

NHS SERVICE RECONFIGURATION INITIAL CHECKLIST

1. Initial Information

<i>Project Title</i>	<i>Pulmonary Rehabilitation</i>
<i>Contact Officer for project</i>	<i>Sally Baughen/Jean Richards</i>
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1.1	<p><i>Please provide as much detail as you can at this stage on the nature of the proposed service reconfiguration</i></p> <p>NDCCG has invested an additional recurrent £114,000 and Hardwick CCG £100,000 in Pulmonary rehabilitation to increase access to pulmonary rehabilitation programmes. This along with the existing investment of £76,988 gives the two CCGs a total resource of £320k</p> <p>This investment should enable access to:</p> <ol style="list-style-type: none"> 1. Newly diagnosed COPD patients who are functionally disabled by breathlessness (usually people with an MRC score of three or more). 2. Patients who have either recently had an exacerbation of COPD requiring a hospital admission or whose functional baseline has significantly altered and is not following the expected recovery path. The NICE guidance is clear that patients who have had an exacerbation of COPD should be referred to Pulmonary Rehabilitation within 4 weeks and the availability of at least one rolling programme should facilitate the CCG meeting this standard. <p>There will also be some access to those people who already have a confirmed diagnosis of COPD and other chronic progressive lung condition (e.g. bronchiectasis, interstitial lung disease, chronic asthma and chest wall disease) and also patient's pre and post thoracic surgery including lung transplant, who meet the criteria and have never had access to a structured PR education programme or would benefit from further access.</p> <p>Key changes:</p> <ol style="list-style-type: none"> 1. The plan will increase the total capacity of the service <p>On average over the last 2 years, 144 patients a year have commenced on a PR programme across ND and Hardwick CCGs (the data was not historically provided at CCG level).</p> <p>Under the revised proposal, North Derbyshire and Hardwick CCGs will commission a joint service with approximately 850 places (FYE) for people commencing a programme. In 2014-15 as there is a transition from the existing model to the new model, the capacity will be approximately 636 under the current proposal. This is a significant increase in capacity across the two CCGs but is dependent on the sites as outlined in the paper below.</p>

2. The proposed model sites will be more in line with where the highest levels of COPD are in each locality but also within a more cost effective model of provision and therefore some of the current locations will need to change

Current data:

Locality	Total COPD population by locality (11-12)	% patients COPD	Exacerbations (2012-13 data)	New patients 2014-15
Chesterfield	2567	44%	186	105
Dronfield	441	7%	27	18
High Peak	1177	20%	97	50
North Dales	769	13%	59	32
North East	936	16%	50	40
Total - NDCCG	5890	100%	419	245
Hardwick CCG	2888	100%	369	108

Local data suggests that the annual increase in incidence of COPD is approximately 4% per year for NDCCG.

Historically, Pulmonary Rehabilitation (PR) was provided as and where it was felt appropriate which consequently resulted in a high cost service with venues in non NHS sites. In the last 3 years, the service was provided at the following sites :

From May 2011

- Bainbridge Hall, Bolsover – 1 programme
- Bolsover Hospital – 3 programmes
- Calow Community Centre – 9 programmes
- Chapel Leisure Centre – 3 programmes
- Clay Cross Hospital – 6 programmes
- Rowsley Leisure Centre – 2 programmes

Since July 2013 to the present date, the programmes we have delivered/are delivering are:

- Bainbridge Hall, Bolsover – 1 programme
- Calow Community Centre – 4 programmes
- Chapel Leisure Centre – 2 programmes
- Clay Cross Hospital – 2 programmes
- Rowsley Leisure Centre – 1 programme
- Clowne Sports Centre – 1 programme
- Eckington Business Centre – 1 programme

	<p>The proposed changes to the new service will significantly increase the number of places available for patients but will involve some changes to the current service.</p> <p>Proposed changes to the current service are:</p> <ul style="list-style-type: none"> ○ Increase the capacity at Clay Cross and Bolsover Hospitals ○ Increase the capacity in Chesterfield but move sessions from Calow Community Centre to Walton Hospital (see point 5 below) ○ Increase the capacity in the Dales but move sessions from Rowsley Leisure Centre to Whitworth Hospital ○ Significantly increase the capacity in the High Peak and move the service from Chapel-en-le-Frith to Buxton. The proposal is currently for all programmes in the High Peak to be operated from Buxton Hospital as this is the most cost effective delivery and will enable adherence to NICE standards and shorter waiting times. However, due to the geography of this patch, a single site may not be considered adequate by the locality or patients. Therefore further feedback will be sought from patients on this. There are two options:- <ul style="list-style-type: none"> • Option 1 – retain some of the service available in Chapel which will result in increased cost implications and therefore a reduced number of programmes in the High Peak, longer waiting times and difficulties meeting NICE standards. • Option 2 – as proposed, move all the service to Buxton Hospital. Patient Transport Services (PTS) are already provided for those patients who meet the criteria. The CCG/DCHS would provide information to patients on High Peak Community Transport for those not meeting the criteria. <p>3. Other factors the CCGs have taken into consideration in agreeing the model of provision:</p> <ul style="list-style-type: none"> • The service has to be responsive and to meet NICE standards (access to a Pulmonary Rehabilitation programme within 4 weeks of an exacerbation). In order to achieve this, activity has to be sufficient in number in each location to support a reasonable number of programmes. The model proposed is recommended as a balance between accessibility, waiting time reductions and provision of a more efficient service. • Any increase to the number of locations proposed for PR will: <ul style="list-style-type: none"> ○ Reduce the capacity of the service as additional travel costs, travel time and venue costs will be factored in ○ Increase the waiting times for the service ○ Risk achievement of the NICE standards • In terms of equity, the model proposed is in line with other
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	<p>areas of Derbyshire in terms of availability of programmes, location of sites and programme offer.</p> <ul style="list-style-type: none"> • Operating the service from DCHS premises is more cost effective which increases the number of places that can be made available. • Patient transport will be provided for all those meeting the criteria • For those not meeting the criteria, DCHS as the service provider, will make patients aware of the voluntary sector community transport options available. • The clinical need of the patients means it is preferable to hold the programmes in NHS premises with access to appropriate clinical back up although it is not essential. • Patients would normally only attend a Pulmonary Rehabilitation programme once for the period of the programme (6 weeks). Therefore, the majority of patients affected by this proposal are new to the service and have not used the service previously at one of the current locations. • It is intended that sessions will continue to run at current locations until all patients who have already been accepted onto a programme and notified of the location have attended their sessions at the location offered. • It is proposed that a rolling programme and ad hoc provision will be provided for all newly commissioned activity and activity where the site has remained unchanged, is in place from 1st April 2014. • Full implementation of the future model is proposed to run from 1st October 2014 following public engagement. • The service in North Derbyshire is a jointly commissioned service between North Derbyshire and Hardwick CCGs. This affords more flexibility in terms of locations of service as patients will be able to choose across 5 sites.
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1.2	<i>What will this proposal mean for patients and the public? (Please include information on potential impact on accessibility of services and general impacts for patients, carers, public etc.).</i>
	<p>The number of available courses will be significantly increased</p> <p>The courses will be in the right place for the numbers needing to access them.</p> <p>The shift in venue will only affect new service users</p> <p>As the proposed new venues are all NHS premises, there will be clinical back-up for any patients whose conditions may deteriorate</p> <p>Assurance that NICE standards will be met with a better quality of service</p>

2. Please outline how this proposal has or will consider the four tests set out in the revised NHS Operating Framework 2010/11.

2.1	<p><i>Have GPs been engaged with the proposals? If not what plans are in place to ensure this happens?</i></p> <p>In North Derbyshire CCG, GPs have been engaged as follows:</p> <ul style="list-style-type: none"> - Practices have been made aware of the investment via the CCG weekly update and views were requested. - Views have been sought from the clinical leads in each of the localities of the CCG. - There is GP involvement on COPD working group - The CCG Clinical Reference Group (which includes a range of GPs from each locality) has supported the proposals <p>Hardwick CCG practices have been made aware of the investment through the Commissioning delivery Group where GPs had an opportunity to comment.</p>
2.2	<p><i>How have patients and the public been engaged in this proposal to date and what further activity is planned?</i></p> <p>Focus groups have been organised with patients who have previously attended for Pulmonary Rehabilitation and patients who have attended the Expert Patient Programme throughout April and May</p> <p>Views have been sought from the local Breathe Easy group (14.4.14)</p> <p>Views of the North Derbyshire CCG Lay Reference Group have been sought (28.3.14)</p> <p>Input from Hardwick Patient Reference group 17.4.14, the group was provided with a briefing paper to allow them to effectively feedback to</p>

	<p>their practice Patient Participation Groups.</p> <p>The feedback so far shows that :</p> <ul style="list-style-type: none"> - patients welcome the investment in the service - availability and location of parking is a priority. The option of reserved parking at DCHS sites for patient attending the programme is being considered to minimise risk - reduced waiting times are welcomed - time of day is important, ideally late a.m. to 3.30/4 p.m. is the optimum time. The programmes currently run within these times <p>The engagement process is still ongoing and all views will feed in to the final decision making process prior to full implementation in October.</p> <p>The uptake of the service will be reviewed against the expected number of referrals and access from practices based on prevalence figures and non-elective admissions. Action will then be taken as appropriate to address this. The drop off rates in attendance from assessment to part and full completion will also be monitored.</p>
2.3	<p><i>What is the clinical evidence base for this reconfiguration?</i></p> <p>There is a strong evidence base for increasing access to Pulmonary Rehabilitation as follows:</p> <p>Several publications at the national level have recommended the use of Pulmonary Rehabilitation for appropriate people.</p> <p>The Outcomes Strategy for COPD and Asthma and the subsequent NHS Companion Document to the Strategy suggested the NHS could:</p> <ul style="list-style-type: none"> • Provide Pulmonary Rehabilitation for all people with COPD with an Medical Research Council (MRC) breathlessness score of three or above (scale none (Grade 1) to almost complete incapacity (Grade 5)) <p>The NICE Clinical Guidelines for COPD highlights Pulmonary Rehabilitation as a priority for implementation, recommending:</p> <ul style="list-style-type: none"> • Pulmonary Rehabilitation should be made available to all appropriate people with COPD including those who have had a recent hospitalisation for an acute exacerbation. <p>The NICE Quality Standard for COPD also highlights the importance of Pulmonary Rehabilitation:</p> <ul style="list-style-type: none"> • Quality statement 6: People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary Pulmonary Rehabilitation programme.

	<p>Evidence suggests that Pulmonary Rehabilitation programmes are a highly cost-effective intervention for people with COPD which is substantially below the NICE threshold for cost-effectiveness at only £2000-£8,000 per Quality Adjusted Life Year (QALY)¹</p> <p>Pulmonary Rehabilitation is an essential option available within a wider, comprehensive respiratory pathway. There is sound evidence on the benefits of Pulmonary Rehabilitation and research studies have shown that pulmonary rehabilitation can:</p> <ul style="list-style-type: none"> · reduce mortality · reduce hospital admissions · reduce inpatient hospital days · reduce readmissions · reduce the number of home visits · improve health-related quality of life in COPD patients after suffering an exacerbation (e.g. dyspnoea, fatigue, depression, and patient control of the disease) · be highly cost-effective – it is substantially below the NICE threshold for cost-effectiveness, at only £2,000 - £8,000 per QALY
2.4	<p><i>How does this proposed reconfiguration fit in with ensuring consistency for patient choice?</i></p> <p>Sessions are provided more frequently so will increase choice of courses and waiting times will be reduced.</p> <p>Sessions are provided throughout the localities within NDCCG and Hardwick CCG so patients will have a choice of venues.</p>

3. Further information

3.1	<p><i>Provide a brief outline of the financial implications of this project.</i></p> <p>The two CCGs have invested an additional £214,000 recurrent funding into pulmonary rehabilitation.</p>
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¹ Griffiths et al. (2001) 'Cost-effectiveness of an outpatient multi-disciplinary pulmonary rehabilitation programme'. Thorax 56: 779 – 784

3.2	<i>Please provide a timetable /summary of key dates for activities relating to this project</i>
	January 2014 – extra sessions set up by DCHS to start to clear waiting list April and May 2014 – Practice and public engagement April - mid-September 2014 - interim model with increased capacity in existing sites August – end September review of patient and clinical feedback to inform new model 1 st October 2014 - full implementation of new model informed by feedback
3.3	<i>Following completion of all engagement activity (Public, Clinical etc.) when will you update the Committee on the project?</i>
	Committee requested to advise.

PLEASE RETURN COMPLETED FORMS AND ANY FURTHER INFORMATION THAT WOULD BE USEFUL FOR THE COMMITTEE TO CONSIDER TO:

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