These standards bring together the aspirations for London, the NICE Asthma standards, British Thoracic Society guidelines and a number of other key resources into one document. We would like to acknowledge the work of the numerous organisations referenced throughout.

These standards have been developed through the London Strategic Clinical Network for Children and Young People’s Asthma Pathway Group and have since been reviewed by members of the SCN Strategic Clinical Leadership Group and the SCN Commissioning Advisory Group, National Paediatric Asthma Group, Royal College of Physicians, British Thoracic Society, Royal College of Anaesthetists, and Asthma UK.

We would particularly like to express our appreciation to the following:

» Dr David Finch, (Chair) Asthma pathway group, North West London Medical Director, NHS England (London region)
» Professor Andy Bush, Consultant chest physician, Royal Brompton and Harefield NHS Foundation Trust
» Dr Richard Chevasse, Respiratory paediatrician, St George’s Hospital
» Dr Rahul Chodhuri, Consultant paediatrician with an interest in respiratory medicine and allergy, Royal Free
» Colette Datt, Paediatric asthma nurse specialist, Whittington Health
» Dr Louise Fleming, Respiratory paediatrician, Brompton and Harefield NHS Foundation Trust
» Rachel Griffen, Paediatric asthma nurse specialist, Imperial Healthcare
» Dr Richard Iles, Chair, National Paediatric Asthma Collaborative, East of England
» Professor Monica Lakhanpaul, Integrated community child health, Whittington Health/UCL Institute of Child Health
» Dr Mark Levy, GP and NRAD lead
» Donal Markey, Pharmacy lead, NHS England (London region)
» Dr John Moreiras, Respiratory paediatrician, Whittington Health
» Sara Nelson, Quality improvement lead, London Children and Young People’s Strategic Clinical Network
» Tracy Parr, Lead, London Children and Young People’s Strategic Clinical Network
» Krisnah Poonisamy, Senior policy officer, Asthma UK
» Nicola Rickards, School nurse, Islington
» Professor Russell Viner, Clinical director, London Children and Young People’s Strategic Clinical Network, and Consultant in adolescent medicine, University College Hospital
INTRODUCTION

PURPOSE
The London Strategic Clinical Network (SCN) for Children and Young People (CYP) was established to bring about transformational change in services for CYP. One of the key pieces of work it has undertaken recently has been to identify standards already in existence relating to the care of CYP. A piece of work was carried out to collate standards for acute care into one document setting out the minimum standards which should be delivered in acute services for CYP in London\(^1\). In addition a piece of work has been carried out by the Primary Care Transformation group to look at a Strategic Commissioning Framework for transforming primary care\(^2\).

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

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

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

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

From this point forward we will use the term *asthma* but these standards also apply to those children (over the age of 1) with viral induced wheeze or any other acute wheezy episode.

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

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\(^{1}\) London SCN 2015

\(^{2}\) For further information please see the reference.

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**INTRODUCTION**

**AUDIENCE**
This document will be of use to commissioners and providers of asthma services for CYP. It sets out our aspirations for CYP asthma care in London alongside the NICE quality standards (NICE, 2013) to enable the effective commissioning of services which meet these required minimum standards. Providers will be able to use these to undertake self-assessment of their ability to deliver the required quality of care for CYP with asthma. The standards can be used to validate, challenge and to quality assure services. It is also suggested that clinical commissioning groups (CCGs) sign the Asthma UK pledge to implement the NICE quality standards within the next three years.

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

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

**POPULATION BASED NETWORKS FOR CYP**
The CYP SCN has identified that some of the issues in delivering effective healthcare to CYP arise because of the fragmentation of services and the lack of integration of providers. This applies to services in primary, community, secondary, and tertiary care.

Analysis of serious incidents by the CYP SCN has shown that CYP are often subject to a failure of care when moving across care settings. More effective linkage of providers and commissioners would help to reduce these issues. A model of population-based networks based on linkages between providers and commissioners across all settings is the SCN’s proposal to address these issues. This is strongly aligned with the recently published Five year forward view (NHS England, 2014). This acknowledges the traditional divide between different parts of the health system which act as a barrier to co-ordination and personalisation of care. It recommends dissolving these boundaries to ensure more effective co-ordination of care. New models will emerge and the SCN is keen that care for CYP is central to these developments.

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

**FURTHER STANDARD DEVELOPMENT**
The SCN is aware that the standards developed so far do not describe all areas of care for CYP. It will continue to develop additional standards across a variety of care settings. Community standards will be the next area of work for the CYP SCN.

Overall care must be based on the United Nation Convention on rights of a child which says that every child has the right to:
- **A childhood** (including protection from harm)
- **Be educated** (including all girls and boys completing primary school)
- **Be healthy** (including having clean water, nutritious food and medical care)
- **Be treated fairly** (including changing laws and practices that are unfair on children)
- **Be heard** (including considering children’s views)
LONDON’S AMBITIONS FOR ASTHMA CARE

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

**Proactive care**

Every child with asthma should:

- Have access to a named set of professionals working in a network who will ensure that they receive holistic integrated care which must include their physical, mental and social health needs.
- 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 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, 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, depending on control, and within two working days after an exacerbation.
- 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.

**Introduction**

**LONDON’S AMBITIONS FOR ASTHMA CARE**

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- 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**.

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- 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.
## A. ORGANISATION OF CARE

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<thead>
<tr>
<th>Standard</th>
<th>Evidence</th>
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<tr>
<td><strong>1</strong> All organisations/services* must have a named <strong>lead responsible and accountable for asthma</strong> (which includes CYP).</td>
<td>» Governance structure which states the asthma lead.</td>
<td>2, 3, 6, 16</td>
</tr>
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<td><strong>2</strong> There are formal partnerships established between providers of CYP services.</td>
<td>» Network terms of reference, membership and accountability of the group.</td>
<td>1, 7, 8, 9, 10, 11</td>
</tr>
<tr>
<td>There is demonstration of a <strong>commitment to work within a multidisciplinary</strong> 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.</td>
<td>» Progress reports to CCGs and trust board as required.</td>
<td>1, 7, 8, 9, 10, 11</td>
</tr>
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<td>The networks develop shared pathways, protocols and consider workforce planning.</td>
<td>» Participation in network meetings.</td>
<td>1, 7, 8, 9, 10, 11</td>
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<td>There is evidence of collaboration between all sectors including local children’s safeguarding boards.</td>
<td>» Shared network protocols and guidelines for diagnosis, treatment and care.</td>
<td>1, 7, 8, 9, 10, 11</td>
</tr>
<tr>
<td><strong>3</strong> There is a programme of <strong>audit and ongoing improvement</strong> within each service. This includes input into the national severe asthma data registry, annual British Thoracic Society (BTS) paediatric asthma audit and any future national asthma registry.</td>
<td>» Regular assessment of performance in place.</td>
<td>1, 3, 10, 11, 12, 30, 44</td>
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<tr>
<td></td>
<td>» Workforce planning.</td>
<td>1, 3, 10, 11, 12, 30, 44</td>
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<tr>
<td></td>
<td>» Examples of measures to improve service delivery across the network.</td>
<td>1, 3, 10, 11, 12, 30, 44</td>
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* Organisations / services - Schools, hospitals, GP surgeries, pharmacy or community providers, prisons and young offender’s programmes.

** Multidisciplinary team includes primary, secondary and tertiary care, schools, pharmacists, local authority, commissioners and providers, children and young people and their family / carers and social worker as appropriate.
## A. ORGANISATION OF CARE

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| 4 The organisation has, or is moving towards, a **strategy that ensures 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 (community to tertiary) and allows for service audit. This includes the ability to flag / code any concerns (eg any child subject to plan). Cultural beliefs of the child and family must be taken into consideration. | » Strategy available for  
» Information systems which facilitate seamless care packages across the pathway.  
» Up-to-date unified record being used by all staff and electronic transfer of information for organisations such as schools and pharmacy. | 1, 7, 13, 14, 28 |
| 5 The organisation allows adequate clinic **time for assessment and management of the child** by a healthcare professional.  
**Best practice:**  
» 20-30 minutes in primary / community care and acute/secondary care.  
» 45 minutes first appointment.  
» 25 minutes for follow up in tertiary care.  
» 10 minutes for a pharmacy advanced medication consultation.  
(The London follow up consultation template, is currently in development.) | » Clinic slots and templates. | 15 |
| 6 Every child has an **assessment of the triggers** for their wheeze and is educated about how to deal with this.  
Children with asthma should be screened for other atopic comorbidities, in particular allergic rhinitis and food allergy.  
There is access to a **paediatric allergy service** for assessment and appropriate management, including adrenaline auto injector device prescription and training if required. | » Service specification or contracts and pathway.  
» Audit of notes, referrals and numbers accessing services. | 3, 6, 16, 17, 18, 19, 20 |
| 7 Consultations **routinely promote healthy lifestyles**, including assessment of long term health needs, such as:  
» Systematic approach to obesity (eg growth measurement, calculation of BMI).  
» Assessment of CYP and family for living conditions and housing freed from damp and mould, alcohol, drugs and smoking.  
Every child and their family are assessed at health or social care encounters for their **exposure to smoking either actively or passively** (this includes e-cigarettes). They should be provided with brief advice and referred to smoking cessation clinics.  
There is access to **smoking cessation clinics** and other support services for families, [Fraser competent CYP](https://www.frasercompetentcyp.org.uk) and carers that address issues of smoking and monitor outcomes. | » Evidence that assessment has taken place and documented.  
» Service specification or contracts.  
» Audits of referrals and numbers accessing services.  

**Numerator** – Number of people in the denominator (including [Fraser competent CYP](https://www.frasercompetentcyp.org.uk)) who are assessed for carbon monoxide levels 4 weeks after the quit date.  
**Denominator** – Number of people who smoke who have set a quit date with an evidence-based smoking cessation service. | 3, 6, 13, 15, 16, 21, 22, 23, 24, 25, 26, 28 |
| 8 There is access to paediatric physiotherapist with an interest in dysfunctional breathing (ideally with ability to direct refer from primary care). | » Service specification or contract. | 15, 27 |
**B. PATIENT AND FAMILY SUPPORT, INFORMATION PROVISION AND EXPERIENCE**

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

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<tr>
<td>9 CYP and their families are <strong>actively involved in reviewing local service provision and giving feedback</strong> on services to improve patient experience.</td>
<td>» Minutes demonstrating patient involvement in decisions about service development.&lt;br&gt;» Patient experience measures in place/feedback regularly audited and fed back.&lt;br&gt;» Evidence that complaints are used to improve services.&lt;br&gt;» Evidence of involvement in relevant consultations.</td>
<td>1, 28</td>
</tr>
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<td>10 The organisation <strong>participates in routine NHS surveys for CYP</strong> (eg CQC National Inpatient Survey, Friends and Family Test and action plans reviewed by network).</td>
<td>» Reporting and action plans.</td>
<td>1, 11, 28, 47</td>
</tr>
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<td>11 CYP and their families receive <strong>sufficient information, education and support</strong> to encourage and enable them to participate actively in all aspects of their care and decision-making. This means information is tailored to their needs in an accessible format (eg written information may use pictures, symbols, large print, Braille and different languages) throughout the care pathway extending into schools and community settings.</td>
<td>» Portfolio of available information.&lt;br&gt;» Available support documentation.</td>
<td>2, 6, 29, 30, 31</td>
</tr>
<tr>
<td>12 CYP and their families have <strong>access to self-management support packages</strong> which may include peer support.</td>
<td>» Service specification or contracts for self-management programmes.&lt;br&gt;» Audits of referrals and numbers accessing services and outcomes.</td>
<td>6</td>
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<td>13 <strong>NICE Statement 4</strong>: People with asthma are given <strong>specific training and assessment in inhaler technique</strong> before starting any new inhaler treatment. (This should be age appropriate.)</td>
<td>» Structure: Evidence of local arrangements to ensure people with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.&lt;br&gt;» Process: Proportion of people with asthma who are given specific training and assessment in inhaler technique before starting any new inhaler treatment.&lt;br&gt;[\text{Numerator} – \text{Number of people in the denominator who have training and assessment in inhaler technique.}]&lt;br&gt;[\text{Denominator} – \text{Number of people with asthma starting a new inhaler treatment.}]</td>
<td>3, 13, 16, 32</td>
</tr>
<tr>
<td>C. OUT OF HOSPITAL CARE</td>
<td>Evidence</td>
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<tr>
<td><strong>Standard</strong></td>
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<td>14 Diagnosis can be difficult in CYP</td>
<td>» Structure: Evidence of local arrangements to ensure people with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance, and that the process is documented in their patient notes.</td>
<td>3, 6, 11, 13, 33, 34, 35</td>
</tr>
<tr>
<td>NICE Statement 1: People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN(^{13}) and NICE(^{34}) guidance.</td>
<td>» Process: Proportion of people with newly diagnosed asthma whose notes describe the process, as outlined in the BTS/SIGN guidance, by which the diagnosis was made.</td>
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<td>15 NICE Statement 6: People with asthma who present with respiratory symptoms receive an assessment of their asthma control.</td>
<td>» Structure: Evidence of local arrangements to ensure people with asthma presenting with respiratory symptoms receive an assessment of their asthma control.</td>
<td>3, 13, 32</td>
</tr>
<tr>
<td>16 NICE Statement 10: People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode are followed up by their own GP practice within two working days or less* of treatment.</td>
<td>» Process: Proportion of people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma who are followed up by their own GP practice within 2 working days of treatment.</td>
<td>3, 13, 16</td>
</tr>
<tr>
<td>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.</td>
<td>» Process: Proportion of people who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma who are followed up by their own GP practice within 2 working days of treatment.</td>
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* Primary, secondary, and tertiary care should put systems in place to enable this.
### D. SCHOOLS

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

### E. ACUTE CARE

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

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</table>
| 21 **NICE Statement 7:** People with asthma who present with an exacerbation of their symptoms receive an **objective measurement of severity** at the time of presentation. | » Structure: Evidence of local arrangements to ensure people with asthma presenting with an exacerbation of their respiratory symptoms receive an objective measurement of severity at the time of presentation.

» Process: Proportion of people with asthma presenting with an exacerbation of their respiratory symptoms who receive an objective measurement of severity at the time of presentation.

- **Numerator** – Number of people in the denominator receiving an objective measurement of severity at the time of presentation.
- **Denominator** – Number of people with asthma presenting with an exacerbation of their respiratory symptoms. | 3, 6, 13 |
| 22 **NICE Statement 8:** People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive **oral or intravenous steroids within one hour of presentation** and seen by the respiratory team directly. | » Structure: Evidence of local arrangements to ensure people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation.

» Process: Proportion of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma who receive oral or intravenous steroids within 1 hour of presentation.

- **Numerator** – Number of people in the denominator receiving oral or intravenous steroids within one hour of presentation.
- **Denominator** – Number of people aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma. | 3, 13 |
| 23 **NICE Statement 9:** People admitted to hospital with an acute exacerbation of asthma have a **structured review** by a member of a specialist respiratory team** before discharge. The structured review includes:

  » Assessment of control ([Children’s Asthma Control Test](#) (ACT)) if aged over 4 years and/or triggers for wheezing.
  » Inhaler techniques.
  » Self-management and how to manage acute exacerbations.
  » Personal asthma action plan. | » Structure: Evidence of local arrangements to ensure people admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

» Process: Proportion of people admitted to hospital with an acute exacerbation of asthma who receive a structured review by a member of a specialist respiratory team before discharge.

- **Numerator** – Number of people in the denominator receiving a structured review by a member of a specialist respiratory team.
- **Denominator** – Number of people discharged from hospital after admission for an acute exacerbation of asthma. | 3, 6, 13, 40, 41, 42 |

* BTS/SIGN guideline: Table 10 or annex 3 for adults; Table 12 or annex 5, 6 or 7 for children older than 2 years.

** Specialist is defined as paediatric consultant with respiratory interest or an asthma clinical nurse specialist with specific training in viral induced wheeze, asthma management and discharge planning.
### F. HIGH RISK CARE

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<th><strong>Standard</strong></th>
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<tr>
<td>24 There are systems in place in acute and community care for identifying patients at high risk, poorly controlled or severe asthma and monitoring/tracing and managing those CYP who have had in the last year: More than one admission. Admission to HDU, ICU, PICU. Two or more attendances to the emergency department or out of hours care in the last year. Two or more unscheduled visits to the GP (requiring short courses of oral steroids). Ten or more salbutamol inhalers. 80 per cent or less uptake of repeat preventer prescriptions.</td>
<td>» System in place to identify and manage high risk patients and ongoing audit to demonstrate effectiveness. » High risk register. » Evidence of inhaler technique medication reviews. » Audit data demonstrating numbers of: Referrals onto secondary/ tertiary care. CYP admitted with asthma and frequency. CYP on high risk register. Patients admitted to HDU / PICU / ICU in last year. Repeat attenders to A&amp;E / GP practice. Children with 10 or more salbutamol inhalers. Repeat preventer prescription.</td>
<td>2, 6, 7</td>
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| 25 There is access to paediatric physiotherapist with an interest in dysfunctional breathing (ideally ability to direct refer from primary care). | » Service specification or contract. | 15, 27 |

### G. INTEGRATION AND CARE CO-ORDINATION

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

| 26 There are agreed effective, integrated pathways to ensure the smooth transition between healthcare settings (ie primary care to secondary or tertiary care). These include shared care, referral and discharge protocols between community and specialist and access to prompt specialist advice and help. | » Shared care, referral and discharge pathways and policies. | 6, 7, 10 |

| 27 NICE Statement 3: People with asthma receive a written personalised action plan. (This should be age appropriate.) | » Structure: Evidence of local arrangements to ensure people with asthma receive a written personalised action plan. » Process: a) Proportion of people with asthma who receive a written personalised action plan. b) Proportion of people treated in hospital for an acute exacerbation of asthma who receive a written personalised action plan before discharge. 

*Numerator* – Number of people in the denominator receiving a written personalised action plan before discharge. 
*Denominator* – Number of people treated in hospital for an acute exacerbation of asthma. | 2, 3, 6, 13 |
## G. INTEGRATION AND CARE CO-ORDINATION

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Evidence</th>
<th>Ref</th>
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</table>
| 28 NICE Statement 5: People with asthma receive a **structured review** at least annually (preferably every three months, depending on severity and clinical need). This must include understanding of their condition and treatment, assessment of adherence, inhaler technique and children’s ACT for those aged over four years. | » Structure: Evidence of local arrangements to ensure people with asthma receive a proactive structured review at least annually.  
» Process: Proportion of people with asthma who receive a structured review at least annually.  

_Numerator_ – Number of people in the denominator who had a structured review within 12 months of the last review or diagnosis.  
_Denominator_ – Number of people with asthma.

» Monitoring QOF exception rates. | 2, 3, 6, 7, 13, 16, 39, 40, 42 |
| 29 NICE Statement 11: People with difficult asthma** are offered an **assessment by a multidisciplinary difficult asthma service.** | » Structure: Evidence of local arrangements to ensure people with difficult asthma are offered an assessment by a tertiary led multidisciplinary difficult asthma service.  
» Process: Proportion of people with difficult asthma who receive an assessment by a multidisciplinary difficult asthma service.  

_Numerator_ – Number of people in the denominator receiving an assessment by a multidisciplinary difficult asthma service.  
_Denominator_ – Number of people with difficult asthma. | 15 |
| 30 There is a system to communicate the name of the **responsible lead / link person** caring for child to patients and families. | » Monitored on a case by case basis.  
» Audit of CYP to see if they know who is their link person. | 1, 10, 11, 42 |
| 31 Support services, both in the hospital and in primary, community and mental health settings are available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily health care professional led review, can be taken. | » Description of services, audit of notes, rotas. | 1, 10, 43, 45 |

* A structured review should follow the London review template (in development) but should include, height, weight, immunisation, health education (diet, exercise and smoking status).

** Children on step 4 / 5 of the BTS/SIGN guidelines with on-going poor control (ACT / cACT ≤19 and / or ≥ 2 admissions in past year and / or ≥ 3 courses of high dose oral corticosteroids (OCS) in past 2 years and/or persistent airflow limitation (FEV1 < 80% post bronchodilator) and all children prescribed maintenance OCS or under consideration for omalizumab or other novel biological drug whatever the level of control.
### H. DISCHARGE / CARE PLANNING

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

<table>
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<tr>
<th>Standard</th>
<th>Evidence</th>
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<tr>
<td><strong>32</strong> Systems are in place to ensure <strong>safe discharge and transfer between providers</strong>. This includes the following:</td>
<td>» Telephone advice offered / feedback from patients / supporters / description of telephone follow up service and GP links.</td>
<td>10, 11, 43, 44, 45, 46</td>
</tr>
<tr>
<td>» All admitted CYP have discharge planning and an <strong>estimated discharge date</strong> as part of their management plan as soon as possible.</td>
<td>» Audit of notes (discharge planning and timelines).</td>
<td></td>
</tr>
<tr>
<td>» The primary care team / GP is informed of discharge within agreed timescale of each attendance and <strong>follow up is booked within two days</strong> (including health visitor and school nurse).</td>
<td>» Discharge information provided within 24 hours.</td>
<td></td>
</tr>
<tr>
<td>» Information is provided to GP and community teams <strong>electronically within 24 hours</strong>.</td>
<td>» System in place for follow up within two days.</td>
<td></td>
</tr>
<tr>
<td>» Clear <strong>written information and advice</strong> 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.</td>
<td>» Standard written discharge information is available.</td>
<td></td>
</tr>
<tr>
<td>» Pharmacies <strong>ensure availability of medicines</strong> and utilisation of home delivery services. This is of greater relevance for weekend discharge.</td>
<td>» Pharmacy systems in place to ensure medicines available in a timely fashion.</td>
<td></td>
</tr>
</tbody>
</table>

### I. TRANSITIONAL CARE

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

| 33 | There is a clear lead clinician responsible for transition leading work on policies and pathway of care to prepare young people for the transition to adult service. | » Operational policy for paediatric service. | 1, 6, 7, 28, 30, |
| | | » Identified lead (role identified in job plan and appraised). | 46, 47, 48, 49, 50, 51 |
| | | » Transition policy and pathway of care available. | |

| 34 | Transition is properly planned, and a named key worker is appointed for each child in their approach to transition to oversee the process and collaborate with other professionals. The young person is involved in the planning and delivery of their own care. | » Operational policy for paediatric service. | 6, 7, 28, 49, |
| | | » Clear referral process in place. | 50 |
| | | » Audit of effectiveness. | |
| | | » Named key worker. | |
| | | » Child / parent being involved in care plan. | |
| | | » Written handover. | |
### TRANSITIONAL CARE

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Evidence</th>
<th>Ref</th>
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</table>
| 35 There is a shared protocol between children’s and adult services, which is a genuinely shared arrangement and is properly implemented. | » Operational policy for paediatric service.  
» Shared protocol available.  
» Patient involvement in plans on audit.  
» Written handover. | 6, 7, 30, 49 |

### EFFECTIVE AND CONSISTENT PRESCRIBING

36 There are systems in place to minimise prescription and drug administration errors. This includes:
» Utilising current systems to monitor adherence to national and local prescribing guidelines.  
» Development or identifying appropriate education and training resources to support adherence to prescribing guidelines.  
» Utilising current systems to monitor near misses and medication errors in primary and secondary care settings.

37 There are systems in place to:
» Identify, monitor, and manage through an alert system to clinicians the numbers of prescriptions for prednisolone, inhaled steroids, 10 or more preventer inhalers in a year, children with asthma and flu jab uptake.  
» Identify and manage CYP prescribed inhalers at doses higher than recommended in product licence.  
» MURs and new medicine reviews for to promote medicines optimisation including inhaler technique assessment for CYP.  
» Note: Reviews with parents for younger children: PSNC guidance states the patient must be competent to give consent to receive the service and to share information as required by the consent arrangements in order to be eligible to receive the service. There is no minimum age, but pharmacists will know that the younger the child, the greater the likelihood is that they would not be competent.  
» Use of CCG medicines management teams to develop local prescribing guidelines to support evidenced based care for CYP.  
» 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.

» Operational policy for paediatric asthma service.  
» British National Formulary for children available.  
» Processes in place to minimise errors, reporting and review of errors and near misses and to spread learning.  
» Adherence to CQC standards in medicines management.  

» Policy in place for medicines optimisation.  
» Audits demonstrating numbers of patients in practice with:  
» Two or more prescriptions for prednisolone in a year.  
» Number of inhaled steroids.  
» Number of preventative inhalers is greater than 10.  
» Flu vaccination uptake.  
» Local prescribing guidelines.  
» Participation in health promotion campaigns and audits.

1, 11, 52, 53
## WORKFORCE EDUCATION AND TRAINING

<table>
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<tr>
<th>Standard</th>
<th>Evidence</th>
<th>Ref</th>
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<tr>
<td>38 There is access to multidisciplinary team for advice, diagnostics and management support which includes specialist paediatric asthma nurse, physiotherapist, paediatric dietician, paediatric pharmacists, psychologist and pulmonary technicians (within tertiary clinic).</td>
<td>- Service specification, job roles and rotas demonstrating available support.</td>
<td>3</td>
</tr>
<tr>
<td>39 Children and young people have contact with healthcare professionals who have received appropriate training and ongoing education in paediatric asthma with appropriate updating at least every three years, including access to a specialist paediatric nurse with asthma diploma level training and CPD in paediatric asthma. This includes primary care and the wider MDT such as pharmacists, health visitors and schools. At least one practice nurse in every practice or someone in every school is trained in managing asthma (ie holds a recognised certificate of competence, such as an asthma diploma), and has experience in supporting children with long term conditions. Community pharmacists who wish to undertake an extended role in delivery of MURs are trained and competent to do so.</td>
<td>- Rotas and training and needs assessment undertaken and action plan for training of current and future MDT workforce. - Continuing professional development and competency.</td>
<td>3, 6, 7, 16, 59</td>
</tr>
<tr>
<td>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.</td>
<td>- Training provision and number of staff who have undertaken the training.</td>
<td>25</td>
</tr>
<tr>
<td>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.</td>
<td>- Staff rotation and education programmes across geographical networks.</td>
<td>1, 60</td>
</tr>
<tr>
<td>42 Unregistered staff* have completed a course of training specific to the setting and tasks being carried out, and in the care of infants, CYP and have undergone a period of competence assessment before carrying out care and delegated tasks.</td>
<td>- Training records for unregistered staff.</td>
<td>1, 61, 62, 63</td>
</tr>
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* Unregistered staff may include receptionists, healthcare assistants and technicians.
# Appendix 1: Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Asthma Control Test</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and emergency</td>
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<tr>
<td>BHfL</td>
<td>Better Health for London</td>
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<tr>
<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>BTS</td>
<td>British Thoracic Society</td>
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<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
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<tr>
<td>CEM</td>
<td>Centre for Evaluation and Monitoring</td>
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<tr>
<td>CYP</td>
<td>Children and young people</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>FEV1</td>
<td>Forced expiratory volume</td>
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<td>GINA</td>
<td>Global Initiative on Asthma</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HDU</td>
<td>High dependency unit</td>
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<tr>
<td>MUR</td>
<td>Medicines use review (Pharmaceutical Advanced Service)</td>
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<tr>
<td>NMS</td>
<td>New medicine service (Pharmaceutical Advanced Service)</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NRAD</td>
<td>National Review of Asthma Deaths</td>
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<tr>
<td>OPD</td>
<td>Outpatient department</td>
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<tr>
<td>PICU</td>
<td>Paediatric intensive care unit</td>
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<tr>
<td>PSNC</td>
<td>Pharmaceutical Services Negotiating Committee</td>
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<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>RCA</td>
<td>Royal College of Anaesthetists</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>RCPCH:</td>
<td>Royal College of Paediatrics and Child Health</td>
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<tr>
<td>SCN</td>
<td>Strategic clinical network</td>
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<tr>
<td>SI</td>
<td>Serious incident</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
</tbody>
</table>
Appendix 2: References

   www.nice.org.uk/guidance/QS43
22. National Institute for Clinical Effectiveness (2008) *Preventing the uptake of smoking by children and young people*
   www.nice.org.uk/guidance/PH14
   www.nice.org.uk/guidance/ph1
   www.nice.org.uk/guidance/ph48
25. London Clinical Senate (2015) *Helping smokers quit: Adding value to every clinical contact by treating tobacco dependence*
   www.londonsenate.nhs.uk/helping-smokers-quit
27. Primary Care Respiratory Journal (2014) *Asthma and psychological dysfunction*
   www.nature.com/articles/pcrj201158
29. National Institute for Clinical Effectiveness (2012) *Patient experience in adult services guideline*
   https://www.nice.org.uk/guidance/qs15
30. Royal College of Nursing (2014) *Healthcare service standards for caring for neonates, children and young people*
32. Global Initiative for Asthma (GINA) (2009) *Global strategy for the diagnosis and management of asthma in children 5 years and younger*
    www.nice.org.uk/guidance/indevelopment/gid-cgwave0640/consultation
39. Whittington Health (2013) *Policy for failure to bring / attend and cancellation of children’s health appointments*
40. Asthma Control Test www.asthma.com/resources/childhood-asthma-control-test.html
41. Asthma UK *Making the most of your asthma review*
    www.asthma.org.uk/advice-manage-your-asthma-better-making-the-most-of-your-asthma-review
APPENDIX 2: REFERENCES

42. Whittington Health, Paediatric annual asthma review
43. Keogh B (2014) Urgent and emergency care standards
   www.nhs.uk/nhsengland/keogh-review/Pages/urgent-and-emergency-care-review.aspx
44. Royal College of Paediatrics and Child Health (2012) Standards for children and young people in emergency care settings
   http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emergency%20Standards%202012%20FINAL%20WEB.pdf
   www.ukpics.org.uk/documents/PICS_standards.pdf
46. OFSTED Standards for children’s services
47. Evans, R (2013) Patient Experience Network: Celebrating the best of children’s and young people’s experience of care
   http://bit.ly/1JZAWCT
48. Royal College of Surgeons (20014) Standards for children’s surgery
   https://www.rcseng.ac.uk/publications/docs/standards-in-childrens-surgery
49. Care Quality Commission (2014) From the pond into the sea: Children’s transition to adult health services
50. Royal College of Nursing (2013) Adolescent transition care: RCN guidance for nursing staff
   http://bit.ly/1B8p7oe
51. Department of Health (2006) Transition: getting it right for young people: Improving the transition of young people with long term conditions from children’s to adult health services
   www.cqc.org.uk/content/essential-standards
   www.nice.org.uk/guidance/cg76
54. Pharmaceutical Services Negotiating Committee Guidance (2013) Medicine use reviews
   http://psnc.org.uk/services-commissioning/advanced-services/murs
   www.nice.org.uk/guidance/ng5
   www.nice.org.uk/guidance/mpg1
57. General Medical Council (2013) Good practice in prescribing medicines and devices
   www.gmc-uk.org/guidance/ethical_guidance/14319.asp
58. NHS England Medicines optimisation dashboard
   www.england.nhs.uk/ourwork/pe/mo-dash/
59. Education for Health (2015) Supporting children’s health asthma module
   www.supportingchildrenshealth.org/asthma-module/
60. Royal College of Anaesthetists (2015) Guidelines for the provision of paediatric anaesthesia services
61. Academy of Medical Royal Colleges (2012) Seven day consultant present care
   www.aomrc.org.uk/doc_view/9532-seven-day-consultant-present-care
   http://hee.nhs.uk/work-programmes/the-care-certificate-new/the-care-certificate
APPENDIX 3: ADDITIONAL READING

» British Thoracic Society  
Difficult asthma registry  
www.brit-thoracic.org.uk/audit-and-quality-improvement/difficult-asthma-registry

Coughs and sneezes spread disease but what about the environment? Thorax May; 61(5): 367–368

» Department of Health (2014)  
Guidance on the use of emergency salbutamol inhalers in schools  


» National Institute for Clinical Effectiveness (2000)  
Guidance on the use of inhaler systems (devices) in children under the age of 5 years with chronic asthma. NICE technology appraisal guidance 10  
www.nice.org.uk/guidance/ta10

» National Institute for Clinical Effectiveness (2002)  
Inhaler devices for routine treatment of chronic asthma in older children (aged 5–15 years) NICE technology appraisal guidance 38  
http://www.nice.org.uk/guidance/TA38

» National Institute for Clinical Effectiveness (2008)  
Inhaled corticosteroids for the treatment of chronic asthma in adults and in children aged 12 years and over. NICE technology appraisal guidance 138  
http://www.nice.org.uk/guidance/TA138

» National Institute for Clinical Effectiveness (2007)  
Inhaled corticosteroids for the treatment of chronic asthma in children under the age of 12 years. NICE technology appraisal guidance 131  
http://www.nice.org.uk/Guidance/TA131

» National Institute for Clinical Effectiveness (2013)  
Omalizumab for treating severe persistent allergic asthma (review of technology appraisal guidance 133 and 201)  
http://www.nice.org.uk/guidance/ta278

» National Institute for Clinical Effectiveness Guidance (2014)  
Inhaled corticosteroids  
http://pathways.nice.org.uk/pathways/asthma?fno=1#content=view-node%3Anodes-inhaled-corticosteroids&path=view%3A/pathways/asthma/asthma-management.xml

» National Institute for Clinical Effectiveness (2014)  
Measuring fractional exhaled nitric oxide concentration in asthma: NIOX MINO, NIOX VERO and NObreath  
http://www.nice.org.uk/guidance/dg12


www.ncbi.nlm.nih.gov/pmc/articles/PMC2111180/
**APPENDIX 4: USEFUL LINKS**

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

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

**NHS PrescQIPP**
Respiratory webkit, asthma focus bulletin and inhaler technique review tools for those who prescribe, covers
» Bulletin and briefing (including implementation versions) with recommendations on NRAD.
» Pathway documents for adults, children and younger children.
» Audit tools, including auto system searches for SystmOne and EMIS.
» Patient materials.
» Inhaler technique assessment tools for nine different kinds of inhalers.
www.prescqipp.info

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

**Asthma UK**
Includes pages on keeping children with asthma safe at school, featuring resources for schools, support for parents and healthcare professionals.
www.asthma.org.uk/Sites/healthcare-professionals/pages/schools-and-early-years
About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children’s Services; and Mental Health, Dementia and Neuroscience.