SCHEDULE 2 – THE SERVICES
A. Service Specifications (B1)

Service Specification No.	02/GMS/0013
Service	Community Pulmonary Rehabilitation
Commissioner Lead	CCP for General Medical & Surgical
Provider Lead	DCHFT
Period	2013/14
Date of Review	To be Agreed

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	*

Key Service Outcomes

To improve the quality of life of patients with COPD by reducing dyspnoea, increasing exercise tolerance, reducing the need for medical intervention and increasing the patient's ability to self manage their disease.

To reduce non elective admissions so that resources can be released to re-invest in COPD services.

1. Purpose

1.1 Aims and objectives

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 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 develop a programme of pulmonary rehabilitation that will be equitable to patients across Bournemouth, Poole and Dorset

To extend Patient Choice

Provide care closer to home

To make better use of clinical skills available in Primary Care

To reduce GP/community nurse visits

To reduce 3 month readmission rates.

1.2 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 shadow GP commissioning consortia in NHS Dorset and the clinical commissioning groups and Pathfinder group in NHS Bournemouth and Poole 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 prevelance 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 highest cause of admissions to secondary care in NHS Bournemouth and Poole and are the highest for the NHS South West. In NHS Dorset COPD accounts for the third highest reason for admission to hospital.

In the most recent year for which data are available NHS Bournemouth and Poole 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. NHS Dorset's ratio was lower at 10.7 admissions per 1000 patients on the disease register.
In 2010-11 COPD accounted for about 10,000 emergency bed days between the two PCTs, and 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 NHS Bournemouth and Poole are due to respiratory disease).
Mortality rates from COPD are similar in NHS Bournemouth and Poole to England at about 23 deaths per 100,000, and slightly lower in NHS Dorset at about 18 deaths per 100,000. Across both PCTs one person dies every day from chronic obstructive pulmonary disease.

2. Scope

2.1 Service Description

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 referrals

- 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 a one hour's exercise and one hour education twice a week. The sessions of education and exercise should be provided back to back so the patients attend 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 the individual patients needs". This also follows the British Thoracic Society recommendations that the patients have at least two supervised exercise sessions per week and meets IMPRESS`S Standard 2 "The programme should be delivered by a multi-disciplinary team and include two supervised sessions per week for at least four weeks".
Potential providers to indicate whether nursing programmes will be provided.

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

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.

2.2 Any exclusion criteria

- Chest pain
- Those unable to socially interact
- Cardiac cause of breathlessness not excluded
- 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

2.3 Geographic coverage/boundaries

Pan Dorset service covering patients registered with a GP in NHS Bournemouth and Poole and NHS Dorset

2.4 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.

Provider 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.

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

2.5 Interdependencies and other services

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

2.6 Training/ education/ research activities

The education sessions would be delivered by a variety of suitably skilled health professions such as dieticians, pharmacists, occupational therapists, lifestyle professionals and doctors from the NHS Dorset and acute Trusts, in addition to the community nurse and specialist respiratory physiotherapists. Local voluntary organisations and patient support groups would be invited to participate.
The provider will ensure that all staff delivering the service will access appropriate clinical supervision and continual professional development.

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)

3. Service Delivery

3.1 Service model

Providers shall ensure that all staff providing services to patients under the Scheme framework shall be registered with the appropriate regulatory body.

Overall leadership and management including appropriate administration of the Pulmonary Rehabilitation service will be provided to ensure the management and administration of the service is effective and that the quality standards are met. Providers should indicate their intentions regarding clinical leadership.

Any Health Care Professional providing services under the Scheme framework shall be included on the appropriate Professional Register. Registration shall be current with evidence of on-going professional development.

Providers shall ensure that any support staff, including rehabilitation assistants and leisure staff, who assist with the provision of services under the Scheme framework have experience in the provision of pulmonary rehabilitation.

Providers should indicate which exercise test they intend to use.

Providers shall ensure that the pulmonary rehabilitation programme is provided in settings that have adequate provision of emergency equipment e.g. Resuscitation equipment and ambulatory oxygen for those patients who de-saturate on exercise.

This could be provided by a portable unit.

Organisational Fitness for Purpose
Providers shall demonstrate to the satisfaction of the Commissioner(s) that they have either appropriate experience of, or can demonstrate their ability to meet, the clinical and corporate governance services similar to that proposed under the Scheme framework.

Clinical Standards
Providers shall provide all premises, facilities and equipment necessary for the provision of services under the Scheme and ensure that at all times such premises, facilities and equipment are suitable for the safe and effective delivery of such services, and sufficient to meet the reasonable needs of patients.

GOVERNANCE ARRANGEMENTS

Standards for Better Health
Providers shall demonstrate that robust and effective governance arrangements have been made, in accordance with the 'NHS Standards for Better Health', to cover all aspects of their provision of services under the Scheme framework.

Clinical Supervision
Providers shall make appropriate arrangements to ensure that clinical staff and any Scheme service provision provided to patients is supported under clinical supervision.

Records
Providers shall ensure that a comprehensive record is made of each patient's pathway within the Scheme and ensure that clinical staff record data including shuttle test results, pre and post results and exercise sheets arrangements relating to Scheme services provided.

Complaints Procedures
Providers shall establish and operate a complaints procedure, in line with the NHS Complaints Procedure, to deal with any complaints in relation to services provided under the Scheme framework.

Confidentiality and Data Protection
Providers shall establish such systems as are necessary to ensure the confidentiality of patient data in compliance with relevant professional standards and legislation.

Appraisal
Providers shall ensure that their clinical staff engaged in providing services under the Scheme cooperate and engage with an annual appraisal to be developed with the PCT and provider in relation to the Pulmonary Rehabilitation programme.

Professional Portfolios
Providers shall ensure that clinical staff engaged in providing services under the Scheme maintain professional portfolios.

Continuing Professional Development (CPD)
Providers shall ensure that each member of their clinical staff, engaged in providing clinical services under the Scheme, undertake annually verifiable CPD specifically related to pulmonary rehabilitation/respiratory disease matters relevant and applicable to the Pulmonary rehabilitation service provision.

Serious/Adverse Incident Reporting
Providers shall comply with the Commissioner(s) policy documents in relation to the reporting of serious/adverse incidents in respect of the Pulmonary Rehabilitation service provision.

Insurance
Providers shall hold adequate insurance against liability arising from negligent performance of clinical services under the Scheme framework.

Providers shall hold adequate public liability insurance in relation to liabilities to third parties arising in connection with the provision of services under the Scheme framework.

Public Involvement
The Commissioner(s) shall engage with the respiratory specialists based in secondary and primary care settings, to share the aims and objectives of the Scheme and will consider

modifications or enhancements to the service specification based on any feedback received.

The Commissioner(s) shall also require prospective Providers of Scheme services, when submitting Business Cases, to demonstrate public involvement and consultation contributing to the formulation of their proposals.

Equality and Diversity
The terms of service of the Pulmonary Rehabilitation will require Providers to comply with all statutory requirements regarding Race, Disability, Gender/transgender, Sexual Orientation, Age, Religion/ Belief

Anticipated implications elsewhere in Health and Social care system
The Commissioner(s) anticipate that the successful implementation of the community based Pulmonary Rehabilitation services will not lead to increased demand for secondary care services. The clear intention is that current levels of patient demand for secondary care services will be reduced through providing this service promoting self care and self management.

MONITORING

Audit and Evaluation
Providers shall issue all patients with a survey form, in a format to be agreed with the Commissioner(s), at the conclusion of each programme. Providers shall collate and share with the Commissioner(s) information obtained from completed survey forms at periodic intervals

Providers shall maintain minimum data set records to provide the Commissioner(s) with information on the number of eligible patients offered, received and declined pulmonary rehab, DNA rates, waiting times, clinical outcomes etc. at quarterly intervals.

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

- Clinical outcomes:
    - a reduction in hospital admissionswill 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

Monitoring Arrangements
The Commissioner(s) shall monitor the Performance of Providers in meeting the Scheme service specification. This monitoring will encompass;

- A quarterly review of survey questionnaires completed by the Scheme service users
- A quarterly review of any service users complaints or compliments received either by the Providers or the Commissioner(s)
- Quarterly review of information obtained from the 'data set' provided by each Provider
- Six monthly review meetings of all Scheme stakeholders, e.g. the Commissioners, Providers, service users

The Commissioners shall reserve the right to cancel any SLA with individual Providers or suspend the Scheme entirely in the event of any serious incident or failure on the part of Providers to comply with the service specification.

3.2 Care Pathway

3.3 Location(s) of service delivery

The location of the service should be provided after taking due account of the needs of the local population. NHS Bournemouth and Poole residents should be able to access up to 4 locations and within half an hour. NHS Dorset similarly should be able to access up to 4 locations within half an hour. Some of these could overlap.

3.4 Days/hours of operation

To be determined as part of the proposal from providers

3.5 Referral criteria and sources

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 GP based in NHS Bournemouth or Poole or NHS Dorset appropriate to undertake a pulmonary rehabilitation programme.

Providers to propose referral documentation to ensure correct diagnosis of COPD for patients referred.

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.

3.6 Referral processes

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.

Communications with Referrers
Providers shall confirm in writing, by fax or secure e-mail receipt of all referrals to the original source indicating the action taken or to be taken.

Providers shall confirm in writing, by fax or secure e-mail the discharge of patients to the original referral source indicating the action taken. This shall also apply to patients who fail to attend scheduled appointments.

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

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.

3.7 Discharge processes

For each patient objectives will be agreed at the commencement of the pulmonary rehabilitation programme for the half way mark and at the end point. This is to ensure progress is made and that patients are preparing for discharge from the programme

3.8 Response time and prioritisation

To provide the patient with pulmonary rehabilitation within a reasonable time of referral – 2 weeks for assessment and to commence the programme for patients post hospital discharge;

Priority to be given to patients discharged from hospital but other patients are expected to be accommodated

4. Other

5. Quality Requirements

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Consequence of Breach*
• Waiting times;	**Maximum of 2 weeks from referral for post discharge patients and maximum of 8 weeks for patients in the community**			
• Number of patient;	**704 NHS B&P 920 NHS Dorset**			
• Number of patients pre-assessed for pulmonary rehabilitation who attend for assessment;	**100%**			
• The record of smoking status for all patients undertaking pulmonary rehabilitation and signpost to smoking cessation services as appropriate;	**100%**			
• Numbers of patients who take up scheme after assessment;	**70% (50% of original referrals)**			
• DNA rates;	**20%**			
• Number of patients completing scheme;	**90%**			
• Referrals – discharges, onward referral to the local acute providers;	**100%**			
• Serious/Adverse Incidents numbers reported and acted upon.	**100%**			