London children and young people
strategic clinical network

London asthma standards
for children and young people
Driving consistency in outcomes for children and young people across the capital

June 2015
These standards bring together the aspirations for London, the NICE Asthma standards, British Thoracic Society guidelines and a number of other key resources into one document. We would like to acknowledge the work of the numerous organisations referenced throughout.

These standards have been developed through the London Strategic Clinical Network for Children and Young People’s Asthma Pathway Group and have since been reviewed by members of the SCN Strategic Clinical Leadership Group and the SCN Commissioning Advisory Group, National Paediatric Asthma Group, Royal College of Physicians, British Thoracic Society, Royal College of Anaesthetists, and Asthma UK.

We would particularly like to express our appreciation to the following:
- Dr David Finch, (Chair) Asthma pathway group, North West London Medical Director, NHS England (London region)
- Professor Andy Bush, Consultant chest physician, Royal Brompton and Harefield NHS Foundation Trust
- Dr Richard Chevasse, Respiratory paediatrician, St George’s Hospital
- Dr Rahul Chodhuri, Consultant paediatrician with an interest in respiratory medicine and allergy, Royal Free
- Colette Datt, Paediatric asthma nurse specialist, Whittington Health
- Dr Louise Fleming, Respiratory paediatrician, Brompton and Harefield NHS Foundation Trust
- Rachel Griffen, Paediatric asthma nurse specialist, Imperial Healthcare
- Dr Richard Iles, Chair, National Paediatric Asthma Collaborative, East of England
- Professor Monica Lakhanpaul, Integrated community child health, Whittington Health/UCL Institute of Child Health
- Dr Mark Levy, GP and NRAD lead
- Donal Markey, Pharmacy lead, NHS England (London region)
- Dr John Moreiras, Respiratory paediatrician, Whittington Health
- Sara Nelson, Quality improvement lead, London Children and Young People’s Strategic Clinical Network
- Tracy Parr, Lead, London Children and Young People’s Strategic Clinical Network
- Ksinsah Poonisamy, Senior policy officer, Asthma UK
- Nikola Rickards, School nurse, Islington
- Professor Russell Viner, Clinical director, London Children and Young People’s Strategic Clinical Network, and Consultant in adolescent medicine, University College Hospital
INTRODUCTION

PURPOSE
The London Strategic Clinical Network (SCN) for Children and Young People (CYP) was established to bring about transformational change in services for CYP. One of the key pieces of work it has undertaken recently has been to identify standards already in existence relating to the care of CYP. A piece of work was carried out to collate standards for acute care into one document setting out the minimum standards which should be delivered in acute services for CYP in London. In addition a piece of work has been carried out by the Primary Care Transformation group to look at a Strategic Commissioning Framework for transforming primary care.

Asthma is the most common long term medical condition in children. It is a long-term inflammatory condition that affects the airways. The usual symptoms include wheeze, difficulty in breathing, chest tightness and coughing, particularly at night or in the early hours. Its severity varies from mild, moderate to severe and can cause physical and psychological distress affecting quality of life. It cannot be cured, but with appropriate management quality of life can be improved.

The London SCN for CYP asthma pathway group were asked by the SCN CYP Commissioning Advisory Group to develop a set of standards for care of CYP with asthma and pre-school/viral induced wheeze (PSW) to complement the existing London Quality Standards, Primary Care Commissioning Framework and CYP Acute Care Standards. Currently there are many existing documents and guidance around asthma but despite this, children in London are still dying of acute asthma attacks and the basic standards are not being carried out. This document is not another set of guidelines but aims to bring together some of the principles from all the other documents to aid the implementation of them and help drive up care for children with asthma or acute viral induced wheeze in London. It should improve diagnosis, management, and continuity of care, prescribing, monitoring and education across London.

Development of the standards was informed through an extensive literature review and wide engagement that included primary and secondary care clinicians, managers, and commissioners from across London, views from professional bodies, and voluntary sector organisations. They have been endorsed by the CYP SCN Strategic Clinical Leadership Group, Commissioning Advisory Group and the Royal College of Physicians.

Utilisation of these standards will start to reduce the enormous variation in outcomes that CYP experience across the capital. In this document the term children or child should be taken as meaning children and young people under the age of eighteen years. There is a need to provide age-appropriate services and settings, particularly for those aged 16-18. Clear policies should be in place in hospitals where such people are admitted (eg paediatric wards, adult wards, or a particular adolescent ward) to avoid disputes in an accident and emergency department as to whether such a young adult is ‘paediatric’ or ‘adult’ for their medical care.

From this point forward we will use the term asthma but these standards also apply to those children (over the age of 1) with viral induced wheeze or any other acute wheezy episode.

SUMMARY
Each organisation (primary and community care, acute care, pharmacy, schools, social care, prisons and young offenders units) will have a clear named lead who will be responsible and accountable for asthma (which includes children) and the delivery of London’s Ambitions for Asthma.
AUDIENCE
This document will be of use to commissioners and providers of asthma services for CYP. It sets out our aspirations for CYP asthma care in London alongside the NICE quality standards (NICE, 2013)\(^3\) to enable the effective commissioning of services which meet these required minimum standards. Providers will be able to use these to undertake self-assessment of their ability to deliver the required quality of care for CYP with asthma. The standards can be used to validate, challenge and to quality assure services. It is also suggested that clinical commissioning groups (CCGs) sign the Asthma UK pledge to implement the NICE quality standards within the next three years.

INCLUSIONS
The standards outlined represent the minimum quality of care that CYP with asthma in London should expect whether they are being cared for in the community, hospital or school setting. All standards apply to all seven days of the week with no difference in the provision of services during the week compared to those at the weekend. All services must meet the Care Quality Commission’s (CQC) 16 essential standards of quality and safety (CQC, 2010)\(^4\).

EXCLUSIONS
All specialised services are additionally commissioned against the appropriate national specialised service specification. Severe asthma is currently commissioned as part of specialised paediatric services. These standards are an adjunct to the requirement of the service specifications and should be used in conjunction with them. Any standards relating to general, community or hospital requirements are not included (ie safeguarding, staff appraisal policies, medical devices standards, moving and handling competencies, service-specific competency frameworks and professional body guidance on professional standards).

POPULATION BASED NETWORKS FOR CYP
The CYP SCN has identified that some of the issues in delivering effective healthcare to CYP arise because of the fragmentation of services and the lack of integration of providers. This applies to services in primary, community, secondary, and tertiary care.

Analysis of serious incidents by the CYP SCN has shown that CYP are often subject to a failure of care when moving across care settings. More effective linkage of providers and commissioners would help to reduce these issues. A model of population-based networks based on linkages between providers and commissioners across all settings is the SCN’s proposal to address these issues. This is strongly aligned with the recently published *Five year forward view* (NHS England, 2014)\(^5\). This acknowledges the traditional divide between different parts of the health system which act as a barrier to co-ordination and personalisation of care. It recommends dissolving these boundaries to ensure more effective co-ordination of care. New models will emerge and the SCN is keen that care for CYP is central to these developments.

In conjunction with this asthma care should also be developed utilising a network model approach either as a subgroup of a regional children’s healthcare network or through more localised borough based networks and as a minimum a network of peers for sharing best practice.

FURTHER STANDARD DEVELOPMENT
The SCN is aware that the standards developed so far do not describe all areas of care for CYP. It will continue to develop additional standards across a variety of care settings. Community standards will be the next area of work for the CYP SCN.

Overall care must be based on the United Nation Convention on rights of a child which says that every child has the right to:
- A childhood (including protection from harm)
- Be educated (including all girls and boys completing primary school)
- Be healthy (including having clean water, nutritious food and medical care)
- Be treated fairly (including changing laws and practices that are unfair on children)
- Be heard (including considering children’s views)
LONDON’S AMBITIONS FOR ASTHMA CARE

Each organisation (primary and community care, acute care, pharmacy, schools) will have a clear named lead who will be responsible and accountable for asthma (which includes children) and the delivery of the following:

**Proactive care**

Every child with asthma should:

» Have access to a named set of professionals working in a network who will ensure that they receive holistic integrated care which must include their physical, mental and social health needs.

» Be supported to manage their own asthma with the help of their family including access to advice and support so they are able to lead lives free from symptoms.

» Grow up in an environment that has clean air that is smoke free.

» Have access to an environment that is rich with opportunities to exercise.

**Accessible care**

Every child with asthma should:

» Have their diagnosis and severity of wheeze established in a timely fashion.

» Have prompt access to their inhaler device and other medicines and asthma care advice from trained named professionals or asthma champions in school.

» Have access to immediate medical care, advice and medicines in an emergency.

» Have access to high quality, evidence based care from primary, secondary and tertiary healthcare professionals within a timely manner, 24 hours a day, seven days a week.

**Co-ordinated care**

Every child with asthma should:

» Be enabled to manage their own asthma by having access to a personalised, interactive, evidenced based asthma management plan linked to their medical record which they understand.

» Have a regular structured review by trained healthcare professionals at least yearly or every three months, depending on control, and within two working days after an exacerbation.

» Have access to a commissioned package of care which includes educational packages, self-management tools and access to peer support.

» Be able to expect all professionals involved in their care to share clinical information in real time to ensure seamless care.

» Have access to a structured, formalised transition processes from child to adult care to ensure children don’t fall between the gaps.
**A. ORGANISATION OF CARE**

**Standard**

*Evidence*

1. All organisations/services must have a named lead responsible and accountable for asthma (which includes CYP).

2, 3, 6, 10, 11, 14, 30, 44

- Governing structure which states the asthma lead.
- Quarterly review.
- Yearly submission to BTS Audit (November).
- Number of follow-ups 6 months after an emergency admission.
- Number of CYP admitted to PICU and HDU.
- Number of prescriptions of inhaled steroids.
- Number of CYP with asthma plans.
- Number of CYP with asthma.
- General care.
- Activities of the following in primary, secondary and tertiary care settings: school asthma database.
- Electronic templates.
- Severe asthma register.
- GP practice children's asthma register.
- School asthma register.
- PICU and HDU.
- Number of annual reviews.
- Number of annual reviews.
- Progress reports to CCGs and trust board as required.
- Participation in network meetings.
- Shared network protocols and guidelines for diagnosis, treatment and care.
- Regular assessment of performance in place.
- Examples of measures to improve service delivery.
- Workforce planning.
- Regular assessment of performance in place.
- School nurses' training and care.
- Shared network protocols and guidelines for diagnosis, treatment and care.
- Progression in network meetings.
- Accountability of the group.
- Network terms of reference, membership and accountability.
- Terms of reference, membership and accountability.

1, 2, 3, 6, 9, 10, 11, 14, 30, 44

- There is evidence of collaboration between all sectors including local children's safeguarding boards.
- There is evidence of shared pathways, protocols and consider workforce planning.
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A. Organisation of Care

Evidence

Ref

Standard

1. Organisation has, or is moving towards, a strategy that ensures communication / interoperability between diverse IT systems in hospital, community, pharmacy and any CYP healthcare setting. It uses a unified clinical record throughout the patient's journey, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the care pathway (community to tertiary) and allows for service audit. This includes the ability to flag / code any concerns (eg any child subject to plan). Cultural beliefs of the child and family must be taken into consideration.

2. Strategy available for information systems which facilitate seamless care packages across the pathway.

3. Up-to-date unified record being used by all staff and electronic transfer of information for organisations such as schools and pharmacy.

4. There is access to recording physiologic and other support services for families.

5. There is access to smoking cessation clinics and other support services for families.

6. Every child and their family are assessed for their health or social care needs and smoking status.

7. Every child has an assessment of the triggers for their wheeze and is educated about how to deal with this.

8. Children with asthma should be screened for other atopic comorbidities, in particular allergic rhinitis and food allergy.

9. There is access to a paediatric allergy service for assessment and appropriate management, including adrenaline auto injector device prescription and training if required.

10. Every child has an assessment of their long term health, including a systematic approach to obesity (eg growth measurement, calculation of BMI).

11. Every child is assessed at health or social care encounters for their exposure to smoking either actively or passively (this includes e-cigarettes). They should be provided with brief advice and referred to smoking cessation clinics.

12. There is access to smoking cessation clinics and other support services for families.

13. Numerator – Number of people in the denominator who smoke.

14. Denominator – Number of people in the denominator who smoke.

15. Service specification or contract.

16. Audit of referrals and number accessing services.

17. Service specification of contacts and pathway.


20. Service specification of contacts and pathway.


22. Service specification of contacts and pathway.

23. Service specification of contacts and pathway.


25. Service specification of contacts and pathway.


27. Service specification of contacts and pathway.

28. Service specification of contacts and pathway.
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<thead>
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<tbody>
<tr>
<td>B.</td>
<td>PATIENT AND FAMILY SUPPORT, INFORMATION PROVISION AND EXPERIENCE</td>
<td>3, 13, 16, 28, 30, 31</td>
</tr>
<tr>
<td></td>
<td>This should not only include the experience of the patient and carer going through the service, but also demonstrate how they are involved in the assessment, running and development of any future service.</td>
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<tr>
<td>10</td>
<td>The organisation participates in Routine NHS surveys for CYP (eg CCG National Inpatient Survey)</td>
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<td>9</td>
<td>CYP and their families are actively involved in reviewing local service provision and giving feedback on services to improve patient experience.</td>
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<tr>
<td>11</td>
<td>CYP and their families receive sufficient information, education and support to encourage participation in relevant consultations.</td>
<td>6, 29, 30</td>
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<tr>
<td>12</td>
<td>CYP and their families have access to self-management support packages which may include peer support.</td>
<td>1, 28</td>
</tr>
<tr>
<td>13</td>
<td>NICE Statement 4: People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment. (This should be age appropriate.)</td>
<td>3, 13</td>
</tr>
<tr>
<td>14</td>
<td>NICE Statement 5: Information and advice is given and accessible to all patients (including those with learning disabilities).</td>
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<tr>
<td>15</td>
<td>NICE Statement 6: CYP and their families receive sufficient information, education and support to encourage participation in relevant consultations.</td>
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<td>15</td>
<td>NICE Statement 6: CYP and their families receive sufficient information, education and support to encourage participation in relevant consultations.</td>
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</tbody>
</table>
### Diagnosis can be difficult in CYP

NICE Statement 1: People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance, and that the process is documented in their patient notes.

<table>
<thead>
<tr>
<th>Structure</th>
<th>Evidence of local arrangements to ensure people with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance, and that the process is documented in their patient notes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>Proportion of people with newly diagnosed asthma whose notes describe the process, as outlined in the BTS/SIGN guidance, by which the diagnosis was made.</td>
</tr>
</tbody>
</table>

#### NICE Statement 6

NICE Statement 6: People with asthma who present with respiratory symptoms receive an assessment of their asthma control.

<table>
<thead>
<tr>
<th>Structure</th>
<th>Evidence of local arrangements to ensure people with asthma presenting with respiratory symptoms receive an assessment of their asthma control.</th>
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<tbody>
<tr>
<td>Process</td>
<td>Proportion of people with asthma presenting with respiratory symptoms who receive an assessment of their asthma control.</td>
</tr>
</tbody>
</table>

#### NICE Statement 10

NICE Statement 10: People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode are followed up by their own GP practice within two working days of treatment. If required secondary care follow up is provided within one month for severe childhood asthma and for patients who have experienced the past 12 months during which they have attended the emergency department two or more times in the past 12 months.

<table>
<thead>
<tr>
<th>Structure</th>
<th>Evidence of local arrangements and systems put in place to ensure people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode are followed up by their own GP practice within two working days of treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>Proportion of people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode who are followed up by their own GP practice within two working days of treatment.</td>
</tr>
</tbody>
</table>

#### NICE Statement 14

NICE Statement 14: People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN and NICE guidance.

<table>
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<tr>
<th>Structure</th>
<th>Evidence of local arrangements to ensure people with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN and NICE guidance.</th>
</tr>
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<tbody>
<tr>
<td>Process</td>
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</table>

Days for follow up by their own GP practice within 2 working days of treatment.
### D. SCHOOLS

<table>
<thead>
<tr>
<th>Standard Evidence Ref</th>
<th>32</th>
<th>39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear effective partnership arrangements are in place between health, education and local authorities for management of CYP with asthma within primary and secondary schools (Asthma friendly schools programmes).</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate local policies and procedures and NICE guidance which incorporates NICE Asthma friendly schools programmes.</td>
<td>17</td>
</tr>
<tr>
<td>Education programme for staff, students and parents.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
<td>6, 7, 36</td>
</tr>
<tr>
<td>Directory of updated asthma leads shared between organisations.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
<td>13, 35, 36, 37, 38</td>
</tr>
<tr>
<td>Student in care: evidence to demonstrate effective implementation of national standards and regulations, and education and training for all staff, students and senior management to improve asthma care.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
<td>1, 11, 39</td>
</tr>
</tbody>
</table>

### E. ACUTE CARE

<table>
<thead>
<tr>
<th>Standard Evidence Ref</th>
<th>36, 7, 10, 13, 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CYP who present in an emergency are managed according to local policies and procedures and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
</tr>
<tr>
<td>The organisation complies with existing standards, such as the London Quality Standards, such as the London Quality Standards and safeguarding policies.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
</tr>
<tr>
<td>CYP have an Individual healthcare /action plan in place.</td>
<td>» Joint policy and protocols and NICE guidelines which incorporate NICE Asthma friendly schools programmes.</td>
</tr>
</tbody>
</table>

### Ref
- 32: 10, 13, 36, 39
- 39: 37, 39, 38
- 36, 7, 10, 13, 32: 32, 33, 36, 39

### 77
- 1, 11, 39: 36, 39, 38
NICE Statement 7: People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.

**Structure:** Evidence of local arrangements to ensure people with asthma presenting with an exacerbation of their respiratory symptoms receive an objective measurement of severity at the time of presentation.

**Process:** Proportion of people with asthma presenting with an exacerbation of their respiratory symptoms who receive an objective measurement of severity at the time of presentation.

Numerator – Number of people in the denominator receiving an objective measurement of severity at the time of presentation.

Denominator – Number of people with asthma presenting with an exacerbation of their respiratory symptoms.

NICE Statement 8: People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation and seen by the respiratory team directly.

**Structure:** Evidence of local arrangements to ensure people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation.

**Process:** Proportion of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma who receive oral or intravenous steroids within one hour of presentation.

Numerator – Number of people in the denominator receiving oral or intravenous steroids within one hour of presentation.

Denominator – Number of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma.

NICE Statement 9: People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

The structured review includes:

1. Assessment of control (Children's Asthma Control Test (ACT) if aged over 4 years and/or lung function for wheeze).
2. Inhaler techniques.
3. Self-management and how to manage acute exacerbations.
4. Personal asthma action plan.
5. Assessment of control (Children’s Asthma Control Test (ACT) if aged over 4 years and/or lung function for wheeze).
6. Inhaler techniques.
7. Self-management and how to manage acute exacerbations.
8. Personal asthma action plan.

**Structure:** Evidence of local arrangements to ensure people admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

**Process:** Proportion of people admitted to hospital with an acute exacerbation of asthma who receive a structured review by a member of a specialist respiratory team before discharge.

Numerator – Number of people in the denominator receiving a structured review by a member of a specialist respiratory team before discharge.

Denominator – Number of people discharged from hospital after admission for an acute exacerbation of asthma.
### High Risk Care

<table>
<thead>
<tr>
<th>Standard</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2, 3, 6, 13</td>
<td>There are systems in place in acute and community care for identifying patients at high risk, poorly controlled or severe asthma and monitoring/tracing and managing those CYP who have:</td>
</tr>
<tr>
<td></td>
<td>» More than one admission.</td>
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<tr>
<td></td>
<td>» Admission to HDU, ICU, PICU.</td>
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<tr>
<td></td>
<td>» Two or more attendances to the emergency department or out of hours care in the last year.</td>
</tr>
<tr>
<td></td>
<td>» Two or more unscheduled visits to the GP (requiring short courses of oral steroids).</td>
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<tr>
<td></td>
<td>» Ten or more salbutamol inhalers.</td>
</tr>
<tr>
<td></td>
<td>» 80 per cent or less uptake of repeat preventer prescriptions.</td>
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<tr>
<td></td>
<td>System in place to identify and manage high risk patients and ongoing audit to demonstrate effectiveness.</td>
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<tr>
<td></td>
<td>» High risk register.</td>
</tr>
<tr>
<td></td>
<td>» Evidence of inhaler technique medication reviews.</td>
</tr>
<tr>
<td></td>
<td>» Audit data demonstrating numbers of:</td>
</tr>
<tr>
<td></td>
<td>» Referrals onto secondary/tertiary care.</td>
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<td></td>
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<thead>
<tr>
<th>15, 27</th>
<th>G. Integration and Care Co-ordination</th>
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<tbody>
<tr>
<td>118</td>
<td>NICE Statement 3: People with asthma receive a written personalised action plan.</td>
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<tr>
<td>2, 3, 6, 13</td>
<td>Provided specialist advice and help to discharge procedures between community and specialist care including shared care, referral and access to secondary or tertiary care.</td>
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<td>202</td>
<td>Services for children, young people and their families should be provided by a range of health and social care professionals and agencies working collaboratively to ensure the highest standard of care for children and young people at all times.</td>
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<tr>
<td>220</td>
<td>Service specification or contract.</td>
</tr>
<tr>
<td>220</td>
<td>» Shared care, referral and discharge pathways and policies.</td>
</tr>
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| 2, 3, 6, 13 | Structure: Evidence of local arrangements to ensure people with asthma receive: |
| 2, 3, 6, 13 | » High risk register. |
| 2, 3, 6, 13 | » Evidence of inhaler technique medication reviews. |
| 2, 3, 6, 13 | » Audit data demonstrating numbers of: |
| 2, 3, 6, 13 | » Referrals onto secondary/tertiary care. |
| 2, 3, 6, 13 | » CYP admitted with asthma and frequency. |
| 2, 3, 6, 13 | » CYP on high risk register. |
| 2, 3, 6, 13 | » Patients admitted to HDU / PICU / ICU in the last year. |
| 2, 3, 6, 13 | » Repeat attenders to A&E / GP practice. |
| 2, 3, 6, 13 | » Children with 10 or more salbutamol inhalers. |
| 2, 3, 6, 13 | » Repeat preventer prescription. |

| 220 | Process: |
| 220 | a) Proportion of people with asthma who receive a written personalised action plan. |
| 220 | b) Proportion of people treated in hospital for an acute exacerbation of asthma who receive a written personalised action plan before discharge. |
| 220 | Numerator – Number of people treated in hospital for an acute exacerbation who receive a written personalised action plan. |
| 220 | Denominator – Number of people in the denominator receiving a written personalised action plan. |
| 220 | Structure: Evidence of local arrangements to ensure people with asthma receive: |
| 220 | » High risk register. |
| 220 | » Evidence of inhaler technique medication reviews. |
| 220 | » Audit data demonstrating numbers of: |
| 220 | » Referrals onto secondary/tertiary care. |
| 220 | » CYP admitted with asthma and frequency. |
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| 220 | » Repeat attenders to A&E / GP practice. |
| 220 | » Children with 10 or more salbutamol inhalers. |
| 220 | » Repeat preventer prescription. |

| 24 | Identifying patients at high risk. |
| 24 | Poorly controlled or severe asthma and managing those CYP who have: |
| 24 | » More than one admission. |
| 24 | » Admission to HDU, ICU, PICU. |
| 24 | » Two or more attendances to the emergency department or out of hours care in the last year. |
| 24 | » Two or more unscheduled visits to the GP (requiring short courses of oral steroids). |
| 24 | » Ten or more salbutamol inhalers. |
| 24 | » 80 per cent or less uptake of repeat preventer prescriptions. |

| 25 | There is access to specialist physiotherapist with an interest in functional breathing (ideally able to direct refer from primary care). |
| 25 | Service specification or contract. |
| 25 | » Shared care, referral and discharge pathways and policies. |
| 25 | » Proven specialist advice and help to discharge procedures between community and specialist care including shared care, referral and access to secondary or tertiary care. |
| 25 | Services for children, young people and their families should be provided by a range of health and social care professionals and agencies working collaboratively to ensure the highest standard of care for children and young people at all times. |
| 25 | There are agreed effective integrated pathways to ensure the smooth transition between healthcare settings (e.g. primary care to secondary or tertiary care). |

| 27 | NICE Statement 3: People with asthma receive a written personalised action plan. |
| 27 | (This should be age appropriate.) |
| 27 | Structure: Evidence of local arrangements to ensure people with asthma receive: |
| 27 | » High risk register. |
| 27 | » Evidence of inhaler technique medication reviews. |
| 27 | » Audit data demonstrating numbers of: |
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| 27 | » Repeat preventer prescription. |
Integration and Care Coordination

Services for children, young people and their families should be provided by a range of health and social care professionals and agencies working collaboratively to ensure the highest standard of care for children and young people at all times.

**Structure:** Evidence of local arrangements to ensure people with asthma receive a proactive structured review at least annually.

**Process:** Proportion of people with asthma who receive a structured review at least annually.

Numerator – Number of people in the denominator who had a structured review within 12 months of the last review or diagnosis.

Denominator – Number of people with asthma.

Monitoring QOF exception rates.

**Evidence:** Evidence of local arrangements to ensure people with difficult asthma receive an assessment by a multidisciplinary difficult asthma service.

**Process:** Proportion of people with difficult asthma who receive an assessment by a multidisciplinary difficult asthma service.

Numerator – Number of people in the denominator receiving an assessment by a multidisciplinary difficult asthma service.

Denominator – Number of people with difficult asthma.

There is a system to communicate the name of the responsible lead / link person caring for children to patients and families.

Audit of CYP to see if they know who is their link person.
DISCHARGE / CARE PLANNING

Discharge and care planning should commence on admission in order to provide a smooth transfer of care back to primary care or further care as appropriate.

Standard

Evidence

Ref

Systems are in place to ensure safe discharge and transfer between providers. This includes the following:

- All admitted CYP have discharge planning and an estimated discharge date as part of their management plan as soon as possible.
- The primary care team / GP is informed of discharge within agreed timescale of each attendance and follow up is booked within two days (including health visitor and school nurse).
- Information is provided to GP and community teams electronically within 24 hours.
- Clear written information and advice is provided to families which includes what to do, when and where to access further care if necessary, clear instructions on follow up and arrangements in case of emergency at home. This includes telephone advice.
- Pharmacies ensure availability of medicines and utilisation of home delivery services. This is of greater relevance for weekend discharge.
- Telephone advice offered / feedback from patients / supporters / description of telephone follow up service and GP links.
- Audit of notes (discharge planning and timelines).
- Discharge information provided within 24 hours.
- System in place for follow up within two days.
- Discharge information provided within 24 hours.
- Auditor notes (discharge planning and timelines).
- Telephone advice offered / feedback from patients / supporters / description of.

I. TRANSITIONAL CARE

Transition to adult services should be seamless as possible for the young person. It may commence from age 12 onwards and last until 25 depending on child’s needs or condition. It requires careful planning and collaborative working between the child / young person, adolescent services and adult services. The process of transition is expected to take longer where a child has multiple, complex needs, but the key feature of transition is that care should remain flexible at all times.

There is a clear lead clinician responsible for transition planning and preparation for the transition to adult service.

- Operational policy for paediatric service.
- Identified lead (role identified in job plan and appraised).
- Transition policy and pathway of care available.
- Written handover.
- Transition is properly planned and a named key worker is appointed.

Transition to adult services should be seamless as possible for the young person. It may commence from age 12 onwards and last until 25 depending on child’s needs or condition. This is of greater relevance for weekend discharge. This includes telephone advice.

- Pharmacies ensure availability of medicines and utilisation of home delivery services. This is of greater relevance for weekend discharge.
- Telephone advice offered / feedback from patients / supporters / description of telephone follow up service and GP links.
- Audit of notes (discharge planning and timelines).
- Discharge information provided within 24 hours.
- System in place for follow up within two days.
- Standard written discharge information is available.
- Discharge information provided within 24 hours.
- Auditor notes (discharge planning and timelines).
- Telephone advice offered / feedback from patients / supporters / description of.
I. TRANSITIONAL CARE

Transition to adult services should be as seamless as possible for the young person. It may commence from age 12 onwards and last until 25 depending on child and/or condition. It requires careful planning and collaborative working between the child, young person, adolescent services and adult services. The process of transition is expected to take longer where a child has multiple, complex needs, but the key feature of transition is that care should remain flexible at all times. There is a shared protocol between children's and adult services to develop local prescribing guidelines to support evidence-based care for CYP.

J. EFFECTIVE AND CONSISTENT PRESCRIBING

There are systems in place to:

- Identify, monitor, and manage through an alert system to clinicians the numbers of prescriptions for prednisolone, inhaled steroids, 10 or more preventer inhalers in a year, children with asthma and flu jab uptake.
- Identify and manage CYP prescribed inhalers at doses higher than recommended in product licence.
- Modules: PROVIDE training in respiratory guidelines and support adherence to MURs and new medicine reviews for to promote medicines optimisation including inhaler technique assessment for CYP.
- Note: Reviews with parents for younger children: PSNC guidance states the patient must be competent to give consent to receive the service and to share information as required by the consent arrangements in order to receive the service. There is no minimum age, but pharmacists will know that the younger the child, the greater the likelihood is they would not be competent to give consent for the service to receive the service and share information as required by the consent arrangements. In order to be eligible to receive the service, there is no minimum age, but the patient must be competent to give consent for the service and share information as required by the consent arrangements. In order to be eligible to receive the service, there is no minimum age, but the patient must be competent to give consent for the service and share information as required by the consent arrangements.
- Use of CCG medicines management teams to develop local prescribing guidelines to support effective care for CYP.
- Co-ordination between CCG medicines management pharmacists, secondary care pharmacists and community pharmacists to monitor adherence to national and local prescribing guidelines and to promote medicines optimisations initiatives throughout the community pharmacy and community pharmacies to monitor and promote medicines optimisation initiatives through joint working.
- Operative policy for paediatric asthma service.
- British National Formulary for children available.
- Processes in place to minimise errors, reporting and review of errors and near misses and to support adherence to CQC standards in medicines management in primary and secondary care settings.
- "Thursdays out patient clinics to monitor near misses and medication errors in primary and secondary care settings."
- "Developing and implementing improved education and learning resources to support adherence to national and local prescribing guidelines."
- "Modules: PROVIDE training in respiratory guidelines and support adherence to MURs and new medicine reviews for to promote medicines optimisation including inhaler technique assessment for CYP."
- Notification of changes in treatment to all services should be seamless as possible for the young person. This may commence from age 12 onwards and last until 25 depending on child and/or condition. If a child has multiple, complex needs, the process of transition is expected to take longer where a child has multiple, complex needs, but the key feature of transition is that care should remain flexible at all times.
There is access to multidisciplinary team for advice, diagnostics and management support.

Evidence: 

Service specification, job roles and rotas...
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Asthma Control Test</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and emergency</td>
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<tr>
<td>BHfL</td>
<td>Better Health for London</td>
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<tr>
<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>BTS</td>
<td>British Thoracic Society</td>
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<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
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<tr>
<td>CEM</td>
<td>Centre for Evaluation and Monitoring</td>
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<tr>
<td>CYP</td>
<td>Children and young people</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>FEV1</td>
<td>Forced expiratory volume</td>
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<tr>
<td>GINA</td>
<td>Global Initiative on Asthma</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HDU</td>
<td>High dependency unit</td>
</tr>
<tr>
<td>MUR</td>
<td>Medicines use review (Pharmaceutical Advanced Service)</td>
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<tr>
<td>NMS</td>
<td>New medicine service (Pharmaceutical Advanced Service)</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NRAD</td>
<td>National Review of Asthma Deaths</td>
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<td>OPD</td>
<td>Outpatient department</td>
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<tr>
<td>PICU</td>
<td>Paediatric intensive care unit</td>
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<tr>
<td>PSNC</td>
<td>Pharmaceutical Services Negotiating Committee</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<td>RCA</td>
<td>Royal College of Anaesthetists</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>RCPCH:</td>
<td>Royal College of Paediatrics and Child Health</td>
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<tr>
<td>SCN</td>
<td>Strategic clinical network</td>
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<tr>
<td>SI</td>
<td>Serious incident</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
</tbody>
</table>
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Education for health free asthma module training tool
Working in conjunction with the George Coler Memorial Fund, Education for Health has developed this free online educational resource ‘Supporting Children’s Health’. The online resource provides basic information on how to support children and young people with asthma.
www.supportingchildrenshealth.org/asthma-module

PRIMIS
The Asthma Care audit tool has been designed to help practices to audit their clinical data helping them to optimise the management and care of patients with active asthma and reduce their risk of exacerbation and hospital admissions
www.nottingham.ac.uk/primis/tools/audits/asthma-care-audit-tool.aspx

NHS PrescQIPP
Respiratory webkit, asthma focus bulletin and inhaler technique review tools for those who prescribe, covers
» Bulletin and briefing (including implementation versions) with recommendations on NRAD.
» Pathway documents for adults, children and younger children.
» Audit tools, including auto system searches for SystmOne and EMIS.
» Patient materials.
» Inhaler technique assessment tools for nine different kinds of inhalers.
www.prescqipp.info

Primary Care Respiratory Society UK
PCRS-UK resources have been written by authors with appropriate expertise of primary care and respiratory medicine. Resources include guidelines and guidance, opinion sheets and nurse materials.
www.pcrs-uk.org

Asthma UK
Includes pages on keeping children with asthma safe at school, featuring resources for schools, support for parents and healthcare professionals.
www.asthma.org.uk/Sites/healthcare-professionals/pages/schools-and-early-years
About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children’s Services; and Mental Health, Dementia and Neuroscience.