NHS
Sunderland
Clinical Commissioning Group

Multi-Specialty Community Provider

MCP

Listening and engagement summary

8 November to 13 December 2017

Better health for Sunderland

Introduction

Sunderland is an area that in general has poorer health than the rest of the country. The city suffers from significant pockets of deprivation and is recovering from its loss of past position as a world leader for mining and heavy industry.

Sunderland is also a vibrant city with great energy and opportunity. Sunderland has a population and workforce that are committed to embracing any opportunity.

The Multi-Specialty Community Provider (MCP) is a new approach to out of hospital health and care services. This will ensure that our NHS healthcare is fit for the future and delivering the effective, efficient and seamless care that the people of Sunderland expect.

When receiving care in the community you are able to access some fantastic services. We want to join these together so that they provide an even better service for the future.

In the next few pages we have set out our plans to improve our healthcare services to deliver our out of hospital model.

We move forward together as always under our "All Together Better" vision.

Dr Ian Pattison
Chair

David Gallagher
Chief Officer

Multi-Specialty Community Provider (MCP) Model

The MCP is a new approach to out of hospital health and care services. It has been developed to ensure that our care systems work together to meet the future needs of the local population and deliver the effective, seamless care that the people of Sunderland deserve.

This summary public engagement document is based upon our prospectus 'Commissioning of a Multi-Specialty Community Provider (MCP)'. It contains key information about the future of out of hospital healthcare services in Sunderland.

You will find more details about the integrated care services in the full prospectus, which is available online: www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model

The local picture

In 2017 Sunderland's population stands at 284,219 and this figure is expected to increase by 3,000 by 2020.

The population profile is changing with a rapidly ageing population and a decline in the number of younger people. Ethnic diversity is lower than the England average but this figure is growing.

Around 79,000 people in the City of Sunderland live with at least one long term condition, and one in four adults report some form of long term illness, health problem or disability.

Life expectancy for both men and women is lower than the England average and approximately 80% of local people between the age of 70 and 79 have at least one long term condition. Long term conditions become more common with age.

Addressing current and future healthcare needs, the All Together Better Sunderland care programme was set up to strengthen connections between local health services and social care services. All Together Better is one of only 14 national multi-specialty community provider schemes (Vanguards) chosen to spread good practice to other areas of the country.

As a result of this care programme, we now have a community-based care model that is centred on the patient being managed at home or in the community wherever possible – the Out of Hospital Care Model.

Taking this one step further, we have started to look at ways of securing this care model for the longer term. This includes combining all of the out of hospital or community care services the CCG commissions into one single Multi-Specialty Community Provider (MCP) contract.

This contract will bring together all of those who are funded by the CCG to look after people's physical and mental health (including GPs, nurses and other health professionals, the voluntary sector and healthcare managers) under a single contract, to plan and deliver a new form of integrated care designed to bring about better health outcomes for the local population.

Once in place, it means that the MCP will hold the budget for all the out of hospital health services. It will be expected to join up those services, reducing duplication and transfers between services, and will coordinate the care around a person's needs. This will increase the possibility of more people being cared for at home or in the community, freeing up hospital staff and resources, allowing them to focus on dedicated specialist care and enabling more resources in the community.

What is a Multi-Specialty Community Provider?

Here in Sunderland, we provide a wide range of healthcare services. Strengthening the links between community-based health and working with social care providers is the best way to protect local services, deliver better outcomes for patients and improving access to services in the future.

To secure the joining up of services to date, and to ensure more and more services are joined up in the future, NHS Sunderland Clinical Commissioning Group (CCG) is now investigating the best way of creating a Multi-Specialty Community Provider (MCP).

The aim is to improve the quality and efficiency of out of hospital services through the sharing of resources, records, data and information. Instead of being passed from one service to another and telling your story numerous times, the CCG would like a wider range of services to work together to provide the community with a more efficient, joined up system of care.

The MCP will be a community based organisation. Its success, in part, will be based on the development of strong local relationships with, and trust from, the community it serves.

It will incorporate mental as well as physical health services, and will be expected to work with social care and public health services, wherever this makes sense and adds value. Following ongoing service reviews it may also expand to incorporate some services that are currently based in hospitals, such as some outpatient clinics or some care for frail and older people. It is likely to include:

- Community nursing
- Urgent care (non-life threatening cases where the patient needs to be seen the same day)
- Ambulatory care (emergency care that can be treated without an admission to hospital)
- Some outpatient appointments
- Therapies (such as physiotherapy and occupational therapy)
- Rehabilitation services (support to help people remain as independent as possible)
- Community bed based services (short stay beds to support patients as they work towards returning to their own homes and preventing them needing an admission to hospital)
- Enhanced care in care homes (to improve quality of life, healthcare and health planning for people living in care homes).
- Mental health, learning disabilities and autism

Each GP practice can decide how they wish to become involved with the MCP – either by signing an agreement about how they will work together, or moving the practice to become part of the MCP. For the MCP to work, we need to have GP practices involved.

The purpose of the MCP is to ensure that our care system is fit to meet patients' future needs, delivering the effective, efficient and seamless care that the local population deserves.

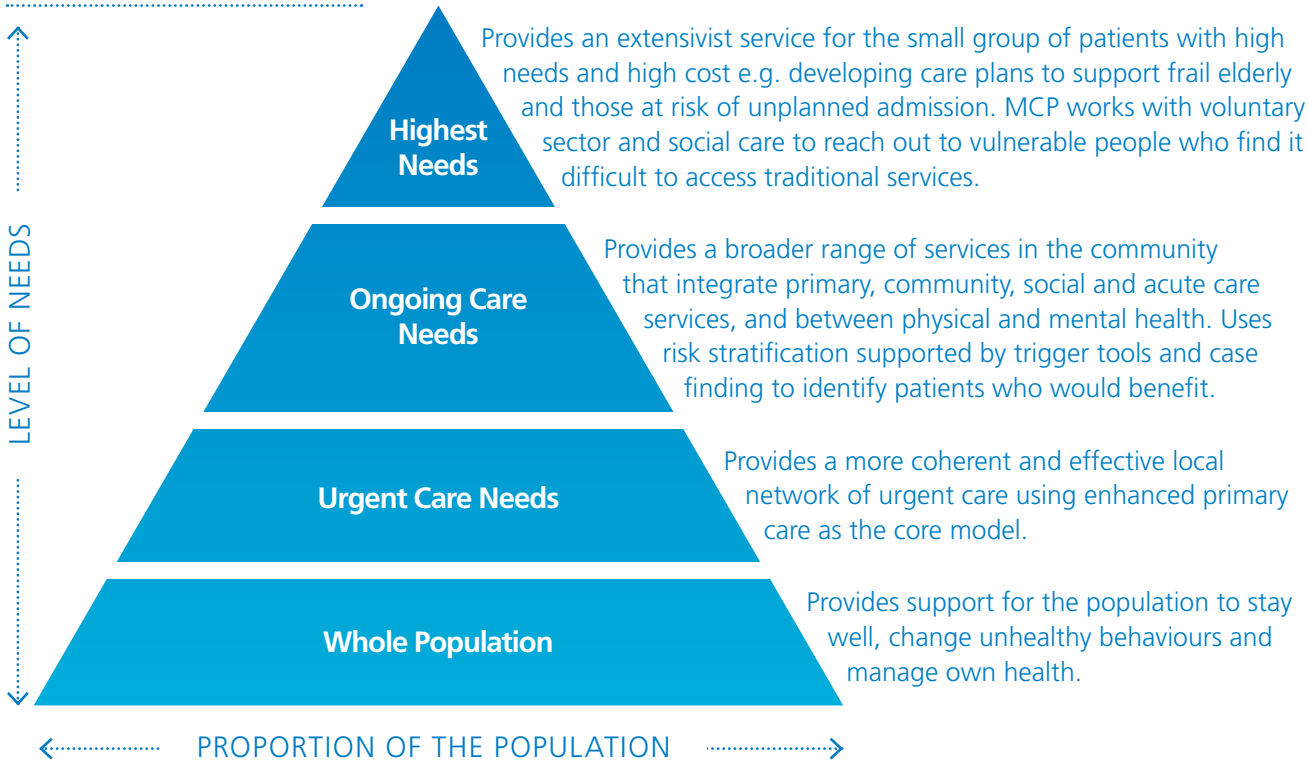
To achieve this it must work towards a service which focuses on:

- Improving care quality including safety, clinical effectiveness and patient experience
- Improving health and wellbeing
- Creating a more sustainable health and care system

What will the MCP do?

The proposed MCP model is made up of four key elements. Whilst some of these elements are already in the early stages of implementation thanks to the All Together Better programme, the MCP model will bring about closer integration at every level.

Diagram 1: MCP Framework



More effective prevention – where appropriate, patients will be given more control over managing their own care. Bringing health and care together in one coordinated response will give providers a deeper understanding of the links between health and wellbeing in an individual. In many cases this approach could avoid long term treatment and life-long dependency on health and social care.

Focusing more closely on **area and community** - All Together Better has demonstrated the importance of better coordination of care across teams and organisations. When community based care and recovery teams work with GPs they have access to more information and can benefit from each other's skills and experience and understanding of the person needing the support. This means

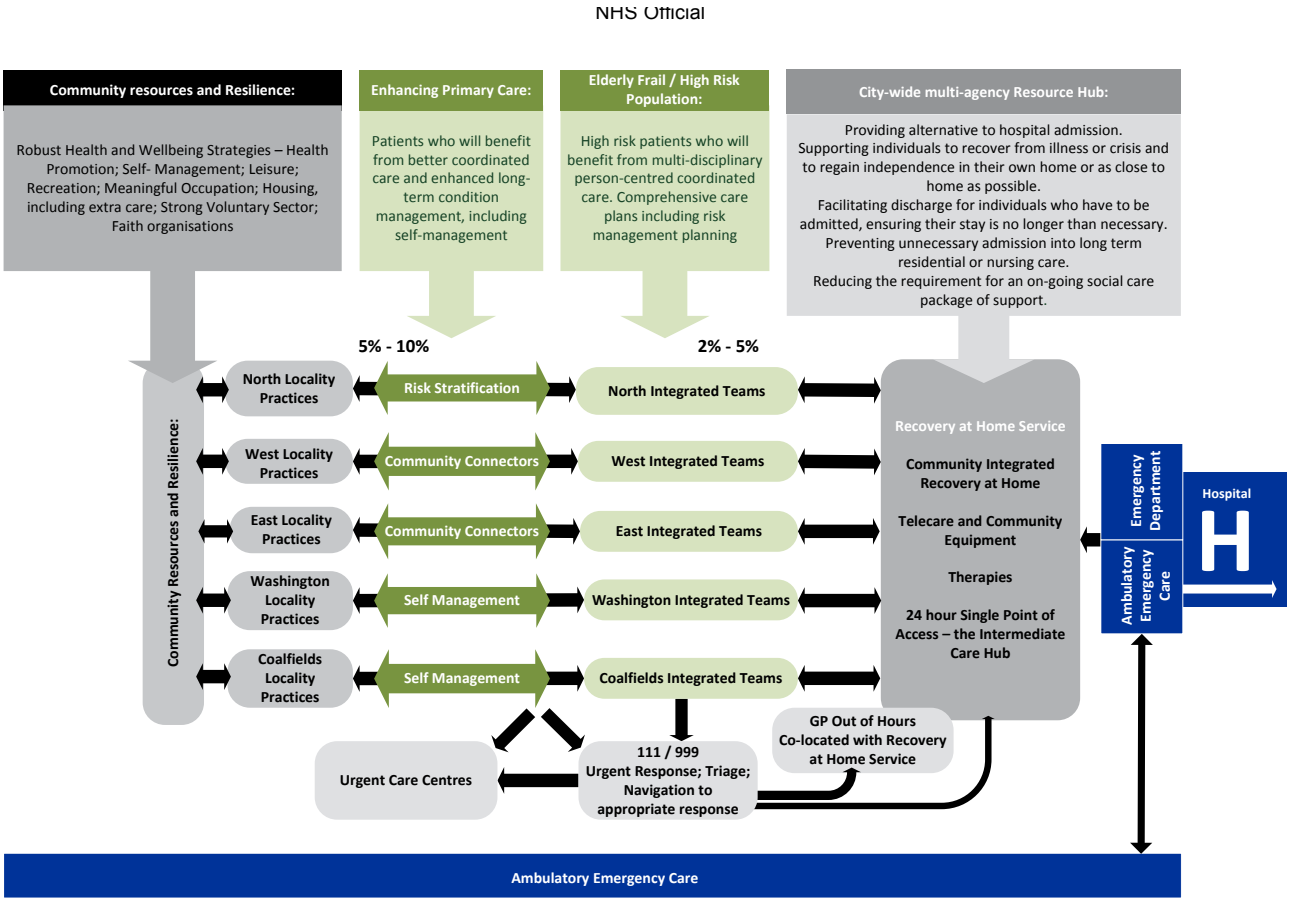
they can take a more proactive approach to healthcare where the patient's social and emotional needs are taken into account when considering medical needs.

A focus on maintaining the patient's stability and **preventing escalation to more hospital based care** by making greater use of community and voluntary services. The All Together Better programme has already increased the number of community-based care and support services for many higher risk patients. This has resulted in fewer emergency admissions and A&E attendances for the targeted patients and a reduction in delayed transfers of care and fewer permanent admissions to care homes across the population.

The new **Recovery at Home hub**, a 24/7 multi-agency service, which has been created to offer alternatives to hospital admission. This hub is used when patients are at real risk of serious decline in their condition and/or being admitted as an emergency to hospital.

Improvements are being made at General Practice through **Enhanced Primary Care**, such as making GP appointments available at evening and weekends and better links between a General Practice and a Care Home and older people community nurses, so the staff in the home are able to work more closely with one or two Practices and the Practice can give a better level of support to the home as a result.

Diagram 2: The current Sunderland Out of Hospital Model



Engaging with the community

We want to place people at the heart of planning and commissioning services and as the proposed MCP develops, it is essential we gather the views of patients, service-users and carers about any potential change. A significant amount of engagement has already been carried out to plan the MCP. It started in 2013 and followed on through the Sunderland vanguard programme, All Together Better.

The All Together Better programme began in 2015, bringing important changes to how health, social and support services work together throughout the city. In the first quarter of 2016, and again in 2017 the All Together Better Sunderland vanguard undertook a survey to better understand perceptions and satisfaction of care services and how they work together, awareness of 'All Together Better' itself and attitudes towards self-care.

After reviewing the feedback, we learned that the most important issues are:

- Staying independent for longer (40%)
- Faster access to care and support (22%)
- Seeing a health and social care professional together rather than wait for separate appointments (13%)
- A single point of contact to access the required services (13%)

In addition to the formal research exercises, charity partners, Age UK Sunderland carried out valuable engagement of local groups and communities in the form of providing information about the programme and gathering some informal feedback about the programme. This included formal engagement with 34 groups as well as 61 informal exercises.

There were a number of positive outcomes from the exercises:

- Increased awareness of the All Together Better programme in the community
- Helped us understand how the public felt about the model of care
- Gave us a greater insight into patient and carer experiences of existing services

This feedback cemented the very early feedback from patient groups and the voluntary sector in the various events led by the CCG which informed the development of the model and supported the application to be a Vanguard.

The key message was the fragmentation of community services and the lack of co-ordinated care for people who needed it most. This was supported by feedback from frontline staff, particularly GP practices, which felt they had lost the connection with community health and care services making it harder for them to respond to the needs of their patients.

What happens next?

Between 8 November and 13 December 2017, the CCG will begin a further period of public engagement on the plans to set up a Multi-specialty Community Provider (MCP).

We are encouraging potential providers to propose improvements to services in line with our principles and once the contract is awarded, they will be required to communicate and engage with the public on any service changes. Our engagement is therefore focused on what we expect from such an MCP provider and whether the public think those expectations are sufficient.

The CCG will consider the results of the public engagement process along with the key messages from the engagement to date before moving to the next stages of the commissioning process to secure an MCP.

Timeline

May 2013

Set out the new vision for providing out of hospital care

August 2013

Established a 'Community Integrated Teams Steering Group' with staff from organisation who provide the care to move the vision into reality

April 2014

Local engagement event sharing best practice re integration from across UK. Key messages included coordinating care, length of time, culture and co-locating services

May 2014

Agreed vision for integration of health and social care with the Local Authority and led to engagement events including two major events with key stakeholders including voluntary / community sector to design the model of care

February 2015

Submitted application to NHS England to become a Vanguard and test a new model of care - MCP

Continued on next page >>

November 2015 and ongoing

All Together Better Vanguard launched including Better Health and Social Care in Sunderland website, case studies, attendance at events, 40 public engagement meetings, market research and regular information in press
January - March 2016 and 2017 Surveys with the public and engagement meetings (34 formal groups and 61 informal)

November - December 2017

Currently asking what the public think about the MCP (public engagement)

November - December 2017

Asking current and potential providers what they think (market engagement)

January 2018

Update the draft prospectus to include feedback from public and market engagement

February 2018

Determine the best way to secure the MCP provider

April 2018 - March 2019

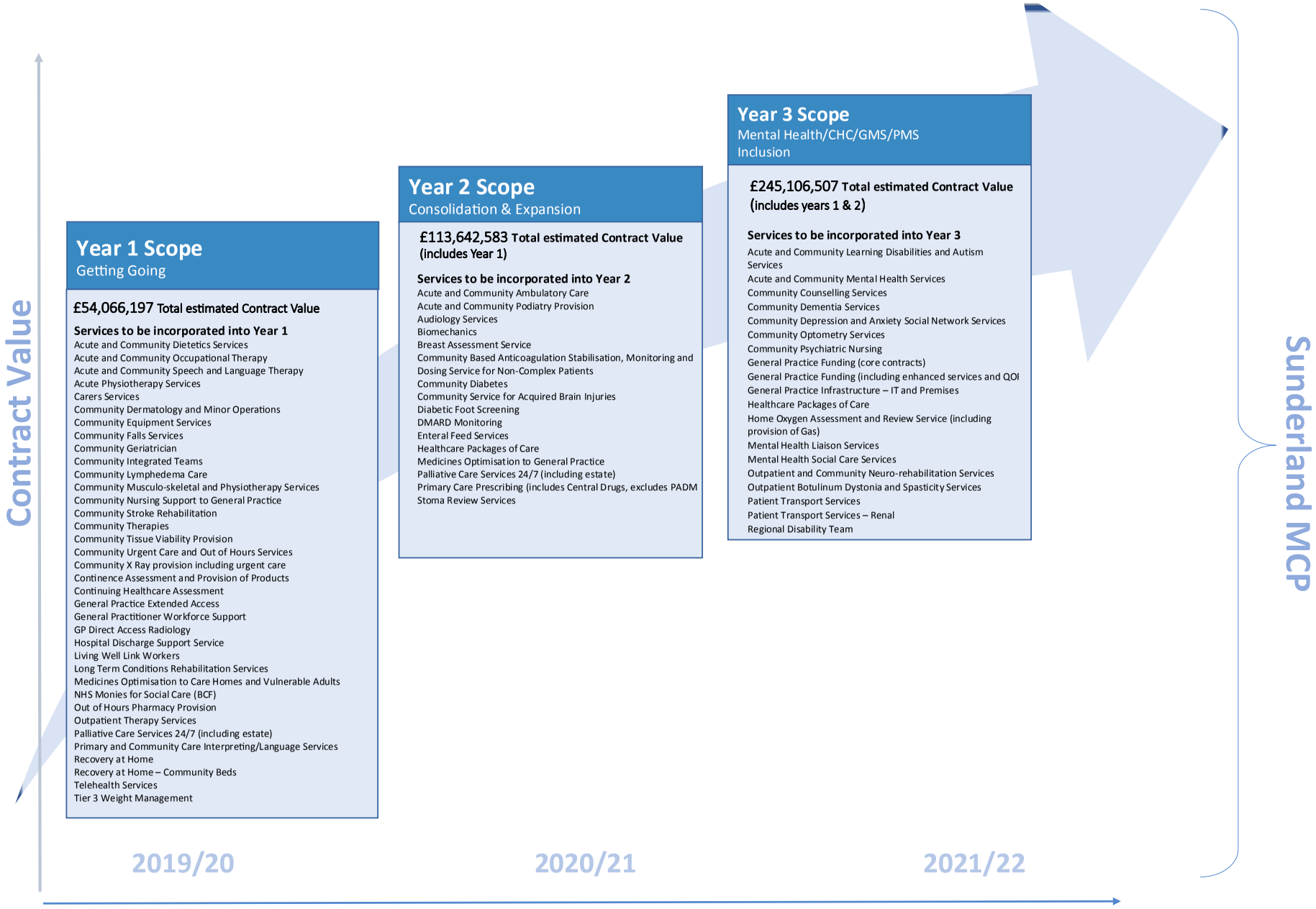
Secure the new MCP provider and mobilise ready for April 2019

November 2018 - March 2019

From April 2019 the MCP will come into operation and will take on accountability for the majority of community health services over the next three years

The MCP will have a budget of up to £240m per year and the contract is planned to run for 10 years, beginning in April 2019. This will mean that the CCG will commission one accountable body (there are currently about 40 different contracts with different providers).

From 2019, that accountable body will take on increasing responsibility for the services. By March 2022, the MCP provider will be accountable for all the services noted below. While they are able to sub-contract some of these to other providers, especially in the shorter term, they will retain overall responsibility for joining up the services.


Contract Value
Year 1 Scope
Getting Going
£54,066,197 Total estimated Contract Value
Services to be incorporated into Year 1
Acute and Community Dietetics Services
Acute and Community Occupational Therapy
Acute and Community Speech and Language Therapy
Acute Physiotherapy Services
Carers Services
Community Dermatology and Minor Operations
Community Equipment Services
Community Falls Services
Community Geriatrician
Community Integrated Teams
Community Lymphedema Care
Community Musculo-skeletal and Physiotherapy Services
Community Nursing Support to General Practice
Community Stroke Rehabilitation
Community Therapies
Community Tissue Viability Provision
Community Urgent Care and Out of Hours Services
Community X Ray provision including urgent care
Continence Assessment and Provision of Products
Continuing Healthcare Assessment
General Practice Extended Access
General Practitioner Workforce Support
GP Direct Access Radiology
Hospital Discharge Support Service
Living Well Link Workers
Long Term Conditions Rehabilitation Services
Medicines Optimisation to Care Homes and Vulnerable Adults
NHS Monies for Social Care (BCF)
Out of Hours Pharmacy Provision
Outpatient Therapy Services
Palliative Care Services 24/7 (including estate)
Primary and Community Care Interpreting/Language Services
Recovery at Home
Recovery at Home – Community Beds
Telehealth Services
Tier 3 Weight Management
Year 2 Scope
Consolidation & Expansion
£113,642,583 Total estimated Contract Value (includes Year 1)
Services to be incorporated into Year 2
Acute and Community Ambulatory Care
Acute and Community Podiatry Provision
Audiology Services
Biomechanics
Breast Assessment Service
Community Based Anticoagulation Stabilisation, Monitoring and Dosing Service for Non-Complex Patients
Community Diabetes
Community Service for Acquired Brain Injuries
Diabetic Foot Screening
DMARD Monitoring
Enteral Feed Services
Healthcare Packages of Care
Medicines Optimisation to General Practice
Palliative Care Services 24/7 (including estate)
Primary Care Prescribing (includes Central Drugs, excludes PADM
Stoma Review Services
Year 3 Scope
Mental Health/CHC/GMS/PMS Inclusion
£245,106,507 Total estimated Contract Value (includes years 1 & 2)
Services to be incorporated into Year 3
Acute and Community Learning Disabilities and Autism Services
Acute and Community Mental Health Services
Community Counselling Services
Community Dementia Services
Community Depression and Anxiety Social Network Services
Community Optometry Services
Community Psychiatric Nursing
General Practice Funding (core contracts)
General Practice Funding (including enhanced services and QOI
General Practice Infrastructure – IT and Premises
Healthcare Packages of Care
Home Oxygen Assessment and Review Service (including provision of Gas)
Mental Health Liaison Services
Mental Health Social Care Services
Outpatient and Community Neuro-rehabilitation Services
Outpatient Botulinum Dystonia and Spasticity Services
Patient Transport Services
Patient Transport Services – Renal
Regional Disability Team
2019/20
2020/21
2021/22
Sunderland MCP

How to get involved?

Between 8 November and 13 December 2017, engagement will focus on gathering feedback from the public, and stakeholders representing the public on the plans presented in the prospectus which can be found at www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model which have been summarised above.

You can get involved by:

- Answering a survey online at www.surveymonkey.co.uk/r/SCCG-MCP
- or by contacting 0191 217 2803 to receive a paper version of the survey

Attend an event on:

- Thursday 30 November 6 – 8pm
  Sunderland Software Centre,
  Tavistock Place, Sunderland, SR1 1PB
  Register at:
  www.eventbrite.co.uk/e/mcp-public-event-tickets-39396498989
- Friday 1 December 2 – 4pm
  Sunderland Software Centre,
  Tavistock Place, Sunderland SR1 1PB
  Register at:
  www.eventbrite.co.uk/e/mcp-public-event-tickets-39396571205
- Please register your interest online using the above links or call 0191 217 2803

Hold a focus group:

We are keen to hear from groups who work with people who may face barriers in giving their views

- Email us: SUNCCG.sccg@nhs.net
- Twitter: @sunderlandccg
- Facebook: @SunderlandHealth
- Call us on: 0191 217 2803