Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD

Date of Meeting: 27 September 2018	**Paper No: 18/58**

Title of Paper: Integrated Respiratory Team Pilot: A Joint Working Project between Oxfordshire Clinical Commissioning Group and Boehringer Ingelheim Ltd

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	✓

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:

The Integrated Respiratory Team (IRT) Pilot project has been approved by Oxfordshire Clinical Commissioning Group (OCCG) Executive and Finance Committees. The project has been approved by the Boehringer Ingelheim Limited (BI) Human Pharma Leadership Team (HPLT), which is the company's authorising Board within the UK and Ireland. OCCG will be the signatory to the Joint Working Agreement but given the project will be a collaborative system project and delivered by staff from Oxford University Hospitals NHS Foundation Trust (OUHFT) and Oxford Health NHS Foundation Trust (OHFT) the launch of the project will also be subject to their confirmation of support.

The following appended documents are to remain confidential until they receive final certification and formal agreement from OCCG and BI. However, they are available to Board members to review with this report.

- Appendix A – Project Initiation Document (PID)
- Appendix B – Joint Working Agreement (JWA)

Governance review

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.

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 PID and 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 may seek 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.

Project summary

The proposal is a Joint Working Project between OCCG and BI to develop an enhanced integrated multi-disciplinary respiratory team (IRT) to:

- Increase and improve accurate, timely diagnosis of respiratory disease
- Identify a cohort of patients who are at risk of respiratory admissions
- Optimise clinical management, and
- Introduce early holistic and end of life care
- Integrate the care of patients within primary & secondary care and community settings

The defined patient cohort within the remit of the IRT will include:

- Patients with airways disease: Asthma and COPD
- Bronchiectasis patients not requiring intensive secondary care management
- End-stage Interstitial lung disease patients including those with sarcoidosis
- Patients with neuromuscular disease or on home non-invasive ventilation (NIV) requiring physiotherapy input to optimise airways clearance and manage home NIV

It is anticipated that this will achieve improved patient-centred care leading to:

- A reduction in emergency respiratory admissions (and 30-day readmissions) in the IRT patient cohort (defined in Scope section)
- A reduction of the deficit between registered and estimated COPD prevalence
- A reduction in respiratory outpatient appointments within specified clinics
- A reduction in ambulance call outs and emergency department attendances
- An increase in smoking cessation in the IRT cohort
- Better identification of end of life patients and/or patients needing supportive holistic care in IRT patient cohort with increased advance care planning
- Improved identification and treatment of respiratory patients in IRT patient cohort with mental health problems, anxiety and depression in particular.
- Improved quality of life, mental health, and self-care for patients and their carers

Multi-disciplinary integrated care for people with COPD is recommended under NICE guidelines[i] and the NHS RightCare COPD Pathway[ii].

Further detail on the case for change, evidence, clinical model, project costs and estimated outcomes is available within the Project Initiation Document (PID) in **Appendix A**. It should be noted that the Month 4 Integrated Provider Performance Assurance Report (2018/19), shows Respiratory non-elective activity at OUHFT is already at 15.2% activity over-performance (273 extra admissions) and 30.6% price over-performance (extra cost of £1.1m). Respiratory is the highest category of non-

elective price over-performance at Month 4.

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 and supplementary documents. Joint working between OCCG and BI will governed by the PID and the contractual Joint Working Agreement (JWA) available at **Appendix B**.

Any other detailed documentation (including cost calculations) relating to the project is available on request.

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. The following table of COPD prevalence and IRT relevant non-elective admissions across localities provides a rationale for piloting the service in Oxford City and North localities.

Locality	COPD Register	Registered Prevalence (COPD)	Public Health England Estimated Prevalence (COPD)	Locality % of Oxon COPD Register	2017/18 IRT Cohort Oxfordshire NEL Admissions	Locality % of Oxon IRT Cohort NEL admissions
NORTH	1,671	1.50%	2.26%	16.90%	1,024	19.84%
NORTH EAST	1,083	1.30%	1.95%	10.90%	663	12.85%
OXFORD CITY	2,428	1.10%	1.92%	24.50%	1,367	26.49%
WEST	1,163	1.50%	2.01%	11.80%	583	11.30%
SOUTH WEST	2,260	1.60%	2.06%	22.80%	930	18.02%
SOUTH EAST	1,287	1.40%	1.96%	13.00%	593	11.49%
Oxfordshire	**9,892**	**1.40%**	**2.02%**		**5,160**	

Interface with urgent care and frailty service

On 9 August 2018 a joint meeting was held between the IRT Clinical and Prevention Group and Urgent Care/Frailty healthcare professionals to discuss the IRT and Frailty service models and how they may interface. Some outcomes from the meeting were:

- The models complement each other with potential for some synergy.
- The Respiratory GPSIs in the IRT model could have a dual respiratory/frailty role. Agreement that the GPs in both models could be employed by GP Federations.
- Frailty and IRT models would enable identification of patients for each service.
- Oxfordshire Care Alliance (OCA) has already completed significant work on shared records and operational set up that IRT could utilise.
- Agreement for a regular meeting for the IRT group with OCA/Frailty project group to take forward developments.

Engagement: clinical, stakeholder and public/patient:
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. The IRT clinical model has been presented to all OCCG locality meetings in April/May 2018. Further public/patient engagement is required in the delivery of the project. The IRT Operational Delivery Group will include at least one patient who is an expert by experience and establish reliable means to link into relevant patient groups and relevant third sector bodies; the patient representative will be reimbursed for travel costs.

Financial Implications of Paper:
IRT project costs by financial year and contribution

- The IRT costs set out below excludes: spend on project costs, current staff and currently commissioned IAPT and Community Respiratory services and BI project costs. Therefore, it represents only the IRT operational costs.
- Organisational overheads of the provider organisations are included and must be funded by OCCG (classified as new spend) as regulations prevent BI funding overhead costs.

	Total Cost	**2018-19**	**2019-20**
BI Contribution (to IRT Operational excl. IAPT and Community Respiratory Service)	£747,549	£231,211	£516,337
OCCG New Spend Contribution (to IRT Operational excl. IAPT and Community Respiratory Service)	£181,724	£56,980	£124,743
IRT Operational Total	**£929,272**	**£288,191**	**£641,081**

IRT pilot activity and cost saving summary

- The estimated saving is based on the annual (12 month) saving from 2017/18 baseline being achieved over the 15 months of the pilot.
- The ED attendance and non-elective (NEL) admissions data has been provided by South Central and West Commissioning Support Unit (SCW CSU) from Secondary Uses Service (SUS) data. The activity baseline has been discussed and agreed with an OUHFT Respiratory Consultant and estimated activity saving has been discussed and agreed with the IRT Clinical and Prevention working group of healthcare professionals, including the OUHFT Consultant.
- The outpatients baseline and estimated saving is based on specific clinics identified by the OUHFT Respiratory service that can be influenced by the IRT, this baseline and estimated saving has then been proportionately projected for the City and North localities based on the COPD register.
- The estimated prescribing saving is based on medicines optimisation through IRT informed by the OCCG Medicines Optimisation Team.

Activity Type	City and North localities - activity and cost baseline (2017/18)	City and North localities - Estimated IRT Pilot Saving (1 Nov 2018 - 31 Jan 2020)
ED Attendances (activity)	1,429	286
ED Attendances (cost)	£224,299	£44,860
NEL Admissions (activity)	2,391	478
NEL Admissions (cost)	£5,275,235	£1,055,047
Outpatient appointments (activity)	767	215
Outpatient appointments (cost)	£102,949	£29,180
Prescribing (cost)		£74,070
Total (Gross) Saving		**£1,203,156**
OCCG Net Saving (including OCCG New Spend only)		£1,021,433
OCCG Net Saving (including full IRT Operational Cost - if OCCG were covering the total cost of the pilot)		£273,884

Estimated IRT annual activity and cost saving if fully operational across Oxfordshire (post-pilot)

Activity Type	Activity saved	Cost saved
ED Attendances	547	£85,205
NEL Admissions	1035	£2,454,034
Outpatient appointments	520	£70,419
Prescribing		£143,000
Total Annual Saving (gross)		**£2,752,658**

Average length of stay for an NEL admission of the IRT cohort is 5 bed days. Bed days saved from the above annual NEL admissions saved is estimated at 5,234 bed days.

IRT Operational Cost (annual)	£1,416,002
Gross saving from IRT (annual)	£2,752,658
Net saving from IRT (annual)	**£1,336,656**

This illustrates the potential sustainability of the IRT beyond the pilot if estimated outcomes and savings are achieved.

Action Required:

1. Approve OCCG to enter into a Joint Working Agreement with Boehringer Ingelheim Ltd to deliver the IRT Joint Working Project, subject to OCCG receiving independent legal advice.
2. Approve the pilot and for mobilisation to commence from November 2018 in Oxford City and North Oxfordshire localities, subject to formal agreement of health care providers.
3. Approve the development and agreement of contract variations and memorandums of understanding with all providers to deliver the IRT pilot.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Draft Equality Analysis completed. No negative impacts on any groups identified. Potential positive impacts identified for older patients within the IRT cohort and for those with disability and limited mobility as care will be brought into the community and closer to home. The pilot will operate in the localities with the most ethnic diversity and the most deprivation; therefore there could be a positive impact for these groups. IRT pilot will be more sustainable through reducing the burden of disease for patients and carers (reduced travel) with less patient/carer car travel and resulting environmental benefit.

Link to Risk:
AF20/750: There is a risk that current ways of working are not efficient and effective which dilutes priorities and doesn't deliver value for public and patients.

AF22/752: There is a risk that the Oxfordshire Clinical Commissioning Group (OCCG) will not identify and rectify healthcare quality issues in Oxfordshire, resulting in sub-optimal care to patients, poor patient experience and lack of clinical effectiveness.

AF26/794: There is a risk that in some areas the sustainability of primary care is challenged and this will adversely impact on the delivery of primary, secondary and wider health system services which will impact on the care received by patients.

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[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)