

SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	02_GMS_53
Service	Chronic Obstructive Pulmonary Disease (COPD) Care Bundle
Commissioner Lead	General Medical and Surgical CCP
Provider Lead	
Period	1 ST April 2014 to 31 st March 2017
Date of Review	1 st October 2016

1. Population Needs

National/local context and evidence base

Chronic Obstructive Pulmonary Disease (COPD) is characterised by airflow obstruction that is not fully reversible. The airflow obstruction does not change markedly over several months and is usually progressive in the long term. Main risk factors for COPD are tobacco smoking, indoor air pollution (such as biomass fuel used for cooking and heating), outdoor air pollution, occupational dusts and chemicals <http://www.who.int/respiratory/copd/en/index.html>. Exacerbations often occur, where there is a rapid and sustained worsening of symptoms.

COPD produces symptoms, disability and impaired quality of life which may respond to pharmacological and other therapies that have limited or no impact on the airflow obstruction. COPD is now the preferred term for the conditions in patients with airflow obstruction who were previously diagnosed as having chronic bronchitis or emphysema.

There is a local challenge to improving the recognition and early diagnosis of COPD. The estimated prevalence of COPD in Bournemouth, Poole and Dorset is 22,820 people. During 2010/11 the actual recorded prevalence in Dorset was 5,868 with 5,204 potentially undiagnosed (47% of expected), and 3,746 in Bournemouth and Poole with 8,003 potentially undiagnosed (32% of expected).

Both nationally and locally, COPD is one of the highest causes of unplanned admissions. In 2010/11 there were 1435 COPD admissions across Dorset, Bournemouth and Poole, and in 2011/12 this raised to 1452 COPD admissions to hospitals. Furthermore COPD also has particularly long lengths of stay in Dorset and particularly high 90 day re-admission rate in Bournemouth and Poole compared to the NHS South West averages having a major impact on hospital resources.

There is a growing need for community services across Dorset to up skill their knowledge for respiratory conditions and have the right resources to prevent avoidable admissions and to support people back into the community earlier after an acute admission.

Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

NICE guidance CG101 promoted and fully adopted within primary care:

<http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101/introduction>

Reduction in the number of unplanned admissions

2. Scope

2.1 Aims and objectives of service

The aim of the service is to improve the outcomes for people with COPD. It is based on the concept of a 'Care Bundle' as described by West Yorkshire Critical Care network. It requires providers to achieve all recommendations of the NICE guidance for COPD for each individual patient diagnosed with COPD on the practice register. The GRASP – COPD has been developed to improve NHS Quality and can be accessed at:

<https://www.primis.nottingham.ac.uk/index.php/news/hot-news/828>

The objectives are:

- to identify early diagnosis and management of patients with COPD in primary care
- once properly diagnosed, to promote consistent adherence to NICE recommendations for every person with COPD
- to encourage a case finding approach in order to close the gap between expected and actual prevalence
- to reduce the number of people with COPD who have an unplanned admission
- to promote a greater degree of personal control and self care for people with COPD
- promote effective inhaled technique
- promote pulmonary rehabilitation
- manage exacerbations

- to encourage consistency of applications on best clinical practice

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. Focused on the more specialised services to be provided this specification is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services and the Quality and Outcomes Framework or funded under other Enhanced Service provision. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

2.2 Service description/care pathway

The provider shall be required to provide evidence of completion of elements 1 – 4 of the care bundle for each patient. The following elements are **ALL** required for every patient on the register.

- a) Diagnosis shall be made confirmed by post-bronchodilator spirometry. If diagnosed within the last 12 months there should be a records of a chest X-Ray, full blood count and BMI. If diagnosed over 12 months ago, there should be records of a chest X-Ray, full blood count and BMI within 12 months of receiving a diagnosis. *(It is recognised that a chest x-ray, full blood count and BMI are not required for a diagnosis, but to exclude other pathologies)*
- b) Patients diagnosed with COPD (as in 'a' above) shall be using the correct inhaler and the provider shall have checked within the last 12 months that the patient is using the correct type of inhaler and using the inhaler correctly. This shall have been recorded at reviews
- c) Patients diagnosed with COPD (as in 'a' above) shall have been referred for Pulmonary Rehabilitation if over MRC level 3 or if they have had a hospital admission for COPD, if the patient so wishes.
- d) Patients diagnosed with COPD (as in 'a' above) shall have been given a hard copy of a personalised self management plan within the last 12 months which explains:
 - what COPD is;
 - how to best look after themselves and manage their COPD;
 - what they should do in an exacerbation, personalised for their level of COPD and personal situation; and
 - what rescue drugs they should have in an exacerbation and how to obtain them when required.
- e) Where the patient has had an admission in the last 12 months with a primary diagnosis of COPD, they shall have the prescribed set of rescue medications at home. Where this is contraindicated, the provider shall need to provide evidence to that effect.
- f) The provider should mark the records of all people with COPD with the next review appointment which is at least within 12 months, except for those with MRC 'severe'

or 'very severe' who should be reviewed 6-monthly.

This specification does not replace clinical judgement or diminish the responsibilities of clinicians to use their judgement to not follow elements of the care bundle. Exceptions should be recorded.

3.2 Any acceptance and exclusion criteria and thresholds

3.3 Interdependence with other services/providers

3 Applicable Service Standards

3.1 Applicable national standards (eg NICE)

NICE CG101

<http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101/introduction>

GRASP - COPD

<https://www.primis.nottingham.ac.uk/index.php/news/hot-news/828>

3.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

3.3 Applicable local standards

The provider shall:

Ensure that staff providing the service are suitably qualified and competent and that there are in place appropriate arrangements for maintaining and updating relevant skills and knowledge and for supervision.

Ensure that lines of professional and clinical responsibility and accountability are clearly identified.

Ensure that all premises and equipment used for the provision of the enhanced service are at all times suitable for the delivery of those services and sufficient to meet the reasonable needs of patients or clients. This includes provision of a suitable room, with couch and sufficient space and equipment for resuscitation if required.

Demonstrate a robust information service/source for patients and review regularly based on patient feedback.

Ensure that patients are able to contribute to the planning of their own care and that opportunities for feedback are easily available.

Ensure that treatment, care and information provided is culturally appropriate and is available in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English.

The provider must inform NHS Dorset CCG, at the earliest opportunity, if there is a significant disruption to the service in order that continuity can be maintained through an

alternative provider.

The provider shall develop an appropriate record of activity which meets the requirements of this service and shall maintain this for audit and payment purposes.

The provider shall provide an end of year audit to be submitted to NHS Dorset CCG. This should include required data (appendix 1) and include data on COPD patients whom have had their diagnosis confirmed by spirometry, AND had each of the following recorded within 12 months post diagnosis:

- Chest X-ray
- FBC and
- BMI

The provider shall provide an end of year improvement plan for COPD management following the results of the audit.

Several areas of NICE recommended practice are already covered by the Quality and Outcomes Framework and it is not the intention of this service to duplicate this reporting. The following table lists the elements of best practice and the commissioning routes to their achievement for GP practices:

NB QOD not reported to Dorset CCG but to NHS England Obtain an early diagnosis	This contract
Have a COPD practice register	QOF
Confirmation of the diagnosis using post-bronchodilator spirometry	QOF (and this contract)
Smokestop advice	QOF
<i>Ongoing management</i>	
FEV1 recorded annually	QOF
Annual review with recording of MRC dyspnoea score	QOF
Annual influenza immunisation	QOF
Promote effective inhaled technique	This contract
Provide pulmonary Rehabilitation for all who need it	This contract
Manage exacerbations	This contract
Ensure multi-disciplinary working	

4 Applicable quality requirements and CQUIN goals

4.1 Applicable quality requirements (See Schedule 4 Parts A-D)

4.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

5 Location of Provider Premises
The Provider's Premises are located at:
6 Individual Service User Placement