

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

INDICATOR DEVELOPMENT PROGRAMME

Consultation report

Indicator area: Asthma

Consultation period: 17 April – 16 May 2019

Date of Indicator Advisory Committee meeting: 4 June 2019

Output: New indicators for general practice

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Introduction

The [QOF review](#) recommended refreshing and renewing indicators with a focus on personalised care, addressing over- and under-treatment, and ensuring the best outcomes for patients.

In February and April 2019, a respiratory working group convened to consider what matters most to people with asthma and how best to help them achieve their best outcomes. The group had representation from:

- Asthma UK
- British Lung Foundation
- BMA's GPC
- North East Quality Observatory Service
- NHS Digital
- NHS England
- RCGP
- NICE including IAC members
- Primary Care Respiratory Society

The results of these discussions were presented for public consultation in April 2019. The Indicator Advisory Committee is asked to consider this feedback and advise on inclusion on the NICE menu.

Summary of indicators included in the consultation

ID	Existing indicator	Proposed indicator	Evidence source
IND186	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.	The contractor establishes and maintains a register of patients with asthma aged 5 or over.	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80
IND187	AST002: The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis.	The percentage of patients with asthma on the register (date of implementation) with a record of an objective test of FeNO, spirometry, reversibility or variability between 3 months before or 3 months after diagnosis.	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, sections 1.3, 1.4 Asthma (2013) NICE Quality Standard QS25 Quality Statement 1
IND188	AST003: The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions.	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan.	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendations 1.10.1, 1.10.2, 1.14.2 Asthma (2013) NICE Quality Standard QS25 Quality Statements 2, 3 British guideline on the management of asthma (2016) SIGN guideline, section 1.4.
IND189	AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months.	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months.	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendation 1.5.1

IND186 Maintaining a register of patients (5 years and older)

The contractor establishes and maintains a register of patients with asthma aged 5 or over.

Rationale

The current QOF asthma register does not have a lower age range, it includes children under 5 years of age. The new indicator recognises that it can be difficult to confirm a diagnosis of asthma in children under 5 years of age ([NICE NG80](#)). The lower age for the indicator has been added to reflect uncertainty in diagnosis and to reduce the risk of overdiagnosis / overtreatment.

In addition, the current register excludes people who have been prescribed no asthma-related drugs in the preceding 12 months. Originally intended as a proxy for people in whom a true diagnosis is unlikely, the development of robust diagnostic pathways in NICE provides a more accurate method of confirming diagnosis.

An incorrect diagnosis of asthma may result in life-long implications, and unnecessary treatment with the potential risk of adverse effects. ([NICE, 2015](#)).

Summary of consultation comments

- Multiple stakeholders gave comments of support for new indicator IND186. Specific comments referenced the removal of exclusion criteria for patients with no asthma-related prescription in the last 12 months, and the use of a lower age limit which stakeholders felt would reduce misdiagnosis in children under 5.
- Some stakeholders wanted to highlight that children under 5 can still have a diagnosis of suspected asthma, and not be counted for the QOF indicator but will then receive the appropriate tests to confirm diagnosis at age 5.
- Some stakeholders recommended expanding the indicator to include a register of people with suspected asthma.
- Potential barriers to implementation identified by stakeholders included:
 - Risks around conflicting or incompatible treatments when a person is on both the asthma register and the COPD register.
 - Time and resources needed to identify all patients with an asthma diagnosis.

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- Potential unintended consequences to introducing this indicator included:
 - Patients being missed from the register for long periods of time therefore placing them at risk.
 - Patients with resolved asthma or a previous incorrect diagnosis coming back on the register, leading to a large increase in workload and costs.
- Potential differential impact across people with protected characteristics includes:
 - Negative impact on patients under 5 years of age.
- One stakeholder felt that it would be helpful to specify whether confirmation of diagnosis is required for a patient to be on the register
- One stakeholder suggested alternative wording for the indicator, feeling that it would reduce misunderstanding:
 - 'The contractor establishes and maintains a register of patients aged 5 or over with asthma'.

Considerations for the advisory committee

The committee is asked to consider:

- Risks of introducing people with incorrect diagnosis on the register (by removing the requirement for asthma related drugs in the past 12 months).
- Possible negative impacts on children under 5.

IND187 Objective tests to support diagnosis

The percentage of patients with asthma on the register (date of implementation) with a record of an objective test of FeNO, spirometry, reversibility or variability between 3 months before or 3 months after diagnosis.

Rationale

Misdiagnosis of asthma can have lifelong implications and result in inappropriate treatment with the risk of adverse effects. It can also mean alternative underlying conditions are not diagnosed.

Using objective tests to confirm diagnosis can improve the accuracy of a diagnosis and reduce incidences of patients receiving inappropriate care. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing.

This indicator requires a record of an objective test: FeNO or spirometry or reversibility or variability.

Summary of consultation comments

- Multiple stakeholders gave comments of support for new indicator IND187. Specific comments referenced adding an incentive to the establishment of diagnostic hubs, and the welcome addition of objective testing.
- There was mixed reception to the objective tests referenced in the indicator:
 - One stakeholder felt that while the tests were a positive addition, they could not substitute taking thorough patient histories, as both spirometry and FeNO had weaknesses
 - Other stakeholders felt that the indicator should reference or be the same as the NICE diagnostic algorithm in NG80 and suggested wording it as 'This indicator requires a record of an objective test: FeNO and spirometry and additionally if required reversibility or variability' or 'The percentage of patients with asthma on the register (date of implementation) with a record of an objective test of FeNO, spirometry, reversibility recorded between 3 months before or 3 months after diagnosis, in line with the specifications of the NG80 algorithm.'

- There were further comments pointing out difficulties in interpreting FeNO and that it would not be sufficient to confirm diagnosis by itself. One stakeholder suggested listing the following tests in the indicator – ‘variability or reversibility in peak flow measurements over time, spirometry with evidence of obstruction and reversibility, FeNO measurements.’
- One stakeholder suggested that the wording for spirometry should be ‘spirometry with reversibility (of 12% or more).’
- Potential barriers to implementation identified by stakeholders included:
 - The need to train staff in interpreting and using FeNO, spirometry and reversibility measures.
 - A question on how useful a test is if conducted 3 months prior to diagnosis.
 - Accessibility of FeNO in primary care.
 - Funding needed for test equipment.
 - Difficulties conducting tests in primary care on children between 5 and 8 years old.
- Potential unintended consequences to introducing this indicator included:
 - The indicator only applying to newly diagnosed patients, leading to people with a current diagnosis not receiving tests for extended amounts of time. The stakeholder recommended addressing this with staged retrospective testing.
- One stakeholder suggested using the wording ‘test of FeNO or spirometry’ to show that either test would be sufficient
- One stakeholder suggested using the wording ‘spirometry demonstrating reversible airflow obstruction and/or peak flow diurnal/day to day variability’.

Considerations for the advisory committee

The committee is asked to consider:

- Further alignment to NG80 diagnostic algorithm or inclusion of additional tests.

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- Availability and accessibility of tests, including equipment.
- Staged retrospective testing for people not diagnosed in line with current diagnostic algorithms.

IND188 Patients who have had an asthma review

The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan.

Rationale

Published evidence suggests that both people with asthma and clinicians tend to underestimate asthma severity and overestimate asthma control when simply asking a patient 'How is your asthma?'. Asthma control questionnaires assess asthma related quality of life, with evidence ([NICE NG80](#)) that validated questionnaire can lead to reduced exacerbations.

Assessing use of short acting beta agonists and recording exacerbations can help identify people with asthma who are at increased risk of poor outcomes.

People with asthma can use information and advice from these reviews to inform their self-management, maximising their future health.

Summary of consultation comments

- Multiple stakeholders gave comments of support for indicator IND188. Specific comments referenced:
 - Use of a validated questionnaire giving a better picture of asthma severity leading to improved control.
 - Featuring short acting beta agonist use which should help to address safety concerns about over-use.
 - Number of exacerbations being recorded.
 - Featuring written action plans.
- Potential unintended consequences to introducing this indicator included:
 - Consultation time with a patient becoming longer.
- Some stakeholders commented on ways to increase the scope or effectiveness of the indicator such as:

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- Reviews of a patient's asthma management if they use 3 or more SABA canisters per year and recording patient reported and managed exacerbations
- Addressing occupational asthma by checking if symptoms improve during periods away from work
- Including checks of inhaler technique.
- Reviews that involve assessments of OCS prescriptions and assessment of medicines inheritance
- Some stakeholders felt that a single annual asthma assessment is not enough and highlighted the need to identify future risks.
- One provider recommended use of a standardised measure of asthma outcomes that both patients and health care staff could complete.
- Some stakeholders raised concerns about how elements of this indicator would be coded, including SABA, separate codes for the questionnaire and the action plan, and a method of coding that factors in practices still using the RCP 3 questions.
- One stakeholder questioned how useful the personalised action plan would be for patients with well controlled asthma.

Considerations for the advisory committee

The committee is asked to consider:

- Impact on consultation time.
- Increasing the indicator scope to include
 - Annual use of SABA canisters
 - Occupational asthma
 - Inhaler technique
 - OCS prescriptions and medicines inheritance
- Frequency of assessments.

IND189 Patients record of smoking status

The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months.

Rationale

Asthma and tobacco smoke interact to cause more severe symptoms, these symptoms include accelerated decline in lung function, and impaired short-term therapeutic response to corticosteroids ([Thomson, et al. 2004](#)). In addition, exposure to environmental tobacco smoke results in an increase in the frequency of emergency care attendances for the treatment of acute asthma exacerbations ([Chilmonczyk et al. 1993](#))

- The available data for children and young people aged between 11 and 15 years ([NHS Digital, 2017](#)) report that 7% are regular or occasional smokers, these data are for all children and young people rather than those with asthma. The prevalence of smoking increases with age, from less than 1% of 12-year olds to 15% of 15-year olds.
- In addition, children and young people are exposed to ‘second hand’ smoke in their home or in someone else’s home with 14% of children 11 to 15 years being exposed to secondhand smoke “every day or most days” ([NHS Digital, 2017](#)). Over the previous 12-month period 62% reported being exposed to secondhand smoke in their home, someone else’s home or in car.

This indicator aims to encourage general practice to ask children and young people aged 5 to 19 years with asthma about their exposure to tobacco and encourage smoking cessation advice.

Summary of consultation comments

- Multiple stakeholders gave comments of support for indicator IND189. Specific comments referenced:
 - The indicator will encourage and make it routine to ask patients about their exposure to passive smoking, and raise awareness of its effects
 - The indicator may offer an opportunity for health care professionals to deliver advice on the effects of smoking to parents of children with asthma

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- Some stakeholders noted ways that the indicator could have wider scope, such as:
 - Addressing inhaling substances other than tobacco smoke.
 - Requiring a record of referral to smoking cessation services or specialist advice.
 - Recording primary use of e-cigarettes.
 - Using an objective test with the following wording ‘The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months. With a record of an objective test of breath carbon monoxide to check self-reported abstinence, with success defined as less than 10 parts per million (ppm).’
- One stakeholder felt that asking about smoking history in younger children may upset their parents, and that it would lead to wasted time in consultations.
- Some stakeholders recommended using the wording ‘treating tobacco dependency’ rather than ‘smoking cessation’.
- One provider felt that the indicator should specify to ask about exposure to secondhand smoke in the home only.
- One provider suggested using separate indicators for smoking status and exposure to secondhand smoke.

Considerations for the advisory committee

The committee is asked to consider:

- Increasing the indicator scope to include
 - Other inhaled substances in addition to tobacco
 - Objective testing.
- Making the indicator more specific regarding age and setting of secondhand smoke exposure.
- Separate indicators for smoking and exposure to secondhand smoke.

General Comments

Issues raised by stakeholders

- One stakeholder commented that these indicators should play a role in improving the asthma treatment pathway.
- Other stakeholder gave general comments welcoming the changes to the indicators, particularly in the context of increased asthma related deaths in the UK.
- Two stakeholders suggested an additional indicator that aims to ensure that people who have been treated for asthma in an emergency setting are given the appropriate follow up after discharge from hospital.
- A stakeholder identified a need to align these indicators and related coding with ones used in the RCP National Audit of COPD and asthma programme (NACAP) primary care audit.
- One stakeholder suggested an additional indicator that measures patients who have had two or more courses of oral steroids in the preceding 12 months being referred to specialist assessment.

Appendix A: Consultation comments

ID	Indicator	Stakeholder	Comment
1	Asthma	Asthma UK	These indicators should form part of improving the treatment pathway for people with asthma. The recent Neglected Killer article in the BMA's Doctor magazine (April 2019) highlights some of the current, and tragic, problems associated with a lack of joined up care and record-keeping; QoF should be part of the solution to tackling this problem. Indeed, QoF indicators should action-focused indicators which engage clinicians and patients in helping to improve asthma management, patient self-management and activation and patient outcomes.
2	Asthma	AstraZeneca	For reasons mentioned in our previous comment (1), we believe there is opportunity to include a review of SABA use in the new Quality Improvement Prescribing Safety domain. Specifically, indicator QI001 asks for continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance. We ask that the committee considers the inclusion of SABA review as part of this indicator at its next update.
3	Asthma	Elcena Jeffers Foundation	There is a wish to know about self-care in general public education in life as different people has different diseases or ailments
4	Asthma	Novartis Pharmaceuticals UK Ltd	<p>Novartis welcomes this consultation from NICE and the proposal to update the menu of asthma indicators included within the Quality and Outcomes Framework (QOF) as a means of achieving improved outcomes for patients. Novartis plays an active role in developing, manufacturing and commercialising medicines in asthma. Novartis manufactures the severe asthma medicine Xolair® (omalizumab). Novartis broadly agrees with the proposed QOF indicators for asthma included within this consultation document (IND186, IND187, IND188 and IND189), with one suggested amendment to IND188 (as described in comment 2) and a suggestion for an additional indicator (as described in comment 3).</p> <p>Supporting the delivery of high-quality asthma care is of critical importance, and we welcome the timely ambition to achieve improved outcomes for those affected by the disease through the implementation of an updated QOF. As highlighted by the National Review of Asthma Deaths (NRAD), whilst advances in drug treatments, applied research and the development of evidence-based clinical guidelines have contributed to a reduction of deaths from asthma in the past 50 years, people are still dying unnecessarily from the disease, with avoidable factors playing a part in as many of three-quarters of cases of all asthma deaths.¹</p> <p>It is concerning that the UK currently has one of the highest death rates from asthma compared to other countries in Europe, as well compared to other high-income countries worldwide.² Of particular concern is the fact that despite the overall reduction in asthma deaths in the past 50 years, as noted within NRAD¹, recent data shows that asthma deaths in England and Wales have actually increased by a quarter in the last decade.³</p>

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ID	Indicator	Stakeholder	Comment
			<p>Alongside this, multiple Regulation 28 statements have been issued in recent years relating to asthma deaths where severe and repeated failings around the diagnosis of asthma and delivery of adequate follow-up care were found to have contributed to the final outcome.⁴</p> <p>Ensuring accurate diagnosis and appropriate management and treatment of asthma are key to reversing these trends and securing improved outcomes in the condition more broadly. Novartis therefore hope that the proposed updates to QOF, and the comments we have provided below, will help to achieve these aims.</p> <p>References:</p> <ol style="list-style-type: none"> 1. Royal College of Physicians. Why Asthma Still Kills: The National Review of Asthma Deaths (NRAD). Confidential Enquiry Report. May 2014. Accessed May 2019: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills 2. Asthma UK. UK asthma death rates among worst in Europe. April 2018. Accessed May 2019: https://www.asthma.org.uk/about/media/news/press-release-uk-asthma-death-rates-among-worst-in-europe/ 3. Asthma UK. Asthma deaths in England and Wales are the highest this century. July 2018. Accessed May 2019: https://www.asthma.org.uk/about/media/news/statement-asthma-deaths-in-england-and-wales-are-the-highest-this-century/ 4. British Medical Association. A neglected killer. April 2019. Accessed May 2019: https://www.bma.org.uk/news/2019/april/a-neglected-killer
5	Asthma	Novartis Pharmaceuticals UK Ltd	<p>Novartis propose an additional indicator, in line with the NICE Quality Standard³, BTS/SIGN Guidelines² and Global Initiative for Asthma (GINA) guidance⁴, to ensure that people who have been treated in the emergency setting are followed up appropriately after hospital discharge. We are aware that the introduction of this indicator may be more suited to the Clinical Commissioning Group Outcome Indicator Set as it involves input from secondary care, however we urge NICE to consider strengthening the policy framework in respect of asthma more broadly, in light of the significant unmet need that exists in this area. The wording of our proposed indicator is as follows:</p> <p>Proportion of notifications of asthma attack treated in an emergency care setting followed up by a general practice within 2 working days of discharge.</p> <p>NRAD identified that 68% of people who attended hospital did not receive a follow-up appointment within two working days. It also identified that one in six people have another exacerbation in the following two weeks after from receiving emergency asthma treatment and that 10 per cent of all reported deaths reviewed took place within 28 days of being</p>

ID	Indicator	Stakeholder	Comment
			<p>treated in hospital for an asthma exacerbation¹. Past exacerbations are a risk factor for future exacerbations and improvements in the follow-up care for those requiring emergency treatment for asthma exacerbations are required.</p> <p>References:</p> <ol style="list-style-type: none"> 1. Royal College of Physicians. Why Asthma Still Kills: The National Review of Asthma Deaths (NRAD). Confidential Enquiry Report. May 2014. Accessed May 2019: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills 2. SIGN 153. British guideline on the management of asthma. September 2016. Accessed May 2019: https://www.brit-thoracic.org.uk/.../guidelines/asthma/btssign-asthma-guideline-2016/ 3. NICE. Quality Standard 25 [QS25]. Last updated September 2018. Accessed May 2019: https://www.nice.org.uk/guidance/qs25 4. Global Initiative for Asthma. Pocket guide for asthma management and prevention. 2019. Accessed May 2019: https://ginasthma.org/wp-content/uploads/2019/04/GINA-2019-main-Pocket-Guide-wms.pdf
6	Asthma	Royal College of Nursing	Proposed changes to Quality and Outcomes Framework (QOF) Indicator for asthma seem appropriate.
7	Asthma	Task and Finish Group on Asthma Policy	<p>This consultation response has been provided by the Task & Finish Group on Asthma Policy (T&F Group). The T&F Group is a multi-disciplinary group of leading clinicians, practitioners and patient group representatives from across the asthma community. The T&F Group was initiated by Novartis Pharmaceuticals, who are funding M&F Health to provide Secretariat services for the Group. Novartis are acting as an observer to the T&F Group and have no influence on its proposed workplan or outputs. The Group's areas of focus and recommendations have been determined solely by its members, with outputs and materials approved by Novartis only for compliance purposes. No members of the Group are receiving honoraria for their time and contribution.</p> <p>The group has come together to provide independent advice and evidence-based recommendations to support the implementation of the NICE Quality Standard for Asthma (QS25), which was updated in 2018. We have done so because the UK still has amongst the highest death rates from asthma in Europe and across high-income countries worldwide, with recent data showing that asthma deaths in England and Wales have actually increased by over 25% in the last decade.</p> <p>Similarly, recent findings published by the Nuffield Trust demonstrate that the UK has the highest rate of deaths from asthma for young people aged 10-24, compared to all European countries in the comparator group, and the fourth highest overall behind the USA, Australia and New Zealand. They also show that any improvements in asthma mortality rates amongst this group have started to stall in the last few years.</p>

ID	Indicator	Stakeholder	Comment
			<p>These findings reiterate the importance of supporting significant improvements in asthma services to help address these worrying trends and deliver improved outcomes for those affected by this life-long condition. We therefore urge policymakers to raise the prioritisation of asthma within the NHS policy framework to help achieve this, including maintaining a strong presence of asthma within the Quality and Outcomes Framework.</p> <p>Members of the T&F Group include: Dr Andrew Menzies-Gow (Chair), Director of Lung Division and Consultant in Respiratory Medicine, Royal Brompton; Joe Farrington-Douglas, Head of Policy and External Affairs, Asthma UK; Dr Steve Holmes, GP and Clinical Respiratory Lead, Somerset CCG; Dr Mark Levy, Clinical Lead for the National Review of Asthma Deaths (2011-2014), and Chairman of the Dissemination and Implementation Committee, Global Initiative of Asthma (GINA); Sarah MacFadyen, Policy and Public Affairs Manager, British Lung Foundation; Noelle Morgan, Research and Policy Volunteer, Asthma UK (Patient Representative); Professor Anna Murphy, Consultant Pharmacist, University Hospitals Leicester; Samantha Prigmore, Respiratory Nurse Consultant, St George's NHS Trust</p> <p><u>References</u> NICE. Quality Standard 25 [QS25]. Last updated September 2018. Available online at: https://www.nice.org.uk/guidance/qs25 Asthma UK. UK asthma death rates among worst in Europe. April 2018. Available online at: https://www.asthma.org.uk/about/media/news/press-release-uk-asthma-death-rates-among-worst-in-europe/ Office for National Statistics. Deaths registered in England and Wales: 2017. July 2018. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2017 Asthma UK. Asthma deaths in England and Wales are the highest this century. July 2018. Available online at: https://www.asthma.org.uk/about/media/news/statement-asthma-deaths-in-england-and-wales-are-the-highest-this-century/ Nuffield Trust. International comparisons of health and wellbeing in adolescence and early adulthood. February 2019. Available online at: https://www.nuffieldtrust.org.uk/files/2019-02/1550657729_nt-ayph-adolescent-health-report-web.pdf</p>
8	Asthma	Task and Finish Group on Asthma Policy	<p>The T&F Group welcome this consultation from NICE and the proposal to update the menu of asthma indicators included within the Quality and Outcomes Framework (QOF) as a means of achieving improved outcomes for patients.</p> <p>Whilst we recognise that the focus of this consultation concerns potential changes to QOF, we urge NICE and the NICE Indicator Advisory Committee to also consider introducing new asthma-orientated CCG Outcome Indicators. In</p>

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ID	Indicator	Stakeholder	Comment
			<p>particular, there remains a concerning gap within the NHS policy framework with regards to ensuring that people who have an asthma attack receive appropriate follow-up care following hospital discharge.</p> <p>The importance of delivering timely and high-quality follow-up care after an asthma attack has been consistently included as a key recommendation within separate British Thoracic Society (BTS)/Scottish Intercollegiate Guidelines Network (SIGN) and Global Initiative for Asthma (GINA) guidance, as well as featuring as one of only five Quality Statements within the recently updated NICE Quality Standard for Asthma.</p> <p>Despite its inclusion within key guidance and being widely recognised as representing an essential component of the asthma care pathway, data shows that the overwhelming majority of people who have needed emergency care following a potentially life-threatening asthma attack are not receiving appropriate follow-up after they have been discharged from hospital. Findings from the National Review of Asthma Deaths (NRAD) in 2014 for instance showed that around two-thirds of people who attended hospital did not receive a follow-up appointment within two working days. Data from Asthma UK's most recent annual survey in 2018 found that almost exactly the same proportion of people were still not receiving a follow-up appointment after experiencing a potentially life-threatening asthma attack, with 65% alarmingly told by a healthcare professional that they should not even have an appointment in the first place.</p> <p>The fact that there appears to be no demonstrable improvement in the delivery of follow-up care for those requiring emergency treatment for asthma attacks should be of considerable concern. One in six people have another attack in the following two weeks from receiving emergency asthma treatment whilst 10 per cent of all reported deaths included in NRAD took place within 28 days of being treated in hospital for an asthma attack. Past attacks are a clear risk factor for future attacks but more than two thirds (68 per cent) of the people hospitalised in the month before they died did not receive recommended check-ups after discharge.</p> <p>The urgent need for action has been further demonstrated by the issuing of multiple coroner Regulation 28 Statements in recent years, as a result of critical and persistent systemic failings in the delivery of recommended asthma care, including failure to recognise risk; failure to diagnose severe chronic asthma and failure to adequately follow these patients up or to coordinate their care by someone appropriately trained to do so.</p> <p>Introducing a CCG Outcome Indicator to encourage the delivery of follow-up care for those requiring emergency treatment for asthma attacks would help to deliver improvements in this underserved area and would support NHS England's ambition to reduce unplanned hospital readmissions, avoidable A&E attendances and preventable mortalities, as set out by the Five Year Forward View and Next Steps on the NHS Five Year Forward View. It would also help to</p>

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ID	Indicator	Stakeholder	Comment
			<p>achieve the goal of transforming outcomes in respiratory disease to ‘equal, or better, our international counterparts’ as set out in the NHS Long Term Plan.</p> <p><u>References</u> SIGN 153. British guideline on the management of asthma. September 2016. Global Initiative for Asthma. Pocket guide for asthma management and prevention. 2019. Available online at: https://ginasthma.org/wp-content/uploads/2019/04/GINA-2019-main-Pocket-Guide-wms.pdf Royal College of Physicians. Why Asthma Still Kills: The National Review of Asthma Deaths (NRAD). Confidential Enquiry Report. May 2014. Available online at: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills NHS. Asthma attacks. Available online at: https://www.nhs.uk/conditions/asthma/asthma-attack/ British Medical Association. A neglected killer. April 2019. Available online at: https://www.bma.org.uk/news/2019/april/a-neglected-killer NHS England. Five Year Forward View. October 2014. Available online at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf NHS England. Next Steps on the NHS Five Year Forward View. March 2017. Available online at: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf NHS England. The NHS Long Term Plan. January 2019. Available online at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf</p>
9	General	British Lung Foundation	<p>We strongly support the Primary Care Respiratory Society’s (PCRS) recommendation that the phrase ‘treating tobacco dependency’ is used across the indicators rather than ‘smoking cessation.’</p> <p>As QOF is focused on what clinicians do, treating tobacco dependency as a long term condition which starts in childhood is very much the remit of healthcare professionals. NICE has made this distinction in the guideline it is currently updating by making the title –‘Tobacco: preventing uptake, promoting quitting and treating dependence (update) [GID-NG10086]’. We support the suggestion that QOF follows this for consistency.</p>
10	General	Primary Care Respiratory Society	<p>Every effort should be made to align indicators and coding with those being used in the RCP National Audit of COPD and asthma programme (NACAP) primary care audit , so that there is compatibility.</p>
11	General	Primary Care Respiratory Society	<p>We would strongly recommend that the phrase ‘treating tobacco dependency’ is used in these indicators rather than ‘smoking cessation.’ As QOF is focused on what clinicians do, then treating tobacco dependency as a long term condition which starts in childhood is very much the remit of healthcare professionals. NICE has made this distinction in the guideline it is currently updating by making the title –‘Tobacco: preventing uptake, promoting quitting and treating dependence (update) [GID-NG10086]’. We suggest that QOF follows this for consistency.</p>

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ID	Indicator	Stakeholder	Comment
12	General	Royal College of Nursing	<p>The Royal College of Nursing (RCN) welcome the consultation on the listed NICE QOF indicators. The RCN invited members who care for people with the listed conditions to review the draft indicators on our behalf.</p> <p>The comments below reflect the views of our reviewers.</p>
13	General	Royal College of Physicians	<p>The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the responses submitted by the British Association for Sexual Health & HIV (BASHH) and British Thoracic Society (BTS).</p>
14	IND188	British Thoracic Society	<p>The asthma indicators represent a laudable attempt to address some of the items identified in NRAD and incorporated into NICE guidance.</p> <p>The diagnostic indicator suggests criteria would be met if only FeNO is recorded – this is not an adequate stand-alone test - both FeNO and spirometry should be done to merit meeting criteria.</p>
15	IND188	British Thoracic Society	<p>The 2017 NICE Guideline Asthma: diagnosis, monitoring and chronic asthma management (2017) NG80 below states: Occupational asthma 1.1.10 Check for possible occupational asthma by asking employed people with suspected new-onset asthma, or established asthma that is poorly controlled:</p> <ul style="list-style-type: none"> • Are symptoms better on days away from work? • Are symptoms better when on holiday^[1]? <p>Make sure all answers are recorded for later review.</p> <p>1.1.11 Refer people with suspected occupational asthma to an occupational asthma specialist. There is very good evidence of delayed diagnosis in primary care, and that this adversely impacts asthma severity. To us, it is a "no brainer" that primary care is the best place to screen for this, and identify the 1 in 6 occupational causes of adult asthma much sooner - this is in the NICE guidance above and would be very simple to add to QOF 3 by simply adding 12 words:</p> <p>IND188: The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations, a written personalised action plan, and (if employed) documentation of whether symptoms improve during periods away from work.</p> <p>It would fit very well with the stated proposals below and they could add that early and accurate diagnosis of an occupational cause can result in cure of asthma, or stabilisation of asthma control in many patients, preventing a lifetime of unnecessary treatment:</p> <p>"Proposals for respiratory indicators focusing on accurate diagnosis. Given the lifelong implications of misdiagnosis, potential risk of adverse effects from unnecessary treatment and the development of more robust diagnostic pathways in NICE guidance, these indicators can help support accurate diagnosis and inform appropriate treatment."</p>

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ID	Indicator	Stakeholder	Comment
			We note that NICE recently removed asking about this in the Quality Standard, but the good it could offer the thousands of undiagnosed patients with occupational asthma could be huge (and would be very cost effective for the NHS).
16	IND188	KSS AHSN Respiratory Programme	Disappointed that inhaler technique is not specifically mentioned as this should be checked and corrected as required.
17	IND189	KSS AHSN Respiratory Programme	Only goes a small way to address the issue of inhaling multiple substances and needs to include vaping, water pipe smoking and a question that is asked of all ‘ do you or have you ever smoked, tobacco, shisha, cannabis, heroin, crack cocaine.....’ Vaping is particularly important in the younger age group
18	IND186	Asthma UK	<p>Asthma is the most common condition to affect children in the UK, approximately 5.4 million people (1.1 million children and 4.3 million adults) are currently receiving treatment for asthma. Asthma UK is concerned about how and where the data for children under the age of five with suspected asthma would be recorded under this indicator. The proposed indicator outlines that children under the age of five would not have their suspected asthma status recorded on the practice asthma register. However, Asthma UK believes that children under 5 should still have a suspected asthma diagnosis recorded, in order that when they turn five they can receive the appropriate tests as quickly as possible, to confirm or rule out an asthma diagnosis.</p> <p>Tests that measure lung function (peak flow rate and spirometry) and tests for airway inflammation (for example, fractional exhaled nitric oxide (FeNO)) can aid clinical diagnosis, but no single test can objectively confirm asthma or identify all the different types of asthma and some are particularly invasive or expensive. The invasive nature of these tests usually precludes diagnosis in preschool children.</p> <p>Nevertheless, we need to record those under the age of five with “suspected asthma” somewhere in the primary care system, in order that they are then tested when they reach the age of five and put on the asthma register if they do have asthma. We know that symptoms of asthma already occur early in life, with approximately a third of children wheezing during their first three years of life. Whilst the majority of these children will have stopped wheezing by the age of six, 40% will continue to wheeze, having already developed asthma or being in the process of developing asthma at a later stage.</p> <p>There is therefore a risk that toddlers with asthma could ‘fall off the radar’ if their asthma status is not registered anywhere; there should therefore be an active decision required by their GP to include or remove them from the register at the age of five once they can be tested, with opportunities for a further annual review.</p>

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ID	Indicator	Stakeholder	Comment
			<p>We would therefore recommend that this indicator should also include the need to keep a register of people with suspected asthma (both adults and children) for whom asthma is suspected, but not proven. This might help clinicians to care for patients with recurrent asthma-like symptoms, but who haven't had definitive testing (due to age, availability or willingness to have tests) as well as those who have had negative tests because of the variable nature of asthma. Read codes exist in GP IT systems to facilitate this.</p> <p>In terms of health inequalities, we also believe that the more conservative measure proposed in this consultation could put children with wheeze from disadvantaged backgrounds at a higher risk of not being diagnosed when they reach five, if their parents are less assertive with healthcare professionals about requesting a definitive diagnosis, or if it is more difficult to take time off work. Asthma UK's survey found 23% of parents of children with asthma had to take at least ten days off work during their child's diagnosis. We argue that the paediatric patient safety risk of underdiagnosis is greater than the cost risk of overdiagnosis and a precautionary principle should be applied.</p> <p>It should also be noted that some people with asthma and COPD could be on both registers. People with asthma are often put on the COPD register, either through misdiagnosis or because their asthma has got worse over time, but this poses a risk as treatments for these conditions are different. People with both conditions are at risk of getting no life-saving ICS medication. Similarly, people with COPD but with regular flare ups or uncontrolled symptoms, should be reconsidered as possibly having asthma and receive the appropriate diagnostic test for asthma.</p> <p><u>References</u> World Health Organization (WHO), 2019. 'Asthma'. Accessed at https://www.who.int/respiratory/asthma/en/, May 2019. Asthma UK, 2019. 'Asthma facts and statistics'. Accessed at https://www.asthma.org.uk/about/media/facts-and-statistics/, May 2019. Asthma UK, 2018. 'Diagnosing asthma'. Accessed at https://www.asthma.org.uk/supportus/campaigns/publications/diagnostics-report/, May 2019. Martinez F, Wright A, Taussig L, Holberg C, Halonen M and Morgan W, 1995. 'Asthma and Wheezing in the First Six Years of Life'. New England Journal of Medicine, 332(3): 133-138. van Aalderen W, 2012. Childhood Asthma: Diagnosis and Treatment. Scientifica, 1-18.</p>
19	IND186	Boehringer Ingelheim Limited	<p>Do you think there are any barriers to implementing the care described by these indicators? Practices will have to identify all patients on their register with an asthma diagnosis in order to assess asthma status and put on register. This is very positive as people who are not being treated can either be taken off the register or be put onto appropriate treatment, but may be time consuming and depends upon resource.</p>
20	IND186	Boehringer Ingelheim Limited	<p>Do you think there are potential unintended consequences to implementing/ using any of these indicators?</p>

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ID	Indicator	Stakeholder	Comment
			<p>Capturing patients with respiratory disease/pre-school wheeze etc. around their 5th birthday in order to then diagnose them with asthma, if appropriate, and monitor their disease - patients may be missed, for years, and are therefore at risk.</p> <p>Ensure those are not required on the register based on assessment results are removed and withdrawn from treatment where applicable with the education to support understanding of the process.</p>
21	IND186	Boehringer Ingelheim Limited	<p>Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.</p> <p>Could have negative impact on patients under 5 years of age. Diagnosis of asthma under the age of 5 is difficult and patients with respiratory problems should be under the care of a specialist paediatrician. Not sure that this Qof will avoid over diagnosis or overprescribing in this age group, but could lead to harm through under diagnoses and under treatment. Also, not putting these patients on the register may undermine the importance of identifying and managing asthma in under 5s; patients may not be referred appropriately or in a timely manner and may therefore be at higher risk.</p>
22	IND186	Boehringer Ingelheim Limited	<p>If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest how the indicator might be delivered differently to different groups to reduce health inequalities?</p> <p>Suggest removal of the age limit as some children can perform pulmonary function tests and diagnosed with asthma at 4 years of age. Also, even if patients are being treated by a specialist there is no harm in having them on a list for their GP to monitor.</p>
23	IND186	British Medical Association	<p>IND186: The contractor establishes and maintains a register of patients with asthma aged 5 or over.</p> <p>We support the changes to this indicator.</p>
24	IND186	GSK	<ul style="list-style-type: none"> • GSK supports the removal of the exclusion criteria 'excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.' The reason for no asthma-related drugs being prescribed in the past 12 months may be down to non-attendance, patients' perception that their asthma is controlled. On the contrary, the overprescribing of short-acting-beta2-agonists could be masking a patient's lack of asthma control, but this would not be uncovered in the currently metric. • It may be helpful to specify whether confirmation of a diagnosis be required (via a test such as FeNO or spirometry) for a patient to be included on the register.
25	IND186	Leadgate Surgery A83636	<p>The absence of prescription of inhalers is not just a proxy for incorrect diagnosis. It is much more useful (and common) as a proxy for asthma that has resolved or is currently quiescent. This change will lead to a very significant jump in the number of patients diagnosed with asthma. In a sample of 160K North Durham patients, this change would lead to</p>

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ID	Indicator	Stakeholder	Comment
			inclusion of an additional 8658 patients on the asthma register (a 79% increase on the current asthma QoF register). This would lead to an enormous burden of additional work in primary care with almost no benefit (and a lot of extra hassle) for patients.
26	IND186	National Pharmaceutical Advisers Group (PAG)	Makes sense to reduce misdiagnosis of under 5s resulting in unnecessary lifelong medication and associated medication risks
27	IND186	Primary Care Respiratory Society	The rationale for this change is understood. The previous indicator however acknowledged that some children under 5 can be diagnosed with asthma with reasonable confidence, and that securely diagnosed asthma may resolve for many years. We understand the intention for this indicator change is to drive better diagnosis but have some concern that in failing to acknowledge the points above it may cause some problems. The lower age limit is sensible since children can still if necessary be coded as having an asthma diagnosis but will not fall into the QOF measurement process. Removing the 12 month treatment limit will result in an immediate increase in practice asthma registers as patients with resolved asthma or a previous incorrect diagnosis of asthma come onto the register. This requirement for patient recall, review record tidying will involve a significant initial workload at a time when primary care services are by common consent overworked and understaffed. Clinicians and practices will require support and guidance about implementing this change.
28	IND186	Resuscitation Council (UK)	For avoidance of misunderstanding and correct use of English we suggest a change of wording from ' <i>The contractor establishes and maintains a register of patients with asthma aged 5 or over</i> ' to ' The contractor establishes and maintains a register of patients aged 5 or over with asthma '.
29	IND186	Royal College of General Practitioners	IND186: The contractor establishes and maintains a register of patients with asthma aged 5 or over. We support this change. It is beneficial to lower to age 5 years – this fits with difficulties of making a diagnosis of asthma in a child under 5 years.
30	IND186	Task and Finish Group on Asthma Policy	The T&F Group supports the proposal to change the wording of current QOF indicator AST001 to ' <i>The contractor establishes and maintains a register of patients with asthma aged 5 or over.</i> '
31	IND186	KSS AHSN Respiratory Programme	The removal of the exclusion (which works well and has no cost implications) is unnecessary. The change will increase workload and cost, as we will need to assess a greater number of patients for QOF every year. Practices will manage this in different ways, resulting in less good National Data. The patients who only have occasional wheeze, and use salbutamol at these times e.g. with colds, are very, very difficult to get to come for review. One approach practices may take is to do a search and change these people to "asthma resolved" and remove the patients from the register. The Practices will then get warnings e.g. salbutamol without a clinical indication on the years they do require a prescription.

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ID	Indicator	Stakeholder	Comment
32	IND186	NHS England	<p>We would strongly recommend that the phrase ‘treating tobacco dependency’ is used in these indicators rather than ‘smoking cessation.’ Treating tobacco dependency as a long-term condition which starts in childhood is very much the remit of healthcare professionals. NICE has made this distinction in the guideline it is currently updating by making the title ‘Tobacco: preventing uptake, promoting quitting and treating dependence (update) [GID-NG10086]’. We suggest that indicators follow this for consistency.</p>
33	IND187	Asthma UK	<p>Asthma is still commonly misdiagnosed, which means that people with untreated asthma are at risk of having an asthma attack, whilst others who do not have asthma will receive the wrong treatment. We therefore welcome encouraging the use of objective tests like spirometry and fractional exhaled nitric oxide (FeNO) testing to support a diagnosis of asthma, so patients can start receiving the correct treatment for their asthma and be confident about why they need to take their medication. This is also in line with NICE Quality Standard QS25 for Asthma. This should, not, however, be a substitute for taking a thorough patient history, as spirometry is a complex test which only reflects how a patient is on the day of testing and FeNo can produce false positives (e.g. if a patient has sinusitis). Asthma is a variable relapsing condition and that must always be considered by the clinician, including that some tests can produce false positives and negatives.</p> <p>Asthma UK recognises the current access barriers preventing all patients with suspected asthma from receiving objective testing such as spirometry or FeNO to confirm a suspected diagnosis. We have been calling on primary care providers and commissioners to <u>implement diagnostic hubs</u> so that every patient has access to accurate objective tests to help diagnose their asthma, no matter where they live. The NHS Long Term Plan promises to improve diagnosis for all respiratory conditions and we are actively encouraging NHS England to make sure this happens as objective testing is a crucial part of the process in diagnosing and managing asthma. This new Indicator will add valuable incentives to ensure diagnostic hubs are implemented. Failure to resolve this issue and implement the NICE guideline is continuing to be a barrier to people with suspected asthma having access to these important diagnostic tests.</p> <p>We note that the proposed indicator ‘requires a record of an objective test: FeNO or spirometry or reversibility or variability’. This is not precisely what the NICE guideline says. The indicator should ask that GPs follow the NICE diagnosis algorithm, which, at the very least, specifies FeNO and spirometry testing for adults.</p> <p>We also note that this Indicator will only apply prospectively to newly diagnosed patients, which means that it could technically take many decades before everyone with asthma has received an objective test. All people with asthma should receive treatment in line with NICE guidelines, including those previously diagnosed (or misdiagnosed) with the condition, particularly as there is currently a concern that many people have had the wrong diagnosis. Ideally everyone</p>

ID	Indicator	Stakeholder	Comment
			<p>would have retrospective objective tests at their next annual review, but 4 million people in England with asthma could not realistically be tested retrospectively in one year. We believe there is a good case for retrospective testing in stages, for example at the ages of 18 (transition to adulthood) and 40 (as part of the health check), so that more people receive a definitive diagnosis.</p> <p><u>References</u> NICE Asthma Quality Standard 25 Accessed at https://www.nice.org.uk/guidance/qs25, May 2019 Asthma UK, 2018. 'Diagnosing asthma'. Accessed at https://www.asthma.org.uk/support-us/campaigns/publications/diagnostics-report/, May 2019. NHS England, 2019. 'The NHS Long Term Plan'. Accessed at https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/, May 2019.</p>
34	IND187	Bedfont Scientific Ltd	<p>On the rationale says to fulfil this indicator you need '<i>This indicator requires a record of an objective test: FeNO or spirometry or reversibility or variability.</i>' Therefore I believe GPs could still just perform Spirometry alone to comply. However they reference the evidence base to NG80, which in the objective testing section states the following for FENO:</p> <p>Fractional exhaled nitric oxide</p> <p>1.3.2 Offer a FeNO test to adults (aged 17 and over) if a diagnosis of asthma is being considered. Regard a FeNO level of 40 parts per billion (ppb) or more as a positive test.</p> <p>1.3.3 Consider a FeNO test in children and young people (aged 5 to 16)² if there is diagnostic uncertainty after initial assessment and they have either:</p> <ul style="list-style-type: none"> • normal spirometry or • obstructive spirometry with a negative bronchodilator reversibility (BDR) test. <p>Regard a FeNO level of 35 ppb or more as a positive test.</p> <p>Therefore this indicator is not in-line with the evidence base in our opinion and should be amended with something like the following:</p> <p>Change the IND187 rationale to say 'This indicator requires a record of an objective test: FeNO and spirometry and additionally if required reversibility or variability</p>
35	IND187	Boehringer Ingelheim Limited	<p>Do you think there are potential unintended consequences to implementing/ using any of these indicators? FeNO is difficult to interpret - even by an asthma specialist. There could be confusion, along with over or under treatment with ICS. Could be a positive with regards to training and upskilling of staff, if taken on.</p>

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ID	Indicator	Stakeholder	Comment
36	IND187	Boehringer Ingelheim Limited	Do you think there are any barriers to implementing the care described by these indicators? Training in and confidence interpreting/acting upon FeNO, spirometry and reversibility measures. May be better to define variability. FEV1 can be normal in children with asthma and further tests may be required. FeNO may also be normal in asthma - provisions for patients with asthma and "normal" objective measure required. Measures should be done at and after diagnosis. How useful is an objective test 3 months before diagnosis?
37	IND187	British Medical Association	IND187: The percentage of patients with asthma on the register (date of implementation) with a record of an objective test of FeNO, spirometry, reversibility or variability between 3 months before or 3 months after diagnosis. We support the changes to this indicator.
38	IND187	British Society for Allergy and Clinical Immunology (BSACI)	I have a concern with IND187, which proposes that exhaled FeNO can be used as an alternative and possibly isolated criterion for the objective diagnosis of asthma. I feel that this is insufficiently specific, being influenced for example by atopic diseases such as allergic rhinitis in the absence of asthma and also upper respiratory viral infections, and is arguably more difficult to record accurately than basic spirometry in young children. I do not think that FeNO measurement alone is sufficient to confirm a diagnosis of asthma, and that it should ALWAYS be affirmed by documentation of variable airways obstruction as soon as practicable.
39	IND187	British Thoracic Society	The asthma change (IND187) should be spirometry with reversibility (of 12% or more). NOT spirometry or reversibility.
40	IND187	GSK	GSK suggests the addition of the word 'or' between the words FeNO, spirometry to indicate that either test would be sufficient rather than both being required.
41	IND187	KSS AHSN Respiratory Programme	Would suggest 'spirometry, reversibility or variability' is replaced with 'spirometry demonstrating reversible airflow obstruction and/or peak flow diurnal/day to day variability'
42	IND187	KSS AHSN Respiratory Programme	The main issues is FeNO in primary care and availability due to costs but the guidance could support practices in funding buying equipment so it is helpful for it to remain there particularly to reduce over diagnosis. We do not feel that FeNO is required in every case to support diagnosis and it is still not widely accessible in primary care.
43	IND187	NHS England	The primary care respiratory society argued against publication of the diagnostic section of the NICE asthma guideline because we were unconvinced of the necessity of using FeNO testing and spirometry for asthma diagnosis in every case (see extensive previous documentation). They felt that the BTS/SIGN asthma guideline offered a better guide to accurate asthma diagnosis. As such, we question the case for the prominence given to FeNO or spirometry in the proposed indicator. We would prefer to see a wording that required objective evidence for an asthma diagnosis – and listed possible supporting evidence in this order – variability or reversibility in peak flow measurements over time, spirometry with evidence of obstruction and reversibility, FeNO measurements. This indicator has been written to drive adherence to a flawed diagnostic guideline.

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ID	Indicator	Stakeholder	Comment
			<p>NICE's own field testing indicated significant problems with FeNO and did not give any figures about the actual contribution FeNO made to an accurate diagnosis. There are both false positives and false negatives with FeNO and it may not detect asthma in a patient with a chest infection or in patients who smoke.</p> <p>Regarding spirometry, NICE's own field testing report indicated that 'of the 33 people diagnosed with asthma during the project, whose spirometry was successfully completed, only nine had an obstructive result.'(Ref: p849 and p850 of feasibility study report https://www.nice.org.uk/guidance/ng80/documents/guideline-appendices). They previously wrote 'The majority of people with asthma will have normal spirometry when it is tested; these false negatives mean it is not possible to rule out asthma with spirometry, so a normal spirometry result does not exclude asthma.'</p> <p>The final lines of the 'Rationale for new indicator' read as follows: <i>This indicator requires a record of an objective test: FeNO or spirometry or reversibility or variability.</i></p> <p>This implies that a single objective test is sufficient to diagnose asthma. We do not believe that this reflects the diagnostic algorithm in the NICE guideline, nor do we believe it constitutes good practice. It is very important that the indicator does not imply that, for example, a positive FeNO test on its own, is sufficient to confirm a diagnosis of asthma.</p> <p>The previous 8 year age limit for objective diagnosis was sensible given the frequent difficulty of obtaining objective evidence as defined above for diagnosis in children under age 8.</p>
44	IND187	National Pharmaceutical Advisers Group (PAG)	Introduction of objective testing is welcome. This does have implications for funding of test equipment and consumables and training requirements for GP Practices. Most CCGs do not routinely do FeNO testing as this is carried out when referred into hospital.
45	IND187	Primary Care Respiratory Society	We argued as a society, against publication of the diagnostic section of the NICE asthma guideline because we were unconvinced of the necessity of using FeNO testing and spirometry for asthma diagnosis in every case (see extensive previous documentation). We felt that the BTS/SIGN asthma guideline offered a better guide to accurate asthma diagnosis. We would question the case for the prominence given to FeNO or spirometry in the proposed indicator . We would prefer to see a wording that required objective evidence for an asthma diagnosis – and listed possible supporting evidence in this order – variability or reversibility in peak flow measurements over time, spirometry with evidence of obstruction and reversibility, FeNO measurements. This indicator has been written to drive adherence to a flawed diagnostic guideline.

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			<p>NICE's own field testing indicated significant problems with FeNO and did not give any figures about the actual contribution FeNO made to an accurate diagnosis. There are both false positives and false negatives with FeNO, and it may not detect asthma in a patient with a chest infection or in patients who smoke.</p> <p>Regarding spirometry, NICE's own field testing report indicated that 'Of the 33 people diagnosed with asthma during the project, whose spirometry was successfully completed, only 9 had an obstructive result.'(Ref: p849 and p850 of feasibility study report https://www.nice.org.uk/guidance/ng80/documents/guideline-appendices). We have previously written as follows: 'The majority of people with asthma will have normal spirometry when it is tested; these false negatives mean it is not possible to rule out asthma with spirometry, so a normal spirometry result does not exclude asthma.'</p> <p>The final lines of the 'Rationale for new indicator' read as follows: <i>This indicator requires a record of an objective test: FeNO or spirometry or reversibility or variability.</i></p> <p>This implies that a single objective test is sufficient to diagnose asthma. We do not believe that this reflects the diagnostic algorithm in the NICE guideline, nor do we believe it constitutes good practice. It is very important that the indicator does not imply that, for example, a positive FeNO test on its own, is sufficient to confirm a diagnosis of asthma.</p> <p>The previous 8 year age limit for objective diagnosis was sensible given the frequent difficulty of obtaining objective evidence as defined above for diagnosis in children under age 8.</p>
46	IND187	Royal College of General Practitioners	<p>IND187: The percentage of patients with asthma on the register (date of implementation) with a record of an objective test of FeNO, spirometry, reversibility or variability between 3 months before or 3 months after diagnosis.</p> <p>Diagnostic tests for asthma (such as spirometry) may not be able to be conducted in primary care in children between 5 & 8 years – this would lead to increased referral to specialist care. Patients in this age bracket should be excluded from this indicator.</p>
47	IND187	Sefton CCG	<p>The algorithm indicates that definitive tests should be undertaken to make a diagnosis of asthma but acknowledges that a number of patients may have a diagnosis confirmed by looking at variability if the definitive tests have been unhelpful. The wording of the indicator does not appear to align the use of Variability with its position in the algorithm.</p>
48	IND187	Task and Finish Group on Asthma Policy	<p>The T&F Group were not able to reach a unanimous position regarding this proposed indicator. Some group members broadly supported the proposed indicator, with a recommendation that the wording is changed as follows (newly suggested indicator text listed in bold for ease of reference): '<i>The percentage of patients with asthma on the register</i></p>

ID	Indicator	Stakeholder	Comment
			<p><i>(date of implementation) with a record of an objective test of FeNO, spirometry, reversibility recorded between 3 months before or 3 months after diagnosis, in line with the specifications of the NG80 algorithm.'</i></p> <p>Other T&F Group members however did not support the proposed indicator, as a result of concerns around the feasibility of implementing FeNO and spirometry in primary care due to a lack of funding, alongside a lack of evidence supporting the use of FeNO itself particularly by generalists, and the impracticalities regarding spirometry to diagnose asthma. It was suggested that peak flow variability should be an option for primary care instead. T&F Group members that did not support the proposed indicator include Dr Mark Levy and Dr Steve Holmes.</p> <p>References Korevaar D, Westerhof G, Wang J et al. Diagnostic accuracy of minimally invasive markers for detection of airway eosinophilia in asthma: a systematic review and meta-analysis. <i>Lancet Respir Med</i> 2015; 3 (4): 290–300. April 2015. Available online at: https://www.ncbi.nlm.nih.gov/pubmed/25801413 NICE. Asthma: diagnosis and monitoring of asthma in adults, children and young people. NICE guideline NG80 Appendices A - R 2017. Available online at: https://www.nice.org.uk/guidance/ng80/evidence/appendices-a-r-pdf-4656178048</p>
49	IND188	Asthma UK	<p>Asthma UK strongly supports this indicator to ensure high quality asthma reviews are conducted with patients. Our annual survey shows that although most people do attend an annual review, this doesn't always deliver the basic elements of care such as patients having a written asthma action plan or an inhaler technique check.</p> <p>We very much welcome including a review of SABA use in the asthma control questionnaire as Asthma UK has had longstanding safety concerns about SABA over-reliance and use. However, it is important that recording this leads to concrete action which reduces SABA prescribing and improves patients' use of their preventer inhalers. NICE indicator guidelines/ narrative should make specific reference to this and the need for follow-up action to prevent patient over-reliance on SABA with the associated dangers this poses to their health, including poor asthma control, increased risk of exacerbations, hospitalisation and death from asthma. Over-use also needs to be clearly defined. For example, a recent article in the <i>Pharmaceutical Journal</i> stated that: the ideal ratio of reliever to preventer inhalers is 1:6, but it is currently more likely to stand at 2:1. Healthcare professionals need precise measures to be able to record SABA use and risk from prescribing data and for this data to be actioned. Research suggests that a patient having more than 3 reliever inhalers a year can lead to complications so, based on the precautionary principle, we would suggest that a patient having 3 reliever inhalers should trigger a patient review (pending further evidence-based research).</p> <p>Recording the number of exacerbations is another welcome proposal, although Asthma UK research has shown that there can be variance between patients' and clinicians' definitions of what constitutes an exacerbation, so there needs</p>

ID	Indicator	Stakeholder	Comment
			<p>to be clarity around this definition as well as recording of this data. We urge that patient reported and self-managed exacerbations should be recorded, not only those that led to emergency care or a course of oral steroids.</p> <p>All patients who have had two or more courses of oral steroids in 12 months should be referred for a specialist assessment in line with NICE QS25. However our research has found that many patients with difficult or severe asthma “slip through the net” and do not receive the referrals that they need. This is important as it will assist in severe asthma being properly diagnosed and treated; it should form the basis of an additional NICE indicator.</p> <p>We also welcome the inclusion of a written asthma action plan in the indicator, a measure that we have advocated for a long time and which is included in one of the five Quality Statements listed by NICE in QS25. Action plans can help people with asthma to self-manage their own care, doing the essential things needed to keep their asthma under control. More importantly they can help people to recognise when their asthma is becoming less well controlled and what actions are then needed to get their asthma back under control. Only 43.9% of people with asthma say they currently have an action plan, and we know that not having a written asthma action plan makes a person with asthma four times more likely to end up in hospital so we believe that this is a very helpful QoF measure which will improve outcomes for people with asthma. Adults and children should have asthma action plans.</p> <p>Asthma UK has developed written asthma action plan templates for adults and children, which include advice on how to get the most out of them, which we advocate should be used as part of the QoF process. These templates are downloaded from Asthma UK’s website over 100,000 people each year and are mentioned as an example in both the NICE and BTS/SIGN asthma guidelines and are accessible via EMIS. Where possible, and in line with the NHS’ strive to become paperless, Asthma UK would expect asthma action plans to be provided in a digital format, so they can be accessed on patients’ smartphones, laptops etc, to help them self-manage their condition through referring to them when needed.</p> <p>We note that inhaler technique is not included in the review although this is a key element of basic care. Using the right inhaler technique helps people with asthma to manage their condition successfully through breathing vital inhaled steroids straight into their lungs, where it is needed. Good inhaler technique therefore makes a significant difference to how well someone with asthma is able to self-manage their condition; it also means they are less likely to be prescribed higher doses of medication. Incorrect inhaler technique is frequent in patients and has not improved over the past 40 years according to a recent systematic review, pointing to an urgent need for new approaches to education and drug delivery, to ensure patients are getting the benefits they need from their medication. In addition, 60% of patients are unable to use their pressurised metered-dose inhaler devices (pMDI) correctly after being shown how on three occasions. Checking inhaler technique in asthma patients is therefore absolutely key to good asthma management.</p>

ID	Indicator	Stakeholder	Comment
			<p>We understand the argument that inhaler technique checks are not measurable other than through a tick-box approach and are often of variable quality when they are done. We also understand that NHS England plans for all people with asthma to receive medication use reviews performed by pharmacists, that would include inhaler technique checks instead, as outlined in NHS England’s Long Term Plan (para 3.86). Asthma UK requires assurance that high quality inhaler technique checks will be measured effectively through the NICE indicator framework to ensure this crucial aspect of basic care is not neglected.</p> <p>GPs should all be aware of Asthma UK’s <u>inhaler technique videos</u> that we have published, developed jointly with the UK Inhaler Group (UKIG) and fully evidence-based. These videos can be accessed online by healthcare professionals and patients as an aid to help people with asthma improve inhaler technique, helping to improve outcomes. Using our videos would have significant benefits, in terms of reducing medication waste, increasing efficacy and reducing side-effects in people with asthma (relating to one of the NHS’s biggest medicines spends) as well as reducing the time spent by health care professionals in teaching people how to use their inhalers correctly. We would recommend that recording that a patient has been referred to these videos, to help them self-manage their condition, should form part of this Indicator.</p> <p>Asthma UK is concerned that there is still too much focus on a single annual assessment of asthma, which is a condition that can vary across the year. All significant exacerbations such as an asthma attack should therefore prompt another patient review to update the patient’s management, self-management and Asthma Action Plan. We know that too many children and young people have tragically died as a result of a lack of joined-up care following asthma attacks and admissions to hospital. This is simply not acceptable. In order to save lives, Asthma UK recommends that measures are put in place requiring a review of all patients in primary care within 48 hours of discharge by emergency services. It is also a NICE QS25 standard: “People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge. [2013, updated 2018].”</p> <p>However it is problematic to see how this can be incentivised through the QoF indicators mechanism in primary care alone because of the joint nature of this care pathway, but activating this best practice is seen as essential by Asthma UK. This ideally now needs to form part of the NICE indicators process, potentially as a shared QOF, CCG and National Audit indicator.</p> <p>Finally, asthma reviews should also be carried out in primary care by someone appropriately trained to do so (e.g. with a specialist asthma care diploma) – as per BTS/SIGN, NICE QS 25 and GINA, every time a person has an attack,</p>

ID	Indicator	Stakeholder	Comment
			<p>irrespective of where they are treated. Proper training is essential to ensure the healthcare professional carrying out the review fully understands the complexities of asthma as a condition.</p> <p>In summary, we would suggest that the QoF indicator should specify the need for a 'structured patient review,' by a healthcare professional with specialist training, comprising the following essential requirements:</p> <ul style="list-style-type: none"> • the completion of a validated asthma control questionnaire assessing both asthma control and risk; a standard template of such a questionnaire should be easily accessible by all healthcare professionals through primary care IT systems. • an assessment of preventer and reliever inhaler use through monitoring prescribing data, with risk specified for patients who have had more than 3 SABA inhalers in one year, leading to more frequent patient monitoring and recall; • an assessment of the number of exacerbations and OCS prescriptions over the previous year, with referral for a specialist opinion triggered where a patient has had two or more course of oral steroids (NICE QS25) or has persistent poor asthma control; • the production of a written Asthma Action Plan such as Asthma UK's, made available to the patient digitally to improve their self-management; and • an assessment of both (i) medicines adherence and (ii) inhaler technique (by a pharmacist or asthma nurse) including a requirement to share Asthma UK's inhalers videos with patients to help them manage their medicines. <p><u>References</u> Yang JF, Chaudhuri R, Thomson NC, Ramparsad N, O'Pray H, Barclay S et al. Insights into frequent asthma exacerbations from a primary care perspective and the implications of UK National Review of Asthma Deaths recommendations, Primary Care Respiratory Medicine Volume 28, Article number: 35 (2018). Accessed at https://www.nature.com/articles/s41533-018-0103-9, May 2019 Attar-Zadeh D, UK asthma mortality is too high, but pharmacy can help. Clinical Pharmacist 1 FEB 2019. Accessed at: https://www.pharmaceutical-journal.com/opinion/insight/uk-asthma-mortality-is-too-high-but-pharmacy-can-help/20206055.article, May 2019 Stanford RH, Shah MB, D'Souza AO, Dhamane AD, Schatz M. Short-acting β-agonist use and its ability to predict future asthma-related outcomes. Annals of Allergy, Asthma & Immunology 2012;109:403-7. Asthma UK. The reality of asthma care in the UK. Annual Asthma Survey 2018 report. Accessed at https://www.asthma.org.uk/578f5bcf/globalassets/get-involved/external-affairs-campaigns/publications/annual-asthma-care-survey/annual-asthma-survey-2018/asthmauk-annual-asthma-survey-2018-v7.pdf, May 2019 NICE Asthma Quality Standard 25 https://www.nice.org.uk/guidance/qs25 accessed May 2019</p>

ID	Indicator	Stakeholder	Comment
			<p>Asthma UK, 2018. 'Annual Asthma Survey'. Accessed at https://www.asthma.org.uk/get-involved/campaigns/publications/survey/, May 2019.</p> <p>Asthma UK, 2018. 'Your asthma action plan'. Accessed at https://www.asthma.org.uk/advice/manage-your-asthma/action-plan/, May 2019.</p> <p>Asthma UK, 2019. 'Filling in patients' asthma action plans'. Accessed at https://www.asthma.org.uk/for-professionals/professionals/filling-patients-action-plans/, May 2019.</p> <p>Asthma UK, 2018. 'Using your inhalers'. Accessed at https://www.asthma.org.uk/advice/inhalers-medicines-treatments/using-inhalers/, May 2019.</p> <p>Sanchis J MD PhD, Gich I MD PhD, Pedersen S MD PhD Dr Med Sci, Aerosol Drug Management Improvement Team (ADMIT), Systematic Review of Errors in Inhaler Use: Has Patient Technique Improved Over Time? Chest Volume 150, Issue 2, August 2016, Pages 394-406. Accessed at: https://www.sciencedirect.com/science/article/pii/S0012369216475719</p> <p>Hardwell A, Barber V, Hargadon T, McKnight E, Holmes J, Levy ML, 2011. 'Technique training does not improve the ability of most patients to use pressurised metered-dose inhalers (pMDIs)'. Prim Care Respir J, 20(1):92–6.</p> <p>NHS England, 2019. 'The NHS Long Term Plan'. Accessed at https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/, May 2019.</p> <p>Asthma UK, 2018. 'How to use your inhaler'. Accessed at https://www.asthma.org.uk/advice/inhaler-videos/, May 2019.</p>
50	IND188	AstraZeneca	<p>AstraZeneca fully supports the update of this indicator, and the need to improve the identification of asthma patients at increased risk of poor outcomes. However, based on data available, we have some suggestions to strengthen what has been proposed.</p> <p>We agree that, as stated in the rationale, during an asthma review, an understanding of the patient's SABA use is an important part of understanding their risk of poor outcomes. Evidence suggests that patients using 3 or more SABA canisters in a year are at increased risk of asthma exacerbations and therefore increase healthcare resource use. A study by Schatz et al¹ showed that increasing the number of SABA canisters used per year increased the risk of a patient having an exacerbation (defined as hospitalisation or a course of oral corticosteroids). The differences were statistically significant across all SABA inhaler groups but were most pronounced between those patients using 0-2 canisters per year and 3-6 canisters per year, and also between those patients using 7-12 canisters per year and more than 12 canisters per year. These results suggest that there is an opportunity to positively impact on patient outcomes by reviewing asthma patients using 3 or more canisters of SABA per year. This opportunity is recognised in the 2019 update to the Global Initiative for Asthma guidelines, which identifies that 3 or more SABA canisters dispensed in a year is associated with an increased risk of severe exacerbations, whilst 12 or more canisters in a year is associated with increased risk of asthma-related death, and therefore SABA only treatment is no longer recommended.²</p>

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ID	Indicator	Stakeholder	Comment
			<p>Based on this evidence, we urge the advisory committee to strengthen the suggested indicator. We suggest that SABA review should be a key part of an asthma review, and that a patient's management strategy should be reviewed if a SABA threshold of 3 or more canisters per year is exceeded. We suggest the following as an update to the indicator:</p> <p>The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of SABAs used, number of exacerbations and a written personalised action plan, with a medication review for patients using 3 or more SABAs in the preceding 12 months.</p> <p>References Stanford RH, Shah MB, D'Souza AO, Dhamane AD, Schatz M. Short-acting β-agonist use and its ability to predict future asthma-related outcomes. <i>Annals of Allergy, Asthma & Immunology</i> 2012;109:403-7. Shatz et al. <i>J Allergy Clin Immunol</i> 2006;117:995-1000 Global Initiative for Asthma. <i>Pocket Guide for Asthma Management and Prevention</i>. Updated 2019.</p>
51	IND188	Bedfont Scientific Ltd	<p>Evidence base Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendations 1.5.1 Stop smoking interventions and services (2018) NICE Guideline NG92, recommendations 1.2</p>
52	IND188	Boehringer Ingelheim Limited	<p>Do you think there are any barriers to implementing the care described by these indicators? This is a positive change. There should be no barrier as long as HCPs are directed to appropriate asthma control questionnaires and action plans and given the NICE definition of an asthma attack/exacerbation.</p>
53	IND188	Boehringer Ingelheim Limited	<p>Do you think there are potential unintended consequences to implementing/ using any of these indicators? The consultation time with a patient may take longer and would need to be factored in to ensure success.</p>
54	IND188	British Medical Association	<p>IND188: The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan.</p> <p>We support the changes to this indicator.</p>
55	IND188	GSK	<p>GSK is supportive of the proposal to replace the three RCP questions with a questionnaire that enables a more detailed assessment of asthma control. However, we believe further benefit could be achieved if the indicator went further to:</p> <p>a) Recommend the use of a single quantifiable standard measure of asthma outcomes which can be completed by patients as well as healthcare professionals. The implementation of a single quantifiable standard will enable</p>

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			<p>analysis of variability of control across the country, as well as at a local health economy level and can therefore be used to drive action plans and improvements, ensuring that investments into asthma care are maximised and appropriately targeted and progress tracked over time.</p> <p>b) Systematically measure outcomes, by way of level of control (which GINA states is the objective of asthma treatment). This would provide a more meaningful picture of asthma control rather than simply recording whether a review has taken place. This would be more in line with proposed indicator 'the percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale'. Again, this could be achieved through use of the Asthma Control Test.</p> <p>Rationale for the above recommendations. Asthma related hospital admissions are sometimes used as a measure of asthma outcomes, however, for every 100 asthmatics on the register there are only 2 non-elective admissions for asthma in a year across NHS England whereas 81 in every 100 could be uncontrolled and 42 in every 100 say it interferes with daily activities. It is clear from this data that historical interventions have not been effective in patients achieving control of their asthma.</p> <p><u>References</u> NHS Digital, Quality and Outcomes Framework 2016-17: Prevalence, achievements and exceptions, respiratory group, at GP practice level, http://digital.nhs.uk/catalogue/PUB30124, accessed 5 Mar 2018 & Health IQ Vantage data, Asthma Non – Elective Admissions (J45 & J46); April 2016 – March 2017. NHS England CCGs and GP Practices; accessed 5 Mar 2018 Asthma UK Annual Asthma Survey 2018 Report – last accessed March 2019</p>
56	IND188	KSS AHSN Respiratory Programme	Action plans are good idea but presumably it would not need to be a new plan every year, if the current plan is still appropriate. Suggest NICE should provide examples of templates which can be pre populated and printed off GP systems.
57	IND188	NHS England	It is important to clarify how SABA use is to be coded. As the new indicator is currently worded, it seems that clinicians are expected to use a validated asthma control questionnaire, which includes a measure of SABA use. This would rule out using RCP 3 questions, but would support use of the 7-question Asthma control questionnaire, and the 5-question Asthma control test. However, the ACT and ACQ still only record perceived SABA usage, and it is probably worth clarifying if prescribing data from practice computers on SABA usage will be extracted for accuracy and consistency. This would enable practices to continue to use the widely used RCP 3 questions. It is important that as a standard tool, using the RCP 3 questions questionnaire still "counts". We would argue that it should still be valid, since the practicality

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			<p>gain compensates for the lesser degree of validation. Careful thought needs to go into wording the indicator so that clinicians will be prompted to act on a level of SABA use that indicates poor control, not simply record SABA usage.</p> <p>It would be useful to have clarification that clinicians will need to code specifically that they have used a validated questionnaire to establish degree of asthma control, AND a separate code for having discussed and issued a written personal asthma action plan. We believe that using a single code for these e.g. for an asthma review, would be less helpful in driving these important elements of review to become standard, and would favour having separate codes.</p>
58	IND188	<p>National Pharmaceutical Advisers Group (PAG)</p>	<p>Introduction of a validated questionnaire may provide a more sensitive detection of asthma severity and improve asthma control.</p>
59	IND188	<p>Novartis Pharmaceuticals UK Ltd</p>	<p>Novartis believe that assessment of control should include both assessment of current symptom control and identification of future risks. As highlighted by NRAD, failure to identify risk was found to be a major contributory factor in many of the asthma deaths that have been reviewed.¹ Identifying future asthma risk is also set out as a key criterion within the recently updated GINA guidance, which outlines both identification of risk factors for future poor outcomes as well as symptom control as the two domains crucial to achieving high-quality asthma control.²</p> <p>NRAD¹ and British Thoracic Society (BTS)/Scottish Intercollegiate Guidelines Network (SIGN)³ Guidelines recommend that the identification of risks of fatal or near fatal asthma could include patients that received the following in the preceding 12 months:</p> <ul style="list-style-type: none"> • An inpatient admission due to asthma • 2 or more A&E attendances due to asthma • >2 exacerbations requiring systemic corticosteroids (oral or injected) • >3 short acting reliever inhalers (short acting beta agonists, SABAs)* <p>*This recommendation is in line with evidence demonstrating that use of three or more SABA inhalers per year is associated with an increased risk of asthma-related hospitalisation.⁴</p> <p>We recommend the following amendment to this indicator to ensure reviews include the assessment of identification of risk factors:</p> <p>IND188: The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including</p>

ID	Indicator	Stakeholder	Comment
			<p>assessment of short acting beta agonist use), a recording of the number of exacerbations, identification of future risk, and a written personalised action plan.</p> <p>References:</p> <ol style="list-style-type: none"> 1. Royal College of Physicians. Why Asthma Still Kills: The National Review of Asthma Deaths (NRAD). Confidential Enquiry Report. May 2014. Accessed May 2019: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills 2. Global Initiative for Asthma. Pocket guide for asthma management and prevention. 2019. Access May 2019: https://ginasthma.org/wp-content/uploads/2019/04/GINA-2019-main-Pocket-Guide-wms.pdf 3. SIGN 153. British guideline on the management of asthma. September 2016. Accessed May 2019: https://www.brit-thoracic.org.uk/.../guidelines/asthma/btssign-asthma-guideline-2016/ 4. Hull S, McKibben S, Horner K et al. Asthma prescribing, ethnicity and risk of hospital admission: an analysis of 35,864 linked primary and secondary care records in East London. Primary Care Respiratory Journal. 2016; 26. Accessed May 2019: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4989925/
60	IND188	Primary Care Respiratory Society	<p>It is important to clarify how SABA use is to be coded. As the new indicator is currently worded, it seems that clinicians are expected to use a validated asthma control questionnaire, which includes a measure of SABA use. This would rule out using RCP 3 questions, but would support use of the 7-question Asthma control questionnaire, and the 5-question Asthma control test. However the ACT and ACQ still only record perceived SABA usage, and it is probably worth clarifying that prescribing data from practice computers on SABA usage will be extracted for accuracy and consistency. This would enable practices to continue to use the widely used RCP 3 questions. It is important that as a standard tool, using the RCP 3 questions questionnaire still “ counts”. We would argue that it should still be valid, since the practicality gain compensates for the lesser degree of validation. Careful thought needs to go into wording the indicator so that clinicians will be prompted to act on a level of SABA use that indicates poor control, not simply record SABA usage.</p> <p>It would be useful to have clarification that clinicians will need to code specifically that they have used a validated questionnaire to establish degree of asthma control, AND a separate code for having discussed and issued a written personal asthma action plan. We believe that using a single code for these e.g. for an asthma review, would be less helpful in driving these important elements of review to become standard, and would favour having separate codes.</p>
61	IND188 IND189 INDxx INDxx	Resuscitation Council (UK)	<p>The proposed initial wording of these indicators is ‘<i>The percentage of patients with asthma/COPD/heart failure on the register...</i>’. We believe that these sentences would be better worded ‘The percentage of patients on the register with asthma/COPD/heart failure...’. This is a minor point relative to our other more important comments.</p>

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62	IND188	Royal College of General Practitioners	<p>IND188: The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan.</p> <p>We are concerned about the inclusion of a 'written personalised action plan' for all people with asthma on the register. This is likely only to be beneficial to patients with poorly controlled asthma and should not be put forward as a requirement for all asthma reviews.</p>
63	IND188	Task and Finish Group on Asthma Policy	<p>The T&F Group broadly supports the proposal to change the wording of current QOF indicator AST003 to <i>'The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan'</i> although the group believe several additional changes to the indicator would help to strengthen it further. These are listed below.</p> <p>We believe that this indicator should emphasise the importance of asthma reviews being carried out by a healthcare practitioner with appropriate asthma training, as recommended within NRAD. Anecdotal reports suggest that in some parts of the country, asthma reviews are being carried out by healthcare assistants with insufficient expertise, jeopardising the quality of these reviews and subsequent outcomes for asthma patients. Lack of knowledge and improper implementation by healthcare professionals of UK asthma guidelines played a part in nearly half of all avoidable deaths reported in NRAD, demonstrating the significance of ensuring annual asthma reviews are of the highest possible quality.</p> <p>In addition, we also believe it is hugely important that because asthma symptoms vary from time to time, simply asking about symptoms once a year is insufficient, and that the need to identify future asthma risk is incorporated within the wording of this indicator. As highlighted by NRAD, failure to identify risk has been a major contributory factor in many of the asthma deaths that have been reviewed, with reliance on current symptom control in many cases proving to be an unsatisfactory indication of future outcomes. An expert review of just under 100 papers on so-called mild asthma showed that between 30-37% of patients admitted to hospital with acute asthma and 15-20% of adults dying from asthma were having less than weekly symptoms, and there is a strong body of evidence demonstrating the issue of severity classification in relatively non-symptomatic asthma.</p>

ID	Indicator	Stakeholder	Comment
			<p>NRAD makes a clear recommendation that improvements are needed in this area as a result⁸ and the recommendation to identify future asthma risk is also made by the European Respiratory Society and American Thoracic Society Task Force (ERS/ATS Task Force). It is similarly set out as a key criteria within the recently updated GINA guidance, which clearly outlines the two domains crucial to asthma control: symptom control; and risk factors for future poor outcomes.⁷</p> <p>In light of this we believe that assessment of asthma control must therefore include both assessment of current symptom control and identification of future risk. As recommended by NRAD and SIGN/BTS 153 (Table 11), identification of future risk could include assessing whether patients experienced or received the following in the preceding 12 months:</p> <ul style="list-style-type: none"> • Previous near fatal / life threatening asthma attack • An inpatient admission due to asthma • 2 or more A&E attendances due to asthma • >2 exacerbations requiring systemic corticosteroids (oral or injected) • >3 short acting reliever inhalers (short acting beta agonists, SABAs)* <p>*Evidence demonstrates that more than three SABA inhalers per year is associated with an increased risk of asthma-related hospitalisation and more than 12 SABA inhalers per year is associated with an increased risk of asthma-related deaths.</p> <p>Based on the above, we therefore believe that the indicator should be rephrased to (newly suggested indicator text listed in bold for ease of reference):</p> <p><i>'The percentage of patients with asthma on the register, who have had at least one asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan and evidence of appropriate action taken in those with previous attacks.'</i></p> <p><u>References</u> Dusser D, Montani D, Chanez P et al. Mild asthma: an expert review on epidemiology, clinical characteristics and treatment recommendations. European Journal of Allergy and Clinical Immunology. Volume 62, Issue 6. June 2007. Available online at: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1398-9995.2007.01394.x American Journal of Respiratory and Critical Care Medicine. An Official American Thoracic Society / European Respiratory Society Statement: Asthma Control and Exacerbations. July 2009. Available online at: https://www.atsjournals.org/doi/full/10.1164/rccm.200801-060ST</p>

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			<p>Healthcare Improvement Scotland. SIGN 153: British Guideline on the Management of Asthma. September 2016. Available online at: https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-2016/</p> <p>Hull S, McKibben S, Horner K et al. Asthma prescribing, ethnicity and risk of hospital admission: an analysis of 35,864 linked primary and secondary care records in East London. Primary Care Respiratory Journal. 2016; 26. Available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4989925/</p> <p>Stanford RH, Shah MB, D'Souza AO et al. Short-acting β-agonist use and its ability to predict future asthma-related outcomes. Annals of Allergy, Asthma & Immunology 2012;109:403-7. Available online at: https://www.annallergy.org/article/S1081-1206(12)00640-0/fulltext</p> <p>Suissa S, Ernst P, Boivin JF et al. A Cohort Analysis of Excess Mortality in Asthma and the Use of Inhaled Beta-Agonists. American Journal of Respiratory and Critical Care Medicine. Vol 149, No 3. March 1994. Available online at: https://www.atsjournals.org/doi/pdf/10.1164/ajrccm.149.3.8118625</p>
64	IND189	Action on Smoking and Health (ASH)	<p>Including the recording of active and passive smoking status in children aged 19 years and younger would be a very welcome addition to the menu of indicators.</p> <p>This will not only encourage and normalise the asking and recording of exposure to environmental tobacco smoke amongst healthcare professionals, children and families, but will also offer an important opportunity to raise awareness of the significant impact passive smoking can have on children's health and its exacerbation of ill health.</p> <p>Exposure to environmental tobacco smoke amongst children remains significant. ASH's Smokefree GB survey found that, in 2018, exposure to secondhand smoke by someone living in the home amongst children aged under 18 ranged from 10.3% to 26.5%, depending on housing tenure. This demonstrates the challenge that remains with secondhand smoke exposure amongst children in England. An indicator, ensuring passive smoking exposure is recorded, could prompt healthcare professionals to deliver Very Brief Advice on smoking to parents, with the potential to reduce child exposure, and illustrates the positive impact an indicator which would ensure passive smoking status is recorded and encourage the delivery of smoking cessation advice could have on these children's health.</p> <p><u>References</u> Action on Smoking and Health. Smoking in the home: New solutions for a smokefree generation. November 2018. Link: http://ash.org.uk/information-and-resources/reports-submissions/reports/smoking-in-the-home-new-solutions-for-a-smokefree-generation/.</p>
65	IND189	Asthma UK	<p>Passive smoking is a risk for people with asthma, so recording this status is welcomed. Childhood exposure to passive smoke has been shown to be associated with an increased risk of developing asthma. As with active cigarette</p>

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			<p>smoking, we know that exposure to passive smoke can have a number of adverse effects on asthma control in both children and adults. In children who have asthma, passive smoke exposure can result in exacerbations of symptoms such as wheezing and coughing, increased use of reliever medication, hospitalisation and a number of life-threatening attacks.</p> <p>Asthma UK understands that smoking status in adults is recorded via other QoF indicators, but is essential that this information is flagged to healthcare professionals dealing with asthma patients in the clinic. Cigarette smoking in asthma is associated with a range of health risks and if a person with asthma smokes, it increases their risk of having a life-threatening asthma attack. In addition, smoking stops asthma medication from working properly, so, even if someone with asthma is taking all their medication as prescribed, they will be more at risk of symptoms like breathlessness, wheezing and coughing. There is a longer-term risk too: if people with asthma carry on smoking, then their condition continues to be more difficult to manage and they are at risk of developing other serious lung conditions such as COPD and lung cancer. More than half of people with asthma tell us that tobacco smoke affects their asthma.</p> <p>Asthma UK would not only expect that all people with asthma should have their smoking status monitored from the age of 13-19 and beyond, but that there should also be a requirement, recorded in patients' notes, that they have been referred to smoking cessation treatment or specialist sources of advice.</p> <p>In addition, we would advocate that primary use of e-cigarettes should also be recorded.</p> <p><u>References</u> Skorge T, Eagan T, Eide G, Gulsvik A, Bakke P, 2005. 'The Adult Incidence of Asthma and Respiratory Symptoms by Passive Smoking In Uteroo in Childhood'. American Journal of Respiratory and Critical Care Medicine, 172(1): 61-66. Asthma UK, 2018. 'Quit smoking to lower your asthma risk'. Accessed at https://www.asthma.org.uk/advice/manage-your-asthma/quit-smoking/, May 2019. Asthma UK, 2018. 'Quit smoking to lower your asthma risk'. Accessed at https://www.asthma.org.uk/advice/manage-your-asthma/quit-smoking/, May 2019. Asthma UK, 2018. 'Cigarette smoke'. Accessed at https://www.asthma.org.uk/advice/triggers/smoking/, May 2019.</p>
66	IND189	Bedfont Scientific Ltd	Proposed indicator IND189: The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months. With a record of an objective test of breath carbon monoxide to check self-reported abstinence, with success defined as less than 10 parts per million (ppm).
67	IND189	Bedfont Scientific Ltd	Existing QOF indicator: AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months.

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ID	Indicator	Stakeholder	Comment
68	IND189	Bedfont Scientific Ltd	<p>Rationale for the new indicator: Asthma and tobacco smoke interact to cause more severe symptoms, these symptoms include accelerated decline in lung function, and impaired short-term therapeutic response to corticosteroids (Thomson, et al. 2004). In addition, exposure to environmental tobacco smoke results in an increase in the frequency of emergency care attendances for the treatment of acute asthma exacerbations (Chilmonczyk et al. 1993) • The available data for children and young people aged between 11 and 15 years (NHS Digital, 2017a) report that 7% are regular or occasional smokers, these data are for all children and young people rather than those with asthma. The prevalence of smoking increases with age, from less than 1% of 12-year olds to 15% of 15-year olds. • In addition, children and young people are exposed to ‘second hand’ smoke in their home or in someone else’s home with 14% of 11 to 15 year old’s being exposed to secondhand smoke “every day or most days” (NHS Digital, 2017a). Over the previous 12-month period 62% reported being exposed to second hand smoke in their home, someone else’s home or in car. This indicator aims to encourage general practice to ask children and young people aged 5 to 19 years with asthma about their exposure to tobacco and encourage smoking cessation advice. Using objective tests to confirm smoking status can improve the accuracy of a diagnosis and reduce incidences of patients receiving inappropriate care. Results of testing should inform subsequent education for people with asthma and lead to improved health and wellbeing. This indicator requires a record of an objective test: carbon monoxide.</p>
69	IND189	British Medical Association	<p>IND189: The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months.</p> <p>We support the changes to this indicator.</p>
70	IND189	NHS England	<p>This is an important opportunity to raise awareness of the significant impact of exposure to environmental tobacco smoke on young people with asthma – alongside their own tobacco smoking. Recording of passive smoking status should be standard in any history taking process, and its inclusion here will help to normalise asking patients and their families about exposure.</p>
71	IND189	National Pharmaceutical Advisers Group (PAG)	<p>The introduction of a question that includes passive smoking will inform the clinician about issues with response to treatment not in the current indicator.</p>
72	IND189	Primary Care Respiratory Society	<p>This is an important opportunity to raise awareness of the significant impact of exposure to environmental tobacco smoke on young people with asthma – alongside their own tobacco smoking. Recording of passive smoking status should be standard in any history taking process, and its inclusion here will help to normalise asking patients and their families about exposure.</p>
73	IND189	PHE	<p>Smoking is not a good thing for health. Specifically, regarding respiratory disease, the general message should be that that people with lung disease should not be smoking as it will reduce lung function further.</p>

ITEM 5a - Asthma – consultation report

ID	Indicator	Stakeholder	Comment
			<p>Public Health England (PHE) welcomes the proposal to include a record of exposure to secondhand smoke in those aged 19 and under. However, we would suggest a change to the wording, to bring this more in line with standard terminology. Also need to be more specific about the passive smoke exposure, as this is too broad currently (everyone would be exposed to secondhand smoke at some point in last year). Suggested amendment (in bold) to, “The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status or exposure to secondhand smoke in the home in the preceding 12 months.</p> <p>It would be helpful if smoking status and/or exposure to secondhand smoke in the home are two separately recorded indicators. It would be better not to have these combined as one indicator, as we would be unable to distinguish between current smokers and those who are exposed to others` smoking. This would enable the calculation of national smoking prevalence data from these data. The interventions delivered also differ significantly, depending on if the young person smokes (very brief advice for them to quit), or their parents/guardians smoke (in which case the intervention would be aimed at the parent/guardian).</p>
74	IND189	Royal College of General Practitioners	<p>IND189: The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months. We support this change</p>
75	IND189	South Eastern Hants CCG	<p>Asking for smoking history in all age 5-19 group is likely to cause upset to some parents of those at younger end of this age range and take up time in a consultation explaining the reason for it – why not ask age range 12-19- there won't be many below this.</p>
76	IND189	Task and Finish Group on Asthma Policy	<p>The T&F Group supports the proposal to change the wording of current QOF indicator AST004 to <i>‘The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months.’</i></p>

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