TEMPLATE 1 - CLINICAL PATHWAY: ASTHMA - PAEDIATRICS (draft v1 3.10.2016)

	Maintain wellbeing/Prevention (non-symptomatic, pre diagnosis)	Early Diagnosis, Treatment, Care Planning	Ongoing maintenance and management, condition stable	Condition unstable/ deteriorating, acute	End of Life
Principles	Home is best – only activity that needs the specialist workforce **and** supporting infrastructure of an acute hospital site will be managed there				
	Partnership/shared care arrangements between acute and community				
	Put people in control/self care		Put patients in control/self care		Put patients in control/self care
	Enablers: Documentation; *Patient education to incl. check-list/self-care leaflets, Standard Health Care plan - shared across the hospital to primary care to incl. 'emergency escalation management plan'.* **Shared care record and approach to care across providers; IT.** *Mobile phone apps/telehealth to support self-care. Annual training programme across the LHE.*				
Pathway components/interventions	At scale prevention Primary Care/Community Start asap. *Early identification of lifestyle behaviours including weight management, smoking exposure,* starting perinatally with maternity. Early identification; *to refer to appropriate service for support/ help via Family Connect service or school provision and school nursing/health visitors. Practice to call children for a review of care in the summer holidays.*	Notify of diagnosis - Information sharing across providers to exchange care updates. Effective support to child health needs. Universal Partnership Plus 5-19 yrs; Support; parents/carers/Professionals.	Primary Care/Community *Review of 'trial treatment' No home visits tbc – see below Practice Nurse & GP update Children's Nursing Service – support GPs to maintain care in the community/educate*	Primary Care/Community *Wheezing <2/> 2 yrs Bronchiolitis pathway; Red flags to acute SATS monitoring at practice.*	Primary Care/Community *Paediatric Psychology: Containment of families in extreme distress or anguish Skilled interventions/despair (patients and staff).*
		Specialist (delivered in the Community) *Surveillance group Suspected asthma; see patient tests/'trial of treatment' to confirm asthma. Psychological assessment, Incl. education. Psychosocial review meeting. Therapy interventions. Coping indicators, screening for vulnerability/targeted help. Identify risks/resilience. Annual review of care plan/transition. Liaise/consult on psychological aspects with treating.*	Specialist (delivered in the Community) *Team to visit the patient at home if the child/yp is non-compliant. Service response to f/u – outreach if best for family.*	Specialist (delivered in the Community) *Psychology input/management of difficult asthma. Thresholds acute/ chronic. Complex trauma work, neuropsychology assessments incl. changes & impairments*	Specialist (delivered in the Community) Psychology to include families/cyp with complex psychological needs. Evidence that this input is effective - clinically /cost.
	Specialist (delivered in the Community) *Frontline staff and community group to have an understanding of asthma signs and symptoms*	Specialist (delivered in acute) *Surveillance, diagnose, treat/develop care plans, transfer to community. Nurses deliver education at clinics.*	Specialist (delivered in acute) *Ongoing condition management & support to incl.complex issues - group psychological interventions. Behavioural management/risk assess/trauma/PTSD/family relationships. Working with low mood, anxiety, issues around self care compliance.*	Specialist (delivered in acute) *Consultants/Nurse condition management complex/chronic cases. Psychology; Acute/urgent coping strategies*	Specialist (delivered in acute) *Consultant response to acute crisis/deteriorating condition.*
	Specialist (delivered in acute) *Paeds and A&E to recognise lifestyle risk factors that increase risk of becoming asthmatic. To refer to community services*	Self care *Pharmacies; new medication review service incl. inhaler/advice new meds given/fu calls to ensure taking meds correctly incl. child/with parent's consent.*			Self care *Health Care Plan – patient's treatment pathway Care card treatment prompt. To include emergency escalation management plan.*
	Self care *increase awareness of adult lifestyle behaviours that impact on CYP and increase risk of asthma in CYP.*	Targeted/at risk groups *'Suspected asthma' stage of diagnosis, support. Use of mobile phone apps? Asthma formal diagnosis – Advise & support - help child stay symptom-free/get on with life. MUR medicine use reviews, we include children on inhalers, the MUR is done in the presence of the parent/carer. 400 patients funding via NHS England.*	Self care *Patient Care plan to incl. school copy. Share with community groups brownies/scouts. Advice line for worried well.*	Self care. *Emergency escalation care management plan in place.*	

TEMPLATE 2 – ACTIVITY ASSUMPTIONS

'LEFT SHIFT' ACTIVITY PROJECTIONS FROM COMMUNITY FIT PATHWAY **ASTHMA – PAEDIATRICS**

A&E

	Baseline acute activity	Futurefit activity shift assumptions	Community fit pathway activity shift assumptions	Variance from Futurefit shift assumptions
Telford & Wrekin 30-60 months	90	65%+ includes paediatric psychology	70	+.05%
Shropshire 30-60 months	94	65%+ includes paediatric psychology	70	+.05%
Telford & Wrekin 12-30 months	90		40-55%	-15%
Shropshire 12-30 months	94		40-55%	-15%
Telford & Wrekin 6-12 months	90		30-40% pilot 'testing proof of concept'	-25%
Shropshire 6-12 months	94		30-40% pilot 'testing proof of concept'	-25%

Inpatients & Emergency Admissions

	Baseline acute activity	Futurefit activity shift assumptions	Community fit pathway activity shift assumptions	Variance from Futurefit shift assumptions
Telford & Wrekin	194	65%+ includes paediatric psychology	70	+.05%
Shropshire	215	65%+ includes paediatric psychology	70	+.05%
Telford & Wrekin 12–24 months	194		40-55%	-15%
Shropshire 12-24 months	215		40-55%	-15%
Telford & Wrekin 0-12 months	215		30-40% pilot 'testing proof of concept'	-25%
Shropshire 0-12 months	194		30-40% pilot 'testing proof of concept'	-25%

Outpatients New and Follow up

	Baseline acute activity	Futurefit activity shift assumptions	Community fit pathway activity shift assumptions	Variance from Futurefit shift assumptions
Telford and Wrekin	440	65%+ includes paediatric psychology	70	+.05%
Shropshire	406	65%+ includes paediatric psychology	70	+.05%
Telford and Wrekin	440		40-55%	-15%
Shropshire	406		40-55%	-15%
Telford and Wrekin	440		30-40% pilot 'testing proof of concept'	-25%
Shropshire	406		30-40% pilot 'testing proof of concept'	-25%

Figures are modelled based on the Right Care Data 2016.

TEMPLATE 3 – WORKFORCE

COMMUNITY WORKFORCE SKILLS AND COMPETENCY REQUIREMENTS: **ASTHMA - PAEDIATRICS**

	Skills and competencies required to deliver the pathway components/ interventions on page 1	Do these skills and competencies exist in the current workforce? Yes/Needs Expansion/No	If 'needs expansion' or 'no' describe in more detail what is needed
Early Diagnosis, Treatment, Care Planning			
Primary Care/Community	GPs require a good level of education to appropriately support patients Paediatric Psychology upskilling of MDT	Needs expansion	Paediatric Psychology Service commissioned to support/upskill acute staff as part of an MDT approach.
Specialist (delivered in the community)	Need more asthma 'Specialists'	Needs expansion	Upskilling of the community workforce to establish a specialist team approach.
Self care	Pharmacy guidance training staff to support new patients with equipment use and review.	Needs expansion	Training to provide generic advice, guidance and how to use equipment.
Ongoing maintenance and management			
Primary Care/Community	*Ongoing educational updates for GPs to maintain competency, develop skills and effectively manage patients. Children's Community Nurses (CCNs) – asthma maintenance, monitoring /management	Needs expansion. Not all GPs are skilled in asthma care. No - upskill CCNs in asthma assessment. Scale up response to deal with greater numbers, use of bands 3-4 (HCA level).	A structured Workforce Development Plan for the local economy for community workforce in Asthma/Allergies/Respiratory.
Specialist (delivered in the community)	Need more asthma 'Specialists' – Practice Nurses have expertise. GP skills set is variable.	Skills set is in the acute setting. The community needs expansion.	As above
Self care	Schools – annual updates for staff. 1:1 School nurse drop-ins	Needs expansion. Yes – in School Nursing, but resources are stretched across schools.	Additional resources to support school nurses.
Unstable, condition deteriorating, acute crisis			
Primary Care/Community	Ongoing educational updates to maintain competency, develop skills, effectively manage patients/refer to SaTH appropriately as above*	Variable knowledge base across GPs/CCNs/ Physio.	
Specialist (delivered in the community)	Skills to monitor care in the community and identify when to escalate patients to the acute.	Not in the children's nursing workforce. This skills set exists within the acute setting.	Needs expansion. Upskilling of the community workforce is required.
Self care	Upskilling the workforce to provide education/guidance in support of self care.	Yes, in some areas, but needs expansion.	
End of Life			
Primary Care/Community	Upskilling the workforce to help containment of families in extreme distress or anguish. Skilled interventions/despair.	No, needs expansion.	Local health economy training/upskilling to support families appropriately.
Specialist (delivered in the community)	As above. To include acute staff members.	No, needs expansion.	As above.

Community based Children's Paediatric Respiratory Team - multi-disciplinary joint working arrangement between the acute and community