RightCare Asthma Toolkit

Practical advice and guidance for commissioners, service providers and clinicians on how to commission and provide the best system-wide care for people living with asthma.

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People living with asthma in England face challenges such as unwarranted variation in optimal care, increasing attendance at emergency departments which can lead to hospital admissions and in some cases avoidable mortality.

Foreword: Asthma toolkit and support to delivering the Long Term Plan

Asthma results in about 2-3% of primary care consultations and leads to 60,000 hospital admissions every year in the U.K. About 1,200 people are recorded as dying from asthma and many of these deaths could be avoided by taking simple measures to improve care.

This RightCare Toolkit addresses some of the top priorities facing systems for asthma care by providing a set of key actions supported by current guidance, evidence and best practice examples. The toolkit covers high priority areas such as looking at risk factors that exacerbate asthma symptoms; promoting early detection strategies and accurate diagnostics; setting out optimal management for people with asthma and embedding personalised care; looking at improved ways of referrals and system communication for people with asthma; medicines optimisation and providing guidance on supporting specific patient groups such as children and young people, those with learning disabilities, people with mental ill-health and during pregnancy.

The actions set out in this toolkit will help to tackle the urgent challenges facing people living with asthma.

These actions are also aligned with the commitments set out in the NHS Long Term Plan for respiratory disease and will contribute to reducing overall unwarranted variation. Therefore, I am pleased to be supporting this toolkit and its implementation into healthcare systems.

This toolkit has been developed to support the improvement and management of asthma. Although COVID-19 is recognised, this toolkit is not a tool to support the treatment of COVID-19. Please visit the NICE website for further information.

Andrew Menzies-Gow, National Clinical Director for Respiratory Disease

Introduction

This RightCare system toolkit aims to support systems to understand key priorities for asthma care in adults, and ways of optimising, by providing methods for assessment and benchmarking of current systems. It has been developed with reference to NICE guidelines. Wider consultation has taken place with representatives of people with asthma, clinicians, social care organisations, professional bodies and other expert stakeholders.

National challenges:

- To ensure asthma care complies with existing NICE quality standards (NICE QS25)
- To improve patient self-activation to optimise self-management, supported by the NHS Long Term Plan
- To reduce unnecessary asthma exacerbations and asthma mortality rates
- To ensure people with severe asthma receive specialist care at an asthma centre
- To improve the quality of life and well-being of people with asthma

RightCare opportunity:

Around £13.3m* could be saved on non-elective spend (all ages) for asthma if CCGs achieved the rate of their best 5 peers†

• Nearly 11,000 fewer patients (all ages) admitted non-electively for asthma if CCGs achieved the rate of their best 5 peers†

**The approaches outlined within the toolkit should contribute to delivery of efficiency opportunities outlined within*

RightCare packs, however the impact at a local level may differ based upon system configuration, capacity and contractual arrangements and potential need to invest in alternative services, where these do not currently exist.

†Potential national opportunities represent the sum of potential opportunities for all CCGs, if all CCGs with significantly worse (higher or lower, dependent on outcome measure) values reduce or increase these values to the average of the 'Best' 5 of their nearest 10 CCGs.(based on 2018/19 data).

RightCare 'Where to look' data packs

Where to look packs include 'pathway on a page' charts that highlight performance across key clinical care pathways to help understand how performance in one part of the pathway may affect outcomes further along the pathway. We recommend that you view the asthma, and influenza and pneumonia pathway charts to see how your area is performing compared to your demographically similar peers.

Both Where to look and PCN packs, and other RightCare resources, can be found on the RightCare National FutureNHS. Please note that you will need to a become a member of FutureNHS to access the site.

Data and further information sources

There are several other sources of respiratory data that we recommend systems and service leads explore.

Model Health System (MHS) includes RightCare data

RightCare data is now also included on the Model Health System - a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement. Information is presented by Integrated Care Board (ICB) and you can also drill down to place (sub-ICB) level.

Getting It Right First Time

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. A GIRFT review of respiratory medicine was published in October 2021 and includes recommendations and actions for asthma and pneumonia.

NHS Business Services Authority Respiratory Dashboard

The aim of the respiratory dashboard is to highlight the variation in prescribing across the CCGs in England so that CCGs and local health economies can utilise this data at local level to decide if this variation is warranted or unwarranted and if and how they may wish to address this.

Atlases of Variation

The Atlases of Variation help to identify unwarranted variation and assess the value that healthcare provides to both populations and individuals. A defining aspect of the atlases is that each of the indicator's maps, column chart and box-and-whisker plot is accompanied by text which provides: the context for the indicator, a description of the variation and trend data, options for action and a list of evidence-based resources to support action.

The 2nd Atlas of variation in risk factors and healthcare for respiratory disease (2019) includes sections on asthma and pneumonia and can be found on Fingertips. Interactive Atlases services can be accessed via the NHS England website.

Inhale - INteractive Health Atlas of Lung conditions in England

Inhale is an online tool showing data from a range of sources about respiratory diseases including COPD and asthma. It includes data from the Quality and Outcomes Framework (QOF), Hospital Episode Statistics (HES), the Public Health Outcomes Framework (PHOF) and ONS mortality.

RightCare scenarios

RightCare will shortly be publishing an asthma scenario. RightCare scenarios use fictional service users to show the difference between a suboptimal – but realistic – pathway of care, compared to an optimal one. At each stage the costs of care are highlighted, not only financial to the local health and care system, but also the impact on the individual and their family. This scenario will be published on the NHS England website.

Rightcare toolkit on a page

System Improvement Priorities

1. Risk factors that can exacerbate asthma

1.1 Smoking
1.2 Obesity and lack of exercise
1.3 Low uptake of the flu and pneumonia vaccine
1.4 Non adherance/compliance with treatment

2. Environmental factors for consideration

2.1 Air pollution (outdoor)
2.2 Climate change
2.3 Occupational exposure
2.4 Cold or poor quality housing

3. Early detection and accurate diagnosis

3.1 Know your population
3.2 Follow diagnostic guidelines according to age group
3.3 Use of primary care diagnostic hub and overseen by specialists

4. Optimal management and personalised care

4.1 Use of asthma action plan
4.2 Use of patient activation strategies
4.3 Supported self-management using digital tools where appropriate
4.4 Accessing alternative asthma support in the community

5. Referral and system communication

5.1 Improved dialogue and transition between paediatric and adult NHS asthma services
5.2 Communication between emergency department and primary care
5.3 Referral for specialist assessment for difficult/ severe asthma

6. Medicines optimisation

6.1 Optmised inhaler choice
6.2 Optimal inhaler technique
6.3 Medication adherance

7. Supporting specific patient groups

7.1 Suport for children and young people
7.2 Support for people with learning disabilities
7.3 Support for people with mental ill-health
7.4 Support in pregnancy

8. Experience of care

8.1 Improving the experience of care for people living with asthma and their family/ carers

System enablers

Self-assessment questionnaire

System improvement priority 1: Risk factors that can exacerbate asthma

Good asthma management includes strategies to avoid and/or manage known triggers of exacerbations. Also to identify and manage patients' over-reliance on reliever treatments and where patients are suspected to have severe asthma ensuring referral for rapid assessment and treatment. For some triggers such as smoking, being overweight and sedentary, not being vaccinated against influenza and pneumonia and lack of treatment adherence or using inhalers inappropriately, certain strategies can be put in place in order to reduce the asthma exacerbations.

Key areas for focus:	
Smoking	Smoking and breathing in other peoples smoke can trigger asthma symptoms or even cause an asthma attack. There is strong evidence that expert support from a stop smoking advisor combined with one or more stop smoking aids is the most effective quitting method.
Obesity and lack of exercise	Supporting people with asthma to undertake physical activity and, if appropriate, to lose weight will help to improve respiratory and asthma symptoms.
Low uptake of the flu and pnuemonia vaccine	People living with asthma are more likely to develop potentially serious complications from influenza and pneumonia. Therefore encouraging the uptake of the flu and pneumonia vaccinations is an important strategy, especially in light of COVID-19, to minimise such complications.
Non adherance and compliance with treatment	It is important to support people with asthma to undertake their treatment appropriately and correctly in order to manage their condition optimally. Utilising shared decision making methods can support better treatment adherence.

Key area of focus	Actions to take	Guidance and best practice
1.1 Smoking	• Where local stop smoking services are commissioned and available in your local area refer patients to them for help to stop smoking or provide alternative methods stop smoking support if there are no local services available. • Embed NHS Long Term NHS-funded tobacco treatment services. • Embed tobacco dependence treatment in primary care systems. • Ensure all staff know/are trained to give Very Brief Advice (VBA), including midwifery and health visitors. • Ensure NICE guideline PH26 is embedded in systems where all pregnant, postnatal smokers and household members are referred to smoking cessation support.	

System improvement priority 1: Risk factors that can exacerbate asthma

Key area of focus	Actions to take	Guidance and best practice
1.2 Obesity and lack of exercise	• Refer patients to weight management/exercise referral schemes if they are commissioned and available in your local area.	
1.3 Low uptake of flu/ Pneumonia vaccine	• Refer to NICE guideline NG103. People in these groups are eligible for free flu vaccination and are specified in the Green Book and the annual flu letter. Due to COVID-19 there has been an expansion of those eligible for a flu vaccination, which can be found in the updated flu letter. • Promote education and awareness of the importance of receiving appropriate vaccinations for both patients, staff and the general public. • Ensure that front line staff with patient contact receive their flu vaccination. • Target asthma patients to receive their annual flu/ pneumonia vaccine; for example, send them digital reminders to book a flu jab appointment. • Commission pharmacies to provide the flu jab for at risk groups to increase uptake. • Work with community pharmacies to increase awareness through public health campaigns.	
1.4 Non adherance/ compliance with treatment	• Discussions should take place between a health professional and the patient, to understand any barriers to adhering to the medication regime and these should be worked through with the patients in line with NICE guidance CG76 and specifically recommendations 1.2 on supporting adherence. • Undertake shared decision making with the patient when it comes to choosing medication to ensure that any treatment regimen suits their lifestyle and personal preferences.	

System improvement priority 2: Environmental factors for consideration

Environmental risks and factors can also trigger and exacerbate asthma symptoms. Environmental risks and factors include the presence of air pollution; poor living conditions that affect respiratory health and occupational exposure to risks that may exacerbate asthma symptoms. Furthermore, the use of certain inhalers that contain propellants that contribute to climate change.

Key areas for focus:	
Air pollution	When levels of air pollutants rise, adults and children with lung conditions are at increased risk of becoming ill and needing treatment. The risk is particularly high in inner-urban areas where just under two thirds of people with asthma say that poor air quality makes their asthma worse. Providing advice to children, young people and adults at routine health appointments will support self-management, improve their awareness of how to protect themselves when outdoor air quality is poor and prevent their condition escalating (NICE 2019).
Occupation	Exposure to substances such as dust, chemicals, fumes and animal fur through the workplace may lead to some adults developing asthma. For those that do go on to develop asthma, the length of time it takes to display symptoms is variable due to how long it takes the immune system to become sensitive to workplace triggers. However, once a person is sensitive to occupational substances, asthma symptoms are likely to be triggered every time they come into contact with it.
Low uptake of the flu and pnuemonia vaccine	Poor or substandard housing, for example where damp and mould is present, can have an impact on respiratory health. Furthermore there is sufficient global evidence demonstrating that occupants of damp and mouldy buildings are at increased risks of respiratory problems including exacerbation of asthma. Therefore it is important for systems to support people with asthma living in such conditions appropriately.

Key area of focus	Actions to take	Guidance and best practice
2.1 Air pollution	• NHS and local authorities will benefit from working together to reduce air pollution as outlined in the NHS Long Term Plan e.g. use of virtual clinics, provision of low emission zones. • Support patients and the public to understand health effects of air pollution and offer patients and their carers clear advice on managing their conditions, as well as actions they can take to reduce their day-to-day and lifetime exposure to air pollution. • Consider air quality when procuring vehicles (ultra low emissions vehicle-an NHS Long Term Plan priority)and training staff in fuel efficient driving (including anti-idling), or creating no-idling zones on NHS sites and/or utilising Clean Air Zones developed by the Local Authority as per NICE guidance NG70.	

System improvement priority 2: Environmental factors for consideration

Key area of focus	Actions to take	Guidance and best practice
2.1 Air pollution	• Refer to Met Office air pollution alerts through the Daily Air Quality Index (DAQI). • Ensure that patients with asthma, and their carers, know that on days of high air pollution that they may need to increase their use of prescribed medication, in line with advice from their healthcare practitioner. • People experiencing symptoms relating to air pollution should be aware of and follow the guidance provided through the Daily Air Quality Index (DAQI). • Clinicians to consider indoor and outdoor environmental risks and triggers, and consider how to support the patient (such as signposting to council/housing services).	
2.2 Occupational exposure	• Improve primary, secondary and occupational health communication with workplaces. • Refer people with suspected occupational asthma to an occupational asthma specialist as per NICE recommendation 1.1.11.	
2.3 Cold or poor quality housing	• Work with local authorities to support the healthy homes initiative. • Clinicians should ask about damp and mould when taking a respiratory history/consultation, and direct patients to the NHS Choices website (How do I get rid of damp and mould?) or the 2009 WHO brochure on damp and mould for the public for further information. • Undertake the free e-learning module Helping People Living in Cold Homes, which supports health and social care professionals to put NICE Guidance NG6 ‘Excess winter deaths and illness and the health risks associated with cold homes’ into practice. • Signpost patients who live in poor or cold housing to initiatives such as the Affordable Warm Grants scheme.	

System improvement priority 3: Early detection and accurate diagnosis

Detecting and diagnosing asthma early and accurately will enable patients to manage their conditions better. It is important to know the type of asthma population in your geography so that services can be planned accordingly. Embedding national guidance for appropriate diagnostics according the age group will also ensure correct and accurate diagnoses are made. Having access to diagnostic hubs in primary care that are overseen by specialists will ensure patients are diagnosed accurately and in a timely manner.

Key areas for focus:	
Know your population	By knowing your asthma population and furthermore patients with uncontrolled and severe asthma, services can be better planned and commissioned to support this group of people. There should also be a focus on those from more deprived communities and from BAME groups where asthma prevalence tends to be higher, as well as those who may have low levels of health literacy or have difficulty in accessing services.
Follow diagnostic guidelines according to age group	Asthma can be misdiagnosed, which means that people with untreated asthma are at risk of an asthma attack, and people who do not have asthma receive unnecessary drugs. Following both the NICE Quality Standard (1) on undertaking objective tests to aid diagnosis and the QOF AST006 requirements for diagnosis, will help to optimise the accurate diagnosis of asthma and distinguish it from a diagnosis of other conditions, such as COPD.
Primary care diagostic hubs overseen by specialists	Where available, and as per NICE recommendation 1.3.1, use spirometry and FeNO testing (for over 5 yrs of age) at asthma diagnostic hubs to provide the most accurate diagnosis of asthma or to rule out asthma (and instead diagnose COPD where appropriate). This should be undertaken by trained and experienced clinicians (see PCRS Fit to Care for guidance on skills, knowledge and training required). This is to avoid misdiagnosis and inappropriate treatment for other causes of breathlessness, and unnecessary side- effects from medication that is not required or appropriate.

Key area of focus	Actions to take	Guidance and best practice
3.1 Know your population	• Undertake a review of your local and primary care network (PCN) respiratory registers to ensure that those on the register have an objective confirmation of diagnosis recorded in their patient record. • Identify those from more deprived or BAME groups who have diagnosed asthma to ensure they are accessing primary care services for their annual review. • Ensure those patients with education or health literacy needs are supported to access respiratory services by providing tailored information on the importance of their asthma care.	

System improvement priority 3: Early detection and accurate diagnosis

Key area of focus	Actions to take	Guidance and best practice
3.1 Know your population	• Identify patients with uncontrolled asthma. Pro-actively manage those who have multiple acute care episodes, or who have high Oral Corticosteroid (OCS) use or are over-reliant on Short-Acting Beta-Agonists (SABA) inhalers as a rescue medication for their asthma symptoms. • Those with uncontrolled asthma (as per the NICE definition), who are already on an optimal treatment regime without resolution of their symptoms, may benefit from a referral for a specialist assessment. • Refer those with difficult to treat or suspected severe asthma for specialist assessment. Where a diagnosis of severe asthma is made, this should be clearly flagged within the patient record.	 
3.2 Follow the diganostic guidelines according to age group	• Ensure that diagnosis of asthma patients is in line with the Quality and Outcomes Framework 2022/23. • Ensure that the NICE guidance is applied consistently across the system with regards to diagnosis based on age stratification, and diagnosis is confirmed by appropriately trained health professionals.	
3.4 Primary care diagnostic hubs overseen by specialists	• Those responsible for planning diagnostic service support to primary care (e.g. ICBs, PCNs) should consider establishing asthma diagnostic hubs to achieve economies of scale and improve the practicality of implementing the recommendations in the NICE asthma guidelines. • Where primary care diagnostic hubs are established, these need to have the necessary diagnostic equipment and trained healthcare professionals to perform the appropriate respiratory diagnostic tests for diagnosing asthma, e.g. spirometry and FeNO testing. • Consideration should be given to how the diagnostic hub can be used to support PCNs with leadership, education and training, audit and quality improvement.	

System improvement priority 4: Optimal management and personalised care

For many health conditions people are already taking control themselves, which is supplemented with expert advice and peer support in the community and online. As part of a wider move to what The King's Fund has called 'shared responsibility for health', over the next five years the NHS will ramp up support for people to manage their own health. This will start with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems.

Key areas for focus:	
Use of asthma action plans	Involving people with asthma (including their families and carers) in developing a written personalised action plan can help them to respond to changes in their symptoms. It also enables them to self-manage their asthma and reduce the risk of serious asthma attacks and hospital admission. Regular reviews of the action plan, either face to face or in a virtual setting, with a healthcare professional can help to prevent complications arising.
Use of patient activation strategies	People who recognise that they have a key role in self-managing their condition (and have the skills and confidence to do so) experience better health outcomes. Yet the ability of people to successfully self-care and stay well at home can vary considerably from person to person. People with long term conditions and their carers need to be better supported to manage their own condition(s).
Supported self-management using digital tools	Where appropriate, digital tools can be an important way of supporting patients to better self-manage their condition through improved adherence to medications and understanding potential triggers to exacerbations.
Accessing alternative asthma support in the community	Directing people to where they can access additional support services, including face to face groups, online or digital platforms can really help patients to feel in control of their condition.
Structured annual review	Asthma patients should receive a review every 12 months with their GP (and after every exacerbation). Proactive structured reviews, rather than opportunistic or unscheduled reviews, are associated with reduced exacerbation rate and fewer days lost from normal activity. The review should incorporate the three Royal College of Physicians (RCP) questions in line with current QOF guidance, exacerbation frequency (both as a measure of asthma control) as well as information relating to what to do in an emergency or the adverse effects relating to the overuse of OCS or SABA.

System improvement priority 4: Optimal management and personalised care

Key area of focus	Actions to take	Guidance and best practice
4.1 Use of asthma action plans	• All patients should have a comprehensive personalised asthma action plan available across all heath care settings, in-line with NICE QS25 statement 2. The Asthma + Lung UK Personal Action Plan template is an ideal tool for patient self-management. • A patient's asthma action plan should be reviewed and amended regularly and where necessary, based on changing needs and especially after an asthma exacerbation. Ensure that medications and contraindications are included in the plan. • Where possible, it should be available digitally for ease of patient access (e.g. stored on a patient's phone for use in an emergency). • Medicines use should be added digitally to the patient's action plan. • Digital means should be used to flag which patients would benefit from a review or referral (e.g. based on exacerbations and OCS and SABA use). • Every patient to have a care plan, created in partnership with a relevant healthcare professional who is suitably trained in lined with PCRS Fit to Care, and includes emergency care advice and planning.	
4.2 Use of patient activation strategies	• Measure patient activation levels using Patient Activation Measure (PAM) tool to determine the realistic 'next steps' for individuals to take in terms of self-management. • There should be supported use of patient decision aids, e.g. NICE decision aid on asthma inhalers, with patients. • Health literacy should be improved for both patients and carers by referral to appropriate resources such as the Asthma + Lung UK website which hosts useful advice on self-management and Beat Asthma for advice for children and young people. • Provide training and education resources (e.g. healthunlocked community) tailored to the levels of activation of different individuals within the population. • Target resources and support at people with lower levels of activation who are less confident about their ability to manage their own care. • Address equality and health inequalities by targeting interventions at disadvantaged groups to increase their health literacy and patient activation.	

System improvement priority 4: Optimal management and personalised care

Key area of focus	Actions to take	Guidance and best practice
4.3 Supported self-mangement using digital tools where appropriate	• Direct patients to digital or online platforms, such as Asthma + Lung UK's inhaler videos, for support on how to correctly use inhalers. • Signpost patients to Asthma + Lung UK's Asthma Attack Risk Checker to identify their risk of an attack and to give tips and advice on to help them deal with their asthma. • Increase accessibility to use of smart inhalers in-line with NHS Long Term Plan 1.43 (p.26).	
4.4 Accessing alternative asthma support in the community	• All patients and carers should have an identified mechanism of support between appointments set out in their personal action plan. • Provide signposting to patients and carers to third sector (such as Breathe Easy Groups) and pharmacists to access alternate support. • Consider providing community asthma clinics.	
4.5 Structured annual review	• Use the Royal College of Physicians '3 questions' to assess asthma control. • Clinical pharmacists based within GP practices can support the proactive delivery of annual reviews by undertaking audits to identify patients who haven't received an annual review or where a patient has uncontrolled asthma. • Patients are able to receive an enhanced medication review from either their GP or a clinical pharmacist in line with The Community Pharmacy Contractual Framework (2019/20 – 2023/24). This review should cover the NICE recommendations for monitoring asthma control.	

System improvement priority 5: Referral and system communication

It is important that there is good communication between different services and providers to ensure that patients do not 'fall through the gaps' and that they receive high quality continuous care where and when they need it.

Key areas for focus:	
Improved diaglogue and transition between paediatric and adult NHS asthma	Transition to adult services is important for all adolescents with asthma, irrespective of the severity of their condition. This can be a difficult time and should be made easier by it being planned in advance, involving the person and with good communication and co-ordination across services.
Communication between emergency departments and primary care	There should be good communication systems in place to inform GPs of patients who are treated in A&E or in urgent care centres for an asthma attack. This will help GPs to review these patients in line with the NICE Quality Statement 4 - 'People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within two working days of discharge'.
Referral for specialist assessment for difficult and severe asthma	A small number of patients with suspected severe asthma (or those with difficult asthma due to poor asthma control) will need to be referred to secondary care and on to tertiary severe asthma centres, where they will have access to biologic drugs (monoclonal antibodies). It is important that all patients have equal access to biologic drugs through application of equal and validated referral criteria across the system. Referral should be in line with NICE Statement 5 'People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service' and the NHS England Specialised Commissioning Services Specifications for Severe Asthma (adult) and Specialised Allergy Services (all ages).

System improvement priority 5: Referral and system communication

Key area of focus	Actions to take	Guidance and best practice
5.1 Improved dialogue and transition between paediatric and adult NHS asthma services	• Transition should not be defined by an arbitrary age cut off and should be based on developmentally appropriate healthcare and the needs and wishes of the young person. • Implementation and development of a joined-up transition process across the system. • Ensure that all relevant information is transferred with the patient during the transition into adult services and provide key points of contact and information for the patient, family and carers throughout the transition as appropriate. • The transition process needs to be clearly communicated and explained to all patients and their families and carers at an early stage and before transition. • Refer to the NICE guidance NG43 - Transition from children's to adults' services for young people using health or social care services and Quality Standard 140 that includes five quality statements.	
5.2 Communication between emergency departments and primary care	• Systems communication to inform GPs of patients who are treated in A&E or in Urgent Care Centres for an asthma attack; this will help GPs to review these patients within two working days (in line with the NICE Quality Standard: QS25). • Use electronic means to communicate and flag the need for a patient review (to implement NICE QS25) within two working days. • System communication between emergency departments and respiratory units to fast-track patients for diagnostic tests to support suspected severe asthma referral and diagnosis.	
5.3 Referral for specialist assessment for difficult and severe asthma	• Local referral pathways need to be in place to ensure that where patients have uncontrolled asthma, they can be referred for specialist assessment (in line with NICE recommendation QS25) and to a tertiary severe asthma centre where severe asthma is suspected. • Where a patient has been referred for assessment, if possible during the COVID-19 pandemic, they should be offered a virtual appointment such as via telephone, or online. • If a patient is required to attend a face to face appointment for investigations during the COVID-19 pandemic, these should be carried out in line with the NICE rapid guideline for severe asthma (NG166).	

System improvement priority 6: Medicines optimisation

The NHS Long Term Plan (3.86) states that we will do more to support those with respiratory disease to receive and use the right medication. 90% of NHS spend on asthma goes on medicines, but incorrect use of medication can also contribute to poorer health outcomes and increased risk of exacerbations and admission. Pharmacists in primary care networks will undertake a range of medicine reviews, including educating patients on the correct use of inhalers and contributing to multidisciplinary working. As part of this work they can also support patients to reduce the use of short acting bronchodilator inhalers and switch to dry powder inhalers where clinically appropriate, which use significantly less fluorinated gases than traditional metered dose inhalers. Pharmacists can also support uptake of new smart inhalers, as clinically indicated.

Key areas for focus:	
Climate change	The NHS Long Term Plan has commitments to address climate change with a specific recommendation to reduce the use of short acting bronchodilator inhalers and a move to dry powder inhalers, where clinically appropriate, which use significantly less fluorinated gases than traditional metered dose inhalers. Focussing on reducing the use of reliever inhalers will help to support climate change, however patient should use the inhaler that is best suited to their clinical need. It should also be noted that where people have more serious asthma they will need to use a spacer with a propellant inhaler in an emergency and should have one of these available, spacers cannot be used with dry powder inhalers.
Optimise inhaler choice	Patients should be given a clear explanation of the reasons why they are given a particular asthma treatment and HCPs should also ensure that patients are using their inhalers correctly at every opportunity.
Optimise inhaler technique and use	The UK Inhaler Group (UKIG) has developed standards and competencies for those prescribing inhaled medications: Inhaler Standards and Competency Document (2017). The website for health care professionals was developed on behalf of UKIG by Education for Health to promote these standards. Clinicians may also want to consider the use of RightBreathe, to support inhaler prescribing and the PCRS Asthma Right Care Slide Rule to facilitate conversations around SABA overuse.
Medicines adherance	Patients may need support to help them make the most effective use of their medicines. This support may take the form of further information and discussion, or involve practical changes to the type of medicine or the regimen. Any interventions to support adherence should be considered on a case-by-case basis and should address the concerns and needs of individual patients.

System improvement priority 6: Medicines optimisation

Key area of focus	Actions to take	Guidance and best practice
6.1 Climate change	• Educate and support clinicians to have conversations with patients and their carers about the environmental impacts, particularly on climate change, of inhalers (including used inhalers). However, patients should always use the inhalers best suited to their clinical need. • Promote and offer patients low Global Warming Potential (GWP) inhalers where clinically appropriate, in line with section 8.6 of the BTS/SIGN Asthma Guidelines. • Used pMDI (pressured metered dose inhaler) canisters may still contain propellants that contribute to climate change, remind patients to return cannisters to community pharmacies for environmentally safe disposal along with drugs waste or for recycling (where available).	
6.2 Optimise inhaler choice	• Clinicians (e.g. GPs, practice nurses, pharmacists) should use the NICE Inhaler Decision Support Aid with patients over 12 years of age and, if clinically appropriate, highlight where a lower environmental impact option such as a dry powder inhlaer (DPI) may be available. • Ensure healthcare staff are aware on the availability of new inhalers and their different techniques. • Increased accessibility to the use of smart inhalers as per the NHS Long Term Plan recommendation 1.43 (p26).	
6.3 Optimise inhaler technique and use	• Simplified treatment guidelines shoudl be available in all non-specialist areas. • All HCPs responsible for delivering respiratory care should have regular training updates. • Direct patients to Asthma + Lung UK's Inhaler videos for support on how to use their inhaler correctly. • Use the PCRS Asthma Right Care Slide Rule to facilitate conversations around SABA overuse. • Consider how to utilise pharmacists to deliver training on inhaler use and correct technique.	
6.4 Medication adherance	• Patients to receive an enhanced medication review from a clinical pharmacist in line with The Community Pharmacy Contractual Framework (2019/20 – 2023/24). • Discussions should take place between a health professional and the patient to understand any barriers to adhering to the medication regimen. These should be worked through with the patients in line with NICE guidance CG76 and specifically recommendations 1.2 on supporting adherence.	

System improvement priority 7: Supporting specific patient groups

Some patient groups may require additional or more specialised support than others at various points in their life. This could be due to the development of co-morbidities, a temporary change such as pregnancy or a patient that requires additional needs or reasonable adjustments. Having timely, accessible and correct information as well as additional support when needed will mean that their asthma can continue to be managed safely.

Key areas for focus:	
Support for children and young people	Asthma is very common in children. For most children, asthma symptoms can be easily controlled with the right treatment.
Support for people with learning disabilities	People with learning disabilities often live with a number of long term health conditions and are also at risk of dying younger when compared to the general population. They face significant health inequalities as well as poorer access to healthcare despite having greater need. The Learning Disabilities Mortality Review (LeDeR) Programme published their 2021 annual report which stated that respiratory disease was the third most common cause of death after COVID and diseases of the circulatory system.
Support for people wtih mental ill-health	People with severe mental illnesses are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease and make more use of urgent and emergency care.
Support in pregnancy	Pregnancy has been known to alter the way in which people experience their asthma. Some pregnant women find that their symptoms get worse and it can even trigger asthma that was not already diagnosed.

Key area of focus	Actions to take	Guidance and best practice
7.1 Support for children and young people	• Ensure accurate diagnosis, or where there is doubt, either refer to specialist care or communicate the uncertainty and review the diagnosis at regular intervals (as per NICE guidance). • Ensure that a child diagnosed with asthma has an up to date written action plan in place and discuss what this means with the child and their parent or care giver. Parents and care givers should be advised to share this information with their child's school (see asthma friendly schools programme). • Provide education and support that will improve understanding of asthma and how to self monitor and self-manage their condition. Direct patients, parents and care givers to support groups such as Asthma + Lung UK and Beat Asthma for advice and the Healthunlocked Community.	

System improvement priority 7: Supporting specific patient groups

Key area of focus	Actions to take	Guidance and best practice
7.1 Support for children and young people	• Ensure that children and young people receive an annual review and update their written action plan as necessary. • Prescribe medication to children based on the NICE pharmacological treatments pathway dependent on their age (under 5 or 5-16 years). • Ensure that a child diagnosed with asthma has an up to date written action plan in place and discuss what this means with the child and their parent or care giver. • Parents and care givers should be advised to share this information with their child's school - see Healthy London Partnership's Asthma Friendly Schools resources. • Refer to the National bundle of care for children and young people with asthma and the National Capabilty Framework and accompanying online learning resources for health professionals caring for children and young people with asthma.	
7.2 Support for people with learning disabilities	• Ensure that the Learning Disability Improvement Standards are known and followed across the system. • Embed respiratory checks into the Learning Disability annual health review. • Provide support and education to ensure medication is taken appropriately. Refer to STOMP, the stopping over medication of people with a learning disability, autism or both; a national project involving many different organisations which is helping to better review the use of medication and stopping them where possible. • Reasonable adjustments must be made according to individual patient need and information provided in an accessible and easy read format. • Refer to NICE learning disabilities topic landing page which includes all NICE products on people with learning disabilities (guidance, advice, NICE Pathways and quality standards).	

System improvement priority 7: Supporting specific patient groups

Key area of focus	Actions to take	Guidance and best practice
7.3 Support for people with mental ill-health	• Ensure primary care staff feel knowledgeable and confident to work with people with mental health issues and to avoid 'diagnostic overshadowing'. • People with severe mental illness (SMI) are more likely to be smokers, less likely to attend appointments and more likely to have poor adherance with their medication. Local systems should familiarise themselves with the RightCare CVD Preventiion and Improving Physical Health toolkit which addresses these issues. • Implementing simple screening questionnaires (PHQ9 and GAD7) via GPs or community respiratory services could be an easy way to identify patients with a developing or developed mental health condition. Appropriate referral or sign-posting to mental health services can then be triggered. • Work with mental health teams to ensure that asthma care is included within the person's mental health care plan. This will help both the patient and other healthcare professionals and carers to recognise the importance of treatment and to recognise the signs for when to get additional support for asthma care. • Implement social prescribing to make the most of the community-based and informal support available. Refer to guidance to help primary care networks (PCNs) introduce the new role of social prescribing link worker into their multi-disciplinary teams. • Review guidance on delivering the mental health commitments in the NHS Long Term Plan. • Refer to the NICE mental health and well-being topic landing page which includes all NICE products on mental health and well-being (guidance, advice, NICE Pathways and quality standards).	

System improvement priority 7: Supporting specific patient groups

Key area of focus	Actions to take	Guidance and best practice
7.4 Support in pregnancy	• Refer to NICE pregnancy topic landing page which includes all NICE products on pregnancy (guidance, advice, NICE Pathways and quality standards).	

System improvement priority 8: Experience of care

Experience is important in a number of different, but related ways:

- As a key part of providing high quality care: Those providing health and care services view experience as a natural part of providing high-quality care, and a good experience is now seen as an important 'outcome' in its own right.
- As a way of improving outcomes: There is strong evidence about the links between experience and the other aspects of high-quality care (clinical effectiveness and safety).
- As a way of indicating value for money and whether services are appropriate: Only by understanding what people want from their services and continually focusing on their experiences will we truly be sure we are delivering value for money.
- As a way of supporting staff engagement: There is strong evidence to show the links between staff engagement and the experience of service users.

Key areas for focus:	
Improving the experience of care for people living with asthma and their family/carers	The poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them such as people living with asthma. Also, there are concerns about unfair discrimination in access to care. People who use our services have vital insights into their care and many are experts in managing their own conditions, genuine partnerships gives patients' parity of esteem with health professionals and both improve health outcomes and contribute to more cost-effective use of services. 'Good' experience of care will result in people who use our services being more engaged with their own healthcare, leading to improved patient/service user outcomes and productivity gains for NHS services.

Key area of focus	Actions to take	Guidance and best practice
8.1 Improving the experience of care for people living with asthma and their family/carers	• Ensure that family and carers supporting people with asthma are identified and are supported to live well. • Direct patients, parents and care givers to support groups such as Asthma + Lung UK for advice or the Healthunlocked community. • Services should use experience of care feedback from patients and carers to improve services using co-production and co-design. • Localities to review current experience of care and establish plans for improvement. • Efforts should be made to identify groups within the population who do not engage with services or have poorer outcomes and make provision to assess their experiences specifically.	

System improvement priority 8: Experience of care

Key area of focus	Actions to take	Guidance and best practice
8.1 Improving the experience of care for people living with asthma and their family/carers	• Do this in a way that is accepable for people to enable them to work in partnership with their health professionals. • Staff working with people with asthma should be confident in recognising that a person may also have other health conditions and feel equipped to engage effectively with patients and carers to discuss referral(s) to wider health professionals. • Refer to NICE guideline CG138 - Patient experience in adult NHS services: improving the experience of care for people using adult NHS services.	

System enablers

System enablers are things that are required to be in place for a successful implementation of the system improvement priorities identified in this toolkit.

System enablers	Actions to take and guidance
Trained staff (asthma specialists / COPD, virtual clinics	Primary Care Respiratory Society UK: Fit to care: key knowledge skills and training for clinicians providing respiratory care (2017) General Medical Council: Specialty Training Curriculum for Respiratory Medicine - a competency-based curriculum for doctors in training (Last updated 2015) The e-Asthma programme (e-Learning for Healthcare) is an interactive e-learning resource for healthcare professionals which aims to improve the diagnosis and management of asthma as a long term condition for children and adults. It is a foundation level educational resource aimed at all healthcare professionals who come into contact with children or adults with asthma who are not asthma specialists. This includes GPs, practice nurses, pharmacists, community nurses, school nurses, ambulance staff, 0-19 teams and A&E staff. The Association for Respiratory Technology and Physiology (ARTP) – Quality Assured Spirometry Training **Practical examples** Leeds Respiratory Network: nurse-led education approach to improve the quality of respiratory care (Oct 2018). Practice nurses and respiratory specialist nurses set up the Leeds Respiratory Network to address unwarranted variation in respiratory care across the region. This all stemmed from analysing data identified through the RightCare Atlas of Variation which demonstrated that Leeds had an unwarranted variation with regards to respiratory care and outcomes, especially within primary care.
Participation in and acting upon national adults	National Asthma and COPD Audit Programme Asthma + Lung UK Annual Care Survey

System enablers

System enablers are things that are required to be in place for a successful implementation of the system improvement priorities identified in this toolkit.

System enablers	Actions to take and guidance
Patient and public awareness including parent, carers, teachers, employers etc.	Asthma + Lung UK: Health Advice – online health information and advice which is all evidence-based and regularly updated. Helpline, WhatsApp chat helpline, HealthUnlocked community. Taskforce for Lung Health's five year plan, HealthUnlocked community. Beat Asthma - education, advice and resources for children and tyoung people with asthma.
Joined up whole-system perspective	NHS England's National bundle of care for children and young people with asthma LGA and NHS Clinical Commissioners: Integrated Commissioning for Better Outcomes: a commissioning framework
Shared decision making	What is shared decision making? (NICE) Shared decision making (NHS England)
Make every contact count (MECC)	Making every contact count (Health Education England), for help and guidance when implementing MECC Making Every Contact Count, how NICE resources can support local priorities (NICE)

Guidance and best practice

This section contains all the relevant guidance, evidence and case studies aligned to each of this toolkit's system improvement priorities and key areas for focus. It supports development of improvement actions when system priorities have been identified.

NICE:
All NICE products on Asthma
• NG80: Asthma: diagnosis, monitoring and chronic asthma management
• NG6: Excess winter deaths and illness and the health risks associated with cold homes
• NG166: COVID-19 rapid guideline: severe asthma
• QS25: Asthma
• Sustainability and Transformation resource: Respiratory conditions: reducing pressure on emergency hospital services

NHS England:
• Specialised Respiratory Service Specification - severe asthma (adult)
• Spirometry commissioning guidance

Office for Health Improvement and Disparities (OHID), formerly Public Health England:
• Homes for Health - Strategies, plans, advice, and guidance about the relationship between health and the home.
• Cold weather plan for England - This plan helps prevent the major avoidable effects on health during periods of cold weather in England
• Respiratory disease: applying All Our Health

Priority 1: Risk factors that exacerbate asthma

Smoking

Guidelines

NICE pathways
- Stop smoking intervention and services
- Smokeless tobacco cessation: South Asian communities overview
- Smoking: tobacco harm-reduction approaches overview

NICE guideline:
- NG92: smoking cessation interventions and services

NICE quality standards:
- QS92 smoking: harm reduction
- QS82 smoking: reducing and preventing tobacco use
- QS43 smoking: supporting people to stop

NICE public health guidelines:
- PH26: smoking: stopping in pregnancy and after birth
- PH39: smokeless tobacco cessation in south Asian communities
- PH48 smoking: acute, maternity and mental health services
- PH45 smoking: harm reduction

OHID, formerly Public Health England:
- Smoking and tobacco: applying All Our Health

(updated 2019)

Implementation and practical examples

Asthma + Lung UK:
- Quit smoking to lower your asthma risk

Leicester NHS Stop Smoking Service, Leicestershire Partnership Trust (2014): Initiating a local tobacco harm reduction service using an outreach model

Birmingham Community Healthcare (2013): Varenicline - designing a pathway for a multi-disciplinary team (January 2013)

NHS Trafford (2011): Trafford tobacco control strategy (January 2011)

Healthy Lifestyle Service, Gloucestershire Care Services NHS Trust (2010): Toxic tobacco truths lesson resource pack (developed for the secondary school programme to reduce the uptake of smoking in young people) 2nd Edition (October 2010)

Tees Esk and Wear Valley NHS Foundation Trust (2017): Innovative ways to support smokers requiring nicotine management in a mental health organisation

Primary Care Respiratory Society (PCRS) UK: Tobacco dependency pragmatic guide The guide is a practical, immediately implementable, evidence-based framework to enable healthcare professionals to routinely identify smokers, encourage a quit attempt and support that quit attempt within the real-world context of their own professional sphere.

Priority 1: Risk factors that exacerbate asthma

Obesity and lack of exercise

Guidelines

NICE clinical guidance:
- CG43: Obesity prevention (Updated 2015)
- CG189: Obesity: identification, assessment and management (2014)

NICE quality standards:
- QS111: Obesity in adults: prevention and lifestyle weight management programmes (2016)
- QS94: Obesity in children and young people: prevention and lifestyle weight management programmes (2015)
- QS183: Physical activity: encouraging activity in the community - quality standard (June 2019)

NICE public health guidelines:
- PH42: Obesity: working with local communities (updated 2017)
- PH47: Weight management: lifestyle services for overweight or obese children and young people (2013)
- PH53: Weight management: lifestyle services for overweight or obese adults (2014)
- PH54: Physical activity: exercise referral schemes (2014)

OHID, formerly Public Health England:
- Adult obesity: applying All Our Health evidence and guidance for healthcare professionals, to help people change their eating and activity habits
- Physical activity: applying All Our Health evidence and guidance to help healthcare professionals embed physical activity into daily life.
- Health matters: getting every adult active every day resources to help increase population physical activity and highlighting the associated benefits.

Implementation and practical examples

OHID, formerly Public Health England:
- All Our Health: E-Learning Adult Obesity the information in this session will help all health and care staff use their trusted relationships with patients, families and communities to promote the benefits of achieving and maintaining a healthy weight.
- Healthier weight promotion: consistent messaging a set of training tools providing evidence-based healthy weight messages for health and social care professionals to give to children, young people and families.
- Box Chicken: providing healthy competition to fast food outlets a pilot fast food takeaway project, providing a healthy alternative to fried chicken, for schools and the local community
- Planning document to limit the proliferation of takeaways the number of new hot food takeaways are being limited in areas with high levels of child obesity, using a supplementary planning document.
- Beat the Street: getting communities moving Beat the Street energises whole communities, using a simple game to get people moving
- Creating a culture of physical activity in Sheffield Move More is a Sheffield-wide strategy that aims to make Sheffield the most active city in the UK by 2020.
- Weight management: guidance for commissioners and providers guides to support the commissioning and delivery of tier 2 weight management services for children, families and adults.

Asthma + Lung UK:
- Getting active when you have asthma
- Can losing weight help your asthma?

Priority 1: Risk factors that exacerbate asthma

Low uptake of flu and pneumonia vaccine

Guidelines

NICE guideline:
- NG103: Flu vaccination: increasing uptake (2018)

NICE quality standard:
- QS190: Flu vaccination: increasing uptake (2020)

NHS England:
- CQUIN Guidance for 2023/23: CCG1: Flu vaccinations for frontline health workers

Pharmaceutical Services Negotiating Committee (PSNC) and NHS England:
- Service Specification: Community pharmacy seasonal influenza vaccination advanced service

Implementation and practical examples

International Longevity Centre:
- Under the skin: listening to the voices of older people in influenza immunisation (2019)

Public Health Matters Blog:
- Increasing vaccine uptake: Strategies for addressing barriers in primary care (2019)

Asthma + Lung UK:
- Flu vaccinations for people with asthma

Priority 1: Risk factors that exacerbate asthma

Non adherance/compliance with treatment

Guidelines

NICE clinical guideline:

- NG70: Air pollution: outdoor air quality and health
- CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence

NICE quality standards:

- QS25: Quality statement 3: Monitoring asthma control
- QS190: flu vaccination: increasing uptake

Implementation and practical examples

Asthma + Lung UK:

- Connected Asthma (2016): How technology will transform care

Priority 2: Environmental considerations

Air pollution (outdoor)

Guidelines

NICE guidelines:
- NG6: Excess winter deaths and illness and the health risks associated with cold homes
- NG80: Asthma: diagnosis, monitoring and chronic asthma management
- NG70: Air pollution: outdoor air quality and health

NICE quality standard:
- QS181: Air pollution: outdoor air quality and health

NICE sustainability and transformation resource:
- Respiratory conditions: reducing pressure on emergency hospital services

OHID, formerly Public Health England:
- Health matters: air pollution a resource focusing on air pollution: sources, impacts and actions

Implementation and practical examples

Health Outcomes of Travel Tool: Developed by the Sustainable Development Unit (SDU), whose work is now being taken forward by the Greener NHS programme.

Department for Environment, Food and Rural Affairs: Daily Air Quality Index

Centre for Sustainable Energy:Condensation, damp and mould advice

World Health Organisation: Damp and mould infomation brochure

Royal College of Physicians and Royal College of Paediatrics and Child Health report: Every breath we take: the lifelong impact of air pollution (2016)

Local Government Association: Healthy Homes, Healthy Lives

GOV.UK: Affordable warm grants scheme

OHID, formerly Public Health England:
- Health matters on air pollution (short summary and infographics)

Asthma + Lung UK:
- Air pollution
- Air pollution and asthma

Priority 2: Environmental considerations

Occupational exposure

Guidelines

NICE guideline:

- NG80: recommendation 1.1.10 - Occupational asthma

Asthma + Lung UK:

- Occupational asthma

Implementation and practical examples

British Occupational Health Research Foundation: Occupational Asthma – includes:

- A guide for occupation health professionals, safety professionals and safety representatives (2010)
- A guide for employers, workers and their representatives (2010)
- A guide for GPs and practice nurses (2010)
- Case finding and management in primary care

Standards of care for occupational asthma: an update (2012)

Health & Safety Executive: List of the top jobs with highest rates of occupational asthma, each with links to tips and advice on how to protect yourself in the workplace.

Priority 2: Environmental considerations

Cold or poor quality housing

Guidelines

NICE guideline:
- NG6: Excess winter deaths and illness and the health risks associated with cold homes (2015)
- NG149: Indoor air quality at home (2020)

NICE quality standard
- QS117: Preventing excess winter deaths and illness associated with cold homes (2016)

NICE quick guide:
- Helping to prevent winter deaths and illnesses associated with cold homes

NICE sustainability and transformation resource:
- Respiratory conditions: reducing pressure on emergency hospital services

OHID, formerly Public Health England:
- Cold weather plan for England (updated 2019)

WHO Europe:
- Guidelines for indoor air quality: Dampness and Mould (2009)

Implementation and practical examples

Local Government Association:
- Health homes, healthy lives (2014)

NHS Choices:
- How do I get rid of damp and mould? (2018)

WHO Europe:
- Damp and Mould: Health risks, prevention and remedial action (2009)

Help from your energy supplier: The Affordable Warmth Obligation

Affordable warmth grants

NEA Action for Warm Homes

Asthma + Lung UK:
- Indoor asthma triggers

Priority 3: Early detection and accurate diagnosis

Know your population

Guidelines

NICE quality standard:

- QS25: quality statement 1: Objective tests to support diagnosis (updated 2018)

NHS England:

- Spirometry Commissioning Guidance

Asthma + Lung UK:

- On the edge: How inequality affects people with asthma (2018)

Implementation and practical examples

Primary Care Respiratory Society UK:

- The nine processes to achieve Asthma Right Care (ARC)
- Asthma Right Care (ARC) Slide Rule

Health Education England:

- Health Literacy Toolkit

Priority 3: Early detection and accurate diagnosis

Follow diganostic guidelines according to age group

Guidelines

NICE guidelines:
- NG80: 1.2 Diagnosing asthma in young children
- NG80: 1.3 Objective tests for diagnosing asthma in adults, young people and children aged 5 and over
- NG80: 1.4 Diagnostic summary
- NG166: COVID-19 rapid guideline: severe asthma

NHS England:
- Spirometry commissioning guidance

British Thoracic Society (BTS/SIGN):
- British guideline on the management of asthma – Chapter 3 on diagnosis

Primary Care Respiratory Society UK:
- Fit to Care - key knowledge, skills and training for clinicians providing respiratory care

Implementation and practical examples

Asthma + Lung UK:
- Asthma
- A guide to getting an asthma diagnosis for your child
- When your child is diagnosed

Primary Care Respiratory Society UK:
- Asthma Guidelines in Practice – A PCRS Consensus was commissioned to provide clarity on aspects of diagnosis, management and monitoring of asthma that are uncertain due to differences between current national guidelines
- Early and accurate respiratory diagnosis

Priority 3: Early detection and accurate diagnosis

Primary care diagnostic hubs overseen by specialists

Guidelines

NICE guidelines:

- NG80: 1.3.1 Diagnostic Hubs

Implementation and practical examples

Primary Care Respiratory Society UK:

- FeNO Testing For Asthma Diagnosis - A PCRS consensus
- Poorly controlled and severe asthma: triggers for referral for adult or paediatric specialist - a PCRS pragmatic guide

Priority 4: Optimal management and personalised care

Use of asthma action plan

Guidelines

NICE quality standard:

- QS25: Quality Statement 2: written personalised action plan (updated 2018)

Implementation and practical examples

Asthma + Lung UK:

- Asthma action plans
- Downloadable asthma action plan
- Asthma attacks

Primary Care Respiratory Society:

- Fit To Care: Key knowledge, skills and training for clinicians providing respiratory care

Priority 4: Optimal management and personalised care

Use of patient activation strategies

Guidelines

OHID, formally Public Health England:

- Local action on health inequalities: Improving health literacy to reduce health inequalities.

The Kings Fund (2014):

- Supporting people to manage their health - an introduction to patient activation

Implementation and practical examples

NHS England:

- Module 1: PAM – implementation quick guide
- Patient Activation Measures: West London CCG case study

The Health Foundation: Webinar: Understanding and using the Patient Activation Measure in the NHS

NICE:

- Patient Decision Aid for asthma inhlaers and climate change

Asthma + Lung UK:

- Asthma attack risk checker

Health Education England:

- Health Literacy Toolkit

Priority 4: Optimal management and personalised care

Self management using digital tools where appropriate

Guidelines

NICE guideline:

- NG80: 1.10 self management
- NG80: 1.10.2 Increasing ICS treatment within a self-management programme

British Thoracic Society/SIGN:

- British guideline on the management of asthma – chapter 5, Self Management

Implementation and practical examples

Asthma + Lung UK:

- Smart inhalers
- Breathe Easy support groups

Primary Care Respiratory Society UK:

- DIY Self Management
- Supported self management case histories
- Patient support for self-management of respiratory disease
- Supported self-management for respiratory conditions

Asthma + Lung UK:

- Digital health: key resources
- Smart asthma report (2017)
- Breath Easy Groups

HealthUnlocked: The world's largest network for health

Priority 4: Optimal management and personalised care

Structured annual review

Guidelines

NICE guideline:
- NG80: 1.13 Monitoring asthma control
- CKS: Asthma: Scenario follow-up - RCP 3 questions

Quality and Outcomes Framework Guidance:
- Asthma Indicator AST0003

British Thoracic Society/SIGN:
- British Guideline on the management of asthma – Chapter 4, Monitoring asthma (*Table 7: Components of an asthma review, pg30*)

Department of Health and Social Care:
- Community Pharmacy Contractual Frameowrk 2019 to 2024

Implementation and practical examples

Asthma + Lung UK:
- How to get the best from your annual review

Primary Care Respiratory Society UK:
- Building blocks of a good asthma review
- Why I hate asthma reviews

Priority 5: Referral and system communications

Improved dialogue and transition between paediatric and adult asthma services

Guidelines

NICE guideline:

- NG43: Transition from children's to adults' services for young people using health or social care services

NICE quality standard:

- QS140: Transition from children's to adults' services

University Hospital Southampton NHS Foundation Trust:

- Transition to adult care: Ready Steady Go

Implementation and practical examples

NHS England:

- Diabetes transition service specification

Asthma + Lung UK:

- Transition from child to adult asthma care

South East Strategic Clinical Networks (2015) Transition of children and young people to adult services: best practice pathways guidance

Rogers J, Brook L. ENT and Audiology News. 25(6) (2017): 10 steps to improving transition to adult services

University Hospital Southampton NHS Foundation Trust: Implementing transition care locally and nationally using the 'Ready Steady Go' programme (2017)

Priority 5: Referral and system communications

Communication between emergency departments and primary care

Guidelines

NICE quality standard:

- QS25: quality statement 4: People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within two working days of discharge (updated 2018)

Asthma + Lung UK:

- What to do after an asthma attack

Implementation and practical examples

Primary Care Respiratory Society UK:

- Diagnosing and managing asthma attacks and people with COPD presenting in crisis during the UK Covid 19 epidemic - a pragmatic guide

Priority 5: Referral and system communications

Referral for specialist assessment for diffcult and severe asthma

Guidelines

NICE quality standard:

- QS25: quality statement 5: People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service. (updated 2018)

NHS England:

- Severe asthma (adult) specialised respiratory service specification

Asthma + Lung UK:

- Difficult to control asthma
- Severe asthma

Implementation and practical examples

Asthma + Lung UK:

- Difficult and severe asthma: Slipping through the net: The reality facing patients with difficult and severe asthma
- Living in Limbo: The scale of unmet need in difficult and severe asthma

Prmary Care Respiratory Society UK:

- Poorly controlled and severe asthma: triggers for referral for adult or paediatric specialist care – a PCRS pragmatic guide

Priority 6: Medicines optimisation

Climate change

Guidelines

NHS England:

- Further resources are available from the Greener NHS programme and in the "Tools & Resources" section of the Greener NHS programme's FutureNHS workspace. For any queries, please email sustainabilitynetwork-manager@future.nhs.uk
- Network Contract Directed Enhanced Service Investment and Impact Fund 2022/23: Updated Guidance includes indicators to incentivise the prescription of both lower carbon devices and fewer reliever inhalers'
- Investment and Impact Fund (IIF) 2022/23 one page summary for primary care teams

Implementation and practical examples

BTS/SIGN asthma guidance section 8.6
'Environmental impact of metered dose inhalers'

Recycle Now: What to do with Inhalers: Safe disposal

Office for Health Improvement and Disparities (OHID), formerly Public Health England case studies:

- Reduced bus emissions and improved air quality in Brighton and Hove
- ECO Stars Fleet Recognition Scheme
- BLF new data on pollution levels around hospitals and surgeries
- Clean Air Day 2018: UK's largest air pollution campaign
- Primary school celebrates Clean Air Day with street party

Priority 6: Medicines optimisation

Optimised inhaler choice

Guidelines

NICE guidelines:
- NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes
- NG80: Asthma: diagnosis, monitoring and chronic asthma management

NICE clinical guideline:
- CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence

NICE quality standard:
- QS120: Medicines optimisation

NICE Sustainability and Transformation resource:
- Medicines optimisation

NHS Business Services Authority:
- Respiratory dashboard

DHSC, NHS England, PSCN:
- The Community Pharmacy Contractual Framework (2019-2024) (July 2019)

Implementation and practical examples

NICE Patient Decision Aid: Inhalers for Asthma

Primary Care Respiratory Society UK:
- Fit to care: key knowledge skills and training for clinicians providing respiratory care (2017)
- Inhaler devices
- The importance of choosing the right inhaler
- Asthma Right Care (ARC) Slide Rule

NICE Shared Learning Database:
- Isle of Wight respiratory inhaler project (2011) - poor inhaler technique was an issue for the Isle of Wight PCT, as across the NHS. Through a simple, patient-led intervention, significant reductions in hospital admissions and the cost of medication have been achieved. So much so that the Isle of Wight now has the lowest standardised admission rate for asthma in the UK.

Priority 6: Medicines optimisation

Optimal inhaler technique

Guidelines

Asthma + Lung UK:

- How to use your inhaler videos

Primary Care Resiratory Society UK:

- Inhaler technique tips

Implementation and practical examples

NHS City and Hackney CCG (2016) Impact of a pharmacist-led Asthma and COPD respiratory clinic in General Practice

Capstick T, Burnley M, Higgins (2019) HP234 Improving in inhaler technique: a community pharmacy service. Thorax 2019;74:A217-A218

Priority 6: Medicines optimisation

Medication adherance

Guidelines

NICE clinical guideline:

- CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherance

NICE quality standard:

- QS25: quality statement 3: Monitoring asthma control

Implementation and practical examples

Primary Care Respiratory Society UK:

- The nine processes to achieve Asthma Right Care (ARC)
- Asthma Right Care (ARC) Slide Rule

Priority 7: Supporting specific patient groups

Support for children and young people

Guidelines

NICE guideline:

- NG43: Transition from children's to adult's services for young people using health or social care services
- NG80: 1.8 Pharmacological treatment pathway for children under 5
- NG80: 1.7 Pharmacological treatment pathway for children and young people aged 5 to 16

NHS England:

- National bundle of care for children and young people with asthma - this is phase one of a plan to support integrated care systems to deliver high quality asthma care. The resource pack should be used in conjunction with the other documents to support the implementation of the deliverable.

Department for Education (2017) Supporting pupils with medical conditions at school – statutory guidance about the support that pupils with medical conditions should receive at school.

Implementation and practical examples

Asthma + Lung UK:

- Child asthma action plan
- Asthma and my child
- School asthma card

Health Education England:

- Online learning resources for health professionals caring for children and young people with asthma.

Healthy London Partnership:

- Asthma friendly schools programme - The asthma friendly schools programme sets out clear, effective partnership arrangements between health, education and local authorities for managing children and young people with asthma at primary and secondary schools.

HealthUnlocked: World's largest social network for health - support for parents and carers

Priority 7: Supporting specific patient groups

Support for people with learning disabilities

Guidelines

NICE: Learning disabilities topic landing page

NICE guidelines:
- NG96: Care and support of people growing older with learning disabilities
- NG93: Learning disabilities and behaviour that challenges: service design and delivery
- NG54: Mental health problems in people with learning disabilities: prevention, assessment and management
- NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

NICE quality standards:
- QS142: Learning disability: identifying and managing mental health problems
- QS101: Learning disability: behaviour that challenges
- QS187: Learning disability: care and support of people growing older

NHS England:
- Learning Disability Improvement Standards for NHS Trusts
- Stopping over medication of people with a learning disability, autism or both (STOMP)

NHS Digital:
- Health and care of people with learning disabilities: 2017-18

Implementation and practical examples

Asthma + Lung UK
Easy Read resources:
- Easy read: asthma attack card
- Easy read: all about asthma
- Easy read: medicine card

Helping people get the right medicines in Bury – case study looking at how people with learning disabilities, autism or both are getting the correct medicines. NHS England

Priority 7: Supporting specific patient groups

Support for people with mental ill-health

Guidelines

NICE:
All NICE products on mental health and wellbeing

OHID, formally Public Health England:
- Prevention concordat for better mental health
- Wellbeing and mental health: applying All Our Health

NHS Health Education England / UCLPartners:
- Breaking down the barriers

NHS England:
- NHS Mental Health Implementation Plan 2019/20 – 2023/24
- Improving the physical health of people with mental health problems: Actions for mental health nurses
- RightCare Toolkit: Physical ill-health and cardiovascular disease prevention in people with severe mental illness
- Universal Personalised Care: Implementing the Comprehensive Model
- Social prescribing link workers - a guide for primary care networks

NHS Health Education England / PHE: e-learning on: community-centered approached to health improvement

Implementation and practical examples

West Suffolk CCG: Expansion of mental health support for those with a long-term health condition (2019)

Asthma + Lung UK:
- Managing your depression

Screening questionnaires to identify patients with a developing or developed mental health condition:
- Patient Health Questionnaire PHQ-9
- General Anxiety Disorder Assessment GAD-7

Cochrane database of systematic reviews:
- Yorke J, Fleming SL, Shuldham C: Psychological interventions for adults with asthma (2006)
- Thabrew H, Stasiak K, Hetrick SE, Wong S, Huss JH, Merry SN: e-health interventions for anxiety and depression in children and adolescents with long-term physical conditions (2018)

Priority 7: Supporting specific patient groups

Support in pregnancy

Guidelines

NICE topic page for pregnancy

BTS/SIGN158 (July 2019 update): British guideline on the management of asthma (pg126)

Implementation and practical examples

Asthma + Lung UK: Asthma and pregnancy

NHS: Asthma and pregnancy - your pregnancy and baby guide

Priority 8: Experience of care

Improving the experience of care for people living with asthma and their family/carers

Guidelines

NICE guideline:

- NG86: People's experience in adult social care services: improving the experience of care and support for people using adult social care services

NICE clinical guidelines:

- CG138: Patient experience in Adult NHS Services: improving the experience of care for people using adult NHS services
- CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services

NICE sustainability and transformation resources: mental health

NHS England: Commitment to carers

National Quality Board: Improving experiences of care: our shared understanding and ambition (2015)

Implementation and practical examples

The Beryl Institute: Patient experience resources

A Co-production Model - Coalition for collaborative care

NHS England:

- Improving experience of care through people who use services (2015)
- An integrated approach to identifying and accessing carer health and wellbeing (2016)
- Insight resources
- Always Events

NHS Improvement: Patient experience improvement framework (2018)

Patient Experience Network: Case studies

Picker: Always Events: what have we leaned so far? (2018)

Self-assessment questionnaire

The aim of the self-assessment questionnaire is to assist local systems and services to reflect on their current service provision and to identify where there are opportunities to improve across the pathway. These questions should be used alongside other resources to facilitate discussion and identify improvement opportunities or exemplars of good practice. The self-assessment questions have been developed in partnership with our stakeholders.

Specifically these questions are designed to:
- Assess the existing system provision of services and quality care for people along the pathway.
- Identify any current gaps in service provision and current opportunities to enhance or develop services/systems at a local level.
- Consider future demand, using local intelligence alongside projected data to ensure accuracy and consistency.
- Assess the progress of any system improvements over time.

For each question, please select the response (using the interactive buttons) which best describe your current asthma service provision. Response options are:
- Yes = Met
- Partly = Partly met
- No = Not met
- N/A = Not applicable

A page for notes and comments is included at the end.

Please note that there is also an interactive self-assement tool available within the Asthma Toolkit page of the National RightCare FutureNHS site. Please note that you will need to regsister as a member of FutureNHS.

If you wish to complete and save this questionnaire please enter your organisation name and date of completion below.

Name of organisation:_____ Questionnaire response date:_____ Completed by:_____

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Risk factors that can exacerbate asthma	1.1	Do you record the smoking status of your asthma patients and refer those who smoke to local stop smoking services (where available)?	☐	☐	☐	☐
	1.2	Do you have alternative methods of providing stop smoking support where there are no local services available e.g community pharmacists or prescription of stop smoking medicines?	☐	☐	☐	☐
	1.3	Are all healthcare staffed involved in providing asthma care trained in providing brief advice to stop smoking?	☐	☐	☐	☐
	1.4	Do you refer patients to weight management and exercise referral schemes if they are commissioned and available in your local area?	☐	☐	☐	☐
	1.5	Do you target at risk patients, their carers and healthcare workers to receive their influenza and pneumococcal vaccinations?	☐	☐	☐	☐
	1.6	Do you educate and raise awareness in your population about the importance of receiving appropriate vaccines (implementing the NICE Quality Standard QS190: Flu vaccination: increasing uptake)?	☐	☐	☐	☐
	1.7	Do you commission pharmacies to provide the flu and pneumococcal jab for at risk groups to increase uptake where patients may find it difficult to come into their GP surgery?	☐	☐	☐	☐
	1.8	Do you undertake shared decision making with patients over medication choice to understand any barriers to adherence and to ensure that any regimen suits their lifestyle and personal preferences?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Environmental factors for consideration	2.1	Have you undertaken any work within your local system and with partners, e.g. the local authority, to investigate opportunities to reduce air pollution such as the use of virtual clinics and telemedicine?	☐	☐	☐	☐
	2.2	In your local system have you considered the impact on air quality when procuring vehicles (ultra low emissions vehicle being an NHS Long Term Plan priority)?	☐	☐	☐	☐
	2.3	Have you implemented no-idling zones on NHS sites and utilised Clean Air Zones developed by the local authority as per NICE guidance NG70?	☐	☐	☐	☐
	2.4	Do you ensure that people with suspected occupational asthma are referred to an occupational asthma specialist as per NICE recommendation 1.1.11?	☐	☐	☐	☐
	2.5	Do healthcare prefessionals ask about damp and mould when undertaking a respiratory consultation and direct patients to the NHS Choices website (How do I get rid of damp and mould?) or the 2009 WHO brochure on damp and mould for the public for further information?	☐	☐	☐	☐
	2.6	Do you work with local authorities to support the healthy homes initiative and signpost patients who live in poor or cold housing to initiatives such as the Affordable Warm Grants scheme?	☐	☐	☐	☐
	2.7	Have staff undertaken the free e-learning module Helping People Living in Cold Homes, which supports health and social care professionals to put NICE Guidance NG6 ‘Excess winter deaths and illness and the health risks associated with cold homes’ into practice?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Early detection and accurate diagnosis	3.1	When reviewing asthma registers, do you give particular attention to those from more deprived or BAME groups to ensure they have been receiving their annual review?	☐	☐	☐	☐
	3.2	Do you provide easy to read or tailored information to ensure that all patients are supported to access respiratory services, including those with poor health literacy?	☐	☐	☐	☐
	3.3	Do you identify asthma patients who have had multiple acute care episodes, a high OCS use or are over-reliant on SABA, and review their medications?	☐	☐	☐	☐
	3.4	Do you have a strategy in place to ensure that all patients with uncontrolled asthma (as per the NICE definition), difficult to treat or suspected severe asthma are referred for specialist assessment?	☐	☐	☐	☐
	3.5	Do you ensure that a patient diagnosed with severe asthma has a flag put on their patient record?	☐	☐	☐	☐
	3.6	Do you ensure diagnosis is confirmed by appropriately trained health professionals, in line with NICE guidelines and irrespective of age?	☐	☐	☐	☐
	3.7	Has your local system establishing asthma diagnostic hubs to achieve economies of scale and improve the practicality of implementing the recommendations in the NICE asthma guidelines?	☐	☐	☐	☐
	3.8	If not, have you considered implemented asthma diagnostic hubs?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Optimal management and personalised care	4.1	Do you ensure that all patients have a comprehensive care plan in line with NICE QS25 statement 2, that has been created with a relevant healthcare professional who is suitably trained in line with PCRS Fit to Care, that includes emergency care advice and planning?	☐	☐	☐	☐
	4.2	Do you have processes in place to ensure the patient's asthma action plan is regularly reviewed and updated?	☐	☐	☐	☐
	4.3	Do you have systems in place to flag patients who would benefit from a re-view or referral to specialist asthma services (e.g. based on exacerbations and OCS/SABA use)?	☐	☐	☐	☐
	4.4	Do you use tools such as Patient Activation Measure (PAM) or the NICE de-cision aid on asthma inhalers to determine optimal treatment and to support self-management?	☐	☐	☐	☐
	4.5	Are healthcare staff aware of resources available on Asthma + Lung UK to support self-management such as videos on how to correctly use inhalers and asthma attack risk checker tools and signpost patients to them?	☐	☐	☐	☐
	4.6	Do you signpost patients to other support services such as websites, the third sector and community pharmacists to access support in between appointments?	☐	☐	☐	☐
	4.7	Do you currently commission community asthma clinics for your local population?	☐	☐	☐	☐
	4.8	If not, have you considered the benefits of providing this service to your local population?	☐	☐	☐	☐
	4.9	Do you have plans in place to increase accessibility to the use of smart inhalers in line with the NHS Long Term Plan (1.43)?	☐	☐	☐	☐
	4.10	Are clinical pharmacists based in GP practices supporting the proactive delivery of annual reviews by undertaking audits to identify patients who haven't received an annual review or where a patient has uncontrolled asthma?	☐	☐	☐	☐
	4.11	Are there systems in place to ensure that patients receive an enhanced medication review from either their GP or a clinical pharmacist in line with The Community Pharmacy Contractual Framework (2019 - 2023/24) where this review covers the NICE recommendations for monitoring asthma control?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Referal and system communication	5.1	Do you have clear policies and a joined-up process for transition between child and adult services which is implemented and known across all services?	☐	☐	☐	☐
	5.2	Upon transition is all relevant information transferred with the patient during the transition into adult services and key points of contact and information provided to the patient, family and carers throughout?	☐	☐	☐	☐
	5.3	Is this process clearly communicated and explained to patients and their families and carers at an early stage and before transition happens?	☐	☐	☐	☐
	5.4	Do your services refer to the NICE guidance NG43 ‘Transition from children’s to adults’ services for young people using health or social care services’ and the Quality Standard 140?	☐	☐	☐	☐
	5.5	Are there systems and processes in place (including electronic) to inform GPs of patients who are treated in A&E or in Urgent Care Centres for an asthma attack to ensure that GPs are able to review these patients within two working days?	☐	☐	☐	☐
	5.6	Do you have local referral pathways in place that are followed by all to ensure patients with uncontrolled asthma can be referred for specialist assessment and to a tertiary severe asthma centre where severe asthma is suspected?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-Assesment Questions	Yes	Partly	No	N/A
Medicines optimisation	6.1	Do you provide education and support to clinicians around the environmental impact, particularly on climate change, of different inhalers (including used inhalers)?	☐	☐	☐	☐
	6.2	Do you promote, In line with section 8.6 of the BTS/SIGN asthma guidelines, low global warming potential (GWP) inhalers where clinically appropriate to patients?	☐	☐	☐	☐
	6.3	Is the NICE decision aid on asthma known and routinely used with patients and, if clinically appropriate, patients are advised where a lower environmental impact option, such as DPI may be available?	☐	☐	☐	☐
	6.4	Is the Primary Care Respiratory Society's Asthma Right Care Slide Rule known by healthcare professionals as a tool to facilitate conversations around SABA overuse?	☐	☐	☐	☐
	6.5	Are pharmacists being used effectively to deliver training on inhaler use and correct technique to patients?	☐	☐	☐	☐
	6.6	Are there regular training updates for all healthcare professionals responsible for delivering respiratory care, including on the availability of new inhalers and their different techniques in using them?	☐	☐	☐	☐
	6.7	Do you promote shared decision making between health professionals and the patient, to understand any barriers to adhering to medications and work through these in line with NICE guidance CG76 and specifically recommendation 1.2 on supporting adherence?	☐	☐	☐	☐
	6.8	Are individuals involved in decisions about their treatment and care, including, for example, offering accessible information about medication, its benefits and side effects, and discussing this with individuals so they can make an informed choice about their treatment?	☐	☐	☐	☐
	6.9	Are regular reviews undertaken of patients' medication and any side effects that they may be experiencing?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Supporting specific patients groups	7.1	Do you ensure that all children who have a diagnosis of asthma have an up to date written action plan in place, that is reviewed regularly and as necessary, and that this is discussed with the child and their parent and care giver?	☐	☐	☐	☐
	7.2	Do you direct parents and care givers to share this information with their child's school?	☐	☐	☐	☐
	7.3	Do you ensure medication is prescribed to children based on the NICE pharmacological treatments pathway dependent on their age (under 5 or 5-16 years)?	☐	☐	☐	☐
	7.4	Do you provide signposting and guidance to patients, parents and care givers to support groups such as Asthma + Lung UK's Parents' Facebook page or the Healthunlocked community website?	☐	☐	☐	☐
	7.5	Are the Learning Disability Improvement Standards for NHS Trusts known and followed across the system?	☐	☐	☐	☐
	7.6	Is appropriate support and education provided to people with a learning disability to ensure medication is taken appropriately?	☐	☐	☐	☐
	7.7	Are healthcare staff made aware of the dangers of overprescribing of medication for people with a learning disability, autism or both? See STOMP for guidance.	☐	☐	☐	☐
	7.8	Are reasonable adjustments routinely made for people with learning disabilities to enable better flu vaccination uptake and do you offer intra-nasal vaccination for needle-phobic patients?	☐	☐	☐	☐
	7.9	Are easy read resources available for those who need them, especially for treatment plans and medication directives?	☐	☐	☐	☐
	7.10	Are all staff, including reception staff, trained to understand the needs of different population groups and how to make them comfortable when accessing services?	☐	☐	☐	☐
	7.11	Are primary care staff trained sufficiently so they feel knowledgeable and confident to work with people with mental health issues and to avoid 'diagnostic overshadowing?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Supporting specific patients groups (continued)	7.12	Have you used the RightCare CVD Prevention and Improving Physical Health Toolkit, which addresses CVD risk factors in those with severe mental illness?	☐	☐	☐	☐
	7.13	Do you use screening questionnaires (e.g. PHQ9 and GAD7) via GPs or community respiratory services to identify patients with a developing or developed mental health condition and then refer them on or signpost them to appropriate mental health services?	☐	☐	☐	☐
	7.14	Do you work with mental health teams to ensure that asthma care is included within the person's mental health care plan to help both the patient and healthcare professionals and carers to recognise the importance of treatment and signs for when to get additional support for asthma care?	☐	☐	☐	☐
	7.15	Have you implemented social prescribing to make the most of the community-based and informal support available?	☐	☐	☐	☐
	7.16	Have you reviewed the guidance on delivering the mental health commitments in the NHS Long Term Plan?	☐	☐	☐	☐
	7.17	Does the GP or asthma nurse undertake a review of asthma medications, inhaler technique and written asthma action plans for all pregnant patients?	☐	☐	☐	☐
	7.18	Is the workforce that supports pregnant patients, i.e. midwives and health visitors, aware that they have asthma and that it is noted in their birth plan?	☐	☐	☐	☐
	7.19	If the pregnant patient has severe asthma, do you consider the need for an asthma specialist as well as an obstetrician to care for the patient during their pregnancy?	☐	☐	☐	☐

Self-assessment questionnaire

Priority areas		Self-assesment questions	Yes	Partly	No	N/A
Experience of care	8.1	Do you have a mechanism in place to collect patient experience of asthma clinics and services for individual sites and providers and across the whole system?	☐	☐	☐	☐
	8.2	Do you use the experience of care feedback from patients and carers on an ongoing basis to improve and develop services (e.g. undertake analysis of complaints)?	☐	☐	☐	☐
	8.3	Do you work with third sector organisations to engage and support patients to access services, particularly in more disadvantaged groups who may not be accessing services?	☐	☐	☐	☐
	8.4	Do you have patient voice representation on local asthma groups (where they exist)?	☐	☐	☐	☐
System enablers	9.1	Are all staff trained in the principles of Making Every Contact Count (MECC) and is this embedded across your system?	☐	☐	☐	☐
	9.2	Do your services take part in national audits (e.g NACAP) and act upon the findings to improve services?	☐	☐	☐	☐
	9.3	Are people with asthma actively involved in shared decision making and supported in self-management of their condition, e.g. use of personalised action plans, and does this plan address the full needs of the individual, including wider social issues such as housing problems that may impact on health?	☐	☐	☐	☐

Self-assessment questionnaire

Please use the box below to add any notes or comments

Acknowledgements

We would like to thank the following organisations for their input into the production of this toolkit:

- Asthma + Lung UK
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