**World Asthma Day 2022 – morning of learning event discussions**

**General questions and responses**

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| Question | Answer |
| Are you able to explain how you distinguish asthma vs viral induced wheeze. When is viral induced wheeze asthma? | There are some useful resources here: [Diagnosis - Healthy London Partnership](https://www.healthylondon.org/resource/london-asthma-toolkit/primary-community-care/diagnosis/) |
| Practically, how are GPs practices accommodating the "review in 48 hours". Is this a standard that is being met in London? Any audit data from this? And what would your tips be for GP practices everywhere else with limited appointments for everything else, to meet this standard? | Accommodating 48 hour reviews in primary care does not represent a significant increase in workload. A large practice of 15000 might only expect an average of 1 a week. The main issue is around creating systems locally that support timeliness of communication and agreed processes around who has responsibility for ensuring this happens. This is something that practices can attempt to do on  their own and there are examples of where this has been done but realistically this work should be done at a system level across an ICS foot print as all trusts, primary care, community asthma services etc should be involved in creating the local process. |
| How and who follows child up within 48hours after discharge. Is this face to face or virtual. Also is this primary or secondary care? | Jo: This should ideally be the GP or Practice Nurse in primary care, however this can be difficult to accommodate.  Zainab: We refer to the GP which is the recommendation but also arrange local follow ups if needed within the 48 hours depending on the case or if worried about availability of appointments.  Alison: In Hillingdon it is primary care |
| How much use do you make of peak flow devices for older children? Do you encourage them to get to know what their acceptable peak flow is and to test when symptomatic or randomly? | We use it for children 7+ it’s a very good tool , it gives them an idea of how they are with their control. We often give them one with a symptom diary, so when the child is reviewed you can get a good idea of how they have been or their response to treatment. We use it in conjunction with their personalized asthma plan  Jo: Echoing statement as above, useful tool for monitoring asthma control and guiding treatment.  Also useful as an objective measurement in asthma diagnosis  Zainab: I echo Jo’s comments, we do use them to aid in diagnosis, assessing severity and control. |
| Where can you access the asthma control test? Would this be included in the discharge bundle? | GSK will send you paper pads for free otherwise its also online <https://www.asthmacontroltest.com/> |
| What is the current advice / recommendations for the use of spacers? Should all children and young people always use a spacer when taking their inhaler? | Yes with PMDI / aerosol generated inhalers always even adults |
| I’m doing some work in West Yorkshire bringing together healthcare, affordable warmth and housing services. The cases have mentioned psychosocial challenges including mould and damp. What pathways do any of you have in place or who do you refer to if children are identified to be living in cold/damp conditions? We’re looking at a range of different models to address this | Evelina has a housing letter template based around the NRAD report that is sent out to parents who have emailed in photos and videos of severe mould/damp. These photos are then uploaded to the CYP’s electronic records. Most housing associations respond well to the letter according to feedback from parents. Evelina do not provide housing letters for CYP who live with smokers (i.e parent) or a pet that they are allergic/sensitised too as these are contraindications. The CYP would usually have had a basic aeroallergen screening (i.e skin prick test) +/- specific & total IgE’s. They also then add in additional information based on the CYP and families specific accommodation needs and change it to reflect whether they live in a hostel, B&B or housing association property. |
| The SMART inhaler has been very useful in my practice to deal with difficult asthma but suspected poor compliance. However that was based on a research study we participated. How did you manage to access smart inhalers please? | Smartinhalers cost about £150 each and can be purchased easily via the adherium website  Usually only tertiary care patients receive these. |
| Where are the London Asthma Standards? | The most recent version of the London Asthma Standards can be found here: [London-Asthma-standards-CYP-Dec-2021-updates.pdf (healthylondon.org)](https://www.healthylondon.org/wp-content/uploads/2021/12/London-Asthma-standards-CYP-Dec-2021-updates.pdf) |
| Nina - what sort of numbers have you identified from your searches please? Have you worked with 1 x PCN at a time? | We work with all GP practices in Lambeth & Southwark and group some practices together so we have 15 PCNs. We had existing relationships with a few practices already so they were quick to set up but it took around a year to fully establish all practices. Over the 6 years the service has been running, we have received over 11,000 health checks although not everyone has met service criteria. We currently have a caseload of 550 for asthma but over 1000 patients when factoring in eczema & constipation |
| Any info on group consultations in the community? | Some useful resources on group consultations: [Group consultations - Healthy London Partnership](https://www.healthylondon.org/resource/primary-care-children-young-peoples-toolkit/education-workforce/group-consultations/) |
| Do you have a pathway/ consent process that allows you to feed directly into primary care if you identify children who need their SABA too frequently or who you have identified as a concern ? | I know St Georges do. We are very lucky to have supervision with the Evelina London psychiatry & neurodevelopmental team who offer great tips and help to guide us to the best services if there are any mental ill health concerns or neurodisabilities.  Important to have multidisciplinary approach even in the community - better training for health professionals in community settings will ensure more consideration of biopsychosocial factors impacting adherence and control. Then link in to wider multidisciplinary team to access appropriate interventions whether that’s safeguarding, CAMHS, housing support etc  Psychological support (especially thinking about anxiety) is a fundamental need within asthma services. |
| How long are pts on biologics for?  In terms of homecare for biologics, do you have competencies for parents or how do you assess they are okay to give? | We carry out assessments every 4 months for Xolair and 6 months for MEPO as per the guidelines. If we don’t think there is any improvement we will stop the biologic (usually a joint decision with the family and MDT). We also offer biologic holidays if a child has been on a biologic for a long time – we may consider a trial off a biologic and closely assess for any deterioration. If so we will re-start again.  We have a competency document we use for training parents |
| Few questions on training courses – eg paediatric asthma course for HCPs, asthma diploma for community nurses -will the new framework replace this, as a practice nurse I'm working along side lots of newer nurses without formal qualifications. Is there is a clear pathway for education for newer clinical staff. Ideally it would be a nationally recognised pathway. | The asthma capabilities framework will soon be published on Health Education England Website along with links to accredited training courses. The framework sets out the skills and capabilities expected depending on the role that the professional plays. Are they just doing annual reviews? are they making diagnosis and adjusting medications? are they accepting referrals from colleagues for more complex cases? Each training programme assumes that a professional has a level of baseline skills appropriate to their role. For example – a practice nurse who is new in post would require skills and experience in consultations with children as well as doing the asthma-specific training at tier 2 before doing annual reviews. |
| Are nominated community pharmacies involved in any MDTs, or is information passed onto the pharmacies to provide an extra layer of support? | Jo : Pharmacists should be part of the MDT but in practice this doesn’t always happen.  Many practices in primary care have in-house pharmacists that carry out asthma reviews; they are well-placed to identify high SABA users  Alison: We are working with many of our Community PCN pharmacists through a role modelling approach to support and upskill them in managing childrens asthma care.  All have access to MDT’s across the PCN network and further afield in NWL.  Not specifically worked with community pharmacy. |

**Questions related to salbutamol weaning plan**

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| What is London Asthma Leadership and Implementation group’s guidance on salbutamol use post discharge? | Here is LALIG's clinical recommendation: [Salbutamol-recommendation-\_asthma-toolkit.docx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.healthylondon.org%2Fwp-content%2Fuploads%2F2017%2F10%2FSalbutamol-recommendation-_asthma-toolkit.docx%23%3A~%3Atext%3DPurpose%2520of%2520the%2520recommendation%2520To%2520increase%2520understanding%2520of%2Cleast%25204%2520hours%2520following%2520short-acting%2520beta-agonist%2520%2528SABA%2529%2520dosing.&wdOrigin=BROWSELINK) |
| Are children returning to school sooner using the new going home plan? How do young people and children feel about the changes from the weaning plan to the new model? | Jo: It’s difficult to measure this as there are so many variable factors, but we know anecdotally that CYP we see often have improved school attendance after being given self-management plans and education.  CYP tell us that they like their action plans, but we don’t have specific data on how they feel changing from one to the other.  Zainab: The previously used weaning plan is quite rigid on the amount of salbutamol needed. As the plan is now personalised to the needs of the child or young person, there is the option of returning sooner.  In general, the feedback has been positive in terms of wider knowledge, understanding and increased confidence. |
| Is there a RCT of standard weaning plan vs NWL bundle? Is there appetite (from funding bodies) to explore this as a research study? Standard weaning plan still emphasise for carers to assess their child. | This has not been done but would be a very interesting study to consider. |
| You mentioned salbutamol allergy, is this a real problem? Where is the research? | Jo: It’s not really an allergy, more of a toxicity that can occur with overuse of Salbutamol. This can trigger airway hyper-responsiveness and reduce the effectiveness of the medication.  Zainab: Increased use over time can cause increased allergic response and increased eosinophilic airway inflammation, encourage pro-inflammatory pathways and beta2 receptor downregulation.  Some useful reading:  Turner S, J Allergy Clin Immunol 2016; 138:107.e5–113.e5.  Hancox, Respir Med 2000  Aldridge, AJRCCM 2000 |
| Can you clarify what advice you are giving parents instead of 4 hourly for 1-2 days etc, Just take it as its needed? | Take the blue reliever inhaler as needed if you/your child has any symptoms (these include wheeze, chest tightness, shortness of breath, cough and difficulty breathing). Give 2 puffs, one at time and wait 2 minutes, repeat if necessary until you have given up to 6 puffs. The symptoms should have disappeared. The effects should last for at least 4 hours. |
| If children are requiring more than 6 puffs 4 hourly - ie  8 or 10 puffs salbutamol should they be seeking urgent medical attention or is that ok if managing 4 hourly? | If you/your child need(s) the blue reliever inhaler more than every four hours, your/your child’s asthma attack is not controlled and you need to take emergency action now. Take up to 10 puffs and seek urgent medical attention either by arranging an urgent appointment with your GP or if this is not possible by attending the Emergency Department.  If you/your child is having difficulty breathing not relieved by 10 puffs of salbutamol or is requiring repeated doses of 10 puffs you should call 999. |
| Comment on teaching | Ashira Simmons - My colleague and I at the ELCH did weekly teaching in our Paeds ED when we removed out SABA guideline in 2019 for 3-4 months. It was very time consuming but our ED referral pathway was also amended and made easier for all staff to ensure every CYP has follow up. |
| Comment on integrated bundle for wheeze | Denise Ullman in Plymouth (UHPT) we have introduced an integrated Paed Ed / Paed department wheeze / asthma bundle which includes a clerking booklet, discharge bundle and a combined BTS guideline and drug formulary booklet in order to establish more consistency regarding the management of the wheezy children. We have tried to address our issues we identified in the NACAP and previous audits which incl. discharge, FU etc. We are working now together with our regional CCG to implement the National Asthma bundle for CYP. |
| Wouldn't a move to a MART regimen make it simpler for CYP and parents? Gets round the problem of over use of SABA but inadequate ICS at start of exacerbation too. | The problem with SMART is it’s only licensed for 12 + , it’s a breath actuated inhaler and the Asthma plan is more complex, so children really need to know how to use it properly, but it’s great for older children but needs surveillance in case they are using high doses of steroid. |
| How are you dealing with the persistent attending preschool wheezers - that end up on preventers and salbutamol? | Jo: In the same way as asthma patients, with a PAAP and appropriate management advice  Zainab: Education, close monitoring and follow up |

**Questions re asthma friendly schools**

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| Question | Answer |
| Can you signpost what asthma training your asthma champions do please? | We devised our own role for asthma champions |
| We have a huge problem with schools giving Salbutamol at break times, lunch times and PE due to shortness of breath only, particularly in primary schools. Does your training address this /normal response to exercise and how they can distinguish between this and asthma symptoms? | Alison: Definitely covered in our Schools Asthma workshop for staff and the Asthma Champion.  Emphasis being that children should be able to participate in all areas of the curriculum (emphasising the benefits and importance of exercise) and not require their inhaler. This is one of our RED flags – we have a system in place to monitor SABA use (with or without exercise) & school absence which then triggers a SN intervention and CNS referral – all “free”  The training provided is very “practical” and focuses on distinguishing such but very often these children need a structured review to help the child /family appreciate the difference too |
| If the school is slow to respond any suggestions? | Write to chairs of governors |
| Who provides the certificate, who’s the governing body? | In Newham the whole school asthma programme reports to the Project management board and the Children’s Health 0-19 and HeadStart Governance and Quality Board.  The programme was approved also by the ELFT Governance Board.  The schools self-assess against the AFS standards using a checklist we provide, we hold training records so we know who has been trained and when. We provide a policy pro forma to check theirs against or to localise and use as their own. They provide details of who their asthma lead is.  The school signs a declaration that they have self-assessed and have everything in place and that they will maintain the standards and alert us if for any reason the standards are not met. This is reviewed annually. The school health services pledges to support the schools to meet the standards asap if they cease to be met i.e. training dropped below 85% due to staff leaving/new ones joining, we will facilitate training to get back above 85%.  In NWL they have developed a certificate – North West London AFS certificate. As the Borough Lead (CNS) we award the certificate once all criteria (London Asthma Standards) have been met |
| How much nursing resource is needed to successfully implement the asthma friendly school initiative? | Newham  You need 1 person who co-ordinates the programme, the training is shared across the workforce but is primary delivered by myself who co-ordinates the programme.  Based on 100 schools per academic year.  Asthma awareness training – 75- 100 hours (for whole school workforce). Plus travel if face to face delivery.  Management of asthma and allergies – 40 hours  (for asthma leads, medical leads etc.)  Each school has a 30 min ‘start-up’ meeting – 50 hours  Emailing schools details/updates every month – 12 hours  General enquiries and support – 30 hours  Head Teacher forums – 2 hours  Management of dashboard and data collection/analysis – 18 hours  Asthma champion training for nursing workforce – 18 hours (delivered by ELFT)  Engagement meetings with HV and SN – 6 hours (just keeping it on the agenda)  Asthma sessions in school – 1 hour per school who request this (plus travel)  Development of materials   * Checklist * Policy pro forma * Training materials * Reports/briefing papers/presentation for boards etc. * Whole school asthma poster * Sign off by varies professionals/organisations   Children are referred to the school health service who are   * Absent due to asthma * Difficulties in PE * Using inhaler more than 2 times in a week (including home) * A&E attendance   These are seen as part of the school nurses caseload as they are all trained asthma champions by ELFT.  I’m available for trouble shooting as I lead the service, this need as def reduced as time has gone on. We have a ‘consultation checklist’ that the HV/SN have to follow to ensure they ask/cover all the pertinent areas when meeting with children for the above reasons.  Alison Summerfield adds that it is dependent on number of schools within the locality / borough. 0.5 WTE may be a fair estimation. |
| If you have different asthma plans compared to the ones provided from hospital, could that give parents mixed messages regarding which plan to follow? Why not have all the same plans which caters school and different health care settings needs to make it easier for parents? | In Newham we use the Monkey Wellbeing/Asthma UK plans. If they are seen in any of the local asthma clinics, admitted to hospital or attend A&E these are the plans they will be issued. CYP who are GP managed can end up with a number of different plans or no plan at all. We of course continue to recommend the Monkey Wellbeing/Asthma UK plans to GPs with varying degrees of success.  The whole school asthma plan is aligned with the Monkey Wellbeing/Asthma UK plans ones as much as it can be (preventer info is omitted as they are not required in schools/peak flow info omitted as schools unable to interpret etc.) The Monkey Wellbeing/Asthma UK plans do not remind staff to think about allergies which we know from lesson learnt has been missed previously so the whole school plan has a ‘think allergies’ section.  In Hillingdon, they have adopted an Emergency Asthma Plan across the borough for all schools and nurseries. It is consistent, simple and clear.  For any CYP that need a bespoke plan (MART regime) and individualised plan is put into place with a CNS visit to school and meeting with the Asthma Champion in school. |
| In terms of care/actions plans, are they shared directly with school medical leads? | In Newham the ELFT asthma team and the LBN school health service share the same electronic records (RIO). This means when the asthma team issue a plan they are attached to the records. If the parent doesn’t take a copy of the plan into school, with consent we can share the copy from RIO.  Plans from GP, parent would have to take in  Plans from hospital/A&E, as above.  The whole school asthma plan is issued once the school becomes AFS for all CYP in that school with asthma  Alison Summerfield adds, for asthma – we have borough wide plan in place.  If necessary to have an individualised plan then Yes. |