Paediatric Asthma Local CQUIN

**Note on CQUIN indicator**

**There are 5 parts to this CQUIN indicator:**

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| --- | --- | --- | --- |
| **Local CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| CQUIN 1a  | Meet London Asthma Standards for Acute Asthma for inpatient admissions. | 20% | £90,000 |
| CQUIN 1b | Ensure appropriate follow up for children attending ED / PAU at St Georges Hospital  | 20% | £90,000 |
| CQUIN 1c | Develop outpatient services for children at high risk from asthma  | 20% | £90,000 |
| CQUIN 1d | Closer integration of primary and secondary care asthma services | 20% | £90,000 |
| CQUIN 1e | Set up of school asthma programme | 20% | £90,000 |
|  | Total Value | 100% | £450,000 |

**1a. Meet** **London Asthma Standards for Acute Asthma for inpatient admissions.**

| **Indicator** |
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| **Indicator name** | Meet London Asthma Standards for Acute Asthma for inpatient admissions. |
| **Indicator weighting (% of CQUIN scheme available)** | 20% |
| **Description of indicator** | There are four parts to this indicator:* To develop the paediatric asthma team to comply with the London Asthma Standards and be able to provide 7 day services. To include recruitment of a consultant respiratory paediatrician, four paediatric asthma CNS, a therapist, a psychologist and administrative support.
* A member of the specialist asthma team to see all children admitted with acute asthma within 36 hours. Indicator: The percentage of children admitted with acute asthma who seen by the specialist asthma team within 36 hours of admission.
* All children admitted with acute asthma to have an assessment of severity of the attack, preceding asthma care and control and factors leading to the attack. Assessment of inhaler technique. Indicator: The percentage of children admitted with acute asthma who have an assessment of: severity of asthma attack, recent asthma control, inhaler technique and environmental smoke exposure.
* Every acute asthma attack should be used as an intervention to reduce future acute attacks. Indicator: The percentage of children admitted with an acute asthma attack who are discharged with a written asthma action plan, a plan for follow up in primary within 48 hours and a secondary care hospital clinic follow up within 4 weeks.
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| **Numerator** | The total number of children, of greater than 1 year of age, admitted to the children’s wards / PICU with a discharge diagnosis of acute asthma or viral wheeze who:1. Seen by a member of the specialist asthma team within 48 hours
2. Documented evidence of a structured assessment
3. Documented evidence of a written asthma plan including follow up.
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|  | The total number of children, of greater than 1 year of age, admitted to the children’s wards / PICU with a discharge diagnosis of acute asthma or viral wheeze |
| **Rationale for inclusion** | The outcome for children with acute asthma attacks is significantly poorer than the majority of European neighbours. The National Review of Asthma Deaths published in 2014 identified suboptimal management of children with acute asthma. This included the identification of the severity of acute asthma attacks and a structured approach to actions taken to reduce the risk of future attacks. Every asthma attack should be used as an opportunity to optimise asthma control and future management. In 2015, the London Asthma Standards were published to improve asthma care.The St Georges Hospital paediatric asthma team does not meet the criteria published in the London Asthma Standards for Children and Young People. Increases in staffing to provide adequate staff to see and assess children within their acute stay is required. There is poor documentation of a structured asthma assessment and education which can be improved with the input from a specialist asthma team.  |
| **Data source** | **Screening**Number of children admitted to the inpatient wards at St Georges Hospital.The following exclusions should be applied:1. Discard from sample all children who do NOT have a discharge diagnosis of asthma or acute viral wheeze. Number now remaining in sample becomes denominator.
2. Identify those who have been offered to be seen by a member of the specialist asthma team. Numerator 1
3. Identify those who have been offered a complete structured asthma review documented: severity of attack, recent asthma control, inhaler technique and smoke exposure. Numerator 2
4. Identify those who have a complete discharge plan documented: Written asthma action plan, Primary care follow up advised, secondary care follow up. Numerator 3

 Audit undertaken by specialist asthma team. |
| **Frequency of data collection** | Quarterly – see schedule |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | End of year |
| **Baseline period/date** | Q2 2016/17 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** |  |
| **Final indicator value (payment threshold)** |  |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |  |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see payment section below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |  |
| **EXIT Route** | To be determined  |

**1b. Ensure appropriate follow up for children attending ED / PAU at St Georges Hospital**

| **Indicator** |
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| **Indicator name** | Ensure appropriate follow up for children attending ED / PAU at St Georges Hospital |
| **Indicator weighting (% of CQUIN scheme available)** |  20% |
| **Description of indicator** | There are four parts to this indicator:* The percentage of children attending the Emergency Department at St Georges Hospital (not requiring admission to inpatient wards or PAU) who have a documented plan for follow up in primary care within 48 hours.
* The percentage of children attending the Emergency Department at St Georges Hospital for the second time within twelve months (not requiring admission to inpatient wards or PAU) who have a documented plan for follow up in secondary care.
* The percentage of children admitted to the Paediatric Assessment Unit (PAU) with acute asthma who seen by the specialist asthma team during their admission.
* The percentage of children admitted to the Paediatric Assessment Unit with an acute asthma attack with a structured review of their asthma and who are discharged with a written asthma action plan, a plan for follow up in primary within 48 hours and a secondary care hospital clinic follow up within 4 weeks.
 |
| **Numerator** | **Screening** Total number of patients sampled for case note review who were seen and treated in the Emergency Department (ED) with acute asthma or wheeze (greater than 1 year of age) with a documented plan for follow up in primary care. Numerator 1Total number of patients sampled for case note review who were seen and treated in the Emergency Department (ED) with acute asthma or wheeze (greater than 1 year of age) on more than one occasion within 12 months with a documented plan for follow up in secondary care. Numerator 2Total number of patients sampled for case note review who were seen and treated in the Paediatric Assessment Unit (PAU) with acute asthma or wheeze (greater than 1 year of age) offered to be seen by the specialist asthma team. Numerator 3.Total number of patients sampled for case note review who were seen and treated in the PAU with acute asthma or wheeze (greater than 1 year of age) who were offered a documented structured asthma review (severity of attack, recent asthma control, inhaler technique and smoke exposure and discharged with a written asthma plan and follow up. Numerator 3 |
| **Denominator** | **Screening**Total number of patients sampled for case note review who were seen and treated in the Emergency Department (ED) with acute asthma or wheeze (greater than 1 year of age).Total number of patients sampled for case note review who were seen and treated in the Paediatric Assessment Unit (PAU) with acute asthma or wheeze (greater than 1 year of age). |
| **Rationale for inclusion** | The outcome for children with acute asthma attacks is significantly poorer than the majority of European neighbours. The National Review of Asthma Deaths published in 2014 identified suboptimal management of children with acute asthma. This included the identification of the severity of acute asthma attacks and a structured approach to actions taken to reduce the risk of future attacks. Every asthma attack should be used as an opportunity to optimise asthma control and future management. In 2015, the London Asthma Standards were published to improve asthma care.The St Georges Hospital paediatric asthma team does not meet the criteria published in the London Asthma Standards for Children and Young People. Increases in staffing to provide adequate staff to see and assess children within their acute stay is required. There is poor documentation of a structured asthma assessment and education which can be improved with the input from a specialist asthma team. Many patients seem to use the ED for the mainstay of their asthma management. It is important to identify children attending the ED / PAU and ensure that they receive appropriate advice and follow up to reduce the chance of future significant attacks. |
| **Data source** | **Screening**Provider audit children attending the ED / PAU with a respiratory illness. From these, children with an acute asthma or wheeze (> 1 year of age) will be identified for inclusion. * Number of children attending ED / PAU with acute wheeze / asthma (>1 year) who were advised to arrange a follow up in primary care in 48 hours. Numerator 1
* Number of children attending ED / PAU with acute wheeze / asthma (>1 year) for the second time in 12 months who were offered a hospital asthma clinic follow up. Numerator 2
* Number of children attending ED / PAU with acute wheeze / asthma (>1 year) offered a structured review by the specialist asthma team whilst in the PAU. Numerator 3

Audit undertaken by the specialist asthma team staff. |
| **Frequency of data collection** | Quarterly – see schedule |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | End of Year |
| **Baseline period/date** | Q3 2016/17 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** | See section on payments |
| **Final indicator value (payment threshold)** | See section on payments for full information |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |  |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** |  |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |  |
| **EXIT Route** | To be determined  |

**1c. Develop outpatient services for children at high risk from asthma**

| **Indicator** |
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| **Indicator name** | Develop outpatient services for children at high risk from asthma |
| **Indicator weighting (% of CQUIN scheme available)** |  20% |
| **Description of indicator** |  There are five parts to this indicator:1. The clinic allows adequate time for the assessment and management of asthma.
2. Children should be seen by the multidisciplinary team for a structured review of their asthma. This should include a member of the medical team and a clinical nurse specialist at each appointment. Children over 5 should have physiology recorded at least annually.
3. Children with more difficult asthma should have access to a respiratory physiotherapist for assessment of dysfunctional breathing and a psychologist.
4. Children, or their families, should be able to access the clinic within 7 days if they are concerned about a loss of asthma control.
5. To develop a suitable database to record clinic activity.
 |
| **Numerator** | **Screening** Total number of number of children seen in clinic with a documented review by the medical team and asthma CNS including an asthma control test, inhaler technique assessment and written information including asthma action plan. Numerator 1Number of children with difficult asthma (see London Asthma Standards for definition) seen by a MDT (Medical, nursing, psychology and physiotherapy) Numerator 2 |
| **Denominator** | **Screening**Total number of children seen in the specialist asthma clinics run by the specialist asthma team at St Georges Hospital. Denominator 1Total number of children with difficult asthma. Denominator 2 |
| **Rationale for inclusion** | The outcome for children with acute asthma attacks is significantly poorer than the majority of European neighbours. The National Review of Asthma Deaths published in 2014 identified suboptimal management of children with acute asthma. This included the identification of the severity of acute asthma attacks and a structured approach to actions taken to reduce the risk of future attacks. Every asthma attack should be used as an opportunity to optimise asthma control and future management. In 2015, the London Asthma Standards were published to improve asthma care.The St Georges Hospital paediatric asthma team does not meet the criteria published in the London Asthma Standards for Children and Young People. Increases in staffing to provide adequate staff to see and assess children within their acute stay is required. There is poor documentation of a structured asthma assessment and education which can be improved with the input from a specialist asthma team. Children with asthma need regular review to ensure compliance with treatment and treatment techniques. There should be regular review to ensure that medications are used at an appropriate level in parallel to symptom control. Children with more problematic asthma must be assessed for underlying factors which may complicate their asthma or increase the risk of future acute attacks.Children whose control has deteriorated need access to specialist the asthma team at that time to try and prevent an acute deterioration. Development of a drop in service may help reduce ED attendance and hospital admissions.The current asthma clinic has limited flexibility as the appointments are at capacity. There is limited availability of asthma CNS to support the medical team. There is no dedicated physiotherapy or psychology to support the service. |
| **Data source** | **Screening**Provider audit children attending asthma clinics. To develop a suitable database for the clinic to record activity. Audit undertaken by the specialist asthma team staff. |
| **Frequency of data collection** | Quarterly – see schedule |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | End of year |
| **Baseline period/date** | Q3 2016/17 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** |  |
| **Final indicator value (payment threshold)** | See section on payments for full information |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |  |
| **Final indicator reporting date** | Q4, 2016/2017 |
| **Are there rules for any agreed in-year milestones that result in payment?** |  |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |  |
| **EXIT Route** | To be determined locally |

**1d. Closer integration of primary and secondary care asthma services**

| **Indicator** |
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| **Indicator name** | Closer integration of primary and secondary care asthma services |
| **Indicator weighting (% of CQUIN scheme available)** |  20% |
| **Description of indicator** | There are five parts to this indicator:* Regular meetings between primary and secondary care leads for asthma in children to review performance.
* Network of Paediatric Asthma CNS and primary care practice nurses to enable closer sharing of information regarding children with asthma. Develop mechanisms to ensure 48 hour review after acute presentation (consider appointments made in secondary care). Regular feedback on medicines management including uptake of preventers and bronchodilators.
* To develop joint primary and secondary care asthma clinics to share good practice and manage children and young people with uncertain diagnosis or problems with control. Consideration for secondary care led nursing clinics in areas where primary care unable
* Asthma CNS structured reviews in home
* Roll out of Children’s asthma toolkit. Shared documentation.
 |
| **Numerator** | **Screening**  |
| **Denominator** | **Screening**The number of Primary Care Centres in Wandsworth and North Merton.  |
| **Rationale for inclusion** | The outcome for children with acute asthma attacks is significantly poorer than the majority of European neighbours. The National Review of Asthma Deaths published in 2014 identified suboptimal management of children with acute asthma. This included the identification of the severity of acute asthma attacks and a structured approach to actions taken to reduce the risk of future attacks. Every asthma attack should be used as an opportunity to optimise asthma control and future management. In 2015, the London Asthma Standards were published to improve asthma care.Improving communication between primary and secondary care is very important in driving more consistent asthma care. Primary Care requires information regarding acute attendances to enable them to book a 48 hours review. Secondary care requires information about factors indicative of poor asthma control (medicines management, interval presentations, psychosocial issues) which are held in primary care. Consistent advice needs to come from all sources (inhaler techniques etc). Working together, more integrated primary and secondary care teams may reduce the number of children requiring direct referral to secondary care clinics and improvements in diagnosis, poor control and improved patient information may reduce acute asthma admissions. |
| **Data source** | **Screening**We aim to have a directory of practices, nominated asthma leads and practice nurses providing asthma clinics / reviews for children. Once set up this will be maintained.  |
| **Frequency of data collection** |  |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | End of year |
| **Baseline period/date** | Q3 2016/17 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** |  |
| **Final indicator value (payment threshold)** |  |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |  |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** |  |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |  |
| **EXIT Route** | To be determined locally |

**1e. Set up of school asthma programme**

| **Indicator** |
| --- |
| **Indicator name** | Set up of school asthma programme |
| **Indicator weighting (% of CQUIN scheme available)** |  20% |
| **Description of indicator** | There one part to this indicator:To develop a schools asthma programme akin to that devised in Ealing and NW London. Liaison with school nurses to focus on asthma in schools with agreed asthma policies, asthma registries, staff education and emergency plans / inhalers.  |
| **Numerator** | **Screening** Number of schools involved in schools asthma programme |
| **Denominator** | **Screening**Total number of primary and secondary schools in Wandsworth and North Merton. |
| **Rationale for inclusion** | The outcome for children with acute asthma attacks is significantly poorer than the majority of European neighbours. The National Review of Asthma Deaths published in 2014 identified suboptimal management of children with acute asthma. This included the identification of the severity of acute asthma attacks and a structured approach to actions taken to reduce the risk of future attacks. Every asthma attack should be used as an opportunity to optimise asthma control and future management. In 2015, the London Asthma Standards were published to improve asthma care.Children with poorly controlled asthma have increased time off school and are unable to fully access their education. School absence also impacts parental work. Schools with appropriate training may recognise poor asthma control and can be empowered to notify health services prior to a crisis. Children developing an acute asthma attack at school are likely to be transferred to hospital as a place of safety. Developing simple management plans and having appropriate medications on site may reduce the number of children requiring hospital transfer.There is little consistency in school asthma policies. Only a few schools have acted on the change in legislation allowing schools to hold emergency inhalers.  |
| **Data source** | **Screening**We will obtain a comprehensive list of schools in the boroughs and attached school nurses. Together to develop appropriate literature and education to standardise and improve asthma care in schools.  |
| **Frequency of data collection** |  |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | End of year |
| **Baseline period/date** | Q4 2016/17 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** |  |
| **Final indicator value (payment threshold)** |  |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |  |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** |  |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |  |
| **EXIT Route** | To be determined locally |

**Rules for payments**

**Meet London Asthma Standards for Acute Asthma for inpatient admissions.**

**Ensure appropriate follow up for children attending ED / PAU at St Georges Hospital**

| **Quarter** | **Acute Asthma Targets** | **Value** |
| --- | --- | --- |
| Q1 | **Complete internal business case for additional members of paediatric asthma team****Recruit project manager** | **£50000** |
| Q2 | **Advertisement for additional clinical staff****Baseline audit of inpatient care** **Engage IT services** **Interviews for additional clinical staff** | **£50000** |
| Q3 | **Baseline audit of ED / PAU assessment and discharge planning by interim resources** **(agency cost)** | **£50000** |
| Q4 | **Additional clinical staff start** **(use of temporary resource where recruitment unsuccessful) to hit 80% of identified post minimum****First audit of inpatient care – target 40% children >1 admitted with asthma offered to be seen, within 36 hours, by specialist asthma team with documented evidence of structured assessment and discharge planning.****First audit of ED / PAU care – target 20% children >1 seen suggested to have 48 hour Primary Care review arranged.** **To develop local tariff to cover recurrent staffing costs to provide ongoing service.** | **£50000** |
| **Full year – % of indicator weighting available** | **45%** | **£200000** |

**Develop outpatient services for children at high risk from asthma**

| **Quarter** | **Outpatient Asthma Targets** |  |
| --- | --- | --- |
| Q1 |  |  |
| Q2 | **Identify sites for additional clinics. Base line audit of OPD clinics.****Baseline audit of asthma clinic** | £100000 |
| Q3 | **Paediatric asthma database to go live** | £50000 |
| Q4 | **Additional clinical staff start** **(use of temporary resource where recruitment unsuccessful) to hit 80% of identified post minimum****First audit of outpatient care – target 40% children seen in OPD with asthma offered to be seen by MDT team (medical and CNS), given written asthma plans and inhaler technique checked, appropriate smoking cessation advice and medicines management.****Start of additional consultant led asthma clinics. Identify site and time of drop in clinics.****To develop local tariff to cover recurrent staffing costs to provide ongoing service.** | £50000 |
| **Full year – % of indicator weighting available** | **45%** | **£200000** |

**Closer integration of primary and secondary care asthma services**

**Set up of school asthma programme**

| **Quarter** | **Out of Hospital Targets** |  |
| --- | --- | --- |
| Q1 |  |  |
| Q2 | **Identify primary care centres, asthma leads and practice nurses.** | £16000 |
| Q3 | **Meeting for Clinical Leads****Start development of Paediatric Asthma Toolkit** | £7000£10000 |
| Q4 | **Additional clinical staff start** **(use of temporary resource where recruitment unsuccessful) to hit 80% of identified post minimum****Meeting with School Nurses,****Audit of Schools Asthma Policies****Identify first schools for asthma education project.** **To develop local tariff to cover recurrent staffing costs to provide ongoing service.** | £8500£8500 |
| **Full year – % of indicator weighting available** | **10%** | **£50000** |

**Supporting Guidance and References**

Standards for Children with Asthma in London http://www.londonscn.nhs.uk/wp-content/uploads/2015/07/cyp-asthma-stds-

062015.pdf.

Royal College of Physicians. Why asthma still kills: the National Review of Asthma Deaths (NRAD) confidential enquiry report.

London: RCP, 2014.

British Thoracic Society and Scottish Intercollegiate Guidelines Network (SIGN). British guideline on the management of asthma. A

National Clinical Guideline. (SIGN publication no. 101) <http://www.sign.ac.uk/guidelines/fulltext/101/index.html>.

Haahtela T, Tuomisto LE, Pietinalho A, Klaukka T, Erhola, et al. 10 year asthma programme in Finland: major change for the better.

Thorax 2006; 61: 663e70.