NHS
Oxfordshire
Clinical Commissioning Group

Template for Presenters at Meetings of the North Locality Group

Meeting date	13th December 2018
Name of presenter	Dr Karen Kearley and Paul Swan
Organisation	Oxfordshire CCG
Title of Paper / Presentation	
Integrated Respiratory Team Pilot: A Joint Working Project between Oxfordshire Clinical Commissioning Group (OCCG) and Boehringer Ingelheim Ltd (BI)	
Main message(s) for the locality	

Overview

1. The Integrated Respiratory Team (IRT) Pilot project was approved by OCCG Board on 27 Sept 2018: https://www.oxfordshireccg.nhs.uk/board-meetings/board-meeting-27-september-2018/72229
2. The proposal is a Joint Working Project between OCCG and BI to develop an enhanced integrated multi-disciplinary respiratory team (IRT) to:
   2.1. Increase and improve accurate, timely diagnosis of respiratory disease
   2.2. Identify a cohort of patients who are at risk of respiratory admissions
   2.3. Optimise clinical management, and
   2.4. Introduce early holistic and end of life care
   2.5. Integrate the care of patients within primary & secondary care and community settings
3. The defined patient cohort within the remit of the IRT will include:
   3.1. Patients with airways disease: Asthma and COPD
   3.2. Bronchiectasis patients not requiring intensive secondary care management
   3.3. End-stage Interstitial lung disease patients including those with sarcoidosis
   3.4. Patients with neuromuscular disease or on home non-invasive ventilation (NIV) requiring physiotherapy input to optimise airways clearance and manage home NIV
4. It is anticipated that this will achieve improved patient-centred care leading to:
   4.1. A reduction in emergency respiratory admissions (and 30-day readmissions) in the IRT patient cohort
   4.2. A reduction of the deficit between registered and estimated COPD prevalence
   4.3. A reduction in respiratory outpatient appointments within specified clinics
   4.4. A reduction in ambulance call outs and emergency department attendances
   4.5. An increase in smoking cessation in the IRT cohort
   4.6. Better identification of end of life patients and/or patients needing supportive holistic care in IRT patient cohort with increased advance care planning
   4.7. Improved identification and treatment of respiratory patients in IRT patient

cohort with mental health problems, anxiety and depression in particular.

4.8. Improved quality of life, mental health, and self-care for patients and their carers

5. Multi-disciplinary integrated care for people with COPD is recommended under NICE guidelines[i] and the NHS RightCare COPD Pathway[ii].
6. The pilot will operate in the Oxford City and North Oxfordshire localities. It will start in November 2018 and project duration will be 15 months, ending 30 January 2020.
7. BI and OCCG will jointly fund the IRT and will collaborate to evaluate clinical, patient reported and health economic outcomes; this is in line with the principles of joint working endorsed by the Department of Health and as described in Clause 20 of the Association of the British Pharmaceutical Industry (ABPI) Code of Practice 2016. However, Boehringer Ingelheim Ltd will have no access to patient identifiable or pseudonymised data throughout this project – the only information they receive will be anonymised and aggregated.
8. The operational delivery of the IRT pilot will be delivered by Oxfordshire health care providers: Oxford University Hospitals NHS Foundation Trust (OUHFT), Oxford Health Foundation Trust (OHFT), GP Federations and the Oxfordshire County Council (OCC) commissioned stop smoking provider, Solutions 4 Health Ltd (S4HL). The IRT will work in close collaboration with the emergent Frailty pathway and model of care. The IRT will operate Monday – Friday 9am-5pm.
9. Oxfordshire healthcare professionals from primary, community and secondary care with expertise and interest in respiratory disease have been involved throughout development of the project through the IRT Project Group. Further patient engagement will be incorporated into the delivery of the project. The IRT Project Implementation Group will include at least one patient representative and establish reliable means to link into relevant patient groups and relevant third sector bodies.

IRT Staff

Role	WTE
Respiratory Consultant	0.5
Specialist Respiratory Nurse Manager (Lead)	1
Specialist Respiratory Practitioner (Nurse/Physio)	2
Physiotherapist Team Leader	1
Smoking Cessation/Home Assessment Advisor	0.5
Palliative Occupational Therapist	0.5
IRT Administrator	1
IAPT Clinical Psychologist/Supervisor	1
IAPT CBT Therapist/Supervisor	1
IAPT Psychological Wellbeing Practitioner	1
Respiratory GP	0.6
Clinical Pharmacist	0.5
Lung Function Technician	0.2
Health Care Assistant (HCA/CSW)	1

IRT Activities

10. **Population Review Meetings (PRM)** – Bi-annual meetings for each practice within the pilot area to support the management of complex / difficult diagnosis in order to reduce referrals to respiratory hospital out-patient clinics in secondary care, and unscheduled (re-) admissions. To pro-actively review practice register search results diagnosed patients with IRT relevant conditions. To build relationships between the IRT and primary care.
11. **Joint Respiratory Nurse and Practice Nurse Asthma/COPD Training Clinics** – monthly training clinics within primary care to improve long term conditions management of patient cohort; to educate and support practice staff, particularly with spirometry training and prescribing recommendations; to identify patients with more complex needs for neighbourhood groups.
12. **Clinical IRT Multi-Disciplinary Meetings** – weekly IRT internal multi-disciplinary meeting in each area (City and North) to discuss patients at current risk of admission, to review discharge support for patients currently admitted or under hospital at home care, to discuss patients with complex needs. These meetings, clinical triage of referrals and PRMs will determine which IRT interventions are required for patients under review; these will broadly fall into the following categories:
    - *12.1. Further diagnostics arranged*
    - *12.2. Self-management advice*
    - *12.3. Referral for assessment*
    - *12.4. Referral for treatment*
    - *12.5. Medicines*
    - *12.6. Other*
13. **Locality Physiotherapy Support –** Home visits for airway clearance neuromuscular disease patients
14. **Locality Physiotherapy Support** – Home visits for patients unable to access pulmonary rehab
15. **Consultant-led Community Respiratory Clinics** – community respiratory clinics will take place weekly in Oxford City area and bi-monthly in the North area. These clinics will operate from community/primary care locations within the respective areas and will be an alternative to patients being seen in hospital outpatient clinics. An outcome would therefore be to reduce hospital out-patient new and follow-up referral numbers seen in patient cohort in secondary care settings; will also provide support for spirometry interpretation (email or telephone/ telemedicine discussion); to assess patients with advanced disease or significant breathlessness requiring medical assessment in a setting nearer to their home.
16. **Advanced Breathlessness Service** – multi-disciplinary team domiciliary visits for patients with complex breathlessness needs or palliative issues.
17. **Analysis of patient population from admission data per practice** - to identify opportunities for intervention e.g. diagnosis, long term conditions management, medicines optimisation for each practice.
18. **Healthcare Professional (HCP) Education Programme**
19. **IAPT Psychological input into IRT:**
    - 19.1. The IAPT Clinical Psychologist that will form part of the IRT will provide:
    - 19.2. Consultation and advice to the IRT

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Please ensure that the completed document does not exceed 1 side of A4

19.3. Provide psychological training and regular clinical supervision to IRT and clinical staff in the community seeing respiratory patients
19.4. Attend Community Respiratory Clinics and PRMs
19.5. Provide assessment/treatment to some patients at home
19.6. Triage patients suitable for treatment by IAPT Psychological Wellbeing Practitioners and HI intensity CBT therapists
19.7. Provide specialist supervision to the IAPT workers seeing respiratory patients
19.8. IAPT CBT Therapists will provide support to primary care, GPs, practice nurses and multi-disciplinary team: with joint co-located clinics with nurses/physio/respiratory consultant etc.; to provide a psychological assessment and treatment service for patients with moderate severe anxiety/depression.
19.9. IAPT Psychological Wellbeing Practitioners will provide telephone screening assessment, treatment planning (can be face-to-face in GP practices/clinics) and treatment sessions for people with mild/moderate anxiety/depression (fitting within IAPT criteria) usually by phone or computer-based (may extend to skype and other methods of delivery that patient can access from home), and managing anxiety/low mood in groups for patients with respiratory long term conditions. To provide psycho-education sessions delivered to each pulmonary rehabilitation programme to increase patient understanding of manging their mood and health condition and how to access psychological treatments and resource.

20. **Clinical Pharmacist input into IRT** - to identify opportunities for appropriate prescribing, optimising medicines management and improving inhaler technique for each practice through involvement in PRMs, in-practice visits/sessions and other IRT activities.
21. **Smoking cessation clinics** in neighbourhoods for smoking patients identified by the IRT, with the aim of improving smoking quit rates in IRT cohort.
22. **Identification of at risk, frail patients** for liaison and referral to the Frailty Service. Particular patients to be discussed and jointly handled within IRT/Frailty neighbourhood meetings.
23. **Spirometry training and performance of hand-held and diagnostic spirometry** for patients identified from primary care record searches as at risk/possible undiagnosed COPD.
24. **Assessment of home/environment and air quality –** all IRT staff to have general awareness and knowledge to make assessment when visiting patient's homes with signposting to local authority, community and social prescribing services coordinated through smoking cessation advisor.
25. **Response to urgent email/phone queries within 24 working hours**, including provision of urgent advice and support to prevent respiratory admissions where appropriate.

Governance review

26. An OCCG governance review has been undertaken on the project following an enquiry from some South East locality practices. There were four recommendations from the governance review that specifically relate to the IRT project. These are set out in the table below with the actions taken to address them. The project has also been loaded onto Verto, which is OCCG's new project

management system.

27. Audit Committee will continue to consider the result of the governance review and ensure recommendations are enacted as appropriate, this will be reported to the OCCG Board through the Audit Committee minutes.

Governance Review Recommendation	**Action**
1. The project group should refocus its resource on reducing the risks highlighted in this report particularly in respect of IG issues and data management, stronger financial contractual agreements with BI and clear agreements with providers supported by an agreed exit strategy.	a) Negotiation between OCCG Directors and BI has resulted in clarification and agreement of specific wording in the Project Initiation Document (PID) and Joint Working Agreement (JWA) that addresses information governance, data management, contractual agreement between OCCG and BI including an agreed exit strategy. b) A Data Protection Impact Assessment (DPIA) has been completed on the data sharing with BI for any project evaluation. This has been done with advice and guidance from the SCWCSU Information Governance Manager. c) It has been agreed between OCCG and BI that BI will have no access to patient identifiable or pseudonymised data, only fully anonymised and aggregated data will be shared with BI in the course of the project and its evaluation. Any sharing of data with BI will be governed by UK data protection law, OCCG's information governance framework and a Data Sharing Agreement agreed and signed between OCCG and BI. This is documented in the PID. The SCWCSU Information Governance manager has advised that as only anonymised and aggregated data will be shared with BI and a data sharing agreement will be signed by BI, this is appropriate for information governance and risk is minimal. d) Contract variations / memorandums of understanding (MoU) with providers will be completed and signed following final approval of the project by OCCG Board and BI. This is subject to approval from providers: OUHFT and OHFT. e) The PID and JWA includes additional wording on exit, cost liabilities for both parties on exit, reputational impact, recourse and damages, intellectual property. f) Key updates in the final PID (Project Controls section) from previous versions is that: (1) all project materials shared outside of the Joint Project Board and Operational Delivery Group will be subject to approval/certification to ensure compliance with the ABPI code of practice, and (2) in line with Clause 20 of the ABPI code of practice and the requirement of openness and transparency, materials and communications developed from the project will need to include the following wording: *This material/poster/educational programme has been produced as part of a joint working partnership between NHS Oxfordshire CCG and Boehringer Ingelheim Ltd.*

	Consideration will be given to using both party logos where appropriate. This requirement will cease at the end of the project.
2. The Joint Integrated Respiratory Team Project Group should seek IG governance advice from appropriate sources within SCWCSU and the CCG and make clear who has what access to data and for what purpose. It should not continue to rely on Clause 20 of the Association of British Pharmaceutical Industry Code of Practice and broad statements about the ownership of intellectual property in the Joint Working Agreement and the PID.	g) A Data Protection Impact Assessment (DPIA) has been completed on the data sharing with BI for any project evaluation. This has been done with advice and guidance from the SCWCSU Information Governance Manager. Data will be shared with BI for the purpose of monitoring and evaluation of the project. h) It has been agreed between OCCG and BI that BI will have no access to patient identifiable or pseudonymised data, only fully anonymised and aggregated data will be shared with BI in the course of the project and its evaluation. Any sharing of data with BI will be governed by UK data protection law, OCCG's information governance framework and a Data Sharing Agreement agreed and signed between OCCG and BI. This is documented in the PID. The SCWCSU Information Governance manager has advised that as only anonymised and aggregated data will be shared with BI and a data sharing agreement will be signed by BI, this is appropriate for information governance and risk is minimal. i) Wording has been included in the PID and JWA that guarantees all intellectual property from the project (including all developments and materials) and its evaluation will be freely shared in the public domain and will be free for the NHS to use.
3. The project group should take advice on the development of a robust financial contractual agreement between the CGG and BI that clearly sets out the risks and penalties for both parties to the agreement prior to implementation of the project and before any staff are recruited.	j) Negotiation between OCCG Directors and BI has resulted in clarification and agreement of specific wording in the PID and JWA that addresses information governance, data management, contractual agreement between OCCG and BI including an agreed exit strategy. k) The PID and JWA includes additional wording on exit, cost liabilities for both parties on exit, reputational impact, recourse and damages, intellectual property. This wording is mainly set out within the following sections in the documents: PID – 'Exit' and 'Project Controls' sections. JWA – 'Data Ownership'. l) OCCG has received independent legal advice on PID and JWA wording before signing the JWA.
4. The PID, Joint Working Agreements and the contract variation should also detail the exit strategy and the arrangements in the event of the project not being able to demonstrate the clinical outcomes and/or the savings projected and the new service not being commissioned in April 2020.	m) OCCG and BI are committed to the pilot operating in Oxford City and North Oxfordshire localities for 15 months. The 'Exit' section within the PID defines the exceptional circumstances in which either party would exit the project before its end point. n) Contract variations / memorandums of understanding (MoU) with providers will be completed and signed following final approval of the project by OCCG Board and BI. This is subject to approval from providers: OUHFT and OHFT. It will be set out clearly in the contract variations/MoUs with providers that there is no guarantee of funding for the IRT beyond the pilot and that any wider rollout and substantive commissioning of the IRT going forward after the pilot will be dependent on evaluation of pilot outcomes and a business case for a substantive Oxfordshire-wide IRT service.

What would you like the localities to do?

28. Identify locations, primarily the East Oxford area, to run a weekly IRT community respiratory clinic in the City locality. The preferred date and time of the clinic is Thursday 09:00-13:00. 2 clinical rooms will be required. Are there locations available at low or zero cost, considering IRT support to primary care?
29. Provide a view on neighbourhood or practice approach to case finding through hand-held/diagnostic spirometry sessions following 'undiagnosed/at risk' search.
30. To provide optimal support to primary care the IRT could enter directly into the primary care record. Practices to consider giving named IRT members access to their EMIS systems. IRT healthcare professionals will be formally trained in use of EMIS.
31. Practices to run undiagnosed/at risk search and diagnosed COPD search for review.
32. Practices to book in Population Review Meetings (PRM) - termed as Respiratory MDTs within the Long Term Conditions LCS 2018/19.
33. Practice agreement to allow sharing and analysis of primary care data with CSU/OCCG/independent 3rd party to enable evaluation of the IRT and thereby inform possible substantive commissioning of the service after the end of the pilot.
34. Allow IRT access to practice bypass phone numbers.

Points for discussion/clarification to be addressed in the meeting

Link to further information

[i] National Institute for Health and Care Excellence (2010), *Chronic obstructive pulmonary disease in over 16s: diagnosis and management*, Clinical Guideline CG101, [online] Available from: https://www.nice.org.uk/guidance/cg101/chapter/Working-definition-of-COPD (Accessed 17 August 2018)

[ii] NHS England (2018), Chronic Obstructive Pulmonary Disease (COPD) Pathway, [online] Available from: https://www.england.nhs.uk/rightcare/products/pathways/chronic-obstructive-pulmonary-disease-copd-pathway/ (Accessed on 19 August 2018)