Bedfordshire, Luton and Milton Keynes
Integrated Care Board

BLMK Chronic Obstructive Pulmonary Disease (COPD) Primary Care Guidelines

Introduction

Chronic Obstructive Pulmonary Disease (COPD) is a lung condition characterised by persistent airflow limitation, leading to symptoms such as breathlessness, chronic cough, and sputum production. Effective management involves a combination of pharmacological treatments, non-pharmacological interventions, and lifestyle modifications.

Chronic Obstructive Pulmonary Disease (COPD) remains a leading cause of morbidity and mortality worldwide and poses a significant burden on primary healthcare services. Effective management in primary care is crucial for early diagnosis, symptom control, risk reduction, and prevention of exacerbations.

This guidance aims to provide primary care professionals with a concise, practical summary of current best practices in COPD management, aligned with the latest Global Initiative for Chronic Obstructive Lung Disease (GOLD) and (National Institute for Health and Care Excellence) NICE recommendations. By incorporating these updates into routine care, primary care teams can play a central role in improving outcomes and quality of life for patients with COPD.

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Developed and updated by	Medicines Optimisation Team BLMK ICB;
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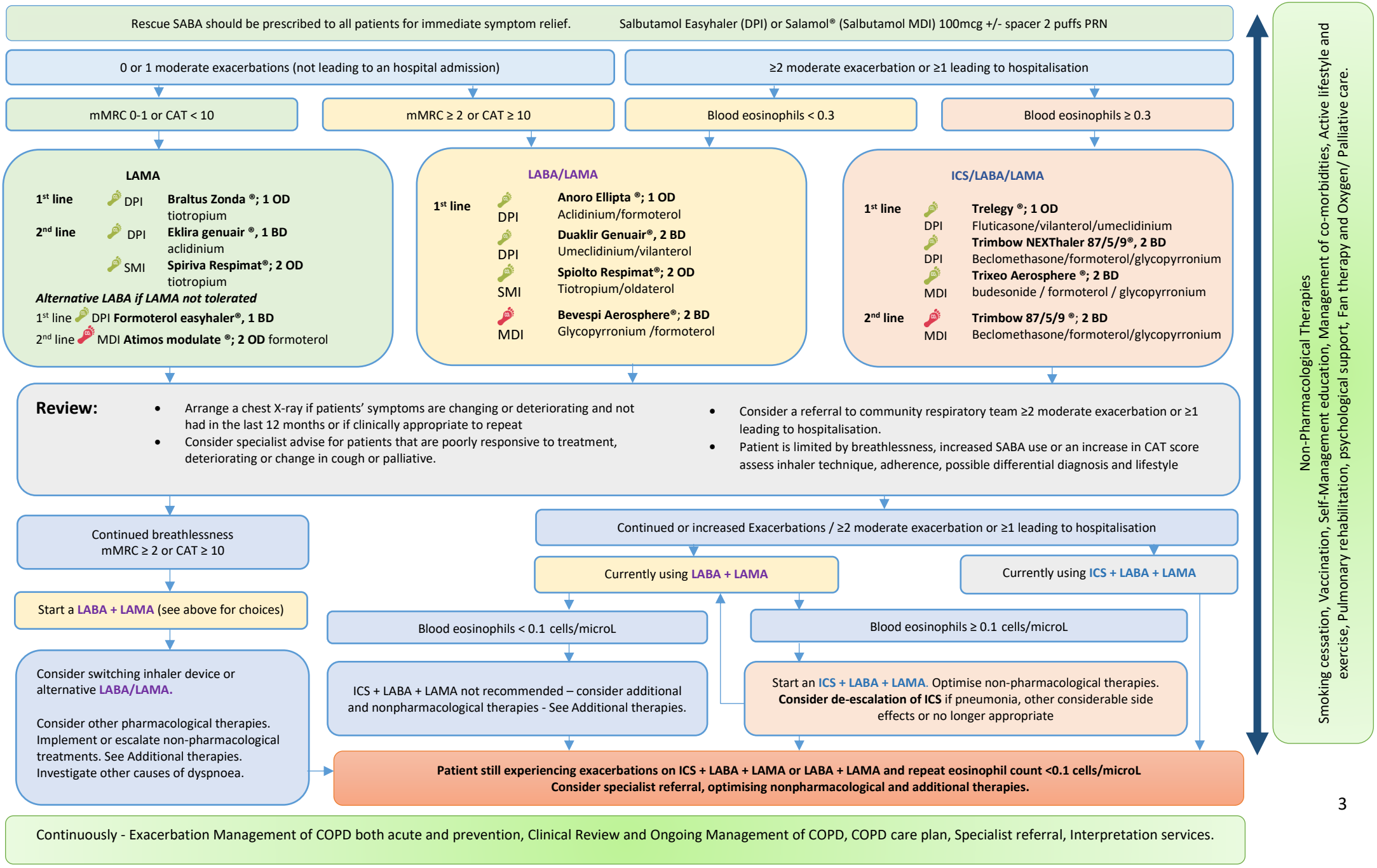
Content

1. Stable COPD Management One Page Quick Guide

A concise summary of key recommendations for managing stable COPD, presented on a single page for quick reference. For full details, please refer to the complete guidelines.



2. COPD diagnosis and review cycle

The use of a structured COPD diagnosis and review cycle is essential for delivering comprehensive, patient-centred care, as recommended by both the GOLD and NICE guidelines. This cyclical approach ensures that all aspects of COPD management, diagnosis, assessment, optimisation of pharmacological and non-pharmacological treatment, prevention of exacerbations, and regular review are systematically addressed. It forms the foundation of high-quality COPD care, promoting early and accurate diagnosis through spirometry, ongoing monitoring of symptom burden and exacerbation risk, and timely adjustment of therapy based on clinical response and disease progression.

Each component of the cycle is detailed in the guidelines, providing clear direction for primary care teams to personalise treatment, support self-management, and coordinate multidisciplinary input where needed. Using the cycle consistently helps to improve outcomes, reduce hospital admissions, and enhance the quality of life for patients living with COPD.

Select each title to navigate to the corresponding section for additional information.

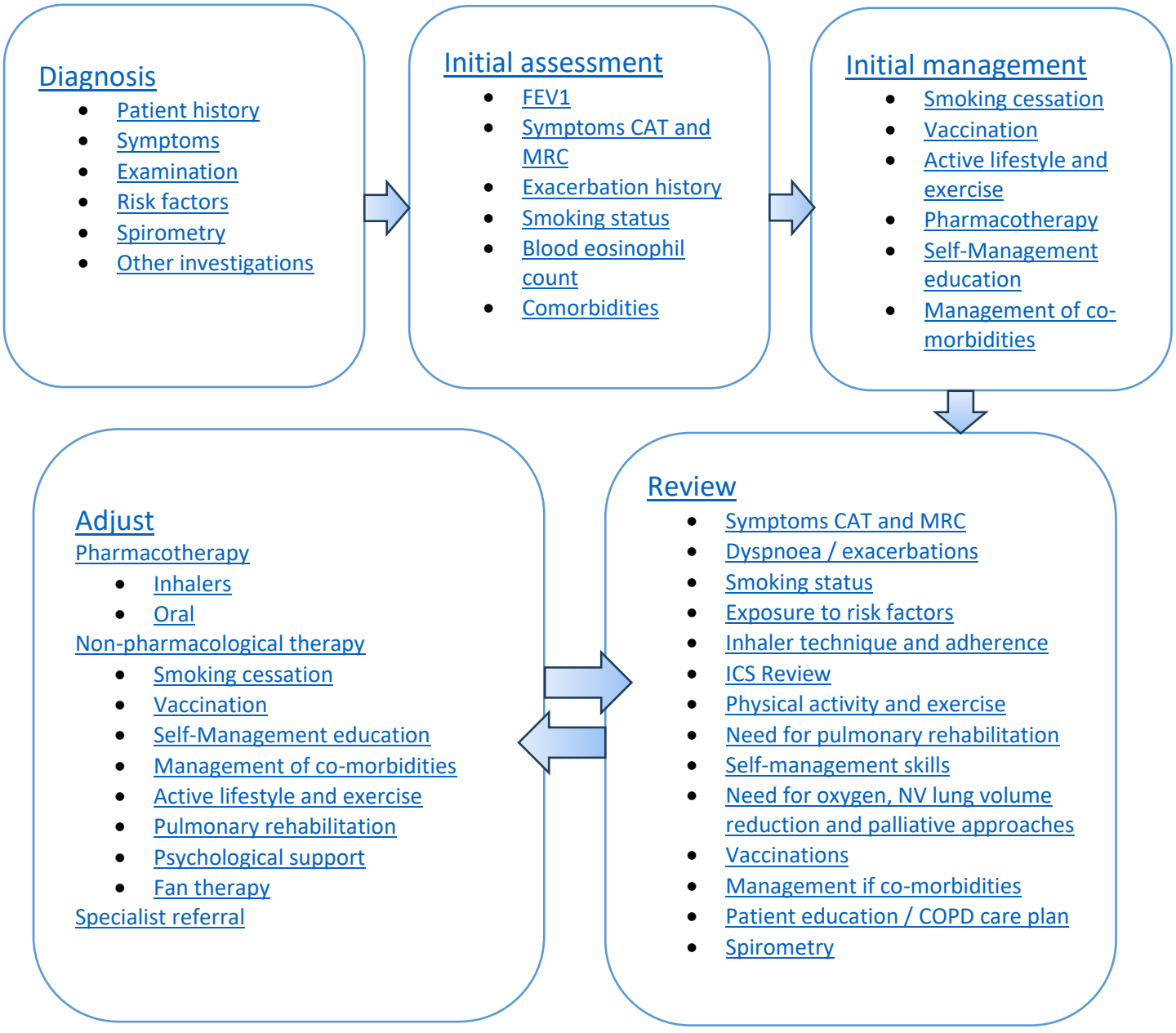


Figure 1. COPD diagnosis and review cycle

3. Diagnosis

a) Patient history

A detailed medical history of a new patient suspected or known to have COPD should include a thorough assessment of risk factors, such as smoking history or exposure to environmental pollutants. The past medical history should also cover early life events that may have influenced respiratory health, along with a family history of COPD or other chronic respiratory diseases. The history should note the pattern of symptom development, the frequency and severity of exacerbations, and any previous hospitalisations related to respiratory issues. Additionally, it is important to evaluate the presence of comorbidities, the impact of the disease on the patient's daily life, and the level of social and family support available to the patient. The possibility of reducing risk factors, especially through smoking cessation, should also be explored to help mitigate disease progression. GOLD

b) Symptoms

Suspect COPD in patients aged over 35 years, presenting one or more of the following symptoms:

- Breathlessness
- Chronic cough
- Regular Sputum production
- Frequent recurrent lower respiratory tract infection
- Wheeze

Other symptoms that may be present include:

- Weight loss, anorexia, and fatigue which is common in severe COPD, but other causes must be considered.
- Waking at night with breathlessness.
- Ankle swelling - consider cor pulmonale.
- Chest pain - uncommon in COPD, consider other causes.
- Haemoptysis - uncommon in COPD, consider other causes.
- Reduced exercise tolerance

c) Exposure to risk factors

These can include:

- Smoking - if the person is a current smoker document pack-years smoked (the number of cigarettes smoked per day, divided by 20, multiplied by number of years smoked).
- Occupational or environmental exposures. Occupational exposures to dusts (such as coal, grains, and silica), and certain fumes or chemicals (such as welding fumes, isocyanates, and polycyclic aromatic hydrocarbons) have been associated with the development of COPD.
- Air pollution - Exposure to high levels of indoor air pollutants from burning wood and other biomass materials (such as coal) has been associated with an increased risk of COPD.
- Genetics - Less common risk factors for the development of COPD include genetic abnormalities such as alpha-1-antitrypsin deficiency.

d) Examination

Examination may be normal, but signs may include:

- Cyanosis.
- Raised jugular venous pressure and/or peripheral oedema (may indicate cor pulmonale).
- Cachexia.
- Hyperinflation of the chest.
- Use of accessory muscles and/or pursed lip breathing.
- Wheeze and/or crackles on auscultation of the chest.

e) Spirometry

Perform post-bronchodilator spirometry to confirm the diagnosis, with a forced expiratory volume in one second (FEV1)/forced vital capacity (FVC) ratio of less than 0.7 indicating airflow obstruction. GOLD
In older individuals without typical COPD symptoms and an FEV1/FVC ratio below 0.7, consider other potential causes, while in younger individuals with COPD symptoms, even with a ratio above 0.7, the possibility of COPD should still be considered. The use of the Association for Respiratory Technology and Physiology (ARTP) guidelines of z score and lower limit of normal for ratios may help to when deciding how to best manage these patients.
ARTP Spirometry Guidance link: Spirometry Guidance

f) Other Investigations

Arrange investigations including:

- Chest X-ray – to help exclude other causes such as lung cancer, bronchiectasis, tuberculosis, or heart failure.
- Full blood count – to identify anaemia, polycythaemia and monitor eosinophil count.
- FENO or Peak flow diary while assessing at variability of symptoms.

Consider depending on the clinical situation – See NICE for more details

- Sputum culture
- Serial home peak flow measurements
- ECG and serum natriuretic peptides
- CT thorax
- Serum alpha-1-antitrypsin.
- Differential diagnosis

In Milton Keynes, consider referral to Assessment & Investigation of Respiratory symptoms (AIRS) team for initial diagnostics and assessment.
In Luton and South Beds, consider referral to Respiratory CAS clinic (refer via ERS) for diagnostics and review.

For further information on diagnosis consult:

- Chronic obstructive pulmonary disease CKS Feb 2025. Link: Chronic obstructive pulmonary disease | Health topics A to Z | CKS | NICE
- Chronic obstructive pulmonary disease in over 16s: diagnosis and management NICE guideline NG115 Updated 26/07/2029, Link: Overview | Chronic obstructive pulmonary disease in over 16s: diagnosis and management | Guidance | NICE
- GLOBAL STRATEGY FOR PREVENTION, DIAGNOSIS AND MANAGEMENT OF COPD: 2024 Report. Link: 2024 GOLD Report - Global Initiative for Chronic Obstructive Lung Disease - GOLD

4. Initial assessment

Once diagnosis has been confirmed by spirometry look at the following five aspects to guide therapy in COPD.

a) FEV1 and Severity of airflow obstruction

Where post-bronchodilator FEV1/FVC ratio is less than 0.7, the severity of airflow obstruction is graded according to the reduction in FEV1 compared to appropriate reference values (based on age, sex, height, and ethnicity).

Stage	Severity of airflow obstruction	FEV1
1	Mild	80% of predicted value or higher.
2	Moderate	FEV1 50–79% of predicted value.
3	Severe	FEV1 30–49% of predicted value.
4	Very Severe	FEV1 less than 30% of predicted value or FEV1 less than 50% with respiratory failure.

Table 1. A table showing the severity of airflow obstruction and FEV1

b) Symptoms

There is a weak correlation between the severity of airflow obstruction and symptoms experienced by a patient so a formal assessment of symptoms using validated questionnaire is required.

Medical Research Council (MRC) dyspnoea scale
The MRC scale is used to assess the degree of baseline functional disability due to dyspnoea. Offer pulmonary rehabilitation to patients with MRC score >2.

MRC Dyspnoea Scale	
Description	Grade
I only get breathless with strenuous exercise	1
I get short of breath when hurrying on level ground or walking up a slight hill	2
On level ground, I walk slower than people of my age because of breathlessness, or I have to stop for breath when walking at my own pace on the level	3
I stop for breath after walking about 100 yards or after a few minutes on level ground	4
I am too breathless to leave the house, or I am breathless when dressing/undressing	5

Table 2. A table showing the Medical Research Council (MRC) dyspnoea scale

COPD assessment test (CAT)
The COPD assessment test (CAT) can be used to assess the health status in patients with COPD and is a validated, short and simple patient completed questionnaire.
COPD Assessment Test (CAT) can be accessed here: https://www.catestonline.org/hcp-homepage.html

c) Previous history of moderate and severe exacerbations

Patients may be aware of periodic worsening of symptoms even if these episodes have not been identified as exacerbations of COPD.

d) Smoking status

If the person is a current smoker document pack-years smoked (the number of cigarettes smoked per day, divided by 20, multiplied by number of years smoked).

e) Blood eosinophil count

Higher blood eosinophil counts in COPD patients are associated with increased lung eosinophil numbers which could guide the use of ICS as part of the pharmacological management.

f) Comorbidities

COPD is often accompanied by other health conditions known as comorbidities, that can significantly affect the progression and management of the disease. Cardiovascular diseases are among the most common and serious comorbidities in people with COPD. Lung cancer is also more frequently seen in this population and remains a major cause of death. Other conditions, such as osteoporosis, depression, and anxiety, are also common. These are often underdiagnosed and can worsen overall health and outcomes.

When managing COPD and its comorbidities, it's important to keep treatment plans as simple as possible and to minimise the use of multiple medications (polypharmacy) to reduce the risk of side effects and interactions.

5. Initial management

a) Non-Pharmacological

I. Smoking cessation

All patients still smoking, regardless of age, should be encouraged to stop, and offered help to do so, at every opportunity.
Smoking Cessation Service Contact details:
Bedfordshire and Milton Keynes: Professionals - Choose You
Luton: Total Wellbeing Luton

II. Vaccination

All patients should be offered the pneumococcal vaccine and annual influenza vaccine (inactivated).
Encourage uptake of COVID 19 vaccine and RSV (75 and over) where appropriate. For more information see the links below.
Chronic obstructive pulmonary disease | Treatment summaries | BNF | NICE
Immunisation against infectious disease - GOV.UK

III. Self-Management education

Self-management skills include a written action plan, assessing and managing risk factors and inhaler technique.
How to use your inhaler link: How to use your inhaler | Asthma + Lung UK
Rightbreathe link: RightBreathe

IV. Management of co-morbidities

People with COPD often suffer with other co-morbidities which may influence mortality and hospitalisation independently of the severity of airflow obstruction. Therefore, comorbid conditions should be looked for routinely and treated appropriately.

V. Active lifestyle and exercise

Advise on the importance of regular physical activity to prevent deconditioning and maintain functional independence. Patients can be referred to active lifestyles via general practice.

VI. Pulmonary rehabilitation

Pulmonary rehabilitation (PR) is a comprehensive, evidence-based program designed to improve the physical and emotional well-being of patients with chronic respiratory conditions, particularly COPD. It combines supervised exercise training, education, and psychological support, with a focus on increasing physical endurance, reducing symptoms, and enhancing quality of life. The program typically includes tailored exercise regimens to improve lung function and fitness, as well as education on self-management techniques, breathing exercises, and strategies to

cope with the challenges of living with a chronic respiratory disease. Pulmonary rehabilitation has been shown to reduce hospital admissions, decrease the frequency of exacerbations, and improve overall functional status and wellbeing in patients with COPD.

Offer and refer to pulmonary rehabilitation early for patients with MRC score >2 or recent hospitalisation with acute exacerbation after excluding co-morbidities.

- In Bedford / North Bedfordshire: Service provided by the Bedfordshire hospitals Integrated COPD service. Refer on Systm One. Contact email: bhn-tr.bedfordrespiratory@nhs.net
- In Luton & South Bedfordshire: Use single point of referral on ICE.
  Contact email: ldh-tr.LDHPulmonaryrehab@nhs.net (Services provided by the Bedfordshire hospitals Integrated COPD service or Cambridgeshire Community Services.)
- In Milton Keynes: Refer to CNWL Link : Milton Keynes Community Pulmonary Rehabilitation Service :: Central and North West London NHS Foundation Trust
  Refer to MKUH for patients requiring transport / on >5LO2/min.

VII. Psychological support

For patients requiring psychological support, self-referral or GP referral:

- In Bedfordshire - Bedfordshire Wellbeing Service
  Email: elt-tr.bedfordiapt@nhs.net
  Tel@ 01234 880400
- In Luton - Total Wellbeing Luton | Talking Therapies
  Email: info@totalwellbeing.org
  Tel: 0300 5554152
- In Milton Keynes - MK Talking Therapies
  Tel: 01908 725099
  Email: cnw-tr.iaptmiltonkeynes@nhs.net

VIII. Fan therapy

Consider the use of hand-held fans or bigger fans (pass air over trigeminal nerves which then slows respiratory rate down.)

b) Pharmacotherapy

Drug treatment should be guided by breathlessness and exercise limitation, exacerbation frequency, symptoms, disability, and physiological complications that the patient experiences. At different times in the natural history of their disease different features may predominate and their management should change to reflect this.
Before initiating a new prescription:

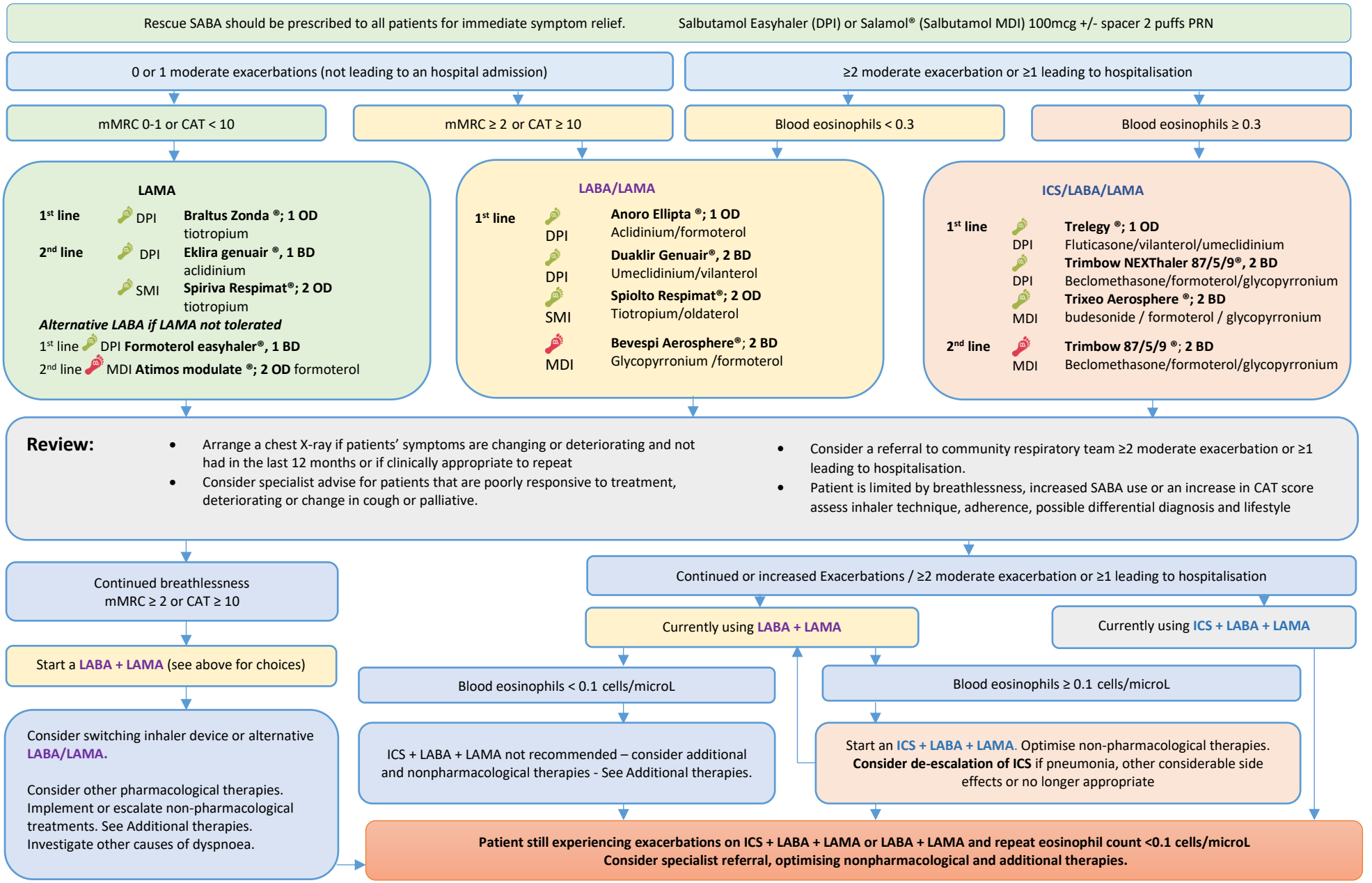
- Check adherence with medicines (order history,)
- Consider greener choice (information on carbon footprint use DPIs / SMIs in preference, where appropriate)
- Teach inhaler technique and ask patients to demonstrate regularly,
- Provide and update plan for responding to symptoms.

Although asthma and COPD can coexist in the same individual, the term asthma and COPD overlap (ACO) is no longer recommended. Current guidelines emphasize that asthma and COPD are distinct clinical entities, despite occasionally sharing overlapping features such as eosinophilic inflammation or variable airflow reversibility.

In cases where a concurrent diagnosis of asthma is suspected, management should be guided primarily by asthma treatment protocols to ensure appropriate control of airway inflammation and to reduce the risk of adverse outcomes.

BLMK Asthma guidelines can be accessed here: BLMK Asthma Guidelines for Adults in Primary Care – BLMKICB Medicines Optimisation

i) Medicines Management of stable COPD - Inhaled therapy



ii) Carbon footprint

Environmental Considerations in Inhaler Prescribing: Inhaler Carbon Footprint

- Dry powder inhalers (DPIs), soft mist inhalers (SMIs) and low carbon pressurised metered dose inhalers (pMDI) do not contain hydrofluorocarbon propellants and therefore have a lower carbon footprint.
- Where clinically appropriate, low carbon inhalers (indicated ) should be used in preference to reduce environmental impact.
- Refer to the BLMK Strategies for Lowering Inhaler Carbon Footprint (Dec 2021) for guidance.
- Information on the carbon footprint of each inhaler is available in the local inhaler formulary.

See Medicines Optimisation tool for adults via the below links.
Link : Meds-Opt-tool_greener_inhalers-1.1.pdf

iii) Inhaler device decision aid

Sub-optimal technique is widespread and linked to poor clinical control of COPD / asthma. Consider the patients ability to use different types of inhalers:

- Use an Incheck device or Placebos which can help assess the inspiratory flow and inform choice
- Where possible keep inhaler devices similar (e.g., where SABA DPI keep maintenance inhaler DPI)
- Use BLMK inhaler device decision aid. Link : Inhaler-device-decision-aid.pdf
- Consider the environmental impact
- Assess at every opportunity by a competent healthcare professional.
- Signpost to videos, e.g. How to use your inhaler | Asthma UK RightBreathe
  Link: RightBreathe

iv) Spacers

If using an MDI, a spacer should be used

- Teach use, ensure patient can demonstrate use
- Ensure patient aware of cleaning requirement, (not more frequently than monthly).
- Replace Spacer every 12 months
- The Rightbreathe website has information regarding which spacers are compatible with different MDIs.
  Link: RightBreathe

Aero chamber Plus Flow-Vu Antistatic is the preferred spacer choice in BLMK. Other choices are available – refer to online formulary. See link for instructions on use and cleaning instructions. The device will make a whistle sound if the inhalation is too fast, (if there is a good seal.)

Link: AeroChamber Plus Flow-Vu Anti-Static (Trudell Medical UK Ltd) 1 device - RightBreathe

Other Treatments

Mucolytics

- For patients with chronic productive cough and difficult to expectorate sputum, consider a trial of NACSYS® (Acetylcysteine) 600mcg effervescent tablets daily (prescribe as NACSYS brand,) or 2nd line Carbocisteine capsules 750mg TDS for 6 weeks then reduce to BD.
- Exclude dry cough driven by reflux which can be seen in patients with COPD
- Review if improvement in sputum production and reduced viscosity.
- Stop if no improvement.

Specialist medication

- Prophylactic antibiotics (e.g. Azithromycin) To be initiated and guided by specialist respiratory physician only.
- Roflumilast – For respiratory specialist initiation and stabilisation. Hospital to review benefits of continued use. Suitable for continuation in primary care as per local formulary.
- Theophylline – could be initiated in primary care at a low dose or specialist care if deemed appropriate. Monitoring would be required – please refer to SPC.

v) COPD formulary choices

Drug	Image	Dose	Inhaler device	Carbon Footprint
SABA				
1st Line Easyhaler® Salbutamol 100 micrograms/dose Inhaler Features a dose counter		1-2 doses when required.	DPI Inhale quick and deep	
1st Line Salamol MDI (Salbutamol) 100 micrograms/dose Offer a spacer device		1-2 doses when required.	MDI Inhale slow and steady	
SAMA				
Atrovent® 20mcg (ipratropium) Offer a spacer device		2 doses four times a day	MDI Inhale slow and steady	
LAMA				
1st line Braltus Zonda® (tiotropium) 10mcg powder capsules with device		1 dose once a day	DPI Inhale quick and deep	
1st line Spiriva Respimat® (tiotropium) softmist inhaler 2.5mcg		2 doses once daily	SMI Inhale slow and steady	
2nd line Eklira Genuair® (aclidinium) 375mcg		1 dose once a day	DPI Inhale quick and deep	
Incruse® Ellipta 55mcg (umeclidinium) 55mcg Inhaler features a dose counter		1 dose once a day	DPI Inhale quick and deep	
Seebri® (glycopyrronium bromide) 44mcg powder capsules with device		1 dose once a day	DPI Inhale quick and deep	

Tiogiva® Tiotropium bromide 18microgram inhalation powder capsules with device		1 dose once a day	DPI Inhale quick and deep	
LABA				
Formoterol® Easyhaler 12mcg Features a dose counter		1 dose twice daily	DPI Inhale quick and deep	
Atimos Modulite® (Formoterol) 12mcg Offer a spacer device		1 dose twice daily	MDI Inhale slow and steady	
LABA/LAMA				
1st line Spiolto Respimat® (tiotropium & olodaterol) softmist inhaler 2.5/2.5mcg Inhaler features a dose counter		2 doses once daily	SMI Inhale slow and steady	
1st line Duaklir Genuair® (aclidinium & formoterol) 322/12mcg		1 dose twice daily	DPI Inhale quick and deep	
1st line Anoro Ellipta® (umeclidinium & vilanterol) 55/22mcg Inhaler features a dose counter		1 dose once a day	DPI Inhale quick and deep	
Ultibro breezhaler® (Glycopyrronium & indacterol) 85/43mcg		1 dose once a day	DPI Inhale quick and deep	
Bevespi® Aerosphere (Glycopyrronium & formoterol) 7.2/5mcg Inhaler features a dose counter Offer a spacer device		2 dose twice daily	MDI Inhale slow and steady	

ICS /LABA/LAMA (triple therapy)				
1st Line Trelegy® (fluticasone / vilanterol / umclidinium) 92/22/55mcg Inhaler features a dose counter		1 dose once a day	DPI Inhale quick and deep	
1st Line Trimbow Nexthaler® (glycopyrronium / beclomethasone / formoterol) 88/5/9 Inhaler features a dose counter		2 dose twice daily	DPI Inhale quick and deep	
1st Line Trixeo Aerosphere® pMDI (budesonide / formoterol / glycopyrronium) 160/5/7.2 Inhaler features a dose counter. Offer a spacer device		2 dose twice daily	MDI Inhale slow and steady	
Trimbow® pMDI (glycopyrronium / beclomethasone / formoterol) 87/5/9 Inhaler features a dose counter. Offer a spacer device		2 dose twice daily	MDI Inhale slow and steady	

6. Exacerbation Management of COPD

a) Acute exacerbation management of COPD

Definition of Exacerbation

A COPD exacerbation is defined as a sustained worsening of respiratory symptoms beyond normal day-to-day variation, typically lasting more than 48 hours, and may include one or more of the following:

- Increased breathlessness
- Change in sputum colour
- Increased sputum volume

Assessment and Differential Diagnosis

It is essential to exclude other acute conditions that may mimic or contribute to the presentation and are potentially life-threatening. Consider alternative or additional diagnoses such as:

- Pneumothorax
- Pneumonia
- Heart failure
- Pulmonary embolism

Initial Treatment

Oral corticosteroids:

- Prednisolone 30 mg once daily for 5 days

Antibiotics (only if sputum is purulent or signs of infection are present):

First-line options include:

- Amoxicillin 500 mg TDS for 5 days

- Doxycycline 200 mg stat on day 1, then 100 mg OD for a further 4 days
- Clarithromycin 500 mg BD for 5 days

For patients at higher risk of treatment failure or with antibiotic resistance concerns, refer to the BLMK Antimicrobial Prescribing Guidelines for Primary Care for alternative regimens.
Link : BLMK ICB Antimicrobial Prescribing Primary Care Guidelines – BLMKICB Medicines Optimisation

Bronchodilator therapy:
Increase the frequency of short-acting bronchodilators as required. Ensure correct technique and use of a spacer if using a metered dose inhaler (MDI).

Pulmonary rehabilitation
Consider early referral following recovery to improve quality of life, reduce re-admission risk, and enhance exercise capacity.

Specialists / secondary care
If patient is not responding to treatment refer patient to specialist services – information in Section 9. Specialist referral.

b) Prevention of Future Exacerbations

Educate at-risk patients on how to recognise early signs of exacerbation and respond promptly. A self-management leaflet is available. For example, see links:
Your COPD self-management plan | Asthma + Lung UK.
ANP Respiratory Medicine

Carefully select patients who are appropriate for rescue packs, ensuring clear education and an individualised self-management plan.
Rescue packs must include guidance on:
- When and how to increase short-acting bronchodilators
- When to initiate oral corticosteroids ± antibiotics (antibiotics are not always required, patients should be clearly counselled)
- When to seek further medical advice or contact healthcare professionals

Important considerations:
- Rescue packs are not a substitute for clinical review and should not be used in cases of sudden or severe deterioration.
- Rescue medications should not be placed on repeat prescription.
- Patients should be advised to notify the practice when they initiate their rescue pack.
- Patients requiring two or more rescue packs per year should be reviewed to assess for overuse, ensure correct usage, and optimise regular maintenance therapy.

Oxygen / Palliative Care
- If SpO2 is <92% (when stable or 6 weeks after an exacerbation) refer for long term oxygen (LTOT) assessment.
- Where appropriate consider gold standard framework palliative care or discuss at palliative MDT.
- To refer to palliative care: In Milton Keynes; Willen hospice, In Luton; Keech hospice, In Bedfordshire (for inpatient services; Sue Ryder palliative care hub,) (for outpatient services; palliative care ELFT.)
- Assess as part of the ongoing management of COPD.

7. Clinical Review and Ongoing Management of COPD

Patients with COPD should be reviewed at least annually in primary care. More frequent reviews are warranted for those with ongoing symptoms, frequent exacerbations, or recent hospital admissions.

At Each Review:

- Reassess diagnosis: If the clinical course is atypical or symptoms persist despite appropriate treatment, consider alternative or additional diagnoses (e.g. bronchiectasis, heart failure, ischaemic heart disease, anxiety or depression).
- Review exacerbation history: Document the frequency, severity, and treatment of exacerbations.
- Evaluate medication adherence: Check prescription refill history and discuss any barriers to adherence with the patient.
- Assess inhaler technique: Confirm that the patient is using their inhalers correctly and consistently. Re-educate and reinforce technique where necessary.
- Review clinical records: Ensure completion of recommended interventions, including vaccinations (influenza, pneumococcal, COVID-19) and referral to pulmonary rehabilitation if appropriate.
- Optimise pharmacological therapy:

  Adjust treatment based on symptoms, exacerbation history, and inhaler use.
  Discontinue or switch inhalers if not tolerated, ineffective, or used incorrectly.

Inhaled Corticosteroids (ICS) Review
For patients with stable COPD (especially those with mild to moderate disease, no asthmatic features, and fewer than two exacerbations per year without hospital admissions), consider stepping down or discontinuing ICS therapy. Particular attention should be given to those where ICS may no longer be indicated as eosinophil count is <0.1. This could include those on triple therapy (LABA + LAMA + ICS) or double therapy (LABA + ICS).

- Be aware of, and be prepared to discuss, the risk of side effects (including pneumonia) in people with COPD taking ICS. Link: Inhaled corticosteroids: pneumonia - GOV.UK
- Follow the MHRA advice on the risk of psychological and behavioural side effects associated with inhaled corticosteroids. Link: Inhaled and intranasal corticosteroids - GOV.UK
- Give steroid card at ≥1000mcg beclometasone dipropionate (BDP) equivalent daily. Link : Beclometasone dipropionate | Drugs | BNF | NICE

Use local step-down protocol for guidance. Link : Inhaled-Corticosteroids-in-COPD-Stepdown-guidance-2024-Final-V4.2.pdf

8. COPD care plan

Patient Education and Self-Management
Effective patient education is central to the long-term management of COPD. All patients should receive structured education about their condition, treatment options, and strategies to support self-management.

Key Elements of Patient Education:

Nutritional Support

- Assess nutritional status using the MUST (Malnutrition Universal Screening Tool) and document the score in the patient record.
- Provide 'Food First' advice for those at risk of malnutrition.
- Consider referral to a dietitian if weight loss is ongoing or nutritional risk remains high.
- Additional guidance is available for patients and carers via: Managing Malnutrition in COPD – malnutritionpathway.co.uk

Physical Activity and Exercise

- Advise on the importance of regular physical activity to prevent deconditioning and maintain functional independence.
- Encourage participation in pulmonary rehabilitation where appropriate.

Personalised Self-Management Plan
Provide a tailored, written self-management plan that includes guidance on:

- Symptom recognition and monitoring
- When and how to adjust medications
- Appropriate use of rescue packs
- When to seek medical attention
- Define Treatment Goals
- Collaboratively identify patient-specific treatment objectives, including:
    - Symptom control
    - Improved quality of life
    - Prevention of exacerbation frequency and hospital admissions

Medicines Support Services

- At the time of new medication initiation or change in therapy, consider referring suitable patients to the Community Pharmacy New Medicines Service (NMS) to support adherence and optimise use.
- Structured medication reviews within primary care play a vital role in supporting patients with polypharmacy, ensuring safe, effective, and optimised use of their medications.

9. Specialist referral

Patients with COPD should be considered for specialist respiratory review in the following situations:

- Diagnostic uncertainty
- Haemoptysis (follow 2-week pathway.)
- Onset of cor pulmonale
- Assessment for long term oxygen therapy (for hypoxia, if SpO2 ≤ 92% breathing air during clinical stability) or long-term nebuliser therapy.
- Symptom onset at age <40 years, or a family history of alpha1-antitrypsin deficiency
- Symptoms disproportionate to disease severity, as assessed on spirometry
- Pulmonary rehabilitation
- Frequent exacerbations
- Rapid clinical or FEV1 decline
- Problematic withdrawal of steroids
- Bullous lung disease
- Complex patient requiring specialist MDT review

In MK, consider referral to Assessment & Investigation of Respiratory symptoms (AIRS) team for complex / continuing exacerbations with maximal therapy. (To contact for a query use: respiratory.airs-anp@nhs.net)
Refer to Acute Respiratory Assessment Service (ARAS) at L&D/Bedford Hospital

10. Interpretation services

If required, BLMK commissioned interpreter services are:
For Bedford, Central Bedfordshire and Milton Keynes practices; Language is everything. Practice booking codes are needed. Email: hello@languageiseverything.com
For Luton practices; DA Languages. Email: lccginterpretation.services@nhs.net

References

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