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Service Specification

Service Specification No.	
Service	**Mid Nottinghamshire Community Respiratory Service**
Commissioner Lead	**Mid Notts CCGs**
Provider Lead	**NHT**
Period	**April 2019- March 2020**
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

As part of the Better Together programme; Mid Notts CCGs seek to develop a service fit for the future delivering quality outcomes. The Better Together programme has developed the blue print for the future, identifying the growing evidence base for delivery of care at home and in community settings to improve the patient experience and help to reduce the costs of delivery within a hospital setting.

The development of this infrastructure and model of care will meet the needs of Increasing numbers of frail elderly patients with complex Long Term Conditions and subsequent co morbidities.

In line with this is the recognition for the local need to develop the current Community Respiratory Specialist Service. This will involve the service integrating with the Local Integrated Care teams whilst continuing to support Respiratory disease management in General Practice and Community Respiratory Clinics.

1.1
Mid Notts CCGs aim to commission a Community Respiratory Nurse team to support patients and GP Practices across Mansfield, Ashfield, Newark and Sherwood. The team will improve the standard of care provided to respiratory patients by ensuring:

- all general practice professionals are provided with high quality clinical education,
- the implementation of the evidence based NHS and Social Care model for LTC within the primary care setting
- providing more clinically led patient-centred service with proactive professional skilled individuals delivering a high quality service which relies less on admission to hospital

- Increased communication and collaboration between care givers
- Improved patient outcomes

Evidence Base

M&A is an area of high deprivation with a significant COPD population; **2.3%** compared with **2.0%** for Nottinghamshire County and **1.7%** for the United Kingdom (**2012/13** data).

There is currently variation in how patients with COPD are managed in primary care, and emergency admission rates vary significantly across practices from **1.14 to 5.95** per 1,000 population (**Oct 2012-Sep 2013**). COPD is one of M&A Clinical Commissioning Group's (M&A CCG) key strategic priority areas.

The M&A Asthma prevalence is **6.2%** compared with **6.5%** for Nottinghamshire County and **6.0%** for the United Kingdom (**2012/13** data). Emergency admission rates for Asthma range from **0 to 1.62** per 1,000 population (**Oct 2012 – Sep 2013**).

Respiratory conditions are one of Mid Notts CCG's strategic priorities and to improve current services and raise standards of Respiratory care is in line with Strategic impetus for this (DH 2005, 2008, 2009, 2010, 2011-12 & NICE 2010, 2011, 2013). Further data for Newark and Sherwood is available separately.
Currently there is one Respiratory Nurse Educator working with the 31 Practices in M&A; this post will form part of the new service.

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**	√
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 nd protecting them from avoidable harm**	

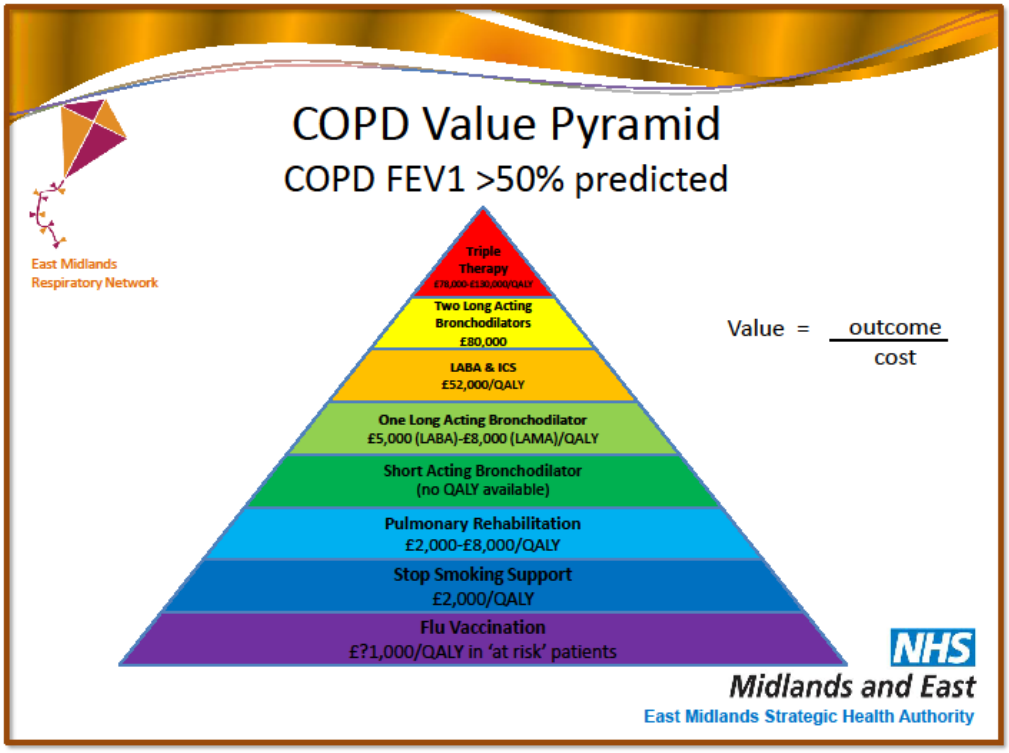
2.2 Local defined outcomes

Expected Outcomes

For the health community

- Early identification of respiratory problems will reduce or delay the need for costly interventions due to disease progression without treatment. E.g. A&E attendances for breathlessness/wheeze due to undiagnosed asthma.
- Increase in the ability of patients to self-manage their conditions will reduce the need for urgent health care such as same day GP appointments due to increased breathlessness.

- Appropriate prescribing (as per APC and NICE guidance) will reduce spend for the CCG.
- Early identification and Proactive management and education will reduce hospital admissions and associated bed days.
- Better utilisation of services intended for first line treatment/management such as flu vaccination take up, smoking cessation and pulmonary rehabilitation. The following figure shows the value of various interventions based on outcome and cost highlighting the importance of these three interventions in particular



For patients

- Improved coordination and continuity of care by coordinating Respiratory services around the patient
- Promotion of a seamless patient journey for patients utilising the Respiratory Services
- Early diagnosis will reduce the time patients spent with distressing symptoms without diagnosis
- Improved management of their Long Term Condition and any co-morbidities
- Early coordinated support of all needs including carer support
- Increased patient knowledge about their condition and increased ability to self-manage
- More patients receiving diagnosis and treatment in a setting close to home i.e. GP Practice or usual place of residence
- Patients' symptoms reduced/well managed leading to an improvement in quality of life
- Improved respiratory performance and expected life expectancy
- Reduction in hospital admissions = reduction in stressful situations for patients
- Improved care for respiratory patients at the end of their life, more patients

achieve their preferred place of care

3. Scope

3.1 Aims and objectives of service

The overarching aim of the service is to improve the primary care management of respiratory patients through an integrated approach.

Objectives

- Reduce variation in the management of, and outcomes for, respiratory patients
- Support General Practice with the development of robust COPD/ASTHMA registers, through education, diagnosis and interpretation of spirometry testing
- Improve the patient experience of primary and community care
- Improve patient confidence in self-management, by development of self-management plans and increasing individual knowledge on how to manage their condition
- Improve the skill, knowledge and confidence of primary care clinicians in respiratory diagnosis and ensure sustainability of high quality management
- Ensure Primary Care clinicians are using high quality resources to support themselves and their patients
- Ensure all respiratory patients have accurate diagnosis, pharmacological and non-pharmacological treatments, self-management plans and action plans
- Prevent unnecessary acute admissions by supporting early identification of those at risk of admission by use of the Risk stratification tool within the Integrated team structures and effective self-management
- Provide Case management to those identified via risk stratification and Integrated team reviews
- Reduce unplanned admissions/readmissions/length of stay by networking with the Clinical Navigation system and utilisation of the early supported discharge schemes
- To provide Specialist Respiratory clinics in the Community with the support from Respiratory Consultant
- Improve on local knowledge of demand and subsequent level of need for Pulmonary Rehabilitation and Oxygen Assessment services
- Preferred place of care achieved for more patients with life limiting Respiratory disease, when planning end of life care

3.2 Service description/care pathway

The service will be available to Mid Notts GP Practices and people with suspected or confirmed respiratory conditions.

Resource Requirements

The service is expected to employ 5WTE Respiratory Nurses who are qualified prescribers. It is envisaged that four of the Nurses will be paid at AFC Band 7 and one of the Nurses will be paid at AFC Band 8a, this member of staff will take on leadership responsibility within the team.
This leadership will be focused on managing the four Band 7 nurses and manage whilst also supporting the Band 7 Team Leader for the Pulmonary Rehabilitation and

Oxygen service in order to ensure overall overview of the primary care Respiratory Services.
The Respiratory Nurses will be aligned to Primary Care Networks though given the leadership responsibilities of the 8a post this individual will have a reduced caseload.
The service provider will ensure adequate access to appropriate clinical supervision with consideration to the speciality of the service to be provided. The service will also be expected to participate where appropriate in practice based MDTS.
The service would be expected to have access to the integrated clinical systems used by Practices to record patient appointments, treatment and any outcomes. The provider will need to work with the GP Practices and the commissioner to gain access to these systems for all patients that the service works with. This will mean assuring Practices of the safety and benefits of allowing the service access to their patients' records. The provider will need to ensure they have appropriate systems to support service monitoring and performance, and clinical audit.

Services will be provided from the GP Practices and other community venues. The Nurses will need to be provided with a base offering adequate space.

Each member of the team is equipped with the basic clinical equipment needed for respiratory nursing. This will include, but not be limited to, a thermometer, spirometer, calibration syringe, pulse oximeter, blood pressure cuff and stethoscope.

Staff will also need to have remote access to clinical systems and mobile phones if lone working is anticipated.

The team will have four main roles;

1) Supporting primary care clinicians to manage known respiratory patients. This will include clinical advice and guidance around specific patients and a comprehensive education programme to up-skill staff and ensure they are always up-to-date with current guidance and legislation.
2) Community clinics to see more complex respiratory patients (that do not need to see a Consultant). This may be informal i.e. supporting a GP or Practice Nurse within a GP Practices or more structured clinics where a formal referral is needed. This may include urgent clinics so patients can be seen within 24hrs as an admission avoidance strategy.
3) Assessment of Respiratory patients from early identification as a result of Risk Stratification use and integrated care multidisciplinary meetings, promoting a seamless patient pathway through the respiratory services, including; Pulmonary Rehabilitation and 02 assessments where indicated.
4) Supporting Practices to case find; identifying respiratory conditions early and completing accurate diagnosis. This will include using clinical systems to complete risk profiling to 'find patients 'and be integral to the structure of Proactive Team meetings.

Service model

The service provider will:

- Support GP Practice staff to improve their skills and knowledge around diagnosing respiratory conditions and caring for patients once diagnosed.
- Review patients by the request of the GP or Practice Nurse. Where

appropriate this will be in the GP Practice with GP Practice staff shadowing the consultation in order to up-skill the primary care work force.

- Review patients identified by the Risk stratification tool, as indicated at Integrated team meetings (as appropriate) and case manage those identified, and signpost where indicated to additional services, this will include, but not be limited to, the long term conditions specialist nursing teams, the end of life team and dementia services.
- Review the medication provided to patients alongside the CCG medicines management support, ensuring it is always clinically appropriate and cost effective
- Build relationships with the GP practice staff and in the Integrated care teams to support patient management and the multidisciplinary approach of care to those affected by Respiratory Conditions
- Involve the patient with decisions about their care
- Work with carers and family members to ensure they are informed about/involved with the care provided to the patient
- Work flexible so that urgent advice or visits can be scheduled where clinically appropriate
- Work under the clinical supervision of the lead Respiratory Nurse, the COPD GP leads for the Practices and the Secondary Care Respiratory Consultants
- Produce/provide professionally printed information for clinicians and patients alike
- Provide reviews for patients ensuring onward referral as necessary. Work with GP Practices to agree process for onward referral to community or secondary care, ideally the service would refer directly on behalf of the Practice
- Resource the service and ensure adequate cover in times of staff absence, holidays, staff leaving the service
- Review and follow up patients as clinically appropriate
- Ensure that all patients have a treatment and/or self-management plan to promote self-care
- Ensure patient, family and carer education is an integral aspect of the service delivery to ensure long-term patient support measures
- Ensure staff are suitably trained to spot safeguarding issues and that all issues are reported to the appropriate agencies as a matter of urgency
- Write prescriptions for patients –using System One (or a similar clinical system) to support the safety and recording of prescribing
- Be paper light and utilise electronic systems already utilised by the GP Practices
- Support patients at the end of their life ensuring local and national standards are upheld
- Apply the principles of the Mental Capacity Act 2005, knowledge and awareness
- Maintain adequate and appropriate care records
- Instigate end of life care planning, advanced decisions, anticipatory medicines and complete EMAS forms ensuring the original is kept by the patient
- Work with the Practices to ensure post discharge assessments where appropriate
- Provide HR, support and clinical supervision to the nursing team

The commissioner will provide a prescribing code for prescriptions issued by the provider.

Specific areas of focus;

Self-Care and Patient and Carer Information

Patient, family and carer education is an essential aspect of the service delivery to ensure long-term and sustained improvement.
It is expected that patients will be provided with on-going advice, support and education on the self-management of their own conditions. It will be the role of the Respiratory Nurses to ensure that the Practice staff are appropriately skilled and have the information resources to do this.
The provider must work in partnership with the commissioner to ensure on-going communication about the service.
Any information provided by the service should be available in a range of formats, e.g. large print, other languages, Braille.
The patient, their relatives and GP Practice staff will be involved in discussions around the patients care and this will be documented in the care record.

End of Life

The principles of advanced care planning for all diagnosis should be considered in all care settings when the person is believed to be in the last year of life. End of Life care is the responsibility of all health care providers and there is an expectation that the principles of Advanced care planning (DH 2009) is used as guidance to support the decision making process and promote the patients preferred priorities of care. This includes use of Respect.

Equality

The Provider has a duty to co-operate with the commissioner in considering equality and diversity as a requirement of the Equality Act 2010.
Equality Impact Assessments will be undertaken by the provider as a requirement of equality legislation, and in co-operation with the Commissioner's Equality Impact Assessments processes.

Protection of Vulnerable Adults

In line with existing policy for Vulnerable Adult(s), the provider will ensure that concerns around vulnerable adults are reported to the relevant local team(s), who will take the matter forward.

The Police should also be contacted where it is thought a criminal act may have been committed.

Safeguarding Children

In line with the policy for Vulnerable Children, the provider will ensure that concerns regarding children and safeguarding issues are reported to directly to Social Services or the relevant local team.

3.3 Population covered

Mansfield,Ashfield , Newark and Sherwood GP practice area.

3.4 Any acceptance and exclusion criteria and thresholds

Any patients with either suspected or confirmed respiratory disease.

Referral route

The Respiratory Nurses will have a relationship with each of the Practices they are assigned to; the referrals can be informal but will need to be documented in such a way as to assure on the management of patient level of need and subsequent priority.

Community Clinic referrals will require a more formal route of referral to ensure consistency in up to date relevant patient data and reasons for referral.

A request to see the patient could come from a number of sources; however the most common will be the patient's GP, Practice Nurse and any source within the MDT meetings.

Clinical responsibility for individual patients lies with the GP with which they are registered.

Exclusion criteria

Any suspected cancers should be referred via the 2 week wait policy as they are not suitable for this service.
Patients with an acute one off episode of a respiratory infection; with no known or suspected respiratory diagnosis.
Those under the age of 18

Days/ Hours of operation of the service

The service will operate on Monday to Friday between 8.30am and 5pm although flexibility is expected based on patient need and demand.

Response time of the service, detail and prioritisation

Routine requests for review should be seen within a week from the request being made. Urgent referrals needing seen should be reviewed within 24 hours where possible or telephone advice at the time of the request being made to ensure appropriate action put in place for the patient, this response may be by the a member of the wider nursing team or Call for Care during the Out of Hours period. Clinical judgement about whether a patient is routine or urgent will be made by the service provider and not the person making the request.

As the service will have a large number of patients on the Practice records, requests should be reviewed on a case by case basis to determine the need for clinical prioritisation, which will also be determined by the level of dependency of individual caseloads triggered by integrated team working.

Discharge criteria and planning

Patients will stay under the care of their GP and will receive support from the community respiratory team when needed. As such patients will be followed up

according to need and will move on and off the 'active' caseload of the service as clinically appropriate.

3.5 Interdependence with other services/providers

It is expected that in providing this service there will be effective communication between the provider, general practitioners and local health services such as secondary care and early supported discharge schemes. Where necessary the service will have a duty to signpost and work with other services in achieving improved seamless patient care particularly in cases of potential differential diagnosis.

The service will work closely with the CCG prescribing and medicines management team to ensure appropriate prescribing for the management of respiratory conditions for all patients.

The service will work collaboratively with the care home service to support the management of patients in care homes with respiratory conditions linking into CCG medicines management staff.

There will be a requirement for communication with other services, e.g. for analysis and reporting of tests, support with community services where relevant, patient support groups (especially the M&A BLF Breathe easy Group), voluntary services, prescribing and pharmacy teams, reporting & performance monitoring, CCG.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Department of Health (2005) *The National Service Framework for Long Term Conditions*. DH:London.
Department of Health (2008) *Raising the Profile of Long Term Conditions Care:A Compendium of Information*. DH:London.
Department of Health (2009) *Supporting People with Long Term Conditions:Commissioning Personalised Care Planning-a guide for commissioners*. DH:London.
Department of Health (2010) *Equity and excellence: Liberating the NHS*. DH:London.
Department of Health (2011) *An outcomes strategy for Chronic Obstructive lung Disease (COPD) and Asthma in England. DH: London Department of health (2011-12) The NHS Outcomes Framework. DH London*
NICE Clinical Guideline 101(2010) Chronic Obstructive Pulmonary Disease http://guidance.nice.org.uk/CG101
NICE QS 10 (2011) Chronic obstructive pulmonary disease quality standards.
NICE QS 25 (2013) Quality standard for Asthma

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

The service provider will be expected to comply with all relevant policy and guidance, e.g. Data Protection Act 1998, Caldicott Guidelines 1997, Access to Health Records 1998 and Confidentiality Code of Practice 1998.

4.3 Applicable local standards

Ensure all staff are suitably trained and up to date with current guidance (in particular Nottinghamshire guidance) around medicines management and appropriate prescribing
Ensure staff delivering services are competent and skilled, and undertake ongoing professional development to maintain skills and accreditation
The service will be expected to comply with national and local clinical guidance or policy.
Ongoing clinical audit will be undertaken to evaluate clinical effectiveness of the service and the provider will have arrangements in place to manage; Untoward Incidents, including reporting mechanisms to communicate with the CCG and relevant stakeholders.
The service will be expected to establish and maintain robust systems for data recording and sharing, in line with current codes of practice for Data Protection and Information Governance

Service Risks
The provider will be expected to identify and mitigate for any potential risks to the service, through robust systems and processes, e.g. operational, governance, business continuity

Continual service Improvement Plan

The commissioner and provider have a commitment to work together to continually improve the service and react to innovative and dynamic ideas.

Service improvement may be stimulated through areas such as:

- complaints
- monitoring information
- provider feedback
- learning from other services
- needs assessments
- service user feedback
- national or local guidance

This must be an ongoing and dynamic process.

5. Applicable quality requirements and CQUIN goals

NB: SECTIONS 5-7 ARE OPTIONAL

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

SEE KPIS on separate sheet

KPIs for Resp spec.docx

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
Bases provided by NHT across Mid Nottinghamshire

Location of service delivery
Staff will spend their time with patients in GP practice and their usual place of residence; however they may also provide clinics from other community locations. The provider will need to evidence an approach to Health and Safety requirements and evidence a Lone Working Policy.

7. Individual Service User Placement

COST ENVELOPE TO BE EMBEDDED