UNIVERSITY OF CAMBRIDGE

Cambridge University Hospitals NHS
NHS Foundation Trust

Practical management of chronic breathlessness

Respiratory Matters webinar

21 January 2026

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Overview

1. Context and challenges — Making sense of breathlessness with the BTF model

2. Clinical management — Practical strategies, top tips and service implications

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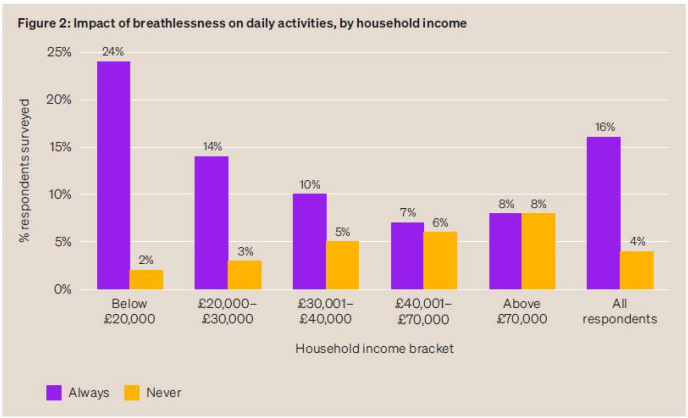
July 2023

ASTHMA+ LUNG UK

BREATHING UNEQUAL

Examining health inequalities and lung conditions

Breathlessness is felt the most by the people who have the least



Poorest respondents three times as likely to experience breathlessness daily (24% vs 8%)

Poorest respondents more than twice as likely to have given up work due to breathlessness (27% vs 12%)

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Chronic breathlessness

Common

- 1 in 10 of general population; 1 in 3 older adults
- 98% of 1 million people with moderate-severe chronic lung disease in UK

Debilitating

- Associated with fear, distress, disability, social isolation
- 1 in 5 ED attendances for acute-on-chronic breathlessness

Neglected

- 1 in 3 people do not seek support; 2 in 3 of those that do are not helped
- Less than 1 in 10 health professionals recognise need for symptomatic treatment

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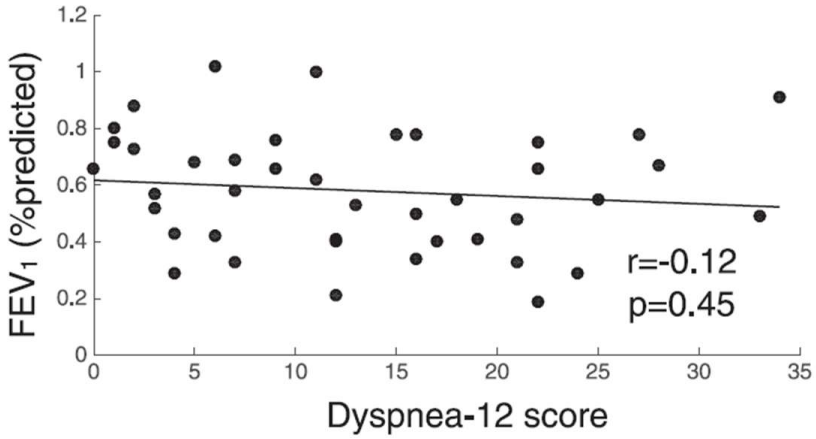
Little relationship between breathlessness severity and condition severity



Herigstad et al 2015

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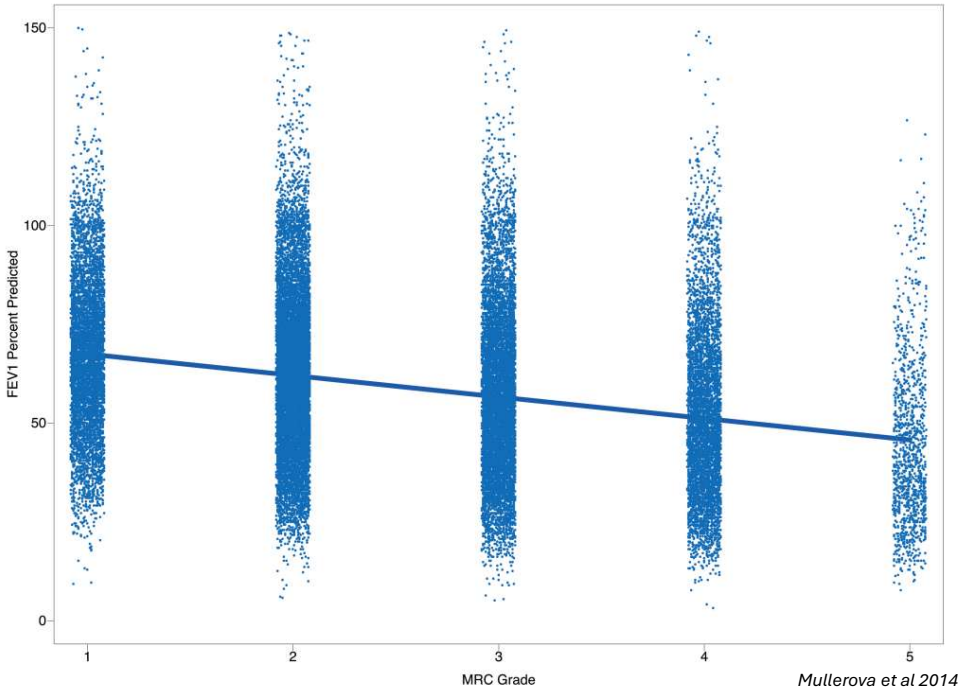

Mullerova et al 2014

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Disease-focused	Symptom-directed
Primary care services	Pulmonary rehabilitation services
Secondary care services	Palliative care services
Community respiratory/HF services	Specialist breathlessness services

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EUROPEAN RESPIRATORY REVIEW
SERIES
N.E. SMALLWOOD ET AL.

Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis

Natasha E. Smallwood [1,2], Amy Pascoe [2], Marlies Wijsenbeek [3], Anne-Marie Russell [4,5], Anne E. Holland [2,6,7], Lorena Romero [8] and Magnus Ekström [9]

Number 1 in the Series "Symptom management for advanced lung disease"
Edited by Anne E. Holland, Magnus Ekström and Natasha E. Smallwood

[1]Department of Respiratory Medicine, The Alfred Hospital, Prahan, Australia. [2]RespiratoryResearch@Alfred, Central Clinical School, The Alfred Hospital, Monash University, Melbourne, Australia. [3]Centre of Excellence for Interstitial Lung Diseases and Sarcoidosis, Department of Respiratory Medicine, Erasmus MC, University Medical Centre, Rotterdam, The Netherlands. [4]Institute of Clinical Sciences, College of Medical and Dental Sciences (MDS) University of Birmingham, Birmingham, UK. [5]Birmingham Regional NHS ILD and Occupational Lung Disease Service, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK. [6]Departments of Respiratory Medicine and Physiotherapy, Alfred Hospital, Melbourne, Australia. [7]Institute for Breathing and Sleep, Melbourne, Australia. [8]The Ian Potter Library, The Alfred Hospital, Melbourne, Australia. [9]Respiratory Medicine, Allergology and Palliative Medicine, Department of Clinical Sciences Lund, Lund University, Lund, Sweden.

Corresponding author: Natasha E. Smallwood (natasha.smallwood@monash.edu)

Shareable abstract (@ERSpublications)
Opioids were shown to improve exertional breathlessness in exercise studies, but had no impact on breathlessness, cough or quality of life in daily life. Significant reported adverse events, including hospitalisation and death, may outweigh any benefits. https://bit.ly/3JTtD2A

Cite this article as: Smallwood NE, Pascoe A, Wijsenbeek M, *et al*. Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis. *Eur Respir Rev* 2024; 33: 230265 [DOI: 10.1183/16000617.0265-2023].

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Guideline Or Statement | Free

European Respiratory Society Clinical Practice Guideline on symptom management for adults with serious respiratory illness

Anne E. Holland | Anna Spathis | Kristoffer Marsaa | Claudia Bausewein | Zainab Ahmadi | Angela T. Burge | Amy Pascoe | Adelle M. Gadowski | Phil Collis | Tessa Jelen | Charles C. Reilly | Lynn F. Reinke | Lorena Romero | Anne-Marie Russell | Ravijyot Saggu | John Solheim | Guido Vagheggini | Chantal Vandendungen | Marlies Wijsenbeek | Thomy Tonia | Natasha Smallwood | Magnus Ekström See Less

European Respiratory Journal 2024 2400335; DOI: https://doi.org/10.1183/13993003.00335-2024

- Current research evidence does not support the use of opioids for chronic breathlessness.
- European Respiratory Society taskforce does **not recommend** use of morphine for breathlessness due to respiratory illness.

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Morphine for chronic breathlessness (MABEL) in the UK: a multi-site, parallel-group, dose titration, double-blind, randomised, placebo-controlled trial

*Miriam J Johnson, Bronwen Williams, Catriona Keerie, Sharon Tuck, Simon Hart, Sabrina Bajwah, Nazia Chaudhuri, Mark Pearson, Judith Cohen, Rachael A Evans, David C Currow, Irene J Higginson, Peter Hall, Marek Atter, John Norrie, Marie T Fallon, on behalf of the MABEL collaborative**

Findings Between March 18, 2021, and Oct 26, 2023, 143 participants were randomly assigned to receive either morphine (73 participants) or placebo (67 participants) and were included in the analyses; three participants did not receive the allocated treatment. Participants had a mean age of 70·5 (SD 9·4) years, were mostly male (93 [66%]), and were mostly White (132 [94%]). By day 28, 64 (88%) participants in the morphine group versus 66 (99%) in the placebo group had 90% adherence or greater. We found no evidence of difference in worst breathlessness at day 28 (morphine 6·19 [95% CI 5·57 to 6·81] *vs* placebo 6·10 [5·44 to 6·76]; adjusted mean difference 0·09 [95% CI −0·57 to 0·75], p=0·78) or any secondary measure, except for improved cough seen at day 56 (adjusted mean difference −1·41 [−2·18 to −0·64]). Increased moderate to vigorous physical activity was seen at day 28 (adjusted mean difference 9·51 min/day [0·54–18·48]) but this was not significant after multiple-measures correction. The morphine group had more adverse events (251 *vs* 162), serious adverse events (15 *vs* three, of which three in the morphine group and zero in the placebo group were deemed to be related to the study), and study drug withdrawals (13 *vs* two). There were no treatment-related deaths.

Interpretation We found no evidence that morphine improves worst breathlessness intensity. Further research is needed to understand whether there is any role for morphine in chronic breathlessness, but our findings do not support its use in this setting.

Johnson et al. Lancet Respiratory Medicine 2025

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	Evidence	Clinical recommendation
Morphine	❖ Several recent studies negative ❖ More adverse effects ❖ Worse outcomes particularly with higher doses	❖ Avoid using for chronic breathlessness ❖ Only potential exceptions are very near the end of life or after maximising non-drug approaches with a specialist ❖ Consider low dose only eg Oramorph 1mg (0.5ml) bd
Benzodiazepines	❖ No significant benefit	❖ Avoid using for chronic breathlessness ❖ Occasional short-term PRN role for acute symptoms eg panic, in parallel with non-drug approaches
Oxygen	❖ Benefit if pO2<7.3kPa (LTOT) ❖ When pO2 >7.3kPa, similar benefit to flow of air ❖ Sometimes helpful in COPD and ILD if desaturation on exercise	❖ If pO_2<7.3kPa needs formal oxygen assessment for long-term oxygen therapy (LTOT) ❖ If pO_2>7.3kPa: ❖ Encourage use of fan instead of oxygen ❖ Ambulatory oxygen therapy if saturation falls by >4% to <90% during exercise ❖ Palliative oxygen therapy only if saturation <92%, and other treatments optimized

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Disease management is vital, but often not enough…

Drugs (e.g. morphine) can harm, and mostly not evidence-based…

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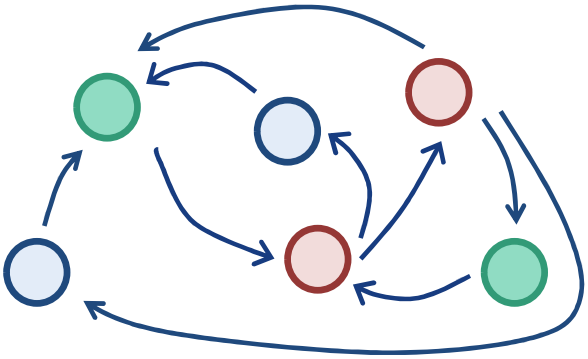
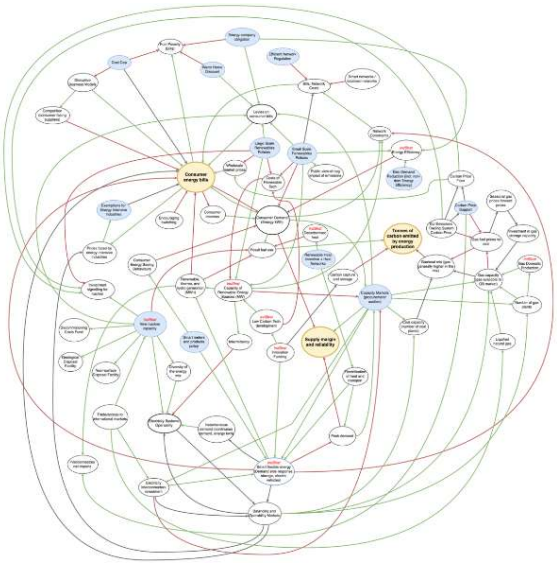
Thinking differently…

A whole person (systems) approach





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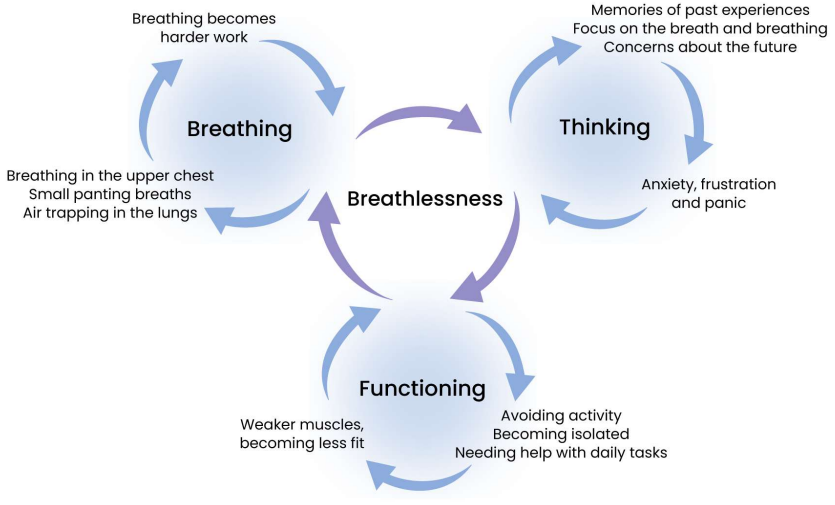

Primary Breathe

FUNDED BY NIHR | National Institute for Health and Care Research

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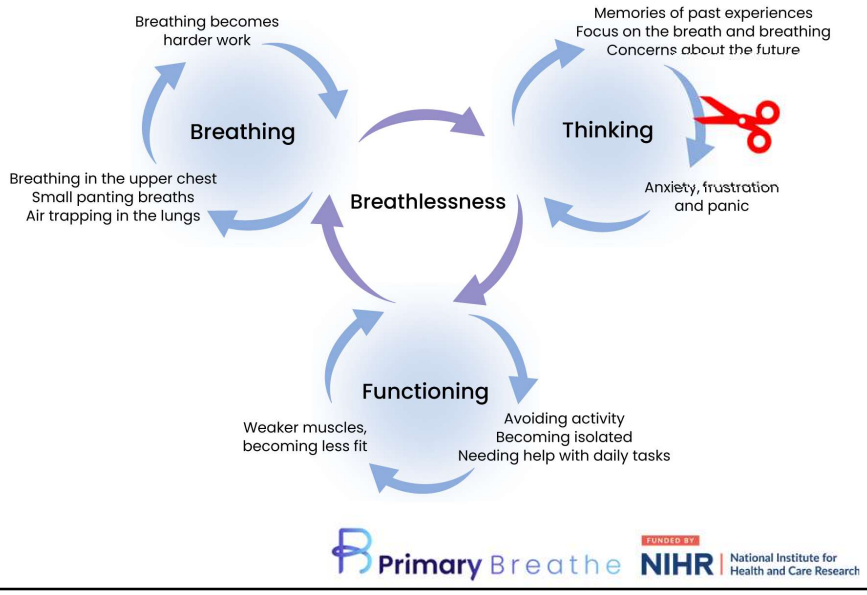

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Strength of evidence

Non-drug strategy	Evidence of benefit
✓ Pulmonary rehabilitation	Significant benefits on breathlessness, fatigue, emotional function, quality of life, exercise capacity
✓ Fan, facial cooling	Most people feel benefit from short-term use, both at rest and on exercise
✓ Breathing techniques	Many have a positive impact on breathlessness, with most evidence for pursed-lip breathing
✓ Mindfulness	Improvement in breathlessness can happen even with a single short session
✓ Relaxation	Helps breathing and well-being; people have a wide range of preferred techniques
✓ Walking	Building up walking and step counting can help along with walking aids like a rollator

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Fan evidence example

Review Article

PALLIATIVE MEDICINE

Palliative Medicine
2019, Vol. 33(6) 618–633

DOI: 10.1177/0269216319835393
journals.sagepub.com/home/pmj
SAGE

Airflow relieves chronic breathlessness in people with advanced disease: An exploratory systematic review and meta-analyses

Flavia Swan[1], Alison Newey[2], Martin Bland[3], Victoria Allgar[3], Sara Booth[4], Claudia Bausewein[5], Janelle Yorke[6,7] and Miriam Johnson[1]

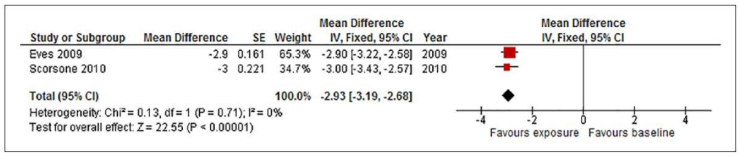

Figure 4. Meta-analysis of cylinder medical air for exertion-induced breathlessness.

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Breathing techniques evidence example

EUROPEAN RESPIRATORY REVIEW
SERIES
A.T. BURGE ET AL.

Breathing techniques to reduce symptoms in people with serious respiratory illness: a systematic review

Angela T. Burge[1,2], Adelle M. Gadowski[2], Alice Jones[3], Lorena Romero[4], Natasha E. Smallwood[2,5], Magnus Ekström[6], Lynn F. Reinke[7], Ravijyot Saggu[8], Marlies Wijsenbeek[9] and Anne E. Holland[1,2,5,10]

Number 3 in the Series "Symptom management for advanced lung disease"
Edited by Anne E. Holland, Magnus Ekström and Natasha E. Smallwood

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Corresponding author: Anne E. Holland (anne.holland@monash.edu)

Check for updates

Shareable abstract (@ERSpublications)
Pursed lip breathing, diaphragmatic breathing and yoga breathing may reduce breathlessness and consistently improve quality of life in people with serious respiratory illness. These findings support the use of breathing techniques in clinical practice. https://bit.ly/4cM5APs

Cite this article as: Burge AT, Gadowski AM, Jones A, *et al.* Breathing techniques to reduce symptoms in people with serious respiratory illness: a systematic review. *Eur Respir Rev* 2024; 33: 240012 [DOI: 10.1183/16000617.0012-2024].

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Mindfulness evidence example

The Effect of 20-Minute Mindful Breathing on the Rapid Reduction of Dyspnea at Rest in Patients With Lung Diseases: A Randomized Controlled Trial

Seng-Beng Tan, MBBS, MRCP, Chong-Kin Liam, MBBS, FRCP, Yong-Kek Pang, MD, MRCP, Diana Leh-Ching Ng, MD, MMED, Tat-Seng Wong, MBBS, Kelvin Wei-Shen Khoo, MBBS, Chieh-Yin Ooi, MBBS, and Chee-Shee Chai, MD, MMED

Department of Medicine (S.-B.T., C.-K.L., Y.-K.P., T.-S.W., K.W.-S.K., C.-Y.O.), Faculty of Medicine, University of Malaya, Kuala Lumpur; and Department of Medicine (D.L.-C.N., C.-S.C.), Faculty of Medicine and Health Science, University Malaysia Sarawak, Kota Samarahan, Sarawak, Malaysia

Abstract

Context. Dyspnea is a common and distressing symptom in respiratory diseases. Despite advances in the treatment of various lung diseases, the treatment modalities for dyspnea remain limited.

Objectives. This study aims to examine the effect of 20-minute mindful breathing on the rapid reduction of dyspnea at rest in patients with lung cancer, chronic obstructive pulmonary disease, and asthma.

Methods. We conducted a parallel-group, nonblinded, randomized controlled trial of standard care plus 20-minute mindful breathing vs. standard care alone for patients with moderate to severe dyspnea due to lung disease, named previously, at the respiratory unit of University Malaya Medical Centre in Malaysia, from August 1, 2017, to March 31, 2018.

Results. Sixty-three participants were randomly assigned to standard care plus a 20-minute mindful breathing session ($n = 32$) or standard care alone ($n = 31$), with no difference in their demographic and clinical characteristics. There was statistically significant reduction in dyspnea in the mindful breathing group compared with the control group at minute 5 ($U = 233.5$, $n_1 = 32$, $n_2 = 31$, mean $rank_1 = 23.28$, mean $rank_2 = 37.72$, $z = -3.574$, $P < 0.001$) and minute 20 ($U = 232.0$, $n_1 = 32$, $n_2 = 31$, mean $rank_1 = 23.00$, mean $rank_2 = 36.77$, $z = -3.285$, $P = 0.001$).

Conclusion. Our results provide evidence that a single session of 20-minute mindful breathing is effective in reducing dyspnea rapidly for patients with lung cancer, chronic obstructive pulmonary disease, and asthma. J Pain Symptom Manage 2019;57:802–808.

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EUROPEAN RESPIRATORY REVIEW
SERIES
A. SPATHIS ET AL.

Multicomponent services for symptoms in serious respiratory illness: a systematic review and meta-analysis

Anna Spathis [1,2], Charles C. Reilly [3,4], Claudia Bausewein [5], Lynn F. Reinke [6], Lorena Romero [7], Natasha E. Smallwood [8,9], Magnus Ekström [10] and Anne E. Holland [8,9,11,12]

Number 4 in the Series "Symptom management for advanced lung disease"
Edited by Anne E. Holland, Magnus Ekström and Natasha E. Smallwood

Shareable abstract (@ERSpublications)
Multicomponent services improve breathlessness mastery and health-related quality of life, with minimal risk. These findings support use of these services for people living with serious respiratory illness, although the certainty of evidence is very low. https://bit.ly/3WFsTUE

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Johnson et al. BMC Medicine (2015) 13:213
DOI 10.1186/s12916-015-0453-x

BMC Medicine

RESEARCH ARTICLE Open Access

A randomised controlled trial of three or one breathing technique training sessions for breathlessness in people with malignant lung disease

Miriam J Johnson[1*], Mona Kanaan[2], Gerry Richardson[3], Samantha Nabb[4], David Torgerson[2], Anne English[5,6], Rachael Barton[7] and Sara Booth[8,9]

Conclusions: There was no evidence that three sessions conferred additional benefits, including cost-effectiveness, over one. A single session of breathing training seems appropriate and minimises patient burden.

Johnson et al. BMC Med 2015;13:213

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How does this help?

Making sense of breathlessness

- ❑ Why underlying disease management may not be enough
- ❑ Why non-pharmacological interventions (NPI) work

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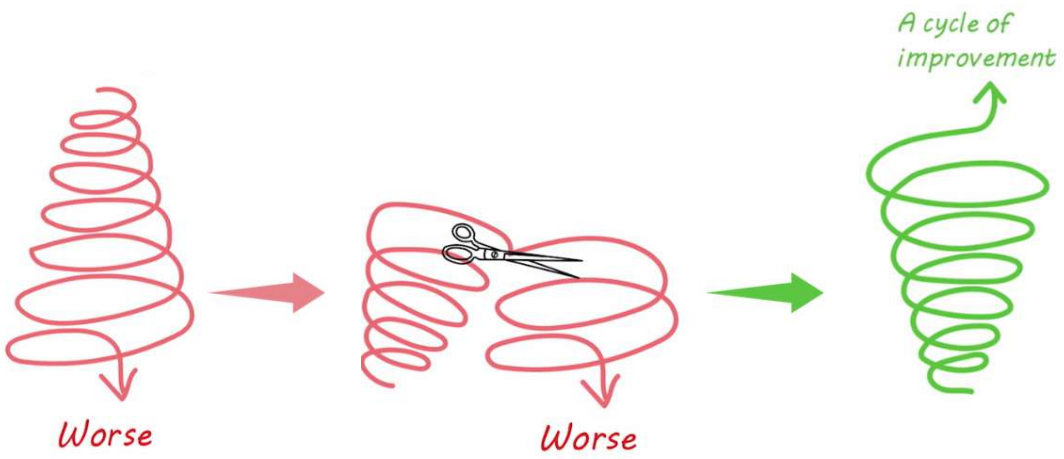

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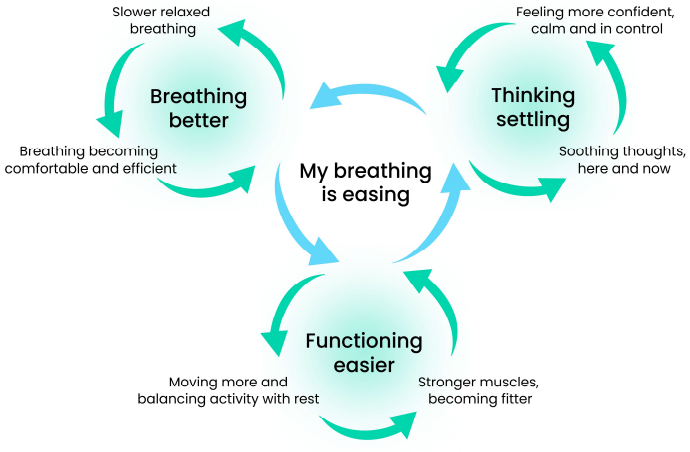

Primary Breathe

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How does this help?

Making sense of breathlessness

- ❑ Why underlying disease management may not be enough
- ❑ Why non-pharmacological interventions (NPI) work

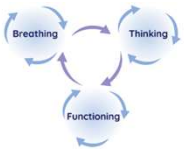
Motivation and hope

- ❑ 'Something can still be done even if the disease cannot be improved'
- ❑ 'Small changes can make a big difference over time'

Management structure

Break the main cycle(s) experienced with:

1. Brief explanation to address any misconception
2. One or two strategies aligned with a values-based goal



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Step 1

Brief explanation to address any misconception

B

Breaking the Breathing cycle

When feeling breathless, it's natural to think you need to take more air in. There's plenty of air in your lungs. Try to lengthen your **out** breath instead. This makes the breathing more efficient and gives space for the next breath.

T

Breaking the Thinking cycle

Many people instinctively feel something bad might happen when they're feeling breathless. Although very understandable, this tends not to happen with usual day-to-day breathlessness.

F

Breaking the Functioning cycle

Choosing to make yourself moderately breathless by being active will not harm you. In fact, it builds up muscle fitness again, improving your breathing and general health over weeks and months.

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Step 2

Examples of strategies targeting each cycle

Breathing

Do you sometimes take quick, shallow breaths (panting)? Are your neck and shoulders sometimes tense or tight?

1. Tummy breathing
2. Activity and recovery
3. Shaped breathing
4. Positions to ease breathlessness

Thinking

Do your thoughts about your breathing make you feel frightened, stressed or low?

1. Tranquillity
2. 54321 technique
3. My action plan
4. Muscle relaxation

Functioning

Are you less active because it's hard to move around when you're feeling breathless?

1. Finding your activity
2. Walking programme
3. Managing energy
4. Setting goals

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Overview

1. Context and challenges — Making sense of breathlessness with the BTF model

2. Clinical management — Practical strategies, top tips and service implications

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Jan's story (1)

- Aged 63, stage 3 COPD
- 'Panic' walking along coast path
- Increasingly housebound, sleeping badly, drinking more alcohol
- Repeated hospital attendances with breathlessness, non-infective exacerbations
- Insisting on cylinder oxygen at home, as oxygen helpful during admissions

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Find out

Experiences

Existing coping strategies

Expectations, concerns

Each of the B, T and F cycles

Manage

Making sense of breathlessness

Motivation and hope

Management structure
- Step 1: explanation
- Step 2: one to two strategies

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Measuring your breathlessness

1) How breathless are you these days on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Not breathless — Worst imaginable

2) How does your breathlessness make you feel? And how [*insert emotion*] do you feel these days?

0 1 2 3 4 5 6 7 8 9 10

Not at all — Worst imaginable

3) How confident are you in managing your breathlessness?

0 1 2 3 4 5 6 7 8 9 10

Not confident at all — Extremely confident

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Breathing cycle

Activity and recovery

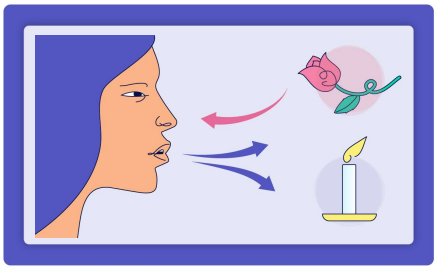
Three Fs

Facial cooling with a fan or damp cloth

Flop and drop your shoulders

Focus on relaxed, long breaths out

Pursed lip breathing



Blow as you go...

Keep in mind when you're moving about:

Blow as you go and If in doubt, breathe out

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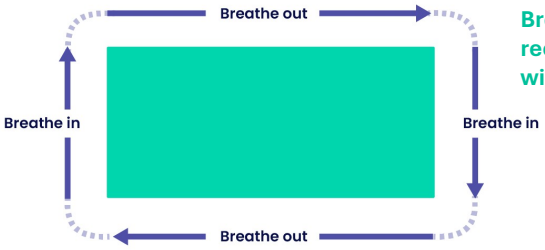
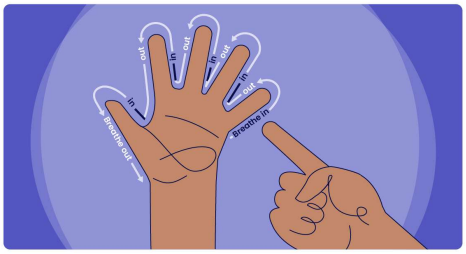
Breathing cycle

Shaped breathing



Breathing around a rectangle like a window...



...or five-finger breathing around your hand

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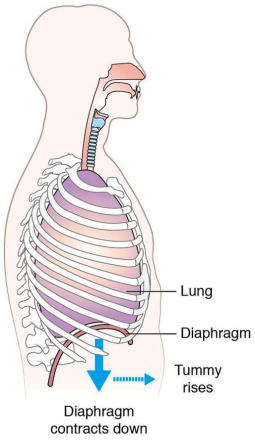
Breathing cycle

Tummy breathing



Rise the tummy as you breathe in

Relax the breath out

Rest in the pause

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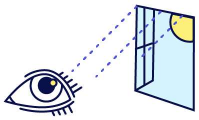
Thinking cycle

54321 technique

5 Notice and name five things you can **see**

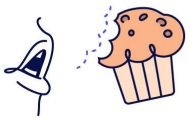


4 Now notice four things you can **touch or feel**

3 Notice three things you can **hear**

2 Notice two things you can **smell**

1 Finally notice one thing you can **taste**



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Thinking cycle

Tranquillity

Think about
the word **tranquillity**.
Say **tranquillity** three times
in your mind.
Think about a colour associated
with **tranquillity**.
Imagine all the things this colour
reminds you of.
Now imagine yourself in a place
that brings a feeling of
tranquillity.
What does it smell like in this
place? What can you hear?
Enjoy this feeling of
tranquillity.

Miranda Thew

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Thinking cycle

My action plan

My action plan

I have had this feeling before. I know it will go away soon.

I am going to:

1) Support my arms and lean forward

2) Cool my face with a fan or with a damp cloth

3) Focus on breathing out, a little longer with each breath out

I can do this. I am doing it now.

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Functioning cycle

Walking programme

	Goal	Steps done
Week 1		1018
Week 2	1100	1148
Week 3	1250	1421
Week 4	1350	1337
Week 5	1470	1501
Week 6	1600	1617
Week 7	1800	1724
Week 8	2000	2105

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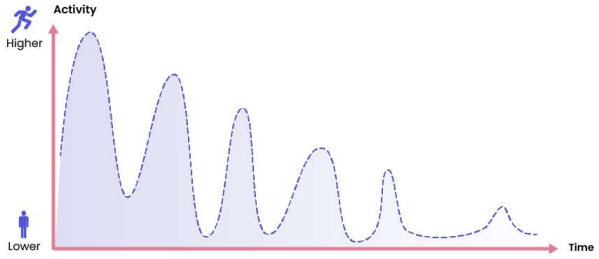
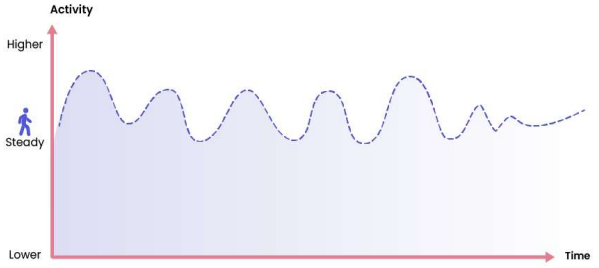
Functioning cycle

Managing energy

The 5 Ps

1. Planning
2. Pacing
3. Prioritising
4. Posture
5. Permission





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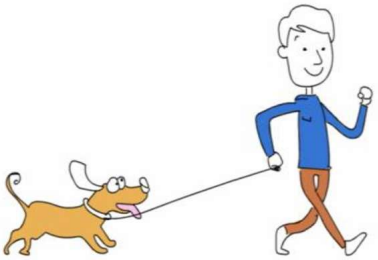
Jan's story (2)

- Understood impact of the 'panic' trigger, and relevance of Thinking and Functioning cycles
- Encouraged to use handheld fan for 5 mins before turning on oxygen
- Explained that making himself moderately breathless by moving is not harmful; explored his fear of dying 'gasping'
- Practiced a muscle relaxation technique, always after lunch 'like a daily tablet'
- Walking programme with step counting; achieved goal of walking dog around back field in seven weeks

It's making sense now.
I can break those coils...
my breathing can get better

Actually you didn't really talk about my breathing, yet it's improving...



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A	Acknowledge: listen to people's experiences of breathlessness as this can be therapeutic in itself
B	Be reassuring: normalise the cycles as they are natural and it would be strange if they didn't happen
C	Choose your words: use positive language about what can be done, not what is wrong or has been lost
D	Daily pill analogy: support people to practice techniques at a specific time of day 'like a daily, safe pill'
E	Empower: build on what people are already doing and aim to give a sense of control and confidence
F	Flexible: adapt the intervention strategies tailoring according to needs, interests and personal goal

Primary Breathe

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	Rather than saying this...	...you might want to consider this
All cycles	× Get rid of bad habits × Avoid vicious cycles	✓ New habits building on what you're already doing well ✓ This is usual, in fact it would be strange if it wasn't happening
Breathing	× Dysfunctional breathing × Not breathing the right way	✓ Forming efficient breathing habits ✓ Using the breathing muscles that get less tired
Thinking	× Need to keep calm × Try to calm down and relax	✓ Taking a moment ✓ Giving yourself a bit of 'time out'
Functioning	× Need to exercise, get fit × Become more active	✓ Moving more, balancing moving and resting ✓ Doing things you want to do, things you enjoy

Primary Breathe

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Cambridge Breathlessness Intervention Service

Cambridge University Hospitals NHS Foundation Trust

Referral criteria
- Diagnosed cause of breathlessness
- Optimal medical management of underlying condition(s)
- Able to benefit from self-management programme

Team
- Therapist-led service
- 3.0FTE occupational therapists and physiotherapists
- 0.6FTE administrator and 0.2FTE medical consultant

Activities
- Referrals from hospitals > GP > community teams
- Most patients seen at home, with some telephone follow up
- Weekly MDT meeting with over 100 active patients

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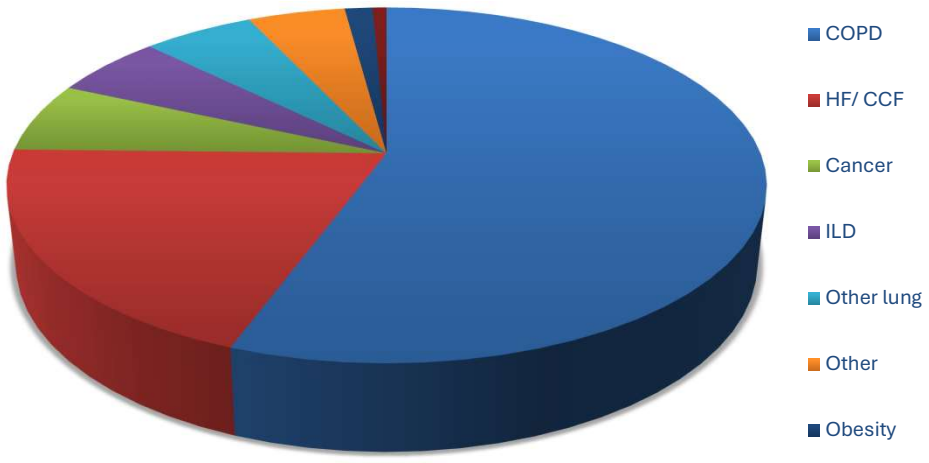
Cambridge Breathlessness Intervention Service

Cambridge University Hospitals NHS Foundation Trust



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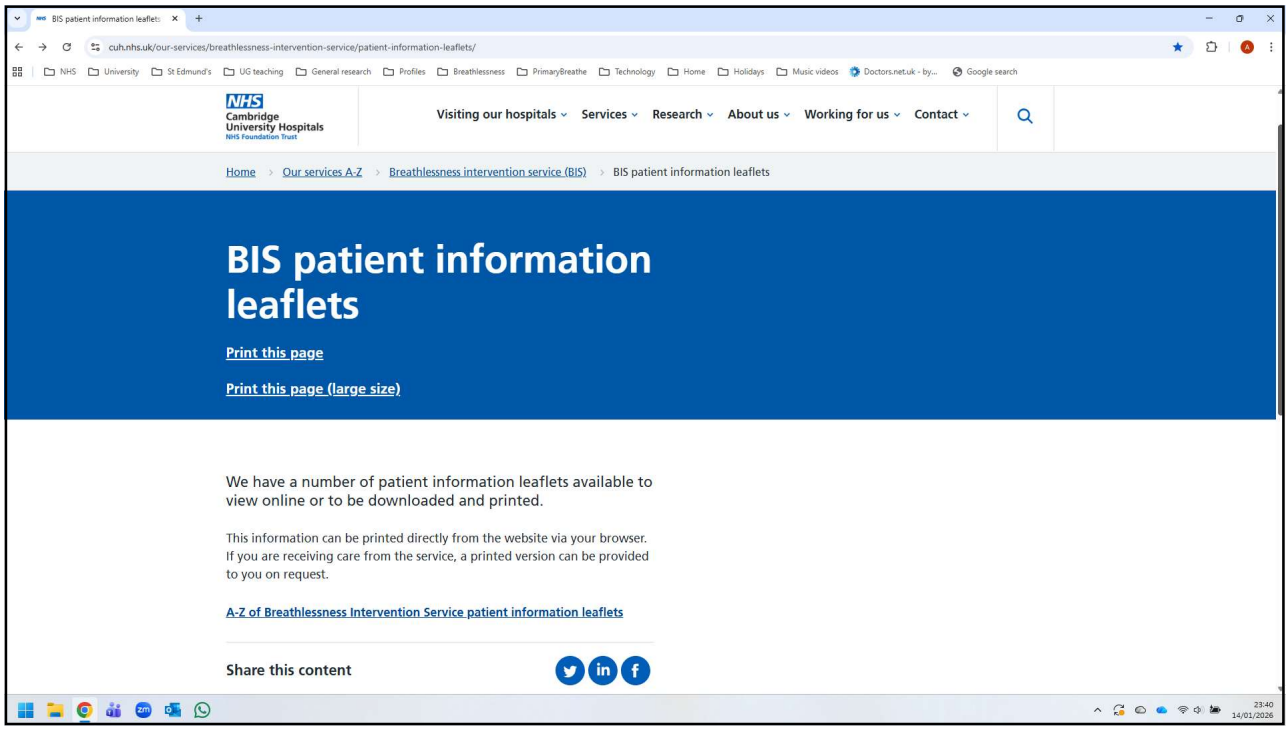
BIS patient information leaflets
cuh.nhs.uk/our-services/breathlessness-intervention-service/patient-information-leaflets/
NHS
Cambridge University Hospitals
NHS Foundation Trust
Visiting our hospitals
Services
Research
About us
Working for us
Contact
Home
Our services A-Z
Breathlessness intervention service (BIS)
BIS patient information leaflets
BIS patient information leaflets
Print this page
Print this page (large size)
We have a number of patient information leaflets available to view online or to be downloaded and printed.
This information can be printed directly from the website via your browser. If you are receiving care from the service, a printed version can be provided to you on request.
A-Z of Breathlessness Intervention Service patient information leaflets
Share this content

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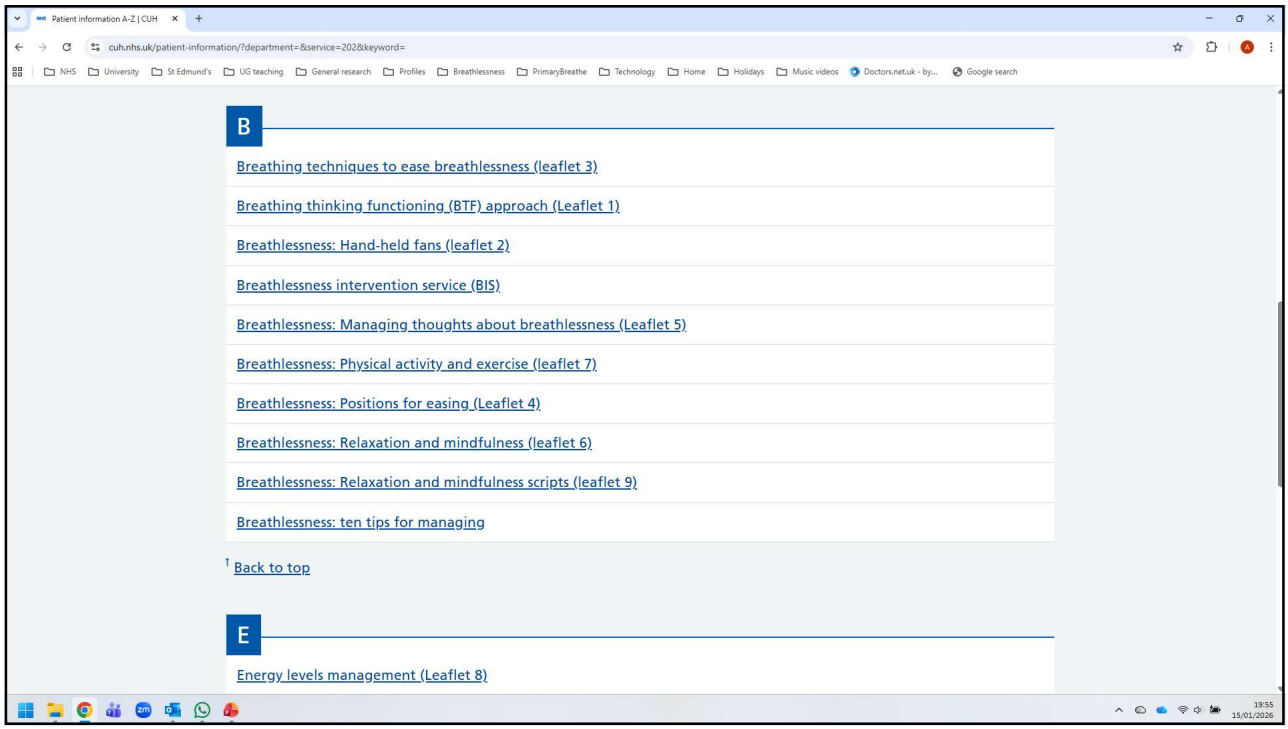
Patient information A-Z | CUH
cuh.nhs.uk/patient-information/?department=&service=202&keyword=
B
Breathing techniques to ease breathlessness (leaflet 3)
Breathing thinking functioning (BTF) approach (Leaflet 1)
Breathlessness: Hand-held fans (leaflet 2)
Breathlessness intervention service (BIS)
Breathlessness: Managing thoughts about breathlessness (Leaflet 5)
Breathlessness: Physical activity and exercise (leaflet 7)
Breathlessness: Positions for easing (Leaflet 4)
Breathlessness: Relaxation and mindfulness (leaflet 6)
Breathlessness: Relaxation and mindfulness scripts (leaflet 9)
Breathlessness: ten tips for managing
Back to top
E
Energy levels management (Leaflet 8)

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Primary Breathe

Programme to develop and test a brief remote primary care intervention for chronic breathlessness

FUNDED BY NIHR | National Institute for Health and Care Research

NHS Cambridgeshire & Peterborough

University of Cambridge, Public Health and Primary Care, The Primary Care Unit

UEA University of East Anglia

University of Hull

University of Leicester

NHS King's College Hospital NHS Foundation Trust

King's College London

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Primary Breathe

Programme to develop and test a brief primary care intervention for chronic breathlessness

Workstream 1

Developmental studies
1. Optimal medical management checklists (OptiMed)
2. PrimaryBreathe intervention co-design study
3. Feasibility study

Workstream 2

Intervention testing
4. Randomised controlled trial (or cluster randomised)
5. Parallel process evaluation

Workstream 3

Preparing to implement
6. Implementation strategy co-production

Inclusivity theme

Implementation theme

Randomised controlled trial
330 patients across from 30-35 practices in the UK

- Intervention +OptiMed
- OptiMed

Key outcomes
- ❑ CRQ mastery
- ❑ GP or ED attendances

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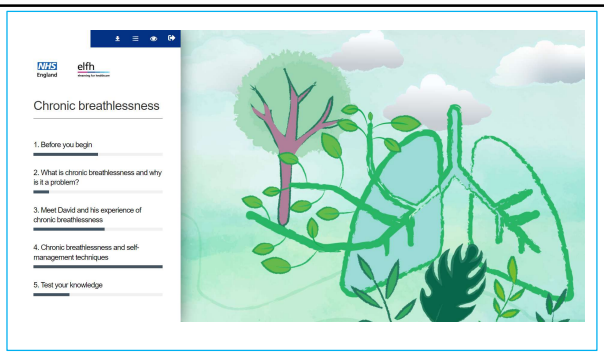
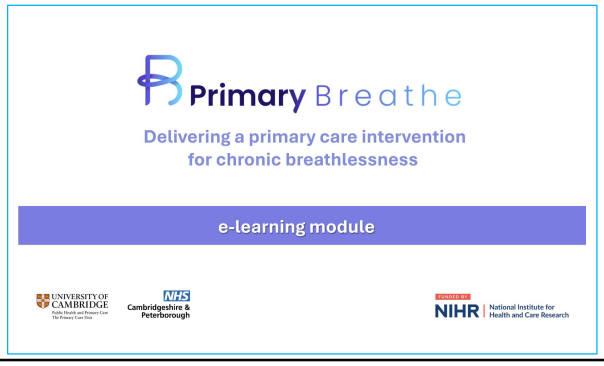
Primary Breathe

Step 1: staff training
A: e-learning (30 mins)
B: core training (60 mins)
C: top-up training (30 mins)





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Primary Breathe

Step 1: staff training
A: e-learning (30 mins)
B: core training (60 mins)
C: top-up training (30 mins)

Step 2: intervention delivery
2-3 consultations over 4 weeks
Website, booklet
Consultation summary

Summary consultation guide

Appointment summary

Self-management website or booklet

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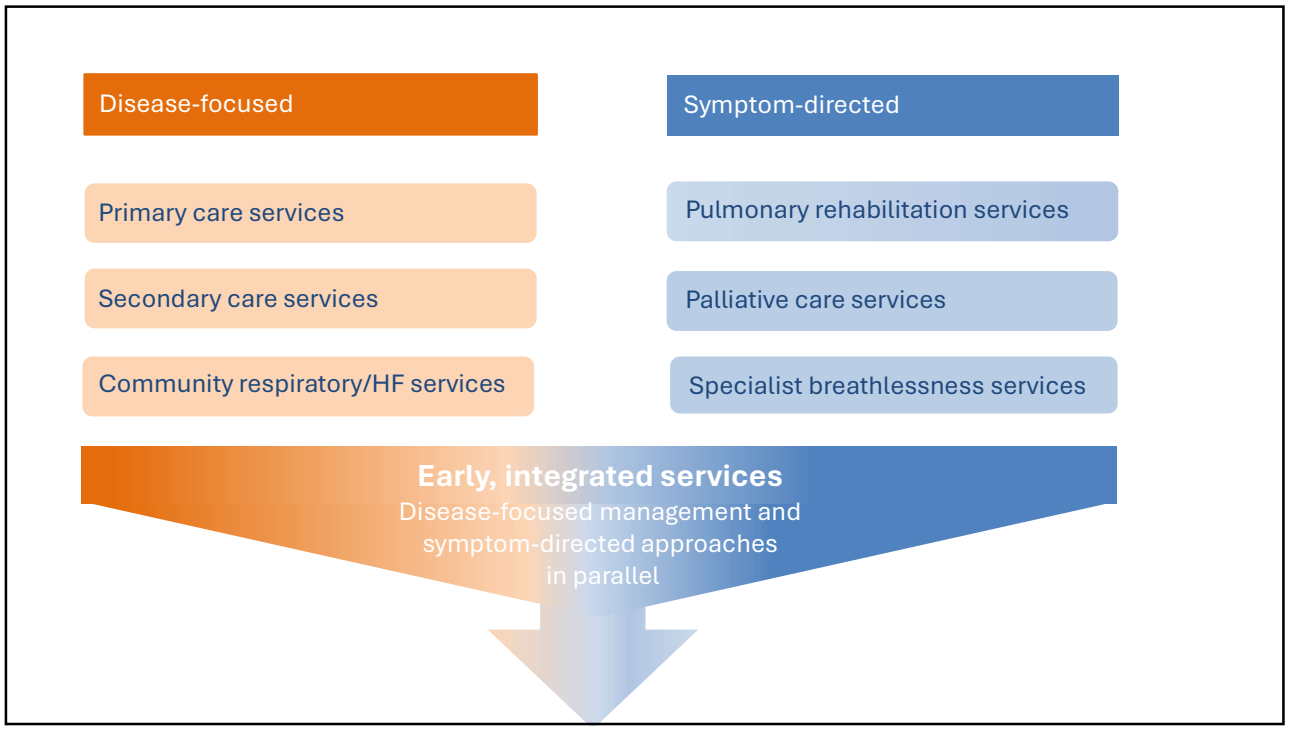

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Main messages

1. Disease management alone is often insufficient to relieve breathlessness; use of morphine is not evidence-based and can cause harm.
2. Make sense of breathlessness, motivate people and provide a structure for personalised management with the BTF model.
3. Non-drug approaches can be brief, adaptable and taught by any interested health professional, supporting people to regain a sense of control and confidence.
4. Early parallel integration of disease-focused and symptom-directed approaches may best meet the needs of people living with breathlessness.



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