Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Suffolk County Council**
Clinical Commissioning Groups	**Ipswich and East Suffolk**
	Great Yarmouth and Waveney
	West Suffolk
Boundary Differences	**Great Yarmouth and Waveney CCG is located in two HWB areas – Suffolk and Norfolk. The information in this template refers to the Waveney element of the CCG geography only, although where possible, plans are aligned with Norfolk plans for Gt Yarmouth.**
Date agreed at Health and Well-Being Board:	**Initial submission (version 8) agreed on 07/02/2014** **Second submission (version 11) agreed by HWB Chairman on behalf of the Board on 04/04/2014** **This submission (version 12) agreed by HWB Chairman on behalf of the Board on xx/xx/2014**
Date submitted:	**20/06/2014**

Minimum required value of ITF pooled budget: 2014/15	**£2,718,000**
	£50,042,000
Total agreed value of pooled budget: 2014/15	**£2,718,000**
2015/16	**£50,042,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Ipswich and East Suffolk
By	
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	Great Yarmouth and Waveney
By	
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	West Suffolk
By	
Position	
Date	

Signed on behalf of the Council	Suffolk County Council
By	
Position	
Date	

Signed on behalf of the Health and Wellbeing Board	Suffolk Health and Wellbeing Board
By Chair of Health and Wellbeing Board	
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Suffolk Better Care Fund Plan (the Plan) has been developed by working groups of the Suffolk Health and Wellbeing Board. The accountability for the development work is the two System Leaders Partnerships which include Chairs of the three Suffolk CCGs,

the Chief Officers of the CCGs, the Director of Public Health, the Director of Adult Social Care and Director of Children's Service, Chief Executive of the Norfolk and Suffolk Foundation Trust, Chief Executives of Ipswich, West Suffolk and James Paget Hospitals, the Chief Executive of Suffolk Community Healthcare, the Chief Executive of East Coast Community Healthcare, Healthwatch, Community Action Suffolk/Suffolk Congress representing the voluntary and community sector, the Cabinet Lead for Health and Adult Care and District and Borough representatives.

In the IEWS area the Health and Care Review has been led through three work streams which charged with developing a blueprint for a new integrated health and care system. Provider organisations have been involved in each of these three work streams and have played a core role in shaping the designs so that they meet the needs of people in Suffolk. One of the consequences of their involvement has been a greater understanding of the risks and opportunities of developing safe and effective care that puts the person at the heart of the design. This work is on- going.

The Plan builds on the outcomes of a leadership workshop in December 2013 for Health and Wellbeing members held in 2013, further collaborative work through January, February and March 2014, the Suffolk Joint Health and Wellbeing Strategy and existing engagement throughout the three CCG areas in Suffolk. These have included:

- A Great Yarmouth and Waveney integrated care system event in December 2013, attended by all public sector commissioners and providers from the area including health and social care. At this event the development of an Integrated Care System was fully debated including the opportunities presented by the Better Care Fund. Key principles were agreed and issues discussed in greater detail to inform the plan including seven day working, cohesive pathways, combining budgets and impacts on the workforce.

- In the Ipswich and East and West Suffolk (IEWS) areas, two initial workshops to build the vision for integrated care were attended by provider organisations. During these workshops they played a critical role in shaping the vision going forward, and the work streams that are developing the proposed changes.

- There has been extensive provider engagement in a number of work stream groups, and forums where practical plans for integration have been developed, for instance around urgent and integrated care.

- Market shaping events and provider forums run by Suffolk County Council have involved our private sector partners in redesigning the home care market for a more integrated system.

- Two mental health workshops (April 2014) have been co-produced between service users and commissioners focussing on early intervention and prevention, crisis response and recovery. The workshops will support the development of the Suffolk Needs Assessment for Mental Health, shape the 5 year Joint (CCG's and County Council) Commissioning Strategy for Mental Health and clarify how to continue to engage with service users and mental health organisations alike.

The Health and Care Review is supported by a resource hub which brings together key enabling functions. Provider organisations are involved in a number of these functions:

Financial modelling - Commissioners will be working closely with partners towards achieving the savings in the acute sector, namely 15% reductions in emergency non-elective activity and 20% efficiency savings in planned care.. A commissioning modelling group has been developed to understand the impact of changes to service specification, flows of finance around the system, and to help build the business cases for change. This work will be shared with provider organisations.

Workforce development - A county wide joint workforce development forum has been established across the whole of Suffolk and the acute providers in Suffolk are core members of this group. This forum will be working closely with commissioners to reviewing the workforce requirements as plans develop, looking at roles and skill mix as well as organisational development and reflective team learning.

Property – Commissioners are working with provider organisations to achieve colocation as a core element of the Health and Care Review design and better use of the Suffolk public sector estate.

In the IEWS CCG area some services currently provided in out of county acute settings will be provided in Suffolk, some in community settings for example:

- Review of the obesity pathway and weight management treatment services which will result in a better experience for patients at a lower cost.
- Reduction in acute activity and out of county placements for Children and Young People and people with mental health problems and learning disabilities.

Commissioning organisations across Suffolk are also using contract negotiations to achieve alignment of provider organisations and the market to the developing plans.

Examples of this include:

- Suffolk Brokerage contract includes a provision for working with both health and social care staff to support workforce development in an integrated system.
- Identifying services currently provided in an out of county acute hospital that will be in community settings within Suffolk.
- Block contracts and design requirements for new builds to replace ex-SCC residential care homes are increasing capacity for residents with complex needs, including nursing and dementia care.
- The CCGs are supporting GP practices in transforming the care for patients over 75 years old by providing funding to commission additional local services that will improve the quality of care for older people and reduce avoidable emergency admissions. This funding is seen as an enabler to the CCGs' Integrated Care programme in supporting people with complex needs. The CCGs are supporting primary care to develop plans relating to case finding, comprehensive assessment and proactive case management with shared care planning. The plans being developed by primary care aim to further develop the accountable GP and case management approach to managing people with complex care needs with a focus on

prevention and admission reduction.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our Plan is based on what people have told us is important to them over a number of years. We know, from Suffolk consultation events, the Voice Project and involvement forums that people are less concerned about structures and more concerned about their own care and independence, and that any support should be tailored to their needs, provide them with choices and control, be delivered with dignity and respect and for their care to be planned with them, so that it will support their aspirations of living well.

In developing our integrated health and social care plans we are also building on pre-existing partnership work and plans, which have had active public, service user, patient and family carer involvement. The views of these groups have been regularly sought with wide ranging engagement events to inform the development of integration and future commissioning intentions.

For example, in the Health and Care Review stakeholder events were held prior to the Urgent Care work stream starting to inform the work programme, for example Town Talk Village Voices where lead GPs and officers went to ten locations across East Suffolk, such as Felixstowe's Morrison and Ipswich Crown Pool, asking for the public's opinion on the NHS 111 service and what would they would like the NHS to do differently if they were taken suddenly ill. In addition, we are building on existing public consultations, working alongside patient groups in GP Practices, and the Council's connecting communities work in localities, working with Healthwatch and Health Scrutiny Committees.

The Suffolk System Leaders Partnership agreed an Engagement and Communication Plan in February 2014, which aims to

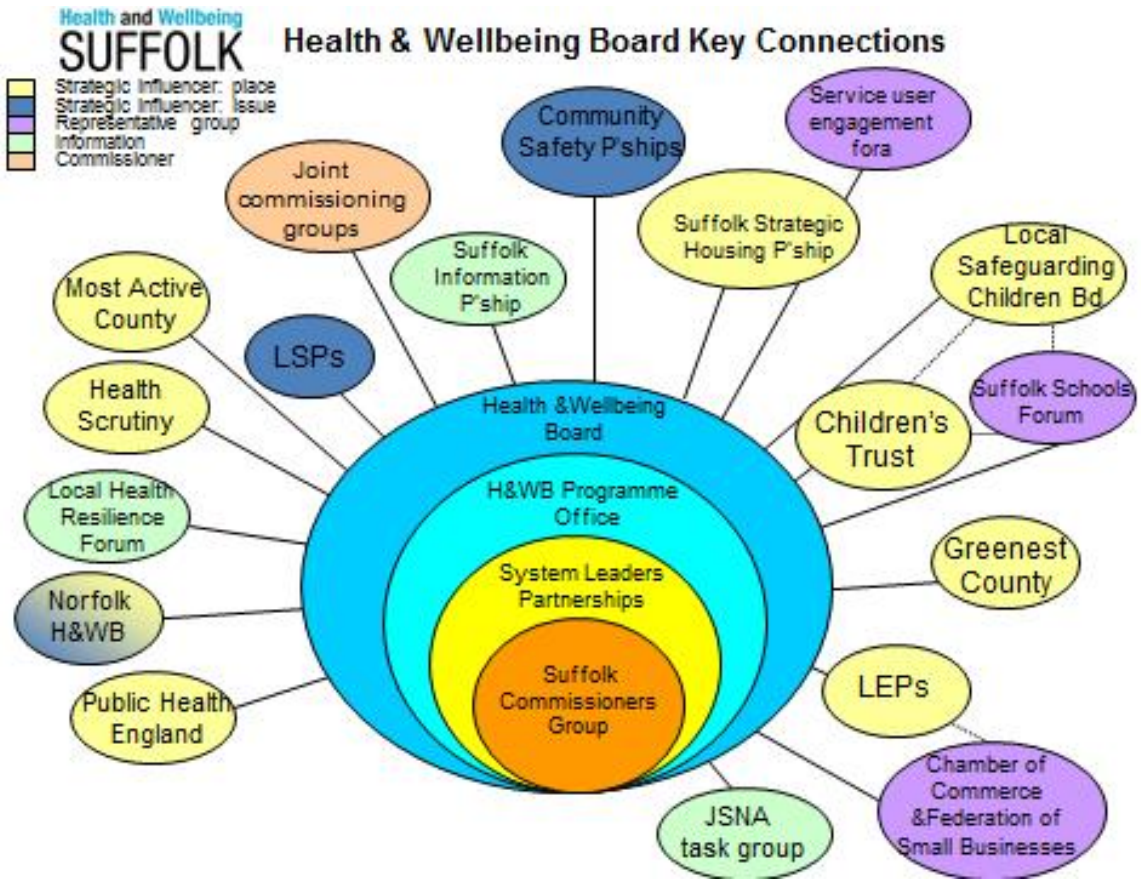
- Ensure that engagement starts with co-production with people who use our services
- Include statutory and voluntary stakeholders, with service users as equal partners
- Recognise the need for engagement with staff
- Ensure engagement and communications are planned and co-ordinated
- Build a long term engagement partnership across organisations in Suffolk

The Engagement and Communications Plan enables the SLP to ensure that key messages and questions are developed and that there is a timetable for engaging with key partners not already involved with the Health and Care Review. Healthwatch and other voluntary sector partners have agreed to lead on co-production and engagement with service users and to bring insights and experience into the debate.

We have a track record of co-production, for example in developing our integrated plans for dementia services, in integrated health and care service delivery for children in our Suffolk Family Focus (troubled families) programme, in Lowestoft Rising (testing place based models of service delivery) and in the development of the new operating model for adult social care: Supporting Lives Connecting Communities and children's services:

Making Every Intervention Count.

The following diagram shows the Suffolk Health and Wellbeing Board organisational engagement map.



This diagram shows the connections from the Suffolk Health and Wellbeing Board and the two System Leaders Partnerships in Suffolk (which include a wide range of commissioner and provider organisations).

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
A Joint Health and Wellbeing Strategy (JHWS) for Suffolk	Sets out a joint vision for health and wellbeing in Suffolk. The focus of this report is on four areas jointly agreed as priorities for the first three years of a 10 year health and wellbeing strategy, 2012-2022. The priorities are used to provide focus for plans across health, local authorities and other relevant organisations ensure sure we work together as efficiently and effectively as possible, spending public money in a better way. http://www.transformingsuffolk.co.uk/partnerships/suffolk-health-a-wellbeing-board
Joint Strategic Needs Assessment (JSNA)	The Suffolk JSNA is a suite of resources to inform health and care commissioning. It is formed of a dynamic set of data presented in the Suffolk Observatory, alongside reports, profiles and health needs assessments produced to inform the JHWS and other commissioning plans and strategies. http://www.suffolkobservatory.info/jsna.aspx
Ipswich and East CCG Operational Plan 2014/15 – 2015/16	The Operational Plan includes the key operational metrics needed to support the assurance of and measure performance against strategic plans including financial and QIPP plans. http://www.ipswichandeastsuffolkccg.nhs.uk/Portals/1/Content/Library/Governing%20Body%20papers/25%20March%202014/Agenda%20item%2008%20-%20IESCCG%2014-14%20Two%20Year%20Plan.pdf
West Suffolk CCG Operational Plan 2014/15 – 2015/16	The Operational Plan includes the key operational metrics needed to support the assurance of and measure performance against strategic plans including financial and QIPP plans. Operational Plan 2014/15 and 2015/16 | NHS West Suffolk Clinical Commissioning Group
NHS Great Yarmouth and Waveney CCG Operational Plan 2014/15 – 2015/16	The Operational Plan includes the key operational metrics needed to support the assurance of and measure performance against strategic plans including financial and QIPP plans. http://www.greatyarmouthandwaveneyccg.nhs.uk/page.asp?fldArea=4&fldMenu=4&fldSubMenu=2&fldKey=442

Document or information title	Synopsis and links
Suffolk County Council Cabinet Paper 21 February 2012: Adult and Community Services: Supporting Lives Connecting Communities	Within Adult and Community Services (ACS) a new social work operating model has been developed to reflect the directorate's Service Plan and priorities including the new way of working titled: Supporting Lives, Connecting Communities (SLCC). SLCC relies on a person centred approach to planning and designing care, collaborative working between all parties around the person, keeping people li**v**ing independently at home, helping people to help themselves, putting people in touch with what's happening in the community that can help them, getting people back to independence as quickly as possible after a crisis and providing ongoing support only for those who need it. http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=0900271180640bea&qry=c_committee%7e%7eThe+Cabinet
Great Yarmouth and Waveney CCG Engagement Strategy	This Engagement Strategy reflects the vision and goals of HealthEast. It builds on extensive engagement completed during the development of NHS Great Yarmouth and Waveney's Communications and Engagement Strategy, with focus on patient engagement and clinical commissioning, engagement from staff, partners, stakeholders, individuals and groups, as well as a baseline mapping exercise. http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/commsandengagementstrategy_july2013update.pdf
Tricordant Report: Joined up Services for Older People	The Tricordant pathway enables health and social care integration at both micro and macro-levels. Tricordant was jointly commissioned to map its person centred health and care pathway for older people in Suffolk. It included not just partnership between health and social care, with local authority housing, leisure and education services as well as the police, backed by the social capital in the voluntary and faith sectors. This work has informed the service model design, priorities and work programmes. The outcomes of this report was taken to the shadow Health and Wellbeing Board on the 1st December 2011 within the Suffolk Ageing Well – Transformation for Achievement Stage 2 Report". Copies of the HWB report are available from Committee Services at Suffolk County Council (committee.services@suffolk.gov.uk)

Document or information title	Synopsis and links
Terms of Reference GYW Integrated Care System Programme Board	Sets out the remit and responsibilities of the Programme Board http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/agenda_governing_body_part1-30january2014.pdf
Integrating health and care systems to support healthy ageing: Public Health Suffolk December 2013	This paper summarises the findings from an evidence review of health system models that support healthy ageing. The review focuses on healthy ageing policies and on the integration of health and social care systems. Both local and international examples are presented. Discussed at the Health and Wellbeing Board on 12th December 2013. http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=0900271180fc1023&qry=c_committee%7e%7eSuffolk+Health+and+Wellbeing+Board
Everybody Counts – Planning for Patients 2013/14	Outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners. http://www.england.nhs.uk/everyonecounts
Age UK Suffolk – Voice Project Reports	Older people are interviewed individually in their own homes, two or three times per year, on various subjects. These are agreed by a reference group, with members from Suffolk County Council ACS, NHS Suffolk, NHS Great Yarmouth and Waveney, Age UK Suffolk and representatives from older people themselves. Voice Project | Age UK Suffolk

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The Better Care Fund is an opportunity to accelerate progress in delivering the vision of the Suffolk Health and Wellbeing Board (HWB). In particular the focus on early intervention and prevention, ensuring services are integrated at the point of delivery.
The Health and Wellbeing Board vision is that people in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent. This will be delivered through achieving greater improvements in more disadvantaged communities.

Health and wellbeing encompasses a person's life experience and includes a sense of physical, mental and social wellbeing. Many factors contribute to a person's wellbeing for example how safe they feel in their community and whether they are able to find a job. We are committed to putting an equal priority on mental health, physical health and frailty in our integrated plans. Through working jointly across health, local government, the Local Economic Partnership, Suffolk Constabulary and with wider communities we can make a real difference in improving the health and wellbeing opportunities for adults, children and families in Suffolk.

Our organisations are committed to creating and delivering an integrated health and care system that supports our population to stay well and to live independently with a good quality of life, with rapid access to the right care in an emergency that meets clinical need. All partners are committed to delivering high quality person centred services, and agree that the only way to do this effectively is to work together to remove barriers, costs and ensure that we spend as much of our budgets as possible on direct provision of care. We believe that a more integrated system will help us to manage demand pressures, as well as give us the ability to use our funding more effectively whilst providing improved customer experience for an adult, child, or someone with a mental or physical illness or a learning disability.

There are existing examples of good practice in Suffolk that we are building on and learning from. These include the integration of universal children's health services into frontline County Council children's social and community services, our joint mental health teams in Suffolk, Suffolk Family Focus and Lowestoft Rising.

The current national, regional and local position provides a unique opportunity and responsibility for transformational change in the system, breaking down historic organisational barriers and radically re-thinking how care is provided in Suffolk, with a much greater focus on preventative action. This is what we have signed up to in Suffolk.

To do this the Suffolk system, including all our local health services, care services, district

and borough councils, Suffolk County Council, our three Clinical Commissioning Groups, our local GPs and our voluntary sector and communities are developing a united vision, focussed on outcomes for integration which allow localised transformation to happen. To deliver this we will provide determined leadership to build a different system, one that works for our customers and patients and is financially sustainable.

Crucial to this is an ambition to focus on our system as a whole rather than fragmented services and organisations with different priorities and drivers. We believe that this shared vision, shared principles and shared priorities will enable us to achieve more than we are able to on our own. We are committed to removing organisational barriers and to having a relentless focus on improving the mental and physical health and care outcomes for people in Suffolk, designing seamless services and support to promote independence, and preventing further dependency on long term and emergency health and care services.

As a system, we want to invest in the right things for our customers and patients. We know there are perverse incentives in our systems that encourage and reward individual organisations, which prevent money moving flexibly around the system and which perpetuate the differences between acute/community/non-acute care. We are clear that this is not in the overall interests of people in Suffolk. We will identify these perverse incentives through our work, and seek to remove them wherever possible.

There are some established building blocks for integrated health and social care in Suffolk:

- Suffolk Commissioning Group (SCG) which is identifying joint commissioning intentions and joint commissioning frameworks, starting with areas identified in the Tricordant Joined up Services for Older People review.

- Developing neighbourhood teams at a local level as multi-disciplinary networks for pro-active health and social care, with shared information, assessment and care planning processes.

- A Multi-agency Safeguarding Hub.

- Children and Young People (CYP) services in Suffolk County Council are delivering integrated children's universal community health services involving Health Visitors and School Nurses working as part of integrated teams including Children's Centres and Early Years services (traditionally separated into NHS and Local Government arrangements), and have developed award winning ways of working.

- Suffolk commissioners have rewritten the Suffolk Children's Emotional Health and Wellbeing Strategy (CEWG) (previously CAMHS strategy), refreshed the supporting multi-agency governance and identified a supporting Children's Emotional Health & Wellbeing action plan to implement. A 'resilience hub' service specification has been developed across partners which sets out the full pathway approach of access to services for CYP between providers from universal to targeted and specialist provision .

- Within Great Yarmouth and Waveney (GYW) we have a vision for a fully integrated care system which will put individuals at the centre of services, with the needs of the person dictating the way the system responds, rather than requiring them to move between artificial organisational and funding barriers.

- A joint approach has been adopted for the commissioning and delivery of integrated dementia services in Suffolk. We have completed a dementia needs assessment to inform joint commissioning.

- A joint strategic needs analysis for family carers has been commissioned and we are exploring how the funding allocated to family carers in the Better Care Fund can best be used to deliver effective support for family carers.

- District and Borough Councils are exploring how housing advice, streamlined adaptations and housing options can play a part in the multi-disciplinary networks we create.

Our shared vision presents huge opportunities – to deliver excellent care within our communities, to support people, families and children who are tipping into need, to ensure they get the help they need early so that they can stay as well as possible with a good quality of life.

Why is this important now?

Suffolk patients and customers have told us repeatedly that they want to experience a joined up system. The National Voices patient centred coordinated care overarching definition is: "Integrated care means person centred coordinated care [where…] I can plan my care with people who work together to understand me and my carer(s),allow me control, and bring together services to achieve the outcomes"

Reductions in public sector funding are placing a severe strain on all our organisations. This coupled with rising demand, means that we need to make a transformational change in how we deliver services, in order to continue to provide high quality and comprehensive services for the people in Suffolk.

How will we achieve our shared vision?

System leaders are ambitious and are working towards wide scale transformational change that will deliver better outcomes for people. Action that is underway includes developing an expanded pooled funding arrangement so that the amount pooled in Suffolk is much larger and therefore more aligned to the scale of the changes planned. We are not yet able to confirm the value of this as this will depend on further due diligence. We are currently designing specifications for how our integrated system will work. Our systems are tackling this in different ways, but both in Waveney and in IEWS there is a clear vision and outcomes against which the designs are being built.

Our work is underpinned by a belief that we are doing the right thing, and we are testing

out our assumptions by looking at established good practice examples and evidence bases. We are doing so in line with the Kings Fund advice that “decision-makers must balance evidence-based decision-making with a willingness to innovate and try out different approaches”.

Integral to the delivery of our vision will be the involvement of local councillors and community champions: both play a leadership role in their localities.

System leaders have initiated programmes to develop our integrated systems. In IEWS the design is being managed through three work streams: Health and Independence, Urgent Care and Effective Elective Care. In Waveney the focus is on pooling budgets, combined management of teams and collocation of teams.

The difference we will make to people in Suffolk is:

- They will not have to navigate around a complex system to find the right information, care or services that meets their needs.
- They will have their physical and mental health and care needs identified early before a crisis occurs.
- They will have access to a range of local services that focus on supporting people to self-care and supporting primary prevention.
- They will have control and choice over their care, with greater access to personal health and care budgets so that they can manage their own health and support costs.
- They will have a named co-ordinator when they need help who will ensure that the system works effectively, with a single care record.
- They will have access to planned care when they need it.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our aim is to provide care and support to people in their own homes and communities wherever appropriate, by:

- Improving the quality of the services across health and social care, including mental health for our local population.
- Reducing inequalities of both access and outcomes.
- Co-ordinating support around individuals which is are targeted to their specific needs.
- Providing effective support for people with dementia living in the community.
- Reducing premature mortality and morbidity.

- Improving the experience of care, with the right responses available in the right place at the right time.
- Maximising independence by constructing individual, family and family carer resilience at home and in the community.
- Empowering people to manage their own health and wellbeing.
- Developing proactive and joined up case management, with a focus on reablement, rehabilitation and recovery to avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.
- Delivering an integrated urgent care system covering health and care needs .
- Meeting health and care needs with the minimum intervention necessary.
- Providing urgent care for people in Suffolk 24/7 with consistently high quality patient experience and outcomes.
- Achieving the principles, including parity of esteem set out in the Mental Health Crisis Care Concordat.
- Caring for people in Suffolk will be improved by professionals having shared access to information systems ideally with a single care record.
- Developing sustainable long-term improvements to local skills and leadership to ensure that future urgent care needs are anticipated and met for people in Suffolk
- Securing a stable future for all health and social care organisations.
- Improving the efficiency in the provision of the services.
- Creating a sustainable health and care market.

Our aims and objectives are underpinned by the Joint Health and Wellbeing Strategy Outcomes and priority areas, and in particular the following:

1. Prevention including the promotion of health lifestyles and self-care
    a. Decreasing falls and injuries in the over 65s
    b. Decreasing hip fractures in the over 65s
    c. Increasing proportion of over 65s receiving self-directed support
    d. Increasing proportion of vulnerable people achieving independent living
    e. Increased community –based opportunities to promote personal wellbeing indicative measures
    f. Decreasing permanent admissions to residential and nursing care homes
2. Increasing the levels of physical activity
    a. Reduction in the prevalence of obese adults
    b. Increase in the proportion of physically active adults
3. Ensuring health and social care services are integrated at the point of delivery
    a. Decreasing emergency admissions within 30 days of discharge from hospital
    b. Proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
    c. Proportion of people who use services and their carers who report that they had as much social contact as they would like
    d. Increased proportion of people with long term conditions supported to manage their condition
    e. Increased proportion of people who are able to die at home
4. Reducing loneliness and social isolation for older people
    a. Increased self-reported wellbeing

5. Seamless mental health provision across agencies but also for those with multiple problems
    a. Decreased under 75 mortality in adults with serious mental illness
    b. Decreased rates of suicide

These measures are captured on behalf of the Health and Wellbeing Board and monitored at each Board meeting.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The Joint Health and Wellbeing strategy gives us a clear mandate to integrate health and care services at the point of delivery where it makes a positive difference for people. The Joint Health and Wellbeing Strategy outcomes have been informed by the Suffolk Joint Strategic Needs Assessment and will drive all local plans including the CCG Commissioning plans, Suffolk County Council social care plans and housing and development plans.

The following schemes describe specifically how we propose to use the Better Care Fund, as part of our wider transformation programmes.

Ipswich and East and West Suffolk areas – schemes

These schemes have been developed through the Health and Care Review which covers three main areas: health and independence, urgent care, and efficient elective care.

Integrated Neighbourhood Teams (INT)

We will create multi agency teams which will pro-actively work to support people with health and care needs and in particular those who are at risk of hospital admission or deterioration in order to turn unplanned care into planned care. Key features of the INTs are:

- Community health staff, social care staff, mental health staff, practice based staff and GPs, collocated where possible
- Strong local focus with interface with the local voluntary and community sector, district council, police partners and others
- Shared holistic assessment and a single plan to co-ordinate care and support with individuals holding their own plan and playing a key part in designing it
- Build on existing work in Suffolk, but with accelerated progress through commissioning, joint workforce development and the development of joint operational policies and infrastructure
- Aligned core in hours/out of hours
- Appropriate 7 day coverage and clinical standards
- Improved standards and responsiveness of services across community based,

specialist and mental health services
- Shared workforce development plan that supports person centred culture and practice within the INT through shared planning systems

Access to specialist services and supports
This scheme links specialist services (for example continence services, specialist dementia teams) to our INTs to support people with particular health and care needs. The framework includes:
- Clear revised service specifications, jointly commissioned where appropriate
- Clear pathways in and out of specialist services (for example the post diagnostic dementia pathway)
- Working practices that support the INTs to pull the expertise for use with their customers and to enhance skills across the system
- Inclusion of services addressing both mental and physical health
- Consistency of access to specialist services, including by Neighbourhood Networks

Admission Prevention
Our approach to admission prevention is designed to get upstream of crisis in order to reduce the number of people who are admitted to hospital during a crisis. The tools for this include:
- Risk stratification as well as local knowledge to identify and support those at risk of admission.
- A responsive local health and care system which will provide community based services to support people at risk of crisis, including step beds and rapid access to diagnostics and treatment for minor injuries.
- Personalised health and care plans, and holistic assessment which support people to get information, advice and support in a timely way, which more generally will reduce unplanned admissions to hospital.

Admission prevention - Crisis response
Whilst our transformation plans are working to shift unplanned care into planned care we recognise that there are times when a crisis response is needed, including when people have a mental health crisis. To do this we will ensure that:
- Our default response is to treat people at home, or as close to home as is possible
- People get the right response in a timely way wherever they access the system including those with a mental health crisis, which returns them to a stable situation and enables them to retain their home life for longer, whether they contact through 111, out of hours arrangements, through their GP receptionist or through social care contact arrangements.
- This responses enables a timely and skilled response to avoid unnecessary ambulance conveyances to hospital
- We work closely with the Police Emergency Response service to support people with a mental health need in times of crisis
- There is effective transfer back into the non-urgent systems where appropriate, including from the acute trusts so that scarce A&E resources are protected from dealing with primary care problems. This is affected through urgent care centres locality at acute trusts with speciality input for example 136 suites, psychiatric

liaison, diagnosis and minor injuries.
- Support following a crisis is available through our INTs working with their local Neighbourhood Network and with specialist services, including mental health services.

Admission prevention – Reablement, rehabilitation and recovery
The reablement, rehabilitation and recovery pathway is a core element of our integrated design. Getting this right will provide both better outcomes for customers, but also a reduction in demand for longer term services. Key changes we will be making include

- A single outcome focused reablement, rehabilitation and recovery plan
- Delivery of a rapid response so that reablement, rehabilitation and recovery potential can be maximised
- Supervision of outcomes and co-ordination of care by a named case manager in the INT
- A greater use of assistive technology
- Home care market development so that all home care provision is reabling
- Continuous stretch for providers to improve reablement rates, including from mental health and inpatient units.
- Review of step up and step down bed provision as part of the retendering of NHS community services in 2015
- Community Equipment Store re-commissioning in 2015 to meet new integrated service model with a faster access to equipment

Support for Carers
The County Council and the three CCGs in Suffolk recognise the important role that carers play in supporting people who have care and health needs. We will be jointly commissioning carers support which will:

- Support voluntary and community sector organisation who themselves offer carer support through innovation grants
- Increase in the number of carers supported through personalised budgets, access to short breaks and information and advice
- Integrate carer support into all aspects of our service model
- Complete the review of carers support against the Carers JSNA which will be finalised in July 2014. Commissioning plans for carers to be informed by this in 2015.
- Ensure more Emergency Carers Plans are developed to prevent future crisis due to carer breakdown.

Milestones
Year one – 2014/15
Continue to embed strategies for primary prevention in our new service model
Engagement and co-production with public around new service model completed
Joint commissioning plan for carers developed.
Risk stratification in place and being used to identify people at high risk of admission
Agreed approach for joint assessment and allocation of case manager
NHS number used as primary identifier for correspondence across health and care services
Agreed offer for people in the lower risk categories and work commenced with partner

organisations to support delivery
Equipment and housing adaptation pathways developed in readiness for implementation in 2015/16
Joint workforce development plans developed and operational in order to achieve 7 day working
Joint performance dashboard agreed and operational at a leadership and local level

Year two – 2015/16
Full implementation of new service model
Further improve admission prevention activity through INT working culture and practice
Step up and step down bed capacity reviewed and aligned to new service model
All new Support to Live at Home (homecare) contracts rolled out.
towards colocation of services beginning

Waveney schemes

Supporting independence by provision of community based support interventions and carer support
This scheme aims to reduce unplanned admission to hospital through the provision of a broad range of health and social care community based interventions closer to people' own homes. These interventions are:

- Integrated development of Home Care
- Integrated reablement / rehab recovery
- Risk Stratification
- Self-care & self–management interventions for people with long term conditions – Connected communities
- Care Support including Carer Breaks
- Greater use of assistive technology
- Integrated Community Equipment Service
- Housing and Health Programme
- Personal Health budgets

Integrated community health and social care teams including out of hospital teams and integrated community palliative care
We will be developing integrated services and the infrastructure which supports this. Element which will be delivered will be:

- Seven day Social Care Assessment & Care Management
- Establishment of Out of Hospital teams
- Co-location of Health and Social Care Teams
- Shared data / linked IT
- Single point of access
- System wide work force development
- Continued development of Multi-disciplinary Teams

Urgent Care programme
The urgent care programme is aiming to make sure that urgent care situations are managed in a way that returns people home safely as soon as possible.

- Timely / 7 day social care assessment & care management

- Integrated care home and home care commissioning to facilitate hospital discharge
- Streaming inappropriate A&E attendance
- Rapid response vehicle
- Integrated falls service

Support for people with dementia living in the community
We recognise that by building on our current successful dementia services we can ensure that people with dementia are supported to live as full a life as possible, whilst managing their condition through personalised and holistic plans.

- Integrated Post diagnosis core dementia care pathway
- Specialist mental health support
- Raising community dementia care awareness

Milestones
Year one – 2014/15
Selection of pathways or population groups in order to combine resources
Collocation of teams with streamlined management
Explored "at cost services" to inform costed health packages of care/personal budgets

Year two – 2015/16
Further pathways selected to combine resources
Virtual ICS created
More pathways taken out of tariff
Rationalisation of estate and services

Key success factors for our schemes across the whole of Suffolk include:

- Fewer emergency admissions to hospitals
- Fewer admissions to residential care
- Shared care and health plans with clear outcomes for individuals
- Multi professional teams know their population and target interventions to improve physical and mental health and reduce ill health impacts
- An agreed approach to risk stratification and action to reduce demand on our systems
- Services for people with mental health are improved
- A joint approach to commissioning and market shaping, which encourages innovative models and includes a systematic approach to procurement and quality standards across providers of services
- Engagement and action with our wider group of partners in the public, private and voluntary sector and in our communities to build engagement

Schemes have been developed in the context of wider integration plans that encompass the whole health and care system, including hospital provision.

Our programmes are under the oversight of the Health and Wellbeing Board. The HWB is supported by the two System Leaders Partnerships in Suffolk. The Health and Wellbeing Board will oversee the integrated plans and also enable strategic influence and encourage and support integrated working across our whole system.

We are using our joint governance structures to further develop joint delivery programmes, shared risk registers, performance and monitoring arrangements and contingency plans, with a particular emphasis on understanding the financial risks and mitigations.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

NHS commissioners will be working closely with partners towards the savings quantified in Everybody Counts, namely 15% reductions in emergency non-elective activity and 20% efficiency savings in planned care.

The three acute hospitals for Suffolk are committed to playing a full part in the development of an integrated system and are key participants in the design and implementation work. We accept that for effective service planning we must develop clarity around which services we will need in the future and which will no longer be provided, either in a particular setting or at all.

An integral part of the financial plans is to achieve the potential reduction in hospital activity. What must be delivered, in collaboration with our partners, is a radical transformation of the way services are provided which enable public funds to be used more cost effectively, across all sectors.

In **Great Yarmouth and Waveney** the key implications are:

- An innovative scheme being considered with practices in the Gorleston area which would collocate on the James Paget University Hospital (JPUH) site, providing integrated front line care to patients from the whole area attending as emergencies, diverting demand from traditional A&E services and reducing cost. There will also be provision of services by East Coast Community Healthcare (ECCH) within JPUH and provision of services by JPUH staff outside the confines of the hospital buildings to move forward towards a fully integrated provision model.

- Commissioners are working with providers in acute and community health to foster a strategic alliance between JPUH and ECCH. It is intended that JPUH will retain its provision of a full service District General Hospital, but drawing on the opportunities for a networked approach with the Norwich and Norfolk University Hospital (N&N) wherever appropriate, in order to ensure highest standards of clinical safety, but also ensure sustainability of services. It remains very clear that the relative isolation of some Waveney residents means we need strong local services.

- We will need to manage capacity effectively within the system to maintain a balanced financial position over the next five years. Capacity will be supported by an innovative out of hospital team, supported as necessary by additional care home capacity locally. Emergency admissions have reduced compared to 2012/13 and the intention is to build on the evidence that the increasingly integrated working between health and social care is starting to manage down demand.

In **IEWS** we are working with our providers to support their sustainability.
Reducing Emergency Non-elective activity through the Health and Care Review the acute trusts will avoid costs of around £12 million by 2015/16 in the West and the East by reducing the impact of the Marginal Rate Cost pressure. In addition, we are developing a number of schemes which will benefit providers such as:

1. The CCGs are supporting GP practices in transforming the care for patients over 75 years old by providing funding to practices to commission additional local services that will improve the quality of care for older people and reduce avoidable emergency admissions. This funding is an enabler to the CCGs' Integrated Care programme in supporting people with complex needs. The CCGs are supporting primary care to develop plans that underpin the principles of the plans relating to case finding, comprehensive assessment and proactive case management with shared care planning. The plans being developed by primary care aim to further develop the accountable GP and case management approach to managing people with complex care needs with a focus on prevention and admission reduction.

2. Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service: a high profile mental health team at the hospital front door providing a range of mental health specialities within one multidisciplinary team. This is comprised of mental health liaison practitioners specialising in general psychiatry, deliberate self-harm, substance misuse and old age psychiatry. This means patients can be assessed, treated, signposted or referred appropriately. By working closely with hospital clinicians and managers, the professionals ensure that the mental and physical health needs of people are considered and treated together.

3. Clinical Forums: A Commissioning for Quality and Innovation (CQUIN) scheme has been developed to support clinically led transformation of selected specialties to meet the QIPP challenge. This is the vehicle for achieving high quality with significant saving required for financial sustainability. The role of clinical forums is to combine experts and patients to transform the care we deliver in distinct areas across the system for true integration of primary, community, secondary and even tertiary care.

4. In Ipswich and West Suffolk Hospitals the psychiatric liaison service is being embedded and further expanded to include services for young people aged 13 to 18 to address long term conditions. There will be a full evaluation in quarter two of 2014/15 which will inform the commissioning model going forward into 2015/16 and beyond.

5. During 2014/15 post diagnostic service model will be developed for people with

dementia and their carers for procurement in 2015/16 in order to remodel pathways of care for people with dementia to eliminate gaps in service and support people and their carers to live well with dementia in their own homes for as long as possible.. This work is being undertaken jointly by West Suffolk CCG and Suffolk County Council.

6. The 2014 mental health needs assessment will include a specific focus on perinatal mental health. Ahead of its publication: we are working with Norfolk and Suffolk NHS Foundation Trust to ensure that the services offered by the Suffolk Wellbeing Service are accessible and available to pregnant women and new mothers. We will support Norfolk and Suffolk NHS Foundation Trust to develop more effective relationships with the Ipswich Hospital Midwifery Service so that there is a better understanding of what the Wellbeing service offers and to establish clear referral pathways. These pathways will help contribute to the 15 per cent treatment rate for IAPT during 2014/15. We are also participating in the Strategic Clinical Network Pilot to develop the Integrated Delivery Commissioning Toolkit for perinatal and post natal mental health care.

7. A mental health practitioner has been commissioned to work alongside a Police Emergency Response vehicle to support people with mental health care needs in crisis.

We are also working through the consequences of non-achievement of the targeted savings and associated contingency plans.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Our programmes are under the oversight of the Health and Wellbeing Board. The HWB is supported by the two System Leaders Partnerships in Suffolk. The Health and Wellbeing Board will oversee the integrated plans and also enable strategic influence and encourage and support integrated working across our whole system.

In Waveney the Integrated Care System Senior Programme Board (sitting under the Great Yarmouth and Waveney SLP) is responsible to the Great Yarmouth and Waveney System Leaders Partnership for progress against the programme plan, tracking the delivery of the plans and escalating issues and risks.

In IEWS the System Leaders Partnership are responsible for the Health and Care Review which is designing the proposed integrated health and social care system.

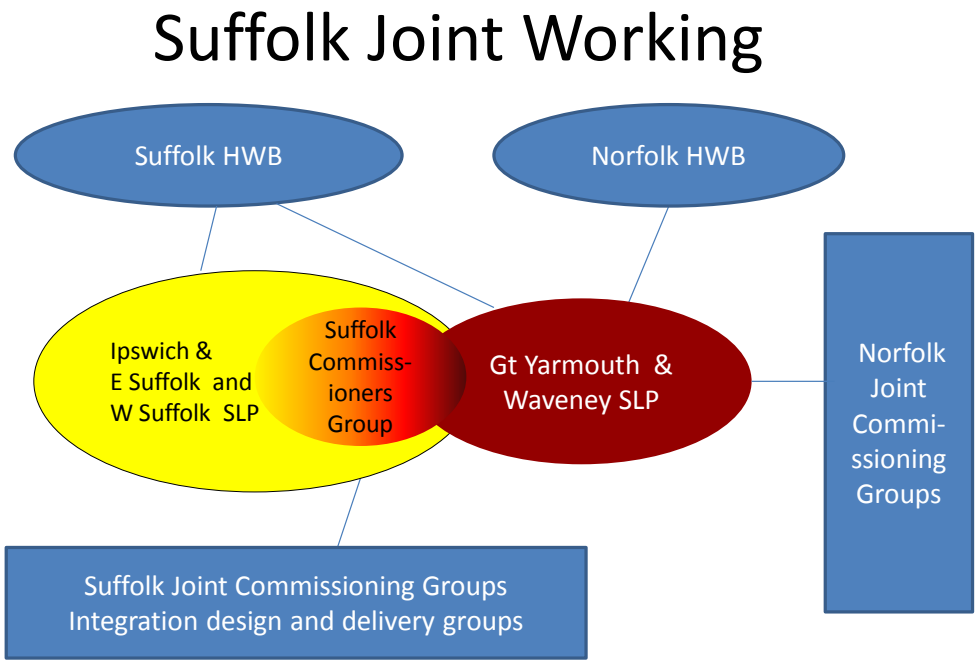
Once the design phase is completed at the end of June 2014 the Suffolk Commissioners Group will be responsible for progress against the programme plan, tracking the delivery of the plans and escalating issues and risks.

Our joint governance arrangements are designed to enable us to work in a different way than we have experienced in the past and to prioritise the needs of people over organisations, and the effective operation of the whole system over any of its parts.

Whilst our individual organisation remain accountable for the services they deliver we will ensure that joint governance arrangements as described above can provide a robust framework for the successful delivery of our integration plans, including the ambition and schemes described in this document. Specifically they will be responsible for:

- Shared risk registers
- Programme delivery plans
- Programme level data and metrics
- Escalation plans and routes where the system is not moving fast enough, where there are barriers to change or where achieving the target metrics is in doubt.

The following diagram describes the joint working structures in Suffolk.



3. NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care service

Our definition of protecting social care in Suffolk is that the criteria for adult social care will remain at substantial and critical and that the provisions of the Care Act will be fully implemented. This means that people in need of care and support will continue to receive the appropriate services they need in an integrated health and social care system. Our approach is founded on a whole system approach to health and care services.

The Health and Wellbeing Board understands the vital importance of robust social care provision in Suffolk as part of a whole system approach to health and social care.

We recognise that the way we allocate resources within adult social care may change because of our shared transformation programmes, but what we are interested in is delivering the better outcomes for individuals.

In Suffolk we know that the social care demands from our population are increasing year on year in part because of the rising numbers of older people in our communities. At present approximately 10% of Suffolk's population is aged over 75 and this is set to rise by 72% by 2031. Between 2012 and 2017 there is a predicted 15% increase in people with high and very high care needs and the number of people with dementia will double between 2013 and 2030. The cumulative effect of demographic changes will place additional demands on adult social care, which translates into ongoing financial pressures of around £5 million each year.

Meeting these challenges requires transformation of the health and social care system and we recognise that the best way of protecting adult social services is to do this together. This means developing integrated services together, commissioning jointly and differently and working to ensure that different elements of the health and care system interact in an effective, efficient way in the interests of the service user.

Please explain how local social care services will be protected within your plans

We will retain existing arrangements to transfer NHS funding to the local authority for care services that have a health benefit in 2014/15 and 2015/16. This and the additional funding for 2014/15 and 2015/16 will support the County Council to retain existing eligibility criteria for adult social care and to implement the requirements of the Care Act.

This means that customers will continue to receive timely assessment, care management and review, with personal budgets or with services directly commissioned to meet their needs 7 days a week. SCC will continue to provide reablement services, as well as information, advice and signposting for people who are not FACS eligible.

Current S256 funding has been spent on;

- Reablement services (including additional occupational therapy capacity) to reduce admissions to hospital and residential/nursing care and ensure timely hospital discharge
- Supporting family carers with respite care and moving and handling training
- Specialist support for people with dementia
- Improved access to 24/7 rapid assessment capacity
- Provision of equipment and assistive technology

All parties have agreed that the Care Act will bring new responsibilities for Suffolk County Council and our Better Care Fund makes provision for this as reflected in the finance template.

We will be using the next year as the guidance firms up, to assess the additional demands for social care services and the likely impact on the Better Care Fund. In our financial calculations we have estimated an amount of £4.103 million in 2015/16 to recognise demand pressures in adult social care.

All parties recognise that existing S256 funding and the proposed BCF allocations for demand and Care Act costs represent a significant national investment in social care services.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

In Suffolk, the three CCGs and social care are already committed through our System Leadership Partnerships to providing person centred health and social care services seven days a week.

Gt Yarmouth and Waveney CCG and partners, including social care, have successfully bid to be an early adopter for the Seven Day Services Transformational Improvement Programme. This work is supported by a strategic ambition to include all public sector partners in an integrated system, and will deliver initiatives such as 7 day working through one part of the patient pathway at a time.

All three CCGs in Suffolk have CQUIN initiatives with provider organisations that incorporate the 10 clinical standards, and require 7 day services to support discharge and admission prevention.

Whilst there are already existing services operating and available 7 days a week in Suffolk, a more effective response is being developed through our integration delivery plans. New service models will ensure that health and care services work together to support discharge and admission prevention both in-hours and out of hours with scalable health and social care capacity to match demand.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is a key field in all social care records, and is populated in around 55% of these records. A project has been put in place that will achieve 100% coverage and allow for information sharing at customer and population levels by September 2014.

The NHS is already using the NHS number as the primary identifier for correspondence across all health and social care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

NHS partners in Suffolk and Suffolk County Council are committed to using the NHS number as the primary identifier for correspondence. This is a key enabler for integrated working.

Suffolk County Council has committed to making sure that all adult care records have the NHS number by September 2014. After this date the NHS number will become the primary identifier for correspondence between the NHS and social care.

Our service redesign plans will ensure that as a default health and care staff will be using a shared care plan. This will use the NHS number as the common identifier.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Suffolk County Council and the three CCGs in Suffolk are committed to Open APIs and Open Standards. We wish to ensure that that they are secure for information and data in all cases.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring all appropriate IG controls are in place. Suffolk Information Sharing is a general protocol already in use across our system.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Suffolk County Council and NHS organisations in Suffolk are committed to ensuring that there is joint assessment and accountable lead professionals for people at high risk of hospital admission.

The key tools to do this are as follows:
Multi-disciplinary team (MDT) meetings in GP surgeries are used to identify adults at high risk of hospital admission or of needing long term care. MDTs are attended by GPs, Community Health staff and social care staff. Currently these meetings take place on a monthly basis, but it is intended that the identification of high risk patients will become more frequent as integrated neighbourhood working develops and within the implementation of the new risk stratification tool.

Risk stratification tools identify the top 5% of high risk customers for intervention and support. These people at high risk will have a named case manager, who will help them to develop a shared outcome focused plan which will assess risk and plan care. This lead professional will be the most appropriate based on the needs of the customer. Risk stratification tools will be in place in 2014

Will also be identifying the cohort of people who are not yet frequent users of services or at risk of hospital admission but who are developing LTCs and therefore who potentially could fall in the high risk group. Our new service models will define the support offer for people in these groups in order to reduce or mitigate the risks and help people to sustain independent living.

We have defined as high risk the top 5% of our adult population who are at risk of emergency admission in the following year. This cohort is identified through our risk stratification tools. The total number of people in Suffolk that this gives us as high risk is slightly more than 30,000.

Case management to provide the lead professional role, co-ordinated care and to ensure that joint assessment is carried out. The case manager is determined based on which professional has the most appropriate skill-set at the time.

Joint assessment that will be based around a core assessment covering a standardised set of questions and fields. Specialist assessment will build on the core assessment to provide a comprehensive assessment across health and social care. In Children's services the Common Assessment Framework (CAF) and Single (Statutory) Assessment provides the framework for multiagency assessment and planning and allocation of a

lead professional to oversee the implementation of the care plan.

Shared care planning is being developed across health and social care so that people have a single outcome focused plan that co-ordinates all their immediate health and care needs.

Workforce development will define roles within new teams, build the culture to support joint working and embed working practices so that joint working becomes the norm for health and care staff.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
1. A lack of coherent, rigorous delivery of this plan, including our organisations ability to co-ordinate and manage change will lead to inefficient service models.	Medium	Senior leadership directly involved, with strong programme governance arrangements and robust plans. Strong culture of public sector collaborative working in Suffolk.
2. Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality	High	A performance dashboard will be developed as part of the year one activity which will be under the oversight of the Suffolk Commissioners Group. This will identify system stress and where schemes are not delivering. By using clear metrics success can be accelerated and unsuccessful interventions reviewed.
3. Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing/care home activity by 2015/16, impacting on the overall funding available to support core services and future schemes.	High	We shall model our assumptions using a range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. We will monitor delivery of our action plans against

		anticipated outcomes and take action as a system when anticipated outcomes not achieved.
4. The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact on the sustainability of current social care funding and plans.	High	Suffolk adult social care has undertaken an initial assessment of the effects of the Care Act and the additional costs associated with its introduction. This is reflected in the BCF finance table. This will continue to need significant focus as our integrated plans develop.
5. Having a Suffolk overview of performance fails to recognise changes in performance in constituent planning unit areas.	High	Performance dashboard will include overview of performance on constituent planning unit areas.
6. Sharing data at a system level is not possible due to restrictions on NHS organisational use of local patient information.	High	Use of the Data Services for Commissioning Regional Offices (DSCROW) will allow us share information, but this is not functional yet.
7. Public confidence is not maintained during the development and implementation of our plans.	High	We have clear communication and engagement strategies so that people in Suffolk know what we are doing and why. We will provide opportunities for people to be involved in shaping the changes. The Health and Wellbeing Board takes an active role in overseeing the Suffolk wide shift to integrated working.