Update on All Together Better – Sunderland's 'new model of care'

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Better Health and Care for Sunderland.

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Sunderland's 'new model of care'

Around 4 years ago health and care commissioners in Sunderland started a conversation about how best to address the challenges being faced due to:

- The ageing population and the resulting increased health (physical and emotional) and social care needs
- A need to reduce pressures on health an social care overall – otherwise the system could break and we could lose some services altogether
- Sunderland population's comparatively, ongoing poor-health and low life expectancy

In 2015 we got a big cash injection from NHS England who was asking for areas to test 'new care models' – called ***Vanguards*** – to address some of these issues nationally as part of the *Five Year Forward View*

And All Together Better was born

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Where to start?

We have really clear goals:

1. To reduce the number of people visiting A&E and reduce unplanned admissions by looking at how a more integrated (joined up) community-based health and social care service could support people ***before*** **they needed hospital care**

2. To **help people get home as soon as possible after hospital treatment**, if they don't need to be there – or what we say reduce *delayed transfers of care*

To do this we had to improve community based care – that's everything outside hospital

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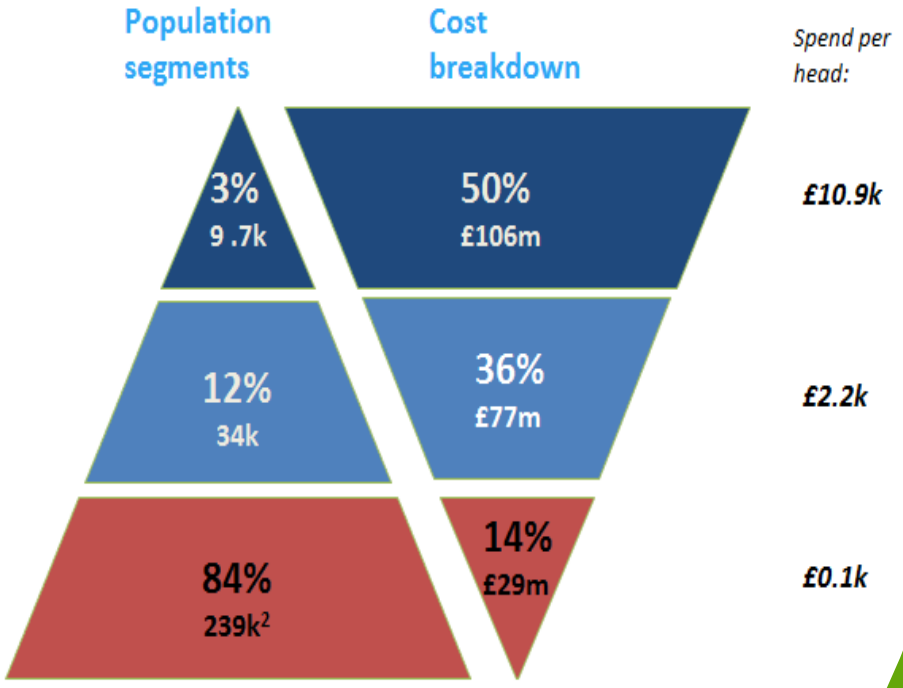
We had to start somewhere…

At first we focused on the people who need the most care and support in the city.

We knew just 3% of the population used around 50% of health care resources

So, based on GP records, we identified that, on the whole, those people were mostly the fail, elderly with multiple, long-term conditions who need a lot of health and social care.



Source: Sunderland CCG secondary, community care and mental health data, Oliver W
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community car
2 – 127k registered patients with no secondary, community or mental health

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What did we do?

By creating effective **Community Integrated Teams** of health and social care staff working together; in key locations across the city and forming a strong networks with other professionals and support agencies, local people are more supported and less likely to need an visit to A&E or an unplanned admission.

Now nurses; GPs and practice staff; social-workers; mental health nurses; care homes; Age UK Sunderland Living Well Links workers; Sunderland Carers' Centre teams; community matrons; palliative care nurses and therapists all communicate and work closely together to support those who need it most.

GP practices carry out multi-disciplinary team (MDT) meetings and call on the relevant professionals needed to produce effective, holistic care plans around patients with the most need, keeping them as well as possible and out of hospital.

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What did we do?

And, if people did need hospital care, to make sure they could be discharged as soon as they were well enough, we we needed to be able to treat and care for people at home – where most people want to be!

We have developed the **Recovery at Home** service which provides a 24/7 urgent response to people who need help if their condition changes or they are just out of hospital and need some extra support.

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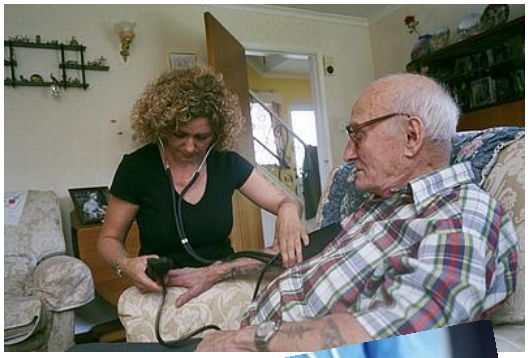
John's story

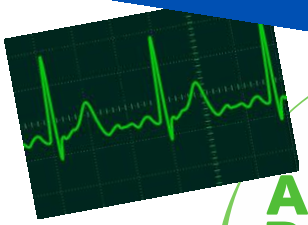
What did we do?

All this is underpinned by **Enhanced Primary Care** – which is all about giving your GP additional support, tools and technology on which to offer the best community-based care possible.

So, as well as developing Community Integrated Teams and Recovery at Home to support local GPs, a key partner in All Together Better has been the Sunderland GP Alliance who has led on key projects like:

- GP alignment with care homes
- better use of new technology for diagnostics and managing medicines
- improved information sharing
- self-care





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What next

The All Together Better Sunderland vanguard has begun to change the face of health and social care for local people – but this is still a new concept.

Change as big as this takes time.

To take the work further and build on the positive improvements and learning from the vanguard, we need to look at how we can continue to bring services together and commissioning them jointly across a big partnership.

This is best done when it is led by proactive commissioners and managed by the teams delivering the services working with patients and carers to make it happen.

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What next

Priorities going forward:

- **Emergency Department Interface** – a front line to support people arriving at hospital who aren't an emergency but need rapid; high quality physical; mental or social care support potentially without admission

- **Falls prevention** – helping people understand the risks and how to prevent falls. Then, working in partnership with all relevant services to respond better when people do fall

- **Self-care –** how we can help people look take control of their own health and well being

- **Public, Patient and Carer engagement –** continuing to involve people when designing services and creating change

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Questions and views

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