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Draft Commissioning Framework for Home Oxygen Clinical Assessment and Follow Up Services

The aim of this paper is to set out guidance for commissioners to support the establishment of clinical assessment and follow up services for Home Oxygen services within each PCT.

It is designed to provide information and support for clinicians and commissioners to ensure effective commissioning of clinical assessment and follow up services to achieve the best possible health outcomes and best value for money. Ultimately, the aim of these services is to improve patient care and the quality and cost effectiveness of the new contracted Home Oxygen service.

Key Messages

PSA targets
(suggested text to follow)

1. Background

The change to the service has been sought by both patients and health care professionals and aims to improve support for patients with long term conditions; to support hospital discharge and reduce inappropriate hospital admission (COPD patients account for 10% of emergency admissions each year); to support other service provision. Previously GPs issued an FP10 and Community Pharmacists provided cylinder oxygen directly to the patient, with specialist companies delivering an oxygen concentrator service. The new integrated service, when fully operational, will no longer involve Community Pharmacists. Four suppliers have been awarded contracts to deliver all home oxygen requirements in each of the 10 service regions in England (and one covering the whole of Wales).

The service specification for the new Home Oxygen Therapy Service (HOTS) is linked to the availability of clinical assessment services to support delivery and cost effectiveness. It takes into account the importance of assessment and patient follow up services highlighted in the Royal College of Physicians report, issued in 1999, in NICE COPD guidelines issued in February 2004 and in updated clinical best practice guidance published by the British Thoracic Society in December 2004. This paper is intended to provide guidance and a framework for the commissioning of clinically and cost effective oxygen therapy assessment and follow up services.

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2. Vision of the service

The vision for the service is that all patients whose clinical condition needs a home oxygen therapy services for their clinical condition receive the right treatment at the right time in a timely and cost effective way. Assessment of their need to receive oxygen therapy should be made by a health care professional with appropriate expertise so that their health and quality of life is maximised, any risk is minimised, and the right oxygen levels including flow rates and duration, and equipment is provided to meet their clinical needs. The initial clinical assessment should be followed up by further visits and regular reviews.

3. Current position

Patients currently receive an oxygen therapy service as specified in a Home Oxygen Order Form (HOOF) completed by the relevant health professional and sent directly to the regional supplier. Supply of the order is normally made within 3 working days, unless urgent supply is required which must be delivered within 4 hours. Currently, many patients have not been assessed for oxygen therapy by specialist staff nor reviewed at appropriate intervals. As a consequence, many patients may not be receiving the most appropriate oxygen service, modality or flow rate. In addition, some patients will continue to receive a home oxygen service where there is little clinical evidence that the patient continues to benefit from this service, for instance where cylinder oxygen may have been prescribed on a "just in case" basis.

NICE guidelines on COPD refer to the British Thoracic Society recommendation that patients, when first prescribed oxygen therapy at home, should be followed up by an appropriate specialist after three months and then yearly. Updated guidance on assessment and patient follow up services was issued by the British Thoracic Society in January 2006 and is available on the BTS website (www.brit-thoracic.org.uk).

Commissioners need therefore to ensure that the best quality and cost effective clinical assessment and follow up services are delivered at a local level. In addition, all current patients in receipt of home oxygen should be reviewed on a timely basis.

Appendix 1 illustrates an example of an assessment model currently in place in Wales (Blaenau Gwent). Attached as *Appendix 2a* is a brief summary of the variance of models currently being undertaken. It is understood that different models will be adopted to suit the host of the assessment services (ie within a recognised primary or secondary setting). *Appendix 2b* is a draft Oxygen Service Flowchart from Liverpool PCT (?name)

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4. Benefits of commissioning clinical assessment and follow up services

By commissioning clinical assessment and follow up services the PCT will be contributing to a reduction in -

- inappropriate or over-prescribing of oxygen therapy
- inappropriate admissions (and emergency admissions);
- bed days;
- ambulance call-outs;
- readmission rates;
- GP visits;
- clinical risk;

and related costs.

The newly commissioned assessment and follow up services will play their part in ensuring an increase in -

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

and the related cost savings.

5. Improvement and Impact On Other Services:

An extract from the Doncaster PCT (*Appendix 3*) proposal highlights the links (and links directly to the DH website reference) –

Integration of the new Home Oxygen Service can serve to support existing frameworks for self care and chronic disease management will help towards the goals of the NHS Improvement Plan i.e.

- the vision for a patient centred care system ([Link 3](#)) and the National Service Framework For Long Term Conditions ([Link 4](#)).
- Development of care pathways for oxygen will help organisations to implement the NICE guidelines for chronic obstructive pulmonary disease that are a Healthcare Commission Developmental Standard ([Link 5](#)). Note that c80% of patients requiring oxygen are COPD patients. This can also link in to the ongoing work on a COPD NSF.
- The pre-assessment step of the capacity model will ensure that there is a holistic review of the patients' condition and appropriate referral for co-morbidity e.g. coronary heart disease. This will contribute to sustaining delivery of the Public Services Agreement target to reduce substantially the mortality rates from the major killer diseases by 2010 ([Link 6](#)).
- The capacity in Oxygen Assessment Centres will be the rate limiting step for patients. Good capacity and service planning will ensure that the new oxygen service does not pose a risk to progress towards the Public Services Agreement target to reduce the maximum wait for an outpatient appointment to 3 months by the end of 2005 ([Link 6](#)).

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- Long-term oxygen therapy has been shown to reduce admission rates, hospital days and “ever hospitalised” rates especially in those who started LTOT as outpatients . Among a wide range of potential risk factors, researchers have found that only previous admissions, lower forced expiratory volume and under prescription of LTOT were independently associated with a higher risk of admission for a COPD exacerbation .

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

6. Cost benefits

Patient backlog

Patients currently in receipt of oxygen from an “old” prescription need to be reviewed and assessed, especially as it is probable that these patients have never been assessed. They may no longer actually need oxygen, or now require different flow rates/duration. Assessment services should review the patients who have been identified as part of the transition to the new supplier and are held on PCT databases.

In one example PCT there are 900 patients in this backlog category needing assessment. Assessment services will be able to identify patients in receipt of unnecessary or inappropriate prescription for oxygen and the related cost savings, within a short time period.

Invest to Save

The resources and funds required upfront to set up new, and further develop current assessment services compared to the continued high cost of current over and mis-prescribing is not seen as a risk but one that will save money for PCTs in the future of oxygen provision.

Practice Based Commissioning

Practice Based Commissioning is about engaging practices and other primary care professionals in the commissioning of services. Front line clinicians are provided with the resources and support to become more involved in commissioning decisions and have greater freedom to tailor services to the needs of the local community. One aspect is to move services out of hospitals and make them more accessible in the community.

Groups will work with PCTs to put together business cases for local services. One of these could be for oxygen assessments. This could mean one practice providing the services for all patients within the group or for specialists to come into the community to provide the service, rather than patients attending the hospital.

Benefits realisation

Commissioning clinical assessment services will ensure that COPD is managed in the most cost effective manner using the tools available to deliver the service and results required. For example, the use of pulmonary rehabilitation may offer a patient a superior alternative.

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Payment By Results

(Suggested text to come)

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/NHSFinancialReformsArticle/fs/en?CONTENT_ID=4127039&chk=bypVXH

Appendix 4

Please see the attached, Cost Benefits Analysis *Appendix 5* (*– currently being undertaken by NERA Economic Consulting*)

An example of a successful business case which has achieved inclusion in the LDP from East Kent PCT is attached as *Appendix 6*.

7. Challenges/Issues

There are historical concerns and also issues around financial constraints and those relating to personnel. Outlined below are common concerns raised when discussing the development of clinical assessment and follow up services.

- 7.1 A lack of, or perceived lack of specialist staff
- 7.2 A lack of resources
- 7.3 Availability of space required to carry out assessments (for instance walking tests for ambulatory oxygen)
- 7.4 Differing models and varying awareness of the clinical assessment and review services currently provided in different parts of the country

There is a need to be cognisant of the fact that some patients may be referred to a clinical assessment in a primary setting and therefore their 18-week pathway will not be measured but others may be referred in and the clock will start ticking at the point of referral and care should be taken not to create a two tier system.

8. Suggested responses

There is a perceived lack of suitably trained healthcare professionals to undertake the assessments and run service in some places. However, a range of clinical staff in primary and secondary care would be able to undertake all assessment procedures, with suitable training and practice which would need to be evidenced and reviewed. This allows a wide range of professionals to be involved (for example Community Matrons; District Nurses; GPs with Special Interest; Healthcare Support Assistants) and would not necessarily require recruitment and new employment costs.

Assessment service providers are encouraged to be creative in their use of resources and to look at how to best use the personnel available.

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For example in East Kent PCT, the Specialist Respiratory team is proposing that GP practices purchase pulseoximeters to carry out pre-assessments/screening themselves. They are also training their Healthcare Assistants to be able to undertake elements of the assessment tests which will free up more trained and experienced professionals to concentrate on more complex patients maximizing the number of patients who can be seen at each clinic session. The Healthcare Assistant can, for example, take the blood reading and the more experienced professional interprets the results.

Similarly, a creative approach will be required as to where to undertake the assessments. Assessments can be carried out in general practice, the patient's home (if appropriate), hospitals or clinics. It may be effective to share the commitment and offer assessments at more than one location for the community across several PCTs.

9. Education

An education programme is required to ensure that a more consistent approach is adopted. Elements include the need to -

- Educate patients about what to do if they think they need oxygen. Where will they go to get the appropriate referral to the "new" clinical assessment service? How will they access the services?
- Educate health professionals about alternative, less expensive treatment options such as pulmonary rehabilitation, use of fans, medicine reviews and the correct use of inhalers. For many patients these will be a better course of action than the supply of oxygen.
- Educate primary and secondary clinicians on how to refer to, access and provide the clinical assessment services to ensure that all patients are receiving recommended assessment and follow up in the same kind of setting (may have local modifications) by a qualified and suitably trained healthcare professional.

10. Recommendations and next steps

It is recommended that clinical assessment services and follow-up plans for patients receiving oxygen therapy in the home are included in commissioning plans and Local Delivery Plans (LDPs) this autumn to ensure they can be up and running in early 2007.

Missing this deadline will almost certainly further interrupt the improvements in the service and delay the potential benefits of assessment and follow-up for patients and the NHS. The overall cost to the NHS of oxygen services will be greater where assessment and follow up services are not in place.

It is recommended that assessment teams and PCT HOS leads continue to educate GPs and other clinicians to ensure that they are all consistent and thorough in their approach and that oxygen referrals and the content of HOOFs are appropriate and accurate.

It is recommended that "champions" are identified to spread the word and raise awareness.

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It is recommended that relationships are built and cultivated across primary and secondary care, for instance by holding a Respiratory Forum.

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