

Children’s Community Asthma and Atopy Nursing Service Operational Policy

|  |  |
| --- | --- |
| Version number : | 2.0 |
| Consultation Groups | Specialist Children and Young People Services Governance Group, CCNS Senior Management Team |
| Approved by (Sponsor Group) | Specialist Children and Young People Services Governance Group |
| Ratified by: | Community Health Newham Children’s Clinical Governance Group |
| Date ratified: | 13th March 2024 |
| Name of originator/author: | Community Children’s Matron, Newham  Children’s Community Atopy CNS  Children’s Community Asthma and Wheeze CNS |
| Executive Director lead: | Director of Specialist Services |
| Implementation Date: | March 2024 |
| Last Review Date | January 2024 |
| Next Review date: | January 2027 |

|  |  |
| --- | --- |
| Services | Applicable |
| Trust wide |  |
| Mental Health and LD |  |
| Community Health Services |  |

Version Control Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Date | Author | Status | Comment |
| 1.0 |  | Emily Guilmant-Farry | New policy written |  |
| 2.0 | December 2023 | Emily Guilmant-Farry, Faiza Ali and Cloe Smith | Review Due | Section 1- references updated.  Section 4- Team composition updated.  Section 9- Group consultation added. |

**Contents**

|  |  |  |
| --- | --- | --- |
| **Paragraph** | **Topic Heading** | **Page number** |
|  | **Definitions** | 4 |
|  | **Team Model and Structure** | 5 |
| 1 | **Purpose of policy** | 5 |
| 1.1 | **Purpose of operation** | 6 |
| 1.2 | **Aims of service** | 6 |
| 2 | **Philosophy of care** | 6 |
| 3 | **Introduction to the team** | 7 |
| 4 | **Team composition** | 7 |
| 5 | **Hours of Operation and service provision** | 8 |
| 6 | **Team meetings** | 8 |
| 7 | **Supervision and Leadership** | 8 |
|  | **Clinical Processes** | 9 |
| 8 | **Referral to CCANS** | 9 |
| 9 | **Assessment** | 11 |
| 10 | **Allocation and co-ordination of care** | 12 |
| 11 | **Medication arrangements** | 12 |
| 12 | **Discharge procedures** | 13 |
| 13 | **CYP and Family/Carer involvement** | 13 |
| 14 | **Team documentation** | 14 |
| 15 | **Safeguarding Children and Vulnerable Adults** | 14 |
| 16 | **Equality and Diversity** | 15 |
| 17 | **Liaison with other teams/agencies** | 15 |
|  | **Quality and Governance** | 15 |
| 18 | **Equipment** | 15 |
| 19 | **Information governance** | 15 |
| 20 | **RIO** | 15 |
| 21 | **Management of clinical case files** | 15 |
| 22 | **Incident management** | 15 |
| 23 | **Health and Safety/Lone Working** | 16 |
| 24 | **Governance: quality, safety and performance monitoring** | 16 |
| 25 | **Implementation and monitoring of the operational policy** | 16 |
|  | **References** | 16 |

**Definitions**

|  |  |
| --- | --- |
| **ACT** | **Asthma Control Test** |
| **BTS/SIGN** | **British Thoracic Society / Scottish Intercollegiate Guidelines Network (2019/2020)** |
| **CAMHS** | **Child and Adolescent Mental Health Service** |
| **CCAANS** | **Children’s Community Asthma and Atopy Nurse Service** |
| **CCG** | **Clinical Commissioning Group** |
| **CNS** | **Clinical Nurse Specialist** |
| **CYP** | **Children and Young People** |
| **ED** | **Emergency Department** |
| **ELFT** | **East London Foundation Trust** |
| **GC** | **Group Consultation** |
| **GINA** | **Global Initiative for Asthma (2020)** |
| **GP** | **General Practitioner** |
| **HV** | **Health Visitor** |
| **LABA** | **Long Acting Beta Agonist** |
| **LAS** | **London Ambulance Service** |
| **LD** | **Learning Disability** |
| **LS** | **London Standards [for Asthma]** |
| **MDT** | **Multi-Disciplinary Team** |
| **NICE** | **National Institute for Clinical Excellence (2020)** |
| **NL** | **Nurse Led** |
| **NUHT** | **Newham University Hospital Trust** |
| **PAAP** | **Personalised Asthma Action Plan** |
| **PALS** | **Patient Advice and Liaison Service** |
| **RLH** | **Royal London Hospital** |
| **SABA** | **Short Acting Beta Agonist** |
| **SCYPS** | **Specialist Children’s and Young Peoples Services** |
| **Staff** | **Anybody working on behalf of the Trust whether permanent employed, agency, bank, locum, contractor, volunteer or on work experience** |
| **PN** | **Practice Nurse** |

|  |
| --- |
| **Team Model and Structure** |

1. **Purpose of the policy**

This policy provides clear information about the operating procedures of the Children’s Community Asthma and Atopy Nursing Service [CCAANS] in the London Borough of Newham, which sits within the Children’s Community Nursing Service, and the Specialist Children’s and Young Peoples Services [SCYPS] directorate. It is for use by new and existing staff. Where asthma is mentioned, atopy is implied, if not discussed directly.

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 (World Health Organization, 2023). 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**.**

Atopy is the genetic tendency to develop allergic diseases, such as Asthma, Allergies, Eczema and Allergic Rhinitis. Atopy is typically associated with heightened immune responses to common allergens, especially inhaled allergens and food allergens.

Asthma and Atopic conditions must be managed in accordance with the available national guidance, such as the British Thoracic Society / Scottish Intercollegiate Guidance Network [BTS/SIGN] and the National Institute for Clinical Excellence [NICE], British Society for Allergy and Clinical Immunology (BSACI), Global Initiative for Asthma (GINA 2022). East London Foundation Trust [ELFT] is a London Trust, therefore they must also align with the London Asthma Standards produced by Healthy London Partnership (2020).

*The London Standards [LS] (2020) highlight three areas for transformation:*

Proactive care

Every child with asthma should:

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

Accessible care

Every child with asthma should:

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

Co-ordinated care

Every child with asthma should:

* Be enabled to manage their own asthma by having access to a personalised, interactive, evidenced based asthma management plan linked to their medical record which they understand.
* Have a regular structured review by trained healthcare professionals at least yearly or every three months (GINA guidelines state 3-6 monthly), depending on control, and within two working days after an exacerbation (the 48-hour review – conducted by GP in Newham).
* Have access to a commissioned package of care which includes educational packages, self-management tools and access to peer support.
* Be able to expect all professionals involved in their care to share clinical information in real time to ensure seamless care.
* Have access to a structured, formalised transition processes from child to adult care to ensure children don’t fall between the gaps

***1.1 Purpose of operation***

The purpose of the CCAANS is to work in partnership with children and young people (CYP) with asthma or wheeze and their families/carers to provide education and support that enables them to live a life that is not impeded by asthma symptoms or life threatening events. CCAANS will also support CYP and their families who suffer from any of the atopic conditions in addition to their asthma or wheeze diagnosis. The CCAANS aim to improve the care and support for CYP with asthma and wheeze and atopy, making care more accessible. We aim to have up to date knowledge of evidence based care that is benchmarked with national standards and with other local services.

***1.2 Aims of the service***

* To provide safe, effective and consistent care in the community setting, by ensuring national guidance is embedded in the pathways/policies/procedures and followed consistently by health care professionals. To provide care of the highest standards based on research evidence, up to date knowledge, and respect for dignity, ethnicity and culture
* To provide community based specialist nursing interventions; clinical assessment, monitoring, education and support to children and young people with asthma and atopy, their family and carers in order to improve their quality of life
* To support high quality training and education to a range of community and acute setting practitioners to develop their professional practice to facilitate the best care for children and young people in the community
* To provide training/education to CYP/parents/carers to ensure that the care needs of each child/young person can be met in the home or other community setting;
* To provide patients with appropriate physical access/delivery in community settings;
* To work in partnership with CYP and their parents within a relationship of mutual trust and respect;
* To reduce and prevent, where appropriate, re-attendance and/or re-admission to hospital;
* To strengthen professional networks across acute and community care, as well as across primary care networks. This includes multi-disciplinary routine meetings to ensure accurate sharing of information across different services and trusts.
* To ensure that patients are seen by the service in accordance with the agreed service guidelines and are subsequently referred back to specialist or general service providers as required;
* To raise safeguarding concerns appropriately with families and safeguarding services where appropriate to keep the CYP safe from harm

These align with the BTS/SIGN Guidelines (2019) which state “All people with asthma (and/or their parents or carers) should be offered self-management education, which should include a written personalised asthma action plan and be supported by regular professional review.

Adherence to long-term asthma treatment should be routinely and regularly addressed by all healthcare professionals within the context of a comprehensive programme of accessible proactive asthma care”. (p.7)

1. **Philosophy of Care**

Before establishment of this service, there were no specialist nurses for asthma in the community, and so patients were managed by GP or Newham Hospital Paediatricians. There was no support open to these families outside of this scope that could offer early intervention when children were unwell, or post discharge from hospital/A+E and so these children and families were regularly representing to A+E. The service was established to reduce winter pressures on acute services and provide support outside of these times by regular care and review by specialist nurses.

Following referral, families are invited to either a Pre-School Wheeze Group Consultation (0-5yrs), a School aged Group Consultation (6-11yrs) or are offered an initial home visit. In all setting, asthma/wheeze education, teaching and Personalised Asthma Action Plan is completed, triggers identified and any changes to medication needed are identified. The children are then followed up in nurse led clinic, either telephone or face to face, until they have a stable control measurement and the families are happy to maintain this without support (see discharge criteria below). Families are then discharged from the service to manage their condition independently (under their GP) with open re-referral back to the service if required. There may be complex children who remain open to the caseload for some time, but do not require regular follow up, as due to their complexity they are managed by Local Paediatricians or Tertiary Centres but still require support and input from CCANS. Discharge will only occur as their needs subside or they can be discharged due to their age to the adult services.

1. **Introduction to the team**

*Service context*:

* Children and young people with a diagnosis of wheeze/asthma.
* Children and young people with an atopic condition in addition to asthma/wheeze.

*Clinical setting:* Community, based a Appleby Health Centre, Canning Town, E16 1LQ. East Ham Care centre, Shrewsbury Road, E7 8QH for Saturday Clinic. Patients own homes.

*Funding and management stakeholders:* ELFT, Newham CCG, NEL CYP Asthma Network, Healthy London Partnership (HLP)

*Catchment area:* CYP living in the London Borough of Newham.

*Age Range:* New referrals are accepted for 0 - 18 years. Anyone near to their 18th birthday at time of referral should be discussed with referrer as it may be more appropriate to refer straight to GP as no local adult CNS service to refer on to at 18 years.

1. **Team Composition**

1x Band 7 Children’s Community Atopy Nurse Specialist

1 xBand 7 Children’s Community Asthma Nurse Specialist

1 x Band 6 Children’s Community Asthma Nurse

All nurses hold a caseload of patients, but all nurses are expected to support the caseload as a whole to cover leave and sickness and out of office.

The Band 7 Asthma Nurse has an extended role of supporting public health initiatives, local nurses and strategic networks for asthma and has a role as Co Chair of the Pan London Asthma Nurses Network.

The Band 7 Atopy Nurse has extended role supporting public health initiatives, local nurses and strategic networks for asthma and has a role of supporting, educating and empowering the wider asthma team members in the management of atopic conditions.

Both the Band 7 Community Asthma Nurse Specialist and the Band 7 Atopy Nurse Specialist are line managed by the Children’s Community matron and accountable to the Lead Nurse for Children’s Services.

The Band 6 Community Asthma Nurse is line managed by the Band 7 Community Asthma Nurse Specialist, with support from The Band 7 Atopy Nurse Specialist, then as above

1. **Hours of Operation and service provision**

*Clinical*

The CCAANS service operates Mondays to Fridays from 09:00 to 17:00 with no bank holiday cover. There is a Saturday clinic on the second Saturday of every month based at East Ham Care Centre, Shrewsbury Road, E7 8QH.

Contact is via the main office phone number of 0203 738 7063. An answerphone is available at all times on the main office number; messages are checked daily during working hours. Families and professionals are able to contact the Asthma Nurses via mobile phone during working hours. These do not have answerphone facilities and divert to the office if not answered. This is to ensure no calls/messages are missed if the asthma and atopy nurses are not available or not in work (annual leave or sickness). The team can be contacted via email [elt-tr.CCNSNewham@nhs.net](mailto:elt-tr.CCNSNewham@nhs.net) which ensures that the messages for the team are dealt with in a timely fashion if team members are not in work. Text messages are available to families and prioritised with other work to be responded to.

The service is mainly provided from the operational base (nurse led clinics), but also includes contact in family homes, outpatient clinics, schools and by telephone or video call.

*Training of other professionals*

The CCAANS deliver training packages independently or in partnership with The North East London (NEL) Asthma Nurses Network, to develop the skills of other professionals. This training is offered in the form of workshops and formal training with updates held as necessary. Those trained as Asthma Champions (predominately School Nursing and Health Visitors) can then deliver planned training with others who are coming into contact with children or young people with wheeze and asthma. The CCAANS currently deliver asthma champion training, and basic training on inhalers and devices for new medical staff at Newham University Hospital. Capacity within the CCAANS limits the amount of training that can be delivered but aims to include GP training as desired or as workload allows.

1. **Team meetings:**

* Weekly asthma team case loading, to look at patients being seen the following week (Thursdays).
* There are CCNS meetings every other week, minutes of which are kept on the CCNS N drive.
* Senior Nurse (band 7 and above) meetings monthly.
* Peer Asthma Nurse Group meetings both local to the NEL region and Pan London 2-3 monthly.
* NEL CYP ASTHMA Group (with Healthy London Partnership) every 2 months.
* MDT Meeting with Royal London Hospital Monthly.

1. **Supervision and leadership**

This is the same as per the CCNS, and that Standard Operating Policy should be considered here.

* Monthly 1:1 supervision for both Band 7 and Band 6 nurses.
* Child Protection Supervision quarterly.
* Team development days.

|  |
| --- |
| **Clinical Processes** |

The pathway of specialist nursing care begins with referral to the service, either from an acute admission, multiple ED attendances, concerns from professionals (such as school), or a new diagnosis of wheeze/asthma (either by primary or secondary care). We will accept a family referral if it meets criteria.

The service has a referral form for practitioners to complete however referral will also be accepted via or clinic letter when sufficient information is provided. Due the pressures of the Emergency Department, a joint referral list with Epilepsy is collected by CCAANS from the nurses’ station 3 days week.

1. **Referral to CCANS**

*Inclusion Criteria*

1. **The child or young person must have a diagnosis of Asthma/Viral Induced Wheeze (wheeze).**

However, referral will also be accepted when a medical practitioner has a strong suspicion of asthma (high probability asthma (HPA). If after the initial visit this is felt to be a differential diagnosis, CCANS will refer back to original referrer to discuss the need for different services.

1. **Children and young people must be aged 0-16 years on referral.**

Anyone near to their 18th birthday at time of new referral should be discussed with referrer as it may be more appropriate to refer straight to GP as no local adult CNS service to refer on to at 18 years. Young people who are current or previous recipients of the asthma nursing service may remain so until they transition to the adult services and/or before they turn 18 years of age.

1. **The child or young person must be resident of the London Borough of Newham.**

Their GP does not need to be in the borough, but their home address must be – so that we can perform home visits and follow up appropriately.

1. **The Child or Young Person has had two acute attendances and/or admissions in the previous year.**

This shows poor control of symptoms or inadequate knowledge of how to treat acute symptoms.

1. **Any PICU Admission in the past year relating to wheeze/asthma**

This is classified as a life threatening event and so must be referred for education and review of medication and its delivery.

1. **Any Admission that requires IV rescue therapy to be administered during that admission**

This is classified as a life threatening event and so must be referred for education and review of medication and its delivery.

1. **Any child who has asthma symptoms where adherence to therapy is thought to be the root cause.**
2. **Any professional concern around the management of asthma.**

*Exclusion criteria*

Where a child has wheeze as part of another complex medical condition, the service may work with other agencies to provide appropriate care support but will not see the child as part of the caseload.

Any Child who doesn’t meet the essential criteria.

*Response time, detail and prioritisation*

The service is an open referral service. Referrals are triaged on receipt and prioritised as appropriate against the above criteria and following an initial telephone call to the family.

If immediate action is required (i.e. it is felt that the situation is unsafe to be left to the home visit), then this will be carried out by a longer telephone call (usually at the same time as initial call).

If they are stable on initial call, then any changes can occur at the home visit after initial assessment (group consultation or home visit as appropriate).

All phone calls must occur within 2 working days of receipt of referral, and home visits with one month of the initial phone call to the family (where contact is made), and if this is not possible then reasons must be documented.

Admin team then acknowledge receipt of referral and outcome to referrer, add patient to RIO Caseload, and add a diary contact and appointment to Nurses Rio diary. Nurse documents triage on Progress notes and adds them to patient spreadsheet held on Teams, with limited access to data.

If contact is not made, all contact details to be checked to ensure they are correct (from referrer/RIO/GP). Contact then attempted the next working day. If contact is not made after this, text to be sent by admin to family, asking them to make contact and be booked in. If no contact to CCAANS after 2 weeks, discharge to be completed informing the GP & referrer why referral did not proceed, copied to family. RIO to be checked to ensure child is not missing any other appointments, if so SCYPS DNA/WNB policy to be followed – with consideration for discussion with safeguarding team if across multiple services.

*Referral route*

Referral sources may include (but not exclusive to):

* Acute sector specialists, the wards or A+E’s of local hospitals
* General Practitioners
* Community paediatricians
* Health Visitors / School health 0-19 services
* Community Children’s Nursing Service
* Paediatric therapy services
* Social care services (e.g. Looked After Children teams, Disabled Children’s teams)

Referrals from schools/nurseries should follow Asthma Friendly Schools policy and refer via 0-19 services in the first instances of concerns. Please see Asthma Friendly School Newham policy.

*Onward referrals*

As required but may include:

* General Paediatricians at Newham University Hospital
* General Practitioners
* Tertiary Referral (Royal London Hospital)
* Social care services
* Therapy teams within CCG (i.e. CAMHS for anxiety)
* Health Visiting Service
* School Nursing Service
* Shelter/Tenants Advice Service for Housing Issues
* Money Works
* Social Prescribers

1. **Assessment**

*Group Consultation*

Children aged 0-5 offered Pre-school wheeze Group Consultation (GC) as first option.

Children aged 6-11 offered Primary School Aged GC

12+ currently offered Home Visit, but this is a work in progress with our CYP in co-production to meet their needs within a group setting.

Please see separate SOP for further information on Group Consultation and processes.

*Home Visit*

A CYP may require a home visit if home environment plays a large role in determining why the child has been unwell (home triggers such as pets/mould/damp etc.). Safety of staff must be considered based on location of home, method of transport to get there and any previous known risks associated with family living in the home. To address this, RIO alerts and safe guarding issues to be considered, with use of School Nurse RIO as appropriate via Senior Staff. If any risk is identified, then visit should be with 2 members of staff and lone worker safety policy used, even if 2 staff visit, alternative would be a clinic visit, with remote video call to assess home.

Specific paperwork is completed for this assessment, so that thorough assessment is completed.

Whatever their first appointment type, all families should have a booklet about their condition(s) given that supports visit, and patient specific handouts and documents from Trust (How to make a comment, compliment or complaint and Your and Your Information), along with a Personalised Asthma Action Plan (PAAP) if one not correctly in place.

*Nurse Led Asthma Clinics*

All routine follow up will be in planned Nurse led asthma clinics, either face to face at Appleby Health centre/East Ham care Centre or via telephone / Video call appointment depending on patient status and choice (where applicable). This will be documented on RIO.

Clinics shall provide ample time for a structured assessment of the CYP as well as education and supported self-management, in line with the London Standards. Allowances must be made for CYP and parents/carers with SEN and/or additional needs including interpreters.

Nurse-led face to face clinics shall include the following, in line with the London Asthma Standards

-Assessment of triggers for wheeze

-Supported self-management

-Inhaler / device /peak flow technique

-Promotion of healthy lifestyle

If the CNS team have urgent queries, or require consultant input, they may call or email the Consultant at NUHT. If the CNS suggest that a CYP may require consideration for stepping-up or down therapy, they shall discuss with the consultant if CYP is known to them, and documented in the patient notes. Where non-urgent suggestions may be made, the CNS may choose to liaise with the patient’s GP directly.

Where step up therapy reaches threshold for BTS/GINA guideline level 4 (medium ICS +/- Laba or LTRA), therapy should be initiated by discussed with NUHT and referral made to paediatricians. \*\* To be confirmed but likely discussed in Monthly asthma meeting with consultant before referral.

*Emergencies*

If the CYP is seen and deemed to require urgent medical attention due to asthma flare up they should follow their care plan and administer 2-6 puffs of salbutamol via spacer (or their appropriate device) – up to 10 puffs if not resolved. If symptoms continue or no inhaler is present, then London Ambulance should be contacted via 999, and once the child is under their care, CCAAN to call ahead to Emergency Department to give advanced knowledge of the child being sent in. Let the CYP consult know of this either via telephone or email so that appropriate follow up can be made.

1. **Allocation and co-ordination of care**

Allocation of care and establishing a named nurse for care is completed at Triage. Appointment is arranged with family, for first available appointment that is appropriate for family and nursing staff. It is usual for the nurse that completes the initial assessment to be the named nurse for the CYP for continuity of care. However, during exceptionally busy periods, it may be appropriate that one nurse completes the initial appointment but follow up and care is then assumed by another nurse. This is always discussed with staff before booking. This will always be to meet the needs of the CYP and families.

1. **Medication arrangements:**

Asthma medication will be prescribed at the point of discharge from hospital (Inpatient care/accident and emergency/ outpatient clinic) or by GP. Effective medication management is critical to the well-being of the child or young person, alongside effective technique with suitable devices. The CCANS will support good medication management by offering practical suggestions around taking of medication, possible side effects and concerns around dosage.

Medication can be reviewed by the CCANS at home/clinic visits to meet the stands set by NICE/BTS/SIGN/GINA guidelines around stepping up and down treatment depending on control of symptoms. CCAANS will liaise with the CYP’s named consultant and/or GP by telephone or email. At all times the CCAANS aims to ensure that the child or young person has the best possible control of their asthma as a priority with minimal side effects. The CCAANs are not responsible for any further repeat prescription provision which should be actioned by the family via the GP.

Training is provided to parents in the administration of emergency medication (salbutamol reliever/SABA and Adrenaline Auto Injectors) for use in the event of an acute asthma/wheeze/allergy exacerbation. This will be in conjunction with the PAAP and allergy plans, which all children are given and updated as necessary, but as a minimum yearly.

*Device choice*

ELFT and the CCANS have no affiliation to pharmaceutical companies, and as such the device choice shall be based on their clinical value, along with local prescribing guidelines and national guidance.

Spacer devices should be chosen as clinically appropriate. Mouthpiece spacers should be implemented as soon as possible (from aged 3 years), with the CYP’s development in mind, to optimise lung deposition. Where there is poor dexterity, additional learning needs or complex medical needs, a mask spacer may be more appropriate, but this must be considered with the fit and appropriateness in mind.

|  |  |
| --- | --- |
| Infant (<6 months) | Small volume infant mask spacer |
| Infant – toddler | Small volume child mask spacer |
| 3 years + to School age | Small volume mouthpiece spacer |
| CYP >5 with complex or additional needs | Small volume adult mask spacer |

A mouthpiece spacer must be considered in children over three years old, in line with guidance (BTS/SIGN, NICE, GINA) – uptake and appropriateness shall be determined on an individual basis, taking into consideration the child’s development, any deficits neurologically and their ability to use effectively. For school-age children a mouthpiece should be the norm.

Where appropriate: breath-actuated devices must be chosen with the specific patient in mind, and in alignment with national guidance. Clinicians must remain mindful of the equivalency of steroid potency, using guidance from the BTS guidelines to gauge relative potency. Devices for prevention and relief of symptoms must match as far as possible in terms of technique and action, for ease of use and to foster good technique. For example, it would be considered good practice to prescribe a breath actuated reliever along with a breath-actuated preventer, with a similar inhalation technique (BTS 2019, NICE 2020).

It must be noted that all CYP must be prescribed a standard salbutamol pressurised metered-dose inhaler [PMDI] and spacer for use in an emergency, and this must feature in safety netting information, unless they are on SMART for reduction of salbutamol usage.

Asthma therapy must be prescribed following current, national guidance (CCAANS have chosen to follow BTS/SIGN and GINA) and stepped up/down in accordance with this guidance. Similarly, relative potency of preventer therapy can be checked using the BTS/SIGN guidance in this way to ensure effective treatment pathway. It is vital that these resources are used, and prescribing is carried out in line with the guidelines to ensure safe therapy.

1. **Discharge procedures**

*Discharge criteria*

* Care complete, indicated by ACT score 20 or above and no emergency attendances in previous 3 months
* Parent/carer self-discharge in discussion with CCAANS
* Relocation of client to another borough
* Inappropriate referral so no care identified/given
* Child reaches 18 years of age
* Two “were not brought” to Group Consultations/ Visit/ Clinics with no contact from families despite text/call/letter offering a rebooked slot. A consideration of raising this as safeguarding must be discussed before discharge, especially if the child has attended ED in the past 3 months (outside of referral) and this must also be discussed with GP.

At discharge, a summary letter is prepared, and copies sent to parents and professionals involved to confirm:

* The input provided from the service
* Discharge date/reason for discharge e.g. moved from borough
* Any services the child/young person has been referred/open to
* Any patient initiated follow up from the service. This is where the family are wishing to remain in contact with the service for up to 3 months post discharge, despite the child being well. After discharge, if the family contact the team and need to be seen again, their discharge is reversed and seen again as a follow up visit (this is actioned by admin by request on the IT portal).

1. **CYP and Family/Carer involvement**

Should be part of every contact especially when discussing plans around:

* Devices/techniques,
* Medicines,
* Adherence/compliance to medicines and plans,
* Referrals to other teams.

Patient participation in service

CYP and families must be actively involved in reviewing service provision, via (but not limited to) patient participation groups, feedback for any patient facing literature, service changes.

*Patient feedback*

Feedback from service users must be used to inform and improve the service. This can be collected in several ways, including (but not limited to):

PREMS – electronic anonymous feedback

Any complaints are directed towards the PALS service.

Specific feedback forms for clinical activity

*Written Information for CYP and Family/Carers*

Staff and clinicians caring for CYP with asthma must use ratified and approved documents and resources, which have been co-created and ratified to give to families and CYP.

Personalised asthma action plans (PAAP’s) are a written document of advice for everyday and emergency care, and this is standardised across all ELFT teams and in line with Barts Health information (local acute trust), to ensure consistency of care and information. These must be given to **all CYP** on the first initial visit, and be updated annually unless changes have been made, when a new one should be issued.

|  |  |  |
| --- | --- | --- |
| Age | Plan | Available as: |
| Pre-school  (0-5 years)  Primary School  (6 – 11 Years)  Secondary School  (12 years +) | Asthma UK Children’s Asthma Plan  Asthma UK Children’s Asthma Plan  Asthma UK Adult Action Plan | PDF Semi populated version held by CCANS or downloadable from Asthma and Lung UK.  PDF Semi populated version held by CCANS. Downloadable from Asthma and Lung UK.  PDF Semi populated version held by CCANS or downloadable from Asthma UK |
| SMART | AstraZeneca Symbicort Action Plan | PDF semi populated version held by CCAANS. |
| Eczema | University of Bristol 2017 | Held by CCAANS and available online. |
| Allergy | Bsaci – dependant on devices | PDF semi populated version held by CCAANS and available online. |

When signposting to external resources it is the signposting clinician’s responsibility to ensure that this is an up-to-date and appropriate resource for that individual. Wherever possible, validated resources will be sourced in other languages and formats (for example, the Asthma Control Test and information from Asthma UK). For some children and families, bespoke resources may be required (e.g. where the family cannot read PAAPs). In this instance it is the individual clinicians’ responsibility to ensure signposting is appropriate and information given is evidence-based and current.

1. **Team documentation**

We aim to have all documentation completed electronically where possible, and outcome and uploaded to RIO within 24 hrs as per trust policy. Documentation includes:

* Referral form
* Triage assessment (On rio progress notes)
* Initial Assessment
* Personalised asthma action plans.
* On initial visit, on any changes to medication or yearly if no changes
* Clinic assessment form, shared with GP/Consultant post visit if applicable.
* Prescription requests
* Transfer Requests (moving out of borough)
* Discharge notification form
* Discharge summaries and correspondence

1. **Safeguarding Children and Vulnerable Adults**

We follow the CCNS policy but also:

Is the responsibility of all CCAANs seeing CYP and families:

* Concerns to be discussed with CYP and family where appropriate and documented.
* To discuss concerns with senior line management/safeguarding leads.
* Use of safeguarding supervision meetings.
* Children visiting clinic should be accompanied by a responsible and appropriate adult, unless of an age where it is appropriate for them to be alone and/or transition is in progress, but this should be in discussion with families and the young person themselves.
* Child protection policy to be used.
* Where children are on Child Protection/Child in need plans, to attend meetings/core groups as requested.

1. **Equality and Diversity**

All CYP and their families have the ability to access the service as per criteria above.

* Access to interpreting is through Language Shop, either face to face or via telephone, or via an adult based within the home if appropriate.
* Access to appointments that fit around factors for that family, be it work, activity, or religious observances

1. **Liaison with other teams/agencies**

As required and as requested

* NEL CYP ASTHMA Group
* Royal London Hospital Difficult Asthma Service
* Newham University Hospital Consultants
* Liaison with GPs

|  |
| --- |
| **Quality and Governance** |

1. **EQUIPMENT**

Equipment must be ordered, checked and registered as per Trust policy. Devices must be registered and tested by provider (Enabled Living) before use. Servicing must occur in line with guidance from Enabled Living.

Disposable equipment (e.g. Peak flow mouthpieces and demonstrators) are strictly per patient for infection control and must be ordered via supply chain via admin team/device representatives to ensure supply (patients should bring their own to clinic where review is taking place).

1. **Information Governance**

* You and Your Data Booklet
* Subject access requests
* Informing patients when their personal information is used or misused

1. **RiO**

* Opening and closure of patients – at admission and discharge
* Contact recordings, all telephone, clinic or home visits should be documented with a corresponding professional HCP diary entry and progress note.
* Clinical document upload as relevant from consultation/home/nurse led and consultant clinics

1. **Management of clinical case files**

* Storage of files – kept on the N drive/Teams which is protected access.
* Caseload is kept on Microsoft Teams – minimal access granted to this
* Management of individual file content, on N drive, minimal content should be stored here post upload to RIO. This may include alterable letters/clinic invites and GP repeat requests
* Reporting of lost files – as per local policy

1. **Incident management**

* Reporting Datixs, for near misses and events.
* Remedial action taken as soon as identified.
* Roles and responsibilities – all members of the team.
* Documentation both on Rio and Datix system.
* Securing evidence e.g. case files

1. **Health and Safety/Lone Working**

Please see CCNS Lone worker policy.

* Sign on/off from first and last visits via PANDO App and follow the Lone Worker Policy for CCNS.
* Roles and responsibilities for own and other welfare.
* Security (alarm systems, CCTV etc.). If you are the last person to leave the office then shut all windows/doors/shutters and turn off heaters/fans.
* Emergency procedures as per local policy, if in Clinic reassure CYP and their families, and ensure safe and swift evacuation as directed by signs or Marshalls.

1. **Governance: quality, safety and performance monitoring**

* Clinical audit for teams outcomes
* CQC compliance
* Complaints (formal and informal) – as per CCNS policy
* Learning from complaints, incident reviews and other feedback mechanisms
* Key performance indicators

1. **Implementation and monitoring of the operational policy**

* Annual review by team manager/modern matron/operational lead/ACD
* Agreement and sign off by the team
* Implementation and dissemination plan (team, directorate and Trustwide)
* Monitoring of update by service manager/ACD
* Guidance for local operational policies in the Organisation-wide Policy for the Development and Management of Procedural Documents

**References**

* ELFT Trust policies
* SCYPS/CCNS Directorate policies
* CCNS Procedure for Group Consultation Clinics for Children and Young People with Asthma and Viral Induced Wheeze (VIW)

British Thoracic Society/Scottish Intercollegiate Guidelines Network (2019) *Guideline on the management of asthma.* Available at: <https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/nice-guideline-asthma-diagnosis-monitoring-and-chronic-asthma-management/>

Global Initiative for Asthma (2020) *Pocket guide for asthma management and prevention (for adults and children older than 5 years)*. Available at: <https://ginasthma.org/wp-content/uploads/2020/04/Main-pocket-guide_2020_04_03-final-wms.pdf>

Healthy London Partnership (2020) *London asthma standards for children and young people: driving consistency in outcomes for children and young people across the capital.* Available at:

<https://www.healthylondon.org/wp-content/uploads/2020/09/HLP-Asthma-standards-1.pdf>

National Institute for Clinical Excellence (2020) Asthma: diagnosis, monitoring and chronic asthma management. Available at:

<https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/nice-guideline-asthma-diagnosis-monitoring-and-chronic-asthma-management/>

World Health Organization (2023). *Asthma*. [online] WHO. Available at: <https://www.who.int/news-room/fact-sheets/detail/asthma>.

‌