UEC Vanguard

Total Population Solution

SOLIHULL TOGETHER

for better lives

www.solihulltogether.co.uk

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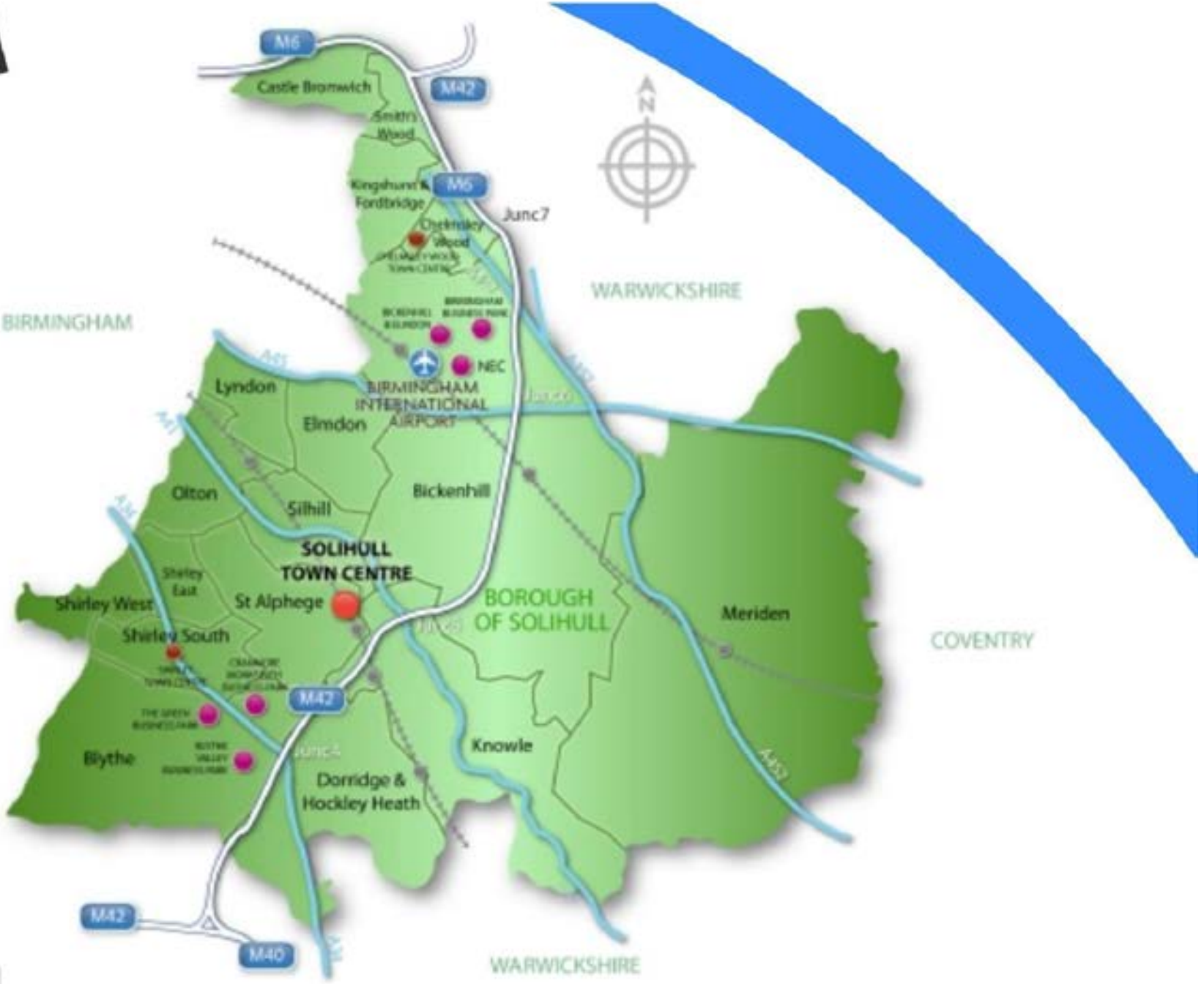
M6
M42
Castle Bromwich
Smith's Wood
Kingshurst & Fordbridge
M6
Junc7
Chelmsley Wood
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WARWICKSHIRE
BIRMINGHAM
NEC
BIRMINGHAM INTERNATIONAL AIRPORT
Lyndon
Elmdon
Olton
Silhill
Bickenhill
SOLIHULL TOWN CENTRE
Shirley East
Shirley West
St Alphege
BOROUGH OF SOLIHULL
Meriden
COVENTRY
Shirley South
M42
Blythe
Knowle
Dorridge & Hockley Heath
A452
M42
M40
WARWICKSHIRE



Our Vision for Solihull

Solihull in 2020

1. Strong Communities
2. Better Lives
3. Economic Prosperity

for better li

Governance

- Leaders Board / ICE
- Finance Directors
- Clinical Leadership
- Population Health IT
- Quality & Outcomes
- Communications
- Workforce
- PMO

Solihull Together Board

- *Birmingham & Solihull Mental Health FT*
- *Heart of England FT*
- *Local Primary Care*
- *Solihull CCG*
- *Solihull Metropolitan Borough Council*
- *Third Sector*
- *West Midlands Police*

Prevention & Early Intervention

Out of Hospital Care

Hospital Transformation

"Total Population Approach"

Community Well Being Service

Jack and Eileen will be able to access advice and support to enable them to live independent lives

Local Area Coordination:

- Online
- Telephone
- Advice and Support Hubs
- 3 Well Being Centres
- Care Navigation Service

Integrated Care Service

Wrapped around communities of c 40k pop

- *Mental health*
- *Community services*
- *Social care*
- *Integrated Frailty Service*
- *Dementia*
- *EoLC*

Frailty

- **Get in Early**
- **Choose to Admit**
- **Specialist Acute Care**
- **Discharge to Assess**
- **Recovery Before Placement**
- **Every Moment Counts**

All Age Urgent Care Service

- *24/7 Urgent Care Centre*
- *Clinical Advice Hub*
- *Ambulatory Care Service*

Solihull Together UEC Vanguard

1. Community Well Being Service
2. Integrated Health & Care Service
3. Urgent Care Service

Population Health Approach

Six Frailty Principles

- *Get in Early*
- *Choose to Admit*
- *Specialist Acute Care*
- *Discharge to Assess*
- *Recovery Before Placement*
- *Every Moment Counts*

Get in Early

Two thirds of risks to health independence and well-being in older people are not recognised.

- ***Community Well Being Service***
- ***Population Data (Caradigm)***
- ***Easy Care Assessment***
- ***Care Navigation***
- ***Local Information Portal***
- ***Social Prescribing***

Measurement

- **Proportion of older people over 75 who have had a holistic needs assessment**

Choose To Admit

2 hour 'Golden Window' when it is possible to provide safe and effective alternatives to admission for older people with a frailty crisis

- *Clinical Assessment Hub*
- *Integrated Community Teams*
- *Specialist Advice & Guidance*
- *Improved Diagnostics*
- *Ambulatory Emergency Clinics*
- *Step Up Intermediate Care*
- *Care Homes Projects*

Measurement
- Rates for Non Qualified admissions
- Adherence to Local Care Plans

Specialist Acute Care

Outcomes are improved by early access to frailty specialist

- ***Identify Frail Older People in Hospital***
- ***Early Intervention by Geriatrician***
- ***Comprehensive Geriatric Assessment***

Measurement

- **Time from 1st contact to senior clinical review**

Discharge To Assess

The majority of adverse events in hospital occur in older people awaiting discharge

- *Domiciliary Discharge to Assess*
- *Bedded Discharge to Assess*
- *Supported Integrated Discharge Service*

Measurement

- Reduction in numbers of patients Medically Fit for Discharge

Recovery Before Placement

Frail Older people take up to 6 weeks to recover from an acute episode.

- *6 weeks Rehabilitation and reablement prior to provision of long term services*

Measurement

- **Proportion of older people receiving long term care / placement without access to post acute pathway**

Every Moment Counts

Many frail older people experience recurrent admissions to hospital in their last year of life

- *End of Life Care Planning*
- *Advanced Care Plan*

Measurement

- proportion of people who have had a CGA with an Advanced Care Plan in place