Best practice in district nursing services – achieving maximum impact?

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The King’s Fund Annual Conference, 9th November 2016
Requirement to respond to a changing context and developing evidence base

• FYFV
• Sustainability and Transformation Plans – triple aim
• What is the future for district nursing within integrated teams?
• Improving patient flow across the primary, community and hospital interface
• Dealing with comorbidity
The recent evidence base for change

• The King’s Fund (August 2016) Understanding quality in district nursing services
• The Nuffield Trust (November 2016) Using data to identify good quality care for older people
• The Nuffield Trust (October 2016) Understanding patient flow in hospitals
• The King’s Fund (March 2016) Bringing together physical and mental health
Haven Court – South Tyneside Integrated Care Hub

- Long-term residential and nursing
- Respite/Short breaks
- Residential Reablement
- Time to Think

- Specialist day care

- Memory protection services

- Information and advice

- Wrap-around health and social care expertise

- General Practice
Sunderland Context

Map showing population density of Sunderland

Population characteristics

- Currently a population of around 283,000 in Sunderland
- A population increase of 8,100 (3%) forecast over next 20 years
  - 37% increase amongst those aged 65-84
  - 105% increase amongst those aged 85+
- Life expectancy in Sunderland is 78 for males and 82 for females (approx. 2% lower than the England average)

Source: ONS Statistics, Sunderland CCG Prospectus and Business Plan
Population Segmentation

**Population cost pyramid:** Top 3% of patients drive 50% of cost in Sunderland

**Population cost segmentation, secondary care, community and mental health spend**

- **High cost:** Over £5,000 per year
  - 3% (9.7k) with 50% (£106m) of total cost
  - Spend per head: £10.9k

- **Moderate cost:** £1,000 to £5,000 per year
  - 12% (34k) with 36% (£77m) of total cost
  - Spend per head: £2.2k

- **Low cost:** Under £1,000 per year
  - 84% (239k) with 14% (£29m) of total cost
  - Spend per head: £0.1k

Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – 127k registered patients with no secondary, community or mental health interactions
The MCP Care Model
Sunderland’s Response to challenges is an evidence based - Whole System Approach

• **Community Integrated Teams** – Proactive Care (Wrapping services around patients to deliver a person centred individualised care)

• **Recovery At Home** – Responsive Care (Intermediate Care / Urgent Care / Social care support / OPAL service)

• **Enhanced Primary Care** – To focus on patients with morbidity who would benefit from a more streamlined care in the community

• **Digital Solutions / Digital Roadmap**

• **Interface with Urgent and ambulatory care**
Delayed Transfers of Care (DTOC)

- DTOC in Aug-16 significantly lower than any previous month for Sunderland and CHS NHSFT

- Apr-16 to Aug-16 for Sunderland – DTOCs are 26% lower for the 5 months compared to 15/16
Looking forward – delivering impact

• System leadership
• A joined up drive for population health, community alternatives and self care
• Four habits of high-value health care organisations (Bohmer, 2011)
• Focus on the quadruple aim: care, health, cost and meaning at work
Vision, aims and objectives

*All Together Better - better health and care for Sunderland*

What do we want for local people? Meet [Jack](https://youtu.be/GzjXvo3XKFQ)

*Jack’s Journey*

How All Together Better Sunderland’s new care model is helping keep people out of hospital and as independent as possible.

*All Together Better*

Better Health and Care for Sunderland.