

Pathway Transformation Fund (PTF)
Evaluation – interim report
Early & accurate diagnosis;
Risk stratification &
optimisation

Executive summary

August 2026

Context

The Pathway Transformation Fund forms part of the [Respiratory Transformation Partnership](#). This partnership is designed to drive whole pathway transformation in asthma and chronic obstructive pulmonary disease (COPD) care, creating a new model of joint transformation delivery. Between October 2025 and March 2026 nine consortia were funded by the Pathway Transformation Fund to implement new approaches to the identification, diagnosis and optimisation of those at risk of lung disease. Each site was funded to focus on:

- **Early & Accurate Diagnosis:** initiatives designed to identify patients at risk, and to increase the rate of access to spirometry and FeNO testing in order to secure a rapid and reliable diagnosis
- **Delivery of the OPTIMISE approach:** a 4-step approach to improve care outcomes in a rising risk cohort of COPD patients. This involved the use of developed searches, expert review with delivery of evidence-based care, patient support and education as well as patient initiated follow up & links to virtual wards

This interim report describes progress and emerging impact arising from this activity. It draws on a range of evaluation methods, including monthly data collection, patient & staff engagement and final reports prepared by each site. A final report is expected in December 2026 when outcomes arising from a patient data study will be available.

Emerging findings

The project has delivered a number of important outputs.

- **Early & Accurate Diagnosis:** 2,389 spirometry tests and 1,747 FeNO tests were conducted, resulting in 2,266 COPD diagnoses and 2,150 asthma diagnoses.¹
- **OPTIMISE Reviews:** 5,029 patients were identified as suitable for a review, 29% (1,440) of whom received their review during the reporting period (Oct 2025 – Mar 2026).

The tables overleaf summarise key findings and indicators of success which have emerged. Data limitations affect our ability to answer some of the evaluation questions, but clear themes are emerging.

¹ Excludes data for Humber

Figure 2 What are the factors that contribute to success?

Workforce

- There is clear evidence that the workforce is confident and clear in its work. They deliver these services with kindness, knowledge, professionalism and in a way which ensures patients feel unhurried, confident and involved.
- Training, templates, tools & guidance have been highly valued and have increased people's confidence and ability to deliver the services.

Partnership working

- Where collaboration with the voluntary sector works well, it is valued in improving patient engagement.
- Where MDTs are working well, which includes the involvement of specialists, they are seen to be a major benefit to the work.

Equity considerations

Whilst the data is not always consistent, and is not matched against population baselines, there is evidence that the Early & Accurate Diagnosis work is reaching a diverse range of people.

Patient satisfaction

Patient satisfaction is consistently positive, with some patients being able to articulate notable health improvements which they attribute to the OPTIMISE review.

Figure 1 What are the factors that create challenges?

Data

Challenges with data is a consistent theme. This includes difficulties in (a) accessing data and the significant amount of time this absorbs (b) the inconsistency of coding within primary care (c) the need for consistent coding of patients taking part in OPTIMISE reviews to enable more effective monitoring of their outcomes post-review (d) the ability to consistently capture key metrics to inform our understanding of the work.

Capacity and resourcing

It's clear that the project has absorbed more staff capacity than was anticipated and that this has hindered the project's ability to deliver more substantial results.

Standardising the OPTIMISE process

It would be useful to explore options for increased streamlining of the service as well as creating a standardised model which builds on the more promising elements of the varied implementation approaches.

Patient engagement and support for patients

An increased focus on creative engagement approaches, including collaboration with the voluntary sector is likely to improve patient engagement, reduce DNAs and increase the diversity of patients who attend. A greater focus on ensuring that understandable advice and information is shared consistently with patients may also be valuable.

Figure 3 SUMMARY – What can we infer about Early & Accurate Diagnosis?

Theme & key evaluation question	What can we infer at this stage?
Timeliness: Has timeliness improved? - Are patients waiting less time from referral to diagnostic test? - Are patients waiting less time from diagnostic test to confirmed diagnosis?	- There is limited data regarding waiting times (although Mid Yorks consortia showed a reduction in the waiting time for spirometry tests). Most patients reported no concerns about waiting times. - Among those referred, 55% of received a spirometry test and 40% received a FeNO test during the lifetime of the project.
Quality & Outcomes - Are DNA and cancellation rates reducing over time? - Are more COPD and asthma diagnoses being confirmed?	- DNA rates fluctuated throughout the project, influenced by seasonable changes and variations between sites. It is difficult to draw clear conclusions about DNA reductions due to limited baseline data. There is some evidence that DNAs decrease with phone calls from a trusted connector prior to appointment. - There has been a notable increase in diagnoses from November onwards perhaps representing a lag in diagnostic test to diagnosis made in GP records
Equity How are different population groups accessing diagnostic services?	Demographic data proved difficult to collect consistently, so results must be treated with care. Gender: 54% of those identified were female and 45% were male. The detail for each site varies. Ethnicity: Reassuringly, those areas which have higher levels of diversity have more diverse ethnicities represented among the patients supported. Age: All age ranges are represented. Mid to older age bands (40+) occur most commonly. Deprivation: The data suggests EAD is successful at identifying and diagnosing people in areas of high deprivation.
Patient experience What are patient experiences of accessing diagnostics?	A very positive experience: Staff are well-regarded, a high proportion of patients would recommend the service to others. Improvements focused on facilities and accessibility. A small number of patients also commented on waiting times and confusion about the diagnosis.
Workforce experience What are staff experiences of delivering diagnostics?	A mixed experience: Staff very much valued the training and easier access to equipment. However, the lack of time and resources was a major barrier for staff, with project data challenges being a significant contributory factor.

Figure 4 SUMMARY – What can we infer about Risk Stratification and Optimisation?

Theme & key evaluation question	What can we infer at this stage?
Patient identification and engagement - What proportion of rising-risk patients complete an OPTIMISE review? - Which patients do not complete an OPTIMISE review, and what are the perceived reasons for non-attendance? - What support or engagement strategies are associated with increased uptake of OPTIMISE reviews?	- Between Oct 25 and Mar 26, 29% of patients whose notes suggested they were suitable received a review. This metric showed significant variation between sites (from 18% to 70%). - Detailed data regarding non-attendance is currently not available, however staff report it to be a problem. Key issues: (i) <i>persuading people to attend a review when they don't feel unwell</i> and (ii) <i>wider determinants of health</i>. - Working with Care Navigators, running Saturday events, the voluntary sector, local authorities and taking creative approaches (e.g. referrals from Citizen's Advice Bureau) appear to be useful strategies in encouraging engagement.
Patient experience - What is the patient experience of OPTIMISE? - What is the impact of OPTIMISE on self-management?	Very positive feedback - Patients value the quality of communication & involvement, the staff team (kind, knowledgeable, professional), and the well-coordinated multi-disciplinary approach. - Some people explained that they felt more confident in managing their condition. - Improvements should focus on even clearer communication and information, ease of access, and ensuring sufficient time to discuss issues.
Workforce experience What are staff experiences of delivering OPTIMISE?	A mixed experience - Staff largely report feeling clear, confident and well-equipped in their work. - However, they report significant challenges with time and capacity to deliver. - They are generally optimistic about the work and what it can achieve but recommend a number of improvements.
Equity: Are inequalities in COPD care reduced? Clinical value: What clinical value does OPTIMISE provide? Does OPTIMISE improve prescribing quality? Outcomes / system impact: Does OPTIMISE reduce avoidable healthcare utilisation? Does OPTIMISE improve disease stability and reduce acute burden?	<i>Initial data is available from one consortia (Humber) which shows improvements in prescribing rates, and Patient Reported Outcome Measures. We anticipate addressing these questions in more detail when further data is available (Final Report - Dec 2026).</i>

Emerging conclusions

Based on the available evidence, a number of emerging conclusions can be drawn:

- The programme appears to have had a **positive impact on the availability of spirometry and FeNO services**, contributing to an increase in the number of diagnostic tests conducted and diagnoses delivered. In some areas, we have evidence of reduced waiting times (Mid Yorkshire)
- The programme has **reached a wide set of demographics**. We can be confident that the programme is accessible to people living in the areas of highest deprivation, and to people of all ages. More women than men access the services which is promising as evidence suggests that women may be under-diagnosed.^{2 3 4} A wide range of ethnicities are represented in those locations where diversity is known to be higher (e.g. Merton, NW London, Manchester).
- **Patient feedback** suggests the programme is **highly valued** and largely delivered in a way which meets their needs.
- **Workforce** feedback suggests that people **see potential** in the approach and are **motivated** by the opportunity to work collaboratively and access training. However finding the **capacity to deliver everything that is required has been extremely challenging** suggesting that the time given to delivery of OPTIMISE reviews within some projects was set too low and primary care will need to lengthen the review times.
- Where it works well, **integrated neighbourhood partnership working involving specialists has been key**. Multi-disciplinary teams appear to be an important part of the process. Specialist support and collaboration with the voluntary, community sector and Local authorities has been key to reaching those groups who might not traditionally engage and addressing barriers created by the wider determinants of health.
- **Not all reviews are delivered consistently**, and outputs vary by site (for example, there is a wide variety in DNAs across the nine sites, ranging from 1% in Sherwood to 33% in Manchester). This needs to be understood further.

² McLean, S., Hoogendoorn, M., Hoogenveen, R. *et al.* Projecting the COPD population and costs in England and Scotland: 2011 to 2030. *Sci Rep* **6**, 31893 (2016).

³ Calverley PMA, Walker PP. Contemporary Concise Review 2022: Chronic obstructive pulmonary disease. *Respirology*. 2023 May;28(5):428-436. doi: 10.1111/resp.14489. Epub 2023 Mar 15. PMID: 36922031.

⁴ Perez TA, Castillo EG, Ancochea J, Pastor Sanz MT, Almagro P, Martínez-Cambor P, Miravittles M, Rodríguez-Carballeira M, Navarro A, Lamprecht B, Ramírez-García Luna AS, Kaiser B, Alfageme I, Casanova C, Esteban C, Soler-Cataluña JJ, De-Torres JP, Celli BR, Marin JM, Lopez-Campos JL, Riet GT, Sobradillo P, Lange P, Garcia-Aymerich J, Anto JM, Turner AM, Han MK, Langhammer A, Sternberg A, Leivseth L, Bakke P, Johannessen A, Oga T, Cosío B, Echazarreta A, Roche N, Burgel PR, Sin DD, Puhon MA, Soriano JB. Sex differences between women and men with COPD: A new analysis of the 3CIA study. *Respir Med*. 2020 Sep;171:106105. doi: 10.1016/j.rmed.2020.106105. Epub 2020 Aug 13. PMID: 32858497.

- There is **limited evidence regarding effective approaches to reducing DNAs**. More work is required to ensure all individuals are able to access a diagnosis.
- **Data has been a critical challenge**. This manifests in a number of ways: IG challenges in data sharing with inability to access primary care data; poor quality of coding in primary care records; challenges in recording results and capturing monitoring data effectively. The workforce report that these challenges have been the most difficult part of the programme and taken up a large amount of time.
- Five sites (Humber Liverpool, Manchester, Mid Yorks and Southampton) appear to have **advanced plans for sustaining at least part of the EAD / OPTIMISE programme**. Other sites are actively exploring options and presenting evidence to try to ensure this approach is adopted to business-as-usual activities.
- The evaluation suggests that the **expanding of EAD and OPTIMISE approach has merit** and qualitative feedback suggests there is an expectation that this programme could be **successfully scaled**. Site interviews and outcome data (which we expect to share in December 2026) will provide important triangulation for this finding.

Emerging recommendations

At this stage, recommendations focus largely on process and learning.

Recommendation One: continue to deliver respiratory diagnostics with similar operating models with linkages to onward pathways of care. Draw on the recommendations below to enhance the approach.

Recommendation Two: Integrated neighbourhood approach

Create a clear framework which is understood and agreed by all key stakeholders. This is likely to include:

- Integration of the respiratory specialist (eg: consultant and specialist nurse) workforce into neighbourhood teams, to support training delivery of EAD, OPTIMISE reviews and MDTs
- Defining and recognising the key role of respiratory champions
- Clear and standardised definition of cohorts for inclusion in EAD and the OPTIMISE approach
- Involvement of the voluntary sector or other connectors to help access those patients who are currently under-served by this approach.
- Consistent use of multi-disciplinary teams, which includes effective triaging of cases for inclusion at consultant-chaired MDT

Recommendation Three: Take steps to understand and standardise variations in the model - ensure that the most effective approaches become business as usual and inform a scaling model.

The evidence highlights some variation between sites in the approaches to delivering EAD and OPTIMISE. These variations include:

- rates of DNA and the underlying issues which drive variation
- rate of delivery
- delivery approach (e.g. one-stop clinics, Super Saturday events, standard clinics)
- approaches to training the workforce
- content of the OPTIMISE review (i.e. some evidence that patient information / care plans and inhaler technique do not always form part of the OPTIMISE review, not always clear that the 5 fundamentals are in place)
- length of the OPTIMISE review (evidence suggest 30 minutes may be optimum)
- variations in the cohorts who are referred for EAD
- approach to training to support the delivery of OPTIMISE reviews (improved competency of workforce)
- PIFU⁵ not always delivered by an appropriate respiratory specialist team
- Approaches to patient education and self-management information: a constructive approach is likely to include discussion AND follow up information (e.g. leaflets)

Whilst outcome data is not yet available to conclusively comment on the value of different models, further investigation of these differences will be useful. This would ideally explore the difference in cost of delivering a standard annual review compared with an OPTIMISE review. The results should be used to inform our understanding of those elements which are 'core' and essential to good quality delivery, and those elements which can be flexed to meet local requirements.

Recommendation Four: Continue efforts to upskill the workforce and create more capacity.

- Ensure there is greater capacity to focus on delivering EAD (including linkages to local pathways of care) and OPTIMISE reviews. Ensuring capacity for project management and engagement with data is key.
- Training in the use of spirometry and FeNO should be maintained and extended, with other learning opportunities (e.g. lunch and learns, shadowing & specialist-led MDTs) also encouraged. This builds skills and creates a culture of multi-disciplinary neighbourhood working.
- Maintain and extend the use of clinical protocols checklist or templates. They are valued, and support consistency.

⁵ Patient Initiated Follow Up

- Consider role redesign or greater use of allied health professionals to add capacity at a more modest expense.

Recommendation Five: Improve consistency of data collection and performance monitoring

Not all sites were collecting data equitably, with baseline data being especially sparse. Work with neighbourhoods to ensure a reliable and workable focus on:

- Collecting baseline data (including for example, the number of smokers in the cohort)
- Understand DNAs: exploring demographics and understanding what would improve engagement
- Collecting equity data (and comparing it to local profiles)
- Work with sites to agree a more practical and workable approach to collecting waiting time data

Recommendation Six: Improve equity targeting

Without better equity data, it is difficult to determine the extent to which sites are accessing patients which represent their local populations. However, it's clear that many sites have been very successful in accessing people who live in IMD 1. Encourage a continued focus on equity and intersectionality in targeting people for EAD, learning from those sites which have been more successful. This will include involving the voluntary sector and working with community respiratory teams.

Recommendation Seven: Ensure a strong and early focus on data quality, infrastructure and governance

There is an urgent need to improve the quality of data and enable easier access. Improvement here will influence the ability to deliver many of the recommendations outlined above.

- Resolve information governance (IG) barriers to enable appropriate data sharing across settings
- Improve data quality by standardising coding practices and templates in primary care records
- Simplify and streamline data collection systems to reduce administrative burden on staff
- Ensure clear and consistent coding for the interventions