Community Outreach to Strengthen Winter Resilience in Respiratory Patients within a PCN.

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Introduction.

Weymouth and Portland Primary Care Network have a large COPD and asthma population. It is also an area of significant deprivation.

Dorset ICB has developed a population health management database since 2018, the Dorset Insight and Intelligence Service (DiiS), which enables oversight of population health and care metrics, and identification of cohorts of patients for intervention.

In December 2025, with just three weeks' notice, Dorset Primary Care Respiratory teams received targeted ICB funding to reduce winter respiratory admissions and improve access to timely respiratory care. Within this short timeframe, the Weymouth and Portland team delivered a five-pronged initiative combining digital innovation, data-driven risk stratification, and community engagement.



Method.

The five-pronged initiatives adopted included

Digital Outreach: 10,000 text messages were sent to existing patients with a registered diagnosis of asthma and COPD, sharing links to Asthma + Lung UK's winter self-management resources and flu vaccine reminders.

Risk Stratification Using Shared Data: Using Dorset Integrated Intelligence Service (DiiS) data, the team identified high-risk asthma and COPD patients based on recent exacerbations and hospital use. These patients were invited for reviews to optimise care, and update management plans.

Vaccination Uptake: DiiS data identified 328 unvaccinated COPD patients for pneumococcal vaccination. The team set up weekend vaccine clinics and used digital booking links, improving accessibility and reducing missed opportunities for prevention.

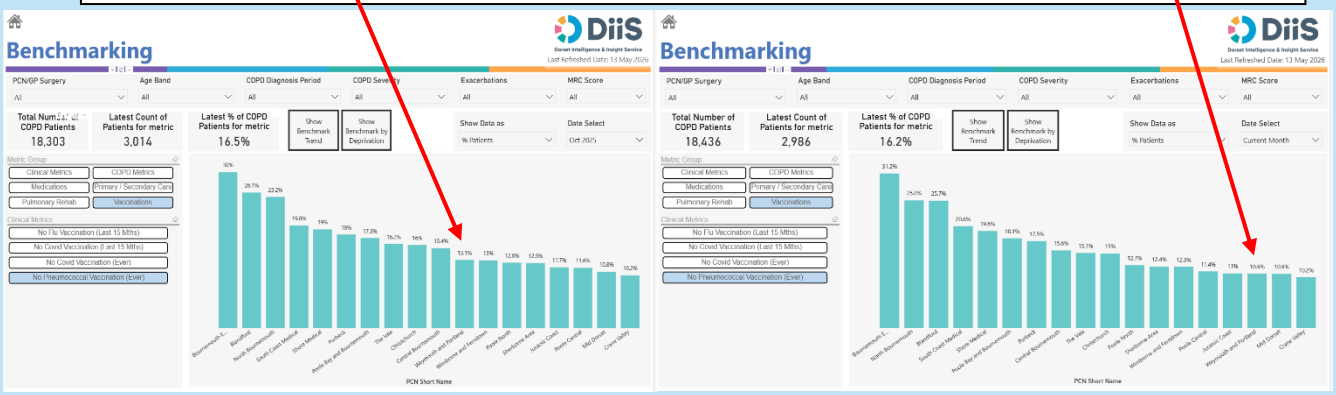
Staff Education: Education sessions were delivered to same-day access teams on effective inhaler optimisation and the use of FeNO testing, helping prevent unnecessary prescriptions and admissions.

Community Lung Health Fairs: To address health inequalities and reach residents hesitant to engage via traditional GP routes, three local "Lung Health Fairs" were organised (January–March 2026). Combining specialist teams and associated relevant services into one fair. The first event, promoted via 3,500 text invites and social media advertising, drew approximately 300 attendees, well above anticipate numbers.

Results.

- 323 Patient assessment forms completed.
- 91 follow-up appointments required with specialist nurses.
- 47 pulmonary rehab referrals and 43 hypertension referrals generated.
- 50% of attendees had not had a respiratory review in the previous year, improving QOF coverage.
- Vaccination uptake: - 56 pneumococcal vaccines administered within this period, likely resulting from awareness at fairs, and targeted clinics.

Improving from 8th best PCN for Pneumococcal vaccines uptake, to joint 2nd best.



Conclusion.

This initiative demonstrated how targeted digital outreach, can:

Prioritise integrated data analytics, and community-based engagement.

Prioritise high-risk patients effectively using shared system data.

Reduce winter pressures by optimising care before deterioration.

Discussion.

The patient feedback was very positive, with high engagement in underserved groups, and a strong demand for repeat events.

The process generated actionable data for primary care teams to follow up and sustain improved outcomes moving forward. It is hoped the funding can be recurring to repeat and expand on the initiatives next year.