Taskforce for Lung Health

Breathing Life into the NHS:

Improving outcomes, reducing inequalities, and enabling innovation through a respiratory Modern Service Framework

Produced by

Taskforce for Lung Health

The Taskforce for Lung Health is a collaboration of the largest ever group of organisations and individuals who have come together to improve lung health in England.

The Taskforce has nearly 50 members including patients, carers, healthcare professionals, the voluntary sector and professional associations.

The Taskforce for Lung Health receives financial support from both pharmaceutical and med-tech companies. However, contributing companies have no editorial control over Taskforce activities, decisions, or publications. The Taskforce for Lung Health retained full editorial control over the content of this report. A full list of contributing companies in 2026 can be found at **www.taskforceforlunghealth.org.uk**.

Contents

Why respiratory should be in the next wave of MSFs	04
Understanding patients' experiences of care	11
The building blocks of a respiratory MSF	15
Creating a scalable, equitable and innovation-ready system	22
Delivering Government priorities through a respiratory MSF	29
Next steps: An invitation to co-design a respiratory MSF	32
Taskforce organisational members endorsing this report	35
References	36

Why respiratory should be in the next wave of MSFs

Sarah Sleet

Chair of the Taskforce for Lung Health and CEO of Asthma + Lung UK

The case for improving respiratory health is overwhelming. We have already set out the need for change in our 'Consensus Statement for a Modern Service Framework for Respiratory'[1]. Current outcomes are unacceptable, with high levels of avoidable illness, premature mortality and the widest health inequalities of any major condition.

The Government has been clear that Modern Service Frameworks (MSFs) will be used to drive improvement where there is potential for rapid and significant gains in both quality of care and productivity. Respiratory is the ideal candidate and should be prioritised immediately given the significant opportunity to improve population health, reduce system pressure and increase productivity at scale.

Despite affecting around one in six people in England[2] and being the third leading cause of death[3], progress has lagged behind comparable conditions. This reflects inconsistent delivery of effective interventions, not a lack of clinical knowledge.

Respiratory disease has a substantial economic impact, contributing to economic inactivity and reduced productivity. For many people, respiratory conditions can limit their ability

to carry out everyday activities, remain independent and participate fully in work, family and community life. It is also a major driver of NHS pressure, particularly in winter, with breathing issues being the leading cause of all emergency admissions[4]. Both issues can be addressed through a more proactive model of care focused on prevention, early intervention and community delivery, enabled by a respiratory MSF.

The opportunity is huge. Evidence-based interventions already exist that can improve outcomes, reduce pressure on the NHS and address inequalities. A respiratory MSF offers a viable mechanism to reduce unwarranted variation and health inequalities at scale, creating a consistent national approach rather than relying on differing local priorities.

A respiratory MSF would also deliver an opportunity to create the conditions to accelerate research, innovation and adoption. UK respiratory research and innovation is world class, but it is not supported by the conditions needed to maximise its impact and value. An MSF offers the standards and consistency required to unlock this potential.

Fundamentally, a respiratory MSF would:

- Improve outcomes and quality of life
- Reduce health inequalities
- Alleviate NHS pressure and improve productivity
- Support economic participation
- Strengthen the UK's position in life sciences

There is clear consensus across the system. Through the Taskforce for Lung Health, patients, clinicians and partners support the need for a respiratory MSF to embed systematic, national improvement.

This report is a step forward in that process. It sets out potential key interventions aligned to patient priorities and MSF ambitions, while supporting further engagement across the system. In parallel, we are working with partners to develop a comprehensive, sector-backed roadmap for a respiratory MSF, drawing on the full breadth of our expertise.

This is a rare opportunity to deliver meaningful, system-wide change. We are determined to seize it.

> **"I don't feel like I'm living day to day, I feel like I'm just waiting for this disease to take me."**
>
> **– Person living with interstitial lung disease**

About this report

This report draws on extensive engagement conducted between January and March 2026, involving clinicians, patients, charities, professional bodies, academics, industry partners and system leaders. This included a formal consultation with 40 responses and patient insight generated through a survey of more than 100 people with lung conditions and in-depth online sessions with 20 patients from under-represented groups over five weeks.

Building on the case for change set out in the consensus statement, the report outlines the key elements of a respiratory MSF and how these could be delivered to achieve rapid and measurable improvement.

Lung health and the need for improvement

8x

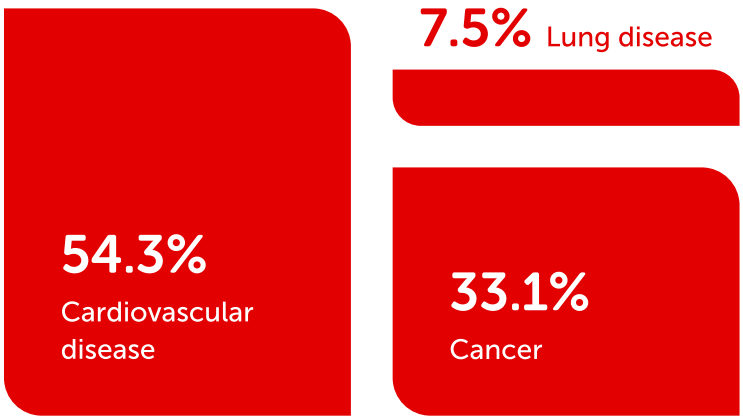
Avoidable respiratory mortality is over 8 times higher in the **most deprived** areas in England than in the least deprived.[5]

12%

Between 2022/23 and 2024/25, there was a 12% increase in the rate of emergency admissions for respiratory disease in England.[6]

60%

of respiratory disease deaths among people aged under 75 in England in 2024 were due to causes deemed preventable.[7]



Between 2001 and 2024 in England, the rate of preventable deaths from respiratory disease decreased by 7.5% among people under the age of 75. This is compared to a decrease of 54.3% for cardiovascular disease and a decrease of 33.1% for cancer.[8]

The UK has the **highest death rate** from respiratory disease in Europe.[9]

In 2019, lung conditions cost the UK economy an estimated

£188bn[10]

In 2025, there were

821,520

emergency hospital admissions for respiratory disease[11] and 65,021 deaths in England.[12]

Respiratory conditions affect around

1 in 6

people in England[13] and are the **third leading cause of death.**[14]

Summary

Understanding patients' experiences of care

Care is characterised by inequality in access, quality and outcomes. Diagnosis is often late or inaccurate, pathways are fragmented, and coordination across services is limited.

There is the opportunity for rapid improvement

There is strong consensus on a set of evidence-based interventions that can improve outcomes and reduce demand. Many are already in use in parts of the system, but access remains uneven and delivery inconsistent.

The building blocks of a respiratory MSF

A "moonshot" – the goal that can be achieved

A 25% reduction in premature respiratory mortality and halving the deprivation gap by 2036.

Core interventions with potential for rapid, wide-reaching impact, delivered closer to home

- **Smoking cessation** and prevention embedded within care pathways
- **Immunisation** to reduce exacerbations and deterioration
- **Timely and accurate diagnosis** through systematic use of diagnostics, earlier identification and proactive case finding
- **Structured education and self-management** tailored to patients' needs
- **High-quality basic care** aligned to clinical guidelines
- **Pulmonary rehabilitation** to improve outcomes and reduce admissions
- **Access to advanced therapies** through clear referral pathways
- **Integrated biopsychosocial** care within multidisciplinary teams

Service and system interventions for delivery at scale

- Neighbourhood models delivering integrated, proactive and preventative care keeping people out of hospital
- Structured post-exacerbation and high-risk pathways to reduce readmissions
- Digital and virtual care models to support self-management
- Dedicated respiratory clinical leadership to drive service improvement
- Integrated multimorbidity approaches to improve outcomes across conditions
- Addressing poor housing, air pollution and deprivation

Enablers for delivering improvement at pace

- Workforce design, capacity and capability aligned to integrated, pro-active, community-based care
- Consistent data, coding and population health management
- Access to diagnostics and supporting infrastructure
- Incentives and accountability mechanisms to drive behaviour change
- Embedded evaluation and research within care pathways
- A strong focus on equity to reduce variation and inequalities

An opportunity for research, innovation and growth

More consistent pathways and data would enable faster research, improved trial recruitment and stronger real-world evidence, alongside a coordinated approach which would support adoption of new technologies and treatments at scale.

Understanding patients' experiences of care

Our survey and direct qualitative engagement with patients found consistent, system-wide challenges in respiratory care. Delays, fragmentation, missed diagnoses and a lack of holistic support are not isolated issues but reflect the absence of a coherent national framework.

Delays in access were reported at every stage, from difficulty securing GP appointments to long waits for tests and results. Patients often described deterioration while waiting, leading to crisis presentations. Patients living with pulmonary fibrosis reported significant delays often driving them to private care for help for their life-limiting condition. This underlines the need for clear expectations on timely access to diagnostics, follow-up and specialist care.

> **“When I had my lung function test, I was told that the results would be back in around 11 weeks. I actually waited five months before I heard anything … I felt really let down, and abandoned, uncared for. I felt as though … I didn’t matter.”**
>
> – Person with COPD

Fragmentation of care is a defining feature of the current system. Patients frequently have to co-ordinate their own care across services, creating inefficiency and clinical risk, particularly for those with multiple conditions. More integrated, multidisciplinary models with shared records are needed to improve coordination and accountability.

> **“My daughter got loads of help, as we did when she was little, very quickly diagnosed, very quickly put on a treatment plan, looked after for a long time, till she hit about 12 or 13. Then it died away... So there was like no transition at all. It was like a rock solid wall in her early teens and then starting again as she got older. And that’s the battle she had and we had with her. There was no almost continuation of care.”**
>
> – **Parent of someone with a respiratory condition**

Missed and late diagnoses are common, with some patients experiencing years of incorrect or unclear diagnosis. This leaves patients at risk of further damage to their lungs while they wait for a diagnosis and appropriate treatment. This reinforces the need for systematic approaches to early and accurate diagnosis, supported by wider access to testing and clear pathways.

> **“Initially GPs would not accept there was a respiratory issue four years ago when I was struggling with symptoms and infections affecting my daily life. One GP was convinced it was an abdominal problem rather than respiratory despite having had a productive chesty cough and breathlessness for months and I was sent for many other investigations other than respiratory to rule those out first before considering a respiratory referral. All of this caused considerable delay whilst respiratory symptoms were ongoing”**
>
> – **Person with asthma and sleep apnoea**

Patients also described a lack of holistic, personalised care. Factors such as mental health, employment and housing are often overlooked, despite their impact on outcomes, highlighting the need for more integrated, patient-centred models.

> **“We need to be listened to, have time to learn how to manage our condition, understand our medications, have clear plans to know what to do if our treatment doesn’t work.”**
>
> – Person with asthma

The emotional and psychological burden of respiratory disease is frequently underestimated. Patients reported anxiety, isolation and loss of independence, often without appropriate support, with impacts extending to family members and carers, highlighting the need to embed psychological expertise within respiratory teams.

> **“Living with a life-limiting disease is very frightening and affects your mental well-being. I wish there was more mental health support to help you cope with the fear of a life-limiting disease”**
>
> – Person with pulmonary fibrosis

Communication and digital barriers further compound these challenges. Patients described confusion about their condition and treatment, as well as difficulty accessing or understanding information. Respiratory disease is strongly shaped by social determinants of health, but care often depends on an individual’s ability to self-advocate, disadvantaging those with fewer resources. This runs counter to the NHS’s equity ambitions and reinforces the need for proactive, targeted care.

> **“And it’s like little things like that, you’re always having to like chase it up, it’s like a full-time job to deal with all these things.”**
>
> – Person with bronchiectasis

Taken together, these findings provide a clear mandate for change. The current system is not consistently delivering timely, coordinated or equitable care. A respiratory MSF offers a structured approach to addressing these gaps at scale.

The building blocks of a respiratory MSF

The 10 Year Health Plan for England[15] defined several core elements of an MSF. It includes having a clear goal, evidence-based interventions, strategies for ensuring their uptake, and a plan to partner with the wider eco-system. Based on our research and engagement, the building blocks for a respiratory MSF are set out below.

A "moonshot" – the goal that can be achieved

A clear national goal is essential. For respiratory, this should focus on reducing premature mortality and closing the inequality gap, which is currently the largest of any major condition.

This level of ambition is achievable. Other disease areas, such as cardiovascular disease (CVD), have delivered significant improvements through sustained, system-wide action. If lung health had improved at the same rate as CVD over the past two decades, there would now be around 8,000 fewer deaths each year from lung conditions[16].

A 'moonshot':

A 25% reduction in premature respiratory mortality and halving the deprivation gap by 2036.

Progress should be tracked through a focused set of measures, including:

Outcome metrics

- Avoidable urgent respiratory presentations in community and out-of-hours settings
- Emergency admissions and readmissions for major respiratory conditions
- Health-related quality of life for people with long-term respiratory conditions

Economic and societal impact metrics

- Work and school absence linked to respiratory illness

System performance metrics

- Winter respiratory bed days
- Vaccination coverage among people with chronic respiratory disease
- Referral and completion rates of pulmonary rehabilitation
- Appropriate prescribing and correct use of inhalers
- Innovative treatment uptake and equity in access
- Time to diagnosis and treatment
- Reduction in tobacco use

These metrics provide a clear link to government priorities and create a framework for evaluating and scaling innovation.

Core interventions with potential for rapid, wide-reaching impact

Smoking cessation is one of the most effective interventions to prevent and slow progression of respiratory disease[17], particularly in high-risk and deprived populations, yet access to high-quality, embedded support remains variable and is not routinely integrated into care. A respiratory MSF would embed smoking cessation within respiratory pathways, setting expectations for systematic identification, referral and follow-up, and supporting consistent access across systems.

Immunisation reduces exacerbations, hospital admissions and deterioration in people with chronic lung disease[18], but uptake remains uneven, particularly among high-risk and deprived populations[19] and among children[20]. A respiratory MSF would support systematic identification and consistent delivery of vaccination, alongside monitoring of uptake and outcomes to reduce variation and improve coverage through additional access and encouragement of a make every contact count approach.

Timely and accurate diagnosis reduces misdiagnosis, delays and inappropriate treatment, but access to diagnostic tests such as spirometry, FeNO and CT imaging remains inconsistent, particularly in primary and community care[21]. A respiratory MSF would define minimum diagnostic standards and embed their consistent use within pathways, including direct access from primary care and neighbourhood services, supported by improved coding, data flows and case-finding. The recently announced chest X-ray self-referral pilot for people with symptoms suggestive of lung cancer, as part of the National Cancer Plan, may also increase identification of incidental respiratory findings. A respiratory MSF should ensure these findings are not missed by linking expanded imaging access to clear follow-up pathways, diagnostic confirmation, and timely referral into community respiratory care.

Structured education and self-management support improve patients' understanding, confidence and ability to manage respiratory disease, leading to better adherence, reduced exacerbations and improved quality of life, yet access to consistent, evidence-based education for patients, parents and carers remains variable and is not routinely embedded within pathways[22]. A respiratory MSF would support the development and rollout of nationally consistent structured education programmes, embedded within respiratory pathways and tailored to different conditions and population groups.

High-quality basic care improves disease control, reduces exacerbations and avoidable hospital admissions, and supports better quality of life, yet delivery remains inconsistent. Key elements of routine care, including inhaler technique checks, monitoring symptom control, reviewing oral corticosteroid (OCS) use

and timely follow-up after worsening symptoms, are not consistently embedded across pathways. A respiratory MSF would support consistent implementation of evidence-based respiratory care across primary, community and specialist settings.

Pulmonary rehabilitation (PR) improves breathlessness, exercise capacity and quality of life, while reducing hospital admissions and healthcare use, with an estimated 8:1 return on investment[23], yet it is not offered to all eligible patients[24]. A respiratory MSF would set clear expectations on referral, access, capacity and completion, reinforced by standardised pathways, and would support the scaling of digital and hybrid models.

Access to advanced therapies, including biologics, antifibrotics and lung volume reduction procedures, can significantly improve outcomes and quality of life, yet access varies across systems[25, 26]. A respiratory MSF would define clear referral criteria and standards, ensuring equitable access and consistent use, supported by outcomes tracking, enabling evaluation and wider adoption.

Integrated biopsychosocial care improves quality of life, treatment adherence and overall outcomes, yet psychological support is not routinely embedded within respiratory pathways[27]. A respiratory MSF would embed psychological support within multidisciplinary care, setting expectations for access and integration, while enabling evaluation of different models and their impact on outcomes.

“Bronchiectasis was very much a Cinderella condition. So much of my poor treatment in the past was due to a lack of understanding on the part of medics. There was no need for me to be as ill as I sometimes was... But two key problems stand out for me: lack of coordination between primary and secondary care; a shortage of the appropriate workforce to carry out the treatments and support now known to be necessary/possible to give patients a good life and keep them from hospitalisation as far as possible.”

– Person with bronchiectasis

Service and system interventions for delivery at scale

Primary care led neighbourhood models deliver multidisciplinary care closer to home, including community diagnostics, rehabilitation and pharmacy support, improving access, coordination and patient experience while reducing pressure on hospital services[28]. A respiratory MSF would support defining the core components of neighbourhood respiratory models, including workforce, diagnostics and multidisciplinary delivery, setting expectations for consistent implementation while allowing local flexibility. It would also support equitable access to specialist respiratory care through clear referral routes and escalation pathways from neighbourhood teams into secondary and tertiary services. It would also support evaluation of different models of care, enabling innovation in service delivery.

Post exacerbation and frequent attender pathways improve recovery and reduce readmissions. Only four patients need to receive pulmonary rehabilitation after an exacerbation to prevent one readmission[29], yet timely access to follow-up, rehabilitation and proactive management remains limited. A respiratory MSF would establish standardised post-exacerbation pathways, including timely review, access to PR, breathlessness interventions, medication optimisation and psychosocial support, alongside proactive management of high-risk patients. It would also support research into risk stratification and integrated virtual support to reduce readmissions.

Digital and virtual care can improve outcomes and reduce hospital use through self-management tools, remote monitoring and virtual wards, but there is limited clarity on where these models add most value[30]. A respiratory MSF would define where digital and virtual models should be used, set expectations for implementation, and support consistent evaluation of their impact on admissions, patient experience and workforce, creating a clearer evidence base for scaling effective approaches.

Respiratory clinical leadership is essential to translating national ambition into local delivery, supporting pathway redesign, quality improvement, innovation and reduction of unwarranted variation. However, respiratory leadership capacity has been reduced across many Integrated Care Systems, regional teams and Primary Care Networks, limiting the ability to implement and sustain service transformation[31]. A respiratory MSF would support dedicated respiratory clinical leadership at neighbourhood, system and regional level, helping to drive implementation, strengthen clinical governance, support multidisciplinary working and ensure that data, evidence and innovation are translated into improved outcomes for patients.

Multimorbidity approaches can improve outcomes and reduce duplication by integrating respiratory and cardiovascular care, reflecting the high overlap between conditions, with cardiovascular disease present in 30% to 60% of hospitalised COPD patients[32], yet care pathways remain fragmented. Multimorbidity care should also include access to occupational therapy within multidisciplinary teams, supporting people to manage breathlessness and fatigue in everyday activities. A respiratory MSF could support integrated pathways, including shared risk stratification, coordinated diagnostics and aligned management approaches, enabling development and evaluation of cross-pathway models to improve outcomes.

Poor housing, air pollution and deprivation are major drivers of respiratory ill health, exacerbations and health inequalities, contributing to higher rates of asthma, COPD and respiratory infection in disadvantaged communities[33]. Exposure to damp, mould, cold homes and poor outdoor air quality increases the risk of developing and worsening lung conditions, yet action across health, housing and local government remains fragmented[34]. A respiratory MSF would support a more coordinated approach to prevention and respiratory health improvement, embedding links between respiratory services, public health, housing and environmental policy. It would also support targeted action in high-risk communities.

This set of interventions provides a clear foundation for delivery. An MSF would enable them to be implemented consistently, and evaluated systematically, creating a pathway that supports both better outcomes and ongoing innovation.

Creating a scalable, equitable and innovation-ready system

A primary care-anchored model that supports equity and innovation

There is strong cross-sector agreement, reflected in NICE guidelines, that most respiratory care should be led in primary care and neighbourhood teams, with specialist services providing targeted support and specialist interventions, while ensuring timely access to specialist and tertiary expertise for complex, rare or severe conditions, including interstitial lung disease and pulmonary fibrosis, rather than hospitals acting as the default entry point to care. A respiratory MSF would operationalise this shift by setting clear standards at Primary Care Network level, moving care from a reactive, hospital-based model to a proactive system focused on prevention, early diagnosis and long-term management. Delivering this shift will require strong clinical leadership across primary, community and specialist care to support pathway redesign, build confidence in new models of care, and drive consistent implementation.

Primary care also offers a significant opportunity to maximise the use of digital tools and partnership working to support people with respiratory conditions. The Government's Diagnosis Connect programme has identified respiratory as a priority area, with plans to better connect patients with trusted charities to support earlier access to personalised advice, emotional support, information, and community services alongside their NHS care[35]. Respiratory self-management is an early priority for integration into the NHS digital services through specialised apps, as identified by the NICE Early Value Assessments for respiratory digital technologies. These innovations enable quicker intervention and reduce avoidable demand on hospital services.

From an inequalities perspective, an MSF would build on Core20PLUS5, which identifies respiratory disease as a priority, for adults and children, and includes smoking as a key cross-cutting intervention. An MSF would support broader, targeted action across tobacco control, air quality and housing, alongside tracking outcomes across deprivation, ethnicity and housing status to drive improvement.

Case study

Putting the pathway into practice, a multi-neighbourhood respiratory model in Birmingham

Birmingham provides a practical example of how a multi-neighbourhood model can work at scale. Across five localities, the system is shifting respiratory care into primary and community settings while maintaining strong links to specialist services. Primary care teams focus on prevention, early identification and routine management, supported by access to community diagnostics. Neighbourhood hubs provide multidisciplinary care, including assessment, rehabilitation and follow-up, with regular input from specialist teams. This creates a more flexible pathway, allowing patients to move between community and specialist care as needed, rather than remaining in hospital-led pathways. The result is improved access, better coordination and more effective use of specialist capacity. This demonstrates that an MSF would not need to create new models, but scale and standardise approaches that already exist.

Unlocking research, innovation and investment

In 2022, industry-sponsored clinical trials contributed £7.4 billion to the UK economy; generated £1.2 billion for the NHS; and supported around 65,000 jobs[36]. Clinical trials provide patients with access to innovative treatments not otherwise available.

The UK has a unique advantage in clinical research through its NHS data and life sciences ecosystem. However, fragmented data systems, complex governance and slow study set-up continue to limit patient recruitment and participation. This is particularly acute in respiratory disease, where eligible populations are often difficult to identify through routine data, and variation in care makes it harder to establish consistent baselines for research.

A respiratory MSF would help address these barriers by providing a coordinated, primary care-anchored platform linking NHS organisations, data partners, academia and industry. This would enable faster study set-up, improve recruitment and support more consistent delivery of trials within care pathways. It would provide a clearer route for engagement, supporting investment and helping to translate innovation into practice. Strengthening the respiratory research ecosystem could unlock greater investment and wider economic benefit. If respiratory research funding proportionally matched the burden of disease, it could have contributed an additional £851 million to the economy between 2023 and 2030[37].

Case study

AI-enabled breathing tests helping diagnose lung disease earlier and more accurately

AI-supported breathing tests show how practical innovation can improve access and diagnosis. These tests are essential for diagnosing conditions such as asthma and COPD, yet access and interpretation remain inconsistent. In the North East and North Cumbria, evaluation of ArtiQ.Spiro showed that it improved test quality and reduced interpretation time by around 50%, while supporting clinicians to identify cases requiring further investigation[38]. This addresses a key challenge in respiratory care: delayed and variable diagnosis. The technology is now moving into wider NHS use, with NICE supporting adoption alongside further evidence generation. This reflects a broader pipeline of digital innovation with the potential to transform respiratory pathways.

Enablers for delivering improvement at pace

Delivering improvement at scale requires more than clinical standards. It depends on workforce, infrastructure, data and incentives being aligned with a clear delivery model.

Workforce design, capacity and capability are essential to delivering rapid improvement, with neighbourhood teams needing sufficient skills and time to provide high-quality respiratory care. This requires expanding capability across primary and community roles, alongside protected leadership time for multidisciplinary team working, service redesign and continuous quality improvement supported by appropriate clinical leadership.

Case study

National capabilities framework supporting a more skilled respiratory workforce

The National Capabilities Framework for Professionals who care for Children and Young People with Asthma provides a practical example of how nationally consistent standards can strengthen workforce capability in respiratory care. Developed by NHS England, the framework sets out clear competencies for professionals across healthcare, education and community settings, supported by aligned training and e-learning. This helps standardise knowledge, improve confidence and reduce variation in care for children and young people with asthma. The framework demonstrates how nationally defined capabilities and structured education can support more consistent, integrated and higher-quality respiratory care. A respiratory MSF could build on this approach by embedding nationally recognised competencies, training expectations and career development pathways across the wider respiratory workforce.

Diagnostics and infrastructure underpin delivery, as policy ambition will not translate into impact without sufficient capacity. Community spirometry, FeNO testing, imaging, pulmonary rehabilitation and virtual care all require infrastructure, quality assurance and clear referral and escalation pathways.

Data and population health management are critical to identifying risks, tracking delivery and measuring outcomes consistently. This depends on improved coding, shared records across care settings, timely diagnostic data flows and dashboards that support both performance management and evaluation.

Case study:

Virtual specialist support improving pulmonary fibrosis pathways

East of England interstitial lung disease (ILD) clinical network demonstrates how integrated specialist networks can improve care for complex respiratory conditions. Since 2023, the network has piloted the OneVoiceILD Optimum Integrated ILD Care Pathway, using a virtual regional multidisciplinary team to support specialist and non-specialist sites. This has enabled more pulmonary fibrosis care to be delivered locally while maintaining access to specialist expertise. In the first year, 77% of patients discussed had a change in diagnosis, 38% were identified as suitable for antifibrotic treatment, and 39% avoided unnecessary travel by continuing care locally, improving coordination, consistency and specialist capacity across the region. An MSF could support scaling of the impact of initiatives like the OneVoiceILD and support more equitable access to specialist expertise and tackle unacceptable variation[39].

Incentives and accountability are needed to drive behaviour change. This includes transparent outcome reporting, equity metrics, targeted improvement support and incentives, such as the Quality and Outcomes Framework, and directed and local enhanced services, aligned to prevention, early diagnosis and care closer to home.

Evaluation embedded in delivery ensures that service change is measurable from the outset. Rapid-cycle evaluation of diagnostics, post-exacerbation care, rehabilitation and virtual pathways should guide adoption based on evidence rather than local variation or enthusiasm.

Research-ready pathways enable respiratory care to function as a learning health system, with research embedded. Standardised pathways, outcomes and follow-up support recruitment, real-world evidence and continuous improvement in care.

Equity as a core principle is essential given the strong social patterning of respiratory disease. Improvement must be targeted through stratification by deprivation, ethnicity and housing, alongside outreach and accessible delivery to avoid widening inequalities.

Put simply, the infrastructure needed to deliver an MSF is the same infrastructure required for a strong research and innovation ecosystem. By bringing this together, an MSF would create a platform for improvement, investment and innovation.

Case study

Next-generation inhalers improving patient care while driving UK innovation

Next-generation inhalers are an example of how respiratory innovation can deliver both patient benefit and economic growth. These new inhalers significantly reduce environmental impact while maintaining clinical effectiveness for some lung conditions. They are already moving through the pipeline into real-world use, supported by UK-based manufacturing, research and regulatory activity. This positions the UK as a leader in both clinical innovation and sustainable healthcare. A respiratory MSF would support adoption at scale, embedding these technologies into routine care, generating real-world evidence and providing a clear route for industry collaboration. This would ensure that innovation delivers both improved outcomes for patients and long-term value for the UK economy.

Delivering Government priorities through a respiratory MSF

Delivering the 10-Year Health Plan

The three shifts in the 10-Year Health Plan are the right direction for the NHS, and respiratory disease offers a clear route to deliver them. This includes earlier diagnosis and management in community settings, more systematic prevention through smoking cessation and vaccination, and scaling digital models such as remote monitoring, pro-active multidisciplinary team clinical care, virtual wards and self-management.

Supporting elective recovery and system flow

Respiratory disease is a major driver of emergency admissions and seasonal pressure, contributing to high bed occupancy and delays in elective care. It is an area of priority focus as set out in the Government's plan for 'Reforming elective care for patients'[40]. Respiratory disease also places significant pressure on ambulance services, particularly during winter[41], and reducing respiratory-related demand could support improved ambulance response times, turnaround times and wider operational performance metrics. Delayed diagnosis and limited access to community diagnostics also lead to inefficient referrals and repeat outpatient demand. A respiratory MSF would support recovery by reducing admissions and length of stay through earlier intervention and consistent post-exacerbation care, improving referral quality through stronger community diagnostics, and shifting follow-up into neighbourhood and virtual models. Respiratory is therefore both a source of pressure and part of the solution.

Aligning with the Neighbourhood Health Framework

The Neighbourhood Health Framework prioritises integrated, locally-led care. A respiratory MSF would provide national consistency while allowing local flexibility, strengthening multidisciplinary working, improving coordination across care settings, and embedding prevention and population health into routine pathways. Expanded access to community diagnostics would reduce delays and improve patient flow.

Enabling the Life Sciences Sector Plan

Respiratory disease presents a significant opportunity for the UK's life sciences ambitions, but fragmented care limits progress. A respiratory MSF would support research and innovation through clearer pathways, consistent outcomes and improved data, enabling faster trials, better recruitment and stronger real-world evidence, while embedding innovation in routine care.

Delivering transformation programmes

Programmes such as the Respiratory Transformation Partnership and Pathway Transformation Fund are already driving improvement. A respiratory MSF would scale this work nationally, aligning stakeholders, supporting evaluation and moving effective models into practice.

Supporting environmental sustainability

By preventing exacerbations, reducing avoidable hospital use and supporting the appropriate use of lower-carbon treatments where clinically suitable, a respiratory MSF would contribute to NHS net zero ambitions while improving outcomes for people with lung conditions.

A respiratory MSF offers a coherent way to improve outcomes, reduce NHS pressure and support economic growth. It provides a practical route to deliver government priorities while strengthening the UK's position in life sciences.

Next steps: An invitation to co-design a respiratory MSF

This report is the starting point for a collaborative conversation, inviting Ministers, NHS England, Department of Health and Social Care, HM Treasury, Department for Business and Trade, industry and the research community to co design a respiratory MSF that:

Aligns an ambitious moonshot goal with a focused set of high-value interventions.

Uses respiratory as a testbed for primary care-led neighbourhood models.

Explicitly integrates research and innovation into its delivery model.

The Taskforce for Lung Health recommends that:

1. Ministers commit to the development and implementation of a respiratory MSF

The scale of avoidable harm, NHS pressure, inequalities and productivity loss, combined with a strong, sector-backed improvement and research agenda, makes respiratory a clear priority.

2. Government and NHSE convene a focused co-design process

Building on the work underpinning this report, this should bring together clinical leaders, patients, Integrated Care Systems, local government, life sciences, data partners and economists to shape the final moonshot goal and metrics, the core intervention bundle and stretch ambitions, and the research and innovation priorities to be embedded from the outset.

3. Ministers and officials deliver policy, investment and system levers needed for a respiratory MSF to succeed

In particular, this should consider the balance between national consistency and local flexibility; the level and nature of investment and incentives needed to shift care into primary and community settings; the protection of respiratory clinical leadership, and how MSF implementation can best align with the UK's life sciences and innovation growth agenda.

Respiratory disease is a standout opportunity for Government to show how MSFs can drive better outcomes, cut pressure on the NHS, and position the UK as a global leader in respiratory research, innovation and commercial investment.

It is rare to find a single policy area that can simultaneously address system pressure, health inequalities and economic growth; respiratory is that opportunity.

The Taskforce for Lung Health, and the wider respiratory sector, is ready to work at pace with Government, NHS England and system partners to design and deliver a framework that unlocks this potential.

Taskforce organisational members endorsing this report

- Action for Pulmonary Fibrosis
- Association of the British Pharmaceutical Industry
- Association of Chartered Physiotherapists in Respiratory Care
- Association of Respiratory Nurse Specialists
- Association for Respiratory Technology and Physiology (UK)
- Asthma + Lung UK
- British Society of Thoracic Imaging
- British Thoracic Oncology Group
- British Thoracic Society
- Chartered Society of Physiotherapy
- Community Pharmacy England
- Cystic Fibrosis Trust
- Health and Safety Executive
- Interstitial Lung Disease Interdisciplinary Network
- Mesothelioma UK
- Primary Care Respiratory Society
- Pulmonary Fibrosis Trust
- Respiratory Futures
- Roy Castle Lung Cancer Foundation
- Royal College of Anaesthetists
- Royal College of General Practitioners
- Royal College of Occupational Therapists
- Royal College of Paediatrics and Child Health
- Royal College of Pharmacy
- Royal College of Physicians
- Royal College of Radiologists
- Sarcoidosis UK
- Society for Cardiothoracic Surgery in Great Britain and Ireland, on behalf of the Royal College of Surgeons
- UK Lung Cancer Coalition

References

1 **Taskforce for Lung Health.** *A Modern Service Framework for Respiratory.* November 2025. Available at: https://live-aluk-taskforce.pantheonsite.io/wp-content/uploads/2025/11/MSF-consensus-paper-FINAL.pdf

2 **Institute for Health Metrics and Evaluation.** *Global Burden of Disease 2023: Findings from the GBD study.* 2025. Available at: https://www.healthdata.org/research-analysis/library/global-burden-disease-2023-findings-gbd-2023-study

3 **Office for National Statistics.** *Deaths Registered in England and Wales.* 2025 (2024 data). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenglandandwalesseriesdrreferencetables

4 **Asthma + Lung UK.** *Breathing issues are the leading cause of all emergency admissions.* 2024. Available at: https://www.asthmaandlung.org.uk/media/press-releases/breathing-issues-are-leading-cause-all-emergency-admissions

5 **Office for National Statistics.** *Socioeconomic inequalities in avoidable mortality in England and Wales.* February 2026, 2024 dataset. Additional calculations by Asthma + Lung UK. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/socioeconomicinequalitiesinavoidablemortalityinenglandandwales. Age standardised avoidable mortality rates per 100,000 population used.

6 **Taskforce for Lung Health.** *Hospital Admissions Trends Dashboard.* 2026. Available at: https://www.taskforceforlunghealth.org.uk/data-dashboards/trend/

7 **Office for Health Improvement and Disparities.** *Public Health profiles.* 2026. Additional calculations by Asthma + Lung UK. Available at: https://fingertips.phe.org.uk/profile/respiratory-disease. COVID-19 and lung cancer are not included in the respiratory diseases referred to.

8 **Department of Health and Social Care.** *Health trends in England.* 2026. Additional calculations by Asthma + Lung UK. Available at: https://fingertips.phe.org.uk/static-reports/health-trends-in-england/England/overview.html

9 **Eurostat.** *Causes of death – standardised death rate by NUTS 2 region of residence.* 2026 (2018 dataset). Available at: https://ec.europa.eu/eurostat/databrowser/view/hlth_cd_asdr2__custom_2053067/bookmark/table?lang=en&bookmarkId=cdf401a1-5053-4ef5-a270-e1e0390de382&c=1781699740000

10 **Asthma + Lung UK.** *Investing in breath: reducing the economic cost of lung conditions through increased research and innovation.* 2023. Available at: https://www.asthmaandlung.org.uk/investinginbreath-reducingeconomiccostoflungconditions-autumn-2023

11 **Taskforce for Lung Health.** *Hospital admissions trend dashboard.* Additional calculations by Asthma + Lung UK. Available at: https://www.taskforceforlunghealth.org.uk/data-dashboards/trend/

12 **Office for Health Improvement and Disparities.** *Public Health Profiles.* 2026. Available at: https://fingertips.phe.org.uk/profile/respiratory-disease

13 **Institute for Health Metrics and Evaluation.** *Global Burden of Disease 2023: Findings from the GBD study.* 2025. Available at: https://www.healthdata.org/research-analysis/library/global-burden-disease-2023-findings-gbd-2023-study

14 **Office for National Statistics.** *Deaths Registered in England and Wales.* 2025 (2024 data). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenglandandwalesseriesdrreferencetables

15 **Department of Health and Social Care.** *Fit for the Future: 10 Year Health Plan for England.* July 2025. Available at: https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf

16 **Asthma + Lung UK.** *Saving Your Breath.* September 2023. Available at: https://www.asthmaandlung.org.uk/saving-your-breath-report

17 **Willemse, B.W.M., Postma, D.S., Timens, W. and ten Hacken, N.H.T.** *The impact of smoking cessation on respiratory symptoms, lung function, airway hyperresponsiveness and inflammation.* European Respiratory Journal. 2004. Available at: https://publications.ersnet.org/content/erj/23/3/464

18 **Poole, P.J. and Black, P.N.** *Influenza vaccine for patients with chronic obstructive pulmonary disease.* Cochrane Database of Systematic Reviews. 2006. Available at: https://pubmed.ncbi.nlm.nih.gov/11034751/

19 **Powell, A., Jones, A., Van Hout, M.-C. and Montgomery, C.** *Influenza vaccine uptake in socially deprived areas: A multilevel retrospective population-based cross-sectional study using electronic health records in Liverpool, United Kingdom. Vaccine.* 2025. Available at: https://www.sciencedirect.com/science/article/pii/S0264410X25001343?via%3Dihub

20 **Zhang CX, Quigley MA, Bankhead C, Varughese R, Parekh N, Kwok CH, Carson C.** *Ethnic inequities in childhood influenza vaccination coverage in England 2013–2021: An observational cohort study.* Vaccine. 2025. Available at: https://www.sciencedirect.com/science/article/pii/S0264410X25010072

21 **Asthma + Lung UK.** *Integrated Care Systems Respiratory Review 2024/2025.* Available at: https://www.asthmaandlung.org.uk/healthcare-professionals/ics-respiratory-review

22 **Primary Care Respiratory Society UK (PCRS).** *Supported self-management for respiratory conditions in primary care.* Available at: https://www.pcrs-uk.org/sites/default/files/SupportedSelfCare_HPSJCT.pdf

23 **Charted Society of Physiotherapy.** *Adding Value, Changing Lives.* December 2025. Available at: https://www.csp.org.uk/system/files/documents/2025-12/Adding%20Value%2C%20Changing%20Lives.pdf

24 **Asthma + Lung UK.** *Life with a Lung Condition 2025, Basic care briefing.* December 2025. Available at: https://www.asthmaandlung.org.uk/sites/default/files/2025-12/Life%20with%20a%20Lung%20Condition%202025%20briefing.pdf

25 **Health Innovation Network.** *Improving access to asthma biologics.* Available at: https://thehealthinnovationnetwork.co.uk/programmes/respiratory-disease/improving-access-to-asthma-biologics/

26 **Lee J, Park S, Yoon H-Y.** *Effectiveness of antifibrotics on health-related quality of life in patients with interstitial lung disease: a systematic review and meta-analysis.* 2025. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12580519/

27 **Farver-Vestergaard I, Jacobsen D, Zachariae R.** *Efficacy of psychosocial interventions on psychological and physical health outcomes in chronic obstructive pulmonary disease: a systematic review and meta-analysis.* 2015. Available at: https://pubmed.ncbi.nlm.nih.gov/25547641/

28 **NHS England.** *Next steps for integrating primary care: Fuller stocktake report.* 2022. Available at: https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

29 **Maddocks, M., Kon, S.S.C., Singh, S.J. and Man, W.D.C.** *Rehabilitation following hospitalization in patients with COPD: Can it reduce readmissions?* Respirology. 2015. Available at: https://onlinelibrary.wiley.com/doi/10.1111/resp.12454

30 **NHS England.** *Rapid evaluation report: chronic obstructive pulmonary disease virtual ward enabled by technology.* 2023. Available at: https://www.england.nhs.uk/publication/rapid-evaluation-report-chronic-obstructive-pulmonary-disease-virtual-ward-enabled-by-technology/

31 **PCRS.** *Serious concerns regarding the erosion of respiratory leadership and expertise across ICBs, regional and primary care networks.* 2026. Available at: https://www.pcrs-uk.org/resource/current/pcrs-position-statement-serious-concerns-regarding-erosion-respiratory-leadership

32 **Cobb K, Kenyon J, Lu J, Krieger B, Perelas A, Nana-Sinkam P, Kim Y, Rodriguez-Miguelez P.** *COPD is associated with increased cardiovascular disease risk independent of phenotype.* Respirology. 2024. Available at: https://onlinelibrary.wiley.com/doi/10.1111/resp.14799

33 **Asthma + Lung UK.** *A mission for lung health.* Available at: https://www.asthmaandlung.org.uk/support-us/mission-lung-health

34 Ibid.

35 **Department of Health and Social Care.** *Patients with long-term conditions to receive help from charities.* July 2025. Available at: https://www.gov.uk/government/news/patients-with-long-term-conditions-to-receive-help-from-charities

36 **The Association of the British Pharmaceutical Industry.** *The value of industry clinical trials to the UK - extended report.* December 2024. Available at: https://www.abpi.org.uk/publications/the-value-of-industry-clinical-trials-to-the-uk-extended-report/

37 **Asthma + Lung UK.** *Investing in breath: reducing the economic cost of lung conditions through increased research and innovation.* 2023. Available at: https://www.asthmaandlung.org.uk/investinginbreath-reducingeconomiccostoflungconditions-autumn-2023

38 **Adams C., Smets E., Maes J., Rees J., Topalovic M.** *A case study on the impact of artificial intelligence supported spirometry in primary care.* Presented at the European Respiratory Society (ERS) Congress, 2024. Available at: https://publications.ersnet.org/content/erj/64/suppl68/pa4337

39 **NHS England.** *East of England. Annual Report 2024-2025 CVD, Respiratory, Diabetes and Renal Clinical Networks.* Available at: https://www.england.nhs.uk/east-of-england/wp-content/uploads/sites/47/2025/09/Annual-Report-2024-25-FINAL-PDF.pdf

40 **NHS England.** *Reforming elective care for patients.* January 2025. Available at: https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/

41 **BBC News.** *Life-threatening 999 calls reach record levels.* Available at: https://www.bbc.co.uk/news/articles/c24n4j10ygvo

To contact the Taskforce for Lung Health, please email taskforce@asthmaandlung.org.uk.

The secretariat for the Taskforce for Lung Health is provided by Asthma + Lung UK.

Taskforce for Lung Health

Asthma and Lung UK is a charitable company limited by guarantee with company registration number 01863614 with registered charity number 326730 in England and Wales, SC038415 in Scotland, and 1177 in the Isle of Man.