



THE GREAT ASTHMA DIVIDE

THE ANNUAL ASTHMA SURVEY 2019

We work to stop asthma attacks and, ultimately, cure asthma by funding world leading research and scientists, campaigning for change and supporting people with asthma to reduce their risk of a potentially life threatening asthma attack.

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FOREWORD

Asthma can have a devastating impact on those who suffer from it. Each year, there are over 75,000 emergency admissions for asthmaⁱ, and tragically, the number of people dying from asthma is at the highest level this centuryⁱⁱ. Asthma affects people of all ages, genders and social backgrounds. However, this report shows that your life circumstance can affect your level of asthma control, how many asthma attacks you have, and how often you end up in hospital.

We have also seen a stalling of basic care levels. This is particularly disappointing, as we have become used to seeing a steady increase in this measure in the six previous editions of this survey. 60.5% of people with asthma in the UK – equivalent to 3.27 million peopleⁱⁱⁱ – are still not receiving the most basic level of asthma care. We are also concerned that even when people do have an asthma review, it is too often a box-ticking exercise. It's crucial that everyone gets a good quality review that is personalised to their needs, so that everyone, regardless of background, can self-manage their asthma well and reduce the burden of asthma attacks and avoidable hospital admissions – especially at a time when respiratory doctors are struggling to cope. The COVID-19 epidemic has also highlighted the problems the NHS has had in identifying people with severe asthma, and better provision of basic care would have helped this task. Furthermore, the NICE guidelines for managing severe asthma during the coronavirus recommends following a written asthma action plan^{iv} – something 48% of people with asthma are still not receiving.

Health inequality has been prominent as an issue in relation to health in recent years, and it is clear that it has a significant impact on asthma outcomes. We are calling for urgent action across the UK to address the health inequalities we have found in this report, as well as the variation in care and shortfalls against key quality measures. No-one should be at more risk of a life-threatening asthma attack because of their economic circumstance, or because of where they live.

Kay Boycott

Chief Executive, Asthma UK



EXECUTIVE SUMMARY

Asthma UK conducted a survey of over 12,000 people in summer 2019. This report presents the key findings.

For the first time our survey asked people their household income group, so we have new insights about the effect of asthma across different levels of our society. We found that people on lower incomes suffer from more frequent asthma symptoms. Over twice as many from the top income band have well controlled asthma, compared to those in the lowest quintile. There are similar effects of inequality on frequency and severity of asthma attacks and use of emergency care and oral steroids.

It appears to be that it is asthma severity and symptoms that are unequal between different socio-economic groups, rather than the numbers of people who have asthma. We have previously shown a correlation between hospital admissions and geographical deprivation, but this is the first time we have shown the impact of inequality on asthma symptoms through our survey. The findings demand further investigation to understand the drivers and inform urgent action. These asthma inequalities are a blight on people's lives, and an avoidable cost on the NHS and society.

Our survey suggests that access to basic asthma care by household income level is not the main driver of differences in asthma outcomes. Digging deeper, we found that although lower income groups appear to be getting similar access to basic asthma care and its components (an asthma review, an inhaler technique check and a written asthma action plan), the quality of asthma reviews they receive is poorer. People are not asked about their symptoms, their inhaler usage is not assessed and their adherence to their preventer inhaler is not discussed as often. It is not surprising that worse care leads to poor outcomes and this must be addressed. There are also other factors that drive asthma inequalities – particularly the link between low income and asthma triggers like chronic exposure to air pollution, tobacco smoke, damp and mould in poor quality housing and poor working environments.

For the first time in seven years, we have seen no improvement in access to basic care – an asthma action plan, inhaler technique check and an annual asthma review, and 60.5% of people with asthma – equivalent to 3.27 million people – are not receiving the most basic level of asthma care, and this is unacceptable. When people do have an asthma review, we have shown that these are not meeting the quality standards expected. Of those who do



Northern Ireland



Scotland



Wales



London



North East and
South West

This year, the highest level of basic asthma care was once again provided in Northern Ireland (53%). Scotland provided the lowest level of basic asthma care (36%) and Wales was 39%. There was significant variation in England. The lowest level of basic care in England was in London, with only 35% receiving basic asthma care. The North East and the South West performed best, with 43% receiving basic asthma care.

have an asthma review, fewer than half are asked about recent asthma attacks or their use of reliever inhalers, despite these being key risk factors for future asthma attacks. Once again, only one in three people who received emergency asthma care had a follow up appointment within two working days despite quality standards mandating this.

Basic care levels in Wales have increased by seven percentage points in each of the last two years of the survey, which is to be applauded. However, Scotland has dropped from 43% to 36% in the same period. We call for improvements in the quality of basic asthma care, to improve asthma control and save lives. All nations and regions can improve and learn from each other.

We thank the 12,876 participants (including 11,004 in England, 254 in Northern Ireland, 1,043 in Scotland and 575 in Wales) for sharing their experiences.

KEY POLICY RECOMMENDATIONS

Based on the findings of this report, Asthma UK is calling for the following to improve asthma care and outcomes:

- Asthma to be positioned at the heart of efforts to address health inequalities.
- Improved quality of basic asthma care.
- Incentives to target quality as well as quantity of care.
- Using data to better target interventions.
- Improving asthma control levels through appropriate prescribing, improving health literacy and self-management.
- More work done for people with asthma to understand what to demand when talking about their asthma with their healthcare professionals.
- Using the proposed expansion of structured medicines reviews in England to improve self-management.
- Joining up data to better improve rates of post-admission follow-up care.
- In Scotland, the implementation of the *Respiratory Action Plan for Scotland*.
- In Wales, the development of a successor respiratory plan and the implementation of the proposed new guidelines, as well as the roll out of the AsthmaHub.
- In Northern Ireland, the development of a respiratory plan by the new Executive is needed to continue to build on their improved basic care results.
- In London, we want improvement in the diagnosis and monitoring of people with asthma.

KEY HEALTH ADVICE FOR PEOPLE WITH ASTHMA

1. Demand your basic care. It's important to keep and use a written asthma action plan, have your inhaler technique checked regularly and receive your annual review. We have 'how to' videos for **many different inhalers** on our website, and you can download a written asthma action plan **here**.
2. If your asthma symptoms are causing problems, such as interfering with daily activities or interrupting your sleep, the best way to address this is to arrange an asthma review with your doctor or asthma nurse.
3. Message one of our Asthma UK expert nurses on 07378 606 728 on WhatsApp for advice on your asthma. More information about our WhatsApp service is available **here**. You can also call an asthma nurse specialist on 0300 222 5800 (Monday to Friday, 9am to 5pm).
4. If you do have to attend A&E or receive out of hours care, make sure you demand your follow-up with your GP, even if you aren't told to do so. If there is no availability for an urgent appointment within two working days, then ask for a phone call, so your GP can assess if you need to be seen face-to-face. Make sure you tell your healthcare professional about any recent hospital admissions during your regular asthma review.
5. If you're experiencing frequent asthma attacks, such as two a year, arrange an asthma review with your GP. With two attacks a year, you should talk to your GP about being referred to a specialist centre for further tests.
6. If you manage an asthma attack yourself, always follow up with your GP afterwards. An asthma attack isn't something you should deal with alone and could be an indicator that your medicine needs to be changed or you need more specialised care.

SURVEY METHODOLOGY

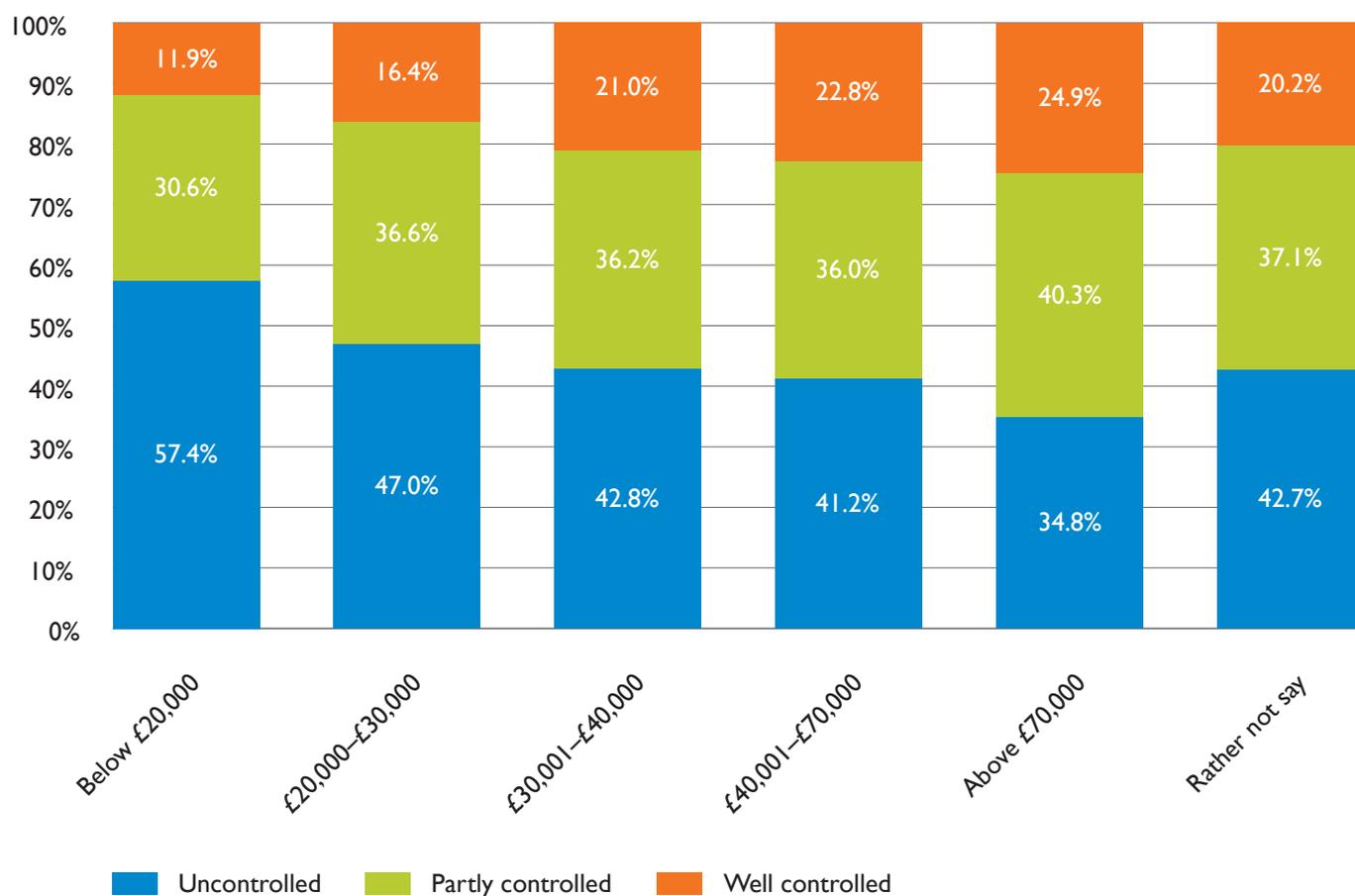
The survey was conducted by Asthma UK from June 2019–September 2019. It was online, and responses were encouraged via both paid and organic social media promotion, emails to our supporter base and promotion on our website. After data cleaning (removing duplicate and incomplete responses), we received 12,876 responses. A full breakdown of the demographics or the survey respondents, as well as data tables for this report and references, is available in the appendix.

HEALTH INEQUALITY HAS A MAJOR IMPACT ON ASTHMA OUTCOMES

Health inequality – the variation in health status, access to care and outcomes – is one of the great health challenges of our time. Health inequalities affect asthma, and we have previously written about the impact of economic circumstance, age and geographic location on people’s experience of living with asthma in our 2018 report *On the Edge*^v. This includes exposure to asthma triggers, asthma self-management and outcomes. In the past decade in England, improvements in life expectancy have ground to a halt for the most deprived, and people are living longer in poor health. Overall, health inequality is more acute than it was ten years ago^{vi}. In this survey, we asked people about their household income level, as well as using a measure to find out levels of material deprivationⁱ. Using these measures, we were able to find out differences in asthma care, control and outcomes by income and deprivation levels.

If you are poorer you are more likely to have uncontrolled asthma and more asthma attacks

Figure 1: Levels of asthma control, by household income

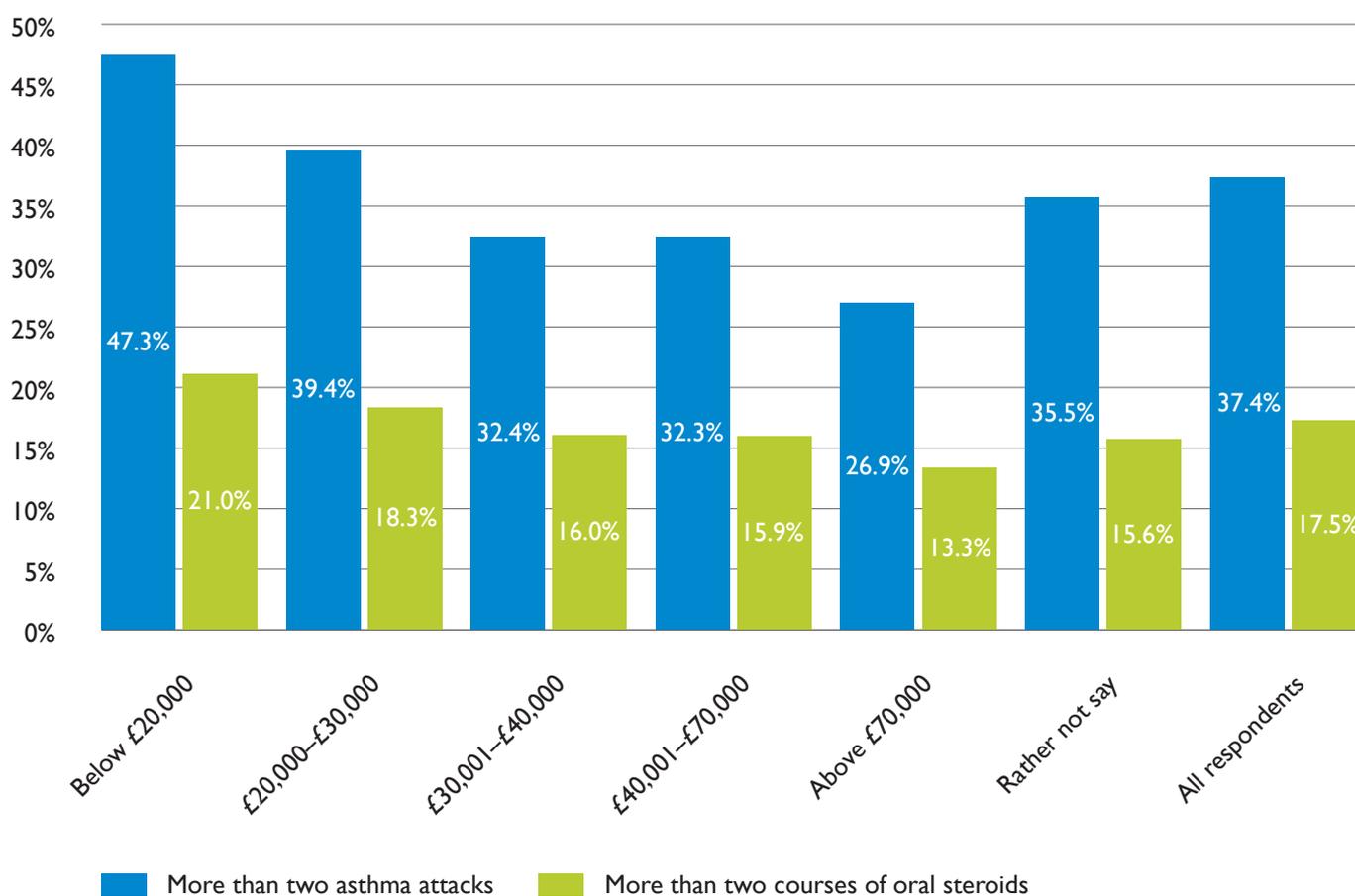


ⁱ The questions for this measure were originally developed by Eurostat. A full list of questions used in the survey is available in the report appendix. Looking at material deprivation help find out how income levels affect quality of life, as household income levels can vary in impact due to differing levels of wealth, house prices/rent levels and life circumstance.

People with a lower household income suffer from asthma symptoms more frequently². Over twice as many from the top income band (24.9%) have well controlled asthma, compared to 11.9% of those in the lowest quintile in the survey. The lowest income band is the only one where over half (57.4%) of people have uncontrolled asthma. These findings indicate that those on lower incomes are suffering more asthma symptoms.

Poorly controlled asthma is a significant risk factor for asthma attacks^{vii}. We asked respondents how many asthma attacks they had had in the past 12 months³, and the median figure was 2. We have looked at those who had more than two asthma attacks and who were prescribed more than two courses of oral corticosteroids (enough to trigger a referral to secondary care, according to the National Review of Asthma Deaths)^{viii}. Figure 2 shows the results of these two indicators by household income. 21% of those in the lowest household income band had two courses of oral steroids in the past year, compared to 13.3% of those in the highest. Of self-reported asthma attacks, 47.3% in the lowest quintile had more than two, comparing to 26.9% of the highest – almost double the level of difficult-to-control asthma.

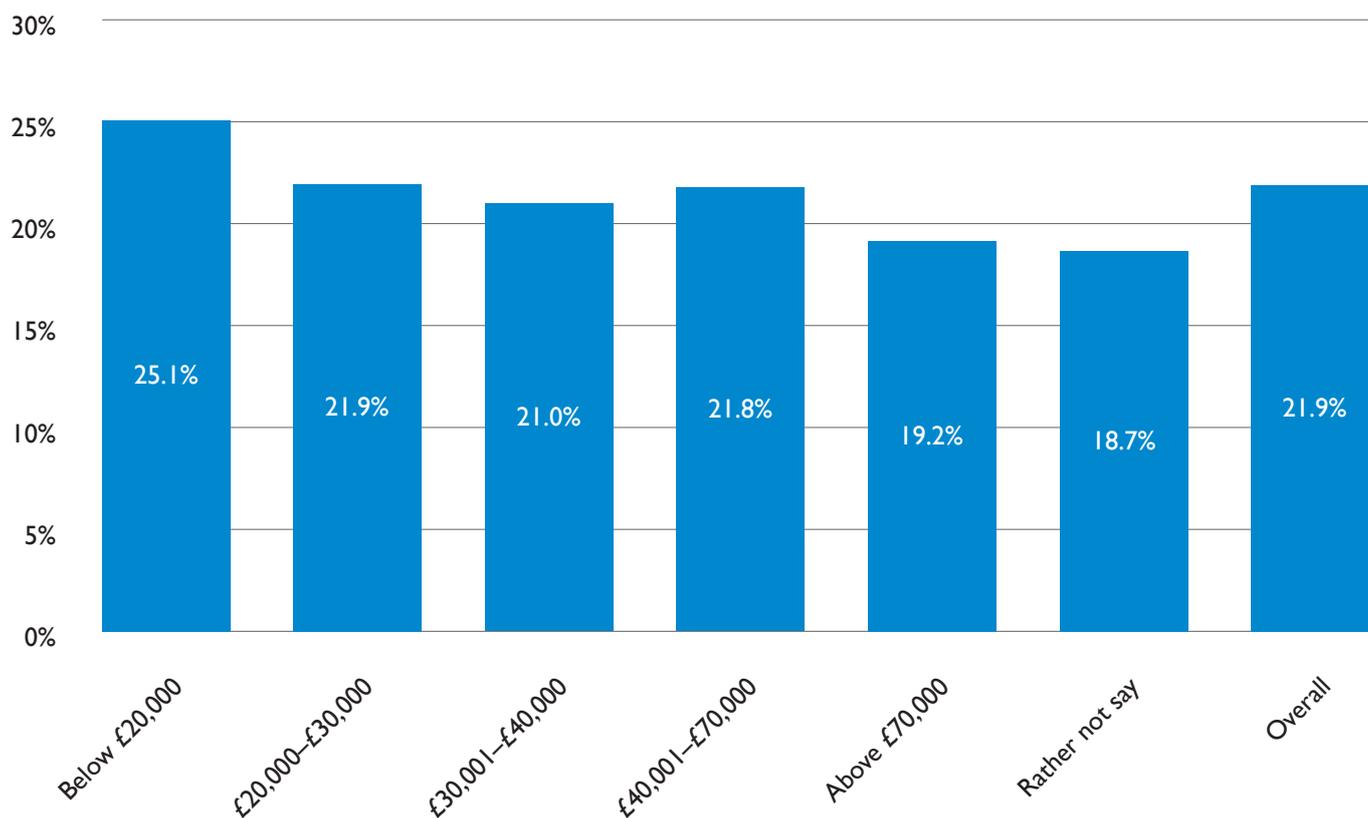
Figure 2: Respondents who had more than two asthma attacks, and more than two courses of oral steroids by household income



2 We asked questions on asthma control in the survey. This is a way to find out what proportion of asthma regularly suffer its symptoms.
 3 To define ‘asthma attacks’, we asked whether they had experienced all of the following symptoms during an episode: reliever inhaler not helping or needing to use it every four hours; wheezing a lot or had a tight chest or were coughing a lot; breathless and finding it difficult to walk or talk; struggling to breathe.

Our previous report on health inequality^{ix} showed a correlation between the rate of emergency admissions for asthma and deprivation. Areas with a higher index of multiple deprivation (IMD) rank generally had a higher rate of asthma emergency admissions. The findings of this survey help reinforce what we know about the stark impact of inequalities on individuals and on hospitals.

Figure 3: Percentage who used emergency care for their asthma in the past 12 months, by household income



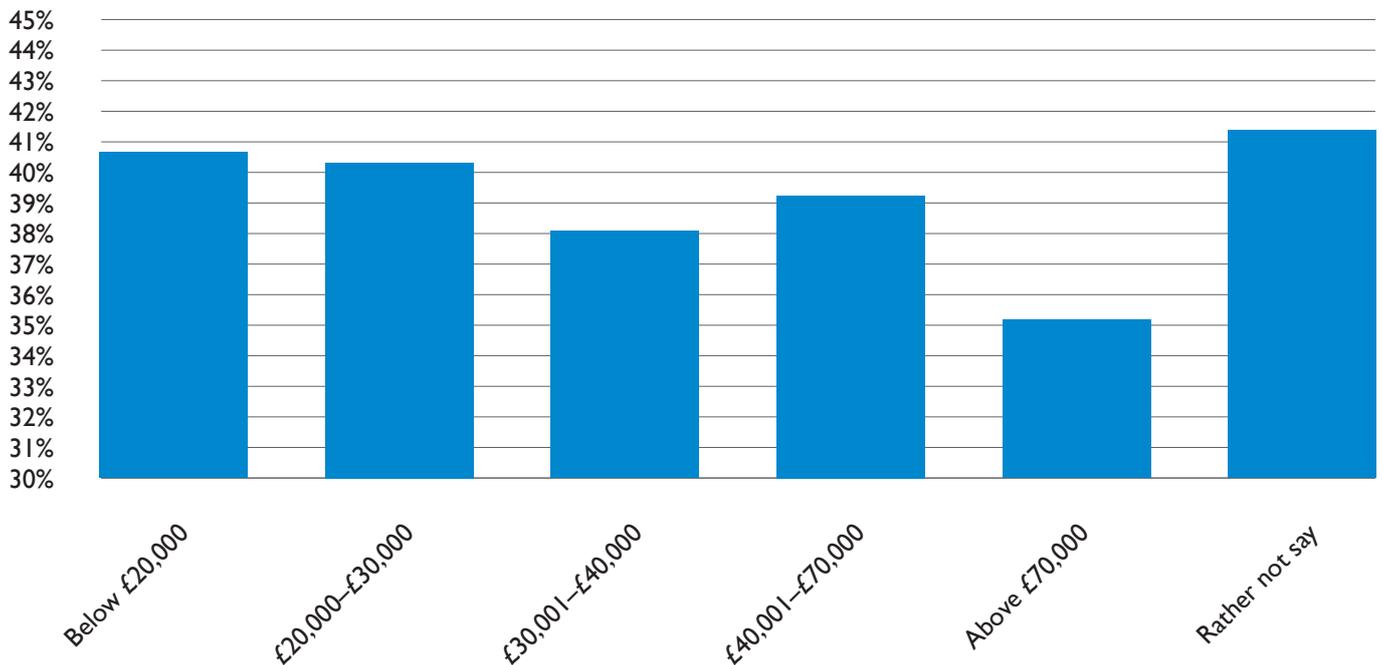
There is a near six percentage point difference in the use of emergency or unplanned care between the highest and lowest income quintiles. This is an important difference in outcomes. These findings echo other research into this issue, which found a trebling of emergency admissions for asthma with increasing deprivation^x. Higher rates of poor asthma control lead to higher rates of asthma attacks, which leads to higher rates of emergency admissions for asthma.

More deprived people are getting worse quality of basic care

The survey results have highlighted how income inequality affects asthma outcomes. Asthma can affect people of any gender, at any age, and from any walk of life. Recent results from the Health Survey for England 2018 indicated that prevalence levels of both diagnosed and currently treated asthma in England were not noticeably affected by deprivation levels^{xi}. Therefore it appears to be asthma severity and symptoms that are different, rather than the numbers of people who have it.

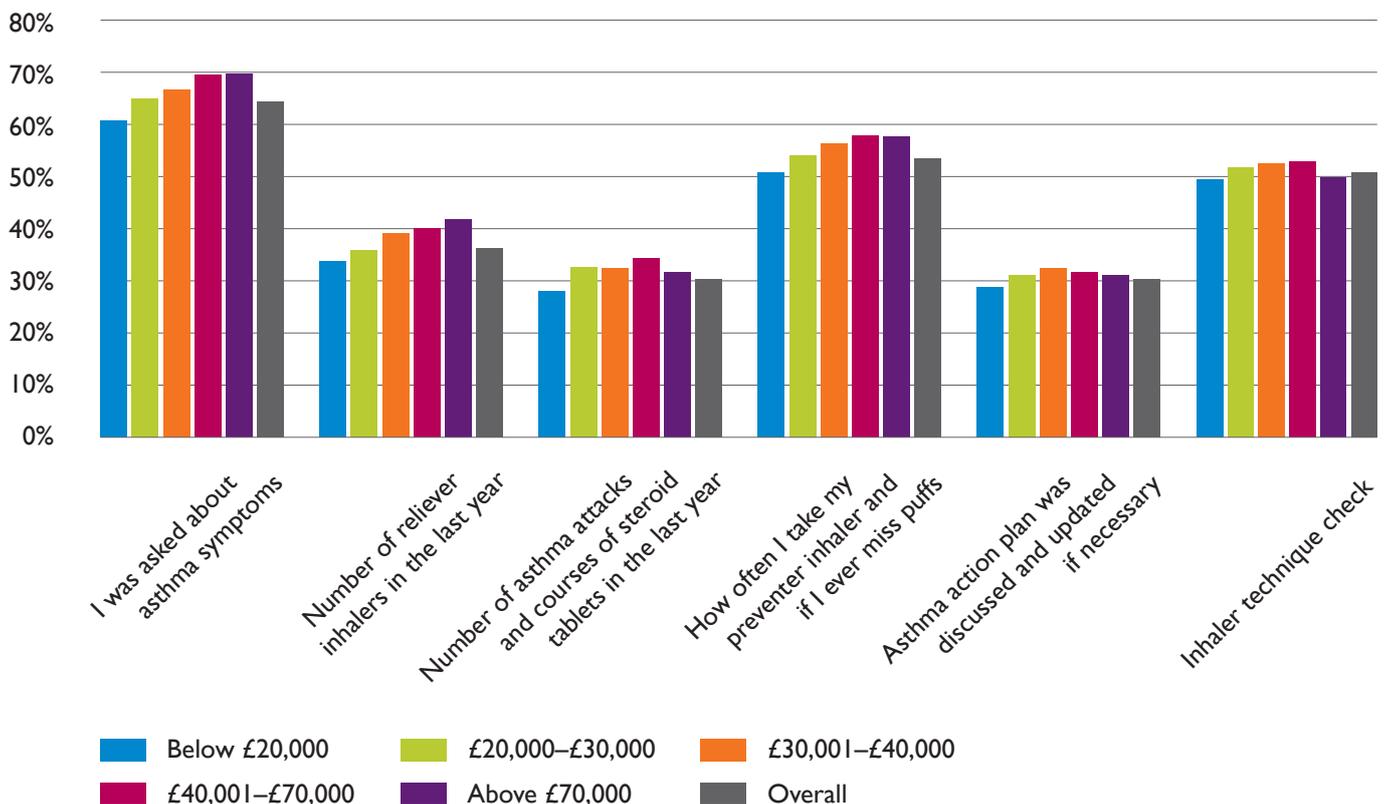
The highest income group receive the lowest levels of basic care. This indicates that access to basic asthma care by household income level is not the main driver of health inequalities in asthma outcomes. Indeed, there is some evidence that the more deprived use primary care services more frequently^{xii}. There is also evidence of higher 'did not attend' (DNA) rates among those in a lower socioeconomic circumstance^{xiii}.

Figure 4: Percentage receiving basic asthma care, by household income level



However, if we look at the quality of care provided in those who had an asthma review, there are differences in the care provided by income level. Figure 5 highlights people in the lower income band were least likely to receive each component of the asthma review.

Figure 5: Elements of an asthma review, by household income level



For those in the lowest income group, only 60.8% (of those who had an annual review) were asked about how their asthma symptoms were, compared to 69.8% of those in the highest income group. This outcome may help to explain the inequalities in asthma control – without a discussion about asthma symptoms, it is understandable that people with asthma have less of an idea about what good asthma control looks like. This can increase complacency about poor asthma control. Having this discussion may also assist in developing health literacy and knowledge about the condition. We found that 49.2% of those in the lowest income band had accessed online information about managing their asthma, compared to 59.0% of those in the highest income band. This indicates that those on lower incomes may be getting less health advice. There is a potentially a ‘digital literacy gap’, with those in lower income households less likely to have an internet connection at home^{xiv}. This means that this group may be likely to get information about their asthma from meetings with healthcare professionals, thus making these reviews of even greater consequence. Being able to confidently self-manage is a key part of asthma management. This includes adhering to preventer medication. Only 50.8% of those in the lowest income group had a discussion about this in their annual review, compared to 57.7% in the top income group. Again, without this discussion about managing asthma through adhering with preventers (and with similar results in discussions about the number of reliever inhalers), it is little surprise that those on lower income levels are more likely to have asthma attacks and end up in hospital.

The reasons behind the health inequality data in this report are multifactorial, going beyond the scope of this survey. Quality of basic care is not the only driver behind the data presented here. Air quality is worse in more deprived areas^{xv}, and poor housing increases exposure to mould, cold air and dust triggers^{xvi}. Recruiting GPs to work in primary care in deprived areas can be difficult, and GPs in deprived areas have larger patient lists^{xvii}. This increased pressure may lead to vital parts of an asthma review being missed. People on lower

incomes are more likely to skimp on medication due to the cost of prescription charges in England^{xviii} – a situation that does not occur in Scotland, Wales or Northern Ireland, where prescriptions are free. Although health inequalities are not linked to asthma prevalence, there is some evidence that severe asthma is linked to deprivation^{xix}. These factors, as well as the quality of care evidence presented here, must be taken into account if this variation is to be addressed.

What do we think about it?

These results are concerning. Asthma can affect people of any income, but people on lower incomes are suffering from the worst effects of the condition – including potentially life-threatening asthma attacks. The stark link between low income and poor asthma outcomes is a gross injustice, and urgent action is needed to address it.

Asthma UK has campaigned for better access to basic care since the National Review of Asthma Deaths in 2014. Although it has further to go, access has improved in that period and we can see it is reaching all income groups. There needs to be a stronger focus on the quality of the asthma review and self-management, with meaningful conversations about symptoms, the role of medication, the importance of good adherence and inhaler technique and management plans that are personalised to the needs of the individual. This is not only about the very poorest or excluded – although there must be adequate services for the homeless and other at risk groups. The effects of inequality begin at middle income groups, showing how important it is to provide services that are high quality for all and personalised to each.

There is a role for this for both people with asthma and healthcare professionals. People with asthma need to know what to demand in their basic asthma care, and healthcare professionals need to ensure that annual asthma reviews, as well as all other contacts with people with asthma, include a comprehensive discussion about asthma self-management, prescriptions and the impact

of asthma which are tailored to the person with asthma's health literacy, digital literacy and lifestyle and behaviours.

What do we want to happen?

Asthma inequalities – the fact that lower income leads to more asthma attacks – are a poor reflection on our society. To redress this injustice, we are calling for:

- **Asthma to be positioned at the heart of efforts to address health inequalities.** In England, health inequality has a prominent position in the *NHS Long Term Plan*^{xx}, and we want to see asthma positioned at the heart of the implementation of the plan, and the lessons from the *Marmot Review: 10 Years On* report acted on. In 2018, Public Health Wales published their *Long Term Strategy*, with a strong focus on health inequalities^{xxi}, and health inequalities have been a prominent issue in Scotland for many years, with a Ministerial Taskforce set up on the issue in 2007^{xxii}, and a 2018 report outlining the persistence of health inequalities in Scotland^{xxiii}. Despite these commitments, health inequalities persist across the UK.
- **Improved quality of basic asthma care.** Basic care for asthma cannot be a tick-box exercise. These basics, such as highlighting fundamental aspects of asthma and its management, its medicines and what they do still need to happen. GPs and asthma nurses need to spend time learning where asthma fits into the lives of people with asthma. This can help professionals work with people with asthma to understand how problems in control and asthma management can be overcome.
- **Incentives to target quality as well as quantity of care.** The new quality and outcomes framework (QOF) for England aims to do that through more specific rules on the elements of an asthma review. Other nations need to address this challenge as well, to ensure that those on lower incomes can and do access services they need.
- **Using data to better target interventions.** This would involve improving coding on records in a consistent manner. This, along with improving gatekeeping of patient records, would allow the better use of data to find those whose needs are not being met, patients with poor adherence, and those not engaging with managing their asthma, and would best use resources to improve outcomes by reducing asthma attacks and keeping people out of hospital. We would also like to see better patient access to their healthcare records.
- **Improving asthma control levels through appropriate prescribing, improving health literacy and self-management.** However, with such a complex picture, interventions to address inequalities will need to be personalised and sensitive to local variations in need. Local government and health services need to work together to address the social determinants, as proposed in the *Marmot 10 Years On* report^{xxiv}. Population health approaches will identify cohorts and localities that would benefit from an integrated health and public health approach to improving outcomes.

BASIC CARE LEVELS HAVE STALLED

In each edition of the Annual Asthma Survey, we have asked about the three elements of basic asthma care. These are:

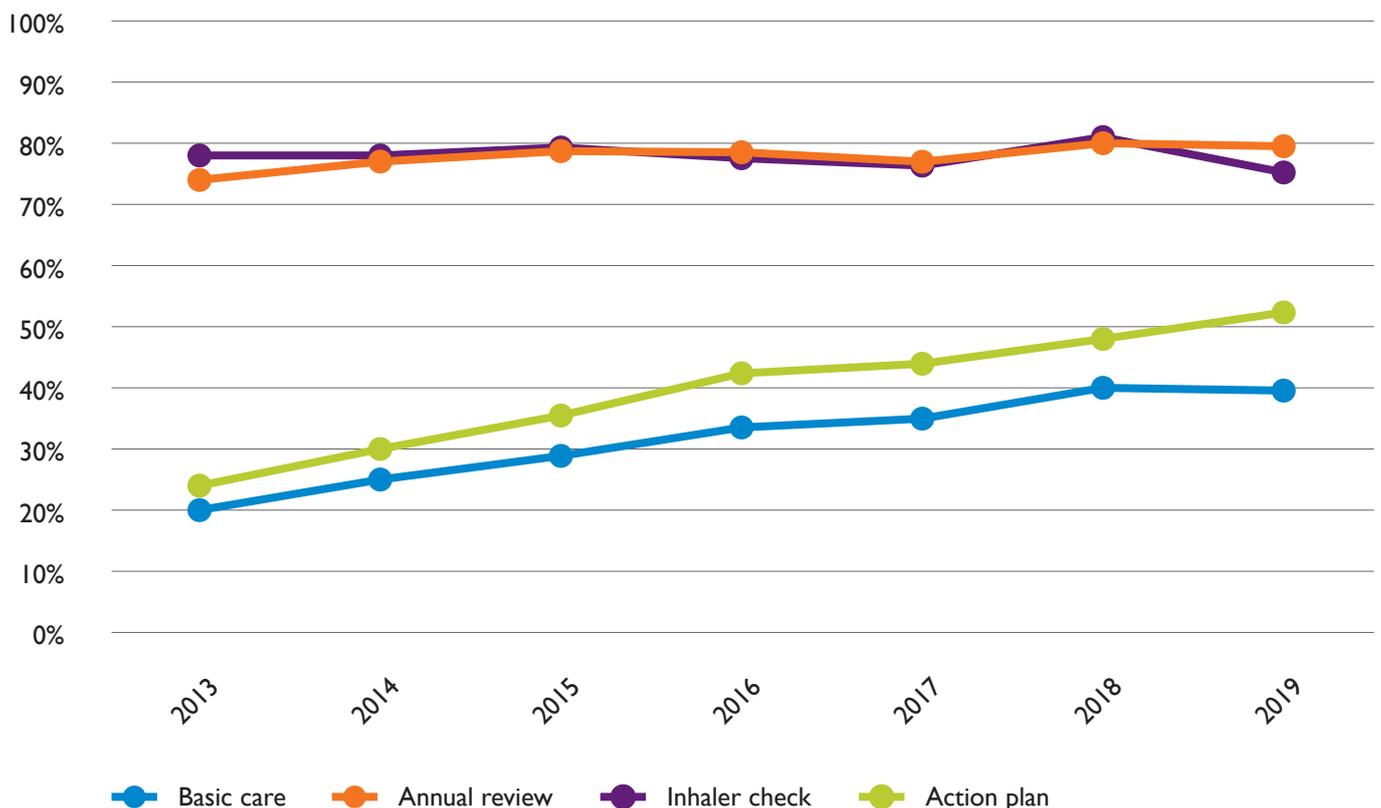
- receiving an asthma review
- having an inhaler technique check
- having a written asthma action plan.

Everyone with asthma should receive these three most basic elements of asthma care – though these simple actions are really the building blocks of optimal asthma care. Not receiving one of these three elements means you are not receiving basic asthma care. Receiving these measures contributes to helping people with asthma self-manage their condition, stay out of hospital and not let their asthma affect their lives. These measures are recommended in the British Thoracic Society clinical guidelines and are endorsed by NICE^{xxv}.

Improvements in basic care have stalled

We now have seven years of data on this important measure. Each year, we have used these findings to campaign and influence to try and improve the levels of care provided. Until 2019, each year saw an improvement in the levels of basic care received by people with asthma. But in 2019, 39.5% of people with asthma received basic asthma care – down from 40% in 2018. This means 60.5% – equivalent to 3.27 million people in the UK^{xxvi} – are not receiving the most basic level of asthma care, and this is unacceptable.

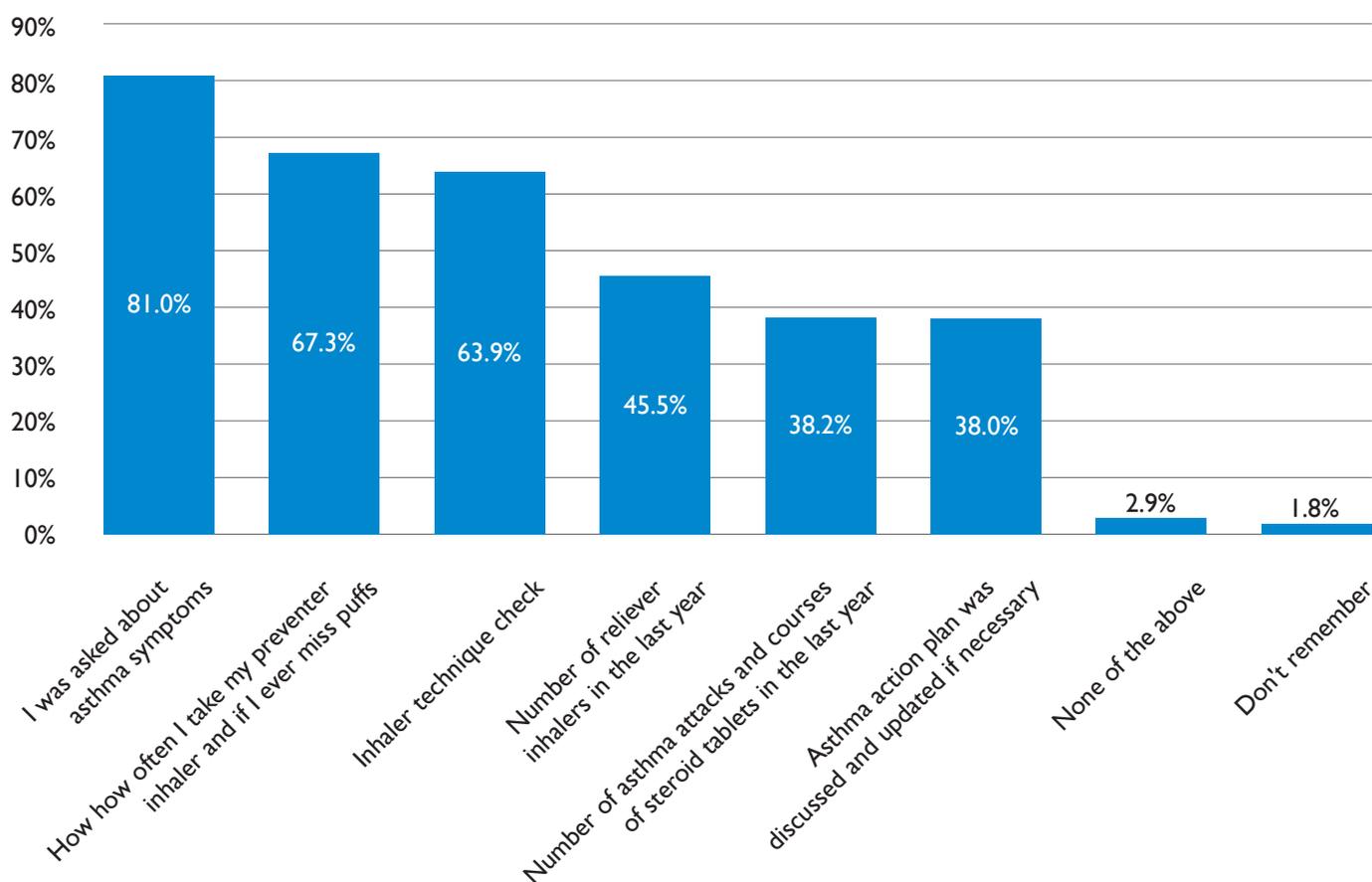
Figure 6: Trends in basic asthma care, 2013–2019



The drop in the overall level of basic care was driven by falls in the level of inhaler technique check (81.0% in 2018 to 75.2% in 2019) and the asthma review (80.0% in 2018 to 79.5% in 2019)^{4,xxvii}. Encouragingly, the proportion of people with asthma who have a written asthma action plan is now over half (52.3%) for the first time – and is up from 24.0% in 2013, the first year of the survey.

In this survey, we asked those respondents who had received an asthma review what had happened in this key appointment. There is a perception that these reviews can be a ‘tick-box’ exercise, and that the care received is of variable quality. The results in Figure 7 show that these appointments do indeed have varying content.

Figure 7: Proportion receiving different elements of an annual review



Of the elements of asthma care listed, only three were received by more than half of respondents. As well as a chance to have a discussion about asthma symptoms experienced and adherence to preventer medication and provide the other two elements of basic care, asthma reviews offer the chance to review what has been prescribed to manage asthma over the previous year. Fewer than 4 in 10 had a discussion about the number of reliever inhalers they had used in the past year, and the number of asthma attacks (and subsequent courses of oral steroids) they had suffered. Although this discussion may take place at another opportunity (such as with a pharmacist or in a hospital setting), it is incredibly important for a GP or asthma

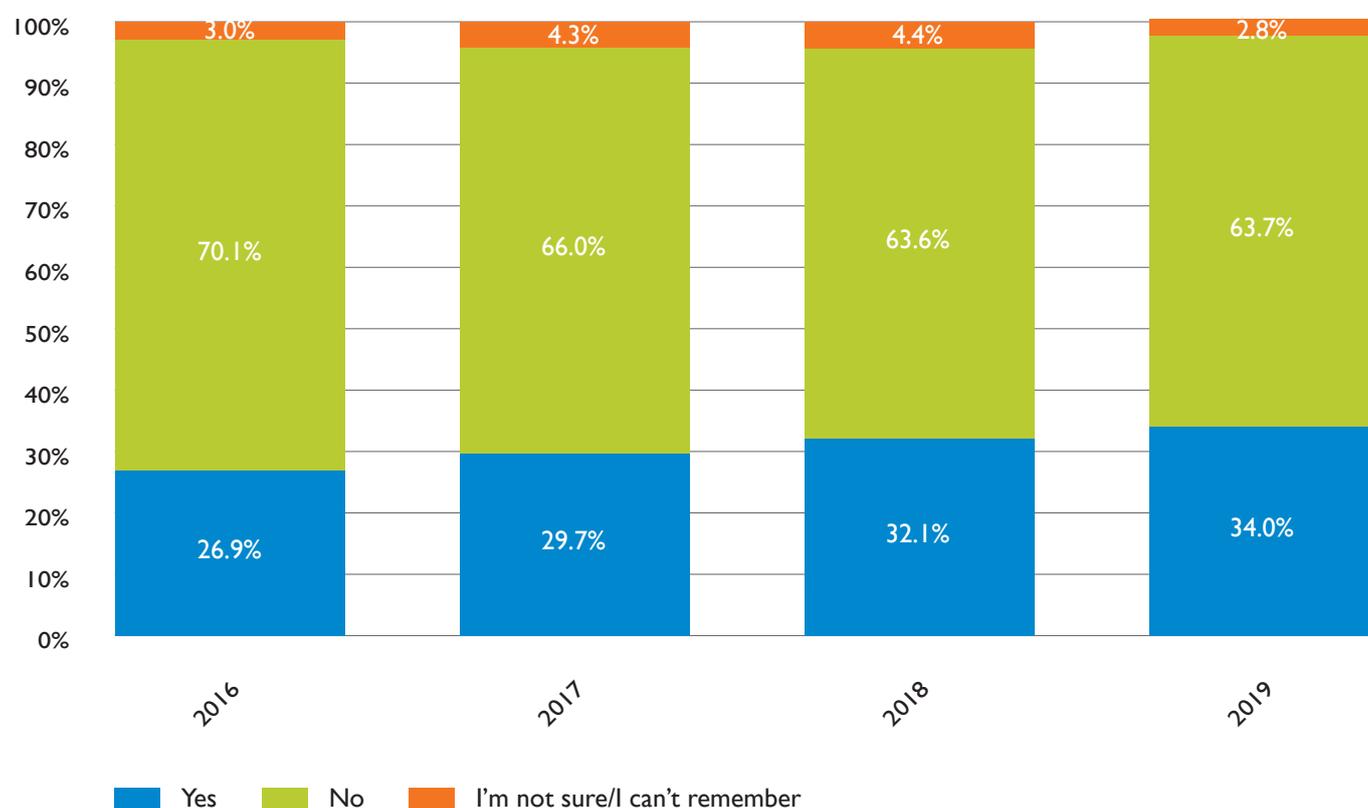
4 The results of the NACAP Primary Care report showed low levels of basic care. This included 25% having evidence of a written asthma action plan and 49% having had an inhaler technique check.

nurse to understand what medicines have been used to manage asthma. We know that there is a shortfall in the number of people with asthma who are referred to secondary care for more appropriate management, with only 18% of adults with possible difficult and severe asthma getting referred^{xxviii}. Failing to have these discussions will contribute to people with asthma being on the wrong medicines for their condition, and potentially having avoidable asthma attacks. With the current focus on the environmental impact of inhalers, poor preventer adherence and inhaler technique contribute to avoidable emissions as well as wasted costs.

Crucial follow-up care is still not happening

If you are unlucky enough to be admitted to hospital, according to clinical guidelines^{xxix} everyone who has had an asthma attack should receive a follow-up appointment within two working days of being discharged. This is a crucial part of asthma care, and offers a chance to discuss what asthma medicines have been prescribed and improve self-management to reduce the risk of another asthma attack and being readmitted.

Figure 8: Percentage of respondents receiving a follow up appointment within two working days



In this survey, only 34% of people who received emergency asthma care had a follow up appointment within two working days^{5,xxx}. This indicates that a majority of people with asthma who have used emergency care have not had this crucial follow-up care. This needs to change, in order to keep people with asthma out of hospital, and to improve asthma control and self-management. A previous emergency admission is a key risk factor for predicting a future hospital admission for asthma^{xxxi}, and this is preventable with better follow-up care.

5 These results closely match the *National Asthma and COPD Audit Programme (NACAP)* findings on this measure, which found that 34% of people admitted to hospital had a community follow up requested upon discharge.

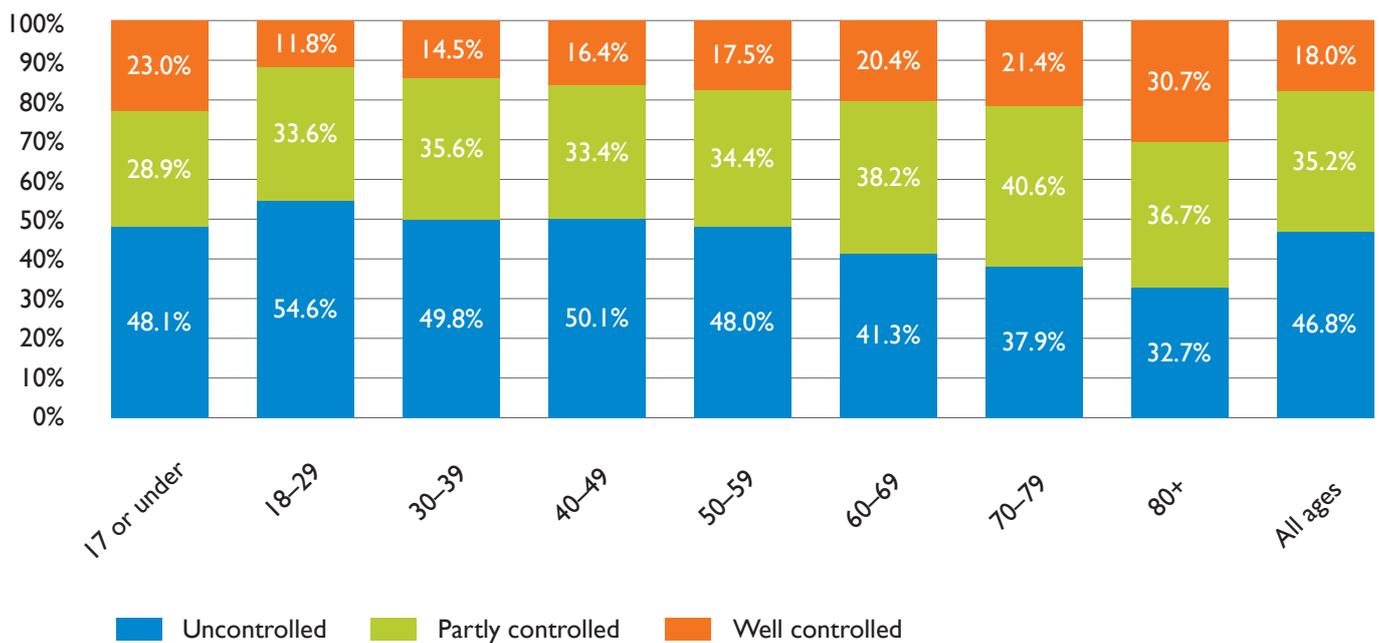
Asthma control levels are still worryingly low

Monitoring asthma control is a key part of asthma management, and this control can be maintained by a regular asthma review and self-management with a written asthma action plan^{xxxii}. Not receiving adequate asthma care can lead to poorly controlled asthma. Asking about asthma control is a method to understand the day-to-day impact of living with the condition. We asked survey respondents whether they had experienced, in the past four weeks⁶:

- daytime asthma symptoms more than twice a week
- any night waking due to asthma
- reliever inhaler needed for symptoms more than twice a week
- activity limitation due to asthma^{xxxiii}.

Answering 'no' to these four questions means that their asthma is well controlled; answering positively to one or two means it is 'partly controlled'; answering positively to three or four means their asthma is 'uncontrolled'.

Figure 9: Levels of asthma control by age group



Nearly half (46.8% – equivalent to 2.53 million people^{xxxiv}) of people with asthma in our survey have uncontrolled asthma, with those aged 18–29 being the age group with the highest proportion of uncontrolled asthma. This echoes findings from the 2018 survey^{xxxv}, albeit with slightly different questions. Only 18% of people with asthma have their condition fully under control, which indicates the scale of the problem of improving asthma management.

6 We have amended the asthma control questions from previous years, to put them in line with current research developments. They are based on questions developed for the *Global Initiative for Asthma 2019*. This means we cannot track trends in asthma control from previous editions of the survey.

What do we think about it?

Everyone with asthma should receive basic asthma care, and this year's results show us that the progress in improving basic care levels in the UK in previous years has stalled. It is shocking that 8 in 10 people do not have well controlled asthma. We also note that asthma control levels for young people are the lowest of all age groups – indicating that the findings from last year's Annual Asthma Survey^{xxxxvi} report have not been addressed. We are also disappointed to see limited progress in improving post-emergency care follow-up, which is a crucial part of asthma care for those who receive emergency care that can help reduce readmissions.

What do we want to happen?

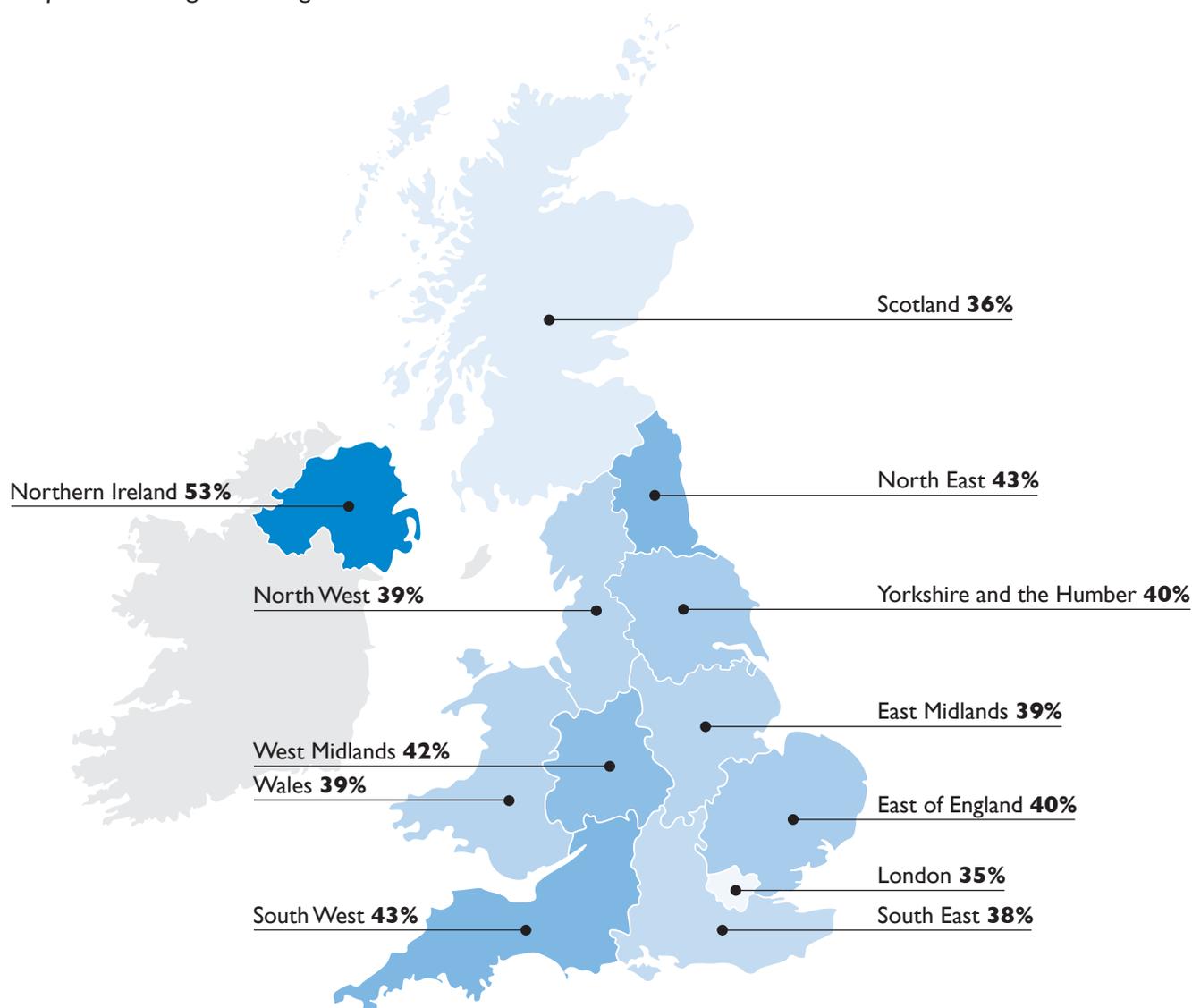
To address the findings outlined above, we are calling for:

- **More work done for people with asthma to understand what to demand when talking about their asthma with their healthcare professionals.** Some recent positive steps have been taken to improve the quality of asthma reviews, with changes in the Quality and Outcomes Framework (QOF) in England meaning that GPs will have to assess asthma control, record the number of asthma exacerbations, assess inhaler technique and issue a written asthma action plan to every person with asthma every year^{xxxxvii}. If this is adhered to, then we expect to see improvements in uptake of written asthma action plans and inhaler technique in future editions.
- **Using the proposed expansion of structured medicines reviews in England to improve self-management**^{xxxxviii}. These will be the perfect opportunity for people with asthma to discuss their use of relievers and oral corticosteroids over the previous year, but the proposed plans do not cover people with asthma who do not have ten or more medications. This leaves a potential unmet need, which will need to be addressed in asthma reviews.
- **Joining up data to better improve rates of post-admission follow-up care.** Unlike other aspects of asthma care, there are no policy levers currently in place to implement this important quality standard. This part of asthma care is just as important as basic care, and needs a combined effort from policy makers and professionals in both primary and secondary care to improve these levels.

THERE IS GEOGRAPHIC VARIATION IN BASIC CARE AND CONTROL

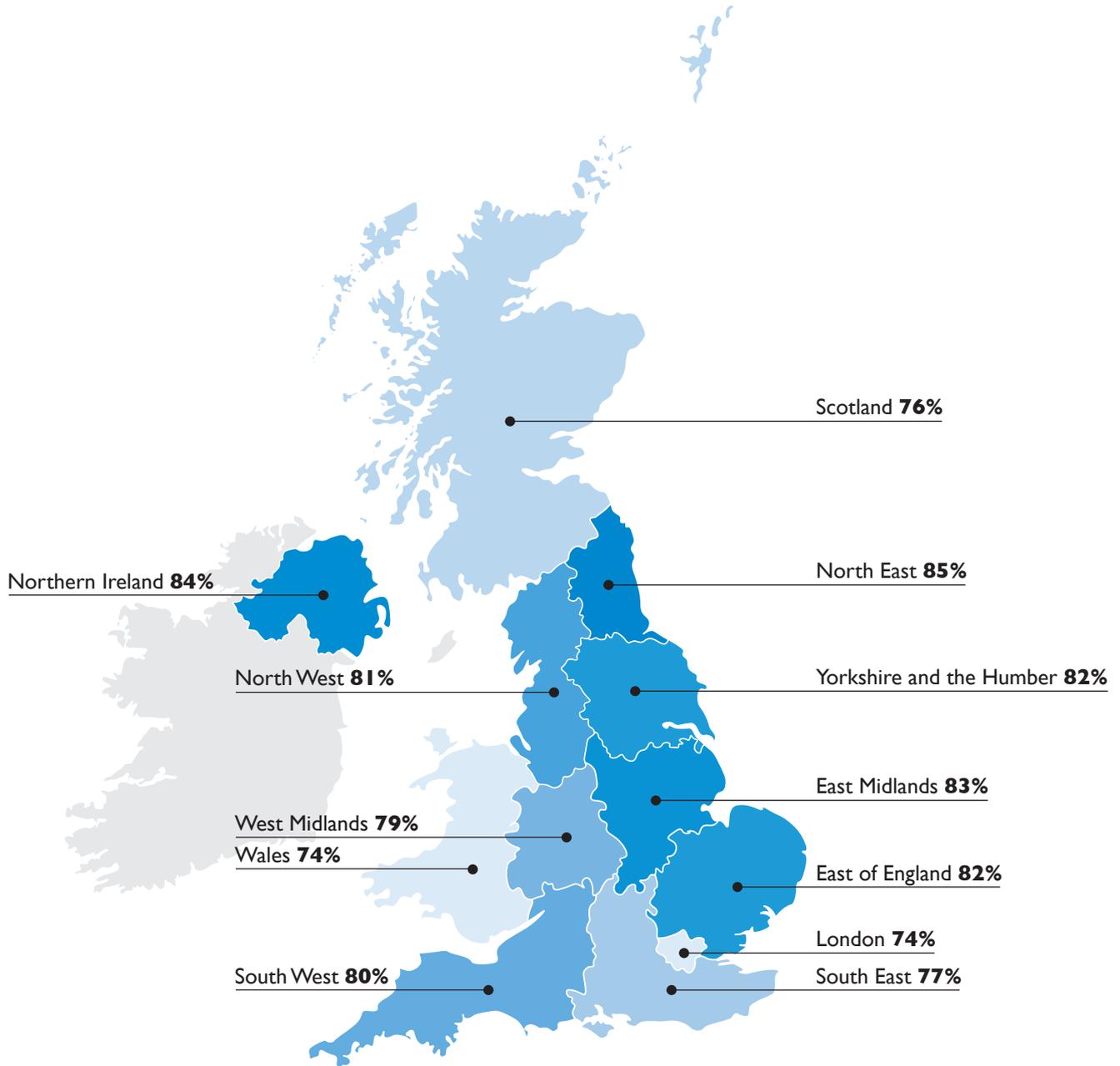
We have discussed the impact of income and health inequalities on key asthma outcomes. Previous editions of this survey have highlighted how there are different levels of care across the UK, and once again, this has persisted. This year, the highest level of basic asthma care was once again provided in Northern Ireland, with 53.1% receiving it. Scotland received the lowest level of basic asthma care, with 36.3% receiving it – 3.2% percentage points below the UK level, with Wales at 38.6%. Within England, significant variation is present⁷. The lowest level of basic care in England was in London, with only 35.1% receiving basic asthma care. The North East and the South West performed best, with 43.1% receiving basic asthma care. There is further variation in the individual measures of basic care, with London having the lowest proportion receiving an annual review or inhaler technique check, with Wales having the lowest proportion receiving a written asthma action plan.

Map 1: Percentage receiving basic care across the UK

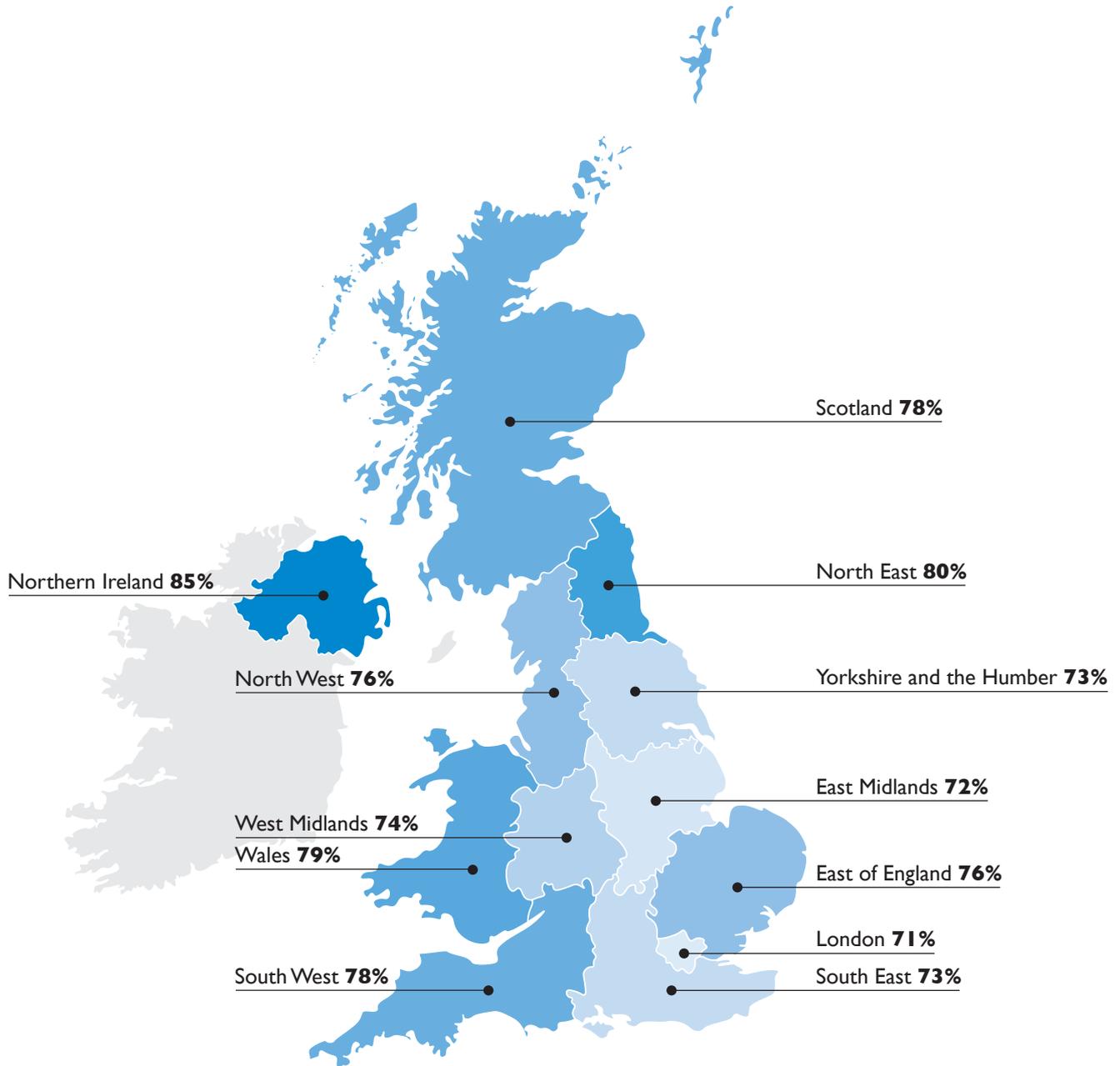


⁷ Although we asked which health board region respondents in Scotland, Wales and Northern Ireland lived in, the number of respondents was not great enough to present in these findings.

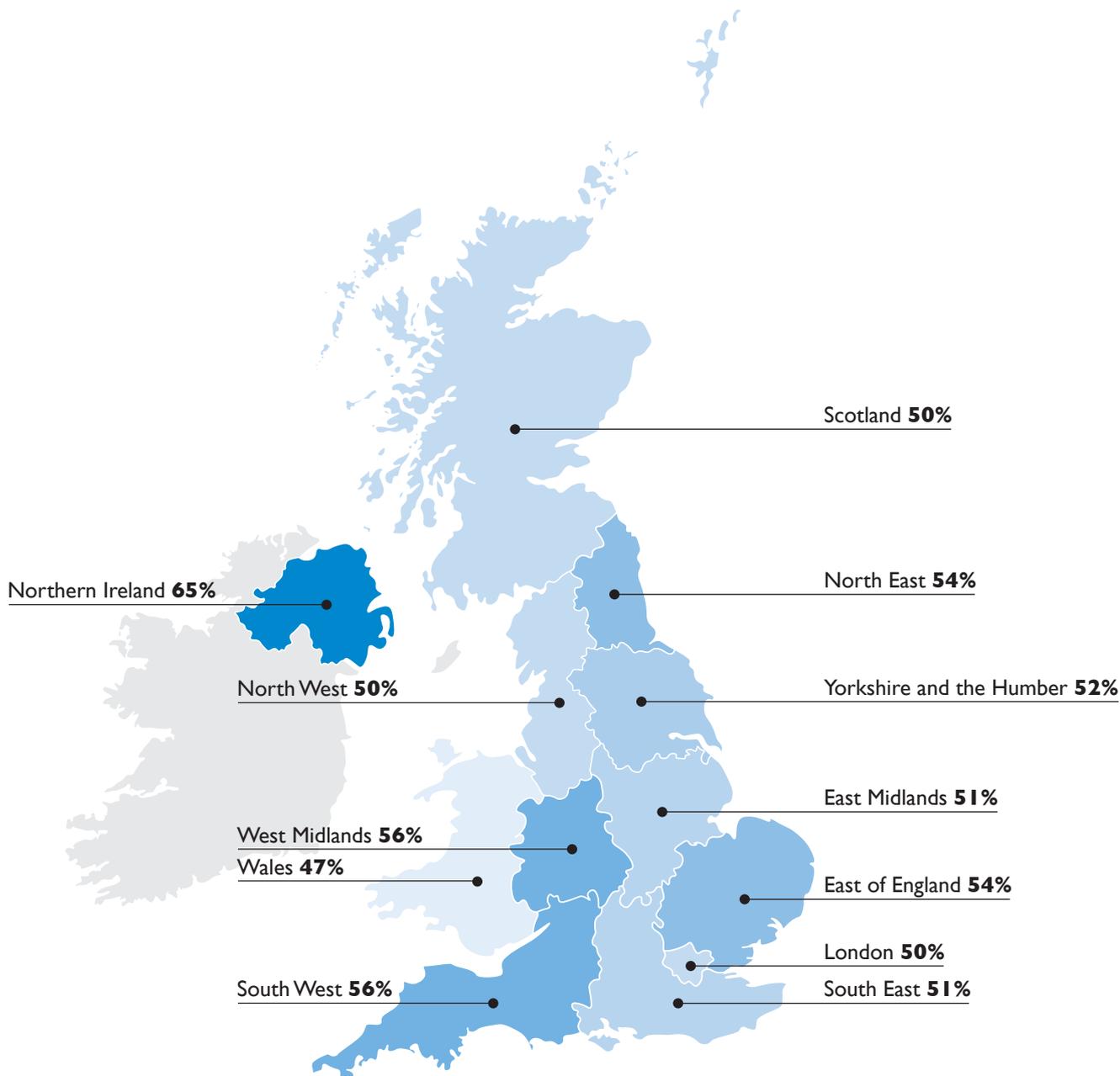
Map 2: Percentage receiving an annual asthma review across the UK



Map 3: Percentage receiving an inhaler technique check across the UK

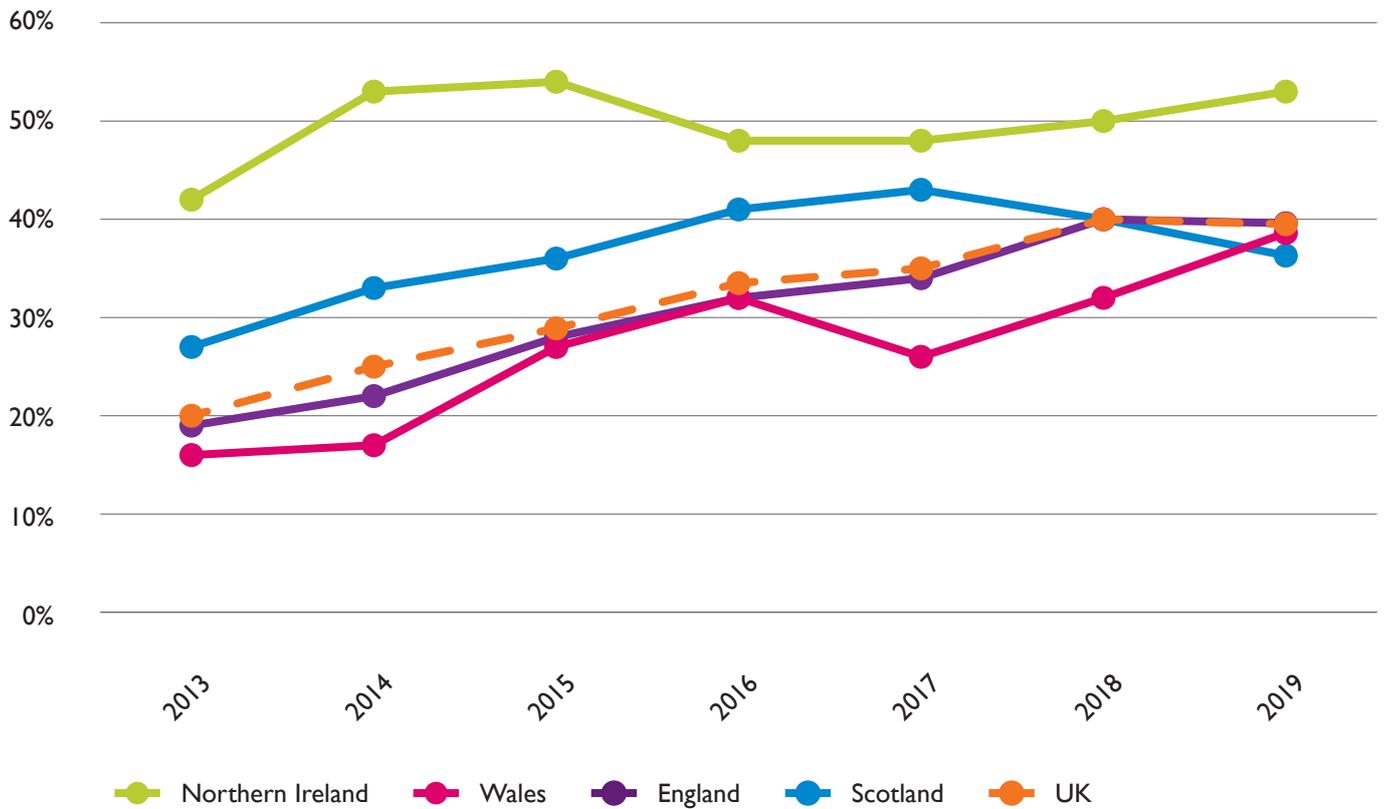


Map 4: Percentage receiving a written asthma action plan across the UK



While the trend for basic asthma care provision in the UK over the past seven years has been of steady improvement followed by a plateauing, there have been contrasting trends in Scotland and Wales. For the first time, basic care provision in Wales is at a higher level than that in Scotland. Basic care levels in Wales have increased by seven percentage points in each of the last two years of the survey, which is to be applauded. However, Scotland has dropped from 43% to 36% in the same period. These results make the development and eventual publication of the *Respiratory Care Action Plan for Scotland* particularly necessary.

Figure 10: Trends in basic care provision in constituent nations in the UK



As we have observed in England, there is wide variation within each nation. However, this year's results are notable and demand action. It is unacceptable that levels of care vary based on what part of the country you live on, and this inequality has persisted over several years.

What do we want to happen?

In addition to the calls made earlier in this report, we are calling for the following to help address the trends in basic care described above:

- **In Scotland, the implementation of the *Respiratory Action Plan for Scotland*^{xxxix}.**

Unfortunately, during the period waiting for the plan's publication, levels of basic care for people with asthma have dropped significantly. Several of the proposals, such as better support for self-management, provide an opportunity to help reverse the downward trend of basic care. Equal access to care is one of the main priorities for the plan, and we welcome this renewed focus. The key will be to gain buy-in to this plan, and to implement it. It recognises the uneven access to written asthma action plans, as well as variation in referral rates. The development of the Scottish Atlas of Variation^{xl} will also help track progress in access to asthma care and outcomes, and the role of Integrated Joint Boards and Community Planning Partnerships will be important to addressing health inequalities.

- **In Wales, the development of a successor respiratory plan and the implementation of the proposed new guidelines, as well as the roll out of the AsthmaHub.** The *Respiratory Delivery Plan*^{xli} was published in 2018, and the improvements made in Wales since 2018 could reasonably be attributed to this. The challenge will be to build on this improvement. Improving uptake of written asthma action plans should be the priority for future, as Wales has the lowest rate (47.0%) of issuing in the UK. We also note the proposed introduction of new asthma guidelines for Wales. While the guidelines contain good ideas for managing asthma, the presence of a further guideline may exacerbate variation, as people with asthma could be being managed on multiple different guidelines across the country. The publication of the National Asthma and Chronic Obstructive Pulmonary Disorder Audit Programme (NACAP) primary care report^{xlii}, with its findings of low levels of basic asthma

care, should also help inform improvements. We are also looking forward to planned introduction of the *AsthmaHub* app, which should help improve asthma self-management.

- **In Northern Ireland, the development of a respiratory plan by the new Executive is needed to continue to build on their improved basic care results.** The restoration of a power-sharing government with a new Health Minister and new Executive offers the possibility of a renewed focus on improving respiratory care. Even without a government basic care levels in Northern Ireland are once again the highest in the UK (53%), reflecting the good practice in primary care. We are calling for the Health Minister to establish a Taskforce for Lung Health, bringing together patient groups, health care professionals and other experts to draft a new Northern Ireland respiratory plan.
- **In London, we want improvement in the diagnosis and monitoring of people with asthma.** It is the region with lowest levels of basic care, we are concerned that many people with asthma are undiagnosed or have fallen off the primary care radar. The proportion of the population in London who are on GPs' asthma registers are consistently low, despite high levels of hospital admissions. This is possibly due to high churn of patients between practices but requires a strong drive to improve diagnosis and records of people with asthma so that they can start to access basic care.

WHAT ARE THE MOST COMMON ASTHMA TRIGGERS?

Everyone's asthma is different, and knowing about your asthma triggers is an important part of your asthma management. We asked respondents to tell us what triggered their asthma.

Table 1: Top 10 asthma triggers

	All ages		Adults		Children	
	Number of respondents	% of respondents	Number of respondents	% of respondents	Number of respondents	% of respondents
Colds and flu	9633	74.8%	8765	74.1%	868	83.1%
Changes in weather	8276	64.3%	7573	64.0%	703	67.3%
Dust	7698	59.8%	7242	61.2%	456	43.7%
Cold weather	7616	59.1%	6958	58.8%	658	63.0%
Air pollution	7460	57.9%	6984	59.0%	476	45.6%
Pollen	7444	57.8%	6799	57.5%	645	61.8%
Other people smoking cigarettes (e.g. passive cigarette smoke)	6787	52.7%	6401	54.1%	386	37.0%
Exercise	6248	48.5%	5660	47.8%	588	56.3%
Cleaning products	5626	43.7%	5423	45.8%	203	19.4%
Stress	5623	43.7%	5319	45.0%	304	29.1%

Colds and flu were the most common trigger for both adults and children, reinforcing again the need for better uptake of the flu vaccine. Seven triggers were listed by more than half of respondents, illustrating the daily challenges faced by people with asthma to avoid triggers. Dust, cleaning products and stress were unsurprisingly more common triggers for adults than children. Children (or their parents) reported weather and exercise triggers more often than adults with asthma. With high prevalence rates in pollen, changes in weather and cold weather, these results show how asthma can affect people around the year.

In London, 67.5% of respondents told us their asthma was triggered by air pollution. This compares to 48.8% of people in Scotland listing it as a trigger. Air pollution and weather are particularly difficult triggers for people with asthma to avoid.

Use of e-cigarettes has increased rapidly since 2012^{xliii}. For the first time, we asked people about the impact of second hand vapour from e-cigarettes. Over a quarter (26.2%) of people told us passive e-cigarette vapour as a trigger, which requires further investigation. Although vapour only triggers half as many people as cigarette smoke (52.7%), it still appears to be an irritant for many.

CONCLUSIONS

The findings of this survey should be a wake-up call to policymakers. Income disparities are having a major impact on asthma outcomes, including the number of potentially life-threatening asthma attacks suffered. More focus is needed on ensuring that all people with asthma have their asthma under control, which will help prevent asthma attacks and keep people with asthma out of hospital. Geographic inequalities in basic care provision have also persisted this year, with wide variation in basic care levels across the UK. As well as these findings on health inequalities and asthma, we have seen a stagnation in the basic care levels. This is particularly disappointing, given that it comes after steady year-on-year improvements in the previous six editions of this survey. Improvements cannot be taken for granted, and action to improve basic care levels is required.

This report only scratches the surface of the potential scale of health inequality and asthma. We have not looked at differences in access and outcomes for different ethnic groups or people for whom English is not their first language (including native Welsh speakers). This is an area that needs further research, and there will also be notable variations within these results. For instance, we have only presented data at a regional level for England, and a national level for Scotland, Wales and Northern Ireland. There will be significant variation in asthma outcomes and access within these areas that need attention as well. It is of paramount importance that asthma outcomes are not influenced by economic circumstance, in order for people with asthma to not have their lives be controlled by the condition.

This report was written by Andrew Cumella, Senior Analyst at Asthma UK.

The Asthma UK And British Lung Foundation Partnership

18 Mansell Street
London E1 8AA
United Kingdom

info@auk-blf.org.uk
asthma.org.uk | blf.org.uk



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