

Written evidence submitted by Asthma UK and the British Lung Foundation (CBP0033)

Executive Summary

1. Asthma UK and the British Lung Foundation are pleased to submit written evidence to the inquiry.
2. The COVID-19 pandemic has had an enormous impact on the care of people with lung disease as the NHS suspended many of its services during lockdown, and an average of over 3,000 respiratory patients per week having missed out on a referral for specialist care, treatment or diagnosis in England.ⁱ
3. Of people diagnosed with a lung condition in the last year, 25% had to wait 6 months to receive a diagnosis, while a further 20% had to wait over a year.ⁱⁱ These significant delays are extremely problematic for effective and safe care, but also indicate that there are large volumes of patients in the system in need of diagnosis. The fact that spirometry testing was suspended for a long time, and its restart appears to be extremely slow and without publicly available data, is a great worry.
4. Of patients with a diagnosis, 85% of have experienced some sort of delays or disruptions to their care. While the use of remote or virtual appointments has been both useful and necessary, there are concerns about the quality of these and the fact that conducting proper inhaler technique checks virtually is unlikely to be effective. This drop in the standard of care is likely to result in worse outcomes, and additional demand on the NHS.
5. This scenario suggests that there is currently not enough capacity to see and support all the patients in need of respiratory care, especially in light of the fact that many with poorly managed lung conditions are at high risk of needing hospital treatment over the winter, with suggestions that this may be worse than normal this year.ⁱⁱⁱ
6. If capacity issues are not urgently addressed people waiting for care will not only be dealing with life-limiting breathlessness and worsening symptoms, but may be at risk of dying before they are diagnosed and treated. In December 2020 a cancer recovery plan was published by NHS England^{iv}, but we have not had such concrete commitments to restoring respiratory services.
7. We support the call from NHS Providers and the NHS Confederation for an additional £10bn in funding for the NHS in order to address the patient backlog,^v and to avoid having to make cuts in services elsewhere, which seem likely to be a false economy.

Our recommendations to address the backlog in respiratory care:

8. We recommend that GPs proactively contact high risk patients, offering them an annual review and inhaler technique check to ensure that their condition is under control. Where further diagnostic tests are needed they should be prioritised. In addition they should encourage them to have a flu jab this coming winter. These actions will help to prevent exacerbations and prevent additional pressures on the NHS.
9. We recommend that local NHS bodies such as Integrated Care Systems prioritise and sufficiently fund high quality Pulmonary Rehabilitation (PR) for people with lung conditions, whether delivered face-to-face or remotely. PR is a key method of managing respiratory conditions and preventing exacerbations, which increase the demand on the NHS.
10. We recommend that statistics on spirometry testing are made public, with NHS England strongly encouraging its full resumption.
11. We recommend that Community Diagnostic Hubs are implemented as originally intended, with three hubs per million people.

12. We recommend the government ensure NHS funding commitments for respiratory programmes in the Long Term Plan are honoured, and that extra funding is provided to help people manage their conditions at home.
13. We support the call from NHS Providers and the NHS Confederation for an additional £10bn in funding for the NHS in order to address the patient backlog,^{vi} and to avoid having to make cuts in services elsewhere, which seem likely to be a false economy.
14. We recommend the government continues to fund research monitoring levels of long COVID in the general population and provides adequate funding for specialist and mainstream services to meet the needs of people experiencing symptoms long term.
15. To effectively deal with the backlog of care, we recommend that NHS England publish a respiratory recovery plan, complete with targets, similar to the cancer recovery plan published by NHS England.
16. We recommend that the national breathlessness pathway be introduced nationally by NHSE as soon as possible, compete with waiting time standards and incentives for speeding up the diagnosis and treatment pathway, as is the case with cancer treatment.

About Asthma UK and British Lung Foundation

17. Building on existing collaboration, in January 2020 Asthma UK and the British Lung Foundation merged to become the Asthma UK and British Lung Foundation Partnership. Both retain individual identities and have different service channels to obtain insights from the lived experience of beneficiaries living with a lung condition.
18. Every 10 seconds someone has a potentially life-threatening asthma attack and three people die every day. Tragically the majority of these could be prevented, whilst others suffer with asthma so severe current treatments don't work. This must change. That's why Asthma UK exists. We work to stop asthma attacks and, ultimately cure asthma by funding world leading research and scientists, campaigning for improved care and supporting people with asthma to reduce their risk of a potentially life-threatening asthma attack.
19. The British Lung Foundation offers hope, help and a voice for people with all lung conditions, including COPD, bronchiectasis and pulmonary fibrosis. Our research finds new treatments and cures. We help people who struggle to breathe to take control of their lives. And together, we're campaigning for better lung health so that one day everyone can breathe clean air with healthy lungs.

What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?

Delays in Diagnosis

20. A survey of 4,752 people with lung conditions by the Taskforce for Lung Health found that a quarter of people diagnosed with lung conditions in the past year had to wait six months for a diagnosis.^{vii} The survey also found that:
 - 1 in 5 (20%) of people had to wait longer than a year for a diagnosis last year
 - More than a fifth (23%) of people experienced symptoms of a lung condition for over a year before seeking a diagnosis
 - 1 in 5 people on waiting lists for care have been waiting for the care they need for more than a year
21. While COVID 19, and in particular the halting of spirometry testing, has contributed to these delays, it should be remembered that before the pandemic people who experienced worsening or particularly severe respiratory symptoms often had to wait a very long time to get referred to and seen by specialist teams, leaving them at risk of hospitalisation. Mortality rates for lung disease have not improved in the last decade and hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in winter pressures faced by the NHS.^{viii}
22. The current backlog has added to this already poor situation, and services will be unable to support the number of people in need even if they return to pre-pandemic levels of capacity.

Delays in Care

23. As a result of the pandemic, there have been 107,930 fewer hospital appointments for respiratory care in England compared with the average number seen each year. During the peak of the pandemic the number of expected appointments taking place was down by 85%.^{ix}
24. A Taskforce for Lung Health survey of over 8,000 patients with lung disease found very much the same picture, with over a third of people having had their care delayed or cancelled during lockdown.^x This could be a cancelled annual review, a delayed appointment to see a specialist, or not being referred for an essential test. Also, a quarter of people experienced worse symptoms as a result of care being delayed or because they avoided seeking treatment – due to worries about putting pressure on the NHS and fears around the spread of COVID-19.^{xi}
25. An average of over 3,000 respiratory patients per week have missed out on a referral for specialist care, treatment or diagnosis in England.^{xii} Overall, 85% of people have experienced some sort of delays or disruptions to their care.^{xiii} We have continued asking people with lung disease about interruptions to their care since July 2020, when in theory, services should have been getting back to normal, and 23.7% have had their care delayed or cancelled since July.^{xiv}
26. This scenario suggests that there is currently not enough capacity to see and support all the patients in need of respiratory care. This includes significant numbers of new patients in need of a diagnosis, and those who are in the system but have had their treatment disrupted. If this is not urgently addressed people waiting for care will not only be dealing with life-limiting breathlessness and worsening symptoms, but may at risk of dying before they are diagnosed and treated.

27. For example, for people with conditions such as idiopathic pulmonary fibrosis, which has a life expectancy of three to five years after diagnosis, any delays in diagnosis could mean the difference between life and death as access to life-extending treatments is only possible after diagnosis.
28. In December 2020 a cancer recovery plan was published by NHS England,^{xv} but we have not had such concrete commitments to restoring respiratory services. In fact, because there is no standardised clinical pathway for diagnosing breathlessness and cough (which are the most common symptoms of lung disease), people with suspected lung conditions who see their GP have always been at risk of being misdiagnosed or left without a clear diagnosis. NHSE have been working on the Breathlessness Pathway for some time, but it is yet to be introduced.

The Backlog impact on Primary care for respiratory patients

29. The majority of routine asthma and COPD care takes place in primary care, so any disruption in services is likely to have a significant impact. Having a clear management plan, supported by health care professionals, is critical for ongoing COPD care, and access to primary care is evidenced to reduce emergency admissions for asthma, provide better patient outcomes, and reduce overall costs.^{xvi} However, there continues to be a marked reduction in asthma related appointments within primary care,^{xvii} with activity around half the expected levels for asthma, and even lower for all respiratory system diseases (which will include COPD).
30. Research^{xviii} suggests that asthma annual reviews were 29% below normal levels in April 2020, and recovered somewhat to 12% below normal levels by September 2020. COPD reviews dropped by 67% in April 2020, and were still down by 36% in September 2020.
31. Our own research with COPD patients (not yet published, please do not share), found that just over 55% had had to wait six months or more for a diagnosis. Of these, 18.3% had had to wait over a year, with 17% waiting over two years.
32. While the pandemic has resulted in fewer appointments within primary care overall, appointments coded for asthma or general respiratory have reduced to a greater extent than overall appointments. This suggests that there is a significant problem with people seeking proactive appointments, such as if their symptoms have deteriorated, as planned reviews cannot account for the reduced primary care activity levels.
33. Our 2020 Annual Asthma Survey shows that many people with asthma have had their regular care cancelled, and have had to adapt to the changing circumstances. Over half (57.2%) of people with asthma had a GP appointment conducted over the phone, while 18% had a hospital appointment conducted over the phone. There was in fact an 178% rise in telephone appointments from January to November 2020, and the rise in remote care shows that a level of routine remote respiratory management is possible.
34. However, there is also a question about the quality of remote or virtual appointments. Our 2020 Asthma survey found that 47.7% of those having a remote appointment thought that they did not receive the same quality of care as a face-to-face appointment.^{xix} Previous research^{xx} has shown there is widespread variation in the quality of annual reviews, and we are concerned that these crucial appointments can be 'box-ticking exercises', especially when carried out remotely.
35. Despite these concerns, the use of remote consultation has clearly been a very necessary response to the pandemic, but certain key diagnostic tests and other procedures – such as spirometry or FeNO – cannot be done remotely (more on this below). The low uptake in video appointments compared to telephone appointments suggests that inhaler technique checks are likely to have been very rare, as the majority of these cannot be performed

adequately over the phone. Not being able to undertake these checks may add to the backlog for procedures and tests, and means that GPs and nurses are not able to identify patients who are at risk as a result of poor inhaler technique, something that is known to be an important issue.

We recommend that GPs proactively contact high risk patients, offering them an annual review and inhaler technique check to ensure that their condition is under control. Where further diagnostic tests are needed they should be prioritised. In addition they should encourage them to have a flu jab this coming winter. These actions will help to prevent exacerbations and prevent additional pressures on the NHS.

The Backlog impact on referrals into secondary care

36. As mentioned above, our survey found that 1 in 5 people diagnosed with respiratory conditions in the last year had been waiting for the care they need for more than a year.
37. A key area of backlog for respiratory care is the missed referrals to specialist care during the pandemic. This means that people with lung conditions may be missing out on access to diagnostics for more complex conditions and a chance to be on the best treatment for their condition. The Taskforce for Lung Health analysed this data during the first wave of the pandemic, and found out that on average, 3,399 patients missed out on urgent and routine referrals per week. They also found that nearly 2 in 5 (39%) of CCGs in England did not see a single appointment booking for respiratory conditions in May 2020, and 65% of CCGs had 5 or less bookings.^{xxi} Referrals rates have now more or less recovered to pre-pandemic levels, but bookings (i.e. actually getting an appointment) are still much lower, at about half of pre pandemic levels.^{xxii}
38. Bookings for respiratory care are still around two thirds below the baseline. This indicates that there is a very significant pinch point comes in accessing secondary care. This may be a result of large numbers of respiratory clinicians being redeployed to COVID wards, meaning they are unavailable for routine respiratory care. The fact that, in contrast to cancer, we do not have any waiting time standards for respiratory means that there is little incentive to speed up the process and guarantee appointments for people who need to be referred.

The Backlog impact on Pulmonary rehabilitation

39. Pulmonary rehabilitation (PR) has been dramatically affected by the pandemic. Face-to-face PR programmes were paused in March last year – with our October 2020 survey revealing that 36.2% of respondents had their PR classes cancelled in the intervening period.^{xxiii}
40. However, some PR programmes moved online – our survey found that 14.7% of respondents had accessed digital PR. Digital PR can, where appropriate expand access to PR and remove barriers to participation for some people, such as those too ill to travel. However, we are also concerned that the move to remote services has in some instances led to variation in the availability and quality of PR.
41. There is growing demand for PR, from people who have been shielding, people who have deconditioned and missed out on PR over the last year, and from people recovering from COVID or with long COVID. This backlog of unmet need is putting increasing pressure on those PR services which are currently open. NHSE have estimated that it would take around a year to clear the current backlog. This is based on national audit data (NACAP) which estimates around 11,500 people are assessed for PR in England every six months, so a six month pause in services could lead to a backlog of this size.

We recommend that local NHS bodies such as Integrated Care Systems prioritise and sufficiently fund high quality PR for people with lung conditions, whether delivered face-to-face or remotely. PR is a key method of managing respiratory conditions and preventing exacerbations, which increase the demand on the NHS.

What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?

42. As mentioned above, there have been 107,930 fewer hospital appointments for respiratory in England compared with the average number seen each year, and during the peak of the pandemic the number of expected appointments taking place was down by 85%.^{xxiv} This suggests that there is a large backlog of patients in need of diagnosis and treatment, and it is our view that the NHS is currently unlikely to have the capacity to deal with this backlog effectively.
43. This situation has been exacerbated by the fact that, despite not being an aerosol generation procedure (AGP), spirometry testing was stopped in primary care in 2020 because of fears that this test could be contributing to the spread of COVID infections. The Association for Respiratory Technology & Physiology estimate 20,000 spirometry tests and 15,000 full respiratory function tests are ordinarily performed in hospital every month in England.^{xxv} This will have resulted in thousands of people missing out on these vital diagnostic tests.
44. In 2021, NHS England convened a task & finish group to produce guidance^{xxvi} on how spirometry could be safely restarted in primary care, which was published in April 2021. Yet despite this, the resumption of spirometry is thought to be extremely slow and there is no publicly available data monitoring this restart. We are very concerned that the lack of any public data will further delay efforts to improve the situation.
45. When spirometry testing stopped, patients who were going through the system were diagnosed based upon their history alone and without any diagnostic test. This is far from ideal and is much less accurate than testing. It seems likely that for most patients who are currently being seen this remains the way in which they will be diagnosed, and represents a huge step backwards for respiratory treatment. With a higher chance of misdiagnosis, those patients who are lucky enough to be seen at the moment are more likely to be given incorrect care.

We recommend that statistics on spirometry testing are made public, with NHS England strongly encouraging its full resumption.

46. Community Diagnostic Hubs, which are new 'one stop shops' for diagnosis, are part of the solution to addressing the backlog of patients waiting for comprehensive diagnostics, as they have the potential to relieve the capacity issues in diagnostics that is affecting both primary and secondary care. However, we need to see multi-year investment to support the Community Diagnostic Hubs. Local areas need to ensure they can secure the right workforce and provide access to the greatest numbers of patients, but our current understanding is that the Hubs will be rolled out at a much lower scale than original proposed in the Richards Review of Diagnostics.^{xxvii} This proposed three hubs per million people, but our current understanding is that the Community Diagnostic Hubs roll out is planned at one hub per three million population – a significant reduction that seems likely to detract from their effectiveness. While no clear figures have been published, the last spending review in 2020 allocated £325 million of new investment 'in NHS diagnostics equipment to improve clinical outcomes'. This however is lower than the figure requested by NHSE when they

commissioned Mike Richards' independent report (although it has not been published what that figure requested was). We are very concerned that this will hamper efforts to successfully address the significant backlog in respiratory care.

We recommend that Community Diagnostic Hubs are implemented as originally intended, with three hubs per million people.

47. Spirometry needs to be delivered by staff with the correct skills and training, and there are concerns about this and staff shortages in this area. For example, results of The National COPD Audit in Wales found that only 54.3% of newly diagnosed patients had a FEV1/FVC ratio coded in their records, only 11.1% were coded as post bronchodilator FEV1/FVC ratio, and of those, only 8.5% had a result consistent with obstructive disease. This demonstrates a number of potential factors – poor performance, poor interpretation of the test results and poor ability to consider spirometry in the clinical context.^{xxviii}
48. At present this responsibility falls to CCGs, but will transfer to ICS's in the near future. Given the reorganisation of the NHS and the potential underfunding of Community Diagnostic Hubs, we are concerned that workforce planning in this area will not receive the attention it deserves. There is also a need to support the PR workforce, especially in light of the significant number of people suffering from long COVID in addition to those with pre-existing respiratory conditions. In addition to expanding and developing the workforce, the Chartered Society of Physiotherapy has highlighted the need to shape care around long term conditions for people of a working age, in contrast to supporting people around one off or single events.^{xxix}

How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?

49. Lung disease costs the UK £11 billion every year, with £9.9 billion falling directly on the NHS and patients in private costs. Among the most costly conditions are COPD (£1.9 billion each year) and asthma (£3 billion).^{xxx} The funding situation for respiratory care has similar shortfalls to the state of respiratory care itself; even before the pandemic there was a need for significant investment, and the current backlog has made that need all the more pressing.

Honour NHS funding for respiratory commitments in the Long Term Plan

50. In January 2019, NHS England published a new Long Term Plan for England, laying out what the health service will do over the next decade. Significantly, the plan made lung health a priority area for the first time. Over the next ten years, the NHS Long Term Plan aims to improve treatment and support for those with respiratory disease, with an ambition to transform services, treatment and outcomes to equal, or better, than international counterparts. This represented a huge step forward for people with lung disease, but it is now being put at risk if the plan cannot be delivered because of funding uncertainties.
51. Since the COVID-19 pandemic, some NHS funding which had been allocated for taking forward respiratory commitments in the Long Term Plan has been diverted away from services for people with lung disease and reprioritised elsewhere. For example, the Cardiovascular Disease and Respiratory Programme was allocated £8.4 million in NHS Long Term Plan funding for 2020 but over £3.5 million has been reprioritised to support people recovering from Long COVID.^{xxxi} Although the Government provided NHS England with £3bn of additional funding in the Spending Review 2020, new analysis by the Health Foundation

indicates that delivering the Long Term Plan will require additional funding for NHS England of up to £10bn next year, reducing to £5bn from 2023/24.^{xxxii}

52. The NHS Long Term Plan represented a huge step forward for people with lung disease. If implemented, it would deliver real change for the 1 in 5 of us living with a lung condition in the UK but it is now being put at risk if the plan can't be delivered because of funding uncertainties due to COVID-19. If we are to build on this opportunity to improve the lives of people with lung disease, then funding for respiratory commitments must be honoured so the plan can be delivered effectively, ensuring that people with lung disease can access the health services they need to keep them well and out of hospital. This is particularly important at a time when our health service is under immense pressure as we approach winter with COVID-19 still present.

We recommend the government ensure NHS funding commitments for respiratory programmes in the Long Term Plan are honoured, and that extra funding is provided to help people manage their conditions at home.

We support the call from NHS Providers and the NHS Confederation for an additional £10bn in funding for the NHS in order to address the patient backlog,^{xxxiii} and to avoid having to make cuts in services elsewhere, which seem likely to be a false economy.

Additional funding to support people with post-COVID respiratory complications

53. A survey by Asthma UK and the British Lung Foundation found that people recovering from mild-moderate COVID are struggling for weeks with symptoms, raising concerns that there is not adequate support for people who have not been in hospital with the illness.^{xxxiv} In order to take on this added responsibility and support people with post-COVID complications, the Government needs to ensure that additional funding is made available for the NHS respiratory programme.
54. It is vital that existing resources are not diverted away from respiratory commitments in the Long Term Plan to support this new cohort of patients. Across the UK we estimate there are 5.4 million adults and children in the UK who are currently receiving treatment for asthma, and around 1.4 million adults diagnosed with COPD.^{xxxv} Supporting patients affected by COVID-19 will involve rehabilitation and it is expected that there will be significant demand for services such as pulmonary rehabilitation, which are already under resourced in some cases.
55. Pulmonary rehabilitation is one of the most effective and cost-effective interventions for people with lung conditions. It has proven success in increasing exercise capacity, reducing breathlessness and reducing levels of anxiety and depression. Making pulmonary rehabilitation more widely available than it is currently would bring significant financial savings for the NHS and social care. If everyone in England eligible under current NICE COPD guidelines was referred to pulmonary rehabilitation, over 26,600 hospital admissions and 100,000 bed days would be avoided. This could save NHS England up to £69 million every year.^{xxxvi} We must commit to delivering high quality pulmonary rehab to everyone who can benefit from it, including both people living with COPD and those who need rehab post-COVID.

We recommend the government continues to fund research monitoring levels of long COVID in the general population and provides adequate funding for specialist and mainstream services to meet the needs of people experiencing symptoms long term.

How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?

56. As demonstrated above, respiratory outcomes were poor before the pandemic, with mortality rates for lung disease not having improved in the last decade. The backlog of care seems likely to make this situation worse.

To effectively deal with the backlog of care, we recommend that NHS England publish a respiratory recovery plan, complete with targets, similar to the cancer recovery plan published by NHS England.

The introduction of the national breathlessness diagnosis pathway

1. The national breathlessness diagnosis pathway has been under development for some time, and its swift introduction would enhance the NHS's ability to deal with the respiratory backlog. This would streamline the diagnosis process for patients and ensure that no one is misdiagnosed or mist in the system. We would also like to see waiting time standards and incentives for speeding up the diagnosis and treatment pathway, as is the case with cancer treatment.
2. Proper testing is part of this pathway, and as per NICE guidelines, it should be used for all patients presenting with breathlessness, chronic cough, regular sputum production, frequent winder 'bronchitis' and wheeze. It is known that spirometry and structured assessments can inform clinical judgement and provide more definitive diagnoses,^{xxxvii} in the absence of a single diagnostic test for COPD.^{xxxviii} Early diagnosis and treatment can slow disease progression and improve quality of life.^{xxxix}
3. The proper use of this pathway across primary care will help ensure that all those with respiratory conditions are identified, diagnosed and helped to properly manage their condition. This is important for good patient outcomes, but also important for reducing demand on the NHS, with poorly managed lung conditions at high risk of needing hospital treatment over the winter, and suggestions that this may be worse than normal this coming winter.^{xl}

We recommend that the national breathlessness pathway be introduced nationally by NHSE as soon as possible, compete with waiting time standards and incentives for speeding up the diagnosis and treatment pathway.

What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?

4. The Government should provide additional support to projects working alongside the Long Term Plan including the NHS@Home Programme which is looking to help people with respiratory disease manage their condition at home by distributing spirometers, peak flow monitors and oximeters where clinically appropriate to reduce unnecessary hospital admissions. Self management and some aspects of Pulmonary Rehabilitation are also part of this programme. This is a rare opportunity to test the delivery of home care at scale and establish new models of care which will have benefits for both patients and the NHS in years to come.

How effectively has the 111 call-first system for A&E Departments been? What can be done to improve this?

No comments

What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?

No comments

To what extent is long-COVID contributing to the backlog of healthcare services? How can individuals suffering from long-COVID be better supported?

Breathlessness is currently the second most prevalent symptom reported by those with Long COVID, experienced by 388,000 people.^{xi} These patients will need care, potentially including diagnostic tests such as spirometry, the prescription of inhalers with inhaler technique checks, and possibly a referral for pulmonary rehabilitation. As already outlined, we have real concerns around the adequate provision of these services, and the prospect of the demand created by 388,000 additional patients is a daunting one. There is still more to understand about what interventions will best support people with Long COVID-related breathlessness and we would urge the Government to continue to fund research into this.

-
- ⁱ Taskforce for Lung Health data analysis. Available from: <https://www.blf.org.uk/taskforce/get-in-touch/media/patients-needing-urgent-care-for-lung-conditions>
- ⁱⁱ <https://www.blf.org.uk/taskforce/press-release/1-in-3-people-with-lung-disease-end-up-waiting-longer-than-six-months-for-a-diagnosis>
- ⁱⁱⁱ <https://www.express.co.uk/life-style/health/1484505/flu-season-winter-2021-prediction-evg>
- ^{iv} <https://www.england.nhs.uk/coronavirus/publication/cancer-services-recovery-plan/>
- ^v <https://www.theguardian.com/society/2021/sep/02/nhs-needs-10bn-annual-boost-to-tackle-backlog-and-covid-cost>
- ^{vi} <https://www.theguardian.com/society/2021/sep/02/nhs-needs-10bn-annual-boost-to-tackle-backlog-and-covid-cost>
- ^{vii} Data via an Asthma UK and British Lung Foundation Partnership survey of people with lung conditions. Survey ran from March 3rd – 10th 2021, and received 4, 730 respondents. 397 of these respondents were on a waiting list for either diagnostic tests, a procedure or a referral to specialist care.
- ^{viii} British Lung Foundation (2017) Out in the cold – lung disease, the hidden driver of NHS winter pressure. Available from: <https://www.blf.org.uk/policy/out-in-the-cold>
- ^{ix} The Taskforce for Lung Health, <https://www.respiratoryfutures.org.uk/news/lung-health-care-backlog-reaches-100-000-hospital-appointments-according-to-the-taskforce/>
- ^x Asthma UK and the British Lung Foundation surveyed 8495 people with lung conditions from 10 July to 15 July.
- ^{xi} Ibid
- ^{xii} Taskforce for Lung Health data analysis. Available from: <https://www.blf.org.uk/taskforce/get-in-touch/media/patients-needing-urgent-care-for-lung-conditions>
- ^{xiii} Asthma UK and the British Lung Foundation surveyed 8495 people with lung conditions from 10 July to 15 July.
- ^{xiv} Asthma UK and the British Lung Foundation surveyed 6345 people with lung conditions from 10 October to 19 October 2020.
- ^{xv} <https://www.england.nhs.uk/coronavirus/publication/cancer-services-recovery-plan/>
- ^{xvi} <https://bjgp.org/content/66/650/e640>
- ^{xvii} https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013301/GPinHoursEngBulletin2021Wk33.pdf
- ^{xviii} <https://www.medrxiv.org/content/10.1101/2021.01.06.21249352v2.full.pdf>
- ^{xix} 2020 Asthma Survey, p17
- ^{xx} <https://www.asthma.org.uk/58a0ecb9/globalassets/campaigns/publications/The-Great-Asthma-Divide.pdf>
- ^{xxi} <https://www.blf.org.uk/taskforce/get-in-touch/media/patients-needing-urgent-care-for-lung-conditions>
- ^{xxii} <https://digital.nhs.uk/dashboards/ers-open-data>
- ^{xxiii} Asthma UK and British Lung Foundation survey, 10th – 19th October 2020, over 6,000 respondents in total. Filtered for those with PR in their care, 483 respondents to Q) How have your PR classes been affected.
- ^{xxiv} The Taskforce for Lung Health, <https://www.respiratoryfutures.org.uk/news/lung-health-care-backlog-reaches-100-000-hospital-appointments-according-to-the-taskforce/>
- ^{xxv} Association for Respiratory Technology and Physiology, Respiratory function testing during endemic COVID-19. 2020. Available at: https://www.artp.org.uk/write/MediaUploads/Standards/COVID19/Respiratory_Function_Testing_During_Endemic_COVID_V1.5.pdf
- ^{xxvi} https://www.artp.org.uk/write/MediaUploads/Standards/COVID19/ARTP_PCRS_spiro_re-start_FINAL2.pdf
- ^{xxvii} <https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf>
- ^{xxviii} <https://www.rcplondon.ac.uk/projects/outputs/primary-care-audit-wales-2015-17-planning-every-breath>
- ^{xxix} <https://www.csp.org.uk/news/2021-08-26-have-your-say-physio-workforce-needed-england>
- ^{xxx} <https://www.blf.org.uk/policy/economic-burden>

^{xxxvi} Parliamentary question raised by Andrew Percy MP. Available from: <https://questions-statements.parliament.uk/written-questions/detail/2020-11-12/114825>

^{xxxvii} The Health Foundation (2020), *Spending Review 2020: Managing uncertainty. COVID-19 and the NHS long term plan*. Available from: <https://www.health.org.uk/publications/long-reads/managing-uncertainty>

^{xxxviii} <https://www.theguardian.com/society/2021/sep/02/nhs-needs-10bn-annual-boost-to-tackle-backlog-and-covid-cost>

^{xxxix} An ongoing survey being run by Asthma UK and the British Lung Foundation through their [post-COVID HUB](#). Since June 2020, the survey has so far been filled in by almost 1,000 people, of which over 800 had not been in hospital with COVID.

^{xl} Asthma UK, Asthma facts and statistics. Available at: <https://www.asthma.org.uk/about/media/facts-and-statistics/>

COPD statistics estimated through QoF for England and Wales, Scottish health survey and RQIA in Northern Ireland.

^{xli} Chartered Society of Physiotherapy, Pulmonary Rehabilitation in COPD, <https://www.csp.org.uk/professional-clinical/professional-guidance/pulmonary-rehabilitation-copd> and Taskforce for Lung Health analysis of CSP's COPD Prime Tool

^{xlii} Stone et al. *Clinical audit of COPD exacerbations admitted to acute units* p.15

^{xliiii} NICE (2010) *Clinical Guideline 101* p.7

^{xliiii} Jones, RCM et al. (2014). *Opportunities to diagnose chronic obstructive pulmonary disease in routine care in the UK: a retrospective study of a clinical cohort*. *The Lancet Respiratory Medicine*, 2 (4), 267-276 p.267

^{xliiii} <https://www.express.co.uk/life-style/health/1484505/flu-season-winter-2021-prediction-evg>

xliiii

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/5august2021>

Sept 2021