Suffolk County Council

Agenda Item 8

Health Scrutiny Committee, 14 October 2015

Information Bulletin

The Information Bulletin is a document that is made available to the public with the published agenda papers. It can include update information requested by the Committee as well as information that a service considers should be made known to the Committee.

This Information Bulletin covers the following items:

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1. Great Yarmouth and Waveney – Winter Planning 2015/16 and Delayed Transfers of Care Update

Suffolk Health Scrutiny Committee has asked for an update on planning for winter within the Great Yarmouth and Waveney system, and also the work taking place to reduce the number of delayed transfers of care at the James Paget University Hospital (JPUH).

Winter Planning 2015/16

The system is finalising the Integrated Resilience Plan which will set out the steps being taken collectively across the Great Yarmouth and Waveney health and social care system to ensure that appropriate arrangements are in place to provide high quality and responsive services to patients.

This is supported by individual organisation plans which provide a more detailed description of operational systems and processes which will be in place to support winter 2015/16.

Operational Management - The system will draw upon tried and tested operational management processes put in place during 2014/15 to ensure operational resilience and stability.

These will include:

- 3 x **daily dashboards** (JPUH) including real-time activity data to inform the system of current demand, flow and pressure points.
- **A&E breach process** to alert commissioners of potential issues regarding the A&E four hour wait target
- Fortnightly **Urgent Care Board meetings** which will change to weekly during the busy winter period to discuss operational issues to ensure plans are in place to address these
- A weekly telephone conference with senior members of the CCG and key providers to discuss system capacity and to highlight issues which may require intervention from senior managers
- The **Systems Resilience Group** will continue to meet on a fortnightly basis to provide operational scrutiny and oversee strategic developments
- During periods of increased pressure, all system partners will be required to attend the **James Paget University Hospital Operational meetings** to discuss and agree mitigating plans, system capacity and delayed transfers of care. This includes support from senior colleagues within social care and community nursing.

Service Developments. Through operational resilience funding, Commissioning for Quality and Innovation (CQUIN) and other contractual agreements, a number of developments are planned or are already in place to support continued operational resilience both year round and to support the periods of peak pressure over winter and Easter. These include:

- **North Out of Hospital Team (NOHT)**. The NOHT continues to embed in Great Yarmouth, Gorleston and the Northern Villages supporting those patients who may otherwise have been admitted to an acute or community bed. The service became operational on 1 April 2015 covering seven days a week 8am until 8pm. It is now available until midnight and from 1 October the service will provide 24/7 cover. The service supports facilitated discharges from JPUH where patients are medically stable but require some rehabilitation and re-ablement in the community. Such a service is already in place and well established in Lowestoft.
- **Ambulatory Care Unit (Ambu)**. Ambu at JPUH is continuing to operate five days a week and this has supported same day discharge for a number of patients presenting with an ambulatory condition. The service has relocated within JPUH which will support the resilience of the service and reduce the likelihood of the unit being used for in-patient facilities during periods of peak pressure. From October 2015, Ambu will be operating seven days a week from 8.30am until 9.30pm. It is anticipated that the service will see approximately 20 patients a day with the majority being discharged on the same day.
- **Hospital Ambulance Liaison Officer (HALO)**. The HALO post will be reinstated from September/October 2015 until the end of March 2016. The primary purpose of this role is around integration, demand management and assistance with hospital turnaround delays and has operated successfully over the previous two winters. This year we strive to improve collaboration and integrate this role into the wider health economy to assist with frequent callers,

admission avoidance access and allow timely feedback to EEAST clinicians regarding patient outcome from transports to A&E, creating a positive feedback loop to strengthen decision-making around admission avoidance.

- **Mental Health Support in A&E**. In line with the national CQUIN guidance Norfolk and Suffolk Foundation Trust and JPUH are working collaboratively to develop a service for patients presenting at A&E with a mental health issue. This is specifically targeted at frequent attenders who are accessing multiple services, but will also target those presenting for a first time. The aim is to improve their experience and reduce the re-attendance rate of a specific cohort of mental health patients by engaging with them and providing appropriate dedicated services to minimise their need for emergency care. This is a targeted and focussed intervention aimed at reducing relapse. Crisis care plans will be shared with relevant organisations with patient consent.
- **JPUH FLO Discharge Planning**. From August 2015 JPUH have been implementing the visual hospital model as part of their patient flow initiatives. This includes a new system for monitoring patients to ensure real-time data to inform capacity and support flow throughout the hospital. This approach also includes bed managers visiting wards every two hours, to see what patients are waiting for and why they are remaining on the wards, to expedite actions. It is anticipated that this new process will improve flow throughout the hospital and implementation now will ensure the new model is in place before winter. The second phase (a plan for every patient) will be rolled out across ward areas from September 2015.
- **Community Pharmacy Emergency Supply Service**. The service will be in place over the Christmas and New Year bank holiday weekends to ensure patients can access an urgent supply of their regular prescription medicines when they are unable to obtain a prescription before they need to take their next dose. The service may be needed because the patient has run out of a medicine, because they have lost or damaged their medicines, or because they have left home without them. The aim of this service is to relieve pressure on urgent and emergency care services through patients being able to access their pharmacy directly rather than going to A&E or Out of Hours GP services.
- A **winter communications plan** has been developed and is being discussed with system partners to ensure a coordinated approach. This will be in line with the national campaign.
- During August the CCG's provider of NHS 111 services has implemented a **re-triage process for Green Ambulance dispatches (**ie dispatches for less serious illness or injury). This ensures every green ambulance dispatch is reviewed by a clinician for appropriateness and if an alternative is more suitable e.g. attendance in primary care, this will be advised to the patient. This process aims to reduce inappropriate use of ambulances by NHS 111 ensuring they are kept free for appropriate calls.
- **Social Care at JPUH will be working weekends** to ensure referrals to the team can continue over the weekend, and discharge planning can continue.
- Seven **discharge to assess beds** have been commissioned to enable patients awaiting the NHS Continuing Healthcare (CHC) process to complete, to be discharged from the JPUH to an appropriate environment whilst the assessment takes place. This scheme has been in place since 1 April 2015. It provides an

improved patient experience and enables early discharge of this patient group from the JPUH, improving flow.

Delayed Transfers of Care (DTOC)

Over the past few months the system has worked collectively to reduce the number of delayed transfers of care. For January 2015 the DTOC rate was 10.5% and in July 2015 this was reduced to 4.3%, however the rate has been as low as 3%.

Nationally there is a drive from NHS England to reduce rates further from 3.5%, as detailed in planning guidance, to 2.5%.

The table below shows the split between those DTOCs attributable to health and those attributable to social care:

2015-16	Health	Social Care	Joint Health & Social Care
April	**95%**	**0%**	**5%**
May	**91%**	**0%**	**9%**
June	**96%**	**0%**	**4%**
July	**98%**	**0%**	**2%**

The system has been working on a number of initiatives to support discharge planning in order to reduce the number of DTOCs within our hospitals. These include:

- As described above, seven **discharge to assess beds** have been commissioned at a local residential home, so that patients awaiting NHS Continuing Healthcare assessment but no longer requiring acute care can be discharged, reducing the number of delayed transfers of care. The CCG is currently looking at opportunities to commission additional discharge to assess beds.
- JPUH has developed an **internal discharge logger system** to be able to monitor delays. This system is also accessed by social care. The discharge logger is currently reviewed three times a week with social care to support the transfer or discharge of those patients deemed medically stable. The expectation is that this will increase to daily action meetings during winter.
- An NHS **Continuing Healthcare (CHC) delay dashboard** has been compiled by the JPUH, which monitors and highlights delays allowing responsive actions. The dashboard is shared with key individuals both internally and externally from the JPUH.
- **Out of hospital teams** in Lowestoft and the North support a number of facilitated discharges from JPUH for those patients who no longer require acute care but are not yet safe to return home without some support or re-ablement needs. As the North team increases its operational hours to 24/7 in the lead up to winter, this will support those referrals which require some form of support at night.
- Patients who require on-going therapy support, but are medically fit, can be referred to the Lowestoft or North out of hospital teams to continue their therapy at home.
- Supported discharge is also in place for stroke and, more recently, for Chronic Obstructive Pulmonary Disease (COPD) patients who may have been admitted

with an exacerbation of their condition but can be safely discharged home with support.

For further information please contact: Cath Gorman, Director of Commissioning and Quality, Great Yarmouth and Waveney CCG; Email: Catherine.gorman@nhs.net, Telephone: 01502 719500.

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2. Joint Working between Suffolk Coastal and Waveney District Councils and NHS Great Yarmouth and Waveney CCG

This item provides a brief update on an innovative joint post funded by NHS Great Yarmouth and Waveney CCG and Suffolk Coastal and Waveney District Councils. An appointment was made to the post of Joint Head of Communities in May 2015 The post works across the East Suffolk area, with bases in Beccles, Lowestoft and Woodbridge.

The appointment has built on a strong track record of joint working and integration between Waveney District Council and the CCG. Practical examples of alignment and integration, in the new draft Enabling Communities Strategy produced by the two Councils, include greater focus on individuals and families and the role of communities in helping people to stay healthy and well. A new CCG Communities Delivery Plan identifies ten specific areas where communities and/or the voluntary sector could potentially play a greater role, many of which will involve joint working between the CCG and Districts. The ultimate aim is to reduce the number of visits to GPs, reduce hospital admissions, increase levels of self-help and self-management and support additional years of healthy life. Areas of focus include dementia, mental health, carers, loneliness and isolation, and falls prevention.

The Active Communities Team at Waveney District Council, led by the Head of Communities, will ensure that mental and physical health and wellbeing are further embedded in their activities, for example neighbourhood plans, place-based working (including Lowestoft Rising) and diversionary activities with young people. A programme of joint themed workshops are planned for end of 2015 and early 2016 to raise awareness of key health issues, share what other communities in East Suffolk (and beyond) are doing to tackle these issues and stimulate new community-led solutions that benefit the local population.

The post also provides an opportunity to ensure that the right connections are made between the emerging work programmes and commissioning intentions of the Council and CCG, for example opportunities for joint work around assets, joint engagement events, embedding health within planning and housing proposals and decisions and joint commissioning opportunities.

For further information, please contact: Nicole Rickard, Head of Communities, 01502 523231, Nicole.rickard@eastsuffolk.gov.uk

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3. Report of the Norfolk Health Scrutiny Committee NHS Workforce Planning Task & Finish Group

The Norfolk Health Scrutiny Committee recently convened a task and finish group to consider NHS workforce planning across the acute, community, mental health and primary care sectors in Norfolk. The Task and Finish Group was concerned that it is

hard to recruit staff to vacancies in many NHS specialisms, which increases pressure on existing NHS staff and will potentially result in increased waiting times and a reduction in quality of service for patients. Clinical staff shortages are of concern nationally, and this issue is on the forward work programme of the Suffolk Health Scrutiny Committee.

The Task and Finish Group considered extensive written evidence and heard from a number of representatives from healthcare education and training commissioners, healthcare education providers, NHS System Resilience Groups (SRGs), Clinical Commissioning Groups (CCGs), NHS Trusts, Norfolk County Council, the Local Planning Authorities, Norfolk and Waveney Local Medical Committee (LMC) and NHS Midlands and East.

Having made recommendations to a number of organisations, the Task and Finish Group concluded that the current problems could be attributed to a lack of foresight in the past. It was satisfied that the issues are now fully recognised at national, regional and local levels, and was reassured that all parts of the local health system, the higher education institutions and Health Education East of England are working hard to deal with the immediate challenges and improve workforce planning for the future.

The report can be downloaded in full from the following web page: http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/386/Committee/22/Default.aspx

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4. Healthwatch Suffolk Report - "Non-Emergency Patient Transport, Public Perceptions in Suffolk"

Healthwatch Suffolk has produced a report on patient perceptions of non-emergency patient transport in Suffolk (which is provided by the East of England Ambulance Service). The report contains responses to questionnaires and interviews from 337 patients, distributed over a large part of Suffolk, who were asked about their travel to and from health care facilities, the accessibility of non-emergency transport, the cost of travel, missed healthcare appointments due to lack of transport, access to information on healthcare services and their overall sentiments regarding transport to and from healthcare facilities in Suffolk. The authors of the report also spoke to Community Transport Operators (CTOs).

The survey identified a lack of public transport, high transport costs and a tightening of criteria for hospital transport as significant barriers to accessing local health services, which have a major impact on the most vulnerable people in the county. The following are some of the issues identified in the report:

- Most people drive, walk or use public transport to access hospital, or rely on the goodwill of friend or relatives;
- Tightening of criteria for hospital transport has put a strain on community services and volunteers;
- Almost half of respondents said that patient transport call centre staff were not friendly or polite;
- Often hospital appointment letters arrive too late for the patient to arrange transport;

- Almost 1 in 4 respondents have had a hospital appointment changed at short notice, meaning that they were unable to access transport;
- 16% of people had missed appointments due to a lack of transport (27% of disabled people);
- On average patients paid £26.52 for a taxi to hospital (£30.06 for over 65s);
- Cancer patients often have low immunity so cannot use public transport. Some cancer treatments can require 8 visits to hospital per month and the maximum state pension is £115.95 per week, which means that accessing treatment can put a huge financial strain on some patients.

The report, which makes a number of recommendations to service providers, can be downloaded in full via the following link:
http://www.healthwatchsuffolk.co.uk/wp-content/uploads/2015/08/Transport-Final-PDF.pdf

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5. Suffolk County Council's Scrutiny Committee considers items on the Care Act and the Better Care Fund

At its meeting on 2 July 2015, the Scrutiny Committee considered issues relating to adult care. It initially considered the financial implications for Adult and Community Services (ACS) of changes in adult social care legislation (the Care Act 2014) and case law relating to deprivation of liberty safeguards, and was subsequently provided, in a second agenda item, with an update on progress towards the delivery of savings from work taking place under the Better Care Fund.

Financial implications of changes in adult care legislation and case law

The Committee first heard from the Cabinet Member for Adult Care, Officers from Adult and Community Services (ACS), a representative from Suffolk Family Carers and the Chairman of Suffolk Carers Partnership Board, who provided information on the main provisions and implications of the Care Act 2014, the implications for ACS and the consequences of case law relating to Deprivation of Liberty Safeguards (DoLs) as defined by the Mental Capacity Act 2005.

The Committee heard that whilst the fundamental reforms of the Care Act were welcomed, there were concerns about how the changes would be implemented and funded, which meant that it was difficult to gauge accurately the impact the new criteria would have on the Council's care-purchasing budget.

The Committee made a number of recommendations to the Cabinet Member, Director and officers of ACS, which can be found in the minutes of the meeting. The minutes and full details of the information that the Committee received are available in the meeting papers, which can be found via the following link:

http://committeeminutes.suffolkcc.gov.uk/meeting.aspx?d=02/Jul/2015&c=Scrutiny Committee

Since the Committee considered this subject, on the 17 July 2015 the Government announced its decision to defer a cap on lifetime care costs set at £72,000 for people above pension age. This was due to be introduced in April 2016 but now will not take effect until 2020.

A rise in the amount of assets at which people would be eligible for state aid with residential care costs irrespective of the cap, from £23,250 to £118,000, has also been delayed.

Work is continuing on the "Trusted Advisor" pilot in the north of the county, which is being trialled with five partners. These are Suffolk Family Carers, Age UK, Suffolk Libraries, The Citizen Advice Bureau and The Access Community Trust. The purpose of this pilot was to primarily test out whether the provision of information and advice and digital on line assessment for self-funders could be delegated to community partners. As there is wider applicability to this approach there is value in continuing to trial this model.

Better Care Fund

In consideration of this matter, the Committee heard from the Directors of Resource Management and Adult and Community Services (ACS), ACS Officers, and representatives of the three Clinical Commissioning Groups (CCGs).

Members were provided with information relating to the finances and timetable for the Better Care Fund, plans for protecting ACS and social services, the savings that had been identified, the potential risks and challenges and arrangements for monitoring progress.

The Committee heard that the Better Care Fund had been introduced nationally for 2015/16 but there had as yet been no government announcement about whether it would continue into 2016/17 and beyond, which made it extremely difficult for the parties involved to carry out meaningful financial planning. The Council's budget assumption for 2015/16 was that health and care integration would generate savings of £4.1m, but it was doubtful whether this would be achieved in the current year, which would mean that ACS would need to identify savings from elsewhere. These savings would need to come from areas of discretionary (rather than statutory) spend and could therefore impact on preventative work, potentially resulting in an increase in demand for both health and social care services.

The Committee made a number of recommendations to the Leader, Cabinet and ACS. Further details can be found in the minutes of the meeting, and the agenda papers, which are available via the following link:

http://committeeminutes.suffolkcc.gov.uk/meeting.aspx?d=02/Jul/2015&c=Scrutiny Committee

For further information please contact: Theresa Harden, Business Manager, Democratic Services, email: Theresa.Harden@suffolk.gov.uk, Telephone: (01473) 260855.

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6. NHS Community Services Contract

Background

In May 2015, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group announced that a new provider will be delivering the NHS community health services. People will still have the same safe, high quality services, by the same staff.

West Suffolk NHS Foundation Trust, Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust have worked together on this. The contract will be held by West Suffolk Hospital.

The previous three year contract to deliver NHS community services, which will end on 30 September 2015, was with Serco. The new contract begins on 1 October 2015.

The year-long contract delivers a range of adult community services, specialist children's services and community hospitals to people in Suffolk, excluding those in Waveney. There is an option to extend this contract for another 12 months, by mutual agreement.

Timeline of community health services in Suffolk

2010 The Government directed all primary care trusts to transfer their community services to provider organisations so commissioners and providers would be separate. The two-year process to identify a provider of community health services in Suffolk began.

2012 The contract for community health services in Suffolk was awarded by NHS Suffolk to Serco for a period from 1 October 2012 to 30 September 2015.

2013 NHS Suffolk, the primary care trust, was disbanded as part of Government reforms. All primary care trusts nationally were disbanded.

2013 Clinical commissioning groups (CCGs) were established nationally. CCGs are GP-led organisations with responsibility for commissioning most local healthcare services.

2014 The process to identify a new provider for community health services in Suffolk, ahead of the planned end of the Serco three-year contract in 2015, began.

2014 Health and Care Review began to establish people's views on how health services in Suffolk should adapt to meet increasing demand. The review has led to the introduction of models which are currently being tested and will see more care in the community, with the voluntary sector and communities working with health and care.

October 2015 The preferred bidder for community health services in Suffolk will begin.

Progress

Between May and the time of writing, a lot of effort has gone into making sure that community services transfer smoothly on 1 October. This will ensure that there is service continuity and that there is no disruption to patient care. Detailed plans have been developed to support this.

Serco have left a good legacy, generally meeting the contract requirements, including clinical quality with high levels of patient satisfaction.

West Suffolk NHS Foundation Trust (WSFT), Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust and Serco have a dedicated transition team in place to support services to transfer safely.

The transition team is supported by various expert work streams such as Information Management and Technology, Clinical and Governance, Estates and Infrastructure etc. WSFT is working well with the other organisations involved in providing community services and the transition plan is on track.

The CCGs' Accountable Officer chairs a weekly Transition Board made up of commissioners, Serco and WSFT to review progress, support resolution of issues and assure the commissioners that the transfer will be successful. The board will continue to meet weekly for some time after the contract has started.

The CCGs will monitor the provider against the contract and review meetings have been scheduled.

For further information please contact: Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group, email: isabel.cockayne@suffolk.nhs.uk Telephone: 01473 770012

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7. Eye Services in Suffolk

Background

Over the last ten years, the Department of Health has increasingly encouraged the delivery of more routine and minor emergency eye care outside hospital in community optical practices. New national guidelines for the management of glaucoma published in 2009 by the National Institute for Health and Clinical Excellence (NICE) identified the increasing pressures on secondary eye care services. There is also evidence that with the right safeguards, many ophthalmology services traditionally referred to secondary care for monitoring and treatment can now be performed safely and effectively by specialist optometrists in community settings. Around the UK, community optical practices are successfully and safely delivering local enhanced services in primary care with high levels of patient satisfaction, as part of local integrated pathways linking into secondary care as appropriate.

Over recent years commissioners, hospitals and the public have worked together to improve services for those who need eye care. Suffolk has been:

- the first county to implement direct referral from optometrist to hospital
- the first area to test a single point of access referral platform on behalf of Local Optometric Committee Support Unit (LOCSU) a national body that supports Local Optical Committees (LOCs) across England in developing local eye health services and community optometrists and opticians work with local commissioners to make community eye services accessible for patients and cost effective for the NHS. This includes policy and direction of service development.
- New Community Glaucoma – I-Van services have been cited in the Dalton Review, NICE Quality Care Study and BMJ Award shortlisting.
- Consultant led Community Clinics for Ophthalmology, commenced as a Pilot I in September 2015.

By 2021 it is estimated that 24.5% of residents in Suffolk will be aged 65 and over. There are rising numbers of people being diagnosed with diabetes. Therefore there will be an increase in those people who will require treatment for Age-related Macular Degeneration (AMD), cataracts, glaucoma and diabetes eye checks.

This means further changes need to happen to eye services.

Budgets remain static, which means there is no extra money which can be put into services without losses elsewhere. At the same time there are some significant improvements to be made in hospital follow-up services.

Engagement

Building on the work we have done historically to meet national guidelines to support rising numbers of people who have clinical problems with their eyes, the CCGs have for the past year been seeking opinions from the Suffolk population on the existing Ophthalmology Service.

The themes from the feedback collected (through online and face to face methods) have found that most people were largely happy with the care, but had issues, predominantly for the East Service, with long waiting times, cramped conditions in the clinics and parking shortages and costs.

In April 2015 service users, clinicians from both hospitals and the private providers, as well as managers and commissioners, held an event to look at current services.

Service Proposal

Using patient feedback, along with the NICE guidelines on eye care, a new model for delivering a truly Integrated Eye Service is being proposed, the aims being to improve services in the community and in the hospital. This will mean more community services with increased local access for patients.

A Clinical Transformation Group, which was made up of representatives from many clinical organisations, the voluntary and community sector and service users, has developed a framework for a new service model in line with national clinical evidence. A new model of care consists of a 6 tiered arrangement:

- The first tier is associated with primary prevention and self-care;
- The second tier is associated with interventions delivered by GPs, optometrists, opticians, pharmacists, school nurses and health visitors;
- The third tier is for specialist community based services delivered by ESPs and underpinned by a community consultant;
- Tier four will take all of the services that need to see an ophthalmologist but do not need the infrastructure of the hospital/eye unit;
- Tier five is for complex cases that need increased infrastructure to support their delivery;
- Tier six remains as specialised commissioning eye care.

Next Steps

The key next steps are to complete the public engagement in support of the new model to work with stakeholders to move towards integration. Key dates are:

- 13 October 2015 (provisional date): to hold a market development day as part of the pre procurement process;
- to continue the transformation programme timetable with procurement likely to commence from November 2015 –April 2016;
- April-May 2016: contract award;
- May-October 2016: implementation phase
- October-November 2016: service commencement

For further information please contact: Nerinda Evans, Clinical Commissioning Manager, Email: nerinda.evans@ipswichandeastsuffolkccg.nhs.uk

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8. Connect Sudbury and Connect East Ipswich

The purpose of this item is to update members on progress on the delivery of the Health and Care review model, specifically on the two integrated care projects: Connect Sudbury and Connect East Ipswich.

Background

Connect Sudbury and Connect East Ipswich are ambitious projects aimed at answering people's calls to bring services together, including police, housing, health and social care services, voluntary sector and community organisations. The shared aims are to make sure that services are wrapped around people so that they can better look after themselves, and to minimise duplications in services. The concept of these sister projects was shaped by clinicians and public representatives last year during the Health and Care Review.

Integrated Neighbourhood Teams (INTs). Teams directly working with customers have supported the development of this work programme. These multi-agency teams are identifying those patients and customers who have the most complex health or social care service needs, and working together to ensure care and treatment is anticipated as far as possible, planned and fully co-ordinated across all the agencies involved.

A deeper review of specific individuals and families is now underway to examine how many times high users need support from other public sector organisations and whether information can be shared to ensure quality and safety of service. One significant step has been the creation of a multi-agency shared care and support plan. Another has been a directory of services which shows staff how to contact each other.

Teams reported that co-location would improve working relationships between organisations. Therefore the ACS team moved into the Sudbury Community Health Centre on 3 September. In East Ipswich, a joint business case has been developed by the East Suffolk CCG and Suffolk County Council on the potential use of premises at 214 Sidegate Lane to create a health, wellbeing and reablement centre, providing co-located accommodation for an INT team. The business case is agreed and approved and work is now moving forward on the planning application needed and the detail of how the property would need to be converted.

Neighbourhood Networks (NNs). Through the HIVE in Sudbury, a survey of Voluntary and Community Sector (VCS) organisations demonstrated a need to better work with public sector teams to strengthen their position and build capacity. In East Ipswich, Community Action Suffolk has mapped networks of VCS organisations and has established networks in the locality. VCS organisations aim to use this to better communicate and work with one another as well as across INTs. In addition the online service, Infolink, has been re-launched and offers a more user friendly experience when searching for information, and this is being promoted across the voluntary and community sector.

In Sudbury, Community Pharmacies are being approached to see how they can support neighbourhood networks. In both areas, a Local Area Co-ordinator will be recruited, to promote a model of individual community support which connects people to community and voluntary sector support and helps manage demand on statutory services.

Integrated Reablement and Rehabilitation (IRR). The Health and Care Review service model is built on the move towards prevention, self-management and preparedness as key to driving down longer term reliance on care and support and stopping people reaching a crisis. One of the key enablers to achieving this is reablement and rehabilitation. It will mean individuals can access support to help them to achieve the independence and wellbeing they want and value. This approach will be developed and embedded in Integrated Neighbourhood Teams and Neighbourhood Networks.

Prevention. Using "Embedding Prevention in Suffolk" recommendations, the approach endorsed by the Health and Wellbeing Board in March 2015, and this year's Public Health Annual Report, short to medium term prevention interventions are being explored.

Practical applications include training of INT members and other public sector partners (e.g. customer facing district council staff) to deliver brief lifestyle advice to clients with modifiable risk factors (e.g. smoking). In the longer term a target operating model within the INTs will be developed. This shift to a more preventative approach will require resources to move upstream.

Engagement and Communication. Since January 2015, the HIVE and Sudbury WATCH, and Community Action Suffolk in East Ipswich have helped coproduce the communications and engagement plans. A number of events have been held for staff and voluntary sector to improve networking and share the project so that they can help develop new ways of working. The plans shaped the work being delivered above. There is:

- A Connect brand, developed with the input and support from a number of organisations working in the Sudbury area and East Ipswich.
- A website (www.connectsuffolk.co.uk) providing information on the projects, frequently asked questions and maps.

Workforce. In supporting integrated working, a work shadowing programme has been started, as well as the development of an early professional development programme and joint work to support recruitment. Workforce development is critical to the success of the programme.

Next steps

A joint Health, Care and Safety Commissioning Group is in place to oversee plans and receive escalation reports on cross county issues. A Connect Coordinating Team, with representatives from NHS and the County Council, is in place to link across both the Sudbury and East Ipswich sites.

A draft Operational Toolkit Manual for staff working in INTs will be further developed to bring together all of the work that has been completed so far by the Connect Sudbury work.

Staff in Sudbury and its locality, and in East Ipswich (based around the IP3/4) area are testing the system, keeping people safe at the same time, and should this system model be successful, this approach will be used across Suffolk with local variations.

For further information please contact:

Communications: Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group, email: isabel.cockayne@suffolk.nhs.uk Telephone: 01473 770012

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Connect East Ipswich: Gillian Mountague, Project Manager;
email: gillian.mountague@ipswichandeastsuffolkccg.nhs.uk

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9. Suffolk Learning Disability Service re-design - update

Background

Plans to improve specialist services for children, young people and adults with learning disabilities in Ipswich and East Suffolk CCG and West Suffolk CCG were outlined in a bulletin published with the January 2015 Health Scrutiny papers, a copy of which can be found at:
http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=090027118161f858&qry=c_committee%7e%7eHealth+Scrutiny+Committee

Great Yarmouth and Waveney CCG has also planned for redesign services, which means the three CCGs with responsibilities for Suffolk will work together with the county council to progress the matter.

1. The reasons for making changes are because of national and local developments in recent years including:

- The Winterbourne View report, which states an expectation for an end to all inappropriate placements so that every person with challenging behaviour gets the right care in the right place together. This is now called Transforming Care.
- Active decommissioning of inpatient units and institutions to support reductions in admissions and inpatient numbers.
- Implementation of a Suffolk Learning Disability Strategy and Service Specification and a managed clinical network to support this process.
- Focus on supporting people to live in the community and independently

2. This model of care for learning disability patients who need intensive support is being developed.

Key points

The existing provider, Norfolk and Suffolk Foundation Trust (NSFT), and Ipswich and East Suffolk CCG and West Suffolk CCG are currently working on ensuring they understand existing and future demand for inpatient beds for children and adults.

Children and Young People (CYP)

The current buildings are not fit for purpose. The movement of existing learning disability inpatient units from the Lothingland site into new fit for purpose buildings will only take place once it is clear what need there is. There are currently three children/young people (one Suffolk CCGs and two Great Yarmouth CCG patients) in the building.

Adult

More work needs to be done to understand how many beds would need to be commissioned in the medium to longer term for assessment and treatment for adults. This work is currently underway.

"Transforming Care" out of area placements (previously known as "Winterbourne View")

There are 20 adult patients with learning disability and a number of children and young people's placements out of area. Each needs assessment to decide if it is appropriate and beneficial to them to bring those individuals back into county.

Next steps

The intention is to work to a date of 31 March 2016 for the redesign of learning disability services in Waveney and Suffolk CCGs to be completed.

For more information please contact: Alison Leather, Associate Director of Redesign (Mental Health/LD & Children's & Maternity);
Email:Alison.leather@ipswichandeastsuffolkccg.nhs.uk or Kim Arber, Programme Manager for Mental Health and Learning Disabilities, NHS Great Yarmouth and Waveney CCG; Email: kim.arber@nhs.net

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10. Suffolk Stroke Service Update

Introduction

In March 2013, the Governing Bodies of both Suffolk CCGs received the results of a local review into stroke services and their comparison to the standard set out in a model service specification published by NHS Midlands and East. The CCGs Governing Bodies released a statement of intent which stated that the CCGs wished to (i) commission hyper acute stroke services at both Ipswich and West Suffolk hospitals (ii) establish an early supported discharge (ESD) service. A project board was established with oversight of two work streams dedicated to these priorities. The Health Scrutiny Committee last received information about hyper-acute stroke services and the development of the early supported discharge for stroke patients on 22 January 2014. This update summarises recent quality developments in stroke care by acute providers at West Suffolk and Ipswich hospitals. It outlines quality data, as publicly available, for both Trusts within the SSNAP (Sentinel Stroke National Audit Programme) and provides information about collaborative working initiatives since the formation of the Suffolk Stroke Review Board.

Background

The Suffolk Stroke Review Board was established in 2013 to oversee the Suffolk Stroke Service development and in particular to continue hyper-acute services at both acute trusts, develop 7 day working and establish an early supported discharge service.

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks. SSNAP results are available to the public from the

Royal College of Physicians website on https://www.strokeaudit.org/results/Clinical-audit.aspx

The audit programme looks at a range of factors, designed to measure the quality of care which patients receive, including how quickly patients can access a brain scan, whether they are rapidly transferred to a dedicated stroke unit and how many patients are given clot-busting thrombolysis treatment. It also measures the help put in place to aid recovery and rehabilitation, such as access to speech and language therapy, physiotherapy and occupational therapy.

Changes

The Suffolk Stroke Review Board and Stroke Service providers have enhanced integrated delivery of stroke care with improved quality of stroke service delivery as reflected in SSNAP standard measure.

SSNAP Audit	Overall score (WSH)
January to March 2015	B
October and December 2014	A
July and September 2014	B

The Suffolk Stroke Service delivers a high quality service within the East of England. This includes:

- since January 2014, provision of 7 day stroke services across disciplines of physiotherapy, occupational therapy, specialist nursing and stroke medicine, on both sites, contributing to improved consistency of stroke service delivery;
- acute providers are collaborating within an evolving joint framework and clinical engagement and leadership;
- the operational stroke pathway at both acute trusts has been reviewed and is on-going;
- collection of SSNAP data has consistently improved at both sites with cooperation day to day;
- recent recruitment of further stroke specialist nurses at Ipswich Hospital with training provision from West Suffolk Hospital is working well.

Since November 2014, informal and formal meetings of acute providers, ESD service and other agencies have coordinated to improve communication, enhance timely service delivery, 7 days a week service provision, explore cross agency governance and patient safety issues.

Comments

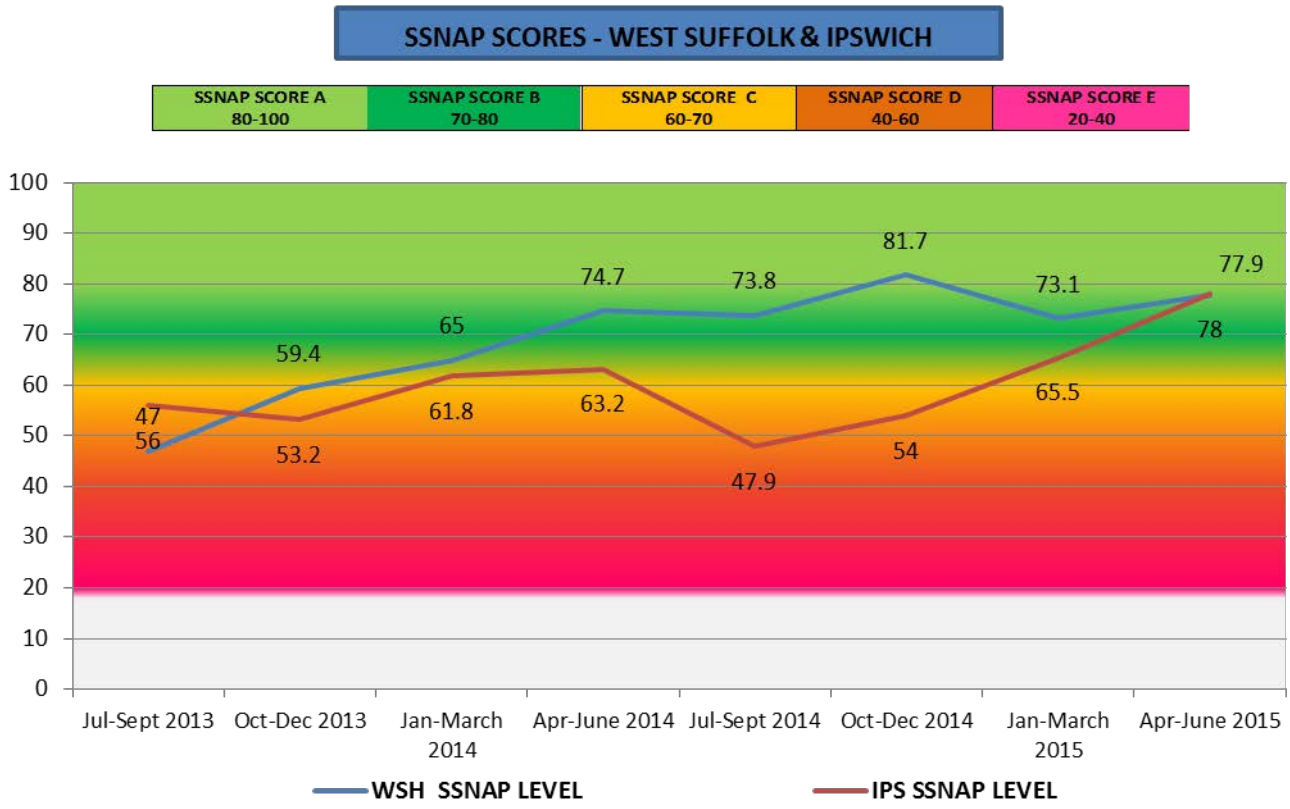
Staff recruitment to stroke services is a national issue across many disciplines - maybe most particularly in Speech and Language Therapy.

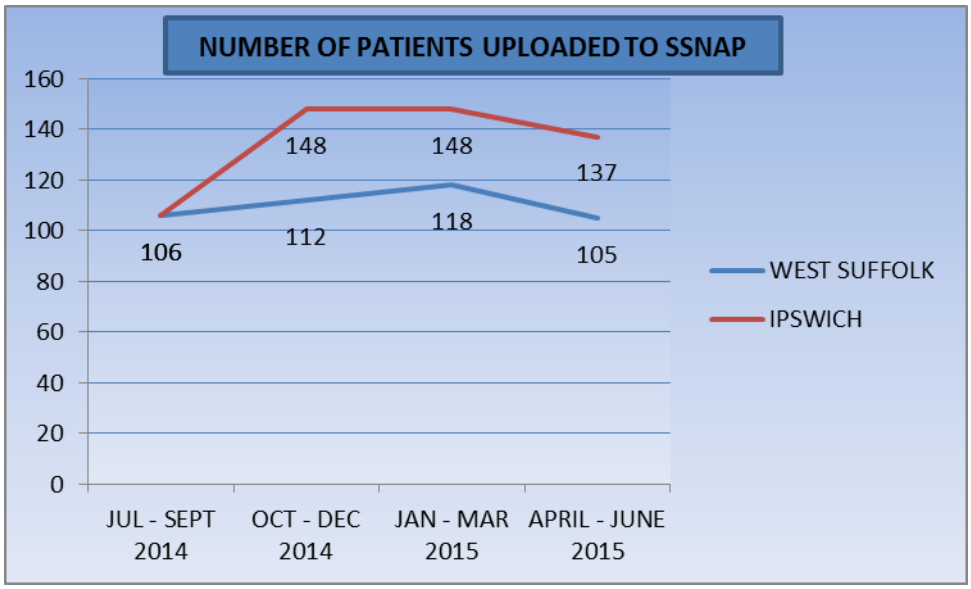
The provision of stroke service delivery beyond 6 weeks after discharge has been highlighted as an issue since ESD service commenced November 2014.

The East of England provision of thrombectomy (catheter or similar removal of a clot in the brains blood vessels after clot busting drugs (thrombolysis)), is in the early stages of planning. This is a significant development for patients with a stroke but with constraints, particularly suitably trained staff (neurologists).

Appendix A

East of England SSNAP Levels	SSNAP Level	SSNAP Level	SSNAP Level	SSNAP Level
	July - Sept 2014	**Oct - Dec 2014**	**Jan - Mar 2015**	**Apr- June 2015**
Basildon Hospital	C	C	B↑	C↓
Bedford Hospital	D	E↓	D↑	D
Addenbrookes Hospital	D	D	D	D
Colchester General Hospital	B	B	C↓	B↑
Lister Hospital	D	D	D	D
Ipswich Hospital	D↓	D	C↑	B↑
James Paget Hospital	D	C↑	B↑	C↓
Luton & Dunstable Hospital	E	E	E	E
Broomfield Hospital	D	C↑	C	C
Norfolk & Norwich University Hospital	C↑	C	C	C
Peterborough City Hospital	E	E	D↑	D
Princess Alexandra Hospital	D	E↓	E	E
Queen Elizabeth Hospital Kings Lynn	E	E	E	E
Southend Hospital	C	B↑	B	B
Watford General Hospital	D	E↓	E	D↑
West Suffolk Hospital	B	A↑	B↓	B





For further information please contact: Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group, email: isabel.cockayne@suffolk.nhs.uk Telephone: 01473 770012

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11. Care Quality Commission (CQC) Inspections of Care Homes in Suffolk

At its meeting on 7 July 2015, the Committee considered its forward work programme. The Committee agreed it would wish to keep the quality of local residential and nursing care homes under review, through information bulletin updates.

The Care Quality Commission publishes details of 217 Suffolk care homes, along with the status of their current inspection, on the Care Quality Commission website at: http://www.cqc.org.uk/search/services/care-homes?location=Suffolk%2C%20United%20Kingdom&sort=default&la=&distance=15&mode=html. Anyone can also register to receive alerts when new information is published by visiting: http://www.cqc.org.uk/content/our-email-alerts

Care UK Care Homes Update

In October 2012, Suffolk County Council's Cabinet agreed the business case for the transfer of the Council's 16 care homes and 8 community wellbeing centres to Care UK. The plan would provide 10 new purpose-built care homes and 10 community wellbeing centres for the accommodation and support of people with dementia and other complex care needs. Care UK took full operational control of the 16 care homes and 8 community wellbeing centres on 1 December 2012.

Development plan update

Care UK and their build partners Castleoak have continued to progress the development of 10 new purpose built care homes for older people with dementia and complex care needs.

The most recent development has been the completion of Phase 2 of Mills Meadow in Framlingham in September 2015, with residents transferring from Lehmann House in Wickham Market.

The homes which have opened are:

- Mildenhall Lodge, Mildenhall;
- Asterbury Place, Ipswich;
- Davers Court, Bury St Edmunds;
- Britten Court, Lowestoft;
- Cleves Place, Haverhill;
- Prince George House, Ipswich;
- Cedrus House, Stowmarket;
- Mills Meadow, Framlingham (Phase 1 and 2).

Homes which are due to open by the beginning of 2016 are:

- Hartismere House, Eye, replacing Paddock House in Eye. Hartismere House will be able to accommodate residents from 19 October 2015;
- Glastonbury Court, Bury. This home is planned to open in December 2015. Ixworth Court will close, completing the development plan.

CQC ratings

ACS has continued to monitor the Care UK care homes closely, though attendance at relatives' meetings and visits to the homes. Information from social workers is reviewed. There is an 'Issues Log' which continues to be shared with senior Care UK managers on a weekly basis. There are formal meetings with Care UK including contract meetings and Board meetings attended by senior managers from ACS and Care UK. There is regular informal contact throughout each week.

ACS has continued to monitor CQC ratings and reports about the Care UK homes. This has included the discussion of details in CQC reports with Care UK and the actions undertaken by Care UK to address issues and concerns. This has included the common themes which have arisen in the CQC reports about management of medication, the use of agency staff and the review and knowledge of care plans. Particular attention is being given by ACS staff to these issues when visiting the care homes and working with Care UK.

In order to rate care homes, CQC previously used five key areas of quality and safety which services need to meet to be fully compliant: treating people with respect and involving them in their care; providing care, treatment and support that meets people's needs; caring for people safely and protecting them from harm; staffing, and; quality and suitability of management.

From October 2014, CQC introduced a new inspection model which is explained on the CQC website: http://www.cqc.org.uk/content/our-new-inspection-model . CQC now consider these key questions about services:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Services are now rated either 'Outstanding', 'Good', 'Requires improvement', or 'Inadequate'.

Cedrus House in Stowmarket and Prince George House in Ipswich have recently been inspected with the publication of the CQC reports awaited. A summary of inspections and reports by CQC shows the following:

Care Home	Inspected by CQC	Date of last published CQC report	Rating
Paddock House, Eye	20 & 30 January 2015	8 May 2015	Good.
Ixworth Court, Ixworth	17 April 2014	14 May 2014	Fully compliant under previous inspection arrangements.
Mildenhall Lodge	17 & 22 December 2014	28 April 2015	Requires improvement
Asterbury Place, Ipswich	28 & 29 October 2014	5 June 2015	Not sufficient evidence to rate this service
Davers Court, Bury St Edmunds	21 January 2015	10 June 2015	Requires improvement
Mills Meadow, Framlingham	29 April 2015	30 July 2015	Requires improvement
Britten Court, Lowestoft	30 April 2015	26 June 2015	Requires improvement
Prince George House, Ipswich	25 & 29 September 2015	Report awaited	Report awaited
Cleves Place, Haverhill	Not yet inspected	Not yet inspected	Not yet inspected
Cedrus House, Stowmarket	21 August 2015	Not yet inspected	Report awaited

For further information please contact Ian Patterson, Project Manager, Adult and Community Services, Email: ian.patterston@suffolk.gov; Tel: 0143 265802

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