NHS
Oxfordshire
Clinical Commissioning Group

OCCG SERVICE SPECIFICATION (2020/21)

Primary Care Covid Oximetry @ Home 2020/ 2021

1. Introduction

Early detection of silent hypoxia reduces mortality and morbidity for patients with COVID-19. The use of pulse oximeters for self-monitoring at home enables early signalling for patients and healthcare professionals. System partners have been recommended to set up models as rapidly as possible.

No part of this specification by commission, omission or implication defines or redefines essential or additional services.

2. Background

Primary Care Covid Oximetry @ Home is part of the ongoing response to the pandemic. To aid implementation of this early detection of deterioration model, NHSE published Pulse oximetry to detect early deterioration of patients with COVID-19 in primary and community care settings, which should be read alongside the COVID Oximetry @home standard operating procedure, November 2020.

Primary Care Covid Oximetry @ Home (PCCO@h) is one of the priority goals for the additional funding for General Practice as part of the COVID Capacity Expansion Fund. In Oxfordshire the General Practice COVID capacity expansion fund will support practices to enrol patients onto the service and utilise any digital platform that is provided. A separate LCS will be in place to cover the monitor requirements of the PCCO@h SOP (i.e. this LCS).

In Oxfordshire a number of practices instigated their own version of a PCCO@h from early in the pandemic, utilising a range of approaches and staff members, and many continue to do so. This LCS provides a clear framework for practices to set up PCCO@h for their patients using structured and clear resources for both practices and patients and a ready additional supply of pulse oximeters. National guidance also stipulates expectations for the service and the local implementation intentions for these follow below.

3. Service Outline

Learning from pilots and emerging practice, NHSE have developed a model and are recommending that all clinically suspected or confirmed COVID positive patients who are symptomatic, and either over 65 years old or under 65 years and clinically extremely vulnerable to COVID, are supplied with an NHS pulse oximeter and clear instructions and guidance for patient self-monitoring with clinical oversight during the first two weeks of their illness.

Entry Criteria

COVID Oximetry @home pathway should be available to people who are:

i. Diagnosed with COVID-19: either clinically or positive test result **AND**
ii. Symptomatic **AND EITHER**
iii. Aged 65 years or older **OR**
iv. Under 65 years and clinically extremely vulnerable to COVID. (Clinical judgement can apply and take into account multiple additional COVID risk factors; for the most part, it is anticipated that this will already have led to inclusion on the CEV list. National criteria for inclusion on the CEV list are set and updated by the Government.)

Please see Appendix 1 for an overview of the patient pathway. Note that if patients are escalated to secondary care, they will be enrolled into the secondary care virtual ward and thus can be discharged from primary care follow up.

4. Service Delivery

To be delivered in conjunction with the National Standard Operating Procedure and the updated Pulse oximetry to detect early deterioration of patients with COVID-19 in primary and community care settings, in summary:

Referral
Patients with symptoms of COVID-19 may make direct contact with practices or be referred to practices by NHS 111 and the COVID-19 Clinical Assessment Service (CCAS). Practices are also likely to need to enrol patients into the service having received notification of positive COVID-19 test results organised in the community.

Triage
Patients referred to the service should have a standard assessment (with potential for face-to-face clinical assessment through CALM services if deemed necessary), with shared decision making prior to entry onto the pathway and a discussion about any support requirements for patients or carers. This should happen as soon as possible and ideally the same day as the referral. As per national SOP, patients should receive pulse oximeter and pack within 12 hours of the practice being aware of symptoms or positive test result. CALM clinics will be able to distribute packs directly to patients but the on board process and monitoring will remain the responsibility of the practice.

On boarding
Patients entering the pathway should be provided with a pulse oximeter and supporting information (including a paper diary which is being made available in a variety of languages, or suitable app / regular call mechanism), contact details to report oximetry reading / symptoms, and clear safety netting instructions both in and out of hours.

Patients should be encouraged to record oximetry readings daily, usually three times a day. Through a shared decision making conversation, they are also given the option of a prompt at days 2, 5, 7, 10 and 12, either by (a) text message or (b) by e-mail, or instead

(c) a clinician or non-clinician led check-in phone call. Each option should ensure a same-day response is received from the patient.

Monitoring those who have COVID-19 and who are at greater than average risk
Patients should receive text or email prompts, or check-in calls, as agreed during on-boarding. Check-in calls should confirm that the patient is using the oximeter and diary correctly, and that the readings are within range. The frequency of these calls can be reviewed with the patient if appropriate.

A digital support tool will be implemented by Inhealthcare to assist with the patient monitoring where patients are digitally enabled, though at publication this tool is in pilot phase with the aim of rolling out in the coming weeks.

Recovery and discharge
Patients who do not show signs of deterioration within 14 days of onset of symptoms should be actively discharged and supplied with leaving information, safety netting and safe advice on how to return the oximeter if necessary. Patients may be on the pathway for a shorter period either if they have been awaiting a test result or this is negative, or subject to clinical review. Patients who remain symptomatic at 14 days should receive a further clinical assessment and action taken as clinically appropriate. Patients escalated to secondary care should be discharged from the primary care oximetry service, once the discharge summary has been received from secondary care.

5. Reporting / Monitoring

The CCG is working to develop a digital platform with SCWCSU and InHealthCare to support practices monitoring their patients through a practice level dashboard.

Practices are encouraged to use the Ardens COVID oximetry at home template* and will need to complete the following fields on the template for each patient as a minimum to be eligible for payment (see section 7):

1. COVID-19 confirmed using clinical diagnostic criteria code (only if the template isn't already displaying an entry relating to a positive test result/recent legitimate diagnosis).
2. Remote monitoring commenced
3. Remote monitoring ended (at end of period of monitoring)
4. Oxygen saturations code (there will be several over the course of the monitoring period)

See Appendix 2 for full coding

*More information regarding the Ardens template and reporting see Appendix 3.

The CCG may request information on the number of unused Oximeters in stock at end of reporting period

This will enable the CCG and NHSE to manage stock levels. Advance notice of one week for requests for additional oximeters is required, and/or when practice stock is at

50%. Please email occg.primarycarecontracting@nhs.net if you require further supplies of pulse oximeters.

SCWCSU will extract weekly data for reporting on practice caseload.

The model will be subject to ongoing evaluation and adaptation.

6. **Accountability**
The Provider is ultimately accountable to the Commissioner for the delivery of this service.

7. **Payment**
A fixed payment of £150 per patient that meet the eligibility criteria, both on boarded and discharged and coded as per section 5 (see appendix 2). Practices do not need to invoice, payment will happen at the end of each quarter.

This includes

- Clinical oversight, monitoring (active monitoring where requested) and sign off.
- Where clinically beneficial, a patient may have the opportunity to keep the monitor. If it is to be re-used this fixed payment also includes delivery, collection and cleaning of saturation probes (subject to national stock continuing to meet supply demand).

The funding from the General Practice COVID Capacity Expansion Fund will cover

- on boarding
- InHealthCare digital staff training and set up administration.

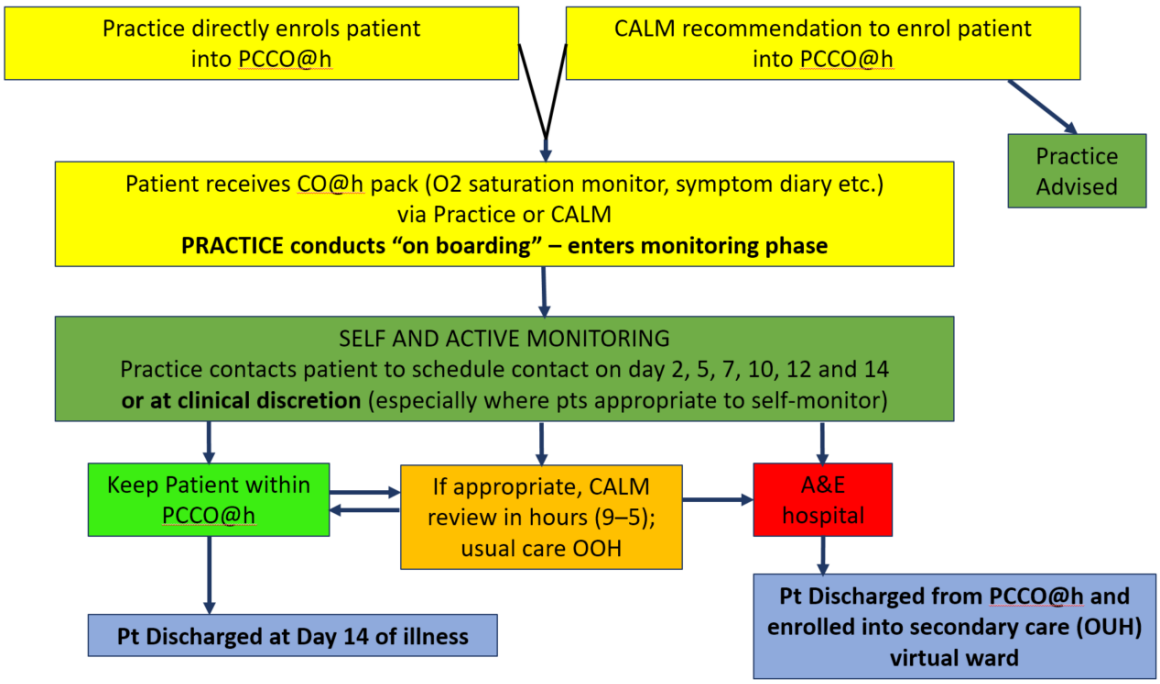
8. **Service Duration and Termination**
This LCS is for immediate implementation in primary care due to the potential reduction in mortality rates. Other providers have set up rapid delivery models. A centralised system is being explored and changes may occur where working at scale will add value to the patient, system and individual organisations. Should a central model be implemented this LCS will be terminated.

One months' notice will be provided if this service is to be terminated.

The service will run from January 2021 until June 2021. A review will be undertaken to understand the ongoing need for a CO@H service.

9. **Contact**
Contact for queries: Leila.jb@nhs.net
Clinical lead: sam.hart-occg@nhs.net

APPENDIX 1: Oxfordshire Primary Care Covid Oximetry @ home (PCCO@h) – patient enrolment, monitoring and discharge



APPENDIX 2: Coding for Primary Care Covid Oximetry @ home (PCCO@h)

Definitions:

Cohort of eligible patients: Patients with a covid diagnosis (either lab or clinical judgement), who have symptoms (uncoded), age 65 or older OR under 65 but in high risk/shielding/CEV group.

Patients 'on the remote monitoring register': Patients with a covid diagnosis (either lab or clinical judgement) AND Remote monitoring commenced AND without a later 'remote monitoring ended' code.

Payments: Patients on the register with remote monitoring commenced code AND a sats code recorded on the same day as the 'remote monitoring commended'

Other information that can be looked for in a report but not linked to payment:

- Equipment loaned to patient
- Remote monitoring ended etc

Relevant codes for the above items are below:

	Item	SNOMED Concept IDs	Term
Search population	COVID diagnosis code (any one of these)	12802201000006101	Confirmed 2019-nCoV (novel coronavirus) infection (EMIS code)
		1240751000000100	COVID-19
		840539006	COVID-19
		1240571000000101	Gastroenteritis caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240541000000107	Upper respiratory tract infection caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1300721000000109	COVID-19 confirmed by laboratory test
		1300731000000106	COVID-19 confirmed using clinical diagnostic criteria
		882784691000119100	Pneumonia caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240551000000105	Pneumonia caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240531000000103	Myocarditis due to disease caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240521000000100	Otitis media due to disease caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		119731000146105	Cardiomyopathy due to disease caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1321241000000105	Cardiomyopathy due to disease caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240561000000108	Encephalopathy due to disease caused by SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2)
		1240581000000104	SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2) detection result positive
		1324601000000106	SARS-CoV-2 (severe acute respiratory distress syndrome coronavirus 2) RNA (ribonucleic acid) detection result positive
		1322781000000102	SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) antigen detection result positive
		1324881000000100	SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) RNA (ribonucleic acid) detection result positive at the limit of detection
For payment	Remote monitoring commenced (AND)	897931000000108	Remote monitoring commenced
For payment	Remote monitoring ended (AND)	897951000000101	Remote care monitoring ended
For payment	Oxygen saturations code	866661000000106 OR 866681000000102	Peripheral blood oxygen saturation on room air at rest OR Peripheral blood oxygen saturation on room air on exertion
For information	Date of onset of symptoms	520191000000103	Date of onset of symptoms (observable entity)
For information	Equipment loaned to patient	21801000000106	Equipment loaned to patient (finding)

APPENDIX 3: Ardens template

Practices should use the Ardens template for COVID Oximetry @ home. This template is available free of charge to all Oxfordshire CCG practices and the coding is aligned with the LCS requirements.

Existing Ardens subscribers using Resource Publisher will already have the latest template installed. Please can all other practices download this template from the Ardens Portal. This is a dedicated area to access the latest versions of Ardens resources that may not yet be deployed.

How to download the template and searches

Practices will need to register for a free account at www.ardens.live/portal and then follow these instructions to download the Ardens CO@H template and searches.

Where to find more information:

Available on Clarity are the following;

- Example of the Ardens Covid Oximetry @ home template
- PCCO@h LCS with payment details and relevant codes

Technical issues with downloading the resources:

If you have trouble downloading or accessing the resources, please email support-emis@ardens.org.uk and a member of the Ardens support team will assist.