SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	02/GMS/0004
Service	Community Pulmonary Rehabilitation
Commissioner Lead	LTC and Frail Elderly CWG
Provider Lead	
Period	1st April 2015 to 31st March 2016
Date of Review	To be Agreed.

1. Population Needs

1.1 National/local context and evidence base

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 (usually Medical Research Council level 3 or above). Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.'

The commissioners have also considered the recommendations made in the NICE paper entitled 'Commissioning a Pulmonary Rehabilitation Service for Patients with COPD' published in 2006' and the White Paper 'Our Health, Our Care, Our Say' in relation to the development of accessible healthcare services in the Community. The draft national strategy for COPD also refers to the benefits of Pulmonary rehabilitation.

The locality commissioning groups and NHS Dorset Clinical Commissioning Group strongly support the development of Pulmonary Rehabilitation Pan Dorset.

Needs Analysis

Nearly 900,000 people in the UK have been diagnosed as having COPD and half as many again are thought to be living with COPD without the disease being diagnosed. Symptoms develop insidiously making it difficult to determine the incidence. Often patients are not diagnosed until they are in their fifties.

COPD is the sixth most common cause of death in England and Wales killing more than 30,000 people each year. Morbidity is high with patients requiring frequent primary and secondary care input. The population prevalence of COPD is expected to increase over time due to aging of the population, and the cumulative effect of smoking.

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

COPD and chronic respiratory conditions are the second highest cause of admissions to secondary care and in Dorset is among the highest for the NHS South West region.

In the most recent year for which data is available Dorset had the highest ratio of emergency admissions for COPD per 1000 patients with COPD on the disease register (15.8) in the NHS South West region.

In 2010-11 COPD accounted for about 10,000 emergency bed days in Dorset on average there are four people admitted each day to hospital with COPD. In addition, there are many more emergency admissions due to respiratory disease not coded as COPD, many of which will be due to obstructive airways disease (13 per cent of the 35,000 emergency admissions per year in the East of the County are due to respiratory disease).

Mortality rates from COPD are similar in Dorset to the National average at about 23 deaths per 100,000, Across Dorset one person dies every day from chronic obstructive pulmonary disease.

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 performance of service from the providers shall be assessed in terms of the following;

- Clinical outcomes:
  - a reduction in hospital admissions will be monitored against each patient by the commissioners
  - a reduction in dyspnoea
  - improved exercise tolerance
  - improved quality of life to be measured using an approved tool to be agreed with the commissioner – it is expected that these may be from the following: St Georges questionnaire, DUKE Health Profile, London Handicap Scale, EuroQuol
  - reduced dependence/greater independence – monitor ability to undertake basic tasks of daily living (shopping, housework, bed making etc)
  - Correct use of medication using observer assessment before rehabilitation and on completion of the course
- Patient satisfaction survey responses – (not a reproduction of the questions in the QuOL tool) preferred survey is CRDQ

Patient reported outcomes to include patients to be asked if:

- I understand my condition and therefore can make good decisions about my care and how I live my life
- I know what I can do to help myself and who else can help me
- I am treated with dignity and respect
- I can enjoy life

3. Scope

3.1 Aims and objectives of service

To offer community based pulmonary rehabilitation to patients post hospital discharge and also who are already in the community who are functionally disabled by COPD and have a clear diagnosis of COPD at MRC grade 3 or above. To be provided in a setting which is conducive with the delivery of an education and exercise programme such as a leisure centre or community clinic.

To offer a choice of pulmonary rehabilitation sessions at practical times and convenient, accessible venues suitable for the patient.

To provide programmes that are multi-component, multidisciplinary and tailored to the individual patients needs including physical training, disease education, nutritional, psychological and behavioural intervention.

Provide education that has an empowerment based focus to ensure patients develop greater self-management skills.

To deliver a programme of pulmonary rehabilitation that will be equitable to patients across Dorset.

To extend Patient Choice, provide care closer to home, make better use of clinical skills available in Primary Care, reduce GP/community nurse visits and reduce 3 month readmission rates.

3.2 Service description/care pathway

Any patient referred to Providers under the Scheme:

- For post hospital discharge patients with a diagnosis of COPD at MRC 3 or above shall be offered an appointment for assessment within 2 weeks of referral and a place on a course within 2 weeks of the date of the receipt of referral;

- Patients with an MRC score of 3 or more shall be assessed and offered a place on the programme within 8 weeks of referral.

Providers to confirm administration structure processes to ensure good communication, outcomes and monitoring of service. Patients to be offered a copy of communication. Commissioners must be notified of commencement of individual patients entering the programme to enable tracking of their hospital admission status.

Following assessment and agreement of goals with the patient, should pulmonary rehabilitation be deemed appropriate, the patient would be offered a place on the programme. The patient would then commence the programme which comprises one hour of exercise and one hour of education twice a week. The sessions of education and exercise should be provided back to back so the patient attends for a maximum of twice per week Once the patient has reached week six, patients to 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 and the programme duration and content is in accordance with the NICE guidance and “should include multi-component, multi-disciplinary interventions which are tailored to individual patient needs”. This also follows the British Thoracic Society recommendations that the patients have at least two supervised exercise sessions per week and meets IMPRESS Standard 2 “The programme should be delivered by a multi-disciplinary team and include two supervised sessions per week for at least four weeks”.

The exercise sessions for the programmes would be delivered by qualified physiotherapists (or exercise physiologist), supported by suitably trained physiotherapy assistants, and would ensure that pre-existing co-morbidity problems would be taken into consideration when the patient starts the programme or as they progress through. Each education session would have a staff/patient ratio in line with the dependency of patients and not exceed a ratio of 1:8 for moderate cases.

Training/ education/ research activities

The education sessions would be delivered by a variety of suitably skilled health professionals such as dieticians, pharmacists, occupational therapists, lifestyle professionals and doctors from the NHS Dorset acute Trusts, in addition to the community nurse and specialist respiratory physiotherapists.

The topics would cover disease education, nutritional and psychological support as well as behavioural interventions as recommended by the NICE guidelines and the specific sessions would be:

- COPD disease process
- Medicine management
- Relaxation
- Lifestyle management
- Healthy Eating/ Eating in ill health
- Management of breathlessness
- Sputum clearance techniques
- Role of specialist nurses such as the Community Matron and outreach nurses
- Self-management of COPD and exacerbations

The duration of all programmes, frequency of supervised exercise sessions and content of the educational sessions will also meet the standards recommended in "Principles, definitions and standards for pulmonary rehabilitation." Published in January 2008 with the support of IMPRESS (Improving and Integrating Respiratory services in the NHS).

A six month follow-up service would be conducted by a patient telephone interview/postal questionnaire and the results will be submitted to the referrer within five working days.

3.3 Population Covered

Any patient registered with an NHS Dorset CCG GP Practice.

3.4 Any acceptance and exclusion criteria.

Acceptance

Referral Criteria

Providers will accept referrals from patients post discharge from hospital or with a diagnosis of COPD MRC level 3 or above, encompassing the British Thoracic Society guidelines of COPD diagnosis which includes emphysema, chronic bronchitis, chronic obstructive bronchitis, chronic airflow limitation, chronic airflow obstruction, non-reversible obstructive airways disease, chronic obstructive airways disease and chronic obstructive lung disease.

Providers shall reject any referral received for patients not considered suitable for community based pulmonary rehabilitation. Inappropriate referrals will be sent back to the referrer with a full explanation. Incorrectly completed referral forms will be sent back to the referrer for amendment and subsequent referral back to the pulmonary rehabilitation service.

Sources of Referrals
The Scheme services shall be accessed by practice nurses, community matrons, all appropriate' referrals from any Respiratory Consultant, General Practitioner, Respiratory Specialist Nurse of any adult patient registered with a Dorset GP practice appropriate to undertake a pulmonary rehabilitation programme.

The scheme will also accept self-referrals of individuals who have not had pulmonary rehabilitation in the last 2 years, who have previously undertaken Pulmonary Rehabilitation, providing these individuals meet defined criteria.

Onward Referrals
Provider shall immediately refer directly to the local acute provider any patients assessed as requiring emergency examination or treatment in the acute sector 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). Any patient presenting with a respiratory emergency should immediately be referred to A&E, and their GP informed.

Patients discharged at the end of the pulmonary rehabilitation scheme will have their ongoing general care returned back to their GP with a request to receive exercise on prescription.

Communication with Patients
Providers shall compile and provide to patients accepted under the Scheme a Patient Information Leaflet, in a form to be approved by the Commissioner(s) providing appropriate information relating to the Scheme services and the Provider organisation including information on complaints procedures etc.

The Provider shall ensure that all communications relating to the care and treatment of patients accepted under the Scheme is offered to be copied to patients in accordance with current NHS policy and procedures.

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

Exclusions
Exclusion criteria

- Chest pain
- Those unable to socially interact
- Uncontrolled hypertension
- Patients unwilling to attend
- Patients who have unstable angina
- Patients who cannot walk
- Patients with a recent myocardial infarction
- Neurogenic disability
- Previously completed pulmonary rehab completed in last 23 months (unless clinical need has been assessed by a Respiratory Consultant)

3.5 Interdependence with other services/providers

This service is part of the overall pathway for COPD patients and is a community based service.

Whole system relationships

Providers of services under the Scheme framework shall establish and maintain contact, communication links and appropriate clinical supervision arrangements with appropriate clinical colleagues working within the local acute providers.

Providers shall establish appropriate knowledge of the support available to patients treated under the Scheme from Social Services, the NHS and/or the voluntary sector and provide guidance and advice to patients to enable them to access services.

Providers shall ensure that the pulmonary rehabilitation service seamlessly integrates into the overall COPD service the patient is receiving.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

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)