SCHEDULE 2 – THE SERVICES (LOCAL INCENTIVISED SERVICE)

Service Specification No.	**Version 3.6 – Approved at 28/11/2019**
Service	Primary Care – Sustainable Asthma Support (SAS) for Children and Young People in Barking and Dagenham, Havering and Redbridge.
Commissioner Lead	Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs)
Provider Lead	BHR GP Federations
Delivery Leads	BHR GP Federations/Primary Care Networks
Period	December 2019-April 2021 (17 months)

1. Background

1.1 Introduction

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.

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.

With a consensus across the BHR system that a consistent approach 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.

BHR GP Federations and 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. It is anticipated that the delivery of the LIS will be managed by the GP Federations in the BHR system. It will require that all three federations sign up to the LIS and either all practices in a federation sign up to the LIS directly or 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.

[1] See: Insert weblink
[2] Insert weblink

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 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

Wider asthma networks and systems 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.

1.2 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.
The specific issues for Primary Care arising from the Regulation 28 report include the following:

Number	Issue	LIS Element that has been designed to address this
1.2.1	No clear agreed practice protocol for managing asthma, in particular named person responsible to oversee patients suffering recurrent attacks.	**Element 1, 2, 3, 4**
1.2.2	The medical records did not contain an up to date summary of current and past problems; in particular correspondence from hospitals following treatment for asthma attacks was not	**Element 1, 2, 3, 4**

[3] See https://www.judiciary.uk/wp-content/uploads/2019/05/Sophie-Holman-2019-0035_Redacted.pdf

	Read Coded. As a result clinicians consulted could not readily see the evidence of this child's severe, chronic poorly controlled asthma.	
1.2.3	A failure to recognise the risks of future poor outcomes such as asthma attacks, excessive salbutamol prescriptions. Failure to recognise that only 5 of the required preventer inhalers were collected in her final year of life	**Element 1, 2, 3, 4**
1.2.4	No clear supervision of junior doctors and nurses (e.g. Primary Care based locums, trainees ST1, ST2 and ST3) delegated to provide asthma care.	**Element 1, 3**
1.2.5	Failure to recognise that absence of symptoms and distress does not exclude the presence of a severe attack, as highlighted in the UK BTS/SIGN asthma guidelines.	**Element 1, 2, 3, 4**
1.2.6	Failure to follow up attacks as detailed in the NICE Quality Statement 25. (2013)[4]	**Element 1, 4**
1.2.7	Only one example (in the child's 48 attacks) where one GP who treated the child arranged a post-attack follow-up review soon after the attacks.	**Element 1, 4**

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.

1.3 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,	Element 1.

[4] See https://www.nice.org.uk/guidance/qs25

	minuted practice meetings that discuss the practice approach to caring for children in asthma	
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.

1.4 Asthma Health Inequalities and Learning Disabilities

The 2018 Asthma UK report "*On the Edge: How inequality affects people with asthma*"[5] 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.

1.5 Implementing the LIS with BHR GP Practices

Given the context of three recent deaths and the two near misses 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.

1.6 Asthma Cohorts 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 aged 3 to 18 years-old. Additionally, for any CYP with identified Learning Disabilities (See section 1.4) the age range will be extended to 25 years to help address asthma health inequalities.

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

Those 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).

The Cohorts to be used will therefore be:

- Children with Asthma, 3-11 year olds
- Adolescents with Asthma, 11-18 year olds
- Young adults with Asthma + Learning Disabilities, 18-25 year olds

1.7 Adherence to the Asthma Guidelines

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)**[6] and the **National Institute for Health and Care Excellence (NICE)**[7] alongside other validated management templates for supporting asthma management in CYP***.***

1.8 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.

1.9 Overview of the LIS

In response to the issues outlined above the LIS has been designed to address and support practice level systems and enhance leadership and management at practice level for asthma. There are four key areas for development and to support these the schedule consists of **four elements.**

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

Element Number	Name	Components/Focus
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

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Alongside meeting local requirements, the Asthma SAS meets the requirements for all five Domains.

Domain 1	Preventing people from dying prematurely	√
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

3. Scope

3.1 Aims and Objectives

The aims and objectives of the LIS are to ensure all asthmatic children and young people in BHR have access to:

1. A primary care service offer that is focused, sustainable, supported and consistent
2. High quality prescribing that meets appropriate guidance
3. Appointments that are arranged and followed up to ensure optimum attendance levels, whilst addressing potential safeguarding and accessibility issues ,through use of consistent Was Not Brought (WNB) and Did Not Attend (DNA) policies
4. Annual asthma reviews and personalised asthma plans that are shared with families, carers, schools and the young people themselves
5. Appropriate timely follow-ups for CYP who have had an acute episode using pathways and referrals between primary/secondary/tertiary care when needed

To achieve these aims the schedule consists of four operational elements across the life of the LIS.

3.2. Specification Scope

Where this document makes reference to list sizes these will be based on the weighted list size of practices as at Q3 2019.

The specification is composed of 4 elements:

Element Number	Name	Focus
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

<table>
<tr><td></td><td colspan="2">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 practices 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</td></tr>
<tr><td></td><td>Timescale for Delivery: December 2019 to March 2020 and onwards through the life of the scheme.</td><td>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.</td></tr>
<tr><td rowspan="2">E2</td><td>Operational Element: Medications Management for CYP with Asthma</td><td>Consistent High-Quality Prescribing.

From April 2020 onwards</td></tr>
<tr><td colspan="2">Consistent High-Quality Prescribing for CYP</td></tr>
</table>

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**

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

<table>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td></td><td>Timescale for Delivery: September 2020 and onwards</td><td>Evidence of delivery:

Evidence of annual review policies, procedures and action planning, evidence that a WNB policy is in place.</td></tr>
<tr><td rowspan="3">E4</td><td>Managing Acute Asthma</td><td>Interface with Secondary/Tertiary Care and Follow Ups within 7 days, referrals, notifications, WNB management</td></tr>
<tr><td colspan="2">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 <u>or</u> 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.</td></tr>
<tr><td></td><td>Timescale for Delivery: By December 2020 and onwards</td><td>Evidence of delivery:

Provision of policies and protocols</td></tr>
</table>

		Evidence of action planning

3.3. Inclusion Criteria

The LIS covers all registered patients in BHR CCGs as set out in in section 1 above

3.4. Exclusion Criteria

The project does not cover those registered patients deemed as excluded as per section 1 above.

3.5 Equality analysis

It is the provider's responsibility to ensure there is equality of access to their services and to put in place reasonable adjustments where necessary to ensure parity.

3.6 Clinical Governance

The referrals, post discharge follow ups, updates to asthma care plans and consultant and/or CNS guidance or response will be transferred over the patient's electronic record. This will provide a data and audit trail for the purposes of good governance, providing clear written details of the history of the individual patients asthma care, prescribing history, medical problem and ask specified.

If an adverse incident occurs this must be reported to the CCG as a clinical incident in the usual way via NLRS and investigated in partnership between the acute Trust and GP to identify the root cause and mitigating actions.

Dissemination of learning and any future training needs arising from the operation of the asthma LIS will be tabled as an agenda item at future clinical peer review meetings.

4. Applicable Service Standards

4.1. Applicable standards set out in BTS, SIGN or NICE Guidance and/or issued by a competent body (e.g. Royal Colleges) and GINA

4.2. Applicable local standards.

4.3 Healthy London Partnership Asthma Standards

5. Applicable Practice Requirements

5.1. Each practice will be sent a quarterly data pack for their network from their respective Federation. This data will include planned and unplanned asthma care activity and will include secondary and tertiary care referral activity.

5.2. The Federation on behalf of practices will set up monthly Clinical Peer Review network meetings for the duration of one hour. Practices should nominate a lead GP for the Sustainable Asthma Support LIS as described in element 1 who will be expected to attend this meeting on a monthly basis. Should they find themselves unable to attend, then they should identify a deputy who can attend meetings in their place. Payment for Element 1 (Page 4) will be based on attendance at these meetings.

5.3. Payment for practice indicator achievement will be formally approved at BHR CCGs formal contract meetings, held between the respective Federation and primary care commissioner.

5.4 Payment for outcomes achieved will be made between the federation and practices (Networks) (following invoice approval from the commissioner).

The CCG will not be party to discussions between said partners.

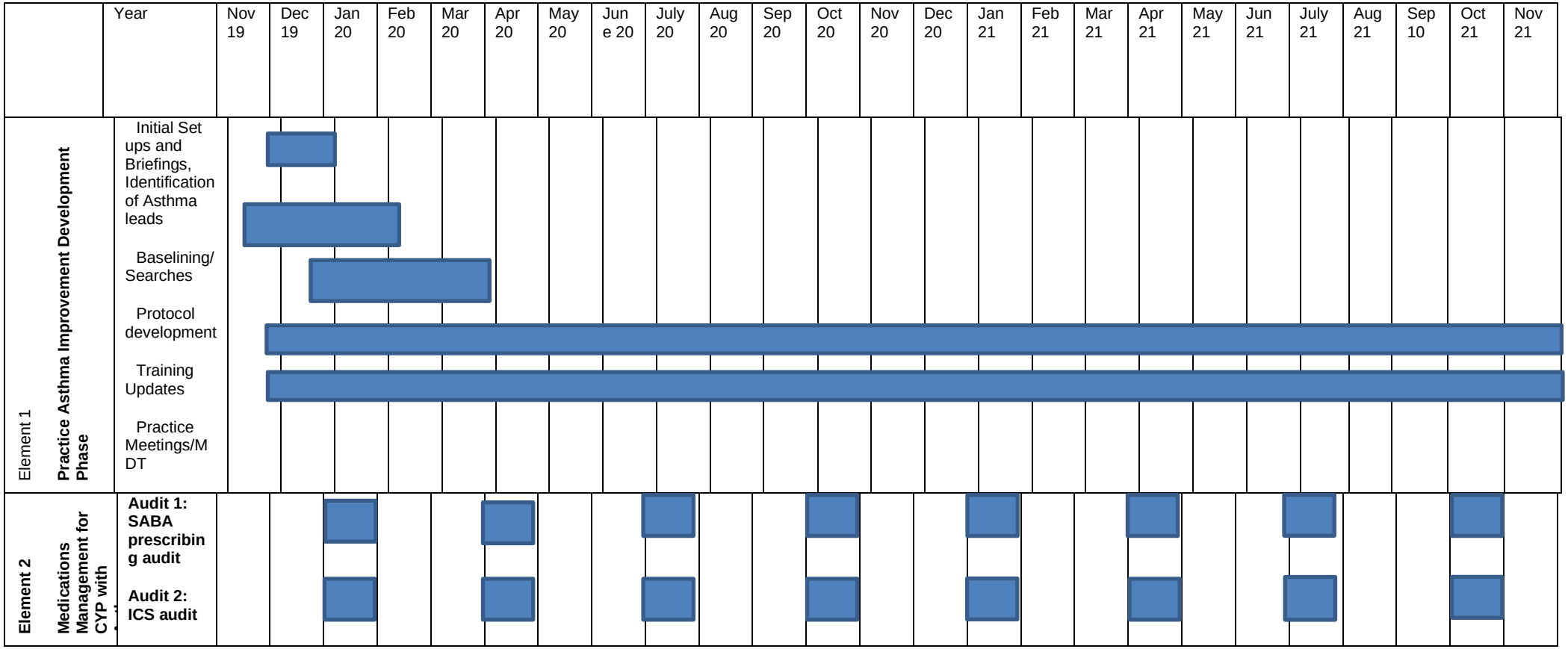
6. Payment Schedule

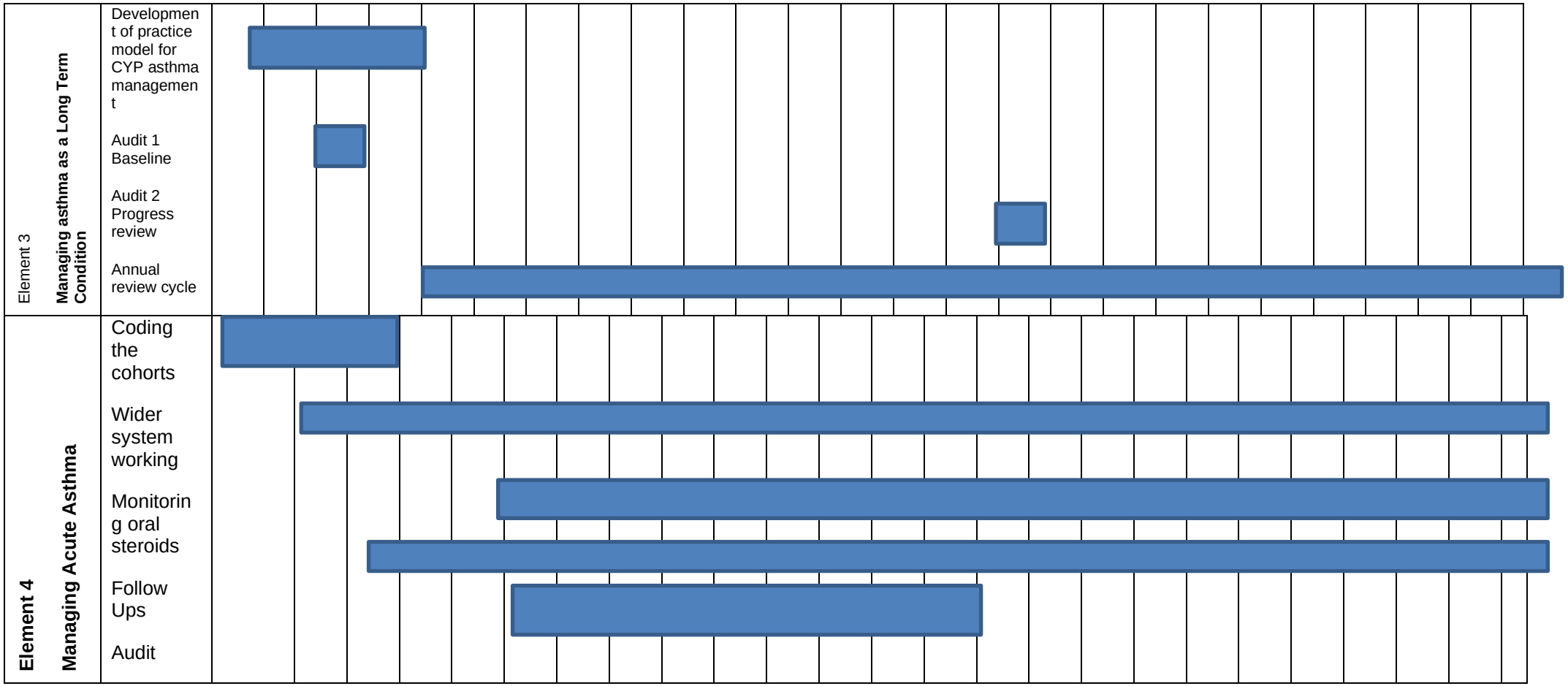
These payments set out the structure that the practices should adhere to against key deliverables.

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

Core actions for the LIS




Element 3
Managing asthma as a Long Term Condition
Development of practice model for CYP asthma management
Audit 1 Baseline
Audit 2 Progress review
Annual review cycle
Element 4
Managing Acute Asthma
Coding the cohorts
Wider system working
Monitoring oral steroids
Follow Ups
Audit