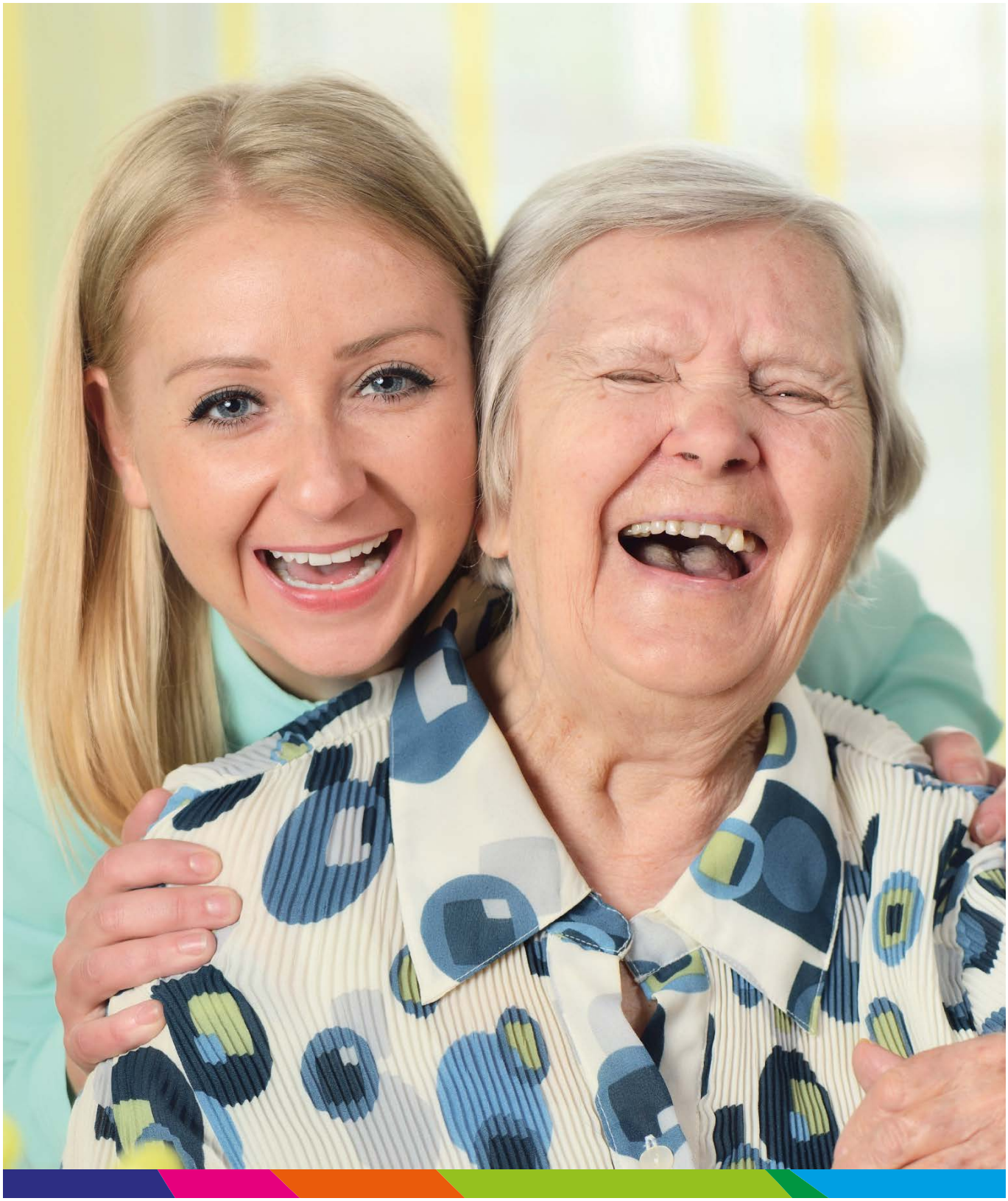
Living Well Links
Evaluation Report

July 2016

Sunderland age UK



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Report conducted by Dr. Paul Andrew of Paul Andrew Consultancy.

The Context

This report will evaluate the impact of the Living Well Link (LWL) Service in Sunderland. The LWL workers became operational during the final quarter of 2015 and introduced evaluation tools that measured their impact with service users. The first period that can be examined as a result of the data gathered covers the opening three calendar months of 2016, from 1st January to 31st March. The evaluation of the outcomes can help inform the development of the LWL Service moving forward.

From April 2015, NHS England has been working with 50 'vanguard' areas to accelerate change on new models of care delivery. The first wave of 29 vanguard sites, within three strands - integrated primary and acute care systems; enhanced health in care homes; and multispecialty community provider vanguards, target people with long-term health conditions. The intention is to transform care out of hospital with a more person-centred approach, delivered by a greater integration of services between health and social care professionals. This will give local people, and their carers, a seamless service when they need it most, by wrapping services and care around an individual depending on their needs.

Sunderland was one of three vanguard sites to be selected in the North East, and the only multispecialty community providers care model. The Vanguard programme in Sunderland has been branded as All Together Better, a part of All Together Sunderland, the locally recognised overarching brand for community activity. It is an innovative programme that brings together health and social care teams, as well as the voluntary sector, to create a new way of delivering care to some of the most debilitated people in Sunderland.

Sunderland's population is ageing, and in terms of health the older patient population presents particular pressures for NHS funding. The Frail Elder (65 and over with two or more comorbidities) and Patients with Long Term Health Condition groups together represent over 5,000 people who have varied and complex needs. 3% of this group drive 50% of NHS costs (excluding social care) in the city.

Particularly for those with long term, multiple or complex health needs, the aim is for people to have a better experience of care and to live life as fully as possible, whilst living in their own homes. The increased integration of services and more person-centred care also means a greater number of services being provided out of hospital.

The Sunderland Clinical Commissioning Group (CCG), City Council and local providers have formed a representative Provider Board to oversee the mobilisation of these integrative changes. The three key strategic projects within the programme are:

Recovery at Home

This service aims to deliver a single point of contact for patients and professionals, with appropriate nursing and social care teams being based centrally. It supports people's recovery after discharge from hospital and prevents future emergency admissions. Support is tailored to a person's needs when they have short-term health or social care support requirements. It can be any combination of a short-term package, from nursing to therapy, to get them back on their feet without having to be hospitalised or needing long-term care. Those who need greater support while getting back to normal can also be provided with bed-based care, meaning more intensive support can be offered in their own home, including residential or nursing care homes. People are given all the support and advice they need to get them ready to return home and live independently.

Enhanced Primary Care

This involves greater support for local GP practices to work more autonomously to provide enhanced care, above the normal agreed GP strategy. Enhanced Primary Care is targeted towards people who have one or more long-term health condition, but who are not counted among the frailest in the city. Representatives from many GP practices are working to redesign care for these people, looking at how they can deliver the best possible level of care, while also ensuring it is delivered in the most efficient way possible.

Community Integrated Teams (CITs)

These bring together district nurses, community matrons, social workers, GPs, Age UK Sunderland (AUKS) LWL workers and Sunderland Carers' Centre workers into Multi-Disciplinary Teams (MDTs) for each of the city's five localities. Based at Bunny Hill, Hendon, Houghton, Grindon and Washington, and linked to clusters of GP practices, care is provided in a more coordinated, planned and proactive way, particularly for the most complex patients at risk of avoidable emergency admissions.

Sunderland CCG and partners have identified that these patients would benefit from a person-centred co-ordinated care model. In addition, the top 3% of frail patients would benefit from a pro-active multi-disciplinary model of care.

The CITs are creating holistic health care plans with patients and carers, tailored to the individual, and supported by their own GP, who will lead clinical decision-making to ensure that the medical, social and emotional needs of their patients are taken into account. The LWL service fits directly into these new integrated models of care and support.

The Living Well Link Service

The LWL Service works alongside and is part of the CITs, becoming fully established within MDT structures towards the end of the 2015.

The LWL team work to support those frail and often elderly people who:

- Are usually over 65 years old
- Have two or more complex health conditions
- Face social challenges as a result of their health, such as not knowing their benefit entitlements or struggling to get out of their house.

Operating city wide, the LWL team was recruited and in place by September 2015, for a 18-month period with a total contract value of £247,026 until February 2017. The composition of the team consists of 5 LWL Workers, with one of these being a Senior worker who manages the team and liaises with the Age UK Sunderland (AUKS) Senior Management Team (SMT). There is a dedicated LWL worker in each CIT, linking people to the services in the community that can improve their health and well-being and support them to live as independently as possible. Experienced AUKS volunteers support the sustainability and community elements of the service.

The purpose of the LWL Service is to put people in personal control of their health and to provide them with integrated care and support in their local community, by focusing on preventing ill-health and promoting well-being. This allows people to be more independent, whilst easing the resource and financial burdens on NHS Services, by reducing GP visits, Out of Hours Contacts and Emergency Admissions. The LWL Service delivers a flexible, person-centred social care approach that complements the clinical and social care provided by the CITs.

LWL workers visit people in their homes, care homes and other community settings. They work directly with patients, their carers and families to plan non-medical support that is based on the goals most important to them. LWL workers offer a first point of contact for people, to provide on-going support so that they are equipped to engage with mainstream services and do not automatically look for medical or social care when they may not need it. An important part of their work is to support individuals to regain social contact, avoiding loneliness and the associated health and well-being risks being isolated can cause.

The LWL team provides practical support, referring people to relevant community and professional agencies and helping them to self-manage their own needs in a range of ways. These include:

- **Assisted signposting** to services in the community which will help maintain their health and well-being such as leisure and learning, social groups and events.
- **One to One Support** to help with issues such as arranging medical, social care and other appointments, such as linking people with housing or benefits officers; and ensuring that support is put in place to help with domestic tasks for example cleaning or shopping.
- **Social Contact** to access support from befriending and many other Voluntary and Community Sector (VCS) services for those who live alone and may get lonely.
- **Interim support** to help people whilst other support is put in place, such as visits from a volunteer for companionship and support.

With clinical and social health care professionals responding to primary service user needs on a daily basis, it is unsurprising that gaps in community and social support can arise. Indeed, these gaps can occur at key moments for service users, at times when they may be less in need of direct clinical care but significantly in need of additional social support and signposting in order to better manage their own health. The voluntary sector's involvement can act as a bridge that can deliver continuity of support and encourage empowerment. This can in turn enhance the relationships between the statutory, private and voluntary sectors, and the interactions with their communities.

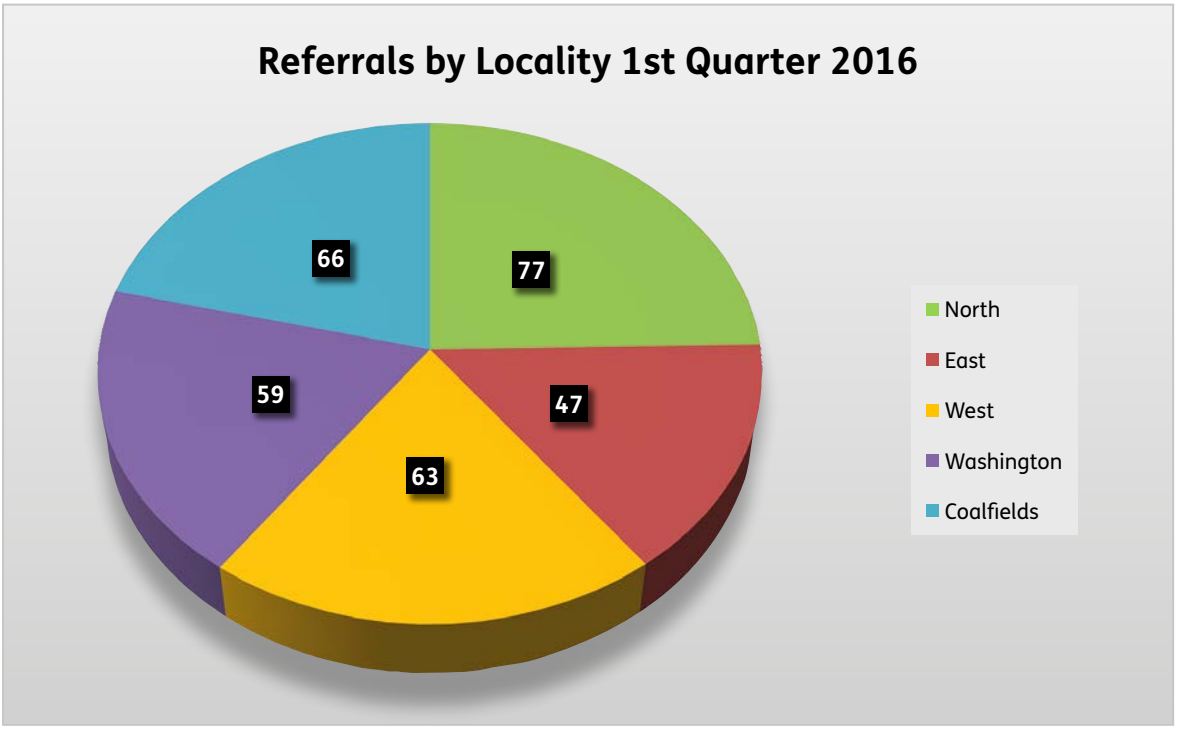
With the effective integrated working of LWL workers, CIT colleagues and partners, providers will be better equipped to identify gaps in local community provision for patients. This will help to address any associated capacity issues, and develop systems to ensure that patients receive support that is relevant to their circumstances. This is in line with the aim of the LWL service, of delivering improved health, maintaining quality of life and preventing future crisis through structured social support, and thereby avoiding expensive NHS interventions and social care options.

The working arrangements of the LWL service operating as part of the CIT's will continue into February 2017. The first operating quarter of 2016, 1st January to 31st March, provides the opportunity to evaluate progress to date, with findings outlined below.

The Outcomes

Project Brief Commitments and the Evaluation Approach

Referrals into the LWL service are received in each of the five localities via the MDT using the Risk Stratification tool. and through clinical judgement. The Project Brief of the LWL Service outlined a projected caseload of 1,035 patients in year one. This equates to 279 people being supported over the first three calendar months of 2016. This target was exceeded, with a total of 312 service users supported across the city. 1225 support interventions, or contacts, were made with the 312 service users over this period.



This evaluation of the LWL Service was tasked to measure the impact against the five following patient benefits and outcomes as set out in the service specification:

1. **Improved wellbeing and confidence to tackle health conditions.**
2. **Independence, choice and control over their health and wellbeing.**
3. **Improved social interactions within their local community.**
4. **Improved understanding of what support is available to them in their local community and from health and social care services.**
5. **A support network accessible and dedicated to their specific needs.**

During the period of LWL support, an initial meeting between the service user and the LWL worker uses the AUKS LWL assessment and enablement plan to agree realistic goals and expectations, to ensure that the service is tailored and person-centred to each service user's needs.

A Star Outcome measuring tool is then used to enable service users to score themselves against the five target outcomes, with a score of 1 being the worst it could be, and a score of 5 being the best. The forms are completed twice; at the beginning of the support and at the end of the intervention, which is typically a period of up to 12 weeks. It has delivered an effective and easy to use measurement of developments, allowing staff and the service users themselves to monitor progress towards outcomes.

During the period of evaluation, 52 individuals completed their measurement forms against the target outcomes both at the beginning and at the end of the interventions. These responses will be used to inform the findings outlined.

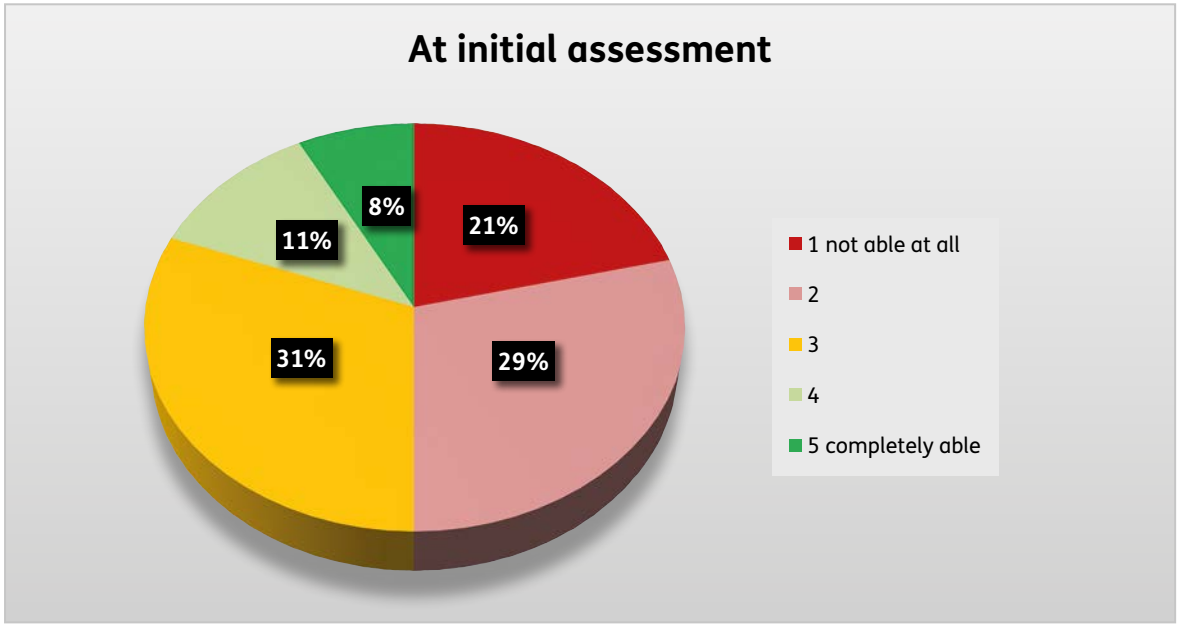
Case studies from patients, carers and health professionals have also captured a qualitative narrative of the patient journey through the LWL Service.

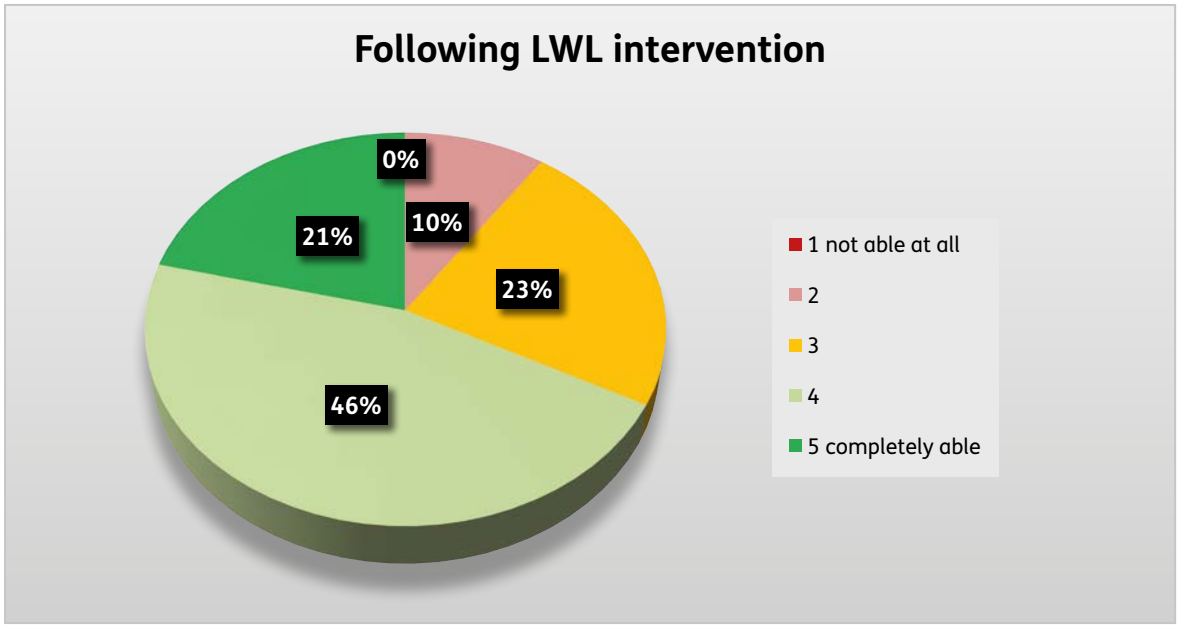
Findings

The outcomes from the first quarter of 2016, 1st January to 31st March, are as follows:

❶ Improved Wellbeing and Confidence to Tackle Health Conditions.

This explores the person's levels of confidence and wellbeing, and his or her perception of being able to manage health conditions. Service users showed a significant improvement in their wellbeing and confidence following support from their LWL worker. The charts demonstrate that lower scores (low wellbeing) decreased, and that higher scores (higher wellbeing) increased, following the LWL intervention.



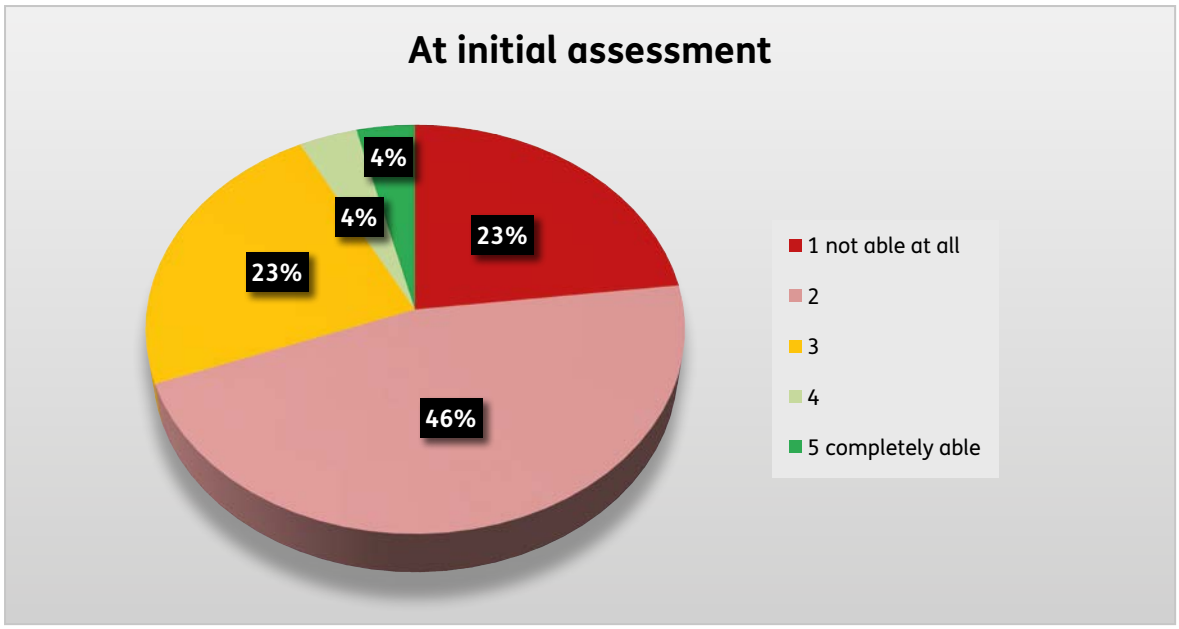


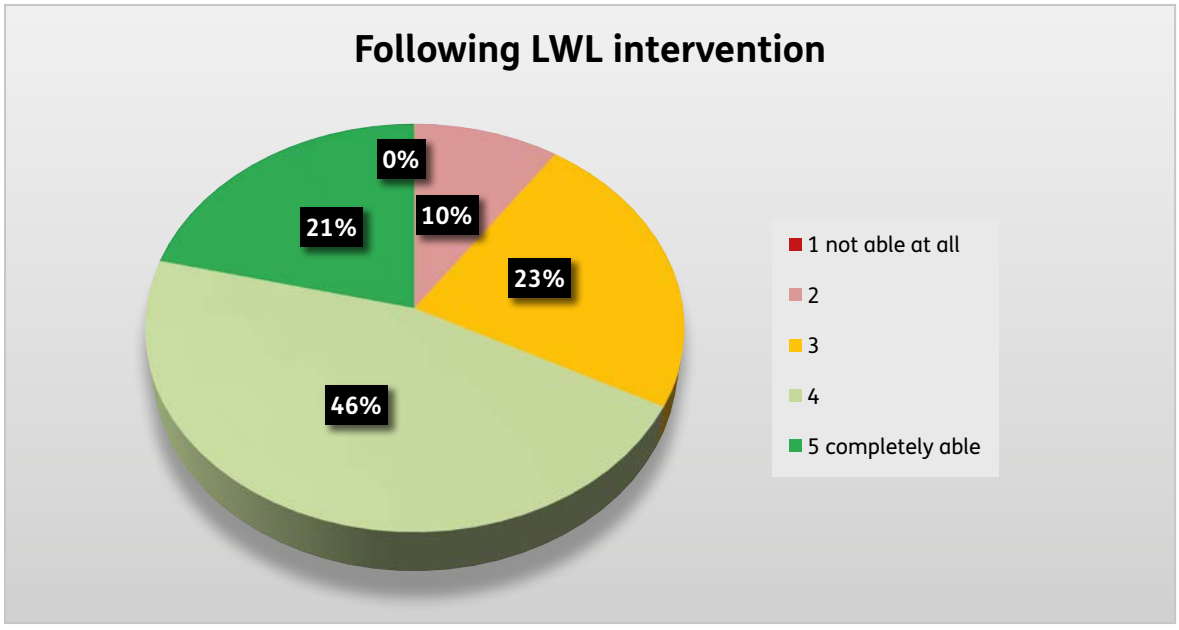
Mrs. B, *84, lives alone. She has asthma and COPD, and was recently discharged from the stroke team after her symptoms improved. She was referred to the LWL service from an MDT meeting as her GP identified her as at risk of social isolation and loneliness. After some wariness from Mrs. B, visits from the LWL worker led to her enjoying assisted shopping visits and gradually becoming more confident. She now engages in social keep fit activities and has made fresh connections with old and new friends.*

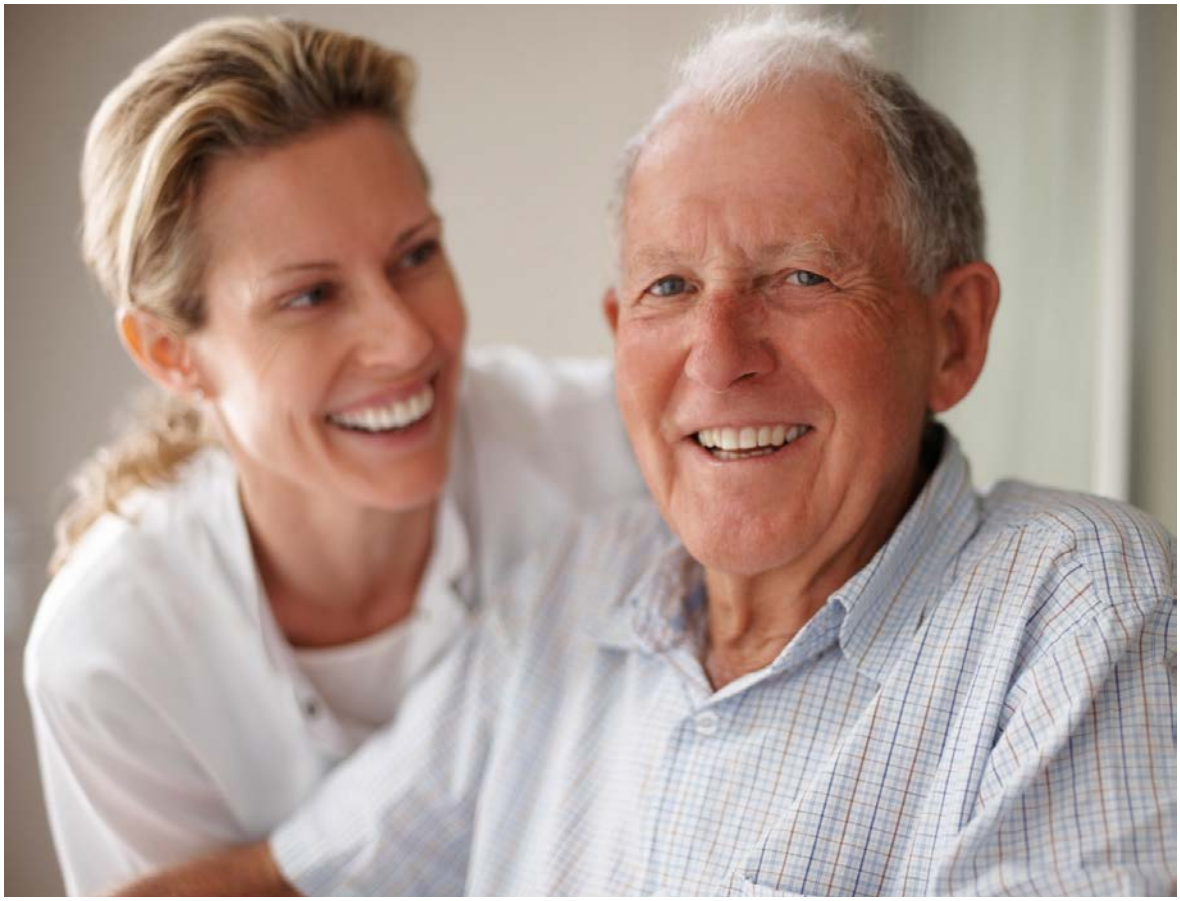
Mr. H, *80, lives alone. He has breathing difficulties, arthritis and diabetes. He uses a mobility scooter and wheelchair. Although his daughter visits regularly to help with cleaning, he is isolated and lonely. The LWL worker linked him up initially to AUKS befriending services, which then led to him attending AUKS Activage music sessions, where he has made new friends. His increased levels of confidence have also encouraged him to go out more on his own, and to become more aware of the opportunities around him.*

❷ Independence, Choice and Control over their Health and Wellbeing

This refers to the individual's ability to live an independent life, understand the choices available, and feel in control of their own health and wellbeing. Service users indicated higher levels of empowerment after the LWL intervention.







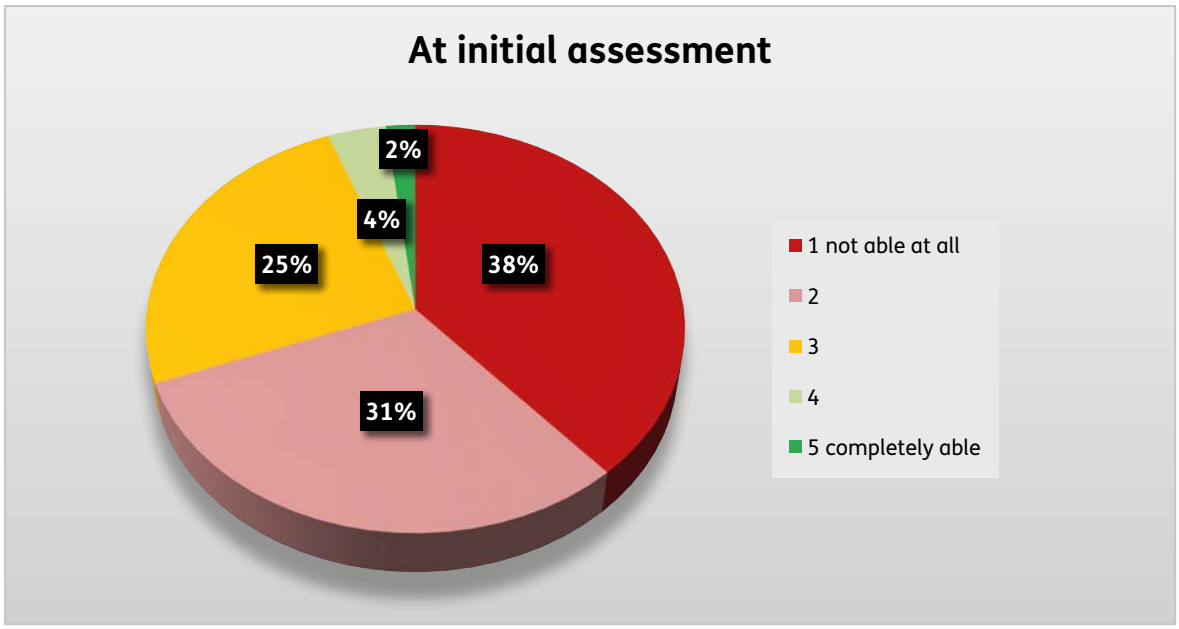
"I feel extremely happy with the service I received from the LWL worker. It has helped me to retain my independence in my own home and within my local community." ***(Anon).***

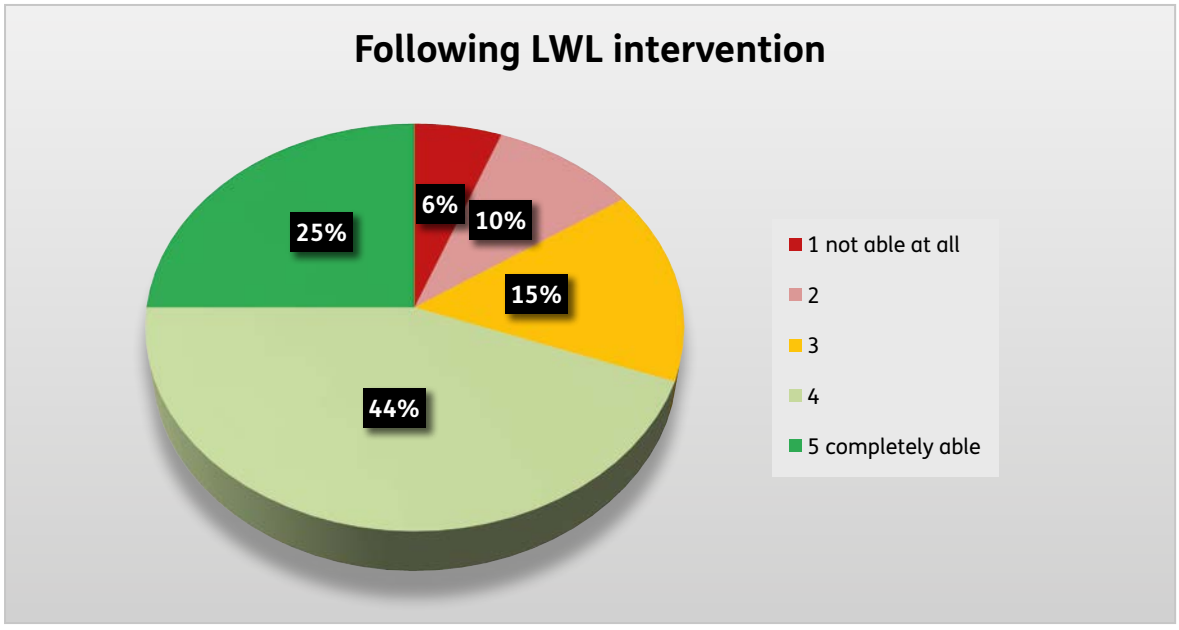
Tony*, 67, is a wheelchair user with cerebral palsy and arthritis. Despite personal hygiene support from carers, he was socially isolated. The LWL Co-ordinator arranged for support from an AUKS lifestyle worker, who takes him for lunch and coffee each week. He also now has Care Messenger installed in his home, to keep in touch with his family and carers via his TV.*

"I appreciate the support and look forward to my weekly outing with the Lifestyle worker."

❸ Improved Social Interactions within their Local Community

This examines individuals' perceptions of their connectivity with the community around them. It could include activities they are engaged in, people they speak to and the contribution they make. Although some challenges were still evident on social engagement with the local community, service users confirmed significant levels of improvement.



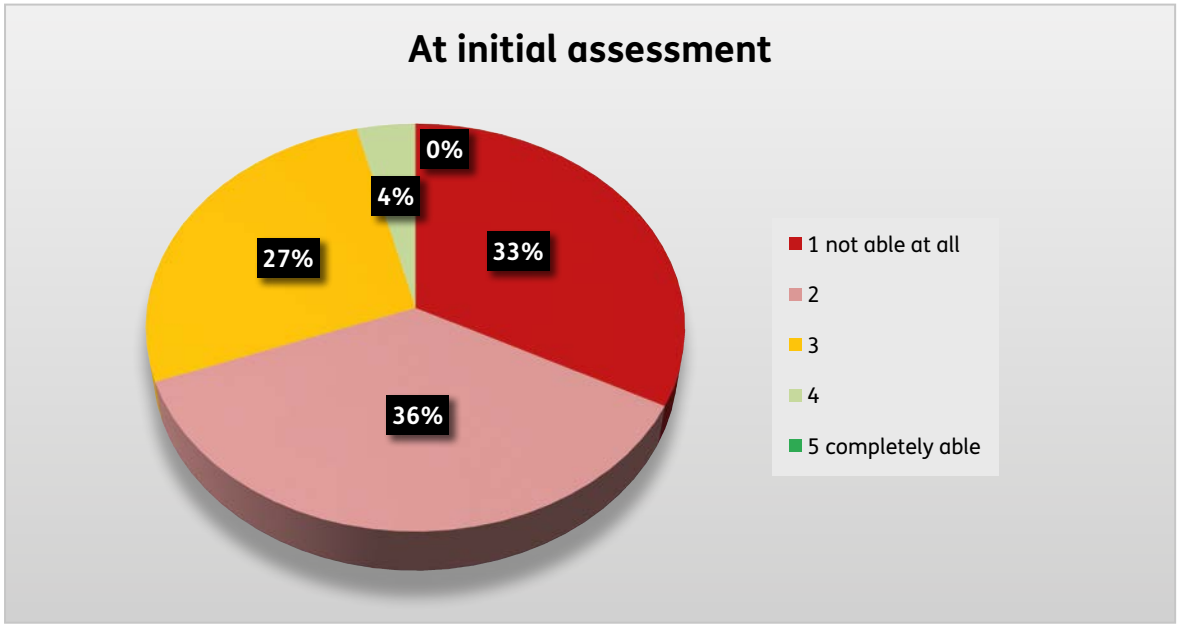


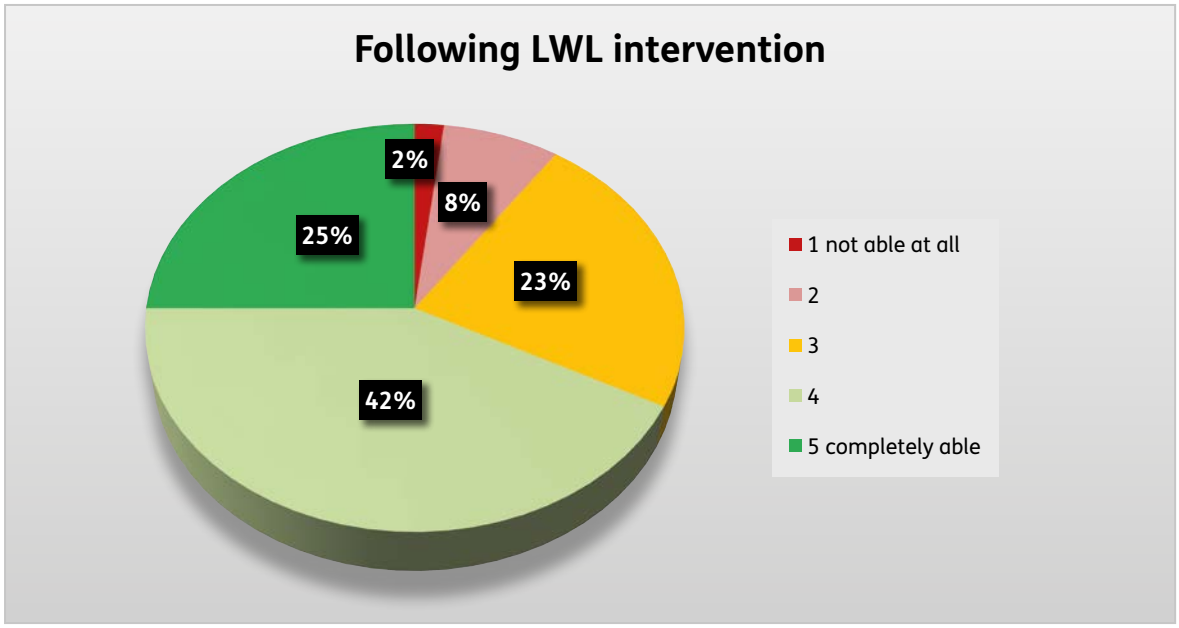
Mrs. S: *"I've loved meeting people my own age, I feel more confident."*

Marj*, 89, has a number of long-term conditions, including COPD, and lives with her son. He is the main carer who carries out domestic and personal needs. She was isolated and they felt that they would both benefit from personal time. After meeting the LWL worker, Marj now receives her proper benefit entitlements, has additional personal carers and attends an AUKS Day Care. She is laughing again and, as her son says of the Day Care: "Mam loves it, she is always very happy on a Tuesday."*

❹ Improved Understanding of what Support is available to them in their Local Community and from Health and Social Care Services

This is about the person's understanding of the support available in terms of health, social, voluntary and community services. This may involve planning positively for the future and having a sense of engaging with it. This is an area that demonstrated very low levels of understanding prior to the LWL involvement. The ability of LWL workers to signpost service users and connect them to relevant services resulted in greatly improved awareness of available support.



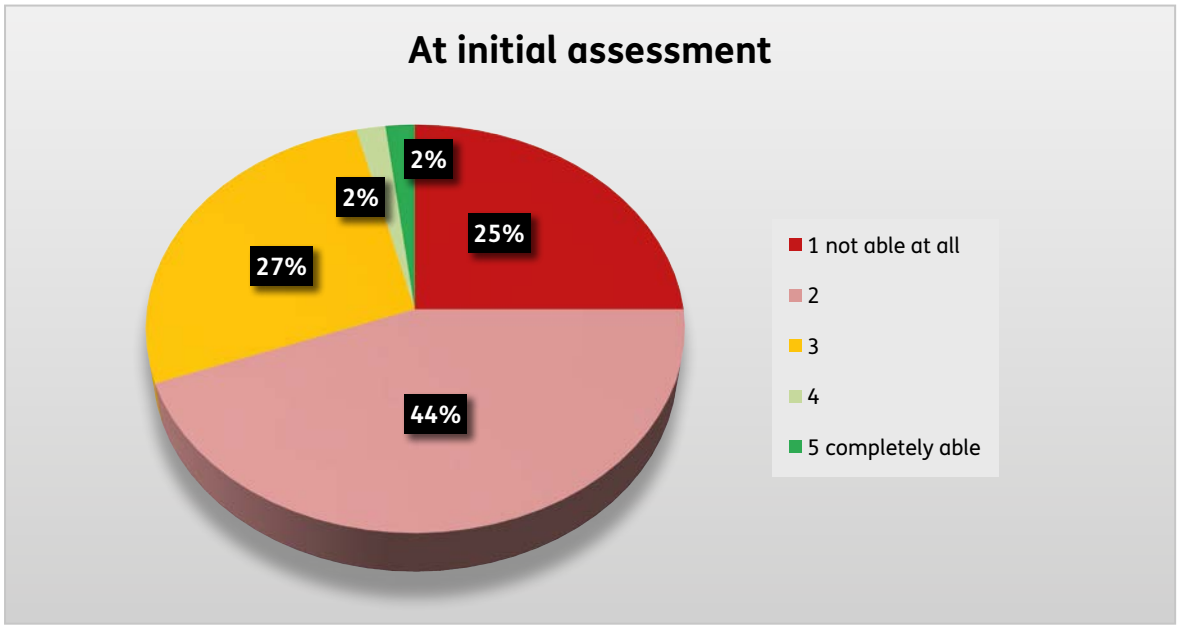


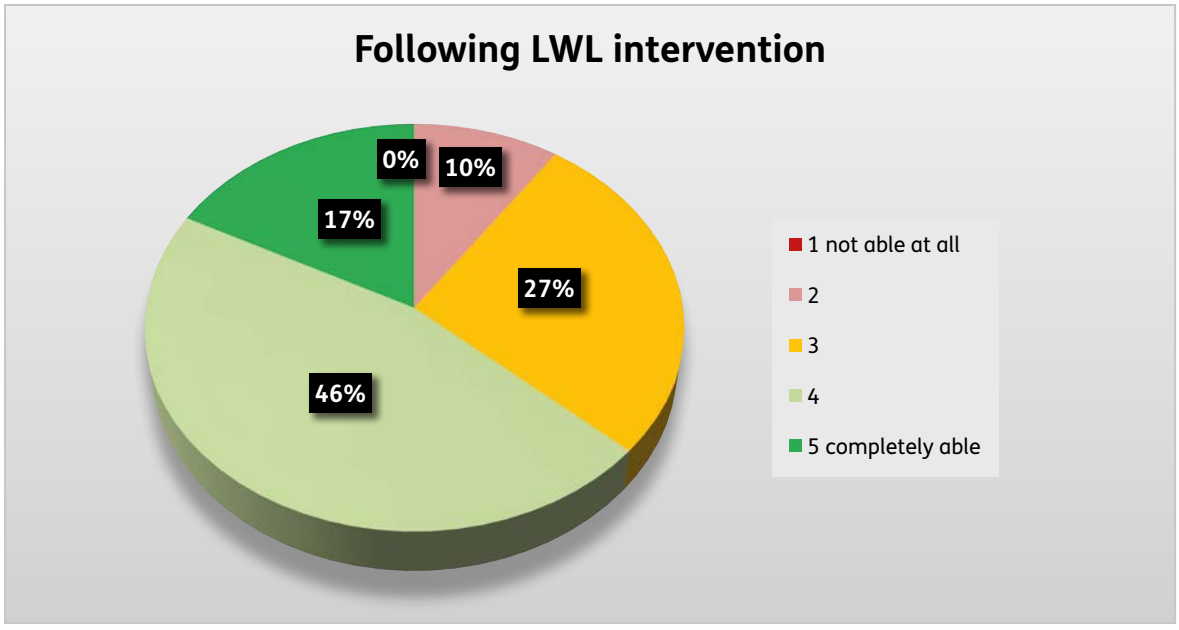
"My Mam was new to the area so we weren't aware of the help we could get or what was there. Now we are." ***(Anon)***

K*, a 76 year-old man, has long-term conditions that include heart failure, diabetes, COPD, and prostate cancer. A recent stroke left him with a right-sided weakness. He rarely went out, living at home with his wife, who is his carer but who also has long-term conditions. The LWL worker supported K and his wife, linking him up to day centres that have given him social contact and his wife some respite. They are also now more aware of their welfare entitlements and feel that they have stronger networks and less sense of isolation.*

❺ A support network accessible and dedicated to their specific needs

This measures how people feel about their accessibility to support within their own communities, and how they easily can access a support network that is dedicated to their specific needs. Once more, service users indicated that they felt more connected and confident following the LWL intervention.





"I cannot thank you enough for the support you have provided for my mother. I have been extremely worried about her as she has refused the help from other services. You have done what others have been unable to do and I am extremely grateful for that." ***(Anon)***

Mrs. T*, "You have helped me so much since my husband died. After being married 56 years I did not know which way to turn. You have done all sorts and have been there on the end of the telephone when I have needed someone to listen to me". After an LWL assessment and two home visits with her Social Worker, Mrs T now receives home care calls during the day and attends a lunch and Day Club. Support has also been put in place for help with documentation following her husband's death.*

The service users supported by the LWL workers have by definition complex health conditions. In many cases therefore, a prevention of the continued deterioration of their health, which would be indicated by a levelling of these scores, would itself be an achievement.

The marked improvements of these service user self-assessment ratings across all five outcomes demonstrate the impact of the LWL worker interventions. They provide a measurable indication of how positively their contributions have been received by those they have supported.

The Feedback

All service users who are supported by LWL are also encouraged to complete a feedback form on the service they receive. In this evaluation, the feedback forms of the 52 service users who had completed both measurement forms at the beginning and end of their interventions are outlined below, with the results as follows:

Question on LWL Service	Yes %	No %
Were you happy with the support you received from the LWL Team?	100	-
Did the team assist you with referrals/signposting to other services?	100	-
If yes, did you find these services helpful?	100	-
Do you feel the support you received from the LWL team has enabled you to feel more confident about your health conditions?	88	12
Do you feel more connected to your local community as a result of the Living Well Link Service?	87	13
Do you feel the overall time the LWL staff/volunteers spent with you was enough for your needs?	100	-
Have you been admitted/re-admitted to hospital since you received support?	15	85
Do you think the support you received from the team helped you to remain independent?	94	6

Case Studies

The role of the CITs, which include the LWL service, has led to the implementation of health care plans with patients, carers and GPs leading clinical decision-making as an essential part of a proactive, enhanced level of care. Their impact on individuals and on the allocation of resources is illustrated in the following case studies:

Mrs. M,

"In the last few years I was going backwards and forwards into different parts of the hospital. I went in with one thing and was diagnosed with another. I even had an ambulance to pick me up for regular physio.

When Age UK Sunderland came to see me as part of the Community Integrated Team, I was a bit apprehensive. My stomach was going twenty to the dozen but I have got to know everyone and it's been great. I wasn't getting out at all but I now go to seated exercise classes and "knit, stitch and natter", as well as the day clubs. It's something I look forward to, I see the same people every week and I'm more confident.

I'm now not even going to hospital as an outpatient. At the moment all I need is to see the Community Nurse and that's fine. The Community Nurse pops in once a month. He says hello and checks my blood pressure. If something is bothering me I raise it with him.

I wear my telecare bracelet and I can press it for help if I need it. Things are going pretty well."

Brenda,

Brenda, 68, lives alone. She has long-term complex health conditions and received care from the Community Matron from 2014 under the previous way of working. A hospital bed and standard raiser recliner chair were provided, which improved her rest but did not alleviate other situations. She was experiencing physical and mental health challenges, with social isolation and increased hospital admissions.

As a result of the new integrated model, Brenda was identified as suitable to receive support via the CITs. An assessment resulted in Brenda receiving a moulded chair, which addressed posture problems and made a big impact on her daily living conditions. A Community Matron visit triggered changes to Brenda's door locks and key safe, improving her mental wellbeing. District Nurses have visited for skin integrity management and the monitoring of routine bloods.

Brenda was referred to the LWL service, as she was lonely and socially isolated. She agreed to accept support and to access services from AUKS, Sunderland Carers' Centre and Gentoo. AUKS has helped secure appropriate benefits, improving Brenda's living environment and diet. Contact with the AUKS befriending services has boosted her confidence. Brenda's niece is now registered as a carer, improving access to medical support. These community integration interventions have meant that Brenda is in more control of her health and well-being, has a higher level of income to support her needs, feels empowered and is becoming socially integrated with her local community. She has rebuilt a network of friends and maintains telephone contact with friends outside her local area.

The CIT has delivered a co-ordinated response, meeting a vulnerable adult's complex clinical and social needs and preventing previously repeated hospital admissions. Brenda now receives less intervention, having moved from weekly to monthly visits from her community matron due to self-management of health and wellbeing.

Testimonials

In addition to the feedback and case studies from service users, testimonials from health professionals were also gathered as part of the LWL evaluation.

"This work really does have an impact on patient care. On an individual level, I know that patients really appreciate the support and it improves their own and their carers quality of lives. Through the LWL service, they can also access other services that the patient and even their GP would not have been aware of. For patients living alone with little stimulation and day-to-day loneliness, an increase in socialising can make a huge impact. Improving patient's mood and giving them something to live for can subsequently improve their physical health and on a bigger level can reduce crisis and admission to hospital."

GP.

"There are people who've been discharged from hospital and still have needs and the LWL worker helps them recover. As a result, they don't need my help but are not left unsupported when they are back home. I'm sure it helps them get on their feet and helps to stop them being readmitted in the longer term."

Alison, Community Matron.

"Our LWL worker has been a great asset to the team. Her knowledge on local services is exceptional. She has worked to prevent social isolation, which has improved the health and well-being of several patients."

Louise, District Nursing Sister.

"Having the LWL worker based within our team has been very beneficial. She has a great knowledge of services available with the local community. She has been very proactive in helping service users access services and very helpful in supporting the team to work well together as an integrated service for customers. The new way of working within a CIT is positive as we are all based together, it produces quick answers. This is providing better outcomes all round."

Debra Johnson, Social Worker.

"She [the LWL] has become an invaluable member of the CIT. She is visible and offers guidance on services to our team as well as to our patients. The patients she has worked with are very happy with her interventions".

District Nurse.

"Some of my patients have highly complex health and social care needs. The support and knowledge of the LWL worker is invaluable. It is producing good team working and helping to deliver good outcomes for our patients. Their feedback is very positive and there appears to be significant benefits for the wellbeing of individuals who have been supported."

Deborah Porter, Community Matron.

"The LWL co-ordinator is really helping our integrated working. She helps with the team's knowledge and makes a real difference to service users. For example, the support she gave to an elderly man, who was in the rehabilitation unit following a hospital stay, meant that he was happy to be discharged, freeing up a bed. He rebuilt his confidence and is totally independent again. Another outcome was that my own input was no longer required."

Karen Turner, Social Worker.

"Some people are lonely and isolated, situations that can be more than clinical needs. This is where the LWL worker comes in, befriending, signposting and accessing services. It is giving people an interest in life again. The integration is working well in the centres. As a result of MDT discussions, the LWL worker will take referred service users. She makes a difference to patients, as well as keeping us informed as to their wellbeing. I think we are more joined up. We are aware of individuals' progress and it's better for patients. They are not falling through a gap; someone always has responsibility for them. It's helping to turn people around."

Claire Curtis, MDT coordinator.

"I have been pleasantly surprised about the Living Well Link workers, they have added an enormous and unexpected amount to the MDTs and they are proving to be an invaluable support to patients. They have offered a 'soft' and non-clinical aspect to the patients' care that has often been ignored in the past but actually sometimes turns out to be as important as the clinical issues. I believe their role is of vital importance to the success of the Integrated teams and Vanguard."

Dr Jane Halpin.

"As a community matron I deliver a clinical service. Our LWL worker provides a holistic approach alongside the team. I feel she has made a huge difference, her widespread knowledge of community services and links are invaluable. It has changed patients' lives, involving them in social and community activities."

Community Matron.

The Impact on Resources

We have seen that the LWL workers are empowering service users to take more control over their health and to be become more connected with their communities. They achieve this by spending time working with individuals to focus on outcomes that will improve their lives, and delivering tailored support via existing networks, whether from volunteers, local services or by liaising with MDT colleagues. An associated effect of this empowerment is to make service users less dependent upon health professionals.

> "The LWL worker has created a sense of purpose for my client and helped him to meet new people. This in turn has improved his mental health and wellbeing. He is now better linked up and makes more of his own decisions."
>
> ***Ami, Social Worker.***

There is also confirmation from the testimonials that the MDT's are delivering better person-centred care and that the LWL workers are contributing to the effective use of resources within these teams. Colleagues are aware of each other's roles, whether clinical or pastoral, and can work to their strengths in a manner that benefits patient outcomes.

> "The LWL worker is taking some of the strain off me, so that I can specialise more on clinical need."
>
> ***Alison, Community Matron.***

These factors would lead us to assume that the levels of hospital admissions and GP appointments from the group of service users supported will reduce in the shorter and longer terms. The average cost of an overnight hospital stay is estimated to be £694 (Sunderland CCG, 2016) and a GP home visit to be £90 (Unit Costs of Health and Social Care, 2015). Identifying the financial impact can however be difficult as it inevitably involves assumptions about service users who by definition have complex health issues.

We are in the early stages of the implementation of the LWL service and their integration into the MDTs. With structures not being properly established until the final three months of 2015, the first three calendar months of 2016 have offered the first opportunity over which to begin to quantify impact.

Integrated working and co-location is still in its infancy, but it is already clear from this short period of evaluation that the LWL service has become integral to the work of the CITs. The LWL workers are not only a valuable part of the joint working between colleagues that is saving time, increasing shared information, and delivering efficiencies. The contribution of the LWL service is also bringing direct benefits to service users themselves, enabling them to remain safely and confidently at home, in an environment where they are less physically isolated and better socially connected.

Looking ahead, the CITs in Sunderland are tasked with helping to deliver reduced emergency admissions and re-admissions by 14% by 2019; improved health-related quality of life for people with long-term conditions by 7.2% by 2019; reduced years of life lost by 7% by 2019; and improved diagnosis of dementia from 62% to 68% by 2016. The early indications are that the achieving of these targets can be supported by the LWL service, through their empowering of patients, their contribution to integrated working, and their encouragement of better two-way relationship between individuals and service providers.

Conclusions

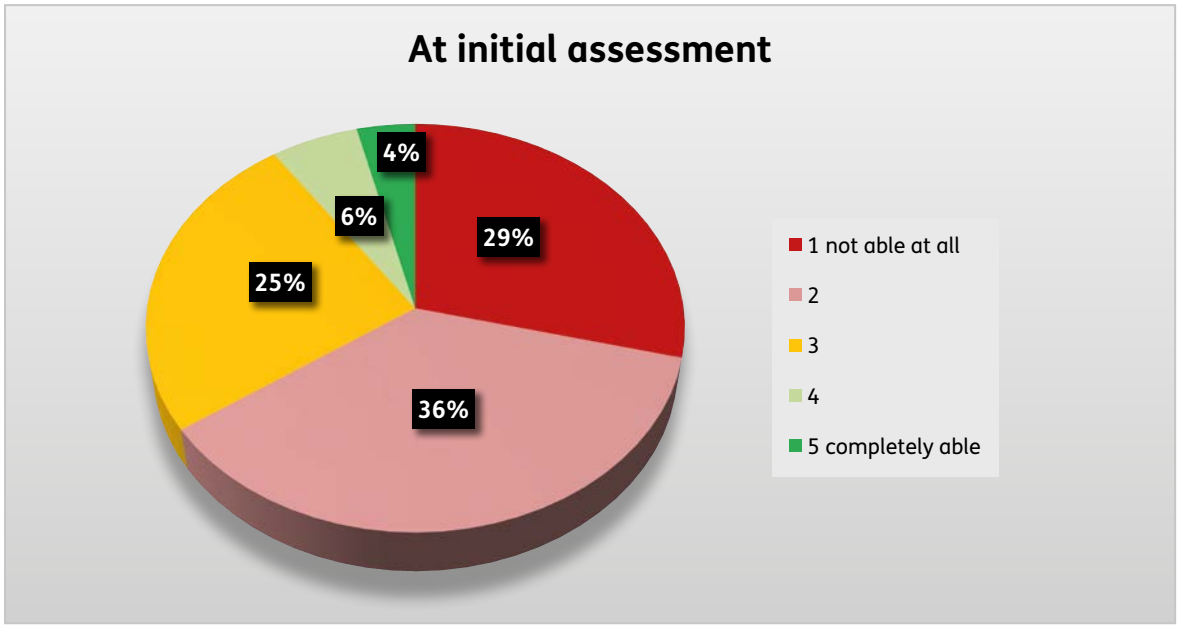
Social and Business Benefits

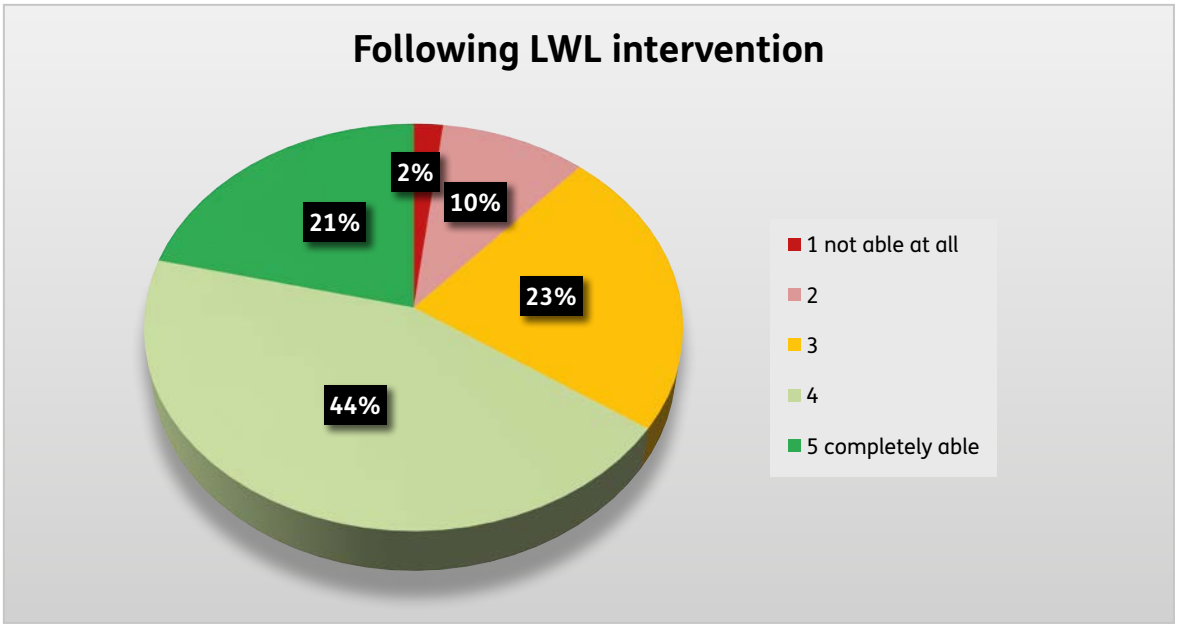
It is evident that the LWL service is currently well on track in terms of meeting the targets of the total numbers of patients supported per year. It is also clear that patient feedback on the quality of the service they have received is extremely favourable.

In terms of the impact of the LWL service on the five patient benefits and outcomes as set out in the service specification, the findings from service users have revealed significant improvements in all the areas measured, following the interventions of the LWL workers.

These areas examined levels of wellbeing, independence, social interactions, understanding of support and accessibility of networks. The traffic light pie charts show the service users collectively moving from scores of 1 (not able at all) towards 5 (completely able), and can be summarised collectively:

Summary of Ratings Against the Five Patient Benefits and Outcomes





The LWL team is proving to be an effective and successful conduit in terms of CIT colleagues being able to focus on their clinical, professional or pastoral skills, whilst delivering tailored support to improve wellbeing.

The managing of resource capacity is a challenge whenever VCS services are being delivered, particularly if awareness and expectations are heightened concerning available support in the local communities. The LWL team constantly monitor demand for support services and, with their access to volunteers and wider existing networks, can use innovative methods in ensuring that service users remain connected and supported until other relevant capacity becomes available. This is helping CIT colleagues and partners to ensure that the services being signposted have the capacity to respond effectively to the level of demand.

The heightened awareness of the LWL workers of any gaps in community service delivery is valuable intelligence and can contribute to future considerations on VCS/ community service provision and commissioning opportunities, as service providers continue to seek a realistic balance between expectations and achievable outcomes.

In the shorter term, evidence suggests that the interventions with service users by LWL workers not only facilitate relevant support but also deliver in themselves a powerful positive influence on patient motivation and morale. The continued strengthening of integration and knowledge-sharing in the CITs can maximise the benefits to both service users and to the CCG.

For the CCG, the LWL service represents a mechanism in which the voluntary sector can deliver a defined role within strategic plans and, in doing so, contribute towards cost and resource saving targets. For Sunderland City Council, the service contributes towards meeting key health targets, works towards greater inclusion of all communities in the wellbeing agenda, and helps deliver the efficient use of staffing resources.

For the service users supported, the LWL team is offering a helping hand to people living with some of the most complex health problems, securing the support required for patients to retain as much independence as possible. The service is ensuring that people gain access to practical support and activities to improve their daily lives, and help reduce the devastating effects of loneliness and isolation that many unwell and often older people in Sunderland face.

This evaluation has been undertaken during a period in which the LWL service and the CITs are still establishing themselves within their local and professional communities. The evidence from the testimonials and case studies is already illustrating good business synergies. This indicates that the LWL service will produce NHS cost savings by delivering improved individual health and well-being and a more efficient use of primary and secondary health care.

"The role of the Living Well Link Worker is absolutely key to the improvement in the health and wellbeing of patients with multiple co-morbidities. Clinical and social care issues are important to deal with but the additional holistic approach from the LWL worker adds to the overall wellbeing of patients.

One of the most important issues they deal with is reducing social isolation and there is evidence that this increases overall wellbeing, and reduces use of healthcare resources via decreasing GP appointments, house visits and admissions to hospital. There is no way I, as a GP, know all the services in the city, especially across the voluntary sector, but I know the LWL worker can help my patients often more than I can.

I have had feedback from several patients that the LWL worker has made a big difference to their lives and improved how they feel about life and cope with their illness. This service is proving very effective in helping to reduce costs in the healthcare sector."

Dr Val Taylor.

Moving Forward

The NHS Five Year Forward View, published October 2015, set out a vision for the future of health and social care in England. It called for the health and care system to fully engage with people and communities, sustaining new relationships where patients are partners, and communities can play an active role in their local health and care services. It also described new care models, which will break down traditional divisions between primary care, community services and hospitals.

Vanguard sites are taking the lead on the development of new care models, which will act as blueprints for the NHS. The new care models programme is underpinned by four core values: patient involvement; clinical engagement; national support; and local ownership.

The NHS Five Year Forward view argues that we can only achieve better health, better care and better value by fundamentally changing the health service's relationship with patients and communities. The vanguards worked with the national People and Communities Board to set out six principles to help define expectations of how they will work.

These six principles for new care models are: Care and support is person centred, personalised, coordinated and empowering; Services which are created in partnership with citizens and communities; Focus is on equality and narrowing health inequalities; Carers are identified, supported and involved; Voluntary, community, social enterprise and housing sectors as key partners and enablers; and Volunteering and social action are recognised as key enablers.

In line with these principles, better health and care for Sunderland will increasingly involve moving specialist care out of hospitals and into the community. Community organisations and specialist providers will need to work even more closely together to meet changing expectations. All Together Better would therefore continue to evolve from a new care model vanguard to a business as usual service in Sunderland. This would include the further development of Community Integrated Teams in each locality.

The LWL service has become an important feature of the CITs, by putting both these national principles and local strategies into practice. In a matter of months the LWL service has made a positive difference to the lives of people coping with some of the most complex and debilitating conditions. The LWL workers are providing the human touch, with practical support that is helping people who are managing their health conditions to regain their independence and access to community services.

This is enabling service users to lead a more comfortable, connected and fulfilled life, with the LWL service working in partnership with health professionals who can take care of their medical needs, and social workers who support their social needs. As a result, patients are in greater personal control of their health and well-being, have access to integrated care and tailored support in their local community, and are less dependent on core NHS resources.

"The successful joint working between the VCS and statutory sectors is necessary for the success of All Together Better. There can be challenges to make this work effectively. The feedback on the LWL service is very good; they are integrated within the CITs and their work is helping to engage our communities. The LWL workers are important parts of a broader structure that is supporting people and directing them to relevant pathways at difficult times in their lives.

The response on LWL workers from colleagues in the MDTs has been overwhelmingly positive. This has been not only due to their perceived impact on patients, but also because their integration into the CITs is helping clinical specialisms and social support mechanisms to be used appropriately.

The LWL workers have become essential to the teams they are working in. The All Together Better programme is being delivered by a range of partner providers and is providing a coordinated response to people with complex needs. Moving forward, there needs to be a holistic approach to service provision, and the LWL Service has shown that they can be an valuable part of this provision."

Kerry McQuade, Head of Vanguard Delivery, Sunderland.

The voluntary sector's involvement will continue to be pivotal to the success of the overall empowerment approach, due to its ability to positively engage with the target groups via extensive networks within the local communities of Sunderland. The stronger relationships between the statutory, private and voluntary sectors will help to develop service solutions that meet the needs of health and social care commissioners and providers, and enable the people of Sunderland to improve their lives and be as independent as possible.

Age UK Sunderland is committed to partnership working, by linking providers and communities closer together. This evaluation demonstrates that the Living Well Link Service is proving to be an important bridge between patients and providers. The provision of this service is delivering significant benefits in terms of the effective use of NHS resources, the increased engagement of communities and the tangible improvements to individuals' health and wellbeing.

Our mission

To promote and support the well being of all older people throughout the City of Sunderland, improve their quality of life and help them maintain independence.

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Registered charity number 1086995. Registered company number 4199449.