



All Party Parliamentary Group
for Respiratory Health

APPG Report

Improving Asthma Outcomes In The UK ONE YEAR ON



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February 2022

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All-Party Parliamentary Group for Respiratory Health

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Introduction

This has been a difficult year. In 2020 we published our report “Improving Asthma Outcomes in the UK”¹, containing a number of recommendations designed to assist with the tremendous work being undertaken across the asthma disciplines to improve patient outcomes.

The report was in response to the (then) latest figures on asthma which showed that asthma attacks in the UK had increased by a third over the last decade² and that the number of people affected by asthma in the UK is amongst the highest in the world.³

Our intention was to produce a One Year On report on asthma outcomes to highlight and emphasise the tremendous work that has been carried out by those working in asthma. We intended to highlight the progress that had taken place in the last year and any further areas that needed to be reconsidered.

Pre-COVID, there were some very promising initiatives being undertaken – the unified NICE/BTS/SIGN guidelines were being developed and the transition to the ICSs looked to reduce regional variations and inequalities.

The COVID-19 outbreak was declared a pandemic by the WHO on the 12th March 2020⁴, although the impact was felt earlier in a number of countries including the UK. The outbreak and its consequences have had a devastating effect on many lives and impacted asthma care in a number of ways.

The COVID pandemic and its devastating impact has affected the scope of this report and instead of concentrating on asthma outcomes one year on, we have also looked carefully at the impact of COVID on respiratory health and tried to assess those areas within asthma care that suffered most and what it would take to restore these to pre-COVID levels or beyond.

The pandemic led to significant disruptions in respiratory disease care, compounding many existing issues with chronic airways disease management. We have seen a big impact on central respiratory care capacity and clinicians in a time of crisis.

Sustainably strengthening care provision for chronic airway disease patients has a vital role to play, not only in chronic airways disease management and relieving pressure on healthcare systems but also, as we have seen, in times of crisis such as during the pandemic. COVID-19 must serve as the trigger to upgrade and reset approaches, in line with the latest evidence and establish key recommendations on best practice.

COVID has severely impacted respiratory services both globally⁵ and across the UK⁶, which have come under increasing demand at all levels of care. We have heard from clinicians, support staff and all those working on respiratory services in the NHS that they have been stretched to the limit by the pandemic and that it has not been an easy year.

We have nothing but the greatest admiration and respect for all those working in the NHS during these difficult times and especially for those in respiratory health, which has been the hardest hit of the clinical disciplines. They are a credit to their profession and the NHS and we place on record our thanks and gratitude to them all.

¹ appg-asthma-report-2020.pdf (ed.ac.uk)

² appg-asthma-report-2020.pdf (ed.ac.uk))

³ appg-asthma-report-2020.pdf (ed.ac.uk)

⁴ WHO/Europe | Coronavirus disease (COVID-19) outbreak - WHO announces COVID-19 outbreak a pandemic)

⁵ The Impact of the COVID-19 pandemic on noncommunicable disease resources and services. WHO, 2020 9789240010291-eng.pdf (who.int)

⁶ Next Steps on COVID-19 Response, NHS England, 2020. urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf (england.nhs.uk)

The effects of the pandemic on asthma care have been most noticeable in reduced contact time with GPs, with face to face GP consultations during the first lock down falling by 90% and a substantial fall in asthma specialist referrals of 75%⁷, together with delays in the introduction of key policy initiatives such as the unified guidelines and improvements to levels of access for biologics for severe asthma.

We note that progress has been made in some other areas despite the pandemic and reduced resources within the DHSC and NHS England, such as the roll out of the community diagnostic centres and policies and these should be welcomed.

We have looked at the current situation and have raised a number of straightforward recommendations to enable the DHSC, NHS England and Improvement and the asthma community to have greater confidence in the delivery of asthma care and treatment following the pandemic.

To assist us, we continued our engagement with senior clinicians and patient groups and they have added their expert advice on the current situation as it is affected by COVID. We have taken their views into careful consideration and we have revisited a number of issues that were identified in our initial inquiry as being of particular importance.

We are indebted to those who have helped us to put this report together. We are especially grateful to Professor Andrew Menzies-Gow, the National Clinical Director for Respiratory Disease for his leadership and incomparable advice.



The effects of the pandemic on asthma care have been most noticeable in reduced contact time with GPs, with face to face GP consultations during the first lock down falling by 90% and a substantial fall in asthma specialist referrals of 75%⁷, together with delays in the introduction of key policy initiatives such as the unified guidelines and improvements to levels of access for biologics for severe asthma.



⁷ NHS e-Referral Service (e-RS) open data dashboard - NHS Digital

Asthma

Asthma is a common long-term, usually inflammatory condition that can affect people of all ages. Asthma attacks in the UK have increased by a third over the last decade² and the number of people affected by asthma in the UK is amongst the highest in the world, with up to 5.4 million people estimated to suffer from asthma.³

Many patients however, do not receive the standard of asthma care that they should and this is reflected especially in severe asthma. The impact is notable for patients:

Asthma

- ▶ Almost two thirds (65%) of people with asthma do not receive a yearly review, despite recommendations by The National Institute for Health and Care Excellence (NICE) that they should^{8, 9}
- ▶ Regular use of blue inhalers is associated with asthma deaths^{10, 11}
- ▶ 22.5 million blue inhalers are dispensed to asthma patients each year (an average of 5 per diagnosed asthma patient when 3+ blue (reliever) canisters per year is associated with a two-fold increased risk of severe asthma attack¹²
- ▶ 130,000 patients receive 3+ courses of oral corticosteroids per year¹³

Severe asthma

- ▶ In England, Asthma UK estimates that up to 50,000 may be eligible for biologic treatment and 11,800 are estimated to be receiving treatment in June 2020.¹⁴
- ▶ NHS England estimates 140 per 1 million people are eligible for new severe asthma treatments¹⁵
- ▶ Studies show that over two out of three of all asthma deaths are associated with major potentially preventable factors^{16, 17} and could be prevented with better routine care¹⁸
- ▶ Asthma attacks lead to over 77,000 hospital admissions each year¹⁹

- ⁸ Pharmaceutical Services Negotiating Committee -- Essential facts, stats and quotes relating to asthma. <https://psnc.org.uk/services-commissioning/essential-facts-stats-and-quotes-relating-to-asthma/>
- ⁹ National Institute for Health and Care Excellence -- Asthma scenario follow-up - <https://cks.nice.org.uk/asthma#!scenario:1> Last accessed September 2021
- ¹⁰ Suissa S, Blais L, Ernst P. Patterns of increasing beta-2-agonist use and the risk of fatal or near-fatal asthma. *European Respiratory Journal*. 1994;7(9):1602-9
- ¹¹ Suissa S, Ernst P, Boivin JF, Horwitz RI, Habbick B, Cockcroft D, Blais L, McNutt M, Buist AS, Spitzer WO. A cohort analysis of excess mortality in asthma and the use of inhaled beta-agonists. *Am J Respir Crit Care Med*. 1994;149(3 Pt 1):604-10
- ¹² Bloom, C.I., Cabrera, C., Arnetorp, S. et al. *Asthma-Related Health Outcomes Associated with Short-Acting β_2 -Agonist Inhaler Use: An Observational UK Study as Part of the SABINA Global Program*. *Adv Ther* 37, 4190–4208 (2020). <https://doi.org/10.1007/s12325-020-01444-5> [Last accessed 16th November 2020]
- ¹³ *Asthma UK, Living in Limbo: the Scale of Unmet Need in Difficult and Severe Asthma* (2019) Pg. 10. <https://www.asthma.org.uk/69841483/globalassets/get-involved/external-affairs-campaigns/publications/living-in-limbo/living-in-limbo---the-scale-of-unmet-need-in-difficult-and-severe-asthma.pdf> [Last accessed 13th November 2020]
- ¹⁴ Do No Harm, Asthma UK, *severe-asthma_report_final.pdf*. Last accessed, September 2021
- ¹⁵ Service Specification, Specialised Respiratory Services (adult) – Severe Asthma. NHS England. [specialised-respiratory-services-adult-severe-asthma.pdf](https://www.nhs.uk/england.nhs.uk/specialised-respiratory-services-adult-severe-asthma.pdf) (england.nhs.uk). Last accessed October 2021
- ¹⁶ Royal College of Physicians & Health Quality Improvement Partnership, *Why Asthma Still Kills: The National Review of Asthma Deaths [confidential enquiry report]* (May 2014) Pg. 4
- ¹⁷ British Thoracic Association. Death From Asthma in Two Regions of England *BMJ* (Oct 30th 1982) 285(6350): 1251–1255 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1499823/>
- ¹⁸ Royal College of Physicians & Health Quality Improvement Partnership, *Why Asthma Still Kills: The National Review of Asthma Deaths [confidential enquiry report]* (May 2014) Pg.43
- ¹⁹ Asthma UK, *Asthma Facts and Statistics* (2017) <https://www.asthma.org.uk/about/media/facts-and-statistics/> [Last accessed, 13th November 2020]

Impact of COVID on asthma treatment

COVID-19 has had a severe effect across all aspects of healthcare²⁰, which has been felt in every part of the UK. The impact and consequences have been unprecedented within respiratory care services and have presented unique and difficult challenges for everyone and we recognise the work undertaken by the Government and their clinical and scientific advisers to try to minimise the impact on patients and the UK economy, in what has been an unenviable situation.

Respiratory services have been the clinical area that has been hardest hit. The pandemic impacted asthma care in a number of ways, with the prescription of inhalers to the reduction in GP services, the drop in referrals and drop in patient attendances in A&E and primary care due mainly to patients being concerned to leave home to see a doctor, it has been a very difficult time for clinicians and patients.



²⁰ Elective care in England - Assessing the impact of COVID-19 in 2020 and where next. The Health Foundation, 2020. Elective care in England - The Health Foundation

Restoration of asthma reviews

Normal NHS respiratory services were badly affected and many of the services were reduced or stopped completely during the pandemic and although a large number of patients were able to access their GPs through video consultations, face to face consultations are still a long way from full recovery. To complicate this further, the wait for diagnostic tests is at a record high.

A recent study from the University of Edinburgh, reported in the BMJ, stated that presentations to primary care for asthma exacerbations dropped by a fifth. The reduction was observed in all age groups, both sexes and across most regions in England.²¹

This was also reflected in emergency admissions for asthma during the height of the pandemic. Emergency admissions due to asthma fell by a remarkable 67% in April and May 2020.²²

It is clear from these outcomes that it is possible to reduce asthma attacks, albeit in this instance under severe circumstances. The reduction will have been helped by a mixture of shielding for severe asthma patients, lower air pollution rates, the government advice to stay at home more and the widespread use of masks, inhaled corticosteroids and lower social interactions. There is also the possibility that many patients were too scared to access health services or did not wish to burden them and so may have not reported exacerbations.

NICE introduced new rapid guidelines for severe asthma which contained some innovative new practices such as virtual MDT meetings to speed up access to specialist care and widening of home-administration of biologics, which could have the potential to be carried forward into routine care to significantly accelerate care.²³

It is however vital to protect and improve patient access to face-to-face support where this is needed. Virtual consultations have assisted clinicians in offering patients continuity of treatment but there are ongoing issues with the widespread switch to virtual consultations.

A recent survey of people with lung conditions by Asthma UK/BLF²⁴ showed that 1 in 10 patients with asthma had routine care cancelled by their GP

In addition to these complications, in order to increase capacity in front line services in respiratory health, NHS England amended parts of the GP Contract which permitted GPs to suspend annual reviews and medication reviews for people with asthma and COPD. It is estimated that as many as 630,000 people with asthma may have missed their annual reviews.²⁵

In their 2020 survey,²⁴ Asthma UK identified problems within basic asthma care levels around their recommended care for patients, which they defined as:

- ▶ an annual asthma review
- ▶ an inhaler technique check
- ▶ a written asthma action plan

The Asthma UK 2020 survey found that In 2020, 34.7% of people with asthma received essential basic care. This means that fewer than 35% of patients with asthma (an estimated 3.53 million) received basic levels of care.²⁴

²¹ Impact of COVID-19 national lockdown on asthma exacerbations: interrupted time-series analysis of English primary care data | Thorax (bmj.com)

²² Hospital Episode Statistics data (2018/19 to 2020/21) and NHS England, A&E Attendances and Emergency Admissions. Nuffield Trust, Chart of the week: Emergency admissions for asthma and COPD during Covid-19 | The Nuffield Trust

²³ Overview | COVID-19 rapid guideline: severe asthma | Guidance | NICE

²⁴ Asthma Care in a Crisis, Annual Asthma Survey 2020. Asthma UK. aas-2020_2a-1.pdf (asthma.org.uk)

²⁵ Asthma UK and the British Lung Foundation – Written Evidence (PSR0027) House of Lords Public Services Select Committee inquiry on public services: lesson from coronavirus. <https://committees.parliament.uk/writtenevidence/7867/pdf/>

The survey data also showed that remote annual asthma reviews do not always provide the same level of care as face-to-face appointments. Nearly half (47.7%) of people with asthma reported that the remote care they received was not of the same quality as a face-to-face appointment.²¹

Reduced face to face consultations also deny GPs the means to make a full diagnosis. They are prevented from diagnosing signs and symptoms of other respiratory diseases that would normally be picked up in person.²⁶

To help patients during the pandemic, the Taskforce for Lung Health, in partnership with NHS England, has produced a position paper to assist patients on how to optimise inhaler technique during remote consultations.²⁷

We commend the taskforce and NHS England for their outstanding efforts in devising a working solution for patients struggling with the lack of face-to-face consultations.

On the 14th October, NHS England published “Our plan for improving access for patients and supporting general practice”,²⁸ which sought out to address the access challenge and although many practices are getting back to normal, in August 2021 over 15% of practices still recorded less than 20% face to face GP appointments.

The two main principles behind the plan are to improve access to urgent, same day primary care, ideally from patients’ own GP practice and expand same day urgent care capacity to ease the winter pressures on the NHS. The government also announced new £250 million funding to support the plan.

We welcome the funded strategy from NHS England although we note that it is very early in the process and that it will be necessary to see how the initiative works in practice and to what extent it gains the confidence of clinicians. We hope that people with severe asthma and asthma that is difficult to control can be prioritised in the planned increase.

Remote care is likely to remain as part of the future care of asthma patients and in some cases can work well for some patients but for patients with severe asthma, this would present more of a challenge. We believe it is a matter for clinicians, together with their patients to decide the best method of consultation, whether remote or face to face.

NHS England has published the “National Bundle of Care for Children and Young People with Asthma”, which is designed to reduce avoidable harm to children and young people from asthma and improve their quality of life. It takes a whole system approach to asthma treatment and care and is due to be rolled out in 2022.²⁹

Recommendations

- ▶ We recommend annual asthma reviews are restored as soon as possible and that face to face consultations are made available once again to all who would benefit from them
- ▶ We recommend that NHS England and NICE should review those elements of the Severe Asthma Rapid Guidelines which worked well to accelerate specialist care and expand capacity and consider what should be retained in the future joint guidelines and national severe asthma service specification
- ▶ We recommend that electronic alerts be introduced into primary care when steroids are prescribed which will identify when patients require an exacerbation or post exacerbation review
- ▶ We recommend that the children and young people care bundle for asthma is rolled out without undue delay in 2022

²⁶ Virtual consultations in the lung cancer pathway - What works for patients and healthcare professionals? https://www.msconnect.co.uk/static/mciuk/pdf/Virtual_consultations_in_the_lung_cancer_pathway.pdf Last accessed August 2021

²⁷ Medicines optimisation working group | Taskforce for Lung Health (blf.org.uk)

²⁸ BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf (england.nhs.uk)

²⁹ <https://www.england.nhs.uk/wp-content/uploads/2021/09/B0606-National-bundle-of-care-for-children-and-young-people-with-asthma-phase-one-September-2021.pdf>

SABA prescribing

During the pandemic, we saw SABA prescribing rise which is a concern and in itself could present an increased risk to patients.

In June 2020, the Pharmaceutical Journal reported a substantial increase of 60% in SABA inhaler prescriptions from the year prior to COVID and 2020.³⁰

NHS data also showed a similar, large increase in inhaler prescribing across the UK. In March 2020, 2.77 million prescriptions were made for salbutamol inhalers – a rise of 63% from the previous February. The comparable figures for the year to March demonstrated a slightly smaller increase but still significant.

The rise has been caused by patients “stocking up” before the first lockdown with the consequence that it may encourage greater reliance and inappropriate use of SABA reliever inhalers although we note that there was an increase in preventer inhaler prescriptions in the same period.

Integration with ICSs

A recent survey of people with lung conditions run by Asthma UK and the British Lung Foundation showed that the time needed to restore referrals and treatment to pre-COVID levels remains unclear but the time is right to consider ambitious steps to accelerate asthma services to beyond COVID levels.

There are many challenges ahead within respiratory services and asthma provision. It is clear that to return asthma diagnosis and referral figures to pre-COVID levels, or even improve them, will take some time.

The necessity for adequate services for treating long COVID patients further complicates the timescale and this will take additional resources to manage with the risk that this extension of provision may come at the expense of regular respiratory provision.

We welcome the set up of the new Integrated Care Systems (ICS) and their promise to bring greater integration of health and care services; improve population health and reduce inequalities; support productivity and sustainability of services.³¹

The transfer of services from the present CCGs to the (ICS) by April 2022 will be challenging for severe asthma services and we believe that the national service specifications will be central to achieving sustainability in respiratory services.

The first principle for the ICSs has been defined as:

“All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.”³²

Severe asthma care is likely to move to a mostly regionally-mandated model and the process of developing regional service specifications and an updated national service specification is a good opportunity to re-evaluate how capacity to treat severe asthma can be increased, such as better upskilling and empowering secondary care such that they can initiate biologics where clinically appropriate.

³⁰ (Salbutamol inhaler prescribing jumped 60% at start of COVID-19 pandemic – The Pharmaceutical Journal (pharmaceutical-journal.com))

³¹ Report template – NHS website ([england.nhs.uk](https://www.england.nhs.uk))

³² Report template – NHS website ([england.nhs.uk](https://www.england.nhs.uk))

However, we are concerned that there is no mention of any respiratory criteria in the ICS performance metrics in the NHS system oversight framework, when respiratory disease is the third leading cause of death in the UK. It deserves therefore to be included alongside the existing ICS specifications on cardiovascular, mental health and cancer outcomes and we call for asthma outcomes to be included in the next version.^{33, 34}

The switch to ICSs presents an opportunity to ensure that capacity can better match need at a population level but it will require consistency not only within the service specifications themselves as they move towards regional specifications but in the roll out at a local level. To manage this and ensure consistency we believe that respiratory planning and standards should be built into the ICS performance frameworks and reassessed after twelve months to determine how they may be improved further.

Recommendations

- ▶ The transition to ICSs presents an opportunity for local care systems to be more reflective of local needs. In order to achieve consistent asthma provision, we recommend that respiratory planning and standards be built into the ICS performance frameworks from the beginning
- ▶ We recommend that respiratory disease be included alongside the existing ICS specification on cardiovascular, mental health and cancer outcomes and we call for asthma specific outcomes to be included in the next version
- ▶ We recommend that the updated national service specifications for severe asthma and the regional specifications should identify ways to better enable secondary care to initiate and/or monitor biologics prescribing to free up capacity in tertiary care



The switch to ICSs presents an opportunity to ensure that capacity can better match need at a population level but it will require consistency not only within the service specifications themselves as they move towards regional specifications but in the roll out at a local level.



³³ <https://www.england.nhs.uk/publication/core20plus5-infographic/>

³⁴ <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0693-nhs-oversight-metrics-for-2021-22.pdf>

Life Sciences Vision

In the recently published Life Sciences Vision report, the government accepts that there is an over-reliance in the UK on “rescue” therapies prior to or after an attack, with over 15.5 million blue rescue inhalers prescribed every year, and more than 130,000 people taking at least three courses of oral corticosteroids each year.³⁵

The Life Sciences Vision goes further and includes the potential to advance the science and significantly reduce the number of attacks, hospitalisations and deaths over the next decade.

It describes a collective effort from Government, Industry and NHS England to explore options to create “more effective treatment options for asthma, particularly for children and young adults, to build on the significant improvements in the understanding of the biological processes that lead to the airway inflammation that causes asthma by identifying new risk biomarkers for asthma and leverage genetics to better identify populations that will respond to new treatments and support patients with uncontrolled disease.”

The Vision will also work to improve care pathways by improving diagnostic capacity and technology. This is designed to provide earlier access to treatment for a number of respiratory diseases including asthma and help to better use diagnostics and monitoring technologies to improve understanding of respiratory diseases and their underlying causes.

Such technology could improve the speed with which individuals can move through clinical pathways.

We strongly welcome the aspirations around respiratory health and asthma in particular in the vision but to realise these effectively there needs to be a delivery plan with clear steps and resources.

We were disappointed that beyond setting out funds for the mental health, cancer and obesity missions in the Vision, there has been no resource allocation for respiratory health arising from the Vision. Clinical capacity in hospital settings is a straightforward method to support trials and we believe that specific resources are required in order to deliver on the ambitions in the vision.

Recommendation

- We recommend that the R&D aspirations in the Life Sciences Vision for precision medicines in asthma should be supported by a defined resource, committed to increasing the capacity in hospitals for asthma clinical trials

The Vision will also work to improve care pathways by improving diagnostic capacity and technology.

³⁵ Life Sciences Vision (publishing.service.gov.uk)

Overuse of SABA

Prior to the COVID pandemic, responders to our inquiry last year identified the overuse of SABA inhalers as both the biggest area for improvement and the most important causes of unnecessary asthma deaths within asthma care and management. These were identified as matters of some concern by both clinicians and patients.

In our report we cited the numerous studies which had shown that over-reliance on reliever inhalers (SABA) may lead to reduced use of preventer inhalers and to a greater risk of preventable attacks.^{36,37} These conclusions were supported by the respondents to our enquiry, many of whom focused on these dangers.^{38,39,40,41}

We also pointed out that the NRAD report included evidence that regular over-use of short acting relievers increases the risk of asthma attacks^{42,43} hospitalisations and deaths.^{44,45}

The SABINA (SABA use In Asthma) study found that high SABA inhaler use was frequent among UK patients and was associated with a significant increase in exacerbations, deaths and asthma-related healthcare reliance, regardless of treatment step or asthma severity and stated that there is a need to align SABA prescription practices with current treatment recommendations.⁴⁶

The SABINA study defined high SABA use as ≥ 3 SABA canisters per year and found that high use was observed in over one-third of UK asthma patients, with those prescribed excess SABA having twice as many asthma attacks.⁴⁷

Patients who are using excessive numbers of inhalers should be flagged^{48,49} and identified^{51,51,52} and reviewed in primary care with inhaler technique, adherence, treatment escalation and smoking cessation. If they remain uncontrolled then they need to be referred immediately to an asthma trained clinician.⁵³

Innovative approaches have also been demonstrated on the ground in order to achieve SABA reduction. A 2018 study commissioned by The Lancet suggested that in some patients, where clinically appropriate, a MART strategy involving use of a combination steroid and long acting beta agonist would allow a SABA-free regimen and therefore be an effective way to reduce SABA overuse.⁵⁴

³⁶ O'Byrne P, Jenkins C and Bateman E. The Paradoxes of Asthma Management: Time for a New Approach? *Eur Respir J.* 2017;50:1701103. <https://doi.org/10.1183/13993003.01103-2017>; [Last accessed 16th November 2020]

³⁷ Partridge M, van der Molen T, Myrseth S-E and Busse W. Attitudes and Actions of Asthma Patients on Regular Maintenance Therapy: the INSPIRE Study, *BMC Pul Med.* 2006;6:13. <https://doi.org/10.1186/1471-2466-6-13> (Last accessed 16th November 2020)

³⁸ Asthma UK Centre for Applied Research's Evidence

³⁹ Cheryl Seymour's Evidence to APPG report "Improving Asthma Outcomes in the UK"

⁴⁰ Royal College of Physicians & Health Quality Improvement Partnership, Why Asthma Still Kills: The National Review of Asthma Deaths (confidential enquiry report) (May 2014) Pg. 37

⁴¹ Dr Adel H Mansur's Evidence

⁴² Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. 2020 Update. https://ginasthma.org/wp-content/uploads/2020/06/GINA-2020-report_20_06_04-1-wms.pdf

⁴³ Asthma UK: Reducing prescribing errors in asthma care. Available at: <https://www.asthma.org.uk/support-us/campaigns/publications/nrad-one-year-on/>

⁴⁴ 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: 403-407

⁴⁵ Nwaru BI, Ekström M, Hasvold P, et al. Overuse of short-acting β 2-agonists in asthma is associated with increased risk of exacerbation and mortality: a nationwide cohort study of the global SABINA programme. *Eur Respir J.* 2020;55(4):1901872

⁴⁶ Janson C, Menzies-Gow A, Nan C, et al. SABINA: An Overview of Short-Acting β 2-Agonist Use in Asthma in European Countries. *Adv Ther.* (2020 Mar) 37(3):1124-1135. <https://pubmed.ncbi.nlm.nih.gov/31981105/> (Last accessed 13th November 2020)

⁴⁷ Bloom, C.I., Cabrera, C., Arnetorp, S. et al. Asthma-Related Health Outcomes Associated with Short-Acting β 2-Agonist Inhaler Use: An Observational UK Study as Part of the SABINA Global Program (2020)

⁴⁸ Dr Adel H Mansur's Evidence

⁴⁹ Great North Children's Hospital's Evidence

⁵⁰ Dr Mark Levy's Evidence

⁵¹ Asthma UK Centre for Applied Research's Evidence

⁵² Dr Adel H Mansur's Evidence

⁵³ Dr Mark Levy's Evidence

⁵⁴ Pavord ID, Beasley R, Agusti A et al. After Asthma: Redefining Airways Diseases. *Lancet.* 2018;391:Pg 350-400. [https://doi.org/10.1016/S0140-6736\(17\)30879-6](https://doi.org/10.1016/S0140-6736(17)30879-6) [Last accessed 16th November 2020]

The SENTINEL project, a quality improvement initiative undertaken in Hull and East Yorkshire, improved outcomes for adult asthma patients through identification of SABA over-reliance and appropriate implementation of a SABA-free maintenance and reliever treatment (MART) based strategy.

Pilot data from the SENTINEL project demonstrated that implementation of a MART focussed asthma guideline where clinically important can substantially reduce SABA prescribing.^{55, 56}

The SENTINEL pilot collected publicly available National Health Service data to characterise asthma patients. 63.5% of patients who were deemed appropriate for a therapy change transitioned to MART. SABA prescriptions vs all inhaled therapies decreased from 59.1% to 46.4% reflecting 2,018 fewer SABA issues vs the same period in the previous year.

“ We also pointed out that the NRAD report included evidence that regular over-use of short acting relievers increases the risk of asthma attacks^{42, 43} hospitalisations and deaths.^{44, 45} ”



⁵⁵ Crooks, M et al. Impact of maintenance and reliever therapy (MART) focussed asthma guideline on SABA prescriptions. Abstract presented at European Respiratory Society (ERS) International Congress, 2021; Sep 5-8: Abstract no. OA80

⁵⁶ Open Prescribing. Available from <https://openprescribing.net/pcn/U64827/measures/?tags=respiratory> Last accessed October 2021

Primary care incentives

We suggested in our report that QOF is an appropriate mechanism to incentivise primary care to help prevent the overuse of reliever inhalers and OCS. We believe that system incentives, such as QOF or the Investment and Impact Fund have a lot of potential to help reduce reliance on SABA.

SABA reduction is also included within the Investment and Impact Fund, which incentivises PCNs to target six prescriptions and over in their structured medicine reviews. An additional incentive encourages more patients to be treated with ICS. As progress is made with the patients receiving 6 and over SABA prescriptions per year, the threshold should be assessed after 12 months and the threshold moved to over three SABA prescriptions per year.

QOF should include clearly defined thresholds of reliever inhaler prescribing designed to trigger follow-up action and improve adherence to preventative inhaler medication. Asthma patients should be reviewed within two days of receiving emergency care, by appropriately trained individuals.⁵⁷

This is a crucial aspect of asthma care and one of the single biggest but avoidable causes of asthma deaths. We believe that primary care networks could consider learnings from the SENTINEL project and the BLF Taskforce resources on reducing SABA overuse.

The patient pathway is also an important method for reducing SABA use, through a clear and unambiguous pathway within the new unified guidelines. We recommend that those putting the new guidelines together take this opportunity to help control SABA use.

Recommendations

- ▶ We recommend that the NHS investigates the potential of utilising MART approaches where clinically appropriate, in order to reduce SABA overuse and the necessary changes to primary care data recording to make this happen
- ▶ We welcome the inclusion of SABA-reduction primary care incentives in the IIF and call for this to help drive SABA use down further. We recommend a similar QOF measure to widen the reach to all GP practices
- ▶ We recommend that the agencies producing the unified asthma guidelines include recognition of the importance of SABA overuse and include the necessary steps to reduce SABA use into the new guidelines

We suggested in our report that QOF is an appropriate mechanism to incentivise primary care to help prevent the overuse of reliever inhalers and OCS. We believe that system incentives, such as QOF or the Investment and Impact Fund have a lot of potential to help reduce reliance on SABA.

⁵⁷ appg-asthma-report-2020.pdf (ed.ac.uk)

Inappropriate use of oral corticosteroids

The overuse of OCS is potentially very serious for severe asthma patients and recent studies have shown that cumulative OCS use is associated with a risk of serious adverse effects.

Many studies have shown that long term OCS use is associated with increased mortality, reduced quality of life and increased costs and resources,^{58, 59} while a qualitative study of the impact of severe asthma and its treatment showed that the treatment burden is neglected in existing asthma assessment scales.⁶⁰



The extended use or repeated courses of OCS has been noted as causing damaging side effects such as osteoporosis, hypertension, obesity, type 2 diabetes, gastrointestinal ulcers/bleeds, fractures, and cataracts.⁶¹

Asthma UK/BLF stated that 'now that we finally have specialist services and biologic treatments, frequent OCS prescriptions are no longer a justifiable treatment option and should be seen as a failure of care that should trigger a referral.'⁶²

One potential contribution to reducing the use of OCS is tapering. Although tapering is not included in official guidelines, a recent clinical consensus study found that OCS tapering should be attempted in all asthma patients receiving maintenance OCS therapy regardless of comorbidities and the speed and rhythm of the tapering should be personalised.⁶³

Many patients who are prescribed repeat courses of OCS may be eligible for biologic treatments which may be more beneficial to them. Greater access to biologics in severe asthma treatment is widely supported by clinicians and asthma organisations,⁶⁴ and are compared favourably to OCS by Asthma UK/BLF. Overall, the respondents to our report strongly supported the use of biologics as an effective treatment for severe asthma for appropriate patients.

Severe asthma treatment – biologic therapies

Biologic therapies are a more recent life-saving treatment for people with certain types of severe asthma and asthma that is difficult to control. They can reduce asthma attacks in severe asthma, reduce the need for oral steroids and improve symptoms.

At present they are only offered to patients through the specialist asthma clinics. There was very strong support in our report last year for the use of biologic treatments and we supported the choice of clinicians to prescribe them for severe asthma patients.

Many clinicians viewed the use of biologics as a better alternative to traditional oral corticosteroid (OCS) treatment for severe asthma and we received evidence that a large majority of patients who are eligible still do not have access to them⁶⁵ and a large proportion of patients eligible for referral to specialists are not referred.⁶⁶

⁵⁸ Ekstrom M, Nwaru BI, Hasvold P, et al, Corticosteroid Use, Morbidity and Mortality in Asthma: a Nationwide prospective Cohort Study in Sweden. *Allergy*; 2019; 74: 2181-2190

⁵⁹ Canonica G W, Colombo G L, Bruno G M, et al, Shadow cost of oral corticosteroids-related adverse events: A pharmacoeconomic evaluation applied to real-life data from the Severe Asthma Network in Italy (SANI) registry. *World Allergy Organ J*; 2019 Jan 26;12(1):100007.

⁶⁰ Michael E Hyland, Ben Whalley, Rupert C Jones, Matthew Masoli. *Qual Life Res* 2015 Mar;24(3):631-9

⁶¹ Asthma UK and British Lung Foundation's Evidence

⁶² Asthma UK and British Lung Foundation's Evidence

⁶³ Carey M Suehs, Andrew Menzies-Gow, David Price, et al, Expert Consensus on the Tapering of Oral Corticosteroids for the Treatment of Asthma. A Delphi Study, *Am J Respir Crit Care Med*. 2021 Apr 1;203(7):871-881

⁶⁴ "Improving Asthma Outcomes in the UK". APPG for Respiratory Health. [appg-asthma-report-2020.pdf](#) (ed.ac.uk). Last accessed October 2021

⁶⁵ "Improving Asthma Outcomes in the UK". APPG for Respiratory Health. [appg-asthma-report-2020.pdf](#) (ed.ac.uk). Last accessed October 2021

⁶⁶ Bloom CI, Walker S, Quint JK. Inadequate specialist care referrals for high-risk asthma patients in the UK: an adult population-based cohort 2006-2017. *Journal of Asthma*. 2019;1-7.

There is an ongoing treatment shortfall in the use of biologic treatments – Asthma UK research suggests that 82% of difficult and severe asthma patients are often not being referred at the right time, or sometimes, not at all.

Asthma UK/BLF also told us that the current NHS asthma care pathway does not take full account of the availability of these new treatments and so most people with severe asthma are still reliant on OCS in primary and secondary care.

In their report “Do No Harm”, they stated that:⁶⁷

- ▶ Three in four people eligible for biologic treatment are still not accessing it.
- ▶ of an estimated 50,000 patients who are eligible for biologic treatment in England, just 11,800 are estimated to be receiving treatment in June 2020
- ▶ Thousands of patients are having to endure treatments that are considered inadequate
- ▶ Patients have to suffer unnecessary side effects

In 2018 the government agreed a “voluntary scheme for branded medicines pricing and access” which is designed to improve access to medicines in the UK.⁶⁸ It introduced the commitment of the UK matching or surpassing comparative nations in the prescribing of new innovative medicines in five clinical areas. These are referred to as the five highest health gains (5HHGs).

The scheme, which was agreed by the Government and the NHS, included the following commitment: “The Parties are committed to the objective of reaching the upper quartile of uptake (in relation to comparator countries) for the five highest health gain categories during the course of the first half of the Voluntary Scheme (mid-2021)”.

It was confirmed in the Life Sciences Council earlier in 2021 that biologics for severe asthma would be one of the five categories selected for tailored support to increase their adoption in the NHS. This is an important commitment to life-saving treatment for severe asthma patients.

We applaud the Government's initiative and actions to date but we are concerned that the asthma biologics element of the 5HHGs has been delayed. With uptake as low in the UK as it is, new data commissioned by NHS England has shown that the UK is far from the upper quartile and confirms that we are currently 9th out of 10 with comparison countries.⁶⁹ This missed opportunity could have a major impact on the severe asthma patients who stood to benefit from the commitment.

Given that the timings are so tight we would like to see a renewed commitment by the DHSC to the asthma biologics and if the AAC programme can be extended, to allow uptake to continue to be supported beyond the end of April 2022 and at least by the end of 2023, as well as increased resources to increase capacity in the system to ensure that the uptake can deliver from the start.

The timing of the programme is of great importance. The Accelerated Access Collaborative's (AAC) Rapid Uptake Programme, designed to implement the commitment, puts an emphasis on severe asthma across the whole patient pathway from primary to tertiary care.

The programme is due to end in April 2022 and although we are aware that delays to the roll out have been caused by the COVID pandemic, there is clearly significant work still to do in improving biologics uptake.

⁶⁷ “Do No Harm” Asthma UK/BLF. Severe-asthma_report_final.pdf. Last accessed September 2021

⁶⁸ The 2019 voluntary scheme for branded medicines pricing and access: chapters and glossary (publishing.service.gov.uk)

⁶⁹ International Medicines Uptake Comparator - LOGEX Healthcare Analytics

A recent clinical consensus study around severe asthma care found that delays in access to advanced treatments for severe asthma found that these can be minimised by defining clear targets in the time between referral and assessment by specialist asthma services. The study also suggested that patients should be started on biological therapy within eight weeks of MDT approval, with a substantial majority supporting a four week target.⁷⁰

We believe that it is not right that eligible severe asthma patients should be unable to access NICE approved treatments and have to rely on conventional therapies that are not addressing their symptoms. The biologics gap needs to be addressed and progress made to allow patients access to these life-saving treatments.

In our discussions with clinicians, the wider use of the biologics for severe asthma was considered essential and one option that was strongly supported by them was for training of secondary care to initiate biologics where appropriate, freeing up tertiary care to deal with more complex cases. This would allow asthma specialists in secondary care access to the best available treatment options and help alleviate COVID-related and other delays in the system.

Recommendations

- ▶ We recommend that DHSC and NHS England confirm their commitment to 5HHGs by setting clearly defined targets, delivery plan and accountabilities and extend the AAC Rapid Uptake Programme to the end of 2023
- ▶ We recommend the introduction of incentives to drive down inappropriate use of OCS medicines in primary care, and prescription targets to flag SABA and OCS use for potential referral to a severe asthma specialist
- ▶ We recommend the introduction of monitoring on the progress of severe asthma networks to implement specialist assessment within eight weeks of referral and starting biological therapy within four weeks of MDT approval
- ▶ We recommend that clinicians be supported in their clinical judgment to prescribe biologic treatment to severe asthma patients and that the initiation of biological therapies be available to clinicians in secondary care



We believe that it is not right that eligible severe asthma patients should be unable to access NICE approved treatments and have to rely on conventional therapies that are not addressing their symptoms.



⁷⁰ David J Jackson, Claire Butler, Rekha Chaudhuri, et al, "Recommendations following a modified UK-Delphi consensus study on best practice for referral and management of severe asthma", BMJ Open Respiratory Research, 2021, <http://dx.doi.org/10.1136/bmjresp-2021-001057>. Last accessed October 2021

Diagnostic hubs

In our report we noted that the NICE Asthma Guideline (NG80) recommends that ‘those responsible for planning diagnostic service support to primary care should consider establishing asthma diagnostic hubs to achieve economies of scale and improve the practicality of implementing the recommendations’.⁷¹ This is reinforced by NICE anticipating the use of diagnostic hubs in their latest Asthma Quality Standard.⁷²

There was unanimous support for diagnostic hubs from our experts and we strongly supported their introduction. On the 1st October, 2021 the Government announced 40 new Community Diagnostic Centres, which are set to open across England in a range of settings from local shopping centres to football stadiums which will offer new earlier diagnostic tests closer to patients’ homes.⁷³

In the Budget debate on the 28th October 2021, the Chancellor announced an additional £5.9 billion to tackle the backlog of diagnostic tests to deliver more checks, scans and treatment. The intention is to increase the number of centres to “at least” 100.⁷⁴

The Minister also confirmed during the Budget debate that this figure includes £1.5 billion for increased bed capacity, equipment, new surgical hubs to tackle waiting times for elective surgeries and at least a total of 100 community diagnostic centres to help to clear backlogs of people waiting for clinical tests such as MRIs, ultrasounds and CT scans, together with £2.9 billion alone to be used on diagnostic scanning equipment such as CT, MRI, and ultrasound scanners.

This is a very welcome announcement and a clear commitment to increase the diagnostic capability across the country. We do not yet know the details of the new centres - how they will coordinate with the rapid diagnostic centres, where they will be based and exactly what checks and scans will be included but we believe this is a significant development.

The new centres will be backed by a new £350 million investment and provide around 2.8 million scans in the first full year of operation. They are designed to assist with earlier diagnosis through faster and easier access to diagnostic tests for symptoms including breathlessness, cancer and ophthalmology.

Each of the centres will include a multi-disciplinary team of staff including nurses and radiographers and will be open seven days a week.

We strongly welcome the creation of the centres and the funding that will enable them to be realised. They should provide additional confidence to patients and relieve pressures in the secondary care appointments system.

We also welcome the inclusion of breathlessness diagnostics in the centres and we think it is essential that the centres should be equipped to diagnose any-cause breathlessness, whether it is cardiovascular, lung cancer, asthma or COPD. It is also important to establish an optimal referral system from the centres should further investigation be warranted.

In our last report we noted widespread variation in referrals to specialist centres for severe or difficult to control asthma and the treatment of patients in referred care and we believe that the new centres are a welcome initiative and can materially help to address the inequalities we have seen across the country in asthma care and treatment.

Although there needs to be greater clarity on what additional workforce will be available for the CDCs, we believe that they will introduce greater consistency and awareness, which will benefit patients for whom referrals are necessary.

⁷¹ Asthma: diagnosis, monitoring and chronic asthma management, Nice Guideline NG80, Overview | Asthma: diagnosis, monitoring and chronic asthma management | Guidance | NICE. Last accessed October 2021

⁷² Asthma, Nice Quality Standard, QS25, Overview | Asthma | Quality standards | NICE. Last accessed October 2021

⁷³ 40 community diagnostic centres launching across England - GOV.UK (www.gov.uk). Last accessed, October 2021

⁷⁴ <https://www.gov.uk/government/news/budget-and-spending-review-october-2021-what-you-need-to-know>

Recommendations

- ▶ We recommend that the community diagnostic centres build in appropriate capacity for respiratory services, including personnel and provide for diagnostic checks specific to asthma such as inhaler technique checks, spirometry and FeNO testing
- ▶ Provision needs to be made for onward referral for some patients, especially for uncontrolled asthma and COPD and we also recommend that a simplified but consistent referral pathway is built into the centres from the start

Unified guidelines

In our inquiry last year we analysed the challenges faced by clinicians in diagnosing and treating asthma, especially severe asthma and we found that almost all the respondents identified the existence of multiple asthma guidelines as confusing, unnecessary and a cause for concern.

The Royal College of Physicians (RCP), in their submission told us that “national audit data collected from England, Scotland and Wales indicates that the standard of care against national guidelines (NICE and BTS) and recommendations from NRAD are variable and on the whole substandard.”⁷⁵

As a consequence, we strongly welcomed the commitment and the ongoing work to produce unified guidelines as a necessary step forward to improve asthma outcomes. It is especially important for time-stretched primary care doctors that all guidelines on asthma are in one place.

The unified guidelines have been delayed due to COVID but are due in late 2023. However, we understand that the NICE/BTS/SIGN unified asthma guidelines draft scope “Asthma: diagnosis, monitoring and chronic asthma management” does not include severe asthma.

This appears to us to be a serious omission and it is unclear how the guidelines could be described as “unified” when the most serious type of asthma is not included. This is especially puzzling when the respondents to our inquiry noted that NICE, BTS/SIGN, GINA and NRAD guidelines all give similar criteria for referring a patient to a specialised asthma centre (mainly for severe asthma).

Specialised asthma centres are seen as crucial for the treatment of severe asthma in particular, with the BTS, one of the unified guidelines partners, stating: ‘Raising awareness on severe asthma, earlier diagnosis of severe asthma and better identification of the severe asthma patient is being driven by clinicians from nationally commissioned severe asthma centres’.

If severe asthma is excluded from the scope, then the treatment shortfall for the newer treatment options will not be addressed. These include the use of biologic treatments and the latest best practice in phenotyping, which were widely recommended by both clinicians and severe asthma patients.

The Long Term Plan states that “We will do more to support those with respiratory disease to receive and use the right medication” but without severe asthma included in the unified guidelines this is unlikely to happen.⁷⁶

⁷⁵ “Improving Asthma Outcomes in the UK”. APPG for Respiratory Health. [appg-asthma-report-2020.pdf](#) (ed.ac.uk). Last accessed October 2021

⁷⁶ NHS Long Term Plan v1.2 August 2019

A number of biologic treatments have been approved by NICE through its HTA process and approved for use in the NICE asthma pathway. It is therefore inconsistent for these treatments not to be included in the scope of the unified guidelines.

It appears to us that unified guidelines for asthma are essential in improving asthma outcomes but the omission of severe asthma would be inconsistent with both the existing guidelines and the expectations of the clinical and patient communities.

It would be preferable not to wait until 2023 for new guidelines and consideration should be made for regularly updated 'active guidelines' to reflect the constant pace of innovation in best practice and treatment. To do this effectively, an adherence mechanism, such as through the CQC, should be introduced to minimise local variation.

Recommendations

- ▶ We recommend that severe asthma, biologics and phenotyping be included in the scope of the upcoming unified asthma guidelines
- ▶ We recommend that regular, active updates for implementation in clinical practice are produced by the guidelines committee before the guidelines are finalised in 2023



“The Royal College of Physicians (RCP), in their submission told us that “national audit data collected from England, Scotland and Wales indicates that the standard of care against national guidelines (NICE and BTS) and recommendations from NRAD are variable and on the whole substandard.”⁷⁵”

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Conclusion

Our report has changed from our original intention to look at asthma outcomes in context to a review of the impact of COVID on asthma services and the most important steps needed to restore and improve those services to a more normal post-COVID level.

COVID has presented us all with enormous and daunting challenges and respiratory services have been one of the hardest hit in the NHS.

Small changes can make enormous differences and we have highlighted some simple steps that we believe will make a difference to patients' lives and help restore confidence in the asthma services they rely on.

There are many new initiatives due to be delivered in asthma care in the next few years – the Community Diagnostic Centres, the unified guidelines, the transition to the ICSs and the appropriate use of biologic treatments, that there should be great optimism for the future of asthma care and the impact on patients' lives.

We recognise that difficult decisions will need to be made in the restoration of asthma services and that it has not been easy to improve outcomes during the pandemic, however, the consequences for healthcare in the aftermath of COVID cannot be readily dismissed or ignored.

We call on the Government and NHS to implement the recommendations in this report as soon as possible, given that respiratory patients remain some of the most underserved for many decades, as we believe they are critically needed by the asthma community.



Small changes can make enormous differences and we have highlighted some simple steps that we believe will make a difference to patients' lives and help restore confidence in the asthma services they rely on.



Recommendations

- ▶ We recommend annual asthma reviews are restored as soon as possible and that face to face consultations are made available once again to all who would benefit from them
- ▶ We recommend that NHS England and NICE should review those elements of the Severe Asthma Rapid Guidelines which worked well to accelerate specialist care and expand capacity and consider what should be retained in the future joint guidelines and national severe asthma service specification
- ▶ We recommend that electronic alerts be introduced into primary care when steroids are prescribed which will identify when patients require an exacerbation or post exacerbation review
- ▶ We recommend that the children and young people care bundle for asthma is rolled out without undue delay in 2022
- ▶ The transition to ICSs presents an opportunity for local care systems to be more reflective of local needs. In order to achieve consistent asthma provision, we recommend that respiratory planning and standards be built into the ICS performance frameworks from the beginning
- ▶ We recommend that respiratory disease be included alongside the existing ICS specification on cardiovascular, mental health and cancer outcomes and we call for asthma specific outcomes to be included in the next version
- ▶ We recommend that the updated national service specifications for severe asthma and the regional specifications should identify ways to better enable secondary care to initiate and/or monitor biologics prescribing to free up capacity in tertiary care
- ▶ We recommend that the R&D aspirations in the Life Sciences Vision for precision medicines in asthma should be supported by a defined resource, committed to increasing the capacity in hospitals for asthma clinical trials
- ▶ We recommend that the NHS investigates the potential of utilising MART approaches where clinically appropriate, in order to reduce SABA overuse and the necessary changes to primary care data recording to make this happen
- ▶ We welcome the inclusion of SABA-reduction primary care incentives in the IIF and call for this to help drive SABA use down further. We recommend a similar QOF measure to widen the reach to all GP practices
- ▶ We recommend that the agencies producing the unified asthma guidelines include recognition of the importance of SABA overuse and include the necessary steps to reduce SABA use into the new guidelines
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- ▶ We recommend that the community diagnostic centres build in appropriate capacity for respiratory services, including personnel and provide for diagnostic checks specific to asthma such as inhaler technique checks, spirometry and FeNO testing
- ▶ Provision needs to be made for onward referral for some patients, especially for uncontrolled asthma and COPD and we also recommend that a simplified but consistent referral pathway is built into the centres from the start
- ▶ We recommend that severe asthma, biologics and phenotyping be included in the scope of the upcoming unified asthma guidelines
- ▶ We recommend that regular, active updates for implementation in clinical practice are produced by the guidelines committee before the guidelines are finalised in 2023



All Party Parliamentary Group
for Respiratory Health

APPG Report

Improving Asthma Outcomes In The UK

ONE YEAR ON

February 2022