

Co-designing a neighbourhood model of care for chronic cough and breathlessness

Findings from the CLEAR Respiratory Neighbourhood Extension Programme
Author: Katie Abrahams, Managing Consultant, The National CLEAR Programme



Commissioned by NHS England · Hosted by East Lancashire Hospitals NHS Trust ·
Delivered by CLEAR · In partnership with PCRS

01 The problem

Patients presenting with chronic cough or breathlessness in primary care face fragmented, inequitable services. The model of care for these undifferentiated symptoms remains predominantly medically led, with no standardised

pathway: the default response is referral into secondary care rather than assessment and management closer to home. This drives avoidable demand on elective services.

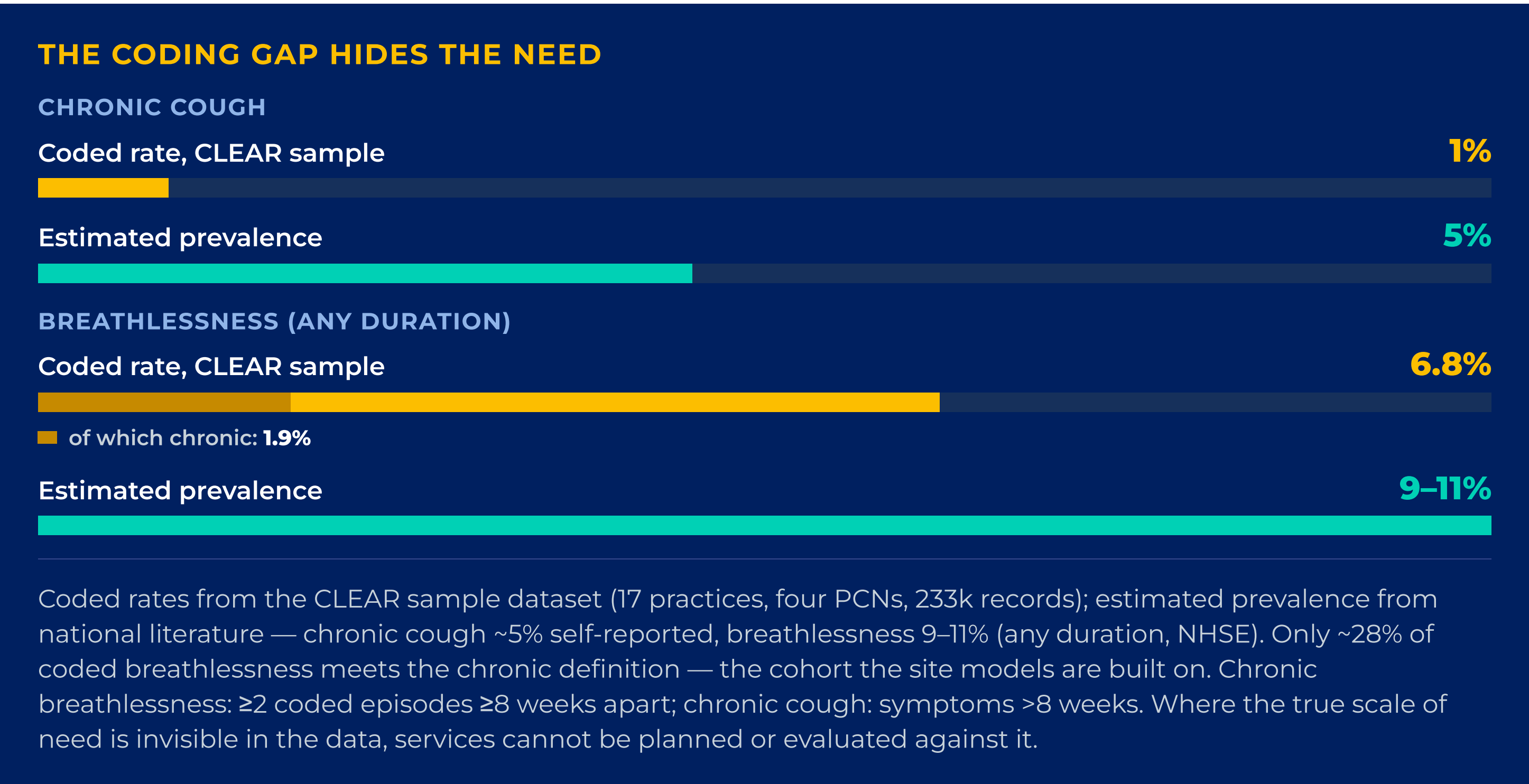
THE BURDEN ACROSS THE FOUR SITES

up to 3×	more likely to be referred to secondary care than baseline
1.5–2.2×	more ED attendances
2.4–3.5×	more unplanned admissions
11.5–19	GP appointments per patient per year, against a 5.8–7.9 practice baseline

Ranges span the low and high values reported across three of the site case studies, each derived from that site's own patient-record analysis. Appointment figures compare patients coded for chronic cough or chronic breathlessness against the whole-practice average at the same site. Site-level findings are provisional and not yet signed off, so sites are not named here.

Where neighbourhood services do exist, they are often underutilised or unevenly developed, and maturity varies markedly by area: some local systems have well-established services that are simply

underused, while others have no neighbourhood offer at all. **This variation perpetuates inequity in access and outcomes.**



02 How we co-designed it

The CLEAR Programme, commissioned by NHS England, convened a national Design Board of 20 stakeholders from NHSE, ICBs, secondary and primary care, and PCRS to co-design a blueprint model of care across

three virtual workshops. Each of the four sites then ran three further workshops of its own at the CLEAR Focus stage to adapt the blueprint locally.

3 + 3 virtual workshops: 3 for the Design Board, then 3 per site at CLEAR Focus	10 hrs clinical engagement	720 rows of qualitative data	233k+ patient records analysed
--	-------------------------------	---------------------------------	-----------------------------------

ADAPTED LOCALLY ACROSS FOUR SITES OF DIFFERING SERVICE MATURITY

Site A — established hub model but low utilisation An existing specialised respiratory hub model serving a large urban population. Established but underused: under 2% of the coded cohort reach the clinic against around a quarter estimated suitable.
Site B — no neighbourhood clinic to refer into and limited diagnostic capacity No neighbourhood clinic to refer into and limited diagnostic capacity in house. Around one in seven of the coded cohort referred to secondary care and a similar share again via advice & guidance — possible duplication rather than deflecting.
Site C — no neighbourhood clinic pathway but some diagnostic infrastructure Diagnostic infrastructure in place but no standardised pathway or neighbourhood clinic; diagnostic uncertainty prompts variable onward referral.
Site D — no neighbourhood clinic to refer into and inconsistent diagnostic testing Starting from scratch: inconsistent diagnostics and no neighbourhood clinic, with a coding gap estimated in the low thousands of patients.

Five challenges across the current pathway shaped the new model

- Triage inconsistency** — the first decision determines the route
- Multifactorial complexity** — symptoms are rarely condition-specific
- Service fragmentation** — specialty ‘ping-pong’, duplicate testing, long waits
- Geographic inequity** — pathways vary by place, so do outcomes
- Workforce and education gaps** — skill mix, workflow and communication

THE BLUEPRINT MODEL OF CARE

Access Standardised triage and routing · skill-based access to the most appropriate professional first · one integrated pathway · frequent users identified proactively	Coordinate Neighbourhood respiratory clinic and MDT across primary, community and secondary care · diagnostics closer to home · tests bundled into a single visit	Sustain Standardised coding and use of data · holistic and preventative care · recurrent funding · targeted education and workforce redesign
---	---	--

03 The new model

The pathway, as designed by the Design Board



04 What we found

Projected Year 1 cost avoidance by site, post full implementation against each site's coded chronic cough and chronic breathlessness patients, with a coding uplift to account for improved chronic coding and identification of the broader 'breathlessness' group.

Site A £12–20m	Site B £0.7–0.8m
GP / ACP appointments	GP appointments
290–580k	13–18k
Secondary care referrals	Secondary care referrals
13,000–18,000	~570
ED attendances / admissions	ED attendances / admissions
~7,000 / ~270	~220 combined
Site C £0.8–0.9m	Site D £0.8–1.1m
GP / ACP appointments	GP / ACP appointments
~9k	~6k
Secondary care referrals	Secondary care referrals
~550	~1,070
ED attendances / admissions	ED attendances / admissions
~210 combined	~120 / ~55

Year 1 reflects working up each existing coded cohort once; recurring savings from Year 2 are lower — at Site A, £8–10m a year. Figures are indicative and provisional, pending sign-off.

Conclusion

A single blueprint can be adapted across very different starting points. Where a service already exists, the gain comes from using it — better coding, standardised triage and diagnostics closer to home — not from building a new, directly reducing elective demand.