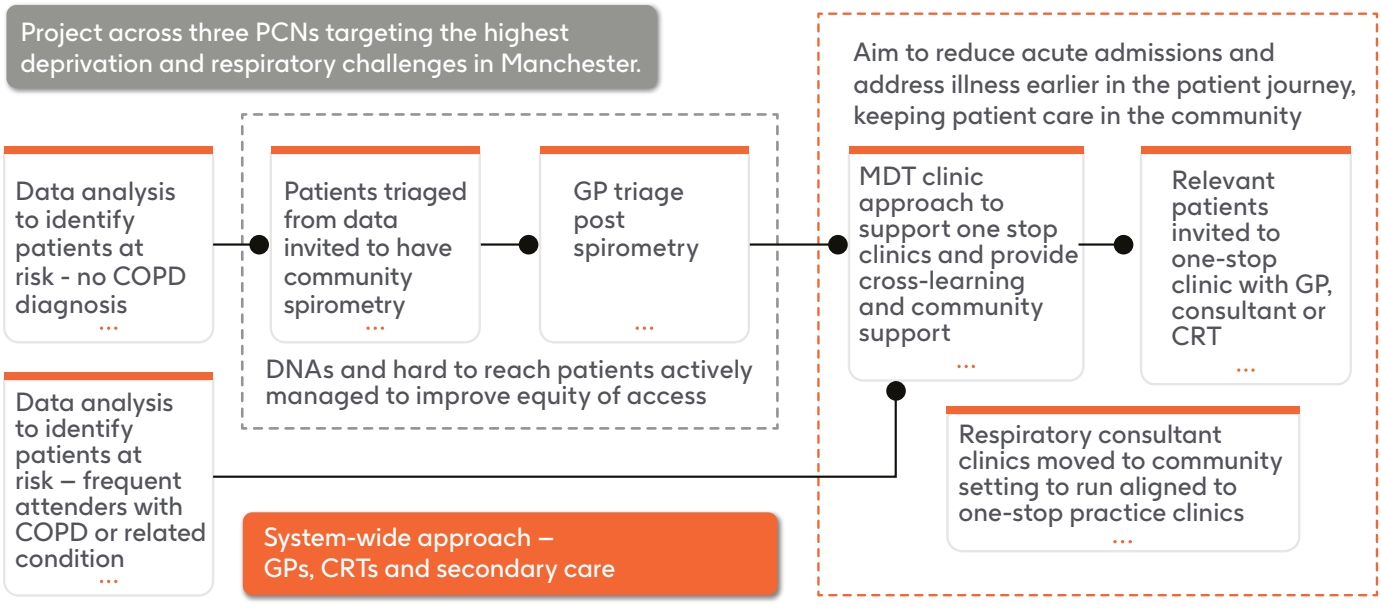
- Faster, fairer access to diagnosis—all patients receiving timely spirometry and early treatment
- Reduction in COPD admissions and premature mortality in deprived populations
- Sustainable primary care led pathway blueprint for wider rollout
- Genuine joined-up system working and pathways, removing barriers between health care providers

Patient benefits

- Increased patient education and patient self-management, using digital and non-digital support tools
- Improved patient flow, when needed into primary rather than secondary care
- Improved patient experience of receiving specialist input closer to home

The pathway begins with searches to identify patients at higher risk of disease progression or exacerbations, who are then directed through the pathway according to whether or not they had a diagnosis of COPD and their spirometry results.

Patient pathway



DNA, did not attend.

Outcomes, challenges and learnings

- Targeted diagnostics for asthma as well as COPD would have been beneficial, as most spirometry tests were normal
- Information technology and information sharing between primary and secondary care is a long-term issue and needs to be looked at if more joint working 'left shift' projects are developed in the future.
- Standardised templates and spreadsheets for all elements of clinical delivery, including clear reporting models, would have been helpful.
- The large number of meetings put pressure on management time, and outputs were not always disseminated down to GP practice level. Indeed, clinical resource proved challenging, including tight restrictions on NHS professionals and the amount of time managers required to attend meetings, facilitate discussions, send emails, and follow up tasks. This was not accounted for or back-filled, which means some other projects were put on hold.
- Levels and types of deprivation varied across the target population. Digital access was an issue for some patients who only know how to use their phone to make calls. Many patients have chaotic lives and find it difficult to look after their own health, which was a real challenge, so the team worked with care coordinators to identify what could be done to engage with these people.
- Some patients were waiting for 12 months to get spirometry, and one of the main aims was to have a legacy of trained staff from the project. Some areas now have three or four trained nurses, and this is likely to be expanded as a result of the programme.
- Overall feedback around set up, administration, and coordination was good.
  - A full-time coordinator/manager to 'own' the project and liaise with each of the PCNs would have been beneficial.
  - A greater lead time when submitting the bid would have enabled thorough programme planning and minimised delays with data collection, access to documents (prevented by security issues), and finances (which meant some PCNs had to use their own money initially).

Patient feedback

Patient feedback was very positive, with high levels of satisfaction, particularly in relation to short waiting times and timely access to appointments. Patients were grateful for having half an hour of time with a clinician explaining the diagnosis and discussing issues and actions moving forward.

Primary care feedback

Primary care clinicians also expressed satisfaction with the joint working approach, increased interaction with other GPs across the PCN footprint, and easier access to consultants and other secondary care clinicians for advice and guidance in a more integrated approach. They also saw the benefits of working directly with the PCN to implement changes without an additional layer of management, as well as the ability to adapt the model as needed rather than working rigidly to the original plan.

Pitching solutions to address the challenges: what could/should a new model of care look like?

In this session, participants worked in five groups to discuss potential new models of care focusing on the 'left shift' in respiratory management. Each group was assigned a different topic and had 1 hour to develop a new model of care and 40 minutes to prepare a 5-minute 'pitch'. Each group then presented their pitch to an investor panel, followed by a 5-minute Q&A session. Each 'investor' and each group voted on their favourite proposal, and the top 3 scoring pitches are described here.

Workforce-skilling and utilisation	2 Service delivery and capacity	3 Readmission/ admission avoidance	Improving access to care for advanced patients	1 Primary care patient identification and risk stratification

1 Primary care patient identification and risk stratification

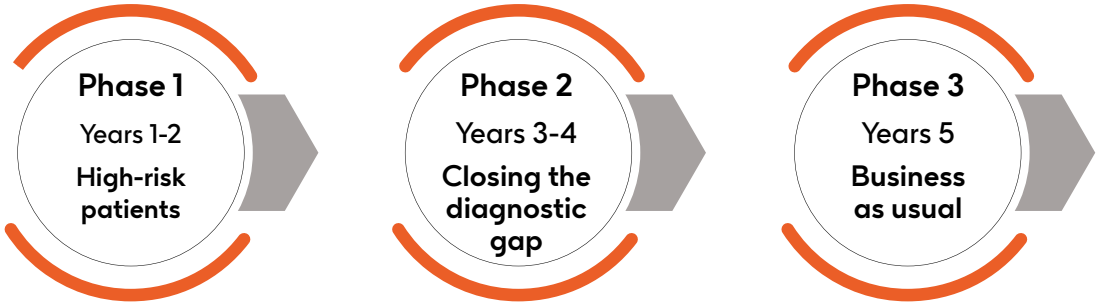
The problem

Many patients with COPD are undiagnosed, and many patients who are diagnosed are not optimised on treatment, which results in attendances at ED and hospital admissions. In addition, many patients are at increasingly high risk or have already had a severe exacerbation; healthcare utilisation for these patients is poor, as they are not being identified early in their disease pathway.

The solution

A 5-year plan to optimise care for high-risk COPD patients, focusing on early diagnosis and intervention, using a risk stratification tool to classify patients as low, medium or high risk based on criteria such as smoking status and modified Medical Research Council (mMRC) dyspnoea scores. Clinicians would be incentivised through a local scheme to encourage practices to review high-risk patients.

The aims were to reduce hospital admissions and premature mortality and improve primary care activity, with an emphasis on early intervention and collaboration with local organisations.



Phase 1 – High-risk patients

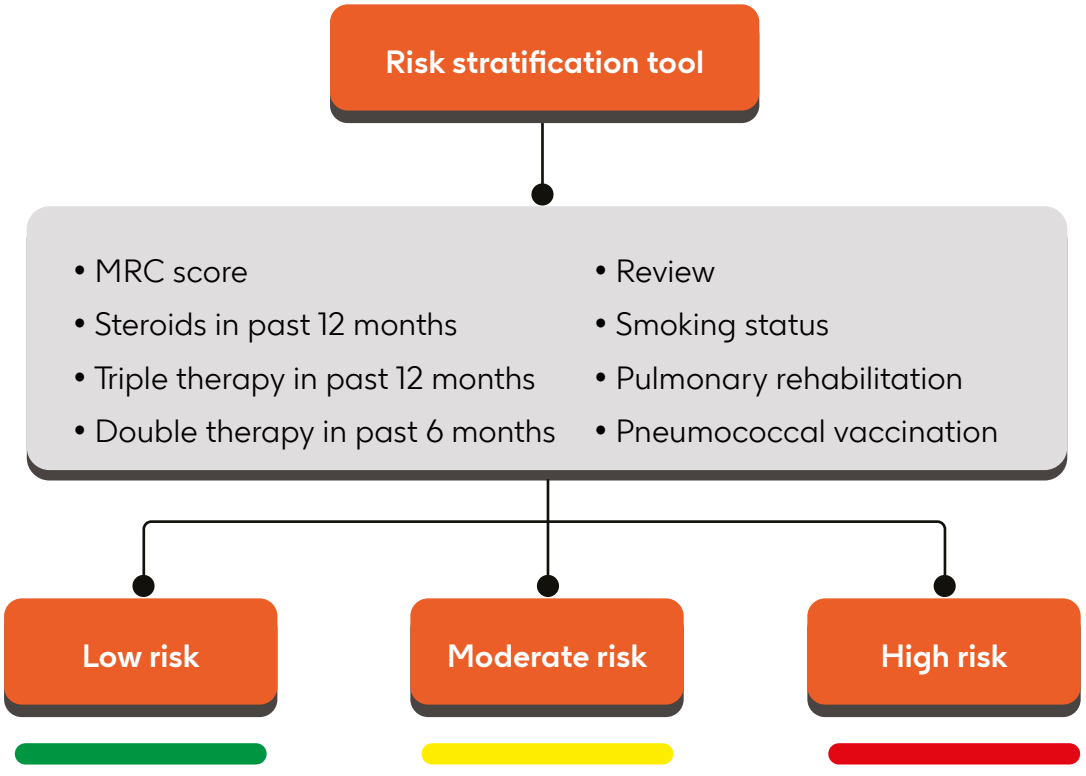
Phase 1 would be an initial 2-year focus on high-risk patients. A risk stratification/search tool would be run at ICB level across practices using coded data (e.g. prescriptions, reviews, MRC score, pulmonary rehabilitation) to identify patients with COPD who are high-risk and under-treated. For example:

- A patient with ≥2 courses of steroids in past 12 months, no evidence of triple therapy in the past 12 months or double therapy in the last 6 months, missing reviews, no rehabilitation, and no annual review in the past 18 months would be classified as high risk.
- A patient with recorded smoking status, pneumococcal vaccination, MRC score 3 and pulmonary rehabilitation might be considered low risk.

Each practice would receive a list of their high-risk COPD patients, who would be invited by the practice/GP for review and optimisation. GPs and practice nurses would perform structured reviews to ensure high-risk patients are treated following guidelines and care is optimised, including:

- Diagnostics and monitoring:
  - Appropriate spirometry
- Therapy escalation:
  - Ensure patients are on the right level of therapy
  - Move to double therapy or triple therapy according to COPD guidelines if indicated
- Preventive care:
  - Vaccinations (e.g. pneumococcal)
- Smoking cessation
- Pulmonary rehabilitation:
  - Offering and referring patients with functional limitation (e.g. MRC ≥3).

Locally commissioned incentive schemes aligned with NHS frameworks were considered for this new model of care. The proposed solution included a financial incentive (e.g. £70 per patient reviewed), intended to support the additional workload associated with structured reviews, proactive recall and optimisation.



Phase 2 – Closing the diagnostic gap

Phase 2 would represent Years 3 and 4 of the 5-year plan and would build on the work done in Phase 1. The aims would be to:

- increase appropriate identification and diagnosis of patients
- enable earlier intervention for newly diagnosed patients (triple/double therapy, smoking cessation, pulmonary rehabilitation, vaccines)
- reduce severe exacerbations and admissions (tied directly to the 'left shift' concept)
- reduce premature mortality and improve quality of life
- ensure a more predictable elective care environment.

This would involve diagnosing patients who are currently undiagnosed but at risk of COPD, with a focus on smokers and other risk groups using the same risk stratification tool as in Phase 1, as well as specific search/selection criteria (e.g., smokers, repeated courses of steroids, missed review). Spirometry would be used to confirm or rule out COPD, with newly diagnosed patients then optimised in a similar way to in Phase 1. Standardised templates and guidance would be developed for COPD reviews.

Phase 3 – Business as usual

Phase 3 would be Year 5 of the programme, representing a shift from a pilot scheme to routine implementation. The aims would be:

- reduced acute care burden though decreased emergency admission and severe exacerbations and more stable management in the community
- better diagnosis and optimisation and increased elective activity due to reduced acute pressures
- better quality of life for patients, allowing them to remain in work and be economically productive
- redirection of resources to other elective care.

Processes introduced earlier in Phases 1 and 2 – risk stratification, proactive recall, systematic optimisation, and spirometry pathways – would now be standard operating practice rather than a special scheme. Templates and guidelines to direct step up to double or triple therapy, vaccines, pulmonary rehabilitation referral and smoking cessation would be available so that reviews are structured and repeatable. Staff would be competent and confident, as a result of training and multi-year exposure to the process. Although incentives could still be in place, financial levers should no longer be required as the behaviour and workflow changes should be ingrained in routine practice to support ongoing proactive COPD management.

2 Service delivery and capacity

Community-based respiratory hub model designed to reduce avoidable admissions and manage long-term conditions more holistically. This would include a mobile 'green bus' outreach, broad community-level identification, centralised expert diagnosis, long-term hub-led management, embedded peer/community support, with support of appropriately governed, non-promotional partnerships with industry where relevant.

While reactive care managing current exacerbations and high-risk patients is essential now, the strategic goal is to reduce future generations' need for such intensive reactive services and build a proactive, universal support model for respiratory health, which could be scaled beyond COPD and respiratory conditions to other long-term conditions.

The model would involve a three-step respiratory pathway:

1. Identify:

- Broaden who can refer patients – so that anyone in the community who sees early signs of deterioration can flag someone at risk
- Increase recorded prevalence (e.g. moving beyond the current ~1.9%) by picking up more undiagnosed/under-diagnosed patients

2. Diagnose:

- Shift respiratory specialists out of hospital into a single community hub where accurate diagnostics and interpretation are performed in one place
- Improve diagnostic quality by concentrating expertise and equipment instead of it being fragmented in multiple primary care settings with variable skills and interpretation

3. Manage (long-term):

- Use the respiratory hub as the ongoing route for follow-up and long-term management, so patients do not deteriorate to the point of needing hospital admission
- Align with quality and outcomes framework/ annual or biannual reviews, which can be performed in primary care (not necessarily by GPs), connected back into the hub when needed.

Key features included:

- 'Green bus' model to travel around neighbourhoods and bring specialists directly into communities to deliver diagnostics, education, and management closer to patients' homes
- Community-embedded, co-designed model run with patients, charities, local community groups, secondary care, primary care, and industry all at the table
- Education sessions for community members and HCPs to explain who can be referred, inclusion and exclusion criteria, and how the service works
- Existing community outreach/research teams embedded so housebound patients can still be seen and community nurses can access specialist advice for these patients
- Strong emphasis on proactive, population-level prevention
- Incorporate peer support from existing or new groups (e.g., 'Breathe Better' get-togethers, breathing groups, local social groups, and mosque-based groups).

Readmission/admission avoidance

Exacerbation response and prevention service for COPD would use digitally enabled care bundles, virtual wards, and primary care respiratory champions to improve continuity of care after hospital discharge. The model aims to reduce readmissions and bed days, shift more care into the community, and use flexible workforce deployment (more acute support in winter, more prevention and upskilling in summer), initially implemented as a pilot in three PCNs, with appropriately governed, non-promotional collaboration where relevant.

A system-wide service would include:

1. Digitally enabled COPD care bundles (secondary care):

- Standardised discharge pathways and COPD bundles in hospital
- Use of digital tools (e.g. myCOPD) for self-management on discharge

2. Virtual wards and integrated care:

- Virtual wards for patients post-exacerbation to support them at home
- Integrated working between secondary care, community and primary care
- All patients admitted with COPD exacerbation receive some intervention, even if not in a pilot PCN

3. Primary care respiratory champions (PCN level):

- Designated respiratory champions in three pilot PCNs initially
- Champions support integrated working with hospital teams and virtual wards
- Role includes supporting continuity of care and prevention in primary care.

The model would be developed with extensive patient consultation based on:

- patient feedback that many do not know what to do when exacerbations start
- evidence from virtual ward work from various localities
- external evaluation (e.g. King's College London work) used to understand the patient voice and current gaps in care.

The model would include a seasonal workforce approach:

- Key workforce of specialist nurses, pharmacists, physiotherapists and primary care staff
- Network of 'respiratory champions' in the community
- Winter focus on virtual wards and managing acute exacerbations
- Summer staff shift to preventive work and upskilling community/primary care professionals.

System-level leadership would be required to coordinate across sectors. The programme would start with a pilot in three PCNs, with all patients admitted for a COPD exacerbation receiving an intervention and patients in pilot PCNs receiving additional support from respiratory champions. Industry partners could provide collaborative resources, experience, support, or funding for pilot set-up, evidence generation, and digital tools and infrastructure.

Levers for GP involvement would include upskilling and easier access to specialist support, with patient feedback about current poor experiences as a driver for change. GPs would be expected to respond to external patient evaluations and clear evidence of improved outcomes and more joined-up care.

Potential outcomes for success

- Reduced readmission rates and bed days for COPD
- Compliance with:
  - COPD best tariff (second care)
  - National audits (NRAP)
  - British Thoracic Society (BTS) discharge pathways and COPD bundles
- Evidence that primary care respiratory champions:
  - improve continuity and integration
  - enhance patient self-management and experience

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