GPIAG

IMPRESS

Improving and Integrating Respiratory Services

August 2008

Best practice guidance on developing a respiratory service specification

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The British Thoracic Society (BTS)+ has over 2,800 members who are actively working in a variety of healthcare professions to improve the standards of care for people with lung diseases. Just over half the members are secondary care physicians and doctors in training and the remainder are respiratory nurse specialists, respiratory physiotherapists, respiratory technical and physiological measurement professionals, smoking cessation practitioners and staff working in primary care. The Society publishes treatment Guidelines and related educational materials; runs an annual Scientific Meeting and an annual conference and short course programme catering for the multi-professional team; publishes the journal *Thorax*; provides tools to assist individual and team review and performance improvement (including audit and peer review); and works with strategic partners such as GPIAG and patient organisations to raise the profile of the speciality and advocate for improvements in standards.

http://www.brit-thoracic.org.uk/

The General Practice Airways Group (GPIAG) is an independent charity representing primary care health professionals interested in delivering the best standards of respiratory care. It is dedicated to achieving optimal respiratory care for all through:

- Representing primary care respiratory health needs at policy level
- Promoting best practice in primary care respiratory health through education, training and other services
- Supporting the development of primary care health professionals in respiratory medicine
- Facilitating and leading primary care respiratory research

For further information and details of how to join the GPIAG see www.gpiag.org

This document is available to download from the IMPRESS website as a pdf file. Text marked in blue contains hyperlinks which can be clicked to access further information from the web version.

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Best practice guidance on developing a respiratory service specification

Executive Summary

This paper is written by IMPRESS, a joint initiative between the British Thoracic Society (BTS) and the General Practice Airways Group (GPIAG) for improving and integrating respiratory services in the NHS. It is for clinicians, managers and commissioners who have a stake in the development of high quality respiratory care.

It takes people through the process of developing a service specification for respiratory care from the point of agreeing a shared vision, aims and objectives, to determining what should be included in the specification, what resources are available, and what form of procurement might be chosen.

It advocates the creation or further development of a clinical network that can provide expert advice and input on needs assessment, service models and care pathways as well as overseeing and supporting an appropriate training and development programme for the respiratory workforce, particularly those working in the community.

It provides the structure and headings for a specification for Chronic Obstructive Pulmonary Disease (COPD), as an illustration.

In line with World Class Commissioning[1], IMPRESS strongly urges commissioners to work locally with local stakeholders including clinicians and patients to develop a specification appropriate to local circumstances. Whilst it acknowledges that some new services may need to be procured using a competitive process[2], it encourages clinicians, in collaboration with commissioners, to actively seek patient views and experiences, and to ensure that existing services meet the best evidence and their patients' needs and preferences. This might require reallocation of existing budgets and redeployment of staff. This is preferable to the upheaval and cost (human and financial) involved in a competitive process.

Although it uses respiratory examples, many of the principles apply to other long term conditions and could be used as the basis of the approach for them all.

[1] **http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm**
[2] Primary Care Trust Procurement Guide for Health Services May 2008: **http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084778**

Best practice guidance on developing a respiratory service specification

1. Aim

The aim of this paper is:

1. To provide a framework for service specifications for COPD and other chronic respiratory diseases
2. To provide stretching targets for service providers and to stimulate local debate about standards of care
3. To suggest how the specification should be developed and used to ensure high quality care is provided to local populations

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

This paper is written for all those who could contribute to the commissioning process. That is, firstly for PCO and practice-based commissioners, 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 paper 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[3]
- **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)

[3] 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

- 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.

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.

How to commission respiratory services

4. Developing the service specification - networks
The need to involve clinicians and patients is borne out in World Class commissioning (WCC) and in the process demonstrated in the Our NHS, Our Future review. WCC requires commissioners to:

- Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation (Competence 4)
- Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration (Competence 8)
- Proactively seek and build continuous meaningful engagement with the public and patients, to shape services and improve health (Competence 3).

We strongly advise that the local health economy sets up, or expands, existing networks/planning and strategy groups to ensure that there is representation of service users and carers, public health, smoking cessation and exercise experts, primary and secondary care clinicians (doctors, nurses and allied professionals), practice based commissioners, PCO commissioners, social care, and other parties who have expertise and local knowledge to contribute. There are useful resources from **NHS Networks** about running networks and from the **NHS Library**. The evidence about networks suggests that the inclusion of "boundary spanners" and a network manager is also vital to its success. We suggest its role should be to agree on an assessment of local need, undertake a gap analysis using pathway mapping or other **improvement tools** describe a vision for local services and set standards. In Scotland, where Managed Clinical Networks are an essential part of policy implementation, one of the key roles is overseeing the training and education requirements of local clinicians, audit, and monitoring service provision. In Scotland this role has come out of the findings of the needs assessment process that typically highlights a lack of knowledge amongst clinicians in primary care.

It may be possible to build on the review group work that contributed to the Our NHS, Our Future as the starting point.

***Example**: use of a network for implementing NICE guidance*
***Source**: Dr Steve Connellan*
We had a NICE implementation group which sat monthly and comprised consultants/GPs/finance/audit/IT/pharmacy reps and was chaired by the acute trust and PCT alternately. This considered all issues to do with horizon scanning, recently published guidance, Payment by Results, and financial implications for the whole health economy rather than 'them and us'. Whenever a new guidance was published, a grid of recommendations was produced and this happened for COPD and more recently TB. All stakeholders were then given the opportunity to respond to the guide and the collated response distributed so that everyone could see any hurdles to NICE implementation and (usually) any financial restrictions. There were timeframes for completion of these parts of the process and a database produced that could be accessed by both primary and secondary care. With regard to COPD, we were able to proceed with appointment of a GP with a Special Interest (GPwSI) (with session for Consultant Respiratory Physician and training resource), establishment of a resource centre, community pulmonary rehabilitation and stronger links between our Consultant Respiratory Nurse and the PCT. There were inevitable frustrations regarding timeframes, finance, attendance and it certainly wasn't all 'rosy' but the model was at least one way, based on NICE, to have a structured dialogue which required a response, whether negative or positive.

5. What is the network's role in service delivery?

The network may also have a role in service delivery. In the Scottish system, the network acts as an advocate, plugging into existing systems for provision and commissioning and offering /expert advice and facilitating change. In England, networks are less formally developed. However, the more successful the trust and relationships are between the network, the more likely it is that the commissioner would look to the network to advise on the service and to find ways to improve it.

If a new service is required, with significant investment, then commissioners are likely to be bound by European Union rules on procurement, and they will have to decide how best to do that.

This specification offers a starting point for local discussion and decisions about what is needed locally.

6. Needs assessment

To familiarise yourself with the scale of the problem locally, you can find basic country-level statistics from the **British Lung Foundation**.

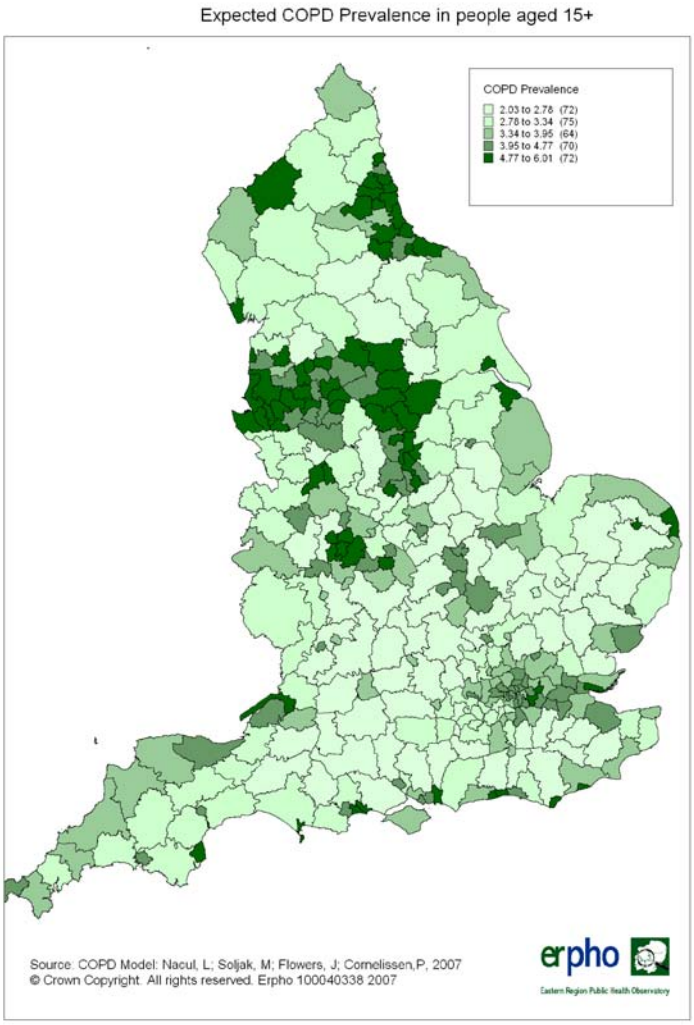
A report by a collaboration of all the UK respiratory societies also did some modelling in their report **Bridging the Gap**, which remains a useful quick guide to what needs to be considered in more depth locally.

Standards sources of data for a needs assessment of respiratory services will include:

- Quality and Outcomes Framework (QOF) data
- GP templates that collect data in addition to QOF (this would normally require Local Medical Committee (LMC) approval. Contact your local LMC.
- Hospital utilisation data (the **NCROP** study due to be published in late autumn 2008 will give some useful comparative data)

For much more complete public health modelling, the Eastern Region Public Health Observatory (PHO) has developed **prevalence modelling for COPD** that can be used to assess the completeness of disease registers in primary care or the completeness of case finding. There is also a set of slides that describes the method. It can also be used to compare outcomes such as complication rates or admission rates after adjustment for variation in expected prevalence compare service provision with population need undertake health equity audits.

The risk factors he included are age, sex, smoking and ethnicity, degrees of urbanisation and deprivation. The data were validated against a direct model obtained from epidemiologic studies and showed a **7-fold variation** in the prevalence across subgroups of the population, with lowest values in Asian women from wealthy rural areas (1.7 %), and highest in black men from deprived urban areas (12.5 %).



You may also have local patient surveys to supplement this.

An example of a comprehensive local needs assessment was reported by June Roberts and colleagues from Salford at the 2007 British Thoracic Society Winter Meeting.[4] The respiratory team used Read Coded templates to collect data automatically from GP computer systems and combined it with QOF, public health, socio-economic deprivation and Hospital Episode Statistics (HES) data to create a city-wide COPD register. They then mapped COPD outcomes (QOF prevalence, COPD severity by lung function, hospital admissions and length of stay) by individual practice and Practice-based Commissioning group to identify areas of greatest need. They found a QOF prevalence of 2.3% n=5501, (range 0.1% – 4.7% across all practices); mean age of 68 years; 41% current smokers,12.5% never smoked; severity by FEV_1% predicted values[3]: 50% mild, 30% moderate, 9% severe; 11% had an FEV_1 %predicted value > 80% . They concluded that COPD prevalence was twice the national average and positively associated with deprivation; however, other factors such age and smoking status of the population were also important.

There are also a range of tools to analyse the data in terms of predictive risk (of hospital admission), such as PARR, PARR++ and the combined predictive risk model all available from the **Kings Fund** in collaboration with Health Dialog.

In terms of planning appropriate interventions, the **British Lung Foundation** (BLF) has experimented with social marketing approaches by using a range of postcode level data to identify where people with COPD are most likely to live, and what might be predicted about their lifestyles.

The BLF work aims to address the issue of unmet need, and those patients at risk of COPD, or with COPD that have not yet been diagnosed – a case finding approach.

It will also be important to gain some more local knowledge about patients' needs such as their level of literacy, health literacy, language support, housing, mobility and comorbidities. Particularly, a service for people with COPD cannot be "carved out" of a general service without taking account of their needs from other parts of the NHS and other agencies.

Trends

It is important when planning services to know the trends in admissions, prevalence, survival rates, therefore historical 5-year data may be useful, bearing in mind that coding accuracy may have changed over that period, so it is useful to have secondary care input into the analysis.

7. Creating and describing a vision for high quality integrated respiratory care

Local health economies will have visions for healthcare that use frameworks such as the "no needless framework" from the Institute of Healthcare Improvement (Don Berwick) www.ihi.org

[4] Roberts and Bakerly Benchmarking COPD across an inner city primary care organisation *Thorax* 2007 62 suppl III S134

To have health care with

- No needless deaths
- No needless pain or suffering
- No unwanted waiting
- No helplessness
- No waste

The attributes of such a system are likely to include:

- Safety – As safe in health care as in our homes
- Effectiveness – Matching care to science; avoiding overuse of ineffective care and under-use of effective care
- Patient-centredness – Honouring the individual, and respecting choice
- Timeliness – Less waiting for both patients and those who give care
- Efficiency – Reducing waste eg there is significant scope to reduce costs and improve care by providing integrated oxygen services[5]
- Equity – Closing racial and ethnic gaps in health status: service specifications will need to be tested by the EIRA process (equality impact risk assessment)

The Northern Ireland respiratory framework lays out these aims:

- Promote health, well-being and independence;
- Prevent respiratory disease;
- Reduce inequalities in health;
- Develop person-centred, multidisciplinary care;
- Develop services appropriate to patients' needs taking into account evidence-based care and good practice; and
- Deliver more effective links between primary, secondary and tertiary care services.

A vision of integration

IMPRESS was set up to provide and campaign for a model of integrated care that we think is the best way to deliver these attributes reliably. As we have explored what we mean by this, we have reached the view that we support vertical integration, between primary and secondary care; where, the patient receives the right level of specialism for their needs, throughout their life. This is also likely to involve a team approach. At times this may be provided in primary care; at times, this may require secondary care. At all times it should be delivered in a way that is appropriate, convenient and sensitive to the individual patient's needs.

Whatever vision you create, we would expect it to comply with national policy and frameworks, and therefore include such principles as:

1. Service configuration should focus on patients and care, rather than institutions
2. Health care should be provided in out-of-hospital settings, where it is clinically appropriate, safe, and provides best value for money
3. Models of care should minimise the inappropriate use of acute care facilities
4. A multi-disciplinary team approach is likely to be most effective for most patients
5. Opportunities for greater local provision of care integrated with primary care should be maximised
6. The management of acute facilities should focus only on those patients whose care needs to be provided in that setting and should be designed to ensure that the patient receives the care from the appropriate specialist team as soon as possible after admission
7. Tertiary services have to see and treat a specific number of patients to maintain viability
8. Any emerging national or regional strategies arising from the Our NHS Our Say review will be taken into account, as well as practice-based commissioning plans, and also the impact of neighbouring health economies' plans
9. Plurality of provision should be encouraged in line with government policy
10. Collaboration and co-operation with other public sector organisations, in particular health and social care will be enhanced
11. There should be equal access to health services for the whole population, including those who currently under-use health services from which they would benefit – this should be tested through an equality impact risk assessment
12. There should be ongoing audit and evaluation of any service provided, utilising data on admissions, health care contacts and costs

[5] Deeming C, Ward L, Townsend J, Ganeslingam K, Ansari SO, Powrie D, Davison AG. An integrated home oxygen service saves £130,000 in one year on home oxygen tariffs. *Thorax* 2008; 63: 566.

13. Providers should actively seek out the views of patients and carers when designing services

The IMPRESS response to the Lord Darzi consultation in early 2008 may also provide some points for local discussion.

8. Local clinical leadership

Where this comes from will very much depend on local circumstances. The majority of expertise resides within secondary care. We would expect that most secondary care hospital departments and consultant job plans would include statements such as this:

- To provide a high quality acute medical and respiratory service to the local community, including provision of Non Invasive Ventilation (NIV).
- To work with PCTs and local GPs, to improve the respiratory health of the local community in particular supporting stopping smoking and care for patients with chronic respiratory disease with the aim of reducing A&E attendances, admissions and length of stay.

However, we also recognise that many hospital departments may not have overtly demonstrated such a leadership role in the community. In some places, this does not matter because the leadership will be community-based, perhaps from a Practitioner with a Special Interest (PwSI), or the commissioner. The leadership role of the consultant should also be recognised as a vital part of the network. There is no "one size fits all" system, with a leadership role falling to only one of the partners involved in the network. Both Pinnock[6] and the Shared Leadership work of the Health Foundation suggest leadership is probably best shared between the network of stakeholders. However, in some communities, there is vacuum waiting to be filled. In such circumstances, the commissioner may feel it is appropriate to bring in external resource. We would encourage local clinicians to consider whether this is best for the local community and to demonstrate leadership by advocating for improvements in care, particularly in anticipation of the NSF, and for developing a clear policy on education and training of the local health economy.

Our strong recommendation would be to describe a vision and specify respiratory services as a whole, and then, within that, ensure that specific elements are in place for the needs of people with COPD, asthma, cystic fibrosis, sleep apnoea, pneumonia and so on. From this point, this paper focuses on COPD care, which we understand is a priority for many commissioners.

9. What do you want?

Having prioritised attention to respiratory care, it is most likely that whilst some elements of an integrated service are in place, the needs assessment process suggests a reallocation of resources based on geography, complexity, skill mix or balance between the levels of the long term conditions pyramid. So, the task of describing what you want is important. Are you describing the total pathway of care, the missing elements, or the elements that need to be redesigned and for which you are considering a competitive procurement process? Will the "upstream" primary prevention functions of health promotion and public education be commissioned separately as well as, or instead of, in the main specification? What about co-morbidities? Data[7] suggest that about a third of people with chronic significant disease have depression; and 50% of those admitted to hospital have major depression; 67% of people with severe COPD have osteoporosis and more than 60% of people with COPD die from coronary heart disease.[8] So they have to cope with multiple pathways, and the most important attribute of the service is continuity of care. Will the provision of primary care through locally enhanced service (LES) contracts as part of the General Medical Services contract options be included?

10. How much do you want to spend? Programme budgeting

The starting point in any planning should be the assumption that there are enough resources available in terms of budget and workforce, but they may not be deployed to most effect to meet current and future needs. If a respiratory programme budget can be calculated, then it becomes possible to look at the best ways to allocate resources for the total local population with respiratory diseases. Whilst there are far more people with asthma, the cost of the care for people with COPD is significantly greater, due to the number of hospital admissions. Practice-based commissioning makes the budgeting process easier, as the primary care prescribing budgets can be more easily incorporated into the total budget available [for example, in Somerset PCT, there is one practice-based commissioning group of 74/75 practices that covers the population of 524,600. Their combined respiratory drugs budget is £6.8million for a known

[6] Pinnock H et al. The process of planning, development and implementation of a General Practitioner with a Special Interest service in Primary Care Organisations in England and Wales: a comparative prospective case study for the NHS SDO

[7] Soriano, Joan B., Visick, George T., Muellerova, Hana, Payvandi, Nassrin, Hansell, Anna L.
Patterns of Comorbidities in Newly Diagnosed COPD and Asthma in Primary Care
Chest 2005 128: 2099-2107

[8] Gan, WQ, Man, SF, Senthilselvan, A, et al Association between chronic obstructive pulmonary disease and systemic inflammation: a systematic review and a meta-analysis. *Thorax* 2004;59,574-580

COPD		Prevention Health promotion	Investigation and Diagnosis	Follow up management	Acute management	
↓ Estimated Prevalence → Coding of Inter-vention		Smoking cessation - Advised to stop - Wants to stop and support given - Support and treatment given - Referral to specialist smoking services - Spirometry screening	QOL MRC dyspnoea Full PFTs Rx Assessment BMI Mental health assessment CHD assessment Osteoporosis risk assessment	↑ Beta 2 / IB ? ICS ? Pulmonary Rehab ? O2 assessment ? non face-to-face contacts routine follow up	In-patient care ?NIV/intubation ?palliative care	**Outcome indicators**
Needs-based category ↓	**Definition of category** ↓					
At risk	Smoker > 35 yrs Cough and sputum +/- dyspnoea	**Matrix 1**				% quitting smoking % BMI % undergoing Spirometry
Presentation	1st presentation to primary or secondary care		**Matrix 2**			% QOL % MRC dyspnoea score QoF data “
Confirmed diagnosis and long term care	Follow up primary care H@H			**Matrix 3**		% of patients receiving: - Pulmonary rehabilitation - Oxygen supplementation - Exacerbation rates - Admission rates “
Acute exacerbations requiring admission	Acute admission to secondary care				**Matrix 4**	Assisted early discharge Readmission rates NIV/intubation rates Advanced directives Surgical intervention “ Palliative care
→ **Estimated Cost**						

COPD population of 8000. In addition, there is a current expenditure of £1.4million on oxygen.] One of the hardest budgeting exercises may be to apportion community nursing resource, because whilst a proportion of community nursing time should be spent on people with respiratory problems, given the likely local morbidity, the reality may be that currently most care is provided by general practice teams and respiratory-specific teams rather than general community nurses and so their time is probably not disaggregated.

a Grid

As an example, this COPD grid enables you to map what you may already have in place and from this, to construct a programme budget based on historic spend. Any gaps in provision that you identify from this mapping will also help you to make decisions about what else may need to be provided. It is not yet possible to benchmark programme budgets to know if your organisation's spend would require reallocation in order to cover the services in the matrix, or whether you will require new investment.

However, we can say, that generally, **investment in respiratory services** has lagged behind expenditure in other long term conditions; that the NSF for COPD is likely to recommend pulmonary rehabilitation for all disabled by their disease; and that, at least in the short to medium term, new community services will be needed to provide high quality care.

Theoretically, it can be argued that if the outcomes of a new respiratory service include shorter lengths of stay and/or avoided admissions, then new resources become freed up. The **Opportunity Locator** offers PCTs a tool to look at the scale of any potential gains. See However, until payment by results becomes more sophisticated and rewards improved outcomes rather than volume of activity, alternatives such as hospital at home and community-based services may still require additional investment. There is also an acknowledged under-investment in **allergy** and sleep services.[9]

b Identifying and valuing local human and intellectual capital

In addition to using readily available data on prescribing, QOF points, workforce and hospital utilisation, it will be important for the service specification process to understand, and to make visible elements of care and service that may be currently invisible, or not paid for, such as work by certain professional groups such as nurses and physiotherapists (note that the latest HRGv 4.3 codes offer codes for such care) but also mentoring, telephone consultations with colleagues, informal training and education, networking opportunities, peer support and so on. These relationships, the goodwill, human and intellectual capital, should be valued and protected. If they are specified they can then be costed into any service, and also there will be a benchmark against which to evaluate change.

c Identifying and valuing local research

Many NHS professionals also undertake a research role that is valuable nationally and locally as it is the way that services continue to develop and best practice is tested and improved. This is different from audit, which is an essential element of any service. Original research is another element that needs to be quantified, and decisions made about what is wanted.

11. Who should be accountable for what?

The commissioners (PCT and practice-based) are responsible for the **service specification** and for the **procurement** of a service that best meets the local specification. It is therefore their responsibility to ensure no patient is excluded by the service, and to ensure it is provided as **equitably** as possible (here is another example of the NHS response to **equality impact risk assessments**). This may require monitoring of referral patterns from primary care to ensure specialist services are available to all patients who would benefit; and monitoring emergency admissions as a way of seeing whether any particular practice's patients are more likely to require unscheduled care.

In terms of **clinical accountability**, it is imperative that the specification addresses this. There have been sufficient public inquiries into errors in health and social care that have concluded that no-one was in overall charge of a person's care for us to know that it won't "just happen" unless accountability is negotiated and documented at all stages in a person's care. It might be assumed that if a patient is on a clinical pathway, then the accountability is defined in the pathway and the patient is therefore safe. However, many patients with long term conditions have more than one condition, and so need to be on more than one pathway, so they will only be safe and receiving the best possible care if there is someone responsible for their individual case. Typically, that would be the GP. However, it is best that the specification addresses the issue. Commissioners should have a strategic view of how the intertwining of pathways should work best.

[9] Sleep apnoea - continuous positive airway pressure (CPAP). NICE Technology Appraisal 139 March 2008

12. Training and education

The commissioner is also responsible for ensuring the service meets **quality standards**, specified outcomes and is sustainable. Service **sustainability** would require the existence of an affordable strategy for **continuing training and education** of primary and secondary care professionals. One solution to this is to delegate the role to the network. This is only possible if there is funding for a clinical lead, network manager, a training and education budget, and documentation to keep track of which individuals and practices have been targeted or missed. In addition, the original needs assessment should be repeated regularly, and adapted to highlight new developments or challenges. Without this, the detection and diagnosis of COPD and other chronic respiratory diseases may not be sufficient, and appropriate referrals to specialist care may not be made at the right time.

13. Governance

The commissioner will have generic standards and approaches for combined governance, including financial and clinical. We refer here to the clinical governance issues. Any organisation awarded a service level agreement or contract must have the competence and senior authority to be responsible for clinical professional behaviour and standards, to have appropriate systems to deal with risk, audit and information, appraisal, improvement and change and collaboration and networking with other organisations.

14. How to procure respiratory services

The simplest way to procure a service will be to revise or develop the service level agreement (SLA) that the commissioner already has with the provider(s) of care. This might extend or change certain elements such as the location of delivery or the numbers of hours, and/or set tighter performance standards or outcomes. This will work best where there is agreement that services are mainly appropriate, but that there need to be some relatively modest changes. It might depend, for example, on the readiness of the healthcare community to deliver the NSF for COPD.

For example, could more care be delivered closer to home by improved team working between the hospital specialist team and generic community nurse teams? Could some pulmonary rehabilitation be sited out of hospital in the community? Equally, the trigger might be an audit or other process initiated by the providers that can demonstrate a better way to do things.

However, if the commissioner intends to make a considerable new investment (for example if there is no pulmonary rehabilitation service at present), the service development will probably require a competitive procurement process. If the new service is awarded to a non-public sector body, it will require a contract rather than a service level agreement. An Alternative Provider Medical Services (**APMS**) contract might apply. NHS Providers may also use this weblink: **nww.pasa.nhs.uk**

Having decided the scope of what you are specifying you will be guided by local strategy on procurement and by European Union rules. If the amount of the procurement is above a given figure (currently if the service is likely to be worth more than £99,000 over the life of the contract) one of the EU public procurement directives is likely to apply. These **directives** specify detailed procedures, adherence to strict timetables, requirements for advertising, invitations to tender and the award of contracts.

IMPRESS would strongly argue for the avoidance of a competitive tendering process wherever possible as we believe that it is an inappropriate and inefficient method for the procurement of long term care where long term, robust personal relationships, trust and sustainability are key requirements. There is therefore, an imperative for providers to listen to patients and audit and assess their service regularly against the best evidence and patient need to ensure it remains appropriate, equitable, effective and efficient. This should reduce the necessity of a competitive process. However, local circumstances may suggest that the only way to achieve the level of change required is through the introduction of competition or a new provider. See the IMPRESS guide to commissioning and the dos and don'ts of procurement on the Commissioning pages **IMPRESS commissioning pages** or download **IMPRESS lessons in procurement**.

Whatever rules apply, the process is likely to follow the schedule laid out in the **Desk Guide** to Procurement. DH. 2005 Edition.

- Identify the need and develop an outline specification for inclusion in the business case
- Obtain financial approval/authority to proceed
- Identify prospective suppliers/contractors/
- Finalise the specification and prepare the rest of the Invitation to Tender (ITT) documents
- Issue ITTs and handle enquiries
- Evaluate tenders
- Award and manage the contract and
- Notify DH Procurement Policy and Advisory Unit (PPAU) so it can maintain a central record

15. Contracting currency, incentives and penalties

IMPRESS has argued strongly for respiratory care to be commissioned in a more sophisticated way, by developing a hospital at home costed package, as well as considering options such as year of care that specify what level of support and clinical intervention a patient could expect over a year.[10]

In addition, follow-up telephone consultations with patients, and telephone calls between referring professionals and their specialist colleagues also need to be contracted for in a way that incentivises the sharing of information, and encourages learning.

A Service Level Agreement will typically set a threshold activity level (for example hospital spells or community contacts) above or below which the contract value will be reviewed by the commissioner and provider together.

In order to incentivise providers to reduce emergency admissions by early response and strong case management, commissioners might choose to set a target about the numbers of admissions that is lower than the previous year (taking into account any pre-existing trend). For example, the target might be a 20% reduction in emergency admissions. The target could also be set in terms of financial value (that is, the numbers of admissions multiplied by the tariff). This latter option means that providers could choose to focus on a few individuals with multiple high-cost admissions, or on a more widespread approach. Both require the commissioner to validate the coding. Some commissioners are offering a financial reward – up to £50,000 if these targets are exceeded.

If managing prescribing expenditure is a priority, for example, oxygen prescribing, then there is the possibility to set a financial target with or without a financial incentive for achieving that target. For example, if oxygen prescribing was contained at the budgeted level, when the trend is for an over-spend, the commissioner might offer 50% of that underspend as a reward in the first year, and perhaps set lower levels in subsequent years.

The next section gives an outline service specification for COPD.

16. The specification

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 123**: except where indicated below. The international standard is Global Initiative for Chronic Obstructive Lung Disease (GOLD).[11]

Diagnosis

See **BTS Guideline 1997**; 52:Suppl 5 and **NICE Guideline Number 123**, *Thorax* 2004;59:Suppl1; and two peer-reviewed documents from primary care: International Primary Care Respiratory Group Guidelines on **diagnosis**[12] and the **GPIAG** guide for those working in primary care.[13]

Smoking cessation

See **NICE Technology Guidance** on smoking cessation – bupropion and nicotine replacement therapy[14] and NICE Smoking cessation - **varenicline; Final scope** and a **1998 Thorax supplement**.[15] 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**.

[10] Degeling P, Close H, and Degeling D. 2006a. *Re-thinking long term conditions: A report on the development and implementation of co-produced, year-based integrated care pathways to improve service provision to people with long term conditions*. Durham: Centre for Clinical Management Development

[11] 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

[12] 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.

[13] 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.

[14] Technology Guidance No 38. Nicotine replacement therapy (NRT) and bupropion for smoking cessation. March 2002.

[15] 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

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 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 high yields is proposed in a BMJ paper from 2002 using age, smoking and symptoms such as cough.[16]

Routine treatment and monitoring in primary care including immunisation for influenza and pneumoccus
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 pneumoccus. We would recommend that the NICE guideline be encouraged. The GPIAG summary is available for primary care.[13]

Pulmonary rehabilitation
Standards for pulmonary rehabilitation published by **IMPRESS** and British Thoracic Society Standards of Care Subcommittee on Pulmonary Rehabilitation.[17] There is also a **NICE** commissioning guide.

Supported self-management/guided self-care
See NICE Guideline Number 12[3]

Onward referral for specialist opinion
NICE Guideline Number 12[3] and BTS statement on criteria for specialist referral, admission, discharge and follow-up for adults with respiratory disease.[18] IMPRESS has also published an **example** of a referral letter.

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.

Nebuliser service
BTS Nebuliser Treatment Best Practice **Guideline**.

Surgery including transplantation
NICE Guideline Number 12[3]

High quality acute medical and respiratory service including provision of non-invasive ventilation
NICE Guideline Number 12[3] and BTS Standards of Care Committee **NIPPV** Non-Invasive Ventilation in Acute Respiratory Failure.[19]

Acute use of oxygen
The forthcoming guideline will be available from the **British Thoracic Society** in late 2008.

Community care during an exacerbation
This should include supported self-management/guided self-care. See NICE Guideline Number 12[3]

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**.

[16] 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
[17] 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.
[18] 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
[19] NIPPV Non-Invasive Ventilation in Acute Respiratory Failure. British Thoracic Society Standards of Care Committee - *Thorax* 2002; 57:192-211

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[3] and BTS Guideline 1997; 52:Suppl 5.[20] There is also a **NICE** commissioning guide.

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.

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.

Active provision of end of life care
NICE Guideline Number 12[3] 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.

Provision of support for mental health problems, tobacco dependency and nutrition problems
NICE Guideline Number 12.[3]

Audit and evaluation
NICE Guideline Number 12.[3] There are also increasingly a range of audit tools available, particularly for primary care. For example see this **link**.

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**.

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.

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
- 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.

[20] BTS Guidelines for the Management of Chronic Obstructive Pulmonary Disease *Thorax* 1997; 52 (Suppl 5): S1-S28.

Outcomes

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.[4]
- Stratification of COPD population according to **disease severity**: by FEV_1% predicted values to categorise as % mild, % moderate, % severe.[3]
- 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.[21]
- 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.

Referrals to smoking cessation services.

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".[22] Rudolf's editorial provides a good summary of these issues for COPD.[23] 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)[24] 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.'[25] SF36 has also been tested in a pulmonary rehabilitation programme[26] 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.[27] 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.

[21] R Ahmed, A Dinham, L Starling, A Bastin, N Hill, M Stern, L Restrick, 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
[22] Jarman B et al *BMJ* 1999;318:1515-1520 (5 June)
[23] Rudolf M. COPD and death - what exactly is the relationship? *Thorax*. 2007 May ;62 (5):378-9
[24] *Thorax*. 1997 Jan;52(1):67-71
[25] Osman et al. Quality of life and hospital re-admission in patients with chronic obstructive pulmonary disease. *Thorax*.1997; 52: 67-71
[26] Fernanda M. V. Boueri et al *Chest.* 2001;119:77-84
[27] 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

- **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 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).[28] 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.

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**

- **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.

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)

- **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.

[28] 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: 10.1191/1479972306cd117oa http://crd.sagepub.com/cgi/reprint/3/3/123.pdf

- **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[29] 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[29] showed that length of stay is related to patient factors:-
  - Performance status and albumin
  - Age
  - SaO2 and respiratory rate

  and 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**

- 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.[21]

Financial and information measures

- Total cost of prescribing of **oxygen** for those with respiratory problems on oxygen therapy using Prescription Pricing Authority (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.

[29] 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*

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.

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**.

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

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.

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