

**NATIONAL INSTITUTE FOR HEALTH AND CARE  
EXCELLENCE**

**Asthma**

**NICE quality standard**

**Draft for consultation**

April 2018

**This quality standard covers** diagnosing, monitoring and managing asthma in children, young people and adults. It describes high-quality care in priority areas for improvement.

**It is for** commissioners, service providers, health, public health and social care practitioners, and the public.

This quality standard will update the existing quality standard on [asthma](#) (published February 2013). For more information see [update information](#)

This is the draft quality standard for consultation (from 20 April to 29 May 2018). The final quality standard is expected to publish in September 2018.

## Quality statements

[Statement 1](#) People aged 5 and over with suspected asthma have objective tests to support diagnosis. **[2013, updated 2018]**

[Statement 2](#) People aged 5 and over with asthma have a written personalised action plan. **[2013]**

[Statement 3](#) People with asthma have their asthma control monitored at every review. **[2013, updated 2018]**

[Statement 4](#) People who receive hospital treatment for an asthma attack are followed up by their GP practice within 2 working days of discharge. **[2013, updated 2018]**

[Statement 5](#) People with severe asthma are referred to a specialist severe asthma service for assessment. **[2013, updated 2018]**

In 2018 this quality standard was updated and statements prioritised in 2013 were updated (2013, updated 2018). For more information, see [update information](#).

Statements from the 2013 quality standard for asthma that may still be useful at a local level, but are no longer considered national priorities for improvement:

- Adults with new onset asthma are assessed for occupational causes.
- People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
- People with asthma receive a structured review at least annually.
- People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
- People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
- People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

The [2013 quality standard for asthma](#) will be available as a pdf when the update is published.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing asthma services include:

- [Emergency and acute medical care in over 16s](#). Publication expected September 2018
- [Chronic obstructive pulmonary disease in adults](#) (2016) NICE quality standard 10
- [Transition from children's to adults' services](#) (2016) NICE quality standard 140
- [Medicines optimisation](#) (2016) NICE quality standard 120
- [Smoking: supporting people to stop](#) (2013) NICE quality standard 43

A full list of NICE quality standards is available from the [quality standards topic library](#).

## Questions for consultation

### ***Questions about the quality standard***

**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?

**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

### ***Questions about the individual quality statements***

**Question 4** For draft quality statement 2: Which specific components of the written personalised action plan are most important? Would it be helpful to focus on ensuring specific components are included in the written personalised action plan?

**Question 5** For draft quality statement 5: We have suggested using the European Respiratory Society/American Thoracic Society definition of severe asthma in line with NHS England's [specification for adult specialised respiratory services for severe asthma](#). Is this reasonable and will it be possible to identify this population in practice?

### ***Local practice case studies***

**Question 6** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to [NICE local practice case studies](#) on the NICE website. Examples of using NICE quality standards can also be submitted.

## Quality statement 1: Objective tests to support diagnosis

### ***Quality statement***

People aged 5 and over with suspected asthma have objective tests to support diagnosis. [2013, updated 2018]

### ***Rationale***

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. Objective tests can help healthcare professionals to diagnose asthma correctly. The basis on which a diagnosis of asthma is made should be documented.

### ***Quality measures***

#### **Structure**

a) Evidence of local arrangements or referral pathways to diagnostic hubs to ensure that people aged 5 and over with suspected asthma have objective tests to support diagnosis.

**Data source:** Local data collection, for example, service protocol or referral pathways.

b) Evidence of local arrangements to ensure that healthcare professionals in primary care are trained and competent to carry out objective tests to support diagnosis of asthma.

**Data source:** Local data collection, for example, training records and competency assessments.

c) Evidence of local processes to ensure that the basis for a diagnosis of asthma is documented.

**Data source:** Local data collection, for example, service protocol.

**Process**

Proportion of people aged 5 and over with newly diagnosed asthma who have a record of objective tests to support diagnosis.

Numerator – the number in the denominator who have a record of objective tests to support diagnosis.

Denominator – the number of people aged 5 and over with newly diagnosed asthma.

**Data source:** Local data collection, for example, audit of patient health records.

**Outcome**

Prevalence of asthma.

**Data source:** Local data collection. [Quality and Outcomes Framework](#) indicator AST001: The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.

***What the quality statement means for different audiences***

**Service providers** (such as GP practices, community health services and hospitals) ensure that processes are in place for people aged 5 and over with suspected asthma to have objective tests to support diagnosis. Depending on local arrangements, this may involve referral to a local asthma diagnostic hub for access to objective tests. Service providers ensure that healthcare professionals are trained and competent in performing objective tests and that processes are in place to record objective tests when a diagnosis of asthma is made (for example, see [NICE asthma diagnosis implementation data collection sheet](#)).

**Healthcare professionals** (such as doctors and nurses) are aware of local arrangements for accessing objective tests for asthma and ensure that people aged 5 and over with suspected asthma have objective tests to support diagnosis. When making a diagnosis of asthma, healthcare professionals record objective tests.

**Commissioners** (clinical commissioning groups and NHS England) commission services that ensure that people aged 5 and over with suspected asthma have

objective tests to support diagnosis. Commissioners consider whether local diagnostic hubs for asthma would optimise the investment in equipment and staff training.

**People aged 5 and over with suspected asthma** have tests to confirm if they have asthma. An accurate diagnosis will ensure they get the treatment they need.

### ***Source guidance***

[Asthma: diagnosis, monitoring and chronic asthma management](#) (2017) NICE guideline NG80, recommendations 1.1.2 and 1.3.22

### ***Definitions of terms used in this quality statement***

#### **Objective tests to diagnose asthma**

Tests carried out to help determine whether a person has asthma, the results of which are not based on the person's symptoms, for example, tests to measure lung function or evidence of inflammation. There is no single objective test to diagnose asthma. Objective tests should be performed in accordance with the NICE guideline. [NICE's guideline on [asthma](#), 'terms used in this guideline' and algorithms B and C]

#### **Suspected asthma**

A potential diagnosis of asthma based on symptoms and response to treatment that has not yet been confirmed with objective tests [NICE's guideline on [asthma](#), 'terms used in this guideline'].

### ***Equality and diversity considerations***

Objective tests cannot be conducted in children under 5 years and therefore symptoms should be treated based on observation and clinical judgement. A diagnosis of asthma should not be confirmed until the child is old enough to perform objective tests.

If a child is unable to perform objective tests when they are aged 5, healthcare professionals should continue to treat them based on observation and clinical judgement and should try doing the tests again every 6 to 12 months until satisfactory results are obtained.

Some people with learning disabilities or mental health problems may need additional support to help them to perform objective tests to diagnose asthma.

## Quality statement 2: Written personalised action plan

### ***Quality statement***

People aged 5 and over with asthma have a written personalised action plan. [2013]

### ***Rationale***

A written personalised action plan can help people with asthma to respond to changes in their symptoms, enabling them to self-manage their asthma and reduce the risk of serious asthma attacks and hospital admission. Regular reviews of the action plan with a healthcare professional can help to prevent complications arising.

### ***Quality measures***

#### **Structure**

a) Evidence of a local framework and guidance for healthcare professionals on developing a written personalised action plan for people aged 5 and over with asthma.

**Data source:** Local data collection, for example, service protocol.

b) Evidence of local arrangements to ensure people aged 5 and over with asthma have a written personalised action plan.

**Data source:** Local data collection, for example, service protocol.

#### **Process**

a) Proportion of people aged 5 and over with asthma who have a written personalised action plan.

Numerator – the number of people in the denominator who have a written personalised action plan.

Denominator – the number of people aged 5 and over with asthma.

**Data source:** Local data collection, for example, audit of patient health records.

b) Proportion of cases of treatment for an asthma attack that had a review of the person's written personalised action plan.

Numerator – the number in the denominator that had a review of the person's written personalised action plan.

Denominator – the number of cases of treatment for an asthma attack.

**Data source:** Local data collection, for example, audit of patient health records.

### **Outcome**

a) Rate of hospital attendance or admission for an asthma attack.

**Data source:** NHS Digital's [Hospital Episode Statistics](#) includes data on admissions and A&E attendances for asthma attack.

b) Satisfaction of people with asthma aged 5 and over and their family and carers (as appropriate) that they are able to self-manage their condition and their asthma is well controlled.

**Data source:** Local data collection, for example, patient and carer surveys.

### ***What the quality statement means for different audiences***

**Service providers** (such as GP practices, community health services and hospitals) ensure that processes are in place to involve people with asthma aged 5 and over, and their family and carers if appropriate, in developing a written personalised action plan to help them self-manage their symptoms. Service providers ensure written personalised action plans are reviewed following an asthma attack to prevent further asthma attacks.

**Healthcare professionals** (such as doctors, nurses, healthcare assistants and pharmacists) involve people with asthma aged 5 and over, and their family and carers if appropriate, in developing a written personalised action plan to help them self-manage their symptoms. Healthcare professionals review and update written personalised action plans with the person following an asthma attack to prevent further asthma attacks.

**Commissioners** (clinical commissioning groups and NHS England) commission services that involve people with asthma aged 5 and over, and their family and carers if appropriate, in developing and reviewing a written personalised action plan to help them self-manage their symptoms. Commissioners should ensure consistency by providing a local framework and guidance to healthcare professionals on developing and reviewing written personalised action plans for people with asthma.

**People with asthma aged 5 and over** have their own asthma care plan to help them take their asthma medicines and to know what to do if they are not working. Their healthcare professional should involve them in developing the plan and help them to use it. Their family and carers should also be involved if appropriate. If the person has an asthma attack they should review their asthma care plan with a healthcare professional.

### ***Source guidance***

[Asthma: diagnosis, monitoring and chronic asthma management](#) (2017) NICE guideline NG80, recommendations 1.10.1

### ***Definitions of terms used in this quality statement***

#### **Personalised action plan**

A personalised action plan should be tailored to the person with asthma, enabling people with asthma to recognise when symptoms are worse and setting out actions to be taken if asthma control deteriorates. [BTS/SIGN's guideline on [management of asthma](#) recommendation 5.2.2]

#### ***Equality and diversity considerations***

Healthcare professionals should have a discussion with family or carers of children under 5 with symptoms of asthma to agree if a written personalised action plan would be helpful.

The personalised action plan should be tailored to meet individual needs, taking into consideration their capacity or ability to care for themselves. Additional support may

need to be provided to people with learning disabilities to ensure they understand how to use their plan.

***Question for consultation***

Which specific components of the written personalised action plan are most important? Would it be helpful to focus on ensuring specific components are included in the written personalised action plan?

## Quality statement 3: Monitoring asthma control

### ***Quality statement***

People with asthma have their asthma control monitored at every review. [2013, updated 2018]

### ***Rationale***

Monitoring asthma control at every review will enable the identification of any difficulties with adherence, medication use or inhaler technique. Support can be provided for people having difficulties taking their medicine to improve adherence and inhaler technique. Healthcare professionals may adjust treatment if necessary. This will help to improve the person's quality of life and reduce the risk of serious asthma attacks and hospital admissions.

### ***Quality measures***

#### **Structure**

a) Evidence that tools, such as a validated questionnaire, are available locally for monitoring of asthma control in adults.

**Data source:** Local data collection, for example, service specifications.

b) Evidence that spirometry or peak flow variability testing are available locally for monitoring of asthma control in people aged 5 and over.

**Data source:** Local data collection, for example, service specifications.

c) Evidence of local arrangements to ensure people with asthma have their asthma control monitored at every review.

**Data source:** Local data collection, for example, service protocol.

#### **Process**

a) Proportion of asthma reviews that include monitoring of asthma control.

Numerator – the number in the denominator that include monitoring of asthma control.

Denominator – the number of asthma reviews.

**Data source:** Local data collection, for example, audit of patient health records.

b) Proportion of people with asthma who had a review of their inhaler technique within the past 12 months.

Numerator – the number in the denominator who had a review of their inhaler technique within the past 12 months.

Denominator – the number of people with asthma.

**Data source:** Local data collection, for example, audit of patient health records.

### **Outcome**

a) Proportion of people with asthma prescribed more than 12 short-acting beta agonist (SABA) reliever inhalers within the past 12 months.

**Data source:** Local data collection, for example, electronic prescribing data.

b) Rate of hospital attendance or admission for asthma attack.

**Data source:** NHS Digital's [Hospital Episode Statistics](#) includes data on admissions and A&E attendances for asthma attack.

### ***What the quality statement means for different audiences***

**Service providers** (such as GP practices, community health services and hospitals) ensure that processes are in place for people with asthma to have their asthma control monitored at every review. Service providers ensure that if asthma control is suboptimal, processes are in place for an assessment of adherence and inhaler technique to be carried out before treatment is adjusted. Service providers ensure that staff are trained to use the tools and tests needed to monitor asthma control and to assess adherence and inhaler technique.

**Healthcare professionals** (such as doctors, nurses, healthcare assistants and pharmacists) monitor asthma control when carrying out reviews for people with asthma. Healthcare professionals ensure that if asthma control is suboptimal they

carry out assessments of adherence and inhaler technique before adjusting treatment.

**Commissioners** (clinical commissioning groups and NHS England) commission services that monitor asthma control at every review for people with asthma. Commissioners ensure that tools, such as a validated questionnaire, and spirometry or peak flow variability testing, are available for monitoring asthma control.

**People with asthma** have their asthma control checked when they have a review. If their asthma is not well controlled they get support to make sure they are using their medicines correctly, for example a check of their inhaler technique. If this doesn't help, they may have their medicines or inhaler changed to prevent an asthma attack.

### ***Source guidance***

[Asthma: diagnosis, monitoring and chronic asthma management](#) (2017) NICE guideline NG80, recommendations 1.14.1 and 1.14.3

### ***Definitions of terms used in this quality statement***

#### **Monitoring asthma control**

Consider using a validated questionnaire, such as the Asthma Control Questionnaire or Asthma Control Test, to monitor asthma control in adults. Asthma control should be monitored in people aged 5 and over using either spirometry or peak flow variability testing. [NICE's guideline on [asthma](#) recommendations 1.14.2 and 1.14.3]

## Quality statement 4: Follow-up after hospital treatment for an asthma attack

### **Quality statement**

People who receive hospital treatment for an asthma attack are followed up by their GP practice within 2 working days of discharge. **[2013, updated 2018]**

### **Rationale**

People who have an asthma attack may be at risk of further acute episodes. Follow-up in a GP practice after treatment in hospital (both in accident and emergency departments and as inpatients) can explore the possible reasons for the asthma attack and the actions needed to reduce the risk of further acute episodes.

### **Quality measures**

#### **Structure**

a) Evidence of local arrangements to ensure hospitals notify the person's GP practice following treatment for an asthma attack.

**Data source:** Local data collection, for example, service protocols.

b) Evidence of local arrangements to ensure that, when notified, GP practices arrange a follow-up appointment with people treated in hospital for an asthma attack within 2 working days of discharge.

**Data source:** Local data collection, for example, service protocol.

#### **Process**

a) Proportion of cases of asthma attack treated in hospital that are notified to the person's GP practice.

Numerator – the number in the denominator that are notified to the person's GP practice.

Denominator – the number of cases asthma attack treated in hospital.

**Data source:** Local data collection, for example, audit of patient health records.

b) Proportion of notifications of asthma attack treated in hospital followed up by a GP practice within 2 working days of discharge.

Numerator – the number in the denominator that are followed up by a GP practice within 2 working days of discharge.

Denominator – the number of notifications of asthma attack treated in hospital.

**Data source:** Local data collection, for example, audit of patient health records.

### **Outcome**

a) Hospital readmission rate for people with an asthma attack.

**Data source:** Local data collection, for example, audit of patient health records.

National data on emergency readmissions within 30 days of discharge are included in NHS Outcomes Framework – indicator 3b available from NHS Digital's [Clinical Indicators](#).

b) Mortality rate for people with asthma.

**Data source:** Local data collection, for example, audit of patient health records.

National data on the under 75 mortality rate from respiratory disease is included in NHS Outcomes Framework – indicator 1.2 available from NHS Digital's [Clinical Indicators](#).

### ***What the quality statement means for different audiences***

**Service providers** (such as hospitals, including accident and emergency departments) notify the person's GP practice when treatment for an asthma attack has been provided. Once notified, GP practices arrange a follow-up appointment with the person within 2 working days of discharge. GP practices ensure that staff undertaking follow-up appointments are trained in asthma care.

**Healthcare professionals** (such as doctors, nurses and healthcare assistants) ensure a notification is sent to the person's GP practice when an asthma attack is

treated in hospital. On receipt of a notification, healthcare professionals in GP practices arrange a follow-up appointment within 2 working days of discharge.

**Commissioners** (clinical commissioning groups and NHS England) commission hospital services that have notification processes in place to alert the person's GP practice when treatment is provided for an asthma attack. Commissioners ensure there is sufficient capacity to enable follow-up appointments in GP practices to be arranged within 2 working days of discharge.

**People who receive hospital treatment for an asthma attack** have a follow-up appointment at their GP practice within 2 working days of discharge from hospital. This will help them to understand why their asthma got worse and how to prevent it happening again.

### ***Source guidance***

[BTS/SIGN British guideline on the management of asthma](#) (2016) SIGN clinical guideline 153, recommendations 9.6.3, 9.9.7, and annexes 3, 4, 6 and 7

## Quality statement 5: Severe asthma

### ***Quality statement***

People with severe asthma are referred to a specialist severe asthma service for assessment. [2013, updated 2018]

### ***Rationale***

People with severe asthma need specialist assessment to accurately diagnose their asthma, exclude alternative causes of persistent symptoms, confirm adherence to therapy and ensure they are receiving the most appropriate treatment. Specialist care can help to improve asthma control, prevent asthma attacks and reduce harmful long-term dependence on oral corticosteroids.

### ***Quality measures***

#### **Structure**

a) Evidence that specialist severe asthma services are available for people with severe asthma.

**Data source:** Local data collection, for example, service specifications.

b) Evidence of local arrangements to ensure that people with severe asthma are referred to a specialist severe asthma service for assessment.

**Data source:** Local data collection, for example, service protocols and referral pathways.

#### **Process**

Proportion of people with severe asthma who are referred to a specialist severe asthma service for assessment.

Numerator – the number of people who are referred to a specialist severe asthma service for assessment.

Denominator – the number of people with severe asthma.

**Data source:** Local data collection, for example, audit of patient health records.

### **Outcome**

a) Rate of hospital attendance or admission for an asthma attack.

**Data source:** NHS Digital's [Hospital Episode Statistics](#) includes data on admissions and A&E attendances for asthma attack.

b) Number of people with asthma who have 3 or more courses of high-dose oral corticosteroids per year.

**Data source:** Local data collection, for example, electronic prescribing data.

### ***What the quality statement means for different audiences***

**Service providers** (such as GP practices, community health services and hospitals) ensure that processes are in place to identify people with severe asthma so that they can be referred to a specialist severe asthma service for assessment.

**Healthcare professionals** (such as doctors and nurses) are aware of local referral pathways for severe asthma and refer people with severe asthma to a specialist severe asthma service for assessment. Healthcare professionals ensure that diagnosis is confirmed, and adherence and comorbidities are addressed before making a referral.

**Commissioners** (NHS England) commission specialist severe asthma services for adults and children with severe asthma. Commissioners ensure that services have sufficient capacity to meet the demand for assessments for people with severe asthma.

**People with severe asthma** are referred for an assessment with a service that specialises in managing severe asthma so that the reasons for their asthma and their treatment can be reviewed.

### ***Source guidance***

[BTS/SIGN British guideline on the management of asthma](#) (2016) SIGN clinical guideline 153, recommendation 10.1

## ***Definitions of terms used in this quality statement***

### **Severe asthma**

When a diagnosis of asthma is confirmed and comorbidities have been addressed, severe asthma is defined as asthma that needs treatment with the medicines suggested for steps 4 to 5 in the Global Initiative for Asthma (GINA) guideline (a high-dose inhaled corticosteroid [ICS] with a long-acting beta 2-agonist [LABA] or leukotriene modifier or theophylline) for the previous year or systemic corticosteroids for 6 months or more of the previous year to prevent it from becoming 'uncontrolled' (that is, controlled asthma that worsens on tapering of these high doses of ICS or systemic corticosteroids (or additional biologics)) or that remains 'uncontrolled' despite this therapy. Uncontrolled asthma is defined as at least one of the following:

- Poor symptom control: Asthma Control Questionnaire consistently less than 1.5 or Asthma Control Test less than 20
- Frequent severe exacerbations: 2 or more bursts of systemic corticosteroids (less than 3 days each) in the previous year
- Serious exacerbations: at least 1 hospitalisation, ICU stay or mechanical ventilation in the previous year
- Airflow limitation: after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal).

[Global Initiative for Asthma [Global strategy for asthma management and prevention](#) and European Respiratory Society/American Thoracic Society [International guidelines on definition, evaluation and treatment of severe asthma](#)]

### **Specialist severe asthma service**

The service requirements for adults are set out in NHS England's [specification for specialised respiratory services \(adult\) – severe asthma](#). The service requirements for children are set out in NHS England's [specification for paediatric medicine: respiratory](#).

### **Assessment**

A systematic evaluation should include:

- confirmation of the diagnosis of asthma and
- identification of the mechanism of persisting symptoms and
- assessment of adherence with therapy.

[BTS/SIGN's guideline on [management of asthma](#) recommendation 10.1]

### ***Equality and diversity considerations***

Specialist adult severe asthma services providing treatment to children and young people should have staff who are trained to meet the needs of children and young people with severe asthma and their family and carers.

### ***Question for consultation***

We have suggested using the European Respiratory Society/American Thoracic Society definition of severe asthma in line with NHS England's [specification for adult specialised respiratory services for severe asthma](#). Is this reasonable and will it be possible to identify this population in practice?

## Update information

**April 2018:** This quality standard was reviewed and statements prioritised in 2013 were updated.

Statements are marked as:

- **[2013]** if the statement remains unchanged
- **[2013, updated 2018]** if the statement covers an area for quality improvement included in the 2013 quality standard and has been updated.

Statements numbered 1, 6, 10 and 11 in the 2013 version have been updated and are included in the updated quality standard, marked as **[2013, updated 2018]**.

Statements from the 2013 version (numbered 2, 4, 5, 7, 8 and 9) that are no longer considered national priorities for improvement, but may still be useful at a local level, are listed in the [quality statements](#) section.

The [2013 quality standard for asthma](#) will be available as a pdf when the update is published.

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See [quality standard advisory committees](#) on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard's webpage](#).

This quality standard has been included in the NICE Pathway on [asthma](#), which brings together everything we have said on [asthma](#) in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references

to organisations or people responsible for commissioning or providing care that may be relevant only to England.

### ***Improving outcomes***

This quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- sickness absence from work/school
- frequency of asthma attacks
- A&E attendances
- hospital admissions
- mortality.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- [Adult social care outcomes framework 2016–17](#)
- [NHS outcomes framework 2016–17](#)
- [Public health outcomes framework for England, 2016–19](#).

### ***Resource impact***

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the NICE guideline on asthma to help estimate local costs:

- [resource impact report](#)
- [resource impact template: asthma diagnosis and monitoring](#)
- [resource impact template: chronic asthma management](#).

***Diversity, equality and language***

During the development of this quality standard, equality issues were considered and [equality assessments](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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