Asthma Sustainable Asthma Service Local Incentive Scheme Support Resource. Version 3 January 2020

Asthma SAS LIS Support Resource Version 3 January 2019

Introduction:

The Asthma Local Incentive scheme was approved by BHR CCGS on the 28th November and went live from the 1st of December 2019.
This Support Resource aims to ensure that the delivery of the LIS results in ongoing processes that improve the care of CYP with Asthma. It suggests a model of care that can be adapted for the support of other Long-term conditions for children and young people.
It presents a compilation of resources and links aimed at helping the Federations deliver the LIS and a range of materials aimed at ensuring that the LIS acts as a catalyst to bring about sustainable change in support of Asthma in Children and young People.
Crucially the LIS has been designed to provide Primary Care in BHR with practical and effective evidence-based support that will help them prevent the avoidable deaths of children and young people with asthma.
We hope you will find this useful.

Julia Cory and Daniel Devitt
BHR CCG January 2020

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1 Why did we design the LIS?

This Local incentive Scheme (LIS) has been established to support the BHR system level works aimed at improving the quality and sustainability of asthma care. Though driven by the Children and Young People (CYP) asthma agenda, and relating to CYP specifically, the LIS has been developed to ensure it is supportive of and links to improvement works underway in adult services focusing on the support available to adults with asthma. This is especially important with older children and adolescents transitioning into adulthood and the care of adult services and the key requirement of the NHS Long Term Plan to move towards delivering services from 0 to 25.

Both the historical National Review of Asthma Deaths (NRAD)[1] report and the more recent Asthma UK[2] report make clear the need to improve the provision of care available to asthmatics.

2 Asthma Deaths in BHR

The BHR system has experienced three asthma related deaths of CYP in recent years (November 2017 in Havering, December 2017 in Barking & Dagenham (B&D) and June 2018 in Redbridge).

The death of a child in B&D resulted in a Regulation 28 Prevention of Future Death Report letter[3] from the Coroner and explicitly referenced areas for development in primary care, and relationships and support available from secondary care.

3 National Context for Asthma work:

The National Review of Asthma Deaths and Asthma UK

Both the historical NRAD[4] report and the more recent Asthma UK[5] report make clear the need to improve the provision of care available to asthmatics.

Asthma UK analysed data from the Office for National Statistics (ONS) and found that:

- Deaths from asthma have risen by around a third in the last 10 years.
- More than 1,400 people died from an asthma attack in 2018 in England and Wales around an 8% increase compared to 2017
- The number of deaths has increased by 33% – up from 1,071 in 2008.
- There has been an increase in men dying from the condition, with 436 men dying in 2018 compared to 370 the previous year.

[1] See: https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths
[2] See: https://www.asthma.org.uk/about/media/news/press-release-asthma-death-toll-in-england-and-wales-is-the-highest-this-decade/
[3] See https://www.judiciary.uk/wp-content/uploads/2019/05/Sophie-Holman-2019-0035_Redacted.pdf
[4] See: NRAD ibid
[5] See Asthma UK ibid

- Overall 4.8 million people in England and Wales are thought to suffer from asthma, indicating the difficulties in definitive diagnoses and the likely scale of the asthmatic cohort.
- More than 12,700 people have died from the condition in England and Wales in the last decade.
- The figures also showed a 24% increase in asthma deaths in the South East over 12 months, rising from 191 in 2017 to 237 in 2018.
- Deaths in London rose 17% from 151 in 2017 to 176 in 2018.
- One third of childhood asthma cases are linked to air pollution

It is important to note that other recommendations, specifically those centring on the whole system, access to specialist asthma services, the child, home and family situation and multi-agency collaborative environment are also pertinent. In addition to this a recent analysis of two “near misses” or serious asthma cases indicate that the issues identified in the Regulation 28 letter persist.

4 Asthma in the Long-Term Plan (LTP):

This sets out measures to improve Respiratory health including better diagnosis of the condition, improved medicine reviews and stronger guidance for local health services to better support families living with asthma, all of which will contribute to more than three million people benefiting from improved respiratory, stroke and cardiac services over the next decade. The LTP notes that Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally. The Long-Term Plan has two central aims relevant for asthma care.

- Aims to improve the lives and outcomes of people with respiratory disease by diagnosing and treating conditions earlier and making sure that people with respiratory disease are receiving the right medication.
- Seeks to increase access to respiratory rehabilitation services to support people living with a respiratory condition to be as independent as possible and experience improved quality of life.

This LIS will provide substantial support for these central aims.

5 Delivering the SAS LIS – The CCG, Federations and Practices

With a consensus across the BHR system that a consistent system is needed to support asthma care, the LIS outlines a model for primary care that can meet the needs of CYP with asthma. It aims to promote and embed a positive culture for delivery and seeks to support a sustainable high-quality model for asthma support beyond the duration of the LIS.

Given the context of three recent deaths of CYP with asthma it is essential that BHR is able to provide primary care asthma support as outlined in this LIS to all CYP registered with a GP practice in BHR.

The delivery of the LIS will be managed by the GP Federations in the BHR system, and either all practices in a federation will sign up to the LIS directly or they will be required to consent to a Primary Care Network providing asthma care support on their behalf, with appropriate proportionate remuneration to the PCN to deliver on behalf of practices that do not engage.

Accordingly, the payment schedule has been adjusted to accommodate their role with a small additional payment available at local level to each federation to support and mobilisation in support of practice level delivery of the LIS.

An overview of the payments schedule

The LIS is well remunerated with a phased payment as set out below.
The costs of the LIS will come from Primary Care budgets and there is a commitment from Primary Care to support the funding of the full life for the scheme. Existing budgets will support delivery in 2019/20 and a commitment to fund the scheme from 2020 into 2021 has been secured.

Sums of investment by CCG	Sum of 19/20 GP Practice 50p pwp	Sum of 19/20 Federation Management Cost (10%)	Sum of 20/21 GP Practice £1 pwp	Sum of 20/21 Federation Management Cost (10%)
NHS Barking And Dagenham CCG	**£107,602**	**£10,760**	**£215,204**	**£21,520**
NHS Havering CCG	**£136,884**	**£13,688**	**£273,768**	**£27,377**
NHS Redbridge CCG	**£145,486**	**£14,549**	**£290,973**	**£29,097**
Grand Total	**£389,972**	**£38,997**	**£779,945**	**£77,994**

The payment schedule has been adjusted to accommodate the federations role with a small additional payment available at local level to each federation to support and mobilisation practice level delivery of the LIS.

Payment Schedule	Value/Rate
Requirement for practices to be engaged at Federation level to achieve funding at federation level or to allow other practices to deliver care on their behalf at Primary Care Network Level if a practice does not engage in the LIS.	100% or practices must engage **or** consent to have a Primary Care Network engage on their behalf to deliver the LIS

The schedule for payment to practices is as follows:

Element	Detail	Timescale for payment
Element 1 Development Stage	25p paid on sign up of all practices **Method**: Via Federations	Payment made by end January 2020

	25p paid on assurance all practices have completed the first element either fully or assurance there are plans in place to hold MDT meetings **Method**: Via Federations	Payment made by end March 2020
Element 2 Consistent High Quality Prescribing	40p paid on evidence that a) Practices have completed an audit to indicate excessive SABA prescribing b) Evidence that practices have changed from repeat to acute prescribing for SABA inhalers **Method:** Via Federations	End June 2020
Element 3 Development of a practice/network approach to managing asthma as a long-term condition	40p paid on evidence that at least 80% of annual reviews cover the twelve key areas as per the specification. **Method:** Via Federations	End Sept 2020
Element 4 Interface with Secondary/Tertiary Care and Follow Ups within 7 days, referrals, notifications, WNB management	20p paid on providing evidence that patient have been coded and have had a review following an acute episode. Practices have a policy/process in place to ensure this happens. Practices can evidence that they are referring those whose asthma gives cause for concern to secondary/tertiary service **Method**: Via Federations	End Dec 2020

6 The importance of this LIS to the local population and to general practice:

This new LIS is being introduced by the CCG and run through the three GP federations across BHR. Funding has been made available through a commitment to ensure that there is an equitable delivery of services reflecting local needs across the BHR system.

The LIS has been established to support the pan BHR system level works aimed at improving the quality and sustainability of asthma care. Though initially driven by the CYP asthma agenda the LIS has been developed to be ensure that it is supportive of improvements for older ages. The LIS is focussed on improving the quality and impact of care experienced by children and young people with asthma.

Through a clear vision for how asthma care could and should be delivered in BHR, the use of best practice resources, peer support, and promotion of better links between primary, secondary and tertiary care and the LIS aims to promote and embed a positive culture of high quality asthma care and ensure a sustainable model of asthma care beyond the timescale of the LIS.

Crucially we seek to fundamentally improve the relationship between primary, secondary and tertiary care to ensure that BHR is well placed to avoid any further deaths associated with childhood asthma.

In line with this and mindful of the particular complexities and clear differences between Adult and CYP facing asthma care we will seek to support both children and adolescent transitional asthma care improvement and develop a model that can with local support meet the needs of asthmatics across BHR.

7 BHR Primary Care Asthma Audit Results 2019

Whilst there are notable exceptions across the Barking and Dagenham, Redbridge and Havering systems, with some practices having exemplary systems in place, there are significant issues and unwarranted variation in the quality of asthma services provided at primary care (GP practice) level.

A recent audit of primary care asthma provision identified some significant variations in provision of asthma services in BHR. The audit went on to recommend areas for improvement including the following:

Issue	Areas identified in the Primary Care Asthma Audit	LIS Element that has been designed to address this issue.
1.3.1	The need to ensure the lead clinician has oversight of asthma care in children and there are regular, minuted practice meetings that discuss the practice approach to caring for children in asthma	Element 1.
1.3.2	The need to develop consistent DNA/WNB policies across BHR CCGs pertinent to children and taking account of asthma.	Element 2.
1.3.3	The need to develop robust audits of asthma medication including antibiotic use, corticosteroids and inhaler therapy with red flag triggers for those receiving too many of these inhalers over the period of a year.	Element 1, 2, 3, 4.
1.3.4	The need to develop processes and systems (and interfaces) to ensure those children and young people who present to accident and emergency, walk in centres, urgent care centres and out of hours with asthma symptoms, are flagged to their respective General Practice and seen or reviewed within 48 hours of discharge.	Element 1, 3, 4.
1.3.5	The need for consistent templates within GP clinical IT systems to ensure children have individualised management plans, are reviewed and referred to tertiary services when necessary.	Element 1, 3, 4.
1.3.6	A need for further, enhanced asthma training for nurses and GPs in primary care.	Element 1.

8 Underlying principles:

There are a number of important principles underpinning the LIS.

If we deliver the LIS well, we can stop the deaths of children from asthma: Inquests into the deaths of children and young people have shown that only a well-focussed approach to care from a network or system geared to deliver high quality evidence care can prevent deaths. For over 50 years we have had the necessary skills and knowledge to stop asthma deaths occurring but due to the complexity of the systems we work in this has continued to occur. Only a system orientated approach – one that links and strengthen primary and secondary and Tertiary or specialist care can really address the management of paediatric asthma as a chronic long-term condition. Our overall aim is that we can ensure a symptom free life for CYP with asthma and stop asthma deaths.

Asthma should be treated as a chronic condition and not as a sequence of acute exacerbations, and to do this well need to work closely and effectively with others in an Asthma Network: If we continue to treat only the acute episodes or exacerbations experienced by Children and Young people we will not be addressing the underlying and enduring causes of their acute episodes. We need to ensure that we are taking every opportunity to treat paediatric asthma as a long-term condition and strengthen the parent, carer and patient facing self-care opportunities we have alongside the care we personally deliver.

Asthma care, prescribing and action planning should be evidence based, personalised and place the empowerment and education of children, young people, parents and carers at the centre of the system we are developing: *We need to ensure that our work supports parents, carers and CYP with asthma with the best possible evidence based care. We know that the delivery of personalised asthma management and action plans is crucial to supporting CYP with asthma as part of a network.*

We can lay the foundations for great asthma care in childhood and this will ensure that transitioning young people and older asthmatics are well prepared to take ownership of their condition and take active steps to manage their health*: If we can ensure that asthma is addressed as a Long term Condition and that we work with CYP, Parents and carers to tackle their asthma*

We need to ensure that the way we manage asthma in Primary Care – both the clinical and the process or administration aspects – is an exemplar of good practice and helps support a sustainable model after the SAS LIS has expired: Though driven by the Children and Young People (CYP) asthma agenda, and relating to CYP specifically, the LIS has been developed to ensure it is supportive of and links to improvement works underway in adult services focusing on the support available to adults with asthma. This is especially important with older children and adolescents transitioning into adulthood and the care of adult services. We need to ensure that practices are able to deliver this work in a way that

can be sustained after the SAS LIS has expired and use it as an opportunity to rethink the way we use practice business processes to support clinical delivery.

9 An overview of the age range served by the LIS:

Given the need to ensure that we can support comprehensive asthma care for children and young people (including adolescents and those transitioning into adulthood), this LIS will cover all children with asthma, registered with a BHR GP, **aged 0 to 18 years-old. Additionally, for any CYP with identified Learning Disabilities the age range will be extended to 25 years to help address asthma health inequalities.**
These cohorts include CYP who are diagnosed with asthma (either with a read code of H33, on a Quality and Outcomes Framework (QOF) list of patients diagnosed with asthma, or are receiving prescriptions for SABA, ICS, Montelukast / LABA).

Children under 5 years old:

Care for children under 5 should follow either the BTS SIGN guidance[6] or NICE guidance[7] with treatment based on **observation, clinical judgement and regular review**.

***This group are NOT included in the core LIS, but* must be clinically assessed and treated in line within the appropriate guidance but are included here in order to be inclusive and to assist consideration of the broader potential impact benefits of the LIS.**

In line with the BTS/SIGN Guidance Management of acute asthma in children under 1 year should be under the direction of a respiratory paediatrician.
It is important to note that children under 5 are difficult to assess and are often unsuitable for spirometry.

10 Potential Benefits of the Asthma SAS LIS for the wider BHR system:

NICE evidence summaries and Asthma UK suggest that reduction of the large number of ED attendances in the under 5s will occur through the general raising of awareness of their treatment requirements and growing confidence in primary care on their management as an additional benefit of the LIS.

The broader cohort of “Itchy, Wheezy, Sneezy” children will benefit from refined asthma care and a structured approach to their management over time, avoiding where possible acute exacerbations and the resulting ED and avoidable inpatient activity.

Given the need to ensure that we can support comprehensive asthma care for children and young people and the need to support adolescents with asthma transitioning into adulthood,

[6] See: https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/ July edition page 32.
[7] See https://pathways.nice.org.uk/pathways/asthma#path=view%3A/pathways/asthma/assessing-and-diagnosing-asthma-in-under-17s.xml&content=view-node%3Anodes-under-5s

this LIS will have an age range that covers the 5 to 18-year-old age range (+18-25 for asthmatic young adults with Learning Disabilities).[8]

11 The evolving asthma Network in BHR:

The LIS will enable effective links from primary care into secondary care primarily focused on Emergency Department attendances and discharge summaries being quickly received by GPs so follow up can be actioned. In addition to this the LIS will complement and be supported by the evolving work of the Asthma Clinical Nurse Specialists who will operate within the community approximately 60% of the time.

Alongside Primary Care the Asthma CNS are crucial elements in building a functioning and sustainable Asthma Network that unites acute and community elements in meeting the needs of CYP with Asthma, parents and Carers to deliver comprehensive and inclusive asthma care across all parts of BHR.

BHRUT Asthma CNS Contact details:

Details are correct as of January 2020.

Team e-mail address: bhrut.cypasthma@nhs.net

Laura King 07973742822
Rachael Young 07957919991
Andrew Farquharson 07966194697

Working Hours –Monday to Friday 09:00 – 17:00

Other Asthma CNS contact details:

Other local areas with a Clinical Nurse Specialist for Asthma which will be potentially useful to liaise with include Waltham Forest and Newham.

Newham Asthma Nurse: Emily Guilmant-Farry emily.guilmant-farry1@nhs.net

Waltham Forest Asthma Nurse – currently covered by WF CCNT:
wfcommunitychildrens.nursing@nhs.net

NELFT School Nursing contacts:

In addition to the CNS team the NELFT School Nursing and Health Visiting services may be useful contacts for practices particularly for sharing asthma management plans. See the table below for key contact information:

[8] Wider age ranges may be considered and subsequent service developments supported to support older asthmatics in due course but are not currently part of this LIS, though they are a focus of the Long-Term Conditions workstream.

Area	Web link
Barking and Dagenham	https://www.nelft.nhs.uk/services-barking-school-nursing/
Havering	https://www.nelft.nhs.uk/services-havering-school-nursing/
Redbridge	https://www.nelft.nhs.uk/service-redbridge-school-health/

12 Asthma Health Inequalities and Learning Disabilities

The 2018 Asthma UK report "*On the Edge: How inequality affects people with asthma*"[9] outlined how Asthma can affect people of any age or background, but issues including poverty, housing and deprivation all have significant impacts on the care received and the efficacy of that care. People with learning disabilities are a particularly vulnerable cohort and will need additional time and support to engage with asthma management strategies from a practice.

The RCGP has an exemplary set of resources tailored towards the delivering of the Learning disability health check which can be readily adapted for a range of consultation scenarios including the delivery of the Asthma LIS.

The main resources can be found here: https://www.rcgp.org.uk/learningdisabilities/

In addition ***e Learning for Health*** offer a very useful online training resource that can help practices deliver inclusive sessions for CYP with Learning Disabilities: https://www.e-lfh.org.uk/disability-matters/.

Disability Matters is an innovative e-learning programme for anyone working or engaging with disabled children and young people (aged 0-25 years).
Co-developed with disabled young people and parent carers the sessions will improve your recognition and management of disability issues, teach you to communicate effectively and give you the confidence to support children and young people achieve the outcomes that matter to them.

13 Structure of the LIS

An overview of the four elements

The Asthma LIS has four elements. Each one complements the others to create a coherent whole and they are arranged in a structure that supports roll pout across BHR CCGs.
In summary a baselining and development phase is followed by three elements that support specific clinical aspects crucial to comprehensive asthma care.

Element Number	Name	Components/Focus

[9] See https://www.asthma.org.uk/dd78d558/globalassets/get-involved/external-affairs-campaigns/publications/health-inequality/auk-health-inequalities-final.pdf

E1	Practice Asthma Improvement Development Phase	• Practice Asthma Improvement Lead (PAIL) • Baseline data / prevalence • Asthma skills training • Multi-disciplinary team meetings • Establishment of updated practice protocol for asthma care
E2	Medication Management for CYP with Asthma	Consistent High-Quality Prescribing for CYP with asthma: • SABA overuse audit • Remove SABA from repeat prescriptions
E3	Managing Asthma as a Long-Term Condition	Development of a practice approach to managing CYP with asthma: • Offering Asthma reviews • Provision of Management Plans • Inhaler technique • Sharing with schools/community • Evidence of WNB in action
E4	Managing acute asthma & poorly controlled asthmatics	Development of practice level approach to managing acute asthma in CYP: • Coding acute exacerbations • Following up acute exacerbations • Secondary/Tertiary referrals • Managing Poorly controlled asthmatics

Core Guidance:

Currently there are two pertinent sets of guidance for asthma in children and young people: The **British Thoracic Society (BTS) working with the Scottish Intercollegiate Guideline Network (SIGN)**[10] and the **National Institute for Health and Care Excellence (NICE)**[11] alongside other validated management templates for supporting asthma management in CYP***.***

A combined NICE and BTS/SIGN guidance is being developed and will be available in the near future. A future update on this can be found here: https://www.brit-thoracic.org.uk/about-us/pressmedia/2019/bts-sign-and-nice-to-produce-joint-guideline-on-chronic-asthma/

A useful summary of the guidelines can be found here: https://www.guidelines.co.uk/respiratory/sign-and-bts-management-of-asthma-in-children-guideline/454880.article

[10] See https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/btssign-asthma-guideline-2016/
[11] See: https://www.nice.org.uk/guidance/ng80

See below for a discussion on then options for which guideline you and your practice will select before the combined guidance becomes available.

Choosing the right guidance to follow. NICE or BTS/SIGN?

There are key differences between the two sets of guidance. In very simple terms NICE addresses asthma from a clinical /Health economy point of view whilst BTS/SIGN addresses the agenda from a clinical respiratory specialist pint of view.

Both sets of guidance have much to commend them, but many differences that can at first sight seem impossible to resolve. As you will see in this support resource alongside other key resources the different guidance sets are included to support an inclusive approach to deciding what works for individual practices, networks or federations will remain an issue for clinicians to reach consensus on.

Whilst it is tempting to suggest or impose a particular paradigm centrally, there are several reasons why commissioners have avoided this:

1. **This is a clinical decision** and whilst commissioners and the expert clinical advisers behind the resource are in a position to give a view and set out key differences this remains an individual clinical responsibility to address.
2. **The discussion on the benefits and differences behind the different paradigms is in itself extremely valuable in itself** and can illuminate practice differences, experiences and preferences that can make the delivery of asthma care at practice level a much richer offer.
3. **Local clinical factors, experiences and the local culture and independence and autonomy of primary care** suggest that it is essential to be prioritising the views of clinicians and not imposing a blanket ruling.
4. **It is difficult to impose one view favouring one or the other guidance** when both are in fact valuable, valid and with specific benefits.
5. **The combined guidance will resolve this issue for users of each set of guidance.**

To support the decision at practice, PCN or Federation level there are a number of support resources in appendix 2 which outline the key difference, similarities and benefits of both sets of guidance. .See also:
THORAX:https://thorax.bmj.com/content/73/3/293

BMJ Blog: https://blogs.bmj.com/thorax/files/2017/12/BTS-SIGN-and-NICE-Asthma-guidelines.pdf

Primary Care Respiratory Society (PCRS):
https://pcrs-uk.org/sites/pcrs-uk.org/files/BriefingAsthmaGuidelines_V3.docx

It should be noted that a close examination of both sets of guidance shows far more similarity between the two sets than is apparent at a casual read through. This has in no small part contributed to the collective efforts of both NICE and BTS/SIGN to create a combined guidance[12] and work on the new guidance is currently underway. It is hoped that new guidance will be available in the next 12 to 18 months, subject to the understandable uncertainties involved in combining the two very different publications and making them available via both organisations via the usual distribution channels.

In essence this will become an academic issue as the combined guidance will become available in the next few years. Until then clinicians must decide which set of guidance to choose and once decided adhere to that set of guidance until the combined guidance becomes available. It is essential that practices choose one or the other and do not adopt a "pick and mix" approach as this has historically led to significant levels of variation in practice and efficacy of approach.

See also Dr Mark Levy: https://www.guidelinesinpractice.co.uk/respiratory/a-personal-critique-of-the-nice-guideline-on-asthma/454011.article

Pharmacotherapy in Asthma management

Excessive Short Acting Bronchodilator Agents (SABA - e.g. Salbutamol / Terbutaline) use is dangerous as it reduces Beta-2 receptor responsiveness and increases bronchoconstriction and allergic responses.

Issuing more than two SABA inhalers at a time is associated with increased secondary care / ED attendances and more than 12 inhalers prescribed in a year is associated with an increased risk of death due to asthma.

Inhaled Corticosteroids (ICS) are the recommended treatment for all but the very mildest intermittent asthma symptoms, and have a good record of efficacy and safety at standard doses (BTS/SIGN 2005). Even low doses of Inhaled Corticosteroids (ICS) have been shown to reduce symptoms, attacks, exacerbations, admissions and deaths from asthma.

There is evidence, supported by the recent Asthma Audit (Section 1.3) that asthma prescribing guidelines are not always consistently followed resulting in SABA overuse / prescribing and ICS underuse / prescribing both of which are high risk factors for poor control, increased morbidity and mortality in CYP with asthma.

Obesity and CYP with Asthma

[12] See https://www.brit-thoracic.org.uk/about-us/pressmedia/2019/bts-sign-and-nice-to-produce-joint-guideline-on-chronic-asthma/

Children with obesity are at increased risk for developing asthma, which is already one of the most common chronic diseases among children. The NICE guidance on childhood obesity[13] has the following information which may prove helpful for management in primary care.
https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations

Children

1.3.8Assessment of comorbidity should be considered for children with a BMI at or above the 98th centile.

1.3.9Take measurements to determine degree of overweight or obesity and raise the issue of weight with the child and family, then assess:

- presenting symptoms and underlying causes of being overweight or obese
- willingness and motivation to change
- comorbidities (such as hypertension, hyperinsulinemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction and exacerbation of conditions such as asthma)
- any risk factors assessed using lipid profile (preferably done when fasting) blood pressure measurement and HbA_{1c} measurement
- psychosocial distress, such as low self-esteem, teasing and bullying[5]
- family history of being overweight or obese and comorbidities
- the child and family's willingness and motivation to change lifestyle
- lifestyle (diet and physical activity)
- environmental, social and family factors that may contribute to being overweight or obese, and the success of treatment
- growth and pubertal status
- any medical problems and medication
- the role of family and care workers in supporting individuals with learning disabilities to make lifestyle changes.

Consider referral to an appropriate specialist for children who are overweight or obese and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs).

14 SAS LIS – ELEMENTS

There are four key elements in the LIS which taken together provide the basic structures that will enable primary care to deliver comprehensive, evidence based, high quality sustainable asthma care for children and young people.
There are four key elements in the LIS which taken together provide the basic structures that will enable primary care to deliver comprehensive, evidence based, high quality sustainable asthma care for children and young people.

Element Number	Name	Focus

[13] See https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations

E1	**Practice Asthma Improvement Development Phase**	**Practice based asthma care leadership, baselining, protocol development and audit**

Practice Asthma Improvement Lead (PAIL)
Identification of a practice asthma lead clinician and named administrator who will take responsibility for driving practice level improvement. They will provide oversight of CYP asthma care and be responsible for the delivery of care in practice.

Baseline data confirmation of asthma prevalence and severity in practice

Establishing the severity of asthma within these groups through searches to determine the following for all asthmatic CYP:

How many of the children in each cohort / group have been prescribed (in the last 12 months):

- *A SABA (> 6 inhalers in the last 12 months)*

How many children in each cohort / group have (in the last 12 months)?

- *Had an acute episode, as coded by **H333***
- *Had a documented inpatient admission*

Children's asthma multidisciplinary team (MDT) meeting
Evidence there have been at least two multidisciplinary team meetings per year where asthma care of children has been discussed which can be evidenced by minutes, agendas and completion of follow up actions.

The MDT should be comprised of the appropriate participants to enable a triangulated view of the asthma care to be delivered. The precise composition will vary from case to case and practice to practice, but as an outline they could include a broad range of personnel depending on if the meeting is unique to an individual practice or delivered at a Primary Care Network Level:

- GP Leadership
- Practice Nursing staff
- Practice Administration
- Pharmacy/medicines management input (via own advisor or via Primary Care Network)
- School nursing – input in person or via offline reporting or liaison
- Secondary Care – input in person or via offline reporting or liaison

The agenda and specific focus of the meeting will be determined locally but should address issues that are directly relevant to the practice or cluster of practices. Sessions might consider prescribing practice, managing the asthma review, a local audit or issues with referrals and actioning follow ups following from acute episodes.

	To make the MDT session work directly to improve the care offer, the session should have a pragmatic and representative invitation list from local system partners to enable a full consideration of the theme selected for the meeting. **Establishment of updated practice protocols for asthma care** Practices should consider developing the following protocols and processes or reviewing effectiveness of those processes if they exist currently. As a minimum practice should have in place processes or protocols to cover: • A&E/ED attendances follow up • Hospital Admission follow up • Managing children who present in primary care with asthma both acute and follow up • Referrals to secondary and tertiary specialists for poorly controlled / managed asthmatics	
	Timescale for Delivery: December 2019 to March 2020 and onwards through the life of the scheme.	**Evidence of delivery:** **Production of evidence of component delivery at contact review meeting.** **This will include minutes of the session with details of agenda theme and personnel invited, detail of those in attendance/apologies for the session and of off-line contributions and actions arising from the session.**

Some useful resources to assist in delivering on Element 1

Element 1 Detail and issues	Useful resources
Practice Asthma Improvement Lead The starting point of delivering the LIS is the identification and support given to, and in time flowing from the Practice Asthma Improvement Lead (PAIL). The PAIL needs to have the leadership and clinical skills necessary to drive improvement in the delivery of asthma at	**RCNi**: See https://journals.rcni.com/home and https://journals.rcni.com/primary-health-care/clinical-leadership-in-primary-care-phc2013.06.23.5.32.e795 **British Medical Journal:** https://bmjleader.bmj.com/content/3/2/59 **The Kingsfund**:https://www.kingsfund.org.uk/blog/2017/10/clinical-leadership-moving-good-will-good-practice and https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf and https://www.kingsfund.org.uk/sites/default/files/2018-06/Innovative_models_GP_Kings_Fund_June_2018.pdf **The Healthy London Partnership:** https://www.healthylondon.org/wp-content/uploads/2019/09/HLP-Clinical-Leadership-Investing-in-the-Primary-

practice level and through inform works at Network and Federation level. A range of specific resources selected to help build these skills are have been compiled to support this. These will also assist clinical staff CPD and revalidation requirements.	Care-Workforce.pdf - *page 11 has a list of additional resources that can assist the development of leadership skills in primary care* and see also: https://www.healthylondon.org/wp-content/uploads/2019/02/Salaried-practice-manager-programme-case-study.pdf **BMJ Learning module:** https://learning.bmj.com/learning/module-intro/acute-asthma-wheezing-children.html?moduleId=10062369 **NHS Networks:** https://www.networks.nhs.uk/nhs-networks/clinical-leadership-in-primary-care/show_all_similar_networks **Primary Care Respiratory Society**: https://www.pcrs-uk.org/pcrs-respiratory-leadership-programme See also **Primary Care Respiratory Update:** https://www.pcrs-uk.org/pcru - **NHS England**: https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/leadership-in-primary-care/ And https://www.england.nhs.uk/wp-content/uploads/2018/03/leadership-development.pdf and https://www.healthcareers.nhs.uk/explore-roles/management/roles-management/practice-manager/training-and-development-practice-management **Health Education England: e learning for health** https://www.e-lfh.org.uk/ https://www.hee.nhs.uk/our-work/primary-care **Royal College of General Practitioners:** https://elearning.rcgp.org.uk/ **National Association for Primary Care:** https://napc.co.uk/primary-care-home/diploma-2/ First Practice Management: https://www.firstpracticemanagement.co.uk/blog/2019-blog-posts/secret-diary-of-a-practice-manager-building-a-primary-care-network/ Practice Managers UK: https://practicemanagersuk.org/
Asthma resources for Primary Care: There are a great number of online clinical skills courses that could be beneficial for clinical and non-clinical staff to be familiar with. Alongside these the NICE and other	**Useful NICE guidance on searches and audit techniques.** https://www.nice.org.uk/about/nice-communities/generalpractice **The British National Formulary for Children:** https://bnfc.nice.org.uk/ **RCGP Practice safety toolkit** https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/patient-safety.aspx **Asthma courses from RCGP:** https://www.rcgp.org.uk/learning.aspx Asthma courses:

guidance on searches will be helpful in managing the searches required at practice level.	https://rcgpportal.force.com/s/lt-event?site=a0d0Y00000AeOP6QAN&id=a1U0Y00000DfTcyUAF and https://rcgpportal.force.com/s/lt-event?site=a0d0Y00000AeOP6QAN&id=a1U1i000001NqCHEA0 **Atopic presentations** https://rcgpportal.force.com/s/lt-event?site=a0d0Y00000AeOP6QAN&id=a1U0Y00000DfTdIUAV **Health Inequalities in General Practice** https://www.kingsfund.org.uk/sites/default/files/field/field_document/health-inequalities-general-practice-gp-inquiry-research-paper-mar11.pdf
Establishment of updated practice protocols for asthma care Practices should consider developing the following protocols and processes or reviewing effectiveness of those processes if they exist currently. As a minimum practice should have in place processes or protocols to cover: • A&E/ED attendances follow up • Hospital Admission follow up	**All practices will need to have a protocol for how they manage asthma that meets their needs in terms of clinical practice and business flow.** The University of California have an online resource, that though developed in the USA has some very useful materials that will assist understanding the business of mapping clinical and administrative workflows in primary care: See https://cepc.ucsf.edu/workflow-mapping. A central aspect of this work is determining the different stages of the work and who is best able to deliver them at practice or potentially network level. A key starting step is to determine which parts of the work need a clinician to deliver on them and which do not and to ensure that the workflow does not inadvertently suffer from bottle necks or blockages from the start. The NHS Improvement leaders guide can also support the thinning you in your practice will need to undertake: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-2.3-Improving-Flow.pdf and https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.2-Process-Mapping-Analysis-and-Redesign.pdf **See also: The Handbook of Quality and Service Improvement (NHS Improvement 2010)** https://webarchive.nationalarchives.gov.uk/20160805122939/http:/www.nhsiq.nhs.uk/media/2760650/the_handbook_of_quality_and_service_improvement_tools_2010.pdf **A&E/ED attendances follow up:** A key issue arising from the +NICE Quality statement 25[14] and Healthy London Partnership Asthma Standards is the ability of primary care to meet the need for review or follow up with children's after an Emergency Department attendance or admission. To be clear the requirement locally is explicitly that the "clock" for this **only starts upon the receipt of the discharge summary by the**

[14] see https://www.nice.org.uk/guidance/qs25/resources/asthma-pdf-2098547456965

• Managing children who present in primary care with asthma both acute and follow up • Referrals to secondary and tertiary specialists for poorly controlled / managed asthmatics	**practice** (and if pertinent the tweaked or revised asthma management plan) and works are underway with colleagues in BHRUT to ensure that the flow of discharge summaries improves in timeliness and quality. Once received the requirement for review seems daunting at first, given the practicalities of arranging slots and the pressures already faced by primary care. There are however a number of approaches that can assist in delivering on this. **1 Triage within 24/48 hrs. and then appointment in person 2within 7 days:** There is little evidence in support of the NICE Quality statement given the after effects of ED, hospital admissions and stabilisation of the CYPS' condition, and the practical implications for review within 48 hrs. given weekend and bank holidays. There is however good evidence to support triage by a clinician and or phone consultation with a follow up in person within 7 days which assesses the urgency of the need to be seen quickly and assesses the risk for the child in line with the relevant guidance and discharge information. **2 Floating appointments:** Practices may choose to hold a floating appointment with a practice nurse or GP that is held back for emergency consultations received on the day that is used only for CYP requiring rapid review of condition. As the Primary Care Networks offer evolves this may become more tenable across a network footprint. **3 Pooled appointments at Primary Care network Level:** Depending on the level of maturity of the network and the buy in of clinicians and practices a PCN could choose to hold appointments to assess emergency or high priority CYP cohorts where review and follow up is required. A PCN level response would possibly be beneficial in development of expertise and specialisation for individuals within the evolving system and facilitate a stronger relationship with colleagues in secondary and tertiary care.

Element Number	Name	Focus
E2	**Operational Element: Medications**	**Consistent High-Quality Prescribing. From April 2020 onwards**

	Management for CYP with Asthma	
	Consistent High-Quality Prescribing for CYP Practices will be required to assess the following prescribing areas and take appropriate action based on the searches conducted. Searches and subsequent actions to be repeated quarterly from Quarter 2, 3 & 4 **Excess SABAs prescribing** • *Identification of Excessive SABA prescribing* • *Identification of more than 6 salbutamol inhalers prescribed per annum (e.g. 2 or more than 2 issued within the previous quarter's search)* • *Offer interim asthma review to review symptom control and usage/context of SABA – revised action planning* **Change of SABA prescribing from repeat prescriptions to acute issue or variable repeat prescription, 1 inhaler (original pack) at a time.** • *Change repeats for SABA to acute prescriptions or if you prefer a variable repeat prescription.* Excess Short Acting Bronchodilator Agents (SABA) e.g. Salbutamol / Terbutaline use is dangerous as it reduces Beta-2 receptor responsiveness and increases bronchoconstriction and allergic responses. Issuing more than 2 SABA inhalers at a time is associated with increased secondary care / ED attendances and more than 12 inhalers prescribed in a year is associated with an increased risk of death due to asthma. [10,11,12, 13] **Guidance Note:** NICE NG80 (Asthma: Diagnosis, monitoring and chronic asthma management 2017) indicates that use of SABA's on three or more days a week on a regular basis is a sign of 'uncontrolled asthma'. Any patient using more than 6 SABA inhalers in 12 months would fall within this definition (unless there are extenuating circumstances). Practices should perform a search to identify all the children with a diagnosis of asthma who have been prescribed more than 6 SABA's in the last 12 months. Practices should then select the patients with the highest usage of SABA from this list as their priority patients for an asthma review. Practices should consider taking SABAs off repeat prescription or use of single repeat prescribing, or set maximum to 6 a year (and may need to use clinical judgement and be flexible if the patients 'run out'—issue prescription and offer an asthma review). Possible mechanisms include adding the SABA to acute or using variable repeat if available. **Outline guidance on setting prescribing alerts in EMIS, System One and Vision systems will follow.**	
	Timescale for Delivery: From April 2020 onwards to June 2020	**Evidence of delivery:** **Completion of audits** **Evidence on prescribing system changes**

Element Number	Name	Focus
E3	**Managing asthma as a Long-Term Condition**	**Annual Asthma Reviews including Personalised Asthma Plans for CYP**

Operational Element

Development of a practice (& / or network) approach to managing CYP with asthma as a long-term condition:
Introduction of a systematic approach to asthma as a Long-Term Condition including the offering and provision of asthma reviews for CYP within the cohorts/groups

Each Asthma Review needs to include within it (but not exclusively) and be read coded where possible:

Evidence of success in meeting this Element will be based on using baseline searches made in Element 1 (e.g. those with inhaler technique assessed), tabulating for each of the following components within a review performed in the previous 12 months (as a retrospective baseline) and subsequently a review performed by end of Q4 2021 to demonstrate an improvement (by > 20% of baseline data OR > 80% to 90% achievement in all those reviewed) in the measured following components

Annual Reviews Cohort and activity:

- Numbers offered annual reviews
- Numbers attending annual review

Asthma Management Action Plan/Review components:

- Inhaler technique assessed
- Peak Flow used to assist management planning (n those > 11 years old)
- Documentation of triggers and explanation
- Documentation of acute symptoms and management
- Documentation of SABA use
- Documentation of School / Nursery attended
- Documentation of Personal Asthma Management Plan (PAMP) issued and explained
- Documentation PAMP issued for school and explained to parent/carers
- Documentation of Spacer
- Documentation O2 Saturations

Practices can still choose to use established templates, RCP/QOF related questioning too if and as they wish, but the above parameters will be used to establish a CYP focused assessment of their asthma for the purpose of achieving Element 3

Evidence of WNB policy for asthma care in use

	• Evidence of a WNB policy in place within the practice / network. • Evidence of use and implementation of the WNB policy over a 6-month period to demonstrate increased provision of asthma care to CYP with asthma.	
	Timescale for Delivery: September 2020 and onwards	**Evidence of delivery: Evidence of annual review policies, procedures and action planning, evidence that a WNB policy is in place.**

Annual Reviews and Personal Asthma Action Plans

Annual reviews are a powerful and effective way of ensuring that the potential benefits of the teachable/reachable moment are not lost for asthmatics of all ages and their parents or carers. Central to this is the creation and updating of personal Asthma plans[15].

1 All children and young people with confirmed/suspected diagnoses of asthma/viral wheeze to receive an annual review and Asthma Management plan[16] in line with the Healthy London partnership Asthma Standards[17] – with copy for School or other settings, and other copies available from the practice on demand to parents and carers of young people or Gillick Competent Children and Young People.[18]

4 All asthmatics over 17 to receive an annual review and appropriate Asthma Care plan[19].

Attention should be paid to young people and older adults with specific language support needs[20], including easy read materials for people with learning disabilities[21] or other protected characteristics requiring different access requirements or longer appointment times.

[15] See https://www.asthma.org.uk/for-professionals/professionals/filling-patients-action-plans/ for details on how to complete these.
[16] See: https://www.healthylondon.org/resource/london-asthma-toolkit/hospital-care/action-plans/ and https://www.asthma.org.uk/a028677c/globalassets/health-advice/resources/children/myasthmaplan-trifold-final.pdf for the Asthma UK Asthma Care Plan.
[17] See: https://www.healthylondon.org/wp-content/uploads/2017/11/London-asthma-standards-for-children-and-young-people.pdf
[18] See: https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines
[19] See https://www.asthma.org.uk/18e901c2/globalassets/health-advice/resources/adults/adult-asthma-action-plan.pdf OR
[20] See https://www.asthma.org.uk/for-professionals/professionals/non-english-action-plans/ for ESOL Asthma Plans.
[21] See: https://www.asthma.org.uk/advice/resources/#easyread

3 Parents and carers of children and young people and older Asthmatics should be encouraged to:

- Keep a photograph of their asthma management plan and keep it on their phones.
- Share a photo of their plans with friends, family, schools, colleges and co-workers/employers
- Ensure that they have copies of their action plan reminders for medicines and usage in places they visit frequently (i.e. School/Work/Sports Club, gym, etc.)
- Use smartphone alarms and reminders to encourage compliance with medication regimes and promote awareness of your symptoms and severity of condition.
- Ensure that the asthma plan is shared at all appointments with health care professionals to allow for updates and changes to the individual asthma management plan. Reminder texts or phone calls for appointments from the practice should reflect the need to bring their asthma plans.

Group Consultations

Given the scale, needs and age ranges of the cohort to be addressed there is an obvious advantage in delivering some elements of the local Asthma Improvement workstream via group consultations. As detailed in the HLP resource found here group consultations have many advantages including scalability of work load, potential for encouraging peer support, normalisation of a resilient and self-caring approach to long term conditions. Group consultations are already in use with both adults and children across a number of long-term conditions[22]. A sample case study noted in the HLP online resource can be located here.

Was Not Brought (WNB) Policy

It is crucial that practices adopt a strengthened response to safeguarding children, and in particular the adoption of a Was Not Brought Policy. There are a number of key resources to support this including

The RCGP Safeguarding toolkits:
https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit/practice-resources.aspx
Asthma UK: https://www.asthma.org.uk/for-professionals/professionals/down-with-dnas/

Re-Thinking Did Not Attend a short film explaining the shift away from “DNA” to “WNB”
https://www.youtube.com/watch?v=dAdNL6d4lpk

Appendix 2 Contains a customisable model WNB policy developed by BHR CCG Safeguarding that we are encouraging all practices to adopt.

See also the Asthma UK resources on how to drive down DNAs and save time and

[22] See: https://www.rcgp.org.uk/clinical-and-research/resources/bright-ideas/shared-medical-appointments-in-the-uk-dr-rob-lawson.aspx

resources for patients with asthma: https://www.asthma.org.uk/for-professionals/professionals/down-with-dnas/

Element Number	Name	Focus
E4	**Managing Acute Asthma**	**Interface with Secondary/Tertiary Care and Follow Ups within 7 days, referrals, notifications, WNB management**
	Evidence of practice level approach to managing acute asthma in CYP or those poorly controlled including evidence of a systematic response to the following • **Coding the cohorts:** Consistent coding and monitoring of high-risk asthmatics • **Wider system working**: Interface with / use of Secondary/Tertiary Care (e.g. referral if 2 or > acute episodes within a 12-month period) • **Follow Ups:** Triage and follow ups for all children following an acute episode • **Audit**: To evidence changes made and impacts achieved over a 9-month period commencing in Q 2. • **Protocol / Policy supporting the capture and appropriate actioning of the following areas of activity.** ○ A&E/WIC/ED attendances due to asthma, requiring nebulisers / steroids ○ Hospital Admissions ○ Interface/Referrals with Secondary and Tertiary specialists, ○ Support Particular priority groups with acute asthma/exacerbations as outlined above Practices should be able to evidence their approach to triage of discharge summaries and substantive contact with parents/carers within 5 days of discharge from the ED or from receipt of discharge summaries received. All CYP who have had an acute episode should have a review within 7 days and an updated asthma plan developed as part of this review.	
	Timescale for Delivery: By December 2020 and onwards	**Evidence of delivery:** **Provision of policies and protocols** **Evidence of action planning**

15 Sustainability and use for other condition groups

The LIS has been designed to be delivered by both clinical and non-clinical staff at a practice level. It is essential to analyse the different aspects of the element and determine who is best placed to deliver the different tasks associated with the work.
A simple test would be what task require clinical training or input and which tasks are more administrative in nature and which require both skills sets and the different staff groups at practice level to work together.

Each of the elements above could be adapted to fit in with the needs of different groups for CYP with Long Term Condition Groups.

Using this analysis and the framework suggested by this LIS which moves from understanding the practice level cohorts and population into clinical and administrative management creates a sustainable model for delivery across the practice which is portable for use with other condition groups, though the details will of course vary.
The success of the LIS will rely on the energy and involvement of staff across practices to deliver a shared approach to delivery and the use of the training materials set out below.
We hope that the existing excellent practice across BHR practices is strengthened and that the area continues to build on the energy and enthusiasm across primary care to support children and young people with Asthma.

Appendix 1 Additional Resources for Practices and the Public:

Theme	Details	Links
Core Guidance for Managing Paediatric Asthma	**NICE**	**NICE Knowledge Summary:** https://cks.nice.org.uk/asthma **NICE Guidance 80: Asthma** https://www.nice.org.uk/guidance/ng80
	BTS/SIGN	**The Main BTS/SIGN Guidance:** https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/
	Royal College of Paediatrics and Child Health	**Care Pathway for CYP with Asthma/Rhinitis:** https://www.rcpch.ac.uk/resources/allergy-care-pathway-asthma-andor-rhinitis
	Quality Metric Incorporated Asthma Control Test	https://www.healthylondon.org/wp-content/uploads/2017/10/Asthma-control-test.pdf see also : https://www.asthma.com/additional-resources/childhood-asthma-control-test.html for an online version
	NHS England	See https://www.england.nhs.uk/childhood-asthma/ and the National Paediatric Asthma Collaborative: https://www.respiratoryfutures.org.uk/programmes/national-paediatric-asthma-collaborative/
Online training	**e Learning for health**	**e Asthma programme:** The e-Asthma programme is an interactive e-learning resource for healthcare professionals which aims to improve the diagnosis and management of asthma as a long-term condition for children and adults. e-Asthma is a foundation level educational resource aimed at all healthcare professionals who come into contact with children or adults with asthma who are not asthma specialists. This includes GPs, practice nurses, pharmacists, community nurses, school nurses, ambulance staff, 0-19 teams and A&E staff. Covering both paediatric and adult asthma diagnosis and management this programme aims to develop a healthcare professional's knowledge and confidence in caring for patients with this long-term condition, improving the quality of care received by children and adults. https://www.e-lfh.org.uk/programmes/asthma/
	RCGP	**GP Self-Test:** https://elearning.rcgp.org.uk/course/index.php?categoryid=56

Learning Disabilities	**RCGP**	**Learning Disabilities Resources:** https://www.rcgp.org.uk/learningdisabilities/
	General Medical Council	Resources to support GP practices meet the needs of people with Learning Disabilities: https://www.gmc-uk.org/ethical-guidance/ethical-hub/learning-disabilities
	NHS England	**Resources for practices on how to support people with autism:** https://www.england.nhs.uk/publication/guides-to-help-staff-support-people-with-access-needs/ **Resources for practices on how to support people with Learning disabilities:** https://www.england.nhs.uk/publication/guides-to-help-staff-support-people-with-access-needs/
	University of Hertfordshire	Article assessing the needs of people with Learning Disabilities in Primary Care: http://www.intellectualdisability.info/changing-values/articles/assessment-in-primary-care
	Asthma UK	**Easy read resources are available here:** https://www.asthma.org.uk/advice/resources/
	MENCAP	**Resources for professionals:** https://www.mencap.org.uk/learning-disability-explained/resources-healthcare-professionals
	Nursing Times	**Article on Asthma and learning disability:** https://www.nursingtimes.net/roles/learning-disability-nurses/providing-effective-asthma-care-to-people-with-learning-disabilities-14-03-2017/
	Improving Health and Lives	**NDTI resources for People with LD:** https://www.ndti.org.uk/our-work/our-projects/peoples-health/improving-health-and-lives-ihal
Key Organisations and resources	**Asthma UK**	**Professional resources:**https://www.asthma.org.uk/for-professionals/professionals/ **Public resources:** https://www.asthma.org.uk/advice/child/ **Asthma Management for parents and carers:** https://www.asthma.org.uk/advice/child/manage/ **Asthma Management Plans:** https://www.asthma.org.uk/advice/child/manage/action-plan/ **Monkey Asthma Management Plan for very young children:**

		https://www.monkeywellbeing.com/monkeys-asthma-plan-poster/ **Asthma UK Expert Nurses Helpline: 0300 222 5800** **Open Monday-Friday, 9am-5pm.** **How to fill in Asthma Management plans:** https://www.asthma.org.uk/for-professionals/professionals/filling-patients-action-plans/ **Asthma management for non English speakers:** https://www.asthma.org.uk/for-professionals/professionals/non-english-action-plans/ **How to use inhalers – video resources for the public:** https://www.asthma.org.uk/advice/inhaler-videos/ **Guide to Spacers:** https://www.asthma.org.uk/advice/inhalers-medicines-treatments/inhalers-and-spacers/spacers/?gclid=Cj0KCQiA04XxBRD5ARIsAGFygj-P4_XZ6lpax16QaysUlGzQJDYHix9kbwW2dLsCg7VJlQPsO-oULUkaAh0HEALw_wcB
	British Thoracic Society	**Quick Reference guide** https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/btssign-asthma-guideline-quick-reference-guide-2019/ **Full guidance library:** https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/
	British Lung Foundation	**BLF guidance for CYP with Asthma:** https://www.blf.org.uk/support-for-you/asthma-in-children
	World Asthma Day	https://www.awarenessdays.com/awareness-days-calendar/world-asthma-day-2020/
	Global Initiative for Asthma GINA	**GINA homepage:** https://ginasthma.org/ **GINA pocket guide to asthma:** https://ginasthma.org/pocket-guide-for-asthma-management-and-prevention/ **GINA Podcasts:** https://ginasthma.org/podcasts/
	Healthy London Partnership Toolkit	**Asthma Resources: CYP with Asthma.** **An essential resource for asthma in CYP with resources for practices, parents and carers and the wider system.**

		Asthma Toolkit: https://www.healthylondon.org/resource/london-asthma-toolkit/ **Asthma Standards:** https://www.healthylondon.org/wp-content/uploads/2017/11/London-asthma-standards-for-children-and-young-people.pdf **Ask About Asthma:** https://www.healthylondon.org/resource/askaboutasthma-communications-toolkit/
	Dr Mark Levy GP Expert Witness, NRAD author (and wildlife photographer)	**Personal view on NICE guidelines:**https://www.guidelinesinpractice.co.uk/respiratory/a-personal-critique-of-the-nice-guideline-on-asthma/454011.article **Core web resources:** http://www.consultmarklevy.com/academic_services/lectures.php and http://www.guideline-audit.com/ **Dr Levy's book on Asthma management in Primary Care:** https://smile.amazon.co.uk/Asthma-Practice-Clinical-Mark-Levy/dp/0850842433/ref=dp_ob_title_bk
	RCGP – see also the section above on Element 1 with Leadership resources.	**e-Learning resources:** **Core Asthma resources:** https://elearning.rcgp.org.uk/course/info.php?id=247 **Allergy resources:** https://elearning.rcgp.org.uk/mod/page/view.php?id=4513 **Safeguarding Toolkit – Practice resources:** https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit/practice-resources.aspx **Re-Thinking Did Not Attend** https://www.youtube.com/watch?v=dAdNL6d4lpk
	Greater London Authority – Air Quality resources	**Air Quality:** Air Quality is an important issue for children with asthma and we need to ensure that children who are exposed to poorer air quality on or around the school run are well supported. See: https://www.london.gov.uk/what-we-do/environment/pollution-and-air-quality
	Healthcare Quality Improvement Partnership (HQIP)	**HQIP Learning Disability Mortality Review resources on audit** https://www.hqip.org.uk/

	Primary Care Respiratory Society	**Asthma Guide:** https://www.pcrs-uk.org/sites/pcrs-uk.org/files/AsthmaGuide_FINAL_2015.pdf **Primary Care Respiratory Update** https://www.pcrs-uk.org/pcru - **Respiratory Academy:** https://respiratoryacademy.co.uk/clinical/
Pharmacy, Prescribing, Inhalers and Spacers	**BHR CCGS Area Prescribing Committee**	**BHR CCGS Medicines Management:** https://www.redbridgeccg.nhs.uk/About-us/Medicines-management/medicines-management.htm **BHR Medicines Management QIPP Schemes:** https://www.redbridgeccg.nhs.uk/About-us/Medicines-management/qipp-for-medicines.htm **BHRUT Formulary:** https://www.redbridgeccg.nhs.uk/downloads/For-health-professionals/Medicines-management/Local-formularies/BHRUT_formulary.pdf
	Right Breathe	**Simple online inhaler, spacer and prescribing guide:** https://www.rightbreathe.com/
	Royal Pharmaceutical Society	**RPS guidelines:** https://www.rpharms.com/resources/quick-reference-guides/asthma-supporting-patients-with-asthma
	NHS E	https://www.medicinesresources.nhs.uk/en/Medicines-Awareness/Guidance-and-Advice/Guidance/British-guideline-on-the-management-of-asthma--update/
	Pharmacy Online	**Community pharmacy training – online module on asthma care: https://www.pharmacymagazine.co.uk/making-a-difference-in-asthma-care**
	Annals of the diseases of childhood - BMJ	Anaphylaxis https://adc.bmj.com/content/104/1/83

Appendix 2 WAS NOT BROUGHT POLICY FOR ADOPTION BY PRACTICES

This policy has been provided for practices to adopt and customise locally in terms of contact details and specific practice considerations.

Significant alterations of the core content of the policy are not anticipated or encouraged to ensure that all practices in the BHR system are working to the same guidelines to deliver comprehensive and inclusive safeguarding care for Children and Young People

Primary Care: Child 'Was Not Brought' Policy (2019)

Provided for reference

Document History	ORIGINAL DOCUMENT DRAFT

Lead/Author(s)	Paul Archer
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AT Practice XXXX (Fill IN YOUR DETAILS)	- Please complete
Date of adoption	*DATE YOU APPROVE THIS*
Practice Asthma Improvement Lead (PAIL)	*Add details for the PAIL as per Element 1 of the SAS LIS*

Version History				
Date	**Version**	**Author**	**Status**	**Description of change/comments**
30/10/2019	1.0	Paul Archer Dan Devitt BHR CCGS	Initial version	Model policy shared with the Sustainable Asthma LIS
ENTER DATE OF YOUR PRACTICE VERSION	*2.0*	*Lead for your practice*	*Status of the draft?*	*Describe any changes*

1. Introduction

1.1 There may be many innocent reasons why children miss appointments, in most cases not attending an appointment will be because of legitimate reasons. For some children, however, missing appointments may indicate more serious issues such as an increased risk of neglect or abuse. Numerous studies have shown that missing healthcare appointments is a feature of many Serious Case Reviews, including those into child deaths (Dept for Education 2016).

1.2 Within a healthcare setting there is a move towards the concept of 'Was Not Brought' (WNB) rather than Did Not Attend (DNA) for children and young people. This is to acknowledge that it is rarely the child's fault they miss appointments. In most circumstances, children require a parent or guardian to take and accompany them to appointments.

1.3 Children who attend appointments on their own will need to be assessed as competent and must be able to give informed consent. Further guidance on assessing competence in children can be accessed here:

https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines

1.4 Care Quality Commission review of safeguarding children arrangements in the NHS (July 2016), identified there should be a process in place for following up children who fail to attend appointments. The review goes on to state:

'Concerns about children are less likely to be missed when there are jointly agreed ways of working that everyone understands and knows how to access.'

'One example is a policy for when children do not attend (DNA) an appointment. It is important to highlight that children themselves do not actually DNA, rather it is that they are not brought to appointments by their parents or carers which could be a flag for safeguarding concerns. This has led to the proposal that DNA should be reframed as 'was not brought' which should trigger the question, why were they not brought.'

1.5 Repeated cancellation and rescheduling of appointments should be treated with the same degree of concern as repeated non-attendance, and considered potentially harmful and possibly a feature of disguised compliance. Disguised compliance or apparently legitimate excuses for not attending appointments should not be accepted at face value. Professionals need to be prepared to challenge excuses for non-attendance and where appropriate carry out relevant safeguarding assessments in order to establish any risk posed to the child (Dept for Education 016).

1.6 The RCGP/NSPCC Safeguarding Toolkit for General Practice makes the recommendations that practices have in place:

- Procedures for identifying and following children who do not attend scheduled appointments within the practice or with other agencies such as therapies, secondary or community care;
- Procedures to identify and follow up children with more than expected unscheduled appointments at the practice, OOHs, A&E Departments, Walk-in Centres

1.7 It should be remembered that parents have the right to make decisions in respect of their child's health. Parental responsibility allows a parent or carer to accept or decline a health service or treatment on behalf of their child. However, if by declining a health appointment or treatment which may be detrimental to the child or young person's health, growth or development, an assessment should be made of the risk this poses to the child or young person.

1.8 It is important that GP practices have processes in place to address any clinical and/or safeguarding issues which may arise as a result of children and young people who are not brought for appointments. These processes should apply to both Secondary and Primary Care services. This policy specifically explains the responsibility of GP practices in relation to safeguarding children and young people who are not brought to appointments or did not attend appointments.

1.9 Please note that other health care providers will have their own Safeguarding WNB/DNA Policies.

2. Scope

2.1 This policy applies to members of staff, whether employed or as partners who work within a **ENTER YOUR PRACTICE DETAILS HERE.** For those staff covered by a letter of authority / honorary contract or work experience (e.g. locums, ST1, ST2, ST3) this policy is also applicable whilst undertaking duties on behalf of the GP practice or working on the practice premises and forms part of their arrangements with the practice. As part of good employment practice, agency workers are also required to abide by the practices policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work.

3. Purpose

3.1 This policy has been developed to ensure that the circumstances and consequences of any child and/or young people failing to attend a health appointment are individually assessed and managed with consideration to their welfare.

4. Definitions

4.1 **Child.** Under the Children Act (1989) a child is defined as anyone who has not reached their eighteenth birthday.

4.2 **Parental Responsibility.** Parental responsibility means the legal rights, duties, powers and authority a parent has for a child and the child's property. In some circumstances there will be shared parental responsibility in place between the parents and the local authority if the child is looked after under a care order (Section 31, 38 Children Act 1989).

4.3 **Was not brought.** Applies to children and young people (who require the presence of a parent or carer to attend appointments) who did not attend a planned appointment and had not cancelled the appointment.

4.4 **Did not attend.** Applies adolescents & young people, (who are old enough to attend appointments without a parent or carer) or to the parents/carers of children who did not attend a planned appointment and had not cancelled the appointment.

5. Was Not Brought Policy

5.1 Children not brought to appointments in a GP practice

5.1.1 It is accepted that there are a significant number of missed appointments in GP practice that are due to the transient nature of many conditions. These may not give rise to concerns about the child's welfare. However if there is no process in place to identify when children are not brought there is no opportunity to recognise when such missed appointments could give rise to concerns.

5.1.2 It is therefore essential that our practice(s) have in place systems to:

- Identify when children are not brought for appointments
- Make contact with the parents/ carers of the child who has not being brought especially if there are multiple instances
- Notify the referring clinician of any missed appointments by a child
- Consider whether there are any actual or possible clinical consequences as a result of the missed appointment and what actions are required
- Consider any other safeguarding concerns especially when there are multiple episodes of not attending health appointments in primary care or other settings
- Take appropriate action if there are clinical or safeguarding concerns (in line with local and national guidelines)
- Ensure there is clear documentation in the patient notes, actions , including risk assessment and any actions taken as a result

5.1.3 The process for managing children who are not brought to appointments in our practice is outlined in appendix 1.

5.2 **Children not brought to appointments with other health professionals outside of the GP practice**

5.2.1 It is usual practice that when children miss appointments the referring clinician is notified and their GP receives notification.

5.2.2 The process for managing these notifications in primary care is:

- Ensuring there is an effective system to flag all WNB/DNA notifications for to the child's GP
- Review the reason for referral and assess if any further action is required to manage the clinical problem that prompted the referral
- Review if there have been any other episodes of missing appointments in any setting including primary care
- Consider and explore whether there are any safeguarding concerns and take any appropriate action to manage those concerns (information sharing, referral to children's social care).
- Contact the family about children not being brought for appointments, especially if there are multiple instances
- Document what action has been taken by secondary care or other health providers following the missed appointment

5.2.3 The process for managing children who are not brought to appointments outside of a GP practice setting is outlined in appendix 2.

6. Recognising safeguarding children concerns

6.1 This policy should be read in conjunction with the following documents:

Nice Guidance and Flowchart 'When to Suspect child maltreatment'.
http://pathways.nice.org.uk/pathways/when-to-suspect-child-maltreatment
http://www.nice.org.uk/guidance/cg89/chapter/introduction

GP Practice Safeguarding Children Policy

INCLUDE A LINK TO YOUR POLICY

Working Together to Safeguard Children (2018)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Royal College of General Practitioners Child Safeguarding Toolkit
https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx

London Child Protection Procedures
https://www.londoncp.co.uk/

The unseen child and safeguarding: 'Did not attend' guidelines in the NHS

https://adc.bmj.com/content/100/6/517

BJGP: Child not brought to appointment

https://bjgp.org/content/67/662/397

References

Care Quality Commission (July 2016) Not Seen Not Heard: A review of the arrangements for child safeguarding and health care for looked after Children in England
http://www.cqc.org.uk/sites/default/files/20160707_not_seen_not_heard_report.pdf

Department for Education (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_Pathways_to_harm_and_protection.pdf

HM Government (1989) Children Act
http://www.legislation.gov.uk/ukpga/1989/41/contents

HM Government (2018) Working Together to Safeguard Children
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

NICE guidelines (2009) Child maltreatment: when to suspect maltreatment in under 16s [CG89]
http://www.nice.org.uk/guidance/cg89/chapter/introduction

Royal College of General Practitioners (2014) Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice.
http://www.rcgp.org.uk/clinical-and-research/clinicalresources/~/media/Files/CIRC/Safeguarding-Children-Toolkit-2014/RCGP-NSPCCSafeguarding-Children-Toolkit.ashx

Equality Impact Assessment Form - Policy

Equality Impact Assessment Form		
Policy author: Paul Archer	Date of assessment: 25/10/2019	
Title of policy: Primary Care 'Was Not Brought' policy (2019)	Is this a new or existing policy? New	
1. Is there a concern that the policy does or could have a differential impact in any of the following areas?		
	Y/N – delete as appropriate	
Age		No
Marriage/civil partnership		No
Disability		No
Religion/beliefs		No
Gender		No
Race		No
Pregnancy/maternity		No
Sexual orientation		No
Gender re-assignment		No
2. If the answer is 'no' for the groups above, please sign and date the form and add this form to the end of the policy. 3. If the answer is 'yes' for any of the groups above, please explain the reasons and complete box 4 (below). For help please contact the engagement adviser for advice (020 8926 5048).		
4. Are there any additions or actions to be added to the policy which ensure the policy does not have an adverse impact on any of the protected groups? If the answer is "yes", please detail below.		
Signed: (Policy author)		**Date: 25/10/2019**

Your contact details (department; e-mail; telephone number)	paul.archer@nhs.net **020 3182 3144**

Appendix 2a: Process for managing children who are not brought to appointments in GP practice

Child was not brought to a GP/Practice Nurse appointment

Childs GP will review child's records undertaking an assessment of risk to child's welfare of non-attendance at appointment considering:

- Previous non attendances, cancellations and rescheduling
- The reasons for non-attendance
- Potential and actual impact of non- attendance on child's/ young person's health and wellbeing
- Any safeguarding children concerns (past and present)
- Is the child Looked After?
- Any concerns with regards to child's, parents and carers which may impact on their ability to parent (drug and alcohol misuse, domestic abuse, mental health concerns, chronic life limiting illness, and or learning disability)

NO CONCERNS

CONCERNS

GP/ Clinician has no concerns about welfare of the child, young person after review of records GP/ Clinician will:

- Document actions and assessment in records
- Ensure appropriate read code present in child's records re non-attendance at appointment
- Arrange a further appointment if it is in the medical interests of the child/young person
- Write to the parents / carers with the plan if appropriate.
- Discuss with HV/SN/midwife/ Social Worker/other if appropriate

GP/ Clinician has concerns about the welfare of the child after reviewing record. GP/Clinician Will:

- Attempt to contact parents / carers by telephone to discuss concerns of non-attendance, impact on their child and current plan. Follow up any contact in writing as appropriate
- Arrange a further appointment if it is in the medical interests of the child/young person
- Document assessment, concerns, and actions in records and ensure appropriate read codes applied
- Ensure appropriate code present in child's records re non-attendance at appointment
- Liaise with the HV / SN / Midwife / Social Worker / other re: information sharing of concerns
- Follow safeguarding Children Policy if child is considered to be at risk of significant harm or in need of children's services support and safeguarding referral is required
- Assess risks again at next review / prescription review and plan action

Appendix 2b: Process for managing children who are not brought to appointments outside primary care

GP Practice receives notification that a child was not brought to a hospital appointment

NO CONCERNS

Hospital letter states that there are no likely adverse effects on child/ young person's health and wellbeing through non-attendance and no further action will be

Information passed to the child/ young person's GP for review of records and undertaking of assessment of risk to child's / young person's welfare of non-attendance at appointment considering:

- Previous non attendances
- The reasons for non-attendance
- Potential and actual impact of non- attendance on child's/ young person's health and wellbeing
- Any Child Protection concerns (past and present)
- Any concerns with regards to child / young person's, parents and carers which may impact on their ability to parent (drug and alcohol misuse, domestic abuse , mental health

NO CONCERNS

GP has no concerns about welfare of the child, young person after review of records GP will:

- Re-refer if it is in the medical interests of the child/young person
- Write to the parents / carers with the plan to refer or not if appropriate
- Document actions and assessment in records
- Read Code for WNB or DNA
- Discuss with HV/SN/ Social Worker if required

CONCERNS

Hospital letter states that clinician has concerns about child / young person's health and wellbeing and action taken by them.

GP will review the child / young person's records considering:

- Previous non attendances
- Potential and actual impact of non-attendances on child's/ young person's health and wellbeing;
- Any Child Protection concerns (past and present);
- Any concerns with regards to child / young person's, parents and carers which may impact on their ability to parent (drug and alcohol misuse , domestic abuse , mental health concerns, chronic life limiting illness, and or learning disability)
- Consider contacting the hospital clinician with any additional information for further action
- Document assessments actions and hospital

CONCERNS

GP has concerns about the welfare of the child/young person after reviewing record ll:

- Attempt to contact parents / carers by telephone to discuss concerns of nonattendance, impact on their child and current plan. Follow up any contact in writing
- Re-refer if it is in the medical interests of the child /young person
- Document assessment , concerns and actions in records including read code for WNB/DNA
- Liaise with the HV / SN / Social Worker , other re the best way forward
- Follow Local Safeguarding Children Board Policy and Procedures if child / young person are considered to be at risk of significant harm or in need of children's services support
- Assess at next review / prescription review and plan action`