Childhood Asthma : Lessons still to be learnt

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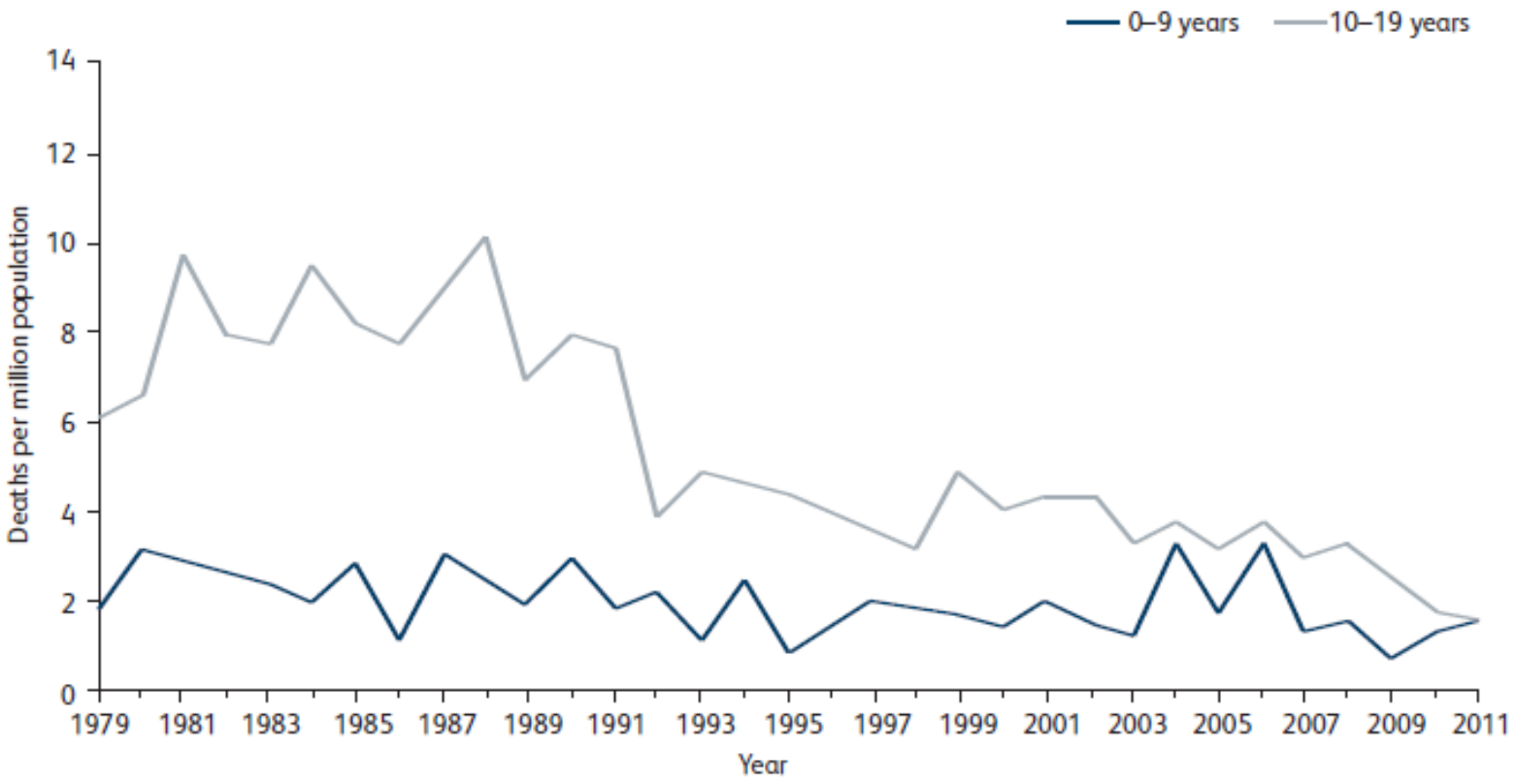
Background

- In the UK, 5.4 million people are currently receiving treatment for asthma: 1.1 million children (1 in 11) and 4.3 million adults (1 in 12).
- The UK has one of the highest prevalence rates for asthma in Europe, according to the ERS Whitebook.
- The UK has some of the highest asthma death rates in Western Europe according to the Death rates (all ages) for OECD nations and the World Health Organisation
- Three people die every day because of asthma; based on mortality data from Office for National Statistics (ONS) for England & Wales, General Register Office for Scotland, and Northern Ireland Statistics & Research Agency (Northern Ireland). 1255 people died from asthma in 2013 – divided by 365, this works out as 3.4 people per day.
- Tragically, the National Review of Asthma Deaths found that two thirds of asthma deaths are preventable with good, basic care.
- 7 out of 10 people with asthma do not receive care that meets the most basic clinical standards.

Asthma deaths : Reduced 80s & 90s but no improvement since 2000

Fig 1.1 Deaths attributed to asthma. Males and females combined, 0–19 years, UK 1979–2011



National Review of Asthma Deaths 2014

- At least Half of deaths avoidable.
- Half of deaths from group thought to have ‘mild or moderate’ disease.
- Evidence of systematic weaknesses in care provided related to poor continuity in GP, lack of systematic overview, excessive prescription of bronchodilators without ICS and LABAs without ICS
- Inconsistent FU of DNAs or WNBs esp for families in difficulty.

How we can do better

- NRAD recommendations are particularly relevant to our child's death.
- Especially: lack of continuity of care,
  unbalanced prescribing,
  lack of clear consistent and escalating follow up plans for DNAs,
  no referral into secondary care

Recommendations

Organisation of NHS services

1. Every NHS hospital and general practice should have a designated, named clinical lead for asthma services, responsible for formal training in the management of acute asthma.
2. Patients with asthma must be referred to a specialist asthma service if they have required more than two courses of systemic corticosteroids (oral or injected) in the previous 12 months or require management using British Thoracic Society (BTS) stepwise treatment 4 or 5 to achieve control.
3. Follow-up arrangements must be made after every attendance at an emergency department or out-of-hours service for an asthma attack. Secondary care follow-up should be arranged after every hospital admission for asthma, and for patients who have attended the emergency department two or more times with an asthma attack in the previous 12 months.
4. A standard national asthma template should be developed to facilitate a structured, thorough asthma review. This should improve the documentation of reviews in medical records and form the basis of local audit of asthma care.
5. Electronic surveillance of prescribing in primary care should be introduced as a matter of urgency to alert clinicians to patients being prescribed excessive quantities of short-acting reliever inhalers, or too few preventer inhalers.
6. A national ongoing audit of asthma should be established, which would help clinicians, commissioners and patient organisations to work together to improve asthma care.

Recommendations

Medical and professional care

1. All people with asthma should be provided with written guidance in the form of a personal asthma action plan (PAAP) that details their own triggers and current treatment, and specifies how to prevent relapse and when and how to seek help in an emergency.
2. People with asthma should have a structured review by a healthcare professional with specialist training in asthma, at least annually. People at high risk of severe asthma attacks should be monitored more closely, ensuring that their PAAPs are reviewed and updated at each review.
3. Factors that trigger or exacerbate asthma must be elicited routinely and documented in the medical records and PAAPs of all people with asthma, so that measures can be taken to reduce their impact.
4. An assessment of recent asthma control should be undertaken at every asthma review. Where loss of control is identified, immediate action is required, including escalation of responsibility, treatment change and arrangements for follow-up.
5. Health professionals must be aware of the features that increase the risk of asthma attacks and death, including the significance of concurrent psychological and mental health issues

Recommendations

Prescribing and medicines use

1. All asthma patients who have been prescribed more than 12 short-acting reliever inhalers in the previous 12 months should be invited for urgent review of their asthma control, with the aim of improving their asthma through education and change of treatment if required.

2. An assessment of inhaler technique to ensure effectiveness should be routinely undertaken and formally documented at annual review, and also checked by the pharmacist when a new device is dispensed.

3. Non-adherence to preventer inhaled corticosteroids is associated with increased risk of poor asthma control and should be continually monitored.

4. The use of combination inhalers should be encouraged. Where long-acting beta agonist (LABA) bronchodilators are prescribed for people with asthma, they should be prescribed with an inhaled corticosteroid in a single combination inhaler.

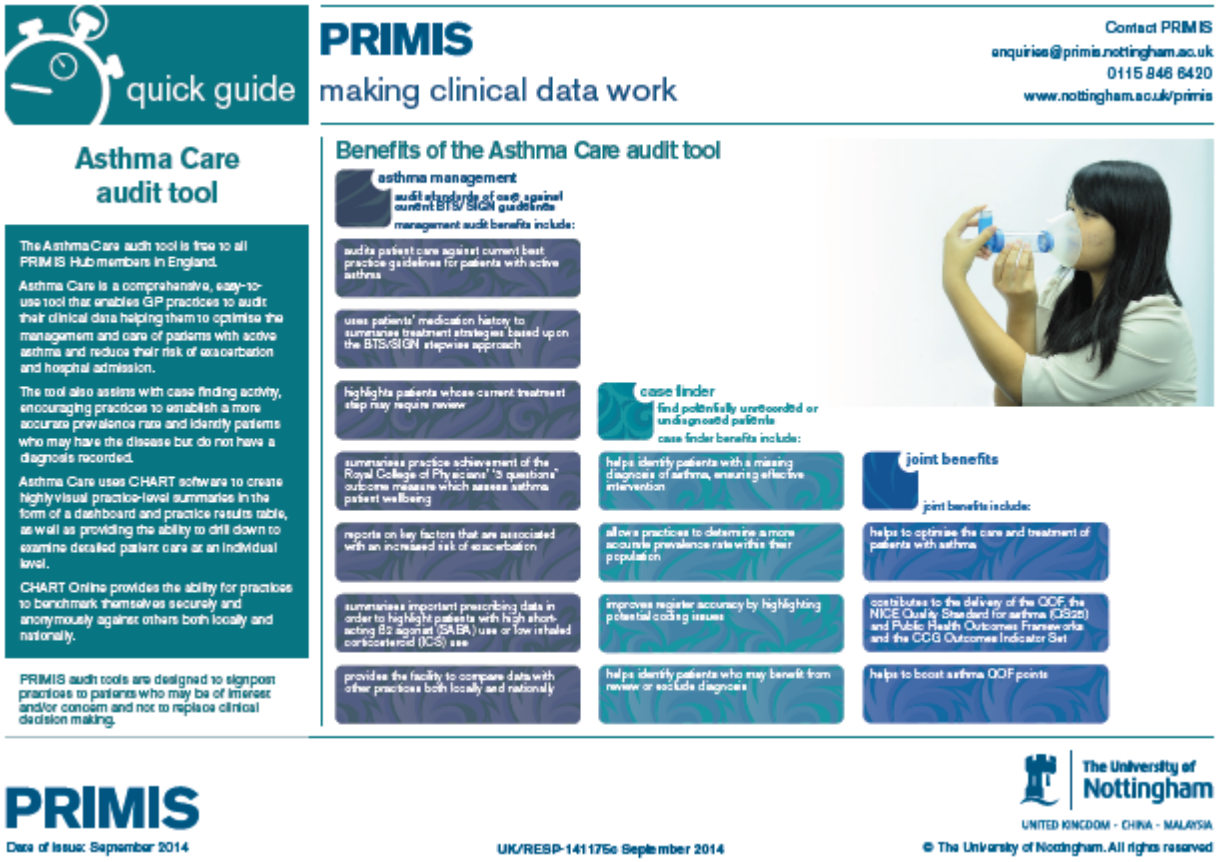
Recommendations

Patient factors and perception of risk

1. Patient self-management should be encouraged to reflect their known triggers, eg increasing medication before the start of the hay fever season, avoiding non-steroidal anti-inflammatory drugs, or by the early use of oral corticosteroids with viral- or allergic-induced exacerbations.
2. A history of smoking and/or exposure to second-hand smoke should be documented in the medical records of all people with asthma. Current smokers should be offered referral to a smoking-cessation service.
3. Parents and children, and those who care for or teach them, should be educated about managing asthma. This should include emphasis on ‘how’, ‘why’ and ‘when’ they should use their asthma medications, recognising when asthma is not controlled, and knowing when and how to seek emergency advice.
4. Efforts to minimise exposure to allergens and second-hand smoke should be emphasised, especially in young people with asthma.

Primary Care Resources to help audit and support good asthma care delivery.

https://www.nottingham.ac.uk/primis/tools-audits/tools-audits/asthma.aspx



quick guide

PRIMIS

making clinical data work

Contact PRIMIS
enquiries@primis.nottingham.ac.uk
0115 846 6420
www.nottingham.ac.uk/primis

Asthma Care audit tool

The Asthma Care audit tool is free to all PRIMIS Hub members in England.

Asthma Care is a comprehensive, easy-to-use tool that enables GP practices to audit their clinical data helping them to optimise the management and care of patients with active asthma and reduce their risk of exacerbation and hospital admission.

The tool also assists with case finding activity, encouraging practices to establish a more accurate prevalence rate and identify patients who may have the disease but do not have a diagnosis recorded.

Asthma Care uses CHART software to create highly visual practice-level summaries in the form of a dashboard and practice results table, as well as providing the ability to drill down to examine detailed patient care at an individual level.

CHART Online provides the ability for practices to benchmark themselves securely and anonymously against others both locally and nationally.

PRIMIS audit tools are designed to signpost practices to patients who may be of interest and/or concern and not to replace clinical decision making.

Benefits of the Asthma Care audit tool

asthma management

audit standards of care against current BTS/SIGN guidelines

management audit benefits include:

- audits patient care against current best practice guidelines for patients with active asthma
- uses patients' medication history to summarise treatment strategies based upon the BTS/SIGN stepwise approach
- highlights patients whose current treatment step may require review
- summarises practice achievement of the Royal College of Physicians' "3 questions" outcome measure which assess asthma patient wellbeing
- reports on key factors that are associated with an increased risk of exacerbation
- summarises important prescribing data in order to highlight patients with high short-acting B2 agonist (SABA) use or low inhaled corticosteroid (ICS) use
- provides the facility to compare data with other practices both locally and nationally

case finder

find potentially undiagnosed or undiagnosed patients

case finder benefits include:

- helps identify patients with a missing diagnosis of asthma, ensuring effective intervention
- allows practices to determine a more accurate prevalence rate within their population
- improves register accuracy by highlighting potential coding issues
- helps identify patients who may benefit from review or exclude diagnosis

joint benefits

joint benefits include:

- helps to optimise the care and treatment of patients with asthma
- contributes to the delivery of the QOF, the NICE Quality Standard for asthma (QS25) and Public Health Outcomes Framework and the CCG Outcomes Indicator Set
- helps to boost asthma QOF points

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Conclusions & Discussion

- GP management of asthma improved in the 80s & 90s but has stalled in the last decade
- There are helpful audit tools readily available to help match management against NRAD recs
- How would you escalate concerns about non-attendance, non-adherence to treatment and concerns about neglect?
- What might be your staged approach?