All Together Better is part of the ‘vanguard’ or new care model programme, funded by NHS England to help transform services, making them more effective and efficient. In 2015 Sunderland was awarded ‘vanguard status’ and this gave us some extra funding to allow us achieve our aims to join up more quickly and to include more partners and support agencies to help us do that.

All Together Better is a large partnership, bringing together health and social care professionals as well as other local support agencies to help improve services for people who need a little bit more help than most. These people are usually older and have several ‘complex conditions’ – quite a few illnesses and/or disabilities. They are often already getting support from health and social care services or are being looked after by family members or friends.

All Together Better is designed to help these people when, for example they get an unexpected illness that makes their condition worse, and their usual support is not enough.

One of the main aims of the partnership is to help people stay out of hospital and as independent as possible, at home (which could be a care home) or, if they have been in hospital, make sure they have the right care and support to help them back on their feet, when they get home.

All Together Better includes doctors; district nurses; social care (home assessment and equipment); social workers; Age UK Sunderland staff/volunteers; as well as a range of other health professionals like therapists and pharmacists working as one team. An important partner is the Sunderland Carers Centre who offer a range of advice and support to family members and friends who look after others in a caring role.

Why do we need this service?

There are two main reasons. Whilst all of these health, social care and voluntary services are already in place, before they all worked independently of each other so it could take longer for people to get the right support, at the right time and in the right order as each service had different ways of working and different priorities when treating people’s problems.

People sometimes didn’t know where to go for help so would spend a lot of time at the doctor’s or simply went to A&E every time they felt unwell. This meant that some people were admitted to hospital more often than they needed to be and staying there longer than they needed to as there was not enough support at home.

A hospital is the right place to be when we require the dedicated services only a hospital can provide, but evidence and patient experience shows that getting help and treatment outside hospital gives better results in many cases and provides much better value for money, ensuring that our hospitals can treat those people who need its services most.

Now, with All Together Better, health and social care professionals are beginning to work directly together, in one place as one team. New services are being added and the community and voluntary sector are helping us out with their specialist skills and knowledge too, so we are able to help keep people as well as possible and at home – usually where they would rather be.
As we have described, All Together Better is focussed on those people who need and access the most health and social care services in Sunderland. To support them better we have introduced three main elements:

1. **Recovery at Home – rapid response, intermediate care**

   Recovery at Home is an important part of All Together Better, designed to greatly improve the care offered to people who need it most if they experiences an unexpected change in their condition that could develop into a crisis.

   Operating 24/7, the Recovery at Home team is ready to respond quickly to provide intensive support to those who need more support while they’re getting back to normal after a short term illness or injury in their own home, including residential or nursing care homes. during times of illness or if someone.

   The team – based centrally in one location at Leechmere, Grangetown – aims to support adults who live in Sunderland and registered with a Sunderland GP.

   Support is tailored to a person’s needs and can be any combination of a short term care package, including nursing and/or therapy, without having to be hospitalised or needing long term care. Recovery at Home also provides social care elements and is aligned with Sunderland Care and Support and the Independent Living Centre where specialist equipment and assessment can be provided.

   There are also two community bed units for those who need to be in a fully supported environment in the transition from hospital to home.

   This centralised team gives carers, GPs, health and social care staff, as well as other agencies, like the ambulance service and police, an invaluable single point of contact for some of the most vulnerable people in the City.

How does it work?

As we have described, All Together Better is focussed on those people who need and access the most health and social care services in Sunderland. To support them better we have introduced three main elements:

Is it a new service and how do I access it?

All Together Better is not a new service as such but the bringing together of a range of services already available to everyone across Sunderland, but just in a more effective way.

In most cases, if you need the services, treatment or support you will be referred by a health or social care professional. Your doctor is working very closely as part of All Together Better, referring patients they know would benefit most through special meetings called multidiciplianry team (MDT) meetings. Were a range of specialist meet to discuss the best possible care you might need and arrange it all, together into a care plan.

Key to this process are the Community Integrated Teams – who are positioned out in each of the five main areas of the city – the North, East, West, Coalfields and Washington.

Another part – called Recovery at Home – is also used by professionals and carers but local people who have health and social care needs, or their families, can also call the service to get short-term help quickly if they get an unexpected illness or their condition worsens.

Both teams include a wide range of health and social care professionals, supported by the local charity organisations Age UK Sunderland and Sunderland Carers’ Centre all working as one team, dedicated to those people who need the most care and support.
2. Community Integrated Teams

Five multi-skilled ‘Community Integrated Teams’ (CITs) are in place to provide an effective, high quality and co-ordinated care to the most vulnerable people, with the most complex needs in Sunderland.

Based in key localities in the city - Bunny Hill, Downhill; Hendon; Houghton; Grindon and Washington - the teams are made up of core staff teams including district nurses; community matrons; social workers; living well link workers and carers support workers. By working from a single, shared base, staff are able to work directly together, not only improving communication; but avoiding duplication and speeding up response times for local people.

Around this core team a wide range of other professionals link in to a wider, locality-based ‘network’ to ensure people get the right care from the right organisation or specialist.

The network includes GPs and practice teams; community physiatrist nurses; community pharmacists; care homes nurses and palliative care nurses, and is growing as relevant organisations or individuals are identified.

MDTs

A key part of community-care integration is the development of multi-disciplinary teams (MDTs) centred on each GP practice in the city and linked to their relevant local CIT. Patients identified as needing extra support by each practice may be subject to an MDT meeting where a range of professionals (including CIT members) discuss; plan and implement an co-ordinated care plan which encompasses a full range of services depending the person’s need.

While the GP leads clinical decision-making through MDTs they can call on a much wider support from the full network to cater for a patients; health; social and emotional care.

Meetings are managed by MDT co-ordinators and tailored to each practice population’s specific needs.

3. Enhanced Primary Care

While your family doctor (GP) is involved in both the important new services outlined above, a group of GPs are working together with all primary care professionals and other key partners across the city to look to the future and develop services further including a wider group of patients cross the city, as well as those in the poorest health.

This includes how the latest technology can be used to deliver the best care possible for patients in their homes; how to provide even more services directly in the community and outside hospitals and how community services can work more closely with other support organisations to make sure people can stay as well as possible and independent as possible longer into life.
Does it cost a lot to run?

All public organisations, in particular the NHS and local councils have to save money.

This work was already being planned in Sunderland with the Clinical Commissioning Group (CCG) and the City Council looking at ways they could join up to provide important health and social services together to cut costs by pooling budgets. They knew that there was a really good network of social workers, social care teams and community-based health professionals like nurses and doctors who could support and care for people out of hospital but who needed to work more closely. By creating All Together Better they will actually save public money and give local people a better service, longer into the future.

What happens when the funding ends?

A key part of All Together Better Sunderland being awarded funding as a vanguard was to ensure the changes put in place were sustainable. From the start, the partnership has made sure all the new ways of working that have been tried out were designed to be long-term and would continue beyond the vanguard programme.

The work undertaken since 2015 in delivering All Together Better has shown the strength of the local commitment to working collaboratively, and realised benefits for local people through providing more streamlined and joined up services. Looking forwards, this joining up of health and social care services is expected to continue and there is sign-up amongst partner organisations to explore the feasibility of forming one, single multi-speciality community provider (MCP) organisation in Sunderland to provide out of hospital health and social care services to local people.

Any new organisation will have the same important goals – to help the people who need it most get the best health and social care possible delivered, where possible, at home without having to go into or stay in hospital if they don’t need to be there.

There is a lot of work to do and it will be done in stages – with consistent engagement with anyone affected including patients; staff; local GPs and the community and voluntary sector.

So, what is an MCP?

In July 2016 NHS England published the MCP emerging care model and contract framework which defines what being a multispeciality community provider means.

In it there are three broad versions of an MCP:

1. The ‘virtual’ MCP, under which individual providers and commissioning contracts are bound together by an ‘alliance’ agreement.
2. The ‘partially integrated’ MCP contract, the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration.
3. The ‘fully integrated’ MCP contract model with a single whole-population budget across all primary medical and community based services.

It outlines that an MCP is about integration (joining up) and involves redesigning care around the health of the population as one organisation, irrespective of the individual partners’ existing organisational arrangements. It is believed that that by focusing on prevention and redesigning care, it is possible
to improve health and wellbeing, achieve better quality, reduce avoidable hospital admissions and in-patient treatment while, at the same time, providing more efficient ways of delivering care.

Based on the successes to date of the All Together Better vanguard programme, commissioners (the people who plan; buy and manage services locally) and providers (the organisations that actually deliver care) have shown their commitment to the vision to draw together services in a single, integrated MCP and have signalled their intent to work jointly to explore if it is possible to do this.

A Joint Senior Leadership Group comprising key leaders from both commissioner and provider organisations has been established to lead the development of a business case which will then provide the basis for more detailed discussion and engagement.

The organisations involved in designing Sunderland’s future health and care system are:

- NHS Sunderland Clinical Commissioning Group
- Sunderland City Council
- Sunderland Care and Support
- Sunderland GP Alliance
- The South Tyneside and Sunderland Healthcare Group (CHS and STFT)
- Northumberland, Tyne and Wear NHS Foundation Trust

We are at a very early stage and there will be opportunities to talk with staff across the partner organisations about the progress of the work as it develops. Most of all, we know from the feedback we have had from staff and patients that the All Together Better programme has made real improvements to the way services are provided and both staff and patients want to see the journey of integration continuing.

**How do I find out more?**

You can read more about All Together Better Sunderland on our website at www.atbsunderland.org.uk