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# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement

Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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| **Service Specification No.** |  |
| **Service** | Asthma & Wheeze Community Service |
| **Commissioner Lead** |  |
| **Provider Lead** |  |
| **Period** | 1st January 2016 – 31st March 2017 |
| **Date of Review** | 31st March 2017 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   Asthma is a long-term inflammatory condition that affects the airways and is the most common long term medical condition in children. Symptoms commonly include wheeze, difficulty breathing, chest tightness and coughing, particularly at night or in the early hours of the morning. Asthma can be mild, moderate or severe and can cause physical and psychological distress, affecting quality of life. Although asthma cannot be cured, appropriate management can improve quality of life and ultimately save the lives of children with the condition.  Healthcare for London’s Case for Change (2009) indicated that on average, 27,500 children and young people (CYP) aged 0-18 nationally are admitted to hospital each year with asthma. It also suggests that, 75% of these attendances could have been avoided if conditions were more appropriately managed within primary and community care.  A pilot service was commissioned in Hounslow from 2009-2011 to support the management of children attending the Accident & Emergency (A&E) or Urgent Care Centre (UCC) with asthma and wheeze, and reduce the high numbers of acute attendances for CYP with these conditions. The service demonstrated improved outcomes for children, increased confidence from parents in managing their child’s asthma, and a reduction in acute attendances. This service specification builds upon the pilot in order to improve community provision for CYP in Hounslow. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **×** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **×** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **×** | | **Domain 4** | **Ensuring people have a positive experience of care** | **×** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **×** |   **2.2 Local defined outcomes**  The intended health outcomes of the Asthma & Wheeze Service are to:   * Improve the health of all CYP using the service * Reduce the amount of time spent in acute settings * Improve the co-ordination of services * Improve the confidence and self-care skills of CYP and their parents/ carers * Increase the satisfaction of CYP and their parents/ carers * Improve emotional and social well-being through the reduction of stress during periods of illness |
| **3. Scope** |
| **3.1 Purpose of the service**  This service specification outlines the requirements for establishing a community Asthma & Wheeze Service for CYP in Hounslow who have attended emergency care for asthma and wheeze, or have received oral steroids from their GP within the previous 14 days, in order to support the improved management and control of the condition.  The purpose of the service is to empower children and parents/ carers to manage their wheeze/ asthma appropriately, through the provision of a range of interventions delivered by the Asthma & Wheeze Team. The service will offer targeted packages of care to CYP who require additional support and training in the management of their condition.  **3.2 Objectives of the service**  The objectives of the Asthma & Wheeze Service are to:   * Support CYP and their parents/ carers to gain the knowledge and skills required to manage their asthma and health status * Support CYP who have previously attended emergency care for asthma/ wheeze * Enable GPs to refer CYP who are identified as high need to reduce the chances of further exacerbations and emergency attendances * Ensure all CYP who are referred to the Asthma & Wheeze Team are competent in the management of their asthma * Prevent unnecessary attendance and re-attendance at the A&E or UCC * Prevent unplanned hospital admission * Reduce school absence due to asthma or wheeze * Work cooperatively and constructively with GPs and other agencies, particularly regarding vulnerable clients to ensure effective communication processes are in place * Improve life chances of children with wheeze/ asthma and ensure their full participation in physical activities * Identify and take action to resolve any safeguarding concerns which may be impacting the health of CYP within the service * Encourage life enhancing choices, for example by promoting smoking cessation   **3.3 Service description**  The Asthma & Wheeze Service will provide specialist support to CYP, parents and carers to enable them to manage their child’s asthma and/ or wheeze. The service will be delivered by a small team of nurses who have undertaken an additional asthma qualification, to provide targeted face to face contact or telephone contact (where appropriate) to CYP within the service.  The service will deliver a number of direct interventions, including making telephone contact and offering a home visit or review in a GP surgery to CYP and their families. This will include a review of the CYP’s understanding of asthma to support them to manage their condition effectively, the development of a care plan and the provision of ongoing support, advice and training to CYP and their families where required.  The service will also provide indirect interventions, including liaison with GP surgeries to ensure they are informed of management plans and the advice given to their patients. This may also include training in the management of asthma and asthma techniques for UCC staff and GP practices (to be agreed locally as required) to support the upskilling of healthcare professionals about the management of asthma. |

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| **4. Service Delivery** |
| * 1. **Clinical pathway** |

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| * 1. **Service model**   The Asthma & Wheeze Service will accept referrals from emergency settings and from GPs who wish to refer CYP who have been prescribed with oral steroids within the previous 14 days (see Section 5.3). Initial contact will be made with all CYP and their parent/ carer within 24 working hours of the referral being received.  The CYP will be triaged by an Asthma Nurse and a decision will be made about how to manage the CYP. Within 5 working days of the referral being received, one of the following options will be offered:   * A home visit to undertake a full assessment of the CYP * A full assessment based at a GP (these will be open to all GP-based healthcare professionals to further support the upskilling of staff) * Discharge home with notification to the GP   During these appointments, the Asthma Nurse will:   * Provide training for CYP, parents and carers on the use of inhalers * Develop a written care plan with the CYP and their parent/ carer for the management of exacerbations and management if the condition deteriorates   Follow up visits will be arranged with the family dependent on individual need until the CYP and their parent/ carer is confident in their ability to independently manage the condition. If follow up is not required, the CYP will remain on the open caseload for 12 months and then discharged back to their GP. During the 12 month period, a family may self-refer back into the service if they have concerns or queries about management.  Information will be sent to the GP via SystmOne (or via email for GP practices not using SystmOne) within 24 hours to inform them of the outcome of all face to face contact. The Asthma & Wheeze Team will liaise with the GP regarding any medication required as a result of the assessment.  If the Asthma & Wheeze Team do not receive a response from the CYP or their parent/ carer within 2 working days of leaving a voicemail and/or sending a letter, the referrer will be informed and these patients will be discharged to their GP.   **4.4 Care pathways**  The provider will develop care pathways across services, involving all partner agencies and aligning with existing local pathways. The Asthma & Wheeze Team will ensure that:   * All record of contact and booked home visits are recorded on SystmOne * The SystmOne template is used to store all patient information including care plans * All contacts are recorded as per the organisation’s record keeping policy * The Personal Child Health Record (PCHR or ‘red book’) is updated for all children under 5 years of age   A care plan will be developed for each CYP who is accepted into the service. The plan will be saved onto SystmOne to be reviewed or re-printed as required.  **4.5 Screening and assessment**  CYP accessing the service will be screened during the initial telephone contact in line with the inclusion and exclusion criteria outlined in Sections 5.1 and 5.2 to establish whether they are eligible for the service. CYP with brittle asthma will be referred to their GP to arrange an outpatient appointment.  **4.6 Population covered**  The service will be offered to all children and young people aged 0-19 years with asthma/ wheeze who are registered with a Hounslow GP.  **4.7 Days and hours of operation**  The service is offered from Monday to Friday. Referrals can be made 7 days a week in line with the referral criteria in Section 5.  The core opening hours of the service will be 9am-5pm, however the service will operate flexibly 11am-7pm two nights per week in order to accommodate CYP who may require appointments outside of school hours.  **4.8 Location of service delivery**  The Asthma Team is based at:  Brentford Health Centre Boston Manor Road Brentford Middlesex TW8 8DS  The service will also be delivered flexibly at additional locations including the patient’s home, GP practices, education settings, children’s centres and Early Years settings.  **4.9 Interdependence with other services/providers**  The Asthma & Wheeze Team will work with other partners for an aligned and co-ordinated approach to care and planning, to ensure the delivery of a service which meets the needs of the local population. This will require linking with the following services:   |  |  |  | | --- | --- | --- | | **Service/ Partner** | **Purpose** | **Method of Communication** | | GP practices (including Practice Nurses) | * To deliver clinic-based appointments for CYP and safeguard joint working * To ensure effective communication and up to date information about medication | * The administrator will liaise with GP practices to book practice rooms * The GP will be notified after all face to face contact * The GP will be notified of any changes to medication or prescription requests | | WMUH A&E, UCC, PAU and Starlight Ward | * To ensure the Asthma & Wheeze Team is integrated with WMUH teams * To review referrals into the service and address any issues | * The Asthma Nurses will meet regularly as required with the WMUH asthma champion and WMUH Paediatric Liaison Health Visitor | | UCC at Charing Cross Hospital, Teddington Hospital, Chelsea & Westminster Hospital, Ealing Hospital and Ashford Hospital | * To ensure other hospitals are aware of the service and how to refer | * Regular communications as required to ensure clarity about referral routes | | Hounslow 0-19 Universal Service | * To work collaboratively with 0-19 teams to ensure children with asthma or wheeze are supported * To act as a conduit for the management and development of all joint health, education and social care, working with Local Authority services and schools in the borough | * The Asthma & Wheeze Team will engage with these organisations on an ongoing basis as required to provide advice and information | | Local pharmacies | * To monitor medicine management * To provide advice to pharmacists for supporting children and families in managing their asthma | * Annual communications will go out to local Hounslow pharmacies to support prevention and early intervention |   **4.10** **Prevention, self-care and patient and carer information**  The Asthma & Wheeze Team should have an awareness and understanding of seasonal trends, such as the third week in September, known as ‘Week 38’, which annually sees a significant spike in hospital admissions for asthma, particularly amongst children. Preparations for this may include:   * Supporting WMUH and other hospitals, local GPs, pharmacies and other healthcare professionals to prevent emergency admissions through the provision of informative communications material to promote preventative action * Sending communications to CYP and their parents to encourage them to review inhaler technique and ensure all medications are up to date. This may also include additional preventative communications for example promoting the uptake of flu vaccinations. All CYP who are accepted into the service will remain on the caseload for 12 months to enable the Asthma & Wheeze Team to access contact details and maintain this communication. |
| **5. Referral, Access and Acceptance criteria** |
| **5.1 Inclusion criteria**  The service is available to:   * CYP who are aged 0-19 * CYP who have attended A&E, UCC a Paediatric Assessment Unit (PAU) or inpatient ward with asthma or wheeze * CYP who are registered with a Hounslow GP * CYP who have been referred by their GP after being prescribed oral steroids within the previous 14 days   **5.2 Exclusion criteria**  Exclusion criteria includes:   * CYP without a history of asthma/ wheeze/ DIB/ shortness of breath * CYP who are not registered with a Hounslow GP * CYP with brittle asthma whose conditions can deteriorate rapidly * CYP who have been discharged from an inpatient ward after a stay of two or more nights * CYP who have been discharged from an inpatient ward and received intravenous medication   **5.3 Referral sources**  Emergency pathway  This pathway is primarily for CYP who have attended emergency care via A&E, UCC, PAU or inpatient ward. Referrals from the UCC and PAU will be made via SystmOne as an e-referral\*. Referrals from A&E and inpatient wards will be made as paper referrals. All referrals should include an oxygen saturation and pulse reading through the use of pulse oximetry equipment. Following each referral, telephone contact will be made to assess whether the CYP is eligible for the service and to offer face to face contact.  The Asthma & Wheeze Team will liaise monthly with a named WMUH Asthma Champion and UCC staff to review referrals into the service from emergency care, in order to ensure alignment and effectively manage and support CYP who have accessed emergency care for asthma or wheeze. The Asthma & Wheeze Team will also send bi-monthly communications to Charing Cross Hospital, Teddington Hospital and Ealing Hospital to ensure that referral routes into the service are clear.  CYP who present at other hospitals with asthma or wheeze and are registered with a Hounslow GP will be referred to the service as paper referrals.  Community pathway  Hounslow GPs, Practice Nurses and Nurse Practitioners will be able to make referrals into the service for CYP who have been prescribed oral steroids within the previous 14 days. Referrals into the Asthma & Wheeze Service from GPs will be made via SystmOne (with the exception of two Hounslow GP practices who do not use SystmOne and will make a paper referral).  \*SystmOne will be in place from 21st January 2016. Until the system is established, referrals into the Asthma & Wheeze service will be made using a temporary e-referral template.  **5.4 Discharge from the service**  CYP will be discharged from the service when:   * Their disease is controlled and suitable for self-management after a 12 month period during which the CYP has had no further contact with the service * The family moves out of the area and they are no longer registered with a Hounslow GP * They reach the age of 19 and are no longer eligible for the service   **5.5 Referral into other community services**  Should specialist follow up be required, the Asthma & Wheeze Team will liaise with School Nursing, Health Visiting (for 0-5 years) and Community Nursing teams to ensure CYP receive the appropriate follow up in the community. This may include ensuring adherence to the asthma management plan and checking prescription collections. |
| **6. Applicable Service Standards** |
| **6.1 Applicable national standards**  The London Strategic Clinical Network (SCN) for CYP was established to enable transformation change in services for CYP, enabled by the development of the *London Asthma Standards for Children and Young People* (2015). This document brings together key principles from the existing London Quality Standards, NICE guidelines, Primary Care Commissioning Framework and CYP Acute Care Standards in order to reduce the significant variation in outcomes that CYP experience across London.  To fulfil its purpose of managing CYP asthma and wheeze within the community, the Asthma Service will align to the applicable standards from this document, as outlined in the table in Appendix 1.  **6.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)**  The service will adhere to the relevant guidelines for paediatrics endorsed by the Royal College of Paediatrics and Child Health (RCPCH), which reviews high quality guidelines and standards produced and published by other organisations. This includes SIGN/BTS *Management of Asthma* (2009), available at http://www.rcpch.ac.uk/improving-child-health/clinical-guidelines-and-standards/endorsed-and-supported/general-paediatrics.  **6.3 Equal access**  The service must ensure equal access for all CYP regardless of age, gender, religion, belief, race or disability. This will include the use of translation and interpretation services where necessary, and appropriate training for staff.  **6.4 Safeguarding**  The service must demonstrate that it is meeting the standards outlined in the Children’s Act (1989) and subsequent national guidance, which requires health care organisations to protect children by following national child protection guidance. It must be ensured that policies and procedures relating to safeguarding are adhered to, and that staff have completed appropriate training for their professional role, and are represented on the local safeguarding children’s board. All staff working with CYP must have undertaken an enhanced Criminal Records Bureau check. |
| **7. Activity and performance management** |
| **7.1 SystmOne**  The Asthma & Wheeze Team must ensure that all patient data is recorded on SystmOne via agreed SystmOne templates. On discharge from the Asthma & Wheeze Service, information relating to the child will be accessible by the GP on SystmOne within 24 hours.  **7.2 Performance data**  The provider must share a monthly performance report with the commissioner to monitor activity and capacity of the service. Reporting requirements may be subject to change following review by the commissioner and provider, however as a minimum should contain the following information:   * Number of referrals * Referral source * Location of face-to-face contact   **7.3 Applicable quality requirements**  The service will be monitored against the key performance indicators defined in the table below.   |  | Key Performance Indicator | **Threshold** | **Method of Measurement** | **Timing of application** | **Consequence to provider** | | --- | --- | --- | --- | --- | --- | | 1 | All CYP will have a named lead responsible and accountable for their care within the service | 95% | Performance report | Monthly | GC9 | | 2 | All CYP who have been referred into the service will be contacted by telephone within 24 hours of receipt of referral (during working days) | 90% | Performance report | Monthly | GC9 | | 3 | Face to face contact with an Asthma Nurse will be offered to all CYP who are eligible within 5 working days of receipt of referral | 80% | Performance report | Monthly | GC9 | | 4 | All CYP have a written asthma care plan in place within 5 working days of receipt of referral | 90% | Performance report | Monthly | GC9 | | 5 | Asthma inhaler technique improved | 95% | Patient satisfaction survey | Quarterly | GC9 | | 6 | Increased confidence of patients/parents and carers to manage asthma/ wheeze effectively within the community | 90% | Patient satisfaction survey | Quarterly | GC9 | | 7 | Reduction in re-attendance rates of CYP in A&E, UCC and PAU within 12 months | To be agreed locally | Performance report (SystmOne/ SUS data) | Annual | GC9 | |
| **8. Continual Service Improvement Plan** |
| **8.1 Development of practice**  All staff are expected to develop their practice to meet the needs of service users and fulfil the requirements of the service. Individuals or teams may choose to develop specific skills and expertise based around the organisational service plans.  NHS Hounslow may identify skills or competencies needs which the entire service is required to develop in order to meet national targets or service trends. In such cases, specific training will be provided and all staff will be expected to benefit from this. In line with the Scope of Professional Practice, staff will not be compelled to practice the new skill until they are confident and competent. However in order to maintain the continuity of the service over time, all practitioners will be required to have a skill and will be supported to develop the necessary confidence and competence.  **8.2 Diversity**  The provider will demonstrate which measures it has taken to ensure quality of access for all groups in the community, including non-English speakers, refugees and new arrivals, people with reduced mobility and other groups facing barriers to access.  The provider will ensure compliance with equalities legislation including the Disability Discrimination Act (2005) and Race Relations Amendment Act (2000), and will keep up to date with the changing ethnic and demographic composition of the local population.  **8.3 Patient and parent survey**  The provider must carry out an annual patient and parent/ carer survey to record levels of satisfaction with the service and identify areas for improving the delivery of the service. |

**Appendix 1**

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| **ORGANISATION OF CARE** | |
| 1 | All organisations/services\* must have a named **lead responsible and accountable for asthma** (which includes CYP). |
| 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. |
| 3 | There is a programme of audit and ongoing improvement within each service, including input into the national severe asthma data registry, annual British Thoracic Society (BTS) paediatric asthma audit and any future national asthma registry. |
| 4 | The organisation has, or is moving towards, a strategy ensuring communication/ interoperability 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 and allows for service audit.  Cultural beliefs of the child and family must be taken into consideration. |
| 6 | Every child has an assessment of the triggers for their wheeze and is educated about how to deal with this. CYP with asthma should be screened for other atopic comorbidities, particularly 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 |
| 7 | Consultations promote healthy lifestyles including assessment of long term health needs e.g.   * Systemic approach to obesity (growth measurement) * Assessment of 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 (including e-cigarettes). They should be given advice and referred to smoking cessation clinics |
| **PATIENT AND FAMILY SUPPORT, INFORMATION PROVISION AND EXPERIENCE** | |
| 9 | CYP and their families are actively involved in reviewing local service provision and giving feedback on service to improve patient experience |
| 10 | The organisation participated in route NHS surveys for CYP (E.g. CQC National Inpatient Survey, Friends and Family Test and action plans reviewed by network) |
| 11 | CYP and their families receive sufficient information, education and support to encourage and enable them to actively participate in all aspects of their care. Information is tailored to their needs in an accessible format (e.g. written info may include pictures, symbols, large print, Braille and different languages). This will apply throughout the care pathway into schools and community settings |
| 13 | NICE Statement 4: People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment (should be age appropriate) |
| **OUT OF HOSPITAL CARE** | |
| 15 | NICE Statement 6: People with asthma who present with respiratory symptoms receive an assessment of their asthma control |
| **ACUTE CARE** | |
| 19 | The organisation complies with existing standards e.g. the London acute care standards for CYP (incorporating the London Quality Standards) and safeguarding policies |
| 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. |
| **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% or less uptake of repeat preventer prescriptions |
| 25 | There is access to paediatric physiotherapist with an interest in dysfunctional breathing (ideally able to direct refer from primary care) |
| **INTEGRATION AND CARE CO-ORDINATION** | |
| 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 |
| 27 | NICE Statement 3: People with asthma receive a written personalised action plan (this should be age appropriate) |
| **DISCHARGE/ CARE PLANNING** | |
| 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. |
| **EFFECTIVE AND CONSISTENT PRESCRIBING** | |
| 36 | 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 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 evidence based care for CYP * Co-ordination 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. |
| **WORKFORCE EDUCATION AND TRAINING** | |
| 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. |
| 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 |