

Post-hospitalisation asthma management in primary care

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DOI:
[10.3399/BJGP.2023.0214](https://doi.org/10.3399/BJGP.2023.0214)

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Document Version
Peer reviewed version

Citation for published version (Harvard):
Punyadasa, D, Simms-Williams, N, Adderley, N, Thayakaran, R, Mansur, A, Nirantharakumar, K, Nagakumar, P & Haroon, S 2023, 'Post-hospitalisation asthma management in primary care: a retrospective cohort study', *British Journal of General Practice* . <https://doi.org/10.3399/BJGP.2023.0214>

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Accepted Manuscript

British Journal of General Practice

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To access the most recent version of this article, please click the DOI URL in the line above.

Received 29 April 2023

Revised 18 September 2023

Accepted 29 September 2023

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Author Accepted Manuscript

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Post-hospitalisation asthma management in primary care: a retrospective cohort study

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Abstract

Background

Clinical guidelines recommend that patients admitted to hospital for asthma attacks are reviewed in primary care following hospital discharge.

Aim

We evaluated post-hospitalisation asthma management in primary care and its associations with patient characteristics.

Design and setting

A retrospective cohort study was performed using English primary care data from the Clinical Practice Research Datalink Aurum database and linked Hospital Episode Statistics Admitted Patient Care data.

Method

Patients with asthma aged ≥ 5 years who had at least one asthma-related hospitalisation from 1st January 2017 to 31st December 2019 were included. The primary outcome was a composite of any of the following delivered in primary care within 28 days from hospital discharge: asthma review, asthma management plan, asthma medication prescriptions, demonstration of inhaler technique, or smoking cessation counselling. The association between patient characteristics and delivery of clinical care was assessed using logistic regression.

Results

The study included 17,457 patients. 10,515 (60.2%) patients received the primary outcome within 28 days of hospital discharge. 2311 (13.2%) received an asthma review, 1459 (8%) an asthma management plan, 9996 (57.3%) an asthma medication, 1500 (8.6%) a demonstration of inhaler technique, and 52 (1.2% of smokers) had smoking cessation counselling. Patients from black ethnic minorities received less of this care (27-54% lower odds, depending on age). However, short-acting bronchodilator prescriptions in the previous year were associated with an increased likelihood of the primary outcome.

Conclusion

A significant proportion of patients do not receive timely follow-up in primary care following asthma-related hospitalisations, particularly among black ethnic groups.

Keywords

Asthma, management, post-hospitalisation, primary care, cohort study.

How this fits in

Asthma is a common cause of hospital admissions and clinical guidelines recommend that hospitalised patients are followed up in primary care. Little research has been done on

evaluating post-hospitalisation asthma management in primary care. We found that 40% of hospitalised patients did not receive asthma management in primary care following hospital discharge, particularly among patients from black ethnic minority groups. Primary and secondary care services should develop systems for ensuring the timely follow-up of asthma patients after hospital discharge and address the observed health inequities.

Accepted Manuscript—BJGP—BJGP.2023.0214

Introduction

Asthma is a common chronic disease in children and adults and is responsible for considerable healthcare use.(1) 5.4 million people in the UK were actively receiving treatment for asthma in 2020.(2) Asthma accounts for 2-3% of primary care consultations,(3) 60,000 hospitalisations with 200,000 bed-days per year and is estimated to cost £1.1 billion a year to UK health services.(4) It is also an important cause of poor quality of life.(5)

Asthma-related hospitalisations remain high in the UK despite efforts to improve care. Clinical guidelines recommend that patients hospitalised for asthma attacks are reviewed in primary care within 48 hours of hospital discharge,(6)(7) since the risk of subsequent exacerbations is higher among these patients.(8)(9)

In the UK, asthma patients are mostly followed up in primary care, and high-risk patients are expected to receive comprehensive post-exacerbation care including an asthma review, asthma management plan, and assessment of inhaler technique.(7)(10)(11) Although extensive evaluations of in-hospital asthma care have previously been conducted,(12) there has been little evaluation of post-hospitalisation follow-up in primary care.(13) Our study aimed to evaluate post-hospitalisation asthma management in primary care and to assess the association with patient characteristics.

Methods

Study Design

A retrospective cohort study was conducted among patients hospitalised with asthma to assess post-hospitalisation primary care management using routinely collected primary and secondary care data. We also assessed the association between patient characteristics and the likelihood of receiving post-hospitalisation asthma management in primary care. This was part of the Preventing Unscheduled Hospitalisations in Asthma (PUSH Asthma) study.(14)

Setting

We used primary care data from the Clinical Practice Research Datalink (CPRD) Aurum database, which contains longitudinal, routinely collected electronic health record data from UK primary care practices. 16% of the general practices in the UK which use the EMIS clinical information system contribute to this database. CPRD Aurum covers 19% of the UK population and includes information on diagnoses (recorded using SNOMED-CT codes) and drug prescriptions.(15) We also used linked Hospital Episode Statistics Admitted Patient Care (HES APC) data, which is coded using ICD-10 codes. Primary care data extraction was done using the Data Extraction for Epidemiological Research (DExtER) tool.(16)

Participants

Eligible patients were aged five years and older with a diagnosis of asthma prior to 1st January 2017 (index date), registered with a general practice contributing to CPRD Aurum at least one year prior to the index date, and hospitalised for asthma during the study follow-up period (1st January 2017 to 31st December 2019).

Asthma was defined as the presence of a SNOMED-CT code for asthma (see supplementary table 1 for SNOMED-CT codes). Asthma-related hospitalisation was defined by the presence of an ICD-10 asthma diagnosis code (J45- 46) as the primary diagnostic code in the linked HES APC data.

Patients who had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), bronchiectasis, obstructive sleep apnea and Interstitial Lung Disease (ILD) in addition to asthma were excluded from the analysis due to the potential for misclassification bias. Diagnoses were identified as a clinical code for each condition at baseline.

Baseline variables

Baseline data were extracted to describe demographic characteristics (age, sex, ethnic group, socioeconomic status measured by the Index of Multiple Deprivation [IMD] quintiles), behavioural risk factors (body mass index [BMI] and smoking status [for adolescents and adults only]) and relevant comorbidities (allergies, atopic eczema, allergic rhinitis, gastroesophageal reflux disease [GORD], chronic rhinosinusitis, anxiety, and depression) prior to the index date.

Age was determined at the index date. BMI was determined by the latest recorded value prior to the index date. Where patients had more than one entry for smoking status in the same record, the most recent smoking status recorded was used. For rare cases where a patient's most recent smoking status was "non-smoker" but also had an ex-smoker/smoker code in the same record, the patient was classed as an ex-smoker.

Asthma-related drug prescriptions within one year prior to the index date were extracted for the following medications: short-acting beta 2 agonists (SABA), oral corticosteroids (OCS), inhaled corticosteroids (ICS), long-acting beta 2 agonists (LABA), long-acting muscarinic antagonists (LAMA), leukotriene receptor antagonists (LTRA), and influenza vaccination.

Asthma-related hospitalisations within one year prior to the index date were also extracted.

Clinical code lists for all conditions were created using a systematic process with clinical input that involved checking existing code lists used by our research team, checking published code lists, searching the SNOMED-CT terminology browser, and searching using free text terms within an inhouse software tool called Code Builder. SNOMED-CT code lists for clinical diagnoses are published on GitHub (https://github.com/annalhead/CPRD_multimorbidity_codelists/tree/main/codelists) and in Supplementary tables 2-6.

Outcomes

The following aspects of asthma care were extracted from primary care records for within 48 hours, 7 days, and 28 days of hospital discharge: provision of an asthma review, asthma management plan, prescriptions of asthma medications (SABA, OCS, ICS, LABA, LAMA, LTRA), demonstration of inhaler technique, and smoking cessation counselling. The primary outcome was a record of any of these items of care being recorded within 28 days following the date of hospital discharge.

We also assessed changes in inhaler medications post-hospital discharge by comparing the drug class of prescriptions recorded in the year before the hospital admission and those prescribed within 28 days after the hospital discharge.

Study size

We used the maximum number of eligible patients available in the database and study size was not determined by a formal sample size calculation.

Quantitative variables

Variables were categorised into the following groupings: age (5-11, 12-17, 18-24, 25-39, 40-59, 60-79 and ≥ 80 years), ethnic group (white, black, mixed, Asian, other, missing), IMD score quintile (1 [least deprived], 2, 3, 4, 5 [most deprived]), BMI ($< 18.5 \text{ kg/m}^2$ [underweight], $18.5\text{-}24.9 \text{ kg/m}^2$ [normal weight], $25\text{-}29.9 \text{ kg/m}^2$ [overweight], $> 30 \text{ kg/m}^2$ [obese], missing), smoking status (current smoker, former smoker, never smoked, missing), SABA prescriptions (0, 1-3, 4-6, ≥ 7 prescriptions), and number of hospital admissions within the previous year (0, 1-3, 4-6, ≥ 7).

Statistical analysis

We stratified the cohort into children (5-11 years), adolescents (12-17 years) and adults (≥ 18 years). Baseline characteristics and outcomes for each age stratum were described using simple descriptive statistics. Missing data were addressed using a 'missing' category for each categorical variable. The primary outcome was presented as the proportion of hospitalised patients who received asthma management within 28 days of hospital discharge. Secondary outcomes were asthma management within 48 hours and 7 days of discharge. The associations between the primary outcome and patient characteristics were assessed using logistic regression, adjusted for demographic and clinical factors. Data analyses were done using Stata SE V.16 and R Studio.

Results

Participants

The study included 17,457 patients who had at least one asthma-related hospitalisation during the study period. This included 2,512 children, 1,511 adolescents and 13,434 adults. Their baseline characteristics are shown in Table 1.

The median age was 9 years (interquartile range [IQR] 8-10 years) for children, 15 years (IQR 13-16 years) for adolescents, and 49 years (IQR 34-64 years) for adults. 11,264 (65%) were female. The majority (62%) were of white ethnicity followed by 1978 (11%) Asians and 876 (5%) black ethnic groups. 2943 (17%) had missing ethnicity data. 5006 (29%) were from the most deprived socioeconomic quintile.

9901 (57%) overall were overweight or obese. 176 (12%) adolescents and 4093 (31%) adults were current smokers. The most common comorbidity was atopic eczema for children (1392/2512 [55%]) and adolescents (871/1511 [58%]) and depression for adults (6432/13,434 [48%]).

Within the previous year, 13885 (79%) had received a SABA, 13548 (78%) an ICS, 8573 (49%) an OCS and 3894 (22%) a LTRA. 8948 (51%) had not received an influenza vaccine within the previous year. 953 (5%) had experienced one or more asthma-related hospital admissions within the previous year.

Outcomes

Post-hospitalisation asthma management is summarised in table 2.

1473 (59%) of children received at least one form of asthma management within 28 days of hospital discharge. This was even lower within 7 days (834/2512, [33%]) and 48 hours (453/2512 [18%]) post-hospital discharge. 257 (10%) received an asthma management plan, 391 (16%) had an asthma review, and 227 (9%) had a demonstration of inhaler technique within 28 days of hospital discharge. 1391 (55%) of children received at least one asthma medication prescription within 28 days of hospital discharge, of which SABA was the most prescribed (1073/2512 [43%]).

880 (58%) of adolescents received some form of asthma management within 28 days of hospital discharge. Again, this was lower within 7 days (483/1511 [32%]) and 48 hours (270/1511 [18%]) from hospital discharge. 156 (10%) had been provided with an asthma management plan, 222 (15%) had an asthma review, 138 (9%) had a demonstration of inhaler technique, and only 3 (2%) current smokers were offered smoking cessation counselling within 28 days of hospital discharge. 828 (55%) of adolescents received asthma medication prescriptions within 28 days of hospital discharge, with SABA again being the most prescribed.

8162 (61%) of adults received some form of asthma management within 28 days of hospital discharge. Again, this was lower within 7 days (4262/13434 [32%]) and 48 hours (1862/13434 [14%]) from hospital discharge. 1046 (8%) had been provided with an asthma management plan, 1698 (13%) had an asthma review, 1135 (8%) had a demonstration of inhaler technique, and only 49 (1%) of current smokers had been offered smoking cessation counselling within 28 days of hospital discharge. 7777 (58%) of adults received asthma medication prescriptions within 28 days of hospital discharge, with ICS being the most prescribed.

9% of children (220/2512) and adolescents (134/1511) had a change in their inhaler medication within 28 days of hospital discharge (supplementary table 7), with the main change being the addition of ICS. 1840 (14%) of adults had a change in their inhaler medication within 28 days of hospital discharge with the main change being the addition of a LABA.

Factors associated with asthma management within 28 days of hospital discharge

In all age cohorts, black ethnic minority groups were the least likely to receive any asthma management within 28 days of hospital discharge (OR 0.62, 95% CI 0.45-0.86 for children; 0.46, 0.29-0.73 for adolescents; and 0.73, 0.60-0.89 for adults) (supplementary table 8).

Obese adolescents were less likely than those of normal weight to receive asthma management within 28 days of hospital discharge (OR 0.60, 95% CI 0.40-0.90). By contrast, obese adults had greater odds of receiving asthma management within 28 days of hospital discharge than patients of normal weight (OR 1.13, 95% CI 1.02-1.25).

Among adults, patients aged 25 years and older had an increased odds of receiving asthma management within 28 days of hospital discharge, compared to those aged 18-24 years. This was most pronounced for patients aged 60-79 years who had an 82% increase in the odds of receiving asthma care 28 days after hospital discharge (OR 1.82, 95% CI 1.56-2.12).

Children who had received SABA and LTRA prescriptions in the previous year were more likely to receive asthma management within 28 days of hospital discharge than those who had not received prescriptions in the previous year. Those who had received 1 to 3 SABA prescriptions in the previous year had almost a 3-fold increase in the odds of receiving asthma care following hospital discharge (OR 2.77, 95% CI 2.00-3.84) while those who had received ≥ 7 prescriptions in the previous year had a more than six-fold increase in the odds (OR 6.44, 95% CI 4.29-9.64) (supplementary table 8). A similar dose-response trend for SABAs was also found for adolescents and adults. In adults, positive associations were also found for previous prescriptions of OCS, ICS, LTRA, and influenza vaccine.

Discussion

Summary

Our analysis of 17,455 asthma patients revealed that a substantial proportion did not receive timely post-hospitalisation asthma management in primary care. 85% of patients had not received primary care-based asthma management within 48 hours of hospital discharge, and 40% had not within 28 days, including an asthma review, asthma management plan, relevant prescriptions, demonstration of inhaler technique, or smoking cessation support. Patients from black ethnic minority groups were the least likely to receive any post-hospitalisation asthma care. Care was also less likely to be received by obese adolescents, and younger adults. Patients who had received asthma medication prescriptions in the previous year were more likely to receive post-hospitalisation care in primary care.

Comparison with existing literature

Multiple studies have evaluated asthma management in UK primary care.(17),(18),(19) To our knowledge, this study is the first to evaluate post-hospitalisation asthma management in a large UK primary care population.

Although evidence suggests comprehensive post-hospitalisation asthma care minimises adverse asthma outcomes,(20)-(21) we found that the practice of such care was significantly below existing standards and guidelines.(7)-(10) We found that more than 85% of asthma patients failed to receive follow-up asthma care within the recommended 48 hours of hospital discharge(7)-(10) which is consistent with previous evidence.(22)-(23) The UK National Review of Asthma Deaths reported that only 23% of asthma patients who had died had ever received an asthma management plan from primary or secondary care.(20) In a survey of Scottish patients who had asthma attacks requiring oral corticosteroids or hospitalisation within the previous six months, only 4% reported receiving a written asthma action plan from primary care.(24)

Ethnic disparities in the provision of asthma care have been reported by several previous studies,(18)-(25) which is also a significant finding in our study, particularly among black ethnic groups. Previous literature suggests that this disparity is due to differences in health-seeking behaviour,(26) and less familiarity with primary healthcare services(27) among these population groups. Given that these population groups exhibit much higher asthma-related hospitalisations and ED visits,(25)-(28) these disparities need urgent intervention. Hospital teams should address essential asthma care and make changes to medications before discharging patients. GPs, practice nurses and school nurses should use every opportunity to educate, review and change asthma management to prevent future asthma attacks.

Socioeconomically deprived asthma patients tend to have relatively poor asthma outcomes,(18)-(9)-(29)-(30) however, receiving post-hospitalisation asthma care was not significantly associated with socioeconomic deprivation in our study. A previous UK study also reported no variation in receiving asthma reviews or asthma referrals by the socioeconomic status of patients.(18) By contrast, Alsallakh et al reported that the most socioeconomically deprived asthma patients in Wales had lower levels of asthma-related primary care consultations and prescribing although they did not specifically describe post-hospitalisation asthma management.(31) Further research is needed to assess post-hospitalisation asthma management in primary care across socioeconomic strata in other populations to assess the consistency of our findings.

Despite evidence indicating that obesity is associated with an increased risk of asthma-related hospitalisations and readmissions,(32)-(33)-(34) we found that obese adolescents were less likely to receive post-hospitalisation asthma care compared to non-obese adolescents. This runs counter to previous literature that suggests that both elective and emergency healthcare utilisation is higher in children with obesity including those with asthma.(35) It is unclear whether our findings were due to chance as the sample size of obese adolescents in our study was relatively small (n=139), and future studies should look to assess whether this is a consistent finding in other populations.

A study from the USA evaluating outpatient follow-up care after an adult ED asthma visit reported that patients aged 45 years and older were more likely to receive follow-up care within 30 days of an ED visit.(22) We observed a similar increased likelihood for older adults to receive post-hospitalisation asthma care compared to younger adults.

Strengths and limitations

The large sample size allowed us to stratify the analysis by three age groups including children, adolescents, and adults. This enabled us to identify disparities in post-hospitalisation asthma care in each age group and the risk factors associated with differences in post-hospitalisation primary care management.

Asthma was defined by the presence of prespecified SNOMED-CT codes in primary care records. Asthma is a clinical diagnosis which can often be misdiagnosed in primary care.(36)-(37) Asthma-related hospitalisation could be misclassified as there may be overlapping symptoms of exacerbations due to other comorbidities. This misclassification bias was minimised by excluding asthma patients with other chronic respiratory diseases such as COPD, bronchiectasis, and ILD.

A significant proportion of hospital attendances with asthma attacks are made to the emergency department, which we did not have data for in our study except for patients who were admitted. Our assessment of clinical management was also limited to using clinical codes corresponding to asthma management, which would not incorporate aspects of care that were documented through free text entries in primary care records. This may have resulted in an underestimate of post-hospitalisation asthma care; however, we expect most asthma care to be well coded as asthma is part of the Quality and Outcomes Framework in England, a payment incentive programme rewarding appropriate reporting and management of specific chronic conditions; any underestimate is therefore likely to be small. A further limitation was a lack of data on asthma care delivered prior to hospital discharge. This information may be included in discharge letters to primary care and influence the necessity of rapid follow-up, which we were unable to adjust for. Future work could address this limitation by linking data from the national asthma audit, which collects data on hospital care.

We were able to explore a range of patient characteristics in our analysis, however, it is likely that there are additional factors which may be associated with post-hospitalisation asthma care which we did not explore, for instance practice-level characteristics including rural/urban location and practice size, and additional patient-level characteristics such as multimorbidity and frailty. Despite adjusting for several potential confounders, due to the cohort study design, it is possible that some results may be affected by residual confounding.

Our study follow-up ended in 2019. Future studies should explore the impact of changes in healthcare delivery during and after the COVID-19 pandemic on post-hospitalisation asthma reviews. The impact of telephone-based asthma reviews in particular needs to be evaluated as essential asthma care assessment, including checking inhaler technique and whether inhalers are empty(38) cannot be adequately performed via a telephone review.

Implications for practice, policy, and research

Our study provides valuable insights into the state of post-hospitalisation primary care-based asthma management in England. The study identified significant shortfalls in implementing recommendations for primary care from the national asthma guideline(39) and National Review of Asthma Deaths,(40) particularly for black ethnic minority groups. Improved communication, data sharing, and integrated clinical pathways are needed between secondary and primary care services so that hospitalised patients with asthma are followed up appropriately in primary care and receive timely interventions.

GPs and practice nurses should receive a clinical handover from secondary care within 24 hours of an asthma patient being discharged from hospital. This information should ideally be structured, containing reconciled discharge information,(41) and be aligned with national standards for discharge summaries.(42) Critically, this should include a summary of the hospital admission, including disease severity and treatments given; relevant findings from clinical investigations; reconciled medications and changes to asthma treatment; patient and carer concerns, expectations and wishes; information and advice given; an updated asthma management plan; and specific actions for the primary care team.(42) This would facilitate the timely review of these patients in the community to help prevent further exacerbations and improve continuity of care.(43) This will be particularly important in high-risk patients such as those from black ethnic minority groups who experience significant health inequalities.

Patients and their caregivers should also be empowered to actively contact primary care services when they are discharged from hospital to ensure they receive timely care. The impact of these service changes could be evaluated by repeating this study in future cohorts and incorporating data on ED attendance.

Conclusion

There are significant shortfalls and inequalities in post-hospitalisation asthma care in general practice in England. Robust systems are needed to ensure the timely follow-up of post-hospitalised asthma patients in primary care, which includes timely handover from secondary care.

Accepted Manuscript—BJGP—BJGP.2023.0214

Funding

This research was funded by the National Institute for Health and Research Clinical Research Network West Midlands Improvement and Innovation Strategic Funding, grant number: 1002281. The researchers were independent of the funders and all authors had access to the study data and take responsibility for the integrity of the analyses.

Ethical approval

This study was approved by the CPRD Independent Scientific Advisory Committee (reference number: 21_000512).

Competing interests

SH reports receiving funding from NIHR and UKRI. KN has been awarded research grants from NIHR, UKRI/MRC, Kennedy Trust for Rheumatology Research, Health Data Research UK, Wellcome Trust, European Regional Development Fund, Institute for Global Innovation, Boehringer Ingelheim, Action Against Macular Degeneration Charity, Midlands Neuroscience Teaching and Development Funds, South Asian Health Foundation, Vifor Pharma, College of Police, and CSL Behring, with all payments made to his academic institution; KN received consulting fees from BI, Sanofi, CEGEDIM, MSD and holds a leadership/fiduciary role with NICST, a charity and Open Clinical, a Social Enterprise. AHM received personal and institutional funds from AZ, GSK, Novartis, Sanofi, BI, Chiesi for talks, advisory board meetings, research and educational grants. NJA reports receiving funding from NIHR outside the submitted work. PN reports receiving grants from NIHR and fees for educational talks and consultancy from Novartis, GSK and AstraZeneca. All other authors declare no competing interests.

Acknowledgements

We would like to thank Dr Richard Hotham for supporting the development of relevant code lists used for part of the analysis.

Accepted Manuscript—BJGP—BJGP.2023.0214

Tables

Table 1 – Baseline characteristics

Characteristic	Children (n=2,512)	Adolescents (n=1,511)	Adults (n=13,434)
Age (years), median (IQR)	8.9 (7.5-10.3)	14.5 (13.2-16.0)	48.9 (33.9-63.9)
Female sex, n (%)	893 (35.6)	747 (49.4)	9,624 (71.6)
Ethnicity			
White	1,323 (52.7)	717 (47.5)	8,893 (66.2)
Black	215 (8.6)	105 (7.0)	556 (4.1)
Mixed	136 (5.4)	79 (5.2)	265 (2.0)
Asian	403 (16.0)	200 (13.2)	1,375 (10.2)
Other	57 (2.3)	53 (1.5)	167 (1.2)
Missing	378 (15.1)	387 (25.6)	2,178 (16.2)
Index of multiple deprivation score, n (%)			
1 – Least deprived	369 (14.7)	210 (13.9)	2,044 (15.2)
2	355 (14.1)	208 (13.8)	2,207 (16.4)
3	400 (15.9)	263 (17.4)	2,435 (18.1)
4	555 (22.1)	336 (22.2)	3,059 (22.8)
5 – Most deprived	831 (33.1)	494 (32.7)	3,681 (27.4)
Missing	2 (0.1)	0 (0)	8 (0.1)
Body mass index, n (%)			
Underweight	186 (7.4)	203 (13.4)	299 (2.2)
Normal weight	1,008 (40.1)	633 (41.9)	3,172 (23.6)
Overweight	245 (9.8)	215 (14.2)	3,587 (26.7)
Obese	122 (4.9)	139 (9.2)	5,593 (41.6)
Missing	951 (37.9)	321 (21.2)	783 (5.8)
Smoking status, n (%)			
Current smoker	-	176 (11.7)	4,093 (30.5)
Former smoker	-	193 (12.8)	5,296 (39.4)
Never smoked	-	921 (61.0)	3,818 (28.4)
Missing	-	221 (14.6)	227 (1.7)
Comorbidities, n (%)			
Allergies	714 (28.4)	605 (40.0)	4,505 (33.5)
Atopic eczema	1,392 (55.4)	871 (57.6)	4,205 (31.3)
Allergic rhinitis	529 (21.1)	569 (37.7)	4,344 (32.3)
Gastro-oesophageal reflux disease (GORD)	162 (6.5)	76 (5.0)	2,328 (17.3)
Chronic rhinosinusitis	0 (0)	3 (0.2)	425 (3.2)
Anxiety	20 (0.8)	104 (6.9)	4,407 (32.8)
Depression	22 (0.9)	59 (3.9)	6,432 (47.9)
Medication use within previous year, n (%)			
Short acting beta 2 agonist (SABA)			
0	323 (12.9)	227 (15.0)	3,022 (22.5)
1-3	1,055 (42.0)	488 (32.3)	4,213 (31.4)
4-6	604 (24.0)	316 (20.9)	2,530 (18.8)
≥7	530 (21.1)	480 (31.8)	3,669 (27.3)
Oral corticosteroid	990 (39.4)	565 (37.4)	7,018 (52.2)
Inhaled corticosteroid	1,973 (78.5)	1,193 (79.0)	10,382 (77.3)
Long-acting beta 2 agonist (LABA)	55 (2.2)	78 (5.2)	2,760 (20.5)
Long-acting muscarinic antagonist (LAMA)	0 (0)	7 (0.5)	1,206 (9.0)
Leukotriene receptor antagonist (LTRA)	804 (32.0)	482 (31.9)	2,608 (19.4)
Influenza vaccine	1,025 (40.8)	564 (37.3)	6,920 (51.5)
Number of hospital admissions, n (%)			

Characteristic	Children (n=2,512)	Adolescents (n=1,511)	Adults (n=13,434)
0	2,254 (89.7)	1,385 (91.7)	12,865 (95.8)
1-3	237 (9.4)	98 (6.5)	469 (3.5)
4-6	14 (0.6)	7 (0.5)	41 (0.3)
7+	7 (0.3)	21 (1.4)	59 (0.4)

Accepted Manuscript—BJGP—BJGP.2023.0214

Table 2 – Post-hospitalisation asthma management received in primary care

Asthma management n (%)	Children (n=2,512)			Adolescents (n=1,511)			Adults (n=13,434)		
	Timeframe within:			Timeframe within:			Timeframe within:		
	48 hrs	7 days	28 days	48 hrs	7 days	28 days	48 hrs	7 days	28 days
Any asthma management, n (%) *	453 (18.0)	834 (33.2)	1473 (58.6)	270 (17.9)	483 (32.0)	880 (58.2)	1,862 (14.0)	4,262 (31.7)	8,162 (60.8)
Asthma management plan *	34 (1.3)	94 (3.7)	257 (10.2)	20 (1.3)	57 (3.8)	156 (10.3)	122 (0.9)	375 (2.8)	1,046 (7.8)
Asthma review *	59 (2.3)	145 (5.8)	391 (15.6)	31 (2.0)	85 (5.6)	222 (14.7)	199 (1.5)	590 (4.4)	1,698 (12.6)
Inhaler technique *	20 (0.8)	66 (2.6)	227 (9.0)	11 (0.7)	43(2.8)	138 (9.1)	99 (0.7)	343 (2.5)	1,135 (8.4)
Smoking cessation ‡	N/A**	N/A	N/A	0 (0)	3 (1.7)	3 (1.7)	15 (0.4)	29 (0.7)	49 (1.2)
Any medication, n (%) *	426 (16.9)	779 (31.0)	1,391 (55.4)	251 (16.6)	447 (29.6)	828 (54.8)	1,713 (12.7)	3,943 (29.3)	7,777 (57.9)
SABA *	298 (11.9)	570 (22.7)	1,073 (42.7)	180 (11.9)	327 (21.6)	670 (44.3)	212 (1.6)	2,137 (15.9)	5,127 (38.2)
ICS *	219 (8.7)	423 (16.8)	927 (36.9)	147 (9.7)	276 (18.3)	603 (39.9)	925 (6.9)	2,251 (16.7)	5,848 (43.5)
OCS *	110 (4.4)	171 (6.8)	267 (10.6)	65 (4.3)	106 (7.0)	169 (11.2)	551 (4.1)	1,408 (10.5)	2,551 (19.0)
LAMA *	0 (0)	0 (0)	0 (0)	0 (0)	1 (0.1)	5 (0.3)	85 (0.6)	247 (1.8)	799 (5.9)
LABA *	5 (0.2)	9 (0.3)	18 (0.7)	9 (0.6)	16 (1.0)	43 (2.8)	253 (1.9)	676 (5.0)	1,908 (14.2)
LTRA *	83 (3.3)	172 (6.8)	435 (17.3)	32 (2.1)	69 (4.6)	220 (14.5)	209 (1.5)	578 (4.3)	1,656 (12.3)

*Denominator is total number of patients in each age-group

**N/A – not applicable as smoking status was unavailable for this age group

‡ Denominator is number of patients who are current smokers in that age group

SABA- short acting beta 2 agonist, ICS- inhaled corticosteroid, OCS- oral corticosteroid, LAMA- long-acting muscarinic antagonist, LABA- long-acting beta 2 agonist, LTRA- leukotriene receptor antagonist

Figure

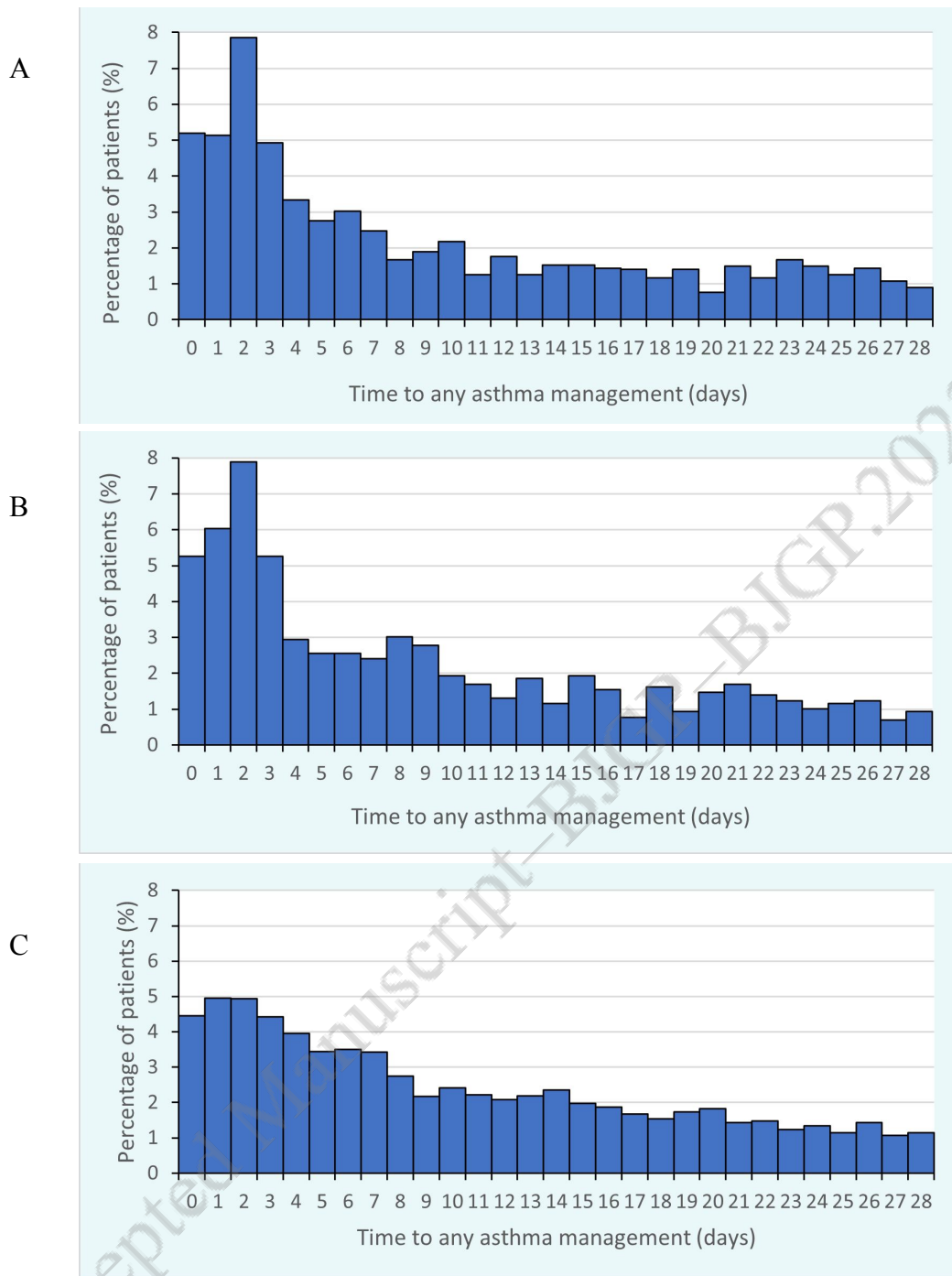


Figure 1. Percentage of patients receiving any post-hospitalisation asthma management in primary care from the time of hospital discharge in children (A), adolescents (B), and adults (C)

References

1. Global Asthma Network. The Global Asthma Report 2018. Auckland, New Zealand: Global Asthma Network, 2018. <http://www.globalasthmareport.org/> (accessed 12 May 2020)
2. Asthma UK. Asthma care in a crisis: Annual Asthma Survey 2020. London: The Asthma UK and British Lung Foundation Partnership, 2021. https://www.asthmaandlung.org.uk/sites/default/files/2023-03/aas-2020_2a-1.pdf (accessed 23 Apr 2023)
3. National Institute for Health and Care Excellence. Asthma: What is the prevalence of asthma? London: NICE, 2023. <https://cks.nice.org.uk/topics/asthma/background-information/prevalence/> (accessed 15 Aug 2023)
4. Mukherjee M, Stoddart A, Gupta RP et al. The epidemiology, healthcare and societal burden and costs of asthma in the UK and its member nations: analyses of standalone and linked national databases. *BMC Med.* 2016;14(1):1–15.
5. Ampon RD, Williamson M, Correll PK. Impact of asthma on self-reported health status and quality of life: a population based study of Australians aged 18-64. *Thorax* 2005;60(9):735–9. Available from: www.thoraxjnl.com
6. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. GINA, 2022. <https://ginasthma.org/wp-content/uploads/2022/07/GINA-Main-Report-2022-FINAL-22-07-01-WMS.pdf> (accessed 15 Aug 2023)
7. Scottish Intercollegiate Guidelines Network, British Thoracic Society. British guideline on the management of asthma: A national clinical guideline. SIGN and BTS, 2019. https://heswrespiratory.files.wordpress.com/2019/07/bts_sign-guideline-for-the-management-of-asthma-2019.pdf (accessed 15 Aug 2023)
8. Buelo A, McLean S, Julious S, et al. At-risk children with asthma (ARC): A systematic review. Vol. 73, *Thorax*. BMJ Publishing Group; 2018. p. 813–24. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6109248/>
9. Eisner MD, Katz PP, Yelin EH, Shiboski SC, Blanc PD. Risk factors for hospitalization among adults with asthma: The influence of sociodemographic factors and asthma severity. *Respir Res.* 2001 Dec 29;2(1):53–60.
10. National Health Services. National Bundle of Care for Children and Young People with Asthma: Phase one. Version 1, September 2021. <https://www.england.nhs.uk/wp-content/uploads/2021/09/B0606-National-bundle-of-care-for-children-and-young-people-with-asthma-phase-one-September-2021.pdf> (accessed 15 Aug 2023)
11. National Institute for Health and Care Excellence. Asthma: Quality standards, Quality statement 4: Follow-up by general practice after emergency care. London: NICE, 2013. <https://www.nice.org.uk/guidance/qs25/chapter/quality-statement-4-follow-up-by-general-practice-after-emergency-care> (accessed 23 Apr 2023)
12. Calvert J, Latchem S, Andrews R, et al. National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Adult asthma clinical audit 2019/20. London: RCP, 2021. https://www.hqip.org.uk/wp-content/uploads/2021/01/Adult-asthma_national-clinical-report_2019-2020_FINAL-VERSION.pdf (accessed 10 Jul 2023)
13. Asthma+Lung UK. Transforming asthma care in the UK Fighting Back. London: Asthma+Lung UK, 2022. https://www.asthmaandlung.org.uk/sites/default/files/Fighting_back_V3.pdf (accessed 10 Jul 2023)
14. Simms-Williams N, Nagakumar P, Thayakaran R, et al. Preventing unscheduled hospitalisations from asthma: a retrospective cohort study using routine primary and

- secondary care data in the UK (The PUSH-Asthma Study)-protocol paper. *BMJ Open*. 2022;12(8):58356. Available from: <http://dx.doi.org/10.1136/bmjopen-2021-058356>
15. Wolf A, Dedman D, Campbell J, et al. Data Resource Profile : Clinical Practice Research Datalink (CPRD) Aurum UK primary care. *Int Epidemiol Assoc Int J Epidemiol*. 2019;48(6):1740–1740. Available from: <https://academic.oup.com/ije/article/48/6/1740/5374844>
 16. Gokhale KM, Chandan JS, Toulis K, Gkoutos G, Tino P, Nirantharakumar K. Data extraction for epidemiological research (DExtER): a novel tool for automated clinical epidemiology studies. *Eur J Epidemiol*. 2021;36(2):165–78.
 17. Lo D, Beardsmore C, Roland D, et al. Risk factors for asthma attacks and poor control in children: a prospective observational study in UK primary care. *Arch Dis Child*. 2022;107(1):26–31.
 18. Busby J, Price D, Al-Lehebi R, et al. Impact of socioeconomic status on adult patients with asthma: a population-based cohort study from UK primary care. *J Asthma Allergy*. 2021;14:1375–88. Available from: <https://www.tandfonline.com/doi/full/10.2147/JAA.S326213>
 19. Lo DKH, Beardsmore CS, Roland D, et al. Lung function and asthma control in school-age children managed in UK primary care: a cohort study. *Thorax*. 2020;75(2):101–7.
 20. Royal College of Physicians. Why asthma still kills: The national review of asthma deaths (NRAD) confidential enquiry report. London: RCP, 2014. [file:///C:/Users/User/Downloads/Why asthma still kills full report.pdf](file:///C:/Users/User/Downloads/Why%20asthma%20still%20kills%20full%20report.pdf) (accessed 15 Aug 2023)
 21. Gibson PG, Powell H, Wilson A, et al. Self-management education and regular practitioner review for adults with asthma. *Cochrane database Syst Rev*. 2002;(3). Available from: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001117/full>
 22. Abbott EE, Vargas-Torres C, Karwoska Kligler S, Spadafore S, Lin MP. Predictors of outpatient follow-up care after adult emergency department asthma visits and association with 30-day outcomes. *J Asthma*. 2023;60(5):938–45.
 23. Cabana MD, Bruckman D, Bratton SL, Kemper AR, Clark NM. Association between outpatient follow-up and pediatric emergency department asthma visits. *J Asthma*. 2003;40(7):741–9.
 24. Wiener-Ogilvie S, Pinnock H, Huby G, Sheikh A, Partridge MR, Gillies J. Do practices comply with key recommendations of the British Asthma Guideline? If not, why not? *Prim Care Respir J*. 2007;16(6):369–77.
 25. Boudreaux ED, Emond SD, Clark S, Carlos A, Camargo Jr. Race/ethnicity and asthma among children presenting to the emergency department: differences in disease severity and management. *Pediatrics*. 2003;111(5):e615--e621.
 26. Hull SA, McKibben S, Homer K, Taylor SJC, Pike K, Griffiths C. Asthma prescribing, ethnicity and risk of hospital admission: an analysis of 35,864 linked primary and secondary care records in East London. *NPJ Prim care Respir Med*. 2016;26(1):1–7.
 27. Griffiths C, Kaur G, Gantley M, et al. Influences on hospital admission for asthma in South Asian and white adults: qualitative interview study. *Bmj*. 2001;323(7319):962.
 28. Netuveli G, Hurwitz B, Levy M, Fletcher M. Ethnic variations in UK asthma frequency, morbidity, and health-service use: a systematic review and meta-analysis. *Lancet*. 2005;365(9456):312–7. Available from: <https://www.proquest.com/docview/199013861/abstract/8ED02B4DF5194148PQ/1?accountid=8630>
 29. Lutfiyya MN, McCullough JE, Lipsky MS. A population-based study of health service

- deficits for US adults with asthma. *J Asthma*. 2011;48(9):931–44.
30. Simms-Williams N, Nagakumar P, Thayakaran R, et al. Risk factors for asthma-related hospital and intensive care admissions in children, adolescents, and adults: a cohort study using primary and secondary care data. *medRxiv*[Preprint]. 2022;2022.11.11.22282223. Available from: <https://www.medrxiv.org/content/medrxiv/early/2022/11/29/2022.11.11.22282223.full.pdf>
 31. Alsallakh MA, Rodgers SE, Lyons RA, Sheikh A, Davies GA. Association of socioeconomic deprivation with asthma care, outcomes, and deaths in Wales: A 5-year national linked primary and secondary care cohort study. *PLoS Med*. 2021;18(2):e1003497.
 32. Schatz M, Zeiger RS, Yang SJ, Chen W, Sajjan S, Allen-Ramey F. Prospective Study on the Relationship of Obesity to Asthma Impairment and Risk. *J Allergy Clin Immunol*. 2015;3(4):560–5.
 33. Taylor B, Mannino D, Brown C, Crocker D, Twum-Baah N, Holguin F. Body mass index and asthma severity in the National Asthma Survey. *Thorax*. 2008;63(1):14–20.
 34. Mosen DM, Schatz M, Magid DJ, Carlos A, Camargo Jr. The relationship between obesity and asthma severity and control in adults. *J Allergy Clin Immunol*. 2008;122(3):507--511. e6.
 35. Hasan T, Ainscough TS, West J, Fraser LK. Healthcare utilisation in overweight and obese children: a systematic review and meta-analysis. *BMJ Open*. 2020;10(10).
 36. Mansur A, Cooper B, Cotter M, et al. P63 Clinical spectrum of patients assessed in a primary care respiratory diagnostic hub; informing referral criteria. In: *British Thoracic Society Winter Meeting, 2021 Feb 17-19; London, UK*. BMJ Publishing Group Ltd; 2021. p. A122–A122. Available from: https://thorax.bmj.com/content/76/Suppl_1/A122.1
 37. Yang CL, Simons E, Foty RG, Subbarao P, To T, Dell SD. Misdiagnosis of asthma in schoolchildren. *Pediatr Pulmonol*. 2017;52(3):293–302.
 38. Fullwood I, Evans T, Davies B, et al. Do you know when the inhaler is empty? *Arch Dis Child*. 2022 Oct 1;107(10):902–5. Available from: <https://adc.bmj.com/content/107/10/902>
 39. National Institute for Health and Care Excellence. *Asthma: diagnosis, monitoring and chronic asthma management*. London: NICE, 2017. <https://www.nice.org.uk/guidance/ng80> (accessed 23 Apr 2023)
 40. Levy M. The national review of asthma deaths: what did we learn and what needs to change? *Breathe*(Sheff). 2015;11(1):14–24.
 41. Hesselink G, Schoonhoven L, Barach P, et al. Improving Patient Handovers from Hospital to Primary Care a Systematic Review. *Annals of Internal Medicine*. 2012;157(6):417-28.
 42. Professional Record Standards Body. *eDischarge summary v2.1*. PRSB, 2019. <https://theprsb.org/standards/edischargesummary/> (accessed 18 Sep 2023)
 43. Dummer J, Stokes T. Improving continuity of care of patients with respiratory disease at hospital discharge. *Breathe*. 2020;16(3): 200161. Available from: <https://doi.org/10.1183/20734735.0161-2020>