# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

|  |  |
| --- | --- |
| **Service Specification No.** |  |
| **Service** | Pulmonary Rehabilitation |
| **Commissioner Lead** | Kate Jackson/Emma Bellamy |
| **Provider Lead** |  |
| **Period** | July 2017 – March 2019 |
| **Date of Review** |  |

|  |
| --- |
| **1. Population Needs** |
| * 1. **National/local context and evidence base** |
| **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** |
| **3. Scope** |
| **3.1 Aims and objectives of service**  The Pulmonary Rehabilitation service will provide a hybrid model of delivery which comprises of both traditional face to face sessions within a community setting and the option of a web based self- management application.  The Pulmonary rehabilitation service will provide a multidisciplinary programme of care for people with chronic respiratory impairment that is individually tailored and designed to optimise each person's physical and social performance and autonomy.  **3.2 Service description/care pathway**  The Provider is responsible for:   * Delivering this service specification as per the NHS Constitution * Responding to requests from Referrers within 7 days * Ensuring that patients who have been admitted to hospital for an acute exacerbation of COPD are commenced on a Pulmonary Rehabilitation programme within 4 weeks * Arranging appointments for assessment via telephone/email or letter and ensure patients are encouraged to bring a Smartphone, tablet or other suitable device where possible to the initial assessment appointment * Offering the online COPD self-management option to patients in the first instance * Providing a traditional face to face pulmonary rehabilitation programme which incorporates physical training, disease education and nutritional, psychological and behavioural intervention * Providing concise information to patients about the service, what is available and the options * Obtaining the consent of patients to treatment and the sharing of their information * Sharing patient reports with the patients, Primary Care Team and/or Integrated Neighbourhood Teams * Promotion and Marketing of the service * Provide outcome data to Commissioners as per the set Key Performance Indicators (KPIs) * Providing the service at times that suit patients with COPD and in locations that are easy for people with COPD to get to, and have good access for people with disabilities   The Provider is not responsible for;  • The provision of transport for patients to and from the Provider’s premises   * Delivering the programme to people with unstable cardiac disease, locomotor or neurological difficulties precluding exercise such as severe arthritis or peripheral vascular disease, and people in a terminal phase of an illness or with significant cognitive or psychiatric impairment.   **3.2 Pulmonary Rehabilitation Service Flowchart**  Patient diagnosed with COPD at GP Practice or at Annual Review/6 month review with Practice Nurse and referred into the Pulmonary Rehab Service (PRS) for assessment  Patient accepts offer Face to face session  £fixed price paid to Provider per completed course per patient  (course activity courses)  Patient assessed in PRS  (£fixed price fee attracted for each assessment)  Patient NOT suitable for therapy in PRS or declines  Patient suitable for therapy in PRS  Refer to INT – Community Therapy  Patient offered self-management via web based platform in the first instance or face to face sessions  Patient accepted self-management  £fixed price paid to Provider for every patient enrolment on the webbased application  Provider to track patient progress online and ensure maintenance of patients record within app i.e. updating of medications etc  **3.4 Face to Face Programme**  The length of each face to face programme will be 6 weeks in duration and include a minimum of twice-weekly sessions.  The programme shall be operated from community sites relative to the neighbourhood footprint of the patient, offering a minimum of 12 sessions with a maximum of 16 patients per session.  The programme will include supervised, individually tailored and prescribed, progressive exercise training including both aerobic and resistance training and include a defined, structured education programme.  The programme shall be operated to facilitate:  • early commencement of a course  • be flexible to the needs of the patient  • accommodate patients referred following an exacerbation within 4 weeks of hospital discharge  The programme provided will follow NICE guidance to provide a structured educational programme.  The programme will follow a pre- agreed programme plan. Any changes to this programme plan should be agreed with the Commissioner.  The programme will have a written curriculum and a session plan for each session.  **3.5 Referrals**  The Provider will only accept patients who are registered with medical practices within Blackpool CCG.  The Provider will accept referrals from General Medical Practitioners, Practice nurses, Integrated Neighbourhood Teams, Respiratory Consultants, Respiratory Nurse specialists and the Rapid Response Team.  The Provider will fast track patients referred following an exacerbation of their condition as per NICE Guidelines. The Provider will have a process in place to manage these patients to ensure they are seen for an assessment within 2 weeks and placed on the next available course within 4 weeks.  The Provider shall be responsible for ensuring that all written referrals include all referral information as agreed between the Referrer and the Provider as being necessary, including being able to demonstrate that the referral is being made by an Authorised Referrer. The Provider shall ensure that Referrers make referrals using the agreed referral form via EMIS.  The referrals process should be electronic and link to GP and Community EMIS systems.  Providers should arrange an initial assessment appointment via telephone and/or email and ensure patients are encouraged to bring a Smartphone, tablet or other suitable device where possible, to the initial assessment.  The Provider will assess referred patients against referral criteria. The referral criteria will be evaluated on an annual basis with the Commissioner.  The Provider shall ensure that the referrer receives an appropriate response detailing the outcome of the initial patient assessment, type of programme to be completed and further details following completion of a face to face course at the Providers premises.  The Provider shall have a process in place to manage an inability to contact a referred patient. The patient shall be offered an assessment twice prior to the Provider returning the referral to the referring professional.  **3.6 Appointments And Waiting Times**  All patients will be seen for an assessment within 2 weeks of the referral. Appointments will be made at suitable times taking into account the needs of the patient.  The Provider shall ensure that no patient is kept waiting on the Provider’s premises prior to being seen by the Provider for more than 30 minutes from their scheduled appointment time.  The expectation is that patients are kept informed regarding any delays in appointment time and given the opportunity to rebook if required.  **3.7 Patient Assessment**  The provider will initially contact the patient following receipt of referral and offer an initial assessment within 2 weeks.  The assessment will entail a brief explanation and demonstration of both the online self-management application and the face to face rehabilitation programme.  If the patient agrees to the online self-management programme then this will be uploaded on their own personal device by the patient with assistance of the provider. The application will be demonstrated to the patient and follow up contact details provided to the patient if there are any subsequent issues.  It will be explained to the patient that their progress will be monitored remotely via the application over the next 2 months.  **Face to Face Assessment and Evaluation**  The Provider will ensure that each patient who wishes to complete the face to face programme completes these assessments on initial assessment:  • Incremental Shuttle walking test with Oxygen Saturation Monitor  • Hospital Anxiety and Depression Scale (HADS)  • CAT score  If necessary, patients can be referred to their integrated neighbourhood team if there are functional difficulties or rehabilitation needs that require an assessment by a member of the Community Therapy team.  The Provider will ensure that each patient completes the following at the end of the programme:  • Incremental Shuttle walking test with Oxygen Saturation Monitor  • Hospital Anxiety and Depression Scale (HADS)  • CAT score  • Patient satisfaction/evaluation survey  It online self-management programme incorporates the above information as standard.  The Provider will analyse the outcomes of the audits listed above and provide these patient outcomes as part of the KPI dataset.  **3.8 Performance**  The Provider will also report the following performance data together with the information as defined within the KPI’s:   * provide a brief narrative report to outline/explain anomalies and describe actions taken to remedy * work with the Commissioner to identify referral trends per neighbourhood (public health data and disease registers) and take positive action to increase marketing in these key areas   **3.9 Marketing**  The Provider shall ensure the service is marketed to all professionals who are eligible to refer to the service.  The Provider shall ensure advice, guidance and information materials are available to patients and referrers where applicable, these materials should include:   * Patient information booklet detailing the service and benefits, service times, location and access i.e. bus times as well as employees supporting the programme and contact numbers. * Promotion of online self-management support materials * Local COPD Self-Management Plans will be utilised and promoted   **3.10 Population covered**  Any patient registered with a Blackpool CCG GP Practice.  **3.11 Any acceptance and exclusion criteria and thresholds**  Patients referred to the Pulmonary Rehabilitation service should be offered the online self-management programme in the first instance at the initial assessment stage.  Face to face courses will be scheduled flexibly to meet the needs of patients. The Provider will provide courses in the morning, afternoon and if required by patient choice twilight or evening to accommodate patient’s health and social needs.  If patients decide not to complete the face to face course either if they have started the programme or not, they should be offered the online self – management programme as an alternative.  **3.12 Interdependence with other services/providers**  The Provider shall ensure that patients are signposted to other appropriate services such as, Voluntary agencies, Vitaline Telecare, Age UK, Blackpool Wellbeing Service and exercise groups eg YActive.  The provider will work collaboratively with services delivering commissioned care to patients from Extensive Care, Enhanced Primary Care (Including Integrated Neighbourhood Teams) and Primary Care services.  The Provider will work with providers across the health economy to identify appropriate follow up services to facilitate patient’s on-going self-management of their condition  The Provider shall work collaboratively with providers and commissioners to implement the COPD Pathway (2012/13) to deliver the following:  • increase pulmonary rehabilitation to patients  • improve health outcomes and life expectancy  • ensure a seamless and integrated service for patients  • reduce admissions and re-admissions  • support early discharge  • support Amber and End of Life Pathway where appropriate |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)**  NICE Guidance for the management of COPD  An Outcomes Strategy for COPD and Asthma in England  **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** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-D)**   2. **Applicable CQUIN goals (See Schedule 4E)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:** |
| **7. Individual Service User Placement** |
|  |