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## Do you meet the London Asthma standards for children and young people: Out of Hospital Care?

All organisations/services\* must have a named **lead responsible and accountable for asthma** (which includes children and young people (CYP)). They must also all meet the organisational standards (No 1-7) and patient family and support information provision and experience (No 9-13). Please also the see the workforce education and training standards that are applicable to the setting (No 38-42).

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| **No** | **Standard** | **Evidence** | **Met**  **(Yes /No)** |
| 14 | NICE Statement 1: People with newly **diagnosed asthma are diagnosed in**  **accordance with BTS/SIGN13 and NICE34 guidance**. | Evidence of local arrangements to ensure people with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance, and that the process is documented in their patient notes. |  |
| 15 | People with asthma who present with respiratory symptoms receive an **assessment of their asthma control**. | Evidence of local arrangements to ensure people with asthma  presenting with respiratory symptoms receive an assessment of their asthma  control. |  |
| 16 | People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode  are **followed up by their own GP practice within two working days or less** of treatment.  If required secondary care follow up is provided within **one month** for every child admitted with asthma and for patients who have attended the emergency department two or more times in the past 12 months. | a) Evidence of local arrangements and systems put in place to ensure people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.  b) Evidence of local arrangements to ensure effective communication between secondary care centres (such as hospitals and out-of-hours services) and primary care. |  |
| 26 | There are agreed **effective, integrated pathways to ensure the smooth transition between healthcare settings** (ie primary care  to secondary or tertiary care). These include shared care, referral and discharge protocols between community and specialist and access to prompt specialist advice and help. | Shared care, referral and discharge pathways and policies. 6, 7, 10 |  |
| 27 | People with asthma receive a written p**ersonalised action plan.** (This should be age appropriate.) | Evidence of local arrangements to ensure people with asthma receive a written personalised action plan. |  |
| 28 | People with asthma receive a **structured review**\* at least annually (preferably every three months, depending on severity and clinical need). This must include understanding of their condition and treatment, assessment of adherence, inhaler technique and children’s ACT for those aged over four years. | Evidence of local arrangements to ensure people with asthma receive a proactive structured review at least annually. |  |
| 30 | There is a system to **communicate the name of the responsible** lead / link person caring for child to patients and families.     | Monitored on a case by case basis.  Audit of CYP to see if they know who their link person is. |  |