

**PCRS briefing paper**

**Single guideline for asthma**

Background

We have guidelines on asthma from two different sources in the UK – BTS/SIGN and NICE. The British Asthma guideline from BTS/SIGN was first published in 2003 and is well established, respected and comprehensive. NICE decided to develop first a guideline on diagnosis and monitoring in asthma, and then a guideline on asthma management, and they finally came together in a single published guideline in November 2017.

We maintain that the existence of two guidelines is confusing for primary care generalists, who need clear evidence based guidance on best practice. We would therefore like to see a single asthma guideline. In our 2017 survey of members, 95% indicated that they would welcome NICE and SIGN/BTS collaborating to develop a single guideline.

We have strongly recommended that NICE collaborates with BTS and SIGN in line with their memorandum of understanding - ‘by working together they can draw on the strength of their organisations and enhance the contribution that they each make towards improving the quality of care for the benefit of patients’ - to develop a single guideline ensuring clarity and consistency. In the meantime, we have asked that they are open about discrepancies and explain the rationale for any differences. To date they have failed to do this.

To date we have expressed our desire for a single guideline primarily to NICE, during the consultations on the 2 asthma guidelines during development (subsequently published as a single guideline), and in letters to NICE. In April 2018 we wrote to NICE, SIGN and BTS in advance of a meeting they held to discuss asthma guidelines to express this view in the same terms to all parties. Two senior members of PCRS also wrote an editorial for the BMJ in 2018, expressing dismay at the continuation of two guidelines.

Nevertheless, BTS/SIGN moved immediately to updating their own guideline using their methodology in 2018 after publication of the NICE guideline, albeit somewhat scaled down due to reduced budget. After a consultation in Jan 2019, we expect publication of this update in summer 2019.

In May 2018, the PCRS Executive committee tabled a paper and discussed their position on the dual/ multiple guidelines issue. It was agreed that whilst we should continue to express the desirability of a single guideline, we should focus our attention on giving our members guidance about what we recommend will work best in primary care. The committee also noted that guidelines are only guidelines and allow for clinical judgement. However they also noted that non-doctors may be more inclined to look for a ‘protocol’ or ‘algorithm’ to follow. CCGs are also recognised to follow NICE guidance rigidly rather than consider guidelines from other sources, so if PCRS is producing pragmatic guidance, it needs to disseminate this effectively to CCGs as well as clinicians.

It is also important to recognise that the guidelines focus on managing individual patients, when increasingly there is interest in how to deliver care at population level. This may become an increasingly important gap in guidelines in future.

We believe that discussions are underway between NICE and BTS/SIGN, and expect to see resolution of this situation over time.

Some key differences in methodology/approach

1. NICE undertakes health economic analyses alongside evaluating clinical effectiveness, which BTS/SIGN does not.
2. NICE is very structured and transparent about consulting with stakeholder groups. Organisations can sign up as a stakeholder, there is a consultation process to set the scope, and again to review a draft. All stakeholder comments are responded to in a publicly available document on the NICE website when the guideline is published. BTS has a less formal approach and consults interested parties on some key points after a draft guideline is made available.
3. Traditionally more of the evidence sifting and evaluation is undertaken by non-clinical information scientists at NICE, while BTS/SIGN uses clinicians to review the evidence. This may change at BTS/SIGN as they have slimmed down the number of clinicians involved.
4. NICE operates strict confidentiality rules for clinicians involved in developing guidelines, and they cannot represent organisations but must contribute in their own right. BTS/SIGN is less strict and concedes that the guideline may be strengthened by clinicians consulting with colleagues.
5. BTS/SIGN has traditionally had more clinicians involved in development than NICE, so their approach is more grounded in the practicalities of real world medicine. BTS/SIGN talks of ‘looking for balance between methodological rigour and practicality of use’ when considering evidence and recommendations.
6. BTS/SIGN does not shy away from ‘Good practice points’ where the evidence may not be strong, but something is commonly considered good practice, whereas NICE rarely strays from a reliance on randomised clinical trials. In selecting the evidence, BTS/SIGN explicitly sets out the kinds of studies it will consider, whereas NICE is clear that RCTs are first choice. SIGN/BTS lists observational studies as being included in searches. Neither mention implementation evidence specifically.
7. There is not a clear view about whether implementation is considered during the NICE guideline development process, but they certainly develop a range of tools to support implementation after publication. But SIGN does not appear to develop tools to support implementation, and states that implementation is a local issue.
8. For both, there is a heavier representation from secondary care than primary care, and in both cases, the voice of the practice nurse is virtually absent.

PCRS response/position:

1. We would like to see a single authoritative guideline across the UK for any respiratory condition. This would avoid discrepancies and duplication of effort and minimise the chances of patients receiving different care from different clinicians following different guidelines.
2. Different methodologies are resulting in different recommendations.
3. We believe that both the SIGN/BTS and NICE approaches have merits and would like to see the best of both being brought into a single guideline.
   1. SIGN/BTS has the strength of an established guideline developed with the involvement of many grass roots health professionals.
   2. NICE has brought a new perspective to asthma guidelines with the addition of health economic analysis, and we welcome this since cost containment is a daily reality in the NHS.
4. It always takes time for best practice to be implemented, and having two guidelines is likely to slow down the uptake of best practice, when there is an urgent need to improve outcomes for people with asthma.
5. The danger of persisting with both guidelines is that discrepancies will undermine the confidence of clinicians in both NICE and SIGN/BTS.
6. We recommend that clinicians in primary and community care follow consensus guidance from PCRS about the optimal approach to asthma diagnosis and management. The latest was published in Primary care respiratory update in Spring 2018, and will be updated in summer 2019 after publication of the latest BTS/SIGN guideline.

References, links and quotes:

NICE guideline on diagnosis, monitoring and chronic management of asthma November 2017 <https://www.nice.org.uk/guidance/ng80> accessed 25.3.19

BTS/SIGN British asthma guideline September 2016 <https://www.sign.ac.uk/assets/sign153.pdf> accessed 25.3.19

BTS/SIGN British asthma guideline – draft for consultation December 2018 <https://www.sign.ac.uk/assets/asthma-consultation-draft.pdf> accessed 25.3.19

Asthma guidelines in practice – a PCRS consensus Spring 2018 <https://www.pcrs-uk.org/sites/pcrs-uk.org/files/pcru/2018-Spring-Asthma-Guidelines-in-Practice%E2%80%93A-PCRS-Consensus.pdf> accessed 25.3.19

Keeley and Baxter Conflicting asthma guidelines cause confusion in primary care Editorial BMJ 2018;360:k29 <https://www.bmj.com/content/360/bmj.k29> accessed 25.3.19

NICE/SIGN memorandum of understanding 2012 <https://www.sign.ac.uk/assets/sign_nice-statement.pdf> accessed 25.3.19

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