Enhanced Care in Care Homes
Sunderland

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All Together Better
Better Health and Care for Sunderland.

Penny Davison
Senior Commissioning Manager
Implementing a proactive and integrated model of care to enable care home staff to better meet residents’ care needs

Establishing a multi-disciplinary team with primary care as the foundation, supplemented by a range of allied care professionals

Working in partnership with care home staff to deliver proactive, person centred care and to support residents and their families to engage in decision making about their future care needs
• Care Home Pilot Nov 13- March 15

• Proactive approach to care
• Patient centred involving residents and their families in decisions
• Integrated way of working
• Built on primary care with a range of allied health professionals
• Partnership with care homes
• Shared information
• **Outcomes**

- Reduction in emergency admissions and A&E attendances
- Significant reduction in out of hours callouts and GP callouts
- Improvements in patient experience and satisfaction
- Communication has vastly improved
- Improvements in clinical effectiveness and patient safety
- Reduction in admissions for foot ulcers
- Pharmacy contribution – improved patient safety and saving money
- An increase in the number of people supported to die in their preferred place
• Emergency Admissions

- Emergency admission rates fell from an average of 36 per month to an average of 20 per month
- 45% reduction
- Full year financial impact of £480k saving
- 31% reduction across the rest of the city
A & E

Accident and Emergency rates fell from an average of 56 per month to an average of 31 per month

45% reduction

Full year financial impact of £27k saving

29% reduction across the rest of the city
The Care Model

Community Resources and Resilience:
- Robust Health and Wellbeing Strategies – Health Promotion; Self-Management; Leisure; Recreation; Meaningful Occupation; Housing, including extra care; Strong Voluntary Sector; Faith organisations

Enhancing Primary Care:
- Patients who will benefit from better coordinated care and enhanced long-term condition management, including self-management

Elderly Frail / High Risk Population:
- High risk patients who will benefit from multi-disciplinary person-centred coordinated care. Comprehensive care plans including risk management planning

City-wide Multi-Agency Resource Hub:
- Providing alternative to hospital admission. Supporting individuals to recover from illness or crisis and to regain independence in their own home or as close to home as possible.
- Facilitating discharge for individuals who have to be admitted, ensuring their stay is no longer than necessary.
- Preventing unnecessary admission into long term residential or nursing care.
- Reducing the requirement for an ongoing social care package of support

North Locality Practices
- Risk Stratification
- North Integrated Teams

West Locality Practices
- Community Connectors
- West Integrated Teams

East Locality Practices
- Community Connectors
- East Integrated Teams

Washington Locality Practices
- Self Management
- Washington Integrated Teams

Coalfields Locality Practices
- Self Management
- Coalfields Integrated Teams

Urgent Care Centres
- 111 / 999 Urgent Response; Triage; Navigation to appropriate response

Recovery at Home Service
- Community Integrated Recovery at Home
- Telecare and Community Equipment
- Therapies
- 24 hour Single Point of Access – the Intermediate Care Hub

Ambulatory Emergency Care
- Hospital

GP Out of Hours Co-located with Recovery at Home Service

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• How does the Out of Hospital Model support Care homes?

- MDT working
- Care Home Nurses
- GP Input and Alignment
- Co - Location of Staff
- Community Pharmacy
How does the Out of Hospital Model support Care homes?

- Community Geriatrician
- Telehealth
- My Home Life programme
- Recovery at Home
- My Care Passport
Performance

Emergency Healthcare Plans/Health and Social Care Plans

- Currently 1.61% of the population with a care plan coded in Primary Care
• Useful web resources from Vanguard site

http://www.atbsunderland.org.uk/information-for-staff/posters-leaflets-factsheets-info/


Contact details and question time?

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