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NEW CARE MODELS AND PREVENTION:
AN INTEGRAL PARTNERSHIP

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FOREWORD

In 2008, I was asked by the then Secretary of State to undertake an independent review to identify the most effective evidence-based strategies for reducing health inequalities in England. *Fair society, healthy lives* (the Marmot review)[1] was published in 2010 and, although the challenge remains great, I am encouraged that the report has fundamentally shifted the discourse on health inequalities in the UK and internationally.

In *Fair society, healthy lives* we described the unequal distribution of health in England. There is a clear and persistent social gradient in length of life and health (measured by disability-free life expectancy) – the lower a person's social position, the less healthy he or she is likely to be. I believed then and believe now that the moral case for addressing this is overwhelming. In the interests of pragmatism, we also pointed out that there is also a strong economic case for action – health inequalities in England result in reduced tax revenues, far greater healthcare costs and approximately £31 to £33 billion in productivity losses annually.

Our report sets out what has come to be known as the 'Marmot principles' for tackling health inequalities. They are:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill-health prevention.

Demand for health services continues to increase, funding remains flat, and speed of access to NHS services has therefore come under pressure. In response, we can choose to reduce demand, increase funding, or just accept that we will have to wait longer for treatment. My view is that as well as investing sufficiently in health and social care, we should be doing everything we can to reduce demand by addressing the social determinants of health – the drivers of health.

While life expectancy for the population as a whole has improved, we have not made progress in tackling the social gradient in health and our life chances are still closely related to experiences in our earliest years, and even before we are born. Yet by focusing on creating the conditions that enable people to live in good health, we could go a long way to closing the health and wellbeing gap.

While much of my focus has been on the social determinants of health, I recognise that we also need to redouble our efforts to prevent ill health through the work of the NHS and local government. This is reflected in the last of the Marmot principles. I am encouraged then that this is at the heart of the NHS *Five Year Forward View* and the new care models vanguard programme, including the vanguards featured in this publication. It's great to see prevention being put into practice in community, mental health, acute, ambulance and care home settings.

The UCL Institute of Health Equity, set up to help implement the recommendations of *Fair society, healthy lives*, is also working with a separate group of vanguards to tackle health inequalities through understanding population needs and outcomes and working out how health sector procurement and collaborations can improve the social determinants of health in local areas. And I was pleased too to learn that 70 per cent of local authorities are now working to embed the Marmot principles in their approaches to improving health and reducing inequalities.

While there is still much more work to do to reduce ill health and face up to the challenge of health inequalities, you may be surprised to hear that I feel positive about the future. The reason is that I believe people are at last finally taking prevention and health inequalities seriously. I will continue working to prioritise health inequalities and support the implementation of good practices, and I believe this publication will help spread ideas about how to make it happen.

Professor Sir Michael Marmot
Director, Institute of Health Equity

"It's great to see prevention being put into practice in community, mental health, acute, ambulance and care home settings."

NEW CARE MODELS AND PREVENTION

Back in 2004, the Wanless report *Securing good health for the whole population*,[2] commissioned by the government, identified the "potentially large gains to be made by refocusing the health service towards the promotion of good health and the prevention of illness"[3] and warned that unless the country started taking prevention seriously, we would be faced with a sharply rising burden of avoidable illness. Yet over ten years later, there remains a broad consensus that this ambition has not been realised and that the NHS is struggling to cope with the consequences.

The *Five Year Forward View* (the *Forward View*), published in October 2014 by the arm's-length bodies of the NHS in England, acknowledged this and argued that "the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."[4]

The *Forward View* sets out a vision for a sustainable NHS which involves addressing three key gaps: the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap. On the health and wellbeing gap, the *Forward View* echoed Wanless by giving a clear warning of its own:

"If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness."[5]

The *Forward View* vision is of a sustainable NHS that delivers care in new ways, underpinned by six principles for empowering people and communities which reflect the commitment to promoting wellbeing, preventing ill health and closing the health and wellbeing gap. They are:

- care and support is person-centred – personalised, coordinated and empowering
- services are created in partnership with citizens and communities
- focus is on equality and narrowing inequalities
- carers are identified, supported and involved
- voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- volunteering and social action are recognised as key enablers.

Many were disappointed that the recent Spending Review did not explicitly invest in prevention or public health funding. However, key to the realisation of the *Forward View* vision and principles has been the development of 'new care models' which have both of these at their heart, and are forging ahead. These are the following: integrated primary and acute care systems (PACS), multispecialty community providers (MCPs), enhanced health in care homes, urgent and emergency care, and acute care collaborations. Through a rigorous process, involving workshops and the engagement of key partners and patient representative groups, 50 new care model 'vanguards' were selected. They are now taking a lead on the development of new care models which will act as blueprints for the NHS moving forward and as inspiration to the rest of the health and care system.

THE VANGUARDS AND PREVENTION

Just as prevention is at the heart of the *Forward View*, it is central to the vanguards, all of which were called upon to set out how they planned to address the health and wellbeing gap in order to be selected for the programme. This publication looks at how five of the vanguards are getting serious about prevention. They are:

- All Together Better Sunderland (MCP)
- West Wakefield Health and Wellbeing (MCP)
- Sutton Homes of Care (enhanced health in care homes)
- Connecting Care – Wakefield District (enhanced health in care homes)
- Solihull Together for Better Lives (urgent and emergency care).

At this stage of the programme, what the vanguards are doing on prevention is very much emerging practice rather than evaluated practice. But given the ambition to deliver the *Forward View* vision at scale and pace, we hope that the case studies will prove to be a valuable resource for other organisations and partnerships developing new care models across the country.

It is important to recognise that prevention of ill health looks different in different circumstances, for example, the needs of a city-wide population will differ from those of the population of a care home. In some cases, 'prevention' might mean preventing an unnecessary admission to hospital, while in others, it could involve proactive monitoring of the health of the whole population and identifying the groups most at risk of ill health. But what different prevention initiatives will have in common is that they are focused on keeping people well and helping them to retain their independence rather than caring for them when they become unwell. Key to the successful prevention of ill health is a collaborative approach, with every health and social care professional, as well as those groups delivering other services, taking every opportunity to 'do' prevention within their communities. Beyond this, it is critical to trust and support people to look to their own health.

The vanguards, like others working on prevention, must seek to empower people to manage their conditions and maintain their good health and wellbeing for the future.

ALL TOGETHER BETTER SUNDERLAND

WELCOME TO SUNDERLAND

The All Together Better Sunderland vanguard serves a population of 275,300 people, bringing together teams of health and social care professionals, alongside local support organisations, to improve the lives of people in Sunderland. Services are designed to wrap around the person and respond quickly to the health and social care needs of people who require a little more help. The aim is to prevent short-term problems from escalating and keep people at home, including by supporting the health and social care services, family members and friends who normally care for them by stepping in to respond to unexpected issues.

All Together Better partners include NHS Sunderland Clinical Commissioning Group, Sunderland City Council, Age UK Sunderland, Sunderland Carers Centre, local NHS community and acute providers, and local GPs via the Sunderland GP Alliance and Washington Community Healthcare.

The partners joined the programme with a view to building on their existing cooperation to trial new ways of working designed to improve care standards for the people in the city who have the poorest health – usually older people with several complex conditions – and use NHS services in a more cost-effective and targeted way.

ALL TOGETHER BETTER'S AIMS AND INITIATIVES

As part of the new model of provision for services in the community, care in hospital and sustainable self-care, staff are working together as part of multidisciplinary teams, with third sector support from Age UK Sunderland and the Sunderland Carers Centre, to focus on more proactive, patient-centred care and prevention. For example, Age UK Sunderland is providing 'Living Well Links' workers and a hospital discharge team to support people in the community and Sunderland Carers Centre offers information, advice and support to those in caring roles.

Empowering people to support self-care and closing the health and wellbeing gap identified in the *Forward View* is an essential element of All Together Better's approach. All Together Better aims to maximise independence and quality of life for people of all ages by placing the individual and their carers and family at the heart of their care and support – ensuring that they have access to information, advice and support to promote real choice and control, increasing self-care and self-management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

All Together Better has three main components which together will provide holistic, person-centred care for vulnerable people in Sunderland:

- **Recovery at Home** – this unique service is designed to greatly improve the care offered to the people who need it most. Recovery at Home teams include a range of health and social care professionals. It operates 24 hours a day, seven days a week to respond quickly (usually within four hours) to provide short-term urgent care at home during times of illness or if someone experiences an unexpected change in their condition that could develop into a crisis. 'Home' includes both residential and nursing homes. Recovery at Home also has two community bed units for people who need some extra support but do not need to go into hospital.
- **Community integrated teams (CITs)** – five multi-skilled community integrated teams, who deliver support for the most vulnerable people across Sunderland, are united to provide an effective, coordinated response for those with complex needs and to ensure that people only need to tell their story once. The CITs include district nurses, community matrons, GPs,

practice nurses, social care professionals, Age UK Sunderland Living Well Links workers, and carers support workers. Key to the way CITs work are multidisciplinary team meetings, involving a range of specialist staff and CIT members to discuss the best course of action for patients identified at GP practice level as being the most vulnerable, with a focus on helping people stay as independent as possible.

- **Enhanced primary care** – in addition to being part of Recovery at Home and CITs, GPs in Sunderland are working to plan and create a better model of care to support the wider population, starting with people with at least one long-term health condition. The intention is to deliver as much care as possible in the community, exploiting the latest technology and working more closely with voluntary organisations to make sure people can stay as well and as independent as possible for longer.

ALL TOGETHER BETTER'S USE OF RISK STRATIFICATION

Central to All Together Better's new model for out-of-hospital services is gaining a better understanding of the population's health needs through risk stratification. This helps identify the most vulnerable people and allows All Together Better to proactively target resources through its three main initiatives to prevent their health from deteriorating.

Evidence shows that 3 per cent of patients in Sunderland account for 52 per cent of NHS costs, with the next 12 per cent of patients accounting for 36 per cent of costs. While there is still work to do on how best to identify who exactly falls into these groups – currently the frailty index, clinical judgment and instinct are used – All Together Better has so far been focusing closely on the top 1 per cent, with the new community integrated teams working to wrap services around these people as holistic support. Next year, All Together Better plans to widen its focus to more of the city's population.

MEASURING SUCCESS

All Together Better has seen early signs of a reduction in emergency admissions for the over 65 cohort, a significant increase in the number of referrals to the Recovery at Home service, a reduction in the use of community beds at Farnborough Court (an intermediate care service), a fall in admissions to residential care and fewer delayed transfers of care.

The programme has agreed a challenging set of metrics for measuring success in the future, including a reduction in non-elective admissions, improvement in health-related quality of life for people with long-term conditions, a fall in years of life lost, and further reductions in admissions to both residential and care homes, and in delayed transfers of care.

FURTHER INFORMATION

For further information, please visit **www.atbsunderland.org.uk**, email **atb@nhs.net** or **@ATBSunderland**.

WEST WAKEFIELD HEALTH AND WELLBEING

The emerging framework for MCP vanguards largely works on a population model of provision, offering proactive care focused on the needs of individuals, and pushing control and accountability to lower levels within organisations, with the aim of enabling people to live independently in their communities for as long as possible.

The West Wakefield Health and Wellbeing vanguard is focused on a population of about 152,000 in West Wakefield, or roughly half the district. The challenges facing Wakefield reflect the national picture: increasing numbers of older people living with long-term conditions, reducing the number of beds that are available, pressure on A&E and shortages in some staff groups, specifically GPs and nurses, which has challenged efforts to improve access to primary care services and ensure their sustainability.

West Wakefield is therefore taking up the *Five Year Forward View* national challenge and applying it in a local context, with the aim of empowering local people to look after their own health as much as possible.

THE HYPOTHESES

When setting up the MCP, the West Wakefield team worked on three hypotheses:

1. Fifty per cent of work done by GPs could be carried out in a more cost-effective way.
2. Thirty per cent of elderly people admitted to hospital acutely for a short stay of between zero and five days do not need to be admitted and could be cared for differently in an alternative setting.
3. Thirty per cent of patients occupying an acute hospital bed do not need to be there because their episode of acute care is over.

Historically, health and care providers in Wakefield had worked independently, with separate teams and cultures, poor information sharing, a lack of communication and mutual understanding of shared and similar issues, overlaps and gaps in the services provided, challenging organisational hierarchies and approaches that were too often reactive rather than proactive.

Partners in Wakefield made a decision to re-evaluate their approach to delivering services across the whole area, and established 'Connecting Care', a Wakefield-wide programme of health and social care integration which forms the bedrock of the care model, and includes the Connecting Care – Wakefield District enhanced health in care homes vanguard, also featured in this publication. The West Wakefield Health and Wellbeing vanguard is developing a multidisciplinary 'team of teams' approach which centres around 'Connecting Care hubs', in which groups of GP practices work as a network with a team of community nurses, social care staff, therapists and voluntary organisations to organise services around the needs of the registered population. In this way, different provider organisations are unified around the common goal and purpose of offering a joined-up service for those who are most at risk of becoming ill, such as people with long-term conditions, complex health needs, or who have been in hospital for an operation or emergency.

These teams will be supported by others working within an information hub – groups of staff known as 'fusion cells' whose job will be to pull together the threads of information about people and services in the area, including health and care services but also the West Yorkshire Fire and Rescue Service and police, for example. They will ensure people receive the right support for them in a timely manner, and that healthcare providers are able to draw on the wide range of other services that are available to their patients.

The West Wakefield vanguard is also working hard to extend and improve primary care access in the face of workforce challenges. As participants in the Prime Minister's GP access fund, the vanguard partners operate extended GP hours that are more convenient

for working people, who are therefore more likely to see their GP before a problem becomes more serious. In addition, 'Physio First' has brought physiotherapists into GP practices, meaning patients can see a physiotherapist first without having to see a GP. Pharmacists are also on hand in practices to handle medicines management and optimisation, freeing up time for GPs to focus on people with more complex issues who really need to see them.

This enhanced primary care offer is supported by improved care navigation, with practice-based care navigators trained to signpost people to the most appropriate services locally. The accredited care navigator course has trained 114 people to date.

Alongside the work in GP practices, the vanguard is developing a wider range of services in the community to help local people remain healthier at home for longer. Among these are:

- **The HealthPod** – a pop-up primary care facility which offers health checks, wellbeing advice and assessments such as cardiovascular disease (CVD) risk, diabetes screening, atrial fibrillation (AF) screening and cholesterol tests in neighbourhood locations such as supermarket car parks. Last month, 16 HealthPod sessions took place which saw 288 people visit the HealthPod. In the same period, the team conducted 116 AF screenings, 266 blood pressure checks and 200 CVD risk assessments. It has now extended the service to offer follow-up tests on site if someone is at high risk of developing one of these conditions, to gain more information and a better understanding of their needs in order to support them with behaviour change or refer them to a GP for diagnosis.
- **The Schools App challenge** – local children design health and wellbeing focused apps, working in teams and with counsellors from Microsoft. The challenge culminates in a dragons' den type event, and the winning app is built. The competition has helped children think more about preventative health measures about which they can then challenge their parents and friends. A video giving an overview of the initiative can be viewed at **vimeo.com/154733302**
- **Social prescribing** – embedded in general practice, staff have access to a directory of services to prescribe or signpost to services such as home visits to assess the wider social determinants of health, for example, the impact of caring commitments, introducing exercise through activities such as walking groups and sports clubs, offering carer support, healthy lifestyle advice, money and benefits advice, and meaningful activities to combat feelings of isolation and lack of purpose.

IMPACT

The vanguard is seeing early signs of success from the changes it has made.

- Patients are supported to access a much wider range of services which is helping transform lifestyles and raise the level of wellbeing across the population.
- Signposting to more appropriate services through care navigation, Physio First, co-located pharmacists and social prescribing has enabled GPs to dedicate more time to frail older patients or those with complex needs, clinical leadership and management and working to continually improve services.
- Seventy eight per cent of local patients referred to the social prescribing service over the last year said that it had improved their wellbeing.
- Through the HealthPod, a significant percentage of people who have had screenings have been referred on to a GP for further tests.

FURTHER INFORMATION

For further information, please visit **www.westwakefieldhealthandwellbeing.nhs.uk** or **@westwakefield**.

SUTTON HOMES OF CARE

Sutton Homes of Care is one of six enhanced health in care home vanguards in England. Each of the vanguards has been working with care homes in their respective areas for a number of years, adopting different approaches to improve care for residents and implement a new model of care.

One of the biggest challenges facing Sutton Homes of Care is in improving the skills of care home staff through the delivery of high-quality training opportunities. Staff employed within care homes are not currently employed under Agenda for Change terms and conditions, which has historically impacted on recruitment and retention. Ensuring care home staff have the knowledge and skills to care for vulnerable and elderly people is a priority for Sutton.

The Sutton vanguard serves a population of around 200,000, with 74 care homes and three more due to open shortly. This includes nursing and residential care as well as a number of mental health and learning disability places. Thirty per cent of beds in the area are statutorily commissioned, and the rest are privately funded. Many of the people cared for in homes have multiple comorbidities and complex needs, and staff are expected to demonstrate the six national values for nursing (care, compassion, competence, communication, courage and commitment).

The vanguard is based on three key pillars:

- **Training and development for care home staff** – through the use of care home forums, shared learning/networking events, education packages, websites, newsletters and focus groups. For example, the 'concerned about a resident' signposting tool is used to identify alternatives to 999 to meet residents' needs, and has led to a 10 per cent drop in A&E attendances. The hospital transfer pathway ('red bag') is a more recent initiative which has introduced standardised documentation and expectations across the whole system to reduce the risk of hospital associated complications.
- **Quality assurance and safety** – monthly meetings of the joint intelligence group, which bring together all stakeholders including the Care Quality Commission, and use hard data and soft intelligence to identify how to support care homes to build skills to meet residents' needs or address issues.
- **New model of integrated care** – pilot health and wellbeing reviews of residents' needs every six months, carried out by a GP or care coordinator. Multidisciplinary care home support teams from community services (pharmacists, link district nurses and end-of-life specialist nurses) are also involved and help provide training and education and clinical advice.

The health and wellbeing review pilot includes six GPs linked to six care homes in Sutton. Stephanie Machin is one of the GPs linked to a nursing home in Sutton. She joined the project because of her special interest in elderly care and palliative medicine. Most patients at the care home suffer from dementia and the home has two nurses and a wider network of healthcare assistants. Stephanie has weekly visits to the home and works alongside the care home manager, staff nurse, community pharmacist and residents/patients and their families.

The pilot project aims to achieve the best possible care by:

- providing focused training, forums and online resources to improve communication between care homes and GPs
- regulating training and skills across Sutton
- getting to know each patient individually
- optimising control of chronic diseases
- rationalising medications

- pre-empting deterioration and planning end-of-life care
- avoiding unnecessary hospital admissions
- keeping families up to date.

Stephanie uses a structured approach to avoid the risk of 'overlooking the well', selecting one or two well patients per week to review as well. Although it was initially challenging to develop this project from a blank canvas, and there were issues with IT and paperwork in the early stages, Stephanie has now got to know all of the residents by name and finds the work very rewarding.

The beneficial outcomes have included the following:

- improved communication – fewer calls and home visit requests
- staff have the confidence not to default to sending people to A&E, for example, when residents lose weight
- people are managed in the care home for longer avoiding distressing trips to A&E
- hospital length of stay has reduced by three days on average
- better outcomes – blood pressure control, insulin, asthma control, and Quality Outcomes Framework
- fewer medications wasted – particularly nutritional supplements through reviewing diet, for example, adding full fat milk, cream to meals
- money saved through medicines management
- increased job satisfaction for staff.

All care homes can phone up and ask staff at the local mental health trust to come in and review or give advice on a resident. A psychologist works with the pharmacist to review medication for residents. The vanguard is currently recruiting for a community geriatrician, and in the meantime they are in discussion with the local hospital to assign a named consultant to provide telephone advice to the care home. Part of the vanguard funding was used to fund an enhanced GP specification for additional time to go into care homes out of hours. As part of the evaluation, the vanguard is looking at whether it has been a good investment.

GPs in Sutton are very positive about the new model of care now being provided:

- "I find it rewarding to be able to properly care for end-of-life patients and now have more time to do so."
- "The health and wellbeing review pilot has given us the gift of time to do our job properly."
- "I feel like we work as more of a team now, like we're all on the same page."

SERVICE USER CASE STUDY

David is an older gentleman who has dementia. He had a cut on the top of his head that kept bleeding and care home staff asked the link GP to look at it. Stephanie took a swab and MRSA was detected, which David was treated for. Stephanie also took a photo for her dermatology colleagues, who thought that the lesion looked suspicious. She was reluctant to send David to a dermatology outpatient clinic to rule out the possibility of a skin malignancy because he had behavioural issues and was subject to a deprivation of liberty order because of the risk of him absconding. Instead, a biopsy was carried out at Stephanie's surgery during the last appointment of the day. David did have skin cancer and Stephanie is now making arrangements to treat him at the local practice rather than in hospital. If Stephanie had not been making regular visits to the care home, the cancer could easily have gone undetected.

FURTHER INFORMATION

For further information, please visit **www.suttonccg.nhs.uk/vanguard** or **@SuttonHoC**.

CONNECTING CARE – WAKEFIELD DISTRICT

Wakefield has a registered population of 364,000 and has significant health challenges; it is the 67th most deprived area in the UK and has a long industrial heritage.

There are 68 care homes in the area housing over 2,400 beds across specialist and residential care. Traditionally, care homes have not been viewed as part of the health and social care collective in the area, but that is changing with a partnership focused on providing more proactive care in care homes.

The Connecting Care partnership brings together NHS Wakefield, Wakefield Council, a provider alliance including Nova-Wakefield, Age UK Wakefield District, Wakefield and District Housing, South West Yorkshire Partnership NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Yorkshire Ambulance Service NHS Trust.

The Connecting Care partnership involves an initial cohort of 11 care homes and 21 GP practices plus two assisted living facilities. Its main focus is on holistic care and prevention, encouraging self-care and social prescribing. The partnership is driven by the guiding principle to respond to people's needs as an integrated whole system. This approach has a specific focus on addressing frailty and social isolation through multidisciplinary working.

In a relatively short space of time, the model has achieved a number of successes. It has established an enhanced primary care service which provides a named primary care professional to care home managers. A multidisciplinary care home support team including therapists and nurses, working closely with a community geriatrician and pharmacists, carries out initial assessments of all residents in the selected care homes and two 'extra care' facilities. Depending on need and complexity, the team supports the care home staff to develop proactive care plans, arranges training and facilitates ongoing health and voluntary input where indicated. The team works closely with the wider community services and local hubs to develop streamlined and safe pathways to access advice and care. It is also working with local partners to develop training and education support for staff in care homes and assisted living.

A number of initiatives have grown from this joint working, including 'Pull up a chair', LEAF-7, and Dementia Care Mapping, which are all designed to put the individual in charge of shaping their care.

'Pull up a chair' gives individuals the opportunity to discuss what life is like, comparing past and present, by keeping video diaries. It allows individuals to say what they would like to change about their care and their lives.

The LEAF-7 initiative is a goal-setting tool which helps older people affect change in their lives through proactive assessments. It sets out seven pathways, essential areas for wellbeing in life and measures the difference made to people's lives as a result of change.

Dementia Care Mapping is an observational tool developed for people living with dementia in care homes. The tool notes and maps people's behaviour, and in doing so helps to feed into their care plans and improve their care environments.

The partnership is also looking at developing carer support to help people when their loved ones move into a care home.

MEASURING SUCCESS

The partnership has put its successes to date down to the following:

- providing a genuinely appealing offer to local care homes
- establishing good relationships with care home managers while understanding the challenges of each home
- well thought-through workforce planning ensuring that there is commonality in training for staff across the health and care system.

The next phase of the partnership will see the initiative rolled out to all 68 homes by March 2019 and will include the Wakefield provider alliance which is formed of health, social care, voluntary, housing and police sectors.

FURTHER INFORMATION

For further information, please visit **connectingcarewakefield.org** or **@NHSVanguardWake**.

SOLIHULL TOGETHER FOR BETTER LIVES

Health in Solihull is good – over 80 per cent of people describe their own health as good or very good. People are living longer in Solihull than many areas across England. Length of life is important but so is quality of life – the focus is now on healthy life expectancy.

Despite this favourable picture, there are a number of health challenges. There is a ten-year gap in life expectancy between the most affluent and most deprived communities. Of greater concern is that the poorest third of people will not reach retirement age without poor health or disability. Solihull has a relatively older population which is projected to become older – levels of frailty, long-term conditions and poor mental health are increasing.

Responding to these challenges, keeping people well and independent, reducing inequalities in health and keeping within available resources requires a radically different approach. Solihull public sector organisations have therefore committed to transform a system now focused on higher cost acute and institutional care to one focusing on earlier interventions, prevention, and wellness which will deliver better outcomes and create a sustainable, value-for-money, urgent and emergency care (UEC) system.

The UEC vanguard offer sits within a wider partnership approach in Solihull which recognises that prevention and wellbeing are as much about aspiration and opportunity and the strength of local communities as it is about health and care interventions.

Making the shift towards a wider population prevention approach requires collaboration across sectors, communities and individuals. In other words, a whole system approach.

There is a Solihull Leaders Board chaired by the Leader of the Council aimed at coordinating efforts across the population to address:

- economic prosperity – critical to achieving better outcomes
- stronger communities – based on good housing, transport, education and environment
- Better Lives – the UEC vanguard.

The leadership structure brings together health and wellbeing along with the economy, education and training as well as the police and fire service. In this way, it is seeking to balance service transformation at the sharp-end of urgent care with a broad-based and long-term population-based approach which recognises the fundamental drivers of local health and wellbeing.

Key to this is co-production – working as equal partners with citizens and communities to offer person-centred care. Through this approach, they have also created a thriving cohort of service users, patients and carers who are now taking forward their own diverse care and support initiatives.

CAFÉ TEMPO

Christine Logan is one of Solihull Council's experts by experience and a carer for her father who has dementia. She has recently set up a community interest company which offers training for carers of people with dementia, as well as health and wellbeing advice for the carers themselves. Christine explains: "Carers play a vital role in our community by providing dedicated support to family members living with dementia. But carers need support too, and opportunities like Café Tempo mean that they can come together and recharge their batteries."

Delivery of the UEC vanguard is via four service offers which could be easily replicable, particularly the learning around the role of a smaller hospital like Solihull within an integrated system. These offers are:

- **Community wellbeing service** – empowering people with the confidence and information to look after themselves when they can, and access

care and support when they need to, giving people greater control of their own health and encouraging behaviours that help prevent ill health in the long term.

- **Integrated primary and community care service** – transformation and integration of primary and community teams into one service that 'wraps around' the needs of the patient.
- **Integrated urgent care service** – the systematic implementation of best practice standards that will reduce variation and improve outcomes and efficiency.
- **Solihull Connected** – the vanguard's population health information system. Learning from international models, they are working to implement a population health information system that will deliver an integrated care record, information and analysis to support flow, decision-making and real-time information for performance and outcome monitoring.

Working as a whole system doesn't come without its challenges. Keeping a system focus is hard, especially given the financial and operational pressures which can so often mean organisational leaders focus on the interests of their organisation rather than the whole system.

The leaders recognise the tensions between adaptive change and conventional project management. Adaptive change means saying 'yes to the mess' and recognising that there are no simple solutions.

But there are some simple rules: work hard to keep the conversation going, encourage connections and build networks and coalitions. Keep yourselves grounded by focusing on what your population needs. That's how they keep going in Solihull.

Within these offers, there are a number of initiatives which focus on prevention.

INITIATIVE	PROGRESS
Local area coordination (LAC) – an evidence-based approach which encourages vulnerable people to find solutions to their needs in their community as opposed to a service response.	Three 'hotspot' areas identified for LAC, now in set-up phase.
Access to information, advice and support.	Community advice hubs, web portal, telephone advice, co-location of key community and voluntary sector providers and peer support networks in place. New 'Better living centre' integrating professional expertise and giving public access to practical support around equipment, adaptations and technology.
Six integrated community teams (ICTs) working with primary care to deliver community alternatives to admission; each ICT supports a local population of 40,000 people.	Rapid response delivering two hour admission avoidance/ multidisciplinary meetings.
Care navigators in ICTs to support patient activation.	Dementia navigators are now part of ICTs. The next phase is to introduce generic navigators.

FURTHER INFORMATION

For further information, please visit **solihulltogether.co.uk** or email **icass@nhs.net**.

PULLING IT ALL TOGETHER – THE TAKE HOME POINTS

While each of these five vanguards has its own individual approach, looking across the work featured in the case studies some clear themes emerge from how they are tackling prevention.

The case studies all show the importance of having as full an understanding as possible of the needs of the local population, including in some cases through risk stratification. Working across organisational and professional boundaries, and getting staff on board, involved and equipped to deliver care in new ways has also proven to be essential. So too is tapping into and getting the most out of the experience and skills of carers, volunteers and third sector organisations, and empowering people to 'self-care'. At the same time, initiatives such as social prescribing have the potential to greatly improve people's wellbeing.

In short, what each of these vanguards has sought to recognise is the need to look beyond the boundaries of health and social care services to the way people actually live their lives, and tailor the support they offer accordingly.

The vanguards featured here can all point to early indicators of success. The hope is that their experiences – what has worked well, what has proven to be difficult and how challenges have been overcome – will be of help to others seeking to develop new care models, address the health and wellbeing gap, and get serious about prevention.

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Thank you to Brickwall for providing the image for the cover of this report.

The NHS Confederation, NHS Providers, NHS Clinical Commissioners and the Local Government Association are working together to help spread the learning from the **vanguard programme** across the health and care sector.

Together, we aim to create greater understanding, involvement and ownership of the vanguard vision, showcasing new ways that health and care economies can help establish a sustainable health service now and in the future.

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