Our operational plan

All Together Better

Health and care partners
working together in Sunderland

Published October 2019

Health and care partners working together

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Welcome to

All Together Better's first operational plan

All Together Better (ATB) is made up of an alliance of provider and commissioning organisations working closely together to plan, deliver and improve health and care services in the community across Sunderland.

Formally coming into operation on 1 April 2019, ATB aims to build upon the success of the 'out of hospital' NHS vanguard programme by improving the health of local people, providing better care and ensuring clinically and financially sustainable services.

Since being awarded 'vanguard' status in 2015, Sunderland has been at the forefront of developing new models of care and a significant amount of work has taken place to integrate services and improve the way care is delivered. As we have done so, our partnership has grown and matured. We have refined and further developed our transformation priorities into clear plans for delivery and we have developed governance and partnership arrangements that facilitate both closer working at a local neighbourhood level and across the wider City of Sunderland.

It is a privilege to have been formally appointed to the role of chair of All Together Better. As a frontline GP in Sunderland, I see every day the fantastic range of health and social care services we have in Sunderland and the hard work and commitment of our workforce.

I also see the reality of the impact of health inequalities and poor health on people and the growing demand and financial pressures faced by services.

All Together Better offers a unique opportunity to build on the strong foundations we have put in place and to provide truly joined up care and support in people's homes, GP surgeries and in the community, helping people to remain independent for as long as possible and reducing the need for hospital stays.

Our one year operational plan for 2019/20 sets out how we will start to deliver high quality and sustainable services into the future and lays the groundwork for the transformation of how we deliver health and social care in neighbourhoods across Sunderland.

This means working in all our communities to tackle health inequalities and the root cause of the issues – whether loneliness, poverty, complex health care needs or disjointed and complicated services.

We will do this by working together and doing things differently to improve care outside of hospital, provide better value for money and make a real difference to the health, wellbeing and every day lives of the people of Sunderland.

Dr Martin Weatherhead, Chair of ATB

Introduction

All Together Better (ATB) is an alliance of commissioners and providers working together across organisational boundaries to better join up health and care services and improve health outcomes for people living in Sunderland.

The purpose of ATB is to maximise people's independence, good health and wellbeing across all of our communities in Sunderland. Our key partner organisations include:

- **Sunderland Care and Support (SCAS)**
- **Sunderland City Council**
- **Sunderland Clinical Commissioning Group (CCG)**
- **Sunderland General Practice Alliance (SGPA)**
- **South Tyneside and Sunderland NHS Foundation Trust (STSFT)**
- **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (NTW)**
- **All other providers and voluntary sector organisations currently commissioned by Sunderland Clinical Commissioning Group**

Our aim is to work with local communities to support people to live a long, healthy and fulfilling life. Through this work, we want to empower people to be able to make healthier choices and ensure that those people living with an existing disability or long-term condition are able to live as well as possible through access to the right advice, treatment, care and support.

Across Sunderland we have so much to be proud of, but we also need to address some significant health challenges and inequalities.

Sunderland in general has poorer health outcomes than the rest of the country with significant pockets of deprivation and is in the top 20% of the most deprived areas in England. Life expectancy for both men and women is lower than the England average and estimated levels of adult obesity, smoking and physical activity are also worse than the England average.

Around 79,000 people in the City of Sunderland have at least one long-term condition and one in four adults also report some form of long-term illness, health problem or disability.

The financial challenge we face is the biggest in a generation. Demands on our resources are growing faster than those available and, as a result, the local health and social care system is under increasing financial pressure.

"We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions."

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. It is the only way we can genuinely put people, rather than organisations, at the centre of what we do. It is also an approach which can maximise the benefit of sharing the expertise and resources we have, including money, buildings and staff, to achieve a greater focus on preventing ill health and reducing health inequalities.

Our operational plan for 2019/20 sets out our key priorities on how we will start to significantly improve health and social care outcomes and reduce the number of people attending hospital by delivering more care closer to home.

This means supporting people in community settings such as their own homes and making more services available in local communities. It also means having health and social care staff working more closely together, with other primary care colleagues, to support people; developing better integration of physical and mental health services; and refocusing our investment so that we are putting our available resources to their best possible use.

Our vision

Better health and care for Sunderland

Our mission:

A healthy city - more people living healthier longer lives

Outstanding care - every time, for everyone and reducing inequality

Delivery of high-quality services - through effective partnerships

System efficiency - deliver innovative, financially and clinically sustainable services

Our values

People-centred

- Care and support organised around the person
- Outstanding, safe and compassionate care
- High quality, responsive and effective community services

Collaborative

- Working together as one team dedicated to meeting peoples' needs
- Clinical leadership guides our thinking
- Listening and learning from each other

Integrity

- Acting with honesty and transparency
- Deliver what we said we will deliver
- Respect and embrace difference

Quality and safety

Quality and safety are implicit in our vision and values and our underpinning governance framework will enable quality and safety to be at the heart of everything we do.

National vision for the NHS

The NHS Long-term Plan was published in January 2019 and sets out a number of key ambitions, over the next 10 years, to create a health and care system which is fit for the future by:

- Increasing focus on population health and taking more action on prevention
- Transforming 'out of hospital' care to build fully integrated community-based services
- Improving the quality of care provided and the health outcomes achieved for local people by reducing variation and improving productivity

Our approach to improving care in Sunderland

In line with the vision outlined in the NHS Long-Term Plan, we firmly believe in the principle that services should be delivered as close as possible to people in their own homes and communities, where this is safe and effective. Only when the safety, quality and cost effectiveness of care are improved by providing it at a greater scale should services be delivered elsewhere.

Our care model in Sunderland (see pages 10 and 11), will be built around geographical neighbourhoods which reflect locality areas and the new 'primary care networks' in Sunderland in which local GPs and health and social care will work together to proactively care for populations of around 30,000 to 50,000 people.

We are already well advanced in developing this place-based or neighbourhood model thanks to the work already undertaken in 2015 as part of the NHS vanguard programme. This means we already have the important building blocks in place across the City to support care for everyone registered with a Sunderland GP, as well as those who are not registered with a GP but live in Sunderland.

Our six integrated neighbourhood teams will cover the following localities:

- Sunderland Coalfields
- Sunderland Washington
- Sunderland East
- Sunderland North
- Sunderland West One and Sunderland West Two

ATB will implement a new integrated neighbourhood operating model. This new neighbourhood operating model will seek to fundamentally reshape mainstream delivery, bringing together the skills, knowledge and experience needed to deal effectively with demand in a specific neighbourhood, ensuring services and staff in that neighbourhood share a common purpose and work in an holistic way with people and communities. The integrated neighbourhood operating model will encompass primary care, social care, mental health, community nursing care, social prescribing and drug and alcohol services and seek to interact and interface with policing, fire service, housing, the voluntary sector and other community services.

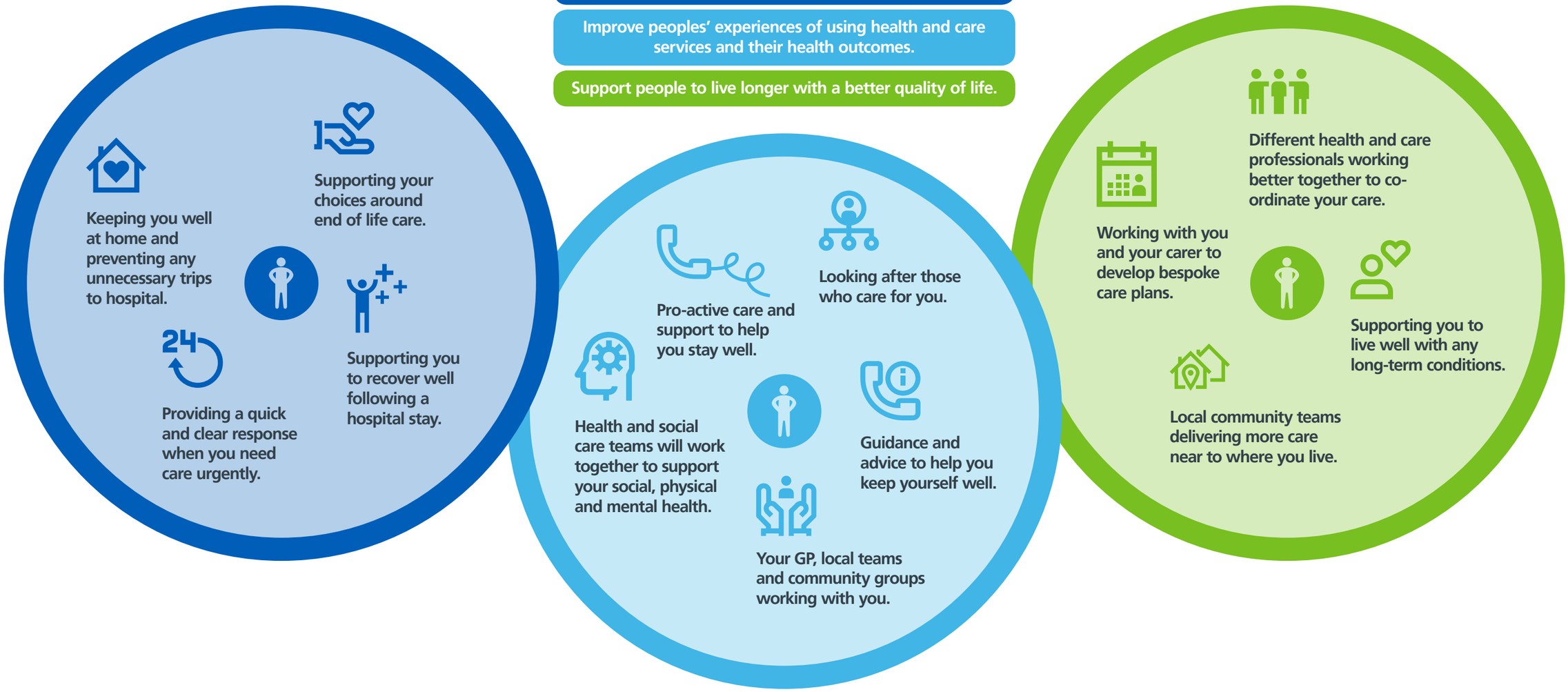
Our neighbourhood model

All Together Better - Care Model

Our vision: Better Health and Care for Sunderland

Our health and care services will:

- Deliver more personalised, pro-active and joined up care.
- Improve peoples' experiences of using health and care services and their health outcomes.
- Support people to live longer with a better quality of life.



Collaborating across all partners

Achieving our collective vision for improving care across Sunderland is supported by a collaborative way of working agreed across all ATB partner organisations. This is shown in our 'business model' diagram below and sets out the four key programmes of ATB work which are designed to transform the way care is delivered across Sunderland.

Sunderland All Together Better Business Model

Vision - Better Health and Care for Sunderland

ATB Executive Group

General Practice Programme	Mental Health Learning Disability and Autism Programme	Enhanced Primary and Community Care Programme	Intermediate and Urgent Care Programme

ATB is an alliance of commissioners and providers working together across organisational boundaries to better join up care for people living in Sunderland and improve their health outcomes.

Operational plan 2019/20

Sustainability is a cross cutting theme in our operational plan and its significance is wider than just long-term financial sustainability.

It is also about increasing productivity, ensuring services provided in the community are good value for money and encouraging the workforce to continually adapt and evolve our services to meet the needs of local communities.

Our operational plan has been informed by the CCG's operational plan 2019/20, Sunderland City Council's City Plan, the NHS Operational Planning and Contracting Guidance 2019/20, the recently published NHS Long-term Plan and the Joint Strategic Needs Assessment for Sunderland.

It sets out three key transformational priorities for the year ahead and 20 projects within these:

01. Improving health outcomes and reducing inequality

02. Enhanced integrated primary care services

03. The transformation of care and support services

Health and care partners working together

The difference ATB will start to make in 2019/20

As our collaborative work gathers more pace in 2019/20, we hope to see these three core transformational priorities resulting in:

01. A strengthening of general practice by enhancing community integrated teams and services built around local neighbourhoods and 'primary care networks'

02. An even greater focus on supporting people to keep healthy and independent, addressing health inequalities by developing active communities and greater social prescribing which means GPs, nurses and other primary care professionals will be able to refer people to a range of local, non-clinical services

03. People with long-term conditions – whether those are physical health, mental health or learning disability related – starting to see more joined up care and support in their own homes, GP surgery and community

04. Implementation of an urgent health care system that provides timely care in a crisis and delivers the best specialist care possible

05. A greater emphasis on recovery and rehabilitation and people being supported to live independently in the community for as long as possible

06. Supporting people in their choices around end of life care, resulting in people dying in their preferred place of care

07. Staff finding it easier to work with colleagues from other organisations to support shared health and social care priorities and remove duplication

08. Measurable improvements in population health and reduced inequalities

09. Greater value in driving improvement across the whole health and care system by taking a more holistic view of resources across all partners and better aligning assets, budgets and staffing resources

10. A comprehensive system leadership approach to improving health and care services and providing high quality integrated services in the community for people across Sunderland

Health and care partners working together

Our three key transformational priorities for 2019/20

01. Improving health outcomes and reducing inequality

Reducing health inequalities, preventing ill health and improving people's wellbeing is at the heart of our approach and a theme that runs through all of our priorities.

Fundamentally, we know that across Sunderland significant inequalities exist and people are living longer in ill health. By preventing physical and mental ill health, and getting to grips with issues before they become bigger problems, people will lead happier, healthier lives.

To start to achieve this 'step change', our efforts will be focussed on social prescribing and a range of projects to enhance recovery and rehabilitation services with the purpose of avoiding long-term treatment and lifelong service dependency.

Project 1

Social prescribing

General practice (Programme one)

Social prescribing is a means of enabling GPs, nurses and other health and social care professionals to refer people to a range of local, non-clinical services. Recognising that peoples' health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address peoples' needs in a holistic way. It also aims to support individuals to take greater control of their own health. This project will design a city wide social prescribing model which will support people with a wide range of social, emotional or practical needs and will focus on improving mental health and physical wellbeing.

Project 2

Promoting employment, education, training and meaningful activities for people with mental health needs, autism or a learning disability

Mental health, learning disability and autism (Programme two)

This project will develop work, education or training opportunities that will contribute to peoples' recovery and wellbeing, supporting people to recognise their own talent and resourcefulness in order to become experts in their own self-management, make informed choices and achieve the things they want to in life.

Project 3

Development of a frailty model

Enhanced primary and community care (Programme three)

Frailty is a term used by professionals to describe the loss of body resilience, which means that in the case of a physical or mental illness, an accident or other stressful event, people living with frailty will not bounce back quickly. Frailty is related to the ageing process however not all older people are frail and not everyone living with frailty is older. This project will develop an integrated frailty model to cover both community and acute hospital services as well as looking at our strategy and approach to prevent falls.

Project 4

Redesign of podiatry services

Enhanced primary and community care (Programme three)

This project will review the current podiatry model with an aim to prioritise patients with high clinical needs, avoid more costly interventions which carry greater risks and give patients a better quality of life for a longer period of time.

Project 5

Respiratory service review

Enhanced primary and community care (Programme three)

This project will review the approach to supporting people with respiratory (breathing) problems with the aim of improving health outcomes and optimising the length and quality of life for people with and at risk of respiratory disease.

Project 6

High intensity users

Intermediate and urgent care (Programme four)

A relatively small percentage of patients are known to generate a disproportionately high percentage of emergency department attendances and unplanned hospital admissions. This project will develop a new service model to support people in Sunderland to reduce their need to use unscheduled care, freeing up front line resources and reducing admissions into hospital.

Project 7

Review of recovery at home service

Intermediate and urgent care (Programme four)

This project will review the current citywide recovery at home service with the aim of maximising independence, improving quality, using resources more effectively to get best value for money whilst improving and simplifying the system for patients and health and social care professionals.

02. Enhanced integrated primary care services

Enhancing primary care is a key priority so that community-based health and social care services are more joined up.

Through the development of our six new integrated neighbourhood teams across Sunderland, our aim is to sustain and transform GP services to ensure that local people have access to high quality primary medical care and a range of community services around which out of hospital care will be organised.

Our efforts will be focussed on providing more personalised, proactive care which is accessible locally and better coordinated with a range of health and care professionals working more closely together in local communities.

Project 8

Delivery of the general practice strategy

General practice (Programme one)

GPs play a pivotal role in community health services and this project will implement the requirements set out in the national GP Forward View, NHS Long Term Plan and Sunderland CCG's general practice strategy.

Project 9

Support the development of primary care networks

General practice (Programme one)

Primary care networks (PCNs) aim to bring together health and care professionals in local neighbourhoods to improve integrated ways of working, provide more joined up experiences of care for local people and embed population health approaches. This project will support the development of PCNs in Sunderland and continue to enhance local services outside of hospital by working closely with GPs and community integrated teams.

Project 10

Medicines optimisation and pharmacy services

General practice (Programme one)

Medicines optimisation is about enabling prescribers and patients to make the most appropriate, agreed treatment choices together. This project will seek to enable high quality, patient centred access to medicines across health and social care and integrate pharmacy services to engage with and support the new 'primary care networks'.

Project 11

Development of an integrated neighbourhood operating model

Enhanced primary and community care (Programme three)

ATB will implement a new integrated neighbourhood operating model. This new neighbourhood operating model will seek to fundamentally reshape mainstream delivery, bringing together the skills, knowledge and experience needed to deal effectively with demand in a specific neighbourhood, ensuring services and staff in that neighbourhood share a common purpose and work in a holistic way with people and communities. The integrated neighbourhood operating model will aim is to wrap care around a person and their family, tailoring services to different community requirements across Sunderland.

Project 12

Enhanced health in care homes

Enhanced primary and community care (Programme three)

This project will seek to develop a clear vision for working with care homes across Sunderland to provide more joined up support and care to residents of care and nursing homes. The aim is to improve and empower the ability of the care home sector to support residents and reduce unnecessary admission into hospital, via a range of 'in-reach' services.

Project 13

Urgent care strategy implementation

Intermediate and urgent care (Programme four)

This project will implement the agreed urgent care strategy enabling the residents of Sunderland to access urgent care which meets their needs in the right place and at the right time.

03. The transformation of care and support services

We need to rethink and improve how health and care services are delivered in line with the expectations of the people of Sunderland.

We want to provide more care in the right place, at the right time and by the most appropriate healthcare professionals within our local communities. To do this, our aim is to develop new innovative ways of working and embrace new technology where appropriate.

Project 14

Delivery of the mental health strategy

Mental health, learning disability and autism (Programme two)

This project will implement the requirements set out in the national Mental Health Five Year Forward View (MHFYFV) now in its fourth year of implementation and the NHS Long Term Plan which reaffirms a national commitment to transform mental health services and put mental health care on a level footing with physical health services.

Project 15

Review of Section 117 aftercare support care packages

Mental health, learning disability and autism (Programme two)

This project will review the Section 117 aftercare policy operating in Sunderland with the aim of ensuring financially suitability and to ensure Section 117 aftercare plans are designed and developed with promoting service users' independence and recovery in mind.

Project 16

Alternatives to hospital care for older people with mental health needs

Mental health, learning disability and autism (Programme two)

This project will develop alternative options to hospital care for older people with mental health needs and dementia. Our aim is to ensure appropriate services are in place to account for the expected increase in demand on these services, as well as developing alternative non-medical models to support greater control, self-management and autonomy.

Project 17

Care packages

Enhanced primary and community care (Programme three)

This project aims to review the approach for NHS Continuing Healthcare (CHC) assessment in order to reduce variation, deliver improved performance and patient experience and ensure a financially sustainable model through an integrated approach to funding of complex care packages.

Project 18

Review of community acquired brain injury service (CABIS)

Enhanced primary and community care (Programme three)

This project will develop cost effective specialist community rehabilitation services for people with a mild, moderate or complex acquired brain injury. Our aim is to support people through local services to improve their long-term potential.

Project 19

Alternatives to detention

Mental health, learning disability and autism (Programme two)

This project aims to develop a much clearer understanding of the use of the Mental Health Act in detentions across Sunderland in order to ensure a least restrictive approach is applied across health and care services.
The aim is to reduce the number of detentions from the community and ensure the Mental Health Act is used appropriately.

Project 20

Transforming community equipment services

Enhanced primary and community care (Programme three)

This project aims to ensure the delivery of sustainable care equipment services, including wheelchairs, to order to improve access and meet national waiting time standards.

Our operational plan at a glance

Our vision:	Better health and care for Sunderland		
Delivered by:	Improving health outcomes and reducing inequality	Enhanced integrated primary care services	Transforming care and support services
Measured by:	All Together Better outcomes		
Underpinned by our values:	People centred	Collaborative	Integrity

Improving health outcomes and reducing inequalities		
Transformation projects	**Programme**	**Objective**
1. Social prescribing	One	Design a city wide social prescribing model to support people to improve their physical and mental wellbeing
2. Promoting employment education, training and meaningful activities	Two	Support the recovery and wellbeing of people with mental heath, learning disabilities and autism
3. Development of a frailty model	Three	Develop an integrated frailty model covering acute and community services
4. Podiatry	Three	Review current model of podiatry to support and improve patients quality of life
5. Respiratory	Three	Improve health outcomes and optimise the length and quality of life for people with and at risk of respiratory disease including care at end of life
6. High intensity users	Four	Support people to reduce their over dependence on unscheduled care and reduce admissions to hospital
7. Recovery at home service	Four	Review current service to maximise independence and improve quality, integration, and sustainability

Enhanced integrated primary care services		
Transformation projects	**Programme**	**Objective**
8. Delivery of general practice strategy	One	Delivery of the CCG general practice strategy, increasing workforce and sustainability
9. Primary care networks (PCNs)	One	Development of PCNs, improving integrated working, joined up pathways and population health approaches
10. Medicines optimisation and pharmacy services	One	Enable high quality, person-centred access to medicines across health and care, integrated with PCNs
11. Development of integrated neighbourhood operating model	Three	Cross cutting project across all ATB Programmes. Promoting a model of integration that is truly preventative, proactive and person-centred
12. Enhanced care in care homes	Three	Provide joined up health and care to residents of care homes via a range of in-reach services
13. Urgent care strategy	Four	Access to urgent care that meets the needs of local people in the right place and at the right time

The transformation of care and support services		
Transformation projects	**Programme**	**Objective**
14. Delivery of the mental health strategy	Two	Implement the requirements set out in the NHS Long term Plan and Mental Health Forward view
15. Review of Section 117 packages of care	Two	Review policy to ensure plans promote service users independence, recovery and contribute to sustainability
16. Alternatives to hospital care for older people with mental health needs	Two	Ensure appropriate services are in place to support people with dementia and or functional illnesses
17. Care packages	Three	Improve patient experience and performance of NHS Continuing Healthcare (CHC) assessment and decision making process
18. CABIS review	Three	Develop a cost effective specialist community rehabilitation service for people with acquired brain injury
19. Alternatives to detention	Two	Ensure appropriate use of the Mental Health Act in detentions
20. Transforming community equipment services	Three	Ensure the delivery of sustainable care equipment services including wheelchairs

Enabled by:			
Integrated commissioning	Digital and technology	Estates	Quality
Communications and engagement	Finance	Business intelligence and performance	Transformation and reform

Enablers to support delivery

To support delivery of our operational plan there are a number of important transformational enablers including:

Workforce and organisational development

Our workforce is our most important asset and we recognise staff have a wealth of experience, knowledge and often the best ideas to make positive change happen. The views of staff are essential to our plans and we will involve them throughout our work, ensuring clinical leadership and expertise are the driving force for the way we do business and transform services in the community. A workforce group has been established with key objectives to:

- promote the development of a system leadership culture and place-based integrated working
- develop workforce plans to include recruitment and retention, introduction of new roles, upskilling of existing roles and opportunities for improved productivity
- ensure the delivery of national workforce priorities
- promote and provide an excellent learning environment and create a reputation where Sunderland is recognised as a great place to work aiding recruitment and retention

Digital and technology

At every opportunity we will consider how digital advances can support our transformation plans and, in particular, how technology can better empower people to stay in control of their care, treatment and overall health and wellbeing.

We want to maximise digital opportunities to enable greater choice on how people access help and support whilst still maintaining equality for those not ready or able to take advantage of these new methods. We also want to drive forward ambitious plans to enable more vital information sharing across different providers to support improved clinical decision making within a robust information governance environment.

Communication and engagement

We are committed to meaningful engagement and timely involvement of staff and key stakeholders. We recognise we need to empower people in Sunderland to better manage their own health and support our health and care staff to have conversations that help people to make decisions that are right for them.

Providing our local communities with timely and accurate information and involving them in discussions about developments in their services will ultimately help us achieve our vision of 'Better health and care for Sunderland'.

To achieve this, a comprehensive communication and engagement strategy has been developed to help us reshape care by listening to how we can improve services to better meet the needs of our local population.

Measuring success

Patients and the public are entitled to know how ATB is performing and we are fully committed to transparency and regular reporting.

During 2019/20 we will introduce a robust outcomes framework to measure our progress and performance against key priorities and the agreed ambitions which we have set ourselves as a health and care system. The two key measures which will act as the touchstones of success across all ATB partners are:

- direct feedback from patients and their families
- feedback from our wider workforce and stakeholders.

The priorities outlined in this operational plan are the first key steps for ATB in creating truly person-centred, proactive and co-ordinated community care across the City of Sunderland. We look forward to updating all stakeholders as we embark on this journey together, as a collective health and care system, to embed our new approach and ways of working to transform out of hospital services.

NHS

Health and care partners working together.

Sunderland Care and Support (SCAS) // Sunderland City Council //
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