

Best practice in COPD care: a health equity approach

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Abstract

There is a strong evidence base for the best care in chronic obstructive pulmonary disease (COPD) as outlined by the National Institute for Health and Care Excellence in its five fundamentals of COPD care: offer treatment and support to stop smoking; offer pneumococcal and influenza vaccinations; offer pulmonary rehabilitation if indicated; codevelop a personalised self-management plan; and optimise treatment for comorbidities. However, only a minority of those living with COPD receive or engage with all five interventions, with clear implications for outcomes. Further, barriers which prevent people who live with COPD accessing necessary care are unequally experienced. In order to overcome many of these barriers, clinicians caring for people with COPD must prioritise personalised treatment and continuity of care.

Key learning points

- ▶ The five fundamental elements of care in chronic obstructive pulmonary disease (COPD) of smoking cessation, vaccination, pulmonary rehabilitation, self-management plan and optimised comorbidities are strongly evidence-based but rarely completed.
- ▶ COPD is a socially determined disease and intersecting factors mean that those more at risk of COPD are also more likely to experience barriers to care.
- ▶ Health professionals caring for people with COPD should be aware of these factors when aiming to implement National Institute for Health and Care Excellence guidelines, as it is possible to act on many of them.
- ▶ Enabling those living with COPD to receive or engage with all five fundamentals of care improves outcomes and equity.

Introduction

The core elements of high-quality care for people with chronic obstructive pulmonary disease (COPD) are well established and include help to stop smoking, provision of routine vaccination, pulmonary rehabilitation, personalised self-management plans and optimised treatment of comorbidities.¹ However, in 2022, only 18% of respondents to a national survey conducted by Asthma+Lung UK had received all of the five fundamental elements, a reduction of 7% compared with 2021.² Delivering these most effective interventions in COPD is clearly a challenge as they are more complex than prescribing a medication as a treatment. Success is predicated on clinicians being willing and confident to carry out effective consultations that enable shared decision-making and lead to behaviour change.³ There is a perception that this takes more time than can be afforded in a standard clinical encounter. However, techniques such as motivational interviewing and 'making every contact count' are effective in behaviour change and, with appropriate training and practice, can save time.^{4,5}

It is also important to recognise that the wider determinants of health, including deprivation, poor housing, employment status, health literacy and minoritisation strongly influence the ability of patients to engage with what we know to be best practice in COPD. This has a significant impact on outcomes including admissions, healthcare resource use and mortality.⁶ COPD is itself a largely socially determined condition; factors from the very beginning of life make some people much more likely than others to develop

COPD and have poorer outcomes from it once established.⁷ Clinicians need to be aware of the structural factors in society that cause people to develop COPD who need not have done so, and disadvantage people who live with established COPD. In addition to the avoidable harms already mentioned, people living with COPD experience diagnostic delay, inadequate care, low status of COPD and lack of support, all leading to worse outcomes.⁸

None of this will come as a surprise to clinicians who care for those living with COPD. We witness their struggle to engage with interventions, such as treatments for tobacco dependence and routine vaccinations, that we know will help them lead longer, healthier lives. In primary care, clinicians may have known individuals for many years and possess considerable knowledge of the intricacies of their lives, including factors that may hinder completing pulmonary rehabilitation or attending a review to codevelop a personalised self-management plan. Indeed, continuity of care, particularly relational continuity of care, is well recognised to improve outcomes and reduce mortality in many chronic conditions, including respiratory disease.^{9,10} Primary care health professionals, including doctors, nurses and pharmacists, are likely to be among those best equipped with the knowledge, experience and expertise to identify barriers that prevent those living with COPD from accessing care. This expertise is an important resource for those working in secondary care, and liaison between individuals working in different care settings is highly valuable. Where available, integrated care services are very effective in managing COPD

by seeing patients across the whole spectrum of disease, from prevention to advanced and palliative care, and working across the boundaries of community, primary and secondary care.¹¹

Despite a strong evidence base, factors which limit or prevent the ability of patients to access and health professionals to deliver the best care are rarely acknowledged in education, training or routine practice and are nearly absent from the National Institute for Health and Care Excellence (NICE) guidelines. While it must be acknowledged that structural issues with equity in COPD care cannot easily be addressed by individual health professionals in their clinical encounters, action can be taken to mitigate some harms, and awareness among health professionals of the systemic nature of these issues is necessary for change.

This article examines each of the five fundamentals of COPD care through consideration of health equity issues and aims to increase clinicians' knowledge and awareness of the evidence that underpins barriers to care. It includes reflections on each of the five fundamentals of care from a lived experience perspective and proposes actions that clinicians can take to reduce inequity and improve outcomes.

Offer treatment and support to stop smoking

Stopping smoking significantly improves outcomes in COPD and all current smokers should be offered treatment and support to quit. Tobacco dependence is a complex, intergenerational condition which starts early in life and requires long-term intervention as quitters commonly experience frequent relapses. Despite there being a strong evidence base for the effectiveness of treating nicotine addiction, funding cuts have meant that access to tobacco dependence treatment services is patchy.¹² Tobacco control is seen as a high priority by only one-third of local authorities.¹³ Training for clinicians on treating tobacco dependence, like many other behaviour change interventions, is often limited to very brief advice, which reduces the effectiveness of consultations. See box 1 for a personal perspective on smoking cessation support.

Initiation and maintenance of smoking is strongly socially determined and associated with deprivation, living in social housing and low educational attainment.^{14–19} Smoking is also strongly linked with mental ill health, a well-recognised comorbidity in COPD and also with experiencing trauma.^{20,21} In addition to the above risk factors, minoritisation is a determinant of smoking and rates of smoking are higher among LGBTQ+ people and some minority ethnic groups.²² Smoking is also highly prevalent in those attending drug services, and in adults admitted to hospital, making these important areas of focus for treating this condition.²³

Tobacco dependence is also an important 'commercial determinant of health'. The tobacco industry is one of just four industry sectors (along with ultra-processed food, alcohol and fossil fuels) responsible for one-third of global deaths.²⁴ All too often smoking is described as a lifestyle factor or individual behaviour,

Box 1 Lived experience perspective

'When quitting smoking, the prospect of not having cigarettes to help cope with stress is very frightening and it is important that people looking after those living with COPD understand this. I've had some conversations with doctors who have been quite dismissive—along the lines of 'what do you expect if you smoked?' I found these very unhelpful, it almost made me want to start again. Smoking used to be a very social thing to do, but that has changed with the no smoking inside law from 2007—it shows how important policy is!'

when in reality a series of factors push people—especially those most vulnerable in society—to buy and smoke cigarettes.

Actions

Clinicians should be appropriately trained in treating tobacco dependence and should prioritise discussion of this when reviewing patients with COPD, recognising and treating it as a chronic condition in its own right.^{25–27}

When offering support, clinicians should be aware of the factors that cause and perpetuate tobacco dependence and understand the context in which smokers continue to smoke or relapse. These factors must be elicited and addressed where possible, alongside offering treatment or referral for nicotine addiction treatment.²⁸ Motivational interviewing, making every contact count and providing individualised care with shared decision-making are effective means of achieving this.

Offer pneumococcal and influenza vaccinations

Pneumococcal and influenza vaccination reduces the risk of exacerbation and mortality in COPD and are key elements of COPD care. Vaccination rates for both in the UK are suboptimal. In 2021–2022, the influenza vaccine uptake for adults aged under 65 years with chronic respiratory disease was 56.1%, and the pneumococcal vaccine coverage was 56.8%.²⁹

Vaccination rates are strongly influenced by deprivation, with those in more deprived areas less likely to be vaccinated across all regions in the UK. Ethnicity is also linked with vaccination uptake, with Black or Black British-Caribbean people least likely to receive the influenza vaccine in the UK.³⁰ Active smoking, heavy alcohol consumption and comorbidities are also independent risk factors for not receiving vaccination.

Barriers to vaccination for those with COPD are both social and psychological, and include concerns about adverse effects, time constraints, variation in eligibility causing confusion, social support and influences, and fear of needles. Language and accessibility barriers and digital exclusion can also prevent access to vaccination.^{31,32} Vaccine hesitancy, the rise of which in recent years is partly attributable to social media, is of considerable global concern.^{33,34}

Actions

Increased contact with clinicians is positively associated with vaccination uptake, as is holistic COPD management and educational interventions for both patients and clinicians.³⁵ In routine clinical encounters, using the principle of making every contact count can help increase trust and confidence in vaccination.³⁶ See box 2 for a personal perspective on the effectiveness of this approach. Offering vaccination during acute admission should also be considered as an effective way of increasing uptake.

At a population level, an inclusion health approach can address some of the barriers to vaccination. A framework for this is included as part of the CORE20Plus5 programme, which aims to reduce healthcare inequalities in areas such as maternity care, severe mental illness, cancer diagnosis, cardiovascular disease and chronic respiratory disease. The COPD component of CORE20Plus5 aims to increase influenza, pneumonia and COVID-19 vaccination uptake in those living with COPD.³⁷

Offer pulmonary rehabilitation if indicated

Pulmonary rehabilitation in COPD reduces admissions and mortality, improves breathlessness, exercise tolerance and quality of life and reduces anxiety and depression. It is very cost-effective and has a number-needed-to-treat of 4 to prevent one admission

Box 2 Lived experience perspective

'Being reminded about vaccines by health professionals is really helpful, especially if it's someone you know well. I see my specialist nurse every three months and she'll give the vaccines if they're due, or I get a reminder text from the surgery. It's so great to have that taken care of and I can discuss any side effects or worries with her when I see her.'

to hospital in those with a recent exacerbation.³⁸ However, referral rates for pulmonary rehabilitation are low. In 2021–2022, only 37% of those eligible were referred (a decrease of 5% compared with 2019–2020) and only 42% of those referred completed the course.³⁹ Those living in deprived areas are less likely to be referred, and current smoking predicts both non-attendance and non-adherence to pulmonary rehabilitation.^{40–41} Completion rates are closely linked with deprivation.^{41–42} Patient-related reasons for low uptake of pulmonary rehabilitation following referral include:⁴³

- Limited understanding of COPD.
- High symptom burden (eg, not able to get to appointments because of breathlessness).
- Fear of exercise in the context of breathlessness.⁴⁴
- Transport barriers (eg, lack of accessible public transport services).
- Financial issues (eg, being unable to afford to travel or take time off work).
- Language barrier.
- Vision or hearing impairment preventing access to written materials or verbal instructions.

Care-related barriers are also significant and include long waiting times, limited availability of pulmonary rehabilitation and inability to access information about pulmonary rehabilitation at appropriate times. The role of the referrer is crucial: limited awareness of the benefits of pulmonary rehabilitation, little knowledge of local providers, limited consultation time and presumed low patient motivation have been identified as important barriers to pulmonary rehabilitation referral and uptake.⁴⁵ Organisational factors are also important: long waiting lists and lack of local availability prevent patients being able to access pulmonary rehabilitation even if they are willing. Finally, the incentive presented by NHS England's Quality and Outcomes Framework influences referral rates, with some centres reporting high rates of inappropriate referrals which impacts waiting times.⁴⁶

Actions

Incorporating partnership working between patients and clinicians increases appropriate referral, uptake and adherence to pulmonary rehabilitation and a person-centred approach is vital.⁴⁷ See box 3 for further insights. Proposed practical interventions to increase referral to and uptake of pulmonary rehabilitation include supportive messaging from respiratory specialist colleagues and services, including those running pulmonary rehabilitation services,

Box 3 Lived experience perspective

'Pulmonary rehabilitation is important but it's like any other treatment—the way the health professionals interact with you is so vital. If those leading the sessions aren't interested in you as a person, it's really hard to take it on board. Where it's held is also key, I did pulmonary rehabilitation during a very hot summer, and it was a long bus ride away, which made it very challenging to attend.'

dedicated referral time (annual review) and on-screen referral prompts.⁴⁸

The complexity of pulmonary rehabilitation as an intervention—socially, psychologically and organisationally—must also be appreciated. Conceptualising pulmonary rehabilitation as a three-way interaction between the patient, primary care and the provider helps to identify and demonstrate barriers and enablers for pulmonary rehabilitation services.⁴⁹ A dedicated health equity approach to increasing pulmonary rehabilitation referral and uptake has been proposed, which recognises the importance of culture, influenced by multiple intersecting factors including socioeconomic status and ethnicity, in driving behaviours.⁵⁰ Cultural competence is understood as a vital component of effective and equitable pulmonary rehabilitation.⁵¹

Codevelop a personalised self-management plan

Self-management plans, codeveloped with patients, have been shown to improve quality of life and reduce hospital admissions. Self-management plans should include cognitive behavioural components for people who experience frightening breathlessness and action plans for exacerbations. Education is a core component of self-management plans as low health literacy is an important barrier to effective self-management.⁵² Clinicians should avoid jargon and use appropriate language when codeveloping plans. Low 'patient activation', described as the knowledge, skills and confidence a person has in managing their own health and care, also impacts outcomes and is an important area for intervention.⁵³ When codeveloping plans, personalisation of care is key as it ensures that the whole person rather than the condition is considered and is central to delivering equitable care.⁵⁴

Currently, only a minority of those living with COPD receive support to develop a self-management plan in line with NICE guidelines. Research using a British Lung Foundation COPD Passport database showed that only 24% of people with COPD had a written action plan, and only 41% understood their COPD and had been told where to find further support.⁵⁵

Access to primary care is clearly crucial for patients and clinicians to codevelop personalised self-management plans, however, availability of primary care is more limited in more deprived areas.⁵⁶ This is an example of the 'Inverse Care Law' in action: the combination of higher need and lower availability of care.⁵⁷ An additional consideration is the ability to access available care. Non-attendance (DNA) at planned appointments is a complex issue and there are many causative factors outside the control of individuals, including travel costs, inability to take time off work and unclear or inaccessible communication about the appointment.⁵⁸ Lack of trust in healthcare services is also an important factor in non-attendance, particularly relevant for minority ethnic groups, and contributes to poor outcomes.^{59–60}

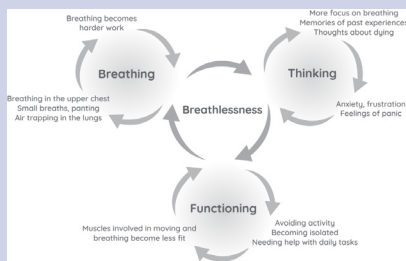
Deprivation limits the ability of those living with COPD to manage their own condition, even if they have been able to codevelop a self-management plan. Recent research from Asthma+Lung UK has shown that nearly half of people living with chronic lung disease in the lowest income bracket (household income of <£20 000) cannot afford to pay for their medication.¹⁶ The report also showed that those living in the most deprived areas were more likely than those in the least deprived areas to experience breathlessness which impacted their daily activities.¹⁶ Coping with breathlessness is also a key component of self-management in COPD (see Box 4).

Actions

When codeveloping self-management plans, clinicians should assess patients' health literacy levels and degree of 'activation' as defined above. Understanding patients' lived experience is also vital to providing high-quality care. As an example, screening

Box 4 An approach to breathlessness—the ‘Breathing Thinking Functioning’ cycle¹⁰⁷

Many patients with COPD can be overwhelmed by their breathlessness, which often leads to inactivity as a coping strategy and limited capacity to withstand exacerbations. A ‘vicious cycle’ of breathlessness containing cycles of thinking, patterns of breathing and physical deconditioning develop. Anxiety and negative thoughts in the ‘thinking cycle’, can worsen breathlessness, especially during exacerbation. Breathing pattern disorder in this cycle can further worsen breathlessness. The ‘Breathing Thinking Functioning’ model can help to frame an understanding of an individual’s breathlessness and guide therapeutic intervention.



for deprivation can help to stratify needs and identify routes to improving access to care. The question ‘Do you ever have difficulty making ends meet at the end of the month?’ is useful for eliciting deprivation and is acceptable to patients.⁶¹ The answer to this question enables identification of support that the person requires to be able to better access the care they need, for example help with applying for appropriate benefits.^{62–64}

Interventions to improve access to and engagement with self-management plan development will necessarily also encompass the other fundamentals of COPD care—treatment of tobacco dependence, vaccination and referral and uptake of pulmonary rehabilitation, as already outlined. A key component of personalised care, social prescribing, offers a way to address the factors beyond healthcare by focusing on the person rather than the condition, asking ‘What matters to you?’ rather than ‘What is the matter with you?’.^{65,66} Social prescribing connects people to activities, groups and services in their community. An example especially suited for people with COPD is Singing for Breathing (see Box 5).⁶⁷ Support is also available from health and well-being coaches, CORE20Plus5 Community connectors and care coordinators.^{62–64}

While pulmonary rehabilitation is the first-line intervention when breathlessness is debilitating and out of proportion to the stage of disease, referral to specialist respiratory team with access to specialist respiratory physiotherapy for breathing pattern assessment and intervention can be helpful. If available, psychological support for developing coping strategies for

Box 5 Lived experience perspective

‘The first time I felt in control of my COPD was when I started singing for breathing. It took such a long time for me to get my diagnosis—I had symptoms for 3-4 years before I had proper lung function tests done. The slow process meant that I was quite confused by all the inhalers and different people I had seen at the start. But singing for breathing meant that I met other people going through the same thing, and it helped me to be more aware of my body, how to control my breathing—and that helped me to much better understand my COPD.’

breathlessness should be sought. In advanced COPD, referral to palliative care services should be made in line with NICE guidelines.

Optimise treatment for comorbidities

Comorbidities in people with COPD impair quality of life, increase mortality and contribute significantly to healthcare resource use, therefore, a holistic approach is essential.⁶⁸ The most common COPD comorbidities are cardiovascular disease, skeletal muscle dysfunction (muscle atrophy, altered fibre type and metabolism which occur as part of COPD) metabolic syndrome, osteoporosis, depression, anxiety and lung cancer. This constellation of comorbidities can be conceptualised as young frailty.^{69,70} It is important to note that many of these comorbidities share common, socially mediated risk factors, both in terms of causation and perpetuation of respiratory ill health. Examples include smoking, deprivation, housing issues and childhood adverse experiences.^{71–78} Social isolation, common in COPD, is a predictor both of admission in chronic respiratory disease and development of cardiovascular disease and is also a risk factor for smoking.^{79–83} In addition, people living with COPD who are part of a minoritised group face further challenges in accessing healthcare for their COPD and associated comorbidities.^{84–86}

The co-occurrence of COPD and common comorbidities can be understood as a ‘syndemic’—population-level clustering of social and health problems which result from the interaction of several diseases, and which are most likely to emerge under conditions of health inequality caused by poverty, stigmatisation, stress and poor access to services and support.⁸⁷ A syndemic understanding of COPD facilitates more holistic care for those living with COPD and prompts clinicians to consider the wider determinants exacerbating both the COPD and associated comorbidities.

This framing extends beyond social factors to include the climate crisis and other environmental determinants of health such as air and water pollution, extremes of heat and cold and other extreme weather events, all of which harm respiratory health.⁸⁸ Deprivation is strongly linked to both air pollution exposure and extreme urban heat—both important risk factors for acute exacerbations of COPD and cardiorespiratory mortality (see Box 6).^{89–95} Heat and air pollution exposure are also strongly associated with poor mental health including mood disorders, which are important barriers both to engagement in care, but also to well-being in COPD.^{96,97} Air pollution and heat exposure, particularly in urban areas, are strongly linked with both the quality of housing and the deprivation level of neighbourhoods, themselves potent determinants of health.⁹⁸

Actions

In order to provide holistic care to people living with COPD, it is important to understand the complex interactions and synergies between factors which cause COPD and determine its outcomes. However, complexity and synergism also present an opportunity; seemingly minor interventions have the potential to impact significantly on outcomes through the establishment of a virtuous cycle where improvement in social determinants positively affect physical health.

Box 6 Lived experience perspective

‘I really know when the pollution levels are high—it feels as though it’s difficult to get oxygen in. It’s the same for heatwaves, which really affect my breathing. I find heat alerts really helpful as I can plan my activities and avoid the highest temperatures. But I’m lucky—I know not everyone can plan, for example, if you need to work or care for another person.’

A focus on breathlessness management offers one such opportunity. Improving breathlessness enables more physical activity, which in turn improves not only respiratory health but also cardiovascular, bone and mental health.⁹⁹ Interventions around anxiety and depression include talking therapies; however, these may be more accessible after other barriers such as financial worries and social isolation have been addressed.

Addressing the environmental determinants of COPD is clearly challenging and individual actions are limited in scope; however, clinicians have a responsibility to educate all patients about health risks of air pollution and actions they can take to reduce their exposure.¹⁰⁰ Resources for health professionals on clean air and how to communicate with patients and families about air pollution and the climate crisis are available from the WHO, Royal College of Physicians and Global Action Plan.^{101–103} Asthma+Lung UK has specialist resources to help people living with respiratory disease prepare for winter,¹⁰⁴ and resources around housing and energy are available from the Centre for Sustainable Energy.¹⁰⁵ Met Office alerts can help prepare for extreme weather events.

Case study: Deborah

Deborah is 63 years old and was diagnosed with COPD 5 years ago. She has made several attempts to quit smoking but still smokes about 15 cigarettes per day and continues to have exacerbations about three times per year. She is on appropriate inhaled therapy.

She is exacerbating frequently and is very anxious about the breathlessness she experiences which is limiting her ability to do housework, despite taking her inhalers 'religiously'. She has a rescue pack at home. She has not engaged with invitations for vaccination, has declined referrals to smoking cessation service on a number of occasions. She is not willing to discuss pulmonary rehabilitation when you have brought this up with her before. Her background also includes anxiety, hypertension and cardiovascular disease.

Deborah has started leaving the house less and has had to ask her neighbour to get shopping for her. She lives in a second-floor council flat with no lift and has recently had to take retirement from

her job as a legal secretary due to ill health. She is now struggling to make ends meet and is very worried about the winter and how she will heat her home which is a bit leaky from the old windows and poor insulation. She is unwilling to have the influenza vaccine as once when she did it made her very unwell, and she had to take two days off work which she couldn't afford. She does not want to attend pulmonary rehabilitation as the idea of being forced to exercise really triggers her anxiety. She takes her inhalers every day and has a pack of steroids and antibiotics at home, though last time didn't take the steroids as she thought it was just a normal chest infection and antibiotics would treat it. She suffers quite badly with anxiety and also worries about her heart as she has high blood pressure and angina.

She lives alone, her wife Angela having died 8 years ago from lung cancer. You looked after Angela when she was dying and did some home visits to their flat so you are aware of the issues with her housing, but Deborah hasn't been in to see you much since Angela died.

Deborah comes in for a prescription review. She's on treatment for COPD, hypertension, coronary artery disease, low mood and anxiety. You are aware of the role social determinants play in respiratory health and are concerned that social isolation and financial worries are contributing to her poor health and wellbeing. You also suspect that these are preventing her from being able to engage with care offered as part of the five fundamentals of COPD care. She has not responded to invitations for vaccination and has declined smoking cessation referral. You make a social prescribing referral with the aim of reducing social isolation and finding support with finances.

Deborah is seen by a link worker who asks, 'What matters to you?' and together they develop a personalised plan of action to increase social connection. Deborah used to go to a pottery class with Angela, but she has felt unable to do this since she died as the grief has been unbearable. Also, she can't really afford to go due to debts which have increased since she had to stop working. The plan she makes with the social prescriber first addresses the need for financial advice, support around benefits and finding help

Table 1 The five fundamentals of COPD care with examples of barriers to engagement and suggested actions

Intervention	Examples of barriers to engagement with intervention	Examples of actions clinicians can take
Stop smoking	Housing-related stress Financial stress	Use motivational interviewing/MECC techniques Training in treating tobacco dependence Social prescribing referral
Vaccinate for influenza and pneumonia	Confusion around eligibility Language barriers Digital exclusion Vaccine hesitancy	Inclusion health approach to vaccination programmes (eg, CORE20Plus5) Motivational interviewing
Offer pulmonary rehabilitation if indicated	Limited understanding of diagnosis High symptom burden (eg, frightening breathlessness) Financial constraints preventing travel to sessions	Person-centred approach to care Curiosity about barriers preventing engagement
Develop a personalised self management plan	Limited health literacy and understanding of diagnosis Low level of relational continuity with health professionals	Management of breathlessness as a problem in its own right, using 'Breathing Thinking Functioning' model Screening for deprivation and other social determinants of health Access ARRS roles such as community connectors
Manage comorbidities	Complexity—living with and managing multiple comorbidities in the context of multiple social determinants (eg, deprivation, poor housing)	Conceptualising COPD as 'syndemic' in order to guide holistic interventions Social prescribing referral

ARRS, additional roles reimbursement scheme; COPD, chronic obstructive pulmonary disease; MECC, make every contact count.

with heating bills and puts her in touch with an organisation that offers support to those in rented accommodation to help improve the condition of her home. She also gives Deborah the number of an organisation that supports bereaved members of the LGBTQ+ community and links her with her local talking therapies provider for some psychological support. This helps reduce Deborah's anxiety and she notices she is able to cut down on a few cigarettes per day and still cope. With support from her social prescribing link worker, she goes to the pottery class and finds that as she's not worrying about how to afford the bus fare there and back, getting out is less stressful than she expected.

There, she meets some friends who she hasn't seen since Angela died. Spending time with them and sharing happy memories of Angela lifts her mood, and further encourages her to make a quit attempt—her friends commented that they are surprised she's still smoking even with the COPD and Angela's lung cancer. She finds that she wants to get out and join gentle walking group that the social prescriber referred her to. This increases her physical activity levels which is great for her overall health and well-being, including bone and mental health. The resulting increased well-being and confidence means that she's willing to consider going to pulmonary rehabilitation which you have been trying to get her to do for years! This positively reinforces healthy and safe physical activity, and really helps with the breathlessness. She also learns lots about COPD and further increases her confidence and skill at managing it.¹⁰⁶ She's now more willing to try the flu vaccine, especially when one of her friends shares that she has had it recently with no ill effect. The five fundamentals have been ticked off!

(This is a fictional case.)

Conclusion

The five fundamentals of COPD care are well-evidenced, high-value interventions but are only of benefit if those living with COPD are able to access them. Clinicians should understand COPD as a manifestation of many complex issues relating to deprivation, poor housing, employment status, minoritisation and lack of support services. The social, environmental and commercial determinants of health both cause COPD and prevent engagement with care, and must be taken into account when offering interventions (see table 1). Not taking action widens health inequalities.

Using principles of personalised care to elicit specific risk factors such as deprivation, while gaining an understanding of patients' lived experience can help identify areas where support is needed and enable those living with COPD to engage with and benefit from high value care.

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