GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 15 January 2020

Subject: Improving Specialist Care – Respiratory

Report of: Nadia Baig, Director of Commissioning at Oldham CCG and Commissioning Lead for Improving Specialist Care - Respiratory and Dr Jennifer Hoyle, Consultant Respiratory Physician at Pennine Acute NHS FT and Clinical Lead for Improving Specialist Care - Respiratory

---

PURPOSE OF REPORT:

This report builds on previous 'Taking Charge' and programme updates that have been provided to the Greater Manchester Joint Health Scrutiny Committee. The purpose of this report is to outline a proposed approach to progress the transformation of Respiratory services to ensure rapid improvement to the clinical service and to provide an equitable service for all patients accessing Greater Manchester Respiratory services.

Respiratory services cover the diagnosis and treatment of a wide variety of diseases of the airway and lungs, their linings and blood vessels and the muscles and nerves required for breathing.

An update reported to the Greater Manchester Joint Commissioning Board Executive, held on 17th December 2019, outlined the key areas of progress on the Model of Care and the intention to present this report to the Committee for its consideration. This follows dialogue undertaken with NHS England on this Model of Care not presenting substantial service change to patients.

RECOMMENDATIONS:

The GM Joint Health Scrutiny Committee is asked to:

- Agree that the scale of change to the Respiratory service is not substantial variation given patients will not be impacted negatively by location or delivery of services

- Note that the revised Model of Care offers an improved, equitable and standardised service to all GM residents

- Note that the new Model of Care was designed and developed in consultation with patients and their families and clinicians

- Agree that the proposed new model of care will meet the needs of patients and improve patient experience and outcomes

- Agree the review of service and transformation to the new model of respiratory care and confirm the GM JOSC is satisfied that there is not a need for wider public consultation. The change in services are all “good practice changes” which involve a better integration and use of resources and a standardised set of protocols and programmes when treating patients

- If further consultation is required, direct the Programme to what level of consultation would need to take place and within what timeframe

CONTACT OFFICERS:

- Dr Jennifer Hoyle, Clinical Lead for Respiratory, Improving Specialist Care, Greater Manchester Health and Social Care Partnership - jennifer.hoyle@pat.nhs.uk

- Nadia Baig, Commissioning Lead for Improving Specialist Care, Greater Manchester Health and Social Care Partnership - nadiabaig@nhs.net

1.0 INTRODUCTION AND BACKGROUND

1.1 People in Greater Manchester are admitted to hospital when their needs could be better met in the community. This continues to increase the pressure on our hospitals and means that our highly trained staff are not freed up to do what they do best: provide more specialist care to those who are most ill. Our population is changing so services need to adapt - more of the population has developed multiple long-term conditions, the focus has shifted from curing illnesses to helping individuals to live with chronic ill health closer to home.

1.2 There are variations in provision and standards of care across the region. Patients with the same severity of the same condition don't always have the same outcome and sometimes are more likely to stay in hospital for an unduly long time depending on which part of the hospital system in Greater Manchester they first attend.

1.3 Our services are under pressure to meet the rising needs every year, there is immense strain on resources significant variation in our estate (i.e. our buildings and where we deliver services) in relation to location, age and quality of facilities, we face significant financial and workforce pressures. Change must happen if we are to maintain the safety and quality of care in the future.

1.4 The 'Improving Specialist Care' programme is one of five interlinking and co-dependent themes identified in the Greater Manchester (GM) Health and Social Care Partnership strategic plan '*Taking Charge'*.

1.5 The transformation priorities for the Programme were developed with clinicians, providers and commissioners over several months culminating in a proposal which was endorsed by the Association of Governing Groups, Provider Federation Board, and the Strategic Partnership Board Executive on the 19th September 2016. The following services are in scope of this Programme:

- Cardiology
- Respiratory
- Musculoskeletal/Orthopaedics
- Benign Urology
- Paediatric Surgery
- Paediatric Medicine
- Breast Services
- Vascular
- Neuro-Rehabilitation

1.6 In June 2018, the Greater Manchester Strategic Clinical Network began liaising with a wide range of respiratory stakeholders and set up a GM Respiratory Steering Group consisting of clinicians, commissioners, Taking Charge leads, Public Health and

patient/public representation. This work encompasses proposals put forward as part of the Improving Specialist Care programme for Respiratory Services and does not propose any significant changes to the patient care within acute sites where Respiratory care is delivered. The improvements focus on streamlining pathways for patients with a Respiratory disease, ensuring a consistent approach utilising a more integrated workforce.

2 DESIGN PROCESS

The design process was a standardised process to support all the identified priority workstreams (Figure 1), shown below. It should be noted that it was widely accepted at an early stage of the Model of Care development that any significant variation to acute delivery of services would not be appropriate as the greatest opportunity lies within the avoidance of an acute admission. As such, the Clinical and Patient standards, Clinical Co-Dependency Framework and Gap Analysis have a reduced role within the Respiratory work stream in comparison to other ISC workstreams.

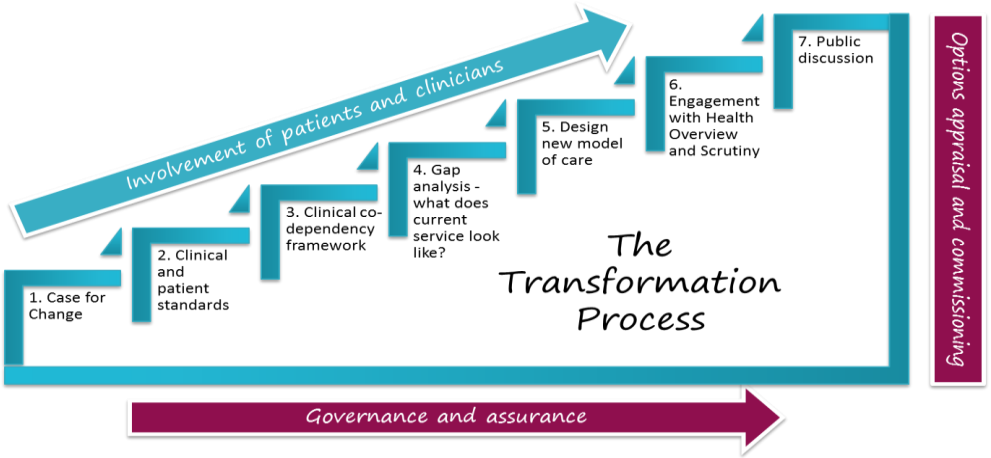

Figure 1. The Transformation Process

2.1 Step 1: Case for Change

2.1.1 Greater Manchester has some of the highest rates of respiratory disease in the country, and mortality rates for preventable respiratory disease are high. The conurbation has a high prevalence of lung cancer, COPD, asthma and unacceptable variation in length of stay across a number of respiratory disease areas. Demand for respiratory services is high and in 2016/17, there were over 50,000 hospital spells for respiratory disease and over 70,000 Finished Consultant Episodes (FCEs). When weighted by age and gender, premature mortality from respiratory disease is

significantly higher than the national rate in seven of the ten Greater Manchester CCGs, and similar for the remaining five.

2.12 From a public health perspective, Greater Manchester has higher-than average smoking rates, and insufficient smoking cessation services to meet demand (though a strategy is being put in place to address this). 18.4% of the adult population smokes compared to a national average of 15.5%, and this contributes to above-average prevalence of smoking-related disease. Greater Manchester's industrial history has also contributed to an increased incidence of industrial lung disease.

2.13 There has already been a number of localised improvements within Respiratory care across Greater Manchester, signalling the willingness to transform services. These plans have been beneficial for local areas but have in turn created or widened the variation in care across Greater Manchester. These projects have focussed on developing community services such as creation of virtual clinics, outreach respiratory nurse specialists, and even advanced nurse practitioners working alongside the ambulance service. There is now a need, for a GM wide solution, that specifically looks at reducing the number of patients escalating to needing hospital care in a consistent and high-level way. This Model of Care provides that solution.

2.14 In summary, the key drivers for change identified by clinicians and commissioners and evidenced were:

- Greater Manchester (GM) has some of the most deprived areas and the poorest respiratory health in the UK, and amongst the highest prevalence rates for lung diseases

- Significant variation in service delivery and the impact of this on outcomes. This is demonstrated by only two Greater Manchester CCGs have a mortality rate for under 75 year olds that is less than the national average

- Over 50% of acute spells in GM in 2016/17 were attributable to two main disease groupings; **chronic lower respiratory diseases** which includes: asthma; COPD; emphysema; and simple and mucopurulent bronchitis, and **influenza and pneumonia**

2.15 The Case for Change was developed from January 2018 onwards in consultation with patients, families, clinicians, commissioners and service providers. The Case for Change was reviewed and endorsed by the Programme's Clinical Reference Group in July 2018 and approved by the Programme's Board and Executive in October 2018. The full Case for Change is included as Appendix 1 of the evidence pack.

2.16 There is a compelling opportunity and need to transform Respiratory services for the many patients that access Greater Manchester services. More people are living

longer with Respiratory diseases and ensuring this is well managed, consistent and outside of an acute setting wherever possible will improve and maintain the well-being of Respiratory patients, their carers friends and families.

2.2 Step 2: Clinical and Patient Standards

As previously described, the proposed Model of Care does not result in any amendments to acute care. As such, the programme has not developed any further clinical and patient standards. However, there are a number of sources available for respiratory standards and guidance, which requires consideration and, where appropriate, incorporation into the model of care. These give clear direction as to the standards expected from the relevant aspects of the model and will be incorporated in at all stages of development.

Further details on these standards can be found within section 10.7 of the Model of Care (Appendix 2).

2.3 Step 3: Co-Dependencies

The Co-Dependency Framework (Appendix 3) was designed to identify the services that Respiratory relies upon in order to provide high quality care for patients.

As the Respiratory Model of Care does not recommend a shift of any services to be provided at an alternative location for acute care, the Co-Dependencies are not fundamental element of the proposed Model of Care.

2.4 Step 4: Gap Analysis

A gap analysis relates to a review of the current service provision across GM. All GM trusts provide some respiratory care, with high rates of emergency Finished Consultant Episodes (FCEs) across the conurbation in all respiratory disease groupings. 10 of the 13 GM hospitals providing respiratory services have a high rate of emergency presentations, classed as those with more than 4000 FCEs in 2016/17. This does not correlate with the population size in the respective areas during this time, with a range between 1.7% and 3.5% of the population being admitted to hospital, suggesting variation in the care received by these patients.

There is considerable research and development in the field of COPD management and a clear imperative to standardise pathways to reduce length of stay and overall

costs, and it is on that basis that the Model of Care largely focuses on the opportunities related to COPD.

Further information on the gap analysis can be found within section 3 of the Model of Care, found in Appendix 2.

2.5 Step 5: Design of the New Model of Care

The full Model of Care document can be found within Appendix 2. The key elements of the Model of Care are the following:

- a model of care for **Chronic Obstructive Pulmonary Disease (COPD)** with standard GM outcomes – to support an enhanced primary and community service by delivering specialist nurse outreach to more complex patients
- a single GM policy for **influenza** – to describe how GM will care for patients, educate the public, and immunise people at risk
- an audit of **pneumonia** diagnosis to understand preventability and risk management

2.5.1 Key Benefits of the Model of Care

The agreed Model of Care sets out the benefits of the proposed model for patients and the service delivery:

- Access to consistent, high-quality care regardless of location
- Timely and safe access to appropriate care throughout the whole pathway, maximising patients' capabilities and quality of life
- Seamless integration with community services, to include patient/social partnerships

2.5.2 External Assurance – External Clinical Assurance Panel

The Model of Care has been independently reviewed by an External Clinical Assurance Panel (ECAP) established by the Northern Senate. The Northern Senate is a non-statutory body made up of clinicians, who provide independent clinical advice to Commissioners. All Models of Care are being reviewed by an ECAP made up of clinicians from the Northern Senate, as Greater Manchester does not fall within their geographical boundaries which ensures impartiality and objective advice to the programme. The process of the review encompasses a written report, culminating in a panel discussion.

The panel were supportive of the model and provided some insights to enhance the model further to ensure the best possible care for patients. Consequently, a number

of recommendations have been built into the Model of Care as detailed below, with the full report available as Appendix 4:

Table 1: Overview of feedback from ECAP

Feedback	Response / Action
Pneumonia proposals need further clarity	Updated to reflect the need for compliance with NICE guidance in the diagnosis and management of pneumonia, which is the first step towards ensuring that pneumonia is only cited as the cause of death where there is a primary diagnosis. This is the starting point in addressing the panel's feedback that clinical coding and data accuracy are critical to informing a true picture of disease incidence.
Point of care testing for Influenza is imperative	The model has been updated to clarify the need for point of care testing and the isolation of patients with suspected influenza. The document will continue to reflect the capacity challenges associated with providing adequate isolation in times of high demand.
NIV standards and domiciliary care require further development	NIV standards are now referenced in the document, though further GM-wide engagement is needed to determine the final NIV model for GM.
Chest infection management of the COPD patient needs to be considered	Updated to reflect this.
Smoking cessation standards need to be agreed	This work is ongoing in GM and the document has been updated to reflect this. Reference has also been made to the GM CURE programme, which is based on the Ottawa Model for Smoking Cessation.
Risk stratification Emergency Departments and Acute Medical Units and access to specialist respiratory clinicians are important inclusions in further iterations of the model of care	GM Trusts already use a range of risk stratification tools, and further clinical engagement is required to assess the available evidence and determine the most appropriate tools for adoption GM-wide.

2.5.3 Governance and Endorsement of the new Model of Care

The Improving Specialist Care Programme works within a rigorous governance structure which ensures continuous oversight and endorsement from a range of

subject matter experts within the GMHSCP, CCGs, Trusts, Local Authority, NHS England/Improvement and includes Patient Representatives.

The governance structure is regularly reviewed to ensure it remains appropriate and effective as the ISC Programme progresses.

The table listed below provides an overview of the Model of Care sign off process. It demonstrates all the expert reference groups and Boards within the Improving Specialist Care governance route:

Table 2: Overview of endorsement of Respiratory Model of Care

Group	**Date of Endorsement**
External Clinical Assurance Panel	September 2018
Clinical Reference Group	September 2018
Finance and Estates Reference Group	October 2018
Workforce Reference Group	October 2018
CCG Directors of Commissioning	October 2018
Provider Federation Board	October 2018
Improving Specialist Care Board (previously Theme 3 Board)	October 2018
Patient Reference Group	January 2019 – *Patient Reference Group do not have requirement to sign off Model of Care, but provide valuable feedback, which is summarised within the presentation to complement this report*
Joint Commissioning Board	Sign off of Model of Care – November 2018 Progression to PCBC – September 2019

3 ENGAGEMENT

3.1 There has been an inclusive approach to clinical and patient/carer engagement to inform the development of patient standards and the proposed new models of care.

3.2 We have benefitted from establishing a robust partnership approach to engagement with clinicians, commissioners, staff members, patient support groups, carers, third sector providers and GM Healthwatch organisations.

3.3 We have also worked closely with the Greater Manchester Strategic Clinical Network to ensure a consistent and joined up approach to transformation of Respiratory services across Greater Manchester. We have ensured that each programme of work complements the other, without resulting in gaps or duplication of work.

3.4 As a result, we developed a multi-layered approach to engagement with our stakeholders to ensure involvement, co-design and co-production with stakeholders throughout the design and development process. A full engagement log can be found in Appendix 5.

3.5 Different approaches have been used to engage with patients, carers and other key stakeholders throughout the development of the Model of Care, including the following:

- Patient focus groups at GM based COPD and other respiratory disease patient groups
- Healthwatch representation on the respiratory design oversight forum, clinical reference group, ISC Board to consistently inform the Model of Care
- Patient and carer surveys undertaken across CCGs, community, trust networks to ensure a targeted engagement
- Identification of patients interested in further involvement, to invite to any further Design Oversight Forum opportunities

3.6 The key feedback received from patient focus groups gave an overwhelming voice for localised services, describing how difficult it is to access services further afield as disease progresses. This was further described in the strong message that respiratory disease is something people live with, that community access to services is essential and that people are keen to have control over their care.

3.7 The programme will continue to proactively engage with patients, their carers/families, staff and the public throughout the life-cycle of the programme. There is an opportunity to enhance current levels of engagement, reaching more patients in a more meaningful way to enhance and inform the programme as the Model of Care is developed through the transformation process. One specific example of this, as

identified through the ECAP feedback, further GM-wide engagement is needed to determine the final NIV model for GM. Patient feedback will feed directly into this model throughout its development.

4.0 TRAVEL AND EQUALITY IMPACTS

4.1 Travel Analysis

As all sites that currently provide Respiratory services are proposed to continue to deliver the same level of care to patients, there is not anticipated to be any increase to patient journeys. As such, there is no requirement for formal analysis as there will be no impact to patient journeys to and from hospital. The proposed Model of Care provides opportunities for patients to receive care within the community, significantly reducing the number of journeys into hospitals that would occur without the progression of this proposed Model of Care. There is anticipated to be a reduced amount of admissions to hospital, which will reduce the number of journeys to existing sites. An individual patient's eligibility for the nationally ran Patient Transport Service remains unchanged.

4.2 Equality Impact Assessment (EIA)

Experts have been brought into support the Programme team in undertaking equality impact assessments for all workstreams. The EIA supports the Model of Care, states that it meets the Public Sector Equality Duty and it does not have an intentional negative impact on any one protected characteristic over another.

The programme will continue to work with Equalities Officers and Communications teams, as part of meeting its ongoing responsibility under Section 149 of the Equality Act 2010 to provide evidence that protected characteristics are satisfied with the service they receive and there are no sub-optimal performance issues with these groups. This will involve talking to current patients and reaching out to community groups and charities and evaluating the level of staff training and development needs that they may have in relation to supporting people's needs. This ongoing work of assessing performance, is not a reason to delay the programme change and the introduction of the model. The EIA states that the proposed Respiratory Model of Care can be implemented at the earliest convenience.

Engagement will continue to be carried out throughout the life-cycle of the project, including that directed within the EIA and will be updated as required. The full Equality Impact Assessment is provided as Appendix 7.

5.0 CRITICAL SUCCESS FACTORS

5.1 The critical success factors for the implementation of the Respiratory Model of Care are shown below, further detail can be found within section 9 of the Model of Care (Appendix 2):

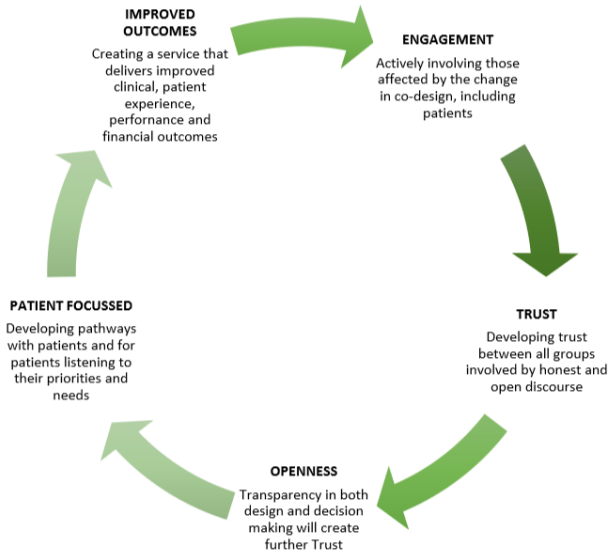

Figure 2: Critical Success Factors for the implementation for the Respiratory Model of Care

6.0 CONCLUSION

- The proposed future Respiratory Model of Care builds upon the work done by individual CCGs and trusts across Greater Manchester to improve the care and well-being of Respiratory patients. This Model of Care seeks to reduce the number of acute admissions because of Respiratory disease

- The Model of Care does not result in significant scale change, and seeks to provide a more equitable, improved patient experience with better outcomes for patients requiring these services. Furthermore, it is not proposed that care provided in an acute setting will be altered in terms of the sites where care is currently provided

- The proposed Respiratory Model of Care will enhance patient experience and ensure a consistent, high quality approach across GM

7.0 RECOMMENDATIONS

The GM Joint Health Scrutiny Committee is asked to:

- Agree that the scale of change to the Respiratory service is not substantial variation given patients will not be impacted negatively by location or delivery of services

- Note that the revised Model of Care offers an improved, equitable and standardised service to all GM residents

- Note that the new Model of Care was designed and developed in consultation with patients and their families and clinicians

- Agree that the proposed new model of care will meet the needs of patients and improve patient experience and outcomes

- Agree the review of service and transformation to the new model of respiratory care, confirm the GM JOSC is satisfied that there is not a need for wider public consultation, as the population will not 'see' a significant change in service negatively affecting them. The change in services are all "good practice changes" which involve a better integration and use of resources and a standardised set of protocols and programmes when treating patients

- If further consultation is required, direct the Programme to what level of consultation would need to take place and within what timeframe.

8.0 APPENDICES

Appendix 1 - Respiratory Case for Change
Appendix 2 - Respiratory Model of Care
Appendix 3 - Respiratory Co-Dependency Framework
Appendix 4 - ECAP Feedback
Appendix 5 - Full Engagement Log
Appendix 6 - Patient Engagement Opportunities
Appendix 7 - Equality Impact Assessment

The above appendices make up the Evidence Pack available to members of the JOSC for further detail and to supplement the above paper. All documentation can be provided on request and has not been accompanied within this paper following feedback from previous meetings.