Better health and care for Sunderland

October 2015

Welcome

At the beginning of this year the NHS invited partnerships to apply to become a 'vanguard' site – or pilot site – for the new care model programme as part of the Five Year Forward View, designed to bring health and care services together, improving them for local people when they need it most and making them more cost effective overall.

Sunderland is one of the very first sites and our partnership, called *Better Health and Care for Sunderland,* will help lead the way on developing a blueprint for a new integrated care model. Our challenges, successes and all that is learned during the process will be shared to help other parts of the country be inspired to do the same.

Just 3% of people in the City use over 50% of NHS resources – excluding additional cost incurred for social care. The plan is to enable health and care services to work as one to wrap care around those who need it most. Services will be initially aimed at those with long term, multiple or complex health needs – the top 3%.

By working together this should give the target group a much better experience of care and, as a result, be able to live life as fully as possible in the best health as possible and remain in their home environment (which could be a care home, an extra care facility, sheltered accommodation, own home or living with family) and not in hospital.

There are three main transformation projects:

- Recovery at home;
- Community integrated teams (CITs); and
- Enhanced primary care.

You can find out more about each project below and this bulletin will keep you up to date on the progress, news, and information about the great work already being carried out by frontline staff as part of the whole programme. *More information will be available soon online and on social media.*

Project updates

Community Integrated Teams (CIT) progress

Five multi-disciplinary community integrated teams (CITs) will provide an effective, high quality and co-ordinated response to the most vulnerable people with the most complex needs, keeping them out of hospital.

Based in key localities in the city (East, West, North, Washington and Coalfields) the teams are made up of district nurses, community matrons; general practitioners, practice nurses, social care professionals, living well link workers and carers support workers.

With a key role being the lead for production and implementation of health care plans with patients and carers, local GPs will lead clinical decision-making as an essential part of a proactive, enhanced level of care within CITs.

Progress to date:

- **Co-located teams** - Some unavoidable, but short term delays with the challenging CIT programme have been brought back on track and the physical movement of teams is now complete.

  For those teams who have been operational for a few weeks, we are already getting some great feedback of the benefits of joined up working, including nurses and social workers resolving an individual's need within hours (rather than days) which included emergency health care planning, medical support from both district nurses and Macmillan Cancer Support. The patient remains at home where she wants to be.

  Age UK living well link workers are now in place and will provide important peer-to-peer, non-clinical contact within communities – particularly those target groups of people; their families and carers.

- **EHCP training** – The first training session for emergency healthcare planning (EHCP) has taken place. It was well attended by over 20 staff.

  A further session is planned for 23 November at Herrington Medical Centre - 9.30 - 4.30. A limited number of places is still available for GPs – contact Dr Jane Halpin (j.halpin@nhs.net)

  Opportunities for EHCP training for other professionals, including social care staff, are being explored.

- **Nurse recruitment** – Recruitment of additional nurses is progressing well, with all staff are anticipated to be place by Jan 2016.

- **Organisational Development (OD) expanded** – OD support and training for the CIT will be expanded to cover all teams across the programme to make sure all staff get the full level of support during the transition and as an ongoing priority. This element of the project is led by a project steering group and delivered by a number of partners including South Tyneside NHS Foundation Trust (STFT).

  Work is being carried out with local delivery teams and other staff to inform the overarching OD plan and early input with teams has already taken place.

Recovery at home – up and running

The recovery at home service now fully operational – ready to respond quickly to provide support during times of illness or if someone experiences an unexpected change that could develop into a crisis.

The team – based centrally in one location at Leechmere - aims to support adults who live in Sunderland, who are registered with a Sunderland GP and need short term health and or social care support, at home rather than being admitted into hospital or long-term care.

Support provided is tailored to a person's needs and can be any combination of a short term reablement care package, nursing and therapy input. GP support is also available within the service. We have access to bed based services should patients require more intensive support than can be provided in their own home (including residential or nursing care homes), with those people who do need a bed being helped to return home safely as soon as possible with support from the team.

This centralised team gives GPs, health and social care staff, as well as other agencies (like the police) an invaluable and highly functional single point of contact for some of the most vulnerable people in our communities.

Progress to date:

- **Just one number** – the single phone number went live in September and has largely been well received. Early teething problems with the phone system have been rapidly resolved and the learning has helped to improve business continuity plans for the future.

- **GP out of hours co-location** – GP out of hours went live as planned at the beginning of October. Initial feedback from the teams is encouraging with joint work already taking place between the staff.

- **GP in-hours** – Support has been increased to Farmborough Court in Town End Farm (one of the integrated care centres with temporary beds available) from once a week to 5 days a week to help maintain an appropriate flow of patients through the service.

- **Older Peoples' Assessment and Liaison Service (OPAL)** – this model will bring together geriatricians and the emergency department at City Hospitals Sunderland with the Recovery at Home service to help people over 65 get either earlier discharge or avoid hospital admission all together. *Further details to come.*

Enhanced Primary Care

Enhanced primary care is one of the three streams of our vanguard proposition, alongside community integrated teams and recovery at home. It is focussed on the 12% of our population who account for 36% of healthcare resource, and who are characterised by living with one or more long term condition – so effectively the next tier of people beyond the primary target group. Its aim is to improve the quality of care delivered to this cohort of patients, and to deliver it in a sustainable manner.

A number of general practice representatives, both through the general practice group and elsewhere, are currently designing the best solutions to deliver this objective. Under consideration are options that use the latest technology to deliver care within patients' homes, delivery of more services in the community, promotion of self-management, and the use of IT to optimise patient pathways and referrals. *Further details of the preferred solutions will be available soon.*

General practice and it's key role in the programme

General practice comprises 51 practices in the city, of which a large number have formed a federation (Sunderland GP Alliance). A smaller federation of practices, has also been formed in Washington. The CCG has supported the development of both federations in line with the ambition of developing primary care working at scale.

Alliance leads on MDT development

The Sunderland GP Alliance is managing GP input into community integrated teams (CITs), and has been in touch with every GP practice to discuss the implementation of the new model. The GP has a pivotal role within the team, and the sector has been highly engaged and supportive of the new way of working.

The Alliance will also be employing five multi-disciplinary team (MDT) co-ordinators to facilitate MDTs across the localities. Three of the 5 positions have been filled to date, with further interviews scheduled for next week.

General Practice Group

General practice within Sunderland is characterised by 51 independent practices operating to the requirements of the GMS, PMS and APMS contracts. This contrasts with the provision of other forms of healthcare, where single providers deliver the majority of care, such as City Hospitals Sunderland in the case of secondary care, and South Tyneside NHS Foundation Trust in respect of community based care. As such, the development of primary care, and other system-wide solutions requiring primary care input, is constrained by the difficulty of engaging with multiple small scale providers.

In response to this issue, general practice has formed a collective representative body, the general practice group, to take forward sector wide issues with a single voice. Vanguard project, namely, recovery at home, integrated care, and enhanced primary care at scale. The vanguard project is a significant departure from traditional commissioning models and will rely on close working relationships between a ranges of delivery partners. The establishment of the general practice group, and the offer of a collective general practice position is a key step in the development of those relationships.

The general practice group consists of a GP, a practice manager and a practice nurse from every locality, each of whom was nominated by the locality delivery team. The group meets fortnightly.

Information Governance and IT

Information Sharing

Workshops have been held to address information sharing concerns. . From them it has been agreed that the Alliance and STFT will work together to develop a robust data-sharing agreement (DSA).

STFT has agreed to start the process with an easy-to-understand, draft 'guide' setting out:

- the reasons for data sharing and the benefits of it;
- what data would be shared and with whom
- what users could do;
- what controls are in place
- the legal basis for sharing;
- what patients need to be told; and
- how patients' objections could be given effect.

This will be a key part of the DSA to help make it less complicated but fulfil any legal and ethical requirements.

The Alliance and STFT will also work together to agree a privacy impact assessment.

Meet the PMO

To help the partnership deliver its ambitions, we have set up a project management office (PMO) with a small team of people, each with different expertise and experience. The majority of staff are part time, seconded from partner organisations. Based at Sunderland Care and Support Centre at Leechmere the team comprise:

Kerry McQuade	Head of Vanguard Delivery
Lynn Dobson	Programme Administrator
Dave Britton	Programme Manager
Penny Davison	Senior Commissioning Manager
Angela Farrell	Senior Commissioning Manager
Helen Gray	Communications Manager
Catherine Roberts	Programme Development Facilitator
Mary Spearman	Programme Development Facilitator
Jackie Spencer	Senior Commissioning Manager
Jayne McQuillan	Programme Development Facilitator
Jennifer Wilkie	Programme Development Facilitator

We'll tell you more about each member over the coming months as well as introduce other members of staff from across the programme. But initially, a little about two key people in the team…

Kerry McQuade, head of vanguard delivery

Kerry joined the team as head of vanguard delivery in August. Kerry's role is to lead and manage all elements of vanguard, including the three major transformation projects and the enabling work streams. Kerry acts as the link between the Provider Board, Sunderland CCG and the Programme Management Office. Working with colleagues, Kerry is responsible for ensuring that the requirements of Sunderland's Partnership Agreement with NHS England are fulfilled.

Kerry is working with the provider board, on behalf of the CCG and local authority, to develop a plan for how community services might be managed differently in the future, reflecting the need for a system wide approach.

Kerry has a background in programme and project management. She previously managed the development and mobilisation of a number of new services for Northumberland Tyne and Wear NHS Trust, and led a region wide public health programme whilst working at the then North East Strategic Health Authority. Having previously worked in Sunderland, Kerry was keen to return to a city where positive partnership working is the norm.

Contact k.mcquade@nhs.net 07557 455 495

Lynn Dobson, PA to Head of Vanguard

Lynn Dobson joined the vanguard delivery team in September from the medicines optimisation team in the CCG as PA to the head of vanguard delivery and programme administrator.

Ensuring the smooth running of the PMO, Lynn also works closely with the rest of the team as first point of contact and providing administration assistance.

With a background working in a team of pharmacists, Lynn has developed links within and outside the CCG which will enable her to develop relevant contacts for the Vanguard programme.

Contact lynndobson1@nhs.net 0191 561 3328

Other news

Positive response from national team

Senior colleagues from the CCG, City Council and Provider Board met with representatives of the NHS England national team to discuss our work to date and future proposals for Sunderland. Our work to date has been positively received, and a Partnership Agreement has been submitted to NHS England describing our commitments to the vanguard programme.

Tell us what you think…

We plan to keep you regularly up to date with progress of our work including case studies; profiles; developments and successes. We'll also soon have a web site; Facebook and Twitter as well as an information support pack for partners to use when sharing information about the project.

If you have any comments; suggestion for news or ideas for what you would like to see let us know!

Contact helen.gray20@nhs.net

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