

Personalised care for adults with asthma
An experience-led care meeting on 6th October 2017
Background resources
UPDATED

The table below provides a summary of articles, reports and other background material suggested by participants and experts. It includes shared decision-making, personalised care and their application in asthma care. These are provided in order to give participants an overview of the evidence that has been identified. Please note there is no expectation that participants will read these documents, although hyperlinks are provided so you can access them if you are interested.

Document Citation	Available	Overview
About personalised care		
Person-Centred Approaches. Health Education England. 2017	http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download	A framework that aims to distil best practice and to set out core, transferable behaviours, knowledge and skills. It describes values, core communication and relationship building skills. It presents behaviours, knowledge and skills to put a person-centred approach into practice in three 'steps': <ul style="list-style-type: none"> • Step 1: Conversations to engage with people • Step 2. Conversations to enable and support people • Step 3. Conversations with people to collaboratively manage highest complexity and significant risk
World Health Organisation. WHO global strategy on integrated people-centred health services 2016-2026, 2015.	http://africahealthforum.afro.who.int/IMG/pdf/the_global_strategy_for_integrated_people_centred_health_services.pdf	Developing more integrated people-centred care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction, improved efficiency of services, and reduced overall costs. The strategy sets forth a vision of "a future in which all people have access to health services that are provided in a way that responds to their life course needs and preferences, are coordinated across the continuum of care and are safe, effective, timely, efficient and of acceptable quality". Includes four different types of country settings: low, middle and high income countries,
The Health Foundation. Person-centred care made simple. Quick guide 2014. Health Foundation Report.	http://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf	Often, health care does 'to' or 'for' people rather than 'with' them. In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. A framework that comprises four principles of person-centred care: <ol style="list-style-type: none"> 1. According people dignity, compassion and respect. 2. Offering coordinated care, support or treatment.

Document Citation	Available	Overview
		<ol style="list-style-type: none"> 3. Offering personalised care, support or treatment. 4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.
<p>Sultan M Mosleh, Christine M Bond, Amanda J Lee, Alice Kiger, Neil CCampbell. Effectiveness of theory-based invitations to improve attendance at cardiac rehabilitation: A randomized controlled trial. 2013.</p>	<p>http://journals.sagepub.com/doi/abs/10.1177/1474515113491348?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed</p>	<p>A report of a randomized controlled trial which found rewriting invitation letters with theory-based wording is a simple way to increase attendance at cardiac rehabilitation. The theory used was the 'theory of planned behavior (TPB)'. The wording of the letter is reproduced in the article.</p>
<p>Noreen M. Clark, Molly Gong, M. Anthony Schork, David Evans, Dietrich Roloff, Martin Hurwitz, Lois Maiman, Robert B. Mellins Impact of Education for Physicians on Patient Outcomes. Pediatrics May 1998, 101 (5) 831-836; DOI: 10.1542/peds.101.5.831</p>	<p>http://pediatrics.aappublications.org/content/101/5/831</p>	<p>This study was conducted to assess the impact of an interactive seminar based on self-regulation theory on 1) the treatment practices and communications and education behavior of physicians, 2) the health status and medical care utilization of their pediatric patients with asthma, and 3) the satisfaction with care of the subjects' parents. It found that the interactive seminar regulation led to patient-physician encounters that were of shorter duration, had significant impact on the prescribing and communications behavior of physicians, led to more favorable patient responses to physicians' actions, and led to reductions in health care utilization.</p>
<p>Fox J., et al. Patient value: Perspectives from the advocacy community. Health Expect. 2017;00:1-7. https://doi.org/10.1111/hex.12628</p>	<p>http://onlinelibrary.wiley.com/doi/10.1111/hex.12628/full</p>	<p>In this paper, a group of patient advocates explore the varying definitions of patient value and make positive recommendations for working together to strengthen the patient voice in this area. The authors call on framework developers, the patient advocacy and research communities, the health-care industry and decision-makers to undertake specific actions to ensure patient value is included in current and future value frameworks. This is justified on compassionate and economic grounds: better health outcomes result when patients receive treatment tailored to individual needs. Paying attention to the patient perspective also results in better use of resources—a goal that should appeal to all stakeholders</p>

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The Kings Fund. Supporting people to manage their health. 2014	https://www.kingsfund.org.uk/publications/supporting-people-manage-their-health	This paper introduces a way of conceptualising and measuring that engagement known as 'patient activation'. Patient activation can be used to reduce health inequalities and deliver improved outcomes, better quality care and lower costs. Drawing on US and UK-based evidence, the paper describes the robust patient-reported measure – the PAM – used to gauge patient activation.
Amutio-Kareaga, A., García-Campayo, J., Delgado, L. C., Hermosilla, D., & Martínez-Taboada, C. (2017). Improving Communication between Physicians and Their Patients through Mindfulness and Compassion-Based Strategies: A Narrative Review. <i>Journal of Clinical Medicine</i> , 6(3), 33. http://doi.org/10.3390/jcm6030033	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5373002/	The goal of this article is to review the potential effect of mindfulness and compassion-based strategies for the improvement of physician-patient interactions. The acquisition of the necessary skills by physicians requires continuous education. Future research will be useful for identifying more evidence on the cost-effectiveness of this type of intervention.
Rob Horne (2017) The Human Dimension: Putting the Person into Personalised Medicine, <i>The New Bioethics</i> , 23:1,38-48, DOI: 10.1080/20502877.2017.1314894	https://www.tandfonline.com/doi/full/10.1080/20502877.2017.1314894	Biomedical advances, although fundamental, cannot deliver on the promise of personalised medicine in isolation. We now have the capacity to characterise Hippocrates idiosyncrasia more accurately from the biological perspective, than ever before. But the promise of personalised medicine will only be fully realised if we develop better methods for characterising the psychosocial idiosyncrasia influencing engagement and outcome. Good prescribing is about the application of psychology as well as pharmacology.
<i>About shared decision making and its implementation in practice</i>		
Coulter A and Collins A. Making shared decision-making a reality. The Kings Fund, 2011	https://www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf	Explains why shared decision-making is important, what shared decision-making involves and the implications for patients, clinicians and the NHS. Makes a number of suggestions about what needs to happen to make shared decision-making a meaningful reality including: <ul style="list-style-type: none"> • Greater national provision of decision aids and the development of common and consistent approaches • The identification of decision points in care pathways and the monitoring of the quality of shared decision-making

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		<ul style="list-style-type: none"> • Better provision, recording of, and support for, shared decision-making by providers • Inclusion of the subject in training; appropriate incentivisation • The inclusion of shared decision-making in commissioning standards and contracts.
<p>Elwyn G, Cochran N, Pignone M. Shared Decision Making—The Importance of Diagnosing Preferences. <i>JAMA Intern Med.</i> 2017;177(9):1239–1240. doi:10.1001/jamainternmed.2017.1923</p>	<p>http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2643350 (not open access)</p>	<p>Shared decision making occurs when patients and clinicians reach a formulation about the presenting problem and discuss how to manage it. It is essential to understand a patient's preferences, including the role he or she wants to play in decision making. Presents strategies on shared decision making:</p> <ul style="list-style-type: none"> • Knowledge Tools: briefer, more accessible tools, such as the Mayo Diabetes Cards and Option Grids patient decision aids • Skills: Sharing decisions, and using these tools, requires skills in effective communication • Measures: Patient experience measures that accurately reflect shared decision making, such as CollaboRATE patient-reported measure • Team Approach: all clinicians in a care team should be involved and supportive. • Organizational Support: Executive leadership and resources are needed
<p>Al Mulley, Chris Trimble, Glyn Elwyn. Patients' preferences matter: Stop the silent misdiagnosis. The King's Fund 2012</p>	<p>https://www.kingsfund.org.uk/sites/default/files/field/file_publication_file/patients-preferences-matter-may-2012.pdf</p>	<p>Presents evidence that patients choose different treatments after they become better informed and there are wide gaps between what patients want and what doctors think patients want. Proposes that patient preference diagnosis should be viewed alongside medical diagnosis. Makes recommendations around supporting doctors in their efforts to make more accurate preference diagnoses and new, dedicated teams focused on gathering and disseminating information.</p>
<p>Brush JE, Brophy JM. Sharing the Process of Diagnostic Decision Making. <i>JAMA Intern Med.</i> 2017;177(9):1245–1246. doi:10.1001/jamainternmed.2017.1929</p>	<p>http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2646776 (not open access)</p>	<p>Describes the diagnostic process. Greater public awareness of the methods, strengths, and limitations of the diagnostic process should also help patients, as well as families and caregivers, set expectations and participate in shared diagnostic decision making.</p>
<p>Enhancing the use of scientific evidence to judge the potential benefits and harms of medicines. The Academy of Medical Sciences. 2017</p>	<p>http://acmedsci.ac.uk/policy/how-can-we-all-best-use-evidence</p>	<p>Poor-quality evidence about medicines, or misrepresentation or misperception of evidence, may present risks to health, for example by leading to under- or over-medication, and prevent the full realisation of the health gains from medical innovation. Makes a series of recommendations aimed at strengthening the use of scientific evidence by the public, patients and professionals when judging the potential benefits and harms of medicines, including supporting joint decision-making between healthcare professionals and patients</p>

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Maskrey N, Gordon A. Shared Understanding With Patients. <i>JAMA Intern Med.</i> 2017;177(9):1247–1248. doi:10.1001/jamainternmed.2017.1932	http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2647326 (not open access)	The evidence does not constitute all the information required for appropriate decision making. Good decisions rest on the quality of the conversation between clinician and patient. The inherent complexity of such dialogues means that striving for the “perfect” consultation will result in professional frustration. Instead, lifelong commitment to improving the context and content of patient-clinician communication, along with a will to partner with the patient, increases the proportion of decisions based on true shared understanding.
Hoffmann T, Straus S. Sharing Knowledge for Health Care. <i>JAMA Intern Med.</i> 2017;177(9):1243–1244. doi:10.1001/jamainternmed.2017.2080	http://jamanetwork.com/journals/jamainternalmedicine/issue/177/9 (not open access)	At present, there is both data overload and a lack of reliable information that can be easily understood and shared between clinicians and patients. The available evidence and the evidence that is needed are poorly matched. By reducing waste in research, and effort duplication in the analysis and synthesis of evidence, resources could be directed toward creating a real-time, global network of cumulative knowledge distribution.
A consensus statement. Shared Decision Making Collaborative.	https://www.nice.org.uk/Media/Default/About/what-we-do/SDM-consensus-statement.pdf	Makes recommendations describing a multi-component approach that, taken together, will encourage a shared decision making culture and approaches to healthcare.
Shared Decision Making webpage. NICE	https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making	Defines and describes benefits of shared decision making Provides tools for patients and clinicians to support shared decision making for some conditions
Shared Decision Making Collaborative –An action plan NICE. 2016	https://www.nice.org.uk/Media/Default/About/what-we-do/shared-decision-making-collaborative-action-plan.pdf	Presents conclusions from the Shared Decision Making Collaborative held on 23 June 2016 in London. Participants from a wide range of organisations and specialities took part in the meeting to build on a shared interest in, and commitment to, shared decision making. Presents proposed actions around the 7 central themes identified in the Collaborative’s Consensus Statement: 1. Leadership and culture change 2. Local leadership 3. Education and training 4. Shared decision making tools 5. Guidance development and evidence reviews 6. Measurements of successful shared decision making 7. Research.

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How to Change Practice. NICE. 2007	https://www.nice.org.uk/media/default/about/what-we-do/into-practice/support-for-service-improvement-and-audit/how-to-change-practice-barriers-to-change.pdf	This guide aims to improve patient care by giving practical advice on how to encourage healthcare professionals and managers to change their practice in line with the latest guidance. It is focused on the healthcare setting, but the general principles of change maybe applicable elsewhere. Part 1 discusses the types of barriers to change encountered in healthcare. Part 2 offers practical suggestions for how to identify the barriers to change. Part 3 shows how to overcome these barriers, and highlights potential levers to do so with examples.
Légaré F, Stacey D, Turcotte S, Cossi MJ, Kryworuchko J, Graham ID, Lyddiatt A, Politi MC, Thomson R, Elwyn G, Donner-Banzhoff N. Interventions for improving the adoption of shared decision making by healthcare professionals. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD006732. DOI: 10.1002/14651858.CD006732.pub3.	http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006732.pub3/abstract;jsessionid=DC0862C8EDC0934321633278EF3CDD28.f02t01	Cochrane systematic review to determine the effectiveness of interventions to improve healthcare professionals' adoption of SDM. Found it is uncertain whether interventions to improve adoption of SDM are effective given the low quality of the evidence. However, any intervention that actively targets patients, healthcare professionals, or both, is better than none. Also, interventions targeting patients and healthcare professionals together show more promise than those targeting only one or the other.
Stacey D, Légaré F, Lewis K, Barry MJ, Bennett CL, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lyddiatt A, Thomson R, Trevena L. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD001431. DOI:	http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001431.pub5/abstract	Cochrane systematic review to assess the effects of decision aids in people facing treatment or screening decisions. Found compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices.

Document Citation	Available	Overview
10.1002/14651858.CD001431.pub5.		
Elwyn G, Dehlendorf C, Epstein RM, Marrin K, White J, Frosch DL. Shared decision making and motivational interviewing: Achieving patient-centred care across the spectrum of health care problems. <i>Ann Fam Med</i> . 2014;12(3):270–5.	http://www.annfammed.org/content/12/3/270.full.pdf+html	When patients face tough treatment decisions, shared decision making alone is appropriate. Where clinicians perceive a need to change behavior to improve health outcomes, motivational interviewing could be used. These 2 methods can be integrated when behavior change and choosing between competing options are relevant
Peek ME, Drum M, Cooper LA. The Association of Patient Chronic Disease Burden and Self-Management Requirements With Shared Decision Making in Primary Care Visits. <i>Heal Serv Res Manag Epidemiol</i> . 2014;1	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4670035/pdf/10.1177_2333392814538775.pdf	Patients with chronic diseases, particularly those requiring self-management, may be more likely to engage in SDM behaviors, but physicians may not be more likely to engage such patients in SDM.
Spatz, E. S., Krumholz, H. M., & Moulton, B. W. (2016). The New Era of Informed Consent: Getting to a Reasonable Patient Standard through Shared Decision Making. <i>JAMA</i> , 315(19), 2063–2064. http://doi.org/10.1001/jama.2016.3070	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5459384/	This viewpoint discusses a recent UK court case involving information sharing. It concludes the case serves as a reminder that at the heart of a reasonable patient standard is respect for patients’ informational needs; preferences, values and goals; safety; and autonomy. By truly embracing this standard through the promotion of shared decision making, patients, the health system and society will benefit.

Document Citation	Available	Overview
Slok, Annerika HM et al. "Effectiveness of the Assessment of Burden of Chronic Obstructive Pulmonary Disease (ABC) Tool: Study Protocol of a Cluster Randomised Trial in Primary and Secondary Care." <i>BMC Pulmonary Medicine</i> 14 (2014): 131. PMC. Web. 16 Oct. 2017.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4130125/	Introduces a new tool, the Assessment of Burden of COPD (ABC) tool, to assess and visualize the integrated health status of patients with COPD, and to provide patients and healthcare providers with a treatment algorithm. This tool may be used during consultations to monitor the burden of COPD and to adjust treatment if necessary.
Elwyn Glyn, O'Connor Annette, Stacey Dawn, Volk Robert, Edwards Adrian, Coulter Angela et al. Developing a quality criteria framework for patient decision aids: online international Delphi consensus process <i>BMJ</i> 2006; 333 :417	http://www.bmj.com/content/333/7565/417.long	Article explain a process to develop a set of quality criteria for patient decision support technologies (decision aids) using two stage web based Delphi process using online rating process to enable international collaboration. This, supported by summarised evidence reports, provided substantial consensus about a framework of quality criteria for patient decision aids. The criteria are available as a users' checklist and are being used as a guide to developers of decision support
Albarqouni L, Doust J, Glasziou P Patient preferences for cardiovascular preventive medication: a systematic review <i>Heart</i> Published Online First: 13 May 2017. doi: 10.1136/heartjnl-2017-311244	http://heart.bmj.com/content/early/2017/05/13/heartjnl-2017-311244	Clinicians often fail to accurately identify patient preferences—a problem termed silent misdiagnosis, and hence guidelines should include tools that promote shared decision making where intervention choices can be tailored to patients' clinical characteristics and to their values and preferences. This means that guideline recommendations should be used as a starting point for the individual patient–clinician decision-making process. In addition, patient versions of guidelines, as well as decision aids tools, should be developed and disseminated along with the guidelines.
Examples of decision aid tools		
Statin Choice Decision Aid, Mayo Clinic	https://statindecisionaid.mayoclinic.org	An example of an online decision aid tool.
Taking a medicine to reduce the chance of developing	https://www.nice.org.uk/guidance/cg164/resources/ta	An example of a patient decision aids designed to help people take part in making decisions about healthcare options.

Document Citation	Available	Overview
breast cancer. Patient Decision Aid. NICE. 2017.	king-a-medicine-to-reduce-the-chance-of-developing-breast-cancer-decision-aid-for-postmenopausal-women-at-high-risk-4422436672	
<i>About shared decision making and personalised care and their application in asthma care</i>		
Hook et al, The 'vicious cycle' of personalised asthma action plan implementation in primary care: a qualitative study of patients and health professionals' views BMC Family Practice (2015) 16:145 DOI 10.1186/s12875-015-0352-4	https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-015-0352-4	Primary care personalised asthma action plan (PAAP) implementation is in a vicious cycle. Professionals infrequently review/update PAAPs with patients; patients with out-dated PAAPs do not value or use these; professionals observing patients' lack of interest in PAAPs do not discuss these. Patients observing this do not refer to their plans and perceive them to be of little value in asthma self-management. Twenty-five years after PAAPs were first recommended, primary care practices are still not ready to support their implementation. Breaking this vicious cycle to create a healthcare context more conducive to PAAP implementation requires a whole systems approach with multi-faceted interventions addressing patient, professional and organisational barriers.
M. Thomas. Why aren't we doing better in asthma: time for personalised medicine? npj Primary Care Respiratory Medicine (2015) 25, 15004; doi:10.1038/npjpcrm.2015.4; published online 5 March 2015	https://www.nature.com/articles/npjpcrm20154	The paper considers why, after decades of improvement, asthma outcomes have stalled. Strategies for improving monitoring and clinician–patient interactions to allow personalised treatment are considered. These strategies have the potential to allow individual patient needs to be recognised and efficient targeting of the variety of effective pharmacological and non-pharmacological interventions that we possess, which has the potential to improve both individual and population outcomes

Document Citation	Available	Overview
<p>Holgate, S. T. (2013). Stratified approaches to the treatment of asthma. <i>British Journal of Clinical Pharmacology</i>, 76(2), 277–291. http://doi.org/10.1111/bcp.12036</p>	<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3731602/</p>	<p>Asthma can no longer be regarded as a homogeneous disorder, with increasing evidence for multiple endotypes now emerging. It is increasingly clear that different causative pathways will become linked to different disease endotypes. The identification of such novel pathways will provide the opportunity to develop novel animal models beyond the allergen sensitization/challenge model and will form the basis for the stratified treatment of this disease, hopefully attacking those pathways high up the causal cascade.</p>
<p>Pollard S, Bansback N, FitzGerld JM, Bryan S. The burden of non-adherence among adults with asthma: A role for shared decision making. <i>Allergy [Internet]</i>. 2016;72(11):705–12.</p>	<p>http://onlinelibrary.wiley.com/doi/10.1111/all.13090/epdf</p>	<p>Research article that describes why a shared approach to treatment decision-making for asthma has the potential to be an effective tool for improving adherence. Follows upon a promising trial published several years ago. Asks as SDM is so well supported throughout the policy and academic literature, and interventions such as this one have shown to be effective in improving various patient and clinically important outcomes, why is it not commonplace in clinical settings?</p>
<p>Wilson SR, Strub P, Buist AS, Knowles SB, Lavori PW, Lapidus J, et al. Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. <i>Am J Respir Crit Care Med</i>. 2010;181(6):566–77.</p>	<p>http://www.atsjournals.org/doi/abs/10.1164/rccm.200906-0907OC?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&#readcube-epdf</p>	<p>In a randomized controlled trial, patients with poorly controlled asthma who shared in making decisions about their treatment showed significantly better adherence to asthma controller medications and to long-acting b-agonists than patients who participated in either of two control conditions.</p>
<p>Chisholm A, Price DB, Pinnock H, Lee TT, Roa C, Cho S-H, et al. Personalising care of adults with asthma from Asia: a modified e-Delphi consensus study to inform management tailored to attitude and control profiles. <i>The Author(s)</i>; 2017 Jan 5;27:16089.</p>	<p>http://dx.doi.org/10.1038/nnpjcrm.2016.89</p>	<p>Identifying patients' attitudes is critical to successfully managing the complexities of asthma. Illustrates the range of clinical management approaches required to tailor support for patients with different attitudinal–control profiles. Recommendations complement guideline-recommended management approaches.</p>

Document Citation	Available	Overview
Heaney LG, Horne R. Non-adherence in difficult asthma: time to take it seriously. <i>Thorax</i> 2012; 67 :268-270.	http://thorax.bmj.com/content/67/3/268.info	There has been a failure to systematically implement processes and clinical tools which have been shown to help identify and address non-adherence. Adherence is influenced by the patients' beliefs about medicines—in particular, how they judge their personal need for the treatment (necessity beliefs) relative to their concerns about potential adverse effects. The key challenge is to empower patients to make informed choices about medicines rather than decisions influenced by misplaced beliefs about benefit and harm.
Kew KM, Malik P. Shared decision-making for people with asthma. <i>Cochrane Database of Systematic Reviews</i> 2016, Issue 8. Art. No.: CD012330. DOI: 10.1002/14651858.CD012330.	http://onlinelibrary.wiley.com/store/10.1002/14651858.CD012330/asset/CD012330.pdf?v=1&t=j7lpxds&s=97f4cc3de3a4f6d335de2a8700470bd570756426	A protocol for a systematic review to assess the benefits and potential harms of shared decision-making for asthma. SDM may improve clinical outcomes and quality of life by educating and empowering patients to be actively involved in their own health. These interventions may be particularly beneficial in people with asthma as self-management behaviours are important and make SDM particularly relevant to a population with asthma.
Kew KM, Malik P, Aniruddhan K, Normansell R. Shared decision-making for people with asthma. <i>Cochrane Database of Systematic Reviews</i> 2017, Issue 10. Art. No.: CD012330. DOI: 10.1002/14651858.CD012330.pub2.	http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD012330.pub2/abstract#footer-article-info	Reports outcomes of the above review. Substantial differences between the four included randomised controlled trials (RCTs) indicate that we cannot provide meaningful overall conclusions. Individual studies demonstrated some benefits of SDM over control, in terms of quality of life ; patient and parent satisfaction; adherence to prescribed medication; reduction in asthma-related healthcare visits; and improved asthma control. Our confidence in the findings of these individual studies ranges from moderate to very low, and it is important to note that studies did not measure or report adverse events.
Gamble, J et al. A study of a multi-level intervention to improve non-adherence in difficult to control asthma. <i>Respiratory Medicine</i> , Volume 105 , Issue 9 , 1308 - 1315	http://www.resmedjournal.com/article/S0954-6111(11)00109-0/fulltext	This study confirms that poor adherence is identified badly by physician assessment and patient self report, and highlights the importance of using objective measures of adherence as part of a difficult asthma assessment. It also demonstrates that when this information is presented to patients in a concordance discussion, there is a significant alteration in patient behaviour with improved adherence and asthma outcome. In addition, a relatively simple menu driven intervention strategy, which could be easily incorporated into a clinical management programme, can further improve adherence in this patient group

Document Citation	Available	Overview
<p>Ryan D, Murphy A, Ställberg, B, Baxter N & Heaney, L (2013). 'SIMPLES': A structured primary care approach to adults with difficult asthma. Primary care respiratory journal : journal of the General Practice Airways Group. 22. . 10.4104/pcrj.2013.00075.</p>	<p>https://www.nature.com/articles/pcrj.201375</p>	<p>SIMPLES is a structured primary care approach to the review of a person with uncontrolled asthma which encompasses patient education monitoring, lifestyle and pharmacological management and addressing support needs which will achieve control in most patients.</p>
<p>Horne R. 2006. Compliance, Adherence, and Concordance CHEST , Volume 130 , Issue 1, 65S - 72S. 2006</p>	<p>http://journal.chestnet.org/article/S0012-3692(15)32958-5/fulltext</p>	<p>Good-quality outcomes in asthma hinge not just on the availability of medications but also on their appropriate use by patients: optimal “self-management.”. We also need more effective ways of communicating the relative benefits and risks to patients in order to facilitate informed adherence. Clinicians must be prepared to work in an ongoing partnership with patients to ensure that they are offered a clear rationale as to why ICS are necessary and to address their concerns about potential adverse effects. This approach, based on a detailed examination of patients' perspectives on asthma and its treatment, and an open, nonjudgmental manner on the part of the clinician, is consistent with the idea of concordance.</p>
<p>Horne R, Weinman J. Self-regulation and self-management in asthma: exploring the role of illness perceptions and treatment beliefs in explaining non-adherence to preventer medication. Psychol Health 2002;17:17e32.</p>	<p>http://www.tandfonline.com/action/showCitFormats?doi=10.1080%2F08870440290001502</p>	<p>The findings showed that non-adherent behaviours were associated with doubts about the necessity of medication and concerns about its potential adverse effects and with more negative perceived consequences of illness.</p>
<p>Pinnock H. Supported self-management for asthma. Breathe. 2015;11(2):98-109. doi:10.1183/20734735.015614 .</p>	<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4487370/</p>	<p>The evidence in favour of supported self-management for asthma is overwhelming. Self-management including provision of a written asthma action plan and supported by regular medical review, almost halves the risk of hospitalisation, significantly reduces emergency department attendances and unscheduled consultations, and improves markers of asthma control and quality of life. Demographic and cultural tailoring enables effective programmes to be implemented in deprived and/or ethnic communities or within schools.</p>

