Meeting Summary and Actions

Meeting:	Asthma audit feasibility study: Steering Group meeting
Venue:	RCP London
Date:	6th February 2017
Attendees:	Shuaib Nasser Clinical Lead, National Asthma Audit Feasibility Study - Chair James Calvert, British Thoracic Society (BTS) Daisy Ellis, Asthma UK Richard Iles, NHS England Erol Gaillard, Royal College of Paediatrics and Child Health Ralph Sullivan, Royal College of General Practitioners Natalie Harper, Association of Respiratory Nurse Specialists Petronella Hutchinson, Patient Representative Luke Daines , Primary Care Respiratory Society Carol Stonham, Primary Care Respiratory Society Liz Harris , College for Paramedics (by phone) Lizzie Grillo, Chartered Society of Physiotherapy Carol Roberts, PrescQIPP Jenni Quint, National Heart & Lung Institute Viktoria McMillan, National COPD audit programme Roz Stanley, Operations Director, RCP Fran Percival, pH Associates Amanda Pulfer, pH Associates Helen Cardy, pH Associates Catherine Bottomley, pH Associates
Apologies	Daniel Menzies, Welsh Government Toby Capstick, Royal Pharmaceutical Society of Great Britain Kevin Gruffydd-Jones, The Royal College of General Practitioners Jeff Keep, College of Emergency Medicine Mike Roberts, National COPD audit programme

Notes	Actions
Introduction and background Shuaib Nasser gave an overview of the audit development process and the objectives of the steering committee meeting.	
Presentation Slides **BTS Audit** James Calvert presented an overview of the 2012 BTS audit.	

Comments:
Data governance and data transparency are important issues to consider in the design of an audit.
The BTS audit is constrained by the data platform that is being used. Datasets need to be as small as possible so as not to burden the clinicians.
Web based data capture was used in the 2012 BTS audit with no patient identifiers. A software package was used to generate automatic reports.
The BTS audit report aimed to come up with 3-5 measureable improvement objectives per year and worked with a communications company to raise awareness of these. These were very simple e.g. 'What should be achieved? By when?'
In addition to measurement Quality Improvement (QI) is key. Measuring alone does not produce improvement. There is a need to allow time between rounds of audit for implementation of improvement initiatives.
Audit design approach: 1 Identify what you want to improve. 2 Measure it. 3. Implement a change/incentive – e.g. Asthma care bundles, CQUINs, QOF.

Royal College Emergency Medicine (RCEM) audit
Shuaib Nasser summarised the design of the recently completed RCEM audit. No results are available yet.

Comments:
There was interest in whether RCEM plan to re-audit.

National COPD audit programme
Viktoria McMillan presented an overview of the National COPD audit programme.
There was a requirement for section 251 support for the first primary care audit in Wales and for the secondary care audit to allow linkage of HES and ONS outcomes. This will not be required for the second round of primary care data in Wales since data will be pseudonymised at source.
Requirement for linkage has led to a 3 year delay from collection to publication of outcome data which it is acknowledged limits the relevance of the data at the point of publication.
It was not possible to collect national primary care data in England as NHS Digital were not able to use Apollo to undertake the data extraction (due to Confidentiality Advisory Group (CAG) concerns and, subsequently, NHS Digital ending the contract). Use of the GPES route was then explored; 3 of 4 system suppliers signed up which represented 67% of all practices. Based on estimates from NDA, RCGP, NHS Digital and CKD opt-in rates, it was thought that only 30-35% of practices would opt-in and hence only 20% of the COPD population would be included in the audit. Given the cost, it was decided this did not represent an acceptable investment of public funds.
The pulmonary rehabilitation audit has required patient consent as CAG decided it was feasible to obtain. This causes attrition – 87% approached for consent, 73% of those consented.

Literature review
pH Associates presented an overview of the literature review which identified

poor and variable care in asthma. This was conducted by review of various guidelines, standards and audits and review of original research into areas of poor and variable care. Findings were grouped into 11 themes: 1. Structure of asthma services 2. Asthma diagnosis 3. Prescribing 4. Personalised asthma action plans 5. Allergens/triggers 6. Asthma reviews 7. Patient information and training 8. Emergency care 9. Discharge process from secondary care 10. Follow up after discharge from secondary care 11. Transition from child to adult services **Comments:** Suggest selecting small number (e.g. 3) key things to measure for each theme to keep it simple.	
Primary care data discussion Jenni Quint has access to primary care (CPRD) data via Imperial and her team uses it widely for research. This has 11% population coverage currently but this is due to increase with addition of EMIS practices. Patient data can be identified as coming from the same practice but the identity of the practice (or indeed the patient) is not available. Roz Stanley expressed concerns about the usefulness of CPRD data for audit purposes since practices are not identified and hence cannot be accountable for quality improvement, and also that it is difficult to obtain this data. It was suggested that Prof John Newton (Chief Knowledge Officer) would be useful to contact re current accessibility of data from GP systems. James Calvert expressed concerns about reporting audit data at individual organisation level in case the data reaches the public domain. There are ethical issues regarding accountability/publication of audit results if data are not completely reliable as it is inevitably used to create a league table which may be misleading. In addition, identifying poor performing practices discourages participation in audit. The QRESEARCH Database (Nottingham University) links EMIS data with HES data. Need to consider whether the datasets are large enough to have statistical meaning. The General Practice Extraction Service (GPES) collects information for a wide range of purposes. Public Health England is working in partnership with NHS Digital looking at uptake of health checks using GPES extraction – covers 100% of practices in England. They are currently working through required IG approvals and expect data to be available in 18 months' time. NHS England is developing Clinical Services Quality Measures (CSQMs), CSQMs	Working group to follow up Working group to follow up Working group to follow up

are a series of metrics using data that are already collected. The intention is take NICE/ CCG data on admissions/ readmissions to create a composite measure of quality to feed into 'traffic light' system. It is important that there is no duplication. Concerns were expressed about public availability leading to league tables and that any composite measures need to be validated. It was recognised that undertaking audit in primary care is of great interest to all parties, should it be possible however it was recognised that primary care is outside the audit scope given to us by HQIP. There was considerable discussion and many of the group were keen to audit primary care if it became practical. Jenni Quint and Ralph Sullivan felt that there were opportunities for audit in primary care	
Other data sources Good intensive care databases are available for adults (ICNARC) and children (PICU) which could be considered The group agreed that patient experience and patient reported outcome measures should be considered	Working group to follow up Working group to follow up
Steering committee members were split into two groups to discuss the top rated themes from the literature review. **Group 1:Emergency Care and Discharge** Patient representative explained that patients want treatment, not questions when they arrive at hospital. They want to be treated as an individual and not just someone trying to be fitted into a care pathway. **Emergency Care** The aim of collecting **data at admission** is to get better asthma care at admission. For audit to be a success, need to focus on 3-4 key things e.g. assessment of severity, time to initial treatment, dose of steroid. Potential questions: Has there been an initial assessment e.g. triage by severity? This initial assessment needs to happen before treatment (i.e. within 1 hour of attendance) Clinical assessment measures: Oxygen sats, peak flow, respiratory rate, heart rate, breathlessness Need to consider how to account for assessment/treatment that happens before A&E presentation i.e. ambulance data Treatment and assessment varies between adult and paediatric care but collecting admission data could cover both. Could consider an **organisational level** component – e.g. service structure. **Retail pharmacy** is an under- used source of data. Potentially an alert could be set where >6 SABA prescriptions within 6 months? However, there is variability	Follow up

in how clinically engaged pharmacies are. Potentially pharmacy new medicine services could audit patients. However this audit is probably too soon for those services and there is a concern about how many patients this could cover? Lack of diagnosis information in Pharmacy records – could not distinguish asthma from COPD? The audit could be focused around **bundle based care** with the care bundles then used to improve quality of care once audited. Potential questions: Do you have an admission/discharge/care bundle? Do you want one? Are you happy with your current one? Brief audit of bundles e.g. % of people who meet each of the bundle criteria	
Group 2: Prescribing and Use of Personalised Asthma Action Plans **Prescribing** Most prescribing for asthma happens in primary care and therefore there is limited value in auditing prescribing in secondary care Would need to conduct any audit at discharge as not feasible on emergency admission Potential questions: What meds at discharge vs what at admission? (however admission meds would be patient reported which may be unreliable especially what actually used vs what prescribed). Community pharmacy data doesn't include diagnosis so cannot be used to audit asthma prescribing specifically but could be used to look at patient training in inhaler technique in context of a combined airways audit where diagnosis is immaterial. **Personalised Asthma Action Plans (PAAPs)** Are usually generated in primary care. Patient unlikely to have this with them when attending hospital but could audit whether they know what is in it. As for prescribing only feasible to ask at discharge. Potential questions: Do you have a PAAP? What is in it? Who gave it to you? Was it co-created with you or just given to you? Could use structure/organisational survey followed by patient level data Potential questions: Do you have an asthma lead? Do you have a discharge bundle? Ask broad questions then drill down later Linkage of readmission rates to PAAP/no PAAP or discharge bundle/no bundle	

Need a tool to collect data for continuous data collection. The Best Practice Tariff has been an effective motivator for audit data collection but it might not encourage high quality audit data collection Continuous audit is only beneficial when running alongside a quality improvement initiative	
Close Shuaib Nasser closed the meeting thanking the committee for their attendance and valuable input and explained that working group recommendations would be circulated to the group for comment end Feb/mid-March.	
Date for next Steering group meeting The next meeting will be held during Phase 2 of the feasibility study.	