PCRS Position Statement

Short-Term Respiratory Admissions

March 2026

Introduction

The Primary Care Respiratory Society (PCRS) recognises that short-term respiratory admissions can be reduced but not always entirely avoided. These admissions occur when patients require hospital-based stabilisation, diagnosis or treatment which is not otherwise available to them in primary care. In line with the 10-Year health plan for England: Fit for the future[1], PCRS supports patient care in the community and care delivered closer to home. To this end, PCRS encourages the use of services such as hot clinics, virtual wards and integrated care services to reduce unnecessary hospital admissions.

Prevention of further acute episodes is key following initial admission. This can be achieved through timely respiratory review delivered by appropriately trained professionals in line with the PCRS Fit to Care Standards[2]. Every respiratory review should produce a personalised self-management plan including patient-centred education, review of vaccination status, smoking cessation support, medication optimisation and review of other co-morbidities as well as signposting for mental health and social support for themselves and carers.

It is well known that both clinician and patient anxiety can play a pivotal role in the decision to admit. Education, local support and involvement of specialist services are therefore key to improving quality of admissions and improving the likelihood of successful care at home. In addition, appropriate access to social care is protective against hospital admissions which could otherwise be avoided.

Primary Care Respiratory Society 483 Green Lanes, London, N13 4BS
Registered Charity 1098117 Company No 4298947 VAT Registration Number 866 1543 09
Telephone +44 (0)1675 477600 Email info@pcrs-uk.org Website http://www.pcrs-uk.org

The Primary Care Respiratory Society is grateful to its corporate supporters including AstraZeneca UK Ltd, Chiesi Ltd, GlaxoSmithKline (GSK) plc, Lupin Healthcare Limited, and Trudell Ltd, for their financial support which supports the core activities of the Charity and allows PCRS to make its services either freely available or at greatly reduced rates to its members. Corporate sponsors have no input into the content of PCRS resources.

Background

Respiratory conditions are a leading cause of hospital admissions,[3] with 854,922 emergency admissions to hospital for respiratory disease in England, a rate of 1,428 (1,424–1,432) per 100,000 population,[3] with similar trends seen in Wales and Scotland.[4,5] Leading causes of acute admission in the respiratory speciality were influenza and pneumonia (26%), chronic lower respiratory diseases (26.4%) and other acute lower respiratory infections (14.9%).[6] Respiratory conditions are the leading driver of hospital admissions and winter NHS pressures, as reported by Asthma + Lung UK (A&LUK).[7] An estimated 25% of the UK population visit their GP for a respiratory tract infection, significantly contributing to the workload of primary care.[8]

With the NHS's planned shifts from analogue to digital, hospital to community, and sickness to prevention,[1] this is a timely opportunity to re-evaluate approaches to managing short-term respiratory conditions. This statement is intended for commissioners and planners of service and healthcare professionals, in all settings, working in or interested in primary care or respiratory medicines.

This Position Statement focuses on short-term respiratory admissions, which are defined as a patient being admitted to hospital for further treatment or observation for 0–1 days; these account for about 16% of all hospital admissions.[9] The term 'short-term respiratory admissions' does not include presentation to Accident and Emergency (A&E) which results in discharge without admission regardless of A&E length of stay.

Key issues

Short-term admissions are often clinically appropriate, particularly for patients who:

- experience an acute deterioration in illness (e.g. viral or bacterial infections);
- require short periods of observation or supportive care (e.g. bronchiolitis in children);
- lack adequate social or clinical support to manage safely at home (e.g. some frail, elderly patients).

However, it is important to note that **social vulnerability and frailty alone should not be considered sufficient justification for admission**. While these factors often drive current short-stay admissions, hospitalisation in such cases can be associated with risks including deconditioning, hospital-acquired infections and increased long-term dependency.[10]

Reducing avoidable short-term admissions will require strengthening community neighbourhood services, improving access to urgent care alternatives, and ensuring adequate short-term social and clinical support is available outside hospital settings.

Short admissions usually take place to rule out acute concerns (e.g. pulmonary embolism). Length of stay is also dependent on the condition with which the patient is admitted. Chronic obstructive pulmonary disease (COPD) and asthma, for example, have a clear treatment pathway and can often be quickly stabilised whereas conditions such as respiratory failure and pneumonia may take longer to respond to treatment. It is important to note that, while conditions such as exacerbation of COPD and asthma, pneumonia and influenza sometimes require hospital admission, many patients with these conditions are managed in primary care without the need for hospital admission.

Follow-up

Short-term respiratory admissions represent key opportunities to improve patient health. Initially, the acute presentation should alert the patient's healthcare professionals to the need for timely intervention to mitigate the impact of the acute episode. Direct value can be seen in intervening early as readmission rates demonstrate that, for example, of those admitted with COPD, ~35% will be readmitted within 90 days.[11] About half of these readmissions will be for treatment of further exacerbation of COPD and are possibly reducible with schemes such as early supported discharge.[10] Work is ongoing to better risk stratify those at high risk of readmission.[11] There is evidence that, in chronic conditions, a previous exacerbation is the strongest predictor of future exacerbation. In COPD, patients with high anxiety and depression scores, frequent antibiotic use and those who are immunocompromised have been suggested as groups requiring robust review as an important consideration after discharge.[12] This follow-up can be done by primary or secondary care, but communication is paramount and patients often cite communication between organisations as a reason for concern and reporting a sense of disjointedness between them.[13]

Prevention

Preventative strategies are essential for reducing respiratory admissions:

Vaccination

Influenza and pneumonia remain major causes of hospitalisation, particularly in those with pre-existing respiratory conditions, and some of these can be prevented with vaccination.[14] Respiratory syncytial virus (RSV) is a key risk both in under 4s and over 75s in whom vaccination efforts are focused.[14]

Social support

Appropriate and accessible social care is key to ensure avoidance of admissions which are necessary due to gaps in social care. Identifying and supporting carers forms a component of this.

Tackling inequality

Those in the most deprived 10% of the population are 2.3 times more likely to be hospitalised for respiratory illness than those in the least deprived 10%.[7]

Tobacco dependence

Smoking is the leading driver of respiratory admissions, with 408,700 admissions attributable to it in 2022/23. Most of them are respiratory.[15] Treating tobacco dependence remains vitally important to support lung health and should be discussed with patients at every opportunity.

Tackling air pollution

Air pollution kills 43,000 people every year and contributes to the worsening of chronic respiratory conditions.[7]

Supporting services

One cause of short admissions can be lack of awareness or access to supporting services. Awareness and availability of the following services should be promoted:

- Local admission avoidance schemes
- Hot clinics
- Community respiratory services
- Virtual wards
- Local community pharmacies to optimise medications including vaccinations and treating tobacco dependence

Primary care clinicians may wish to familiarise themselves with such programmes available locally.

There is some evidence that self-management plans, when created in partnership with patients and explained well, reduce the likelihood of admission in conditions such as asthma.[16] A digital management plan that contains all relevant information and is accessible to both patients and clinicians would improve communication and reduce duplication across the system.[17]

PCRS position

PCRS calls for a joined-up patient-centred approach to short-term respiratory admissions that include the following principles:

- **Workforce and training**: Health professionals delivering a review of chronic respiratory disease should be trained in line with PCRS Fit to Care[2] which includes training on Treating Tobacco Dependence support as well as vaccinations.
- **Timely follow up for long-term conditions** with a health professional trained as per Fit to Care standards[2] may help reduce the risk of readmission.
- **Communication**: organisations should ensure that discharge summaries and relevant clinical information are accessible across primary and secondary care.
- **Integration**: Providers and commissioners should work towards integrated service delivery.

Any unanswered questions/potential research priorities this statement has highlighted

- What is the role of point of care testing (POCT) in primary care? (CRP, rapid testing for COVID-19, influenza, RSV, etc)
- How can integrated working be improved post admission discharge?
- Are short-term respiratory admissions more avoidable than longer admissions?
- How do the features of short-term respiratory admissions vary from those of longer-term admissions?
- Best way to implement a timely post discharge follow-up considering integrated neighbourhood multidisciplinary team (MDT) approach
- Emergency services and out of hours general practice involvement in the best management approach of exacerbations of respiratory conditions and follow-up recommendations

References

1. Department of Health and Social Care. Fit for the Future: 10 Year Health Plan for England. 2025. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-accessible-version (Accessed August 2025)
2. Fit to Care: https://www.pcrs-uk.org/resource/current/fit-care
3. NHS England. Hospital Admitted Patient Care Activity, 2023–24. 2024. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2023-24 (Accessed August 2025)
4. Public Health Wales. Respiratory disease prevalence – trends, risk factors, and 10-year projections. 2025. https://phw.nhs.wales/services-and-teams/

observatory/data-and-analysis/respiratory-disease-prevalence-trends-risk-factors-and-10-year-projections/ (Accessed August 2025)
5. Scottish Government. Respiratory Care Action Plan: 2021–2026. 2021. https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2021/03/respiratory-care-action-plan-scotland-2021-2026/documents/respiratory-care-action-plan-2021-2026/respiratory-care-action-plan-2021-2026/govscot%3Adocument/respiratory-care-action-plan-2021-2026.pdf (Accessed August 2025)
6. Naser AY, Mansour MM, Alanazi AFR, Sabha O, Alwafi H, Jalal Z, et al. Hospital admission trends due to respiratory diseases in England and Wales between 1999 and 2019: an ecologic study. BMC Pulm Med 2021;21(1):356. https://doi.org/10.1186/s12890-021-01736-8. PMID: 34749696; PMCID: PMC8573565. https://pmc.ncbi.nlm.nih.gov/articles/PMC8573565/ (Accessed August 2025)
7. Asthma + Lung UK. Mission for lung health report 2024. 2024. Available at: https://www.asthmaandlung.org.uk/mission-lung-health-report-2024 (Accessed August 2025)
8. The Lancet Respiratory Medicine. Primary care at the heart of respiratory medicine in the UK. Lancet Respir Med 2014;2(2):83. https://pubmed.ncbi.nlm.nih.gov/24503257/ (Accessed 14 November 2025)
9. NHS England. Respiratory metrics – Model Health System. 2025. https://model.nhs.uk/metrics/1d77956f-eec8-45a7-b4b5-aa1c4c8186be?domainId=e5f27084-3c51-4aea-9848-7b46d4fc6899&compartmentId=7c01bdfc-861c-48de-aa7a-24407781f4b6 (Accessed August 2025)
10. Nuffield Trust. Potentially preventable emergency hospital admissions. 2025. Available at: https://www.nuffieldtrust.org.uk/resource/potentially-preventable-emergency-hospital-admissions (Accessed 14 November 2025)
11. Getting It Right First Time (GIRFT). Respiratory Medicine National Specialty Report. 2021. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Respiratory-Medicine-Oct21L.pdf (Accessed August 2025)
12. Baydar Toprak O, Polatli M, Baha A, Kokturk N, Yapar D, Ozkan S, et al. Readmission rates within the first 30 and 90 days after severe COPD exacerbations (RACE study). Medicine (Baltimore) 2024;103(48):e40483. https://doi/org/10.1097/MD.0000000000040483. PMID: 39612431; PMCID: PMC11608697 (Accessed April 2024)
13. South Yorkshire Insights Bank. You Said, Our Response: Development of Respiratory Specification – October 2020. 2020. https://www.syinsightsbank.co.uk/application/files/1817/4799/5924/You_Said_Our_Response._Development_of_Respiratory_Specification_-_October_2020.pdf (Accessed August 2025)
14. Welsh Government. Science Evidence Advice: Winter Modelling 2024 to 2025. 2024. https://www.gov.wales/sites/default/files/publications/2024-09/science-evidence-advice-winter-modelling-2024-to-2025.pdf (Accessed August 2025)
15. NHS England. Statistics on Public Health, England 2023 – Part 1: Hospital Admissions. NHS Digital, 17 December 2024. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-public-health/2023/part-1-hospital-admissions
16. Hodkinson A, Bower P, Grigoroglou C, Zghebi S S, Pinnock H, Kontopantelis E et al. Self-management interventions to reduce healthcare use and improve quality of life among patients with asthma: systematic review and network meta-analysis BMJ 2020; 370 :m2521 doi:10.1136/bmj.m2521
17. Deeny S, Thorlby R, Steventon A. Briefing: Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions. London: The Health Foundation. 2018. https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf

Other PCRS resources you may be interested in:
PCRS Position Statement: Point of Care Testing (POCT) for C-Reactive Protein (CRP) for acute assessment in COPD (Update): https://www.pcrs-uk.org/resource/current/pcrs-position-statement-point-care-testing-c-reactive-protein-crp-acute-assessment
Fit to Care: https://www.pcrs-uk.org/resource/current/fit-care

Authors: Maisun Elftise, GP, Coventry and Nicola Standring-Brown, Nurse, South Yorkshire

Reviewers: Reviewed by members of the policy committee which includes Helen Ashdown, Chloe Bloom, Dhiren Dayal, Daryl Freeman, Sharon Hall, Steve Holmes, Robert Horne, Aleksandra (Ola) Howell, Sian Jones, Deborah Leese, Vincent Mak, Marieke Strange

Approved by PCRS Executive policy lead on committee: 1 January 2026