Primary Care Asthma Monitoring/Annual Review for Adults
NHS Calderdale CCGs, NHS Greater Huddersfield CCGs, NHS North Kirklees CCGs and NHS Wakefield CCGs

**History**

- Number of exacerbations since last seen in clinic.
- Emergency Department attendance since last seen in clinic.
- Emergency asthma admission since last seen in clinic.
- Nebulised bronchodilators required since last seen in clinic.
- Last oral steroid use.
- Work days lost since last seen in clinic.
- Atopy – triggers identified (Exercise symptoms).
- Is there a record of reversibility?
- Is there any suggestion of occupational asthma?
- Smoking status recorded.
- Stop smoking advice given.
- Referral to stop smoking service.
- Flu vaccination recorded in last 12 months, if appropriate.
- Peak flow meter at home - ensure technique satisfactory.

**Assessment of asthma control**

There are a number of validated tools that can be used to assess asthma control.

The asthma control test can be found at [http://www.asthmacontroltest.com](http://www.asthmacontroltest.com) and is an excellent tool for use with adult patients.

Royal College of Physicians 3 Questions (- minimum QOF requirement)

1. Have you had difficulty sleeping because of your asthma symptoms (including cough)?
2. Have you had your usual asthma symptoms during the day (cough, wheeze chest tightness)?
3. Has your asthma interfered with your usual activities (work, sex, housework, exercise)?

**Assessment/examination**

Height, Weight, Body Mass Index, consider need for blood tests eg. IgE RAST if appropriate & will change management of condition.

**Spirometry** Record at each review record FEV1 and FVC, as % predicted and FEV1/FVC ratio. If spirometry not available record Peak Expiratory Flow PEF where possible using patients own peak flow meter to record.

**Peak Expiratory Flow**, record actual PEF, predicted PEFR, best PEF (as value and % predicted)

**Medication review**

Discuss and record current medication.

Assess concordance and understanding.

Assess inhaler technique at every review:

- Is device appropriate?
- Is there a need for spacer/spacer replacement (how long in use)?

Step up/down treatment as needed in response to assessment.

- If control is achieved and maintained, after 12 weeks inhaled cortico steroid therapy should be reduced (dose decreased by 25-50%) to the lowest step that maintains control.

Assess *SABA use/overuse (record reliever – free days and number of puffs used a day)

Assess and record use of OTC */herbal medications.

Drug side-effects (current) and potential risks (eg. Steroid-induced osteoporosis).

Issue steroid safety cards for patients on step 4 & 5 of Stepwise Management of Asthma.

Beclometasone or Budesonide 1000mcg twice daily via spacer device or Fluticasone 500mcg twice daily via spacer device.

Consider referral to Community Pharmacist for further support with medication either through a New Medicines Service assessment or a Target Medicines Use Review.

**Asthma care plan**

Assess patient's understanding of how to recognise worsening asthma (symptoms and *PEF) and what action to take.

Assess understanding of action to take in an emergency.

Agree interval for asthma follow-up.

Assess and address patients needs for education.

Consider referral to Expert Patients Programme.

Written self management/action plan given or updated.


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Routine review in primary care

The SIGN/BTS Asthma Guidelines 2012 state there is strong evidence that proactive clinical review of people with asthma improves clinical outcomes, with those reviews that include discussion and use of a written self management plan being of greatest benefit.

Proactive reviews are associated with reduced exacerbation and days lost from normal activity, as apposed to unstructured or opportunistic review. Outcomes are similar whether reviews are conducted by a Practice Nurse or GP with the best outcomes achieved with those clinicians with asthma management training. Identification of patients at high risk is recommended. Telephone review has been shown to be a suitable option for those patients who fail to attend for routine reviews.

**Routine Management of Asthma**

**Primary care asthma Review**
- Offer at least annual review to all those on the asthma register.
- Time taken: approximately 20 -30 minutes.
- Conducted by healthcare professional with appropriate education.
- Aim: To identify if asthma is CONTROLLED or UNCONTROLLED and take action.

**Prioritise those at greatest risk of attack**
- Identification via computer searches and reviews of medical records.
- Placement on an ‘At risk’ register for Asthma.
- System devised to ‘flag up’ risk and prioritise attendance.

**Prioritisation of care**
- Proactive recruitment to attend for asthma assessment.
- Telephoning resistant ‘DNA’ (Did Not Attend) patients to assess control and encourage attendance.
- Priority / same-day appointments for those with deteriorating symptoms who are ‘At risk’.
- Consider telephone assessments.
- Liaison with community pharmacists, schools, school nurses & community colleagues e.g. community nurses.

**SIGN Definition of Factors Contributing to ‘AT RISK’**
- Previous near-fatal asthma.
- Previous admission for asthma in the past year (including Accident & Emergency).
- Requiring three or more classes of medication.
- Heavy use of short acting B2 agonist.
- ‘Brittle asthma’.
- Hospital attendance with asthma attack in past 2 months (including Emergency Department attendances).
- Presentation with asthma attack in primary care in past 2 months.
- Two or more courses of oral steroids and/or antibiotics in past 6 months.
- Heavy use of short-acting B2 agonist (>3 canisters in 6 months).
- DNA asthma clinic or excepted from QOF.
- Repeated days off school or work with Asthma.
- ‘Brittle asthma’.