NICE National Institute for Health and Care Excellence

NICE quality standard

Asthma

Quality standard
Published: 21 February 2013
Last updated: 20 September 2018

www.nice.org.uk/guidance/qs25

Contents

This standard is based on NG245.

This standard should be read in conjunction with QS10, QS15, QS43, QS120, QS174, QS140, QS118, QS196, QS119 and NG244.

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Statement 1 People aged 5 years and over with suspected asthma have objective tests to support diagnosis. **[2013, updated 2018]**

Statement 2 People aged 5 years and over with asthma discuss and agree a documented personalised action plan. **[2013, updated 2018]**

Statement 3 People with asthma have their asthma control monitored at every asthma review. **[2013, updated 2018]**

Statement 4 People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge. **[2013, updated 2018]**

Statement 5 People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service. **[2013, updated 2018]**

In 2018, this quality standard was updated and statements prioritised in 2013 were updated (2013, updated 2018). For more information, see update information.

The previous version of the quality standard for asthma is available as a pdf.

Quality statement 1: Objective tests to support diagnosis

Quality statement

People aged 5 years and over with suspected asthma have objective tests to support diagnosis. **[2013, updated 2018]**

Rationale

Asthma can be misdiagnosed, which means that people with untreated asthma are at risk of an asthma attack, and people who do not have asthma receive unnecessary drugs. Following taking an initial history and assessment, objective tests can help healthcare professionals to diagnose asthma correctly in people over 5 years. There is no single objective test to diagnose asthma and a combination of tests will be needed for most people. The basis on which a diagnosis of asthma is made should be recorded in the person's medical records. Children under 5 are unable to perform objective tests and should be treated with inhaled corticosteroids based on the recommendations on pharmacological management in children under 5 in the BTS, NICE, SIGN guideline on asthma, until objective tests can be attempted when they reach 5 years.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that healthcare professionals are trained and competent to carry out and interpret objective tests to support diagnosis of asthma.

Data source: Local data collection, for example, training records and competency assessments.

Process

Proportion of people aged 5 years and over with newly diagnosed asthma who have a record of the objective tests used to support diagnosis.

Numerator – the number in the denominator who have a record of the objective tests used to support diagnosis.

Denominator – the number of people aged 5 years and over with newly diagnosed asthma.

Data source:NHS England's Quality and Outcomes Framework indicator AST011 reports data on the percentage of patients with a diagnosis of asthma with a record of objective tests.

Outcome

Prevalence of asthma.

Data source:NHS England's Quality and Outcomes Framework indicator AST001 reports data on the number of patients with asthma.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place for people aged 5 years and over with suspected asthma to have objective tests to support diagnosis. Service providers ensure that healthcare professionals are trained and competent in performing and interpreting objective tests, and that processes are in place to record the basis for a diagnosis of asthma.

Healthcare professionals (such as doctors, nurses and pharmacists) are aware of local arrangements for accessing objective tests for asthma and ensure that people aged 5 years and over with suspected asthma have objective tests to support diagnosis. Healthcare professionals record the basis for a diagnosis of asthma.

Commissioners commission services that ensure that people aged 5 years and over with suspected asthma have objective tests to support diagnosis.

People aged 5 years and over with suspected asthma have tests to confirm if they have asthma. An accurate diagnosis will make sure they get the treatment they need.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. BTS, NICE, SIGN guideline NG245 (2024), recommendations 1.1.2 and 1.1.3

Definitions of terms used in this quality statement

Objective tests to diagnose asthma

Tests carried out to help determine whether a person has asthma, the results of which are not based on the person's symptoms, for example, tests to measure lung function or evidence of inflammation. There is no single objective test to diagnose asthma. Objective tests should be performed in accordance with algorithm A objective tests for diagnosing asthma in adults and young people (aged over 16 years) with a history suggesting asthma and algorithm B objective tests for diagnosing asthma in children aged 5 to 16 with a history suggesting asthma in the BTS, NICE, SIGN guideline on asthma. [Adapted from BTS, NICE, SIGN guideline on asthma, recommendations 1.2.1 to 1.2.9 and expert opinion]

Suspected asthma

A potential diagnosis of asthma based on symptoms that have not yet been confirmed with objective tests. [Expert opinion]

Equality and diversity considerations

If a child is unable to perform objective tests when they are aged 5, healthcare professionals should try doing the tests again every 6 to 12 months until satisfactory results are obtained. [BTS, NICE, SIGN guideline on asthma, recommendation 1.3.2]

Some people with learning disabilities or mental health problems may need additional support to help them to perform objective tests to diagnose asthma.

Quality statement 2: Documented personalised action plan

Quality statement

People aged 5 years and over with asthma discuss and agree a documented personalised action plan. **[2013, updated 2018]**

Rationale

Involving people with asthma (including their families and carers as appropriate) in developing a documented personalised action plan can help them to respond to changes in their symptoms, enabling them to self-manage their asthma and reduce the risk of serious asthma attacks and hospital admission. Regular reviews of the action plan with a healthcare professional can help to prevent complications arising. The action plan should also be reviewed if the person's asthma control is deteriorating, including during hospital admissions and acute consultations.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of a local framework and guidance for healthcare professionals on providing asthma education and developing a documented personalised action plan for people aged 5 years and over with asthma.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of people aged 5 years and over with asthma who have a documented personalised action plan.

Numerator – the number of people in the denominator who have a documented personalised action plan.

Denominator – the number of people aged 5 years and over with asthma.

Data source:NHS England's Quality and Outcomes Framework indicator AST007 includes data on personalised action plans as part of an annual asthma review. The Royal College of Physicians National Respiratory Audit includes data on documentation of a current self-management plan following an admission to hospital due to an exacerbation for adults, children and young people with asthma.

b) Proportion of documented personalised action plans for people aged 5 years and over with asthma that include approaches to minimising exposure to indoor and outdoor air pollution.

Numerator – the number in the denominator that include approaches to minimising exposure to indoor and outdoor air pollution.

Denominator – the number of documented personalised action plans for people aged 5 years and over with asthma.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of hospital attendance or admission for an asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

b) Satisfaction of people with asthma aged 5 years and over and their family and carers (as appropriate) that they are able to self-manage their condition and their asthma is well controlled.

Data source: Local data collection, for example, patient and carer surveys. NHS England's GP patient survey includes data on how confident people with lung or breathing conditions are in managing any issues caused by their condition.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place to involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing a documented personalised action plan and to provide education to help them self-manage their asthma. Service providers ensure that healthcare professionals are able to explain that pollution can trigger or exacerbate asthma, and include approaches for minimising exposure to indoor and outdoor air pollution in personalised action plans. Service providers ensure that documented personalised action plans are reviewed regularly, including after an asthma attack.

Healthcare professionals (such as doctors, nurses, healthcare assistants and pharmacists) involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing a documented personalised action plan and provide education to help them self-manage their asthma. Healthcare professionals explain that pollution can trigger or exacerbate asthma, and include approaches for minimising exposure to indoor and outdoor air pollution in the personalised action plan. Healthcare professionals regularly involve people with asthma in reviewing and updating their documented personalised action plan, including after an asthma attack.

Commissioners commission services that involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing and reviewing a documented personalised action plan and provide education to help them self-manage their asthma. Commissioners should ensure consistency by providing a local framework and guidance to healthcare professionals on developing and reviewing documented personalised action plans and providing education for people with asthma.

People aged 5 years and overwith asthma have their own asthma care plan, which helps them take their asthma medicines and know what to do if the medicines are not working (with support from their family and carers as appropriate). Their healthcare professional gives them (and their family and carers as appropriate) information about asthma, involves them in developing the plan and helps them to use it. Their healthcare professional also

explains that pollution can trigger or make their asthma worse and ensures their care plan includes ways to reduce exposure to indoor and outdoor air pollution. The care plan is reviewed regularly with the person's healthcare professional and also reviewed after an asthma attack.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. BTS, NICE, SIGN guideline NG245 (2024), recommendation 1.14.1

Definitions of terms used in this quality statement

Documented personalised action plan

A documented personalised action plan should be tailored to the person with asthma, enabling them to recognise when symptoms are worse. In adults, they may be based on symptoms or peak expiratory flow (or both) but symptom-based plans are usually preferred for children. The plan should include approaches for minimising exposure to pollution and any other personal triggers. It should set out actions to be taken if asthma control deteriorates and who to contact. For adults aged 17 and over who are using an inhaled corticosteroid in a single inhaler, the action plan should outline how and when to increase their dose of ICS for 7 days, and what to do if symptoms do not improve. [Adapted from BTS, NICE, SIGN guideline on asthma, recommendations 1.14.1, 1,14.4, 1.14.5 and expert opinion]

Equality and diversity considerations

Healthcare professionals should have a discussion with family or carers of children under 5 years with suspected or confirmed asthma to agree if a documented personalised action plan would be helpful. [BTS, NICE, SIGN guideline on asthma, recommendation 1.14.3]

The personalised action plan should be provided in an accessible format and tailored to meet individual needs, taking into consideration a person's capacity and their ability to care for themselves. Additional support may be needed for people with learning disabilities to ensure that they can be involved in the discussion and are able to understand how to use their plan.

Quality statement 3: Monitoring asthma control

Quality statement

People with asthma have their asthma control monitored at every asthma review. **[2013, updated 2018]**

Rationale

Monitoring of asthma control at every asthma review will identify if control is suboptimal. If asthma is uncontrolled, the person should have an assessment to identify possible reasons for this, including suboptimal adherence and inhaler technique as well as other relevant factors, before their treatment is adjusted. Support and education can be provided to improve adherence and inhaler technique. Monitoring asthma control and addressing any problems identified will improve quality of life and reduce the risk of serious asthma attacks and hospital admissions.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with asthma have their asthma control monitored at every asthma review.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of people with asthma who had an asthma review within the past 12 months.

Numerator – the number in the denominator who had an asthma review within the past 12 months.

Denominator – the number of people with asthma.

Data source:NHS England's Quality and Outcomes Framework indicator AST007 includes data on asthma reviews.

b) Proportion of asthma reviews that include monitoring of asthma control.

Numerator – the number in the denominator that include monitoring of asthma control.

Denominator – the number of asthma reviews.

Data source: Local data collection, for example, audit of patient health records. NHS England's Quality and Outcomes Framework indicator AST007 includes data on exacerbations as part of annual asthma reviews.

Outcome

a) Proportion of people with asthma prescribed more than 2 short-acting $beta_2$ agonist (SABA) reliever inhalers within the past 12 months.

Data source: Local data collection, for example, electronic prescribing data. The NHS Business Services Authority Respiratory Dashboard includes data on the proportion of patients prescribed preventer inhalers without antimuscarinics who were also prescribed 6 or more SABA inhalers for a rolling 12-month period. The Pharmaceutical Services Negotiating Committee's pharmacy quality scheme collects data on referrals for an asthma review for people with asthma dispensed 3 or more short-acting bronchodilator inhalers without any corticosteroid inhaler within a 6-month period.

b) Rate of hospital attendance or admission for asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

What the quality statement means for different

audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place for people with asthma to have their asthma control monitored at every asthma review. Service providers ensure that if uncontrolled asthma is identified, processes are in place for adherence and inhaler technique and other relevant factors to be assessed before treatment is adjusted. Service providers ensure that staff are trained to use the tools and tests needed to monitor asthma control and to assess adherence and inhaler technique.

Healthcare professionals (such as doctors, nurses, healthcare assistants and pharmacists) monitor asthma control at every asthma review. If uncontrolled asthma is identified, they assess adherence and inhaler technique and other relevant factors before adjusting treatment.

Commissioners commission services that monitor asthma control at every asthma review. Commissioners ensure that tools, such as a validated questionnaire and testing, are available for monitoring asthma control.

People with asthma have their asthma control checked when they have a review of their asthma. If their asthma is not well controlled, they get support to make sure they are using their medicines correctly, for example, a check of how they are using their inhaler. They are also asked about other factors that may be relevant such as smoking and exposure to air pollution, indoor mould or other risks at work. If this doesn't help, they may have their medicines or inhaler changed to help prevent asthma attacks.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. BTS, NICE, SIGN guideline NG245 (2024), recommendations 1.5.1 and 1.6.1

Definitions of terms used in this quality statement

Monitoring asthma control

Consider using a validated questionnaire, such as the Asthma Control Questionnaire, Asthma Control Test or the Childhood Asthma Control Test, to monitor asthma control.

Consider FeNO monitoring for adults with asthma. Do not use peak expiratory flow monitoring (PEF) to assess asthma control unless there are person-specific reasons for doing so, for example when PEF measurement is part of the personalised asthma action plan. [BTS, NICE, SIGN guideline on asthma, recommendations 1.5.2 to 1.5.4]

Asthma review

Any asthma review, including review after an asthma attack and annual asthma review. [Expert opinion]

Equality and diversity considerations

Healthcare professionals using a validated questionnaire to monitor asthma control should ensure it is provided in a suitable format to meet individual needs. People with a learning disability or low literacy levels may need additional support to ensure that they understand what is being asked and can take part in the discussion.

Quality statement 4: Follow-up by general practice after emergency care

Quality statement

People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge. **[2013, updated 2018]**

Rationale

People who have recently had emergency care for an asthma attack may be at risk of another attack. Timely follow-up in general practice after discharge from emergency care allows healthcare professionals to check that the asthma is responding to treatment, to explore the possible reasons for the attack and to give support and advice about reducing the risk of further attacks.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Process

a) Proportion of cases of asthma attack treated in an emergency care setting notified to the person's general practice.

Numerator – the number in the denominator notified to the person's general practice.

Denominator – the number of cases of asthma attack treated in an emergency care setting.

Data source: Local data collection, for example, audit of patient health records. Data on

community follow-up requests within 2 working days is included in the Royal College of Physicians National Respiratory Audit Programme (NRAP) for adults and children as an element of the patient's discharge.

b) Proportion of notifications of asthma attack treated in an emergency care setting followed up by a general practice within 2 working days of discharge.

Numerator – the number in the denominator that are followed up by a general practice within 2 working days of discharge.

Denominator – the number of notifications of asthma attack treated in an emergency care setting.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of re-attendance within 7 days of a previous attendance in emergency care for asthma.

Data source: Local data collection, for example, audit of patient health records. Data on A&E re-attendance within 7 days is included in NHS England's Accident and Emergency Quality Indicators.

b) Rate of hospital attendance or admission for asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

c) Mortality rate for people with asthma.

Data source: Local data collection, for example, audit of patient health records. Office for National Statistics (ONS) deaths registered in England and Wales provides data on deaths where asthma was the underlying cause of death.

What the quality statement means for different audiences

Service providers (such as A&E departments, out-of-hours services, walk-in centres and general practices) ensure that processes are in place to notify the person's general practice when treatment for an asthma attack has been provided in an emergency care setting. Once notified, general practices ensure follow-up takes place within 2 working days of discharge. General practices ensure that staff who follow-up with people who have had an asthma attack are trained in asthma care.

Healthcare professionals (such as doctors, nurses, pharmacists and healthcare assistants) notify the person's general practice when they provide treatment in an emergency care setting for an asthma attack. Healthcare professionals in general practices ensure that follow-up takes place within 2 working days of discharge from emergency care.

Commissioners commission emergency care services that have processes in place to notify the person's general practice when treatment is provided for an asthma attack. Commissioners ensure that there is sufficient capacity for general practice to follow-up within 2 working days of discharge. Commissioners could consider introducing a local quality improvement scheme to encourage the pathway to be established.

People who have emergency treatment for an asthma attack are checked by a healthcare professional from their GP surgery within 2 working days of discharge. This is to check that their treatment is working and help them to understand why their asthma got worse and how to stop it happening again.

Source guidance

British guideline on the management of asthma. British Thoracic Society and Scottish Intercollegiate Guidelines Network guideline 158 (2019), good practice points 9.6.3, 9.9.7, and annexes 3 and 7. This content is included on the Right Decision Service for hospital discharge and follow up of acute asthma in adults, second-line treatment of acute asthma in children (discharge planning) and algorithms on management of acute asthma in children in the emergency department and management of acute asthma in adults in general practice.

Equality and diversity considerations

Healthcare professionals in emergency care should ensure that alternative follow-up arrangements are made for people who are not registered with a general practice. For example, people experiencing homelessness may be followed-up via the specialist homelessness multidisciplinary team (for more information see NICE's guideline on integrated health and social care for people experiencing homelessness, recommendation 1.3.4).

Quality statement 5 (developmental): Suspected severe asthma

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service. **[2013, updated 2018]**

Rationale

People with suspected severe asthma need specialist assessment to confirm a diagnosis of severe asthma. Specialist assessment is important to revisit adherence to treatment, exclude other causes of persistent symptoms and ensure the most appropriate treatment. Specialist care can help to improve asthma control, prevent asthma attacks and reduce harmful long-term dependence on oral corticosteroids.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

a) Evidence that specialist multidisciplinary severe asthma services are available for people with suspected severe asthma.

Data source: Local data collection, for example, service specifications for children and young people, and adults.

b) Evidence of local arrangements to ensure that people with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service.

Data source: Local data collection, for example, service protocols and referral pathways.

Process

Proportion of people with suspected severe asthma who are referred to a specialist multidisciplinary severe asthma service.

Numerator – the number in the denominator who are referred to a specialist multidisciplinary severe asthma service.

Denominator – the number of people with suspected severe asthma.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of hospital attendance or admission for an asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

b) Proportion of people with asthma who have 2 or more courses of high-dose oral corticosteroids per year.

Data source: Local data collection, for example, electronic prescribing data.

What the quality statement means for different audiences

Service providers (such as hospitals) ensure that processes are in place to identify people with suspected severe asthma so that they can be referred to a specialist multidisciplinary severe asthma service. Service providers ensure that a diagnosis of asthma is made, and adherence and comorbidities are addressed before a referral is made.

Healthcare professionals (such as doctors and nurses) are aware of local referral pathways for severe asthma and refer people with suspected severe asthma to a specialist multidisciplinary severe asthma service. Healthcare professionals ensure that a diagnosis of asthma is made, and adherence and comorbidities are addressed before making a referral. Healthcare professionals ensure that people with suspected severe asthma know what to expect when they are referred.

Commissioners commission specialist multidisciplinary severe asthma services for adults, children and young people and ensure referral pathways are in place. Commissioners ensure that providers identify people with suspected severe asthma so that they can be referred. Commissioners ensure that specialist services have sufficient capacity to meet the demand for assessments for people with suspected severe asthma.

People with suspected severe asthma are referred to a service that specialises in managing severe asthma so that the reasons for their asthma and their treatment can be reviewed.

Source guidance

British guideline on the management of asthma. British Thoracic Society and Scottish Intercollegiate Guidelines Network guideline 158 (2019), recommendation 10.1. This content is included on the Right Decision Service for defining and assessing difficult asthma.

Definitions of terms used in this quality statement

Severe asthma

When a diagnosis of asthma is confirmed and comorbidities have been addressed, severe asthma is defined as asthma that required treatment with a high-dose inhaled corticosteroid and long-acting beta$_2$ agonists (LABA) or leukotriene modifier/theophylline for the previous year or systemic corticosteroids for 50% or more of the previous year to prevent it from becoming 'uncontrolled' (that is, controlled asthma that worsens on tapering of corticosteroids) or that remains 'uncontrolled' despite this therapy. 'Uncontrolled' is defined as at least 1 of the following:

- Poor symptom control: Asthma Control Questionnaire consistently greater than or

equal to 1.5 or Asthma Control Test less than 20.

- Frequent severe exacerbations: 2 or more bursts of systemic corticosteroids (greater than or equal to 3 days each) in the previous year.
- Serious exacerbations: at least 1 hospitalisation, ICU stay or mechanical ventilation in the previous year.
- Airflow limitation: after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal).

[European Respiratory Society/American Thoracic Society International guidelines on definition, evaluation and treatment of severe asthma]

Specialist multidisciplinary severe asthma service

A dedicated multidisciplinary service with a team experienced in the assessment and management of severe asthma. The service requirements for adults are set out in NHS England's Specification for specialised respiratory services (adult) – severe asthma. The service requirements for children are set out in NHS England's specification for paediatric medicine: respiratory.

Equality and diversity considerations

Healthcare professionals should ensure that people with learning disabilities are referred to a specialist service if severe asthma is a possibility but it has not been possible to assess all relevant criteria.

Update information

September 2018: This quality standard was reviewed and statements prioritised in 2013 were updated.

Statements are marked as **[2013, updated 2018]** if the statement covers an area for quality improvement included in the 2013 quality standard and has been updated.

The previous version of the quality standard for asthma is available as a pdf.

Minor changes since publication

November 2024: Changes have been made to align this quality standard with the joint BTS, NICE, SIGN guideline on asthma: diagnosis, monitoring and chronic asthma management. Statement 1 is no longer identified as developmental as access to objective tests in primary care has improved. The wording of statement 2 has been amended from a 'written' to a 'documented' personalised action plan in line with the guideline. Links, measures, definitions and source guidance sections have been updated throughout.

August 2022: The definition of severe asthma for statement 5 was amended in line with the updated European Respiratory Society/American Thoracic Society International guidelines on definition, evaluation and treatment of severe asthma.

March 2022: The equality and diversity considerations section for statement 4 was updated in line with NICE's guideline on integrated health and social care for people experiencing homelessness.

November 2019: References for the evidence sources for statements 4 and 5 were amended to reflect the updated British Thoracic Society/Scottish Intercollegiate Guidelines Network British guideline on the management of asthma.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource

impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the BTS, NICE and SIGN guideline on asthma to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: 978-1-4731-0047-3

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Association of Respiratory Nurse Specialists
- Royal College of Nursing (RCN)
- Royal College of Paediatrics and Child Health
- Asthma and Lung UK