Welcome to Sutton CCG’s Annual General Meeting 2017/18

Dr Jeff Croucher MBBS FRCGP
Clinical Chair

@NHSSuttonCCG
www.sUTTONCCG.nHS.uk
Housekeeping

- Fire exit sign
- Microphone
- No mobile phone sign
- Bathroom sign: Male and female
Agenda

2:00pm  Welcome and Introduction: Dr Jeffrey Croucher, Clinical Chair

2.10pm  Review of the year 2017/18:
   Our Achievements: Sarah Blow, Accountable Officer, South West London Alliance of CCGs

2.25pm  Making a difference for patients:
   2:25pm – 2:40pm  Primary Care at Scale: Dr Chris Elliott, Clinical Lead for Primary Care
   2:40pm – 3:10pm  Sutton Health and Care: Michelle Rahman, Deputy Managing Director

3:10pm  Financial Review: Geoff Price, Director of Finance

3.30pm  Looking forward – our plans for 2018-29: Dr Jeffrey Croucher, Clinical Chair

3.40pm  Question and Answer Session

4.00pm  Close
A “snapshot” of Sutton

Produced by the Sutton Local Transformation Board (LTB) 2017

Compared to the average Londoner, people in Sutton ...

- live longer
- have lower rates of diabetes and heart disease
- do less than the recommended amount of exercise each day
- are more likely to be aged either 5-19 or 30-49

The population in Sutton ..... 

- are positive about their health. In a recent survey 75% said they feel in good or very good health.
- can feel lonely, with one in ten people saying they do not get enough social contact.
- is younger and less diverse than the London average.

Main health challenges for Sutton today

1. Too many people die too early from cancer
2. There are big differences in how long you live across the borough
3. Too many people, especially young people, are suffering with mental health problems

Life expectancy is

80.8 years for men and 83.5 years for women which is slightly above the national average
Who we are and what we do

• Clinically-led membership organisation
• 25 GP practices
• Responsible for the local NHS budget (£285.5 million)
• Our role is to:
  – Make sure that the budget is spent on the right services to meet the health needs of people living in Sutton
  – Commission hospital, community, mental health and primary care services
  – Monitor the quality of local health services
Our focus in 2017/18

• Our priorities are built from:
  – Sutton’s Health and Wellbeing Board Strategy
  – Our emerging joint health and social care strategy (the Sutton Health and Care Plan)
  – The developing South West London Health and Care Partnership plan

• Our priorities in 2017/18 were:
  – Contributing to the development of the Sutton Plan as the platform for Sutton Health and Care Plan
  – Development of the Sutton Local Transformation Board
  – Developing our Primary Care Strategy in line with the GP Five Year Forward View
  – Developing the Sutton Health and Care Programme
  – Development of CAMHs services as part of the CAMHs Transformation Plan
NHS England, the CCGs regulator, set the following priority areas for 2017/18:

<table>
<thead>
<tr>
<th>Clinical Priority Area</th>
<th>Sutton CCG Performance</th>
<th>NHS England Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Meeting most standards except standard for 62 day wait from GP referral to treatment (target 85%, actual performance 84.2%). Earlier diagnosis is improving.</td>
<td>GOOD</td>
</tr>
<tr>
<td>Maternity</td>
<td>Much improved patient experience reported in the 2017 patient survey, which was a priority for both the CCG and Epsom and St. Helier midwifery service</td>
<td>OUTSTANDING</td>
</tr>
<tr>
<td>Diabetes</td>
<td>NHS England has not yet published the 2017/18 assessment. The CCG was rated Good for 2016/17 and performance improved further in 2017/18 with high referral rates into the national diabetes prevention programme and developments in 2017 including new diabetes integrated care guidelines launched in September and redevelopment of both the intermediate (foot protection) and specialist (threatened limb) services.</td>
<td></td>
</tr>
</tbody>
</table>
NHS England, the CCGs regulator, set the following priority areas for 2017/18:

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<tr>
<th>Clinical Priority Area</th>
<th>Sutton CCG Performance</th>
<th>NHS England Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>NHS England has not yet published the 2017/18 assessment. The CCG performed well on the target that people with a first episode of psychosis should start treatment within 2 weeks of referral. CCG also has low rates of out-of-area placements. Performance on the two standards for Improving Access to Psychological Therapies (IAPT), for both the access rate and the recovery rate were slightly below target</td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>We are meeting the trajectory for Transforming Care Programme and improving performance on annual health checks</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>NHS England has not yet published the 2017/18 assessment. The CCG was rated Outstanding for 2016/17 and is continuing to perform well on both diagnosis rates and care planning and support</td>
<td></td>
</tr>
</tbody>
</table>
NHS England, the CCGs regulator, set the following priority areas for 2017/18 (cont.):

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Sutton CCG Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent &amp; Emergency Care</strong></td>
<td>Annual performance for A&amp;E 4 hour max. wait was 92.4%, and the whole NHS experienced a very challenging Winter. Although below the 95% target performance, Epsom and St. Helier was one of the best performers in London</td>
</tr>
<tr>
<td><strong>Elective Access</strong></td>
<td>Annual performance for patients waiting 18 weeks or less from referral to hospital treatment was 90.7%, below the 92% standard. We have maintained this level of performance despite an increase in demand for services.</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>Meeting standards. All practices in Sutton offer extended access appointments</td>
</tr>
<tr>
<td><strong>Continuing Healthcare (CHC)</strong></td>
<td>Meeting the three new standards, including timeliness of assessments and reducing assessments taking place in hospital</td>
</tr>
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Our achievements in 2017/18

Sarah Blow
Accountable Officer,
South West London Alliance of CCGs
Children and adolescent mental health services

- During 2017 we began a review and refresh of our Children and Adolescents’ Mental Health Services (CAMHS)
- We are committed to developing a comprehensive, joined-up, outcomes based CAMHS service to improve the emotional and wellbeing outcomes for children and young people
- We have a number of services designed to improve the mental wellbeing of our young people and are developing more
  - An on-line tool enabling 14-25 year olds to access advice and information and to self-refer is working well and is likely to be extended to 13 year olds
  - Young people wanting face to face support can attend a weekly drop-in session in a town centre location
  - A school based programme means each school has a named mental health lead who is tasked with developing a whole school approach to mental wellbeing for pupils
Sutton Health and Care programme

- Over the last year, partners in Sutton have worked collaboratively to design a new, integrated model of care for people - called Sutton Health and Care
- Commissioners from Sutton CCG and Sutton Council have worked with five local providers to identify a single vision, shared objectives and a ‘one service’ integrated delivery model under the banner of Sutton Health and Care.
- Sutton Health and Care launched the “at home” service on 1 April 2018
Developing our Primary Care Strategy: Extended access

• We worked with our local federation of GP practices – Sutton GP Services – to provide an average of 360 additional patient appointments each week under our Extended Access Programme

• Patients registered with a Sutton practice can book an appointment to see a GP or nurse from 8am to 8pm on weekends and from 6:30pm – 8pm on weekdays

• Located at two surgeries: Wrythe Green Surgery, Carshalton and Old Court House Surgery, Sutton

<table>
<thead>
<tr>
<th>Appointments available (01/04/2017 – 31/03/2018)</th>
<th>Appointments used (01/04/2017 – 31/03/2018)</th>
<th>% of appointments used (01/04/2017 – 31/03/2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18,771</td>
<td>14,388</td>
<td>77%</td>
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The Sutton Plan

We have been working with Sutton Council and other partners on the development of the Sutton Health and Care Plan (a key part of the Sutton Plan)

• Collaborating on a better system of health and social care that provides responsive, seamless, personalised and affordable services for all of those that need them - reducing the need for expensive in-hospital care

• Further promoting single point of access services that are easy to navigate and offer the right care at the right time

• Building upon existing initiatives to increase individual and community resilience

The Sutton Local Transformation Board, formed in June 2017, has been focussed on supporting the development of the Sutton Health and Care Plan
Sutton Plan – proposed health priorities

A thriving Sutton for Everyone

A coherent system of health and care that is shaped around the needs of Sutton’s residents

Think Sutton first
Work across sectors
Get involved early
Build stronger, self-sufficient, communities
Provide coordinated, seamless services

Children
- Special educational needs and disability (SEND)
- Emotional wellbeing of children and young people
- Readiness for School

Adults & Older People
- Preventative & Proactive care for Frail & Elderly
- Mental Health wellbeing for adults with Long Term Conditions
- Social Prescribing and social isolation
- Consistent quality of care across Primary Care
- Effective utilisation of resources to improve lifestyle and self-management

Learning Disabilities
- Earlier preventative and proactive support for children and adults with learning disabilities

Acute Clinical Sustainability
- Epsom and St Helier University Hospitals Acute Clinical Sustainability

Enablers
- Primary Care at scale
- Outcomes Based Commissioning reviews
- Digital Interoperability
- Effective use of population health analytics to support integrated care delivery
- Community Asset Delivery and Compassionate Communities
Sutton’s health and care plan will ....

- Be owned by Sutton Council, the local NHS and the local voluntary sector
- Address the developing health and care needs of the local population
- Outline the local vision for health and care and the health and care model being developed
- Identify and address the clinical, financial, workforce and sustainability issues in the borough so that we can take a system-wide approach to our collective challenges
- Identify what it means to *start, live and age well* in the borough and the actions that will be taken to ensure the vision for each is met
- Outline what the local system will do to support the SWL health prevention priority of Children and Young People’s Mental Health
- Allow partners to shape the developing plans including through their organisational governance structures
South West London Health and Care Partnership

NHS, local councils and the voluntary sector in south west London strengthening our commitment to work together to deliver better care for local people

- In November 2017, we published *The South West London Health and Care Partnership: One year on* for discussion
- Commitment to champion children and young people’s mental health and wellbeing
- Developing Sutton’s Health and Care Plan to be published in March 2019
- We will be hosting a Sutton Health and Care Event in November 2018
South west London CCGs

• **Committees in Common** agreeing collective decisions including funding for the transformation of primary care for 2018/19

• £4.58 million NHS England funding for this implementation providing 18,000 extra appointments each month

• **Cancer care** to improve cancer care for local people by focusing on:
  
  o Early and timely diagnosis and treatment
  
  o Improving uptake of bowel screening
  
  o Increasing screening uptake for people with learning disabilities

• Collective approach to **staying well this winter** to increase flu vaccine uptake and reduce pressure on A&E across south west London as a whole
Making a difference for patients in Sutton
Primary Care at Scale

Dr Chris Elliott
Clinical Lead, Primary Care
Primary care now – surviving?

Workforce:
- Inability to recruit to most staff groups
- Significant proportion of SW London primary care staff coming up to retirement age

Financial:
- Funding not kept pace with demand
- Rising cost of provision

Demand:
- Patient expectations
- Frailty and complexity
- Shift of care from acute to primary care

Estates and IT:
- Many practices operating out of poor estate
- Lack of investment and fragmentation in IT systems and support

Quality Issues
Sutton’s Primary Care Strategy: New ways of working

Enabling this:
- Increase training via multi-professional training hubs
- Recruitment drive reinforcing the benefits to living and working in Sutton
- Integrated cross-organisational records

- Diversify the primary care team to utilise a higher proportion of skilled nurses, healthcare assistants, pharmacists, etc to free up GPs for more complex care
- **Collaborate** across a **locality** footprint of approximately 50,000 population
- **Integrated multi-disciplinary team-working** to improve cross-organisational coordinated patient-centred care
Primary care future – thriving!

Workforce:
- New roles
- Supported, empowered workforce
- Feeling valued

Financial
- Transformation funding
- Operating at scale to reduce costs

Demand
- Self-management, education, prevention, social prescribing
- Technology solutions
- Alternative operating models

Estates and IT
- New commitment to primary care estate
- Online General Practice
- System interoperability
- Safe sharing of data and information

Resilient general practice, operating at scale and harnessing opportunities

Quality of Care, good clinical governance and systems of clinical quality improvement
What have we done already?

• Sutton already has an “at scale” provider
  – Successfully delivering Extended Access Service, 8am-8pm, 365 days per year
  – Provides anticoagulation support for domiciliary patients
  – Borough-wide proactive health checks programme
  – Clinical pharmacist team to support practices and free up GP time
  – Partners in the Sutton Health and Care Provider Alliance
What have we delivered?

• Established Primary Care Programme Board
• Primary Care Planning Workshops
• Developing projects with Sutton’s GP Federation to test:
  – Borough-wide home visiting service
  – Supported organisational development for Sutton GP Services, with further board to board discussions planned
  – Create at scale delivery through hub and spoke models
Implementation timelines

Pilot projects commence

Sep-18

Pilot evaluation

Jan-19

Mar-18

Apr-19

Business case for 2019/20 programme

End of year event and launch of 2019/20 programme
Sutton Health and Care
Proactive MDTs
Getting Started
Developing the proactive multidisciplinary team care planning model

Proactive Multidisciplinary Team (MDT) care planning is an enabler for both Primary Care @ Scale and the Sutton Health and Care Proactive Model, and forms one of the key priorities of our Sutton Health and Care Plan.

These integrated MDTs in each locality will work together to provide coordinated and proactive patient-centred care. The teams will:

1. Bring together existing staff across primary care, social care, mental health, community services, and hospital specialists

2. Focus on supporting prevention and early intervention through proactive case management

3. Identify and support people in their geographical area who are at risk of emergency hospital admissions

4. Work closely with the voluntary sector and communities in their locality to ensure people have the support they need to stay healthy and remain as independent as possible

5. Be aligned with GP localities, and potentially work alongside other providers to deliver services at scale

6. Be easy to access by care professionals and patients and/or their carers
Overview of delivery

Core Locality MDT team (tbc)
- GP (Practice GP)
- Patient advocate
- Social Worker
- Community Nursing
- Consultant Geriatrician
- Specialist Nurses
- Therapists
- Older Adults CMHT
- IAPT for LTC’s
- MDT Administrative support

1. MDT meetings per month (face to face &/or virtual)
2. Risk stratification (healing)
3. Referral for review
4. Review patient records and care before meeting
5. MDT care planning at meeting
   - Agreed care co-coordinator / case manager
   - Agreed MDT approach for providing support
   - Care plan developed with patient and/or their carer
6. Care plan shared with patient and/or carer
7. Regular review until discharged from proactive review list

Potential Enablers
- Social Prescribing
- Sutton Integrated Digital Care Record
  - Access by MDT team to shared information & care plan
- Coordinate My Access to CLAS, NHS111, Patient & MDT team to care plan
Implementation timelines

- Proactive MDT model finalised: Mid-Oct18
- MDT teams in place across all localities: Mid-Nov18
- MDT care planning started in Wallington & Carshalton Localities: Mid-Dec18

- Confirmation of people to be initially supported by MDT: Nov18
- MDT care planning started in Sutton and Cheam Locality: Dec18
- MDT care planning fully implemented across all localities: End Jan19
Sutton Health and Care

Michelle Rahman
Deputy Managing Director
An alliance of providers in Sutton is delivering services in a more holistic way

• Sutton Health and Care is operating as an **alliance of providers**, bringing together teams and staff from five partner organisations

• Staff will continue to hold their existing contract but are **working innovatively and as ‘one team’** to deliver improved care for people

• An **Alliance Board** is jointly accountable for delivering the new care model and how the funding shared between partners is being spent

• Day to day leadership and management of staff will be provided by an **Integrated Management Group**, with representation from across each provider organisation
Partners working together to deliver care differently in Sutton

Our commitments

1. We want to improve the health and care that people in Sutton receive. All partners have all committed to work together in a new way. As a result, Sutton Health and Care At Home Service went live on 1 April 2018.

2. Sutton Health and Care means one integrated service, one ethos, one approach and services without organisational barriers.

3. Teams supporting Sutton’s adult population from our five organisations are using one single assessment and care planning document, and offering one service – all designed to prevent avoidable hospital admissions and accelerated discharges.

4. Although staff remain with their current employers, staff are work as one multidisciplinary service. The team will evolve and grow throughout the rest of 2018/19 to support as many people as possible through extending the single integrated team service.

5. The removal of organisational barriers means that the person is at the centre of services and decisions about their health and care.
Case for change

The current system does not support our growing population adequately in a sustainable way

Increasing demand from an *ageing* and a *growing population*

As the population ages and *long-term conditions* (LTCs) increase in prevalence, providers and commissioners are being asked to do more with less

This makes the economy unsustainable in its present form

To ensure the Sutton economy can effectively support the population in the future, partners will need to work together to transform the way services are delivered
Sutton Health and Care aims to achieve an ambitious set of outcomes

**Aims**

- **Quality of life**
  - Reducing the need for admission to long term care
  - Optimising the health of people with long term conditions
  - Promoting independence and self-management

- **Patient experience**
  - Timely care
  - Responsive care
  - Patient-centred care
  - Joined-up care
  - Safe care

- **Operational performance**
  - Referrals accepted
  - Discharge destinations
  - Reducing readmissions
  - Reduction in to permanent long term care placements

- **Professional experience**
  - Staff opportunities
  - Recruitment and retention
  - Released time to care
  - Organisational development programme

- **Financial sustainability**
  - Reduction in A&E attendances
  - Decreased unplanned admissions and length of stay
  - Increased efficiency for all partner organisations

- **Sutton Health and Care aims to achieve an ambitious set of outcomes**
## I-statements

**Developed with Patient Advisory Group members**

<table>
<thead>
<tr>
<th>Timely</th>
<th>Joined up</th>
<th>Person-centred</th>
<th>Safe</th>
<th>Responsive</th>
</tr>
</thead>
</table>
| • I receive care from the right people, at the right time in the right place.  
• I am able to be discharged at a convenient time knowing I have support.  
• I feel satisfied that I know who will be involved in my care at my usual residence. | • I only have to tell my story/my needs once to the team.  
• I have the help I need to access and find my way through the service.  
• I have a supportive team working with me to deliver my care. | • I am making decisions about my care and my team understands my needs and preferences.  
• I am able to ask questions and get answers that I can understand.  
• I understand my care plan. | • I receive the help I need to be confident in my usual residence.  
• I have the knowledge and ability to manage at my usual residence.  
• I am supported to stay healthy and well at my usual residence. | • I know who to speak to if I have a problem or need support, as do my carers/family  
• I am treated with compassion, understanding and respect by the team providing my care. |
Bob and Barbara

We have used our example local residents from the start to design a system which keeps their needs and views at the heart

- Both 80 years old, live independently in their home in Sutton.
- They have one child nearby and very supportive neighbours.
- They have chronic physical health problems (including diabetes and Parkinson’s).
- Bob is increasingly confused and Barbara has had several emergency admissions to hospital in the last year. More dependent after each admission.
- They regularly see their GP, community nurses, hospital specialists, social care reablement team, dementia services, voluntary sector agencies.
- Bob and Barbara don’t want to bother their GP, feel she is very busy.
- They don’t mind seeing so many different people but it doesn’t help with Bob’s confusion and they are frustrated by repetition.
- They are concerned about managing the next stage of their lives.

One team without boundaries

Shared decision making

True team integration (some co-location)

Focus on what is important to service users

Shared information across organisations
## Spectrum of care

### Preventative
- Social prescribing
- Self management
- Patient education

### Proactive
- Risk stratification
- Case management and care navigation
- Multi-disciplinary locality teams

### Reactive – “Sutton Health and Care at Home”
- START social care
- Hospital discharge teams
- Community admission avoidance and discharge teams
- GP clinical co-ordinator
- “Step Closer to Home” ward
- Older adult mental health services

**Sutton Health and Care at Home launched on 1 April**
New Model of Care: Sutton Health and Care At Home

Sutton Health and Care At Home builds on existing good practice to enable teams to work across organisational boundaries to support people in a more holistic way.

<table>
<thead>
<tr>
<th>Rapid Response</th>
<th>Multi-disciplinary care delivery</th>
<th>Discharge to Assess</th>
<th>Step Closer to Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing access to rapid assessment from a team of professionals and short-term, intensive care packages for people at serious risk of admission, at home or in the Emergency Department (ED) or Acute Medical Unit (AMU).</td>
<td>Delivering targeted packages of care from a team of professionals for up to 6 weeks. The aim is to smooth transition from acute/high-intensity support back into long-term care, reducing the frequency of re-admission.</td>
<td>Supporting patients in hospital to be discharged in a timely way and receive their full assessment from a team of professionals at home, in more familiar surroundings, to provide an accurate assessment of individuals’ needs.</td>
<td>A short stay ward in-patient care for those who do not need acute hospital care, but need a level of ongoing care that cannot be immediately provided in their own home. Integrated whole system multi-disciplinary working will ensure timely, safe discharge, reducing the risk of re-admission and maximising each person's individual independence.</td>
</tr>
</tbody>
</table>
Our achievements

Where we started

- Duplication in work and processes
- Multiple assessments
- Working within organisational boundaries
- Patients bounced between different services

What we have achieved so far

- More effective ways of working to release more time to care
- Using a holistic care bundle encompassing all individual’s needs
- Deliver care as a single SHC Team to an improved care path centered around the patient
- Care coordinated collaboratively with patient through their entire journey
Review of financial year
2017/18

Geoff Price
Director of Finance
Financial targets

• We met all but one of our financial targets for 2017/18
  o We operated within our running cost limit
  o We met our cash targets
  o We operated within our capital limits
  o We met the requirement to pay suppliers (of health and non health services) promptly

• However ……
Financial targets

• We did not meet our target surplus of £1.2 million. Instead we incurred a deficit of £2.4 million.

• The main reasons for this were
  – Acute hospital expenditure around £7.5 million higher than plan
  – Continuing Healthcare expenditure around £2.7 million higher than plan

• These overspends were partially mitigated through reserves held and savings measures taken in year but not enough to prevent us from incurring a deficit.

• Because we incurred a deficit, and because of the level of risk in the 2018/19 plan, we commissioned an external financial review to support the formulation of a plan for financial recovery and long term sustainability.
Where the money was spent in 2017/18

- Sutton CCG spent £285.5 million in 2017/18. Of this £281.4 million was spent on commissioned health services and £4.1m (or 1.4% of total resources) on running costs.
- Spend can be analysed as

<table>
<thead>
<tr>
<th>Service</th>
<th>£m</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospital</td>
<td>155.6</td>
<td>54.5%</td>
</tr>
<tr>
<td>Mental health</td>
<td>23.8</td>
<td>8.3%</td>
</tr>
<tr>
<td>Community</td>
<td>43.6</td>
<td>15.3%</td>
</tr>
<tr>
<td>Primary care</td>
<td>29.0</td>
<td>10.2%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>24.2</td>
<td>8.5%</td>
</tr>
<tr>
<td>Running costs</td>
<td>4.1</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other</td>
<td>5.2</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>285.5</td>
<td>100.0%</td>
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The NHS faces very significant financial challenges and this applies to NHS Sutton CCG.

There is additional funding coming into the service from 2019/20 but at this time we do not know how much that will be and what conditions will be attached to it.

We are producing a Financial Recovery Plan and our Governing Body is committed to putting the CCG on a firm financial footing so that we can continue to commission the best available services on an affordable and sustainable basis.
Looking forward –
our plans for 2018/19

Dr Jeff Croucher MBBS FRCGP
Clinical Chair
Achieving financial recovery and sustainability

• Make difficult choices targeting limited resources on priorities
• Continue to work with patients and residents to inform priorities
• Decommission services faster where intended patient benefits are not realised
Integration

• Develop and agree the vision of integration – identifying what an integrated care system looks likes for Sutton

• Through the Sutton Health and Care Plan secure and deliver integration where coming together with partners delivers more than we can deliver on our own

• Build on the Sutton Health and Care model of service delivery taking into account findings from outcome based reviews
Recognising and building on community assets

Seek opportunities to work closer with:

- Voluntary sector partners
- Carers
- Community stakeholders (eg housing officers, fire services, faith and community groups)

Promote “start well, live well and age well” providing reactive services when required whilst actively promoting prevention, independence and self care