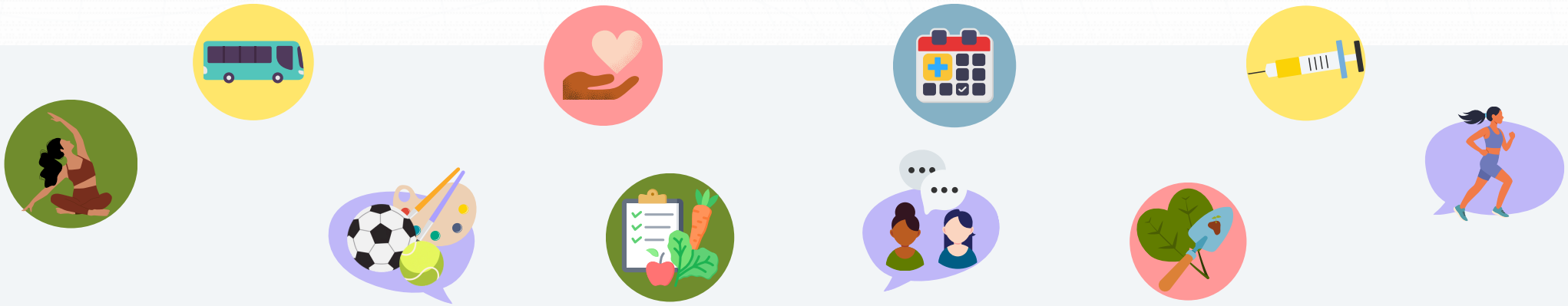
Primary Care Respiratory Society

Blueprint for Chronic Obstructive Pulmonary Disease (COPD) Neighbourhood Health

Additional information

This blueprint outlines how Neighbourhood Health models could organise COPD care around integrated local services. It proposes **clear points of contact**, population health management, coordinated, collaborative and personalised **care planning** and **access to diagnostics, home-based clinical assessment and support, and multidisciplinary support**. Implementation will require appropriate funding, diagnostic capacity and strong collaboration between health, social care and community partners.



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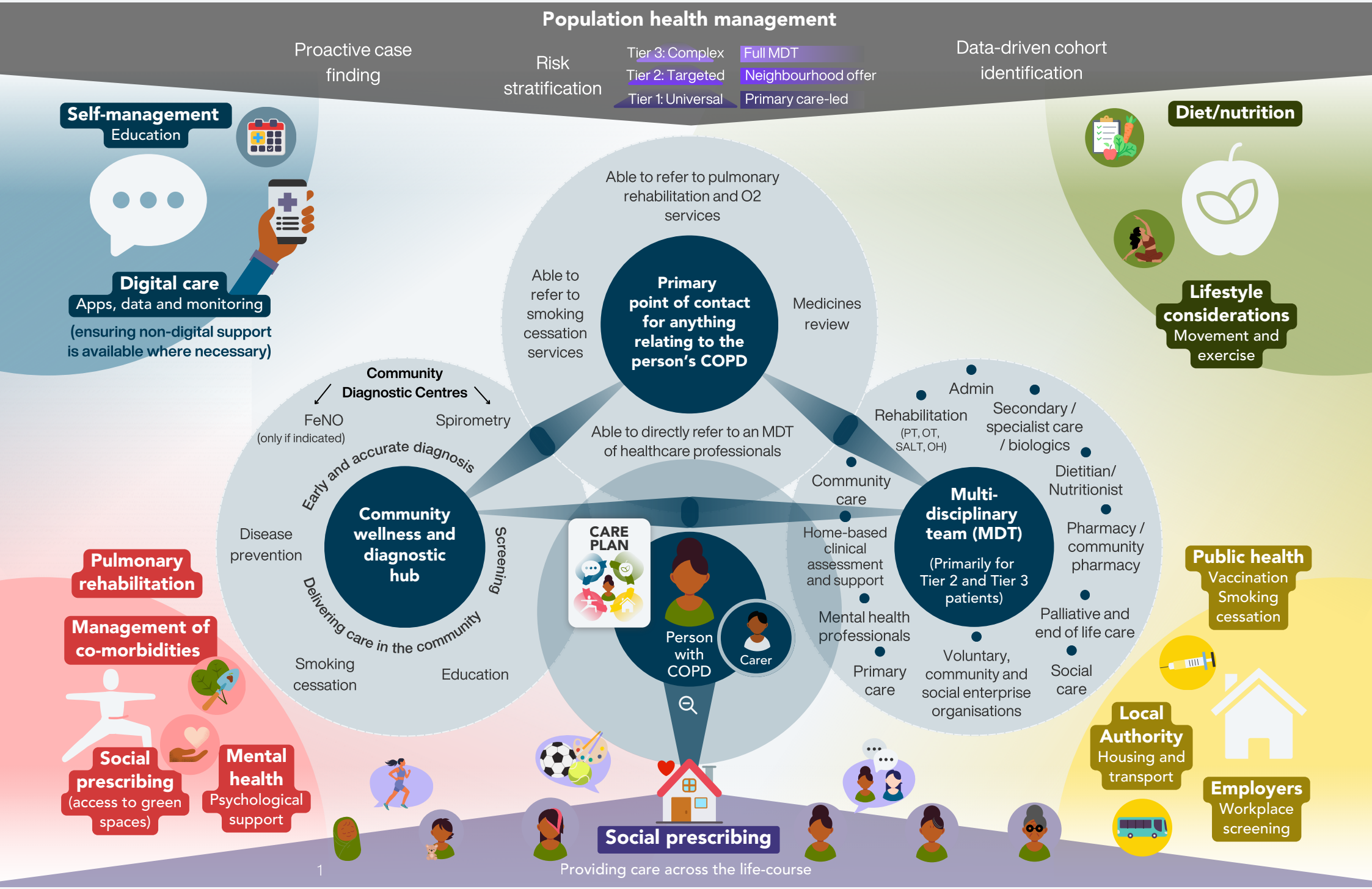


1. Introduction

This work forms part of a wider Primary Care Respiratory Society (PCRS) project around Neighbourhood Health. More information can be obtained from the PCRS Neighbourhood Health Blueprint page: www.pcrs-uk.org/resource/current/blueprint-neighbourhood-health-copd.

Definition of a neighbourhood

The NHS England Neighbourhood Health Framework states that systems are required to agree their own neighbourhood footprint. In some localities this may align with a Primary Care Network (PCN) but in others it will not.[1]

Purpose of the PCRS blueprint for COPD Neighbourhood Health

This blueprint outlines how Neighbourhood Health models could organise care for people with COPD. It provides an example structure that local systems can adapt to their population needs.

The blueprint includes:

- An outline Neighbourhood Health model for COPD (page 1)
- An example patient journey through the Neighbourhood Health blueprint (pages 10-11)
- Whole system blueprint for effective Neighbourhood Health implementation from local delivery to national strategy (page 12)

Examples of Neighbourhood Health models already being implemented are available via the **PCRS Neighbourhood Health repository**.

1.1 PCRS Neighbourhood Health blueprints: Things to consider

- For this model to work, healthcare services require adequate funding and buy-in from national government, healthcare commissioners and managers, as well as local authority services. This should include:
  - Wellness and diagnosis hubs
  - Home-based clinical assessment and support
  - Smoking cessation
  - Access to diagnostic tools and services
  - Multidisciplinary team infrastructure
  - Clear referral routes

  Successful implementation will require appropriate commissioning and resourcing of primary care and community respiratory services. It may also be advisable for PCNs within the same neighbourhood to collaborate on possible Neighbourhood Health models and solutions.
- **No one size fits all:** Local systems should adapt the blueprint to reflect their population needs.
- **Health and Wellbeing Boards:** Local Neighbourhood Health plans will need signing off by Health and Wellbeing Boards.[2]
- **Primary contacts:** The proposed primary contacts may be the same individual or be based within the same team (GP surgeries, community (respiratory) hubs (where they exist) etc) depending on what works best within each individual locality.
- **Roles and services:** PCRS is not advocating for new roles or services to be created but for clear and effective funding, coordination and use of the services and roles already available.

2. Collaborative and personalised care planning

This ensures a **holistic**, person-centred approach and supports value-based care.

Care plans should be personalised and developed collaboratively with the individual. They should be **initiated at first presentation** and continue throughout the person's entire healthcare journey. Plans should be shared with all relevant healthcare professionals, care settings, and carers, where appropriate and in line with patient confidentiality requirements.

The individual should always have access to their care plan and know that it is theirs.

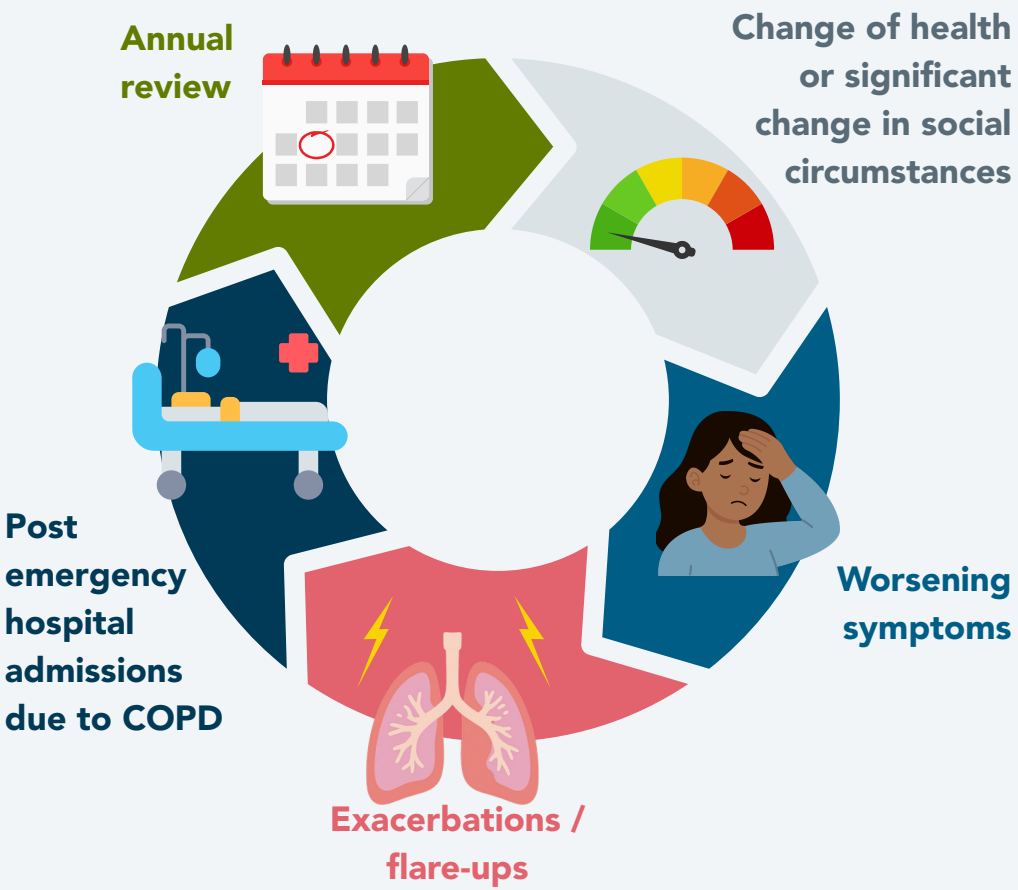
2.1 Care planning for people with COPD

A care plan for someone with COPD should include the following:

- **Contacts:** Where/who to contact for queries on their care plan
- **Confirmed diagnosis:** Including results
- **Treatment:** Current medications and medical treatments, including nonpharmacological
- **Proper medication use:** Including inhaler technique and optimisation, and rescue packs (if appropriate)
- **Symptom control:** Preventing exacerbations/flare-ups and clear action plan for flare-ups. Acknowledge and address other symptoms - breathlessness, mucus etc
- **Social prescribing:** Improving quality of life through lifestyle changes
- **Comorbidities:** Consideration of and action for other health conditions (mental health etc)
- **Referrals and wider determinants of health:** Details of health-related referrals or other (housing, warmth, employment, financial, etc) support
- **Priorities and actions:** Clear indication of what priorities are and what action needs to be taken, by whom (including the individual). With timescales where appropriate:
  - Vaccinations
  - Pulmonary rehabilitation – new and re-referrals, as well as information on any maintenance programmes available
- **Research:** Care planning should consider (where appropriate) getting people access to trials or quality improvement initiatives
- **Self-management:** Providing all tools and resources necessary for individuals to plan and manage their own care. This should include establishing a community support network, using voluntary, community and social enterprise (VCSE) and local authority initiatives

COPD care planning should be undertaken by a COPD primary contact with respiratory training. Care plans can be paper or digital. Digital care plans should only be offered to individuals who can access, and will be confident to use, digital tools with the necessary guidance.

2.2 When should a COPD care plan be reviewed and/or updated?



Who is responsible for the COPD care plan?

Care plans should be initiated at first presentation at the community wellness and diagnostic hub. Once diagnosis is confirmed, responsibility of the care plan should sit with the primary point of contact for anything relating to the person's COPD. However, other healthcare professionals should ensure it's updated with key information along the individual's healthcare journey.

PCRS resources on care planning for people with COPD:

- Podcast: How to undertake a really good COPD review, conversation with HCP and patient (PCRS members only)
- Article: Using the OPTIMISE approach for tailored self-management plans
- Resource: Tailoring Inhaler Devices
- Resource: COPD risk slider
- Resource: Beyond the Lungs
- Resource: COPD prevention and treatment: The role of triple therapy, tobacco dependency, PR and vaccinations

3. Neighbourhood Health model for COPD – Additional information

This model offers an example of COPD Neighbourhood Health which can be used to plan and implement an effective, working model at a local level. To fit with local needs, it may need to be adapted, but we hope that the main principles presented offer a good example of what a Neighbourhood Health model may need for people with COPD.

When planning a Neighbourhood Health model for COPD, we recommend that these six (labelled A-F) overarching areas are considered and included:

A. Population health management

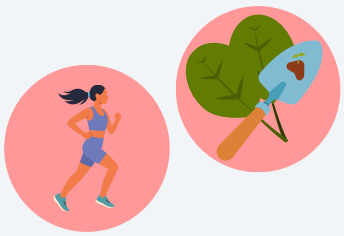
The NHS England Neighbourhood Health Framework encourages proactive and data-driven identification and risk stratification of individuals[1], to identify and address respiratory healthcare inequalities and reach under served groups. This supports the NHS 10-year health plan: Fit for the Future[3] objectives around sickness to prevention and moving towards a more proactive care management approach which manages risk, prevents escalation and reduces inequalities. Examples of how data can be used to plan and implement Neighbourhood Health initiatives can be found within the PCRS Neighbourhood Health repository.

The level of neighbourhood health support offered should be informed by population health management and risk stratification. People in Tier 1 will primarily be supported through their GP and primary care team. The fuller neighbourhood offer, including MDT access, social prescribing referral and wider determinants support, is particularly directed at those identified as Tier 2 or Tier 3.

The OPTIMISE approach offers advice on proactive case finding, and additional NHS England resources are also available via the NHS England site.

B. Good access to open, green spaces

Access to safe outdoor space supports physical activity and wellbeing for people with respiratory disease. Local planning should consider access to suitable environments for exercise and activity. PCNs and Neighbourhood Health teams should review their local green space assets.



*Risk stratification is the process of grouping a population based on their health status, medical history, and projected need for care. In population health management, it identifies which individuals are at the highest risk for adverse events (like emergency hospitalisations) so clinics can proactively target preventative care and resources where they are most effective.

C. Digital healthcare and data

Digital tools and interventions provide different methods of delivering healthcare and support improved access to information, monitoring and communication. This includes things like virtual pulmonary rehabilitation, COPD reviews and wards, as well as self-management apps. They also work to reduce health inequalities by increasing reach into under-served groups.

NHS England provides guidance on medical device apps that support respiratory conditions.[4] Local healthcare commissioners and authorities should review this guidance, as well as the options available and identify which are most suitable for their population. These recommendations should then be clearly communicated to all healthcare professionals responsible for encouraging their use.

To ensure proper use and equitable access:

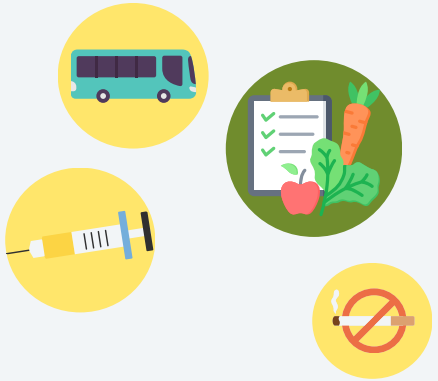
- Digital tools should be supported by clear guidance to ensure safety and effective use.
- Non-digital access must remain available to ensure equitable care.

Many digital tool providers will allow for both digital and non-digital solutions (print options etc).

Digital healthcare also includes the use of **national and local data and research**. This information helps healthcare professionals, teams, and authorities understand population needs, identify at-risk groups, and shape local Neighbourhood Health approaches (see population health management). Examples of how Neighbourhood Health initiatives have used data to inform, monitor, and evaluate their work can be found in the **PCRS Neighbourhood Health repository**.

D. Local councils and public health

Local councils and public health teams should protect and improve population health by preventing illness, promoting healthy living, and reducing health inequalities. Public health focuses on population-wide threats such as infectious diseases, environmental hazards (clean air and water), and behavioural factors (obesity, smoking) through national strategies and action plans.



Their responsibilities include providing:

- Safe, clean housing that does not expose residents to mould, mildew, or environmental triggers such as pollution.
- Transport systems that enable people to access the care and environments they need.
- Local infrastructure such as schools, shops, and community centres.
- Health and wellbeing promotion and education initiatives, including vaccinations, smoking cessation, diet and nutrition, winter-warmers and community hubs/cafes, **facilitating the presence of VCSE organisations in local communities**, and exercise programmes.
- Social care services that support wellbeing and independent or supported living, including community hubs, warm spaces, and local health check days.

It's important for community wellness and diagnostic hubs to recognise how they can bring together NHS and local authority COPD services with initiatives such as community health days and events. These provide people with simpler access to support on multiple fronts. Examples of these initiatives can be found in the PCRS Neighbourhood Health repository.

Those planning Neighbourhood Health initiatives should actively engage with local councils and public health teams to ensure all necessary elements are in place to support effective implementation and the wellbeing of local populations. All key settings should be considered, including health, faith, work (see Employers below), and community environments.

E. Employers

Employers may need to be involved where COPD **could** affect work, or the person's ability to remain in work in the long-term. Where relevant, they should be included in a person's care planning to ensure that occupational health assessments and vocational rehabilitation requirements are met. This should be part of a shared decision-making process with the individual and must comply with all confidentiality requirements and regulations. Employers are encouraged to participate in wellness checks (sometimes called Working Well schemes run by local authorities) for staff with optional health screening to help early identification and appropriate interventions. Whilst costly, the benefits of a healthy workforce are undeniable.

F. Carers

Many people with COPD may have carers. Carers may be formal (paid, organised through healthcare or social services) or informal (unpaid, provided by friends or family). To ensure holistic care, carers should be considered as part of a Neighbourhood Health model. Carers, where appropriate and within all necessary patient confidentiality requirements and regulations, should have a copy of the up-to-date care plan of the person they support and be kept informed of any health or social care decisions made.

Part of a bigger picture

COPD management should consider wider aspects of a person's life including work, relationships and social circumstances.

Providing care across the life-course

3.1 Community wellness and diagnostic hub

These already exist in some PCNs and are based within GP surgeries, community (respiratory) hubs etc, but may be known by a different name. They are a central point for guidance and advice on wellbeing, health concerns and diagnosis of medical conditions, including COPD.

These hubs should provide:

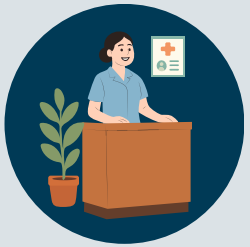
- Care-planning initiation (see page 3)
- Access to diagnostic tests (spirometry or FeNO [if indicated], chest x-rays etc)
- Education and social prescribing, including signposting/referral to support groups and lifestyle interventions
- Referral/signposting to any multidisciplinary team members or organisations for immediate general health and wellbeing concerns (primary care*, diet/nutrition, VCSE organisations such as foodbanks, winter-warmth initiatives, financial support, etc)
- Signposting to vaccination** settings (primary care, pharmacy etc) and smoking cessation support

An individual attending this location **should be given a single point of contact at the hub** until a formal COPD diagnosis is made, and to ensure they have someone to reach out to if necessary. The **title** of this role and **who** is best placed to fulfil it should be **determined locally.** The role may not need to be clinical, but potentially care coordinators, community health connectors, health coaches, work coaches, community champions, or similar roles.

At the point of diagnosis, this contact should coordinate with the primary point of contact for COPD. Clear lines of communication between both roles (if they are separate individuals) are essential to ensure that all needs of the individual are identified and addressed without gaps in care.

***Primary care**

Primary care should remain the main healthcare setting for all general health needs.
Primary care can include GPs, nurses (including community midwives and health visitors), paramedics, pharmacists (including community), physio, occupational and speech and language therapists (PT, OT, SALT), occupational health (OH), mental health professionals (including psychologists) and social prescribing.



****Vaccinations**

Vaccination for individuals with COPD should include influenza, COVID-19, shingles, pneumococcal, respiratory syncytial virus (RSV), and any other relevant vaccination as recommended by the Joint Committee on Vaccinations and Immunisation (JCVI), depending on the age and status of the individual. These will most likely be organised by primary care or pharmacy (including community) settings. Primary contacts must ensure they are part of care planning.

3.2 Primary point of contact for anything specifically relating to COPD

A primary point of contact for someone with COPD. This role should be able to:

- Maintain the care plan, being a point of contact for any queries
- Ensure all necessary reviews and checks are conducted as per the requirements of ongoing COPD care and guidance (annual reviews, inhaler technique checks, proper use of medications, social prescribing etc)
- Disperse responsibility to any multidisciplinary* professionals
- Refer to, and monitor/follow-up actions taken by:
  - community wellness and diagnostic hub,
  - stop smoking services,
  - pulmonary rehabilitation, and
  - (at home) oxygen services



- Signpost to COPD specific support groups (Breathe Easy, Singing, Hubs etc)

They are responsible for the care plan going forward and that it includes a clear strategy for the management of COPD, as well as any other determinants of health and wellbeing, and shared with all necessary parties.

The name of this role and who is best to fulfil it needs to be defined locally. The role will need to be a **clinical professional providing expert or advanced respiratory care** as per the PCRS Fit to Care requirements. This will ensure they can provide all necessary information, guidance and expertise, as well as effectively assess risk and escalate/take action in a timely way. **This individual should be competent and confident in delivering specialist COPD care;** this may be a specialist nurse/pharmacist with lines of support to a consultant or GP with specialist interest.

There should be clear lines of communication between this contact and the contact based at the community wellbeing and diagnostic hub to ensure all necessary patient needs are met and not missed.

***Multidisciplinary team**

This refers to a group of healthcare professionals or support services who can provide clinical or specialist input and support. The primary contact for COPD should be able to disperse responsibility to any members of this group to ensure all needs of the individual are met.

It may include primary care, respiratory specialists, rehabilitation services, mental health professionals, pharmacy, social prescribing and voluntary sector organisations. **Primary care should remain the main healthcare setting for all general health needs.**

3.3 An example patient journey through the Neighbourhood Health blueprint

This approach requires adequate funding and support from healthcare commissioners, managers, as well as local authorities.

This example illustrates how an individual may move through the Neighbourhood Health for COPD model.

Scenario: Working person of 50+. Smoker, isolated, with mould in their home (privately rented) and struggling financially. They visit the community wellness and diagnostic hub (located at their GP surgery) for information and support.

1. Pre-diagnosis of COPD

Community wellness and diagnostic hub

Primary contact identified

Responsible for ensuring early and accurate diagnosis

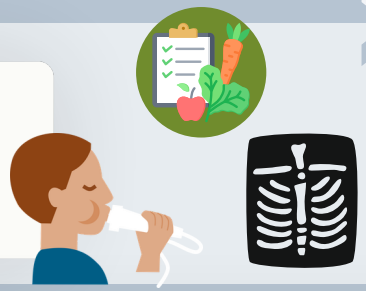
Brief history:

Medical history, current symptoms, wider determinants of health, carers, occupation and best method of communication

Care plan initiated

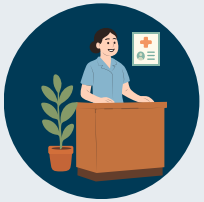
Diagnosis:

Spirometry and/or FeNO (if indicated), Chest x-ray, Baseline bloods



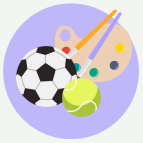
Smoking cessation:

Council-led smoking cessation service



Social prescribing and wider determinants of health:

Housing, warmth, wellbeing/ lifestyle and financial stability
Advice and signposting to community support/VCSE organisations



Priorities and actions:

Diagnosis appointment [Date]
Vaccinations and smoking cessation appointment [Dates]
Education on COPD provided
Follow-up appointment [Date]
Identify any carers
Contact details for any queries/concerns [Details]

COPD diagnosis confirmed

Updated care plan and all necessary coding completed

2. Post-diagnosis of COPD

Community wellness and diagnostic hub

Primary point of contact for anything relating to the person's COPD

Responsible for condition management and the care plan going forward

Diagnosis:

Date confirmed and results

Medication:

Medication prescribed and optimised, how/when it should be taken (inhaler technique). Guidance on repeat prescription and rescue packs (if prescribed).

Self-management care and advice:

Digital enabling (if appropriate)
Medical device apps
COPD self-management plan (physical copy if not digitally enabled) with long-term condition education.*
Instructions for if symptoms worsen, they have a flare-up or are admitted to hospital because of their COPD

Targeted reviews, identification of co-morbidities, smoking cessation, vaccinations and pulmonary rehabilitation (if suitable) including post-exacerbation follow-up:

Using the OPTIMISE approach

Oxygen:

Referral to home oxygen service (if necessary/ appropriate)

Home-based clinical assessment and support:

For prevention of hospital admission

Public health, local authority, employers:

Housing conditions and financial /benefits assessment
Occupational health assessment and vocational rehabilitation

Multidisciplinary team (MDT), including social prescribing:

Mental health professional (impact of isolation)
Occupational therapy assessment
Lifestyle advice
Dietitian/nutrition specialist
COPD biologics (if suitable)
Further signposting to COPD community support /VCSE organisations

Priorities and actions:

Follow-up appointment(s) [Date(s)]
Annual review [Date]
Pulmonary rehabilitation – Start date [Date] (or when they can re-refer)
Contact details for any queries or concerns.

Actions completed

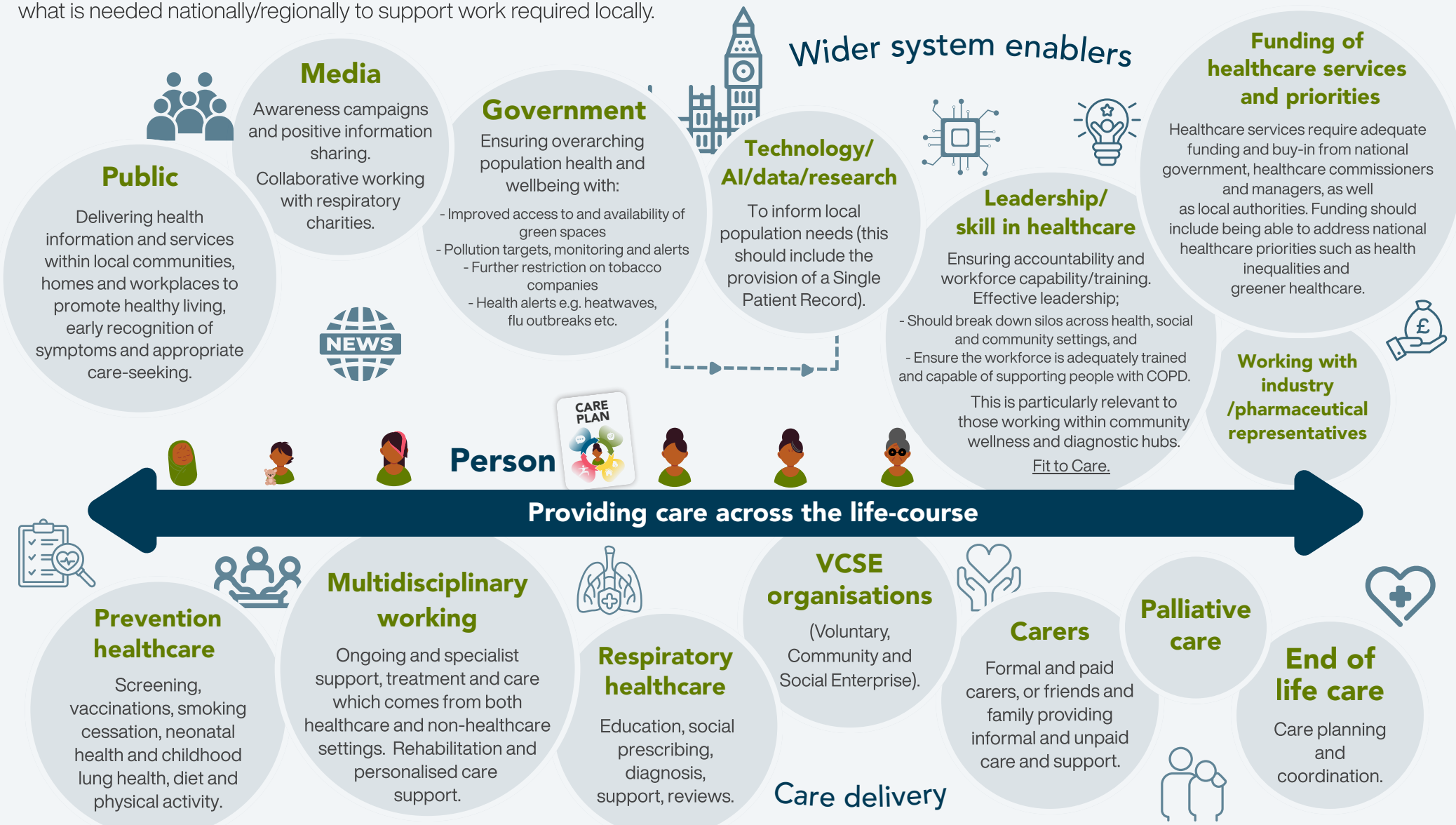
- ☑ Diagnosis confirmed
- ☑ Personalised care plan in place
- ☑ Wider determinants of health addressed
- ☑ Supported with self-management
- ☑ Referrals to all relevant MDT members
- ☑ GP record is updated and coded appropriately

Following this, care going forward should be a triangulation between the primary point of contact for COPD, MDT (including social prescribing) and the community and wellness and diagnostic hub

*This should include information on how COPD impacts other areas of the body. For more information, see www.pcrs-uk.org/resource/current/beyond-lungs.

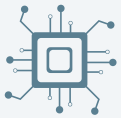
4. Whole system blueprint for effective Neighbourhood Health implementation from local delivery to national strategy

This blueprint depicts what is needed at a higher/national level to ensure that Neighbourhood Health models can be effectively implemented. We recognise that some of these elements will out of the control of local healthcare teams and professionals, but we felt it was important to promote what is needed nationally/regionally to support work required locally.



4.1 Wider system enablers

- **Public:** Delivering health information and services within local communities, homes and workplaces to promote healthy living, early recognition of symptoms and appropriate care-seeking.
- **Media:** National and local media providers to work collaboratively with respiratory charities to run awareness campaigns and positive information sharing.
- **Government:** Providing funding, resources and support to identify local need and inform Neighbourhood models. Ensuring overarching population health and wellbeing with:
  - Improved access to and availability of open, green spaces,
  - Pollution targets, monitoring and alerts,
  - Further restriction on tobacco companies, and
  - Health alerts e.g. heatwaves, flu outbreaks etc.



- **Technology/AI/data:** The necessary technology to support the implementation of digital healthcare across all areas (ensuring equity of access to reduce inequalities, as well as warnings around dis/mis information)*. The safe and appropriate use of Artificial Intelligence (AI) which can be used to optimise healthcare systems and reduce the burden on healthcare professionals, providing them with more clinical time.
  National and local data and research to inform local population needs and identify groups at risk of health inequalities (this should include the provision of a Single Patient Record).

- **Leadership/skill in healthcare:** The necessary national and local healthcare and local authority leadership in place which ensures accountability, and the ability to break down silos to align health, social care and community partners. Leadership should also ensure that their workforce is adequately trained and capable of supporting people with COPD. This will be particularly important for staff working within the community wellness and diagnosis hubs who are responsible for ensuring an early and accurate diagnosis and initiation of the care plan. PCRS recommends use of its Fit to Care resource to support this.

- **Working with industry/pharmaceutical representatives:** Recognise where it is necessary to work with industry and/or pharmaceutical representative/organisations to deliver improved healthcare and initiatives.
- **Funding of healthcare services:** Healthcare services require adequate funding and buy-in from national government, healthcare commissioners and managers, as well as local authorities.

*With appropriate consideration of individuals who cannot access or use digital healthcare and the relevant, effective alternatives in place.

4.2 Care delivery

Providing care across the life-course: Ensuring that all healthcare requirements are in place to provide individuals with equal access to all necessary care and expertise they need throughout their life (pregnancy – end of life).

- **Prevention healthcare:** Includes consideration of preventative measures which can be taken from birth (neonatal health) and through childhood and adulthood, ensuring that a person is aware of being and remaining healthy.
- **Multidisciplinary working:** Ongoing and specialist support, treatment and care which comes from both healthcare and non-healthcare settings and includes rehabilitation and personalised care support. This should include access to mental health services for ALL people with COPD who require it.
- **Respiratory healthcare:** Includes all elements of evidence-based respiratory care which supports implementation of guidance - education, social prescribing, diagnosis, support and reviews.
- **Voluntary, Community and Social Enterprise (VCSE) organisations:** Providing people with the support and information they need outside of their immediate healthcare settings. It includes community support groups, foodbanks/warm spaces, community hubs, Breathe Easy groups etc.
- **Carers:** Whether formal (paid) or informal (unpaid and provided by friends or family), carers play a key role in supporting people with COPD and this role needs to be taken into consideration when thinking about Neighbourhood Health models.
- **Palliative care:** Care that improves quality of life for patients and their families who are diagnosed with life-limiting (usually progressive) illness. This must include advanced palliative care planning and coordination with palliative care teams and social care.
- **End of life care:** Ensuring holistic support for people in their last months or years of life.

1. NHS England. Department of Health and Social Care. Neighbourhood Health Framework. 2026. Available at: www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework
2. NHS England. Department of Health and Social Care. Health and Wellbeing Board - Guidance. Available at: www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance
3. NHS England. Fit for the Future: 10 Year Health Plan for England. Available at: www.england.nhs.uk/long-term-plan/
4. NHS England. Medical devices and digital tools. 2025. Available at: www.england.nhs.uk/long-read/medical-devices-and-digital-tools/

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