

SCHEDULE 2 – THE SERVICES

A. Service Specifications (Full Length Contract)

Service Specification No.	11J/0212
Service	Community Pulmonary Rehabilitation (PR)
Commissioner Lead	Integrated Community Services (ICS)
Provider Lead	Dorset County Hospital NHS Foundation Trust
Period	1 st April 2017 to 31 st March 2020
Date of Review	March 2018

1. Population Needs

1.1 National/local context and evidence base

Pulmonary rehabilitation is an essential treatment option that should be made available within a wider, comprehensive respiratory pathway. There is sound evidence of the benefits of pulmonary rehabilitation in terms of patient outcomes and wellbeing, as well as emerging evidence that it may make an impact on secondary health care utilisation. It is also considered to be highly cost-effective and provide real value for money.

In 2004 the National Institute for Health and Clinical Excellence (NICE) published 'Clinical Guidelines 12 for the care of people with COPD' which highlighted the importance of pulmonary rehabilitation in improving patients' quality of life. These guidelines included recommendations on key components to include in pulmonary rehabilitation programmes and state that 'pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD.

The commissioners have also considered the recommendations made in:

- NICE paper entitled 'Commissioning a Pulmonary Rehabilitation Service for Patients with COPD' published in 2006' and NICE updated guideline on the 'Management of COPD in adults in primary and secondary care 2010.
- The White Paper 'Our Health, Our Care, Our Say' in relation to the development of accessible healthcare services in the Community.
- Pulmonary Rehabilitation: Time to breathe better, November 2015 (Focuses on Resources and Organisation).
- Pulmonary Rehabilitation: Steps to breathe better, February, 2016 (Focuses on clinical outcomes).
- British Thoracic Society (BTS) PR guidelines which subsequently informed the development of BTS quality standards for pulmonary rehabilitation.
- Primary Care Respiratory Society (PCRS) – IMPRESS Standards, 2011

Needs Analysis

The NHS 'COPD Commissioning Toolkit', 2012 highlights the impact of COPD in England including:

- COPD causes 23,000 deaths in England each year. Death rates from diseases of the respiratory system in the UK are higher than the European

average. It is thought that three million people in England have COPD, but only just under a million have been diagnosed with the disease.

- The total annual cost of COPD to the NHS is over £800 million. It costs the NHS nearly ten times more to treat severe COPD than mild disease.
- 10% of people with COPD are only diagnosed when they present to hospital as an emergency. COPD is the second most common cause of emergency admission to hospital. Around a third of those admitted to hospital as a result of their COPD are readmitted with a month of discharge with readmission rates varying up to five times in different parts of the country.

The RightCare analysis February 2016 identifies that Dorset CCG has higher emergency admissions than similar CCGs and the identification of people with COPD is substantially below other similar CCGs, which will affect referrals to this effective intervention.

The potential benefits of an effective pulmonary rehabilitation service are: increased health related quality of life; improved functional and maximum exercise capacity; and reduced dyspnoea. In addition, patients will be empowered to self-manage/self-care their COPD and a reduction in emergency re-admissions should be seen.

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

The Service in conjunction with other respiratory services in primary, community and secondary care (as a healthcare community) will support:

- Reduction in COPD emergency admissions and readmissions
- Increase in self-management and reduction in primary care consultations

We are aiming to achieve the following standards:

- 85% of people referred to the programme, go on to complete an initial assessment and enrol on the programme.
- 75% of people who start (enrol on) the programme go on to complete within 3 months. A programme is a minimum of 6 weeks (2 sessions per week). Completion means that the patient has attended 75% of sessions within 3 months.
- Flexible service with multiple community venues which can flex capacity to meet population need and demand.

- Robust communication processes with localities and individual practices to support referrals at expected levels. Able to evidence at a locality level progress towards 40% of total diagnosed COPD population being referred.
- Offer of an appointment at a suitable venue - Maximum waiting times from **referral to enrolment** will be 12 weeks for referrals from the community.
- Offer of an appointment at a suitable venue - Maximum waiting times from **referral to enrolment** will be 4 weeks for referrals following a hospital COPD related admission.
- Improved quality of life measured using the COPD Assessment Tool (CAT) – www.catestonline.co.uk and EQ5DL – www.euroquol.org
- One referral pathway for all referrals.
- Standardised patient information and ensure it is available electronically.
- Standardised communication to the practice respiratory lead on completion of assessment/programme.
- To meet the BTS quality standards and evidenced through an annual audit.

100% of people who complete 6 week programme, have a written individual plan to support sustained activity beyond the programme with 6 monthly follow up of patients via telephone or postal questionnaire to assess the impact of the programme. NB check should be made with practice first to see if this is appropriate.

3. Scope

3.1 Aims and objectives of service

The Service will provide a comprehensive programme of pulmonary rehabilitation across the County that can flex to meet demand and, through close working with primary care and community services (i.e. community matrons) and secondary care

(ie in-patients, outreach specialist respiratory teams), can ensure people who would most benefit are referred to a local programme.

The high-level objectives of the service are to:

- promote and embed pulmonary rehabilitation as an essential component in the management of patients with COPD and other respiratory conditions;
- improve understanding among health professionals of which patients will benefit and should be referred to PR;
- improve access to PR for eligible patients;
- improve completion rates for PR;
- provide a cost effective, quality assured PR programme that meets the patients' personal needs;
- improve patients' health-related quality of life, breathlessness management, functional and maximum exercise capacity and thus reduce disability associated with chronic respiratory disease;
- ensure service users have a positive experience.

The Service will offer community based pulmonary rehabilitation to:

- Patients with a diagnosis of chronic lung disease (eg COPD (stable) with MRC 3 and above, ILD, Bronchiectasis, asthma) and feel functionally limited by their condition; and MRC2 from April 2018 onwards.
- Patients post hospital discharge following an acute exacerbation of COPD (any MRC).

Programmes will be offered at practical times convenient to the patient population. See section 6 – location of premises.

The provider should be flexible and be able to increase availability in periods of high referral rates and/or waiting times. The expectation is that the provider will work with localities to increase referrals in a planned way and flex programmes within that locality in line with jointly agreed plans.

The Service will look to make available a non-face to face programme provision from 2018. The introduction of a non-face to face programme will provide greater opportunity to pick up MRC 2 patients to prevent deterioration and improve quality of life for COPD patient earlier.

Programmes will be multi-component, multidisciplinary and tailored to the individual patients needs including physical training, disease education, nutritional, psychological and behavioural intervention. The exercise component will be aimed at increasing strength and stamina with education provided to manage breathlessness. The education component will focus on the self-management of COPD and other chronic lung diseases.

3.2 Service description/care pathway

Providers should understand how the service sits within a wider integrated respiratory care pathway with shared outcomes.

There will be one referral pathway for all referrers of eligible patients defined in 3.1.

Stages 0 to 4 outlined below reflect the core stages of the PR pathway.

Stage 0 – Identify and refer patients

The provider should develop a strong interface with primary care and Localities to ensure those who could most benefit gain access to the service. The service should be led by a health professional who will co-ordinate the interface with primary care and secondary care to ensure that we move towards the target of 40% of people with COPD having undertaken a PR Programme.

Stage 1 – Manage referral and recruit patient

- In line with the national direction, the referral process for primary and secondary care will be electronic.
- The provider shall manage capacity to meet demand and ensure that eligible patients are assessed to enable enrolment on a programme within 4 weeks for post discharge patients and 12 weeks for community patients.
- Patients who are unable to attend through personal or medical reasons should be re-offered a place on two further occasions and then discharged to the practice respiratory lead.

Stage 2 – Assess patient for pulmonary rehabilitation

The provider shall undertake an individual comprehensive assessment. Patients should be provided with a clear explanation of what the assessment will involve and advised that they can bring a carer to the assessment. The assessment should determine baseline status and measure exercise capacity, dyspnoea and health status, activities of daily living (ADL) and quality of life using validated tools. These will include a minimum of:

- Dyspnoea levels eg Borg Breathlessness scale
- Exercise tolerance eg 6 minute walk test
- Quality of Life eg EQ5DL
- Disease specific scale, COPD Assessment Test (CAT)

The provider shall discuss any medical issues identified at the assessment that need addressing prior to starting the programme with the practice respiratory lead.

Following assessment and agreement of goals with the patient, should PR be deemed appropriate, the patient will be offered a place on the programme.

Stage 3 – Deliver a comprehensive pulmonary rehabilitation programme

Content and requirements - The duration of all programmes, frequency of supervised exercise sessions and content of the educational sessions will meet national best practice.

The provider shall offer all eligible patients a place on a PR programme within the specified waiting times in 2.2.

The provider shall ensure that the PR programme contains individually prescribed physical exercise training, self-management advice and multi-disciplinary education.

The provider shall ensure that every patient has a training diary with written descriptions of endurance and strength exercise training at the highest tolerated intensity with a requirement for incremental progress for both aerobic and resistance training.

Patients shall be offered a group programme of a minimum of two x 1 hour sessions per week for at least 6 weeks duration. The 12 sessions will include aerobic exercise, strength training and education. A rolling Programme will be delivered where opportunity to start throughout the Programme exist. 75% of people who enrol in the Programme will complete the programme within three months. Completion is defined as at least 75% of sessions within 3 months.

Patients should be encouraged to undertake unsupervised exercise at home during the Programme.

Education Sessions – The provider shall ensure that baseline education needs are identified as part of the development of the PR patient plan. The Programme will include delivery of structured education covering disease education, nutritional and psychological support as well as behavioural interventions, as recommended by the NICE guidelines. The Programme will cover:

- COPD disease process, may need to include other diagnosis depending on attendees
- Medicine management
- Relaxation
- Lifestyle management
- Healthy Eating / Eating in ill health
- Management of breathlessness
- Sputum clearance techniques
- Smoking cessation
- Role of nurses such as the Practice Nurse, Community Matron and other specialist nurses
- Self-management of COPD and exacerbations

Staffing – The provider shall ensure that the programme is delivered by a multi-disciplinary team of specialists experienced in respiratory care and behaviour change alongside the knowledge and skills to lead a safe and effective exercise programme. The Programmes will be led by qualified Physiotherapists or Specialist Nurses, supported by suitably trained Rehabilitation Assistants or Exercise Instructors (Level 4). Additionally, the programme may include specific input from a variety of suitably skilled health professions such as dieticians, pharmacists, occupational therapists and lifestyle professionals.

The provider shall adhere to staffing ratios recommended in the UK for PR supervision of exercises classes (1:8) and education sessions (1:16), with a minimum of two supervisors in attendance one of whom must be a qualified respiratory specialist health care professional to supervise the exercise component (NB: greater staff : patient ratio is required if oxygen users are included).

Safety – The provider shall be aware of the importance of patient safety and ensure that appropriate safety facilities are available. The provider shall ensure that

resuscitation facilities are available and that staff have had recent training. There will be locally agreed medical emergency protocols for all locations hosting group exercise sessions. Staff should be Intermediate Life Support trained.

The provider shall ensure that for patients who desaturate on exercise and require ambulatory oxygen (the prescription of which has been determined by an ambulatory oxygen assessment) that these patients attend PR with their own ambulatory supply.

Stage 4 – Final assessment, discharge and follow up-

Once the patient has completed 12 sessions, patients will be re-assessed with advice for ongoing management. This will be a face to face assessment to include exercise tolerance, patient satisfaction and quality of life assessment. The patient will have an individualised written plan of exercise in order to maintain benefits.

The provider will understand what follow on support is available to people for each locality eg local support groups, local Gym programmes. People should be made aware of local voluntary organisations and patient support groups, and details of Livewell Dorset.

All people who complete the programme will have a six month follow-up by telephone interview/postal questionnaire and the results will be shared with the practice respiratory lead. Prior to contacting the patient a check must be made with the practice respiratory lead to make sure that this is appropriate.

An annual audit of outcomes will be shared with commissioners. Outcomes we want to assess:

- Local analysis of submission to the National Audit compared to the average and best practice
- Analysis of CAT improvement (including median change and % improving by 2 or more on the CAT score by programme).
- Analysis of EQ5DL improvement (including median change and % improving on the QOL outcome measure)
- No. of people following their individualised exercise programme at 6 months

For people who are unable or unwilling to attend a group programme, a non-face to face programme will be developed and provided from April 2018.

3.3 Population Covered

Any patient registered with a Dorset NHS GP Practice.

3.4 Any acceptance and exclusion criteria.

Acceptance Criteria

Providers will accept referrals as detailed in section 3.1.

Individuals who have had PR in the last 2 years should only be accepted back into a Programme following discussion with the practice respiratory lead.

Onward Referrals

Any patient presenting with a respiratory emergency should immediately be referred to emergency services, and their GP informed.

If patients present with deteriorating condition but are stable, they should be referred immediately back to their GP (urgently if necessary).

Communications with Referrers

Providers shall confirm all referrals to the original source indicating the action taken or to be taken.

Providers shall communicate the discharge of patients to the original referral source indicating the outcome. This shall also apply to patients who fail to attend scheduled appointments.

In all cases, Provider communications with the local acute provider, in respect of individual patients, should be copied to the patient's GP.

Communication with Patients

Providers will provide to patients a Patient Information Leaflet about the Programme, education information and a discharge exercise plan. Standard service information will be available electronically. Following assessment, patients will receive a training diary and, on completion of the programme, an individualised written plan / programme of exercise in order to maintain benefits. People will be advised of the six month follow up process.

If, following their assessment it is decided that PR is not appropriate, the patient should be given some advice on self-management.

Exclusion Criteria

Providers shall reject any referral received for patients not considered suitable for community based PR.

- Significant unstable cardiac or other disease that would make pulmonary rehabilitation exercise unsafe and prevent programme participation.
- People who are unable to walk or whose ability to walk safely and independently is significantly impaired due to non-respiratory related conditions. This should not exclude patients who have general musculo-skeletal problems where exercise is recommended.
- People unable to participate in a group environment, or for whom mental health, cognitive, personality or other communication barriers that make group work inappropriate.

Inappropriate referrals will be sent back to the referrer with a full explanation.

3.5 Interdependence with other services/providers

This service is part of the overall pathway for COPD patients.

The Provider shall ensure that the PR service seamlessly integrates into the overall COPD service the patient is receiving.

The provider shall ensure effective communication and referral pathways with secondary care as part of defined post exacerbation pathway.

The provider should consider signposting to the services provided by Livewell Dorset, particularly smoking cessation services, and the role of telehealth in people with respiratory disease.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Detailed above.

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

Detailed above

4.3 Applicable local standards

The provider will submit to the national COPD PR audit.

The provider is required to take account of the Pan Dorset Carers Strategy (2016-2020), which aims to ensure that all carers are fully informed, involved, and valued, and that they receive the right support, at the right time in the right place.

The provider must encourage self-care and empowering service users to be proactive and involved in the management of their condition.

The provider will ensure that all staff delivering the service will access appropriate clinical supervision and continual professional development.

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

Services will be in settings which are conducive with the delivery of an education and exercise programme such as a leisure centre or community clinic. Venues will be accessible with adequate parking and good transport links. A risk and suitability assessment of the venue must be undertaken.

This service is a community based service and is expected to be delivered from sites across the county to meet population need and demand.

7. Individual Service User Placement

Venues will have access to appropriate emergency resuscitation equipment.