

Home Oxygen Service Manual

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Section A - Overview

1. Introduction

1.1. Scope

- 1.1.1. The purpose of this manual is to explain the background to the Home Oxygen Service (HOS), the key issues relating to it, and the ways in which the service works in practice.
- 1.1.2. It is intended to be of assistance to those who have not had any past involvement with the Home Oxygen Service, as well as to those who have been involved for some time. PCT staff who have recently acquired Home Oxygen as part of their portfolio, may find Section A a useful starting point. Sections B and C provide more detail on the issues covered in overview in Section A.

1.2. Contents of the Manual

- 1.2.1. This manual is divided into three sections as follows:
 - Section A - providing an overview of the Home Oxygen Service;
 - Section B - addressing clinical issues; and
 - Section C - providing operational detail on the management of the contact, and expanding on the overview provided in Section A.
- 1.2.2. Section A provides a brief overview of the Home Oxygen Service and may be particularly useful to those who are unfamiliar with the service. It consists of the following sub-sections:
 - this sub-section 1;
 - sub-section 2, which sets out the background to the recent reforms of the Home Oxygen Service;
 - sub-section 3, which sets out the specific aims of the service;
 - sub-section 4, which describes the governance arrangements; and
 - sub-section 5, which provides an overview of the contractual relationship between the NHS and Home Oxygen Service Suppliers.
- 1.2.3. Section B covers subjects of a clinical nature and consists of the following sub-sections:
 - sub-section 6, which provides more details about the clinical guidelines produced by the British Thoracic Society;
 - sub-section 7, which sets out the key points relating to assessment and follow-up services; and
 - sub-section 8, which provides an overview of some of the theory relating to quality and how that links to the Home Oxygen Service and

- sub-section 8, which describes clinical governance, adverse incidents and reporting arrangements.
- 1.2.4. Section C provides more detail on the operational issues affecting the Home Oxygen Service and consists of the following sub-sections:
- sub-section 10, which deals with the mechanics of ordering and stopping a Home Oxygen Service, including details on the different types of service, response rates and necessary stationery;
 - sub-section 11, which deals with obtaining a secondary supply of oxygen for a patient at an address other than their own home, including arrangements for travelling abroad and dealing with overseas visitors;
 - sub-section 12, which sets out the way in which the NHS monitors and manages the Contract;
 - sub-section 12.11.2, which sets out information requirements relating to the Contract;
 - sub-section 14, which deals with the way in which payment is made to the Supplier and the processes for order verification and reconciliation which need to be put in place by PCTs;
 - sub-section 15, which sets out communications issues such as handling media queries and information requests; and
 - sub-section 16, which sets out what happens when the Contract is terminated or expires.
- 1.2.5. The document concludes with a number of appendices including a glossary, Supplier contact details, and useful sources of information.

2. Background to the Home Oxygen Service

- 2.1.1. Oxygen is used mainly to correct, reduce or stabilise hypoxia at rest or following exertion, but is also used to relieve symptoms in a number of disease states. Oxygen therapy services are vital in supporting adults and children with breathing difficulties, including those with long-term medical conditions such as cystic fibrosis and chronic obstructive pulmonary disease (COPD). Access to oxygen at home helps patients to manage their symptoms so that they can live effectively in the community, rather than needing to be cared for in hospital.
- 2.1.2. Prior to 2006 oxygen required to meet the needs of a patient in their own home was ordered by the patient's general practitioner using a prescription form. The service consisted principally of oxygen delivered from cylinders supplied by community pharmacies, or via an oxygen concentrator installed in the patient's home by a specialist Contractor. Portable cylinders and liquid oxygen systems were not readily available to many patients.
- 2.1.3. In 1999, the Department of Health asked the Royal College of Physicians (RCP) to lead a multidisciplinary working party to look at the way in which patients were prescribed oxygen therapy in the home. The RCP working

party recommended, amongst other things, improved patient assessment prior to prescribing of oxygen therapy and the availability on prescription of ambulatory oxygen. These recommendations had implications for the existing home oxygen service and for the way in which the service was delivered. Since then, the British Thoracic Society (BTS) has published updated clinical best practice guidelines on patient assessment and prescribing of oxygen therapy.

- 2.1.4. A further review highlighted that, despite clinical and technological advances, the service had only seen one significant change in the past fifty years – the introduction of oxygen concentrators in the 1980s. Although oxygen concentrators provide a more clinically and cost effective home oxygen service for patients with long term oxygen needs, take up of this service had been relatively small compared with the provision of cylinder oxygen.
- 2.1.5. In June 2003, the Department of Health announced plans to modernise the home oxygen service to improve patient access to a wider range of modern technologies (including ambulatory oxygen).
- 2.1.6. In line with best practice, the Department advertised in the Official Journal of the European Union (OJEU) for expressions of interest in tendering for a new integrated service, with receipt of tenders occurring in November 2004. Contracts were awarded to four companies, in June 2005, for provision of a modern, integrated, service, which started on 1 February 2006.

3. Aims and Principles

- 3.1.1. The change in the provision of home oxygen represents a considerable advance on the previous organisational model. In line with the recommendations of the RCP Working Group report, it is intended that in the longer term, responsibility for ordering oxygen for long term oxygen therapy (LTOT) transfers from general practitioners to specialist respiratory clinicians. In order to realise fully the benefits of the integrated Home Oxygen Service, robust assessment processes will need to be established which reflect the BTS guidance on assessment and use of oxygen (see page 19 for further information on commissioning assessment and follow-up services).
- 3.1.2. As previously, GPs continue to be able to order oxygen, for example, for symptomatic relief in palliative care, or where a patient requires short burst oxygen therapy (SBOT). If a patient requires long term or ambulatory oxygen, the GP can refer the patient to a specialist respiratory team to assess the patient's particular needs, although referral pathways are currently dependent on the circumstances in place within individual PCTs. The healthcare professional will decide, in discussion with the patient, what the patient's need for oxygen is. For example, many patients could benefit from having oxygen available in a form that allows them greater freedom of movement both in and outside the home.

- 3.1.3. Clinical staff are no longer required to choose from a limited range of oxygen equipment listed in Part X of the Drug Tariff. Instead, they identify the patients' clinical need in terms of the type of service required, oxygen flow rate and hours of use per day. The Supplier will then provide the most appropriate modality (equipment) to match that patient's specific requirements indicated on the order form.
- 3.1.4. This relieves general practitioners of the bureaucratic burden of writing repeat prescriptions, effectively on the direction of hospital clinicians. The new service also reduces bureaucracy for the patient, as the order placed provides for the supply of oxygen to continue until the patient's clinical needs change and a replacement order is supplied. Patients no longer need to obtain regular repeat prescriptions for their home oxygen supply.
- 3.1.5. Once the patient's needs have been determined, it is the responsibility of the Home Oxygen Service Supplier to work closely with the patient and decide what modality (i.e. what type of equipment and method of oxygen supply) will best suit the patient's therapeutic needs, and to provide it. The Home Oxygen Service Supplier is not able to make any changes that are of a clinical nature, for example changing the flow rate or hours of use of oxygen. As specialists in this field the Suppliers are well placed to keep pace with developments in the technical aspects of oxygen delivery, so patients will benefit from advances in technology as they are developed, subject to approval by the Medicines and Healthcare products Regulatory Agency (MHRA).
- 3.1.6. The new Home Oxygen Service provides patients with round-the-clock access to expert advice and support. It allows access to the latest equipment, including lighter weight cylinders, smaller concentrators that are more efficient, liquid oxygen and for the first time, portable systems that support greater mobility and independence.
- 3.1.7. The key features of the Home Oxygen Service are:
- improved patient access to modern equipment and a 24/7 service;
 - ambulatory (portable) oxygen widely available to NHS patients for the first time;
 - improved support for patients at school, in the workplace, and on holiday, with a 24/7 patient advice service;
 - GPs and specialist clinical staff able to order home oxygen services. (Although it is likely that there will be a shift towards specialist respiratory clinicians ordering oxygen therapy, GPs may continue to order oxygen);
 - a single order form - a Home Oxygen Order Form (HOOF) - for use in GP surgeries and by specialist teams. Once completed another order is not needed until the patient's requirements change;
 - a single Supplier meeting all patients' home oxygen needs - whether for cylinder, concentrator or liquid oxygen (i.e. an integrated service).

3.2. NHS Principles

- 3.2.1. The Home Oxygen Service is intended to complement existing NHS services. The services offered by Suppliers as part of the Home Oxygen Service must be delivered in accordance with NHS principles, i.e. with treatment free at the point of delivery and available according to clinical need, not ability to pay.
- 3.2.2. The vision for the service is that all patients who require provision of oxygen therapy as treatment for their clinical condition, receive the right treatment at the right time in a timely and cost effective manner.

4. Governance Arrangements

- 4.1.1. During the transition phase of the Home Oxygen Service, when provision was transferring from community pharmacies to the new Suppliers a comprehensive governance structure was put in place. This transition is now completed and the governance arrangements have been amended to reflect that steady state has now been reached. This places much greater responsibility on PCTs.

Table 1 – Governance Roles

Role	Description
Senior Responsible Officer	Responsible for providing strategic direction and securing appropriate resources for the Home Oxygen Service
Programme Director	Responsible for the overall Home Oxygen Service; managing all issues, risks and initiating corrective action. Maintaining a view of service performance and costs in line with contractual arrangements. Has a key role in managing communication relating to the Home Oxygen Service
Policy Lead	Responsible for ensuring that policy remains current and consistent at a national level
NHS Lead	Responsible for ensuring that the Department of Health and NHS are consistent and co-ordinated in the implementation of the Home Oxygen Service
Contract Manager	Manages all contractual issues and changes with Suppliers. Monitors performance against agreed national Key Performance Indicators
Operational Managers	Manage PCT requirements, annual operational plans, contingency plans, HOOF reconciliation, supplier invoicing, SUI and complaints, assessment centres etc One PCT to be nominated in each Supplier contract region as the main point of contact for any policy, contractual and supplier related issues.

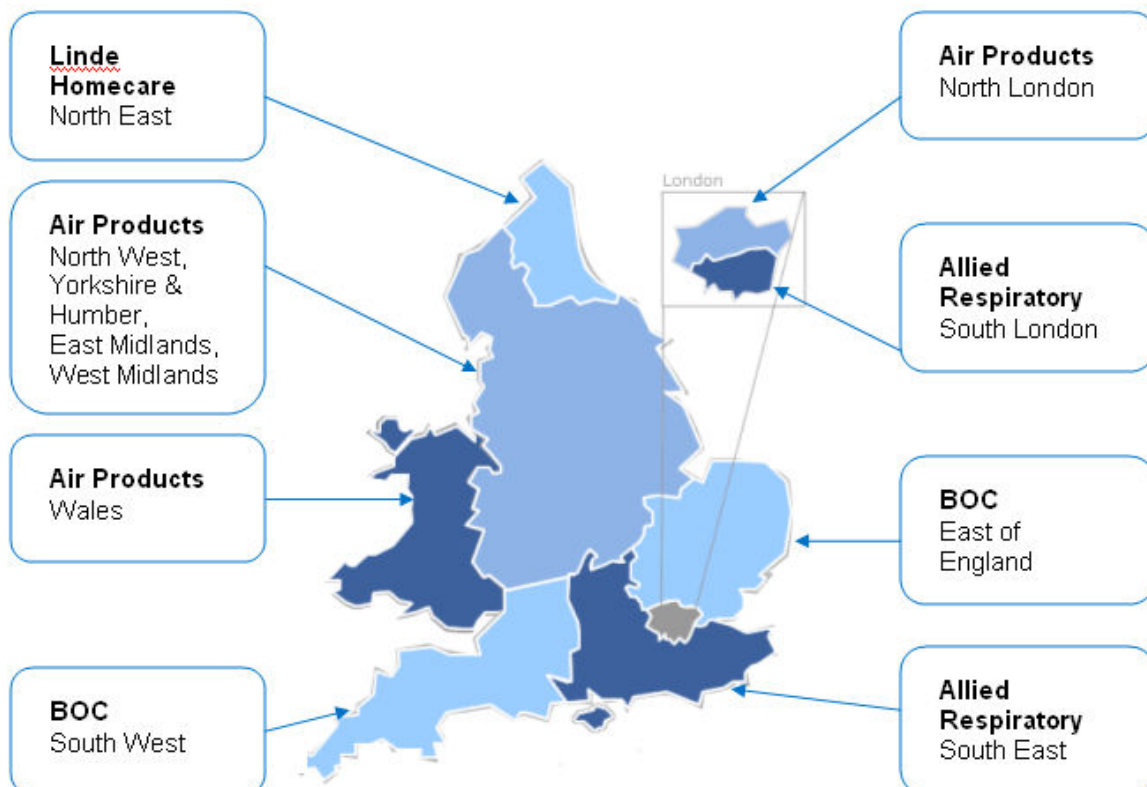
- 4.1.2. More information on the role of PCTs and Lead PCTs can be found in section 12 of this document.

5. Contract Structure

5.1. Overview

- 5.1.1. This section provides a very brief overview of the contract structure and elements covered within it. Greater detail on many of the issues covered can be found in Section C of this Manual.
- 5.1.2. The Contract is a Framework Agreement under which a Supplier is appointed to supply a Home Oxygen Service, in response to orders for oxygen. Provision of the Home Oxygen Service commenced on 1st February 2006. The framework agreement does not guarantee the Contractor any particular level of business.
- 5.1.3. The Contract is split into ten geographical Home Oxygen Service regions covering England, and one covering Wales. The ten regions are of similar size and largely coterminous with the geographic areas covered by Strategic Health Authorities (SHAs). Four Suppliers have been appointed to provide the NHS Home Oxygen Service, to between one and six regions. For Supplier contact details see Appendix 1.

Figure 1 – NHS Home Oxygen Services Suppliers by Region



- 5.1.4. With the exception of the Contract for the Home Oxygen Service in the South West oxygen region, the Contract term is five years from the date of commencement of the service, with an option to extend the agreement for

up to two years. The Contract term for the South West oxygen region is until April 2008; and will be re-procured by the Central Clinical Procurement Programme (CCPP), acting on behalf of the Department of Health.

- 5.1.5. The Supplier is not allowed to assign, sub-contract or dispose of the Contract to any other party without the express consent of the Central Contract Management Unit of the Commercial Directorate of the Department of Health (CCMU). Any changes to the profile of the service or to the total supply chain as a result of policy changes, service review or the development of new products also need to be agreed with CCMU.
- 5.1.6. The NHS Home Oxygen Service is a national service delivered to consistent national service standards in order to avoid local variations. Primary Care Trusts (PCTs) should not enter into any local negotiations with the Supplier in relation to the Contract, including prices. **PCTs are not able to make any changes to the provisions of the Contract, nor can they make a unilateral decision to cancel the Contract and make alternative arrangements for the provision of oxygen to patients at home.** Where PCTs have any concerns about the Contract, they should contact the Home Oxygen Service Contract Manager at the CCMU.

5.2. Services

- 5.2.1. The Contract consists of NHS Conditions of Contract and a detailed Service Specification, which sets out the clinical, technical and operational aspects of the service that are to be provided. Copies of both documents can be downloaded at www.primarycarecontracting.nhs.uk/120.php.
- 5.2.2. Three oxygen therapy services are available, including as part of palliative care for patients being cared for at home - supporting the latest clinical best practice guidelines.
- LONG TERM OXYGEN THERAPY (LTOT) - where a patient requires continuous oxygen for several hours a day and/or night;
 - AMBULATORY - where, following specialist assessment, it is considered that a patient will benefit from the greater mobility provided by use of portable or ambulatory oxygen (for example, to continue to attend school or work);
 - SHORT BURST OXYGEN THERAPY (SBOT) - where oxygen therapy is used intermittently for short periods, for example, to help alleviate breathlessness following exercise.
- 5.2.3. The Contract specifies the response times within which all elements of the service should be delivered, unless the patient has specifically requested a response outside these parameters.
- URGENT - where the clinician decides oxygen is urgently needed but the need is not so immediate that the patient requires admission to hospital. The Supplier must deliver the service within four hours of receiving an order. Urgent supply is available 24 hours per day, 7 day per week;

- HOSPITAL DISCHARGE - a Supplier must provide an oxygen service in the patient's home on the day following receipt of the order. Suppliers are expected to work closely with hospital discharge teams to facilitate discharge from hospital. Next day supply is available between 8.30am and 5.00pm, 7 days per week;
- STANDARD - all other orders for oxygen must be completed within 3 working days of receipt of the order. Standard supply is available between 8.30am and 5.00pm, Monday to Friday.

5.3. Equipment

- 5.3.1. The Supplier is responsible for providing an oxygen delivery system that meets the clinical needs of the patient. The HOOF should not normally indicate a specific mode of delivery or item of oxygen equipment, although the clinician may indicate a requirement for a conserving device, specific nasal cannulae or mask, or a humidifier.
- 5.3.2. In determining the most appropriate system for an individual patient, the Supplier will undertake a risk assessment of the circumstances of that particular patient. In some cases, for example due to the environment of the home, workplace or school, or capability of the patient or their carer, certain systems may not be suitable for installation. It is the Supplier's responsibility to ensure that mode of oxygen delivery can be safely installed and used. Oxygen can be provided from compressed oxygen cylinders, liquid oxygen systems or from an oxygen concentrator.

Oxygen Concentrator

- 5.3.3. A concentrator is a machine that plugs into the household electricity supply, and separates oxygen from other gases in the air in the room. This oxygen is then delivered by plastic tubing to a mask or nasal cannula. Long tubing can be fixed around the floor or skirting board, with points where the user can "plug in" to the oxygen supply.
- 5.3.4. Because a concentrator contains no pressurised oxygen or large volume of oxygen, it offers the safest supply option. In most cases where the patient is using oxygen for a significant number of hours each day, an oxygen concentrator is the most convenient and economical modality of supply. Modern concentrators are very quiet and compact, and cost only a few pence of electricity an hour; this is reimbursed to the patient by the Home Oxygen Service Supplier (see paragraph 10.11). It is anticipated that during the lifetime of the Contract much smaller, more portable concentrators will be introduced.
- 5.3.5. Where a concentrator is provided, a back-up supply of oxygen cylinders (equivalent to 8 hours at the flow rate ordered for the patient) must also be provided for use in the event of failure of the concentrator or electricity



supply. A concentrator may also be provided where the patient's use of oxygen is for a lower number of hours per day, but other circumstances indicate this to be the most appropriate option for supply.

Cylinder Oxygen

5.3.6. Compressed oxygen provided from a large capacity cylinder has been the mainstay of oxygen provision in the home for many decades. This continues to be the most appropriate mode of provision for many patients who only require oxygen for short intermittent periods during a day (SBOT), or where installation of an oxygen concentrator is not possible. Cylinder oxygen will also be provided as a back-up supply for patients using a concentrator.

5.3.7. Standard cylinders usually contain 1360 litres or 2122 litres of oxygen. Within the Home Oxygen Service contract, cylinders should generally be provided with an integral regulator. Cylinders with a separate valve and regulator may be supplied in specific circumstances; these are set out in paragraph 4.4.2.2 of the Service Specification, but patients should not be expected to fit regulators to cylinders.



5.3.8. Smaller portable cylinders, which can contain between 200 and 300 litres of oxygen, are also available to enable greater mobility by patients, for example, to leave their home, attend school or a workplace. These are supplied with a backpack or side holster. For children, adults with slight build, or those with physical frailty, a slightly lighter weight portable cylinder is available, weighting about 500g less than a standard ambulatory cylinder.

5.3.9. Before more than the occasional portable cylinder is ordered, patients should be assessed for ambulatory oxygen therapy by a respiratory specialist to ensure suitability.

Liquid Oxygen

5.3.10. When compressed into liquid form oxygen occupies a smaller volume than when it is compressed as a gas. Liquid oxygen systems (LOX) consist of a compact base unit (sometimes referred to as a "dewar") that contains a reservoir of liquid oxygen, which is used to refill a portable unit, as and when the patient needs it.

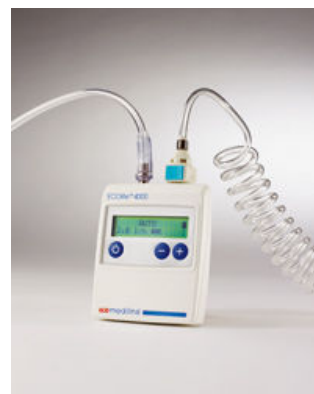


5.3.11. Liquid oxygen enables patients to leave their homes for a longer period than ambulatory cylinder oxygen, making it ideal for people who go out to work or attend school.

Conserving Devices

5.3.12. As a person breathes, most time is spent breathing out. If oxygen is being delivered as a continuous flow from a cylinder or LOX system about two-thirds of the supplied oxygen is wasted as the patient exhales.

5.3.13. An oxygen-conserving device dramatically increases the duration of an oxygen cylinder or LOX system by “turning on” the flow when the user is inhaling, and “turning off” the flow during exhalation. Depending on the conserving device being used and the flow rate of oxygen this can increase the usage time three to four-fold.



5.3.14. However, an oxygen-conserving device will not be suitable for all patients, and the patient’s healthcare professional should indicate on the HOOF if a conserving device is contra-indicated.

5.4. Pricing

5.4.1. The price for each type of service (i.e. not item of equipment) is calculated on a *per diem* basis, dependent on the number of hours of oxygen that has been ordered for the patient and the flow rate (amount of oxygen delivered). Service costs include the provision, maintenance and collection of equipment and other supplies to and from the patient’s home.

5.4.2. Suppliers tendered for each Home Oxygen contract region separately. Therefore, prices for each service category within the Contract vary between Suppliers, and can vary between regions covered by the same Supplier. Despite this variation, as a rule the costs for urgent supply (CC1), and for those categories that involve lightweight ambulatory oxygen supply (CC6 and CC7), are considerably more expensive. Therefore, it is important that PCTs ensure that these service categories are ordered appropriately. Full details of the service categories can be found in Table 2.

5.4.3. The Contract allows for a review of Contract prices at defined stages. This will be undertaken at a national level and negotiated and agreed by the CCMU, based on previously agreed cost price indices, which are detailed in paragraph 4.14.7 of the Service Specification. **PCTs should not enter into any local negotiations on Contract prices.**

5.4.4. Discussions are currently underway between the CCMU and Suppliers about the possible creation of two additional pricing categories. These would accommodate the provision of SBOT with standard or lightweight ambulatory supply. PCTs will be notified if this change occurs, which will also require changes to be made to the PPD website.

Table 2 – Cost Categories

C1	1a	Urgent (only provided for a period up to 3 days)		
CC2A	2a	i) On discharge pending formal assessment	2 l/min	up to & including 1.5 hours per day
		ii) Short burst oxygen therapy (SBOT)		
CC2B	2b	i) On discharge pending formal assessment	2 l/min	more than 1.5 hours per day
		ii) Short burst oxygen therapy (SBOT)		
CC3	3a	Long term oxygen therapy (LTOT)		
CC4	4a	LTOT plus standard ambulatory supply	less than 2 l/min	less than 1 hour per day
	4b			1 to less than 2 hours per day
	4c			2 to less than 3 hours per day
	4d			3 to less than 4 hours per day
	4e			4 hours and above per day
	4f			2 to less than 4 l/min
	4g		1 to less than 2 hours per day	
	4h		2 to less than 3 hours per day	
	4i		3 to less than 4 hours per day	
	4j		4 hours and above per day	
	4k		4 to less than 6 l/min	less than 1 hour per day
	4l			1 to less than 2 hours per day
	4m			2 to less than 3 hours per day
	4n			3 to less than 4 hours per day
	4o		4 hours and above per day	
	4p		6 to less than 8 l/min	less than 1 hour per day
	4q			1 to less than 2 hours per day
	4r			2 to less than 3 hours per day
4s	3 to less than 4 hours per day			
4t	4 hours and above per day			
4u	8 l/min and above	less than 1 hour per day		
4v		1 to less than 2 hours per day		
4w		2 to less than 3 hours per day		
4x		3 to less than 4 hours per day		
4y		4 hours and above per day		
CC5	5a	Standard ambulatory supply only	less than 2 l/min	less than 1 hour per day
	5b			1 to less than 2 hours per day
	5c			2 to less than 3 hours per day
	5d			3 to less than 4 hours per day
	5e			4 hours and above per day
	5f			2 to less than 4 l/min
	5g		1 to less than 2 hours per day	
	5h		2 to less than 3 hours per day	
	5i		3 to less than 4 hours per day	
	5j		4 hours and above per day	
	5k		4 to less than 6 l/min	less than 1 hour per day
	5l			1 to less than 2 hours per day
	5m			2 to less than 3 hours per day
	5n			3 to less than 4 hours per day
	5o		4 hours and above per day	
	5p		6 to less than 8 l/min	less than 1 hour per day
	5q			1 to less than 2 hours per day
	5r			2 to less than 3 hours per day
5s	3 to less than 4 hours per day			
5t	4 hours and above per day			
5u	8 l/min and above	less than 1 hour per day		
5v		1 to less than 2 hours per day		
5w		2 to less than 3 hours per day		
5x		3 to less than 4 hours per day		
5y		4 hours and above per day		
CC6	6a	LTOT plus lightweight ambulatory supply		
CC7	7a	Lightweight ambulatory supply only		

5.5. Payment

- 5.5.1. The Contract sets out the terms on which the NHS must pay the Supplier. At the beginning of each month, the Supplier submits a payment claim to the Prescription Pricing Division of the NHS Business Services Authority (PPD) for the cost of the services provided over the preceding month. The PPD makes payment to the Contractor, which is then re-charged to Primary Care Trusts.
- 5.5.2. Charges for the Home Oxygen Service are based on the PCT within which the patient's GP practice main surgery is located, not the address of the patient. All charges relating to the service are borne by PCTs, regardless of the employing organisation of the clinician placing the order.
- 5.5.3. **Where PCTs receive copies of these payment claims from the Contractor they should not make payment against them.** Further details about PCT's role in payment and reconciliation can be found on page 48.

5.6. Clinical Standards

- 5.6.1. The Service Specification has been designed to support the clinical guidance on oxygen therapy issued by the British Thoracic Society (BTS) Working Group on Home Oxygen Services. This updates the earlier report prepared by the RCP on clinical guidelines for domiciliary oxygen. The guidelines recommend that, with the exception of palliative care patients, all patients with a perceived need for long term or ambulatory oxygen should be referred to a specialist respiratory team with access to the facilities necessary to undertake such assessment.
- 5.6.2. The clinical standards for adults can be downloaded at <http://www.brit-thoracic.org.uk/c2/uploads/clinical%20adultoxygenjan06.pdf>. A paediatric document, which complements the adult guidance, is available to download at <http://www.brit-thoracic.org.uk/c2/uploads/clinicalpaedo2jan05.pdf>.
- 5.6.3. The BTS also produced additional guidance on the assessment of patients, and completion of an oxygen order which is available at <http://www.brit-thoracic.org.uk/c2/uploads/additionalguidancenov2005.pdf>.
- 5.6.4. Guidelines on the treatment of patients with chronic obstructive pulmonary disease (COPD), published by the National Institute for Health and Clinical Effectiveness (NICE) in February 2004, also highlight the importance of oxygen therapy assessment, especially prior to the use of ambulatory oxygen, and warn that inappropriate oxygen therapy in people with COPD may cause respiratory depression. These can be downloaded at http://www.nice.org.uk/pdf/CG012_niceguideline.pdf.

5.7. Patient Experience and Complaints

- 5.7.1. The Home Oxygen Service involves the direct delivery by the Supplier of a service to patients. The intention of the Contract is that the patient experience should be at least equal to the treatment they would receive from the NHS. The Supplier is required to have in place a complaints process which complies with the National Health Service complaints procedure, and must therefore acknowledge complaints within 3 working days and respond within 25 working days.
- 5.7.2. Where a Contractor is unable to resolve a complaint or where the complaint relates to the clinical service received by a patient, rather than to the Home Oxygen Service, the Contractor should inform the appropriate PCT that the complainant has been advised to take this up with the PCT.

5.8. Performance Management

- 5.8.1. The Contract provides for a system of joint reviews to be held on a regular basis, at both national and local level, to review the Supplier's performance in delivering the services against agreed performance indicators. If any problems are identified the action necessary to address areas of dissatisfaction should be agreed. Further details about contract management can be found starting on page 39.

5.9. Commercial Confidentiality

- 5.9.1. The Contract, and the information received under it, contains commercially sensitive information. The PCT is bound by the conditions of confidentiality set out in the NHS Conditions of Contract. These restrict the ability to disclose confidential information outside of the PCT. The Contract may be shared internally with officers of the PCT where it is required in the exercise of the PCT's functions although the PCT should ensure that individual officers to whom the Contract is disclosed are aware of the confidential status of the Contract. This includes information on the prices within the Contract.
- 5.9.2. This restriction is subject to the PCT's obligations under the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR) (see page 55).

5.10. What happens if things go wrong?

- 5.10.1. In certain circumstances where the Contractor fails to perform its obligations within the Contract, the CCMU may terminate the Contract and make other arrangements for the provision of the service. Generally, in other circumstances the CCMU can terminate with three months notice. **PCTs should not take any action to terminate the Contract locally, or to make alternative arrangements for the supply of a Home Oxygen Service.**

- 5.10.2. However, termination would only occur as a final resort and after escalation procedures have been followed. In the first instance, a PCT should discuss any problems with their Supplier and try to reach a suitable resolution. If no resolution is possible, including after the involvement of the Lead PCT, the issue should be escalated to the NHS Lead for the Home Oxygen Service, informing the SHA of the situation.
- 5.10.3. If necessary, the NHS Lead will bring the situation to the attention of the CCMU, who manage the contract with the Suppliers. In the case of no resolution being possible the NHS Conditions of Contract include a Dispute Resolution procedure (paragraphs 123 to 126).

Section B - Clinical

6. Clinical Guidance

6.1. Introduction

6.1.1. The clinical standards for the assessment and ordering of domiciliary oxygen therapy in adults are set out in the BTS guidance, which was updated in January 2006. Details of the web-links from which these can be downloaded are given on page 15.

6.2. Long Term Oxygen Therapy

6.2.1. LTOT is indicated for the treatment of chronic hypoxaemia (arterial blood oxygen (PaO_2) at or below 7.3 kPa) in a range of conditions including, but not restricted to;

- chronic obstructive pulmonary disease (COPD)
- interstitial lung disease
- cystic fibrosis
- pulmonary vascular disease
- chronic heart failure

6.2.2. The aim of providing oxygen therapy is to raise the waking oxygen tension above 8.0 kPa. Once started, LTOT is likely to be life-long, and is usually given for at least 15 hours daily, including at night, in view of the presence of worsening arterial hypoxaemia during sleep.

6.2.3. LTOT may also be appropriate in chronic hypoxaemia patients with a clinically stable PaO_2 between 7.3 kPa and 8.0 kPa in certain circumstance. For more information, see the full BTS guidelines. LTOT should not be used in chronic hypoxaemia patients with a PaO_2 above 8.0 kPa.

6.3. Ambulatory Oxygen Therapy

6.3.1. Ambulatory oxygen refers to the provision of oxygen during exercise and activities of daily living, for patients who require LTOT, and who are mobile and able to leave the home on a regular basis. It has been shown that relatively few patients with COPD actually use ambulatory oxygen for more than four hours per day in the first instance.

6.3.2. Candidates for ambulatory oxygen will already be using LTOT, or will have a PaO_2 above the levels for LTOT, but show evidence of exercise de-saturation. Ambulatory oxygen is not recommended for patients with chronic lung disease and mild hypoxaemia, who are not on LTOT, without exercise de-saturation.

6.3.3. Not all patients receiving LTOT will require ambulatory oxygen, and in clinical terms, patients are considered to fall into one of three categories:

- Grade 1: LTOT low activity - patients who are mainly housebound, and only require occasional ambulatory oxygen use in order to leave the house to visit relatives, attend hospital etc;
- Grade 2: LTOT active group - patients who are mobile and need to leave the home on a regular basis;
- Grade 3: non-LTOT group - patients without chronic hypoxaemia, who show evidence of de-saturation on exercise.

The purpose and nature of the assessment for ambulatory oxygen therapy will vary according to the patient's activity and ability to leave home, and their grading within the above system.

6.4. Short Burst Oxygen Therapy

- 6.4.1. SBOT refers to the intermittent use of supplemental oxygen for periods of 10 - 20 minutes to relieve dyspnoea. Although there appears to be little evidence to support the use of SBOT, it has traditionally been used for:
- breathlessness during recovery from exercise
 - breathlessness at rest
 - relief of episodic breathlessness, not relieved by other treatments, in patients with severe COPD, interstitial lung disease, heart failure and palliative care
- 6.4.2. SBOT should only be ordered where an improvement in breathlessness and exercise tolerance can be documented

6.5. Paediatric Use

- 6.5.1. The BTS guidance contains a separate section relating to the use of oxygen therapy in children, as the paediatric use of oxygen demonstrates many differences from its use in adults. Principle amongst these is the fact that many of the clinical conditions treated in the infant age group are not seen in adults. Prognosis is usually good with many children only needing oxygen for a limited period.
- 6.5.2. Chronic neonatal lung disease is the main indication for LTOT in children. Suitability for home oxygen therapy should be assessed by a specialist with appropriate experience of the relevant condition, and the family must be assessed as competent to manage home oxygen therapy.

7. Assessment and Follow-up Services

7.1. Introduction

- 7.1.1. Used effectively, the Home Oxygen Service can improve support for patients with long-term conditions, support hospital discharge, and help reduce inappropriate hospital admission.

- 7.1.2. The Service Specification for the NHS 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. The importance of clinical assessment services was highlighted in the Royal College of Physicians report published in 1999, in the NICE guidance on the treatment of COPD, and in the clinical best practice guidance published by the BTS.
- 7.1.3. In order to maximise the benefits to a patient of oxygen therapy, minimise any risks, and ensure that Home Oxygen Service patients receive the most appropriate treatment, assessment of their clinical needs should be made by a healthcare professional with the appropriate expertise.
- 7.1.4. Clinicians and commissioners need to be aware that the inappropriate ordering of Home Oxygen Services for patients may result in a higher cost service without delivering required benefits to the patients. For example, if an ambulatory oxygen service has been ordered for 6-8 hours per day, but the patient's clinical condition is such that they only use oxygen away from the home for a few hours each week, this results in an unnecessarily high *per diem* charge for a service that is not benefiting the patient.
- 7.1.5. Services should be commissioned in line with the following principles:
- screening of patients to identify those with an oxygen saturation (SaO₂) of less than 92%;
 - referral to a formal assessment service of patients with a SaO₂ of less than 92% to identify those patients with a PaO₂ level of 7.3 kPa or below, or between 7.3 and 8.0 kPa in the presence of other factors, who are likely to benefit from LTOT;
 - follow-up of patients at home within 4 weeks, including monitoring of SaO₂ via pulse oximetry;
 - follow-up of patients after three months, including monitoring of arterial blood gases to assess progress and exclude hypercapnia; and
 - review of patients at least annually, including monitoring of arterial blood gases

7.2. Commissioning Framework

- 7.2.1. A commissioning framework for Home Oxygen clinical assessment and follow-up services has been prepared to support PCTs in the effective commissioning of these services. This provides information to help achieve the best possible health outcomes and value for money. The commissioning framework can be accessed at www.pcc.nhs.uk/153.php.
- 7.2.2. The framework provides a brief summary of the range of assessment and follow-up services currently being provided to illustrate the different service models that can exist. Whatever configuration is used, clinical assessment and follow-up services need to be provided by healthcare professionals with specialist respiratory knowledge, and an understanding of the relevant clinical guidance, disease management and the Home Oxygen Service. The

healthcare professional needs access to pulse oximetry and arterial blood gas analysis, and should have the skills to interpret SaO₂ and PaO₂ information. Access to spirometry and chest x-ray facilities are also likely to be needed.

7.2.3. Benefits of assessment and follow-up include:

- maximising the benefits to individual patients by ensuring appropriate ordering of oxygen therapy;
- identifying those patients where a change in oxygen therapy is required;
- helping to address patients' perceived need for oxygen, which may not be in line with clinical need; and
- identifying those patients who no longer require oxygen therapy

7.2.4. The overall cost of the Home Oxygen Service, to both individual PCTs and the NHS, is likely to be greater where delivery remains unsupported by clinical assessment and follow-up services.

7.3. Cost / Benefit Analysis

7.3.1. NHS London commissioned an economic analysis to estimate the costs and benefits of pre-screening and clinical assessment (and re-assessment) of patients who are in need of home oxygen therapy. This economic analysis forms part of the commissioning framework and can be accessed at www.pcc.nhs.uk/153.php.

7.3.2. This analysis draws on discussions with a range of stakeholders to identify the appropriate costs and benefits of home oxygen therapy and, in the absence of published data, is based on expert assumptions. A decision tree methodology has been used to estimate the number of patients treated and hence costs, for an average PCT, in three scenarios.

7.3.3. The report concludes that although the costs of delivering clinical assessment for home oxygen are likely to be high, the benefits are likely to outweigh these costs by reducing the number of people receiving oxygen. It also notes that the higher the proportion of patients who are inappropriately receiving oxygen and for whom therapy can be discontinued, or who are not inappropriately started on oxygen because of the availability of a robust assessment service, the more cost effective the provision of the clinical service.

8. Quality

8.1. Background

8.1.1. Improving the quality of healthcare has been a key element of health reform and policy during the last decade. This has underpinned the emergent framework for healthcare inspection and regulation to ensure that appropriate standards are met throughout the NHS.

8.1.2. In December 1997, the Government published a White Paper: *The New NHS: Modern, Dependable*, which set out a ten-year modernisation strategy for the NHS. One of the main aims of the proposals was to bring about a major improvement in the quality of clinical care delivered to patients in the NHS. As part of these changes, a formal responsibility for quality has been placed on every health organisation, through arrangements for clinical governance at local level. This responsibility is underpinned by a statutory duty of quality on NHS providers.

“The new NHS will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality.”

Paragraph 3.2 *The new NHS Modern, Dependable*
Cm 3807: December 1997

8.1.3. Successive policy documents have built on this foundation, including the seminal report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer: *An organisation with a memory*. (2000). This sets out four key areas for action:

- unified mechanisms for reporting and analysis when things go wrong;
- a more open culture, in which errors or service failures can be reported and discussed;
- mechanisms for ensuring that, where lessons are identified, the necessary changes are put into practice; and
- a much wider appreciation of the value of the system approach in preventing, analysing and learning from errors.

8.1.4. Although significant progress has been made to achieve these objectives, a recent report – *Safety First* (December 2006) – highlights that the pace of change has been too slow and the NHS is unable to assure that all organisations are learning from experience in ways that prevent harm to future patients.

8.1.5. The report has made important recommendations for changing the way that the National Patient Safety Agency (NPSA) works, including the redesign of the National Reporting and Learning System (NRLS). It is recommended that the Patient Safety Management function currently delivered by the NPSA will instead be hosted by SHAs. New ‘Patient Safety Action Teams’ will support the delivery of the national patient safety agenda by local organisations.

8.1.6. It is proposed to pilot the development of technical patient safety solutions by the National Institute for Health and Clinical Excellence (NICE).

8.2. What is Quality Healthcare?

8.2.1. Perceptions of the quality of care are very subjective. Measures of the quality of care always inevitably depend on value judgments but there are

determinants that can be measured. Donabedian classified these into measures of:

- Structure – e.g. workforce and facilities
- Process – e.g. diagnostic and therapeutic procedures
- Outcome – e.g. survival rates, patient satisfaction

8.2.2. Within the Home Oxygen Service, information from a number of currently available quantitative and qualitative sources is already available but is not routinely collated into a composite report. The Key Performance Indicators (KPIs) that have been agreed for the Home Oxygen Service (Appendix 5) provide a basis on which to assess the quality of the service and a means to monitor and compare performance across the four Suppliers and their respective regions. As this data set builds, there will be an opportunity to undertake trend analysis.

8.2.3. Any assessment of quality needs to be holistic and to use data from a number of different sources. These can then be used to inform discussion at quarterly Service Review meetings with Suppliers (see section 12.8). It is suggested that information from a range of sources be considered including:

- key performance indicators (KPIs)
- reported serious untoward incidents (SUIs)
- NRLS reports submitted to the NPSA
- complaints and compliments – both supplier and NHS systems
- media coverage

8.2.4. Attention has inevitably been focused on adverse events. These incidents vary in their nature and severity. Whilst Serious Untoward Incidents (SUIs) may highlight operational system failures, intelligence from a range of other adverse incident reporting procedures will provide an overview of overall service integrity and the quality of service provided to service users. The reporting of SUIs is very variable and this disparate ascertainment of events does not at present provide a basis on which to make valid judgments of service integrity and safety.

8.2.5. NRLS data from the NPSA provide some insight into reporting trends, types of service failure and the degree of harm, but the level of ascertainment is still low and the timeliness of data analysis could be strengthened. PCTs should ensure that mechanisms are in place for the appropriate reporting of SUIs and other adverse events.

8.2.6. Systems to monitor and manage complaints have varied between the four Suppliers, with differing interpretations of definitions and variability in how the interface with the NHS is managed. As part of the process of agreeing national Key Performance Indicators (see section 13) complaints categories have been developed which will encourage consistent reporting. PCTs should routinely expect information on complaints levels and types as part

of discussions at quarterly Service Review meetings (see section 12.8) These discussions should of course also capture information on compliments.

- 8.2.7. Measures of media coverage are routinely available and can be used to assess the level, and trends, of positive and negative media coverage of the service. However, the information is not routinely analysed in that format.
- 8.2.8. Significant opportunities exist to enhance information that will provide a measure of patient experience ('customer satisfaction'). The current Service Specification requires a patient experience survey but these arrangements could be enhanced to include:
- an annual patient experience survey undertaken by an independent body, using a consistent assessment framework across the four suppliers.
 - routine customer experience survey tools built into normal service regimes. For instance, building upon the standard approach in the hotel service, a card left in the home following a visit by a homecare technician for completion by the patient or carer and returned by post. Discussions are underway develop a standard approach common to all suppliers.
 - 'mystery shopper' assessment of telephone answering services in call centres.
 - home-based assessments of the quality of service by appropriately trained NHS staff e.g. respiratory nurses.
- 8.2.9. The items listed above are not part of the Service Specification nor a contractual obligation but work has started, at a national level, to develop a quality framework for the Home Oxygen Service building upon this approach and details will be made available in due course.

9. Clinical Governance

9.1. Background

- 9.1.1. Although many of the component activities (such as clinical audit and appraisal) were already being practiced within the NHS, the concept of clinical governance was consolidated in *A First Class Service: Quality in the new NHS* in 1998. This sets out a paradigm of a quality culture in the NHS.

“A framework through which all NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

- 9.1.2. Clinical governance leads have been appointed in all NHS organisations and they continue to provide overall leadership for this important agenda. However, it is important to recognise that clinical governance is “everybody’s business” and needs to be embedded into the daily routine.

“The drive to place quality at the heart of the NHS is not about ticking checklists – it is about changing thinking.”

9.2. Adverse Incidents

9.2.1. Adverse incidents vary in their nature and severity. Whilst Serious Untoward Incidents (SUIs) may highlight operational system failures, intelligence from a range of other adverse incident reporting procedures will provide an overview of overall service integrity and the quality of service provided to service users. Such reports also form an important part of sharing the learning from experience to help prevent future incidents.

9.2.2. Reporting procedures are in place in all health organisations to deal with a range of categories of adverse incidents, including:

- notification of serious untoward incidents (SUIs) from Trusts to SHAs
- local adverse incident procedures
- near miss and patient safety incident reporting to the National Patient Safety Agency (NPSA) using the National Reporting and Learning System (NRLS)
- SHA briefings to DH Patient Safety and Investigations Unit
- complaints
- Media Alerts to DH Communications

9.3. What is a Serious Untoward Incident?

9.3.1. There is no standardised definition of a serious untoward incident (SUI). Although most areas use a broadly similar definition, there is a risk of differences of interpretation and reporting sensitivities and this may result in a failure to capture all incident data. These differences can also result in difficulties in comparing incident data to analyse trends and the lessons learned. A possible definition that may help to determine the reporting of an incident is set out below.

Figure 2 – Serious Untoward Incidents

An incident or accident occurring on health service premises, or in relation to a health service provided in other settings, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern.

Situations highlighting a system weakness (near miss), where sharing of lessons learned would be likely to help to avoid a future incident resulting in a future incident resulting in serious harm or damage, should also be reported.

9.4. Reporting frameworks for SUIs

- 9.4.1. Local arrangements for the notification of SUIs vary, and the NHS does not yet universally use the Strategic Executive Information System (STEIS). Although the majority of SHAs and Trusts have adopted this electronic reporting format, each SHA will have in place local procedures setting out reporting criteria and the performance management of incidents.
- 9.4.2. Notification of a SUI is normally required within 48 hours of the incident but there may be a need for more prompt notification depending on the nature of the incident. Any uncertainties about reporting an incident should be discussed with the Trust or SHA Clinical Governance Lead. Existing procedures require SHA Clinical Governance Leads to notify the DH Patient Safety and Investigations Branch of the most serious SUIs, or those that might attract undue political or media scrutiny.
- 9.4.3. The management of all SUIs will be in accordance with existing procedures. It is imperative that there is full compliance with these reporting procedures with completion of incident reviews in a timely manner. At the local SHA discretion, there may be circumstances calling for an immediate internal review of the more serious incidents with an interim written report submitted within a defined timescale.

9.5. Serious Untoward Incidents and the Home Oxygen Service

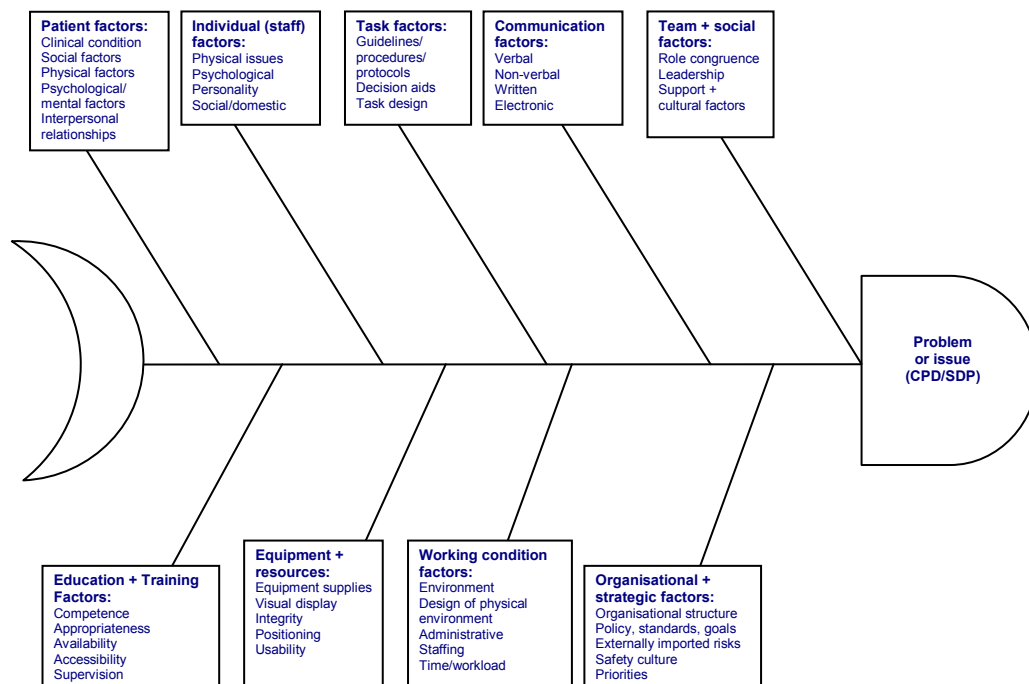
- 9.5.1. As part of monitoring implementation of the service arrangements, the Department put in place enhanced reporting procedures for reporting adverse incidents involving the service. Now that the service has stabilised, these special reporting arrangements have been stood down and incidents involving HOS should be reported using normal reporting procedures. HOS leads should be conversant with local procedures. They should ensure the timely notification of incidents and work with the clinical governance lead to undertake appropriate local investigations and submit reports within required timeframes so that the lessons can be identified and shared.
- 9.5.2. Whilst it is not feasible to be prescriptive about what should be reported, Serious Untoward Incidents will include:
- any incident that involves the death of a patient where the integrity of the home oxygen service is challenged;
 - any serious failure of service delivery, including compromised supply of oxygen;
 - delayed discharge from hospital or inappropriate emergency readmission;
 - health and safety incidents relating to the use of oxygen equipment, including fire, explosion etc; and
 - any incident where the quality of healthcare has been significantly compromised – this may include severe distress to service users and their carers.

- 9.5.3. For the home oxygen service, the last category is specifically included to address broader service quality associated with the implementation of new service arrangements following a change in national policy. However, the above list is not exhaustive or prescriptive. A judgment will need to be made on how the incident meets the reporting criteria - again, any uncertainty about reporting an incident should be discussed with the SHA or Trust Clinical Governance Lead and/or Home Oxygen Lead. It is important that at both Trust and SHA levels, Home Oxygen Leads liaise closely with Clinical Governance Leads and Communication Leads to agree local handling of such incidents.
- 9.5.4. It is recognised that an incident involving the death of a patient, where the integrity of the home oxygen service is challenged, may be by association and not necessarily indicative of causality. It is important that incidents are reported so that the circumstances can be fully investigated.

9.6. Root Cause Analysis

- 9.6.1. The NPSA has developed a methodology to enable a structured and systematic review of adverse incidents. Advice on Root Cause Analysis (RCA), and how this might be used in the context of the Home Oxygen Service, can be obtained from the Trust Clinical Governance Lead and the NPSA Patient Safety Manger. Local structures will change as Patient Safety Action Teams are established and these will provide a source of expertise with skills in data analysis, incident investigation and solution development.

Figure 3 – NPSA “Fishbone Diagram” for Root Cause Analysis



Section C – Operational

10. Ordering Oxygen

10.1. Home Oxygen Order Form

10.1.1. Registered healthcare professionals can order oxygen using a Home Oxygen Order Form (HOOF), which replaces use of an FP10 prescription form for this purpose. The HOOF must state the patient's oxygen need (short burst, long-term, ambulatory or lightweight), the flow rate and the hours of use each day. It should not normally be used to specify the equipment to be supplied, as this decision will be made by the Supplier. Further advice on completing a HOOF can be found on page 30.

10.2. Home Oxygen Consent Form

10.2.1. Patients receiving oxygen for the first time will also need to complete a Home Oxygen Consent Form (HOCF). This is not providing consent to oxygen treatment but giving consent for the transfer of their personal details (e.g. name, address etc) to the Home Oxygen Service Supplier. Without this consent being given, action could be brought under the Data Protection Act 1998 against both the healthcare professional and the Supplier for the unlawful handling and transmission of personal data.

10.2.2. A copy of the HOCF does not need to be sent to the Home Oxygen Service supplier as the HOOF contains a tick box for the healthcare professional to indicate that consent to the transfer of the patient's personal data has been obtained. Where this box has not been ticked, the Supplier will not process the order contained on the HOOF without seeking such confirmation.

10.2.3. If a patient is mentally competent to provide consent, but physically unable to sign the HOCF, an independent witness should sign to confirm that the patient has given consent orally or non-verbally. **Healthcare professionals should not routinely accept verbal consent to transfer patient's personal data to the Home Oxygen Service Supplier as this could constitute a breach of the Data Protection Act 1998.**

10.2.4. The patient should be given a copy of the completed HOCF and a copy filed in the patient's records.

10.3. Obtaining HOCF and HOOF stationery

10.3.1. Both forms are available from Astron as part of the NHS Non-Secure Forms Contract, and can be ordered by PCTs in the normal way as other non-secure stationery. It is anticipated that GPs will need approximately 50 new forms each year. The forms are not self-carbonating and will need to be photocopied to allow copies to be sent to the PCT, and others as appropriate.

- 10.3.2. Examples of the current HOOF and HOCF can be downloaded in PDF file format from the Primary Care Contracting (PCC) Home Oxygen Service website at www.pcc.nhs.uk/217.php.

PCTs should not design their own order form for the Home Oxygen Service, nor amend the nationally agreed HOOF.

10.4. Urgent Supply

- 10.4.1. The Contract provides for the supply of oxygen within 4 hours of the receipt of a HOOF where oxygen is required urgently. However, the Home Oxygen Service should not be used as an alternative to a "blue light" response if the patient's condition is serious enough to warrant admission to hospital. This 4-hour response is available 24 hours per day, seven days per week as all Suppliers have mechanisms in place to respond outside normal working hours.
- 10.4.2. This type of supply, CC1 in the price categories (see Table 2), is a very expensive option. It is important that hospital-based healthcare professionals do not use the urgent supply mechanism as an alternative to effective discharge planning to facilitate discharge especially where a patient already has a supply of oxygen at home.
- 10.4.3. The HOOF indicates that the maximum duration of an order for an urgent supply is three days. Currently the process requires healthcare professionals to complete a second HOOF at the same time as that requesting an urgent supply, ordering the follow-on "normal" supply, where that is necessary. A new HOOF is in the process of being finalised which will change this current practice. The new HOOF will automatically revert to "normal" supply after the 3 days, and healthcare professionals will not be required to send through a second HOOF. Once this process has been agreed, a formal communication will be sent through to all PCTs. In order to ensure that no time is lost in processing an order requiring a 4-hour response. Suppliers request that the faxed HOOF be followed-up by telephone to confirm receipt, wherever possible.

10.5. Hospital Discharge requiring Next Day Supply

- 10.5.1. In order to facilitate hospital discharge the Contract provides for a next day delivery, as long as the HOOF is received prior to 5.00 pm. This service is available during the hours of 8.30 am and 5.00 pm, seven days per week.
- 10.5.2. Experience with the Contract to date suggests that this availability is not well understood by hospital clinicians. It is felt that a number of requests received for a 4-hour urgent response are submitted because clinicians do not realise that they could arrange for a supply to be made the following day, particularly over weekends and public holidays. In many cases when the Supplier makes contact with the ward to make arrangements for delivery of oxygen to the patient's home they are advised that the patient is not being discharged until the following day.

- 10.5.3. Good practice guidance relating to discharge* identifies that discharge from hospital is a process and not an isolated event, which should involve the development and implementation of a plan to facilitate the transfer of the individual from hospital to an appropriate setting. Planning for discharge is part of this ongoing process and should start prior to admission for planned admissions, and as soon as possible for all other admissions.
- 10.5.4. Wherever possible a patient's oxygen requirements should be considered in advance of their discharge, allowing an order to be placed as a standard order for oxygen with a 3-day response. Where this is not possible, the option of placing an order for delivery the next day should be used in preference to placing an "urgent" order.

Table 3 – Response Times

ORDER PLACED	"Next Day" Discharge Order		"Standard" 3 Day Order	
	Received before 5.00 pm	Received after 5.00 pm	Received before 5.00 pm	Received after 5.00 pm
	DELIVERY BY END OF			
Monday	Tuesday	Wednesday	Thursday	Friday
Tuesday	Wednesday	Thursday	Friday	Monday
Wednesday	Thursday	Friday	Monday	Tuesday
Thursday	Friday	Saturday	Tuesday	Wednesday
Friday	Saturday	Sunday	Wednesday	Thursday
Saturday	Sunday	Monday		
Sunday	Monday	Tuesday		

Note: "standard" orders faxed on Saturday or Sunday will be treated by the Supplier as if received before 5.00 pm on Monday

10.6. Standard Response Time

- 10.6.1. Unless the order is specifically marked as requiring "urgent" or "next day" supply, the Supplier is required to provide the patient with the oxygen modality required within three **working** days of the receipt of the HOOF. This includes provision of any training required by the patient and their carer.
- 10.6.2. In practical terms, this means that oxygen should have been installed by the end of the third working day following the day that the HOOF is received (i.e. the day of receipt counts as day zero).

10.7. Placing an Order for Oxygen

- 10.7.1. As well as GPs, other registered healthcare professionals may order oxygen therapy at home for a patient. Therefore, a patient seen by a

* Health & Social Care Joint Unit and Change Agent Team, *Discharge from hospital: pathway, process and practice*. Department of Health, 2003.

respiratory specialist will not need to return to their GP to obtain an order for oxygen; the order can be placed by the clinician at the time of the consultation.

- 10.7.2. Advisory notes on the completion of an oxygen order (HOOF) are contained on the reverse of the form. It is important that clinicians are familiar with both the form and the guidance notes. A useful step-by-step guide to completing a HOOF correctly can be found on the Primary Care Contracting Home Oxygen Service website at www.pcc.nhs.uk/120.php. The clinical information provided on the HOOF will determine the equipment supplied but other essential information supports the timely delivery to the patient's home. Inaccurate and illegible details, or gaps in the information supplied will delay the delivery of the service to the patient.
- 10.7.3. In order to determine the most appropriate modality for the patient the Supplier will need to know the patient's required flow rate, and the number of hours each day that the patient is likely to need to use oxygen. Flow rate must be expressed numerically (eg 2l/min) not given as a general statement such as "high flow".
- 10.7.4. Clinical best practice recommends specialist assessment prior to provision of LTOT and ambulatory oxygen services. However, where home oxygen is required pending specialist assessment, advice on flow rates can be found in the British National Formulary (BNF).
- 10.7.5. Whilst recognising that patient's day-to-day requirements may vary, the number of hours usage each day needs to be reasonably accurate (eg 2 hrs/day; 4-6 hrs/day. The terms "continuous", "24 hrs", "*prn*" and "as required" should not be used. Where ambulatory oxygen is being ordered as well as LTOT or SBOT the hours of use per day are likely to differ, as the portable supply will only be used when the patient is mobile.
- 10.7.6. Accurate flow rate and usage data is needed to determine the appropriate cost category. The use of vague descriptions is likely to lead to the allocation of the patient to a cost category which is unnecessarily high.
- 10.7.7. The HOOF also allows clinicians to include other information that they consider the Supplier needs in order to provide the right equipment. For example, a patient may prefer masks to cannulae. Where a conserving device is contraindicated this should be indicated on the HOOF.
- 10.7.8. In order to ensure that the correct PCT is charged for provision of the service it is important that the patient's PCT (Box 4) and GP practice address (Box 3) are completed. Where a supply is required following a patient's discharge it is important that contact details within the hospital are provided in case the Supplier needs to clarify arrangements (Box 11).
- 10.7.9. The clinician should retain the original completed HOOF for the patient's records and fax a copy to:
 - the relevant Supplier;
 - the PCT Home Oxygen Lead, as it will be needed to reconcile payment;

- the local respiratory Clinical Lead, to support assessment and follow-up services.

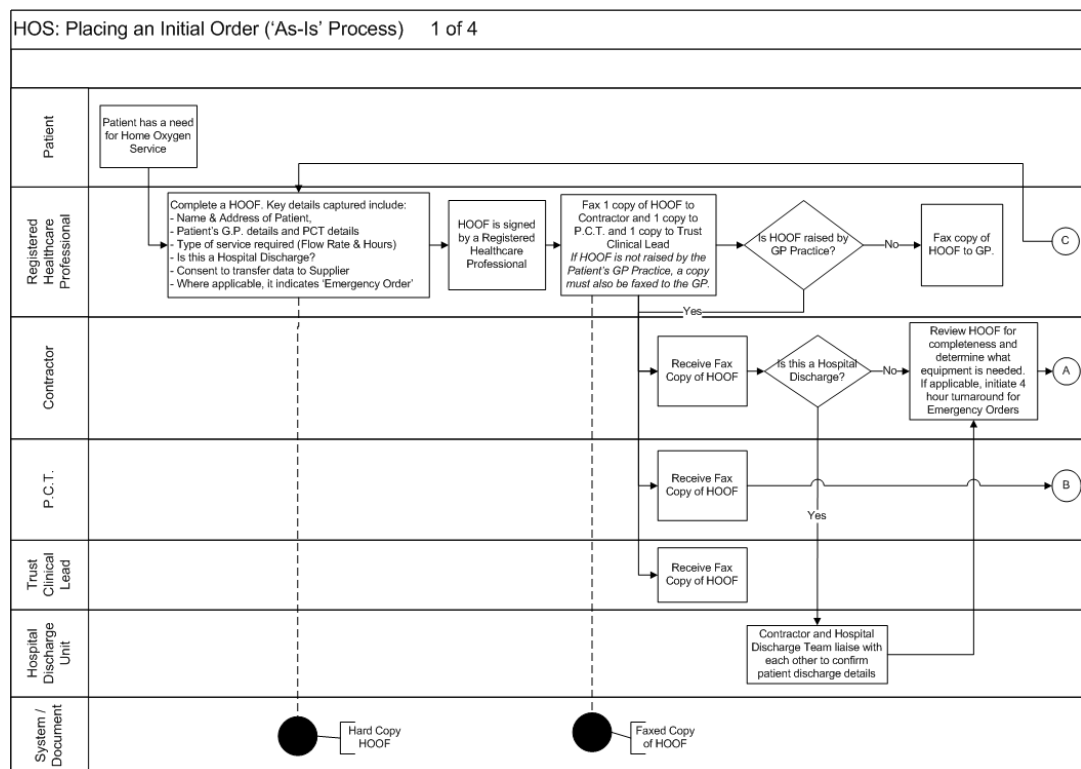
Where a HOOF has been completed by a respiratory clinician or an out-of-hours (OOH) provider, an additional copy should be faxed to the patient's GP.

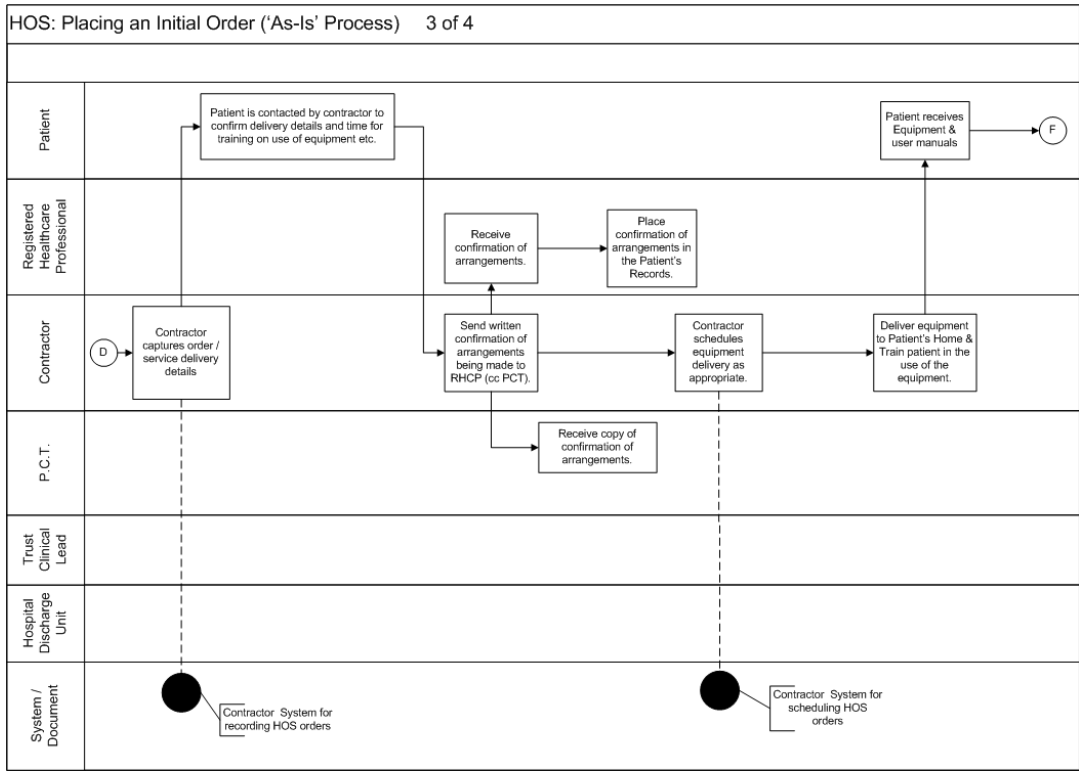
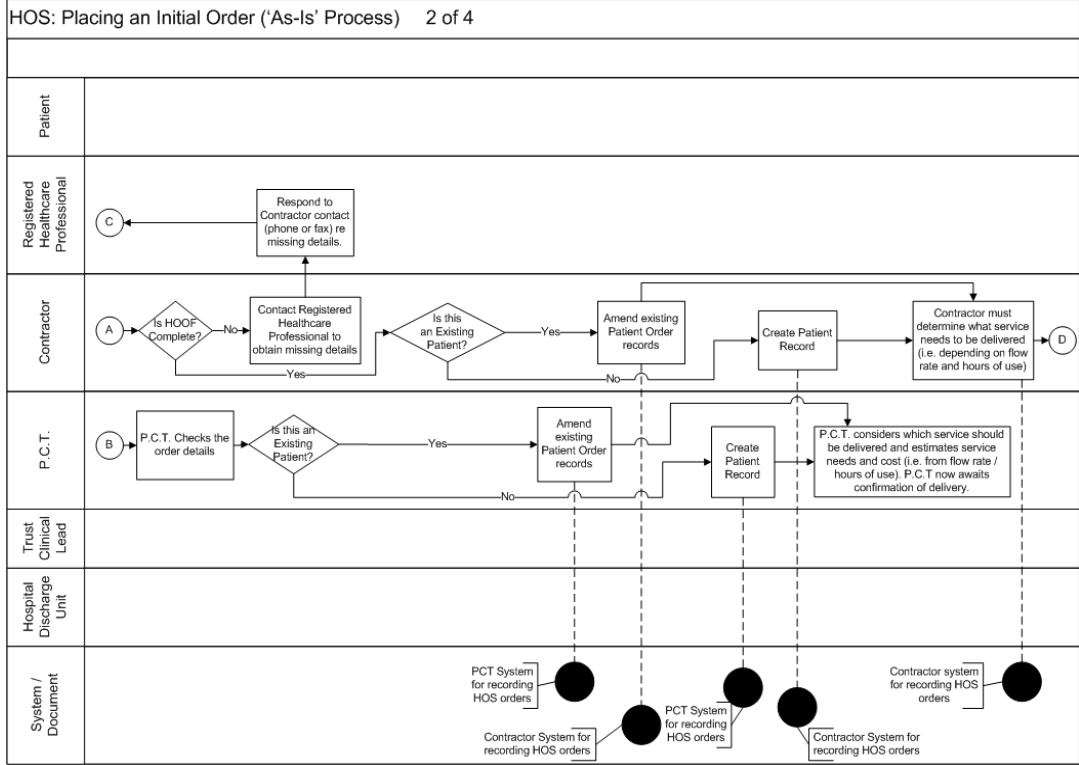
10.7.10. Where facilities exist a copy of the HOOF, and for an initial supply of oxygen the HOCF, should be scanned and appended to the patient's electronic medical record.

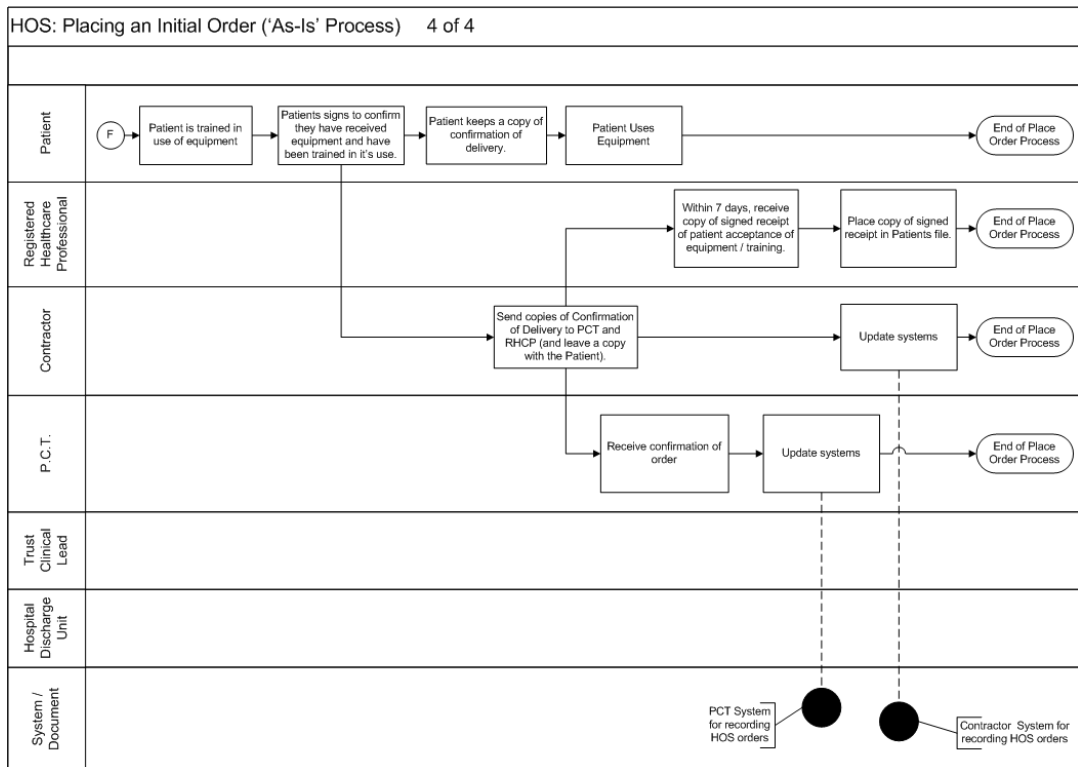
10.7.11. If the order requires a 4-hour "urgent" response, wherever possible the faxed HOOF should be followed-up by a telephone call to the relevant freephone number to confirm receipt (see Appendix 1). Where a HOOF is submitted out-of-hours, it is also good practice to confirm receipt by telephone.

10.7.12. The respective roles and responsibilities associated with placing an initial order are shown graphically in Figure 4

Figure 4 - Placing an Initial Order







10.8. Patient-driven Orders

- 10.8.1. One of the key principles of the Home Oxygen Service is that once an initial order has been placed, as long as the patient's needs remain unchanged, he or she no longer needs to obtain regular repeat prescriptions for their home oxygen supply.
- 10.8.2. All Suppliers have in place a manned 24 hour / 7 day per week freephone telephone number (see Appendix 1), for use by patients to request additional supplies of cylinder oxygen, or items of equipment (i.e. tubing, masks, cannulae etc) as and when they are required. For some patients their Supplier will use information provided on the HOOF to anticipate a scheduled pattern of deliveries (for example every Thursday). This is often the case for patients using LOX systems in order to maintain continuity of supply, as liquid oxygen will also be lost over time due to evaporation. In other cases, as Suppliers become more familiar with the re-ordering patterns of individual patients, similar arrangements may be put in place.
- 10.8.3. Suppliers must provide a back up cylinder service to concentrator patients for use in the event of a power or machine failure. In these circumstances, the patient may also seek help from the Supplier via the freephone number, and may request attendance by the Supplier. The Supplier may consider, from the information provided, that an urgent response is required. The Supplier will have in place procedures to attend a patient's home to deal with an emergency within 4 hours of notification.

10.9. Changing an Order

- 10.9.1. Any change to information contained within the HOOF will require a fresh order form to be completed. This applied to changes of patient's details (surname, address etc) as well as to changes to the clinical requirements of the patient.

10.10. Stopping a Service

- 10.10.1. When a Home Oxygen Service is no longer required, it is essential that the Supplier be informed as soon as possible so that the service can be withdrawn. Equipment may need to be removed for a number of reasons including death of the patient, or where a healthcare professional determines that the patient no longer has a need for oxygen therapy. The Supplier will continue to provide the required service, and therefore charge for it, until notified of its withdrawal.
- 10.10.2. Where oxygen equipment is no longer required a healthcare professional, member of patient's practice staff, or PCT may notify the Supplier that the service should be withdrawn. A member of the patient's family, relative or carer may notify the Supplier only in the event of the death of the patient. Where a PCT is notified that the service is no longer required, it should ensure that the Supplier has been informed.
- 10.10.3. Subject to satisfactory access being available, the Supplier will remove the oxygen equipment within 14 working days of notification. The Supplier will cease to charge for the service to that patient from the date of notification.
- 10.10.4. PCTs should not be charged for any equipment that the Supplier is unable to recover. This should have been covered in calculating per diem costs by the Supplier.

10.11. Reimbursement of Electricity Charges

- 10.11.1. Oxygen concentrators incorporate a non re-settable meter calibrated in hours, to determine the time that the machine has been operating. Suppliers must make arrangements to reimburse patients for that portion of their electricity costs that are attributable to the patient's use of the concentrator. Payment should be made on a quarterly basis. The Supplier is not liable for any part of the patient's electricity standing charge.
- 10.11.2. The Service Specification requires the servicing of oxygen concentrators on a six monthly basis. Therefore, a patient whose only mode of oxygen supply is via an oxygen concentrator may not be seen by a representative of the Supplier more than once every six months. Reimbursement of the patient's electricity charges may be based on an estimate one quarter, and the actual meter readings the next quarter.
- 10.11.3. Suppliers may have systems in place to enable patients to provide a meter reading from their oxygen concentrator each quarter to allow electricity reimbursement to be calculated, for example, the patient completing and

returning a postcard or telephoning the Supplier's freephone number with their meter readings.

- 10.11.4. Reimbursement of electricity charges must be made at a unit rate that is no lower than that charged by the patient's electricity provider.

10.12. Installation of Concentrators

- 10.12.1. Occasionally, although a concentrator is the most appropriate mode of oxygen supply to meet the individual's clinical needs, the patient may refuse to allow the supplier to secure the distribution piping to the walls within the house, for example because of potential damage to skirting boards etc.
- 10.12.2. Where a patient does not wish the distribution piping to be secured, the supplier should obtain a written statement to the effect that the patient does not want this work carried out.

11. Secondary Supply

- 11.1.1. A primary supply of oxygen is that which is delivered to the patient's permanent home. However, patients may also need a secondary supply of oxygen outside their main home, delivered to another address for a defined period, or on a regular basis. For example,
- a holiday or weekend away;
 - where temporarily admitted from home to a hospice or care home for a period of respite care;
 - the patient has a second home, visited on a regular basis, or stays with family or friends each weekend; or
 - where the patient is able to attend school or go to work.

It is important that patients who are considering travelling should check with their healthcare professional that they are actually fit enough to travel, especially if intending to fly or travel abroad.

- 11.1.2. The Contract provides for supply in such circumstances. Where a patient requires secondary supply in a home oxygen region with a different Supplier, responsibility for arranging continuity of supply lies with the patient's "home" Supplier, although delivery of the service in the area to which the patient is travelling is the responsibility of the Supplier for that Home Oxygen region.
- 11.1.3. A home oxygen service is available throughout the United Kingdom. The four UK Health Departments have agreed arrangements, in consultation with Suppliers, to ensure continuity of supply to patients from England and Wales visiting Scotland and Northern Ireland and vice versa. A copy of the Memorandum of Understanding between the Health Departments can be found at www.pcc.nhs.uk/217.php.
- 11.1.4. It is the patient's responsibility to obtain permission from the owners of holiday or other accommodation for the installation, storage or use of

oxygen equipment while they are staying there. This is not the responsibility of the healthcare professional, Supplier or PCT. Advice is available to patients on their responsibilities, including allowing sufficient time to make the necessary arrangements, on the NHS Home Oxygen Service website at <http://www.homeoxygen.nhs.uk/5.php>. A leaflet for patients, "Your oxygen service when staying away from home" is available from Suppliers and can be downloaded from the Home Oxygen Service Website at www.homeoxygen.nhs.uk.

- 11.1.5. It is important that sufficient notice of travel arrangements be provided to Suppliers to allow arrangements to be put in place. Two weeks notice should be provided wherever possible, although more will be required if visiting a remote area (for example the Scottish Isles), or during peak holiday times.
- 11.1.6. Full details of the alternative address and dates of travel should be included in Box 13 of the HOOF, when a secondary supply is being ordered.

11.2. Patients visiting other parts of England or Wales

- 11.2.1. Where a patient requires a secondary supply of oxygen at an address other than the patient's permanent address, a healthcare professional must complete a second HOOF and send it to the patient's normal Supplier who, if necessary, will send it to the relevant Supplier for the area being visited. A copy of the HOOF should be faxed to the PCT in the normal way.
- 11.2.2. The Supplier that will deliver the Home Oxygen Service to the patient whilst they are away from home will confirm delivery details with the "home" Supplier and the patient concerned.

11.3. Patients visiting Scotland or Northern Ireland

- 11.3.1. The delivery system for home oxygen is different in Scotland and Northern Ireland. There GPs continue to use a prescription to order a cylinder service from community pharmacies, with a separate service Contract supporting delivery of the concentrator service.
- 11.3.2. Where a patient is travelling from England to Scotland or Northern Ireland, the healthcare professional must still complete a second HOOF providing details of the secondary supply required and send it to the patient's "home" Supplier. They should not issue a prescription on FP10.
- 11.3.3. The Supplier will liaise with Scottish Healthcare Supplies (SHS) in Scotland or the Central Services Agency (CSA) in Northern Ireland to arrange supply. Contact details for the SHS and CSA can be found in Appendix 2. The SHS or CSA will confirm delivery details with the "home" Supplier and the patient concerned. Although orders will be made via a HOOF, patients need to be aware that, unless they are exempt, they will need to pay a prescription charge for cylinders obtained from pharmacies during their stay in Scotland or Northern Ireland.

- 11.3.4. It should be noted that in Scotland and Northern Ireland the supply of cylinders supporting flow rates other than standard 2l/min and 4l/min is not guaranteed. There is also no provision of liquid oxygen or conserving devices in Scotland and Northern Ireland.

11.4. Billing Arrangements

- 11.4.1. Within England and Wales, the cost of providing a Home Oxygen Service in a location other than the patient's home, will be borne by the PCT in which the patient's GP is located. Where a secondary supply is made the PCT will continue to be charged for the patient's primary supply as well, so the patient will appear on the monthly listing twice.
- 11.4.2. Where the SHS or CSA arranges for a secondary supply to be made to a resident of England the cost of the service will be borne by the Health Board (in Scotland) or Health and Social Care Board (in Northern Ireland) for the area where the patient is staying. PCTs will not be charged for this service.
- 11.4.3. Where a Supplier in England provides a secondary supply to a patient normally resident in Scotland or Northern Ireland, the cost of the service will be borne by the PCT for the area in which the patient is staying in England.

11.5. Travel Abroad

- 11.5.1. The NHS Home Oxygen Service does not include the supply of oxygen outside the UK. The oxygen equipment that is provided to a patient as part of this service belongs to the Supplier not the NHS, and cannot be taken out of the UK without the agreement of that Supplier.
- 11.5.2. Each Supplier may offer arrangements for providing oxygen supplies abroad, but any arrangement made between the patient and the Supplier for an oxygen service abroad (including on cruise ships) is a private arrangement made at a cost agreed between the patient and the Supplier. **Such arrangements are not funded by the NHS as part of the Home Oxygen Service.**

11.6. Overseas Visitors

- 11.6.1. As with UK patients wishing to travel abroad, advice to overseas visitors travelling to the UK should be that they make prior arrangements for the oxygen that they require before they travel to this country.
- 11.6.2. A GP can order oxygen for an overseas visitor if it is the clinician's view that this is necessary. A GP practice can also accept an overseas visitor onto its practice list as a "temporary resident". In these cases the GP will complete a HOOF to order oxygen for the patient in the normal way.
- 11.6.3. Where a GP practice does not accept someone as a "temporary resident", the practice can provide treatment on a private basis, for which the GP will charge. In this case, the GP should not use a HOOF to order a supply of oxygen but contact the local Supplier (or any other oxygen Supplier) to

arrange supply, issuing a private prescription. The patient will be charged directly for this service – it is not funded by the NHS.

- 11.6.4. A healthcare professional should not use a HOOF to order an oxygen service supporting the discharge of an overseas patient receiving treatment in an NHS hospital.
- 11.6.5. Detailed guidance on secondary supply, including travel abroad and overseas visitors, can be found at www.pcc.nhs.uk/217.php. Specific information for patients and healthcare professionals can be found at www.homeoxygen.nhs.uk.

12. Contract Management

- 12.1.1. Successful implementation of the Home Oxygen Service requires robust management structures and the establishment of balanced and effective management interfaces between the CCMU, NHS and the Supplier.

12.2. Commercial Directorate

- 12.2.1. The Commercial Directorate of the Department of Health was set up in 2003 to work closely with the NHS to act as a core interface for negotiations with the independent sector and to ensure commercial and procurement excellence across the DH and NHS.
- 12.2.2. The role of the Central Contract Management Unit (CCMU) is to manage the Suppliers of the Home Oxygen Service at a national level. They manage the Contract with the Suppliers and any associated changes that are required. The CCMU also manage the Supplier's service level agreements and agreed national Key Performance Indicators. The Central Clinical Procurement Program (CCPP) is responsible for the procurement of services on behalf of the Department of Health, including the tendering process for future Home Oxygen Service Contracts.

12.3. SHA Roles & Responsibilities

- 12.3.1. On 1st July 2006, the number of Strategic Health Authorities (SHAs) reduced from twenty-eight to ten, more focused, strategic organisations. As a result of the changing roles of SHAs they will no longer be in a position to take as active a role in the management of the Home Oxygen Service as they have to date.
- 12.3.2. In relation to the Home Oxygen Service Contract, the role of SHAs will be to ensure, through their performance management function, that all PCTs are effectively managing the contract at a local level. SHAs will also need to ensure that where a Lead PCT has been identified the Lead PCT is maintaining links with other PCTs, the relevant Supplier and the CCMU, as appropriate.

12.4. Role of a Lead PCT

- 12.4.1. During the period prior to the introduction of the Home Oxygen Service, throughout the post-Contract transitional period, and for the remainder of the first year of the service, SHA Home Oxygen Leads have undertaken a significant role. This has included overseeing the transition, performance managing the Contract, and facilitating and performance managing the activities of their PCTs in relation to the new service.
- 12.4.2. SHA Home Oxygen Leads have taken responsibility for leading the development of the Home Oxygen Service, and most communication with Suppliers has been via SHA leads, with support from the CCMU. With the change to the role of SHAs, one organisation within each Home Oxygen Service Contract region needs to be identified to act in a “Lead” capacity.
- 12.4.3. The identified Lead PCT, Shared Service Agency or Procurement Hub will need to:
- act as a single point of contact for the Supplier, Department of Health and CCMU;
 - liaise with Lead PCTs in the other Home Oxygen Service Contract regions, and in particular with other Lead PCTs who share the same Supplier;
 - act in an expert capacity to constituent PCTs, providing operational support and advice;
 - act as an interface between the NHS and the CCMU / DH representing the views of constituent PCTs;
 - ensure the effective working of the Service Review Group as the local focus for contract management in the relevant Contract region;
 - maintain close links with the CCMU in their performance management role to ensure compliance with the Contract; and
 - work closely with the CCPP / DH in the procurement of future Contracts for the provision of the Home Oxygen Service.
- 12.4.4. The main forum for dialogue with other PCTs and the Supplier will be via the quarterly Service Review meetings.

12.5. Potential Models

- 12.5.1. A number of potential models exist for both the “lead” arrangement and the management of the Home Oxygen Service by, or on behalf of, individual PCTs. Depending of the circumstances of a particular PCT, and other factors within their SHA, a particular model may be more appropriate in some areas than others.
- 12.5.2. It is unlikely that the final option, of doing nothing, is sustainable, as this model no longer reflects the role of SHAs or PCTs.

Table 4 – Options for Contract Management

Option	Strengths & Advantages	Weaknesses & Risks
Each PCT responsible for own Contract monitoring and performance management	<ul style="list-style-type: none"> • reflects new SHA and PCT roles and functions • supports active involvement of PCTs as commissioning bodies 	<ul style="list-style-type: none"> • increased time commitment and management costs by PCTs (compared to do nothing option) • if Supplier to meet with each PCT individually high burden on Supplier • if Supplier to meet with all PCTs collectively meeting could be unwieldy • lead arrangements will still need to be agreed by PCTs for input into national mechanisms
One or more lead PCT within each SHA area responsible for Contract monitoring and performance management on behalf of a number of PCTs	<ul style="list-style-type: none"> • reflects new SHA and PCT roles and functions • supports active involvement of PCTs as commissioning bodies • facilitates cost effective engagement of purchasing and clinical expertise • allows development of a greater level of knowledge and understanding of the Home Oxygen Service in single organisation • easier for Supplier to meet with one, or small number, of PCTs 	<ul style="list-style-type: none"> • increased time commitment and management costs by PCTs (compared to do nothing option) • need for mechanisms to allow lead PCT(s) to communicate with other PCTs as necessary • reduced engagement of PCTs in the operation of the Home Oxygen Service, for example Long Term Conditions
One or more Shared Services Agency responsible for Contract monitoring and performance management on behalf of a number of PCTs	<ul style="list-style-type: none"> • reflects new SHA and PCT roles and functions • facilitates cost effective engagement of purchasing and clinical expertise • allows development of a greater level of knowledge and understanding of the Home Oxygen Service in single organisation • easier for Supplier to meet with one, or small number, of PCTs 	<ul style="list-style-type: none"> • need for mechanisms to allow Shared Service Agency to communicate with PCTs as necessary • reduced engagement of PCTs in the operation of the Home Oxygen Service • potential for isolation from other relevant policy decisions, for example Long Term Conditions
SHA wide Collaborative Procurement Hub responsible for monitoring and performance management on behalf of all PCTs	<ul style="list-style-type: none"> • reflects new SHA and PCT roles and functions • facilitates cost effective engagement of purchasing and clinical expertise • experience of working with independent sector organisations 	<ul style="list-style-type: none"> • need for mechanisms to allow Procurement Hub to communicate with PCTs as necessary • reduced engagement of PCTs in the operation of the Home Oxygen Service, for example Long Term Conditions
Do Nothing (SHA leadership continues)	<ul style="list-style-type: none"> • minimum change 	<ul style="list-style-type: none"> • not consistent with the new roles and functions of SHAs and PCTs • potential for unstable performance management arrangements across a Home Oxygen region • increased risk of poor financial control • lack of learning from SUIs and other adverse incidents • lack of local leadership in relation to oxygen

12.6. PCT Responsibilities

12.6.1. Although the Contracts for the Home Oxygen Service have been nationally negotiated, all PCTs are responsible for the day-to-day management of this service at a local level, as part of their commissioning and contracting functions.

12.6.2. This involves:

- maintenance of information systems to monitor activity
- verification of activity and reconciliation of payments against the Home Oxygen Therapy reports from the PPD, and monthly patient lists provided by the Supplier;
- financial control, including mitigation of risk ;
- monitoring service quality at a local level and raising performance issues directly with the Supplier, Lead PCT and CCMU as necessary;
- supporting engagement between primary and secondary care teams involved in the management of clinical conditions requiring a Home Oxygen Service;
- commissioning assessment and follow-up services, as appropriate;
- participating in Service Review meetings including receipt of the annual Operational Plan;
- handling patient enquiries about the Home Oxygen Service;
- liaising with their Lead PCT, Shared Service Agency or Procurement Hub, as necessary; and
- participating in planning for service continuity over public holiday period; and involving the Supplier in contingency and emergency planning

12.7. Change Control and Contract Variation

12.7.1. The Contract contains a mechanism that allows the CCMU to vary the terms of the Service Specification, within limits, and therefore the Contract. This ensures that the contract remains flexible to the needs for the NHS for a Home Oxygen Service.

12.7.2. Where a PCT identifies an aspect of the Contract or Service Specification that it believes could be improved, this should be escalated to the CCMU via the designated Lead PCT for the SHA area. Such issues should be discussed and agreed with other PCTs in the area before such escalation takes place. **PCTs must not attempt to alter the Contract or Service Specification at a local level.**

12.8. Service Review Meetings

12.8.1. The Service Specification (paragraphs 4.2.3 and 4.11.1) requires the Supplier and NHS representatives within the oxygen service region concerned to conduct formal review meetings. The purpose of these

meetings is to allow each party to discuss their respective level of satisfaction in respect of the Contract and agree any necessary action to address areas of dissatisfaction.

12.8.2. The Supplier is required to make the arrangements for these review meetings, including ensuring that formal minutes of the meetings are taken. However, nothing discussed and agreed at review meetings can be taken as a variation to the terms of the Contract, and anything of significance which is raised should be escalated via the Lead PCT to the CCMU.

12.8.3. Chairmanship of the meeting may rest with the Lead PCT, or could rotate between Supplier and the Lead PCT. Suggested terms of reference for these meetings are included as Appendix 3.

12.8.4. Each review meeting should have as standing agenda items discussion of service information on:

- response times
- complaints
- key performance indicators

Ten working days notice should be given of any other items to be included on the agenda.

12.8.5. Where any separate working groups or sub-committees are set up as a result of the Service Review process it is important that mechanisms are established for feedback to the Service Review meetings. If this does not occur, there is a risk that issues will be dealt without outside the Service Review process without the full knowledge of the PCT as contract manager, and with no clear audit trail of decisions.

12.8.6. A copy of the minutes of Service Review meetings should be provided to the CCMU Contract Manager.

12.9. Annual Operational Plan

12.9.1. At the beginning of each Contract year, the Supplier must provide an operational plan to the NHS for the forthcoming year. This should set out the steps that the Supplier will be taking to ensure optimum provision of the Home Oxygen Service within that Contract region.

12.9.2. PCTs will wish to satisfy themselves that the operational plan is robust and makes the necessary links with NHS contingency and winter planning mechanisms. In addition to covering the day-to-day operation of the Supplier, subjects covered within the document should include:

- Winter planning;
- Service continuity over public holidays (Easter, May, August and Christmas / New Year periods);
- Contingency planning (major incidents, disaster recovery, security alerts, major equipment failure, utilities failure, severe weather etc).

The suggested elements of an Annual Operational Plan are included in Appendix 4.

- 12.9.3. It is important that close links are developed between PCT emergency planning co-ordinators, communication leads and Home Oxygen Suppliers.

12.10. Winter and Contingency Planning

- 12.10.1. As a service provided on behalf of the NHS, the Home Oxygen Service must demonstrate robust planning for both the winter period and the occurrence of a major incident.

Winter Planning

- 12.10.2. A cold winter combined with high levels of respiratory infection can have a major impact on cardiovascular and respiratory morbidity and mortality. Regular updates from the MET Office should be used by Suppliers to be prepared for any bouts of severe weather.

- 12.10.3. As part of the annual operational plan, Suppliers should specify how they intend to provide a consistent level of service over the winter period, recognising that traditionally this can be a time of increased service demand within the NHS. Effective winter planning should focus on the major areas of:

- Operational readiness
 - staffing capacity (management, engineers, call centre, planning and administration);
 - assets;
 - options for responding to increased demand of 10%, 20% etc;
 - responding to severe weather conditions (fog, snow, flood, etc);
- Out of hours arrangements;
- Preventative measures (i.e. staff vaccination);
- Communications;
 - Internal (including staff training);
 - External (patients, healthcare professionals, NHS, DH etc);
- Escalation procedures.

- 12.10.4. The winter planning element of the operational plan should specifically include service continuity over the Christmas and New Year holiday period, when patients may wish to be away from home, or to be more mobile than at other times of the year. It should be recognised that the impact of this holiday will vary from one year to the next depending where within the week, and in relation to weekends, the public holidays fall.

- 12.10.5. It is important that PCTs develop robust links with hospital discharge co-ordinators, respiratory teams, and other services used by patients receiving

a Home Oxygen Service, for example OOH providers, ambulance services etc, to ensure that communications relating to winter planning are cascaded effectively.

Major Incident and Contingency Planning

- 12.10.6. NHS organisations need to be able to respond in the event of a major incident, and to manage recovery, whether the incident has effects locally, regionally or nationally. PCTs should have in place arrangements for ensuring business continuity linked into their Major Incident Plan, which are tested to various degrees at regular intervals, including a table-top exercise each year
- 12.10.7. PCTs should take into account requirements for the maintenance of the Home Oxygen Service, and how this links into emergency preparedness, when arriving at their Major Incident Plan. When planning table-top emergency planning events PCTs should consider how the provision of the Home Oxygen Service is included in this process.
- 12.10.8. As part of the annual operational plan, Suppliers should specify how they intend to provide business continuity in the event of disruptive challenges, including major incidents, affecting their own facilities or external to them. Examples could include:
- incident affecting Supplier's plant, call centre or distribution network
 - fire, flood, severe weather
 - breakdown of utilities
 - major equipment failure
 - strike, demonstrations, bomb threat, violent crime
 - external incidents
 - flood, severe weather, breakdown of utilities affecting large numbers of patients
 - infectious disease epidemic
 - serious transport accident, explosion, chemical release or series of smaller incidents
 - closure or evacuation of a major facility i.e. hospital requiring large numbers of discharges rapidly
 - fuel strikes
- 12.10.9. Most major incidents are geographically local and are effectively dealt with by emergency services and local acute Trusts. However, they may result in a need for significant increase in community support to enable an acute Trust to discharge patients to enhance acute bed capacity. PCTs will need to ensure that mechanisms are in place to alert their Home Oxygen Supplier if a Major Incident has been declared, so that they are prepared in the event of increased discharge activity

12.11. Patient Experience

- 12.11.1. As well as having in place appropriate mechanisms for dealing with complaints, Suppliers are also required to support steps taken by the PCT to monitor patient satisfaction. This may take the form of independent patient surveys, consultation with patient groups or participation in local patient forums (see also paragraph 8.2).
- 12.11.2. During the life of the Contract, each geographical Home Oxygen Service region will be subject to a national audit of home oxygen installations and the Supplier's operational activities. These will be undertaken at 2-yearly intervals, led by the CCMU.

13. Information

13.1. National Key Performance Indicators

- 13.1.1. Suppliers of the NHS Home Oxygen Service are currently required to provide quantitative service information to the CCMU on a weekly basis, although the frequency of reporting is likely to decrease over time, subject to performance. These Key Performance Indicators (KPIs) are intended as an indication of the success of specific components of the service. KPIs can be used in conjunction with other, qualitative, information to give a rounded picture of the overall performance of the service.
- 13.1.2. Considerable work had been undertaken by the Suppliers and the Department of Health to ensure that all KPIs are consistently understood and reported. The same KPIs that are used by the CCMU form the basis for Suppliers reporting to PCTs each quarter (see section 13.2).
- 13.1.3. The method of reporting KPIs recognises that although the Service Specification includes specific requirements within which an order will be delivered (see paragraphs 10.4 to 10.6), these rigid timeframes may not suit individual patients. For example, the Supplier receives a HOOF for a standard 3-day order before 5.00 pm on Monday, which they are required by the Service Specification to deliver by the end of Thursday. On contacting the patient to arrange delivery, the patient informs them that no one will be available to take receipt of the supply until the following Monday.
- 13.1.4. By accommodating the patient's needs, the Supplier effectively breaches their Contractual requirements. Therefore, those KPIs that relate to response rates are reported both in terms of compliance with the Service Specification requirement and in terms of meeting the agreed visit date, to give a rounded picture of compliance.
- 13.1.5. With the exception of information on urgent call-outs by patients, the service management information requirements set out in paragraph 4.12.1 of the Service Specification have been set aside in favour of the KPI approach previously described.
- 13.1.6. A summary of each KPI can be found at Appendix 5.

13.2. Quarterly Reports

- 13.2.1. Suppliers are required by the Service Specification (section 4.11) to provide PCTs with reports on a quarterly basis. These should provide qualitative and quantitative management information about specifically, response times and complaints.
- 13.2.2. A standard quarterly reporting template has been developed and agreed with all four Suppliers. This comprises two elements, both to be completed at PCT level. The first is a proforma in which the Supplier is asked to provide explanations of any variance in performance, and details of Serious Untoward Incidents. The second is the national KPIs, provided at PCT level. The quarterly reporting template can be found as Appendix 6.

13.3. Reporting Timetable

- 13.3.1. To support Service Review meetings and the production of timely information an annual business timetable has been produced. In drawing up the reporting timetable, it is expected that service review meetings take place at three monthly intervals to allow the speedy resolution of any areas of dissatisfaction or concern.

Table 5 – Annual Reporting Timetable

Annual Operational Plan	April (by week 3)	setting out how the service will be delivered during the forthcoming year including specific proposals for all Public Holidays and the winter period to be sent to PCTs
Quarter 4 report	April (by week 3)	data for the period 1 st January – 31 st March to be sent to PCTs
Service Review Meeting	May	to discuss Quarter 4 data and agree Annual Operational Plan
Quarter 1 report	July (by week 3)	data for the period 1 st April – 30 th June to be sent to PCTs
Service Review Meeting	August	to discuss Quarter 1 data and revisit Winter Planning element of Operational Plan
Quarter 2 report	October (by week 3)	data for the period 1 st July – 30 th September to be sent to PCTs
Service Review Meeting	November	to discuss Quarter 2 data
Quarter 3 report	January (by week 3)	data for the period 1 st October – 31 st December to be sent to PCTs
Service Review Meeting	February	to discuss Quarter 3 data and revisit Easter element of Operational Plan

14. Payment

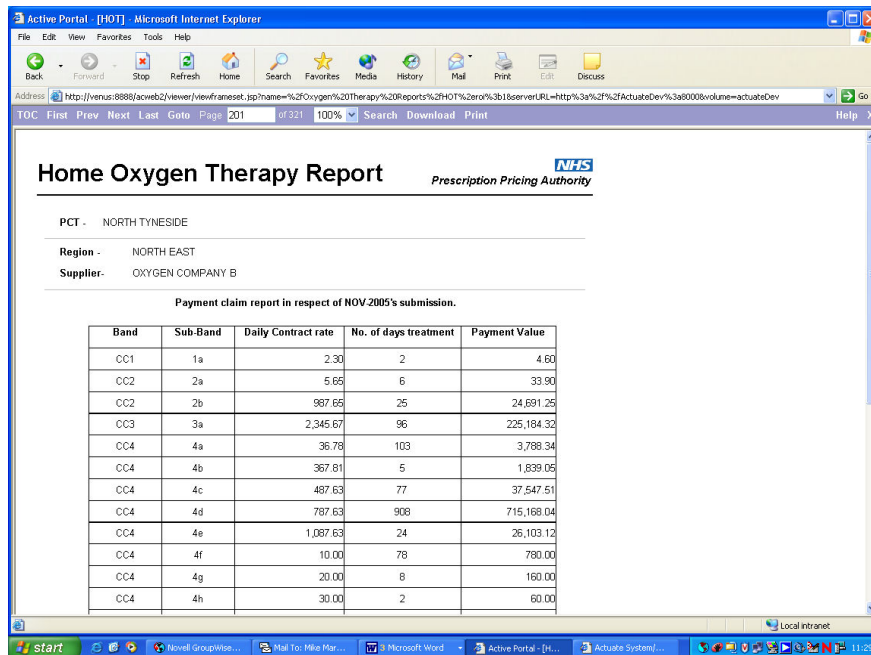
14.1. Payment Claims

- 14.1.1. Each month the Supplier submits a payment claim to the Prescription Pricing Division of the NHS Business Services Authority, using a pre-formatted management information template, which is accessed via the PPD Home Oxygen Service website. The Supplier can enter their payment claim between the 1st and 15th day of each month.
- 14.1.2. The Supplier's payment claim consists of the total number of days treatment provided during the preceding month for each service cost category (see Table 2). The Supplier must also acknowledge an on-screen declaration that they are accountable for the information provided and that details of the service provision at patient level will be provided to the PCT to enable validation of the claim.
- 14.1.3. The PPD aggregates the costs associated with the Home Oxygen Service for all PCTs within each Contract region. On the last working day of the month, payment, inclusive of VAT, is made to the Supplier on behalf of the PCTs. No patient specific information is provided by the Supplier as part of the payment claim, so the PPD is unable to validate payment claims, and the payment claim cannot be authorised prior to payment being made. Patient specific information to enable verification of payment claims is only sent to PCTs.

14.2. Home Oxygen Therapy Reports

- 14.2.1. Home Oxygen Therapy Reports for at least the last 13 months of oxygen usage are available, to registered users, on the PPD website at http://www.epact.ppa.nhs.uk/systems/sys_main_hot.htm. Each PCT should have at least one member of staff able to access this information and responsible for monitoring the payment made to their oxygen Supplier on a monthly basis via the PPD website. Information about how to register a new user can be obtained from the PPD Helpdesk on 0191 2035050.
- 14.2.2. Each month the current month's report is published four working days in advance of the payment date. Key dates can be found on the PPD website at http://www.epact.ppa.nhs.uk/systems/help_hot/hot_keydates.htm.
- 14.2.3. The Itemised Prescribing Payment Report (IPP) is updated to illustrate the recharge for the Home Oxygen Service made to the PCT. This is made inclusive of VAT.

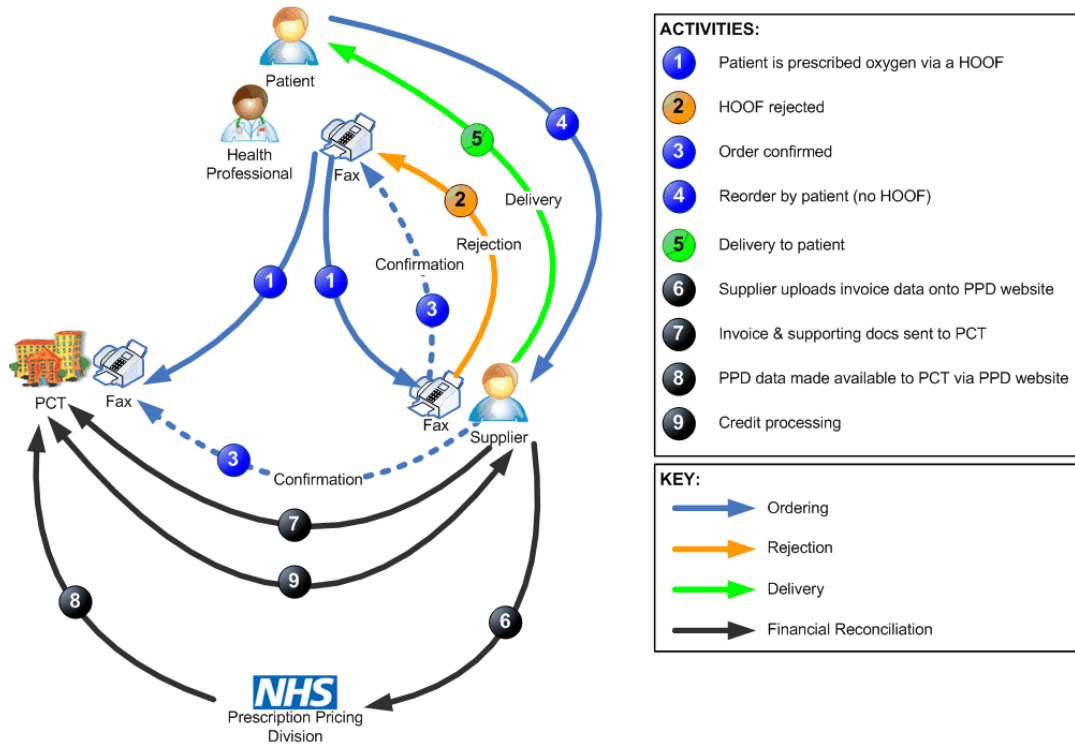
Figure 5 – Home Oxygen Therapy Report



14.3. HOOF Management

- 14.3.1. PCTs should ensure that they have in place an appropriate system to receive copies of HOOFs and record the details of patients for whom oxygen has been ordered. This will be necessary in order to reconcile the order with information received by the PCT from the Supplier as part of the contract management process. The process pathway involved in the supply of a Home Oxygen Service is shown in Figure 6 below.
- 14.3.2. Examples of systems that have already been effectively established by PCTs range from a relatively simple set of spreadsheets, to a bespoke-designed database. In some PCTs the management and reconciliation of the whole process is undertaken by a FHS support agency or specialist respiratory team, who also undertake the clinical assessment and follow up of oxygen patients.
- 14.3.3. PCTs may also wish to use the copy of the HOOF to assess the appropriateness of orders being placed, providing additional support to clinicians as necessary. Where a PCT has issued local guidance to clinicians, for example in relation to availability of lightweight ambulatory cylinders, or use of oxygen in a particular clinical condition, the HOOF will also provide information on compliance.
- 14.3.4. The Service Specification places a requirement on Suppliers to provide the ordering clinician and the PCT with written confirmation of the arrangements being made with the patient for the provision of oxygen, within 24 hours of receiving the HOOF. Suppliers are not required to acknowledge receipt of the HOOF.

Figure 6 – Steps in processing a HOOF



- 14.3.5. Matching the written confirmation received from the Supplier with copies of HOOFs received from clinicians placing orders will allow PCTs to identify those patients for whom they have not received a copy of the HOOF. A copy of the HOOF should then be requested from the clinician. Suppliers are not obliged to provide a copy of a HOOF to a PCT.
- 14.3.6. In order to be able to monitor activity within the Home Oxygen Service effectively, PCTs need to have in place a system capable of capturing a range of information (see Table 6).

Table 6 - Data to be captured from HOOF

Who oxygen was ordered for	Name, address & postcode Date of birth NHS number Patient's GP practice (& code)
Who placed the order	Clinician (GP or other healthcare professional)
When was the order placed	Date
What was ordered	LTOT, SBOT, Ambulatory, Lightweight ambulatory Urgent, next day or standard supply Primary or secondary supply Flow rate Hours per day
Status	New or existing patient
Estimate of cost	Based on service type, response rate, flow rate and hours of service assign a likely cost category

- 14.3.7. To be able to reconcile the total number of days charged by the Supplier for each cost category, the system used by the PCT needs to be capable of recording an expected cost category for each patient, so that these can be aggregated for each month. Calculation will be relatively simple for patients receiving a Home Oxygen Service throughout an entire month, but it will be necessary to calculate the number of day's treatment for patients who start and stop treatment in-month.

14.4. Reconciliation

- 14.4.1. As well as submitting an invoice to the PPD each month, the Supplier provides data to the PCT detailing which patients have received a Home Oxygen Service during the preceding month. This patient listing should include the following fields:

- Patient account number (i.e. unique identifier)
- Surname
- First name
- Street Address
- Town / City
- Postcode
- NHS Number
- GP Practice
- GP / Clinician Name
- PCT Name
- Cost Category
- Daily Charge
- Days Charged
- Total Charge
- Mode of Supply
- Quantity
- Secondary Supply (Y / N)
- New Patient (Y / N)
- Installation Date
- Removal Date

- 14.4.2. The PCT should verify the information provided in the patient listing against data already held in the PCT's system, and reconcile the total charges against the supplier's payment claim detailed in the Home Oxygen Therapy Report on the PPD website. It may not be possible for PCTs to reconcile exactly their estimated costs to the data on the PPD website without adjusting treatment periods for each patient to match the Supplier's patient listing. However it should be possible to reconcile the total cost shown on the PPD website with the aggregated costs of the Supplier's patient listing without adjustment.

- 14.4.3. identifies the data issues which the PCT will need to address during the reconciliation process. Discrepancies should be taken up with the Home Oxygen Service Supplier

Table 7 – Comparison of PCT and Supplier monthly data

Do all patients listed belong to the PCT?	Identify any who are residents of another PCT and notify Supplier
Do new patients and removals shown in patient list match HOOFs and notifications received by PCT?	Check with clinician where no HOOF has been received Check Exeter system for deaths
Do patients appear on the Supplier's data more than once?	Check whether a secondary supply HOOF has been received Identify discrepancies and query with Supplier as necessary
Do dates for installations / removals match PCT data?	For new patients amend PCT data to reflect actual "clock start" date for service charge Identify discrepancies and query with Supplier as necessary
Do the cost categories match those estimated by the PCT from the HOOF?	Identify discrepancies and query with Supplier as necessary
Do total days treatment for each cost category reconcile to payment claim shown in Monthly Home Oxygen Therapy Report on PPD website?	Check that previously agreed adjustments have been actioned by the PPD Identify discrepancies and query with Supplier as necessary

14.4.4. Reasons for discrepancies might include:

- a second HOOF changing the patient's needs (i.e. flow rate, hours per day etc) resulting in a change of cost category has not been actioned;
- a copy of the HOOF has not been faxed to the PCT;
- a HOOF is rejected by the Supplier for correction, but processed by the PCT;
- the PCT has no confirmation of installation from the Supplier;
- a patient has been wrongly allocated to the PCT; or
- a patient appears under several different cost categories for no apparent reason.

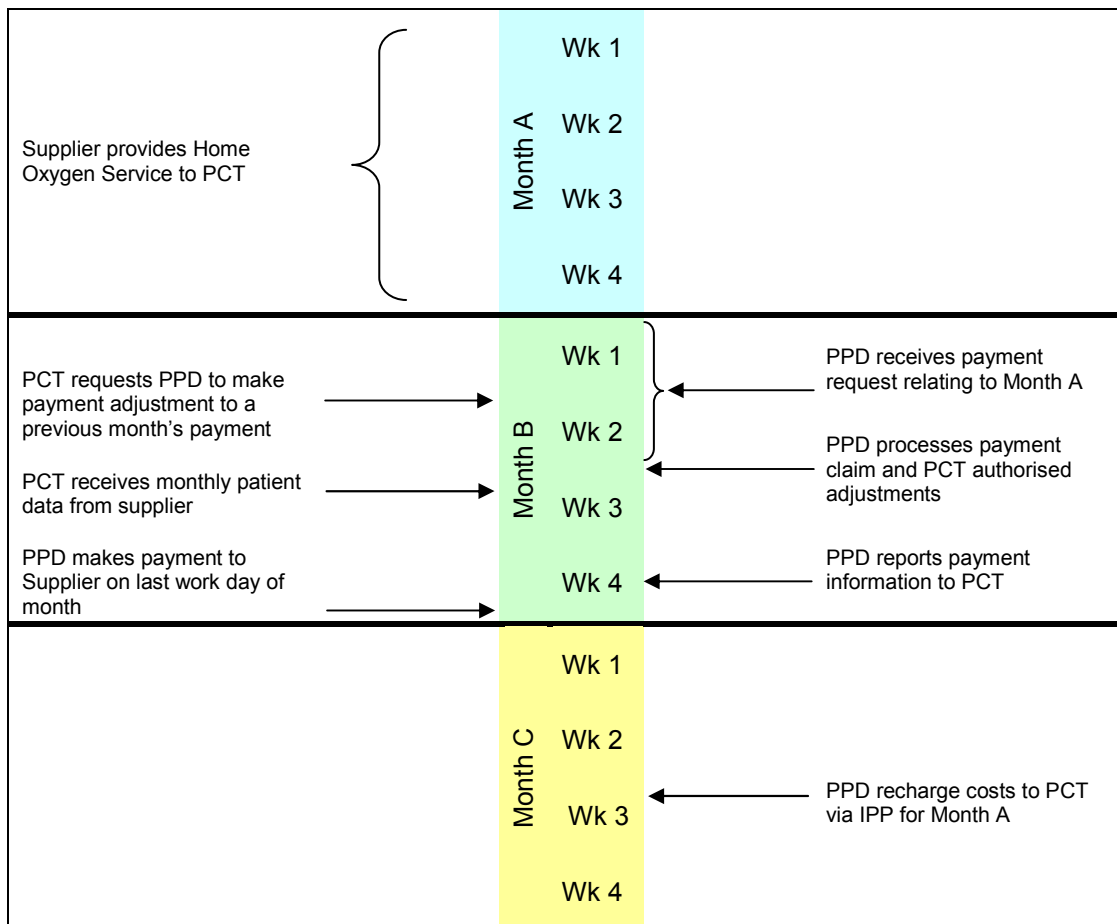
14.4.5. Once a PCT monitoring system has been set up and populated, the number of new patients and patients from whom a service is withdrawn will be relatively small, reducing the ongoing monthly workload.

14.5. Payment Adjustments

14.5.1. Where the verification process identifies discrepancies between the Supplier's payment claim, the patient listing supplied by the Supplier, and data from HOOFs held by the PCT, these should be discussed with the Supplier. Steps in that process will vary between Suppliers but are likely to include the following:

- PCT identifies discrepancies during verification process;
 - PCT informs Supplier of query and any supporting evidence provided;
 - Supplier acknowledges query (which may include issue of a unique identifier for that query)
 - Supplier investigates query
 - Supplier identifies credit due to PCT
- 14.5.2. Agreed adjustments to payment (exclusive of VAT) should be made using the Adjustment Form which can be downloaded from the PPD website at www.epact.ppa.nhs.uk/systems/help_hot/hot_adjform.htm.
- 14.5.3. The Adjustment Form must be authorised by one of the PCT's agreed authorised signatories, and then sent to the Contractor Payment Section of the PPD (Tel: 0191 203 5256, Fax: 0191 203 5252, E-mail Contractor.payments@ppa.nhs.uk). It is important that the Adjustment Form is signed by an authorised signatory, or the PPD will not action the adjustment.
- 14.5.4. Adjustments made will be reflected in the Home Oxygen Therapy Report relating to the month in which they are applied.

Figure 7 – Payment Timeline



14.6. PCT Allocations

- 14.6.1. Prior to the introduction of the Home Oxygen Service both discretionary and non-discretionary funds supported the provision of oxygen. The cost of cylinder oxygen, masks and tubing prescribed by GPs was charged to GP prescribing budgets (discretionary funding) by the PPD in the same way as prescriptions for other drugs and appliances.
- 14.6.2. The Pharmaceutical Services budget (non-discretionary funding) met the cost of the oxygen concentrator services provided by contracted specialist companies. This budget also supported the payment of delivery fees and rental payments for cylinder headsets to community pharmacies, via indicative budgets for oxygen services given to PCTs.
- 14.6.3. The introduction of the NHS Home Oxygen Service provided an opportunity to change the funding arrangements, bringing the whole cost of the service within discretionary funding. Ministers decided that the element relating to pharmacy fees would not transfer, as this was considered part of the national “global sum” for community pharmacy remuneration.
- 14.6.4. Following discussion with the Financial Issues Group[†] (FIG), 2006/07 allocations to PCTs were based on 50% weighted capitation and 50% historic spend. This recognised that the differing prices offered by the four Suppliers potentially had additional cost implications for PCTs in some oxygen contract regions.
- 14.6.5. In 2006/07, £28.7m was allocated to PCTs[‡] as partial funding of the Home Oxygen Service. This allocation was in addition to at least £20m already within PCT baselines due to the previous costs of cylinder oxygen (as part of the prescribing budgets). A further partial allocation[§] has been made in 2007/08, thereafter all funding for the Home Oxygen Service will be built into PCTs unified allocations.

15. Communications

15.1. Media Queries

- 15.1.1. Fundamental change in any NHS service presents challenges and opportunities in communications terms, particularly where change is significant and wide-ranging. The first full year of operation of the NHS Home Oxygen Service (from 1st February 2006) entailed some significant communications challenges; not only communicating benefits, but also communicating changes – from the reorganisation of PCTs to the provider change in South West England. Media attention at local, regional and national level was heightened; this attention was predominately negative.

[†] (comprising Directors of Finance from a cross section of NHS organisations)

[‡] AWP(06-07)PCT07 2006-07 Home Oxygen Service Allocations

[§] AWP(07-08)PCT06 2007-08 Home Oxygen Service Allocations

- 15.1.2. At a PCT level, the service and its managers will continue to evolve and adapt; however those involved in provision and management have reached some level of stability and PCTs should now have the confidence to manage communications and media issues pertaining to the Home Oxygen Service as part of their local procedures.
- 15.1.3. A national HOS Communications Lead will continue, throughout any governance changes, to coordinate communications between the NHS (at local and regional levels), the Department of Health and stakeholders. Although PCTs will be expected to manage comms and media issues at local level, it is helpful for the national lead to remain informed of these issues. Similarly, good practice examples should also be discussed with the national lead.

15.2. Freedom of Information Requests

- 15.2.1. As has been previously described (paragraph 5.9) the Contract contains commercially sensitive information and PCTs are bound by the conditions of confidentiality set out in the NHS Conditions of Contract.
- 15.2.2. The introduction of the Home Oxygen Service has been accompanied by a high degree of public interest. It is important to ensure that a consistent approach is taken to any request that could be considered commercially sensitive, and to the implications for any continuing legal obligation of confidentiality imposed on the NHS.
- 15.2.3. Before responding to any request made under the Freedom of Information Act (FOI) or the Environmental Information Regulations 2004 (EIR) for the release of any information under the Contract, the PCT should consult Home Oxygen Service Contract Manager at the CCMU as to the appropriate response to the request.

16. Expiry and Termination of the Contract

- 16.1.1. With the exception of the current Contract in the South West oxygen region, each Contract for the Home Oxygen Service is intended to provide for the supply of services for a period of five years. The Contract sets out what is to happen on expiry of the Contract term and identifies the arrangements on termination. There are several circumstances where the Contract may be terminated prior to the five-year term. These are set out in paragraph 61 of the NHS Conditions of Contract.

16.2. Early Termination

- 16.2.1. The Contract is expected to operate for its full Contractual term, but there are circumstances that may lead to an early termination. These include
- Supplier failure to perform its obligations under the Contract
 - Supplier failure to satisfactorily remedy failures
 - repeated failures by a Supplier to comply with obligations to CCMU

- Supplier insolvency
- Supplier default of any duty of care, or fiduciary or statutory duty

16.2.2. In the event of early termination the obligations on the Supplier are set out in the Contract.

16.3. Option to Extend

16.3.1. The CCMU has the option to request an extension of the Contract for a period of up to two years beyond the predicted expiry date. The CCMU must issue a Contract variation to this effect at least one calendar month before the Contract would otherwise have expired.

16.4. Expiry

16.4.1. Where a decision has not been made to extend, then the Contract will expire on the expiry date set out in the Contract. Suppliers then have to comply with the obligations set out in the Contract, relating to the transfer of data, documents and records and full cooperation by the Supplier during any handover process.

17. Appendices

Appendix 1 – Supplier Contact Details

AIR PRODUCTS

FREEPHONE: 0800 373 580

Website: <http://www.airproducts.com/medical/uk/homecare/homecare2.html>.

Region	SHA
North West	North West
Yorkshire & Humberside	Yorkshire & The Humber
East Midlands	East Midlands
West Midlands	West Midlands
London North	London (northern part only)
Wales	NHS Wales

ALLIED RESPIRATORY

FREEPHONE: 0500 823773

Website: <http://www.alliedrespiratory.com>

Region	SHA
SW London, Thames Valley, Hants & Isle of Wight	South Central
SE London, Kent, Surrey & Sussex	South East Coast London (southern part only)

BOC MEDICAL

FREEPHONE: 0800 136603

Website: <http://www.vitalair.co.uk>

Region	SHA
Eastern England	East of England
South West	South West**

LINDE GAS

FREEPHONE: 0808 2020999

Region	SHA
North East	North East

** service to be re-tendered from April 2008

Appendix 2 – Sources of Information

Home Oxygen Service	Website for patients, carers and public www.homeoxygen.nhs.uk
	Website for healthcare professionals www.homeoxygen.nhs.uk
	Website for NHS managers www.homeoxygen.nhs.uk
Air Products	www.airproducts.com/medical/uk/homecare/homecare2.html
Allied Respiratory	www.alliedrespiratory.com
BOC Vitalair	www.vitalair.co.uk
Breath Easy Support Groups	www.lunguk.org/support-groups.asp
British Lung Foundation	www.lunguk.org Helpline 08458 505020 (10am – 6pm Mon – Fri) (for patients and carers only)
British Paediatric Respiratory Society	www.bprs.co.uk
British Thoracic Society	www.brit-thoracic.org.uk
Central Services Agency (Northern Ireland)	www.centralservicesagency.com Fax 028 9053 2963
Cystic Fibrosis Trust	www.cftrust.org.uk
Linde	www.linde-gastherapeutics.com
MHRA	www.mhra.gov.uk
Prescription Pricing Division	www.epact.ppa.nhs.uk/systems/sys_main_hot.htm
Scottish Health Supplies	www.show.scot.nhs.uk/shs Fax 0131 314 0724

Appendix 3 - Service Review Group

Suggested Terms of Reference

Membership:

Membership of the Service Review Group will be:

- a commissioner or Home Oxygen Service lead from each PCT;
- the Home Oxygen Service lead from [insert] SHA;
- [Supplier] representatives.

Aims:

The aim of the Service Review Group is:

- to support the contracting role of PCTs in performance management of the Home Oxygen Service Contract;
- to receive and consider the quarterly reports specified in the Home Oxygen Service Specification;
- to allow all parties to discuss their respective levels of satisfaction in respect of the Home Oxygen Service Contract and agree any action necessary to address areas of dissatisfaction;
- to discuss any issues of performance relating to the Home Oxygen Service Contract; and
- to agree the Annual Operational Plan.

Frequency:

Service Review meetings will occur at no less than 6 monthly intervals, and normally at quarterly intervals to coincide with the production of Quarterly Reports by [Supplier].

Agenda Items:

Each Service Review meeting will have as a standing item, service information for the relevant quarter. The format and content of this information will be as defined in the Quarterly Monitoring Template.

Other issues for inclusion on the agenda should be notified in writing by any of the participants, at least ten working days in advance of the Service Review meeting.

Arrangement of Meetings:

Meetings will be held within the [home oxygen Contract region].

[Supplier] shall make arrangements for the Service Review meetings, including those for ensuring that there are formal minutes of the meeting. Such minutes will be issued to all participants for agreement and counter signature.

The signed minutes will not constitute any variation to the terms of the Contract.

Quorum:

For the meeting to be in quorum the following should be present:

- representatives of at least one third of PCTs [insert number]
- representatives of [Supplier]

Appendix 4 - Annual Operational Plan

Elements that a PCT should expect to see within their Supplier's Annual Operational Plan include, but are not limited to the following:

- Executive summary;
- Summary of strategic plan (including mission, strategic goals, market analysis etc.);
- Operational objectives (both for the duration of the programme and specifically for the next year);
- Operational performance targets;
- Organisation chart and governance structure (including escalation process and planned stakeholder meetings);
- Demand forecast;
- Operational structure (e.g. supply chain layout, IT infrastructure etc.);
- Key programmes, projects and major activities planned;
- Capacity plans, relating demand to:
 - Human Resources;
 - Assets and planned purchases;
 - Arrangements in place to “flex” demand;
- Key event arrangements (outlining key dates in the year and the specific plans associated with them e.g. Christmas, Easter etc.);
- Complaints procedures;
- Communications plan;
- Business continuity plans;
- Details of quality assurance programmes and current quality management provisions;
- Risk analysis and risk management approach; and
- Budget and investment plan.

Appendix 5 - Key Performance Indicators

KPI	Counted	Excluded	Clock Starts	Clock Stops	SLA Requirement
Urgent Orders, on-time (%)	CC1	Orders cancelled by a patient, patient's representative or healthcare professional Call outs to respond to a patient concern	From receipt of instruction (written or verbal)	On entry to the delivery address	4 hours
Urgent Call Out, on-time (%)	Agreed visit following a call out by a patient	Call out cancelled by the patient, patient's representative or healthcare professional Urgent orders placed by a healthcare professional	From Supplier agreement to reasonable request		4 hours
Discharges, on-time (%)	All hospital discharges requiring next day delivery	Discharges cancelled by a healthcare professional Hospital discharges that don't require a next day delivery	From receipt of an actionable instruction		Next <u>calendar</u> day
Standard Orders, on-time (%)	CC2A, CC2B, CC3, CC4, CC5, CC6, CC7	Orders cancelled by a patient, patient's representative or healthcare professional Refills, regular scheduled deliveries, "milk-round" deliveries			Three <u>working</u> days
Refills, on-time (%)	Patient-driven orders	HOOB-based orders Regular scheduled deliveries, "milk round" deliveries			
Milk round deliveries, on-time (%)	Supplier-driven refills	HOOB-based orders Refills			
Removals, on-time (%)	Request for removal of equipment				
Servicing, on-time (%)	Inspection, testing or maintenance of equipment	Where the patient has rescheduled or cancelled	Installation of equipment		Concentrator serviced

KPI	Counted	Excluded	Clock Starts	Clock Stops	SLA Requirement
Prompt Call Answering (%)	Calls to Supplier's freephone number answered within 60 seconds	None	First ring on Supplier's telephone system	When patient is answered by a human voice	
Free Phone Uptime (5%)	Availability of freephone telephone line	None	n/a	n/a	
Abandoned Calls (%)	Calls to the freephone number that are not answered	None	n/a	n/a	
Electricity Payments, on-time (%)	Reimbursement of electricity costs paid within 30 days of the quarterly payment period	None	n/a	n/a	
Complaints Level	Complaints per thousand patients	None	n/a	n/a	
Complaints Resolution	Cumulative total of open complaints older than 25 days	None	n/a	n/a	

Reason Codes for failed jobs

Non-Supplier Failure (NSF)

- A incomplete HOOF
- B patient (or carer, family or neighbour) unavailable
- C safety issue
- D patient refused

Supplier Failure (SF)

- A out of time
- B product availability
- C product shortage (on vehicle)
- D vehicle issue
- E planned in error

Category for failed jobs

- SBOT
- LTOT
- Standard ambulatory (SA)
- Lightweight ambulatory (LA)

Complaints Categories

Customer Service

- Electricity reimbursement
- Customer service centre – lack of knowledge
- Customer service centre – attitude

Operations

- Engineer service – lack of knowledge
- Engineer service – attitude
- Late delivery
- Failed delivery
- Shortage / partial delivery
- Out of stock (supplier)
- Damaged property

Equipment Fault / Quality

- Concentrator
- Cylinder
- Liquid oxygen
- Conserver
- Consumables

Appendix 6 - Quarterly Report Template

Integrated Home Oxygen Service Quarterly Reporting

HOS Region:		
PCT Lead:		
SHA or Lead PCT: (to receive copy)		
Supplier:		
Period:		
Completed by:	Name:	
	Job Title:	
	Date:	
Response Times (4.11.1.2)		
Provide an explanation where responses were made outside the specified times and actions taken to improve performance.		
Complaints (4.11.2.2)		
Provide a summary of the nature of the complaints received, together with details of response times and action taken to resolve complaints to the satisfaction of the complainant. Indicate what the trend is relating to complaints by category.		
Provide details of any complaints that have not been resolved to the satisfaction of the complainant.		
Detail any changes to systems and processes / lessons learnt as a result of complaints received this quarter. Give examples.		

Serious Untoward Incidents
Provide (anonymised) details of any SUIs that have occurred during this quarter.
Detail any changes to systems and processes / lessons learnt as a result
Installations (4.12.1)
Provide any comments on service provision
Provide details of urgent call outs, including number of calls to patients, reason for the call-out and action taken
Patient / Public Involvement (4.11.3)
Please describe what activities have been undertaken to monitor patient satisfaction and seek information from those using the home oxygen service on how this might be improved further.

17.1.

Appendix 7 - Glossary of Terms

Ambulatory Oxygen Therapy

Ambulatory Oxygen Therapy refers to the provision of oxygen therapy during exercise and activities of daily living

BSA

Business Services Authority

BTS

British Thoracic Society

CCMU

Central Contract Management Unit of the Commercial Directorate of the Department of Health

CCPP

Central Clinical Procurement Program run by the Commercial Directorate of the Department of Health

COPD

Chronic Obstructive Pulmonary Disease

CSA

Central Services Agency in Northern Ireland
Fax 028 9053 2963

DH

Department of Health

Dyspnoea

Difficult or labourer breathing; shortness of breath; breathlessness

HOCF

Home Oxygen Consent Form

HOOF

Home Oxygen Order Form

HOS

NHS Home Oxygen Service

Hypercapnia

Hypercapnia is an excess of carbon dioxide in the blood, and can result in respiratory depression due its effect on the respiratory centre of the brain

Hypoxaemia

Hypoxaemia is a low partial pressure of oxygen in the blood.

Hypoxia

Deficiency of oxygen at the tissue level

KPI

Key Performance Indicators

LTOT

Long Term Oxygen Therapy refers to the provision of oxygen therapy at home for patients with chronic hypoxaemia (PaO₂ at or below 7.3 kPa (55 mmHg)) usually given for at least 15 hours daily

NICE

National Institute for Healthcare and Clinical Excellence

Oximetry

Pulse oximetry is a simple non-invasive method of monitoring the percentage of haemoglobin (Hb) which is saturated with oxygen. The pulse oximeter consists of a probe attached to the patient's finger or ear lobe that is linked to a computerised unit.

PaO₂

Arterial partial pressure of oxygen

PCT

Primary Care Trust

Per Diem

Latin for "per day." Refers to a payment for services which is made by the day

PPD

Prescription Pricing Division formerly the Prescription Pricing Authority (PPA)

RCP

Royal Collage of Physicians

SaO₂

Arterial haemoglobin oxygen saturation

SBOT

Short Burst Oxygen Therapy refers to the intermittent use of supplemental oxygen at home , usually for periods of about 10 to 20 minutes at a time to relieve dyspnoea

SHA

Strategic Health Authority

SHS

Scottish Health Supplies (Fax 0131 314 0724)

Spirometry

Spirometry is the measurement of timed expired and inspired volumes that indicate how quickly and effectively the lungs can be filled and emptied. Such assessment of lung function is vital for assessing the severity and reversibility of COPD

Working Day

For the purposes of the Home Oxygen Service the working day is between the hours of 08:30 and 17:00, within the working week

Working Week

For the purposes of the Home Oxygen Service the working week is Monday to Friday between the hours of 08:30 and 17:00, excluding public holidays

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