Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD

Date of Meeting: 30 January 2020	**Paper No:** 20/09

Title of Paper: Integrated Respiratory Team Pilot

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:
An update report on the Integrated Respiratory Team (IRT) pilot operating in the City and North localities.

Engagement: clinical, stakeholder and public/patient:
Engagement of healthcare professionals has taken place in the operating area of the IRT. Independent qualitative and quantitative evaluation of the project is being undertaken. Patient engagement is planned in early 2020, to run focus groups with respiratory patients regarding the impact of IRT and future development. The service is currently gathering patient feedback through Oxford Health NHSFT's 'I Want Great Care' profile.

Financial Implications of Paper:
The IRT Joint Project Board has agreed to extend the pilot until the end of June 2020. This will mostly be funded using project underspend, which is currently forecast to be a £136k underspend at end of March. OCCG to fund project costs to the end of June if not fully covered by the project underspend; at most this is projected to be £77k.

Action Required:
The Board is asked to NOTE the progress to date

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:
Equality analysis completed at project outset.

Link to Risk:
AF32: There is a risk that Oxfordshire will not deliver comprehensive services if resources (money and people) are not used optimally leading to poorer health outcomes.

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Date of Paper: 15 January 2020

1. Background

1.1. OCCG Board approved the commencement of the Integrated Respiratory Team (IRT) pilot project on 27 September 2018. The go-live date of the project was 1 November 2018. It is a joint working project between OCCG and Boehringer Ingelheim Limited (BI) and also a collaborative system project delivered by staff from Oxford University Hospitals NHS Foundation Trust (OUHFT) and Oxford Health NHS Foundation Trust (OHFT).

1.2. The project seeks to improve a number of patient outcome measures by coordinating service provision around the needs of patients by forming a multi-disciplinary integrated respiratory team. This aims to enhance existing community and hospital based teams by providing a consultant to work in the community alongside additional respiratory nurses and physiotherapists working with respiratory GPs, a dedicated psychologist, a pharmacist, dedicated smoke-free advisor from Smokefreelife Oxfordshire, (the county council's stop smoking service partner) and specialists in palliative care support.

1.3. This pilot aims to provide more timely and coordinated care closer to home for patients. This proactive and preventative approach aims to reduce system costs by reducing emergency department attendances, non-elective admissions and re-admissions.

1.4. The project is being staffed by NHS clinicians and other professionals from OUHFT, OHFT, local GPs and Oxfordshire County Council. Local NHS healthcare professionals provide all clinical care and support, and take full responsibility for clinical decision making. BI, or any other pharmaceutical company, cannot be involved in the selection, employment or management of any IRT operational staff.

1.5. BI and OCCG are collaborating on an area of known patient priority need, illustrated by Right care for example, and jointly fund the IRT pilot. The total cost for the IRT project is expected to be £1,656,272. BI will input and make contributions valued at £747k and OCCG will also input and make contributions valued at £909k; this includes new staff and current staff and currently commissioned services.

1.6. BI does not have any access to any patients, any information or data about individual patients and their health, or any personally sensitive information. BI does not have any influence over the prescribing of drugs.

1.7. A summary of the project and all key project documents and FAQs are published on the OCCG website: https://www.oxfordshireccg.nhs.uk/about-us/enhanced-integrated-respiratory-mdt.htm

2. Progress

2.1. Relevant contract variations and funding agreements were confirmed with providers delivering the project.

2.2. Governance structures have been established including the IRT Joint Project Board of OCCG and BI voting attendees, with OCCG Chief Operating Officer and Chief Finance Officer in attendance. OUHFT, OHFT and GP Federation representatives are also invited to the Joint Project Board.

2.3. The IRT became operationally live from January 2019, with the first few staff formally commencing their roles, single point of access set up and medication reviews taking place in the City locality during that month.

2.4. A summary of key IRT interventions and their implementation timelines is shown in Appendix A and a patient case summary is shown in Appendix B.

2.5. Recruitment to the team has been challenging and has progressed at stages over time. 11.75 WTE is the full establishment of the team. 2.6 WTE were in place by end of February 2019, 5.02 WTE were in place by end of June 2019, and 10.27 WTE were in place in August 2019. At start of Dec 2019 10.27 WTE were in place (87% of establishment).

2.6. IT developments – the EMIS primary care referral form to the IRT was developed by end of Feb 2019. Key relevant primary care data searches and other EMIS developments for the IRT were completed by end of May 2019.

2.7. Independent evaluators of the project were appointed by the end of July 2019. The independent evaluators are:

2.7.1. **Dr Thoreya Swage** - is an independent consultant with a clinical background in mental health and senior NHS managerial experience in primary care. She has performed many evaluations in the primary and community care setting.

2.7.2. **Dr Siân Rees** - is a public health doctor with a background in national policy, senior NHS management and commissioning. She has led evaluations of a wide range of health services at both local and national level.

2.7.3. **Professor Rafael Perea-Salazar** - completed his graduate studies in Statistics (MSc and DPhil) at Oxford in 1999. He has worked as a Medical Statistician since 2002 designing and evaluating research with a special focus in Primary Care. The types of studies he has been involved range from randomised controlled trials to analysis of electronic health records and evidence syntheses. He has co-authored over 200 peer-reviewed articles and is a statistical editor of the BMJ and the EBM-BMJ Journals.

2.8. By end of November 2019, the project budget was underspent by £279k year to date. It was projected that the project would be £136k underspent at forecast outturn, which was the project end date at the time of end of March 2020. The project underspend is primarily due to the delays in recruitment of staff to the team and will be used to extend the length of the pilot to enable a more meaningful evaluation.

3. Activity and outcomes

3.1. Community respiratory clinics – 31 clinics have been held with 322 attended appointments by end of Oct 2019. This equates to saving £55k outpatient activity in OUHFT. A whole year projection would be 483 community appointments saving £82k outpatient activity in OUHFT. The average wait time for a first appointment in the community clinic is 6.7 weeks compared to 11.4 weeks for a first COPD appointment in OUHFT. The community clinic has a lower first to follow up ratio at 1:1.04 than the OUHFT COPD outpatient clinic at 1:2.43. The community clinic also has a lower DNA rate than the COPD outpatient clinic, and it has received positive feedback from patients. We are also starting to see a lower outpatient referral rate to OUHFT outpatient clinics from IRT area practices, monitoring of this trend will continue as part of overall IRT outcomes tracking.

3.2. IRT impact on non-elective admissions and re-admissions is inconclusive based on current trends, further monitoring of these trends will continue.

3.3. Virtual Ward MDT – patients remain under review by the virtual ward for 30 days post discharge following an admission. So far 263 patients have been reviewed under the virtual ward, 26% have been re-admitted and 74% have not.

3.4. Population Review Meetings (PRMs), where IRT specialists including consultant, nurse/physio and pharmacist meet with practices to review key data on their practice population and provide advice, had been completed for 27 practices in the IRT area focusing on COPD. 4 practices did not take up the meeting. The next round of Asthma PRMs will take place in early 2020.

3.5. Undiagnosed patients – 364 patient records have been reviewed by the IRT and 59 patients now have a respiratory diagnosis following IRT case finding (38 COPD, 21 Asthma).

3.6. There have been 71 additional respiratory referrals via the IRT for IAPT psychological support with interventions delivered by the embedded IAPT psychologists in the IRT. Of the 52 that took up treatment there has been reliable clinical improvement in both anxiety and depression measures.

3.7. Palliative input:

3.7.1. North locality – 22 patients on the palliative care register. 10 patients received support from palliative clinical nurse specialist. 10 home visits. 43 telephone support calls. Some patients

have passed away – all had involvement from palliative care – with the exception of one all patients died at home as their preferred place of death.

3.7.2. City locality – 94 patients discussed in palliative MDT of whom 17 have died during the pilot. 36 patients seen by the Sobell Palliative Care Team. 83 Sobell Community Team home visits. 63 telephone consultations. A small number of Sobell inpatient admissions.

3.8. Pharmacist input – 11 practices have run the medication optimisation EMIS search. Pharmacist has reviewed 211 patient records, and made one or more medication recommendations for 170 of these. There is currently no significant difference in prescribing trends observed overall. However, there is the potential for savings if prescribing switches made for some patients so far are replicated across the wider IRT cohort.

3.9. There has been further positive activity and outcomes from healthcare professional education (2 COPD study days, 40 Practice Nurse training clinics, 7 in-practice education sessions and 2 half-day spirometry sessions) delivered by the team, specialist physiotherapy, occupational therapy and smoking cessation input, and referrals made to the Better Housing Better Health scheme resulting in improvements made to patients' homes. These and the other service elements above have been backed up by a number of detailed case studies which have demonstrated the value of the multi-disciplinary approach of the team to patients.

3.10. In summary, the IRT have delivered effective care to patients with physical, psychological and palliative needs, whilst providing innovative educational initiatives and support to primary care with ongoing engagement. Established community clinics with a reduction in waiting times and low new to follow up ratios. Potential cost savings have been identified through community clinics, pharmacist prescribing changes, psychologist input and reduced admissions from patient case studies. Illustrating reduction overall in non-elective admissions and re-admissions is yet to be shown in outcome tracking data, full quantitative analysis and significance testing is yet to be completed.

4. Challenges and risks

4.1. Recruitment to the team has been the greatest challenge. Not having the majority of the team in post until August 2019 has impacted on the team's ability to deliver against project outcomes. Other workforce challenges have been coordinated operational management of a team coming together from different organisations and disciplines, a remaining gap in the respiratory nursing part of the IRT workforce, and vacancies in the currently commissioned community respiratory nursing team.

4.2. Achieving access to EMIS (primary care system) for the IRT to enable joined up working with primary care has been a major challenge in terms of achieving relevant information governance sign off from all parties and technical access for each relevant member of team. However there has been progress on this in recent months and the team is now waiting on access authorisation from only one practice. Some technical issues remain with some IRT member having difficulty logging into some practices, CSU are working on resolving these issues with clinicians. 28 practices are currently sharing clinically appropriate data with the IRT, 2 practices within the IRT area are either on Vision or have definitely chosen not to authorise access.

4.3. The variable experience and capacity of primary care to complete spirometry is a rate-limiting factor to diagnosing more patients. Development of an Oxfordshire-wide plan for spirometry is underway.

4.4. Pulmonary rehabilitation service across the county is currently at capacity and a waiting list has developed, therefore those IRT patients requiring pulmonary rehab are waiting longer as are other Oxfordshire patients. This is mitigated by domiciliary IRT physiotherapist visits for some patients. A review of pulmonary rehabilitation service capacity across the county is underway to improve the situation.

4.5. One element of one larger Practice has chosen not to fully participate due to pharmaceutical company involvement in the project. Preceding this work was undertaken to seek to provide full

assurance that all due processes are in place and there is no influence on patient treatment. There are 31 Practices participating in the IRT area.

5. Looking forward

5.1. The IRT Joint Project Board agreed on 12 December 2019 to extend the project until end of June 2020. This will allow more time for the team to operate with more staff in place to deliver the project outcomes. It will also allow OCCG to review the interim evaluation and for the full evaluation to be completed before the project ends.

5.2. The project underspend will be used to fund the project extension with OCCG providing additional funding to end of June 2020 should it be required, covering this is projected to be an additional cost of £77k to OCCG.

5.3. A full monthly project outcome tracking report has been established and will continue to be monitored by the IRT Joint Project Board.

5.4. The interim quantitative and qualitative evaluations will be delivered in March 2020 with final evaluation completed by the end of June 2020. This will inform OCCG's decision to commission the service substantively or not.

5.5. Patient engagement on the progress of the pilot so far will take place in early 2020.

Appendix A – Timeline of IRT interventions

		Year	2018				2019												2020		
		Financial Month	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
		Calendar Month	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Activity	Weekly Community MDTs (Virtual Ward) in the City and North begin						**Weekly Community MDTs (Virtual Ward) in the City and North begin**														
	Chipping Norton & City Respiratory Clinics begins							**Chipping Norton & City Respiratory Clinics begins**													
	Physiotherapy Home visits in the City and North begin								**Physiotherapy Home visits in the City and North begin**												
	Banbury Respiratory Clinic begins									**Banbury Respiratory Clinic begins**											
	Weekly Palliative MDTs in the City and North begin												**Weekly Palliative MDTs in the City and North begin**								
	Population Review Meetings (PRMs) in the City and North begin - Focus on COPD												**Population Review Meetings (PRMs) in the City and North begin - Focus on COPD**								
	Training Clinics for Practice Nurses in Primary Care in the City and North													**Training Clinics for Practice Nurses in Primary Care in the City and North**							
	Study days for Primary Care Teams in the City and North - Focus on COPD															**Study days**					
	PRMs in the City and North - Focus on Asthma																	**PRMs in the City and North - Focus on Asthma**			

Appendix B – Case Summary

Before integrated care	After integrated care
Patient with severe COPD and heart failure with four hospital admissions in 2018 and two in 2019. Initial visit with IRT respiratory nurse. CAT score: 27 PHQ 9: 15 GAD7: 0 MOCA 19/30	**IRT Occupational Therapy interventions**: • Referral to council services to install extra fan in shower area to reduce breathlessness when showering. • Encouraging increase in activity level and attendance of Pulmonary Rehabilitation. • Referral to smoking cessation advisor. • Referral to IRT psychologist for emotional support. • Liaison with District nurse regarding care and provision of a riser/recliner chair with pressure relief to manage pressure ulcers. • Referral to IRT palliative team for symptom management, GP update via IRT GP and asked to complete Advanced Care Plan. • **Outcomes:** no further hospital admissions