SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Primary Care Quality Assured Spirometry
Commissioner Lead	Claire Morrissey, Solutions & Development Manager
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Lung disease is the UKs third biggest 'killers', where over 12 million people have a diagnosis of a lung condition, with an estimated total cost to the UK of £11.1billion. Asthma costs the NHS c£3billion per annum, where COPD costs the NHS c£1.9billion per annum.

COPD is the only major cause of death that is on the increase in the UK. Within Respiratory illness, 29% of costs are associated with COPD.

The UK has one of the highest emergency admission and death rates for childhood Asthma in Europe.

Chronic obstructive pulmonary disease (COPD) describes lung damage that is gradual in onset and that results in progressive airflow limitation. This lung damage, when fully established, is irreversible and, if it is not identified and treated early, leads to disability and eventually death. The greatest cause of COPD is smoking. Other factors include workplace exposure, genetic make-up and general environmental pollution.

Around 1.2 million people in the UK are living with diagnosed COPD (British Lung Foundation, 2018) and numbers are increasing which indicates un-diagnosed cases are being identified more readily, and that record-keeping is better, as well as a possible increase in incidence. Previous research indicated that around 60% of cases remain undiagnosed, but more research is needed to ascertain if this is still the case.

The main symptoms of COPD are shortness of breath and reduced exercise ability, together with a cough and production of phlegm, which may get worse at certain times of the year.

COPD is a progressive illness, and the likelihood of people dying as a result of COPD increases with age. Most patients are not diagnosed until they are in their fifties. In the past, many people described as suffering from COPD were diagnosed as having chronic bronchitis, emphysema or chronic unremitting asthma. In some people, chronic bronchitis and emphysema affect different parts of the same lung, and so the two conditions can often occur together.

COPD causes more than 25,000 deaths a year in England and Wales, one person dies from the condition every 20 minutes. Data from the World Health Organization (WHO) shows that death rates from diseases of the respiratory system in the UK are higher than both the European average and

the European Union (EU) average with a marked difference for females where UK death rates from respiratory disease are three times higher than those in France and Italy.

Providing care and treatment for these people places a significant burden on the NHS. The profile of COPD means that it is an expensive disease for the NHS when it is not identified and treated early. It is the second most common cause of emergency admission to hospital and fifth largest cause of readmission. The direct cost of COPD to the UK healthcare system is estimated to be between £810 million and £930 million a year and, without change, this impact is set to grow.

Raising awareness of COPD is an important strand in securing better outcomes. Many people are not aware of COPD, its symptoms and its risk factors and are therefore unlikely to change behaviours that lead them to avoid the causes and exacerbating factors, such as cigarette smoke and workplace dusts and gasses. Lack of awareness also contributes to a tendency to ignore early symptoms of cough and breathlessness, only requiring treatment when the disease is fairly advanced, by which time a major opportunity to intervene has been missed.

COPD is not curable, but it is treatable. Its progress can be halted, and it can be managed to minimise the burden it imposes. There is a great deal of evidence to show that healthcare interventions do improve outcomes in COPD but late diagnosis, unwarranted variations in treatment, incorrect diagnoses and poor prescribing all contribute to a wide variation in outcomes and costs associated with treating the disease. For the majority of sufferers COPD is a preventable disease therefore education and encouragement of positive behaviours is a key element in all preventative and treatment strategies, making early diagnosis through quality assured spirometry important.

Quality assured spirometry measures the total amount of air that an individual can breathe out from their lungs and how fast they can blow it out. It is important that this procedure is carried out correctly to ensure that patients are diagnosed properly.

Spirometry is required to make a diagnosis in the clinical context of suspected COPD:

- Dyspnoea
- Chronic cough or sputum production
- And/or
- History of exposure to risk factors for the disease

Further information can be found in the most recent GOLD Report (2018, p. 23)

Spirometry is the most commonly performed lung function test. By performing maximal inspiratory and expiratory manoeuvres through a mouthpiece, it provides health care professionals with basic information about a patient's airways function and lung capacity.

Spirometry may be performed for a variety of reasons, including:

- To detect the presence or absence of lung disease
- To confirm the findings of other investigations
- To quantify the extent of lung impairment
- To investigate the effects of other diseases on lung function
- To monitor the effects of environmental exposures
- To determine the effects of medication interventions

The Association for Respiratory Technology and Physiology (ARTP) are the guardians of quality-assured diagnostic spirometry in the UK. Training is available to those who are novices to this measurement and a certification system is used to ensure that those who undertake diagnostic spirometry are performing and interpreting the results to internationally acceptable standards.

The All Party Parliamentary Group (APPG) Report on inquiry into Respiratory Deaths (2014) called

for a system to assess and certify the competence of all healthcare professionals undertaking and interpreting diagnostic spirometry. This document, which is part of a suite of resources relating to quality assured diagnostic spirometry, sets out a framework for taking forward the APPG recommendations.

Key to this framework is the establishment of a National Register of certified healthcare professionals and operators. This Register will ensure that commissioners, employers, and patients can be assured that healthcare staff performing and/or interpreting diagnostic spirometry hold a valid, current certificate of competence. The Care Quality Commission[1] expects practices to be able to demonstrate:

- How they ensure spirometry equipment is cleaned and maintained according to the manufacturer's guidance (KLOE S3 – reliable systems, processes and practices).
- That all staff who perform spirometry tests or interpret results are competent (KLOE E3 - staff skills, knowledge and experience). They can demonstrate this if the staff are on the National Register.

The ARTP are also responsible for holding the national register of spirometry certified practitioners.

1.2 Local Context

The CCG has identified COPD and Asthma as a priority area.

Currently in Wolverhampton there are approximately 5200 individuals with diagnosed COPD. In the last year around 500 new cases were diagnosed in the city which was 10.8% of the current register.

In December 2015, there were 17,263 patients on the Asthma QOF registers, approximately 6.5% of the total registered population. National average prevalence for Asthma in 13/14 was 5.9%, locally the prevalence is 6.1%.

Spirometry will be provided for new diagnoses, and should be considered where a patient's condition has deteriorated to assess any changes in lung function only. Taking into account additional numbers for example those that would need to be screened and found not to have COPD or Intermerdiate probability of Asthma, or where a patients condition has deteriorated and requires a repeat test activity has been projected as four times the amount of patients who have had a new diagnosis within 18/19.

As it is expected that this would rise again year on year through enhanced case finding schemes. To be able to meet demand it is important that each practice group is offered the opportunity to provide services to their practice population.

Regarding diagnosis of Asthma; the BTS and NICE are due to release joint guidelines in the summer of 2019. Locally, Wolverhampton, upon clinical advice from Acute and Primary Care respiratory specialists, have adopted BTS guidelines, and will continue to do so until the aforementioned joint guidelines are released.

BTS/SIGN guidelines recommend that Spirometry, with bronchodilator reversibility is the preferred investigating test for patients with Intermediate probability of asthma. For the purposes of primary care registers, QOF also requires a prescription within 12 months of diagnosis.

[1] https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-83-spirometry-general-practice

Through primary care data extracts, it is not possible to extract numbers of new diagnosis that were considered to be of intermediate probability, and therefore requiring spirometry with bronchodilator reversibility.

Therefore the below provides an indication at primary care hub level the number of new diagnosis for COPD and Asthma, with a prescription within the previous 12 months

Group	New COPD cases in 2017/18	New Asthma cases with prescriptions in 2017/18	Subtotal of new diagnosis	No of Spirometry appointments required
PCH1	108	119	227	908
PCH2	134	135	269	1076
Unity	149	175	324	1296
VI	116	77	193	772
Total	507	506	1013	4052

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 and protecting them from avoidable harm	√

2.2 Local defined outcomes

2.2.1 For patients:

- Early/ timely access for diagnostic spirometry and appropriate intervention
- High satisfaction with users of the service
- Improved clinical outcomes for patients
- Patients treated in the right place/ setting
- Reduced referrals into secondary care

2.2.2 For Clinicians

- An improved community offer for patients
- Provision of timely and accurate diagnostic assessment and appropriate intervention
- Improved knowledge and management of respiratory conditions amongst multi professionals, leading to improved referrals and overall proactive patient care
- Good working relationships and robust referral pathways within Wolverhampton City
- Robust clinical governance arrangements

2.2.3 For Commissioners

- Compliance with local and national recommendations to bring care closer to home
- Compliance with national guidelines relating to the competency assessment framework for Quality

Assured Spirometry

- Sustainable, cost effective service without a compromise on quality
- A reduction in secondary care activity and associated costs
- Strong relationships between commissioners and providers to ensure service improvement is a priority

3. Scope

3.1 Aims and objectives of service

Wolverhampton CCG wish to commission primary care based spirometry service to:

- Provide accurate and timely diagnostic quality assured Spirometric assessment of patients with respiratory symptoms that commonly fit with COPD or Intermediate probability of Asthma. To ensure the diagnosis is correct and the right treatment pathway is followed in line with current National and Local Guidelines
- Enable the responsible GP/Clinician to develop a personalised service for individuals
- Provide this assessment to enable the referring GP/Clinician to initiate the future management
- Provide this service in the community closer to home
- Enable early diagnosis leading to improved quality of life for people with specific respiratory conditions and their carers
- Enable Referrer's timely and appropriate access to the services for patients presenting with symptoms
- Proactively improve the service as appropriate to meet evolving local health needs and priorities
- Enables the GP/Clinicians to then enhance and support the service users to 'self-care'
- Represents best value in terms of quality and costs

The provider will perform the diagnostic Spirometric test upon appropriate request, to adults (over the age of 18 years old) living in Wolverhampton or registered with a Wolverhampton GP Practice in a community setting, where the provider is querying a diagnosis of COPD.

The provider will perform the diagnostic spirometric test upon appropriate request to children and younger people (where possible) from the age of 5+ living where the provider is querying **intermediate** probability of Asthma

This is a standalone test to support the comprehensive and holistic assessment performed by the referring GP/Clinician. The Provider will interpret the test and suggest a likely diagnosis. The aim is to deliver care closer to home and helping patients to avoid unnecessary hospital outpatient appointments which prior to this, is the only alternative.

The service will be provided in primary care venues to be determined. The service will provide specialist advice on diagnostic spirometry.

The overall aim of the service provider is to provide Diagnostic Spirometry to those patients identified by their GP/Clinician who have symptoms suggestive of Asthma or chronic obstructive pulmonary disease (COPD), identified opportunistically or through case finding.

The aims of the service are:

- To provide prompt and accurate quality assured spirometry assessments and interpretations

- To accurately assess suspected asthmatic patients with Reversibility testing
- To increase the proportion of people diagnosed with COPD comparing recorded prevalence with predicted prevalence
- To increase the number of people accurately diagnosed at onset or an early stage of the disease
- To help the general population towards decreasing the number of people dying prematurely from COPD due to inaccurate or delayed diagnoses and aim to enhance the quality of life for people with COPD by an earlier diagnosis
- To ensure that all service users have a positive experience of care
- To ensure effective communication between relevant health professionals

The objectives of a primary care Service are:

- to treat all service users and their carers with dignity and respect
- to ensure that the service response will be appropriate, equitable, timely and is convenient and accessible to users, providing a range of clinic availability
- to work in partnership with other health care professionals and provide seamless service to patients and to ensure best outcomes for patients
- to provide direct patient care through a competent, capable and educated, multi-disciplinary workforce of professionals with appropriate ARTP accredited Spirometry training

3.3 Service description/care pathway

The provider will provide ARTP Standard diagnostic assessment and interpretation service to adults (over the age of 18 years old) living in Wolverhampton or registered with a Wolverhampton GP who present with symptoms of Intermediate probability of Asthma or COPD. This is not a service for Annual Reviews.

The service will provide:

- **Quality Assured Diagnostic Spirometry** performed in clinic for people presenting with symptoms of COPD. This will be in line with ARTP accreditation and approaches. (*Quality Assured Diagnostic Spirometry should be delivered in accordance with BTS/SIGN, NICE, ARTP and GOLD guidance)*
- **Working with patients and carers** providing accurate information, advice and education about the test appropriate to the needs of the patient
- **The service provision will enable correct diagnosis** by performing the test, for practices that do not have the scope or ability, thereby reducing health inequalities, in line with the 'missing millions' (BLF, 2009)
- **Communicating with GPs** and other health care professionals (as appropriate) with regards to clinical findings within agreed pathways and timescales

3.4 Service Model and Care Pathways

The service will be delivered in the best interest of the patient, reducing inequality and in accordance with the approved National and Local guidelines.

3.4.1 Manage referral and arrange assessment

The service provider, is responsible for raising awareness of the service and ensuring referrals are made to the service.

- The service shall ensure that all referred patients are offered an assessment if appropriate
- The service shall liaise with primary care practices within their hub in order to achieve integration

across the system and increase uptake of referrals. If the referral information is not complete, the Provider will reject the referral outlining the reasons for rejection of the referral

- The Provider shall accept or reject the referral to the Spirometry Service based on the information contained in the referral information. If the referral is rejected, the Provider shall record the reason and refer the patient onto GP-supported management

The service shall contact eligible patients and carers by telephone or letter within 2 weeks of receipt of referral. In either case, the communication will quote the GP's name as the referrer and will explain the service and invite the patient to attend a spirometry assessment (initial offer).

- The service shall send patients who cannot be contacted after 2 attempts within 4 weeks, an offer of an assessment date in writing. The Provider will use all reasonable efforts to contact eligible patients including contact by mobile phone, text message, and email as appropriate
- If the offer is not accepted, or the patient cannot be contacted within 2 attempts, **the patient shall be referred back to the GP** as a failed attempt
- The referrer shall ascertain whether the patient has had an acute exacerbation within the previous 4-6 weeks. Where there has been an acute exacerbation within the previous 4-6 weeks the patient will not be ready for an assessment, the Provider shall arrange for an assessment to take place no earlier than 4-6 weeks from the start of the acute exacerbation, or within a longer period as agreed to be appropriate in respect of chronic unstable patients. The Provider shall then contact the patient within 3 days prior to the assessment date to confirm that the patient is still willing and ready to attend the assessment, and has not had a further exacerbation. Where the patient is ready and willing, they shall be offered an assessment date that is within 6 weeks of successful contact

The Provider shall re-offer (second offer) an assessment date to patients who are not ready and/or not willing within a reasonable and mutually agreed timeframe of the initial offer.

3.4.2 Confirm COPD Spirometry and Assessment booking

A proposed assessment date should be accepted by the Patient/Carer, assuming the GP/Clinician has provided appropriate information, and the patient is fully aware of the preparation for the appointment. Information provided to the patient, should contain the following as a prerequisite for attendance:
The information shall ask the patient to:

- Avoid smoking for at least 24 hours before the test
- Avoid eating a large meal before the test
- Avoid exercise or exertional activity before the test – Avoid rushing to the appointment and give extra time to arrive
- Not to wear restrictive clothing that may affect ability to blow
- Not take bronchodilators prior to the test Reversibility patients should be asked to avoid short acting bronchodilators (SABA) – e.g. salbutamol, in the four hours before the test. Long acting (LABA) bronchodilators should not be taken in eight hours before test, and Long Acting Muscarinic Antagonists (LAMA) for 36 hours.

The GP shall advise the patient to take all prescribed inhalers to the appointment (in the event that the patient has been prescribed inhalers but has not undergone quality-assured diagnostic spirometry).
The Provider shall send confirmation of the date, time and all relevant information to the patient and/or carer regarding the assessment and encourage the patient to make every effort to attend the assessment.

3.4.3 Clinical Assessment and Diagnosis

It is the responsibility of the referrer to ensure the clinical assessment and differential diagnosis is done before referral into the service. The Provider will only be responsible for suggesting a most likely diagnosis and communicating this to the patient and referrer. It is the GP/Clinicians responsibility to make this diagnosis and commence relevant management.

3.4.3.1 Patients should be made aware of the risk of cancellation of the appointment if they are late by 15 minutes.

3.4.3.2 The Provider shall ensure that the patient has adhered to pre-visit requirements and confirm that there are no contraindications, by utilising a brief pre-assessment checklist of the patient to ensure it is safe to proceed.

3.4.3.3 The referring clinician shall ensure that an up-to-date smoking history is provided. The history shall include an assessment of pack years smoked (number of cigarettes smoked per day multiplied by the number of years smoked and divided by 20).

3.4.3.4 The Provider shall undertake a quality-assured diagnostic spirometry test ensuring that the test is undertaken in an appropriate setting.

3.4.3.5 The Provider shall, depending on the extent that any of the pre-test advice has been followed by the patient, use their discretion to decide whether or not to proceed with the test. If they decide not to proceed they will rebook the test if appropriate.

3.4.3.6 The Provider shall assess the patient for contraindications to spirometry in accordance with the guidelines.

3.4.3.7 The Provider shall explain and demonstrate to the patient what will happen during the tests and ensure that the patient understands what is required of them, and why it is important to perform each manoeuvre as best they can

3.4.4 Post-bronchodilator testing

As discussed above the Provider shall offer post-bronchodilator testing where appropriate.

The Provider shall record:

- the post-bronchodilator results using the largest post-bronchodilator FEV1 and the largest VC or FVC to determine the FEV1/VC ratio
- the flow/volume and time/volume graphs
- any technical comments on the spirometry as detailed in the Guide

3.4.5 Repeat Spirometry Testing

Where a patient has two exacerbations either requiring hospital admission or treated elsewhere and reported in any 12 month period and they have a large "step change" in deterioration they may require a repeat spirometry test.

3.4.5 Diagnosing COPD

The Provider shall suggest a diagnosis based on the findings of the physiological tests in accordance with the recommendations set out in the respective National Clinical Guidelines. As some symptoms are not unique to Asthma & COPD, other disorders may need to be considered. The GP has the responsibility to consider differential diagnosis and confirm with the patient as some patients may not have a respiratory condition.

The Provider shall grade severity of airflow obstruction in accordance with the NICE guidance which grades the disease by reference to airflow obstruction from Stage 1 to Stage 4 (NICE 2010).

3.4.6 Diagnosing Asthma

The Provider shall suggest a diagnosis based on the findings of the physiological tests in accordance with the recommendations set out in the respective National Clinical Guidelines. As some symptoms are not unique to Asthma & COPD, other disorders may need to be considered. The GP has the responsibility to consider differential diagnosis and confirm with the patient as some patients may not have a respiratory

condition.

The Provider shall grade severity in accordance with BTS/ SIGN Guidance 153 (Sept 2016)

3.4.7 Communicate the diagnosis

3.4.7.1 Communicating results to the Referring GP/Clinician
The Provider shall communicate the results of the spirometry to the patient's GP together with all appropriate information in respect of it including the test results. Where possible, the provider shall communicate the results electronically with the GP. A response letter will be sent alternately until communication between computer systems is overcome.

3.4.7.2 Data Collection
The Provider shall employ a system of data collection, storage, retrieval and transmission to capture the information set out below in respect of the COPD Spirometry and Assessment Service. Patient confidentiality and data protection should be considered at all times in this process. This includes appropriate records of the different sections of the spirometry test. Good practice suggests that all efforts should be stored graphically and as raw data with the selected best efforts indicated and an indication of the quality shown. Any technical problems or patient limitations or errors should also be recorded.

3.4.7.3 Patients with an uncertain diagnosis
Should a diagnosis be unclear for any reason, the Provider shall explain the basis of the recommendation and the on-going assessment is the responsibility of the GP/Clinician.

3.4.7.4 Communicate serious illness notification to GP
Where a certain diagnosis is suspected, the Provider shall communicate a 'serious illness notification' to the patient's general practitioner. This can take a format similar to that used for a diagnosis of cancer and communication should be by email or fax via nhs.mail.

3.4.7.5 Discharge Letter
The discharge letter summarising the main points of the tests results. For patients diagnosed with COPD or asthma it is the GP's responsibility to ensure that the patient is entered onto the relevant QoF register and that the correct read codes are added at the same time in the patients records to meet the correct standards for diagnosis and documentation (E.g post-bronchodilator Spirometry, negative or positive reversibility etc

3.4.8 **Review and Audit of the Service**
The Provider agrees to engage and support the commissioner in undertaking periodic review and audit of the service to assess overall results and its performance to ensure a high quality and safe service compliant with all national and local standards is being delivered to the local patient population.

The relevant NICE and ARTP guidelines are to be followed as they relate to equipment calibration, testing methodology and interpretation of results. Practices will accept referrals for spirometry from other GP Practices who are unable to undertake their spirometry in-house. Participation in a quarterly audit and annual audit is required with a maintained register of patients receiving this service.
Nurses and HCAs performing spirometry must hold the appropriate ARTP certificate and remain fully updated thereafter. All practices providing the Service are to provide an annual review which will include:

- Brief details as to the arrangements for testing
- Name and position of staff performing spirometry
- Name and position of staff interpreting spirometry
- Accreditation details of health care practitioners performing and interpreting spirometry
- Details of the standards of calibration and maintenance of Spirometers

3.4.9 **Equipment**
All equipment required by the staff is provided as part of this service by the provider. National guidelines

regarding medical equipment required to deliver the service will be adhered to at all times.

3.5 Population covered

The service will be provided to all Wolverhampton residents (over 18 years for query COPD, and over the age of 5 for query intermediate probability of asthma), registered with a Wolverhampton GP Practice, even if GP surgeries have patients residing outside Wolverhampton boundaries. Such patients need to be able to attend the set clinics.

The service provider will receive referrals from GPs surgeries within their respective primary care network

3.6 Any acceptance and exclusion criteria and thresholds

3.6.1 Referral Criteria and Sources

The service will be expected to meet the needs of adults who are deemed to be at risk and display the symptoms suggestive of Asthma or COPD, but **who have not already received a diagnosis** confirmed by quality-assured diagnostic spirometry.

The service will primarily accept referrals from General Practitioners Surgeries (GPs) within their respective primary care network, although there might be referrals received on occasions where a patient has recently commenced treatment on the Asthma or COPD pathway but does not have a diagnosis confirmed by quality assured diagnostic spirometry.

3.6.2 Exclusion Criteria

Any Patient already diagnosed with COPD or Asthma. Any patient who has had an acute episode within 4-6 weeks

3.6.3 Accessibility

The service will be accessible to all, regardless of disability, race, gender reassignment, religious/belief, sex, pregnancy and maternity or sexual orientation, income levels and deal sensitively with all service users and their family/friends and advocates

3.6.4 Response Time Detail and Prioritisation

- 2 weeks from receipt of referral

3.7 Interdependence with other services/providers

The service will work in conjunction with:

- General Practitioners
- Practice Nurses
- Allied Health Professionals
- Primary Care and CCG teams
- Respiratory Specialists
- Service users, carers and the public
- Nursing and Residential Homes

This list is not exhaustive and may include others at different stages of the patient pathway

3.8 Interdependencies

Effective delivery of the service is dependent upon a number of factors including:

- Promotion and knowledge of the service

- Staff base to accommodate referrals
- Equipment; including spirometry, computers, telephones and other for office based functions
- Estates (availability and accessibility of suitable premises to operate clinics from and rent costs incorporated into the costings)
- Referrals from GP Practices, to include all the clinical information and provide the relevant medication for reversibility

3.9 Days / Hours of Operation

The service should be accessible from Monday to Friday. Operating hours within these days is for the discretion of the provider, but must ensure the hours are appropriate to the needs of the service and patients and that over a weekly period, both morning and afternoon appointments are available. The provider may also wish to provide the service during extended hours.

3.10 Housebound patients

The term 'housebound' means an adult who is unable to leave their place of residence without the support of an ambulance or patient transport. For housebound patients requiring diagnostic spirometry the provider will arrange patient transport to attend the community clinic.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- (ARTP) Association for Respiratory Technology and Physiology: http://www.artp.org.uk/en/spirometry/
- (BTS/SIGN) British Thoracic and Scottish Intercollegiate Guidelines Network – 141 – British Guideline on the management of Asthma, 2014 www.brit-thoracic.org.uk
- (BTS/ SIGN) British and Thoracic and Scottish Intercollegiate Guidelines Network – 153 – British Guideline on the management of Asthma, 2016 www.brit-thoracic.org.uk
- Department of Health: COPD Commissioning Toolkit, 2012
- GOLD (Global initiative for Chronic Obstructive Lung Disease) COPD guidelines www.goldcopd.org
- GOLD Asthma (2015) www.ginasthma.org
- Interactive Health Atlas for Lung conditions in England, 2011
- NICE COPD (2010) www.nice/guidance/cg101.org.uk
- NICE Asthma (2013) www.nice/guidance/qs25.org.uk
- QOF (Quality and Outcomes Framework) www.nhsemployers.org
- Review of Respiratory Care across Sandwell, Birmingham and Solihull (2013), Respiratory Clinical Network.
- 'Why Asthma still Kills' Royal College of Physicians, (2014) www.rcplondon.ac.uk

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

The service will use as a resource to refer to the following organisations to source and share best practice:

- The British Thoracic Society (BTS)
- The Primary Care Respiratory Service (PCRS)
- The European Respiratory Society (ERS)

- The British Lung Foundation (BLF)
- NICE for COPD & Asthma
- GOLD International Guidelines
- Other community spirometry providers

4.3 Workforce

The service provider will:

- Determine the optimum skill-mix of appropriately qualified staff, ensuring annual leave, sickness and maternity/paternity leave entitlements do not affect the service availability
- Provide clinics with a range of appointments in a primary care setting to address inequality
- Ensure that the educational provision for clinical staff employed in providing the service is an integral component of the service
- Encourage and enable staff to undertake spirometry training as appropriate (i.e. as identified via PDR)
- Ensure staff are ARTP qualified and accredited with their respective professional body e.g. NMC, MRCP, HCPC and there are no concerns about clinical practice
- Ensure that all staff in contact with patients are Disclosure and Barring Service (DBS) checked and hold work permits if appropriate
- Be able to guarantee a safe service level at all times to meet the potential demand

4.4 Quality of Service

In order to demonstrate quality of the service, the provider should:

- Assess patients' satisfaction with the service through a monthly patient experience survey
- Be able to demonstrate a robust process for dealing with patient complaints and compliments and evidence that these have been acted upon to ensure continuous improvement
- Demonstrate management of capacity and demand for service delivery within the funding agreement. Additional activity will need additional funding.
- Provide evidence to demonstrate that the service takes in to account the different needs and inequalities for patients using the service, and how service responds to these
- Demonstrate integrated working with other healthcare providers and services to ensure seamless, joined up care for patients
- Conduct quality control checks in accordance with ARTP recommendations
- Maintain an equipment log in accordance with ARTP recommendations

5. Applicable quality requirements and CQUIN goals

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

Local Quality	Threshold	Method of	Consequence of	Timing of application	Service

Requirement		Measurement	breach	of consequence	Spec No
Total number of spirometry tests	100% of contracted value	Review of monthly Service Quality Performance Report		Monthly	
Total number of housebound patients seen by the service	Based line required	Review of monthly Service Quality Performance Report		Monthly	
Percentage of routine appointment patients seen within 2 weeks	100%	Review of monthly Service Quality Performance Report		Monthly	
Number of patients DNA	<10%	Review of monthly Service Quality Performance Report		Monthly	
Number of appointments cancelled by the provider	<5%	Review of monthly Service Quality Performance Report		Monthly	
Percentage of users (patients and carers) satisfied with service	95%	Review of monthly Service Quality Performance Report		Monthly	

5.2 Applicable CQUIN goals (See Schedule 4 Part D)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be provided in primary care venues, providing clinics as required for the safe delivery of the service, in line with the care closer to home agenda. The provider will ensure that where services are delivered that the premises adhere to all External Assurance Standards.

7. Individual Service User Placement