South Tyneside Pioneer Programme – Profile

1.1 What is your area like?

South Tyneside is a compact area with a population of 150,000. It has high levels of income deprivation and social isolation in older people, and a high percentage of people living with long-term conditions, cancer and cardiovascular disease. Many people do not actively seek support and are dependent on statutory services at times of crisis. Many engage in multiple 'unhealthy behaviours' such as smoking, poor diet and no exercise. Communities in South Tyneside, however, are strong and supportive, and have many assets which can be built on to improve health and wellbeing.

Local demographics are as follows:

- 26,853 older people (18% of population – above average and growing)
- 9,973 older people live alone in South Tyneside (37.1% of the total)
- 50% increase in dementia across all ages by 2030
- 23% of older people have long term conditions or disabilities that limit day-to-day life
- 10,132 older people are living in deprivation (29th out of 326)
- Increasing numbers of under-65s with learning difficulties or disabilities

Partners involved in our integration programme include the council, clinical commissioning group (CCG), acute hospital trust, mental health trust and the third sector. As in similar areas, the local authority and the NHS are facing severe financial constraints, but local partners have a long and successful track record of working closely together.

1.2 What are you aiming to achieve?

We want more local people to live longer, healthier and more fulfilling lives. We think better-coordinated health and social care services can make a real difference here, but only if we make radical improvements in how people are encouraged and supported to take better care of themselves.

Our integration board leads our work on health and social integration and by working with patient groups and frontline staff developed this vision:

Building on these principles, 'Integrated South Tyneside' is our plan to join up local health and care services so that people receive a single, seamless service based on personalisation, prevention and self-care.

There are five workstreams; the first four involve structural integration:

- Integrated community teams – integrating and streamlining health and social care services around clusters of GP practices across the whole borough.
- Integrated care services hub – a £30m partnership between the council and foundation trust to house all dementia services in one new facility
- Urgent care hub – streamlining and consolidating A&E and urgent care into one place with accessible support services
- Change4Life wellbeing model – integration of various health improvement programmes into one accessible package of support

The fifth strand, and the focus of the pioneer programme, is a medium to long term programme of fundamental cultural and behaviour change for staff and residents, based on the concept of self-care.

This will mean:

- Staff have the motivation, capability and opportunities to have different conversations with people – promoting self-care
- People of South Tyneside will have the motivation, capability and opportunities to manage their own health and care

While it is in the planning and testing stage, self-care is being viewed as a separate workstream. It will be embedded in all services across South Tyneside. Over time, staff in integrated community teams, the integrated care services hub, the urgent care hub and the Change4Life wellbeing model will all be proficient in promoting self-care and supporting those who do so, as will relevant services in the other health, social and voluntary care sectors.

The self-care programme and integration work as a whole will be supported by an integrated digital care portal (subject to final funding approval), which will help to make our services more joined up and promote self-care through access to personal digital records.

Once implemented, self-care should result in less demand on all statutory health and care services, and is seen as contributing to objectives in the Better Care Fund. Self-care will underpin any new model of care, identified in the Five Year Forward View. Fundamentally, we think the best measures of success will be patient's positive experiences of care and their ability to manage their own conditions, and self-reported wellbeing.

Alongside this we believe that over the short to medium term better coordination of services and the promotion of self-care skills will have a major impact on a range of important indicators, including:

- Reduced A&E attendances
- Reduced admissions to hospital
- Reduced admissions to residential and nursing care homes
- Reduced re-admissions to hospital within 30 days of discharge
- For those in receipt of reablement, percentage reduction in hours support require
- Increase percentage of people feeling supported to manage their conditions
- Reducing depression and isolation
- Closing the life expectancy and inequality gaps that exist in the borough

1.3 What have been the highlights of your first year?

This has been a year of intensive preparation, which has included setting up governance arrangements, creating teams, testing ideas and approaches and working with local people on what better health outcomes means to them.

2014 saw the launch of our programme of NHS IQ-facilitated workshops with a broad cross-section of staff from across the partnership. Kicked off by the chief executives from all the participating agencies, including the council, CCG, foundation trust, mental health trust and HealthWatch, this has seen us take a bottom-up, staff-led approach to service redesign, developing a model which is now in place in Hebburn.

As the winner of this year's LGC Public Health Award for our work to embed 'Every Contact a Health Improvement Contact' across the whole council workforce, we have a strong track record in innovative workforce development. So alongside the restructure of our teams our 'Changing Conversations' programme has been rolled out across the partnership so that over 300 professionals on the front line have now

been equipped with the right skills and knowledge to promote self-care. We were able to showcase this work to Simon Stevens who visited us in the spring, and we have hosted a string of ministers and senior civil servants too.

An example of self-care in action includes one pioneer operating group discussing evidence that 80% of people use their inhalers wrongly. Following this, the group's clinical lead – a GP – saw two of his patients with asthma and asked them to show him their inhaler technique. This turned out to be incorrect, so he was able to correct their technique and give them other advice. Little changes can bring positive impacts.

1.4 Details of the year

A programme of massive cultural change is a subtle and complex thing to achieve, and has to be developed in a way which is both focused and flexible. The key stages so far are as follows.

1.4.1 Leadership and governance

Clear governance The integration board, which reports to the health and wellbeing board, is responsible for overseeing implementation across all workstreams. A pioneer operating group manages the pioneer programme, co-chaired by the director of public health as lead director, and a clinical director and GP.

Top-level support In meetings and workshops with staff, senior leaders have consistently reinforced the message of self-care and empowering bottom-up solutions.

Dedicated support A team able to provide dedicated support to the integration programme was set up, and grew as the programme required more capacity.

Training in large-scale change Staff involved in delivering the programme attended a pioneer workshop on how to implement large-scale change, and have used many of the theories in practice.

Project approach Project plans and risk mitigation logs were used to keep on track and report progress or problems.

1.4.2 Evaluation

We have developed an evaluation framework to assess the impact of the project on service users, residents and local services. This includes quantitative, process and qualitative measures. We are establishing baseline data through 11,000 postcards to residents of South Tyneside and through a staff survey. See case study: An evaluation framework for the self-care programme.

1.4.3 Establishing a prototype

The programme builds on our successful 'every contact a health improvement contact' work. Initially we tried a simple approach by asking a group of staff to ask three questions aimed at promoting self-care to their conversations with service

users. They told us this did not work, so we developed a more sophisticated approach based on their feedback and self-care methodology.

A third sector organisation was commissioned to run workshops for staff and residents together to explore self-care and why it is important, the benefits it provides to individuals, and to start to learn the skills to put this into practice. Workshops are followed by more detailed training. Feedback from the sessions indicates that they are successfully improving staff and public attitudes towards the importance of self-care.

We have also kept a register of attendance which will build into a borough-wide picture of which professional groups, teams and organisations have been involved so far.

1.4.4 Testing our prototype

Initially we had intended to use risk stratification to pilot self-care with particular conditions or demographic groups. We engaged national pioneer support, and were challenged about why we wanted to narrow our focus. We realised that risk stratification was not the way to go initially, and that self-care was for everyone in South Tyneside. The best way forward was to identify a locality to test and learn about implementing self-care. The locality of Hebburn was chosen; Hebburn has a number of socio-economic and health challenges, however the community has a vast range of physical, social, health and environmental assets which we need to utilise more effectively.

Action we have taken in Hebburn so far includes:

- An asset map to identify all the potential for health, wellbeing and care in Hebburn. We are looking at how this can be used to help the environment support our residents
- Building in-depth knowledge about the economic, health and care needs of the area so we understand its challenges
- A schedule of engagement activity to reach the widest range of people, e.g. through liaising with Healthwatch and linking to local events and campaigns
- Provision of workshops, attended by Hebburn residents and staff who work in a health and care setting in Hebburn
- Collection of baseline data to feed into our evaluation framework

All these actions will also help the work of the integrated community teams by developing a greater understanding of their patch.

1.5 What has been the most exciting aspect?

The workshops, attended by 450 people so far, have been a highlight. Bringing together the public, patients, service users and carers with professionals including GPs and care workers has produced massive energy and enthusiasm. See case study: Engaging with the local community to ‘change the conversation’.

It is not easy to establish a framework which captures both hard and soft information about cultural change and its impact; we struggled for two months and involved

further support to help us. We are pleased that we have been able to co-produce such a framework (see case study).

1.6 What has been the most challenging aspect?

As well as being very useful, the workshops have also brought challenges. We did not always have ways of channelling peoples' enthusiasm quickly. To address this we are looking at options such as setting up action learning sets and workplace sessions, such as in GP practices or integrated community teams.

Another issue is that many staff think they are using a self-care approach already, when it has become clear from the workshops that this is not generally the case. We will tackle differences in perception through training.

The area we have struggled with most has been communicating and marketing the programme. There was some scepticism about self-care in organisations and communities, and we needed clear, simple messages to explain what we were doing and why. Because this was a developing process we were not able to be sufficiently clear at first. We have now tendered for support in this area, and the successful provider will help us develop and deliver our message to accelerate the programme.

1.7 What are you planning to do next year?

- Raise awareness of the programme and what it will mean for people by developing and implement the marketing and communication strategy
- Deepen joint work with the third sector, through co-designing a five-year joint plan, requested by the sector
- Build on work in Hebburn, identifying professionals and service users who have attended the workshops and involving them in the development of self-care interventions. An event will be held in February to consider the evidence-base for various interventions and what could be trialled in South Tyneside; this could include, for example, self-monitoring, educational groups etc
- Modify and extend self-care to children and young people
- Evaluate all work which will have taken place in Hebburn (workshops, engagement with residents, marketing and communications, self-care interventions) to support wider roll-out across the borough
- Looking at involving FUSE, a collaboration of five north east universities, to help us with independent evaluation

1.8 What is your advice for areas starting on their own integration journey?

We believe achieving a shared purpose and clear vision has been key to getting so many people involved so many sectors. Achieving this has taken time with many iterations of the vision and challenges of "we do this already" and "it will never work" but the time invested in this has led to a greater clarity and commitment.

We believe that the thorough way we approached planning at the beginning is now starting to result in benefits. Because our programme was an iterative process based

on testing things and learning from them, without a sold framework we would have struggled to keep on track.

Also important are bringing together a mix of professionals with a range of backgrounds and expertise, with input from patients, service users and carers to keep things real.

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