Diagnosing the Problem: Right test, right time

Executive summary

August 2023

Accurate and timely diagnosis of respiratory disease requires primary care pathways that ensure prompt access to diagnostic tests, in particular spirometry and fractional exhaled nitric oxide (FeNO) testing for asthma and chronic obstructive pulmonary disease (COPD), the two most common lung conditions in the UK.

Early and accurate diagnosis of respiratory conditions should be prioritised. This will require funding solutions such as commissioning or other incentives. Our clear and accessible clinical best practice case studies demonstrate how this can be achieved in practice.

This report also discusses how the establishment of ICSs provides greater scope for local planning to meet the needs of local populations.

This report outlines that CDCs are intended to add capacity, not replace it from primary care. Action is still needed elsewhere in primary care and services should not rely on CDCs to meet diagnostic demand in their area.

Forthcoming developments such as the **pre-diagnosis breathlessness pathway Diagnostic Pathway Support Tool**,[1] and the use of AI in spirometry, promise improvements to timely and accurate diagnosis. However, those working in diagnostic testing in primary care in England should not wait for alternative solutions to be developed, as action is needed now.

Barriers to the delivery of key diagnostic tests

Diagnostic tests such as spirometry are not being performed universally across primary care at the moment. Key barriers to the provision of spirometry and FeNO testing include workforce and equipment issues (including training), funding (commissioning), challenges with guidelines and certification, as well as lingering estates/spaces and infection prevention and control issues post pandemic.[2]

During the pandemic there was uncertainty around whether tests like spirometry were an aerosol generating procedure (AGP), which led to services being paused due to concerns around estates and spaces, and infection prevention and control. However, **clear guidance** now states that it is safe to restart spirometry, and there is an urgent need to restore universal access to quality-assured spirometry for all who need it.[3] To remedy this, spirometry must be provided in primary care.

This report aims to identify potential solutions to these common barriers, as follows:

1. Workforce and equipment: Some areas may use a lower-band (3/4) member of staff (possibly through the Additional Roles Reimbursement Scheme (ARRS)) who is trained to deliver the tests and a higher-band (6/7) colleague for interpretation or reporting. See case study three, pp. 27-28 (Open Door Surgery, Balham).

2. Training and accreditation: funding training is key. Case study four, pp. 33-34, describes the work Wessex Academic Health Science Network (AHSN) have done to lead Accelerated Access Collaborative (AAC) work on FeNO testing.

3. Estates, spaces and infection prevention and control: managing COVID-19 as endemic is now recommended, as with any other respiratory infections in winter. Where clinical space is a challenge, weekend clinics like the one described in case study three, pp. 27-28, can help to address this, as spirometry clinics can be arranged when there is less competition for clinical space. Another solution is travelling diagnostic vans, outlined in case study five, pp. 36-37.

4. Lack of funding for spirometry: this remains the biggest barrier in many areas. The Gloucestershire Local Enhanced Service (LES) discussed in case study six (pp. 39-40) is run as a not-for-profit paid-for service.

Key policy recommendations

- **Prioritise respiratory health at ICS level:** Each area should have a local policy about respiratory testing that ensures that NICE guidelines are followed.
- **Integrated Care Boards (ICBs) should develop business cases for respiratory diagnostics** in their area, assessing local need and investing the necessary resources and training, knowing that this is cost effective. If this requires dedicated funding, this should be prioritised.
- Ensure **a respiratory lead in each ICS**.
- **Workforce:** ICBs should have a clear and strategic view of current and future demand on their service and should plan to adequately meet this demand for their population, ensuring that there is an appropriately qualified workforce in place.
- Current practice shows that a number of workforce models are being implemented successfully. ICBs should identify which model will suit their area best.
- **Training:** ICBs should prioritise delivery of training to ensure respiratory workforce are able to perform/interpret spirometry results with appropriate certification.
- **Estates and Infection Prevention and Control (IPC):** read the latest guidance on managing the risk of respiratory infection as endemic and ensure universal access to quality-assured spirometry for all that need it.
- **Funding spirometry:** specific funding is needed to improve spirometry training at primary care level.
- Recognise all costs involved for any provider who wants to provide respiratory tests.
- Develop local payment mechanisms to ensure no one is disadvantaged by setting up a service to meet local needs. Funding should be made available via GP or PCN contracts, or any other suitable mechanisms.
- Ensure that all patients have equitable access to these tests with appropriate governance around the quality of provision and interpretation.
- Providers also need scope to use funding allocated for spirometry training more broadly to cover costs of overheads. Greater flexibility for ICBs to allocate funding where it is most needed would be much more useful.
- Spirometry should be incentivised as a paid-for diagnostic test within the GP contract, until a standardised national or guide tariff for diagnostic testing for different settings can be developed.
- **The role of CDCs:** ICBs should take the role of CDCs carefully into account, ensuring integrated provision across primary care. CDCs should not be relied upon as the sole provider of respiratory diagnostic tests.
- We ask your ICS to restart quality-assured spirometry in primary care in full by the end of the 2023/24 financial year, and to ensure that these tests are available at all community diagnostic hubs, regardless of size or classification.
- NHS England should provide clear guidance that CDCs are intended to boost diagnostic capacity alongside provision in primary care and are unlikely to be able to deliver all respiratory diagnostic testing, even when fully up and running.
- **Targeted Lung Health Checks (TLHCs):** people presenting to TLHCs with respiratory symptoms should have spirometry performed, as per the recommendation in the TLHC national protocol. This is a diagnostic test, not screening.
- **Children and Young People (CYP):** recommendations on early and accurate diagnosis within the NHS

England National Bundle of Care for Children and Young People with Asthma should be kept up to date and implemented universally.

- To address training and registration issues, ARTP (Association for Respiratory Technology & Physiology) should consider making combined certification available for both adults and children and young people, to recognise the skills and experience gained by providing one service and encouraging this to be applied in practice to all people with lung conditions who are able to complete testing, irrespective of their age.
- **Future developments: swift introduction of the new pre-diagnosis breathlessness pathway for adults:** we need to see wider promotion and roll-out of this pathway within ICSs within the next 12 months, to ensure widespread uptake so people with lung health conditions have more consistent and rapid access to diagnosis.
- The results of the pilots of the breathlessness pathway must also be analysed by NHS England as soon as possible, to scope out and understand the staffing models needed so the pathway can enable rapid diagnosis for all those who need it.
- **Research:**
  a) Investigate the best ways to train staff / support them to interpret results.
  b) Investigate possibilities around home monitoring / digital testing.
  c) Investigate service delivery, to establish how different models may work best for varied local settings.

Appendix: References

1 NHS England. 2023. *Adult breathlessness pathway (pre-diagnosis): diagnostic pathway support tool.* Accessed **here** (May 2023).

2 Taskforce for Lung Health. 2023. *The Future of Spirometry in Primary Care.* Accessed **here** (May 2023).

3 Association for Respiratory Technology & Physiology (ARTP). 2022. *COVID-19 Information.* Accessed **here** (March 2023).