

NG245 One Year On: Implementing the BTS/NICE/SIGN asthma guideline



On 27 November 2024, the British Thoracic Society (BTS), National Institute for Health and Care Excellence (NICE), and the Scottish Intercollegiate Guidelines Network (SIGN) published co-produced guidelines for the diagnosis and treatment of chronic asthma. This is guideline [NG245](#).¹

One year on, NG245 has begun to positively reshape asthma care in the UK, with participants in this briefing's research identifying early improvements in diagnosis, prescribing practices, and patient management pathways directly linked to better outcomes. However, persistent structural and resource challenges must be addressed in order for these benefits to be fully realised.

Despite constant calls for asthma care to be improved, 65% of asthma deaths in the UK could be avoided with better care.² The full and thorough implementation of this guideline would go a long way to reducing these needless deaths.

Executive summary

- **Resource and funding shortfalls persist:** Despite broad consensus about the positive value of NG245, inadequate resources and insufficient funding remain serious barriers to its implementation. These limit the guideline's potential to deliver high-quality asthma care, with negative knock-on effects for patient outcomes, especially in poorly resourced areas and for children and young people.
- **Stepwise diagnostic pathway delivers clarity, but access gaps remain:** The introduction of a clear stepwise pathway for diagnosis has made the process more robust and clinician-friendly, reducing unnecessary referrals. Clinicians report heightened confidence in diagnosing asthma and a decrease in primary care referrals to secondary care for confirmation, which bolsters patient flow and supports timely treatment. However, widespread lack of access to FeNO and spirometry testing threatens this progress, often resulting in delayed diagnoses and poorer outcomes in some settings.
- **Treatment pathways (AIR/MART) drive “game-changing” improvements:** The shift to Anti-inflammatory Reliever (AIR) and Maintenance and Reliever Therapy (MART) regimes marks a decisive move toward evidence-based combination inhaler use. Where well supported, patients report improved satisfaction and adherence to treatment, less relapse to older regimens, and overall better asthma control. The early impact includes reduction in harmful SABA (short-acting beta-agonist) prescribing and modest improvements in exacerbation rates—reflecting improved clinical outcomes and patient safety. However, many patients are not well supported when they switch inhalers, and this was thought to undermine the change and cause knock on problems such as poor treatment adherence.
- **Positive outcome signals despite varied implementation:** Clinicians observed reduced asthma exacerbations and hospitalisations for newly diagnosed patients over age 12, correlating with reduced use of SABA inhalers and increased adoption of appropriate combination therapies. These improvements are particularly notable where local implementation has strong clinical leadership and commissioner engagement. In successful areas, patients are more likely to receive correct medication on discharge, personalised action plans, and dedicated follow-up, leading to better management and long-term control.
- **Ongoing challenges in out-of-hours and paediatric care:** interviewees identified ongoing issues with inappropriate SABA prescribing in out-of-hours settings, which undermine progress made elsewhere. Children and young people still face sizeable gaps in access to recommended diagnostics (especially FeNO), risking exclusion from best-practice pathways and perpetuating inequalities.
- **Upskilling clinicians and patient support critical to sustainability:** Sustained improvement in patient outcomes hinges on upskilling clinicians to ensure shared decision-making, gold-standard inhaler switching care, and

continuous training. Both patients and clinical staff benefit where dedicated resources for education, training, and follow-up are in place, driving better engagement, adherence, and advocacy for change within the system.

- National coordination required for full impact: While progress is tangible in “best practice” localities, national consistency remains elusive. Participants called for collaborative learning, data-driven leadership, and renewed national investment in diagnostics, training, and implementation monitoring to fully realise the guideline’s benefits across all regions and patient groups. The introduction of a Modern Service Framework for respiratory conditions would be a clear way to take forward this more coordinated approach.

Recommendations

1. Reduce significant patient risk and improve asthma care by fully implementing NG245:
 - a. Making ICS-formoterol inhalers the standard care for adults and children aged 6 plus.
 - b. Ensure everyone with asthma who is discharged from acute care, including in primary care for an acute event, has their inhaler technique reviewed and corrected, is treated with MART or AIR where appropriate, and is given a Personalised Asthma Action Plan.
 - c. Ensure people with asthma who have had two or more emergency department or hospital admissions or exacerbation in a 12 month period are referred for specialist review.
2. Ensure health systems provide access to comprehensive diagnostic testing within primary care, in line with NG245, by improving access to key tests for all adults and children:
 - a. Providing access to point-of-care FeNO testing in all Primary Care Networks (PCNs). This is essential for the optimal diagnosis of asthma in children and young people, and improved access will also have benefits for adults.
 - b. Maintaining funding for ongoing FeNO costs, including for paid, protected staff training, consumables such as mouthpieces, and FeNO machine maintenance.
 - c. Commissioning quality assured spirometry services, ensuring every health system has adequate access and sufficient capacity to support their local population.
 - d. Expanding quality assured spirometry provision for diagnosing asthma in children and young people to ensure access improves alongside spirometry access for adult diagnosis.
3. Upskill clinicians to improve their competence and confidence in taking a thorough clinical history.
4. Upskill clinicians in out of hours settings to urgently stop inappropriate SABA prescribing, ensuring all adults presenting because of asthma are prescribed a MART regime where appropriate.
5. Support the guideline’s recommended changes to prescribing by upskilling clinicians to provide gold-standard inhaler switching care. Health systems must:
 - a. Ensure all switching is done through shared decision-making so that no patients has their inhaler switched without informed consent.
 - b. Provide in-person inhaler technique guidance alongside any switch: every patient must be shown how to use their new inhaler.
 - c. Arrange and complete clinician-initiated follow-up appointments within four to eight weeks after a person’s inhaler is switched.³
6. Asthma + Lung UK should continue to directly support people with asthma to navigate this period of change in asthma management.
7. Asthma + Lung UK should work with stakeholders, including BTS, NICE and SIGN, to support and progress guideline implementation.

Introduction

NG245 sought to unify asthma care across the UK, and provided a much-needed domestic update to asthma care at a time when many clinicians were following guidance influenced more by work from the Global Initiative for Asthma (GINA)⁴ than previous iterations of guidance from BTS, NICE, or SIGN.

NG245 made significant changes to the diagnosis and treatment of asthma for both adults and children and young people (CYP); introducing a stepwise diagnostic pathway,⁵ and championing the use of combination inhalers through Anti-inflammatory Reliever (AIR) and Maintenance and Reliever Therapy (MART) regimes.⁶ This shift to ICS-formoterol inhalers also saw NG245 significantly reduce the role that should be played by short-acting beta-agonist (SABA) inhalers, particularly in the adult pathway. SABA inhalers only treat the asthma's symptoms rather than the underlying cause of inflammation,⁷ and the overuse of these inhalers is associated with increased risk of asthma exacerbations, hospitalisation and death.⁸ These changes were well received by the respiratory community and offer the opportunity to make impactful improvements to the care of those living with asthma.

Getting the ball rolling: implementation in the first twelve months

NG245 is a unique opportunity to revolutionise asthma care for the 7.2 million people in the UK with the condition,⁹ but unless implemented properly, the opportunity will be lost. In the twelve months since NG245 was published, Asthma + Lung UK, and other organisations, have worked to meet the vast scale of the implementation challenge. We have orientated our asthma resources to support NG245, providing both [patient-facing health advice](#) that helps people with asthma navigate the changes they may see in their care, and clinician-facing resources to support healthcare professionals via our [Healthcare Professionals' Hub](#). We have worked with the Primary Care Respiratory Society (PCRS) to share their system-level resources, including [PCRS's NG245 implementation toolkit](#), aimed at Integrated Care Boards (ICBs), Health Boards and Health and Social Care Boards.

Different health systems across the UK have begun to implement NG245 with varying degrees of success. Clinicians have told us that the difference between good implementation and less-good implementation comes down to the availability of funding for services, resources and training, the engagement and enthusiasm of service commissioners, and the presence of respiratory clinician leadership. Implementation of NG245 has been set against a backdrop of ICBs being told to halve their spending,¹⁰ system-wide changes including the forthcoming dissolution of NHS England and the merging of ICBs, which has slowed the development of local asthma guidance in some cases.

Methodology

This briefing uses insights gathered from interviews with clinicians from across the UK to explore how implementing NG245 is going; what's going well, where there is need for improvement, and what is needed to ensure that people with asthma get the care they deserve. This approach was chosen because of the lack of quantitative data available for assessing implementation, but also gives a more nuanced understanding of how and why implementation varies across the country. Importantly, the use of semi-structured interviews allowed the clinicians to guide the discussions, ensuring this briefing focuses on what clinicians think are the most crucial parts of NG245's implementation.

Eight clinicians were interviewed for this briefing, including clinicians based in each of the UK's four nations. Each interview consisted of series of questions (see Appendix 1) as a starting point, but with the clinicians encouraged to explore tangents in order to explain their views in full. This semi-structured approach also worked to reduce researcher-centred bias. Interviews lasted between 35 and 60 minutes. Thematic analysis and coding were conducted manually with keywords, phrases and themes identified to highlight commonality between interviewees. This analysis then informed a narrative for each question and for the briefing as a whole.

General impressions

“I think interest is building”

NG245 has been welcomed by clinicians, and key parts of the guideline such as changes to asthma prescribing have universal support among the clinicians interviewed for this briefing.

While many of those interviewed had been following guidelines informed closely by the Global Initiative for Asthma (GINA) prior to NG245, they were keen to explain how NG245 is more useful and more suitable. One interviewee explained that NG245 has been a useful tool for influencing NHS commissioners, saying NG245 has “has put weight on what we've been saying and tweaked the interest of people who may not have been very respiratory interested initially.” Another interviewee explained a similar experience, saying that the guideline has helped focus attention on FeNO testing as a core diagnostic test.

The evidence base that supports NG245's recommendations is well established, and has been known to clinicians with a respiratory focus for years. By enshrining this evidence base in a domestic asthma guideline, BTS, NICE and SIGN have produced a guideline that carries the necessary weight required to make health systems pay attention. If properly implemented, NG245 would improve asthma care for millions, reducing adverse health outcomes such as asthma attacks and hospitalisations, which reduces care costs for health systems. Across the board, NG245 has the potential to make a significant, positive change to the way asthma is diagnosed and managed. All it needs is good implementation.

“Implementation in one word: struggle”

Despite welcoming NG245's content, many clinicians raised concerns about its implementation. Some cited logistical concerns with diagnostic provision as much of their ICB's diagnostic capacity relies on Community Diagnostic Hubs. Many others cited general lack of resource across both diagnosis and asthma management as an obstacle that is slowing down or otherwise limiting implementation in certain settings or for specific patient cohorts.

“I think the biggest barrier is the resource within primary care.”

“We don't have enough access to simple diagnostic tests that we should have access to.”

We also heard from clinicians that system changes are delaying implementation as local guidance is being developed at the same time as ICBs are preparing to merge, complicating and delaying the development of local guidance.

In contrast, some clinicians interviewed explained that NG245 has dovetailed well with ongoing work, including SABA-reduction work, and that implementation has been successful so far in some localities. Interviewees explained how successful implementation has relied on strong foundations, both of existing clinical leadership and of prior success in delivering good respiratory care, as well as the persuasive power of domestic asthma guidelines – compared with GINA-based guidance – in influencing service commissioners.

“It has been frustratingly slow locally for a number of reasons. It's just taken a long time to get there because of everything that's been going on.”

“We were ready to go with the guidelines and then the other ICB we're clustering with had release some slightly different guidelines. So we made a decision that we're going to try and make the guidelines all aligned to each other.”

This variety of opinion across interviewed clinicians exemplifies a key challenge for NG245: despite being a national guideline, its implementation is devolved to various health systems across the UK, with each approaching NG245 in its own way, often limited by localised funding availability. Similarly, delegation of implementation allows for the provision of services that go against NG245 and its comprehensive evidence base. This highlights the need for

collaborative thinking, the sharing of best practice, and the need for national clinical leadership to support NG245 and improve asthma care.

There is also a clear need for NICE, as well as BTS and SIGN, to do more to support NG245's implementation. While the guideline itself is detailed and much-praised, its implementation is diffuse and has been left to individual health systems – often to individual clinicians within these systems – and other stakeholders including the charity sector. NICE are well placed to work with stakeholders to produce and share resources and toolkits to support clinicians in implementing NG245, and we would welcome this in the near future.

“Having the new national guidelines saying the same thing [as GINA-based local guidelines] has put weight on what we've been saying. And commissioners are certainly listening.”

Diagnosis

“A very, very clear stepwise pathway”

Those interviewed universally welcomed NG245's introduction of a stepwise pathway for diagnosing asthma, with many championing its clarity and ease of use by clinicians.

Some clinicians explained the system-wide benefits of the pathway's clarity, with one consultant physician explaining that they have seen a drop in the number of referrals for diagnosis in secondary care, suggesting an increase in diagnostic confidence from primary care.

“We have fewer referrals from primary care asking for confirmation of diagnosis.”

“I think the new guideline empowers people to make the diagnosis of asthma and to initiate treatment.”

“[The new guideline is] much more implementable than the previous NICE guidelines.”

By reducing secondary care referrals for diagnosis confirmation, NG245 bolsters patient flow and supports timely treatment. Delays in diagnosis and under-diagnosis can lead to people with asthma having untreated inflammation, putting them at risk of asthma symptoms, exacerbations and poorer health outcomes.¹¹ Preventing this is essential, and a key benefit of NG245's clear diagnostic pathway, improving timely initiation of treatment for people with asthma. We also know that there are significant costs associated with asthma exacerbations,¹² meaning that timely, accurate diagnosis also benefits health systems through reduced care costs.

“Nobody's got any money for FeNO”

Insufficient prioritisation for funding for respiratory care causing poor provision of diagnostics was a universal concern raised across all clinician interviews. Clinicians agreed that poor access to diagnostic testing paralyses the pathway and can lead to delayed diagnosis and poorer patient outcomes while exerting unnecessary pressure on secondary care.

“We don't have enough access to simple diagnostic tests.”

“We had lost capacity at the beginning of the financial year. There was no funding at community level for diagnostics at all.”

Concern about access to diagnostic testing centred on two objective tests: fractional exhaled Nitric-Oxide testing (FeNO) and spirometry.

Across all interviews, many were concerned about limitations to access FeNO testing, with clinicians highlighting its importance both as the sole step-one test in the 5-16 years diagnosis pathway,¹³ and as a point-of-care test. One clinician explained that they have no resource available for the local provision of FeNO testing, and that the key barrier to this is the cost of commissioning FeNO services.

“We need to step up access to FeNO in primary care, and that's not happening. There is very little funding out there.”

This demonstrates the need for local commissioners to understand the role of FeNO in NG245's diagnostic pathway, especially in children and young people's diagnosis. Similarly, FeNO funding needs to be prioritised nationally. This highlights the drawbacks of siloed NHS budgets. While there are costs associated with expanding FeNO provision, we know that if it were expanded to give point-of-care access to FeNO with every GP in England, its use could save the NHS almost £100 million by optimising asthma treatment.¹⁴

In addition to poor access to FeNO, access to spirometry is also poor, particularly for children and young people's diagnosis. Funding for spirometry in adults, though insufficient, is provided more readily, but the resulting services exclude CYP diagnosis. This means that some children and young people are unable to access two essential diagnostic tests. When non-invasive diagnostic tests aren't available, diagnosis of asthma in children and young people can only be done through blood testing, though this is not always available in primary care for CYP, meaning they may need to be referred to secondary care, adding to capacity concerns and delaying diagnosis.

Two clinicians gave examples of spirometry services being commissioned for adults only, leaving CYP spirometry capacity lagging woefully behind. In both instances, the clinicians explained that funding had been made available for ICBs to bid for, but with funding only available from adult respiratory funds, services are limited.

The result of this is that CYP diagnosis is hampered; children and young people will face longer delays to get their

“I'm battling for the voice of children within all of this, and the national policy isn't following suit. So children are excluded.”

condition diagnosed, which can mean similar delays before appropriate treatment is started.¹⁵ Delays in diagnosis and under-diagnosis can lead to people with asthma having untreated inflammation, putting them at risk of asthma symptoms, exacerbations and poorer health outcomes.¹⁶ We know that this can sadly lead to children dying from asthma.¹⁷ Timely and accurate diagnosis relies on access to suitable diagnostic testing, in line with NG245, and health systems must ensure that this access is equitable and universal.

Clinician education

Further to resource paucity impacting access to diagnostic testing, interviewees also revealed widespread concern about a lack of suitably trained clinicians and the impact of this on the provision of high quality asthma care.

“I think we need greater support for patients and for healthcare professionals for the changes in terms of education and resources”

“I think it's all in the healthcare professional education.”

One clinician explained that staff concerns cannot be overcome by NG245 alone, and that staffing shortfalls and the cost of clinician training remain “hurdles that are too high.” Appropriately trained staff are an essential part of NG245's implementation, and are crucial for the provision of high quality asthma care. Health systems must prioritise paid, protected training time for clinicians in order to optimise the benefits offered by implementing NG245.

In hopeful contrast, another interviewed clinician explained that they have seen the uptake of asthma training shift since NG245's publication, with more requests for training now coming from GPs whereas previously this cohort had been, in the clinician's view, less likely to engage. This shift is essential for full implementation of NG245, and universal access to appropriately trained clinical staff is as important as access to necessary diagnostic testing. Where clinicians are unable to implement NG245's diagnostic pathway correctly because of a lack of adequate education, people with asthma will see delays to diagnosis and similar delays to optimised treatment. This drives worsening health outcomes and increased care costs brought about by an increased risk of exacerbation, hospitalisation and death.¹⁸

Clinician confidence

Interviewees have shown that clinician confidence stems from adequate familiarity with NG245 and from adequate clinician education on how best to implement the guideline. As such, the case for clinician education is made even clearer: clinician education can instil increased clinician confidence by outlining how to correctly implement NG245, leading to a more streamlined use of the diagnostic pathway. This would reduce unnecessary referrals for confirmation of diagnosis, potentially decreasing the time needed to confirm an asthma diagnosis and, in doing so, increasing diagnostic capacity.

In addition to the need for suitable training in order to ensure clinician competence, many interviewed clinicians also highlighted the importance of training in order to improve clinician *confidence*, particularly with reference to assessing and using a patient's full clinical history to contextualise objective test results.

"There's quite a skill set for clinical history taking. Diagnosing asthma is quite complex."

"There is a huge educational need out there for understanding proposed changes for managing asthma and proposed changes for diagnosing asthma."

"We need confident, competent healthcare professionals."

While many interviewed clinicians expressed concern about staff ability to confidently apply a patient's clinical history, one clinician explained that they have already noticed a reduction in the number of patients being referred to secondary care for a confirmation of their asthma diagnosis, suggesting regionalised success.

Another interviewed clinician explained that clinician confidence has broader systemic benefits, and that when clinicians are suitably trained and know how best to provide care, they are more likely to undertake "change and quality improvement projects," potentially becoming an advocate for improving respiratory care quality.

Recommendations

1. Ensure health systems provide access to comprehensive diagnostic testing within primary care, in line with NG245, by improving access to key tests for all adults and children:
 - a. Providing access to point-of-care FeNO testing in all Primary Care Networks (PCNs). This is essential for the optimal diagnosis of asthma in children and young people, and improved access will also have benefits for adults.
 - b. Maintaining funding for ongoing FeNO costs, including for paid, protected staff training, consumables such as mouthpieces, and FeNO machine maintenance.
 - c. Commissioning quality assured spirometry services, ensuring every health system has adequate access and sufficient capacity to support their local population.
 - d. Expanding quality assured spirometry provision for diagnosing asthma in children and young people to ensure access improves alongside spirometry access for adult diagnosis.
2. Upskill clinicians to improve their competence and confidence in assessing and using patients' full clinical histories prior to objective testing.

Treatment

“Absolute game changer”

Among NG245’s most significant changes to asthma care is its recommended treatments for asthma, introducing Anti-inflammatory Reliever (AIR) and Maintenance and Reliever Therapy (MART) regimes, dependent on the frequency and severity of their symptoms, as the initial management for newly-diagnosed people aged 12 and over.¹⁹ Interviewed clinicians universally praised this element of the guideline and welcomed AIR and MART as a long-overdue feature of the UK’s asthma guidance: an “absolute game changer.”

Across most interviews, clinicians agreed that patients don’t object to AIR or MART outright, with one clinician summarising that both regimes are “very acceptable to patients.” Clinicians agreed that the acceptability of AIR and MART is dependent on the quality of the inhaler switching care provided to the patient when their treatment is amended. Where patients are well supported, they are more likely to adhere to their new medication and not seek to revert to their previous treatment; where switching care is poor, the opposite is true.

Optimal inhaler switching care is therefore key to NG245’s implementation. Multiple clinicians detailed their

“When patients are educated correctly and they understand, [switching inhaler] is acceptable to them.”

“The difficulties arise if they’ve just been changed without proper explanations.”

approach, highlighting respectful and collaborative communication with the patients as a common theme. One clinician explained:

“I always describe [switching to AIR or MART] as an upgrade to their existing inhalers. Rather than saying ‘I’m stopping your blue inhaler and I’m giving you this instead,’ I’m upgrading your inhaler to something that does everything that your current inhaler does and more.”

Another clinician discussed what they saw as a common patient concern: that patients believe their treatment is being amended in order to reduce NHS costs. While patients that use high levels of SABA are associated with higher care costs, this is because their condition is more poorly managed and they are over three times as likely to be admitted to hospital as a result of their asthma.²⁰ This patient concern was raised in multiple clinician interviews, and tackling it, along with other patient concerns and queries is central to providing good inhaler switching care.

Across these examples, it’s clear that clinicians need to be trained and confident in supporting people through having their inhaler switched in order to get the best from AIR and MART regimes. This means pre-empting and addressing patient concern, and providing gold-standard inhaler switching care to support the patient and improve treatment adherence.

“People don’t like having things taken away, so I always describe [inhaler switching] as an upgrade to their existing inhalers, rather than ‘I’m stopping your blue inhaler and giving you this instead’.”

SABA reduction

The clinicians interviewed were confident about NG245’s role in reducing SABA prescribing. Clinicians, including those leading SABA-reduction work in their ICB, highlighted that the guideline has supported pre-existing SABA-reduction efforts, and has made a considerable impact on the prescribing of medication for newly-prescribed people over the age of 12.

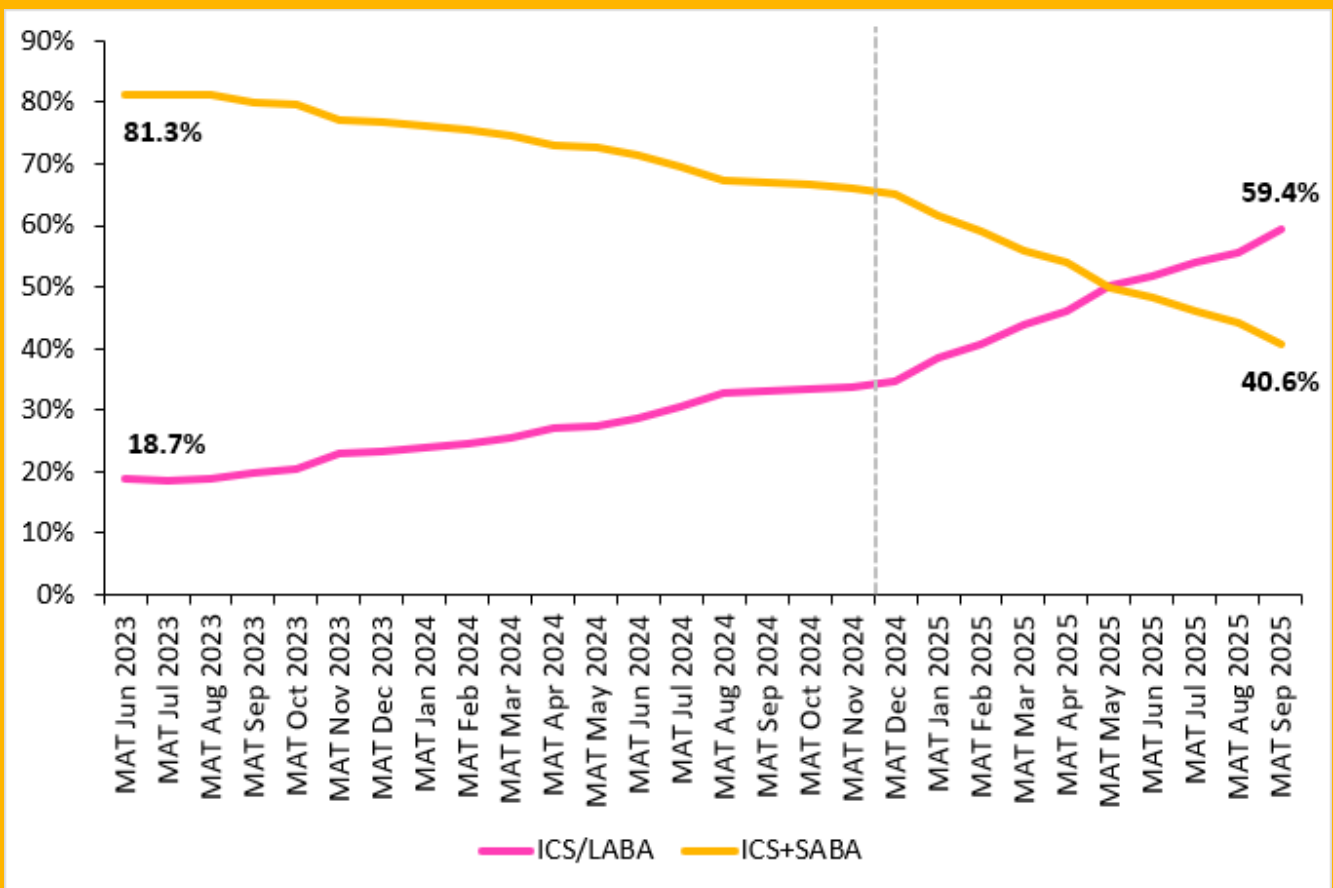
“There’s a duty of care to make sure the patient’s discharged with the correct medication”

Clinicians explained that the move away from SABA inhalers is widespread, with one explaining of their ICB “we’re coming away from salbutamol only monotherapy, which is another big win.” Promisingly, clinicians also explained that they have seen a reduction in the rate of asthma exacerbations, suggesting that amendments to treatment are improving people’s condition control.

SABA’s changing role²¹

Since NG245’s publication in November 2024 – shown on the chart by a vertical dotted line - we know that prescribing for people who have been diagnosed with asthma has changed significantly.

This chart shows the moving annual total (MAT) for new prescriptions of inhaled corticosteroids (ICS) with a long-acting beta agonist (LABA), and for ICS with SABA. In the MAT June 2023, a new person diagnosed with asthma was four times more likely to be prescribed a SABA-based regime than either AIR or MART (81.3% versus 18.7%). By MAT June 2025, this rate had inverted, with 51.7% of new people diagnosed with asthma being prescribed either AIR or MART, while SABA-based regimes had dropped to 48.3%.



While this data only covers new patients diagnosed with asthma, it is a sign of success for NG245’s implementation and is central to improving health outcomes for people with asthma. This data also indicates that NG245 supports existing SABA-reduction work well, and shows promising clinician awareness of new prescribing practices, and the acceptability of AIR and MART regimes by patients.

SABA prescribing in out-of-hours settings

Despite successes in SABA reduction in some settings, NG245’s implementation needs work in others. At present, when a person with asthma presents at A+E, an urgent care centre, or other out-of-hours setting, they are likely to be prescribed a SABA inhaler. Clinicians interviewed raised universal concern about how this inappropriate prescribing in out-of-hours settings undermines NG245’s recommendations for asthma treatment.

“We need to educate A&E clinicians on which inhalers to prescribe.”

“If we're able to embed the correct message A&E upfront, it makes life a lot easier.”

Inappropriate SABA prescribing puts people with asthma at considerable harm. We know that people with asthma are at increased risk of having an exacerbation when they've already had one,²² and that correct intervention immediately after they present at emergency care is crucial for preventing further harm including hospitalisation and death.²³

By being prescribed SABA inhalers in these settings, patients are let down by the system designed to care for them. We also know that follow-up appointments in primary care aren't provided as they should be, with up to 82% of people with asthma not accessing an appointment within two days of presenting at emergency care.²⁴ These appointments are essential for ensuring that the patient is recovering from their exacerbation, and to optimise their care and prevent further exacerbations and urgent care needs.

“There's very little, if not zero, guidance on aftercare or discharge from A&E.”

This inappropriate prescribing also risks reinforcing SABA-reliance, unpicking inhaler switching work done in primary care, or simply confusing people who are trying to manage their condition with whatever their clinician tells them is the most suitable treatment. As one clinician put it: “that is a complete mixed message.”

As a solution, multiple clinicians spoke about localised efforts to improve out-of-hours asthma prescribing, with most conversations focusing on emergency care discharge. Others outlined comprehensive programmes that seek to address prescribing and improve patients' adherence, championing discharge packs that include a MART inhaler, an asthma plan, a peak flow meter and Asthma + Lung UK patient-facing resources. One clinician said that the aim of these schemes is to “set people up to be on the right regime rather than just discharging them with salbutamol [SABA].” We want to see these localised efforts establish a best practice that can inform national implementation of much-needed improvements to SABA prescribing across all out-of-hours settings.

Recommendations

3. Reduce significant patient risk and improve asthma care by fully implementing NG245:
 - a. Making ICS-formoterol inhalers the standard care for adults and children aged 6 plus.
 - b. Ensure everyone with asthma who is discharged from acute care, including in primary care for an acute event, has their inhaler technique reviewed and corrected, is treated with MART or AIR where appropriate, and is given a Personalised Asthma Action Plan.
 - c. Ensure people with asthma who have had two or more emergency department or hospital admissions or exacerbation in a 12 month period are referred for specialist review.
4. Upskill clinicians in out of hours settings to urgently stop inappropriate SABA prescribing, ensuring all adults presenting because of asthma are prescribed a MART regime where appropriate.
5. Support the guideline's recommended changes to prescribing by upskilling clinicians to provide gold-standard inhaler switching care. Health systems must:
 - a. Ensure all switching is done through shared decision-making so that no patients has their inhaler switched without informed consent.
 - b. Provide in-person inhaler technique guidance alongside any switch: every patient must be shown how to use their new inhaler.
 - c. Arrange and complete clinician-initiated follow-up appointments within four to eight weeks after a person's inhaler is switched.²⁵

Conclusion

“Implementation is happening slower than we would like...”

The clinicians interviewed for this briefing outlined that NG245 has the potential to radically improve asthma care for the 7.2 million people with asthma in the UK.

Its diagnostic pathway is clear and, despite shortfalls in access to FeNO and spirometry, is improving care provision while beginning to reduce demand on secondary care in some cases. By promoting AIR and MART above SABA as the primary treatments for asthma, NG245's has brought the UK's asthma guidance in line with international best practice, and clinicians attest to seeing benefits already, with some seeing patients better controlled and less likely to face an exacerbation.

Crucially, however, these successes exist against a backdrop of systemic delay and resource paucity. For each positive note raised by clinicians during their interviews, there were many more points of concern about poor access to diagnostic testing, ongoing poor prescribing practices, and training shortfalls that worked against good implementation of NG245.

"...but hopefully accelerating."

In order to optimise asthma care in the UK, clinician concern must be met with concerted effort by health systems to improve asthma care as recommended in this briefing. Diagnostic access must be improved through blanket, national provision of point-of-care FeNO testing across all primary care networks, spirometry access in all ICBs, and essential training to upskill and instil confidence in clinicians. The expansion of access to core diagnostic testing is essential for providing adequate diagnostic capacity for children and young people.

Adherence to NG245's recommended treatment pathways is vital, and a key step in the provision of optimal for people with asthma. This means ensuring ICS-formoterol inhalers are the standard asthma treatment across all settings for adults, appropriately reducing SABA's role in line with the guideline.

Appendix 1 – list of interview questions

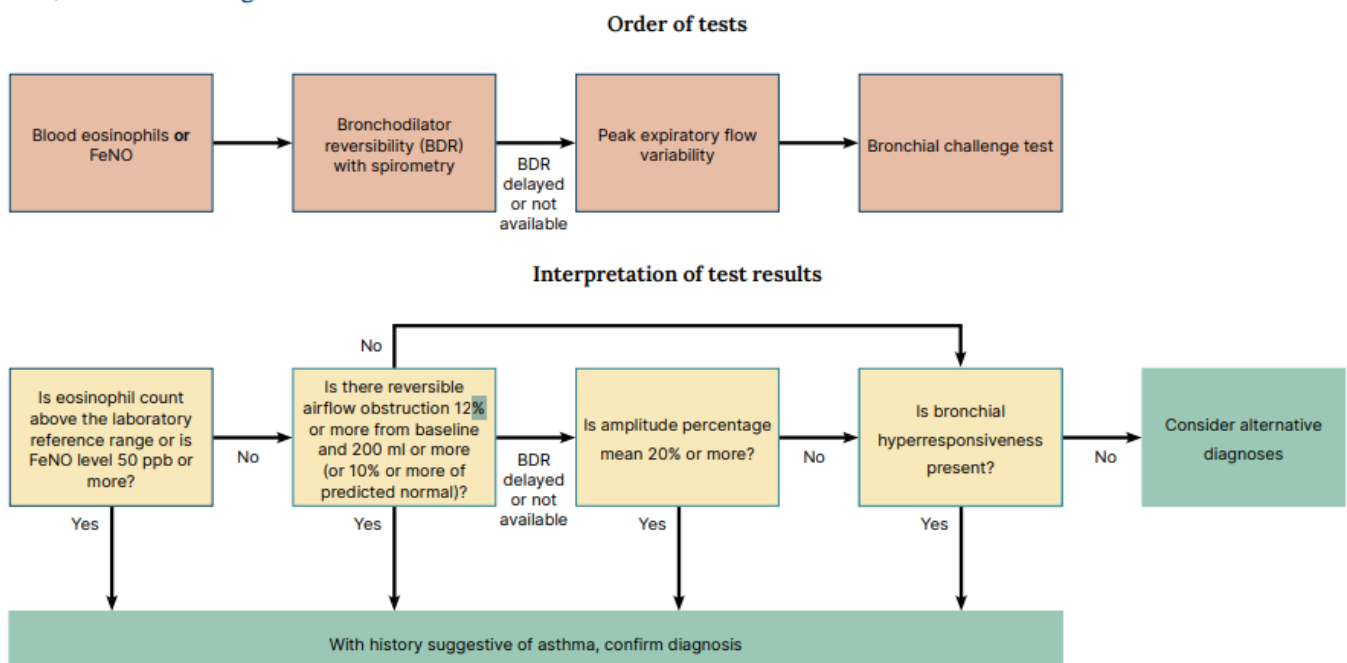
1. How would you summarise the guideline's implementation thus far?
2. How has the new diagnostic approach been implemented in your care setting?
3. What have been the key barriers to implementing the new diagnostic approach? [Potential prompt for FeNO and spirometry.]
4. What have been the benefits of the new diagnostic approach?
5. How has the guideline changed your approach to providing basic asthma care?

6. What are your thoughts on the guidelines' recommended treatments for asthma [primarily MART and AIR]?
 - a. Are the guideline-recommended treatments [primarily MART and AIR] being well accepted by patients and clinicians?
 - b. How can this acceptance/implementation be improved?
7. How has the guideline impacted SABA prescribing? [Ask further on SABA's role in CYP treatment if time allows.]
8. What would help further with implementation in the next year and beyond? [Potential prompt for specific resources, funding, just more time, etc.]

Appendix 2 – An example of the NG245 diagnostic pathway, shown here for diagnosing people aged 16 and over.

Algorithm A: Objective tests for diagnosing asthma in adults and young people (aged over 16 years) with a history suggesting asthma

BTS, NICE and SIGN guideline on asthma



NICE National Institute for Health and Care Excellence



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