NATIONAL CLINICAL PROGRAMME RESPIRATORY

NCP Respiratory
A Competency Framework for Pulmonary Rehabilitation services
Part 1
January 2022

Introduction

This document was developed by the NCP Respiratory to support the "Guidance document for setting up a pulmonary rehabilitation programme for healthcare professionals 2020"(1) and to support the rollout of full time permanent pulmonary rehabilitation services and teams through the Enhanced Community Care project over the coming years. A new community model will see an increased number of integrated pulmonary rehabilitation services (PRS) coordinated across the country.

Community Healthcare Networks (CHN) will provide the foundation and organisational structure through which integrated care for COPD will be provided locally within the new Regional Health Areas (RHA). The CHN will support the GP- led chronic disease management contract including conditions such as COPD and asthma. Each CHN will cover a population of approximately 50,000 people. Three geographically adjoined CHNs will act as a point of access to specialist ambulatory care teams (Hubs) within the community. The three networks will total approximately 150,000 populations. The three networks will have direct links to a local acute hospital service. The CHNs together with the Chronic Disease Management Community Specialist Ambulatory Teams (Hubs) will provide specialist support to the GP in managing COPD in the community and ultimately preventing unnecessary hospital admissions, supporting early discharge and bringing care closer to the patient's home. This includes a new full time pulmonary rehabilitation service in each hub.

A comprehensive national needs assessment for pulmonary rehabilitation services published in 2017 reported that services were considered well below capacity at national level. Significant gaps in service provision and regional variation were identified. It recommended that at a minimum the capacity for pulmonary rehabilitation needed to be increased by 89% in order to meet the existing requirement for patients discharged following an acute exacerbation. To improve access to PR the community specialist ambulatory team (hub) will have a designated Community Pulmonary Rehabilitation team. This pulmonary rehabilitation team will comprise of new roles including a clinical specialist physiotherapist coordinator, a clinical nurse specialist in pulmonary rehabilitation and a basic grade physiotherapist in pulmonary rehabilitation as well as administrative support. This team will provide PRS to their 3 mapped networks population. This will facilitate clear pathways to provide a continuum of care for COPD in keeping with the NCP Respiratory End to End model of care (2019) and the NCEC Guideline no 27 Management of COPD (2021).

Background and Context

Pulmonary rehabilitation is defined as "a comprehensive intervention based on a thorough patient assessment followed by patient tailored therapies which include, but are not limited to, exercise training, education and behaviour change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health enhancing behaviours" (2).

Pulmonary rehabilitation (PR) plays an integral role in the management of patients with obstructive airways disease and in the management of other chronic respiratory conditions where symptoms of breathlessness impact negatively on exercise capacity and quality of life.
It is an effective intervention for improving quality of life, decreasing dyspnoea, and increasing exercise tolerance in patients with chronic respiratory diseases (3). Pulmonary rehabilitation supports self- management which enables with chronic lung disease to better understand and manage their condition. Many studies including the 2015 Health Technology Assessment by HIQA on self-management services identified Pulmonary Rehabilitation as one of the most cost effective methods of supporting patients to self-manage and improve service user outcomes (4).
The HSE "National Framework for integrated prevention and management of chronic disease in Ireland 2020- 2025" and the "End to End Model of Care for COPD 2019" (5-6) both support the implementation of an integrated care programme for COPD focusing on community investment to reduce the pressure on acute services and deliver increased quality of care for patients delivered closer to home. This supports the realignment of care towards the community called for in Sláintecare and prioritises services in the community. The End to End Model of care for COPD (2019) showed the progression of an end to end model across the spectrum of care and into the enhanced community setting. This model along with the National Framework for integrated prevention and management of chronic disease in Ireland 2020-2025 support the implementation of services and care pathways that support the development of ambulatory care services for COPD to reduce hospital admission rates and hospital bed usage. This model of care supports people to live well within the community, with ready and equitable access to General Practitioner (GP) review, diagnostics, Health and Social Care Professionals (HSCP) input and specialist opinion, as required.

Pulmonary rehabilitation services as with a lot of other services had to adapt during the COVID 19 pandemic and developed into a "hybrid model". This allowed services to continue to run in a virtual format where possible as well as face to face when public health guidelines allowed. This model will remain in place for the future (7).

Minimum standards for service provision and staff competency

In order to support the provision of comprehensive quality pulmonary rehabilitation services we need to develop two primary areas.

1. Standards for service provision
2. Competency framework

Standards for service provision

In 2018, the Royal College of Physicians in England, in partnership with the National Asthma and COPD Audit Programme, developed the Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) with the aim of assuring a quality assurance process in the delivery of pulmonary rehabilitation services England (8). To support this process, a document was developed which identified seven standards to guide the scheme.

- Leadership, strategy and management.
- Systems to support service development.
- Person centered treatment and/or care.
- Risk and safety.
- Clinical effectiveness.
- Staffing a clinical service.
- Improvement, innovation and transformation.

These standards were updated in 2020 and readers are referred to this document for audit of their own service standards.

Health Care Professionals Competency Framework

Pulmonary rehabilitation is a service administered by an interdisciplinary team focused on improving functional status, reducing dyspnoea, and improving quality of life for patients with chronic respiratory disorders. To effectively deliver a quality program, health care providers of PRS must be competent in understanding and demonstrating their ability to meet the patients' needs and goals and tailoring a pulmonary rehabilitation programme to achieve this.

Competency development for any discipline or program involves describing the knowledge and skills needed to provide the services (9). In 2014 the AACVPR statement recognised five core competencies for health professionals to meet the dynamic needs of the health care system (10). These competencies are patient-centred care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics (11).

It is acknowledged that individual teams can differ greatly in staffing, skill mix and roles; teams can also work differently depending on local pathways and patient demographics. It was therefore recognised that a single competency document would provide a structured framework, meeting the needs of all service areas whilst avoiding duplication of competence assessment. Over the coming 12 months as the integrated PRS and teams are recruited and services expand more specific competencies related to the individual professionals will be developed with the relevant professional bodies.

The overall purpose of these two documents is to:

- Identify knowledge and skills required for pulmonary rehabilitation services.
- Identify staff learning and development needs.
- Guide continuing professional development.
- Serve as a document to support professional and clinical supervision.

The documents use a common framework of knowledge and skills. The accompanying competency framework Part 2 document covers the following competencies.

Clinical Competencies include:

- Clinical knowledge.
- Core Assessment.
- Assessment of Dyspnoea.
- Exercise Testing.
- Exercise training and prescription.
- Preparing the individual for supervised exercise.
- Leading and delivering the supervised exercise session.
- Managing the unwell patient.
- Collaborative self-management support including psychosocial and multidisciplinary team education.
- Virtual pulmonary rehabilitation.
- Forward planning.

Operational/service competencies include:

- Preparing and adapting environment and equipment.
- Service planning and management.
- Service evaluation.

It is proposed that as the pulmonary rehabilitation services and teams are embedded over the coming years that these competencies will be reviewed with the relevant professional bodies and become more specific for each profession.
Until this time the NCP Respiratory considers the following points must be considered when setting up or working in a PRS:

1. Programme provision by suitably qualified members of the multidisciplinary team, paying attention to the individual needs of patients and carers.
2. Defined role of individuals running the programme.
3. Classes are led by a healthcare professional competent in exercise prescription.
4. Inclusion of individualized physical training, disease education, self-management, nutritional management, psychological, social and behavioural intervention.
5. Development/adoption of Quality Standards for PR and review.
6. Development of standardised education and training of workforce.
7. Continuous audit of effectiveness in terms of clinical outcome measures, and both clinical and cost effectiveness.
8. Patient centered and accessible to all that need it.
9. Prioritize investment in PR services to include virtual technology.
10. Future research to focus on new opportunities and not pulmonary rehabilitation versus conventional treatment.

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