

Breathe Equal:
From Ambition to Action



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Breathe Equal

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Foreword

Shirley Ballas,
Champion Ballroom Dancer,
TV personality and COPD carer

When my mum, Audrey, was diagnosed with COPD, I don't think either of us fully understood how much it would change our lives. I've watched a woman who used to walk to the shops without a second thought become breathless just getting dressed in the morning. Simple things like climbing stairs, carrying shopping, even laughing too hard can leave her gasping for air. Independence has slipped away in small, painful increments, and with it, so much of her confidence.

Caring for Mum has taught me that chronic obstructive pulmonary disease (COPD) doesn't just affect the person diagnosed, it reshapes the whole family. There's the practical reality of hospital appointments, medication routines and the constant vigilance for signs of a flare-up. But there's also the emotional weight: the worry that sits with you every winter, the guilt when you can't be there, and the grief of watching someone you love lose pieces of the life they once had.

It's this that has driven me to speak out about COPD care. I want to use whatever platform I have to make sure people like my mum are seen and heard. COPD is too often dismissed as "just a smoker's cough," but it is a serious, life-limiting condition affecting millions of people around the country. Many of these people don't even know they have it, and those that do often struggle to get the support they so desperately need and deserve.

Being part of *Breathe Equal* has really opened my eyes to these challenges. What has struck me most is how unfair the postcode lottery can be. COPD is more common in the most deprived communities, driven by smoking, air pollution and harmful working conditions, and access to diagnosis, support and specialist care still varies wildly depending on where you live.

What gives me hope is meeting the clinicians, researchers and fellow families who are fighting every day to change this. I've seen pockets of excellent, compassionate care - and the difference this makes. The challenge now is making that the standard everywhere, not the exception.

Looking ahead, there's a real sense of optimism, but also urgency. There is growing recognition of the need to improve COPD care, and promising work is already happening across the NHS. But for people living with COPD and their families, what matters is whether that progress makes a difference to their everyday lives.

My mum's voice, and the voices of millions like her, can help remind decisionmakers that behind every statistic is a person, a family and a life affected by COPD. I hope this report encourages everyone involved in shaping and delivering care to move beyond recognising the challenges, and towards taking practical action to address them.

Executive summary

Two years ago, *Breathe Equal* set out a vision for COPD care in England: earlier diagnosis, better disease management, and equitable access to specialist care, regardless of where someone lives. Today, that vision is more important than ever.

Chronic obstructive pulmonary disease (COPD) continues to have a devastating impact on patients, families and the NHS. Too many people face delays in diagnosis, miss out on receiving established standards of care and struggle to access specialist support if they need it. Deep-rooted inequalities persist, with people in the most deprived communities experiencing a disproportionate burden of the disease.

Yet there is reason for optimism. Two years on, COPD is gaining greater recognition as a national health priority. The *Government's Neighbourhood Health Framework*, the *Respiratory Transformation Partnership (RTP)* and advances in technology and innovation offer new opportunities to improve care. Across England, innovative local services are already demonstrating what can be achieved when clinical expertise, proactive care and joined-up working come together.

The challenge now is to turn this growing ambition into consistent improvements for patients, wherever they live. Without coordinated action, there is a risk that progress will remain fragmented, with some communities benefitting from innovation while others continue to fall behind.

Breathe Equal: From Ambition to Action revisits the challenges identified in 2024, examines what has changed and sets out six practical recommendations across three priorities: improving diagnosis, optimising disease management and ensuring access to specialist care. The recommendations, which are based on insights gathered from the clinical and patient community, include earlier identification of COPD, more consistent delivery of effective care, proactive prevention of deterioration, and stronger national standards and clinical leadership.

The opportunity to transform COPD care is within reach. What matters now is ensuring that progress is felt by every patient, not just those fortunate enough to live in the right postcode.

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Introduction

COPD is a serious and progressive lung condition, which can be fatal. Symptoms include breathlessness, frequent lung infections and reduced energy.[1] A serious worsening of symptoms, called "an exacerbation" or "a flare up", often requires emergency hospital admission and can be life-threatening.[2]

Approximately three million people in the UK are living with COPD, with around two million of these thought to be undiagnosed.[3] In the UK, 30,000 people die from the disease each year, equivalent to one person every 20 minutes.[4]

Richard McCabe, 69, was diagnosed with COPD in 2010 at age 53, while working as a window cleaner. He first noticed something was wrong when a job that normally took him ten minutes took over an hour due to exhaustion and breathlessness. After receiving his diagnosis, Richard had to give up work and he now relies on oxygen and help from his family to complete everyday tasks, such as getting dressed and cooking. Before COPD, Richard was up and down ladders all day every day. Now it takes him 45 minutes to climb the stairs to go to bed.

"I was out of breath; I just couldn't do anything physical. Even trying to play football or kick a ball for a little while would absolutely exhaust me, and I couldn't understand why. I was diagnosed with COPD when I was 53. I assumed I still had years ahead of me, but my life looks very different now to how I imagined.

I can't breathe when I bend forward which makes getting dressed very difficult. I try to stand on one leg and put my trousers on without looking down but sometimes my wife has to help me. I still enjoy cooking but I need my family to take things in and out of the oven for me. There's very little I can truly do independently.

I try to go out regularly on my mobility scooter. That allows me some independence but even then, I need the help of a neighbour to get it back inside. And I always want to know where the nearest toilets are when I'm out. If I get breathless, I can experience incontinence, so I have to plan ahead. It makes me very anxious and hesitant to go to new places.

I miss the life I had before COPD. It can be very isolating. With all the oxygen connected to me, and being out of breath, it's virtually impossible to spend time with loved ones in the same way I used to. And I miss football. I'm mad about football in every way. I used to coach pre-academy football players. I was good at it. Some of the kids I coached went on to play for Chelsea, Manchester United, and Aston Villa. I had to give that up, and I had to give up my season ticket to Leicester too, because I'm physically unable to go. I'm not even able to kick a ball around with my grandson now. It's just heartbreaking."



Sadly, Richard's experience is not unusual. Behind every statistic is a person whose life has been fundamentally altered by a condition that could, in many cases, have been diagnosed earlier, managed better and treated more effectively.

In England, COPD is the second most common cause of emergency hospital admissions, accounting for over 132,000 admissions in 2025/26 alone - equivalent to one person every four minutes.[5,6] This pressure is felt most acutely in winter.

Nearly 80% more COPD admissions occur in the winter months than in the summer.[7]

Admissions between December 2023 - March 2024

46,405

Admissions between June - September 2024

26,105

The burden of COPD is not shared equally across the country. In fact, it has the widest health inequalities of any major condition.[8] Prevalence is 3.6 times higher in the most deprived communities than in the least deprived, and exacerbation and mortality rates are 68% and 41% higher respectively between these communities.[9,10] In 2021, NHS England introduced *Core20PLUS5*, a national scheme to address health inequalities among the most deprived 20% of the population and other underserved groups.[11] COPD was identified as one of the five clinical areas to be prioritised, yet a 2026 study tracking outcomes amongst 1.2 million people living with COPD in England found that inequalities have not improved since 2019.[11]

Exacerbation rates and mortality rates are 42% and 15% higher respectively in the Northeast of England than in the Southwest.[11]

Northeast vs Southwest

Exacerbation rates **+42%**

Mortality rates **+15%**

COPD is not a condition on the margins of the NHS. It's one of its greatest, most persistent and costly challenges, contributing to £2 billion of spending every year.[4] But there are encouraging signs that we may be reaching a turning point. In March 2026 the Government and NHS England's *Neighbourhood Health Framework* explicitly named COPD as a priority long-term condition, committing to measurable improvements in COPD outcomes by March 2029.[12] In the same month, the *Respiratory Transformation Partnership* was announced, a £10 million-plus initiative co-funded by NHS England, the Office for Life Sciences, 15 Health Innovation Networks and four pharmaceutical companies, including Sanofi.[13]

Increasingly, advances in technology are also playing an important role in driving progress. This potential was outlined in a 2026 report developed by Sanofi, in collaboration with expert COPD clinicians, entitled *'Exploring the Role of Digital and AI Interventions in Identifying and Managing COPD'*.[14] The report examined promising pilots and projects across the COPD pathway – from earlier case-finding to smarter risk stratification and more consistent delivery of care. Contributors emphasised the need to move beyond isolated pilots towards consistent, nationwide implementation.

Yet despite growing ambition, the fundamental challenges and inequalities in COPD care persist. It remains the case that meaningful change will require coordinated action across the health system to turn national commitments and local innovation into consistent improvements for patients. This report sets out where that action is most urgently needed.

Then, Now, Next

In 2024, Sanofi and Regeneron, in partnership with Asthma + Lung UK, shone a spotlight on the challenges and inequalities in COPD care. Together, we gathered insights from respiratory healthcare professionals in six locations across England. The findings were reported in our *Breathe Equal* report,[15] which recommended action across three areas: improving diagnosis, optimising disease management, and ensuring access to specialist care. Two years on, this report revisits what we said **then**, considers the situation **now**, and focuses on what must happen **next** to accelerate the transformation that patients like Richard deserve.

Section 1: Improving Diagnosis

Then

In *Breathe Equal* we identified delivery of faster and more accurate diagnosis as a critical first step in helping to transform COPD outcomes. We highlighted high rates of slow diagnosis and misdiagnosis, and called for consistent and timely access to spirometry, the gold standard diagnostic test for COPD. We recommended greater training for primary care professionals and rotation of respiratory specialists within Primary Care Networks (PCNs), as well as proactive identification of at-risk patients to find the estimated two million people living with undiagnosed COPD.[3]

Vivienne Gaynor, 64, was diagnosed with asthma at the age of 45. She didn't think too much of it, since asthma ran in the family. Her daughter had childhood asthma, and her Gran had it her whole life. But something was lingering, something was wrong. Her breathing got worse, she was wheezing, coughing and constantly breathless and tired. It took her six years to convince her physician that this was something else.



"I kept going back to my doctor to tell them my symptoms were getting worse. Every time, it was put down to my asthma and told to keep using my inhalers. Eventually, they sent me for a chest x-ray. I finally received a diagnosis over the phone - I had COPD and that I needed to go to the chemist to collect a new inhaler.

It took six years to get my diagnosis. I was relieved to finally have an answer, but I had no idea what COPD even was. I was given no information and I had no one to support me, so I went home and Googled it. Finding out I had a degenerative lung condition was frightening.

I had to give up the job I loved as a mental health advocate. The fast pace of it was impossible once I couldn't catch my breath. Now I rely on a mobility scooter to get around. My condition has ruined my life. It's cost me my career and my independence.

Unfortunately, lung health doesn't seem to be taken as seriously as other conditions such as cancer or heart conditions. It feels like there is some gap in knowledge and understanding of COPD as a chronic condition with no cure. I do believe that this had an impact on how long it took for me to get my diagnosis.

That's why I'm speaking out now for better respiratory care. No one else should have to fight this hard, for this long, just to be heard."

Now

People with COPD are still waiting too long to receive a diagnosis. Asthma + Lung UK's 2025 *Life with a Lung Condition* survey found that across the UK 15.2% of people with respiratory conditions waited more than a year between first discussing their symptoms and getting a diagnosis, while nearly three quarters (73.4%) reported barriers to diagnosis.[16] Recent qualitative work by King's College London also found that people with COPD reported that healthcare professionals were very often "too busy" to discuss their diagnosis with them, echoing Vivienne's experience.[4]

COPD is primarily diagnosed through spirometry, a simple test which measures how much air you can blow out and how quickly.[1] However, both access to and quality of spirometry remain significant barriers to timely and accurate diagnosis. While 85% of Integrated Care Systems (ICSs) commission adult spirometry in primary care, only 25% report sufficient capacity to meet demand and address backlogs.[17] Alongside workforce and funding pressures, inconsistent test quality and interpretation contribute to misdiagnosis.[18] Approximately 1 in 8 respondents to Asthma + Lung UK's 2025 survey reported having received an incorrect diagnosis initially.[19]

The consequences of delayed or inaccurate diagnosis are far-reaching, increasing the risk of preventable deterioration and exacerbations, while affecting people's ability to work and live independently.[9,19] Asthma + Lung UK found that people who waited two or more years for a diagnosis were more than twice as likely to have reduced their working hours (17% versus 7%) and 75% more likely to have given up work altogether (28% versus 16%), compared with those diagnosed within one month.[19] These impacts extend well beyond clinical outcomes, reinforcing the wider health and socioeconomic inequalities associated with COPD.

Next

Recommendation 1: Increase access to quality-assured spirometry via neighbourhood health and digital technologies

The Government's neighbourhood health approach offers a vital opportunity to address challenges in COPD diagnosis by organising healthcare around small local populations and increasing the convenience of their access to it.[13]

The Primary Care Respiratory Society's (PCRS) *Blueprint for COPD Neighbourhood Health* recommends that community wellness and diagnostic hubs should provide access to spirometry as a core component of the neighbourhood offer and calls for all individuals attending these hubs to be given a single point of contact until a formal COPD diagnosis is made.[20] Quality-assured spirometry, delivered and interpreted by appropriately trained professionals, should therefore be a minimum requirement of neighbourhood diagnostic provision.[19] The Government's commitment to 250 new Neighbourhood Health Centres by 2035, with the first wave focused on the most deprived areas, should provide the physical infrastructure to make this a reality.[13]

AI is also beginning to transform what is possible in diagnosis. In the North East and North Cumbria, an evaluation of AI-supported spirometry showed that it improved test quality and reduced interpretation time by around 50%, while supporting clinicians to identify cases requiring further investigation. This technology is now moving into wider NHS use with support from the National Institute for Health and Care Excellence (NICE).[21] Importantly, technologies like this should be used as a key supporting tool, rather than replacement for, expert clinical interpretation and decision-making.

Realising the potential of these initiatives and technologies at scale will require investment in workforce training and ongoing competency assessment, equipment provision, digital infrastructure, and clear implementation guidance, to ensure these benefits are delivered consistently across the NHS.



Recommendation 2: **Proactively identify and test high-risk patients to address underdiagnosis of COPD**

Breathe Equal featured the Frontier Hull Programme, a pilot leveraging the Lung Cancer Screening (LCS) programme to identify undiagnosed COPD among high-risk groups.[22] This, and similar schemes across England, demonstrate the potential of a proactive, case-finding approach to diagnosis. The LCS programme, previously called the Targeted Lung Health Check, is aimed at identifying lung cancer early in high-risk individuals or people with a history of smoking between the ages of 55 and 74. As of April 2025, the programme had completed 1,268,938 lung health checks across England, diagnosing 7,462 cases of lung cancer and finding over 100,000 cases of emphysema.[23] These findings present an opportunity to identify people who may have undiagnosed COPD and offer further diagnostic assessment where appropriate.

Despite the success of these schemes, and the growing focus on prevention by the NHS and Government, proactive case-finding for COPD is yet to be rolled out nationally. In June 2026, the UK National Screening Committee archived its topic on COPD screening, despite calls from the Taskforce for Lung Health and others for a targeted approach.[24]

In the absence of a national, targeted screening programme, we echo Asthma + Lung UK's calls for greater use of timely case-finding among high-risk groups – including smokers and ex-smokers with respiratory symptoms.[25] This could be implemented via an update to the incidental findings protocol for LCS to mandate the offer of quality-assured spirometry and appropriate follow-up for individuals with findings suggestive of COPD. Use of primary care and annual chronic disease review data could also be used to identify those at high risk. This would help people with undiagnosed COPD access appropriate treatment earlier, with the potential to reduce exacerbations and COPD-related hospitalisations, and move the NHS away from a crisis management model towards a proactive, preventative one.[20,23]

Section 2: Optimising Disease Management

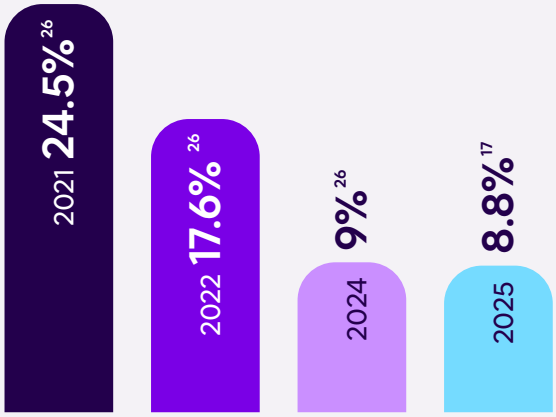
Then

Breathe Equal identified three barriers preventing patients from receiving best practice COPD management:

- Low referrals and uptake for pulmonary rehabilitation (PR)
- A lack of co-developed self-management plans
- Inconsistent access to proactive, preventative approaches to care, including smoking cessation which is the single most effective intervention for preventing or slowing COPD progression

In response, we called for updated patient pathways, opt-out referral to PR, standardised self-management plans, and the use of digital tools to support patients between appointments. Evidence shows these interventions work, yet they're still not available to everyone living with COPD.[17]

Reported receipt of all five fundamentals of COPD care, 2021–2025

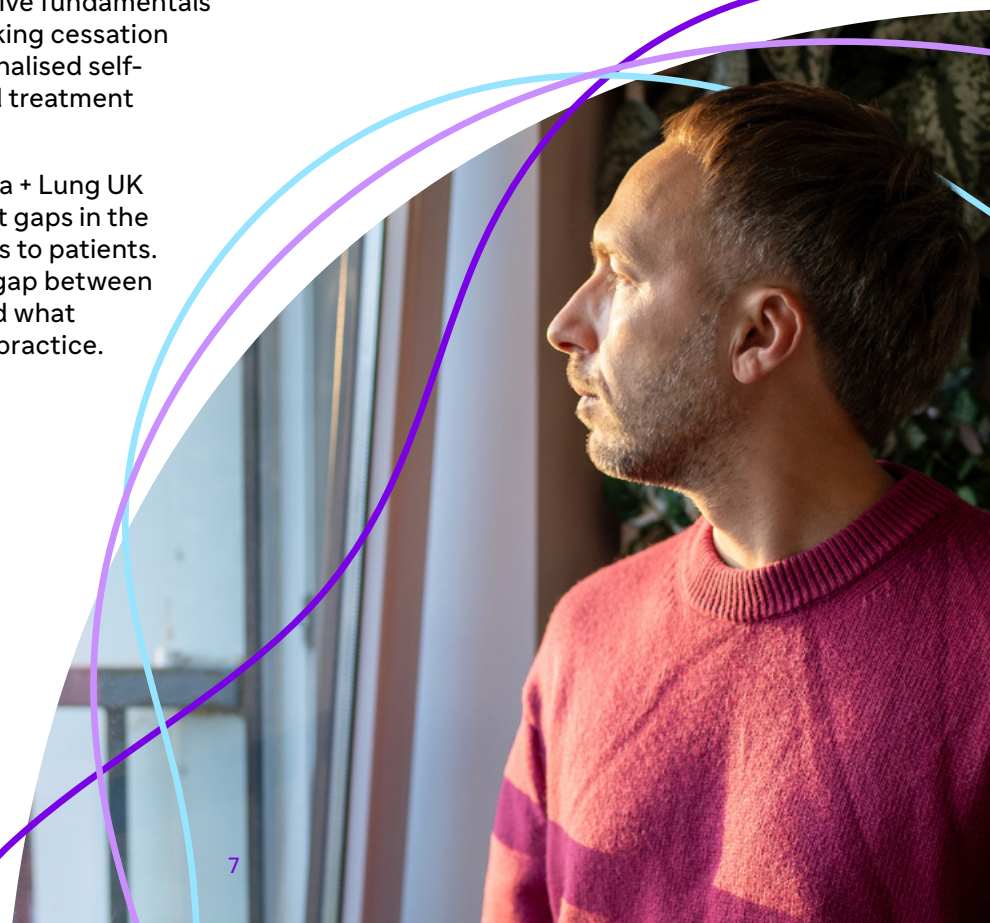


Figures are drawn from Asthma + Lung UK research conducted in different years. Survey populations and methodologies may differ, meaning the figures should not be interpreted as a directly comparable year-on-year trend.[17]

Now

A key indicator of how the delivery of COPD management is progressing is the proportion of people with COPD receiving all "five fundamentals of care" as defined by NICE: smoking cessation support; vaccination; PR; a personalised self-management plan; and optimised treatment for comorbidities.[17]

Concerningly, research by Asthma + Lung UK consistently highlights significant gaps in the provision of the five fundamentals to patients. This data highlights a persistent gap between established standards of care and what people with COPD experience in practice.



Next

Recommendation 3: **Develop neighbourhood health models that consistently deliver the five fundamentals of COPD care and monitor patient outcomes**

Poor outcomes in COPD are not the result of a lack of knowledge about what works. They are the result of poor and inconsistent implementation of what is already known to be highly effective. NHS reform provides an opportune moment to reset and refocus on getting the basics right.



It's estimated that increasing access to PR to all eligible patients would save the NHS £142.6 million annually and result in a reduction of 194,000 bed days, 66,000 of which would be saved over the winter period.[27]

In its *Blueprint for COPD Neighbourhood Health*, the PCRS sets out how the five fundamentals of care can be delivered by appointing a primary contact from the neighbourhood health team for all COPD patients. This point of contact would: manage referrals to supporting services, such as stop smoking services and PR; ensure all necessary reviews and checks are conducted; and maintain each patient's care plan, which should outline steps for day-to-day disease management, and what to do following an exacerbation and discharge from hospital, when patients are most vulnerable.

This initiative would help establish clearer accountability for referring patients to services, ensuring they complete the recommended interventions and escalating their care at the appropriate point. This would in turn address the Taskforce for Lung Health's concern that Quality and Outcomes Framework (QOF) measures, designed to improve delivery of the five fundamentals, are instead perceived by the NHS as a "tick-box exercise", with patients simply referred, but no-one monitoring completion and outcomes.[28]

Case study: **ImpACT+, South Derbyshire**

Since 2018, the ImpACT+ (Improving Adult Respiratory Care Together) programme has brought a proactive, neighbourhood-based model of care to people with, or at risk of, respiratory disease across South Derbyshire. Delivered by University Hospitals of Derby and Burton NHS Foundation Trust with NHS Derby and Derbyshire Integrated Care Board (ICB), the service provides disease management support through pulmonary rehabilitation, home oxygen assessments, smoking cessation services and education and peer support groups. The programme also brings specialist respiratory expertise closer to patients via a combination of neighbourhood multidisciplinary teams (MDTs), a complex MDT and Lung Line, a patient help-line manned by respiratory specialists.

In the first five years of ImpACT+:

- **More than 5,600 cases were discussed via neighbourhood and complex MDTs**
- **The Lung Line fielded 5,723 calls, 81% of which were resolved via advice alone**
- **5,611 patients were referred for pulmonary rehabilitation with 85% of participants showing improved exercise capacity at discharge**
- **Non-elective admissions for COPD fell by 24%**
- **99.6% of people reported a positive experience of respiratory-related care**

Digital tools can also enable more consistent and reliable delivery of the five fundamentals. Participants at the Sanofi-convened roundtable on AI in COPD cited examples of platforms providing personalised education, inhaler technique support, symptom tracking and digitally delivered PR as a way to reinforce and deliver the fundamentals beyond the clinical setting.

Recommendation 4: **Embed proactive risk stratification in COPD management to prevent exacerbations**

Experiencing even one exacerbation worsens future outcomes for someone living with COPD, including increasing their risk of further exacerbations.[26] Each hospitalised exacerbation costs the NHS between £2,000 and £3,000.[29] Identifying and proactively managing those most at risk of deterioration, before they reach crisis, is therefore both clinically and economically compelling.

The *Neighbourhood Health Framework* encourages proactive, data-driven risk stratification to address respiratory health inequalities and reach underserved groups.[13] Both NHS England and the PCRS recommend the OPTIMISE model, which involves identifying at-risk patients, optimising their care through holistic reviews, supporting self-management through education and remote monitoring, and facilitating access to integrated services.[5,21]

Participants at the Sanofi-convened roundtable on digital tools in COPD management highlighted the potential for digital and AI-enabled approaches to strengthen risk stratification by bringing together prescribing patterns, comorbidities, service use and wider social determinants of health. Remote monitoring and digital self-management tools can also provide ongoing insight into patients' symptoms between appointments, helping clinicians to identify deterioration earlier and prioritise timely intervention.[15]

For these benefits to patient care and outcomes to be realised, contributors to the roundtable and resulting digital tools in COPD management report felt that risk stratification tools and the resources associated with their use should be funded within services. A clear escalation pathway for patients who are identified as at-risk is also needed, to ensure it is clear which care setting and clinician should take on responsibility for addressing a patient's needs.



Case study: **COPD Health Inequalities Improvement Programme, Hastings, Sussex**

Hastings, a vibrant coastal town with areas of high deprivation, has a COPD prevalence of 3.2% against a national average of 1.86%, and its GP practices show significant variation in hospital admission rates. Pathway mapping revealed fragmented care, inconsistent annual reviews and variable access to the five fundamentals and to specialist services. In 2026, Sanofi, NHS Alliance, the Sussex Primary Care Provider Collaborative and Hastings Primary Care Network, and East Sussex County Council launched a collaborative programme to address these challenges.

A key element of this work was proactively identifying high-risk patients. Of Hastings' 3,642 registered COPD patients, 1,705 live in the most deprived areas. Within this group, 413 with repeated exacerbations were offered enhanced OPTIMISE reviews: 45-minute holistic consultations covering medication, inhaler technique, smoking cessation, vaccination, mental health and signposting to wider support.

Needs identified through the reviews were met through services close to patients, including additional community pulmonary rehabilitation, peer support and smoking cessation support. A new multidisciplinary pathway also gives primary care clinicians access to specialist respiratory advice without patients joining a 45-to-48-week outpatient queue.

Early feedback on the approach highlights stronger integrated working across primary, community and secondary care, upskilled respiratory nurses, a greater focus on prevention and the potential to reduce health inequalities for people with COPD.

Section 3: Ensuring Access to Specialist Care

Then

Breathe Equal identified access to specialist care as the third critical pillar of COPD transformation, highlighting long waiting lists and stark geographic disparities in access to specialist services. We called for faster routes to specialist review, and mobile and virtual clinics to bring specialist expertise closer to patients. Innovations in COPD treatment make this challenge even more pressing, and the stakes of inaction higher.

Patricia Ireland, 80, was diagnosed with COPD in 2004, age 58. She is married, has three adult daughters and nine grandchildren. With the help of her family and regular input from a respiratory consultant, Patricia manages to stay positive and continues to do things she enjoys, despite her symptoms.

"I have lifelong asthma but at some point I realised that my inhalers were not as effective as they used to be. I would get out of breath going uphill or climbing the stairs. I tried to hide it initially. I'd stop and say that I was enjoying the view. But that was not sustainable.



I've always been very involved in my own healthcare and I do my own research to try to understand my condition and what to expect. I asked to be referred to a respiratory consultant, who I now see every six months. I'm lucky to have received good treatment although I still really struggle when I get a cold or the flu. I've had to go to A&E before because I've been fighting for my breath.

My condition has strengthened my resolve to keep going. I try not to dwell on what I miss but rather make the most of every day. I used to love swimming, dancing and long walks. Now I've picked up new hobbies including knitting, playing the ukulele, researching my family history, and continuing lifelong girl guiding. I also lead my local Breathe Easy respiratory group to meet and support others with COPD.

I am grateful for all the help I have received from the medical profession but I know I must play my part too. I take advantage of all the help I can, such as attending pulmonary rehabilitation courses, so that I can remain a useful citizen for as long as I can. I know every day is precious. It's not how long I live but how well I live, and it's my responsibility to live as well as I possibly can."

Now

For decades, innovation in COPD care remained largely at a standstill, with treatments limited to managing symptoms. That is beginning to change, offering hope to patients who continue to experience debilitating symptoms despite disease management.

This shift is reflected in Government-backed initiatives intended to improve access to all forms of COPD care. The *Respiratory Transformation Partnership (RTP)* aims to accelerate earlier diagnosis, bring high-quality services closer to home and expand specialist care, including improving access to the most effective treatments.[14] Alongside this, a two-year pilot due to start in April 2027 will test whether removing local affordability barriers speeds up and improves the consistency of uptake of medicines for COPD.[30] Both of these initiatives reflect a welcome step-change in ambition.

Yet, at present, a person's postcode too often determines the care they receive, including access to medicines. Some people living with COPD require specialist support, beyond primary and community care, to manage their symptoms. Access to this support varies across the country, likely in part due to workforce and funding challenges.[31] For example, data from the year to July 2026 shows that in Kent and Medway, 42.9% of people referred for specialist respiratory care waited over 18 weeks for their consultation. In contrast, in Gloucestershire, just 11% waited over 18 weeks.[32]

It's important that initiatives like the RTP and the medicines pilot ensure that demonstrable improvements delivered in some areas can be replicated and translated across the country at pace. Targeted action, supported by national standards and clear accountability, is required to build upon the momentum provided by these initiatives and to deliver timely, equitable access to appropriate COPD care across the country and particularly in communities facing the greatest burden of disease.



If lung health had improved at the same rate as cardiovascular disease over the past two decades, there would be around 8,000 fewer deaths from lung conditions every year.[8]

Next

Recommendation 5:
Commit to a Respiratory Modern Service Framework (MSF) in the next wave of MSFs

Modern Service Frameworks (MSFs) were introduced in the Government's *10-year Health Plan* as a new tool to address inconsistent delivery of high-quality care across the NHS. A first wave of six MSFs have been published or are currently being developed. Respiratory disease is yet to be chosen for an MSF but the case for doing so has never been stronger. Between 2001 and 2024 the rate of preventable deaths from respiratory disease in England fell by just 7.5%. Over the same period, preventable deaths from cardiovascular disease fell by 54.3%, and from cancer by 33.1%.[8] Notably, National Service Frameworks (predecessors to MSFs) for both cardiovascular disease and cancer were published in 2000.

Behind these mortality figures are real people and lives lost, underscoring the need for stronger national leadership on respiratory disease.

In its report calling for a Respiratory MSF, *Breathing Life into the NHS*, the Taskforce for Lung Health set out a clear ambition: a 25% reduction in premature respiratory mortality and halving of the deprivation gap by 2036.[8] Given COPD's substantial contribution to the respiratory burden, tackling its persistently poor outcomes and inequalities will be key to achieving this.

Respiratory disease should be prioritised in the next wave of MSFs, with a framework developed in collaboration with respiratory clinicians, patient organisations and wider system stakeholders. This would provide the national consistency, minimum standards and accountability mechanisms needed to ensure that improvements in COPD care, including those supported by the RTP, translate into reduced variation and health inequalities.

The guidance that a Respiratory MSF would provide would also mitigate one of the most significant risks of the neighbourhood health model: that without national standards and accountability, the shift to community-based care could further exacerbate geographic disparities, with well-resourced systems moving quickly and under-resourced systems falling further behind.

Recommendation 6: **Reinstate and prioritise respiratory clinical leadership roles across the NHS with a designated lead embedded in every ICB**

Across the NHS in England there has been a marked reduction in dedicated respiratory clinical leadership, which the PCRS has warned is putting patient care, service innovation and health equity at serious risk.[33] To ensure transformation is delivered consistently across the country, every ICB should have a designated respiratory clinical lead, embedded within its governance structures, with clear responsibility and accountability for improving respiratory outcomes, including for COPD. This would provide the leadership needed to design, drive and implement change locally and regionally.

Respiratory clinical leads should work across PCNs, neighbourhood teams and secondary care to strengthen clinical governance and ensure that data, evidence and innovation are translated into improved outcomes for patients. People like Audrey, Richard, Vivienne, Patricia and the millions of others living with COPD across the country have every right to expect that their local health system is taking responsibility for the quality of their care.



Case study: **Asthma + Lung UK's Respiratory Champions**

Asthma + Lung UK's Respiratory Champions Programme shows what empowered clinical leadership can look like in practice. Now in its third year, the programme places senior clinicians into dedicated leadership roles within ICSs, each with one day a week of protected time to drive system-wide improvement.

In Cheshire and Merseyside, former Champion Samantha Hayes supported implementation of the COMET project, which tackles undiagnosed COPD by using the NHS Lung Cancer Screening programme to identify high-risk individuals for timely spirometry, clinical assessment and nurse-led community interventions. COMET is now being explored by Staffordshire and Stoke-on-Trent ICS as a blueprint for community diagnostics.

In Hampshire and the Isle of Wight, Champion Maria Euton is supporting COPD patients at high-risk of deterioration via a new primary care annual review pathway and the SCOPES post-exacerbation tool. SCOPES stands for: smoking cessation; comorbidities; optimisation; pulmonary rehabilitation; exacerbation history; and self-management. Maria has presented the SCOPES tool to over 350 clinicians and it is now being adopted by South Yorkshire, Cheshire and Merseyside ICS, and Staffordshire and Stoke-on-Trent ICS.

This demonstrates how giving clinicians protected time and a system-wide remit, rather than confining their leadership to a single clinic or ward, can accelerate and disseminate improvements in COPD diagnosis and care.

Conclusions and Recommendations

Two years ago *Breathe Equal* set out a vision for what COPD care in England could look like: earlier diagnosis, consistently delivered best practice management and equitable access to specialist care for every patient, regardless of where they live. That vision has not changed. What has changed is the urgency with which it must be delivered.

The signs of progress are real: the *Neighbourhood Health Framework* names COPD as a priority; the RTP commits substantial investment to systemic change; AI and digital tools have the potential to make patient identification and management more efficient; and local models demonstrate what is possible when innovation is matched with clinical leadership. These are foundations worth building on.

Yet progress remains too slow. Only 8.8% of people with COPD surveyed reported receiving all five fundamentals of care.[17] Inequalities in COPD outcomes have not improved since 2019[11] and one in two patients is readmitted or dies within 90 days of an exacerbation.[4] The gap between established standards of care and patients' experiences remains substantial. For the three million people living with COPD in the UK the cost of continued inaction is measured not in statistics, but in lives. They cannot afford to wait.

Recommendations

To improve diagnosis:

1. **Increase access to quality-assured spirometry via neighbourhood health and digital technologies**
2. **Proactively identify and test high-risk patients to address underdiagnosis of COPD**

To optimise disease management:

3. **Develop neighbourhood health models that consistently deliver the five fundamentals of COPD care and monitor patient outcomes**
4. **Embed proactive risk stratification in COPD management to prevent exacerbations**

To ensure access to specialist care:

5. **Commit to a Respiratory Modern Service Framework (MSF) in the next wave of MSFs.**
6. **Reinstate and prioritise respiratory clinical leadership roles across the NHS with a designated lead embedded in every ICB.**



References

1 National Institute for Health and Care Excellence (2018, updated 2019). Chronic obstructive pulmonary disease in over 16s: diagnosis and management. NICE guideline NG115. Available at: https://www.nice.org.uk/guidance/ng115. Accessed November 2026.

2 Halpin DMG, Gatenby J, Hickman K, Hurst J, Couper A, Dickens AP, Evans A, Adan Coronado A, Pullen R, Alves L, Bafadhel M, Carter V, Crooks M, Miravitlles M, Morris T, Müllerová H, Singh M, Quint JK, Singh D, Wilkinson T, Winders T and Price D (2026'Implementing quality improvement for patients with high-risk chronic disease: lessons from the CONQUEST UK COPD programme'. Primary Health Care Research & Development, 27, e106, pp. 1–11. Available at: https://doi.org/10.1017/S1463423626101480. Accessed November 2026.

3 National Institute for Health and Care Excellence (2024). Chronic obstructive pulmonary disease. NICE Clinical Knowledge Summary. Available at: https://cks.nice.org.uk/topics/chronic-obstructive-pulmonary-disease/. Accessed November 2026.

4 Thomas S and Mehta S (2025). COPD Voices: A matter of life and breath. Available at: https://www.kcl.ac.uk/sims/assets/copd-voices-final-29042025.pdf. Accessed November 2026.

5 NHS England (2026) COPD commissioning strategies and resources. Available at: https://www.england.nhs.uk/long-read/copd-commissioning-strategies-resources/. Accessed November 2026.

6 Sanofi. (2026). Data on COPD in England, 2025-26.

7 Russell R, Bafadhel M, Lupton C, et al. (2025). 'P10 Breathless systems: COPD pressures in hospitals across England'. Thorax, 80, pp. A129–A130. Available at: http://doi.org/10.1136/thorax-2025-btsabstracts.192. Accessed November 2026.

8 Taskforce for Lung Health (2026). Breathing Life into the NHS: Improving outcomes, reducing inequalities, and enabling innovation through a respiratory Modern Service Framework. Available at: https://www.taskforceforlunghealth.org.uk/breathing-life-into-the-nhs-improving-outcomes-reducing-inequalities-and-enabling-innovation-through-a-respiratory-modern-service-framework/. Accessed November 2026.

9 The Health Foundation (2025). Inequalities in specific health conditions by deprivation decile. Available at: https://www.health.org.uk/evidence-hub/health-inequalities/inequalities-in-specific-health-conditions-by-deprivation-decile. Accessed November 2026.

10 Whittaker H, Bolton T, Sinha I, Heaney LG, Busby J, Davies GA, Sheikh A, Quint JK and CVD-COVID-UK/COVID-Impact Consortium (2026). 'Impact of sex, socioeconomic deprivation, ethnicity and region on exacerbation rates and mortality of chronic respiratory diseases in England: population-based cohorts'. Thorax. Published online ahead of print, August 2026. Available at: https://doi.org/10.1136/thorax-2026-224765. Accessed November 2026.

11 NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. Available at https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/. Accessed November 2026.

12 Department of Health and Social Care and NHS England (2026). Neighbourhood health framework. Available at: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework. Accessed November 2026.

13 Department of Health and Social Care (2026). Asthma and COPD patients to receive better care closer to home. Available at: https://www.gov.uk/government/news/asthma-and-copd-patients-to-receive-better-care-closer-to-home. Accessed November 2026.

14 Sanofi (2026). Exploring the Role of Digital and Artificial Intelligence Interventions in Identifying and Managing Chronic Obstructive Pulmonary Disease.

15 Sanofi and Regeneron (2024). *Breathe Equal*: Addressing inequalities in chronic obstructive pulmonary disease care in England.

16 Asthma + Lung UK (2025). Life with a Lung Condition 2025: Basic care briefing. December 2025. Available at: https://www.asthmaandlung.org.uk/blog/research/life-lung-condition-2025. Accessed November 2026.

17 Asthma + Lung UK (2025). ICS respiratory review – spirometry. Available at: https://www.asthmaandlung.org.uk/healthcare-professionals/ics-respiratory-review/spirometry. Accessed November 2026.

18 Asthma + Lung UK (2025). Early Detection, Better Outcomes: Neighbourhood Respiratory Diagnostics 2025. December 2025. Available at: https://www.asthmaandlung.org.uk/neighbourhood-respiratory-diagnostics. Accessed November 2026.

19 Kostikas, K. et al. (2020) 'Clinical impact and healthcare resource utilization associated with early versus late COPD diagnosis in patients from UK CPRD database', International Journal of Chronic Obstructive Pulmonary Disease, Volume 15, pp. 1729–1738. Available at: https://doi.org/10.2147/copd.s255414. Accessed November 2026.

20 Primary Care Respiratory Society (2026). Blueprint for COPD Neighbourhood Health. Primary Care Respiratory Society. Available at: https://www.pcrs-uk.org/resource/current/blueprint-neighbourhood-health-copd. Accessed November 2026.

21 Adams et al. (2024). 'A case study on the impact of Artificial Intelligence supported spirometry in primary care'. European Respiratory Society Congress abstract, PA4337. Available at: https://publications.ersnet.org/content/erj/64/suppl68/pa4337. Accessed November 2026.

22 University of Hull (2026). Project helps find 'hidden millions' living with undiagnosed COPD. Available at: https://www.hull.ac.uk/news-and-events/news/project-helps-find-hidden-millions-living-with-undiagnosed-copd. Accessed November 2026.

23 House of Commons (2025). Parliamentary written question: UIN 67321. Available at: https://questions-statements.parliament.uk/written-questions/detail/2025-07-14/67321. Accessed November 2026.

24 UK National Screening Committee (2026). UK NSC draft minutes June 2026. Available at: https://www.gov.uk/government/publications/uk-nsc-meeting-june-2026/uk-nsc-draft-minutes-june-2026. Accessed November 2026.

25 Asthma + Lung UK (2022). Delayed Diagnosis and Unequal Care: The reality for people with chronic obstructive pulmonary disease (COPD) in the UK in 2022. Available at: https://www.asthmaandlung.org.uk/sites/default/files/2023-03/delayed-diagnosis-unequal-care-executive-summary.pdf. Accessed November 2026.

26 Asthma + Lung UK (2025). Surge in repeat hospital visits for lung conditions. March 2025. Available at: https://www.asthmaandlung.org.uk/media/press-releases/surge-repeat-hospital-visits-lung-conditions. Accessed November 2026.

27 Asthma + Lung UK (2023). Saving your breath: How better lung health benefits us all. Available at: https://www.asthmaandlung.org.uk/saving-your-breath-report. Accessed November 2026.

28 Taskforce for Lung Health (2024). Response to the consultation on Primary Care Incentives. Available at: https://www.taskforceforlunghealth.org.uk/the-taskforces-for-lung-health-submits-response-to-the-consultation-on-primary-care-incentives/. Accessed November 2026.

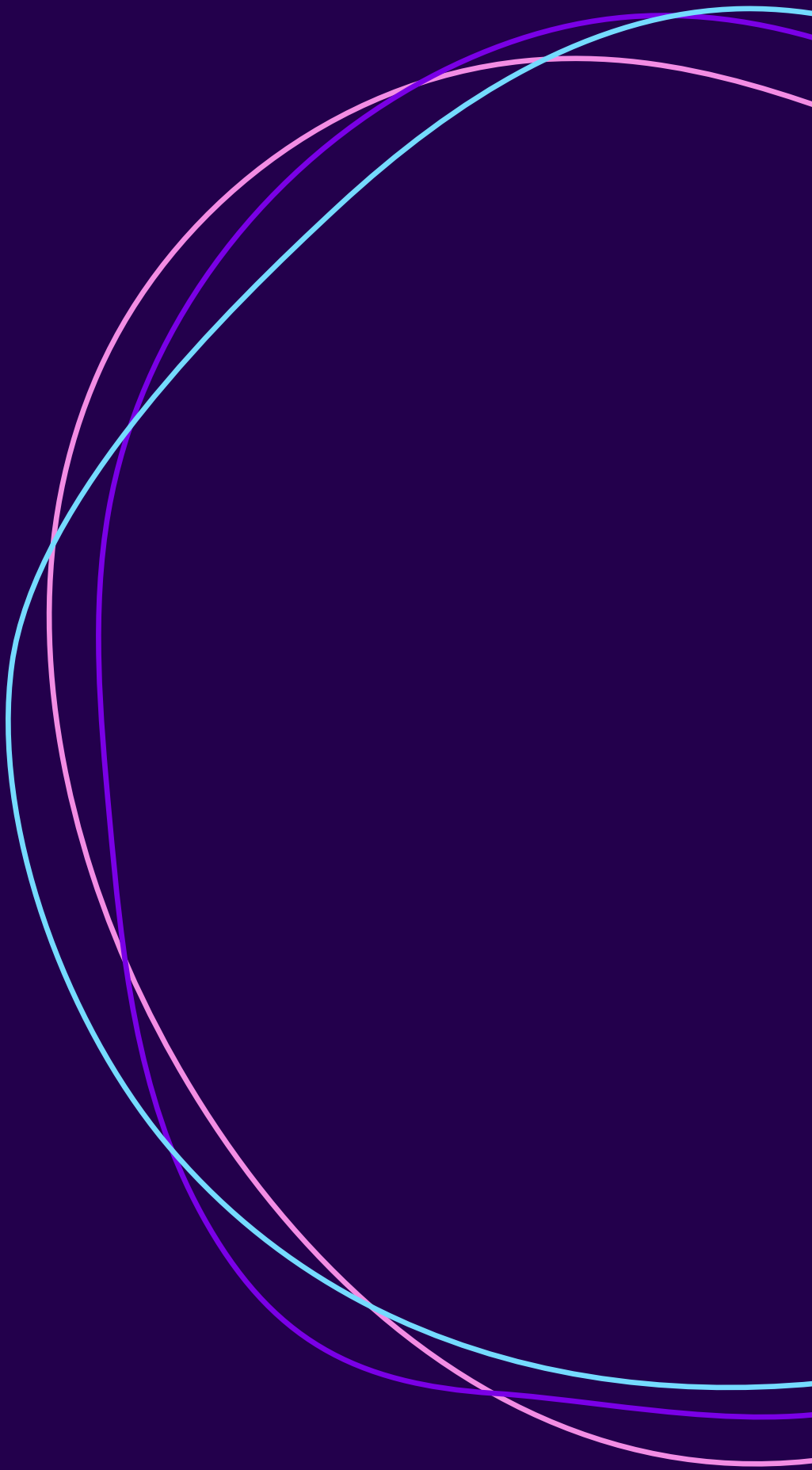
29 National Clinical Guideline Centre (2019) Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care. Available at: https://www.nice.org.uk/guidance/ng115/evidence/full-guideline-pdf-6602767453. Accessed November 2026.

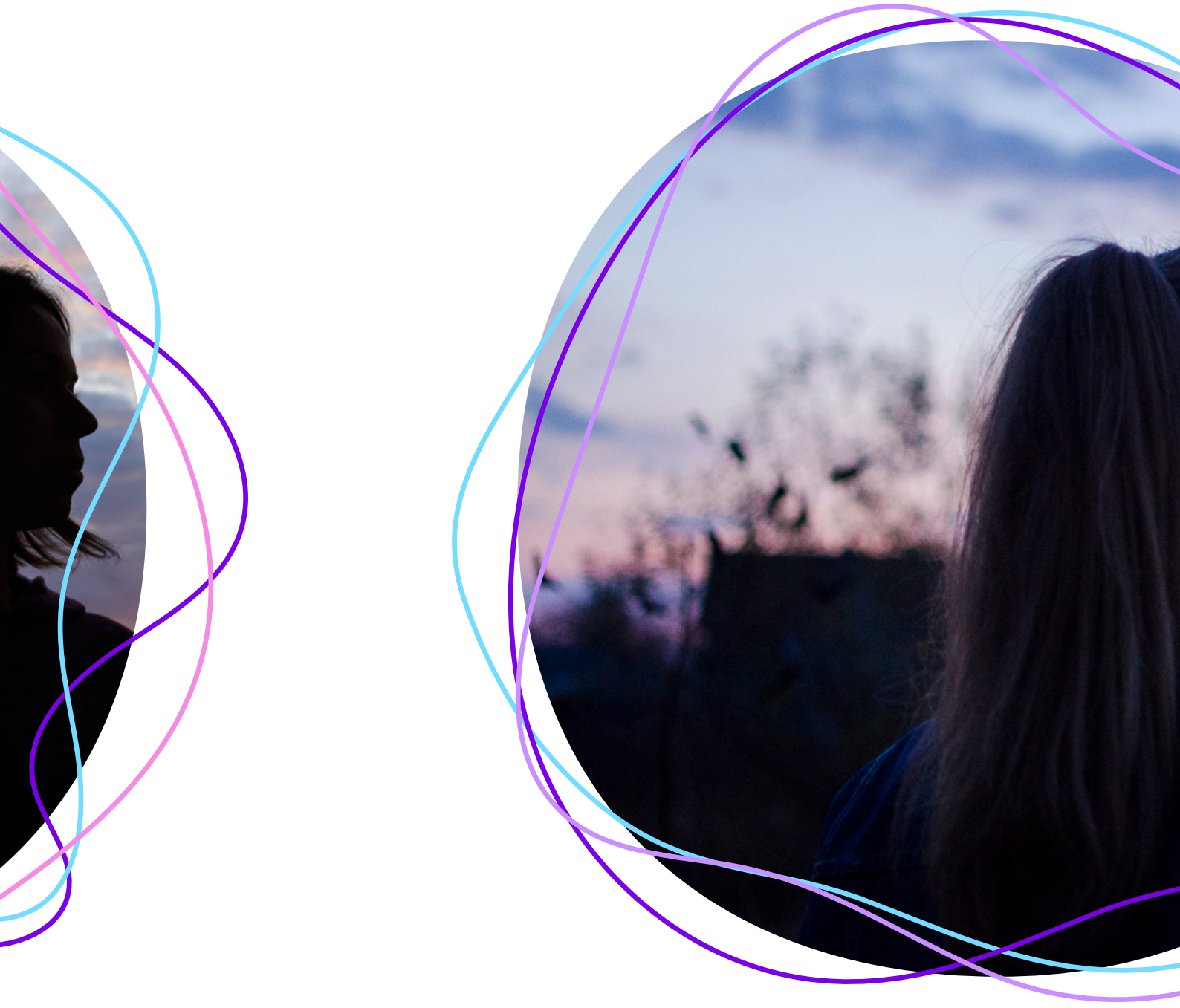
30 ABPI (2026). Guest article from NHS England: New funding approaches to drive adoption of innovative medicines pilot. Available at: https://www.abpi.org.uk/media/blogs/2026/october/guest-article-from-nhs-england-new-funding-approaches-to-drive-adoption-of-innovative-medicines-pilot/. Accessed November 2026.

31 Primary Care Respiratory Society (2026). Serious concerns regarding the erosion of respiratory leadership and expertise across ICBs, regional and primary care networks. PCRS Position Statement. Available at: https://www.pcrs-uk.org/resource/current/pcrs-position-statement-serious-concerns-regarding-erosion-respiratory-leadership. Accessed November 2026.

32 Taskforce for Lung Health (2026) Waiting List Insights. Available at: https://www.taskforceforlunghealth.org.uk/data-dashboards/waiting-list-insights/. Accessed November 2026.

33 Primary Care Respiratory Society (2026). Warning issued by PCRS over loss of respiratory leadership threatening NHS care, innovation and patient outcomes. Available at: https://www.pcrs-uk.org/news/warning-issued-pcrs-over-loss-respiratory-leadership-threatening-nhs-care-innovation-and. Accessed November 2026.





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