SCHEDULE 2 – THE SERVICES

A. 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	1st July 2017 – 30th June 2020 with an option to extend until 31st December 2021.
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Chronic obstructive pulmonary disease (COPD) is a type of obstructive lung disease characterized by chronically poor airflow. COPD typically worsens over time; the main symptoms include shortness of breath, cough, and sputum production. Tobacco smoking is the most common cause of COPD, with a number of other factors such as air pollution and genetics playing a smaller role. COPD is a progressive disease and the damage caused cannot be reversed, although medications and even surgery are available to reduce symptoms. Early detection and abstinence from smoking can reduce or prevent damage to the lungs.

In 2015/16 6,337 people had been identified by NHS Blackpool CCG GP practices as living with COPD.[1] It is estimated that this accounts for only 52% of the total population in Blackpool living with COPD and there are likely to be approximately 2,900 people with undiagnosed COPD.

- An Outcomes Strategy for People with Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England (Department of Health, 2011)
- Management of chronic obstructive pulmonary disease in adults in primary and secondary care (National Institute for Health and Care Excellence, 2010)
- Best Practice Models of Care (Improving and Integrating Respiratory Services, 2008 and 2009)

- Enhancing quality of life for people with long-term conditions (NHS Outcomes Framework, 2011/12)

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

NHS Blackpool CCG believes in the principles of good medical practice and stand by these in the decisions we make as clinical commissioners. We strive to:

- Make the care of our patients our first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
- Treat patients as individuals and respect their dignity
- Work in partnership with patients
- Be honest and open and act with integrity

Blackpool CCG will tackle the challenge that our population brings by focusing on the aspects that really matter:

Preventing People from Dying Prematurely;

Reduce Health Inequalities;

Commission for Better Outcomes;

Our vision is to:

- Improve the health outcomes of the population and reduce health inequalities.
- Work to ensure that commissioned services are responsive to patient needs, and that patients and the public are involved and integral to the work of the CCG.
- Continuously improve quality and outcomes of services and strive for excellence.
- Commission services for the Blackpool population within the financial allocation of the CCG.

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

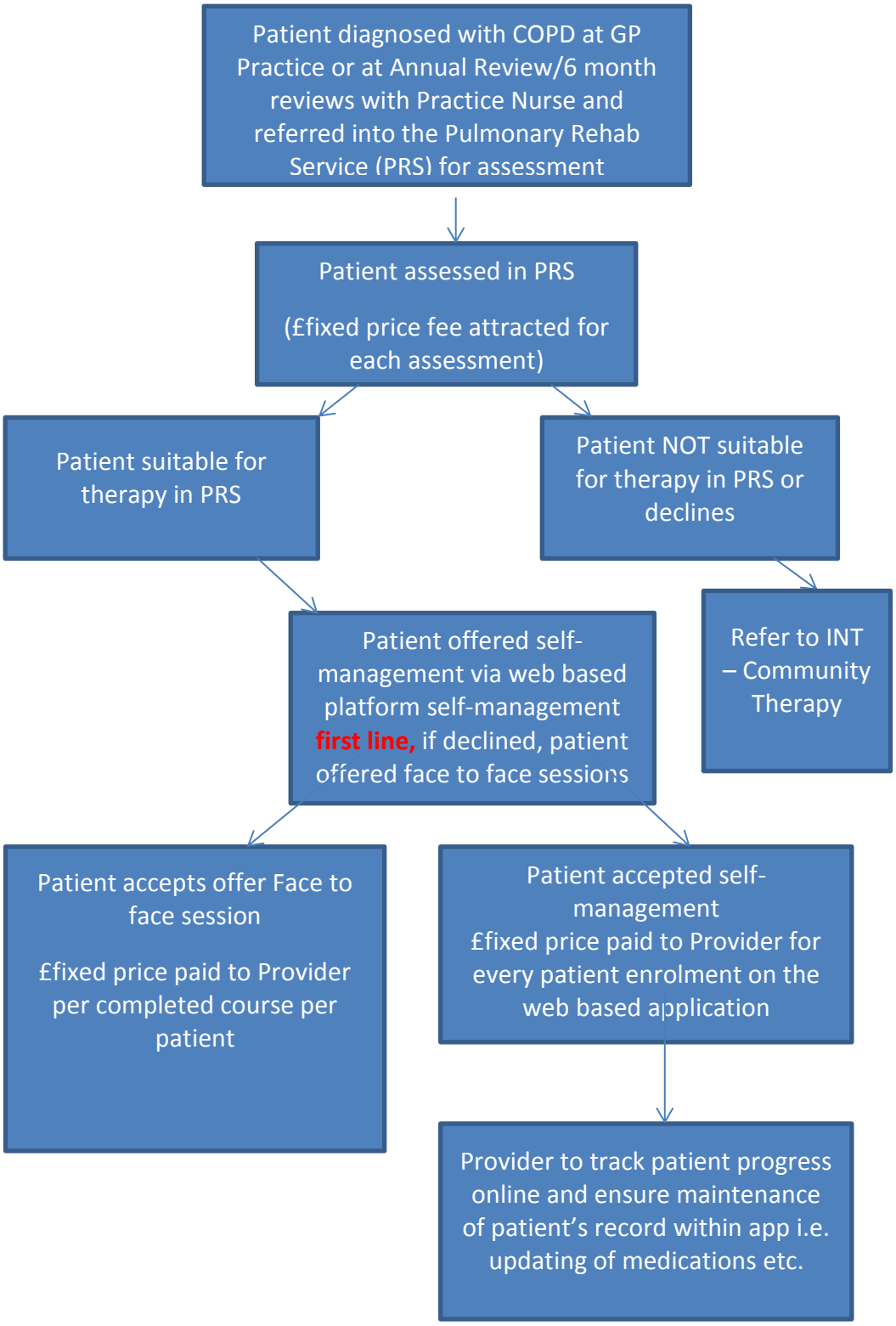
The Provider is responsible for:

- Delivering this service specification as per the NHS Constitution
- Responding to requests from Referrers within 7 actual 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) see Appendix 1 for 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
- Ensuring the patient completes the course which will trigger the Provider being able to claim full payment. The Provider will not be paid if a course is not completed by a Patient unless the patient dies or is admitted to hospital.

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.
- Cost of licences, maintenance or training for the self management software.

3.2 Pulmonary Rehabilitation Service Flowchart



3.3 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.

If a patient drops out of the face to face programme, they should be offered the online programme as an alternative.

3.4 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 8 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.

The Provider will ensure that any patients that do not attend or drop out of the programme early are contacted via letter to ascertain the reason for withdrawal.

3.5 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.

3.6 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.

3.7 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)
- COPD Assessment Test (CAT) score
- MRC Dyspnoea scale

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:

1. Incremental Shuttle walking test with Oxygen Saturation Monitor
2. Hospital Anxiety and Depression Scale (HADS)
3. CAT score
4. MRC Dyspnoea scale
5. Patient satisfaction/evaluation survey (Appendix 2 for an example)

The online self-management programme incorporates the information stated in numbers 2-4 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
- provide a quarterly progress report detailing referral numbers, details of successful completion, dropout rates, percentage of face to face Pulmonary rehabilitation and online pulmonary rehabilitation

Early evaluation of the online/face to face sessions will take place during the contract term, with the option to revise the targets specified in the KPIs, in line with patient demand for the online element of the service.

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 this should include weekends and weekdays if necessary

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 e.g. 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 NHS Blackpool CCG COPD Pathway 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 (e.g. 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 (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

The Provider's Premises will be located within the neighbourhood footprint of NHS Blackpool CCG

7. Individual Service User Placement

Appendix 1 – Key Performance Indicators

KPI number	Metric	KPI Descriptor	Baseline 2015/16	Target 2016/17	Frequency of Monitoring
1	Referrals for both face to face and online programmes	Increase in referrals by 80% minimum	524 (face to face only)	1000	Monthly
2	Assessments	90% conversion from referral to assessment	331	900	Monthly
3	Online Self-Management Programme	Number of patients completing online self-management programme	NONE	500	Monthly
4	Face to Face Programme	Number of patients completing face to face programme	524	250	Monthly
5	DNA Rates/dropout rates from referral to completion	DNA/dropout rates maximum 25%	63%	250	Monthly
6	Breakdown of GP referrals (linked to Primary Care Scheme/COPD scheme)	Referrals by GP Practice recorded	Provider to monitor referrals by practice	Actively target practices that do not refer	Monthly
7	Patient Satisfaction Surveys	Satisfaction Surveys from 80% of total course attendees	NONE	80%	Monthly
8	Patient Experience	Patient experience to be positive from 80% of patients completing a satisfaction survey	NONE	80%	Monthly
9	HADS scores for depression	70% of patients completing the programme showing a reduction in HADS score	NONE	100%	Monthly
10	CAT score	70% of patients completing the programme showing a maintenance or reduction in CAT score by 10% or more	NONE	70%	Monthly
11	Incremental Shuttle walking test with Oxygen Saturation Monitor	70% of patients to show an improvement in sats post programme	NONE	70%	Monthly
12	MRC Dyspnoea scale	All patients to have had MRC scale completed on admission and discharge	NONE	70%	Monthly

Appendix 2 - Patient satisfaction/evaluation survey

PULMONARY REHABILITATION EVALUATION FORM - EXAMPLE

We hope you have enjoyed the pulmonary rehabilitation course; we would appreciate it if you could spend a few minutes to complete this evaluation form to assist us in the planning and development of the course for future participants.

Name (optional) : **Date :**

1. Did you enjoy the course? Yes No

2. What aspects of the course did you find helpful?

3. What aspects of the course did you think were unhelpful?

4. Did the course meet your anticipated needs? Yes No

5. What did you think of the venue?

Excellent Good Medium Poor Very Poor (Please Circle)

6. Did you find the venue easily accessible? Yes No

7. Overall on a scale of 1-5, how would you rate this course?
(Poor) 1 2 3 4 5 (Good) (Please Circle)

8. Would you recommend this course to a friend with COPD? Yes No

Any further comments?

We would like to take this opportunity to thank you for taking the time to complete this evaluation form.