



Clinical Assessment and Follow-up Services

Commissioning Framework

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i Appendices

The following appendices are referred to throughout this document and may be downloaded as separate files from www.pcc.nhs.uk/xyz.php.

Appendix 1	The four Oxygen Suppliers and regions
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ii Introduction

This paper provides a framework that includes information and support for clinicians and commissioners when considering the most effective commissioning of clinical assessment and follow up services to achieve the best possible health outcomes and best value for money. Together with the new contracted Home Oxygen Service, clinical assessment and patient follow up services can improve the quality and cost effectiveness of care provided to patients using oxygen therapy at home.

The aim of this paper is to

- Provide information for commissioners on the establishment of clinical assessment and follow up services, supporting the Home Oxygen Service, for their populations
- Support discussion and encourage consideration of the most effective way of delivering these services locally
- Set out some options and tools that might be considered for further development of these services
- Prompt further discussion of the implementation of local plans, i.e. where and how these services might be provided.

Key Messages

The appropriate management of patients who require a home oxygen service can support achievement by the NHS of targets including :

- improving health outcomes for patients with long-term conditions
- reducing emergency bed-days
- facilitating early and appropriate discharge
- support of self care and better chronic disease management
- choice and flexibility of care

1 Background

1.1 The change to the Home Oxygen Service has been sought by both patients and health care professionals. Used effectively, the Home Oxygen Service can:

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

Previously, GPs issued an FP10, with Community Pharmacists providing a cylinder oxygen service directly to the patient, whilst specialist companies delivered the oxygen concentrator service under contract. Four suppliers have been awarded contracts to deliver all home oxygen requirements in each of the ten service regions in England (and one covering the whole of Wales). See Appendix 1. Community Pharmacists are no longer involved in supplying cylinders.

1.2 The service specification for the new Home Oxygen Service takes into account the importance of clinical assessment 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
- in updated clinical best practice guidance published by the British Thoracic Society in January 2006.

1.3 Costs are charged on a per day basis and on: the type of service ordered, e.g Short Burst Oxygen Therapy (SBOT), Long Term Oxygen Therapy (LTOT), ambulatory; and the flow rate and the hours of use, not the equipment supplied as under previous service arrangements. Therefore, clinicians and commissioners will need to be aware that inappropriate ordering of services may result in a higher cost of service without delivering the required benefits to the patient. For example, where a patient is using oxygen therapy for only a few hours a day, yet the order states a requirement for more than this, this will result in a higher per diem service cost.

2 Vision of the service

The vision for the service is that all patients whose clinical condition needs 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 levels (including flow rates and 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.

3 Ordering home oxygen

- 3.1 Patients receive an oxygen service as specified on a Home Oxygen Order Form (HOOFF) completed by the relevant health professional and sent directly to the regional supplier. Supply of the order is required within 3 working days of receipt of the order, unless urgent supply is required which must be delivered within 4 hours. Currently, many patients have not been assessed or reviewed at appropriate intervals for oxygen therapy and, therefore, may not be receiving the most appropriate oxygen service, modality or flow rate. In addition, some patients will continue to receive a home oxygen service where there is little clinical evidence that the patient continues to benefit from this service, for instance where cylinder oxygen may have been ordered on a "just in case" basis.
- 3.2 NICE guidelines on COPD include reference to the British Thoracic Society recommendation that patients, when first prescribed oxygen therapy at home, should be followed up by an appropriate specialist after three months and annually thereafter. Updated guidance on assessment and patient follow up services was issued by the British Thoracic Society in January 2006 and is available on the BTS website (www.brit-thoracic.org.uk).

- 3.3 Clinicians' and commissioners' attention is drawn to best practice guidelines which support delivery of high quality and cost effective clinical assessment and follow-up services at a local level. These guidelines support consideration of how local services might be developed to assess new patients who may require oxygen therapy, and review their needs and those of existing patients in a timely fashion.

Appendix 2 provides a brief summary of the range of service models currently being undertaken in different parts of the country. These are included to illustrate different service delivery options: for example, in rural and inner-city environments. It is recognised that clinicians and commissioners will wish to consider different models and how these might be adapted or adopted to suit local service needs and local delivery solutions (i.e. within a recognised primary or secondary care setting).

Appendix 3 provides an example of a draft Oxygen Service Flowchart used to develop a service.

4 What are the benefits of commissioning clinical assessment and follow up services?

- 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.

5 How to commission and develop a clinical assessment and follow-up service: A guide and toolkit

When considering provision or further development of clinical assessment and follow up services, clinicians and commissioners will wish to consider the following questions:

- Why should it be done?
- What is required to provide an assessment service?
- How can this be provided?
- How much will it cost?

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%.
- 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.

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

The patient will require referral to an assessment service, directed by a consultant physician with an interest in respiratory medicine, for measurement of arterial blood gases and assessment for LTOT .

Formal assessment will identify patients with a PaO₂ of 7.3kPa or below, who require LTOT for at least 15 hours per day. Safe initiation of LTOT requires arterial blood gas analysis. Assessment also needs to include other criteria, when there is more than 7.3 kPa (i.e less than 8.00 kPa) and in heart failure and other respiratory diseases.

Once assessed, patients will need education about the safe use of equipment and how this will support delivery of their oxygen therapy. Information provided by a healthcare professional will be supported by supplier training in the use of equipment.

Patients will need a healthcare contact to provide support or advice as needed. The BTS good practice guidelines recommend the provision of a follow up visit, within the home within four weeks of formal assessment, to check safety (including a risk assessment), patient education and to monitor oxygen saturations using a pulse oximeter. At this stage, follow up can provide important reassurance to patients about their care and assist development of self-management skills.

It is recommended that a further check is made at three months, including arterial blood gases, to reassess and/or adjust levels and to check there is no carbon dioxide retention.

Continuing follow up can be carried out in patients' homes, including monitoring of oxygen saturations.

Guidelines also recommend an annual review that includes spirometry, arterial blood gases, review of medication and an assessment of the impact of living with oxygen, to support any need for changes in treatment plans.

Ambulatory Oxygen

Patients using LTOT, or who are expected to desaturate on exercise, may need to be assessed for ambulatory oxygen. The BTS Guidelines state:

Ambulatory oxygen therapy may also be indicated in patients with severe hypoxaemia who are on LTOT for up to 24 hours, and are mainly housebound. These patients will need ambulatory oxygen in order to leave the house, visit relatives etc. However, patients in this group may only require occasional ambulatory oxygen use and this will inform decisions or recommendations on the type of equipment provided. The flow rate for ambulatory oxygen is generally the same as that used with LTOT, although hours of use will be estimated during the assessment.

Therefore, these patients may need assessment for ambulatory oxygen. This will consist of education and assessment of potential use of this service, except for patients who lack mobility. It is estimated that about 50% of patients on LTOT may require assessment for ambulatory oxygen.

Assessment will include either a six minute walk test or a shuttle walking test in a room large enough to enable a patient to walk uninterrupted, using the equipment that will be provided by the oxygen supplier (i.e. both standard and lightweight portable cylinders). There may need to be up to 3 or 4 walks with rest periods between each test walk to determine the flow rate of oxygen required.

Patients need education in the effective use of ambulatory oxygen including discussion of the patient's willingness to use oxygen outside the home.

Usually, it will take a patient about a month to adjust to using ambulatory oxygen; however, there is some evidence that some patients, where assessment suggests they may benefit from use of ambulatory oxygen, will not persist in its use outside the home. Therefore, it is recommended that a follow up visit is made two months after assessment to check use of the service, to make any adjustments and to consider if provision remains appropriate or should be discontinued.

Cost effective use can be made of staff and other resources by ensuring that follow up of LTOT patients also assessed for ambulatory oxygen is carried out at the same time.

Please see Appendix 4 for an accompanying toolkit to support this section.

Provision of a Clinical Assessment Service

Pre-Screening

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

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.

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)

6 How can improvements in the delivery of home oxygen impact on delivery of other services?

An extract from a PCT proposal (see Appendix 5) highlights how commissioning and provision of clinical assessment and follow up services for patients using oxygen therapy can play an important part in overall plans for improving services and how these services can impact on delivery of other services. See also links to key service delivery priorities on the DH website.

Clinical assessment services, supported by the new Home Oxygen Service, can contribute to improvements in existing frameworks for self care and chronic disease management and help progress towards the goals of the NHS Plan. i.e.:

- A patient-centred care system¹ and the National Service Framework For Long Term Conditions².
- Development of care pathways for oxygen therapy will help organisations implement the NICE guidelines for chronic obstructive pulmonary disease - a Healthcare Commission Developmental Standard³ (note that c80% of patients requiring oxygen therapy are COPD patients) and ongoing work relating to the COPD NSF.
- The pre-assessment step of the capacity model can help ensure there is a holistic review of the patient's condition with appropriate referral for co-morbidity e.g. coronary heart disease. This can contribute to sustaining delivery of the Public Services Agreement target to reduce substantially the mortality rates from the major killer diseases by 2010⁴.

Good capacity and service planning supporting Oxygen Assessment Centres can improve use of the new home oxygen service in achieving progress towards the Public Services Agreement target to reduce the maximum wait for an outpatient appointment to 3 months by the end of 2005⁴.

Effective use of long-term oxygen therapy (LTOT) has been shown to reduce admission rates, hospital days and “ever hospitalised” rates, especially in those who first received LTOT as outpatients. Amongst a wide range of potential risk factors, researchers have found that only previous admissions, lower forced

¹ <http://www.dh.gov.uk/assetRoot/04/08/45/22/04084522.pdf>

² <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/LongTermConditions/fs/en>

³ <http://www.nice.org.uk/page.aspx?o=106422>

⁴ <http://www.hm-treasury.gov.uk/performance/Health.cfm>

expiratory volume and failure to initiate LTOT were independently associated with a higher risk of admission for a COPD exacerbation.

Supporting self care and better chronic disease management are important strands to the Government's overall strategy for health where there are priorities for local planning and commissioning^{5,6} (Link 9, Link 10).

7 What are the cost benefits?

Cost effective service delivery

7.1 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 changes in flow rates/duration). Clinicians and PCTs took the opportunity to review existing patients during action to identify and transfer patients to new suppliers and this information, held on PCT databases, will be useful in supporting decisions on the development or enhancement of local assessment services.

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).

⁵ <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SelfCare/fs/en>

⁶ http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4075214&chk=YxS1Yj

Invest to Save

- 7.2 It is recognised that commissioners will need to consider the availability and investment of PCT resources to set up clinical assessment and follow up services or to develop existing services. However, commissioners will wish to look carefully at these costs within the wider context of the high costs associated with inappropriate hospital admissions, including emergency admissions, and the effective management of bed days. Investment in clinical assessment and follow up services can help deliver longer term cost improvements and cost savings, not only in use of the contracted home oxygen service but in other clinical services that it supports (such as respiratory care, cardiology services, children's service etc). Short-term financial risk (which may be high) will need to be balanced against the potential for cost savings and the delivery of service improvements across a range of services in the longer term.

Practice Based Commissioning

- 7.3 Commissioners may wish to consider discussion with a PBC consortium (monitoring health needs and having budgetary control) on how PBC might be used to support the sourcing and management of a clinical assessment service across a cluster of PCTs. In this way, commissioners and PBC consortia might work together to achieve local service redesign that matches needs and available resources.

Benefits realisation

- 7.4 Clinicians and commissioners will wish to consider how provision of local clinical assessment services can support improved clinical and cost effective management of COPD, and other long-term conditions. The design of the service, use of available resources and the results required will vary. For example, a local service may include the use of pulmonary rehabilitation where this indicates that patients could be offered a better alternative to home oxygen therapy.

Payment By Results

- 7.5 See Appendix 6. The suggested tariff relates to secondary care activity; however, current experience indicates that an integrated approach to provision of clinical assessment and follow up services may also be effective, with input from specialist services in the primary care setting.

Please see the attached Cost Benefits Analysis Appendix 7 (undertaken by

NERA Economic Consulting).

Providing a Business Case to Support Service Commissioning

- 7.6 Please see: Appendix 8, which provides an example of a successful East Kent PCT business case, which has achieved inclusion of assessment services in the LDP; and Appendix 9, which sets out a proposal from Doncaster PCT.

8 What are the challenges and issues that need to be considered?

In considering the need for local services, commissioners will be aware of local priorities, financial constraints and other important factors such as staff availability and resources.

Experience shows that there are common concerns in discussing the development of clinical assessment and follow up services, including:

- Lack, or perceived lack, of specialist staff;
- Lack of resources, including the availability of space required to carry out assessments (for instance walking tests for ambulatory oxygen);
- Lack of awareness of the range of different service models that might be used or adapted locally;
- Lack of access to information and/or varying awareness of the clinical assessment and review services currently provided in different parts of the country;
- Lack of awareness that where some patients may be referred to a clinical assessment service provided in a primary care setting, their 18-week pathway will not be measured. Other patients may be referred for assessment services in secondary care and the clock will start ticking at the point of referral. Care will be needed to avoid the creation of a two tier system.

9 Staff resources

- 9.1 There is a perception that setting up assessment services will mean provision of a new service that necessarily requires staff recruitment with new appointments made. In addition, in some places, there may be a lack of suitably trained healthcare professionals available to undertake the assessments and other service delivery.
- 9.2 However, commissioners and assessment service providers can assess the scope for making better best use of available staff: for example, by looking at ways of involving a wide range of health professionals in service delivery, including where this can be achieved through suitable training and practice (which would need to be evidenced and reviewed) in all assessment procedures. Health professionals who may wish to be involved include, for example: Community Matrons, GPs with a Special Interest and Clinical Physiologists (respiratory). There may also be scope for making better use of other staff, such as Healthcare Support Assistants. Examination of these options may not necessarily result in the need for additional recruitment and/or extra employment costs to support delivery of this service.
- 9.3 Early engagement with local respiratory physicians and established respiratory teams can also help encourage creative solutions in the use of available staff to enhance and develop services.
- 9.4 For example, in East Kent PCT, the Specialist Respiratory team proposes that GP practices might purchase pulse oximeters to carry out in-house pre-assessments/screening rather than refer patients elsewhere. The team is also training Healthcare Assistants to undertake some elements of the assessment tests so that more trained and experienced healthcare professionals can concentrate on complex patient assessment to maximise the number of patients who may be seen at each assessment clinic session. For example, with appropriate training, a Healthcare Assistant can take the oxygen saturation reading and submit results indicating a saturation less than 92% to a more experienced professional to consider in relation to the patient's overall clinical condition.
- 9.5 Commissioners and assessment service providers are also encouraged to discuss creative approaches to the location of assessment services. For example, where assessment equipment is available, these might be provided within general practice, in the patient's home (if appropriate), in hospitals or in clinics. There is also the option of looking at how a number of PCTs might work together to support commissioning of assessment services, including the possibility of

centralizing this service in a location that offers convenient access to patients across several PCT areas.

10 Education

Commissioners and clinicians will recognise the importance of consistent advice and information about clinical assessment services and the Home Oxygen Service to support the safe delivery of oxygen therapy. Clinical and cost effective use of oxygen therapy services will need to include education programmes for patients and health professionals.

Patients

The need for oxygen therapy, access to assessment, and effective use of the service in helping them to manage their symptoms better at home.

Health professionals

To ensure awareness and access to alternative treatment options that may be more clinically and cost effective for some patients. These will include, as appropriate, pulmonary rehabilitation, medicine reviews, the use of fans and the correct use of inhalers. For example, for many patients with an oxygen saturation >92%, oxygen therapy at home may not be the most clinically and cost effective treatment.

To ensure they remain confident on how to refer to and access clinical assessment services and the home oxygen service with patients assessed and followed up as recommended in a consistent local service setting by a qualified and suitably trained healthcare professional.

To ensure continuous professional development in order to maintain and develop competencies in the provision of assessment service that reflect clinical good practice

To support local health professional education, commissioners and service providers may choose to identify local “champions” across primary and secondary care to raise awareness of assessment services and how these can contribute to service improvements and the quality of care delivered to patients. Local Respiratory Forums and other multi-professional meetings can also be helpful in supporting the discussion and planning of assessment services whilst providing an effective working network across primary and secondary care settings.

11 Different service models

This framework aims to provide information on service models that have been introduced across the country as a means of looking at the kind of service provision that might work locally, given differing service requirements, and suggesting possible next steps in commissioning services that meet local needs.

12 Possible next steps

- 12.1 An important step might be that, following local discussion and consideration of the issues and information outlined in this paper, commissioners may wish to undertake a local needs assessment of the number of patients using the Home Oxygen Service. For example, how many of these are COPD patients who require access to a range of other inpatient and outpatient services? A needs assessment could look at the prevalence and incidence of COPD, the numbers of patients requiring hospital admission/readmission and so on.

Commissioners may also find it helpful to assess the range of home oxygen services being ordered by health professionals and the extent to which this is influenced by any level of clinical patient assessment before these services are ordered. Needs assessment can support commissioners in looking at best and worst case scenarios whilst developing plans to address these in the light of local needs and local resources.

- 12.2 To ensure clinical assessment and follow up services are up and running as soon as possible, commissioners will wish to include these in commissioning plans and Local Delivery Plans (LDPs) in autumn 2007 for delivery in early 2008.

This will help achieve service improvements for the wide range of patients using oxygen therapy at home and will enable PCTs to deliver effective management of the contracted Home Oxygen Service.

Clinical assessment and follow-up services that can help improve clinical and

cost effectiveness of this service in both the short and longer term. The overall cost of the Home Oxygen Service, both to individual PCTs and to the NHS overall, is likely to be greater where delivery remains unsupported by assessment.

- 12.3 The Home Oxygen Service provides an opportunity for clinicians and commissioners to help ensure a consistent and robust approach to ordering home oxygen therapy where this is supported by patient assessment and follow up services. Therefore, PCTs and health professionals with respiratory care experience will wish to continue to provide educational support to GPs and other clinicians in making the best use of the Home Oxygen Service for their patients.

An essential part of this will be full, accurate and legible completion of the HOOF in a way that supports the supplier in provision of equipment that meets a patient's clinical need for oxygen and delivery of the required service as soon as possible. Poor or incomplete orders are known to result in delays in delivery and the provision of equipment inappropriate to a patient's needs.

- 12.4 Commissioners are encouraged to look at how the provision of pre-screening in primary care can help ensure that patients are referred appropriately for formal assessment. It is estimated that pre-screening in a primary care setting can greatly reduce the number of patients requiring formal assessment and the number of patients who need oxygen therapy in the home.

- 12.5 Commissioners will know that clarity on service standards, quality and desired outcomes is essential in planning local services. Guidelines such as the BTS guidelines on clinical assessment of patients requiring oxygen therapy and the NICE guidelines on COPD will inform standard setting with outcomes supported by establishing the local evaluation and review of service delivery, taking into account health professional and patient/carer perspectives.

For example, paediatric services, including neo-natal services, will need to be commissioned separately as children have particular needs whilst palliative care patients requiring home oxygen will need to have their therapy delivered in a way that maps into the whole care pathway.

- 12.6. This framework highlights the importance of identifying "champions" to increase awareness of the clinical and cost effective use of oxygen therapy in the home, and the importance of respiratory forums and other service delivery

networks in developing and extending working relationships across primary and secondary care.

12. 7. This framework can help commissioners identify:

- A requirement for local needs assessment of patients using the home oxygen service;
- The key issues for discussion with the relevant local health professionals and others to determine the development or enhancement of local assessment services that meet local patient needs;
- Funding requirements (offset against costs associated with the Home Oxygen Service unsupported by clinical assessment services and the costs of treating patients who do not have access to the right service to help them manage their condition at home without frequent admission to hospital)
- How to make the best use of available resources (including staff);
- Decisions supporting service delivery and the location of service provision (including opportunities for service provision across a cluster of PCT areas).