

**Commissioning and Developing
Home Oxygen Clinical Assessment and Follow Up Services**
Version 1 (1st June 2008)

This document is an early version of the guidance issued for information. A later version of this guidance will be published by the Department of Health during the summer of 2008.

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Foreword



The Home Oxygen service provides 90,000 patients in England and Wales with different models of home oxygen therapy and a tailored, patient-centred service. Now the challenge is to encourage and enable PCTs to develop and improve clinical assessment and follow up services to provide improved patient care and well-being.

This document aims to offer real solutions and examples from which to learn to those PCTs who have yet to develop formal clinical assessment and follow up services.

The models of service outlined here have been developed and funded in a variety of different ways and serve to illustrate that innovation and creativity, as well as negotiation and business skills are required to complement the clinical expertise which must underpin the home oxygen service.

This document should be used in conjunction with other identified resources which include a network of experts acting as mentors, case studies and examples. Those developing services should link in with one another, with finance directorates, service improvement teams and other clinical services, as well as with the local home oxygen providers. They should ensure that patient views are considered and that patient reps can input directly in a robust and meaningful way. Working effectively between primary and secondary care services will be crucial to the successful commissioning and implementation of further clinical assessment and follow up services.

A handwritten signature in black ink on a white background. The signature is cursive and appears to read 'Gary Belfield'.

Gary Belfield

Director of Commissioning, Department of Health

Purpose of the guidance

The guidance aims to offer practical tools to assist in the development and commissioning of home oxygen clinical assessment and follow up services. It aims to lay out the available resources in a way which will enable new initiatives to be more easily commissioned and to ensure that those developing services have the tools and contacts to move forward.

The Commissioning Framework (<http://www.primarycarecontracting.nhs.uk/118.php>) outlined the need to recognize that Home Oxygen clinical assessment and follow up services can assist in the reaching of various PSA targets and other health initiatives and that as such can be viewed as beneficial to both commissioners and clinicians.

Context

1.1 The Home Oxygen Service changed in February 2006. The changes when implemented and used effectively are:

- improving support for patients with long term conditions;
- supporting hospital discharge;
- helping reduce inappropriate hospital admission (COPD patients account for 10% of emergency admissions each year); and
- supporting other service provision.

Whereas previously GPs issued an FP10 prescription form, with Community Pharmacists providing a cylinder oxygen service directly to the patient, whilst specialist companies delivered the oxygen concentrator service under contract, there are now four suppliers delivering all home oxygen requirements in each of the ten service regions in England (and one covering the whole of Wales). Further details on the history of the changes are on the NHS Primary Care Contracting website (www.pcc.nhs.uk).

1.2 The service specification for the Home Oxygen Service takes into account the importance of clinical assessment and follow up services to support the clinical and cost effective use of oxygen therapy in the home, as highlighted in:

- the Royal College of Physicians report, issued in 1999;
- NICE COPD guidelines issued in February 2004; and
- updated clinical best practice guidance published by the British Thoracic Society in January 2006.

Vision of the service

1.3 The vision for the service is that all patients who have a clinical condition that necessitates the provision of oxygen therapy at home receive the right treatment at the right time in a timely and cost effective way. Assessment of a patient's need for oxygen therapy should be made by a health care professional with appropriate expertise, so that the patient's health and quality of life is maximised, any risk is minimised, and the right oxygen flow rates, daily duration and equipment are provided to meet their clinical needs. It is recommended that an initial clinical assessment is followed up by further visits and regular reviews of a patient's need for oxygen therapy, according to clinical guidelines.

Clinical Indications and Key Features of a Clinical Assessment and Follow Up service

- 2.1 Specific clinical indications and further detail can be found on the British Thoracic Society website <http://www.brit-thoracic.org.uk/> and also on PCC (Primary Care Contracting) and Home Oxygen websites <http://www.primarycarecontracting.nhs.uk/1.php> <http://www.homeoxygen.nhs.uk/>

It is generally agreed that the British Thoracic Society gold standard is to be aimed for. The reality is largely that services build on following the clinical guidelines and work towards achieving the full standard and as such, the models shared in this document are following this principle.

- 2.2 When considering provision or further development of clinical assessment and follow up services, clinicians and commissioners will wish to consider the following questions to ensure that key features are included

:

- Why should it be done?
- What is required to provide an assessment service?
- How can this be provided?
- How can I ensure Value for Money?
- What is the best way of procuring the assessment service – do we need to tender?
- How much will it cost?
- Will the service be following clinical guidelines and best practice?
- Will the service be following standard operating procedures?
- Will the equipment used and procedures followed (blood gas testing, spirometry etc) be according to national standards and protocols?
- Will those operating the service be competent to do so?
- How will the service, its staff and equipment be audited?

In responding to these questions, it is helpful to take into account the following advice and information:

- Any assessment service should include screening to identify patients with an O₂ saturation of less than 92% on air.

- Patients with an O₂ saturation of less than 92% need to be referred to a formal assessment service for Long Term Oxygen Therapy (LTOT).
- Formal patient assessment should be undertaken in accordance with the British Thoracic Society (BTS) guidelines.
- Competencies for spirometry as defined by Association of Respiratory Technicians Physiologists (ARTP) and BTS and Education for Health, Warwick who provide training. National QA standards to be found for spirometry <http://fp.artpweb2.f9.co.uk/>
- Manufacturers standards for machines in quality control
- Assessments and follow-ups can take place in a variety of places including secondary and primary care settings, the home.

2.3 Formal Assessment for Long Term Oxygen Therapy (Adults) requires consideration of three factors:

- A confident clinical diagnosis of the disorder associated with chronic hypoxaemia
- The need for optimum medical management of the particular condition and clinical stability for at least five weeks prior to assessment
- The need for measurement of arterial blood gas tensions

Ambulatory Oxygen

2.4 Patients using LTOT, or who are expected to desaturate on exercise, may need to be assessed for ambulatory oxygen. The BTS Guidelines define three groups of patients, and appropriate prescribing:

Grade 1 Oxygen Requirements - Low Activity Formal assessment is not practicable in this group of patients and the need for ambulatory oxygen will be intermittent and used mainly to travel outside the home to friends and relatives. In general, the same flow rate for portable oxygen should be used as for LTOT provision.

Grade 2 oxygen requirements - LTOT Active Group Ambulatory oxygen therapy is indicated in patients on LTOT, who are mobile and need to leave the home on a regular basis. The type of device that is provided will depend on the patient's mobility and use of ambulatory oxygen. The hours of use will be estimated during assessment, together with the oxygen flow rate.

Grade 3 oxygen requirements - non LTOT patients Patients without chronic hypoxaemia and LTOT, should be considered for ambulatory

oxygen therapy only if they show evidence of exercise oxygen desaturation, improvement in exercise capacity and/or less breathlessness with ambulatory oxygen therapy and the motivation to use the ambulatory oxygen outside the house. The hours of use will be estimated during assessment, together with the oxygen flow rate.

Therefore, these patients in groups 1 & 2 require assessment for ambulatory oxygen in order to determine appropriate usage. It is estimated that about 50% of patients on LTOT may require assessment for ambulatory oxygen.

Pre-Screening

- 2.5 Pre-screening of patients will help to ensure effective use of assessment services through identification of those patients who will require formal assessment. This may be undertaken as part of a patient's consultation with a GP or other primary care health professional and it is helpful if this includes discussion about the patient's presenting condition and potential treatment options (such as pulmonary rehabilitation and the correct use of inhalers). A finger pulse oximeter test may also be required to ensure referral for formal assessment of only those patients who may need home oxygen therapy. Pre-screening can result in a reduced number of referrals for assessment, thus improving clinical and cost effective use of the Home Oxygen Service with patients using the right service to meet their needs.

Clinical Assessment and Follow-up Services

- 2.6 These need to be provided by healthcare professionals with specialist respiratory knowledge, competence and understanding of relevant clinical guidance, disease management and home oxygen therapy. They should have the skills to interpret the oxygen saturation and arterial blood gases information and to give an overall assessment of the patient's underlying respiratory condition.

The healthcare professional needs access to pulse oximetry and an arterial blood gas machine (which must be correctly maintained). Depending on the patient's clinical condition, the overall clinical assessment may also involve spirometry and chest x-ray.

Healthcare Professionals should ensure that other treatments are optimized prior to assessment and should know where to refer patients whose are not medically optimized. Home oxygen assessment needs to be closely aligned to other services provided for the patient.

- 2.7 Provision of these services requires continuous healthcare professional training and education to ensure staff maintain competence, including evidence they are reviewed in respiratory care (arterial blood gases and interpretation in their clinical context).

Models of provision

National overview of provision

- 3.1 There are a variety of different models of assessment services in England and Wales which include nurse led or consultant led services; services run in secondary care or in primary care and those bridging secondary and primary care.

This document aims to illustrate the different types of models and provides details and resources for PCTs to use and learn from in the development of similar services locally.

It is understood that some areas are assessing patients on an 'ad hoc' basis but there is now a recognized need for services to be transparent, accountable and equitable.

The Home Oxygen service is attempting to move from 'ad hoc' practices whereby clinicians may be assessing patients as and when they can, to fully developed clinical assessment and follow up services in order that who is doing what and how can be determined, shared and learnt from.

Model 1 - Hammersmith and Fulham PCT

This service is nurse-led for a PCT population of 179,000 with 164 Home Oxygen patients.

The service works to promote health and self-management which impacts positively on admissions, A&E attendance and GP consultations.

The Community Respiratory Nurse team consists of four nurses split geographically across the PCT covering all practices.

Model 2 - Cornwall and Isles of Scilly PCT

A nurse led service of 3 clinics run with consultant support plus 3 consultant/GPwSI led clinics with nurse support spread throughout the region, these clinics include pulmonary rehabilitation and LTOT assessment. The PCT provides for a population of 500,000 with approximately 1,300 patients. The service is staffed by 4.8 wte specialist respiratory nurses and a 0.6 wte home oxygen service

manager. In addition to the assessment clinics, the respiratory specialist nurses carry out domiciliary visits to all home oxygen patients (excluding palliative care) to review and check the patient is on the correct category of home oxygen for their requirements. All respiratory nurses have access to secondary care support and advice and maintain good working relationships between secondary care and GP practices.

The home oxygen service manager and the clinical team provide a rolling programme of education and awareness raising for other health professionals in primary care, supported by the prescribing team. Data and invoice audits are undertaken by the home oxygen service manager and in the first 10 months of service has resulted in over £700,000 in savings.

Model 3 - Blaenau Gwent, Wales

the assessment service is led by the lead respiratory consultant physician for COPD within Gwent Healthcare NHS Trust, working with specialist nurses and technicians. The service improvement lead for respiratory disease in Blaenau Gwent was a post specifically created for the implementation of the oxygen therapy service. A rapid response team provides a 'Hospital at Home' service, performing assessments in COPD patients who are housebound, and assists the service improvement lead with assessments.

As a result of this success, each LHB has been allocated funds for the development of assessment services.

Model 4 - Walsall PCT

has involved service users and a survey showed that a significant proportion of patients were satisfied to be seen by their Primary Care Team for their reviews and were fully satisfied that they could access an appointment at the hospital should they wish to.

This backs up the success of the oxygen triage pathway for 556 Home Oxygen patients. Patients are assessed in primary care and triaged through to secondary care only when really necessary.

The new service has allowed for the redesign and relaunch of the COPD pathway. It has developed a specification and commissioned Practice-based spirometry testing (with training provided by Clinical Measurement Unit) which is now well established with 52 of Walsalls' 63 practices. Pulse oximetry has been added as a bolt on LES to which 44 practices have signed up. The service can also provide domiciliary visits if required.

Model 5 - Warrington PCT

The service looks after the patients within the Warrington PCT area with a population of 193,700. Initially it was estimated that there were 105 patients on concentrators and 350 patients using cylinders – a total of 455 patients.

The oxygen clinics run over four full days, two within hospital clinic settings and two days within the community visiting patients at home. One day is for administration, audit, teaching, meetings and training etc.

The number of patients has been reduced from 450 to 391 patients on oxygen therapy, having withdrawn oxygen from 37 patients up to this point.

Although patients have had oxygen withdrawn, this amount was an unexpected outcome with the priority at the time being the need for a safe review of oxygen requirements. The review of therapies has in itself generated savings as many patients were found to be on too many therapies, for too many hours and needing alterations in flow rates.

The benefits

4.1 By commissioning clinical assessment and follow up services, the PCT can influence a reduction in:

- inappropriate prescribing or over-prescribing of oxygen therapy;
- inappropriate hospital admissions (including emergency admissions);
- bed days;
- ambulance call-outs;
- readmission rates;
- GP visits;
- clinical risk;
- service related costs.

4.2 Clinical assessment and follow up services can also contribute to achieving improvements in:

- appropriate early discharge;
- the opportunity of meeting A&E 4-hour wait targets;
- effective utilisation of available specialist expertise;
- appropriate use of resources (right patient, right place, right prescription);
- choice and flexibility for patients;
- delivery of key PSA targets and external regulatory requirements;
- the opportunity to advise and inform patients about treatment, thus encouraging and achieving compliance;
- patient satisfaction;
- related service cost savings.

These benefits are now demonstrable via the various models of provision around the country and evaluative work is being undertaken to support this.

Cost effective service delivery

4.3 Provision of clinical assessment services can support delivery of a more cost effective home oxygen service. Many patients use home oxygen therapy without prior assessment or review (for example to check required changes in flow rates/duration).

4.4 Pre-screening and formal assessment can:

- Identify patients who no longer require oxygen therapy or the need for changes in service provision;
 - Help address a patient's desire or perceived need for oxygen, which may not be in line with clinical need for therapy;
 - Improve delivery of a cost effective service, with cost savings achieved through reductions in the inappropriate use or lack of oxygen therapy (e.g. where a service is provided on an "in case" basis).
- 4.5 In addition, work on monitoring and reviewing the monthly data and invoicing results in cost savings as the data is checked by PCT staff for up to date and accurate information. This ensures that information about patients who are deceased; have moved out of the area or who have had their oxygen therapy altered or stopped is reflected in the charges and the PCT can both recoup any accidental overspend in the system and ensure that the providers data is correct for the future.

Errors or discrepancies in the monthly patient data can also reveal patient information indicating a need for a clinical review. HOOF monitoring can be therefore directly linked to clinical assessment services. The use of a dedicated oxygen review Co-ordinator, or Service Manager, to monitor all HOOFs and check invoices on a monthly basis has brought savings of up to £75,000 per month, with local variations.

- 4.6 Although a cost saving cannot be guaranteed, many services are now able to demonstrate significant savings and thereby that the service is a value for money initiative. There may be some original cost outlay, although not necessarily.

It is crucial that PCTs look at those patients currently receiving Home Oxygen and assess them. By ensuring that only those who are clinically appropriate receive home oxygen, the PCT can make saving by the clinical withdrawal of the therapy if required. This would result in the saving of the daily cost of the home oxygen to that patient.

In the following examples, by setting up an assessment service the PCT has also acquired the resources to ensure that invoice and contract management can be incorporated in the newly developed service. Savings can also be made on an ongoing monthly basis by the close monitoring of invoices and data and by reclaiming for patients who have died, moved out of the area or whose Home Oxygen Order Form (HOOF) may have changed.

An example of cost savings via monthly invoice and data monitoring and close liaison with the provider from East Lancashire PCT

In the first year a saving of £50,000 was made across the two PCTs covered by the service through invoice savings from incorrect charges made through deceased patients; incorrect oxygen modes charges, patients not registered in PCT, continuous charges for emergency oxygen which had been cancelled, oxygen which had been removed and still being charged and patients with more than one account entry.

An example of cost savings based on amount saved per patient in one calendar year from Newcastle PCT

It should be noted that any cost savings are recurrent for future years as the oxygen would have remained in situ indefinitely if the review service had not been in place. In the future, correct assessments of patients should allow similar level of savings to accrue.

The review team has ensured that in the first six months the savings made are as follows:

30 patients O2 withdrawn	£ 30,000
25 HOOF forms amended to correct prescription	£ 26,000
65 patients prescriptions transferred to correct PCT (as a one off reduction)	£119,000
7 new patients assessed as not needing oxygen	£ 6,500
Total saving	£186,500

An example of cost savings via the triage care system at Walsall PCT

The cost of the service per annum is £646,000 which includes the cost of the hospital-based assessment service (£111k), local enhanced service (spirometry and pulse oximetry) £50k and the cost of providing an oxygen delivery service for which the budget is £484,000 (or £870 per patient). The locally agreed tariff is as follows:

Hospital assessment clinical measurements	£200.00 per test
Primary care surgery based spirometry/pulse oximetry LES	£16.41 per test
Domicillary visit	£4.17 per test.

Based on the findings of patient survey where 14% of patients were assessed as not requiring continuing oxygen supplies, it is possible that in any year approx 14% of the total patients on oxygen therapy could come off oxygen within a safe and supported process which would give a full year saving of £83,233. This saving could then be spent on new patients and prevent overspend.

An example of cost savings via the appointment of an Home Oxygen Service Manager from Cornwall and the Isles of Scilly PCT

The Home Oxygen Service Manager monitors all HOOFs to ensure appropriate and correct ordering is maintained by clinicians. To support this work a rolling education programme ensures that all relevant health professionals are kept up to date and informed with regard to HOOF completion and related issues through surgery visits and GP prescribing leads meetings. Specialist community respiratory nurses receive up to date individual surgery lists of home oxygen patients each month and will review new patients (excluding palliative) within 6 weeks to ensure that patient's HOOF is appropriate and correct. All surgeries receive a copy of their home oxygen patient list on a quarterly basis, the surgeries then feed back to the Home Oxygen Service Manager with any anomalies and these are then taken up with the home oxygen provider.

To date this new service has saved over £700,000 pa.

Risks incurred due to not having oxygen assessment centre service

- 4.7 **Patient Safety (Inappropriate Prescribing)** - Many patients are receiving home oxygen therapy but have never received an assessment. This means that patients who do not need or benefit from oxygen may currently receive it. If all patients on home oxygen therapy were to receive an assessment and review, patients for whom the therapy is identified as not appropriate could be identified and the therapy could be stopped.

Patient Safety (Inappropriate Management of Condition) – Where assessment and ongoing monitoring is not being carried out the risk to the patient is unknown. In certain patients this could be detrimental to their health and therefore may be unsafe. This could also result in avoidable hospital admissions.

Increasing Cost of Service - The cost of oxygen prescribing has steadily increased since the service was fully rolled out in July 2006, for example, in one PCT it rose from £58,000 per month to current cost of £78,000 per month. Implementation of an oxygen assessment centre service will ensure oxygen is only prescribed in appropriate cases and where prescribed is used correctly and may therefore prevent a steady increase in oxygen patients.

Non-Compliance with directives and guidelines - Implementing an assessment service will ensure compliance with *NICE: (February 2004) Chronic obstructive pulmonary disease – Clinical Guideline 12* and the *BTS working group on Home Oxygen Services (January 2006) Clinical Component for the Home Oxygen Service in England and Wales*.

Lack of Patient Education – In areas where there are no clinical assessment and follow up services there is currently very little education provided to patients on home oxygen therapy. The implementation of the assessment service would formalise and deliver patient education.

Poor Compliance and Concordance - No monitoring means that patient concordance, compliance and technique is not currently monitored. If therapy is not being used the assessment service could provide a mechanism for oxygen therapy to be safely removed.

Future Service Provision – If an assessment service is not commissioned hospitals may no longer choose to employ specialist staff to undertake the existing LTOT assessments. This would result in the assessments being carried out by hospital doctors, who will be removed from ward duties to undertake assessments, which in turn may impact on the quality of in-patient care.

Commissioning a service

- 5.1 In line with World Class Commissioning aims, commissioners will need the competencies to :
- Work collaboratively with community partners to optimize health gains for these patients
 - Manage knowledge and undertake robust and regular needs assessments
 - Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration (taken from World Class Commissioning document Gateway Reference 8754)
- 5.2 It is important that appropriate audits of all services, equipment and equipment users are commissioned and performance management tools included in the scoping of work.
- Commissioners should devise local protocols and checklists with which to measure locally agreed standards and performance.
- 5.3 Commissioners should consider reviewing proposals and presented business cases against agreed criteria, using other samples and examples as comparators.
- 5.4 It is recommended that commissioners ensure that a local needs assessment is carried out and results will need to inform service commissioning and development.
- 5.5 It will also be necessary to ensure that new services include a robust proposal for the assessment and review of all current (and possibly never-assessed) patients. In this way it is possible to remove the oxygen therapy from some patients for whom it is not appropriate treatment. Protocols for the removal of home oxygen will be required and, possibly further specific training for the staff in question. See appendix from Newcastle PCT
- 5.6 Continuing education will ensure that health professionals are well placed and suitably skilled to continue to utilize the Home Oxygen service to its optimum.

Engaging stakeholders

- 5.7 The process is aided by discussion with current existing stakeholders and other services; COPD clinicians and commissioners, medicines management and prescribing teams, Chest clinics, and related health professionals in both secondary and primary services, including and sometimes particularly GPs.
- 5.8 The experience from successful models to date demonstrates that it is the bridging between primary and secondary care services that is often the crucial relationship and therefore it is of great value to build and maintain a healthy and effective dialogue between the two. This can be challenging in areas where, for instance that relationship has a less healthy history and culture.

Patient Focus

- 5.9 Commissioners are encouraged to seek patient views throughout the process via patient forums such as LINKs (Local Involvement Networks, formerly Public and Patient Initiatives (PPI)) and other specifically related groups such as the British Lung Foundation Breatheasy groups. The patient views will inform both at local needs assessment and when performance managing the contract.

Determining a funding mechanism.

- 5.10 Commissioners and service developers may wish to consider the various funding options available to them and this may be aided by talking to those running new services.
- 5.11 Commissioners may wish to decide whether there is a requirement to go out to tender and consider how to develop the market for providers.
- 5.12 Once the providers have been engaged, Service Level Agreements and Contracts should be monitored and evaluated. It is important that the service is appropriately resourced to enable the business elements to be successfully undertaken.

Newcastle PCT - Staggered funding option

The North of Tyne Commissioning consortium awarded Newcastle PCT funding to employ two grade 6 nurses for one year to initiate the new home oxygen assessment service. Their activity is fully integrated with the CHEST (COPD home extended support team), and when shown to be cost-effective the service was refunded for the next year with a view to permanent funding.

The team evaluated their work, regularly reporting back to the commissioning team in order to evidence the success to date and are thus able to secure each next stage of funding and heard in March 08 that the funding has been made permanent.

Performance Management

5.13 The development of a service should include a robust performance management tool.

Recommended next steps for PCTs (for both those developing, and those commissioning services)

1. Locally lead the NHS	Structured discussions with local NHS services (GPs, CPs, Acute Services, Community Nurses) about need and feasibility (early engagement in commissioning process)
2. Work with community partners	See above; also identify and develop relationships with community partners and other NHS organisations (neighbouring PCTs? Is joint commissioning or resourcing feasible?)
3. Engage with public and patients	Use Breath Easy groups, patient groups, LINKs to assess need and issues
4. Collaborate with clinicians	Secure support from other areas, for instance Service Improvement, Medicines Management teams
5. Manage knowledge and assess needs	Needs assessment
6. Prioritise investment	Develop business case; financial and health outcomes data
7. Stimulate the market	Communicate service need/opportunity to local provider market; develop clear quality assurance mechanisms
8. Promote improvement & innovation	Monitor and collate best practice and innovative practice
9. Secure procurement skills	Follow PCT procurement guidelines
10. Manage the local health system	Ensure monitoring and reporting mechanisms are in place

For further information and support, please refer to the Home Oxygen service website www.homeoxygen.nhs.uk

Appendix A: Further Support

In the process of developing this document, examples of services already commissioned, or in the process of being commissioned, have been sought from the NHS. In order to collate this information and to fully understand the different commissioning solutions that have been adopted by PCTs, the Home Oxygen Assessment Resource Network was established by NHS Primary Care Contracting.

The network has no formal membership but is made up of a range of NHS staff involved in oxygen clinical assessment and follow up services. Following an inaugural meeting in London in 2007, network members have committed to sharing their experience, including model documentation, and assisting colleagues in the NHS who are at varying stages of seeking to commission services.

The network is a growing and vital resource for those involved at any stage of the development, commissioning or management clinical assessment and follow up services. For more information about the network, and to access example pathways, job descriptions and other documentation, please visit the NHS section of the Home Oxygen Service website (www.homeoxygen.nhs.uk), where you can also access individual support from a network member.