



## COPD Sample Service Specification

### 1. Aim

The aim of this paper is to provide an illustration of the principles and standards laid out in the companion IMPRESS paper *How to prepare a specification* ([www.impressresp.com/ServiceSpecifications/tabid/60/Default.aspx](http://www.impressresp.com/ServiceSpecifications/tabid/60/Default.aspx)) by giving a sample service specification for chronic obstructive pulmonary disease (COPD).

### 2. Who is it for and how to use it?

It is written for all those who contribute to the development of service specifications. That is, firstly for PCO and practice-based commissioners and public health teams, but also for the clinicians and patient groups who can contribute their expertise and local knowledge to the process and should be an integral part of any development.

This sample specification has received the support of the members of [IMPRESS](#) and its two parent bodies, the British Thoracic Society ([BTS](#)) and the General Practice Airways Group ([GPIAG](#)).

It will be important to secure local ownership and support of any of the material contained within it. That may need to be the PCT Director of Commissioning/Service Development/Market Management, or long term conditions lead, or a local clinical network or public health lead, or a local strategy group. It may also require approval from a clinical governance network.

The sample specification is intended for **local adaptation, adoption and use**. It includes national guidance and recommendations. It would therefore meet nationally set performance measures. It also provides a detailed summary of what providers and commissioners might expect to be provided. It will support those commissioners who are non-specialists.

There is an IMPRESS [Jargon Buster](#) that can be used to check on any terminology that is unfamiliar.

### 3. Legislation and guidance

There is very little disease-specific legislation or guidance, although the **National Service Framework (NSF) for COPD** is due to be published in early 2009. There is no NSF for asthma or other respiratory disorders.

However, the Healthcare Commission now [monitors](#) commissioners on the implementation of NICE guidance.

Respiratory guidance includes

- [A Healthier Future](#): a Strategic Framework for Respiratory Conditions from Northern Ireland Department of Health, Social Services and Public Safety published March 2006
- [British Guideline on the Management of Asthma](#) produced by Scottish Intercollegiate Guidelines Network (SIGN) in conjunction with British Thoracic Society (BTS), GPIAG, Asthma UK and others Updated May 2008
- Chronic obstructive pulmonary disease: management of COPD in adults in primary and secondary care. [Clinical Guideline 12](#). London: NICE; 2004<sup>1</sup>
- [Emergency Oxygen Use](#) in Adult Patients by the British Thoracic Society due early Summer 2008.
- NICE Health Technology Appraisal for Continuous Positive Airways Pressure (CPAP) for sleep apnoea. NICE issued its [Health Technology Appraisal](#) for Continuous Positive Airways Pressure (CPAP) for sleep apnoea. March 2008.
- In addition, there are also NICE commissioning guides that you might find helpful for commissioning [early discharge](#) and [pulmonary rehabilitation](#) services for COPD.

There are a number of relevant generic national policies, to which you should refer, and supplement with regional policy and priorities.

- Our Health, Our Care, Our Say' a new direction for community services (DH, January 2006)
- Practice Based Commissioning: practical implementation (DH, November 2006)
- Choosing Health: Making healthy choices easier (DH, November 2004)
- Commissioning a patient-led NHS (DH, 2006 onwards)
- Commissioning Framework for Health & Well-being (DH, March 2007)
- 10 High Impact Changes (DH, Modernisation Agency 2004)
- The [Operating Framework](#) for the NHS for 2008/09

Please refer to regional visions that were launched during May and June 2008 as part of the review of the NHS led by Lord Darzi, [Our NHS, Our Future](#).

### **Care closer to home**

The thrust of policy is not only to provide care closer to a person's home (where this provides at least equivalent quality and more conveniently than the care they currently receive) but also "involving the local community to provide services that meet their needs, beyond just treating them when they are ill, but also keeping them healthy and independent"  
[*Commissioning framework for Health and Well-being' (March 2007) – [Executive Summary](#).*]

### **Patient engagement**

Therefore development of the service specification needs to involve patients, and should also describe how patients and the public will be engaged in the delivery of care and be supported to take responsibility for their health and care, – that is, in co-creation of services, and in co-production of outcomes. For example, Somerset PCT produced a [video](#) with patient group support that explains how they feel about having COPD and what they want from services.

### **Long term conditions policy**

Most people are now familiar with the [model for long term conditions](#) and the World Class Commissioning aspiration of 'Adding life to years and years to life'. It provides a framework that most people understand and use.

---

<sup>1</sup> National Institute for Clinical Excellence (NICE). Chronic obstructive pulmonary disease: management of COPD in adults in primary and secondary care. Clinical Guideline 12. London: NICE; 2004, Thorax 2004;59:Suppl1

## Carers' involvement

There is a new [national carers' strategy](#) that acknowledges the important role of carers in supporting people with health problems. Any service specification process should engage carers as well as those with COPD, and the standards should address their needs too.

## The COPD sample specification

### 1. Definition of service and standards of care

In this specification, a COPD service is defined as the range of preventive, diagnostic, care, management and palliative services needed by your local population with obstructive, non-reversible lung disease.

We expect to see the core elements listed below included. This paper gives links to national standards, but these would need adaptation to reflect local care pathways. The Map of Medicine offers [COPD pathways](#) including the evidence base. These are free to users. Until the publication of the National Service Framework for COPD, anticipated in early 2009, the key standards document is [NICE Guideline Number 121](#): except where indicated below. The international standard is Global Initiative for Chronic Obstructive Lung Disease (GOLD).<sup>2</sup>

#### 1. Diagnosis

See [BTS Guideline 1997](#); 52:Suppl 5 and [NICE Guideline Number 121](#), Thorax 2004;59:Suppl1; and two peer-reviewed documents from primary care: International Primary Care Respiratory Group Guidelines on [diagnosis](#)<sup>3</sup> and the [GPIAG guide](#) for those working in primary care.<sup>4</sup>

#### 2. Smoking cessation

See [NICE Technology Guidance](#) on smoking cessation – bupropion and nicotine replacement therapy<sup>5</sup> and NICE Smoking cessation - [varenicline](#); [Final scope](#) and a [1998 Thorax supplement](#).<sup>6</sup> There is also the [BTS Smoke Free Hospitals Toolkit](#) and a set of web-based resources for primary care by the International Primary Care Respiratory Group [Tackling the Smoking Epidemic](#).

#### 3. Case finding

There is still a lot of discussion about the most efficient and worthwhile method of case finding. This will be part of the National Service Framework. Without this, we suggest that the main activity should be geared to increasing public awareness – the British Lung Foundation's recent survey [Invisible Lives](#) says that only just over 10% of the public know what COPD is. Primary care needs to look more intensively for the missing 2 out of 3 patients it is not diagnosing. This in turn needs patients to come forward when they have early symptoms, which they are not doing. One relatively cost effective approach, with

---

<sup>2</sup> World Health Organisation (WHO), National Heart, Lung and Blood Institute (NHLaBI). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. Bethesda, MD: GOLD, WHO, NHLaBI; 2005

<sup>3</sup> Levy ML, Fletcher M, Price DB, Hausen T, Halbert RJ, Yawn BP. International Primary Care Respiratory Group (IPCRG) Guidelines: Diagnosis of respiratory diseases in primary care. Prim Care Resp J 2006;15(1):20-34.

<sup>4</sup> General Practice Airways Group Diagnosis and management of chronic obstructive pulmonary disease in primary care A guide for those working in primary care. GPIAG. 2004.

<sup>5</sup> Technology Guidance No 38. Nicotine replacement therapy (NRT) and bupropion for smoking cessation. March 2002.

<sup>6</sup> Raw M, Mcneill A, West R. Smoking Cessation Guidelines For Health Professionals---A Guide To Effective Smoking Cessation Interventions For The Health Care System. Thorax 1998; 53 (Suppl 5): S1-S18. and Parrott S, Godfrey C, Raw M, West R and Mcneill A. Guidance For Commissioners On The Cost Effectiveness Of Smoking Cessation Interventions Thorax 1998; 53 (Suppl 5): S2-S37. An update was subsequently published in 2000 by the Health Education Authority, and published as a supplement to Thorax, 2000, Vol. 55; 987-999

high yields is proposed in a BMJ paper from 2002 using age, smoking and symptoms such as cough.<sup>7</sup>

**4. Routine treatment and monitoring in primary care including immunisation for influenza and pneumococcus**

The GMS Quality and Outcomes Framework (QOF) says very little about routine monitoring except seeing patients yearly for review and doing spirometry and immunisations for influenza and pneumococcus. We would recommend that the NICE guideline be encouraged. The GPIAG summary is available for primary care.<sup>4</sup>

**5. Pulmonary rehabilitation**

Standards for pulmonary rehabilitation published by [IMPRESS](#) and British Thoracic Society Standards of Care Subcommittee on Pulmonary Rehabilitation.<sup>8</sup> There is also a [NICE](#) commissioning guide.

**6. Supported self-management/guided self-care**

See NICE Guideline Number 12

**7. Onward referral for specialist opinion**

NICE Guideline Number 12<sup>1</sup> and BTS statement on criteria for specialist referral, admission, discharge and follow-up for adults with respiratory disease.<sup>9</sup> IMPRESS has also published an [example](#) of a referral letter.

**8. Oxygen assessment and ongoing for support for people on long term oxygen**

The BTS Working Group on Home Oxygen Services completed an [Additional Guidance Paper](#) (Paper No 1) November 2005 with other material.

**9. Nebuliser service**

BTS Nebuliser Treatment Best Practice [Guideline](#).

**10. Surgery including transplantation**

NICE Guideline Number 12<sup>1</sup>

**11. High quality acute medical and respiratory service including provision of non-invasive ventilation**

NICE Guideline Number 12<sup>1</sup> and BTS Standards of Care Committee [NIPPV](#) Non-Invasive Ventilation in Acute Respiratory Failure.<sup>10</sup>

**12. Acute use of oxygen**

The forthcoming guideline will be available from the [British Thoracic Society](#) in late 2008.

**13. Community care during an exacerbation**

This should include supported self-management/guided self-care. See NICE Guideline Number 12<sup>1</sup>

---

<sup>7</sup> C P van Schayck, J M C Loozen, E Wagena, R P Akkermans, and G J Wesseling. Detecting patients at a high risk of developing chronic obstructive pulmonary disease in general practice: cross sectional case finding study. *BMJ* 2002; 324: 1370

<sup>8</sup> Morgan MDL, Calverley PMA, Clark CJ. Pulmonary rehabilitation. *British Thoracic Society Standards of Care Subcommittee on Pulmonary Rehabilitation. Thorax.* 2001 Nov;56(11):827-34.

<sup>9</sup> BTS statement on criteria for specialist referral, admission, discharge and follow-up for adults with respiratory disease. *Thorax* 2008;63(Suppl I):i1–i16. doi:10.1136/thx.2007.087627

<sup>10</sup> NIPPV Non-Invasive Ventilation in Acute Respiratory Failure. *British Thoracic Society Standards of Care Committee - Thorax* 2002; 57:192-211

**14. Secondary care provision during an exacerbation**

All patients admitted for a respiratory cause should be seen or reviewed by a respiratory specialist during the course of that admission. These data are available from the national COPD audits 2003 and 2008. Also refer to the generic [Standards for Better Health](#).

**15. Community and secondary care post exacerbation**

This should include an early supported early discharge service. Note that under the current 2008/09 tariff, there is a significant price difference between stays of less than 48 hours, and over 48 hours or “two midnight crosses”. For standards refer to NICE Guideline Number 12<sup>1</sup> and BTS Guideline 1997; 52:Suppl 5.<sup>11</sup> There is also a [NICE](#) commissioning guide.

**16. Social support**

There is no national standard to refer to, but it should be considered. Personalised care planning should include assessment of social support and whether the patient is eligible for any allowances. They may need assistance to claim for these.

**17. Carer support**

There is no national standard, but without carer support, many people with COPD will require more healthcare intervention. There is a new national [policy](#) launched in June 2008.

**18. Active provision of end of life care**

NICE Guideline Number 12<sup>1</sup> and the [Liverpool care Pathway](#) for the Dying Patient, and for general practice, the [Gold Standards Framework](#) and [GPIAG advice on palliative care](#) for people with COPD.

**19. Provision of support for mental health problems, tobacco dependency and nutrition problems**

NICE Guideline Number 12.<sup>1</sup>

**20. Audit and evaluation**

NICE Guideline Number 12.<sup>1</sup> There are also increasingly a range of audit tools available, particularly for primary care. For example see this [link](#).

**21. Training and development of the workforce (and of patients)**

Training of the workforce is vital and requires local learning needs assessment and audit to inform what is needed. This needs to consider not just practice nurses but also GPs. We would regard the overview of training needs in primary care to be the potential responsibility of a GPwSI or a respiratory consultant. IMPRESS has set out [competence standards](#).

**2. Service aims**

The aim of the service is to provide high quality, personalised, non-judgemental care for people with COPD so that they can have the best quality of life possible.

**3. Objectives /goals**

The objectives of the service (adapted from the Northern Ireland framework, 4.2 page 47) are:

- Accurate and timely assessment and diagnosis
- Proactive support for those who have a diagnosis of COPD and who smoke
- Appropriate treatment and advice in line with recognised standards and guidelines

---

<sup>11</sup> BTS Guidelines for the Management of Chronic Obstructive Pulmonary Disease Thorax 1997; 52 (Suppl 5): S1-S28.

- To work with patients to optimise their health (physically, psychologically and socially) (minimise the impact of the disease; reduce exacerbation rate; minimise side-effects of therapy and promote rehabilitation);
- To ensure timely access to specialist services during an exacerbation (reduce waiting times in primary and secondary care);
- Where appropriate, support patients in their home settings (reduce hospital admissions and re-admissions);
- When hospital admission has been deemed necessary; promote early supported discharge to reduce length of stay
- Provide or initiate palliative care provision, if required.

While other goals may be added, a truly successful respiratory service is one that can demonstrate that it achieves these core patient-centred goals and these, in turn, should drive development of quality indicators for a respiratory service. It should also be noted that guidance in clinical care and standards continue to develop in keeping with research and best practice.

#### 4. Outcomes

##### 1. Outcomes of needs assessment

- Evidence of systematic involvement of local service users and carers in defining their service needs.
- Existence of actively managed and validated **patient registers** that capture the number of patients diagnosed as having COPD using local prevalence and severity data from the Quality and Outcomes Framework (QOF) and Hospital Episode Statistics (HES). Also use local information such as risk occupations, smoking rates, BMI and age and sex profiles. Also risk occupations locally; smoking rates; age-sex mix etc. For example see the work of Salford PCT. Error! Bookmark not defined.
- Stratification of COPD population according to **disease severity**: by FEV<sub>1</sub>% predicted values to categorise as % mild, % moderate, % severe.<sup>1</sup>
- Estimated numbers of **undiagnosed** patients using prevalence models such as that developed by East of England Public Health Observatory for the Association of Public Health Observatories (March 2008) are available as models and datasets: 'Local authority estimates of COPD prevalence and COPD prevalence model' and [Model based prevalence of COPD at PCT level](#) (updated Feb 2008).
- Further assessment of those patients whose contact with **primary care** may be insufficient. For example local audit work can also identify patients whose first contact is with acute services, rather than primary care.<sup>12</sup>
- An **aspirational** outcome would be separate measure(s) for those who are diagnosed and reviewed to be on appropriate medication and whose smoking status is coded and also codes for comorbidities.
- Assessment of numbers of people **suitable for referral to pulmonary rehabilitation** and who accept the referral.

---

<sup>12</sup> R Ahmed, A Dinham, L Starling, A Bastin, N Hill, M Stern, L Restruck, Characteristics of patients who have a first admission with an acute exacerbation of chronic obstructive pulmonary disease (AECOPD). Thorax. 2007;02:3, A117. P. 145

- **Referrals to smoking cessation services.**

## 2. Patient outcomes

- **Mortality** (Standardised hospital mortality ratios and standardised mortality ratios – benchmarked against historical data (given geographical coding differences in death certificates) and, once the National COPD Audit is published (data collection finished summer 2008), against national audit data. **Note that a** locally agreed “audit of accuracy” when reviewing discharge diagnoses could help to improve both local systems and achieve more realistic estimates. There are some key papers regarding accuracy. Jarman found that 'Analysis of hospital episode statistics reveals wide variation in standardised hospital mortality ratios in England. The percentage of total admissions classified as emergencies is the most powerful predictor of variation in mortality. The ratios of doctors to head of population served, both in hospital and in general practice, seem to be critical determinants of standardised hospital death rates; the higher these ratios, the lower the death rates in both cases'.<sup>13</sup> Rudolf's editorial provides a good summary of these issues for COPD.<sup>14</sup> This also includes some good references on the subject.
- **Morbidity** – there should be some measure of quality of life, but there is no standard measure used at present on GP computer systems apart from some use of the MRC Dyspnoea scale. Options include London Chest ADL (short and validated but not widely used)<sup>15</sup> and the St George's Respiratory Questionnaire (SGRQ) that measures patient distress and coping. A Study by the Thoracic Medicine Unit in concluded that - 'poor scores on the SGRQ, a QOL scale which measures patient distress and coping, are associated with re-admission for COPD and use of resources such as nebulisers, independent of physiological measures of disease severity'.<sup>16</sup> SF36 has also been tested in a pulmonary rehabilitation programme<sup>17</sup> and the authors concluded that use of the SF-36 allows comparison of the results of pulmonary rehabilitation to therapeutic interventions in patients with other medical disorders.
- **Patient satisfaction** There has been a tool developed to test comparative satisfaction between patients with asthma and COPD attending outpatients' clinics and general practice in Norway.<sup>18</sup> There are a number of organisations that can provide survey software e.g. <http://www.camsp.com/> Gloucestershire Hospitals NHS Foundation Trust developed a patient satisfaction survey for their COPD assisted discharge scheme. The [Health Foundation](#) and [Picker Institute](#) are both sources of expertise in this area. The [Work Foundation](#) also offers a note of caution, referring to the delivery paradox, that satisfaction never rises at the same rate as quality.
- **Complaints and commendations received by service**
- **Continuity of care**, potentially measured by a random sample of patients. In Southampton as a measure to be used in primary care they applied the UCD 5 or UCD 10, which is the Usual Consulting Doctor who saw a patient most commonly on

---

<sup>13</sup> Jarman B et al *BMJ* 1999;318:1515-1520 ( 5 June )

<sup>14</sup> Rudolf M. COPD and death - what exactly is the relationship? *Thorax*. 2007 May ;62 (5):378-9

<sup>15</sup> *Thorax*. 1997 Jan;52(1):67-71

<sup>16</sup> Osman et al. Quality of life and hospital re-admission in patients with chronic obstructive pulmonary disease. *Thorax*.1997; 52: 67-71

<sup>17</sup> Fernanda M. V. Boueri et al *Chest*. 2001;119:77-84

<sup>18</sup> Gallefoss F., Bakke P.S. Patient satisfaction with healthcare in asthmatics and patients with COPD before and after patient education *Respiratory Medicine*, 94: 11: 1057-1064

their last 5 or 10 presentations for care. It can be used for any presentation or just for one condition or routine only. This study highlighted quite wide variability and it was interesting that individual lists in general practice often had a lower level of continuity than open list but patients are encouraged to see same doctor.

- Some measure of **patient knowledge** of their disease: An example is the Bristol COPD Knowledge Questionnaire (BCKQ).<sup>19</sup> It can be downloaded from [IMPRESS - the BCKQ](#). This takes 20 minutes to be completed and scored. It can be repeated after an education programme to test improvement in knowledge and understanding. In fact, this same questionnaire could also be used for healthcare professionals.

### 3. Service outcomes

- **Evidence of care pathways for COPD** including access to pulmonary rehabilitation and hospital at home. The [Map of Medicine](#) offers six. See [http://healthguides.mapofmedicine.com/choices/map/chronic\\_obstructive\\_pulmonary\\_disease\\_copd\\_1.html](http://healthguides.mapofmedicine.com/choices/map/chronic_obstructive_pulmonary_disease_copd_1.html)
- **Referrer satisfaction** such as time to appointment, and communication. See the [BMA's latest suggested guidelines](#) on improving communication and the exchange of information between secondary care and GPs.
- **Time from referral to initial assessment** will be set by the Choose and Book targets.
- **Numbers of patients** managed by the service and distribution of routine care between secondary care and primary care.

### 4. Process measures

- **Education and training for general practices** – there should be an observable register of qualifications and updates attended by those members of the team responsible for COPD care.
- **Evidence of patient and carer involvement in the development of these care pathways.**
- **Written individual care/action plans** for every patient with diagnosis of COPD. This is a target set in the Next Stage Review to be achieved by 2010.
- **Appropriate medication review** according to severity including assessment of co-morbidities at least annually
- **Referral rates** to pulmonary rehabilitation and smoking cessation
- Number of **weeks** between **referral to pulmonary rehabilitation** and availability [checked through asking for date of next course] Aim: 12 weeks
- Community nursing and physiotherapy **contact rates** by practice (standardised)

---

<sup>19</sup> R White, P Walker, S Roberts, S Kalisky and P White Bristol COPD Knowledge Questionnaire (BCKQ): testing what we teach patients about COPD. *Chronic Respiratory Disease* 2006; **3**:123–131  
DOI: 10.1191/1479972306cd1170a <http://crd.sagepub.com/cgi/reprint/3/3/123.pdf>

- **Take-up rate of allowances** by those eligible, seeing a year-on-year increase. This would require a survey. Given the proposal by the Next Stage Review to start piloting personalised budgets for people with long term conditions, it would seem an important first step to identify who is eligible for allowances, and what the take-up rate is. Anecdotal evidence suggests that there is a gap between those eligible and the rate of take-up.
- **Referral rates** and DNA rates for first outpatient (OPD) appointment by practice (standardised)
- Referral rates and DNA rates for **follow-up OPD** (and equivalent if outside hospital) by practice (standardised) The 2008 COPD audit ought to support the development of an average rate.
- **New to follow up ratios** and consultant to consultant referral. Commissioners typically benchmark against other specialities or against other areas. As long as the situations are similar this may be helpful. Also note that if specialist nurses see patients then the consultant to consultant referral figures may not be a reflection of all activity.
- **Admission rates** by practice (standardised)
- **Readmission rates** by practice (standardised). The evidence<sup>20</sup> from the 2003 audit shows readmissions contribute significantly to the total number of admissions. One in three patients with COPD are readmitted within 3 months. Readmission is related to two patient factors: performance status and previous admission. There is no evidence from this audit that changing service organisation will reduce readmissions.
- **Average length of stay**, and benchmarked data using 2008 National COPD Audit as source. Note that the 2003 audit<sup>20</sup> showed that length of stay is related to patient factors
  - Performance status and albumin
  - Age
  - SaO<sub>2</sub> and respiratory rateand is reduced in respiratory units with
  - more respiratory consultants
  - better organisation of care 'scores'
  - an early discharge scheme
  - local COPD Guidelines
- Percentage of acute admissions for respiratory cause seen or reviewed by a **respiratory specialist during the course of that admission**. These data are available from the national COPD audits 2003 and 2008.
- Number of patients **reviewed in primary care following admission**
- **Compliance with [Standards for Better Health](#)**

---

<sup>20</sup> UK National COPD Audit 2003: impact of hospital resources and organisation of care on patient outcome following admission for acute COPD exacerbation. Price LC, Lowe D, Hosker HRC, Anstey K, Pearson MG, Roberts CM, on behalf of the British Thoracic Society and the royal College of Physicians Clinical Effectiveness Unit CEEU). *et al. Thorax* 2006;61:837-842

- Some PCTs will want to capture something about **admissions that have been averted or delayed**. This requires an agreed and robust method of local data collection for individual patients. It also requires analysis about those who are admitted to understand if their admission could have been avoided. Greater Manchester has done work on this. Others have shown that late diagnosis of COPD in primary care may make it difficult for secondary care to reduce admissions.<sup>12</sup>

## 5. Financial and information measures

- Total cost of prescribing of **oxygen** for those with respiratory problems on oxygen therapy using PPA data, and cross-referencing diagnosis data oxygen providers . The use of **short burst oxygen** needs particular attention, as this is an indicator of inappropriate prescribing. All patients on short burst oxygen who are not on a palliative care pathway should be assessed by a competent assessor of oxygen therapy.
- Cost of inhaler therapy in those aged over 35 (the age cut-off could be debated locally). Percentage of those with COPD on NHS-approved formulary preparations for COPD and co-morbidities. Low numbers of prescriptions for nebulisers.
- Consistent and accurate use of HRG4 and OPCS4 coding.
- It might also be appropriate to review the level of funding for the third sector to support users and carers. This may become more developed as the NHS Next Stage review of 2008 is proposing the testing of personalised budgets for health in addition to social care.

## 5. Eligibility and accessibility

Typically services will be required by smokers, ex-smokers, and those who have been exposed to other known risk factors for COPD. Therefore the population age is likely to be from 35 years of age onwards.

The pattern of smoking prevalence, highest in disadvantaged groups, suggests that those most at risk of COPD may be those who, currently, are relatively excluded from services. Therefore the service will have to be proactive to ensure the full range of preventive and diagnostic services is available to all. Furthermore, people in disadvantaged groups may have other challenges to seeking help such as language problems, mental health problems such as anxiety and depression, and other comorbidities as well as financial difficulties.

The service will need to have systems and networks in place to identify those at risk of receiving sub-optimal care and therefore probable sub-optimal outcomes.

In addition, many people with diagnosed COPD are very short of breath and when asked, they and their carers emphasise the need for services to be provided in safe, easily accessible locations to reduce the burden of mobility problems, anxiety in finding parking spaces, the cost of travel and so on.

Consideration of referral for pulmonary rehabilitation, lung volume reduction and transplantation should not be age related but functional; that is, based on an assessment of the individual's ability to benefit from the intervention.

## 6. Referral

There are a number of options for managing referrals to ensure a person is seen by the right person at the right time.

We would encourage the service to make it as easy as possible for the people who see the patients to refer directly. This will be dependent on the local situation such as

- Continuous professional development for primary care
- Availability of spirometric assessment and competency of person undertaking this
- Pulmonary rehabilitation referrals
- Uptake of Expert Patient Programmes (EPP).
- Availability of Breathe Easy Groups
- Referral to smoking cessation services
- Availability of clinicians with a special interest (“lower case pwsis”) such as practice nurses, GPs who take a practice lead on respiratory care/COPD care, nurse practitioners
- Availability of clinicians With a Special Interest (“upper case PwSIs – who are trained and accredited) such as Clinical Nurse Specialists in the community, GPs with a Special Interest. (Please see the workforce paper for further information about workforce issues and remember that nursing titles do not necessarily signal the level of training or expertise a nurse holds.)
- Referral management centres with respiratory qualified practitioners to triage referrals
- Locally agreed referral protocols (IMPRESS recommends the use of the criteria for specialist referral: [Referral criteria](#)).

## 7. Staffing [see IMPRESS standards and competencies for respiratory care [IMPRESS competence standards for the respiratory workforce](#).]

It is the responsibility of the providers to recruit/provide suitable personnel and therefore the provider will determine the exact person specification. However the following guidelines will apply:

- Staff will be competent to perform their role (McArthur on behalf of the GPIAG has written a useful [skills set document](#) for practice nurses.)
- Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility.
- Staff will have a commitment to continuing professional development through the pursuit of relevant professional and academic study
- Staff will participate in regular personal performance reviews of their performance including the development of a personal development plan and annual appraisal
- Appropriate supervision arrangements for all levels of staff will be in place including clinical supervision
- All staff will have an agreed KSF outline in line with their job requirements
- All staff will attend required mandatory training
- There will be a system of patient feedback incorporated into any performance review

## 8. Performance monitoring

### Risk and governance

The provider must ensure that they have a strong ethical position on governance, and clear guidance from a medical professional to ensure services are safe, efficient, reliable and meet national standards. The provider must be able to explain who provides clinical leadership and to demonstrate that they have appropriate clinical governance processes in place. The designated clinician who leads and is accountable for the service shown be known to all patients and staff so that at any time, when audited, any mentally competent patient or member of staff should be able to name the person who leads the service. Processes should

include methods to report on and learn from Serious Untoward Incidents, Health and Safety issues and other service issues that put staff an/or patients at risk. Suitable infection control procedures are required. The team will also participate in case reviews, regular supervision and appraisal with their manager and an agreed audit programme for the service.

It is the provider's responsibility to ensure that all incidents reportable to The National Patient Safety Agency (NPSA) are documented and notified to PCT Commissioner with any planned remedial action.

All Serious Untoward Incidents will be reported in line with regional guidance.

It is the responsibility of the provider to ensure they have systems to collect and report on the above measures.

### **Meetings**

There will be quarterly performance management meetings with the host commissioner and their representatives. A standardised performance report will form the basis of discussions at these meetings.

---

## **Standard requirements**

**In addition, a specification will contain standard requirements, for which the PCT is likely to have standard paragraphs. It will cover ground such as the statements below, which should not be considered comprehensive but simply illustrative.**

### **Information for monitoring**

The providers will be expected to utilise information systems and to use such systems that enable information to be shared across the relevant health and social care organisations.

Parties acknowledge that in order for the parties to achieve accurate forecasting, activity monitoring and prompt and accurate payment, there needs to be timely regular exchange of detailed and accurate information and accordingly the Provider shall:

- comply with current NHS data standards in relation to the information collected and provided on the services provided,
- submit to the Commissioner all the information required by the Commissioner and set out in section 4.2 to the PCT Performance team and any other nominated representative of the Commissioner within 7 working days of the last day of the qualifying month or by midday the following day if required daily.

If any information to be provided is not received by the Commissioner within 7 days of the due date, then the Commissioner shall be entitled to retain 5 % of the agreed monthly payment. The sum, if any, so retained shall be held by the Commissioner until such time as the information to which it relates is received. The Commissioner shall pay to the Provider the retained sum at the next payment run following the receipt of the information.

### **Confidential Information and data Protection**

Any information of a confidential nature acquired by any individual involved in providing the service shall not, whether during or after an appointment, disclose or allow to be disclosed to

any person (except on a confidential basis to their professional advisers) such information except as may be required by law or as directed by the Trust.

The Providers must protect personal data in accordance with the provisions and principles of the current Data Protection Act legislation and must ensure the reliability of the staff who access such data.

The Providers shall not, whether before, during or after appointments, disclose or allow to be disclosed to any person (except on a confidential basis to its professional advisers) any information of a confidential nature acquired by the Provider in the course of carrying out its duties under this Agreement, except as may be required by law or as directed by the Commissioner. Nothing in the above should be taken as placing any restriction on the provider informing other Commissioners, funders or statutory monitoring bodies of the contents of this Service Level Agreement.

The providers will be expected to utilise information systems and to use such systems that enable information to be shared across the relevant health and social care organisations.

### **Policies and Protocols**

The Providers are expected to have and to use policies & protocols in the following areas:

- Complaints and compensation
- Confidentiality
- Employee induction training and development
- Equal Opportunities
- Health & Safety
- Freedom of information
- Data protection
- Race equality
- Employee rotas and management support
- Protection of vulnerable adult

The above should be maintained and updated in a procedures manual which clearly documents each area of the operation.

There should also be an up-to-date database of where the equipment is and how it is being used.

---

In addition, if there was a **tendering process**, there also need to be further information such as:

### **Pricing for a tender**

The providers must submit a detailed breakdown of the cost of the service. The following headings are compulsory but not exhaustive. The price for the provision of the service should be broken down to show the level of staffing, materials, equipment and management costs included.

- Staff costs by band
- Overhead costs including:
- Equipment costs
- Travel costs

- Accommodation
- Mobile phone
- IT costs

Prices will be valid for 6 months following the tender and should be at 2008/09 prices.  
Anticipated inflation and incremental staff raises should be clearly identified.

August 2008