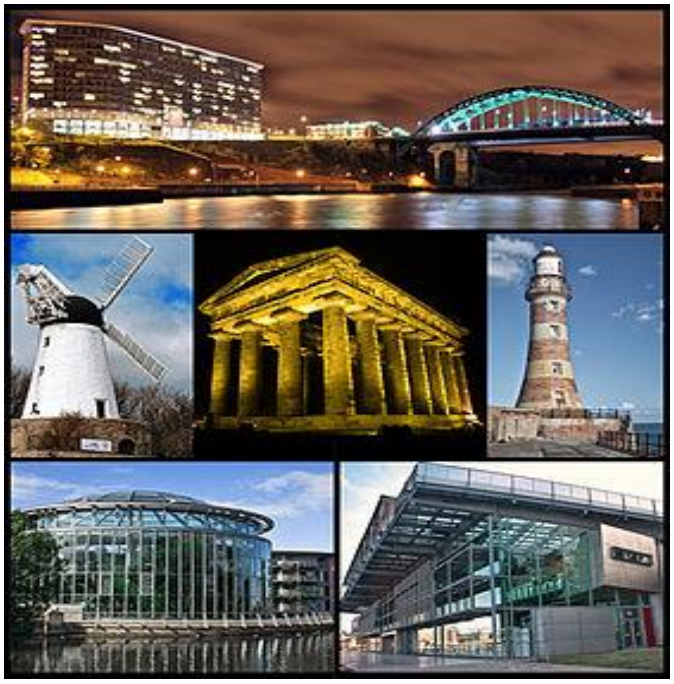
Appendix 2

NHS Sunderland Clinical Commissioning Group

NHS Sunderland Clinical Commissioning Group

The Multi-Specialty Community Provider (MCP) Prospectus



Version Final 23.2.18

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Statement from CCG Chair and Chief Officer

Sunderland is a vibrant city with great energy, proud history and plenty of opportunity which is actively recovering from the loss of its past position as a world leader for mining, shipping and heavy industry.

Sunderland in general has poorer health outcomes than the rest of the country with significant pockets of deprivation. However Sunderland has risen to the challenge of improving those health and care outcomes with a population and workforce committed to tackling those challenges by embracing all opportunities for improvement. It is within this context and ambition that the health and care system has developed the new care model for the out of hospital system

Our community health and care system has some fantastic services, many innovative others traditional but strong with a highly skilled, experienced and committed workforce of fantastic quality.

The MCP will ensure that our care system is fit for the future meeting Sunderland's needs and delivering the effective, efficient and seamless care that the people of Sunderland expect.

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

Dr Ian Pattison
Chair, Sunderland CCG

David Gallagher
Chief Officer, Sunderland CCG

Executive Summary

Closer integration between services in the community is a fundamental part of both national policy and of local strategy with the aim of promoting health and wellbeing, delivering quality care for patients/service users, and ensuring sustainability of the local system.

Since May 2013 Sunderland CCG has been working towards delivering a vision for the future of out of hospital services with the aim of moving from fragmented services to more integrated services, providing more effective person-centred co-ordinated care. This led to Sunderland's selection to join the NHS England vanguard programme with the intention to develop a new care model – the multi-speciality community provider (MCP) model.

The All Together Better (ATB) Sunderland Vanguard Programme has been in place since 2015 and, has had significant success making major progress with the development and implementation of an integrated out of hospital care model.

The CCG now wishes to enhance the care model and secure it for the longer term. In so doing, the CCG believes there is benefit from including and integrating all out of hospital services it commissions into the MCP model of care. This increases the scope and value of the services from the current Vanguard, resulting in up to 240m worth of out of hospital services which need to be integrated in order to deliver the model of care described below responding to the 4 levels of population need.

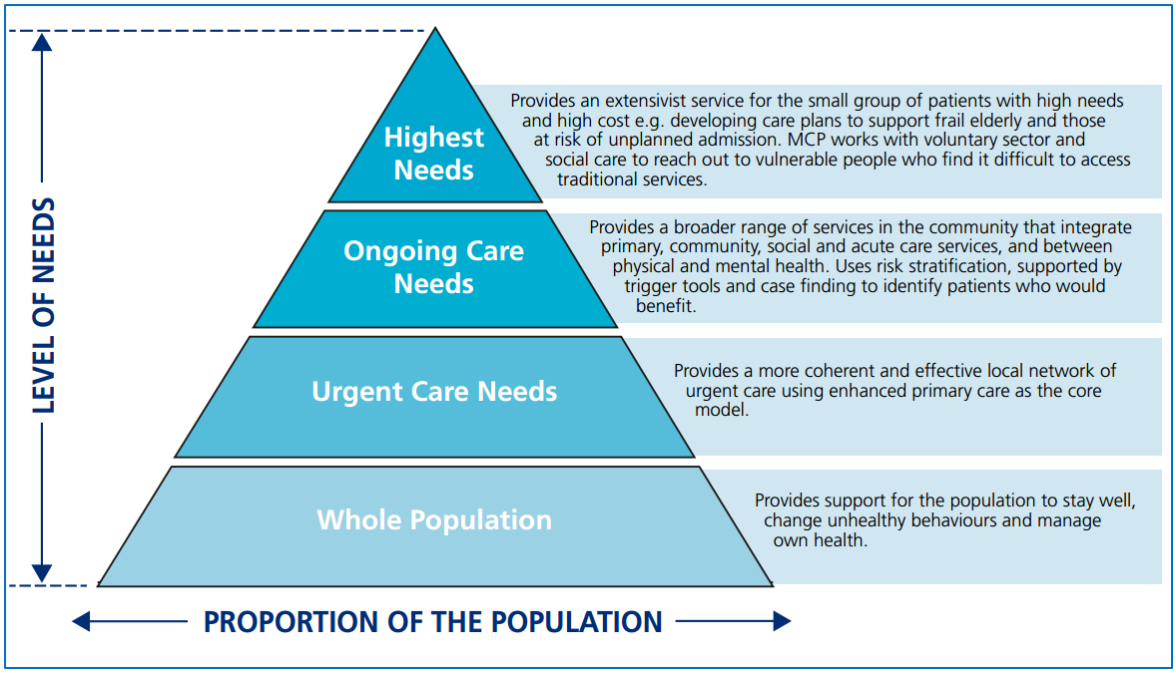

Diagram 1: MCP Framework

The intention is therefore to secure the MCP Care Model for the long term to in order to realise the local strategic ambition of an MCP leading, developing and delivering an effective integrated out of hospital care model in Sunderland.

The underlying principle of the development is that it will enable GPs, nurses and other health and care professionals with the community and voluntary sector to come together

and plan and deliver person centred co-ordinated care that leads to better outcomes for people.

The CCG wishes to work with potential provider(s) who share the vision for our care model and consider that they have the right capacities and capabilities to respond to the challenge ahead.

This will redefine the relationship between commissioner and provider with the ultimate aim of:

- Improving the quality of care
- Improving health outcomes and wellbeing
- Improving the sustainability of the health and care system.

This document goes on to describe:

- What the CCG requires from any Provider(s) delivering the MCP care model, including our design principles,
- Development of the out of hospital model to date
- How the model continues to be developed
- Scope of services included in the MCP
- Outcomes to be achieved
- Findings from public engagement and
- Our Commissioning Strategy to secure the MCP

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of an MCP in Sunderland using the Draft Prospectus. The findings from this engagement have informed this final Prospectus

Background

Closer integration between care services in the community is a fundamental part of both national policy and of local strategy and commissioning intentions the aim being to promote health and wellbeing, delivering better outcomes for patients/service users, promoting ease of access and ensuring sustainability of the local system.

The planning for closer integration between health services and social care in Sunderland began in May 2013, when both the new clinically led CCG with the local authority as Commissioners agreed a vision for the future of community services and was supported by the main local providers. The aim being of moving from fragmented services to integrated services providing more effective person centred co-ordinated care. This led to a range of local developments which together provided the evidence to support Sunderland's application and selection to join the NHS England Vanguard programme with the intention to develop a new care model – the Multi-Speciality Community provider model (MCP).

The **All Together Better (ATB) Sunderland Vanguard Programme** has been in place since 2015 and, through the unified vision and combined efforts of both health and social care commissioners and providers, has had significant success making major progress with the development and implementation of an integrated Out of Hospital Care Model.

The CCG now wishes to secure the Out of Hospital Care Model for the longer term. In so doing, the CCG believes there is benefit from including all out of hospital services it commissions in an MCP care model.

This prospectus describes the CCG's vision to commission an MCP care model.

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of a MCP in Sunderland using the Draft Prospectus. The findings from this engagement have informed the final Prospectus.

Population to be served (Sunderland)

The MCP care model will support the care for all adult patients registered with all Sunderland practices and non-registered adult patients resident in Sunderland. The MCP will cover 43 (as at 1st January 2018) practice populations and along with non-registered patients which will in effect cover the whole adult population of Sunderland The CCG works with the practices in five groupings, split by area described as localities. They are Coalfield, Sunderland East, Sunderland North, Sunderland West and Washington. The relevant practices and localities are set out in Appendix 1.1.

Joint Strategic needs assessment

Sunderland had a resident population of 277,000 in 2015 which is predicted to rise to 285,000 by 2030, with a CCG Registered population of 284,133 at 1st January 2018. It has an ageing population and is much less ethnically diverse than the England average but is becoming more ethnically diverse (See JSNA and Health profile link provided below).

The population profile of Sunderland is changing with a rapidly ageing population and a declining younger population. The key messages are set out below with some further detail in later paragraphs:

- The population is forecast to grow by 3,000 to 2020 – a 1.1% increase compared to 4.7% nationally.
- The 65+ population is growing at a higher rate than the under 65 population which is a significant concern given the typical healthcare service utilisation of this segment of the population
- More people are living with complex health conditions.

Population forecasts

The Sunderland population is expected to **increase** over the next 10 years by 1.8% and by 3.0%[1] over the next 20 years. Although the population is expected to increase marginally overall over the next 10 to 20 years, the rate of growth in particular age groups is of significant concern. It is expected that the under 65 year old population is expected to **decrease** over this period by 2.5% and 5.1% respectively whist the over 65 population is expected to **increase** by 20.2% by 2027 and 37.5% by 2037 which is a significant concern given the healthcare utilisation of this segment of the population. The belief is that as the population increases in the over 65 age group, then the healthcare utilisation will almost certainly increase.

Health issues and concerns

The health of people in Sunderland is varied compared with the England average. Sunderland is one of the 20% most deprived districts/unitary authorities in England and about 26% (12,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.1 years lower for men and 8.2 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

The rate of alcohol-related harm hospital stays (adults) is 948 per 100,000 population, worse than the average for England. This represents 2,592 stays per year. The rate of self-harm hospital stays is 180 per 100,000, which is better than the average for England which is 191.4. This represents 499 stays per year. The rate of smoking related deaths is 423 per 100,000, worse than the average for England. This represents 648 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average.

Around 79,000 people in the City of Sunderland have at least one long term condition, and one in four adults report some form of long term illness, health problem or disability. Long term conditions become more common with age and Sunderland has an aging population. Approximately 80% of local people between the age of 70 and 79 have at least one long term condition.

Key additional messages from the JSNA for localities compared to Sunderland as a whole:

[1] Based on 2014 population estimated provided by the Office of National Statistics (ONS)

- Coalfields – a higher proportion of older people;
- Sunderland East – a higher proportion of people from black and minority ethnic groups;
- Sunderland North – more communities that experience high levels of disadvantage;
- Sunderland West – more communities that experience high levels of disadvantage;
- Washington – a higher proportion of families with children.

The MCP will be expected to take account of the JSNA and ensure awareness of and deliver services in a way that meets the needs identified.

https://www.sunderland.gov.uk/article/13880/Joint-Strategic-Needs-Assessment

https://www.sunderland.gov.uk/media/18724/Joint-Strategic-Needs-Assessment-Summary/pdf/Joint_Strategic_Needs_Assessment-_Summary_.pdf

Multi-speciality Community Provider (MCP)

Vision for Multi-speciality Community Provider (MCP)

Our vision for the MCP is to provide:

A focus on person centred proactive and coordinated care which will support appropriate use of health and care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life

This vision is underpinned with the high-level ***outcomes*** *below*:

- ***To Improve Care Quality including safety, clinical effectiveness & patient experience***
- ***To improve Health and Wellbeing***
- ***To improve Sustainability creating a sustainable health and care system***

The CCG want to commission an MCP model of care that is holistic and addresses all patients' needs in the community and covers the 4 levels of need and using the high level care model identified in the MCP national framework set out below.

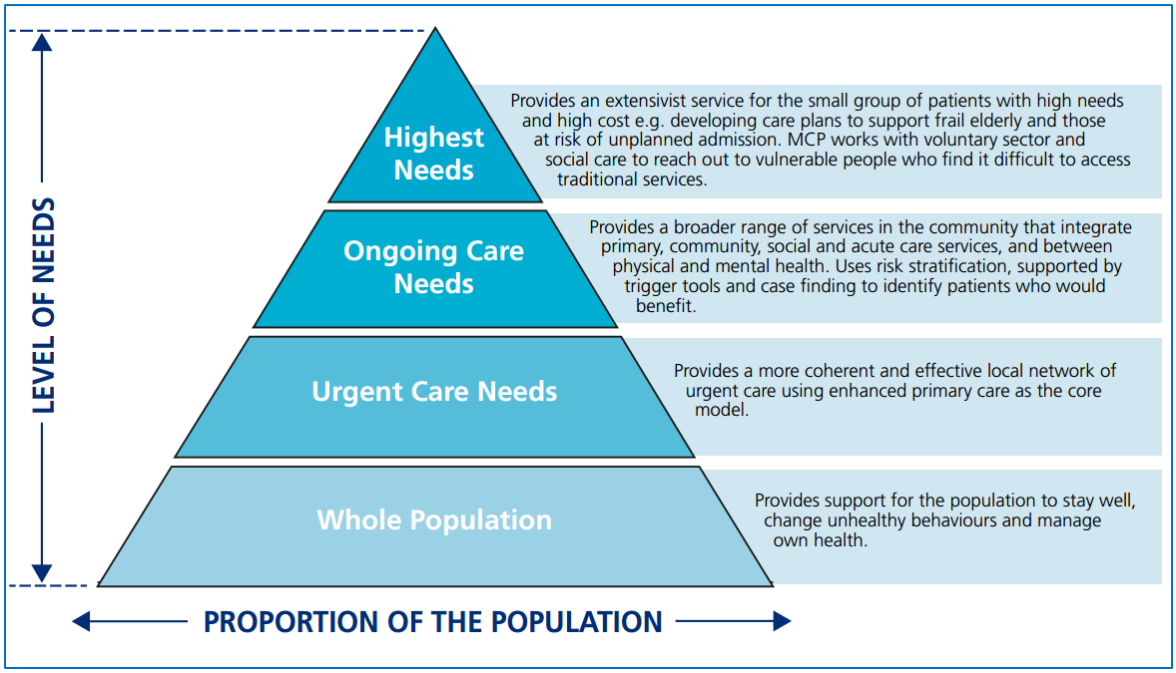

Diagram 1: MCP Framework

An MCP is expected to be a new type of integrated provision. It should bring together the delivery of primary care and community-based health and care services. They can incorporate a much wider range of services and specialists wherever that is the best thing to do. This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics; integrating mental as well as physical health services; and social care and public health provision together with NHS provision wherever possible.

An MCP is a place-based model of care. It will serve the whole population, with the offer of decision-making rights to deploy the integrated budget flexibly, so the provider can reshape the local care delivery system around what really works best for different groups of patients.

The MCP care model operates at four different levels:

- at the whole population level, the MCP aims to reduce future healthcare demand. It aims to address the wider determinants of health, such as low income levels and unemployment, and tackle inequalities. It builds upon social capital by mobilising citizens, local employers and the voluntary sector;
- for people with self-limiting conditions, the MCP helps build and forms part of a more coherent and effective local network of urgent care;
- for people with ongoing care needs, it provides a broader range of services in the community that are more joined-up between primary, community, social and acute care services, and between physical and mental health; and
- for small numbers of patients with very high needs and costs, it delivers an 'extensive care' service with more proactive and co-ordinated care due to the complexity involved.

In addition we have set out some specific local design principles we would expect and MCP Provider(s) to take account of when delivering the above care model. These are set out below. –

Our Design Principles

We have described what is important to us as Commissioners in Sunderland through a series of Design Principles which are set out below following engagement with our clinical leaders, member practices and our executive members. These are illustrated at Appendix 2.1 and described below.

Design Principles	
1	Integrated and holistic approach to care to include physical and mental health integrated with social care
2	Conduct population health needs assessment and develop strategies to improve the health and wellbeing of the population and reduce health inequalities
3	To provide a proactive and patient centred approach that empowers patients and carers and addresses people's needs
4	To provide a consistent and standardised offer of care to the population whilst maintaining the national standards of quality and safety
5	Strategic leadership Role for General Practice within an MCP - Strong GP leadership in the Governance arrangements of the MCP with a Clinical majority (clinical majority in widest sense) on the Board and clear GP leadership throughout all levels of the MCP
6	Strong clinical operational leadership, recognising the role of the GP as the expert generalist and the value of continuity of care
7	Protect existing budgets for general practice and identify additional resource in line with the national ambition to increase investment in general practice
8	To support the delivery of more enhanced and specialised services in the community where appropriate by ensuring a flexible, responsive and sustainable workforce without increasing the workload for General Practice
9	Sustain and support the development of the whole Practice workforce as well as assist the recruitment and retention in areas of scarcity - GPs and Practice Nurses
10	Locality focus (c 50,000 patients) for delivery of services where appropriate whilst wrapped around patients and closely aligned to General Practice

Design Principles	
11	Develop and implements an estates strategy that protects and improves the community and GP estate
12	To provide an intermediate and urgent care system that is responsive to patient needs and integrated within the model of care
13	Ensuring patients and carers have access to high quality services when needed within a simplified system
14	To work closely with the community and the voluntary sector
15	Focus on self-care and prevention to promote independence and reduce pressures on the health and social care system
16	To ensure continuous and effective patient and staff involvement where service changes are proposed, ensuring consultation in line with legislation and best practice
17	To improve the quality and efficiency of services through sharing records, data and information including integrating information management and technology
18	To maximise the agreed outcomes within the resources available
19	To contribute to sustaining and transforming General Practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people now and in the future.

Table 1: Design Principles

The MCP Provider(s) will need to deliver its services taking account of the design principles and success will be linked to its ability to demonstrate how it will take account of the design principles in service delivery.

Whilst we have set out the care model including the key design principles we aim to measure progress increasingly based on achievement of key outcomes. This combination of vision, care model including design principles and outcomes is anticipated to be our approach, rather than detailed service specifications and specified inputs.

The MCP will be community based serving the local Sunderland population, its success, in part, will be based upon the development of strong local relationships with and trust from the community it serves.

Our model rests upon the unique position of general practice starting with the person registered with the practice. The MCP will need to be population-based, linked to the registered lists of the GP practices across Sunderland.

Provider(s) will have to demonstrate how the operating model will be designed to ensure that the foundation of NHS care will remain list-based primary care. The model of care will

be unable to be delivered fully without some form of integration with GP Practices. This includes both ensuring that service delivery starts from the practice as well as ensuring that the patient medical records held by the GP form the basis of the medical records for the MCP. The role of the Practice is therefore fundamental and this is reflected in a number of the service design principles in Table 1.

The underlying principle of the development of the MCP care model is that it will enable GPs, nurses and other health professionals to come together and work with social care and the community and voluntary sector, to plan and deliver integrated care that leads to better outcomes for people. This means that when people do need support from public services it is delivered close to home with hospitals only needed for specialist care, so making best use of the limited resources available. Equally a key principle will be that the MCP will need to develop strong partnership working with the acute sector developing shared clinical pathways and joint working

The local Vanguard (ATB Programme) has helped to shape the national guidance documents on What Good Looks Like, and we would expect any providers of the MCP care model to be familiar with and demonstrate how they will deliver the key service components which align with our Design Principles. We would also advise any providers to consider the ways that the service components could be delivered as described in the good practice guidance – What Good Looks Like.

Delivery of the Out of Hospital Care Model

Delivery of the MCP care model for some of the services in scope has gone a long way to being fully implemented by the delivery of the All Together Better (ATB) Programme, as part of the new care Models programme since 2015.

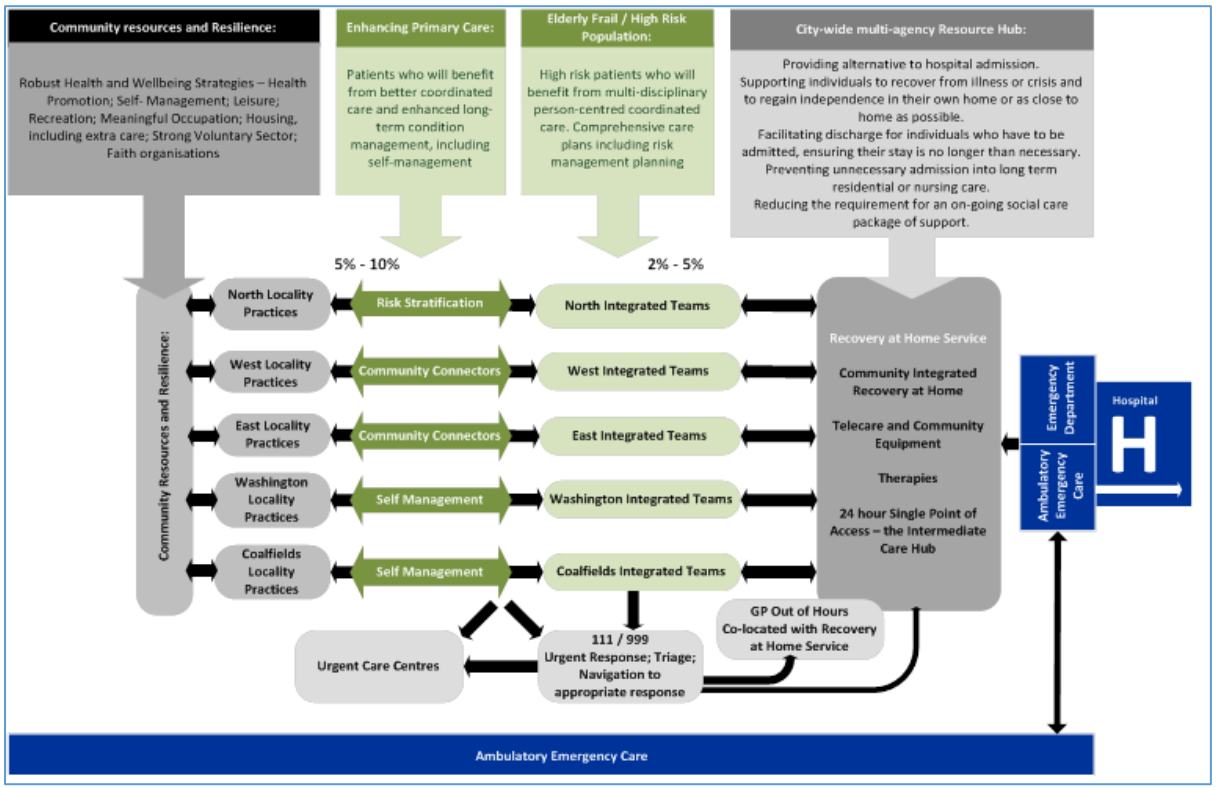

Diagram 2: The current Sunderland Out of Hospital Model

The model, which Provider(s) will be expected to build firmly upon through the wider scope, comprises four key elements. These are:

- **More effective prevention** – through enhancing community resources and resilience. Delivering proactive care which is holistic and preventive, empowering people to play a central role in managing their own care, preventing onset or decline of care needs or health conditions. Bringing health and care services together in one coordinated care response that is underpinned by prevention, self-care, early intervention, re-ablement and rehabilitation can avoid long term treatment and life-long service dependency.

- **Delivering integrated care more effectively** – enhanced Primary Care will be targeted towards people who have one or more long term health conditions, and who depend on support, but who are not counted among the frailest in the city.

- **A locality-based, community-focused delivery model** - All Together Better (ATB) has demonstrated the importance of better co-ordination of care across teams and organisations. The multi-disciplinary approach adopted by our Community Integrated Teams (CITs) and the Recovery at Home Service, working closely with Enhanced Primary Care has enabled a marked shift away from reactive care to proactive care. The CITs will create holistic health care plans with patients and carers, which are tailored to the needs of the person, and these are supported by their own GP, who will lead clinical decision-making to ensure that the medical, social and emotional needs of their patient are taken into account.

- **An approach to care that seeks to maintain stability and prevent escalation** to more acute levels of care with greater use of the third sector as well as recovery at home services to promote this change. Living Well Link Workers connect people to local community resources, whilst the city-wide multi-agency resource hub (Recovery at Home), both home and bed based, has been created to provide alternatives to hospital admission where patients needs have deteriorated placing them at real risk of serious decline in their condition and / or being admitted as an emergency to hospital. There will, of course, always be a need for reactive care, but the balance must continue to move towards proactive care if we are to improve outcomes for patients and maintain safe, sustainable and affordable care services.

To date, the ATB programme has delivered significant improvements to the care and support of individuals in the community following practice risk stratification, resulting in tangible benefits including a reduction in emergency admissions and A&E attendances for patients identified through this risk stratification and supported by Multi -disciplinary teams and care plans. This has also led to a reduction in delayed transfers of care and fewer permanent admissions to care homes.

Now the model has seen significant progress on implementation with improvements and some gaps in provision addressed with continuous refinement, it provides a solid foundation to enable further transformation in relation to the full scope of services intended to be in the MCP and the wider population. This transformation will be expected to be delivered using the same principles of addressing fragmentation; duplication and the lack of co-ordination

and creating integrated care pathways across the wider system, including mental health pathways as well as integration with social care where this is deemed to add value.

It is proposed that these additional services will be brought into the MCP Care Model over a two year period from April 2019. (The detailed scope can be found in Appendix 3.1).

Further Development and Delivery of the MCP Care Model

In line with local system plans, there are key programmes of system transformation linked to efficiencies required over 17/18 and 18/19 currently in progress. These may recommend enhancements/variations to some of the services that will be in the scope of the MCP model of care. Equally they may represent more detailed work on the operating model needed to deliver elements of the overarching MCP Care Model. These changes cannot wait for the MCP care model to be secured due to the pressures associated with them. However, once the MCP model of care is secured, the provider(s) will need to take account of these developments and ensure the more detailed operating models described below are delivered as part of the MCP model of care.

These include:

Mental Health Learning Disabilities and Autism

Significant transformation of Mental Health, Learning Disabilities and Autism has taken place in Sunderland over the past 8 years. The provider led Principle Community Pathways transformation programme has resulted in care now being delivered through a series of service pathways which do not distinguish between community and inpatient care. The CCG wishes to protect this pathway approach to the delivery of these services whilst at the same time expecting further integration within the MCP model of care for Sunderland. This might be achieved either through the current pathways delivered by the MCP provider(s) with integrated mental provision; or through a subcontracting arrangement with a specialist mental health provider.

Urgent care

We are currently working on the transformation of urgent care services in Sunderland in line with our Urgent Care strategy. Urgent Care refers to the care of people who do not have life threatening illness or injury but who have mental or physical health needs that require same day advice, diagnosis and treatment.

We are working with partners and stakeholders across the city so that the residents of Sunderland receive care within a joined up system, where services are not delivered in isolation but are wrapped around the individual needs of each person.

We have developed a vision for Urgent Care in Sunderland with stakeholders and partners to ensure that UC provision is fit for the future and sustainable in light of increased healthcare demand in Sunderland. This vision is set out in the following five design principles which will guide the redesign of Urgent Care services across Sunderland:

1. Increase self-care through access to appropriate clinical advice
2. Ensure appropriate access to treatment as close to home as possible

3. Simplify access by improving integration across health and social care and reducing duplication of services
4. Meet mandated requirements
5. Be safe, sustainable, and provide responsive, high quality care.

We have undertaken engagement activities with members of the public and patients and people have told us the current system of Urgent Care is too complicated and they don't know where to go to get the healthcare they need. The CCG wants to simplify the system so it is easier for people to access the care they need, enabling people to get the right service to meet their needs, first time and every time. To make the system easier to navigate the CCG wants to reduce duplication where there are different services open at the same time offering the same service, as people have said this is confusing.

We want to enable people to care for themselves and their families, where this is appropriate, reducing inappropriate use of services and thus enabling the targeting of resources where they will make a real difference to peoples' health. We also want to shift urgent care access away from the Emergency Department (ED) and closer to people's homes. This would mean that people only need to attend the ED if their condition is life threatening.

People have also said they want to be able to see a GP when they have an urgent care need, and if they have a long term conditions they want continuity of care because their needs are more complex.

Work is also underway to develop an Emergency Department Interface model, where out of hospital and in hospital services meet. Staff are starting to work in new ways across this interface to deliver effective and efficient care with an emphasis on getting people home where this is more appropriate than a hospital stay.

We need to ensure our Urgent Care provision meets the requirements set out by NHS England, including the new service specification for Integrated Urgent Care (111), the standards for Urgent Treatments Centres, and requirements to deliver Extended Access in General Practice. The urgent care clinical model will also build upon the out of hospital reform already undertaken in Sunderland

We have worked with stakeholders to co-design a proposed potential urgent care clinical model. During spring and early summer 2018 we will take this proposed potential model and clinical scenarios to formal public consultation. The feedback from this consultation will be used to inform the final urgent care clinical model. This clinical model is completely in line with the MCP Model of Care and with the Design Principles.

Ambulatory Care

Ambulatory Emergency Care (AEC) is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed. It is a transformational change in care delivery and has the potential to be as significant to emergency care as day case surgery is to elective care.

AEC is a key priority for Sunderland as it's acknowledged that this way of working will support the sustainability and delivery of the urgent and emergency care system.

AEC has been developed with partners across the system, particularly the acute trust and is commended by the National AEC Network for its whole system approach. Sunderland's shared purpose for AEC is as follows:

"Clinical discussion between key partners to ensure the right patients benefit from AEC, in the right place, time and by the right professional thus providing a simple and seamless pathway to patients across different sectors - AEC is not a location but a philosophy of care"

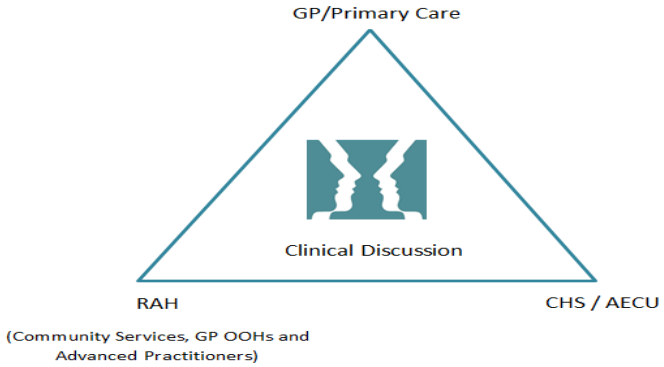

Diagram 3: Ambulatory Emergency Care

AEC has delivered successful outcomes to date, supporting more people to be managed without needing to stay in hospital and an AEC strategy is currently being developed in 2018 to continue to support the whole system manage unscheduled care over the next 3 years. The strategy will need to align with the high level model of care and design principles

Therapies

As part of the ATB programme a review of the provision of most physiotherapy and occupational therapy services providing out of hospital care, to ensure consistency and timeliness of access, is taking place. It is anticipated that this review is expected to recommend a future operating model of delivery that will be in line with the high level care model and design principles.

Falls

A multi-agency falls steering group, under the umbrella of the ATB programme, has undertaken the development of a new Sunderland Falls Strategy. The strategy aims to encourage better health and promote independent living through raising awareness of falls prevention. It aims to deliver new ways of cross agency working and improve patient access for those at risk of falling. The implementation of the strategy will include a new operating model of delivery.

Integrated Rehabilitation

There was evidence to show that there are elements of duplication and fragmentation across rehabilitation services in Sunderland. There was also evidence to show that some services are funded to a greater capacity than they were fulfilling, and that the level of need at a population level (prevalence) was much greater than any contract activity level of any condition/clinical pathway. At the same time referral levels remained low and referrers

found the system complicated to navigate. Patient engagement indicated room for improvement in accessibility and the range of support to be included.

A service re-design event was undertaken. A new model was developed to achieve the scalability required to deliver the outcomes and impact required, and maximize the potential that is possible for individual patients and their lifestyles.

Mobilisation is currently underway, and it is anticipated that the new service will be implemented from April 2018.

Community Bed Based services

A recent audit of patients in community beds has gathered strong evidence to suggest that there is significant scope for improvement in how the beds are accessed, who uses them, and for how long. If improvements in these areas could be made, it suggests that we may not need as many community beds in Sunderland as there are currently. There is also evidence to suggest that a different staffing model could be used in community bed facilities. Work is ongoing to understand the community bed requirements for Sunderland and the outcomes will inform enhancements to the MCP model of care.

Enhanced Care in Care Homes

The ATB programme has undertaken a review of the approach to supporting Care Home patients, in line with the national framework for enhanced health in care homes (2016);

https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

A deep dive and stakeholder workshop took place into care home support and further work is underway to refine the operating model to ensure it is fit for the future, recognising higher numbers of emergency admissions tend to come from care homes.

An action plan has been developed to support this work. This will be supported by the refocussed MDT guidance with practices to include all care home patients into the risk stratification process. This is supplemented by the continued realignment of practices to care homes. A group has been mobilised to oversee this work, led by a senior operational sponsor that has system wide knowledge of the current care home issues/plans. .

Packages of Care

We are leading a programme of reform on the future delivery of Continuing Health care (CHC), for Sunderland. A multiagency group is overseeing a programme of work which aims to ensure care packages are delivered in the most sustainable way. This includes people funded by CHC and Section 117. The programme has four main objectives which are:

1. Overseeing implementation of a new CHC Policy for sustainability
2. The review of high cost care packages
3. Effective application of CHC criteria
4. Efficient delivery of the operational model for CHC assessment.

The programme aims to ensure the basis for a more sustainable delivery of care packages is in place and outcomes will inform enhancements to the model of care the MCP provider(s) will be expected to deliver. The programme is attempting to ensure the same

principles of sustainability are applied across Health and Social Care regardless of the funding stream that pays for the care package.

The new CHC policy has been operational since the 1 September 2017 and has been well received by front line staff, a review policy has been agreed with the Local Authority in respect of high cost care packages and work has been commenced in respect to the application of the CHC criteria which would appear to be successful with the Multi – Disciplinary Team conversion rate falling more in line with the National average in Quarter 3. Site visits have taken place to view alternative operational models for CHC assessment with the aim of establishing greater control of the CHC assessment process.

This work stream is in place until summer 2018 with ongoing plans yet to be agreed; however it is likely that they will include a programme of efficiencies.

Treatment Room Services.

There is current variation across the city on the provision of treatment rooms for General Practices. The current community health services provider provides complex treatment services for all Practices whilst the non-complex care is provided to different degrees in light of the fact that some practices are now providing their own services. Work is underway to address this variation.

Prescribing

We currently have one of the highest prescribing costs per ASTRO-PU and cost growth compared to other CCGs within the North East and Cumbria area. A medicines optimisation work plan includes an extensive improvement programme to bring these figures in line with the area average. This includes:

- The cessation of community pharmacy managed repeats. Incident reports from GP practices have identified that with managed repeats patients may receive medication which is not required. This can be a risk to patient safety and lead to medication waste.
- Changing the method of provision of items such as wound care, incontinence appliances and oral nutritional supplements; currently supplied by the established prescription route.
- Increasing the clinical role of pharmacists in general practice taking a steer from the evaluation of the current NHSE pilot project running in twelve practices.
- Supporting medicines optimisation for patients in care homes and vulnerable patients as part of the integrated teams
- Focusing on deprescribing – encouraging patient-focused, holistic medication reviews, stopping inappropriate and ineffective medication and sharing the decision-making with people about which medicines are beneficial to them.
- Supporting medicines work streams within the NHS right care programme to reduce inappropriate variation and optimise patient care
- Working with secondary care providers to develop and implement a joint formulary of medicines for use in Sunderland
- Supporting patient safety in relation to medicines use in primary care
    - Promoting antimicrobial stewardship in primary care to reduce high antibiotic prescribing levels
    - Monitoring the prescribing of controlled drugs

- Promoting patient safety in relation to medicines including monitoring medicines patient safety incidents and supporting implementation of MHRA alerts

Other

Work is taking place to explore the potential for transformation of:

- **Diagnostic Services**, including community diagnostics. This could entail the development of a Community Diagnostic Centre that deals with, outpatient and non-urgent GP direct access. The community elements are within the scope of the MCP care model.
- **Outpatient** attendances are not currently within the scope of the MCP care model. We plan to incorporate a much wider range of services and specialists wherever that is the best thing to do. The vast majority of outpatient based services are currently carried out in an acute setting but it is acknowledged that some of this activity could be delivered in alternative settings and through the use of technology. Working with general practice and other services, the ability to transform outpatient care will be a key development of the care model and any MCP provider(s) could be expected to provide some of the services needed as a result of the review.

Integration with General Practice

The integration approach with general practice is central to the delivery of the MCP; there is no MCP without General practice. Our aim would be for any MCP Provider(s) to work in an integrated way with all the practices, and with a minimum of 100,000 of the practices population. What this means for General Practice related funding will depend on the level of integration they choose (voluntary for the Practice) and the business model that will be selected by the CCG to secure the MCP care model. Whichever business model is selected, how the Practice chooses to integrate or chooses not to integrate is up to each Practice.

There are 3 levels of integration:

- Full – putting the GP Contract into an Accountable Care Organisation(ACO)
- Partial – signing an integration agreement with an ACO whilst keeping the core contract
- Virtual – being part of a Collaboration of providers.

Integration with Local Authority

Sunderland CCG and Sunderland City Council are developing a plan setting out how health and social care will be integrated by 1 April 2020, in accordance with national requirements. Any MCP provider(s) will need to be engaged in the delivery for achieving this plan.

The CCG would expect any MCP provider(s) to recognise the value and promote the role of social care and social work in the delivery of the service model and the contribution both can make to overall health and wellbeing. The provider(s) will need to forge a successful relationship with Sunderland City Council, in order to determine and achieve a level of integration or as a minimum working arrangement to enable effective joint working between operational staff on the ground, where the needs of local people require a joint approach.

The Council at the current time does not intend to put its commissioning budgets into the MCP. However, there are some services they commission where it would provide added

value to have a working arrangement and/or integration agreement between the Council and MCP provider(s).

The areas are:

- Locality Integrated Teams including Living Well Link Workers
- Recovery at Home including Therapies and Equipment
- Community Equipment Services
- Mental Health and Learning Disability
- Packages of Care – NHS CHC, s.117 MH Act, Joint Packages

The Scope of the Services

Proposed Scope of Services

The proposed scope includes services that are commissioned by the CCG from over 40 organisations (including NHS, Local Authority, Community Interest Company, private, voluntary and charitable) and a current total of 43 general practices.

Fundamentally, the proposed scope of the MCP encompasses everything that is, can or should (taking into account medical, wellbeing, safety and quality matters) be delivered outside of a hospital environment.

In order to establish such a level of detail we met reviewed every service line currently commissioned on a recurrent basis and a decision made on each as to the suitability for it to be potentially included within the scope of the MCP.

In addition to the 'In/Out' status of each of the service lines an extra layer of information was added as to where we viewed the services would become a 'live' element of the MCP.

Our view is that between the commencement of year one (April 2019) and the end of year two (March 2021) all services will be enveloped by the MCP care model.

This scoping was undertaken with the view that it wasn't exclusively developed in a commissioner silo but also required input from the existing providers who have been collaborating on the development of this model of care for several years. Following broad agreement by further commissioner clinical input and approval from a Governing Body perspective the indicative level of scope was shared with the main current providers (for their areas of current provision) to comment and aide in the development.

The scope was then further developed during the market and public engagement phase between November 2017 and December 2017. The main changes made are the reduction of the phasing from 3 years to 2 years, moving GP and Care Packages from year 3 to year 1 to enable alignment with other services, the removal of some hospital services, and services that would no longer be commissioned by 2019.

Adoption of services

Year One

Enhanced Primary Care, CCG health funded elements of both the Community Integrated Teams and the Recovery at Home service established and developed through the All Together Better (ATB) programme. The general medical services (GMS) and personal medical services (PMS) contracts with general practices across Sunderland are within scope along with the responsibility for the general practice prescribing budget. In addition, GP extended access, recovery at home community beds, palliative care services, MSK and physiotherapy, speech and language therapies, dietetics, community equipment services, carers and continuing healthcare assessment, along with other services shown in table 2

A full list of services currently identified as being in scope for the first year are presented in Appendix 3.1.

Services to be incorporated into year 1
Acute and Community Ambulatory Care
Acute and Community Dietetics Services
Acute and Community Occupational Therapy
Acute and Community Podiatry Provision
Acute and Community Speech and Language Therapy
Acute Physiotherapy Services
Audiology Services
Biomechanics
Carers Service
Carers Services – Council
Carers Services - LIS
Community Based Anticoagulation Stabilisation, Monitoring and Dosing Service for Non-Complex Patients
Community Depression and Anxiety Social Network Services
Community Dermatology and Minor Operations
Community Diabetes
Community Equipment Services
Community Falls Services
Community Geriatrician
Community Integrated Teams
Community Lymphodema Care
Community Matrons
Community Musculo-skeletal and Physiotherapy Services
Community Nursing Support to General Practice
Community Optometry Services
Community Service for Acquired Brain Injuries
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
Diabetic Foot Screening
District Nursing
DMARD Monitoring
Enteral Feed Services
General Practice Extended Access
General Practice Funding (including enhanced services and QOF)
General Practice Infrastructure - IT and Premises
General Practitioner Workforce Support
GP Direct Access Radiology
Healthcare Packages of Care
Home Oxygen Assessment and Review Service (including provision of Gas)
Hospital Discharge Support Service
Intermediate Care Hub Provision
Living Well Link
Long Term Conditions Rehabilitation Services
Medicines Optimisation to Care Homes and Vulnerable Adults
Medicines Optimisation to General Practice
Out of Hours Pharmacy Provision
Outpatient Therapy Services
Palliative Care Services 24/7 (including estate)
Patient Transport Services
Patient Transport Services - Renal
Planned Nursing Care
Primary and Community Care Interpreting/Language Services
Primary Care Prescribing (includes Central Drugs, excludes PADMs)
Recovery at Home
Recovery at Home - Community Beds
Stoma Review Services
Telehealth Services
Tier 3 Weight Management

Table 2: Services to be incorporated in Year 1

Year Two

During the second year of operation the remaining out of hospital services will be brought into the MCP care model. These include a large number of mental health, learning disability and autism services, along with other services, as listed in Table 3.

Services to be incorporated into year 2
Acute and Community Learning Disabilities Services
Acute and Community Mental Health Services
Community Counselling Services
Community Dementia Services
Community Psychiatric Nursing
Mental Health Liaison Services

Mental Health Social Care Services
Outpatient and Community Neuro-rehabilitation Services
Outpatient Botulinum Dystonia and Spasticity Services
Regional Disability Team

Table 3: Services to be incorporated in Year 2

Out of Scope

A number of other services have been considered for inclusion, but for several reasons (including complexity, risk, efficiency and co-dependency on other services) have been classed as out of scope for the foreseeable future. These include urgent care transport (999 ambulances) and the 111 service, and maternity pathways. In addition following engagement with providers, outpatients have been removed from the scope in their current form, whilst recognising the outcomes of current Local Health Economy work to transform outpatients may impact on the MCP in the future e.g. the MCP may need to provide services that are currently provided in the hospital but following transformation could be provided in the community.

MCP Outcomes framework

Outcomes have been developed through a process of engagement with commissioners, including CCG and Local Authority staff. The results of the market and public engagement exercise, provided support for the use of the suggested high level outcomes, but that we needed a more detailed framework that measures impact over time. Suggestions for measurements for the MCP included: measure patient experience; develop measurements for physical and mental health separately; develop measurements for self-care; incorporate carers into MCP.

We now intend to continue to take a collaborative approach with stakeholders and MCP provider(s) to develop a more detailed outcomes framework including the set of measures needed to ensure we are assured the MCP provider(s) are delivering the outcomes and not simply relying on existing available measures. We have engaged a specialist organisation in this work. They will facilitate the completion of the Outcomes Framework. This work will begin in March 2018 and fully conclude, by March 2019.

The current **high-level *outcomes are***:

- ***To Improve Care Quality including safety, clinical effectiveness & patient experience***
- ***To improve Health and Wellbeing***
- ***To improve Sustainability creating a sustainable health and care system***

Delivery of these outcomes will be underpinned with a range of measures as follows:

Outcome	Benefits	Example Measures
To Improve Care Quality	• Evidence based effective and safe care pathways	• Proportion of people feeling supported to manage their

Outcome	Benefits	Example Measures
including safety, clinical effectiveness & patient experience	• Accessible services including advice and information which communicate effectively with each other • Patient centred care through shared decision making and integration of services • Excellent patient and carer experience • Identification of and support to vulnerable people to reduce inequality, improve health and wellbeing and keep them safe • Proactive engagement of patients with high health and social care needs and of those projected to have those needs • Patients empowered to be more in control of their care and wellbeing and better able to self-manage, and maximise independence. •	condition • Improving functional ability in people with Long Term Conditions • Reablement after 91 days • Patient experience of GP Services • Proportion of people dying in preferred place of death
To improve Health and Wellbeing	• People are enabled to maintain control over their own lives but know how to access support when they need it • Helping older people to recover their independence after illness or injury • Agreed care pathways will identify and address the needs of people with physical and/or mental health disability and ensure that all patients are treated equitably.	• Potential years of life lost from causes considered amenable to healthcare • IAPT access and recovery standards • Health related quality of life for carers
To improve Sustainability creating a sustainable	• Effective use of resources to meet need and maximise value • Effective use of skill mix	• Reductions in emergency admissions • Reductions in delayed transfers of care

Outcome	Benefits	Example Measures
health and care system		• Increased use of personal health budgets

Table 5 Outcomes, benefits and example measures

Public Engagement

Putting people at the heart of our planning and commissioning is fundamental to what the CCG are trying to achieve. A significant amount of engagement has already been carried out prior to and through the Sunderland Vanguard programme All Together Better. For example, Age UK Sunderland was commissioned to undertake the All Together Better engagement and with Sunderland Carers' Centre, they conducted a series of formal engagements with diverse groups across the City of Sunderland. This raised awareness of All Together Better as well as gained comprehensive feedback regarding the model of care including the publics' recent experience of services culminating in an insightful report in March 2016

We then carried out a communication and engagement exercise between 8 November and 13 December 2017 with stakeholders and the local community regarding the commissioning of a Multi-Specialty Community Provider (MCP) in Sunderland, sharing the Draft Prospectus. The engagement focused on asking people what they thought about the 19 principles for the MCP, as well as the outcomes for the MCP within the MCP Draft Prospectus (available at http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/).

The key findings of the exercise were that the majority of people agreed with the nineteen principles for the MCP and the three outcomes. The Executive summary, full report and a control sheet illustrating how we have used the key findings in relation to this Prospectus can be found at:
http://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/

Commissioning Strategy

This Prospectus sets out the MCP care model for delivery, regardless of the business model chosen for securing the MCP. Our Commissioning Strategy sets out the various business models that could be used to secure an MCP care model and includes an analysis of the strengths, opportunities, weaknesses and threats (SWOT) of each business model that could be used to secure the MCP care model for the longer term. The SWOT has been informed by the outcomes of the engagement described below.

From November to December 2017 the CCG undertook a market and public engagement exercise with general practices, potential providers, stakeholders and the local community regarding the commissioning of a MCP in Sunderland using the Draft Prospectus.

The preferred business model to support the care model will be decided by the CCG Governing Body at the end of February 2018. In summary the potential business models are:

- Accountable Care Organisation (using the new ACO contract). The ACO may be fully or partially integrated with General Practice
- Collaboration with existing contracted providers including general practices (using an Alliance Agreement)

The intention is therefore to commission the MCP care model by using the CCG preferred business model, in order to realise the local strategic ambition of a Multi-specialty Community Provider (MCP) leading, developing and delivering an effective integrated Out of Hospital or Community Care model in Sunderland.

The CCG will need to ensure that provider(s) have the capacity and capacity to bring together and integrate the range of services that are in the scope of the Sunderland MCP care model.

The complexity of this development will require a robust assurance process prior to and during the implementation of the preferred business model for securing the MCP.

This will redefine the relationship between commissioner and provider with the ultimate aim of delivering better, more integrated care and reducing health inequalities.

We do wish to secure the model for the long term. The MCP provider(s) will be expected to have a clear strategy for managing and delivering clinical, patient and service user outcomes. They will need to demonstrate the highest level of commitment to service quality and patient safety, with a payments approach that supports integration across the service scope, delivering outcomes in line with our care model and design principles.

The MCP provider(s) will need to operate in accordance with the requirements of the Public Services (Social Value) Act 2013 and identify opportunities to secure wider social, economic and environmental benefits from its activities.

We are developing our financial framework for the MCP business model, taking account of the national and local requirements. Assessments of the scope, put this potential total current value (17/18 costs) between c£209m to c£240m depending on the level of integration of general practices. The intention is for this overall budget to be used by the MCP provider(s) in a way that enables the MCP Care Model to be delivered and the outcomes achieved.

The CCG and senior leaders from provider organisations have undertaken an initial gain / share loss simulation exercise (based on a fictitious scenario) to understand and inform the potential framework, the outputs of this exercise are available.

We are also developing a contracting strategy which will aim to ensure that the current spectrum of contracts which we commission for services which are within the scope of the MCP are aligned to the timescales outlined within the scope and phasing into the MCP.

The CCG wishes to work with provider(s) who share the vision for our new care model and consider that they have the right capability and capacity to respond to the challenge ahead.

NHS Sunderland CCG – List of practices		
Locality	**Code**	**Name of Practice**
Coalfield	A89028	Grangewood Surgery
Coalfield	A89009	Herrington Medical Centre
Coalfield	A89004	Hetton Group Practice
Coalfield	A89023	Houghton Medical Group
Coalfield	A89021	Kepier Medical Practice
Coalfield	A89030	Westbourne Medical Group
East	A89018	Ashburn Medical Centre
East	A89001	Deerness Park Medical Group
East	A89034	Park Lane Practice
East	A89002	Dr S M Bhate & Dr H El-Shakankery
East	A89612	Dr Nathan
East	A89035	Southlands Medical Group
East	A89013	New City Medical Centre
East	A89005	Villette Surgery
North	A89036	Castletown Medical Centre
North	A89015	Fulwell Medical Centre
North	A89040	Dr Gellia & Dr Balaraman
North	A89008	Red House Medical Centre
North	A89019	Drs Cloak, Choi And Milligan
North	A89603	Dr. R. Obonna
North	A89604	Dr Weatherhead & Associates
North	A89016	St Bedes Medical Centre
West	A89031	Hylton Medical Group
West	A89017	Millfield Medical Group
West	A89007	Pallion Family Practice
West	A89006	Wearside Practice
West	A89623	Chester Surgery
West	A89032	New Silksworth Medical Practice
West	A89041	Happy House Surgery
West	A89011	Village Surgery
West	A89614	South Hylton Surgery
West	A89027	Springwell Medical Group
West	A89024	Broadway Medical Practice
West	A89020	Forge Surgery
Washington	A89022	Concord Medical Practice
Washington	A89025	Sunderland GP Alliance Medical Practice
Washington	A89617	Harraton Surgery
Washington	A89616	Rickleton Medical Centre
Washington	A89012	Galleries Medical Practice

NHS Sunderland CCG – List of practices		
Locality	**Code**	**Name of Practice**
Washington	A89620	Dr Thomas
Washington	A89026	Victoria Medical Practice
Washington	A89624	Dr. N.J. Bhatt & Dr. H.M. Benn
Washington	A89010	Dr Stephenson & Partners

DESIGN PRINCIPLES	 **1**. Integrated and holistic approach to care to include physical and mental health integrated with social care	 **2.** Conduct a population health needs approach in developing strategies to improve the health and wellbeing of the population and reduce health inequalities	 **3.**Proactive and patient centred care that empowers patients and carers and addresses people's needs
 **4.** Consistent and standardised offer of care to the population whilst maintaining the national standards of quality and safety	 **5.**Strategic leadership Role for General Practice throughout all levels of the MCP	 **6.** Strong clinical operational leadership, recognising the role of GP as the expert generalist and the value of continuity of care	 **7.** Protect existing budgets for general practice and identify additional resource in line with national ambition to increase investment in general practice.
 **8.** Support the delivery of more enhanced and specialised community services where appropriate without increasing the workload for General Practice	 **9.** Sustain and Transform General Practice and Primary Care by assisting the recruitment and retention of staff and ensuring a responsive, flexible and highly skilled work force.	 **10.** Locality focus (c 50,000 patients) for delivery of services where appropriate whilst wrapped around patients and closely aligned to General Practice.	 **11.** Develops and implements an estates strategy that protects and improves the community and GP estate.
 **12.** Integrate the intermediate and urgent care system with the model of care to ensure responsiveness to patient needs	 **13.** Ensuring patients and carers have timely access to high quality services within a simplified system	 **14.**To work closely with the community and the voluntary sector	 **15.** Focus on self-care and prevention to promote independence and reduce pressures on the health and social care system
 **16.** To ensure continuous and effective patient and staff involvement where service changes are proposed.	 **17.** To improve the quality and efficiency of services through sharing records, data and information including integrating information management and technology	 **18.** Maximise the agreed outcomes within the resources available	 **19**. To sustain and transform General Practice to ensure the provision of high quality primary medical care delivery improved health outcomes for local people now and in the future

Current services proposed to be in the scope of the multispecialty community provider (MCP) Please note that these services are those services currently commissioned by Sunderland CCG	
Services in the scope of year 1	
Service Line	**Provider**
Acute and Community Ambulatory Care	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Dietetics Services	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Occupational Therapy	City Hospitals Sunderland NHS Foundation Trust
Acute and Community Podiatry Provision	Multiple Providers
Acute and Community Speech and Language Therapy	City Hospitals Sunderland NHS Foundation Trust
Acute Physiotherapy Services	City Hospitals Sunderland NHS Foundation Trust
Audiology Services	Multiple Providers
Biomechanics	City Hospitals Sunderland NHS Foundation Trust
Community Based Anticoagulation Stabilisation, Monitoring and Dosing Service for Non-Complex Patients	Multiple Providers
Community Dermatology and Minor Operations	South Tyneside NHS Foundation Trust
Community Diabetes	City Hospitals Sunderland NHS Foundation Trust
Community Equipment Services	Sunderland Care and Support
Community Falls Services	South Tyneside NHS Foundation Trust
Community Geriatrician	City Hospitals Sunderland NHS Foundation Trust
Community Lymphodema Care	South Tyneside NHS Foundation Trust
Community Matrons	South Tyneside NHS Foundation Trust
Community Musculo-skeletal and Physiotherapy Services	South Tyneside NHS Foundation Trust
Community Optometry Services	Primary Eyecare Ltd
Community Service for Acquired Brain Injuries	Multiple Providers
Community Stroke Rehabilitation	Multiple Providers
Community Therapies	Sunderland City Council
Community Tissue Viability Provision	South Tyneside NHS Foundation Trust
Community Urgent Care and Out of Hours Services	Multiple Providers
Community X Ray provision including urgent care	City Hospitals Sunderland NHS Foundation Trust
Continence Assessment and Provision of Products	South Tyneside NHS Foundation Trust
Continuing Healthcare Assessment	South Tyneside NHS Foundation Trust
Diabetic Foot Screening	City Hospitals Sunderland NHS Foundation Trust
District Nursing	South Tyneside NHS Foundation Trust
DMARD Monitoring	City Hospitals Sunderland NHS Foundation Trust
Enteral Feed Services	South Tyneside NHS Foundation Trust
General Practice Infrastructure - IT and Premises	North of England CSU
GP Direct Access Radiology	City Hospitals Sunderland NHS Foundation Trust
Home Oxygen Assessment and Review Service (including provision of Gas)	Multiple Providers
Hospital Discharge Support Service	Age UK
Intermediate Care Hub Provision	South Tyneside NHS Foundation Trust
Long Term Conditions Rehabilitation Services	Multiple Providers
Medicines Optimisation to Care Homes and Vulnerable Adults	Intrahealth Ltd
Medicines Optimisation to General Practice	Multiple Providers
Out of Hours Pharmacy Provision	Multiple Providers
Outpatient Therapy Services	City Hospitals Sunderland NHS Foundation Trust
Palliative Care Services 24/7 (including estate)	South Tyneside NHS Foundation Trust
Patient Transport Services	Multiple Providers
Patient Transport Services - Renal	NERAMS
Primary and Community Care Interpreting/Language Services	Multiple Providers
Primary Care Prescribing (includes Central Drugs, excludes PADMs)	Prescribing
Stoma Review Services	Securicare
Telehealth Services	Various Providers
Tier 3 Weight Management	City Hospitals Sunderland NHS Foundation Trust
Planned Nursing Care	Marie Curie
Community Depression and Anxiety Social Network Services	Age UK
Community Integrated Teams	Multiple Providers
Recovery at Home	Multiple Providers
Recovery at Home - Community Beds	Multiple Providers
General Practitioner Workforce Support	Multiple Providers
Community Nursing Support to General Practice	South Tyneside NHS Foundation Trust
General Practice Extended Access	General Practice
Healthcare Packages of Care	Multiple Providers
Carers Service	Sunderland Carers Centre
Carers Services - Council	Budget
Carers Services - LIS	Budget
Living Well Link	Age UK
General Practice Funding (including enhanced services and QOF)	General Practice

Current services proposed to be in the scope of the multispecialty community provider (MCP) Please note that these services are those services currently commissioned by Sunderland CCG	
Services in the scope of year 2	
Service Line	**Provider**
Acute and Community Learning Disabilities Services	Multiple Providers
Acute and Community Mental Health Services	Multiple Providers
Community Psychiatric Nursing	Northumberland, Tyne and Wear NHS Foundation Trust
Mental Health Liaison Services	Northumberland, Tyne and Wear NHS Foundation Trust
Outpatient and Community Neuro-rehabilitation Services	Northumberland, Tyne and Wear NHS Foundation Trust
Outpatient Botulinum Dystonia and Spasticity Services	Northumberland, Tyne and Wear NHS Foundation Trust
Community Dementia Services	Multiple Providers
Community Counselling Services	Multiple Providers
Regional Disability Team	Northumberland, Tyne and Wear NHS Foundation Trust
Mental Health Social Care Services	Multiple Providers