London asthma standards for children and young people

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

July 2015 – Produced by the Children and Young People's Strategic Clinical Network

February 2016 – Revised by Healthy London Partnership's Children and Young People's Programme

About this document

These standards bring together the aspirations for London, the NICE Asthma standards, British Thoracic Society guidelines and a number of other key resources into one document. They were developed by the London Strategic Clinical Network for Children and Young People's Asthma Pathway Group, with a review by members of the Strategic Clinical Leadership Group and the Commissioning Advisory Group, National Paediatric Asthma Group, Royal College of Physicians, British Thoracic Society, Royal College of Anaesthetists, and Asthma UK.

This revision has been undertaken by Healthy London Partnership to incorporate the latest standards.

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Introduction

Purpose

Healthy London Partnership is a collaboration between London's 32 clinical commissioning groups (CCGs) and NHS England London region to support better health for London. The Children and Young People Programme was established to bring about transformational change in services for children and young people. One of the key pieces of work undertaken recently has been to identify existing standards relating to the care of children and young people. A piece of work was carried out to collate standards for acute care into one document setting out the minimum standards which should be delivered in acute services for children and young people in London.[1] In addition a piece of work has been carried out by the primary care transformation group to look at the *Transforming Primary Care in London: a Strategic Commissioning Framework*. [2]

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

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

SUMMARY

Each organisation (primary and community care, acute care, pharmacy, schools, social care, prisons and young offenders units) will have a clear named lead who will be responsible and accountable for asthma (which includes children) and the delivery of **London's Ambitions for Asthma**.

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

Utilisation of these standards will start to reduce the enormous variation in outcomes that children and young people experience across the capital. In this document the term children or child should be taken as meaning children and young people under the age of eighteen years. There is a need to provide age-appropriate services and settings, particularly for those aged 16-18. Clear policies should be in place in hospitals where such people are admitted (eg paediatric wards, adult wards, or a particular adolescent ward) to avoid disputes in an accident and emergency department as to whether such a young adult is 'paediatric' or 'adult' for their medical care (London SCN 2015).[1]

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

Audience

This document will be of use to commissioners and providers of asthma services for children and young people. It sets out our aspirations for children and young people asthma care in London alongside the NICE quality standards (NICE, 2013) to enable the effective commissioning of services which meet these required minimum standards.[3] Providers will be able to use these to undertake self-assessment of their ability to deliver the required quality of care for children and young people with asthma. The standards can be used to validate, challenge and to quality assure services.

Inclusions

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

Exclusions

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

Population based networks for children and young people

Some of the issues in delivering effective healthcare to children and young people have arisen because of the fragmentation of services and the lack of integration of providers. This applies to services in primary, community, secondary, and tertiary care.

Analysis of serious incidents by the Children and Young People's Strategic Clinical Networks has shown that children and young people are often subject to a failure of care when moving across care settings. More effective linkage of providers and commissioners would help to reduce these issues. A model of population-based networks based on linkages between providers and commissioners across all settings is proposed to address these issues. This is strongly aligned with the recently published Five year forward view (NHS England, 2014).[5] This acknowledges the traditional divide between different parts of the health system which act as a barrier to coordination and personalisation of care. It recommends dissolving these boundaries to ensure more effective coordination of care. New models will emerge and Healthy London Partnership is keen that care for children and young people is central to these developments.

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

Further standard development

Healthy London Partnership is aware that the standards developed so far do not describe all areas of care for children and young people. It will continue to develop additional standards across a variety of care settings. Community standards will be the next area of work for Healthy London Partnership's Children and Young People's Programme.

Overall care must be based on the United Nation Convention on rights of a child that says that every child has the right to:

- A childhood (including protection from harm)
- Be educated (including all girls and boys completing primary school)
- Be healthy (including having clean water, nutritious food and medical care)
- Be treated fairly (including changing laws and practices that are unfair on children)
- Be heard (including considering children's views)

London's ambitons for asthma care

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

Proactive care

Every child with asthma should have:

- **Named professionals**
  Have access to a named set of professionals working in a network who will ensure that they receive holistic integrated care which must include their physical, mental and social health needs.
- **Support to manage themselves**
  Be supported to manage their own asthma with the help of their family including access to advice and support so they are able to lead lives free from symptoms.
- **Smoke-free environments**
  Grow up in an environment that has clean air that is smoke free.
- **Exercise opportunities**
  Have access to an environment that is rich with opportunities to exercise.

Accessible care

Every child with asthma should have:

- **Timely diagnosis**
  Have their diagnosis and severity of wheeze established in a timely fashion.
- **Prompt access to their inhaler**
  Have prompt access to their inhaler device and other medicines and asthma care advice from trained named professionals or asthma champions in school.
- **Immediate medical care, advice and medicines**
  Have access to immediate medical care, advice and medicines in an emergency.
- **High-quality, evidence-based care**
  Have access to high quality, evidence based care from primary, secondary and tertiary healthcare professionals within a timely manner, 24 hours a day, seven days a week.

Coordinated care

Every child with asthma should have:

- **Asthma management plan**
  Be enabled to manage their own asthma by having access to a personalised, interactive, evidenced based asthma management plan linked to their medical record which they understand.
- **Regular structured reviews**
  Have a regular structured review by trained healthcare professionals at least yearly or every three months, depending on control, and within two working days after an exacerbation.
- **Commissioned care package**
  Have access to a commissioned package of care which includes educational packages, self-management tools and access to peer support.
- **Real time information sharing**
  Be able to expect all professionals involved in their care to share clinical information in real time to ensure seamless care.
- Structured, formalised transition processes
  Have access to a structured, formalised transition processes from child to adult care to ensure children don't fall between the gaps.

A. ORGANISATION OF CARE

	Standard	Evidence	Ref
1	All organisations/services* must have a named **lead responsible and accountable for asthma** (which includes childrem and young people (CYP)).	■ Governance structure which states the asthma lead.	2, 3, 6, 16
2	There are formal partnerships established between providers of CYP services. There is demonstration of a **commitment to work within a multidisciplinary** network of care** across the pathway that focusses on children with asthma and links providers, commissioners, public health and local authorities with CYP and their families. The networks develop shared pathways, protocols and consider workforce planning. There is evidence of collaboration between all sectors including local children's safeguarding boards.	■ Network terms of reference, membership and accountability of the group. ■ Progress reports to CCGs and trust board as required. ■ Participation in network meetings. ■ Shared network protocols and guidelines for diagnosis, treatment and care. ■ Regular assessment of performance in place. ■ Workforce planning. ■ Examples of measures to improve service delivery across the network.	1, 7, 8, 9, 10, 11
3	There is a programme of **audit and ongoing improvement** within each service. This includes input into the national severe asthma data registry, annual British Thoracic Society (BTS) paediatric asthma audit and any future national asthma registry.	■ Terms of reference, membership and accountability of the group. ■ Progress reports to CCGs and trust board as required. ■ Electronic templates, severe asthma registry, primary and secondary care database, GP practice children's asthma register, school asthma register. ■ Audits of the following in primary, secondary and tertiary care: » Number of CYP with asthma. » Number of CYP with asthma plans. » Number of prescriptions of inhaled steroids. » Number of CYP with more than one emergency admission / three A&E attendances. » Number of CYP admitted to PICU and HDU. » Number of annual reviews. » Number of follow-ups 48 hours after an exacerbation. » Yearly submission to BTS Audit (November). » Mortality rates. » Yearly emergency department audit (CEM).	1, 3, 10, 11, 12, 30, 44

* Organisations / services - Schools, hospitals, GP surgeries, pharmacy or community providers, prisons and young offender's programmes.
** Multidisciplinary team includes primary, secondary and tertiary care, schools, pharmacists, local authority, commissioners and providers, children and young people and their family / carers and social worker as appropriate.

A. ORGANISATION OF CARE

	Standard	Evidence	Ref
4	The organisation has, or is moving towards, a **strategy that ensures communication / interaoperability between diverse IT systems** in hospital, community, pharmacy and any CYP healthcare setting. It uses a unified clinical record throughout the patient's journey, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the care pathway (community to tertiary) and allows for service audit. This includes the ability to flag / code any concerns (eg any child subject to plan). Cultural beliefs of the child and family must be taken into consideration.	■ Strategy available for » Information systems which facilitate seamless care packages across the pathway. » Up-to-date unified record being used by all staff and electronic transfer of information for organisations such as schools and pharmacy.	1, 7, 13, 14, 28
5	The organisation allows adequate clinic **time for assessment and management of the child** by a healthcare professional. Best practice: ■ 20-30 minutes in primary / community care and acute/secondary care. ■ 45 minutes first appointment. ■ 25 minutes for follow up in tertiary care. ■ 10 minutes for a pharmacy advanced medication consultation.	■ Clinic slots and templates.	15
6	Every child has an **assessment of the triggers** for their wheeze and is educated about how to deal with this. Children with asthma should be screened for other atopic comorbidities, in particular allergic rhinitis and food allergy. There is access to a **paediatric allergy service** for assessment and appropriate management, including adrenaline auto injector device prescription and training if required.	■ Service specification or contracts and pathway. ■ Audit of notes, referrals and numbers accessing services.	3, 6, 16, 17, 18, 19, 20
7	Consultations **routinely promote healthy lifestyles**, including assessment of long term health needs, such as: ■ Systematic approach to obesity (eg growth measurement, calculation of BMI). ■ Assessment of CYP and family for living conditions and housing freed from damp and mould, alcohol, drugs and smoking. Every child and their family **are assessed at health or social care encounters for their exposure to smoking either actively or passively** (this includes e-cigarettes). They should be provided with brief advice and referred to smoking cessation clinics. There is **access to smoking cessation clinics** and other support services for families, Fraser competent CYP and carers that address issues of smoking and monitor outcomes.	■ Evidence that assessment has taken place and documented. ■ Service specification or contracts. ■ Audits of referrals and numbers accessing services. *Numerator* – Number of people in the denominator (including Fraser competent CYP) who are assessed for carbon monoxide levels 4 weeks after the quit date. *Denominator* – Number of people who smoke who have set a quit date with an evidence-based smoking cessation service.	3, 6, 13, 15, 16, 21, 22, 23, 24, 25, 26, 28
8	There is access to paediatric physiotherapist with an interest in dysfunctional breathing (ideally with ability to direct refer from primary care).	■ Service specification or contract.	15, 27

B. PATIENT AND FAMILY SUPPORT, INFORMATION PROVISION AND EXPERIENCE

This should not only include the experience of the patient and carer going through the service, but also demonstrate how they are involved in the assessment, running and development of any future service.

	Standard	Evidence	Ref
9	CYP and their families are **actively involved in reviewing local service provision and giving feedback** on services to improve patient experience.	■ Minutes demonstrating patient involvement in decisions about service development. ■ Patient experience measures in place/feedback regularly audited and fed back. ■ Evidence that complaints are used to improve services. ■ Evidence of involvement in relevant consultations.	1, 28
10	The organisation **participates in routine NHS surveys for CYP** (eg CQC National Inpatient Survey, Friends and Family Test and action plans reviewed by network).	■ Reporting and action plans.	1, 11, 28, 47
11	CYP and their families receive **sufficient information, education and support** to encourage and enable them to participate actively in all aspects of their care and decision-making. This means information is tailored to their needs in an accessible format (eg written information may use pictures, symbols, large print, Braille and different languages) throughout the care pathway extending into schools and community settings.	■ Portfolio of available information. ■ Available support documentation.	2, 6, 29, 30, 31
12	CYP and their families have **access to self-management support packages** which may include peer support.	■ Service specification or contracts for self-management programmes. ■ Audits of referrals and numbers accessing services and outcomes.	6
13	NICE Statement 4: People with asthma are given **specific training and assessment in inhaler technique** before starting any new inhaler treatment. (This should be age appropriate.)	■ Structure: Evidence of local arrangements to ensure people with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment. ■ Process: Proportion of people with asthma who are given specific training and assessment in inhaler technique before starting any new inhaler treatment. *Numerator* – Number of people in the denominator who have training and assessment in inhaler technique. *Denominator* – Number of people with asthma starting a new inhaler treatment.	3, 13, 16, 32

C. OUT OF HOSPITAL CARE

	Standard	Evidence	Ref
14	Diagnosis can be difficult in CYP NICE Statement 1: People with newly **diagnosed asthma are diagnosed in accordance with BTS/SIGN[13] and NICE[34] guidance**.	■ Structure: Evidence of local arrangements to ensure people with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance, and that the process is documented in their patient notes. ■ Process: Proportion of people with newly diagnosed asthma whose notes describe the process, as outlined in the BTS/SIGN guidance, by which the diagnosis was made. *Numerator* – Number of people in the denominator whose notes describe the process, by which the diagnosis was made. *Denominator* – Number of people with newly diagnosed asthma.	3, 6, 11, 13, 33, 34, 35
15	NICE Statement 6: People with asthma who present with respiratory symptoms receive an **assessment of their asthma control**.	■ Structure: Evidence of local arrangements to ensure people with asthma presenting with respiratory symptoms receive an assessment of their asthma control. ■ Process: Proportion of people with asthma presenting with respiratory symptoms who receive an assessment of their asthma control. *Numerator* – Number of people in the denominator receiving an assessment of their asthma control. *Denominator* – Number of people with asthma who present with respiratory symptoms.	3, 13, 32
16	NICE Statement 10: People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode are **followed up by their own GP practice within two working days or less*** of treatment. If required secondary care follow up is provided within one month for every child admitted with asthma and for patients who have attended the emergency department two or more times in the past 12 months.	■ Structure: a) Evidence of local arrangements and systems put in place to ensure people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment. b) Evidence of local arrangements to ensure effective communication between secondary care centres (such as hospitals and out-of-hours services) and primary care. ■ Process: Proportion of people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma who are followed up by their own GP practice within 2 working days of treatment. *Numerator* – Number of people in the denominator followed up by their own GP practice within two working days of treatment. *Denominator* – Number of people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma.	3, 13, 16

* Primary, secondary, and tertiary care should put systems in place to enable this.

D. SCHOOLS

	Standard	Evidence	Ref
17	Clear **effective partnership arrangements are in place between health, education and local authorities** for management of CYP with asthma within primary and secondary schools (*Asthma friendly schools* programmes). This includes the adoption of government policy on emergency inhalers and early years settings such as children's centres having access to education programmes for the wheezers.	■ Joint policy between CCG and local authority for the improvement of asthma care in primary and secondary schools. ■ Education programme for staff, students and parents. ■ Directory of updated asthma leads shared between organisations.	6, 7, 36
18	CYP have an **individual healthcare /action plan in place**. The school has in place: ■ **Register of all CYP** with asthma. ■ **Management plan** for each child. ■ **Named individual responsible for asthma** in school. ■ **Policy for inhaler techniques** and care of the CYP with asthma. ■ **Policy regarding emergency treatment**. ■ **System for identifying children** who are missing school because of their asthma or who are not partaking in sports / other activities due to poor control.	■ Up to date register of children in school with asthma. ■ Individual management plans for CYP. ■ Named individual's job plan / roles and responsibilities state asthma. ■ Policies for management of CYP with asthma, emergency procedures / treatment and inhalers in schools. ■ Audit of absenteeism monitoring. ■ Audit of asthma care and prevalence across schools. ■ Whole school approach to training. ■ Directory of local asthma leads and contact details.	6, 13, 35, 36, 37, 38

E. ACUTE CARE

19	The organisation **complies with existing standards, such as the London acute care standards for CYP (which incorporate the London Quality Standards)** and safeguarding policies.	■ Demonstrated in published plans, reports and in management structure to support the service. ■ Audit and compliance against standards. ■ Self-assessment against *London Acute care standards for CYP* and action plan. ■ Compliance with regulatory policies in particular safeguarding around failed to attend policies.	1, 11, 39
20	All CYP who present in an emergency are **managed according to local policies and protocols** and NICE guidance which incorporate **acute management, education ongoing treatment and discharge** arrangements, including ensuring communication with community care **electronically within 24 hours**.	■ Local policies and protocols in GP, community care, emergency departments and urgent care centres. ■ Systems in place to communicate electronically, preferably by a single patient record.	3, 6, 7, 10, 13, 32

E. ACUTE CARE

	Standard	Evidence	Ref
21	NICE Statement 7: People with asthma who present with an exacerbation of their symptoms receive an **objective measurement of severity*** at the time of presentation.	■ Structure: Evidence of local arrangements to ensure people with asthma presenting with an exacerbation of their respiratory symptoms receive an objective measurement of severity at the time of presentation. ■ Process: Proportion of people with asthma presenting with an exacerbation of their respiratory symptoms who receive an objective measurement of severity at the time of presentation. *Numerator* – Number of people in the denominator receiving an objective measurement of severity at the time of presentation. *Denominator* – Number of people with asthma presenting with an exacerbation of their respiratory symptoms.	3, 6, 13
22	NICE Statement 8: People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive **oral or intravenous steroids within one hour of presentation** and seen by the respiratory team directly.	■ Structure: Evidence of local arrangements to ensure people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation. ■ Process: Proportion of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma who receive oral or intravenous steroids within 1 hour of presentation. *Numerator* – Number of people in the denominator receiving oral or intravenous steroids within one hour of presentation. *Denominator* – Number of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma.	3, 13
23	NICE Statement 9: People admitted to hospital with an acute exacerbation of asthma have a **structured review** by a member of a specialist respiratory team** **before discharge**. The structured review includes: ■ Assessment of control (Children's Asthma Control Test (ACT)[40] if aged over 4 years) and / or triggers for wheezing. ■ Inhaler techniques. ■ Self-management and how to manage acute exacerbations. ■ Personal asthma action plan.	■ Structure: Evidence of local arrangements to ensure people admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge. ■ Process: Proportion of people admitted to hospital with an acute exacerbation of asthma who receives a structured review by a member of a specialist respiratory team before discharge. *Numerator* – Number of people in the denominator receiving a structured review by a member of a specialist respiratory team. *Denominator* – Number of people discharged from hospital after admission for an acute exacerbation of asthma.	3, 6, 13, 40, 41, 42

* BTS/SIGN guideline: Table 10 or annex 3 for adults; Table 12 or annex 5, 6 or 7 for children older than 2 years.
** Specialist is defined as paediatric consultant with respiratory interest or an asthma clinical nurse specialist with specific training in viral induced wheeze, asthma management and discharge planning.

	Standard	Evidence	Ref
F.	**HIGH RISK CARE**		
24	There are **systems in place in acute and community care for identifying patients at high risk, poorly controlled or severe asthma and monitoring/tracing and managing** those CYP who have had in the last year: ■ More than one admission. ■ Admission to HDU, ICU, PICU. ■ Two or more attendances to the emergency department or out of hours care in the last year. ■ Two or more unscheduled visits to the GP (requiring short courses of oral steroids). ■ Ten or more salbutamol inhalers. ■ 80 per cent or less uptake of repeat preventer prescriptions.	■ System in place to identify and manage high risk patients and ongoing audit to demonstrate effectiveness. ■ High risk register. ■ Evidence of inhaler technique medication reviews. ■ Audit data demonstrating numbers of: » Referrals onto secondary/ tertiary care. » CYP admitted with asthma and frequency. » CYP on high risk register. » Patients admitted to HDU / PICU / ICU in last year. » Repeat attenders to A&E / GP practice. » Children with 10 or more salbutamol inhalers. » Repeat preventer prescription.	2, 6, 7
25	There is access to paediatric physiotherapist with an interest in dysfunctional breathing (ideally ability to direct refer from primary care).	■ Service specification or contract.	15, 27
G.	**INTEGRATION AND CARE COORDINATION** Services for children, young people and their families should be provided by a range of health and social care professionals and agencies working collaboratively, to ensure the highest standard of care for children and young people at all times.		
26	There are agreed **effective, integrated pathways to ensure the smooth transition between healthcare settings** (ie primary care to secondary or tertiary care). These include shared care, referral and discharge protocols between community and specialist and access to prompt specialist advice and help.	■ Shared care, referral and discharge pathways and policies.	6, 7, 10
27	NICE Statement 3: People with asthma receive a written **personalised action plan.** (This should be age appropriate.)	■ Structure: Evidence of local arrangements to ensure people with asthma receive a written personalised action plan. ■ Process: a) Proportion of people with asthma who receive a written personalised action plan. b) Proportion of people treated in hospital for an acute exacerbation of asthma who receives a written personalised action plan before discharge. *Numerator* – Number of people in the denominator receiving a written personalised action plan before discharge. *Denominator* – Number of people treated in hospital for an acute exacerbation of asthma.	2, 3, 6, 13

G. INTEGRATION AND CARE COORDINATION

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

	Standard	Evidence	Ref
28	NICE Statement 5: People with asthma receive a **structured review* at least annually** (preferably every three months, depending on severity and clinical need). This must include understanding of their condition and treatment, assessment of adherence, inhaler technique and children's ACT[40] for those aged over four years.	■ Structure: Evidence of local arrangements to ensure people with asthma receive a proactive structured review at least annually. ■ Process: Proportion of people with asthma who receive a structured review at least annually. *Numerator* – Number of people in the denominator who had a structured review within 12 months of the last review or diagnosis. *Denominator* – Number of people with asthma. ■ Monitoring QOF exception rates.	2, 3, 6, 7, 13, 16, 39, 40, 42
29	NICE Statement 11: People with difficult asthma** are offered an **assessment by a multidisciplinary difficult asthma service**.	■ Structure: Evidence of local arrangements to ensure people with difficult asthma are offered an assessment by a tertiary led multidisciplinary difficult asthma service. ■ Process: Proportion of people with difficult asthma who receive an assessment by a multidisciplinary difficult asthma service. *Numerator* – Number of people in the denominator receiving an assessment by a multidisciplinary difficult asthma service. *Denominator* – Number of people with difficult asthma.	15
30	There is a system to communicate the name of the **responsible lead / link person** caring for child to patients and families.	■ Monitored on a case by case basis. ■ Audit of CYP to see if they know who is their link person.	1, 10, 11, 42
31	Support services, both in the hospital and in primary, community and mental health settings are available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily health care professional led review, can be taken.	■ Description of services, audit of notes, rotas.	1, 10, 43, 45

* A structured review should follow the London review template (in development) but should include, height, weight, immunisation, health education (diet, exercise and smoking status).
** Children on step 4 / 5 of the BTS/SIGN guidelines with on-going poor control (ACT / cACT ≤19 and / or ≥ 2 admissions in past year and / or ≥ 3 courses of high dose oral corticosteroids (OCS) in past 2 years and/or persistent airflow limitation (FEV1 < 80% post bronchodilator) and all children prescribed maintenance OCS or under consideration for omalizumab or other novel biological drug whatever the level of control.

H. DISCHARGE / CARE PLANNING

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

	Standard	Evidence	Ref
32	Systems are in place to ensure **safe discharge and transfer between providers**. This includes the following: ■ All admitted CYP have discharge planning and an **estimated discharge date** as part of their management plan as soon as possible. ■ The primary care team / GP is informed of discharge within agreed timescale of each attendance and **follow up is booked within two days** (including health visitor and school nurse). ■ Information is provided to GP and community teams **electronically within 24 hours**. ■ Clear **written information and advice** is provided to families which includes what to do, when and where to access further care if necessary, clear instructions on follow up and arrangements in case of emergency at home. This includes telephone advice. ■ Pharmacies **ensure availability of medicines** and utilisation of home delivery services. This is of greater relevance for weekend discharge.	■ Telephone advice offered / feedback from patients / supporters / description of telephone follow up service and GP links. ■ Audit of notes (discharge planning and timelines). ■ Discharge information provided within 24 hours. ■ System in place for follow up within two days. ■ Standard written discharge information is available. ■ Pharmacy systems in place to ensure medicines available in a timely fashion.	10, 11, 43, 44, 45, 46

I. TRANSITIONAL CARE

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

33	There is a **clear lead clinician responsible for transition** leading work on policies and pathway of care to prepare young people for the transition to adult service.	■ Operational policy for paediatric service. ■ Identified lead (role identified in job plan and appraised). ■ Transition policy and pathway of care available.	1, 6, 7, 28, 30, 46, 47, 48, 49, 50, 51
34	**Transition is properly planned**, and a named key worker is appointed for each child in their approach to transition to oversee the process and collaborate with other professionals. The young person is involved in the planning and delivery of their own care.	■ Operational policy for paediatric service. ■ Clear referral process in place. ■ Audit of effectiveness. ■ Named key worker. ■ Child / parent being involved in care plan. ■ Written handover.	6, 7, 28, 49, 50

I. TRANSITIONAL CARE

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	Standard	Evidence	Ref
35	There is a **shared protocol between children's and adult services**, which is a genuinely shared arrangement and is properly implemented.	■ Operational policy for paediatric service. ■ Shared protocol available. ■ Patient involvement in plans on audit. ■ Written handover.	6, 7, 30, 49

J. EFFECTIVE AND CONSISTENT PRESCRIBING

36	There are **systems in place to minimise prescription and drug administration errors**. This includes: ■ Utilising current systems to monitor adherence to national and local prescribing guidelines. ■ Development or identifying appropriate education and training resources to **support adherence** to prescribing guidelines. ■ Utilising current systems to monitor near misses and medication errors in primary and secondary care settings.	■ Operational policy for paediatric asthma service. ■ British National Formulary for children available. ■ Processes in place to minimise errors, reporting and review of errors and near misses and to spread learning. ■ Adherence to CQC standards in medicines management.	1, 11, 52, 53
37	There are systems in place to: ■ Identify, monitor, and manage through an **alert system** to clinicians the numbers of prescriptions for prednisolone, inhaled steroids, 10 or more preventer inhalers in a year, children with asthma and flu jab uptake. ■ Identify and manage CYP prescribed inhalers at doses higher than recommended in product licence. ■ MURs and new medicine reviews for to promote medicines optimisation including inhaler technique assessment for CYP. ■ **Note**: *Reviews with parents for younger children:* PSNC guidance states the patient must be competent to give consent to receive the service and to share information as required by the consent arrangements in order to be eligible to receive the service. There is no minimum age, but pharmacists will know that the younger the child, the greater the likelihood is that they would not be competent. ■ Use of CCG medicines management teams to develop local prescribing guidelines to support evidenced based care for CYP. ■ Coordination between CCG medicine management pharmacists, secondary care pharmacists and community pharmacists to monitor adherence to national and local prescribing guidelines. ■ Use of community pharmacists to monitor and promote medicines optimisations initiatives through the application of clinical audits and health promotion campaigns within the community pharmacy contractual framework.	■ Policy in place for medicines optimisation. ■ Audits demonstrating numbers of patients in practice with: » Two or more prescriptions for prednisolone in a year. » Number of inhaled steroids. » Number of preventative inhalers is greater than 10. » Flu vaccination uptake. ■ Local prescribing guidelines. ■ Participation in health promotion campaigns and audits.	7, 52, 53, 54, 55, 56, 57, 58

K. WORKFORCE EDUCATION AND TRAINING

	Standard	Evidence	Ref
38	There is access to **multidisciplinary team for advice, diagnostics and management support** which includes specialist paediatric asthma nurse, physiotherapist, paediatric dietician, paediatric pharmacists, psychologist and pulmonary technicians (within tertiary clinic).	■ Service specification, job roles and rotas demonstrating available support.	3
39	Children and young people have contact with **healthcare professionals who have received appropriate training and ongoing education in paediatric asthma with appropriate updating at least every three years**, including access to a specialist paediatric nurse with asthma diploma level training and CPD in paediatric asthma. This includes primary care and the wider MDT such as pharmacists, health visitors and schools. At least **one practice nurse** in every practice or **someone in every school** is **trained** in managing asthma (ie holds a recognised certificate of competence, such as an asthma diploma), and has experience in supporting children with long term conditions. Community pharmacists who wish to undertake an extended role in delivery of MURs are trained and competent to do so.	■ Rotas and training and needs assessment undertaken and action plan for training of current and future MDT workforce. ■ Continuing professional development and competency.	3, 6, 7, 16, 59
40	All healthcare professionals who work with CYP and their parents and carers should undertake the validated 20 minute online training from the National Centre for Smoking Cessation Training on Very Brief Advice or an equivalent evidence-based programme.	■ Training provision and number of staff who have undertaken the training.	25
41	Networks develop a formal shared education programme and **encourage rotation of staff and shared learning opportunities** and standardisation to develop and maintain skills across the care pathway.	■ Staff rotation and education programmes across geographical networks.	1, 60
42	Unregistered staff* have completed a course of training specific to the setting and tasks being carried out, and in the care of infants, CYP and have undergone a period of competence assessment before carrying out care and delegated tasks.	■ Training records for unregistered staff.	1, 61, 62, 63

* Unregistered staff may include receptionists, healthcare assistants and technicians.

Appendix

Glossary

ACT	Asthma Control Test
A&E	Accident and emergency
BHfL	Better Health for London
BMI	Body mass index
BTS	British Thoracic Society
CCG	Clinical commissioning group
CEM	Centre for Evaluation and Monitoring
CYP	Children and young people
CPD	Continuing professional development
CQC	Care Quality Commission
DH	Department of Health
FEV1	Forced expiratory volume
GINA	Global Initiative on Asthma
GP	General practitioner
HDU	High dependency unit
MUR	Medicines use review (Pharmaceutical Advanced Service)
NMS	New medicine service (Pharmaceutical Advanced Service)
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NRAD	National Review of Asthma Deaths
OPD	Outpatient department
PICU	Paediatric intensive care unit
PSNC	Pharmaceutical Services Negotiating Committee
QOF	Quality and Outcomes Framework
RCA	Royal College of Anaesthetists
RCN	Royal College of Nursing
RCPCH:	Royal College of Paediatrics and Child Health
SCN	Strategic clinical network
SI	Serious incident
SIGN	Scottish Intercollegiate Guidelines Network

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Useful links

Education for health free asthma module training tool

Working in conjunction with the *George Coller Memorial Fund*, Education for Health has developed this free online educational resource '*Supporting Children's Health*'. The online resource provides basic information on how to support children and young people with asthma.
www.supportingchildrenshealth.org/asthma-module

PRIMIS

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

NHS PrescQIPP

Respiratory webkit, asthma focus bulletin and inhaler technique review tools for those who prescribe, covers

- Bulletin and briefing (including implementation versions) with recommendations on NRAD.
- Pathway documents for adults, children and younger children.
- Audit tools, including auto system searches for SystmOne and EMIS.
- Patient materials.
- Inhaler technique assessment tools for nine different kinds of inhalers.

www.prescqipp.info

Primary Care Respiratory Society UK

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

Asthma UK

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

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