Asthma Audit Development Project: Minutes and actions

Minutes of steering committee meeting held on **Friday 7 July from 11am to 3.30pm.**
Pickering Rosenheim Room, House 5, Royal College of Physicians, London

Present

Shuaib Nasser (SN)	Clinical Lead, Asthma Audit Development Project (Chair)
Rachael Andrews (RA)	Project Manager, Asthma Audit Development Project
Catherine Broadbent (CB)	Asthma UK
James Calvert (JC)	British Thoracic Society
Luke Daines (LD)	Primary Care Respiratory Society
Erol Gaillard (EG)	The Royal College of Paediatrics and Child Health
Natalie Harper (NH)	Association of Respiratory Nurse Specialists
Petronella Hutchinson (PH)	Patient
Viktoria McMillan (VM)	National COPD Audit Programme
Professor Mike Roberts (MR)	National COPD Audit Programme
Sophie Robinson (SR)	National COPD Audit Programme (note-taker)
Ralph Sullivan (RS)	Royal College of General Practitioners
Simon Standen (SS)	College for Paramedics
Dr Ian Woolhouse (IW)	Royal College of Physicians

Apologies

Toby Capstick	Royal Pharmaceutical Society of Great Britain
Lizzie Grillo	Chartered Society of Physiotherapy
Kevin Gruffydd-Jones	The Royal College of General Practitioners
Richard Iles	Independent Paediatric Specialist
Jeff Keep	College of Emergency Medicine
Daniel Menzies	Welsh Government
Andrew Menzies-Gow	Difficult Asthma Registry
Jenni Quint	National Heart and Lung Institute
Carol Roberts	NHS England, Pharmacy
Robert Spaight	East Midlands Ambulance Service
Carol Stonham MBE	Primary Care Respiratory Society

Action points

1. Welcome, apologies and minutes from previous meeting — **Dr Shuaib Nasser**

SN welcomed the group to the second Asthma Audit Development Project (AADP) meeting. Introductions and apologies were made.

SN provided an update on the action points from the last meeting and minutes were approved by the group.

2. Project update — **Rachael Andrews**

<u>Outcome of SDM meeting and transparency</u>

HQIP have confirmed that the project can continue as per the Phase 1 report and Phase

2 objectives as set out in the project deed of appointment. From now on information about and from the AADP will be made publically available via the Royal College of Physicians (RCP) webpages. This includes steering group meeting notes and actions, Phase 1 report and pilot information. It was clarified that this AADP was a distinct piece of work from any bids that were planned.

Tender and National Asthma and COPD Audit Programme specification

Details of the specification have not yet been received. Once they are, the bidder will have c.7 weeks to respond. The steering committee (SC) will be updated again at the next meeting.

Communication

The following has taken place to date:

- Engagement with external stakeholders and organisations, as well as submissions to external newsletters and e-bulletins, including paediatric specific audiences.
- Tweets via the RCP London, RCP Wales and COPD twitter accounts with the hashtag #AsthmaAuditDP.
- Postcards and an infographic have been produced.
- An email has been sent to Lead Clinicians of respiratory teams at each acute hospital and a letter to Trust CEOs will follow this.
- Positives messages around the project and forthcoming national audit have been produced and these messages are being woven into all communication activities.
- A pilot information sheet has been produced for those who wish to, or are interested in registering as a pilot hospital.

EG offered to aid this activity by sending project information to the British Paediatric Respiratory Society (BPRS).

Action 2a: RA to provide EG with information about the asthma audit to circulate to members of the BPRS. **2a**

Patient involvement

PH remains as the patient representative for the SC.

The asthma team are currently liaising with Asthma UK with regards to a second representative and the possibility of attending existing patient groups for their feedback on the datasets and the proposed national audit.

Integration with National COPD Audit Programme

The team are currently looking at integration of the audit into the COPD web-tool produced by Crown Informatics. Meetings are planned through the summer to discuss resource, staffing and structure.

Section 251 and Confidential Advisory Group (CAG) requirements

A meeting with the CAG advice service is booked, at which clarification will be sought on if new or amended applications will be required to incorporate asthma. It is expected that other than this, the section 251 application for the new audit would follow the normal processes. VM noted that Section 251 covers both England and Wales.

3. Datasets **All**

Introduction

The asthma audit builds on findings from the 2014 NRAD report *(see slides).* A number of recommendations were made to improve outcomes for asthma patients including structured PAAP and review.

Reference was made by the group to the new NICE guidance on asthma diagnosis and monitoring of asthma in primary and secondary care. This guidance is currently out for consultation so it should be reviewed and incorporated where necessary once published.

Asthma UK's annual report highlighted that follow-up after admission to hospital, or making an emergency visit, is not undertaken in a timely way.

The Asthma Audit Dashboard, used in primary care, provides information that is useful for auditing. RS commented that the dashboard is based on a piece of software called MIQUEST which is managed by NHS digital. Support for this will be discontinued due to reliance of the dashboard on read codes (given the imminent transition to SNOMED-CT).

Overview

The clinical datasets have been designed for a continuous audit and the main objective for the day was to streamline and reduce these further where possible. The datasets must not be too time consuming or onerous for teams to complete and therefore it was suggested that they contain no more than 30 questions.

MR stated that small datasets are favoured (taking around 15 minutes to complete) for continuous audit to allow timely completion of clinical records, and that the datasets should be heavily led by improvements we want to see in the quality of care.

JC pointed out that the datasets do not include any items regarding admissions to intensive care units. RA responded that this was originally included but removed for the purposes of streamlining and consistency with the COPD secondary care clinical dataset.

PH commented that no external factors were included e.g. how asthma impacts the patients day to day. PH asked whether these are collectible as they may impact clinical results. PH also stated that it would also be useful to know staffing levels within services, which may reflect how quickly a patient is likely to be seen/provided treatment.

SN agreed that there are many external factors that play a role in the management of asthma, but if difficult to measure they can not be included in this audit. However,

staffing levels will be captured within the organisational audits.

Key areas for improvement

Following a brief discussion the group agreed what could potentially be key quality improvement aims for the asthma audit. These would be focused on during the meeting as a basis for the audit questions.

Secondary care
- To reduce the number of admissions to hospital.
- To improve the quality of care received (appropriate treatment, timeliness of treatment).
- To improve education around asthma and self-management by asthma patients.

Primary care
- To identify patients at risk
- To identify patients in need of specialist attention

A by-product of these aims should be to reduce the number of asthma deaths.

3.1 Clinical dataset – Adult *(Refer to dataset for full list of questions)* **All**

Q1.1 (Age)
To ask age, options not required. Full audit will ask date of birth and this is only for the purpose of the hospital pilot.

Q1.3 (Arrival at hospital)
Very clear help-text required in order to eliminate ambiguity around what date/time should be entered. Important to include item as helps to show if treatments provided within national guideline timeframes.

Q1.4 (Mental health and learning disability)
Question on parity of esteem. Needs to be simplified otherwise will be badly answered. Amend to:
- *Does this patient have a recorded mental health diagnosis?– Yes/No*
- *Does this patient have a recorded learning disability diagnosis? – Yes/No*

Q2.3 (Smoking status)
To include option for vaping.

Action 3.1a: IW will circulate a CQIN linked to smoking status. **3.1a**

Q3.1 (Peak flow measurement (PEF))
- Change to % previous best.
- *'Not recorded'* and '*not taken'* will mean the same thing in the clinical setting, and '*too unwell'* is essentially a subcategory of these.
- Remove *'not taken'* and '*too unwell'* and leave '*Not recorded'* for PEF, Oxygen, steroids and β2 agonist.

Q3.2 (Oxygen saturation (SpO2) measurement)
- Add further question asking whether patient was on air or oxygen when this

measurement was taken.
- Order item with the other oxygen based questions in the dataset.
- Heart rate and respiratory rate to be added in as indicators of severity of asthma exacerbation.

Q3.4 (First administration of systemic steroids)
'Pre-hospital' section to be added – this would help to identify patients who have received oxygen, steroids and/or β2 agonists prior to arrival at hospital and therefore time-limited measurements would not be appropriate. If '*Yes'*, subsequent questions regarding oxygen, steroids and β2 agonists would grey out. To pilot and change this if does not work.

Q3.6 (Controlled supplementary oxygen administered)
Change to *'Was oxygen prescribed for this patient?'*

Q4.1(Best PEF recorded in 24 hours pre-discharge)
Question useful for looking at appropriate discharge but group agreed to remove question 4.2 (lowest PEF).

Q5.1 (Date of discharge)
Add time of discharge.

Q5.3 (Structured review by member of specialist respiratory team prior to discharge)
Remove date and time, combine with discharge bundle question.

Q5.5 (Elements undertaken as part of the discharge bundle)
- Follow up arrangements (both community and specialist) should be simplified to 'Yes/No' answers.
- Remove date and time.

Q5.6 (Triggers and exacerbating factors identified upon discharge)
- During considerable discussion some of the SC felt the item was not necessary to include and changing wording within Q5.5 to '*discussion about triggers and exacerbating factors document'* would be sufficient. However, SN was concerned that this could be ticked without proper discussion and felt that asking about each trigger would be more likely to reflect quality improvement.
- Conclusion not reached - suggested that alternative be piloted before reassessing.

Q5.8 (Prednisolone prescribed at discharge)
Mgs/day

Q5.9 (Regular inhaled corticosteroid step-up treatment prescribed at discharge)
Amend to 'Before discharge, *has a review of inhaled corticosteroid treatment been documented?'*

Questions for removal from adult clinical dataset:

Question number	Topic	Reason for removal
3.3	Objective measurement of asthma severity	To remove as HR, RR, PEF and Sp02 provide enough information on severity
4.2	Lowest PEF recorded in 24 hours pre-discharge	Not essential for dataset
5.7	Type of asthma at discharge	Not essential for dataset and can be linked to discharge bundle
5.10	Patient referred for assessment by multidisciplinary severe asthma service	Not essential for dataset
6.1 and 6.1.1	Transition of care	Not essential for clinical dataset and possible to include in organisational dataset.

Action 3.1b: Audit team to make necessary changes to above questions as per discussions. **3.1b**

3.2 Clinical dataset – Paediatric *(Refer to dataset for full list of questions)* **All**

EG suggested that the paediatric dataset should align with the NICE asthma guidelines, and therefore, should to be split into 0-5 and 6-18 years of age. Age upon admission should be used as a guide for the most appropriate dataset.

Action 3.2a: All necessary changes made to the adult dataset should be carried over as appropriate. **3.2a**

Q1.4 (Psychosocial or social factors)
Mental health wording to be changed to whether there has been a Child and Adolescent Mental Health Service (CAMHS) referral. This is not applicable to the 0-5 age group.

Q3.6 (First administration of systemic steroids (including oral and IV))
EG stated there is strong evidence to suggest that use of steroids in pre-school asthmatics is not effective. For 0-5 age group, wording of question should be amended to:

- *'Were systemic steroids administered to this patient?' – Yes/No.*
- Guidance note to be added highlighting that patients between 0-5 should not be given steroids for mild/moderate asthma.

Q3.7 (First administration of high dose (β2 agonist) via nebuliser, inhaler or spacer)
Changed to inhaler + spacer, and date/time of administration.

Q5.3 (Structured review by member of specialist respiratory team prior to discharge)

- Change to *'Structured review by a member of staff trained in paediatric asthma'*. This would allow for a link to nurses on children's wards.
- Self-discharge would be very rare, but could remain an option.
    - 0-5 = parental discharge.

- 6-18 = self/parental discharge.

Q5.8 (Prednisolone prescribed at discharge)
Steroid rule applies here for 0-5 age group - Yes/No question.

Section 6: Transition of care
RA highlighted to the group that in the Phase 1 report, transition of care was noted for inclusion in the dataset. The group agreed that although transition of care is important, it is not as relevant to this audit and could be removed to shorten the dataset. However, consideration should be made to including transition of care into the organisational datasets.

Questions for removal from paediatric clinical dataset (0-5 age group):

Question number	**Topic**	**Reason for removal**
1.4	Psychosocial or social factors	Not necessary for age group
2.1	Asthma diagnosed prior to admission	Unlikely to have been diagnosed at this age
2.2	Personalised Asthma Action Plan (PAAP) in place at time of admission	Capturing in discharge bundle will be sufficient
2.3	Smoking status	Not applicable to age group
3.3	Peak flow measurement (PEF)	Not applicable to age group
5.9	Regular inhaled corticosteroid step-up treatment prescribed at discharge	NICE guidance currently under consultation may advise against step-up of regular inhaled corticosteroids. Already incorporated in discharge bundle question
6.1 and 6.1.1	Transition of care	Not necessary for clinical dataset. Possible to incorporate in organisational dataset

Questions for removal from paediatric clinical dataset (6-18 age group):

Question number	**Topic**	**Reason for removal**
2.3	Smoking status	Inclusion within discharge bundle question will provide enough indication of smoking status
5.9	Regular inhaled corticosteroid step-up treatment prescribed at discharge	NICE guidance currently under consultation may advise against step-up of regular inhaled corticosteroids. Already incorporated in discharge bundle question
6.1 and 6.1.1	Transition of care	Not necessary for clinical dataset. Possible to incorporate in organisational dataset

Action 3.2b: Audit team to make necessary changes to above questions as per discussions. **3.2b**

3.3 Primary care dataset *(Refer to dataset for full list of questions)* **All**

Exploration of incorporating primary care, for at least Wales will continue. The team would aim to capitalise on the experience of the National COPD Audit Programme.

This dataset had been produced with the support of Noel Baxter.

A small discussion ensued about the risk of duplication of patients between the asthma and COPD primary care extracts as well as for hospital admissions. MR felt that this would provide us with the opportunity to look at co-diagnosis between asthma and COPD. Within secondary care it would be up to the clinicians to decide if admission was for asthma or COPD, but within the primary care records the reason for admission may not be coded or recorded very well.

<u>Section 1: Demographics and Co-morbidities</u>

- SN commented that the detection of comorbidities was related to parity of esteem.
- RS highlighted that Public Health England have large primary care datasets and linkage. Identifiable information is held by NHS digital.

Action 3.3a: RS suggested that he put SN in contact with Jeremy Wetherhall from PHE to provide further advice. **3.3a**

<u>Section 3: Getting the diagnosis right</u>

Q 3.6 (Spirometry)

- New NICE guidance may include spirometry. RS queried whether any dates will be put around the spirometry test as some practices may have up to 20 years' worth of spirometry data. The dates provided will be reliant on what is deemed relevant to the audit.
- A discussion ensued about appropriate time limits for capturing this and it was agreed that new diagnosis only would be pulled to avoid 'too much noise in the dataset'.

<u>Section 4: Personalised Asthma Action Plans</u>

Q4.9 (Triggers)

- This information would be extractable, but it will be an experiment to see whether triggers are recorded in codes.

<u>Section 5: Providing the right care</u>

Q10 (Annual review in last 18 months)

- Agreement that *'review in the last 18 months'* was useful and appropriate considering patients may cancel and reschedule appointments.
- QOF payment is for 15 months.

Q11 (Annual review – list of elements)

- All elements are relevant to primary care, but recommendation that *'annual review'* be removed as many elements would be captured at different points. Prescriptions may not necessarily fit under '*annual review'.*
- Inclusion of *'4'* relating to prescription of SABA inhalers per year was queried as this may not pick up all asthmatics.

Action 3.3b: LD, RS and NB will review this item in greater detail at a teleconference external to the meeting. **3.3b**

Q12 (Inhaler technique checked within one month of first issue of inhaler)

- Some patients will have had an inhaler check outside of general practice via a pharmacy. In this instance, inhaler checks are not likely to be coded. Pharmacy's may provide a general practice with a letter as acknowledgement that the patient has been seen, but this will most likely not be recorded due to the admin burden.
- Is there any capacity in general practice to check inhaler technique at the point of prescribing? RS responded that, in his experience, a separate appointment would be made with the practice nurse to check inhaler technique due to time constraints.
- Agreement that the inclusion of 'within one month of first issue of an inhaler' remain in the dataset for now.

Q15 (Prescription of more than 12 short-acting reliever inhalers in last 12 months)

- To be removed depending on change made to query 10.

Q16 (Prescription of single component long-acting beta agonists (LABA) bronchodilator not in combination with ICS)

- Timings of this need to be carefully thought out as well as whether ICS inhaler has been prescribed separately rather than as a combined component.

Q18 (children with record of mental health service access, self-harm or overdose)

- Change to CAMHS referral as per paediatric clinical dataset.

<u>Section 7: Paediatric specific</u>

Important to include with regards to growth failure and spirometry.

<u>Sections for removal from primary care clinical dataset:</u>

Section	**Topic**	**Reason for removal**
Section 5, Q17	Screening for depression and anxiety	Duplicate of information within co-morbidities query
Section 6, Q19	Ensuring equal and equitable care	Asked elsewhere in dataset

Action 3.3c: Audit team to make necessary changes to above items as per discussions. Those things that remain outstanding will be discussed at a separate meeting with Noel Baxter and a PC subgroup. **3.3c**

3.4 Organisational audit *(Refer to adult and paediatric datasets for full list of questions)* **All**

Overview

The ambition is that the adult COPD and asthma organisational audit will be run together (as one), therefore, the existing COPD questions have been modified and added to in order to incorporate the new asthma component of the audit.

Due to time constraints of the meeting, the group was asked to raise only pressing issues pertaining to the organisational datasets at the meeting and forward on any other comments to RA once the meeting had finished.

It was recommended that ICD-10 codes be clarified with clinicians and/or a coder to make sure they are accurate and pick up the correct patient cohorts. SN commented that asthma must be the primary diagnosis.

Action 3.4a: Audit team to confirm the accuracy and relevance of the ICD-10 codes with clinicians and/or coders to pick up asthma as primary diagnosis for admission. **3.4a**

Organisational audit – Adult dataset

Q5.3 (Services provided)

- RA queried whether the answer options were suitable. SN highlighted that every respiratory department should be able to link to a specialist asthma service.
- JC commented that NHS England is doing a self-assessment exercise, so this information may be collectable from elsewhere. However, he noted that it would be worth knowing that each hospital has an identified asthma center.

Questions to be removed from adult organisational dataset:

Question number	Topic	Reason for removal
5.1	Discharge bundles used for COPD and asthma patients	Adequately captured within clinical audits
5.5 and 5.5.1	Availability of pulmonary rehabilitation service	Not necessary for asthma audit

Organisational audit – Paediatric dataset

Q1.13 (Frequency of review on admissions wards by a senior decision maker)

- Request for an additional question around paediatric respiratory on-call rota.
- After some discussion it was agreed to add in whether paediatric patients had access to a respiratory specialist and if this was in-hours and/or out of hours.

Q1.14 (Staff posts in paediatric team)

- Amend to *'How many of the following staff posts are there in your paediatric respiratory team?'*
- *'Long Term Ventilation (LTV) nurse'* and *'Cystic fibrosis nurse'* to be removed.

Q1.18 (Availability of smoking-cessation pharmacotherapies)

It was suggested that the British National Formulary (BNF) for children be checked to

ensure the listed smoking cessation pharmacotherapies are relevant to the paediatric setting.

Action 3.4b: Audit team to check BNF for children for list of prescribed smoking cessation pharmacotherapies licensed for children. **3.4b**

Q3.1 (Hospital Oxygen policies)

Action 3.4c: RA to find out whether there are any paediatric specific oxygen policies. **3.4c**

Questions to be removed from paediatric organisational dataset:

Question number	Topic	Reason for removal
1.16	Availability of inpatient dietetic service	Not necessary for paediatric organisational dataset
4.1	Discharge bundles used for COPD and asthma patients	Adequately captured within clinical audits

Action 3.4d: Audit team to make any necessary changes to above items for adult and paediatric organisational datasets as per discussions. **3.4d**

Patient and carer views/engagement

The group were asked to think about questions around patient engagement and seeking their views on respiratory services. Asthma UK is a potential source of external information with their annual survey but it would be good to capture how services are doing this themselves. The COPD audit does not currently do this. The asthma team agreed to go away and investigate how other audits addressed this.

Action 3.4e: Audit team to incorporate a question on if, and how frequently, hospitals seek feedback from patients and their carers. **3.4e**

4. Data extraction and linkages **All**

Primary Care

[This was covered during conversations regarding the datasets.]

Health Episode Statistics (HES) and Office for National Statistics (ONS)

HES have emergency department and outpatient data, and the development group will look into how this can be linked into the audit.

HES and ONS data would be used for the following:

- Re-admissions
- Mortality at 30 and 90 days
- Case ascertainment

Ambulance data

Until recently, a limited audit of asthma care was undertaken by ambulance services with data being collected separately by each service. This audit has now been discontinued but some service are choosing to continue at a local level. Robert Spaight is currently liaising with his ambulance colleague about this and potentially linking with the asthma audit but requires further information about what data the audit would require. Potential issues include the need for data sharing agreements with each individual ambulance service and an unknown cost related to that.

SS informed the group that there was 10 ambulance trusts in total and that most services audit whether care bundles for asthma are provided.

Pharmacy quality payments

SN did not feel any linkages could be made due to lack of standardization on the data collection by each pharmacy.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)

Options for exploration remain the same – Asthma UK annual survey, NHS England National PROMS Programme and bespoke national PROMs audit.

MR highlighted that for COPD there is a self-management tool (part of NHS accelerator and NHS tariff). The self-management tool has been taken up by around 80 CCGs in England. An asthma equivalent has been developed which may be useful to accompany the audit data.

Asthma UK annual survey

CB stated that there are certain questions regarding elements of care, for example, the level of control the patient feels they have over their care, whether inhaler technique has been checked, and identification of an individual's triggers. The feedback may not be reflective of the general population, and may be more biased towards those who are more engaged in their care or those who have more severe asthma. CB also mentioned that although Asthma UK's annual survey stays more or less the same each year; they do incorporate yearly 'focus topics' with triggers being one of this years.

PH highlighted that speed and effectiveness of treatment, as well as understanding triggers, would be a priority for asthma patients.

5. Any other business **All**

JC requested that Sally Welham be copied in to any correspondence regarding amendment to the datasets whilst he is absent.

6. Review of actions arising **Dr Shuaib Nasser**

The amended datasets would be circulated to the group in the week commencing 24 July 2017. Following this the clinical datasets would go out for public consultation for a

3 week period which would allow those professionals and organisations not directly involved in the pilot to contribute to dataset development.

The hospital pilot will start in September 2017 for a duration of around 4 weeks. Recruitment of pilot hospitals has started, and to date 10 pilot sites have been identified. More children's hospitals should be recruited to pilot the datasets.

Action 6a: Audit team to circulate amended datasets to SC **6a**
Action 6b: Audit team to make contact with Patrick Flood-Page. **6b**

7. Date of next meeting

The next AADP meeting will take place in late November, or early December 2017.

Action items

Item no	Action	By
2a	To provide EG with information about the asthma audit to circulate to members of the British Paediatric Respiratory Society	RA
3.1a	Q2.3 could be mapped to CQIN and this will be circulated to SC	IW
3.1b	To make necessary changes to adult clinical dataset as per discussions	RA
3.2a	All necessary changes made to the adult clinical dataset will be carried over as appropriate to paediatric dataset	RA
3.2b	To make necessary changes to paediatric clinical dataset as per discussions	RA
3.3a	To put AADP in contact with Jeremy Wetherhall from PHE to provide further advice on primary care dataset	RS
3.3b	LD, RS and NB to review Q11 of primary care dataset in greater detail at a teleconference external to the meeting	RA
3.3c	To make necessary changes to primary care clinical dataset items as per discussions and outstanding items be discussed in further PC subgroup	RA
3.4a	To confirm the accuracy and relevance of the ICD-10 codes with clinicians and/or coders to pick up asthma as primary diagnosis for admission	AADP
3.4b	To check BNF for children for list of prescribed smoking cessation pharmacotherapies licensed for children with regards to Q1.18 of paediatric organisational dataset	AADP
3.4c	To find out whether there are any paediatric specific oxygen policies with regards to Q3.1 of paediatric organisational dataset	RA

3.4d	To make necessary changes to adult and paediatric organisational datasets as per discussions	RA
3.4e	To incorporate a question on if, and how frequently, hospitals seek feedback from patients and their carers	AADP
6a	To circulate amended datasets to SC	RA