Life with a Lung Condition 2025
Basic care briefing
December 2025

Executive summary

Our Life with a Lung Condition briefing reinforced our concern for people with lung conditions and the quality of basic care they receive. We found that:

- Only 32% of people with asthma in the UK receive good basic care.
- A shocking 9% of people with COPD in the UK receive good basic care, with access to care decreasing year-on-year for the past five years of our survey.
- 60% of people unexpectedly hospitalised because of their lung condition don't receive the vital, time-sensitive follow-up care they deserve.
- Over a quarter (26%) of our survey respondents had used emergency care in the previous 12 months, with those from more deprived backgrounds more likely to access emergency care.

Introduction

For people with respiratory conditions, good access to basic care is an essential part of keeping well.

For asthma, basic care means that people with asthma should receive an annual review, in person, to assess their condition and review their care, a Personalised Asthma Action Plan (PAAP) to aid self-management containing treatment information that is specific to the patient, and inhaler technique training to ensure that the patient is using their inhaler correctly and getting the most from their treatment.[1] The NHS Quality and Outcomes Framework (QOF) – a national incentive scheme that structures payments for specific services provided in primary care – incentives the provision of annual asthma reviews, a recording of a person's asthma exacerbations, and a written PAAP.[2]

For COPD, basic COPD care means that people with COPD should receive the Five Fundamentals of COPD care: help with smoking cessation, including treatment and support; offers of vaccinations for pneumonia and influenza; pulmonary rehabilitation (PR); a personalised self-management plan to aid their care; and optimised care to treat co-presenting conditions, sometimes called co-morbidities.[3] QOF incentives recording the patient's annual number of exacerbations and assessing breathlessness.[4] Crucially, when QOF was updated for 2025/26, the indicator incentivising a referral for patients to attend pulmonary rehabilitation was removed.[5]

Providing good basic care must be a key way in which care is shifted from hospital to community as part of the government's NHS 10 Year Plan. Not only can basic care be readily delivered in the community, but it's also a cost-effective way of providing treatment and reducing strain on the health service. Increasing the number of people with asthma who have their inhaler technique reviewed would save over £7 million per year, as well as offer a 70% reduction in hospital bed days amongst people with asthma.[6] Around 40% of this reduction in bed days would likely occur over the winter months when health services are under increased pressure.[7]

Similarly, we know that by expanding access to PR to all those people with COPD who are eligible, the NHS would see direct savings of £142 million per year as a result of reduced COPD exacerbations, as well as a reduction of 194,000 bed days per year.[8]

Worryingly, rates of basic care for both asthma and COPD are disastrously low, and have worsened over time, putting people with respiratory conditions at greater risk of poor health outcomes, including exacerbations, hospitalisation and death.[9] [10]

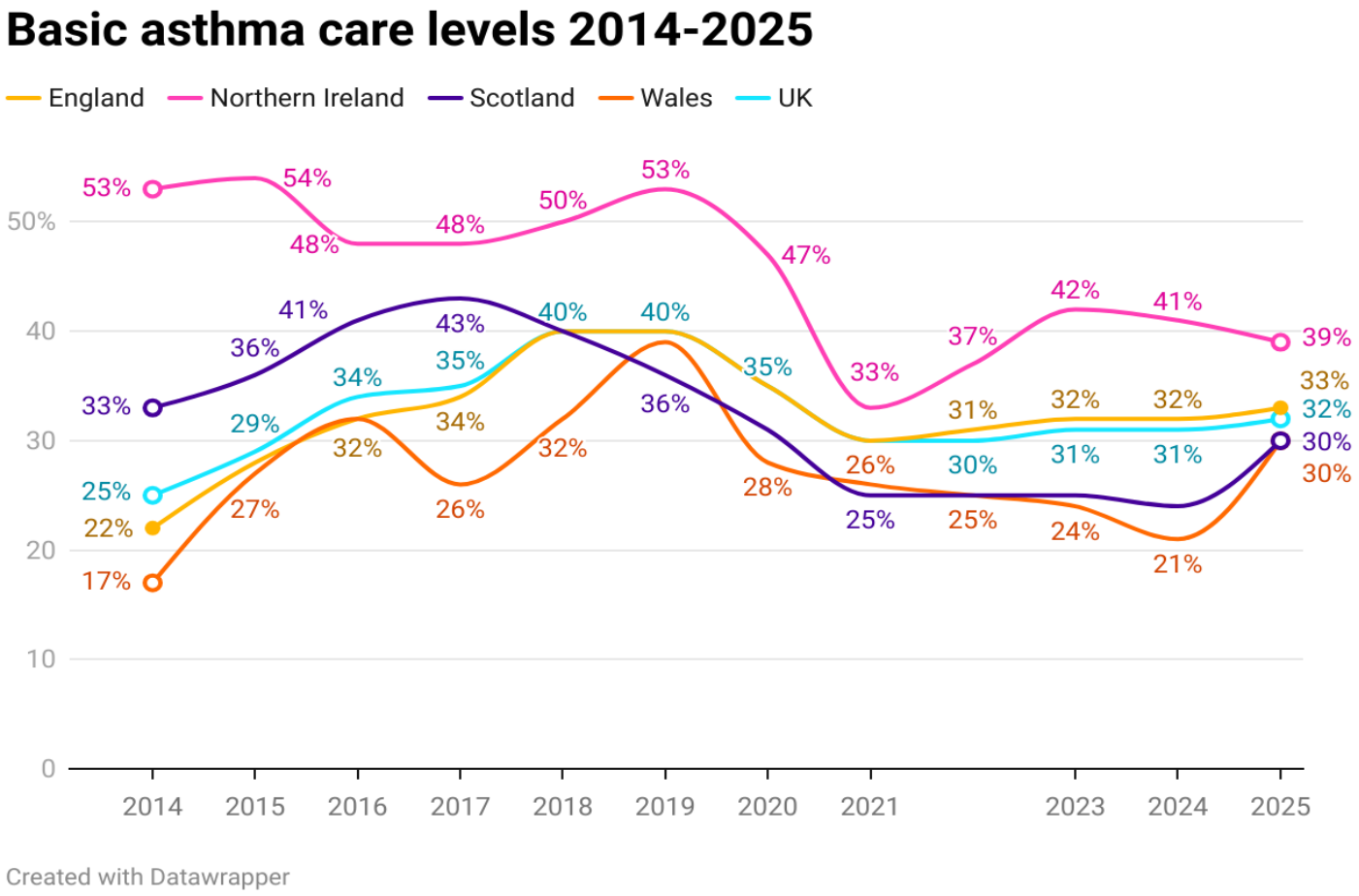
Life with a Lung Condition Survey

The Life with a Lung Condition survey is an annual survey run by Asthma + Lung UK. It covers the whole UK, gathering detailed data from thousands of people with lung conditions.

We ran our survey between January and March 2025, and asked over 70 questions across a variety of health topics. The survey also gathered data on respondents' socio-economic status and other demographics, which allows us to better understand how someone's care may be affected by where they live or their household income. The 2025 survey received responses from 9,438 people.

Access to basic asthma care

Basic asthma care has plateaued in recent years, with less than a third of people (32%) accessing all three elements.[11] While rates vary between the devolved nations, the national trend shows a worrying lack of access for the 7.2 million people in the UK with asthma.[12] Even the potential recovery in Scotland and Wales shown between 2024 and 2025 still leaves both countries below the UK average. Our survey showed that, across the UK, 87% of people with asthma have an annual review, but only 55% have their inhaler technique checked, and only 57% have a PAAP. These are worryingly low figures.



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Sadly, poor care leads to poorer health outcomes.[13] We know that without inhaler technique guidance, a majority of patients will make one or more critical errors when using their inhaler,[14] and that the absence of a Personalised Asthma Action Plan (PAAP) is linked to poor health outcomes, including a heightened risk of death.[15]

We also know that avoidable factors caused by an absence of basic asthma care are linked to avoidable asthma fatalities,[16] showing that poor access to basic asthma care increases a person's likelihood of having an exacerbation (asthma attack), being hospitalised, and dying from their asthma. Poor asthma care contributes to the 60,000 annual hospital admissions made because of asthma, and a total of 200,000 bed days per year. The economic impact of asthma is £1.2 billion annually.[17]

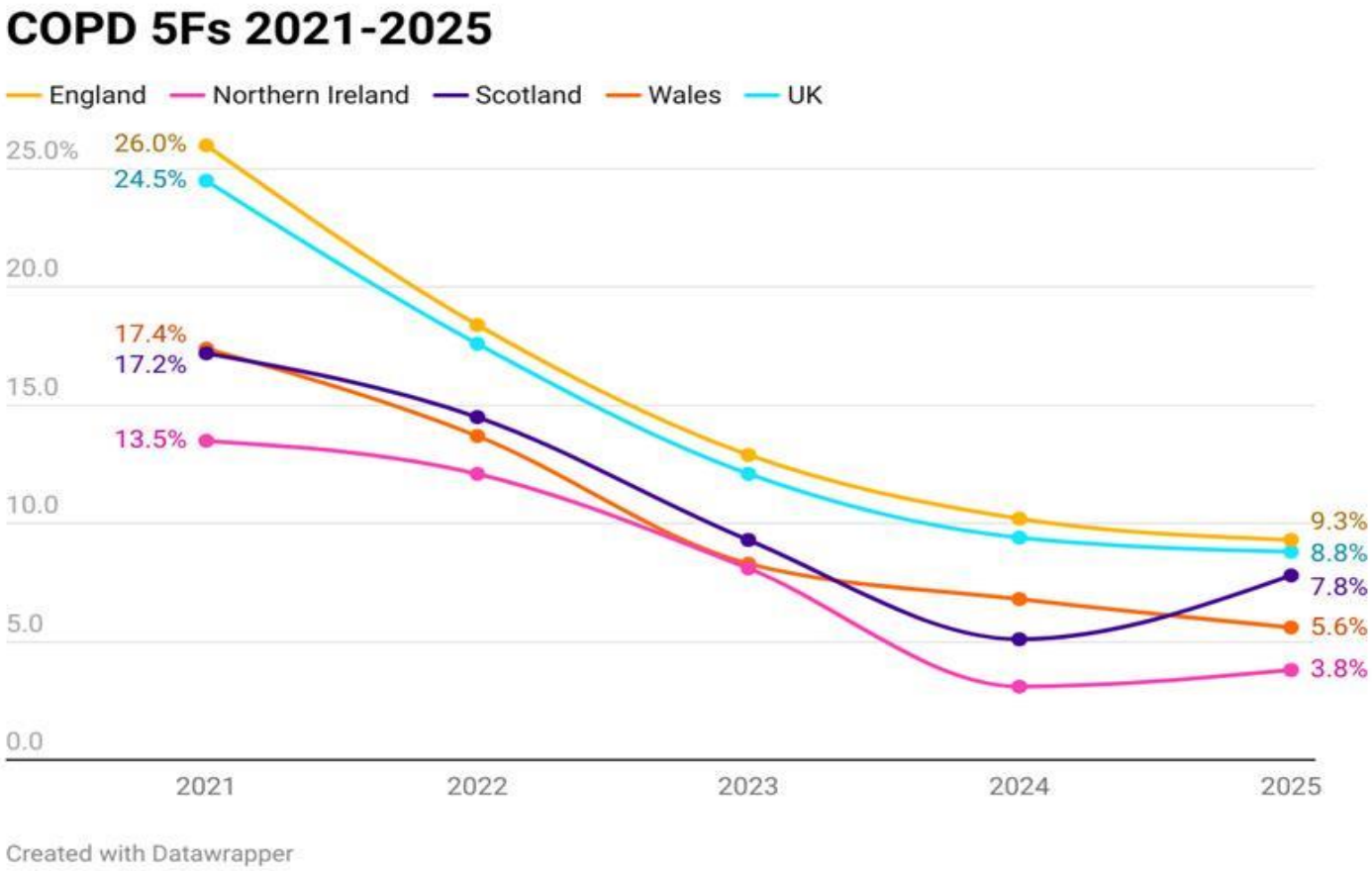
Beyond the vital difference basic care makes to people with asthma, expanding access to basic asthma care would reduce health systems' expenditure. Increasing the number of people with asthma who have their inhaler technique reviewed would save over £7 million per year, as well as offer a 70% reduction in hospital bed days amongst people with asthma.[18] Around 40% of this reduction in bed days would likely occur over the winter months when health services are under increased pressure.[19]

This change could also reduce the number of people with asthma who struggle as a result of poor inhaler use by 45%, thereby significantly reducing their cost to the NHS while improving their quality of life.[20] In addition, £244 million would be achieved in indirect costs such as improved productivity from this patient group, who would become significantly more economically active as a result of better health.[21]

NHS data on the outcomes of QOF also shows how basic asthma care needs to improve. It shows the extent to which asthma prevalence is under recorded, with millions of people with asthma missing from the national asthma register.[22] Only 66% of people with asthma receive adequate ongoing management of their condition as indicated by QOF data.[23] More worryingly, QOF data also shows that one in five (20.64%) of people with asthma are covered by a Personalised Care Adjustment (PCA), meaning these patients are deliberately excluded from QOF calculations and are thus not targeted for essential basic care.[24] The NHS's decision to accept this is woeful, and undermines the care of millions of people with asthma.

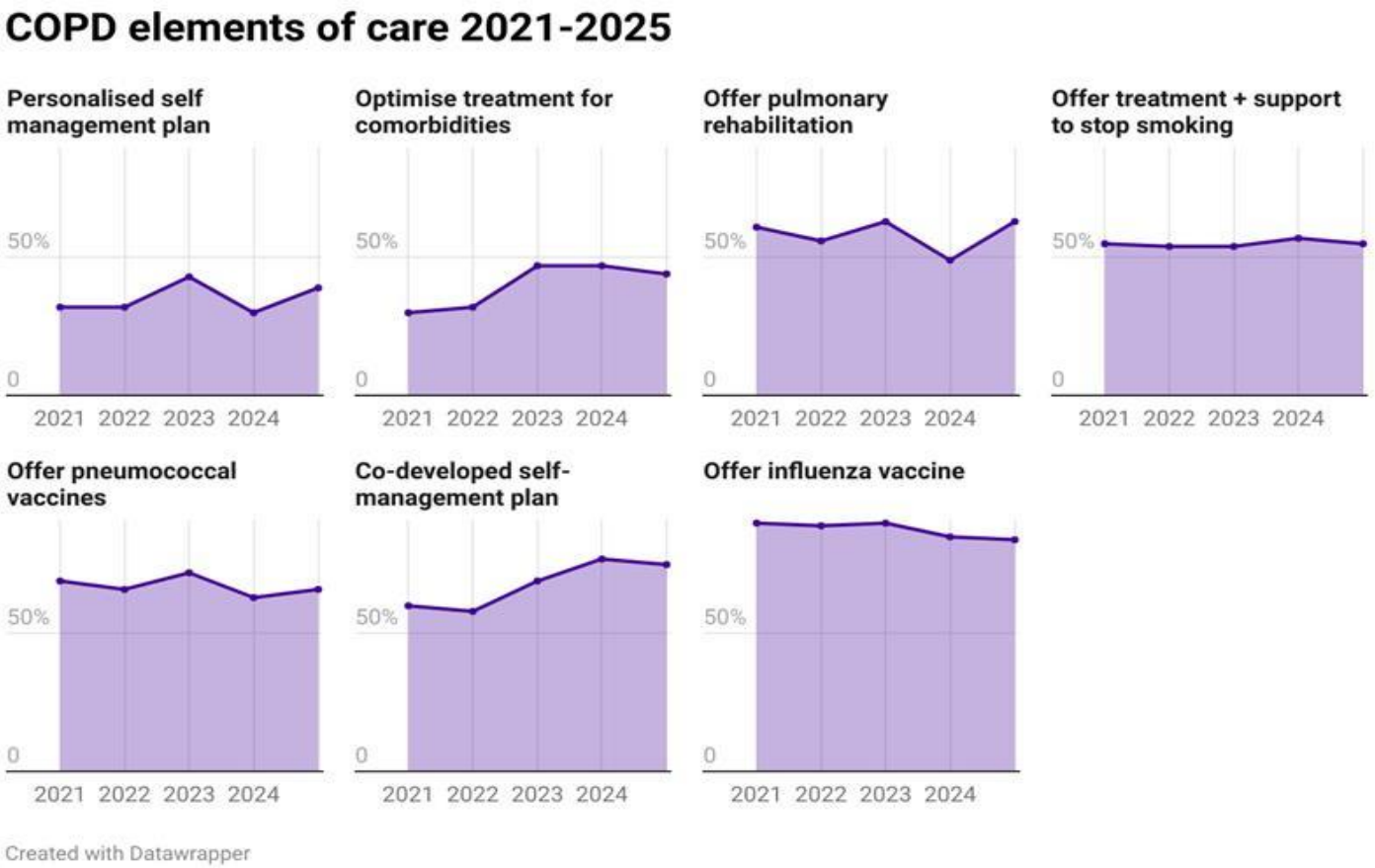
Access to the Five Fundamentals of COPD care

Access to the Five Fundamentals of COPD care – smoking cessation, vaccinations, self-management plans, PR, identification and optimisation of multimorbidity[25] – has continually declined for the last five years, except for modest improvements in Scotland and Northern Ireland. Only 9% of the 2.5 million people in the UK[26] with COPD currently have access to all five fundamentals of COPD care.[27] To put this another way, 91% of those with COPD across the UK do not receive basic levels of care.



Our survey does show that the provision of *some* of the five fundamentals is good: 84% of people with COPD are offered the influenza vaccine, for example. Crucially, however, while delivery of each fundamental is important in isolation, a person with COPD must have access to all five fundamentals to receive appropriate care that manages their condition and keeps them well.

Only 63% of eligible people with COPD were offered PR, only 55% offered support with stopping smoking, and only 39% have a personalised self-management plan.[28] These low levels of many of the five fundamentals are contributing to poor COPD outcomes.



We know that without good basic care, a person with COPD is more likely to experience a higher number of exacerbations, and that they are more likely to experience exacerbations that lead to hospitalisations.[29] We also know that the frequency and severity of COPD exacerbations are associated with the risk of future exacerbations and death.[30] Poor care contributes to the 130,000 COPD hospital admissions made each year – making COPD the second most common cause of emergency admission in the UK. The economic impact of COPD is £1.4 billion in direct NHS costs annually, with a further £1.7 billion in lost productivity.[31]

Improving access to the five fundamentals of COPD care also offers significant savings for health systems. We know that by expanding access to PR to all those eligible, the NHS would see direct savings of £142 million per year as a result of reduced COPD exacerbations, as well as a reduction of 194,000 bed days per year.[32] We also know that vaccinations are well-established as a cost-effective preventative intervention, and ensuring all those who need a respiratory vaccination receive one would help to reduce the 4.8 million working days that are lost in the UK due to seasonal flu every year.[33]

Again, we know from NHS QOF data that people with COPD are being under served and many are likely to experience suboptimal care. The NHS register under-records COPD prevalence, highlighting the fact that many with the condition are underdiagnosed or lack a formal diagnosis.[34] Only 76% of people with COPD receive adequate ongoing management of their condition as indicated by QOF, and nearly one in three people with COPD (29.9%) are covered by a Personalised Care Adjustment (PCA), meaning these patients are deliberately excluded from QOF calculations and are thus not targeted for essential basic care.[35] As is the case with the NHS's poor provision of basic asthma care, the decision to accept this is woeful.

Emergency care

For people with respiratory conditions, unplanned emergency admissions are a sign that their care has been inadequately managed, an increasingly common risk with such poor basic care provision. As well as being a telltale sign of poor basic care, unplanned emergency admissions are a key sign that a person is at increased risk of further exacerbations, worsening respiratory health, and potentially death. Poor access to basic care puts people with asthma and COPD on a longer-term path toward poorer health outcomes; poor access to follow-up care leaves the most vulnerable people without a proper chance of rescue.

Over a quarter (26%) of our survey respondents had used emergency care in the previous 12 months, with those from more deprived backgrounds more likely to access emergency care. This highlights damaging healthcare disparities, showing that those in the poorest communities receive the worst care.
We also know there's a direct link between a person's asthma control – how well their asthma symptoms are managed – and the likelihood of them being admitted to emergency care: 10% of people with well-controlled asthma report having been admitted to emergency care, whereas 33% of those with uncontrolled asthma had been admitted to emergency care. Many of those admissions would be prevented if everyone with a respiratory condition received the basic care they need. Similarly, health outcomes could be improved for many people with respiratory conditions if the NHS proactively identified people at increased risk of poor outcomes and utilised episodes of acute care to assess and improve care.

Preventative care

We asked people who have been admitted to emergency care what they think would have kept them out of hospital. Over half (50%) said better access to GP appointments, and many highlighted a need for better access to basic care, including inhaler technique checks (8%), annual reviews of their lung condition (20%), and having a personalised action plan for their condition (29%). We know that better provision of each of these aspects of basic care would improve health outcomes and keep more people out of hospital,[36] as would the expansion of access to fundamental COPD care such as PR.[37]

GSK case study[38]

Pharmaceutical manufacturer, GSK, ran a non-promotional project, focused on supporting the review of patients with chronic obstructive pulmonary disease (COPD) and optimising their therapeutic management demonstrated that there is unmet need in proactive assessment of COPD.

Since the service was introduced in 2018, it has supported the review of over 160,000 COPD patients across more than 2,500 GP surgeries, increasing the number of patients seen in clinics and number of COPD reviews and inhaler technique assessments delivered by practices. 76% of patients reviewed in 2024 received ≥1 pharmacological intervention, with a quarter of patients receiving an escalation in their inhaled therapy to improve their symptom burden management or reduce the severity/frequency of exacerbations. 80% received a non-pharmacological intervention, 48% of which had a change of device molecule, while 53% of all smokers entering clinic were referred to smoking cessation services and 9% to pulmonary rehabilitation services.

This shows more regular reviews could not only benefit people with COPD but have a potential impact on system capacity and cost by potentially reducing the severity and frequency of exacerbations.

Follow-up care

Follow-up appointments are critical, time-sensitive opportunities to assess and amend a person's treatment following an exacerbation and are key to preventing further harm.[39] While proper diagnosis and treatment can prevent unplanned emergency admissions – and this preventative care should be paramount – follow-up care must be given properly once a person has been hospitalised unexpectedly.

Sadly, as with basic care, levels of follow-up care are poor. 60% of those admitted to emergency care told us they didn't receive follow-up care within two days, leaving them with inadequate care that puts them at a heightened risk of further exacerbations, further hospitalisations, and death.[40] Some studies paint an even more worrying picture, with a 2024 University of Birmingham study showing that 82% of people hospitalised with asthma don't receive follow-up care within two days.[41] This is unacceptable.

Conclusion

Our 2025 Life with a Lung Condition survey found that rates of basic care remain poor, with asthma care plateauing, and COPD care continuing to fall. This lack of basic care has a direct impact on the health of people with these conditions, leading to worse health outcomes, including exacerbations, increased risk of hospitalisation, and death.[42] [43] This increased risk of hospitalisation hits people from the most deprived communities the hardest, with emergency admissions being over three times higher among the most deprived survey respondents compared with the least deprived. Reliance on emergency care reveals the poor state of follow-up care. We know from our survey data that the majority of people (60%) who are hospitalised with a respiratory condition don't receive proper follow-up care.

The NHS 10-year health plan is a significant milestone and presents a key opportunity to tackle poor care and health inequalities. The shift to community and the NHS's aim to provide care at the neighbourhood level could transform the provision of basic care, delivering the care that people with lung conditions need close to their homes.

The government must work with the respiratory community to identify the key levers and barriers to ensuring that basic care is made available for everyone with a lung condition. These evidence based interventions – including annual reviews, vaccinations, pulmonary rehabilitation where suitable, and improved follow-up care – are known to save lives, reduce hospital admissions, and improve productivity. They are essential in helping the shift from hospital to community, and from sickness to prevention.

We're grateful to everyone who completed the survey and shared their experience with Asthma + Lung UK.

Appendix 1 – GSK case study disclaimer

GSK case study
[Disclaimer: This project is funded by GSK and the following information has been provided by GSK at the request of Asthma & Lung UK. GSK has had no involvement in the rest of the document. NP-GB-CPU-CSTY-250001, October 2025]

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