

## SCHEDULE 2 PART A– THE SERVICES

<b>Service Specification No.</b>	02/GMS/0067
<b>Service</b>	Dorset Adult Integrated Respiratory Service
<b>Commissioner Lead</b>	Clinical Commissioning Programme for General Medical and Surgical
<b>Provider Lead</b>	
<b>Period</b>	1 April 2014 to 31 March 2015
<b>Date of Review</b>	Formal review April 2015

### 1. Population Needs

#### 1.1 National/local context and evidence base

Extract from ‘ NHS Service Specification; Service to manage COPD Exacerbations’:

COPD (Chronic Obstructive Pulmonary Disease) exacerbations are associated with increased mortality, and faster disease progression. They can often result in emergency hospital admissions and subsequent readmissions.

Prompt treatment at the onset of exacerbation symptoms can result in less lung damage, faster recovery and fewer admissions and readmissions to hospital.

The National COPD Audit 2008 showed considerable variation in length of stay for an acute exacerbation of COPD, with a median stay of six days.<sup>i</sup>

The same audit showed a COPD hospital death rate of 7.7%, higher than most OECD (Organisation for Economic Co-operation and Development) countries, with a further 14% dying within 90 days of admission.<sup>ii</sup> The audit also showed that the hospital death rate varied across England, and that this was affected by the presence or absence of structured admission with access to specialist respiratory care.

Early discharge schemes or hospital at home can also reduce hospital readmissions;<sup>iii</sup> however the same audit showed that approximately 25% of hospitals had no Early Supported Discharge Scheme.

Readmissions are a significant problem in COPD. Of all emergency readmissions to hospital, COPD is the fifth most common cause. At any one time, around a third of all people admitted as an emergency with COPD have been treated in hospital for the same condition within the previous 30 days. Readmissions could possibly be prevented through better management during the first stay in hospital and better care following discharge.

Extract from Dorset’s future respiratory desired state document - Wessex HIEC, Dorset CCG and Pan Dorset Respiratory Strategy Group

Dorset COPD prevalence is 2 to 3% lower than it should be, owing to a significant degree of under diagnosis which is common throughout the UK. This under diagnosis means that people with respiratory conditions cannot access appropriate care. In Bournemouth and Poole, the diagnostic rate is in the lowest quintile nationally. Furthermore, Dorset’s public health service predicts that by 2020 all districts will show a sizable increase in the numbers of patients living with COPD. An estimated increase of up to 2730 is expected, and this could well lead to an increase in acute admissions, and in patients needing specialist interventions for their condition. Therefore, more emphasis needs to be made in identifying these patients

earlier to prevent escalation in disease severity, to reduce associated costs, and to empower patients to manage their own conditions more effectively.

The current community-based respiratory services vary considerably in their aims, their pathways and their levels of provision. There is little communication between the services leading to a potential duplication of services for some patients and an absence of effective services for others. The lack of an integrated clinical information system means that patients are managed differently across localities which can cause a failure to communicate important changes in patient management to other healthcare workers. Consequently, patients may also be unsure how to access services and education about their condition.

**Pulmonary fibrosis: extract from NICE Idiopathic pulmonary fibrosis**

The diagnosis and management of suspected idiopathic pulmonary fibrosis

Idiopathic pulmonary fibrosis is a chronic, progressive fibrotic interstitial lung disease of unknown origin. It is a difficult disease to diagnose and often requires the collaborative expertise of a consultant respiratory physician, radiologist and histopathologist to reach a consensus diagnosis.

Most people with idiopathic pulmonary fibrosis experience symptoms of breathlessness, which may initially be only on exertion. Cough, with or without sputum, is a common symptom.

Over time, these symptoms are associated with a decline in lung function, reduced quality of life and ultimately death.

The median survival for people with idiopathic pulmonary fibrosis in the UK is approximately 3 years from the time of diagnosis. However, about 20% of people with the disease survive for more than 5 years. The rate of disease progression can vary greatly. A person's prognosis is difficult to estimate at the time of diagnosis and may only become apparent after a period of careful follow-up.

**Bronchiectasis**

The Outcome Strategy for COPD and Asthma NHS Companion Document 2012 specifically identifies the care needs of patients with Bronchiectasis.

The NHS Outcomes Framework has a specific indicator in Domain One to reduce respiratory mortality in the under 75s. This indicator is also shared with the Public Health Outcomes Framework

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

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

### 2.2 Local defined outcomes

### 2.3 It is an expectation that the implementation of an integrated respiratory service will:

**MEASURE**

**EXPECTED OUTCOME**

Mortality from COPD, bronchiectasis and pulmonary fibrosis	No increase in mortality
Emergency admissions and re-admissions for COPD by practice/locality	Prevent or stabilise year on year increase
Number of days in hospital for COPD by practice/locality	Prevent or slow year on year increase
Patient experience (via COPD PREM)	Satisfaction with service and overall wellbeing
Number of people with COPD who receive a Care Bundle on discharge from hospital	Increase percentage of care bundles to 80% of discharges
Oxygen assessments and reassessments	Improve use of these to 90% in this cohort of patients
Referrals to Pulmonary Rehabilitation	Increase number of referrals to Dorset providers
Patient educational sessions	Increase patient understanding of their condition
Number of patients undertaking supported self-management	No increase in mortality as a result of supported self-management

### 3. Scope

#### 3.1 Aims and objectives of service

The Dorset Integrated Respiratory Model will bring together the patient, primary, community and secondary care clinicians to enhance the care of patients with COPD and other chronic respiratory diseases. This service will provide support for patients with potentially more severe symptoms and at risk of rapid deterioration or acute admission.

This service is for patients with chronic lung diseases; COPD, bronchiectasis and pulmonary fibrosis. The service will provide specialist support for patients in the community with these conditions after their diagnosis.

The main aims are:

- to ensure an effective high quality service
- integrated working between primary care localities and the specialist respiratory teams in the local acute providers
- reduce emergency admissions for respiratory conditions
- admission avoidance where appropriate
- provide care closer to home
- provide a service that is more responsive to the patients' needs
- deliver a sustainable healthcare model

The key objectives of the Service are to provide:

- A positive experience for the service users;
- Effective communication and education for the patient and carer to support self-management;
- Support for patients during COPD exacerbations in the community to reduce admissions by means of a single point of contact via 111 and to direct patients to acute units during exacerbations only when appropriate;
- Early supported discharge of patients from acute units;
- Support self-management for patients at home with technology e.g. Telehealth
- Access and signposting to therapy services and psychological support services including onward referral to appropriate services to minimise the impact of the disease and improve quality of life e.g. smoking cessation, pulmonary rehabilitation, support groups as appropriate, oxygen assessment, physiotherapy, specialist consultant advice, access to psychological therapy in the community;

- A multidisciplinary approach across the integrated service to provide specialist advice and care for chronic respiratory patients in a timely way;
- Integrated support to ensure correct diagnoses are made in collaboration with secondary care when necessary;
- Co-ordination across the care pathway to ensure integration and effective communication with GP services, community care, specialist secondary care units, ambulance services, and the palliative care team and social services as appropriate;
- Education of healthcare staff to appropriately manage patients with respiratory disease;
- An equitable and comprehensive service for Dorset with home oxygen assessment, provision and reassessment;
- An equitable nebuliser assessment and provision service;
- Specialist nurse led clinics in the community;
- Community support to patients in need of home IV therapy where deemed clinically appropriate and safe;
- Access to outpatient respiratory physiotherapy

### 3.2 Service description/care pathway

The service will be provided by appropriately qualified clinicians with the necessary knowledge and skills including the biomedical principles of patho-physiology as well as a sound understanding of the bio psychosocial model. This includes the ability to identify potential serious pathology and refer those patients to the appropriate medical professional and understand and manage patients who are at risk of poor prognosis. As clinicians working in the community, staff must be aware of local specialist services and appropriate patient management pathways to refer patients through.

The service will meet all requirements to comply fully with the Equality /Disability Act. In addition to this, the Provider has a duty to undertake Equality Impact Assessments as a requirement of race, gender and disability equality legislation. The Provider will be required to cooperate with the Commissioner's Equality Impact Assessment processes.

See attached pathway and tiered model

Prior to patients being referred for support from the Dorset Integrated Respiratory Service it is expected that all GPs will have maximised their treatment of their patients in line with routine care management

#### **The Dorset Integrated Respiratory Service components:**

- Telephone access for provision of a 'single point of access' provided 24 hours a day and 7 days a week via 111 for patients requiring support with an integrated 'special patient note' facility and access to specials notes for healthcare workers;
- Appropriate written information for patients and carers on what the service provides and also on what is available, where, when, how to access the service and whom to contact;
- Education for community healthcare workers/care homes/GP Practices supported by the REDS/PORT/DORT team ensuring competency and evaluation of training and seasonal balance of workload;
- Full provision/utilisation of pulmonary rehabilitation across the county (see separate service specification);
- Identification of, inclusion, support to and monitoring of those patients who are suitable for tele-health services;
- Nurse led Multidisciplinary team meetings to be held on a weekly basis with access to Consultant advice and guidance;
- Consultant led multidisciplinary meetings to be held on a monthly basis for complex

patients;

- In Reach for early supported discharge.
- The Pan Dorset Formulary for all respiratory medications will be adhered to.
- Assessment and reassessment for oxygen and nebuliser use and annual review.
- The provider will be responsible for the prescribing, supply (or procurement), review and governance processes to support antibiotics treatment of the acutely ill patient. This will include development and adherence to a suitable formulary (agreed by microbiology and internal drug and therapeutics services), which has been approved for inclusion into the pan-Dorset formulary. This may include the parenteral administration of antibiotics including intravenous administration.
- The provider will ensure that the service has access to adequate pharmaceutical advice including specialist advice to support IV antibiotic usage including the procurement and supply systems as well as policies such as IV to oral switches and audit of prescribing against formulary and local and national standards. The provider should have access to the skills of an antibiotic specialist pharmacist.
- The provider will liaise with community providers where the administration of IV antibiotics is not carried out by the provider. This will include appropriate transfer of information and medicines.
- If the provider chooses to contract out the supply of antibiotics to another provider, for example a home care company, the provider will be responsible for the contracting and quality assurance of the service, and procurement should be in line with the recommendations of the Hackett report in liaison with the provider's chief pharmacist.
- The service is responsible for all drugs and consumables associated with parenteral antibiotic administration including diluents, flushes and injecting equipment.
- The administration of parenteral drugs will be in line with the NPSA standards for injectable medicines and risk assessed accordingly.
- Appropriate written information about medication and interactions
- Patient held self-management records;
- Provide an advice and guidance service to all professionals involved in the care of respiratory patients;
- Provide consultant input to a comprehensive education and training service to all professionals involved in the care of respiratory patients;
- Support the community teams and specialist respiratory teams to manage patients within the community.
- Multidisciplinary/multiagency end of life support including palliative care;
- Close liaison with primary care team
- Advanced care planning including patient's preferred place of death;
- Hospice care;

**The service will be provided appropriately in:**

- The patient's home, including residential and nursing homes;
- Community settings;
- Secondary care

**Access to the service**

Access to the service shall be either telephone referral or in writing from

- GP
- Respiratory Locality Clinical Lead
- Community Matron
- Community Nurse

- Community Respiratory Nurse Specialist
- Acute Respiratory Nurse Specialist
- Secondary Care Clinician
- Out Of Hours Clinician
- Self re-referral following previous referral by one of the above

For advice and guidance, help with care management or support to prevent admission the above methods will be used.

Referrals to the Pulmonary Rehabilitation service will be made via choose and book as per current practice for consultants and GPs with an aim for access for community matrons/respiratory nurse specialists to refer on choose and book

Patients will use 111 as the single point of access for this service and for 24/7 advice and guidance and signposting as necessary.

### **Hours of Operation**

The Integrated Respiratory Service will provide a 24 hours per day, 7 days per week service using the established arrangements for out of hour's provision of care via 111.

### **3.3 Any acceptance and exclusion criteria and thresholds**

Acceptance criteria: people with diagnosed COPD, pulmonary fibrosis, bronchiectasis and those with a dual diagnosis of asthma and COPD who require:

- Proactive case management to reduce the risk of unplanned hospital admission
- Supported discharge;

Exclusion criteria:

- People not registered with a Dorset GP;

### **3.4 Interdependence with other services/providers**

- Dorset GP practices and practice teams;
- Pharmacies
- Smoke stop services;
- DHUFT: Community hospitals, intermediate care, long term conditions teams, palliative care, counselling, community therapy teams;
- SWAST (111 provision);
- Social services in Bournemouth, Poole and Dorset;
- Pulmonary rehab
- Telehealth;
- Equipment services;
- Air Liquide (home oxygen);
- Acute hospital respiratory departments;
- Public Health England
- NHS England

### **3.5 Training, Education and Research Activities**

The service providers must describe and demonstrate that they are qualified to provide this service. They must demonstrate to commissioners their competency to deliver the commissioned service through robust clinical governance arrangements.

As per the NHS contract terms and conditions, providers must regularly and systematically review their professional practice in line with the professional standards as set out by the relevant Professional Bodies and be able to demonstrate how they assure this through

regular review and/or appraisals.

A report of any review or appraisal that takes place, including recommendations and any requirements for retraining, should be available to the commissioners upon request in instances of failure of professional standards.

Each provider must ensure their staff undertakes Continued Professional Development consistent with the requirements of the relevant Professional Bodies.

All providers should engage with the Pan Dorset Respiratory Education programme hosted through Dorset County Hospitals NHS Foundation Trust

#### 4. Applicable Service Standards

##### 4.1 Applicable national standards (e.g. NICE)

- Reduction in mortality from respiratory disease in under 75s;
- Chronic obstructive pulmonary disease (updated) (CG101)[link](#);
- An outcomes strategy for COPD and Asthma in England, 2011 [link](#);
- Home Oxygen Service Good Practice Guide for Assessment and Review;
- A guide for commissioners and respiratory teams produced by NHS Primary care Commissioning, August 2011;
- NICE Idiopathic pulmonary fibrosis - The diagnosis and management of suspected idiopathic pulmonary fibrosis;

##### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

##### 4.3 Applicable local standards

Dorset COPD Pathway ;  
Pulmonary rehabilitation service specification;  
Nebuliser pathway;  
Dorset integrated respiratory model

##### 4.4 Integrated Governance

The providers will demonstrate that there are clear organisation governance systems and structures, with clear lines of accountability and responsibility. The providers will ensure clinical and corporate governance processes are in place to include:

- Clinical governance lead
- Incident reporting
- Infection control
- SIRI / PSI reporting and analysis
- Quality assurance
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Evidence of peer and patient review and action taken

#### 5. Applicable quality requirements and CQUIN goals

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

Urgent patients will be reviewed within 2 hours of referral to avoid an acute admission  
Routine patients will be seen within 5 working days  
Advice and guidance will be responded to within 2 working days

All of the below will be reported annually to the commissioners:

- The Service has access to an Antibiotic Specialist pharmacist.
- The Service has an approved formulary for Domiciliary parenteral antibiotics
- The Service has a Domiciliary IV to oral switching policy
- The number of patients prescribed IV antibiotics for Domiciliary administration
- The average duration of treatment of Domiciliary IV administration
- Service prescribing is audited against the approved formulary

### 5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Patient reported outcome measures (PROMS)  
Patient reported experience measures (PREMS for COPD)  
No requirement for additional local CQUIN

## 6. Location of Provider Premises

### The Provider's Premises are located at:

Patients in the community will be seen in their homes (including rest and nursing homes), or in community settings.

The service will be based across the Dorset cluster localities in a range of existing locations to ensure ease of access for the patients and offering choice of locations to patients.

The service will be provided through the three respiratory departments in the three acute provider units in Dorset

## 7. Individual Service User Placement

<sup>i</sup>Royal College of Physicians. The National COPD Audit 2008. Royal College of Physicians, London

<sup>ii</sup>Royal College of Physicians. The National COPD Audit 2008. Royal College of Physicians, London

<sup>iii</sup>National Collaborating Centre for Chronic Conditions. Chronic obstructive pulmonary disease. National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care. Thorax 2004;59 (Suppl 1) :1–232