SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	SS30
Service	Integrated Respiratory Service
Commissioner Lead	NHS Nottingham City Clinical Commissioning Group (CCG) Dawn Jameson
Provider Lead	
End Date	31St March 2018
Date of Review	6-monthly

1. Population Needs

1.1 National/local context and evidence base

Caring for people with long-term conditions, for example, heart disease, asthma and diabetes is a major element of the NHS's work. There are 15.4 million people in England with at least one long term condition (LTC), and it is thought that many more are not yet diagnosed. Three out of every five people aged over 60 in England suffer from a LTC and as the population ages; this proportion is likely to rise. Patients with LTC's use a significant proportion of all appointments with GP's and out-patient clinics and in-patient hospital bed days.

Current policy on LTCs seeks to reduce this burden through prevention, early diagnosis and developing services that enable people to live independently in their own homes. It also seeks to empower patients, give them information about their condition and offer them choice about where and how they are treated (*King's Fund 2009)*.

NHS Nottingham City Clinical Commissioning Group (CCG) has a registered population of more than 300,000 people. The population is diverse and multi-cultural, with high rates of deprivation and poor health. Nottingham City is the 20th most deprived area in the country, as measured using the 2010 Index of Multiple Deprivation (IMD).

Nottingham City has a relatively young population compared to the rest of England, however, people aged 60 or above (the age group most affected by LTC) still account for around 20% of the population and poorer health outcomes suggest that while there may not be as many older people as in other areas of the country, they experience proportionately worse health.

There are around 104,000 people registered with a NHS Nottingham City CCG GP Practice who have a recorded LTC accounting for one in three of the registered population. This figure excludes patients with a diagnosis of depression and so the true figure will be significantly higher. 80,000 of these patients have an LTC associated with vascular risk, the greatest proportion of which is hypertension, followed by Diabetes and CKD. An additional 24,105 patients are registered as having either asthma or COPD, but given known under diagnosis of these conditions, it is likely that there are significantly more patients with these conditions, who remain undiagnosed.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
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	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

The outcomes expected from this service are to:

a. Provide an integrated model of care that is responsive to patients with a respiratory condition
b. Ensure that healthcare professionals managing patients with a long term condition have the appropriate access to services as and when required
c. Empower patients by ensuring that they have access to advice and education and are provided with a care plan
d. Improve the quality of care that patients receive ensuring early diagnosis and prevention
e. Reduce unnecessary admissions to hospital
f. Facilitate early discharges to reduce LOS

3. Scope

3.1 Aims and objectives of service

The aim of the service is to provide an integrated model of care to patients who have a suspected or confirmed diagnosis of respiratory disease. Respiratory conditions will include; chronic obstructive pulmonary disease (COPD), asthma and bronchiectasis. Intensive assessment, monitoring and proactive management of a patient's condition in order to prevent further deterioration and exacerbation will be included in the service. Care planning, spirometry testing for diagnostic reasons if practice has been unable to do so and interpretation as well as direct access to pulmonary rehabilitation is included in the service.

3.2 Service description/care pathway

Patients who have a suspected or confirmed diagnosis of COPD, asthma or bronchiectasis and other confirmed chronic respiratory illness e.g. pulmonary fibrosis will be able to access the Integrated Respiratory Service. Patients will be managed and treated according to the severity of their disease. Where needed Telehealth/Telecare equipment will be provided to patients and the provider is expected to link the Integrated Respiratory Service to the Integrated Adult Care team to promote a multi-disciplinary approach.

The integrated service model will include the following:

3.2.1 General Practice / Community Matron / Community Nursing (Level 1 Patients)

a. It is anticipated that patients with a respiratory condition that are stable will be managed by their GP. Patients who have difficulties with their respiratory conditions (who are not stable) can be referred directly to the Rapid Response Respiratory

Service (RRRS) for further management of their condition. Patients may also be referred directly for a course of pulmonary rehabilitation (if required). Patients who are not stable and require rapid assessment will be referred to the Nottingham University Hospital NHS Trust (NUH) (RAU) Respiratory Assessment Unit.

Pink Card

b. In addition to the above, a pink card is also available. Referral for the Pink Card is initiated by the GP and or Community Matron or (RRR) service. The pink card is a navigation tool to direct ambulances directly to the NUH Respiratory Assessment Unit (RAU) and patients are seen by the respiratory team.

3.2.2 Respiratory Rapid Response Service (RRRS)
(Level 2 Patients)
Patients who are exacerbating but are stable will be referred to this service. Intensive assessment, close monitoring and proactive management of the patient's condition will be provided in order to prevent further deterioration. It is the responsibility of the service to ensure that patients are treated effectively and are discharged after two weeks and a maximum period of three weeks, extended only after discussion with consultant advice. The provider will ensure that where anticipatory medicines are required, they will endeavour to contact the GP in hours for a prescription in advance (where possible).

If after a maximum of three weeks patients are still not stable, an onward referral or discussion with a secondary care consultant may be appropriate, or discharged back to their GP.

3.2.3 Respiratory Education Advice & Diagnostic Service (READS)
(Level 1/2/3 Patients)
It is anticipated that patients who have been managed by (RRRS) will be referred to the (READS) team in order to receive appropriate education and advice about their disease. A care plan will initiated or reviewed to ensure its fit for purpose. In addition to this, pulmonary rehabilitation will be offered as well as spirometry testing and interpretation. Referrals will be accepted via the (RRRS) team, specialist community team or directly from a GP as well as the NUH Respiratory Assessment Unit.

3.2.4 Respiratory Assessment Unit - NUH
(Level 3 - unstable Patients)
Patients who are diagnosed exacerbation unstable by the GP or HCP will be referred and navigated to the RAU unit via NEMS. Once the patient is stabilised, early supported discharge to the (RRRS) or (READS) may be appropriate whereby a patient will undergo an education and advice programme and a care plan will be initiated. If this isn't required the patient should be discharged back to their GP.

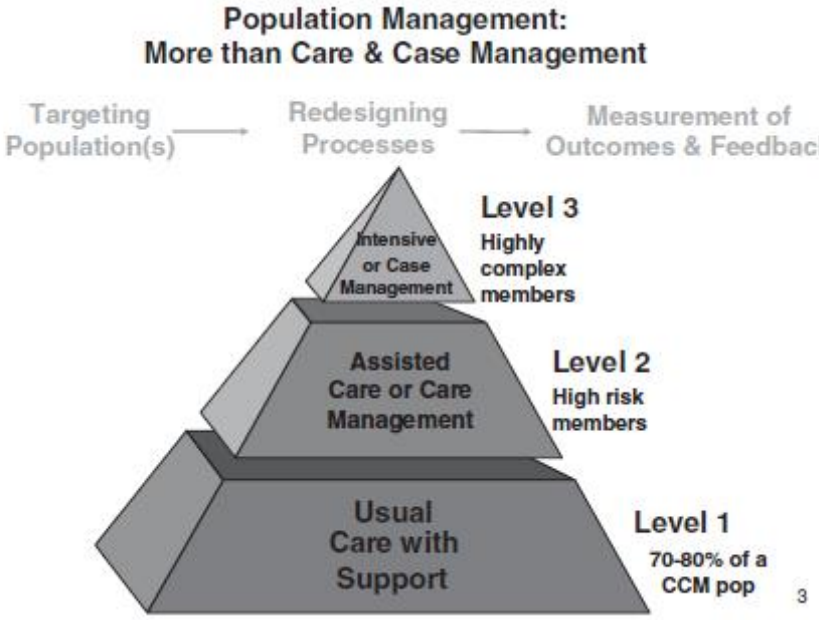
3.2.5 Respiratory Consultant Input
Clinical leadership will be overseen by a Respiratory Consultant. It is anticipated that 2 sessions a week will be provided (to be confirmed) for specialist medical input:

c. providing clinical mentorship to the integrated respiratory team
d. group case discussions/ virtual case conferences.
e. support the respiratory nurses in consultation with Nottingham City GP's in the development of a community focused integrated service to people with respiratory conditions
f. facilitate joint training and learning opportunities.

Discharge Communication Co-ordinators

Discharge from NuH will be facilitated by identifying through clinicians, suitable patients with LTC's for either discharge to the Integrated Respiratory Service, onto a suitable ward and or signpost to other services including social care. It is anticipated that this will:

- Reduce re-admission rates
- Reduce LOS (length of stay)
- Ensure patients are well informed of the services available to them on discharge by providing a 'discharge pack'



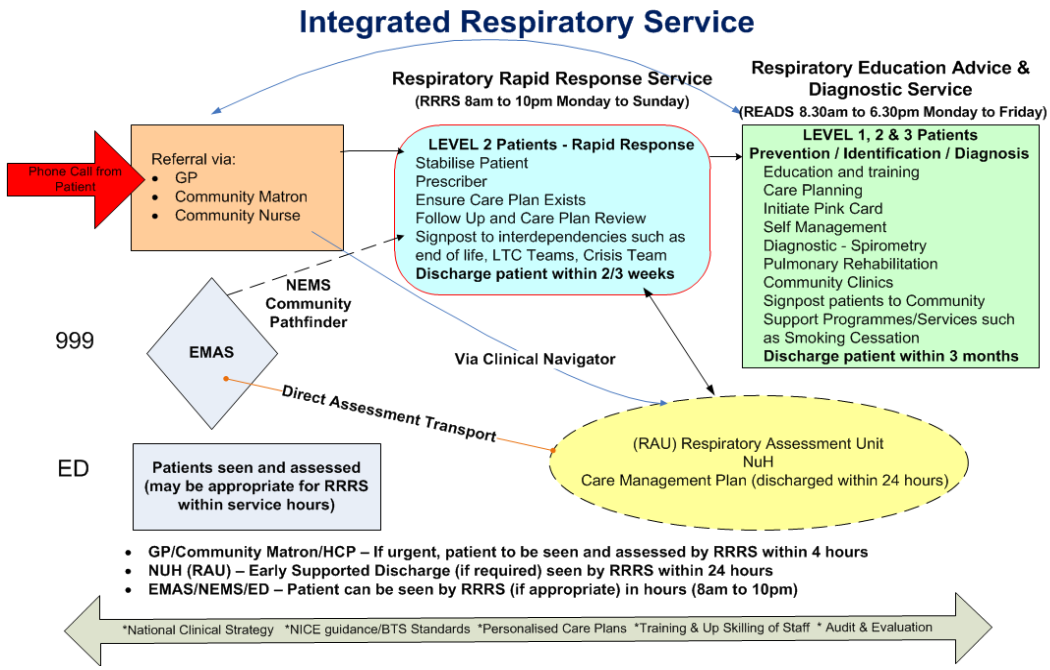
The Kaiser Permanente Risk Pyramid

3.2.6 Oxygen Assessment Service

LTOT and Ambulatory Oxygen
The Integrated Respiratory team provide support for patients on Long Term Oxygen Therapy (LTOT) as well as Ambulatory Oxygen. Patients already on LTOT can be referred directly to service for an assessment, advice and support. Patients who are not yet receiving oxygen therapy (but who are clinically suitable) will be referred by their GP to the Respiratory Outpatient Department at the Treatment Centre (Nottingham University Hospitals, NHS Trust) to start oxygen. Patients undergoing pulmonary rehabilitation will automatically be assessed by a physiotherapist to determine whether or not ambulatory oxygen is required. GPs can refer directly to the service for assessment if oxygen has already been prescribed by NUH. The aim of the oxygen service is to work towards the IMPRESS guidance for Rationalising Oxygen Use to Improve Patient Safety and to Reduce Waste. The service must work closely with primary and secondary care and ensure that up to date information is sent to the appropriate GP about their patient's progress.

Air Liquide
Quarterly reports of under / over users of oxygen generated via Air Liquide will be sent to the Integrated Respiratory Service to prioritise patients in need of an assessment / review. Patients who are presenting over / under (200%) will be prioritized. Six monthly reviews and subsequent 12 month reviews will be carried out by the Integrated Respiratory Service. Air Liquide will be contacted by the service if there are any misplaced cylinders in patient homes. Regular health and safety checks will be carried out by the Integrated Respiratory Service such as, checking concentrators, filters, (reviewed weekly) nasal cannulae (reviewed monthly) masks (washed weekly).
Any correspondence generated to Air Liquide from the Integrated Respiratory Service will be summarised via NHS.net email to the CCG at the end of each month.

3.2.7 Service Model



Assistive Technology (AT)

The service will actively encourage the use of Assistive Technology (AT), in particular Telehealth, in the management of their patients.

AT should be considered for all patients where both the patient and clinician will benefit from its use. There should be clear documented reasons supporting why AT is not offered or accepted by the patient.

Where AT is implemented the service clinician will be responsible for monitoring the patients progress as recorded by the device. This will form part of the overall management and support of the patient.

Feedback will be obtained from all patients to understand the impact and outcomes of AT. This will be used to inform the future use of AT within the service.

3.2.8 Response time and prioritisation

Patients who require a referral to (RRRS) will be seen within 4 hours and within operating hours. Following this, patients will be seen in the (READS) within two to three weeks of being discharged from the (RRRS).
NUH (RAU) – early supported discharge (if required) seen by RRRS within 24 hours
EMAS/NEMS/ED – patient can be seen by (RRRS) (if appropriate) in hours (8am to 10pm)

3.2.9 Discharge Criteria and Procedure

Respiratory Rapid Response Service (RRRS)

g. Patients will be discharged to the READS service once stable or to the care of their

GP (where appropriate) within a maximum of three weeks and once they are stable.

Respiratory Education Advice & Diagnostic Service (READS)

h. Patients will be discharged back to the care of their GP within a maximum of three months.

Early Supported Discharge RAU and ED Patients only – acceptance criteria to be agreed by RAU and ED.

3.3 Population covered

The service will provide support to patients aged 18 years and over and who are registered with a NHS Nottingham City CCG GP.

3.4 Any acceptance and exclusion criteria and thresholds

Patients must have a suspected respiratory disease (COPD, asthma or bronchiectasis, not compete list, other confirmed chronic respiratory illness) and be registered with an NHS Nottingham City CCG GP.
Referrals will be accepted as follows:

Respiratory Rapid Response Service (RRRS)

i. Referrals will be accepted from GPs, Community Matrons, Community Nursing teams and NUH.

Respiratory Education Advice & Diagnostic Service (READS)

j. Referrals will be accepted from GPs, Community Matrons, Community Nursing teams and NUH.

Respiratory Assessment Unit - NUH

k. Referrals will be accepted via NEMS and the Pink Card navigation system.
l. Referrals will also be accepted via the Respiratory Rapid Response Service (RRRS).

3.5 Interdependence with other services/providers

a. GP
b. Community Nurse
c. Community Matron
d. Community Nursing Teams
e. Acute respiratory services
f. Community and acute allied health professionals e.g. NEMS, EMAS, Crisis Team, virtual ward models for Long Term Conditions (this list is not exhaustive)
g. Health and Social Care teams; Local Authority
h. Psychological Therapies

Relevant networks and screening programmes include;

i. City and Southern County COPD Network
j. City Long Term Conditions Board

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

a. NICE Quality Standard QS10 - Chronic Obstructive Pulmonary Disease (COPD)
b. NICE Clinical Guidance CG101 - COPD

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

4.3 Applicable local standards

4.3.1 Respiratory Rapid Response Service (RRRS)

This service will be nurse led and overseen by a Respiratory Consultant. Nursing staff providing this service must have a nurse prescribing qualification and be educated to diploma standard in COPD, asthma and bronchiectasis as well as any other relevant qualifications. The specialist nurses will be working according to APC guidance. FP10 prescription pads will be made available.

4.3.2 Respiratory Education and Advice Service (READS)

This service will be nurse led and overseen by a Respiratory Consultant. There will be a skill mix of staff including a physiotherapist, occupational therapist, nursing staff and support workers. Staff providing this service must have undertaken educational modules in pulmonary rehabilitation and spirometry testing and interpretation and any other relevant qualifications.

This Integrated Respiratory Service will also provide a telephone advice service to ensure patients are provided with a range of educational information. Patients will be supported through their personalised care plans, educate patients to self-manage their condition enabling patients to make a more informed decision

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be provided from a range of locations that are convenient to patients. This will include, the patient's own home, their GP practice and from a centrally located base.

The RRR service will operate from 8am to 10pm, Monday to Sunday. READ 8.30am to 6.30pm Monday to Friday.