Secondary Care Referral Pathway

Asthma Diagnosis

https://www.beatasthma.co.uk/resources/secondary-healthcare-professionals/asthma-diagnosis/

Non-Acute Care Pathway

Primary care team should make sure to address all points highlighted in managing uncontrolled asthma section before referral to secondary care. Primary care teams should use 2ry care referral form for referral to secondary care.

Criteria for referral from primary to secondary care:

- Recurrent severe exacerbations:
  - ≥2 courses oral corticosteroids per year.
  - >1 hospital admission or ED attendance per year
  - persistent chronic symptoms (most days for >3 months) or worsening of symptoms
- The use of >6 SABA inhalers per year (to note, CYP may have inhalers in different locations such as family homes, schools, clubs etc, therefore this might still be a trigger for a review and discussion)
- Asthma Control Test (ACT) / Childhood Asthma Control Test (c – ACT) score of <20 despite trial of appropriate management strategies in primary care following BTS/GINA guidelines: https://www.beatasthma.co.uk/resources/primary-healthcare-professionals/
- Poor asthma control despite GINA step 2: https://www.beatasthma.co.uk/wp-content/uploads/2022/07/GINA-Main-Report-2022-FINAL-22-07-01-WMS.pdf
- Diagnostic uncertainty: Microsoft Word - How to make an Asthma Diagnosis in Primary Care june 22.docx (beatasthma.co.uk)
- Persistent psychosocial concerns despite appropriate support.
- Persistent uncontrolled asthma with safeguarding concerns after referral to social services following local safeguarding pathway.

Chronic Asthma management: https: //www.beatasthma.co.uk/resources/secondary-healthcare-professionals/chronic-management/

Referral Criteria to Tertiary care:

ALL children who meet any of the following criteria should be assessed by the regional tertiary difficult/severe asthma service for an initial assessment and then at least annually if they continue to meet any of these criteria:

- Children prescribed maintenance oral steroids (≥4 weeks over past 12 months)
- Admission to PICU
- On-going poor control despite optimised management and the prescription of high dose inhaled corticosteroids plus a long-acting beta agonist. *Poor asthma control is defined as (one or more of):*
    - Recurrent severe exacerbations in the past year (≥2 per year requiring high dose OCS)
    - Persistent chronic symptoms (most days for >3 months) or an Asthma Control Test (ACT) or Childhood Asthma Control Test (C-ACT) score of <20.
    - Prescription of >6 salbutamol inhalers per year.
    - Persistent airflow obstruction (FEV1 <80% post bronchodilator)

Other children may be considered for referral if it is felt they would benefit from the services of a specialist difficult/severe asthma MDT. For example:

- Diagnostic uncertainty
- Complex psychosocial / safeguarding issues
- Dysfunctional breathing
- Enrolment in clinical studies

Acute Care Pathway

Exacerbation management: https://www.beatasthma.co.uk/resources/secondary-healthcare-professionals/exacerbation-management/

- If a child has symptoms of asthma, they should receive acute treatment after appropriate assessment and modifiable risk factors being addressed.
- When a CYP is admitted to a ward / HDU / PICU or has attendances to paediatric A+E, a review by the respiratory team / MDT should be performed to include:
    - Assessment of control & triggers

- Inhaler technique
- Self-management (PAAP)
- Emergency treatment

- If at any point CYP has acute, severe symptoms or life-threatening symptoms – they need seek immediate medical attention via 999 or accident and emergency.
- If a CYP has severe or life-threatening symptoms, they must be urgently assessed by a specialist, who had appropriate training in paediatric asthma, and if needed admitted to PICU / HDU for ongoing management.
- After either moderate, severe, or life-threatening symptoms of asthma are stabilised, discharge planning should be completed. This would be an opportunity to understand how the CYP is managing their asthma and what factors can be modified to make their asthma control better.
- A post attack review should ideally be completed within 48 hours of the asthma attack. This review can happen during their admission, however, if the CYP has been discharged then an appointment needs to be arranged for a review with their primary care team.
- All CYP who have had an exacerbation leading to a hospital attendance or admission should be reviewed within 1 month with their primary care team to check their ongoing management of asthma. This may also include confirmation of diagnosis if required.
- At either stage of discharge planning, a post attack review or 1-month review, if any of the following red flags are identified, the CYP should be referred to secondary care for a review:

    - Any admission (Hospital stay beyond 4 hours) to hospital with asthma
    - severe asthma attack (lifetime risk)
    - Life-threatening asthma attack (lifetime risk)
    - PICU / HDU admission (lifetime risk)
    - ≥2 unscheduled attendances in last 12m
    - high reliever use ≥6 MDI salbutamol per year.
    - Low preventer use (check records, if possible, i≤ 75% of prescribed inhaled corticosteroids have been collected in the last year (or pro rata).
    - ACT or cACT score <20
    - Safeguarding/ psychosocial issues
    - Unresolved parental/professional concern
    - Concordance issues
    - Other issues or co-morbidities.