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Specification Use

This specification has been designed to assist commissioners in the delivery of services for Home Oxygen Service assessment and review. The text within square brackets [ ] of this document should be completed by the commissioner in order to reflect local needs and to help inform responses from the Provider(s).

The specification is not mandatory and the commissioner should review the whole of the specification to ensure that it meets local needs and, once agreed with the Provider, it should form part of a re-negotiated contract or form the relevant section of the NHS Standard Contract.
A Key Outcomes
The expected high-level, key outcomes of the Home Oxygen Assessment and Review Service (HOS-AR) are:

- To provide a systematic and integrated assessment and review of Home Oxygen services
- To reduce/eliminate waste and poor quality care
- To ensure that users of the Service have a positive experience of care

B Purpose of the Service

B1 National and Local Context
The current model of Home Oxygen Service provision is set out in the Home Oxygen Service – Assessment and Review Good Practice Guide April 2011 published by Primary Care Commissioning (the “GPG”). This was developed by a range of stakeholders including the Primary Care Respiratory Society, the British Lung Foundation, and the British Thoracic Society, the British Paediatric Respiratory Society, the Department of Health and patient representatives.

The purpose of this service specification, which is based on the GPG, is to assist and facilitate Commissioners in the process of re-procuring and managing effectively new oxygen supply contracts. New procurement arrangements apply from 2011 onwards and the clinician will decide on the appropriate equipment, after discussion and in conjunction with the patient and his/her carer, to improve compliance and levels of satisfaction.

The service specification accompanies three other service specifications:

COPD Spirometry and Assessment Service
Manage COPD Exacerbations; and
Pulmonary Rehabilitation

These service specifications support the aims and objectives of the Department of Health’s Strategy for Chronic Obstructive Pulmonary Disease\(^1\), and the Outcomes Strategy for people with COPD\(^2\). They are designed to facilitate and promote systematic and good-quality service provision at suitable levels of competence throughout on an integrated basis across the care pathway and thus promote quality and productivity across the NHS.

This service specification and the GPG should be read together. It is anticipated that both documents will be updated as necessary to reflect the new architecture for the NHS, and any new developments and arrangements that are appropriate for the management of home oxygen.

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\(^1\) Consultation on a Strategy for Services for COPD in England – Department of Health England, February 2010

\(^2\) An Outcomes Strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England – Department of Health 18 July 2011
B1b Local Context

[The commissioner should insert information about the HOS-AR which is relevant to local factors that will influence the way the Provider delivers the Service:

- Demographics
- Epidemiology
- The organisations commissioning the service
- Joint Strategic Needs Assessment (JSNA) and interrelationship with local Health & Well-being Board]

The Department of Health figures indicate that 85,000 patients in England have oxygen at home at an annual cost of about £100 million. It is estimated however that between 24 and 43% of the oxygen provided is not used or delivers little or no clinical benefit. Some patients may be given oxygen to treat breathlessness but unless they are hypoxic, at rest or on exercise, there can be no benefit and it should not be prescribed. Waste may also result from inappropriate methods of delivery e.g. cylinders for LTOT or prescription of ambulatory devices for people confined to the home.

Data made available to PCTs by the oxygen supply companies will identify those people who currently make little or no use, or over use the oxygen they are currently prescribed. In such circumstances a specialist review is needed and where there is no evidence of clinical benefit oxygen therapy removed after appropriate patient advice and counselling.

In a few instances, patients who have a clinical requirement for oxygen may not take advantage of the oxygen therapy prescribed for them. Where regular reviews are in place, the reasons for the under-usage can be established and overcome. In addition, potential risk from fire or explosion in the case of smokers also needs to be assessed by the HOS-AR.

Commissioners therefore need to consider how to best commission a HOS-AR service. Local circumstances will determine the most appropriate service and the extent to which joint commissioning by consortia is appropriate. It is worth noting that economies of scale apply to the home oxygen service, as with other NHS services, and cost reductions can be expected where consortia arrangements are adopted.

PCTs will also want to consider how to balance the opposing objectives of providing ease of access to assessment and review with the need for sufficient throughput to underpin service quality.

Similarly, commissioners will wish to consider where services might be provided and what facilities they should provide. The provision of pulse oximeters in general practice for example would enable general practice to screen patients. If the SpO2 is equal to or more than 92% there is no need for a specialist assessment for LTOT (although there may still be a role for ambulatory oxygen in occasional patients). An increasing number of specialist services provide oxygen assessment services which may avoid delay. Further modest investment in the provision of pulse oximeters and blood gas analysers, for arterial or capillary blood gas measurement, might enable a full assessment to be made, following diagnosis, in the community. Such assessment needs to include testing as to what equipment best suits the individual’s needs. A considerable part of home oxygen prescription is in acute/secondary care and that acute care must provide an integrated service with any HOS-AR service. The assessment service can also be in secondary care.
B2 Aims and Objectives
The aim of the HOS Assessment and Review Service is

- to ensure that people prescribed oxygen and prescribing clinicians alike should be well informed about the nature, scope and capability of the home oxygen service
- to have quality at its core and be accessible, safe, effective and responsive to patients
- be evidence-based, clinically led and continually strive to improve outcomes for patients
- be affordable and represent good value for money

The objectives of the Service are:

- To provide easy access to assessment and follow up procedures carried out by appropriately qualified and trained healthcare professionals using appropriate diagnostic equipment.
- Service quality will be improved through more effective and speedier diagnosis, leading to a higher standard of clinical treatment and improving outcomes.
- By targeting the service on those who will benefit from home oxygen, affordability and value for money will be strengthened.

C Scope

C1 Patients
Adult patients who are prescribed oxygen often have respiratory disease, typically COPD, cystic fibrosis or pulmonary fibrosis. It is also used as treatment for some hypoxic patients with cardiac disease and some neurological disorders. (e.g. Cluster headaches.) Children with chronic lung disease who live in the community, including survivors of premature birth, may require home oxygen. Oxygen is sometimes also of value for palliation in end-of-life care.

The HOS Assessment and Review Service is designed to meet the needs of patients who might benefit from home oxygen. In most cases such people will show resting hypoxaemia with a SaO2 < 92%.

C2 Exclusion criteria for this Service
- Patients who cannot benefit from home oxygen.
- Children (as they are under paediatric services and usually have their own community services. The care pathways for children are set out in Appendix 5 GPG).
- Patients who have not had a clinical assessment and diagnosis (except palliative patients who are not assessed or reviewed through the normal service. Palliative patients should have evidence of hypoxaemia. Some assessment of equipment may be needed and thus prescribers for palliative patients may need discussion with the HOS-AR service).
C3 Equity of access to services, venues and operational hours

- [Describe the Commissioner’s requirements for ensuring that its services are accessible to all, regardless of age, disability, race, culture, religious belief, gender or sexual orientation, or income levels, and deals sensitively with all service users and potential service users and their family/friends and advocates. This needs to reflect The Equalities Act 2010. Commissioners are advised that they may, depending on existing local services & resources, have to commission appropriate venues and transport services separately – see also paragraph C7 below. Language services may also be required in order to assist with translation requirements where patients do not speak English. The general points listed below will apply in all cases.]

- The HOS-AR will need to be sited so as to be suitable and easily accessible to patients with adequate parking and good public transport links with easily accessible buildings including provision for people with disabilities.

- Special consideration should be given to those patients who are most limited by their breathlessness (i.e. MRC 5 – housebound) with regards to the provision of transport

- A risk and suitability assessment of the venue must be undertaken.

C4 Referral sources

The Provider can receive referrals from a broad range of sources that have made an assessment, which include but are not be limited to, organisations in the following settings:

- Primary Care
- Intermediate Care
- Secondary Care
- Tertiary Care
- Others (for example: Occupational health, private health, self referral by patients who carry an assessment)

C5 Interdependencies with other services

[Describe all relationships between the service and other providers of health and other services locally. This will include but not be limited to COPD and other respiratory services (including lung function), cardiac services, neurology, care for the elderly, social care, smoking cessation services and pharmacists and palliative care services.

The fire service should conduct an on site safety check/risk assessment when liquid or cylinder oxygen is provided. Smoking households have a higher risk of domestic fire which could be potentially dangerous when liquid or cylinder oxygen is involved. Fire services must be notified whenever liquid or cylinder oxygen is installed.

In order to minimise the risk of hypercapnic respiratory failure, the ambulance service should also be notified in the event of emergency transport to hospital. See recommendation 18 of the COPD Strategy “All people with COPD in respiratory failure should be issued with Oxygen Alert cards and ambulance staff should be able to recognize and respond appropriately to respiratory failure in COPD”].
D Service Delivery

HOS Assessment and Review Service Pathway

As noted above the HOS-AR service must ensure good integration with a number of different patient pathways. As the GPG states good communication between all staff – multidisciplinary and multiprofessional - is essential: the patient's record needs to be up-to-date and there should be a register in every PCT of all patients prescribed home oxygen. Integration with acute care is necessary if the oxygen is prescribed in acute care and the patient followed appropriately.

The GPG and this Service specification are not mandatory but are designed to implement and reflect existing guidelines of the British Thoracic Society (BTS) and meet the needs of local people and communities. The overriding objective is to drive up standards and improve outcomes and the quality of the service for patients.

The purpose of this document is to set out the principal requirements and characteristics which are expected of a systematic and integrated service for HOS-AR.

There are four principal stages as follows:

- **Stage 0** - Identify and refer patient for home oxygen assessment
- **Stage 1** - Home Oxygen Assessment
  - **Stage 1 A** - Assessment for long-term oxygen therapy
  - **Stage 1 B** - Assessment for ambulatory oxygen
- **Stage 2** - Follow up home visits
- **Stage 3** - Withdrawal of oxygen therapy

The detailed requirements for each stage are set out below, including the key deliverables and associated indicators at each stage. Stage 0 is included in the service specification to confirm the obligations to be placed on the Stage 0 Provider by the Commissioner as it is critical to the success of the service being commissioned.

The Provider is required to follow NICE clinical guidelines and the recently issued NICE quality standards and BTS guidance.

### Stage 0 – Identify and refer patient for home oxygen assessment

<table>
<thead>
<tr>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

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3 NICE Quality standards for chronic obstructive pulmonary disease (July 2011).
3 Any patient who is hypoxaemic needs a diagnosis confirmed by a specialist physician this can be GP with special interest or respiratory consultant physician.

4 Where the patient’s diagnosis is unclear or when significant co-morbidity might contribute to breathlessness or hypoxaemia e.g. heart failure they should be referred to an appropriate specialist physician. Patients with potential hypercapnic respiratory failure should be also reviewed by a physician.

5 Patients whose oxygen saturation levels are satisfactory (above 95%) may remain under their GP.

6 Patients whose level is borderline (between 92 and 95%) may need further assessment if breathless on exertion or when sleep disordered breathing is a possibility and specialist referral required.

7 Patients who show intermittent or fluctuating hypoxaemia will need to be followed up and assessed more frequently.

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### Performance Indicators:

<table>
<thead>
<tr>
<th>All eligible patients are referred for a HOS assessment</th>
<th>[ ] % of eligible patients have an agreed assessment date booked.</th>
<th>Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This contributes to: [please amend]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensuring patients have a positive experience of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treating and caring for patients in a safe environment and protecting them from harm.</td>
</tr>
</tbody>
</table>

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### Stage 1 – Home Oxygen Assessment

#### Overview

1 The assessment should include quality assured diagnosis, assessment of resting and, when indicated, ambulatory finger or earlobe oximetry. In addition measurement of arterial / capillary blood gases will be required.

2 It should be conducted by a suitably qualified and trained healthcare professional (GPG Appendix 3 Workforce Development to support the Home oxygen service as part of the National Strategy for COPD refers to the Competence Framework which has been developed and lists the titles of the relevant units of competence.)

3 If oxygen therapy is indicated, the safety, flow rate and duration of oxygen should be determined for each patient (usually at least 15 hours per day for long term oxygen therapy in most cases but potentially just overnight for some indications e.g. hypoventilation).

4 In addition patients who make regular trips out of the home for work or leisure will need further assessment for ambulatory oxygen and consideration for pulmonary rehabilitation. If possible pulmonary rehabilitation should be given before ambulatory oxygen.

5 In some cases referral to social, psychological, dietary, occupational therapy or palliative care services will be required.

6 A risk assessment (e.g. smoking, risk of falls etc .. ) needs to be undertaken.
7 Following consultation with the patient, the Provider shall identify the nature of the equipment/delivery system most suited to the patient’s lifestyle.

8 Once identified, this equipment is made available to patients by the oxygen supply companies (GPG Appendix 4).

9 The Provider should ensure that patients and their carers understand how to use the oxygen equipment and manage their treatment. Training and written information (in appropriate languages for non English speakers) should be offered to the patient/carer and repeated at reviews.

10 The home oxygen order form (HOOF) should be completed and sent to the relevant oxygen supplier and details of the plan for managing the patient’s condition should be sent to his/her GP and, where appropriate, consultant physician and home care team.

11 Appendix 5 of the GPG sets out the care pathway.

### Stage 1 Service requirements

#### 1 Skills/competences:
A The assessment service should be provided by an appropriately trained health professional with a suitable clinical qualification (GPG Appendix 3 for a description of the skills/competences required) and the service overseen by a clinical specialist who will normally be a respiratory physician.

B The health professional should have knowledge of other conditions causing hypoxaemia.

C They should have appropriate administrative support (Band 3), and operate within a clear clinical accountability structure.

#### 2 Premises:
A The assessment should take place within premises that are in accordance with appropriate physiology testing facilities especially with respect to infection control, risk assessment and health & safety policy; and are spacious enough to allow for the patient’s capacity for exercise to be assessed safely when assessment of ambulatory oxygen requirement is performed.

B Co-location with other diagnostic facilities (e.g. chest x-ray) would be advantageous.

C The assessment can also be carried out in the patient’s own place of residence, provided that infection control, risk assessment and health and safety policy are adhered to.

#### 3 Equipment:
A The assessment requires measurement of arterial or capillary blood gases as well as oximetry, and such equipment, properly maintained, must be available. In addition, a variety of oxygen equipment, both for LTOT and Ambulatory use, must be available in order to assess the patient and ensure they are given the most appropriate equipment for their needs.

### All Stages - Interdependencies with other services & notifications
As noted in paragraph C3 the HOS-AR is interdependent with all other respiratory services (including lung function), cardiac services, neurology, care for the elderly, social care, smoking cessation services and pharmacists and palliative care and the Provider must liaise as appropriate with these services.

**Local Fire Service**

The Provider must notify the local fire service where cylinder or liquid oxygen is provided and, in the case of persistent smokers, a risk assessment of the premises requested of the fire service.

**Ambulance Service**

Whilst ambulance services now employ universal precautions (28% oxygen) with respect to the risk of high concentration oxygen in acutely unwell COPD patients, and others at risk from oxygen induced hypercapnia, patients known to be at risk should be advised and oxygen alert cards provided. In some cases, a patient specific protocol (PSP) may be appropriate depending on local ambulance service arrangements.

### Performance Indicators

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]% of people being offered an assessment for HOS</td>
<td>To improve access to the HOS-AR</td>
</tr>
<tr>
<td>[ ]% of patients who attend their assessment and have it performed.</td>
<td>To ensure that users of the service have a positive experience</td>
</tr>
</tbody>
</table>

### Stage 1A Assessment for long-term oxygen therapy

**Overview:**

1 Oxygen therapy is appropriate for a clinically stable patient where the arterial blood oxygen measurement is at or below 7.3 kPa (or under 8kPa if complicated by pulmonary hypertension).

2 In such circumstances, the acceptability and safety of supplemental oxygen should be assessed by providing sufficient oxygen to increase SaO2 to 92-94% for at least 30 minutes. In patients with an elevated PaCo2 (> 6.0 kPa) the blood gases should be repeated to exclude a significant (>1.0kPa) rise in arterial CO2.

3 Patients with incipient hypercapnic respiratory failure or with complex co-morbidity eg sleep apnoea may need to be referred for further specialist medical assessment.

4 The assessing clinician should explain the rationale for LTOT and its use. If ambulatory or portable cylinder oxygen is indicated the home oxygen equipment that best meets the patient’s needs and preferences should be provided. Examples of the different types of equipment should therefore be available to demonstrate to the patient to facilitate informed choice and help the patient to understand how to operate it. Once chosen, the clinician should complete a home oxygen order form (HOOF).

5 Patients and carers should have the rationale for oxygen therapy explained and given written supporting information.

6 A risk assessment should be undertaken.
Performance Indicators | Outcomes
-----------------------|------------------
[ ] % of all eligible patients booked for their HOS assessment attend their appointment | To improve access to the HOS-AR for eligible patients
[ ] % of patients who attend have their assessment performed | To ensure that users of the service have a positive experience

Stage 1B Assessment for ambulatory oxygen

Overview
1 Certain patients may require ambulatory oxygen. This should primarily be to support normal activities of daily living including undertaking exercise and trips out of the home and allows a longer daily use of LTOT. In these circumstances assessment should be carried out to simulate daily activities with the aim of avoiding significant desaturation and relieving breathlessness.

2 Ambulatory oxygen is appropriate where the SpO2 reading falls by 4% or more and to less than 90% and the patient demonstrates improved exercise tolerance or comfort with oxygen. The main purpose of ambulatory oxygen is to maximise quality of life for the ambulant person on long-term oxygen therapy. In most cases a simple titration of the oxygen flow rate to minimise oxygen desaturation during the relevant activity is all that is required.

3 Some people who desaturate on exertion do not show resting hypoxaemia. Improved performance with ambulatory oxygen should be demonstrated before prescription. Higher flow rates and/or pulsed oxygen delivery systems may be indicated. Staff with additional experience of exercise assessment may be required in such cases.

4 The clinician should demonstrate the types of ambulatory equipment available and agree with the patient what would best meet his/her needs and preferences. The clinician should have confidence that the patient will make sufficient use of any ambulatory equipment provided, and ensure that he/she has the capacity – with adequate training – to operate it effectively (if necessary with the help of a carer). A HOOF should then be completed. [One issue is that patients cannot be provided with various types of equipment – and should probably be limited to only one or two equipment types maximum for ambulatory oxygen].

5 Portable oxygen (cylinders, LOX or concentrators) should also be made available for children using LTOT because they will need to be taken out of the home by parents/carers.

Performance Indicators | Outcomes
-----------------------|------------------
[x] % of
[x] % of

Stage 2 Follow up home visits

Overview
1 When home oxygen therapy has been started during acute illness a follow up visit that includes a review of the need to continue home oxygen should occur within 6 weeks. This specialist and holistic review should be provided by suitably competent staff.

2 For patients starting home oxygen electively a review in 6-12 weeks will enable re-assessment of the patient’s clinical status, compliance with the oxygen therapy regime
(including the appropriateness of the equipment) and whether further action is necessary (e.g. referral back to a specialist clinician – whether respiratory or the patient’s main specialty - or social services).

3 If any adjustment of the oxygen therapy is required, an amended HOOF will need to be completed.

4 The Provider will be required to comply with BTS Guidelines.

5 Stable patients should then be reviewed every six months including monitoring of oxygen saturations and enquiry about smoking habit.

6 Patients whose condition is less stable will require more frequent review and follow up, including blood gas measurement. They may need referral for specialist physician review.

7 All patients should be reviewed by the HOS AR with repeat blood gases annually.

8 Where the review indicates that the patient is no longer deriving clinical benefit from the oxygen (either because the patient was/is not hypoxaemic or they gain no benefit from the therapy), discussion should take place about withdrawing it. Some commissioners have already developed effective protocols for withdrawing oxygen form patients, e.g. Newcastle PCT GPG Appendix 8.

9 Where the patient is not using the oxygen as prescribed, but still clinically needs it, further education may be required or a reduction in the prescribed use should be considered.

10 Patients in receipt of home oxygen should be reviewed after any acute hospital admission or severe exacerbation treated at home.

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>[x]% of patients who have a follow up home visit within 4 weeks</td>
<td>To increase the number of people accurately prescribed HOS treatment</td>
</tr>
<tr>
<td>[x]% of patients requiring adjustment to treatment</td>
<td></td>
</tr>
<tr>
<td>[x]% of patients not hypoxaemic and/or deriving no benefit where withdrawal recommended</td>
<td></td>
</tr>
</tbody>
</table>

**Stage 3 Withdrawal of oxygen therapy**

**Overview**
1 When patients at review are found to no longer meet the criteria for home oxygen, this should be explained, the oxygen provision discontinued (order to gas company required) and other prescribed treatments reviewed.

2 Where the patient continues to meet the criteria but is not compliant with the prescribed oxygen therapy, he or she should be counselled on the merits of the therapy and encouraged to increase usage to the recommended level.

3 In the case of continued smoking, patient education and expert support to stop should be offered. In the persistent smoker a risk/benefit analysis should be undertaken with medical review. In some circumstances it may be appropriate to withhold or withdraw oxygen because of public safety and risk to others.

4 A sample protocol for withdrawal of LTOT/ambulatory oxygen is set out at Appendix 8 of the GPG.

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and % of patients offered HOS-AR assessment</td>
<td>To ensure that users of the services have a positive experience</td>
</tr>
<tr>
<td>Number and % of patients who receive the HOS therapy</td>
<td></td>
</tr>
<tr>
<td>Number and % of patients and carers surveyed who are satisfied with the service</td>
<td></td>
</tr>
<tr>
<td>Number and % patients who are smokers who are offered stop smoking support and pharmacotherapy annually</td>
<td></td>
</tr>
<tr>
<td>Number and % patients who are referred to pulmonary rehabilitation services</td>
<td></td>
</tr>
<tr>
<td>Number of notifications to local fire service</td>
<td></td>
</tr>
<tr>
<td>Number of notifications to local ambulance service to avoid administration of too high a concentration of oxygen in the event of emergency transfer to hospital</td>
<td></td>
</tr>
</tbody>
</table>

Documenting results and Oxygen Register

1 The Provider will be provided with the local oxygen register and will have a grace period of [ ] months[^4] to review and update it to accurately reflect the provision of home oxygen.

2 The Provider shall employ a comprehensive and rigorous system of data collection, storage, retrieval and transmission in order to verify the information provided by the oxygen supplier and to keep the oxygen register accurate and up to date including:

[^4]: This period is to be agreed locally.
i A comprehensive record of the identities and numbers of patients who have been referred for an HOS-AR assessment and who have been provided with HOS therapy; and

ii Appropriate records of the HOS-AR assessments, follow up home visits, adjustments to HOS treatment and review and details of when HOS therapy is withdrawn.

3 The Provider will report all the above information to [the Commissioners\(^5\)] in an agreed format [\(^6\)] or otherwise have it available on line on a real time basis.

4 Patient confidentiality and data protection requirements should be observed at all times in this process.

Patient Care Plan

The Provider shall ensure that the records of all referrals for HOS-AR assessment and those patients who receive HOS therapy are made available to GPs in order to have this information recorded in care plans.

Review and Audit

The Provider agrees to allow the [Commissioner]:

- to review and audit the provision of the Service at least annually and to provide a summary of the overall results and its performance of the Service to confirm compliance with the Indicators; and

- to have reasonable rights of audit and access to any of the Provider’s premises, personnel, the Provider’s systems, sub-contractors and their facilities and premises and the relevant records (including the right to copy) and other reasonable support as the [Commissioner] may require whilst the Service is being provided [and for twenty four (24) months following the end of [the Contract]] in order to verify any aspect of the Service or Provider’s performance.

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\(^5\) Or other appropriate counterparty.

\(^6\) State frequency of reporting here e.g. daily or weekly as agreed.
E. **Indicators**

High Quality Care Indicators

When reporting progress against outcomes Commissioners should consider measures and provisions similar to those set out in Appendix 1 of the GPG.

F. **Dashboard**

The Provider shall report performance on a monthly basis using a dashboard template similar to that below:

<table>
<thead>
<tr>
<th>Activity for GP Consortia/Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP practice</td>
</tr>
<tr>
<td>Practice A</td>
</tr>
<tr>
<td>Practices B</td>
</tr>
<tr>
<td>Practice C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Outcome</td>
</tr>
<tr>
<td>Number and % of patients offered HOS-ARR assessment</td>
</tr>
<tr>
<td>Number and % of patients who receive the HOS therapy</td>
</tr>
<tr>
<td>Number and % of patients and carers surveyed who are satisfied with the service</td>
</tr>
<tr>
<td>No. % patients who are smokers who are offered stop smoking support and pharmacotherapy annually</td>
</tr>
<tr>
<td>No. % patients who are referred to PR services</td>
</tr>
<tr>
<td>Number of notifications to local fire service</td>
</tr>
<tr>
<td>Notifications to LAS to avoid administration of too high a concentration of support in the event of emergency transfer to hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financials</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a description of the key performance issues for each provider. Where possible this information should be benchmarked.</td>
</tr>
</tbody>
</table>

**Provider A:**

**Provider B:**

<table>
<thead>
<tr>
<th>Patient complaints:</th>
</tr>
</thead>
</table>

The commissioner should agree these information requirements with the Provider and these should be inserted into the NHS Standard Contract.