Context
From October 2005, service provision and PCT responsibilities in respect of the Home Oxygen Therapy Service will change significantly. This paper highlights the key components of the change, outlines PCT responsibilities and suggests opportunities that they may wish to consider in managing change.

Current position
The current arrangements for home oxygen prescribing are complex. GPs prescribe this service but are not necessarily the best placed professionals to do so as most patients requiring oxygen therapy have complex needs that can only be fully assessed by specialist staff. Community pharmacists provide the oxygen cylinder service direct to patients. However, the concentrator service for patients with long-term needs is installed and maintained by a range of specialist companies under contract following competitive tender. Ambulatory oxygen is not available on prescription. There is a range of supply and payment routes. There is evidence that lack of specialist assessment results in inappropriate home oxygen prescribing, particularly prescription of cylinder oxygen, as patient needs can be met more effectively and economically through the oxygen concentrator service. In July 2003, Ministers announced plans to streamline and modernise the service.

Home Oxygen Therapy Service from October 2005
The service specification for the new home oxygen service is available on the Department of Health website. Specialist teams will be able to authorise Oxygen Therapy (OT) using their expertise to assess long-term/complex needs. Whilst GPs will retain the ability to prescribe, they are more likely to refer patients for specialist assessment or order oxygen as part of short term arrangements (eg palliative care). These changes mean that PCTs will need to review and discuss with Trusts the local commissioning of respiratory care services, to include provision of specialist clinical assessment and follow up (see below).

The new contract will deliver an integrated (cylinder/concentrator/ambulatory oxygen) service by a single service contractor in each of 10 oxygen ‘regions’. The contractor will provide a ‘one-stop service’ for patients, clinicians and PCTs, with streamlined supply and funding routes. For PCTs, the contract framework supports more effective cost control and improved performance management data.

Clinical assessment and prescribing
Updated clinical best practice guidelines (see British Thoracic Society website, www.brit-thoracic.org.uk) continue to stress that ambulatory oxygen be provided only after specialist team assessment and alongside the provision of effective patient follow-up and review services. The NICE guidelines on COPD (February 2004) also highlight the need to develop clinical assessment to ensure that OT meets patient needs.

Under the new contract, clinical staff will order a service (eg long-term oxygen, ambulatory) rather than specific equipment listed in Part X of the Drug Tariff. The price for each service (i.e. not equipment) is included in
What do the changes mean for PCTs?

1. An integrated service

PCTs will deal with a single service contractor who will meet all home oxygen therapy needs for patients living within the PCT area. For the first time, PCTs will be able to monitor service delivery against a detailed service specification with target response times. The transition to the new service will require PCTs to work closely with new contractors and other stakeholders in managing change, including ensuring that the new contractor has up to date patient data in good time to plan and manage the changeover.

PCT arrangements with local pharmacies for the provision of cylinder service will cease from 1st October 2005. However, PCTs will be aware that some GP prescriptions on FP10s for cylinder oxygen may straddle this date and will wish to discuss with new contractors and pharmacy contractors arrangements for managing delivery of this service, including the payment of any re-imbursement due to the pharmacy contractor.

To improve PCT cost control and monitoring of safety and service standards, the cylinder service has been brought within the contract framework. PCTs will have access to improved cost and performance data to support contract management. Invoicing and payment systems will be streamlined from the current five to one - through the PPA as with the current concentrator service.

2. Contract management

To improve PCT cost control and monitoring of safety and service standards, the cylinder service has been brought within the contract framework. PCTs will have access to improved cost and performance data to support contract management. Invoicing and payment systems will be streamlined from the current five to one - through the PPA as with the current concentrator service.

The contract provides for PCTs to meet with the contractor each year to discuss service delivery and any problems. There is a break clause to review service and prices every two years. In addition, there is to be a rolling programme of audit of contractor services conducted by the Medicines and Healthcare products Regulatory Agency (MHRA) and the NHS Purchasing and Supply Agency (PaSA). This programme will be funded by contractors, with reports submitted to PCTs.

The contractor role is set out clearly in the service specification. From 1 October 2005 contractors are required to deliver and maintain an integrated home oxygen service direct to patients on a 24/7 basis.

Meeting Patient and Carer Needs

Together with the development of local clinical assessment services, the new contract arrangements should result in improved patient access to a wider range of OT services, including ambulatory oxygen. Patients need not return to GPs following assessment or review as the specialist team can order OT for direct delivery to the patient’s home. A single supplier will support all oxygen needs, on a 24/7 basis, including emergencies. And contractors will be required to support/engage in NHS action to develop patient/public involvement in the planning and delivery of the service and to provide information on complaints.

Funding the Service

All funding for the home oxygen service will be allocated to PCT unified budgets on the basis of 50 per cent against the weighted capitation formula and 50 per cent on historical spend. Current plans are to inform PCTs of allocation in February 2004. As the new service is to be introduced on 1 October 2005, the changes will be made within the financial year 2005/06.

Service contractor role

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the contract. These are fixed per day prices. All home oxygen service funding will be allocated to PCT unified budgets (not shared between discretionary and non-discretionary budgets as now). To support these changes, Part X of the Drug Tariff will disappear and clinical staff will use a separate home oxygen form to order services - not the FP10. The order will provide information based on patient need (flow rate and hours of use) rather than the means of delivery.
3. Supporting clinical services
The integrated OT service is not a stand alone. It supports and complements other patient services, in particular respiratory care. The home oxygen service will prove most effective where there are developed local arrangements for patient assessment, follow up and review services. As such, the home oxygen service supports more effective care and better management of patients in the community, including those with long term medical conditions. Used effectively, it can also support the management of hospital admissions and discharge planning - many unplanned, emergency, admissions are for COPD patients. PCTs should also see an improvement in prescribing practice for OT in terms of cost and quality of care.

It is recognised that, in many areas, patient assessment and follow up services are patchy, with shortages of skilled staff. PCTs are encouraged to look at the provision of these services either jointly managed or provided by local Trusts and social care so as to maximise the benefits of the new OT arrangements.

4. Managing service changes
PCTs will lead, co-ordinate and communicate change in their local area, working with a range of stakeholders: GPs; existing concentrator service contractors; pharmacies providing cylinder services; NHS Trusts; new contractors; the PPA and patients.

It is estimated that about eight months is required for the new contractor to gear up for change by the agreed contract start date. During this time, (the transitional period) PCTs will need to develop and lead local plans to manage changes with minimal disruption to patient services. Service contractors will support PCTs in managing change. SHAs will oversee a consistent approach to managing change across oxygen service regions during this time.

PCT key tasks include
- The transfer of essential patient information to the new contractor to maintain service
- Working with GPs and Trusts on arrangements for patient assessment and service ordering and invoicing systems
- Establishing PCT systems for funding and contract management.

The announcement of contract awards is imminent (February/March 2005) and PCTs should begin planning for change now.

Summary
- Integrated home oxygen therapy service will be delivered via a new contract mechanism involving 10 service contractors
- PCT engagement and involvement is critical to lead and manage change locally, with a range of stakeholders, including service contractor
- A very tight timetable. Need to plan and manage change now and involve key stakeholders
- A consistent approach to introducing change in all 10 oxygen regions should be overseen by SHAs.