Findings from the Complete Care Community Programme
2 years in

November 2023

Complete Care Community

healthworks

Arden&GEM

Life expectancy is a key indicator of the health of a population and is closely associated with people's socio-economic circumstances. The social gradient in health recognises the direct relationship between deprivation and life expectancy. Inequality in life expectancy is therefore a principal measure of health inequality.

Increasing life expectancy in the 21st Century has resulted from multiple factors, not least improvements in societal health behaviours, but it could also be considered as a sign of a successful health and care service.

However, unless a longer life is accompanied by increasing healthy life expectancy, it will result in increasing numbers of older people requiring care.

As the gap between total and healthy life expectancy also increases with deprivation, the biggest health gains could be achieved by a more targeted approach to those individuals and groups who are the most socio-economically challenged.

The NHS does not have, to date, a strong track record of this more targeted approach and for the first time in modern history UK gains in life expectancy have stalled. Does this question the impact that the NHS currently has on health inequalities?

A preventative strategy that gives greater emphasis to the health and care issues facing the most deprived citizens in our society should therefore realise the most substantial population health gains.

The Complete Care Community Programme (CCCP) was launched in April 2021 to investigate some of these issues and explore the extent to which the NHS can maximise its contribution in addressing health inequalities.

The CCCP is undertaking field work which is being carried out in numerous demonstrator sites across England and which currently cover nearly 3 million citizens.

More specifically, the CCCP has adopted an approach that;

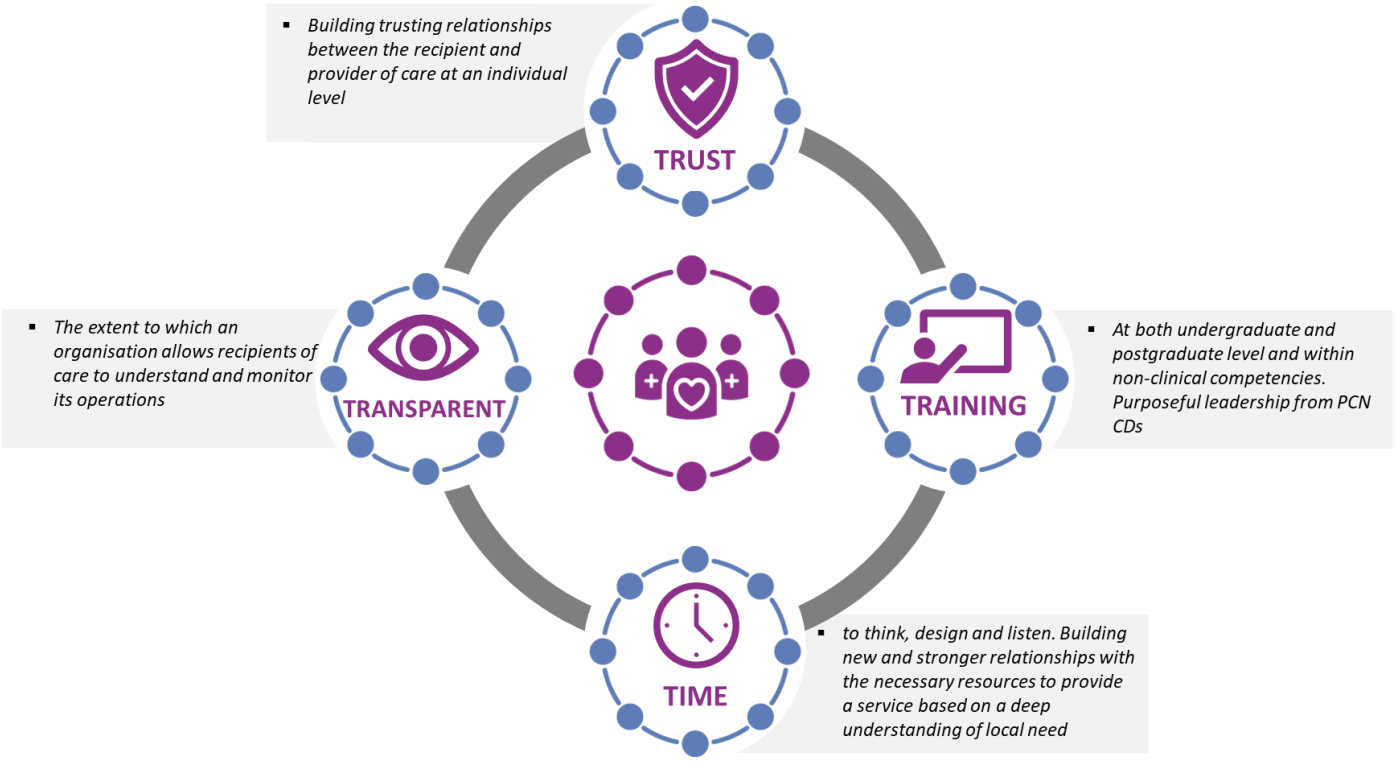
1. moves forward from merely describing the challenges, to enabling a better understanding and rationale for them and then developing strategies for change through new service development.
2. develops and uses multi-level designs and methodologies that facilitate a focus on the factors that impact on people's everyday lives and who are living with deprivation.
3. acknowledges the complexity, diversity, and reciprocity of the relationship between socioeconomic status and health.
4. provides an explanation of the increases in health inequalities from a local community causation perspective.
5. adopts a life-course approach and investigates the aetiology of socioeconomic health inequalities in defined population groups.
6. applies the science of spread and scaling to the findings from the CCCP demonstrator sites.

This is a multiyear task in a very challenging area of research. A programme has now been established that is providing data and starting to inform an approach which is demonstrating success in tackling inequalities in health.

Whilst the CCCP methodology can, and is producing many varied forms of delivery, the extent of the demonstrator sites' effectiveness does depend, at least in part, on;

- the adoption of strategies that are underpinned by social ecological principles,
- that are targeted and inter-sectoral,
- involve community participation, and
- that simultaneously focus on multiple entry points to care.

The first report from the programme highlighted significant findings in four key areas that can be summarised as the CCCP 4Ts. These are;



For individuals within defined population groups, successful care provision requires the building of a relationship between the recipient and the provider at an individual level, while for systems this trusting relationship is developed between the agencies involved.

For the marginalised population 'segments' which the CCCP is interacting with, the recipients have found problems with developing trust with agencies at various stages of the lives. A key aspect of the successful CCCP sites is how care providers have sought to engage with the recipients and to build a relationship in which the latter feel listened to and supported on their terms.

This 'trusted healers' relationship is the cornerstone to supporting 'hard-to-reach' individuals.

The CCCP has also now developed the concept of 'language empathy'. This means that conversations are at a level of understanding and expectation of the person with whom a carer or healer is speaking.

The NHS still has a need to improve health and care encounters and correspondence in which the NHS and the patient converse at a consistent level of comprehension.

CCCP sites have also found that 'demonstrative listening', that is listening with the same intent with which you wish to be heard, is particularly important for people who have previously experienced some societal exclusion.

A social concordance between care provider and recipient has also been found to be very important in connecting with 'hard-to-reach' people and groups.

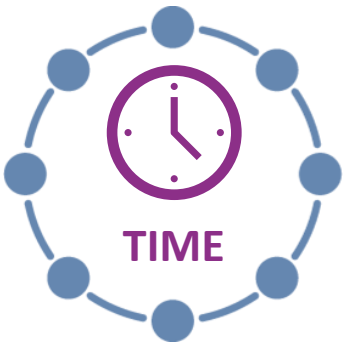
The CCCP espouses transparency. This refers to the extent to which an organisation allows recipients of care to monitor and understand its operations. It has historically been difficult to involve sections of the community in public participation exercises, not least to help them feel included in decision making about their health and care services. A key principle of the CCCP is that clarity should be given to how decisions are made and ensuring that recipients of care are involved in the process. Integrated Care Boards should be researching and understanding their own hard-to-reach groups in this way.

A finding in the first stage evaluation report highlighted a mismatch between what the care system was claiming, for example, in their performance of public inclusion and an individual recipient's actual experiences of it. Whilst there was a recognition that some variation would occur, especially if explanations which resonated with the recipients were provided, all too often such an approach was absent.

The CCCP demonstrator sites saw this component as having significant importance and are actively engaging their population groups in service design.

At both undergraduate and postgraduate level, considerable emphasis is placed on clinical aspects of care provision. However, successful project development in the CCCP demonstrator sites was equally dependent on non-clinical competences. Given the background to the recruitment of health care professionals, especially undergraduate selection, their experiences and appreciation of understanding of the marginalised groups' problems was found to be limited.

The successful CCCP sites reported that care providers who worked with other agencies, especially voluntary sectors were able to better understand the problems of the very groups that they were working with. Furthermore, a key finding in the initial work centred on the role of the Clinical Director to drive through the CCCP proposal within their Primary Care Network and the wider agencies involved.



Against a backdrop of variable and wide-ranging challenges, the CCCP cannot comprehensively address system shortcomings. It is not designed to do so.

Addressing the three aspects above requires significant time and resource, whether it be at an individual level or at a system level.

Time is needed to listen and gain a deeper understanding of the local as well as global issues that lead to inequity and inequality in care provision.

Time is needed to build relationships with organisations that use a different language and cultures to those found in the NHS.

The current allocative value in the NHS will need to be examined if adequate resources (time, people and funding) are going to be deployed in addressing one of society's greatest injustices.

To conclude

A different relationship and approach to care needs to be developed between the NHS and underserved groups of people if the NHS is to achieve its ambition in supporting a reduction in disparities and inequity in health and care.

The CCCP is helping to inform policy and strategies for change to enable the NHS to improve its impact in reducing health inequalities, both locally through its demonstrator sites and nationally through its evaluation of this collaborative approach with other organisations seeking to address the wider determinants of health.

We now wonder if Abraham Lincoln was referring to the gap in total life and healthy life expectancy when he is purported to have said,

"And in the end, it's not the years in your life that count. It's the life in your years."

Professor James Kingsland OBE
National Clinical Lead,
Complete Care Community
Clinical Director, Healthworks

Professor Paul Batchelor
Programme Office
Complete Care Community

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