# Delivering a healthier future

## How CCGs are leading the way on prevention and early diagnosis

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

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# Foreword

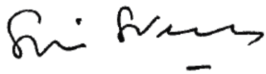
The first argument we made in the Five Year Forward View was that prevention needed to be taken seriously. It said that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain depend on a "radical upgrade in prevention and public health."

That's why I'm pleased to see that CCGs are picking up on this challenge. As this report suggests, commissioners across the country are increasingly taking prevention and early diagnosis seriously.

What's more, they are doing so in partnership with colleagues in secondary care, in the voluntary sector, with patients, citizens, local authorities and others.

It's heartening to see that CCGs are driving improvements in a wide range of areas including mental health care, early diagnosis of cancer and stroke prevention.

But prevention is about more than services, and imaginative commissioners are realising this. Several of the case studies in this report emphasise the importance of asking communities and individuals what's important to them, and to their health and wellbeing – and working with these individuals and communities to come up with solutions.



**Simon Stevens**
Chief Executive
NHS England

"It's heartening to see that CCGs are driving improvements in a wide range of areas including mental health care, early diagnosis of cancer and stroke prevention."

Simon Stevens

# Introduction

As co-chairs of NHS Clinical Commissioners, we are delighted to introduce a report that highlights how our colleagues are really driving prevention and early diagnosis for their local populations.

From Cornwall in the furthest corner of the South West of England, to Hartlepool and Stockton-on-Tees in the North East, from Hampshire to Lancashire (and everywhere in between), there are inspiring examples of real-life projects that are already having an impact. They truly demonstrate the positive difference that local clinically led commissioning can have for patients and communities.

As GPs ourselves, we see the challenges that face primary care every day: increasing numbers of patients with complex needs, often social as well as medical; a growing elderly and frail population; people living with multiple long-term conditions, to name but a few.

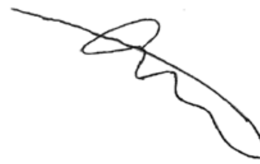
There can be a real temptation in today's stretched NHS to hunker down, try to deal as best we can with what's in front of us and leave tomorrow to take care of itself.

The case studies in this report show, however, that CCGs across the land aren't thinking like that. They are taking a longer view, they are focusing on prevention and early diagnosis and are already demonstrating success.

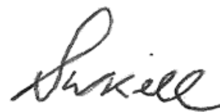
Having said that, we can't expect that change will happen overnight. As Mehrban Ghani, medical director of Barnsley CCG, and a GP like ourselves, says, when you take action today to improve cardiovascular health, you might not see the benefits (in terms of substantially fewer strokes, say) for ten years. And as Andrew Carter in Hartlepool and Stockton-on-Tees CCG says, work to give all children a fairer start in life will bring dividends in years to come.

The Five Year Forward View states, however, it is vital that prevention is at the forefront of our efforts to improve the health and wellbeing of our communities and citizens – and it's great to see tangible examples of how CCGs are driving this.

We look forward to seeing even more innovation and admirable practice coming through in the future, as CCGs continue to work with colleagues in local authorities, secondary care, the voluntary sector and others. We know that there are pressures on the system that require an immediate response, but we also know we have to plan for the future. The case studies in this report show that CCGs are rising to the challenge of making long-term transformative changes to ensure a sustainable and effective NHS for patients and local populations.



**Dr Amanda Doyle OBE**
GP and Chief Clinical Officer, NHS Blackpool Clinical Commissioning Group
Co-chair of NHS Clinical Commissioners



**Dr Steve Kell OBE**
GP and Chair, NHS Bassetlaw Clinical Commissioning Group
Co-chair of NHS Clinical Commissioners

# Summary

In 2014, we published two reports, *Taking the lead* and *Leading local partnerships*. Both showed that CCGs – then very young organisations – were already having a positive impact on the health and wellbeing of the communities they serve.

This report follows on from these and demonstrates that as CCGs continue to evolve and mature, they are increasingly driving change across their local health and care economies.

Focusing on prevention and early diagnosis, the case studies in this publication show that even in challenging times, CCGs are bringing together all the players in their local areas to drill down to the very essence of what populations want and need – and how it can be achieved.

They show how CCGs:

### Are taking the lead in preventing illness and the causes of ill health – and working to keep people out of hospital where possible

- In South Worcestershire, proactively working with older people living with frailty shows promise in preventing A&E attendance and hospital admissions.
- In Brighton and Hove, the preventing premature mortality audit is combining data with the stories of people's care to gain insight into how early deaths could be prevented.
- In Blackpool, work is being carried out to prevent people getting type 2 diabetes – and to support those who have been diagnosed to manage their condition.
- In Chorley and South Ribble and Greater Preston, efforts are being made to prevent hospital admissions in people with COPD – and to prevent c. difficile infections in the community.
- In South Kent, working with the voluntary sector is helping to ensure that people who wouldn't normally access health services are getting care such as flu vaccines.

### Are helping to ensure that people are diagnosed earlier and given the support that they need

- In West Hampshire and Barnsley, CCGs are focusing on atrial fibrillation as part of comprehensive efforts to prevent stroke.
- In Camden, the CCG is using peer educators to improve cancer awareness throughout the borough, particularly in areas of high deprivation and in the Bengali population.
- In Corby, the CCG is leading the way in earlier diagnosis and prevention of HIV and AIDS.

### Are working across boundaries to build on what people want and need to help them lead longer, healthier lives

- In Hartlepool and Stockton-on-Tees, commissioners are working with the voluntary sector to build resilient communities that live longer, healthier lives.
- In Cornwall, the Living Well project is bringing together health, social care, the voluntary sector and communities to help people take control of their lives.
- In Gloucestershire, the CCG is using social prescribing to build on patients' strengths and desires to improve health and wellbeing.

The projects featured in this report are not isolated examples. There are countless other great examples of promising work going on in prevention and diagnosis in CCGs up and down the country.

But we hope that this small selection gives a good flavour of what clinically led commissioning can achieve. We believe that they demonstrate the value of clinically led commissioning and show how CCGs are building relationships, reshaping services and making a real difference for local communities.

# Working proactively with older people living with frailty

## South Worcestershire CCG

Older patients living with severe frailty are the most likely group to have unplanned admissions to hospital – and, once admitted, have the potential to be there for some time. That's why South Worcestershire CCG (SWCCG) has formed an alliance with the local community care trust and GP Federation to develop a proactive care management service that can support this group of individuals.

The development of the Proactive Care Service has involved a number of steps including the inclusion of a frailty component in the local "Promoting Clinical Excellence" contract with all 32 GP practices in the CCG locality and the creation of proactive care teams (PACTs). Practices have been encouraged to use their Avoiding Unplanned Admissions DES register as the cohort on which to concentrate initially and to assess and code everyone within this cohort for frailty.

Since July 2015, PACTs have been attached to GP practices in four different localities in the CCG. They have their own caseload and are actively involved in assessment, care planning and review of patients following hospital admission or attendance at A&E.

Dr Maggie Keeble, clinical lead for proactive care with SWCCG, says it's an ongoing process. "We have been successful in introducing the language of frailty into primary care," she says. "This is the first step on the path to actively case managing this complex population and supporting them to live independently for as long as possible while enabling healthcare professionals to recognise that the end of life is approaching in those most severely frail, with a view to initiating advance care planning discussions."

On the ground, it means that practices are identifying patients with different levels of frailty and managing them accordingly. People with emerging and mild frailty will be given support to self-manage, outcomes for those with moderate frailty will be improved with integrated long-term condition management and those who are most severely frail will be candidates for advance care planning, she adds.

Ongoing education and training are of paramount importance to support staff in the effective delivery of the proactive care service, the CCG believes, and it has implemented an educational programme including a series of study days and workshops.

Menna Wyn-Wright, programme lead with SWCCG, says feedback so far has been positive. "All 32 GP practices responded to a survey we carried out once the system was implemented and the majority felt it was working well. We will take responses into account as the new ways of working continue to evolve and develop. We're anticipating a reduction in inappropriate hospital admissions as a result of the work we're doing and early signs are encouraging."

"We have been successful in introducing the language of frailty into primary care. This is the first step on the path to actively case managing this complex population and supporting them to live independently for as long as possible."

Dr Maggie Keeble, clinical lead for proactive care,
South Worcestershire CCG

# Addressing preventable early deaths

## Brighton and Hove CCG

In comparison with the rest of England and the South East, Brighton and Hove has significantly poorer rates of preventable deaths – particularly in people aged under 75.

Around a third of deaths in the 18–74 age group are related to conditions that can often be delayed, or prevented altogether, namely, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and diabetes.

But how do you find the people who might be at risk of these conditions, with a view to stepping in at an early enough stage to avert them? Are there signs and symptoms that could be spotted in general practice, for example, or in other parts of the health and social care system?

NHS Brighton and Hove CCG decided to conduct an audit to identify potentially preventable risk factors for these conditions, with the aim of seeing what could be done in the future to prevent premature deaths.

GPs in Brighton and Hove have all signed up, giving comprehensive coverage of the city for the pioneering audit.

The process has involved taking data from a number of sources, including Office for National Statistics (ONS) death registration records, primary care registers and lifestyles data, and secondary care admissions and attendance data in the two years prior to death of 651 people who died prematurely of the three conditions.

“We got a lot of data from 2010–2013,” explains James Simpkin, a practising GP, and clinical officer for the CCG’s preventing premature mortality audit (PPMA). “But we also wanted to look at the patient record itself, to learn about their journey to their premature death. We wanted to see if there were risk factors that we could identify, to see the types of patients we were looking at, their lifestyles, quality of care, and links between primary and secondary care.”

He had the task of reading through the patient records – and learning about their very human journey was illuminating. “There were a number of recurrent themes,” he says. “For example, a lot of patients were in an isolated and vulnerable state; many were infrequent attenders [at health services] – they didn’t engage much. They were likely to have two or more long-term conditions, quite a significant section had mental health issues, or alcohol and/or substance misuse. A lot of them had complex medical problems or end stage disease. And it was also clear that there had been missed opportunities along the way to do something about it.”

Having gathered this information, the next step involved seeing how services could be commissioned differently, with the aim of improving the patient journey and, ideally, preventing the diseases that were taking the lives of people prematurely.

“COPD was a big one,” says Dr Simpkin. “And we saw that smoking levels were really having an impact. In fact, one of the highlights of the research was that among patients who died in their 40s and 50s, a lot of them had smoking as a risk factor.”

The CCG and public health have been looking to improve the smoking cessation services that the CCG commissions, and looking at new and innovative ways of reaching those who traditionally don’t engage with health professionals. “We’re moving towards domiciliary smoking cessation services, going into people’s houses to support them to stop,” he says.

The CCG and public health are also trying to find ways of taking opportunities to help people tackle alcohol or substance misuse problems, by ensuring there is support in A&E, for example.

A concrete development has been that the local public health team and CCG have each committed to funding three extra health trainers to work with GP practices to provide more coordinated support to people with long-term conditions with the aim of improving health behaviours – and hence health.

“There’s still a way to go, but we’re making changes based on what has actually been happening, and we hope it will make a real difference to our premature mortality rates,” says Dr Simpkin. “Reading these patient records was very powerful – these were the stories of people’s lives; lives that ended too soon.”

"Reading these patient records was very powerful – these were the stories of people's lives; lives that ended too soon."

Dr James Simpkin, clinical officer for Brighton and Hove CCG's preventing premature mortality audit

# Supporting people to prevent and manage diabetes

## Blackpool CCG

Working as a practice nurse, Jeannie Hayhurst has seen first hand the impact that diabetes can have on patients, and, indeed, on health services.

Complications of the disease – including foot amputations, heart disease, and eye problems – can be devastating for individuals and their families. But there's a financial cost too, with Diabetes UK estimating that the NHS spends around £10 billion per year on diabetes, with around 80 per cent of that going on complications.

Now clinical project manager with Blackpool CCG, Ms Hayhurst is at the heart of commissioners' efforts both to prevent people getting type 2 diabetes in the first place, and to help improve outcomes in those who have been diagnosed.

"Part of a practice nurse's role is to improve quality of life for people with type 2 diabetes, and as a CCG we're keen to do what we can to empower and enable primary and community care staff to do that, as well as supporting patients to manage their condition," she says. "There's a lot of poor health in Blackpool and diabetes is a really key area for us."

The CCG has been working with the local authority both to prevent diabetes and to promote early diagnosis. "We're lucky as a CCG because we're co-terminus with Blackpool Council, which makes joint working easier," she explains. "We've been working closely with our public health colleagues on prevention programmes and diabetes is a very strong focus for both organisations."

The CCG has made training and education a priority – for patients and for people working in primary care and the community. For example, a diabetes professional education programme has been rolled out to all Fylde Coast GP practices. Starting in mid-2015, this has already seen funding for 20 GPs and practice nurses to undertake a diabetes care diploma, a series of six diabetes workshops for primary care clinicians to enhance their knowledge and skills in managing diabetes, and a rolling programme of foot check training to ensure that nurses working in primary care and the community are confident in screening for diabetes-related foot problems.

This last initiative is particularly important in Blackpool, which has historically had high levels of diabetes-related foot amputations, says Ms Hayhurst.

The role of the CCG has been crucial, she adds. "At the end of the day, we know that primary care is stretched, and that demands are increasing," she says. "CCGs are there to support primary care to deal with that, for example, by pulling together the training and making it available."

Along with neighbouring Fylde and Wyre CCG, Blackpool CCG has commissioned a new provider for patient education courses for patients with type 2 diabetes. "A lot of nurses will agree that managing patients with diabetes can be a heartsink sort of task," she confesses. "They know that for a lot of people, there are lifestyle factors that can make a real difference, but maybe that's not a priority for that patient. Having run diabetes clinics for many years, I know that sometimes patients aren't ready to change.

"But by providing good education for patients, as soon after diagnosis as possible, we put the ball in their court. Early reports are very positive for the new patient education programmes."

The two CCGs, in collaboration with their respective local public health departments, have also submitted an expression of interest to be among the first areas to adopt the wider NHS Diabetes Prevention Programme – which would continue their work to promote healthy lifestyles in an effort to cut rates of the disease among their populations. Already there are quarterly audits that help practices identify patients who might be at risk of developing diabetes so that they can be invited for screening.

"This is an incredibly important area and a priority for the CCG," adds Ms Hayhurst. "Diabetes is a real challenge for the health service and for Blackpool, and we are all working together to meet that challenge."

"As a CCG, we're keen to do what we can to empower and enable primary and community care staff to improve quality of life for people with type 2 diabetes, as well as supporting patients to manage their condition."

Jeannie Hayhurst, clinical project manager, Blackpool CCG

# Reducing hospital admissions in people with COPD

## Chorley and South Ribble CCG and Greater Preston CCG

Keeping people out of hospital unless they absolutely need to be there is a strong driver for the NHS, as well as being popular with patients.

But how do you ensure that people with serious long-term conditions get enough support at home so that hospitalisation can either be prevented, or, where necessary, kept as short as possible?

NHS Chorley and South Ribble CCG and NHS Greater Preston CCG have been working with local providers to improve support and community-based services for people with chronic obstructive pulmonary disease (COPD).

As one of the most common respiratory diseases in the UK, COPD is the second most common cause of emergency admission to hospital. This is a particular concern for the North West of England, as the rates of admission [for COPD] are among the highest in the country.

The CCGs are taking action to improve diagnosis, so that people can be treated in as timely a way as possible. But it is also trying to build support around patients to stop their condition getting to a point where there's no alternative to going to hospital.

Gaynor Thomas, service transformation coordinator with the CCGs, explains that new pathways have been developed for people with COPD: an ambulatory care pathway for patients who arrive at the emergency department, and a community care pathway.

The community pathway kicks in when patients are first seen by the specialist COPD nursing team. To reduce the demand on the ambulance service, patients who have a confirmed diagnosis of COPD are issued with a yellow card which remains in the patient's home. This card contains baseline observations which can be accessed by the ambulance crews to inform clinical assessments and more importantly aid them with the decision as to whether the patient requires an admission to hospital.

The ambulatory care pathway is implemented when patients come in to the emergency department with an exacerbation, and essentially links them in to the community care pathway.

"We've introduced more intensive home support, including nebuliser therapy, chest physiotherapy and non-medical prescribing," says Ms Thomas. "The service can manage people with exacerbations who do not require hospital admission – we're keeping people at home where we can, but making sure they have the high-level support that they need. We're also reducing demand on A&E."

Giving patients the information and support that they need to prevent exacerbations in the first place, or to know what to do if they become ill, has also been an important goal.

To that end, the COPD specialist team has extended its opening hours. From July 2014, the service was open from 8am to 8pm from Monday to Friday, and 9am to 5pm at weekends and bank holidays. As of 1 November 2015, the team is available from 8am to 8pm seven days per week.

The aim is that all patients receive a home visit within 24 hours of a telephone referral, with most patients who call within the opening hours receiving a call-back within two hours.

"The patient can call the community team if they worry that they are going downhill, and can get advice and support if it's needed," says Ms Thomas. "It means that patients feel supported and, hopefully, can avoid getting worse, and can avoid going to hospital."

The team can also access the hospital IT systems to see if patients are admitted, and can visit them on the wards to help expedite early discharge.

Ms Thomas can already point to hard improvements in outcomes. Initial data (for the eight Lancashire CCGs) showed that there were 273 emergency admissions for COPD in July to October 2014, compared to 315 over the same period the previous year, a drop of 13.3 per cent. Length of stay and numbers of COPD readmissions are also falling.

"One of the really important elements has been communicating the changes to GPs, practice nurses, practice managers, and out-of-hours services," explains Ms Thomas. "We've been using every avenue we can to get the message across about the work we've been doing in this important area. It's in all our interests to get it right."

“We’re keeping people at home where we can, but making sure they have the high-level support that they need. We’re also reducing demand on A&E.”

Gaynor Thomas, service transformation coordinator, Chorley and South Ribble CCG and Greater Preston CCG

# Mind the gaps – managing c. difficile infections in the community

## Chorley and South Ribble CCG and Greater Preston CCG

When Carley Tomlinson took up her role as healthcare associated infection lead with Chorley and South Ribble CCG and Greater Preston CCG, there was very little in the way of management for c. difficile infections (CDI) in the community.

Although the acute sector was making good progress in cutting numbers of infections in hospitals, there was practically no sense of how many non-acute cases there were, or how they were being managed.

"We didn't have the numbers [of how many people were infected]," she says. "But we know that there are cases of CDI in community settings, including care homes, GP practices, and people's own homes."

Ms Tomlinson worked with infection control nurses at Lancashire County Council to find a way of managing these infections. "Over the past 18 months, we've been working with GP practices and have provided them with documentation to fill in when there are cases of CDI.

"We've looked at what other CCGs have been doing around this, and have introduced post-infection panel reviews. Using the information from the GP practices, we can review what happened in each case, and act on any themes that come through. The idea is to learn from what is happening, so that we can take action to prevent further infections."

One of the main issues that was flagged up early on was around antibiotic prescribing. "We've found that GPs and nurse prescribers aren't always adhering to the Public Health England Formulary," explains Ms Tomlinson.

"We've been sharing this information in many different forums, such as GP education and practice nurse forums in the hope that adherence to the formulary will improve.

"We're also working with care homes, and with community nursing teams, to raise awareness and to improve practice across the local health and care economy."

Just 18 months on, she knows the numbers of non-acute CDI infections and has details around which of those were avoidable and unavoidable and is starting to work on the key themes and trends which are emerging. Importantly, they are starting to see the results of their efforts. "We always knew that this wouldn't be an overnight thing, but we are already beginning to make a difference. We're getting better GP engagement, we're raising awareness with a lot of different groups, and we're trying to find – and fill – these gaps."

"We always knew that this wouldn't be an overnight thing, but we are already beginning to make a difference. We're getting better GP engagement and we're raising awareness with a lot of different groups."

Carley Tomlinson, healthcare associated infection lead, Chorley and South Ribble CCG and Greater Preston CCG

# Improving access to health services for homeless people

## South Kent Coast CCG

Encouraging people who are homeless people to engage with health services is a challenge nationally, and Folkestone in Kent is no exception.

Without a settled address, people who are homeless, or who are sleeping rough or couch-surfing often aren't registered with a GP, or, if they are, do not attend appointments.

Yet it's well known that homelessness comes with its own vulnerabilities and health problems, with conservative estimates suggesting that around three quarters of homeless people have physical health problems, while around eight out of ten have some form of mental health problem.

Just the group, then, that might benefit from flu immunisation, let alone other health services. But how to make it happen?

Commissioners at South Kent Coast CCG have taken the first steps towards tackling that conundrum by providing flu vaccines in a place that homeless and other disadvantaged people already are.

This is part of efforts to work with local organisations to try to provide services in a way – and places – that will capture those who might find it difficult, if not personally impossible, to get to a GP appointment, for example.

"There's a place called the Folkestone Rainbow Centre, a charity that runs a crisis drop-in centre for people in difficulty, including those who are homeless and vulnerable," explains Sue Baldwin, head of planning and delivery with South Kent Coast CCG.

"There are already some services based there – for example, a health trainer, and support from Turning Point [for people with drug and alcohol problems] – but we wanted to see what else we could do.

"So, as our starter for ten, as it were, we decided to try to wrap more services round the Rainbow Centre so that we could offer more help and support to people that use it."

From idea to implementation, the project – which started in early 2015 – took less than a year, and involved bringing together a number of organisations and individuals. "One of our GPs was very keen to do more work with homeless people, and we also involved public health, and others," says Ms Baldwin. "Really, we brought a group of people round the table to see what we could do to boost the support already given at the Rainbow Centre, and make it more flexible."

So far, this has included making imaginative use of staff and services already available through the CCG and public health commissioning. "The health trainer working there has lots of experience and understanding of people attending the Rainbow Centre, and those who have come out of prison and their needs," says Ms Baldwin. "And we know that medicines management can be an issue, so our head of pharmacy is now getting involved to look at how we might provide more support."

Commissioners are already working creatively to make a difference. The flu vaccination session is a case in point. Invicta Health, the primary care hub in Folkestone, delivered the vaccines in the centre.

"It was a drop-in clinic, essentially, and people using the centre were told that it was happening and given the chance to be vaccinated," says Ms Baldwin.

"The session attracted approximately 25 people, which we thought wasn't bad for a first attempt. In fact, we were pleasantly surprised by the number of people who were keen to have it."

Centre manager Richard Bellamy says that the session was publicised with posters, flyers (in different languages) and through word of mouth.

"I went to see it working on the day and was very impressed," he says. "Some of the people I saw being vaccinated would never had gone to see a GP – they are people who are really on the edge of society. It was great to see these disadvantaged people being given back their dignity in a place that they have come to trust."

Future plans include running screening services at the centre, hopefully through development of a locally enhanced service, for example, for blood borne viruses such as hepatitis and HIV, and screening for sexually transmitted diseases.

"These are people who probably wouldn't have accessed a flu vaccine if it hadn't been available at the Rainbow Centre," adds Ms Baldwin. "We have a big job to do, but we're making a good start."

"Some of the people I saw being vaccinated would never had gone to see a GP – they are people who are really on the edge of society. It was great to see these disadvantaged people being given back their dignity in a place that they have come to trust."

Richard Bellamy, Rainbow Centre manager

# Taking a strategic approach to stroke prevention

## Barnsley CCG

As a practising GP, Mehrban Ghani sees what cardiovascular disease (CVD) means for patients and their families. But as medical director of Barnsley CCG, he also sees its impact on health services and the wider social care and economic arenas.

The CCG has been working for the last two years on initiatives to reduce CVD in the population, taking a multi-pronged approach that is already having an impact.

For example, the CCG has invested in new high-specification ECG and blood pressure equipment for all GP practices, reducing variance and ensuring that everyone has access to the latest kit, no matter where they live in the Barnsley area.

It is also taking an innovative approach to health checks (see box), and working with people to help them make the changes that will help them live longer, healthier lives.

Like West Hampshire CCG (see page 24), commissioners in Barnsley have made atrial fibrillation (AF) a key focus of their efforts to reduce CVD. This condition, which causes an irregular and often abnormally fast heart rate, is the most common heart rhythm disturbance, affecting around a million people in the UK.

"A high prevalence of atrial fibrillation is a cause for concern because people are at risk of stroke unless they are on [anticoagulant] drugs like warfarin," says Dr Ghani. "But quite a significant number of people in our area weren't taking any medication or were taking aspirin, which we now know offers no benefit."

The new equipment is a key part of this. The ECG machines are integrated into the GP systems and are of similar quality to those used in hospitals, while the blood pressure machines can be used to detect atrial fibrillation.

The CCG has introduced a local enhanced service to encourage GPs to ensure that they are following the latest NICE guidance on AF, which is that people with a certain level of disease should either be taking warfarin (first choice) or newer anticoagulants (if they can't tolerate warfarin).

As part of the process, the CCG invested in training for GPs so that they were aware of the latest guidance and were confident in prescribing the new drugs where required. Practices were also empowered to monitor how well patients' conditions were controlled (INR) – a process that was traditionally the responsibility of secondary care.

"As a result of CCG investment, all practices have access to high-quality testing," explains Dr Ghani. "This improves the patient's experience, while also ensuring equity of access. We're also trying to reduce health inequalities. We know that life expectancy varies by seven or eight years, depending on where people live in our area, and we want to do something about that.

"As practising GPs, we see the harmful effect that CVD has on families, so our local practices were keen to do this. And from a CCG point of view, we see it as investing to save."

Commissioning to prevent disease and to reduce health inequalities involves taking a long-term view, he stresses. "We won't see results immediately – we hope that we are preventing strokes that would have happened ten years down the line.

"But we're taking a holistic approach, upskilling the workforce, giving practices the right equipment, and ensuring that they are supported by the medicines management team."

"Good clinical leadership is essential," he says, "and the CCG structure helps to make sure that change happens. Our members are practices, and our members have bought into this," he says. "We also make sure that everything passes the 'GP test'. We [GPs working at the CCG] all do at least two days a week in practice, so we know what's happening on the ground, and what is realistic. We also have the experience to recognise where our local needs are and what we need to do about them: what works in London might not work in Barnsley, for example.

"As commissioners, we have to look at the bigger picture – we can't just look at the day-to-day. But by taking that longer, broader view, the hope is that our patients will be less likely to go to hospital, and, of course, we'll be preventing conditions like CVD."

## It's the way that you do it

Barnsley CCG is taking a fresh approach to NHS health checks by making use of an in-house behaviour change expert.

Although the health checks are being delivered largely by nurses and healthcare assistants, they have been trained to do it in a motivational way, involving the patients in coming up with their own goals and finding a way forward.

"In the words of Bananarama, it ain't what you do, it's the way that you do it," explains Dr Ghani. "If we change the way we work with patients, and get them involved, then there is more chance that we will develop cultural change."

Other steps at the CCG have included appointing a CVD nurse and improving statin prescribing so that it complies with NICE guidelines.

"As commissioners, we have to look at the bigger picture – we can't just look at the day-to-day. But by taking that longer, broader view, the hope is that our patients will be less likely to go to hospital, and, of course, we'll be preventing conditions like CVD."

Dr Mehrban Ghani, medical director, Barnsley CCG

# Addressing early diagnosis of cancer

## Camden CCG

Camden CCG is harnessing the power of local communities in a bid to improve early diagnosis of cancer.

The CCG has commissioned a project that uses peer educators to improve cancer awareness throughout the borough, particularly in areas of high deprivation, and in the Bengali population.

According to Imogen Staveley, a GP in Kentish Town and the CCG's clinical lead for cancer, there's a real need to drive improvements. "As a nation, we've been lagging behind on cancer outcomes; it's a national issue, but there's also a lot of local variation, even in London. In Camden, we have a very mobile population, with ethnic and socioeconomic variation. Cancer is a leading cause of early death and a key driver of the difference in the most and least deprived areas. There's a huge need out there, and we think we can improve outcomes by catching cancer at an early stage."

The CCG has been tackling this from a number of angles. These include improving screening (Camden has the lowest rate of breast screening in England, says Dr Staveley), raising awareness of signs and symptoms of cancer and encouraging GPs to make appropriate referrals. "Too many cases of cancer are diagnosed in A&E," says Dr Staveley. "That's not the best possible experience for the patient and people diagnosed through that route tend to have poorer outcomes."

Awareness raising is being focused on people aged over 50 in four of the most deprived wards in Camden, and in the large local Bengali population. The idea is to use community organisations to link in with local people, getting information across in a friendly, often informal way, by encouraging local ambassadors to share messages.

A number of groups have been involved with the project from its inception, including the CCG, London Cancer, Cancer Research UK, the Bengali Workers' Association, and Tottenham and Arsenal Community Associations.

"The aim is to train trainers," says Dr Staveley simply. "They can then link in with local community groups, such as Bengali women's groups, to pass on that training to others."

Since the project started some three years ago, volunteers have spoken to around 6,000 members of the public in local communities. Lessons have also been learned. "It can be really difficult to work with community groups where they don't have infrastructure in place to do things like that," she says. "But it's a novel idea and there's been a lot of interest in it – I think it will be important for us to publish our results so that we can see if this approach works in actually raising awareness and improving early diagnosis."

Data, including on levels of cancer awareness, is being gathered, and this is currently being analysed.

Skilling up GPs to improve referrals has also been a priority for the CCG, which has, for example, commissioned education for practices. Innovative methods are being used to boost knowledge, including 'speed dating' type of events where GPs have the chance to quiz specialists.

Dr Staveley is realistic about the length of time it will take to make a real impact – although the peer education project has already reached more than 6,000 Camden residents. "In three years, you can't expect to make a big difference; it's iterative," she says. "But we hope that by involving communities in their own health in this way, that we can both prevent cancers and ensure that where people do get cancer, it's diagnosed as early as possible."

## Delivering health messages through community outreach

Alina is a community health ambassador for the Tottenham Hotspur Foundation, one of the organisations commissioned by Camden CCG, to deliver health messages to the public through community outreach such as workshops and stalls in places including libraries, supermarkets and job centres.

She finds it a rewarding, if challenging experience. "We get a mixed reaction from the individuals we speak to, from the positive 'if you guys weren't around we would never have known this' to the fatalistic, such as 'my family and friends have been diagnosed with cancer: it's in God's hands'.

"Through these conversations we try to transfer as much knowledge as possible, adapting our style to each individual."

Sometimes it's difficult, she says, because it can involve talking to people who don't want to listen, but having the conversations – and passing out information to other people – means she feels she is raising awareness to those who might not otherwise be reached.

"Even though I've worked in this role for over three years, it is still mindblowing to hear people's views on cancer," she says.

"We hope that by involving communities in their own health in this way, that we can both prevent cancers and ensure that where people do get cancer, it's diagnosed as early as possible."

Dr Imogen Staveley, clinical lead for cancer, Camden CCG

# Earlier diagnosis and prevention of HIV

## Corby CCG

The outcome for people diagnosed with HIV in the UK has transformed in the last quarter century. While there is still no cure, there are treatments that mean that most people with the virus can live long and healthy lives.

Early diagnosis is the key to this: getting started on antiretroviral therapy as soon as it is indicated not only improves outcomes for individuals, but also helps prevent passing the infection on.

So when NHS Corby CCG realised that a relatively high number of people with HIV were being diagnosed at a late stage (58 per cent compared to an England average of 45 per cent), they knew it was important to take action.

"We've been working on this in a multi-pronged way, and are beginning to see results," explains GP Joanne Watt, who has a special interest in HIV and sexual health, and who is interim clinical chair of Corby CCG.

"We actually have a high prevalence of people living with HIV in our registered population – more than two per 1,000 people, and that is rising. My own practice has a prevalence of 4.5 per 1,000.

"We know that people who are diagnosed late have worse outcomes, but that those who are diagnosed early stay well and are less likely to pass on the infection to others. People who take their treatment and get regular follow-up are now likely to have a normal life expectancy, can get life insurance and mortgages, and are able to follow most careers without restriction."

The CCG has been working with partners to drive up early diagnosis in a number of ways. This has included a determined effort to increase numbers of people being tested.

"Corby CCG first started to work closely with our local public health specialists prior to authorisation of our CCG in 2013," Dr Watt explains. "We were already aware that the public health data for our CCG showed some areas of significant difference in health outcomes compared to the rest of Northamptonshire. Our CCG has focused on these areas of health inequalities to improve the health of our population and prevent deterioration of health due to unrecognised chronic health conditions."

Corby has been adopting different ways of testing for HIV to get earlier diagnosis, she says. "For example, we've been working with Sunrise, our local HIV support charity. They are hosted by one of our member practices and carry out HIV finger prick testing on a drop-in basis in the 'Knowledge Clinic' every week, with results available in a few minutes.

"The practice also hosts a level 3 integrated sexual health clinic, which starts immediately after the Knowledge Clinic, and means that specialist care can be started for people who have a reactive test as early as possible."

Raising awareness of the importance of early testing among GPs and other clinical staff in member practices has also been a key component of the work.

"In February 2015, we held a protected learning time session and all practices attended, sending nurses and healthcare assistants as well as doctors," she says.

As well as being important for individuals, and to prevent transmission, early diagnosis also has implications for local health services, she adds. Simply considering HIV as a possible diagnosis at an early stage might mean that costly and often invasive investigations could be avoided. "Before someone is diagnosed, typically they might have undergone other tests and procedures – such as endoscopy, or biopsies – for symptoms that have nothing to do with anything other than HIV," she says.

There are also longer-term economic considerations – to put it bluntly, treating someone with advanced untreated HIV who has developed AIDS is enormously expensive because that's when the health problems really mount up. Avoiding that stage is desirable on financial as well as human grounds.

Improving confidence among non-specialists in promoting testing is also important, she says. For example, she will suggest HIV testing as part of a conversation about checking out a patient's immune system where symptoms or circumstances indicate that this might be a good option.

Two of the CCG practices are also taking part in a study where new patients are offered mouth-swab testing to detect HIV shortly after registering with a new practice, she adds.

"Public health colleagues and consultants from our local sexual health services worked together with primary care colleagues to try and raise awareness and increase HIV testing among professionals, and the North project for mouth-swab testing was part of this joint working," adds Dr Watt. "We were all aware that by diagnosing HIV at an early stage we would be preventing the onset of AIDS and reducing onward transmission of HIV. This would not only reduce morbidity but have additional financial and economic benefits."

The proportion of HIV cases diagnosed late is falling, says Dr Watt. "We are also monitoring the numbers of HIV tests requested by practices and would expect them to rise as clinicians gain confidence. We've also noticed that once a patient is diagnosed, they attend primary and secondary care services less as their health improves. It's still early stages, but early detection of HIV is already making an impact."

"We were all aware that by diagnosing HIV at an early stage we would be preventing the onset of AIDS as well as reducing onward transmission of HIV."

Dr Joanne Watt, interim clinical chair, Corby CCG

# Improving early diagnosis and treatment of people with atrial fibrillation

## West Hampshire CCG

Atrial fibrillation (AF), the most common cause of heart rhythm disturbance in the UK, is an unpleasant condition that causes problems including shortness of breath, dizziness and tiredness.

Importantly, however, it's also a major risk factor for stroke. What's more, people with AF who go on to have strokes are more likely to suffer serious long-term disability than other stroke patients.

That's why West Hampshire CCG (WHCCG) decided two years ago to make AF a priority in its stroke prevention activities – and it's already paying off. Even after the first year, the CCG could demonstrate a modest reduction in stroke and numbers are predicted to fall significantly in the medium to long term.

Before the initiative started in 2014, the CCG estimated that there were around 2,000 people with undiagnosed AF in West Hampshire. Under the leadership of Dr Chris Arden, WHCCG cardiovascular lead, the CCG bought 128 WatchBP machines for its 51 general practices, to be used in long-term conditions clinics, flu clinics, and health checks. The machines – blood pressure monitors that also detect AF – showed good results even in early tests, with one practice finding five new patients with AF in three months.

As well as finding undiagnosed patients, the CCG used audit tools to identify patients who had a diagnosis of AF but whose treatment had not been optimised. "The first phase, in 2014–15, involved finding people with AF and a high risk of stroke (CHA2DS2-VASc score of >1), and starting them on treatment with an oral anticoagulant medicine," explains Liz Corteville, a locality lead pharmacist with the CCG.

"We also had a legacy of people who were taking aspirin for AF stroke prevention, so we wanted to identify them so that they could be assessed for, and advised, regarding the option of more appropriate treatment."

GP practices were incentivised to find, assess and treat (where appropriate) the patients, and the initial phase has resulted in an 8 per cent yearly increase in prescriptions for all oral anticoagulants.

This phase required education and training for GPs, as well as support from the medicines management team. And it also needed investment in medicines, including newer anticoagulant drugs which are more expensive than the traditionally used warfarin, but don't require regular blood tests, and which extend the available treatment options for GPs and patients.

"AF has to be managed very carefully," says Ms Corteville. "These are treatments that aren't without risk, so the risks and benefits have to be considered for each patient. But we know that the right medicine, taken in the right way, substantially reduces the risk of stroke in patients with AF."

As well as the year-on-year increase in anticoagulant prescriptions, the CCG can demonstrate a significant drop in numbers of patients taking aspirin (as a stroke preventative). While 345 fewer patients were taking aspirin, 741 were receiving an oral anticoagulant for stroke prevention.

Significantly between September 2014 – March 2015 the total annual expected strokes for the year ahead in high-risk (for example, CHADS VASc score 2 or more) people with atrial fibrillation fell by 10 per cent, from 166 to 150.

Furthermore, from April to July 2015 there were seven fewer actual strokes than in the same period the previous year. Given that the CCG estimates that the health costs of one stroke amount to some £11,000 (jumping to £44,000 if you take social care costs into account), that's a significant saving.

The second phase (for 2015–16) involves reviewing patients already taking warfarin for AF. "We're looking for people who are poorly controlled on warfarin to see if they would do better with a newer anticoagulant," explains Ms Corteville. "We don't have results on that yet but would anticipate a further reduction in numbers of strokes."

This is, of course, significant in human terms too. Each year in West Hampshire, some 11,000 people will be affected by stroke or transient ischaemic attack. In the UK, around 12 per cent of people who have strokes will die within 56 days, while others will be left with severe disabilities.

In AF, the right medication, used correctly, will reduce the risk of stroke by two thirds.

"That's a real motivator," says Ms Corteville. "We have lots and lots of meetings, and this has been a real team effort, but when it comes down to it, what matters is that we're really making a difference to people and their lives. GPs will sometimes say that their hearts sink a little when they have to give a diagnosis of AF. It's not something you can do in a standard ten minute GP appointment. But the fact that they can really make a difference is what makes it worth it; that's the rewarding thing."

"When it comes down to it, what matters is that we're really making a difference to people and their lives."

Liz Corteville, locality lead pharmacist, West Hampshire CCG

# Working with the voluntary sector

## Hartlepool and Stockton-on-Tees CCG

Most people would agree that when it comes to illness, prevention is better than cure. Similarly, however, commissioners know that they have to grapple with the here and now.

But with budgets becoming more constrained, rising demand, and the availability of new, effective (and expensive) technologies, the challenge of squeezing a quart from a pint pot is only going to become more acute. That's why Hartlepool and Stockton-on-Tees CCG is taking prevention very seriously indeed. Along with colleagues in Stockton-on-Tees Borough Council, the CCG is working with local voluntary organisations to build healthier communities for now and in the future.

According to Andrew Carter, corporate governance and risk manager with the CCG, the new approach makes sense.

"You can solve many health problems by looking at the issues that underlie them," says Mr Carter. "Okay, if someone needs a hip replacement, then they need a hip replacement. But if you can support someone to stop smoking in pregnancy, then you're stopping problems for that child that might not have shown for 30, 40 or 60 years down the line."

Ever since its inception, the CCG has been keen to invest in initiatives that reach people who don't traditionally engage with primary care, such as older people who may be socially isolated, or at risk of dementia, families at risk of obesity, as well as smokers.

"As CCGs, we can be a bit limited in our reach – statutory services can be seen as corporate entities," says Mr Carter. "But working with the voluntary sector means that we can access organisations that are already embedded in communities, and people who really know what's going on in local areas, and what the needs are."

Specifically, commissioners and local public health have been working with Catalyst, which represents the local voluntary, community and social enterprise (VCSE) sector. The idea is that commissioners fund local organisations to carry out projects that align with CCG and Stockton-on-Tees public health priorities.

"It's partly about developing our community assets," explains Mr Carter. "We've been looking for projects that match with our aims and objectives, and which show a real return on investment, but understand that it can be difficult to separate health and community outcomes."

A small number of initiatives were chosen for funding in the first year (2013–14) with more coming on stream the following year. Initial results were published in 2015 in a formal evaluation, which suggested that the initiative was running along the right lines.

The individual projects cover a broad spectrum of conditions and situations, and the evaluation suggests that, on average, for every pound spent, around three is saved. With some, the cost argument is even more compelling.

For example, a home advice service run by Age UK generated £264,425 of value for an investment of £45,000. Also impressively, Close2Home, an initiative to provide a six ten week programme of reablement, confidence-building and welfare optimisation intended to support people and reduce hospital admissions and readmissions, created £1,026,938 of value for funding (over two years) or £220,311.

Building resilience in communities so that people don't need to use health services in the first place is also a priority. That's where things like community gardening or men's groups, or support for families come in. "By supporting someone at an early enough stage, we can potentially avoid getting to the point where they need a course of talking therapy, for example," says Mr Carter.

He points to A Fairer Start, a project that offers classes to parents in deprived areas so that children are ready to make the most of school when they get there.

"It's a really good project," says Mr Carter. "The aim is to ensure that every child gets a fair start in life, from an educational, health and social perspective. We're already seeing positive results in that outcomes for younger children are improving.

"Like much of the VCSE initiative, it's about investing now to give everyone a fairer chance – and that should pay dividends for all of us in the future."

"Working with the voluntary sector means that we can access organisations that are already embedded in communities, and people who really know what's going on in local areas, and what the needs are."

Andrew Carter, corporate governance and risk manager, Hartlepool and Stockton-on-Tees CCG

# Living Well having an impact

## Kernow CCG

It's the story of a man who wanted to walk his dog on a beach that sums it all up for Joy Youart.

The managing director of NHS Kernow CCG, which serves Cornwall and the Isles of Scilly, can point to many impressive results from the area's Living Well initiative.

These include a dramatic *34 per cent reduction in emergency hospital admissions and a 21 per cent drop in attendances at emergency departments.

But it's the human impact of the initiative that really brings it home for her. "The first person I met who had benefited from Living Well was a man in Newquay," says Ms Youart.

"His ambition was to be able to walk his dog on the beach. He hadn't been out of the house for two years, so it wasn't going to be easy. But different agencies were able to work together to support him to do it, for example, health professionals helped him to improve his fitness. As a result, he was able to walk his dog on the beach, and that made a huge difference to him and his wife."

The Living Well scheme, which brings together health, social care, the voluntary sector and communities to help people take control of their lives, is having a huge impact locally and is also making waves at a national level.

In a nutshell, it involves helping people to take control of their lives with the aim of reducing dependency on services. Developed with the Age UK integrated care programme, it is now supporting around 1,600 people in Penwith, Newquay and east Cornwall.

"The idea came from a GP in Newquay, who highlighted that many of the patients seen in general practice were people regarded as having run out of options," says Ms Youart. "In many cases, it was social, not medical issues that were bringing them to the surgery. Something had to change in the way that services were run, bringing together health, social care, the voluntary sector and communities, to help people live the lives they want to live."

The resulting scheme, Living Well, is focused on people identified as having a high dependency on health and social care services. In practice, that means people with two or more long-term conditions, or who receive certain social care packages. It also includes those who have received support from the early intervention service three or more times in the last 12 months, or who have been supported through an urgent response or emergency duty three times or more in the previous year.

People who are identified as being suitable – usually through being referred by their GP – are taken through a guided conversation with a voluntary sector worker, who can then help to build a programme around them. This could include referral for a formal health and fitness programme, or a social or voluntary activity that promotes health, independence and wellbeing such as sailing or a 'knit and natter' group.

"It's about talking to people about their goals – what they actually want to achieve. We want to know what's actually important to them, how people want to live their lives, and how we can support them to achieve that," says Ms Youart.

"We're taking a wellbeing approach, which looks at the whole person, and asks how we can keep people well for longer."

She believes the CCG approach has changed commissioning. "There's much more clinical input. CCGs started from a clinical perspective, looking at things on a population health basis. It's really that clinical lens that is making the difference."

The array of services and activities that are available is immense, she says, but it would be impossible for a GP to know the details of what there is locally. Voluntary sector organisations, working in the community, are ideally placed to see what will suit individuals. "There's all sorts of things connecting people together, like a group for blokes that brunch," she said.

The scheme is aligned with Cornwall's devolution ethos, which is that services should be designed around the needs of individuals, and that all sectors, including local business and enterprise, should be focused on making life better for people across the region.

Indeed, Ms Youart's advice for others thinking of following the Living Well path is ensuring that this common purpose is there. "You've got to get people aligned to the end goal," she says. "It's not an easy thing to do, but the things that glue you together are the sense of ownership and shared goals."

*Based on a cohort of 325 people supported by Living Well in Penwith from January 2014 to January 2015, the figures show:

- a 34 per cent reduction in emergency hospital admissions
- a 21 per cent reduction in emergency department attendances
- a 32 per cent reduction in hospital admissions overall.

"It's about talking to people about their goals – what they actually want to achieve. We want to know what's actually important to them, how people want to live their lives, and how we can support them to achieve that."

Joy Youart, managing director, Kernow CCG

# Social prescribing to improve outcomes in Gloucestershire

## Gloucestershire CCG

Mary Walker (name changed) was caring for her father, who had dementia, when she developed breast cancer. It was, to say the least, a lot for the Gloucestershire woman to think about.

But when she reached the stage where her treatment had finished, and her father had died, she was, she says "in a very bad place" and needed help to move on.

A routine visit to her GP introduced her to social prescribing, a model that uses a structured way of linking patients with sources of support within their communities.

People who are referred to the service have a conversation with a coordinator to find out about their strengths, and their goals. They are then put in touch with relevant organisations and community groups. This can include anything from art classes and exercise to self-help and volunteering, as well as support and advice for a wide range of issues such as benefits, housing, legal advice and parenting problems. One-to-one support is also offered for people who need it.

The initiative is a partnership between Gloucestershire CCG, G.DOC, the local authorities, Gloucestershire Voluntary and Community Services Alliance and third sector organisations and community groups.

Having started in just two localities, the scheme is now available in the majority of the county's 81 GP practices, with coverage of all practices expected by the end of this financial year; referrals will also be made by staff in community hospitals and integrated community teams.

Dr Simon Opher, a GP in Gloucestershire, believes that social prescribing enables health professionals to view patients through a social lens. "What excites me about social prescribing is that it provides a more holistic view of health. Due to the media and the cultural norms, a lot of mental health issues particularly can become overtly medicalised since they present in the first place to the doctor. GPs are increasingly being faced with problems such as bereavement and work stress or social isolation, which are really just normal episodes in being human. Social prescribing allows us to address these problems in a more creative and appropriate way."

According to Helen Edwards, who leads on social prescribing for Gloucestershire CCG, prevention and self-care are a key priority for local commissioners – and this approach is seen as one good way of achieving that.

By the end of November 2015, some 1,000 people had been supported through social prescribing. This includes Ms Walker, who, after an initial assessment, was referred to The Independence Trust. She was asked about what she needed help with, what would she like to achieve, the sort of work she would like to do, and what she would like to do in the meantime. Now she is volunteering with the charity Barnardo's, and is enjoying it greatly.

"It's just lovely being part of a working community again. I'd no idea that Barnardo's were looking for volunteers, although they'd been running a campaign for some time, so I wouldn't have found out about it.

"I don't know if it's too much to say that it's turned my life around."

Mrs Edwards says that the impact of social prescribing is having a really positive ripple effect – and that Ms Walker's case exemplifies that. "This is a great example of how people can be supported through social prescribing – and how they can help other people in turn," she says.

Although it's relatively early days for social prescribing, it's already having an impact. An interim evaluation has found that social isolation and mental wellbeing were the most common reasons for referral, and those taking part reported that the experience of the approach was positive, and that their mental wellbeing had improved.

Although sample sizes are small, 100 per cent of patients in South Cotswolds and almost three quarters (72 per cent) in the Forest of Dean saw an improvement in their health and wellbeing.

The initiative was boosted in April 2015, winning money from the Prime Minister's Challenge Fund to improve and scale up the social prescribing programme further.

"We're trying to make it systematic," explains Matt Pearce, senior commissioning manager (self-care and preventative strategies) at the CCG.

"We don't want it to be an add-on. We want to make the process as simple as possible so that it becomes just a part of what we do.

"The Five Year Forward View makes it clear that we need to look at people's health and lives through a wider social perspective. We believe that this social prescribing approach does just that."

"The Five Year Forward View makes it clear that we need to look at people's health and lives through a wider social perspective. We believe that this social prescribing approach does just that."

Matt Pearce, senior commissioning manager (self-care and preventative strategies), Gloucestershire CCG

## Cultural commissioning in Gloucestershire

The idea that arts and culture can be used to improve people's health and wellbeing is gaining traction, with research suggesting that it has a positive impact.

Gloucestershire CCG and partners (CREATE Gloucestershire, Forest of Dean District Council, Gloucester City Council and Tewkesbury Borough Council) have been working alongside the New Economics Foundation, the National Council for Voluntary Associations and Arts Council England as one of two national pilots to test out the feasibility of how arts and culture can in practice support clinical priorities, such as cancer, respiratory conditions, musculoskeletal problems, mental health and diabetes.

VCSE organisations were invited to bid for a range of projects through an innovative grant programme. This included projects on how to improve lung function through singing and exploring practical opportunities to support people with challenging behaviour caused by advanced dementia.

"We want to improve the health and wellbeing of our local communities with a specific focus on prevention and developing strategies for self-management of long-term conditions," explains Matt Pearce. "It could be that arts and culture have some of the answers that we're looking for."

## Further information and acknowledgements

If you would like to speak to NHS Clinical Commissioners about this report or any of the case studies, please contact Poppy Bragg, communications and networks officer, at **press@nhscc.org**

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