Enclosure No:	6/AWMSG/1226
Agenda item No:	10 – All Wales COPD Management and Prescribing Guideline
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1.0 Action for AWMSG

AWMSG members are asked to consider the minor update to the *All Wales COPD Management and Prescribing Guideline* document which is provided here for information. Changes made to both the updated prescribing algorithm and the supporting notes have been highlighted in blue. Updates include additions to reflect the recent availability of biological medicines in COPD, revised phenotype information and a validated National COPD Primary Care Review Template.

For reference, the current published version of the *All Wales COPD Management and Prescribing Guideline* is available here.

2.0 Purpose

The *All Wales COPD Management and Prescribing Guideline* was originally published in May 2019. The guideline was updated to encourage consideration of the decarbonisation agenda in NHS Wales in 2021; to include treatment for phenotypes 2 and 3 now recommending triple therapy first-line in 2023; and to reflect the availability of Trixeo Aerosphere as a low global warming potential metered dose inhaler in 2025.

The proposed update reflects the recent availability of biological medicines in COPD and includes revised phenotype information. The newly added National COPD Primary Care Review Template has been designed to support standardised, high-quality reviews that are in line with the *All Wales COPD Management and Prescribing Guideline*.

Please note that AWMSG and its subgroups only consider the guideline content, and not the mobile technology application (app) or digital education platform referred to within the document, as these fall outside the remit of AWMSG.

2.1 Process

- September 2026: AWPAG meeting
- *December 2026: AWMSG meeting*

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

The All Wales COPD Management and Prescribing Guideline

Y Grŵp Gweithredu ar Iechyd Anadlol
Respiratory Health Implementation Group

GIG CYMRU NHS WALES

Also available in digital format

The All Wales COPD Management and Prescribing Guideline

CORE PRINCIPLES

People aged over 35 years who present with one or more features from the COPD likelihood checklist should have post-bronchodilator spirometry.

Once diagnosis is confirmed, start with high-value interventions, including smoking cessation, appropriate vaccinations in accordance with current national guidance, pulmonary rehabilitation and, where appropriate, oxygen therapy.

Inhaled therapy is prescribed according to the patient's phenotype.

Find out more here

COPDhub

Get your patients to download the COPD App

STEP 1 INFORMATION:
ASSESSMENT

COPD likelihood checklist

Perform investigations

- Post-bronchodilator spirometry
- Chest X-ray (CXR)
- Full Blood Count (FBC)
- Oxygen saturation on air (SpO_2)
- a-1 anti-trypsin (if early onset, strong family history or minimal smoking history)

Red Flag Symptoms

- Persistent cough in a smoker
- Haemoptysis
- Chest pain
- Unexplained weight loss
- Clubbing in a smoker
- Abnormal CXR

STEP 1: ASSESSMENT

COPD likelihood checklist

- ☑ Smoking history or exposure to tobacco smoke
- ☑ Other exposures (pollution, biomass fuel burning, other noxious fume exposure)
- ☑ Exertional breathlessness
- ☑ Reduced exercise tolerance (document MRC score)
- ☑ Chronic cough
- ☑ Regular sputum production
- ☑ Frequent winter 'bronchitis'
- ☑ Wheeze

Any red flag symptoms?
Perform CXR and refer as urgent suspected cancer

STEP 2: DIAGNOSIS

Post-bronchodilator FEV_1/FVC <0.70 confirms persistent airflow obstruction.

Interpret alongside the clinical features, exposure history and LLN where appropriate.

STEP 3: REFER

- ☑ Vaccination (where eligible)
  - Seasonal influenza
  - COVID-19
  - RSV
  - Pneumococcal
- ☑ Exercise, education & pulmonary rehabilitation
- ☑ Smoking cessation therapy if required
- ☑ Referral for oxygen assessment if SpO_2 is less than or equal to 92% and not smoking
- ☑ Dietary advice Refer if low or high BMI

STEP 4: PRESCRIBE

From the list of inhalers provided, choose the most suitable for the patient, considering inspiratory flow and inhaler technique. Choose a dry powder inhaler preferentially to reduce the carbon footprint, unless the patient cannot use one.

Phenotype 1	Phenotype 2	Phenotype 3
Prescribe LABA + LAMA	**Prescribe triple therapy** (stop other preventer inhalers)	**Prescribe triple therapy** (stop other preventer inhalers)
Review exacerbation frequency regularly, and escalate to Phenotype 2 if ≥2 exacerbations/year.	If continued exacerbations or breathlessness, review adherence, inhaler technique, and consider referral (see below).	If asthma is the predominant phenotype, refer to All Wales Asthma Management and Prescribing Guidelines.

STEP 5: REVIEW

Review annually if COPD is well controlled, review also when reasonable e.g. following an exacerbation, using the National Primary Care COPD Review Template to support comprehensive assessment and optimisation of ongoing management.

Poorly controlled?

Consider:

- Inhaler technique and adherence
- Non pharmacological interventions
- Smoking status
- Alternative cause for symptoms (e.g. anaemia, heart failure etc.)

If exacerbation frequency high (2 or more moderate or 1 or more severe) despite optimal medical therapy, consider referral to secondary care for consideration of azithromycin (former smokers), roflumilast (chronic bronchitis) or biological agents (if blood eosinophil count ≥0.3).

Manage exacerbations

- Prescribe a SABA
- Prescribe prednisolone (30-40mg once a day for 5 days)
- Consider an antibiotic guided by sputum purulence/colour change, increased sputum volume or thickness, previous exacerbations/ hospital admissions and risk of complications.

Phenotype 1

COPD with predominant breathlessness and low exacerbation risk (1 or fewer moderate exacerbations and no severe exacerbations)

Phenotype 2

COPD with high exacerbation risk (2 or more moderate exacerbations or 1 or more severe exacerbations)

Phenotype 3

Predominant COPD with features of asthma

STEP 4 INFORMATION:
PRESCRIBE

Prescribe a LABA + LAMA
Below are options in this category

Duaklir Genuair 340/12 1 dose BD *Forceful and deep*	Ultibro Breezhaler 85/43 1 dose OD *Forceful and deep*	Anoro Ellipta 55/22 1 dose OD *Forceful and deep*
		

Spiolto Respimat 2.5/2.5 2 doses OD *Gentle and deep*	Bevespi Aerosphere 7.2/5 2 doses BD via spacer *Gentle and deep via spacer*
	

Ensure patient can use device. All MDIs must be used with a spacer

Prescribe triple therapy (ICS + LABA + LAMA)
Below are options in this category

Trelegy Ellipta 92/55/22 1 dose OD *Forceful and deep*	Trimbow NEXThaler 88/5/9 2 dose BD *Forceful and deep*
	

Trimbow MDI 87/5/9 2 doses BD via spacer *Gentle and deep via spacer*	Trixeo Aerosphere 5/7.2/160 2 doses BD via spacer *Gentle & deep via spacer*
	

Ensure patient can use device. All MDIs must be used with a spacer

Manage exacerbations
Prescribe a SABA
Below are options in this category

Salbutamol 100mcg Easyhaler PRN *Forceful and deep*	Ventolin Accuhaler 200mcg PRN *Forceful and deep*	Salamol 100mcg MDI via spacer PRN *Gentle and deep via spacer*
		

Ensure patient can use device. All MDIs must be used with a spacer

CXR: Chest X-ray
DPI: Dry Powder Inhaler
GWP: Global warming potential
FBC: Full Blood Count
ICS: Inhaled Corticosteroid
LABA: Long-acting $Beta_2$ Agonist
LAMA: Long Acting Muscarinic Antagonist
LLN: Lower limit of normal
MDI: Metered Dose Inhaler
MRC: Medical Research Council
SABA: Short-acting $Beta_2$ Agonist
SpO_2: Oxygen Sats
OD: Once daily
BD: Twice a day
Low global warming potential
High global warming potential

Find out more about this guideline
icst.info/the-all-wales-copd-and-management-prescribing-guideline

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Designed by The Institute of Clinical Science & Technology

GIG CYMRU NHS WALES

Respiratory Health Implementation Group

Y Grŵp Gweithredu ar Iechyd Anadlol

The All Wales COPD Management and Prescribing Guideline

Supporting notes

THE ALL WALES COPD MANAGEMENT AND PRESCRIBING GUIDELINE

https://allwales.icst.org.uk/programmes/long-term-management-of-copd/

SUPPORTING INFORMATION

1. Post-bronchodilator spirometry is required to confirm a diagnosis of COPD. COPD should not be diagnosed solely from symptoms, exposure history or radiological emphysema. Long-term inhaled treatment for COPD should not normally be initiated without spirometric confirmation. Where coexisting asthma is suspected, treatment - including inhaled corticosteroids (ICS) where clinically indicated - should not be withheld while appropriate diagnostic assessment is completed.

2. NICE and GOLD define persistent airflow obstruction as a post-bronchodilator FEV_1/ FVC ratio below 0.70. However, the fixed ratio may overdiagnose airflow obstruction in older people and under-recognise it in some younger adults. Results should therefore be interpreted alongside the quality of spirometry, the clinical features and relevant exposure history, with reference to the lower limit of normal where appropriate, particularly in borderline cases and at age extremes.

3. Non-pharmacological interventions are highlighted as first steps in this pathway since they are the highest value interventions. Smoking cessation in particular should be addressed at every opportunity.

4. Ensure patients with COPD and coexisting asthma do not have their ICS stopped. If they clearly have a predominant asthma phenotype then manage them as people with asthma and refer to the All Wales Adult Asthma Management and Prescribing Guideline.

5. The use of short-acting $beta_2$ agonists (SABAs) on a regular basis for stable COPD is not recommended in line with GOLD guidance[1].

6. As detailed within the document, *Decarbonisation: inhaler prescribing, use and disposal 2023–2030. A national strategy for Wales*[2], always involve the patient when choosing the device. Take into account individual preference, ease with which the device can be used and prior success or failure with different preparations, as well as the environmental impact of the inhaler. Where possible, the inhaler with the lowest carbon footprint should be considered (e.g. dry powder inhaler [DPI], soft mist inhaler [SMI] or next generation metered dose inhaler [ngMDI]). Lastly, as the costs of inhaler devices are prone to changing over time, prescribers should consider the most cost-effective option when choosing a device.

7. An essential part of COPD management is to minimise exacerbations, which have been shown to increase mortality, worsen quality of life and result in lung function decline. Patients who have two or more exacerbations in the community or an exacerbation leading to a hospital admission within the last 12 months, should be regarded as “high risk” for exacerbations and should have a step up in their pharmacotherapy.

8. Other interventions which have been shown to reduce exacerbations include smoking cessation and vaccinations in accordance with national guidance. Patients should be referred to secondary care for consideration of azithromycin (in former smokers), roflumilast (in patients with chronic bronchitis) or biological agents (in patients with raised blood eosinophils (≥0.3) at a time of stability).

9. Nebulised bronchodilators confer no significant advantage over inhaled bronchodilators and are likely to cause more side effects. They should only be considered in palliative patients or when the use of a nebuliser during exacerbations is likely to avoid admission to hospital. Nebulised saline may be useful to aid sputum expectoration.

10. In patients with chronic bronchitis (daily cough and sputum), particularly when sputum is thick and difficult to expectorate, consider a trial of a mucolytic agent such as carbocisteine 750 mg TDS for 2 weeks (then reduce to 750 mg BD long term) or Nacsys 600 mg OD. Reassess and stop mucolytic agents if no clinical improvement.

11. Rescue packs can be a useful means by which patients can initiate prompt effective treatment for an exacerbation of COPD. They are NOT suitable for all patients and should be used in conjunction with a written COPD action plan. Healthcare professionals issuing rescue packs need to be confident that the individual patient is able to recognise a true exacerbation and be able to differentiate an exacerbation from chronic symptoms. Ideally, such patients should have attended a COPD education programme. Rescue packs should not be a substitute for a consultation where this is clinically indicated. Patients should be advised to contact their healthcare team in a timely manner when a rescue pack is started so that the exacerbation frequency, treatment response and need for clinical review or replenishment can be assessed.

1. 2026 GOLD Report and Pocket Guide. 2026. Link: https://goldcopd.org/2026-gold-report-and-pocket-guide/
2. All Wales Medicines Strategy Group, Inhaler Decarbonisation Task and Finish Group. Decarbonisation: inhaler prescribing, use and disposal 2023–2030. A national strategy for Wales. November 2023. Link: https://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/policies-and-strategies/decarbonisation-inhaler-prescribing-use-and-disposal-2023-2030-a-national-strategy-for-wales/