Health and Wellbeing SUFFOLK

Agenda Item 9

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Better Care Fund and progress towards integrated working update
Meeting Date:	28 January 2016
Chairman:	Councillor Alan Murray
Board Member Lead(s):	Julian Herbert, Anna McCreadie, Andy Evans
Author:	*Jo Cowley, Business Development Team, Suffolk County Council*

Brief summary of report

1. This report provides the Health and Wellbeing Board with an update on the progress and delivery of the Better Care (BCF) Fund Plan for Suffolk. The report is produced quarterly for review by the Health and Wellbeing Board. It is based on the quarterly return that is made to the National Better Care Fund Team at the Department of Health. It also includes information from the health and care integration programmes in Suffolk and details around winter planning in our health and care systems. In addition it gives the timetable for the development of the Better Care Fund 2016/17 and proposes delegated authorities to get the Plan signed off in time for the national deadlines.

Action recommended

2. The Health and Wellbeing Board is asked to:

   a) Note this report which shows the progress made towards delivering Suffolk's Better Care Plan, including the delivery of integrated care through our transformation programmes in Suffolk

   b) Review the outstanding risks to delivery of the Better Care Fund and the proposed mitigation

   c) Note the timetable for the development of the Better Care Fund Plan 2016/17

   d) Agree delegated authority in order to meet national deadlines for submission of the draft Better Care Fund Plan 2016/17 and final plans.

Reason for recommendation

3. The Health and Wellbeing Board (HWB) has responsibility for the oversight and agreement of the Better Care Fund Plan in Suffolk. The Board needs to be assured that the integration programmes in Suffolk will deliver the vision for health and care as set out in the Better Care Fund Plan. The HWB also has the responsibility for oversight of the development of the Better Care Fund Plan for 2016/17.

Alternative options

4. The Health and Wellbeing Board can ask for further information about the delivery of the Better Care Fund where it feels that the risks to delivery are not being adequately addressed.

5. In respect of the delegated authority decisions the HWB could determine an alternative way of agreeing the plans.

Who will be affected by this decision?

6. The delivery of the Better Care Fund affects all people in Suffolk.

Introduction

7. This report gives the Health and Wellbeing Board an update on integration activity in Suffolk covering:

   - **Implementation of integrated care in Suffolk, including planning for the winter period.**
     - Appendix one covers update information for Waveney, including the recommendations from the Shape of the System consultation
     - Appendix two covers update information for Ipswich and East Suffolk and West Suffolk, including information about winter plans
     - Appendix three is an update from the Suffolk Informatics Partnership
     - Appendix four is an update from the Suffolk Workforce Forum
   - **The Better Care Fund Quarter 2 report covering the period July to September 2015.**
     - Appendix five gives the financial position for the Better Care Fund
     - Appendix six gives the return in respect of the National Conditions
     - Appendix seven provides information on the BCF metrics
   - **The development of the next Better Care Fund Plan covering the period April 2016 to March 2017.**

Section 1 - Implementation update

8. Implementation of the Better Care Fund schemes is through the two integration programmes in Suffolk. Progress is being made through the Connect sites in Sudbury and East Ipswich, with plans under development to accelerate the pace of change and streamlining of plans and programme delivery resources. Other joint initiatives which will benefit the whole of East and West Suffolk are being lead through System Resilience Networks and Integrated Care Networks. In Waveney the Shape of the System Consultation and the Most Capable Provider process are providing a way forward for wider integration within the Great Yarmouth and Waveney area.

9. Recent local strategic developments such as the Suffolk devolution proposal and the establishment of Shadow Integrated Care Organisations in East and West Suffolk will further support the delivery of integrated care in Suffolk.

10. National direction including the latest NHS guidance 'Delivering the forward View – NHS Planning Guidance 2016/17 – 2020/21' support the delivery of integrated care. Local health and care systems are required to develop Sustainability and Transformation Plans which are described as an "ambitious local blueprint for accelerating its implementation of the Forward View".

11. Updates on the delivery of the Health and Care model (through the Connect sites) and the Waveney Integrated Care System are attached as Appendix 1 and 2 to this report. This section also includes information about programmes to manage anticipated winter pressures.

12. Appendix 3 includes an update from the Suffolk Informatics Partnership and Appendix 4 an update from the Suffolk Workforce Group. These groups support the work in the Connect sites as well as the wider integration agenda.

Section 2 – National Better Care Fund reporting

13. The requirements from the national Better Care Fund Team for the Quarter 2 report were different from the previous quarter (April – June 2015). The Quarter 2 report covered the following information:

    a) Progress on the delivery of the BCF national conditions (see Appendix 6 for the information provided)

    b) Progress on the delivery of the BCF target to reduce non-elective emergency admissions (see Appendix 7 for update on BCF metrics)

    c) Confirmation of the amount of expenditure from the BCF pooled fund (see Appendix 5 for and income and expenditure summary)

    d) A narrative summary of progress on the BCF metrics – this gave an opportunity to comment on our performance and explain any mitigations in place.

    e) Preparations for BCF 2016 – 17 – Suffolk confirmed that preparations for the development and delivery of BCF 2016/17 are in place and that support and learning opportunities through the regional and national infrastructure would be welcomed.

    f) Proposed new metrics – the Better Care Fund team is trialling new metrics around personal health budgets, integrated digital records and the use of risk stratification. Suffolk information was provided on all three areas.

    g) Narrative on overall progress in delivering our BCF plan was provided.

Section 3 - Risks update

14. This section highlights BCF risks that have been scored as high. The text for the risk is directly from the Better Care Fund Plan. A comment is put in after each risk to help the Board to understand the latest position. The full list of Better Care Fund Risks can be found in the main BCF Plan which is on the Health and Wellbeing Board website at the following link

    http://www.healthysuffolk.org.uk/health-and-wellbeing-board/useful-documents/ (see pages 32 – 42).

15. This risk remains in place since the Quarter 1 report.

1. There is a system wide risk that resources available to us are unable to reduce forecast demand growth and manage the impact of reductions in central government resources for health and care.	4	5 Our target reduction in non-elective admissions will result in a cost saving of £1.7m. In the event that this saving is not realised the cost of this activity will be compensated by the clinical commissioning groups (CCGs).	20 High	We recognise that this is a risk that we need to manage together across the health and care system. All partners are involved, as the impact of this risk affects all our organisations. We have committed to managing this risk together as system leaders, dynamically and collaboratively. We will ensure effective joint working to implement the schemes, timely monitoring and evaluation of the impact when schemes are implemented and joint governance, risk sharing and financial monitoring/planning Owner – System Leaders Partnerships

Comment – Indications are that in Suffolk we are not meeting the BCF non-elective admissions target on a county wide basis, although performance across CCGs varies.

Mitigation – There are detailed plans developed within the Integrated Care Networks in all three CCG areas to manage the growth in demand. These include the plans for the winter pressures period.

Ipswich and East Suffolk - The Integrated Care Programme aims to achieve a reduction in acute emergency admissions during 2015/16 (excluding <19 years, maternity and reproductive health, oncology and obstetrics) equating to £1.5 million (net) savings for 2015/16. This project will primarily focus on the frail population who require a multi-agency approach to crisis management and who currently have a 1+ day length of stay. A new appointment has been made to ensure that Continuing Healthcare delays are minimised.

Integrated working will consolidate the multi-agency approach to reactive care which builds upon both health care admission prevention services (Crisis Action Team and Frailty Assessment Base). Services will be enhanced to provide a 24/7 urgent response function through single holistic assessments, including involving the voluntary care sector at the beginning of the patients/customers pathway. The aim is to manage the individuals' expectations to remain independent or return to independence within a given timescale from 72 hours with a maximum intervention of 7 days. There is further work going on to pilot ring fencing the use of community beds to support reductions in emergency admissions.

West Suffolk – The establishment of the Enhanced Early Intervention Team alongside the development of the Integrated Neighbourhood Teams and other projects aims to reduce the number of people attending West Suffolk Hospital in an

emergency. Results for the Care Home Project (which increases co-ordination and support to care home residents) has shown excellent results in reducing emergency admissions. This project will be expanded in the Autumn.

Waveney – results for the Lowestoft Out of Hospital Team show that this model of care can have a positive impact on the numbers of people attending hospital in an emergency. Recommendation from the Great Yarmouth and Waveney Shape of the System Public Consultation have now been agreed by the CCG Governing Body.

Section 4 - Finance update

16. The tables in Appendix 5 reflect the contributions and schemes (expenditure) as agreed in the Better Care Fund financial agreement (known as a Section 75 agreement) for the year 2014/15 between the parties for the 3 pooled funds. Minor amendments to the allocation of spend across some of the Great Yarmouth & Waveney schemes have been approved by the Great Yarmouth & Waveney BCF Partnership Board and will be reflected in subsequent reports.

17. The profile of spend (and therefore the corresponding contributions into the pool) for the quarter are largely based on an equal quarters share of the annual amount. This is because most CCG spend is tied into block contracts and across health and social care the BCF element is a small part of much larger budgets and spend and therefore any meaningful spend profile is not possible.

18. Included within the pooled fund agreement is the provision for a transfer of funding from the CCGs to Suffolk County Council in order to protect social care – one of the founding principles of the Better Care Fund. Whilst some elements are guaranteed transfers i.e. a contribution to assist in the funding of the Care Act (£1.8m), the continuation of what was previously the section 256 funding (£14.9m), and Great Yarmouth and Waveney CCG have agreed an additional transfer of £1m, other elements of transfer were tied to the ability to make savings within the CCG, either via the payment for performance element through a reduction in non-elective admissions or via other savings measures. A total of £4.4m was agreed as a potential transfer, but to date no savings have been achieved and there is now little likelihood of this amount being transferred in this year. By the end of the next quarter those working on the savings initiatives will have a much better indication of the likely saving in this year and this will be reflected in the next update report.

19. The Better Care Fund includes a pay for performance element. £1.7 m of the Suffolk BCF allocation will be contributed into the fund subject to the achievement of a reduction in non-elective admissions, to the target levels set out in the Better Care Fund Plan. This target has not been met to date, and the amount allocated has been used by the Clinical Commissioning Groups to part fund the additional non-elective activity over and above the BCF target.

Section 5 – Better Care Fund Plan 2016/17

20. Health and Wellbeing Boards, CCGs and local authorities have been advised that they must develop a BCF Plan for 2016/17. The Comprehensive Spending Review (25 November 2015), confirmed that the Better Care Fund will continue into 2016-17 – with a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

21. Information from the national BCF team states that "The process for the development and assurance/approval of local Better Care Fund plans in 2016-17 will be more streamlined and better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities. ". However it is not yet clear what this means in practice.

22. The Better Care Fund planning guidance will be issued directly to Councils and as an annex to the NHS technical planning guidance, which will be published on NHS England's website in early January 2016. At the time of writing this report the guidance had not yet been received.

23. The timescales for submitting Better Care Fund local plans will follow the deadlines set out in the NHS Planning Guidance:

    - First draft – 8 February 2016
    - Refresh – mid-March 2016
    - Final submission (signed off by Health and Wellbeing Boards) - mid-to-late April 2016.

24. In acknowledgement of the tight timescales involved, it is expected that the first draft submission of Better Care Fund local plans on 8 February will be high-level, focused around the finances and core principles, while providing sufficient detail to support Councils' budget setting processes. The detailed requirements for submissions and the exact timings for the March and April resubmissions will be confirmed in the guidance.

25. It is anticipated that the next BCF Plan will build on the existing Plan, bringing it up to date with current partnership structure and integration action plans. It will reflect the refreshed Health and Wellbeing Strategy, as well as the great deal of work that has gone on within our localities to integrate and improve services.

26. The writing of the Plan is being co-ordinated by a group of officers from Suffolk County Council and all three CCGs. As the drafts develop they will be shared at appropriate points with Health and Wellbeing Board members to ensure that the Plan is developed in line with HWB ambition.

27. The Health and Wellbeing Board will be required to sign off the final Plan and probably the drafts too. There is an opportunity on 10 March to review the draft plan, but following that there is not another Board meeting until May, which is after the submission deadline.

28. The following timetable is therefore proposed:

First draft – to be submitted 8 February – sign off by HWB Chairman, Chief Officers of the CCGs, Director of Adult Social Care.

Presentation re draft plan – 10 March Health and Wellbeing Board

Circulation of "final" draft to HWB for comment – end March

Sign off of final plan – mid to late April – by HWB Chairman, Chief Officers of the CCGs, Director of Adult Social Care.

29. The final agreed plan will be available on the Health and Wellbeing Board website, as is the current Plan for 2015/16.

Sources of further information

Suffolk's Better Care Fund Plan can be found on this page

http://www.healthysuffolk.org.uk/health-and-wellbeing-board/useful-documents/

Information about the integration programmes in Suffolk can be found here http://www.healthysuffolk.org.uk/health-and-wellbeing-board/suffolk-care-and-health-review/

The full Better Care Fund Q2 return can be obtained from Jo Cowley by emailing jo.cowley@suffolk.gov.uk

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Appendix 1

Waveney – Implementation update

Shape of the System Public Consultation Recommendations
At the NHS Great Yarmouth and Waveney GY&W) CCGs Governing Body meeting in public on Thursday 5 November 2015, the Governing Body agreed the recommendations from the GY&W Shape of the System Consultation. Four recommendations relate to the Waveney area. Recommendation one: Develop out of hospital services supported by beds with care in the Bungay area. These will be developed with local clinicians. Once these services are in place we would anticipate that there will not be a need for the GP community hospital beds at All Hallows Hospital and we will then be able to close those beds. Recommendation two: Change the use of the GP community hospital beds at Beccles Hospital to provide an intermediate care facility for the whole of Great Yarmouth and Waveney. This will be for patients who have longer term needs due to medical and/or social care issues which need to be resolved before the patient goes home. This would include locally designed out of hospital services and appropriate support in beds with care within Beccles. Recommendation three: Halesworth have put a strong case for their bedded care being a successful model in such a rural area and we will develop a new service with local clinicians. This will include beds with care being available and we hope that this will be in the new Castle Meadow facility. Out of hospital services will be developed to support this model of care. Once these services are in place we would anticipate that there will not be a need for the GP community hospital beds at Patrick Stead Hospital and we will then be able to close the hospital. Recommendation four: We have heard from the Southwold community that the current out of hospital model will not work in the same way in more rural areas. We will work with the local community and clinicians to design a model with out of hospital services and appropriate beds with care in the local area. Southwold Hospital now only contains GP community hospital beds with all other services having relocated to the new Sole Bay Health Centre. GP community hospital beds at Southwold Hospital are temporarily suspended due to staffing issues. During this time the local community has been able to support patients well and we will work quickly with the local community to put the new out of hospital services in place to support this further. We would anticipate that once they are in place there will not be a need for the GP community hospital beds at Southwold Hospital and we will then be able to permanently close the hospital. There are a number of principles for the new services: • NHS funded beds with care will be provided in local nursing and residential homes and these will be provided to NHS quality and safety standards and be closely monitored. • Out of hospital teams will be based in new community hubs across the area.

- The CCG will work with local providers to make sure services are tailored to the needs of the local population.
- The CCG will work with local providers to make sure staff are appropriately supported throughout the changes.

Great Yarmouth & Waveney (GY&W) Integrated Resilience Plan

The Great Yarmouth and Waveney health and social care system has an agreed Integrated Resilience Plan which details the steps being taken collectively to ensure that appropriate arrangements are in place to provide high quality and responsive services to patients.

Operational Management - The system has drawn upon tried and tested operational management processes put in place during 2014/15 to ensure operational resilience and stability and these have continued during winter 2015/16.

Update on Service Developments

- The impact of the Out of Hospital Team(s) has been noticeable in supporting people to stay at home or enable early discharge from hospital which has had a positive impact on the acute hospital to enable more capacity to be available for the residents of GYW.
- From 28 December the Ambulatory Care Unit (Ambu) at James Paget University Hospital (JPUH) went operational 7 days a week. This continues to prove very successful in discharge patients on the same day where clinically appropriate and avoiding unnecessary hospital admissions.
- Acute psychiatric liaison in JPUH Accident and Emergency (A&E) is now in place 7 days a week and includes support for adults (7 days a week) and the availability of an additional CAMHS service at weekends (previously this was only available on weekdays and Saturday mornings). The service also links with a local voluntary agenda (MIND) to support patients when they return home.
- The JPUH FLO programme is continued to be rolled out across all wards. This now includes a plan for every delay which is supporting wards in identifying bottlenecks to ensure speedy resolution to support patients being discharge sooner.
- The NHS111 Services has put additional staff in place over the busy winter period. The service has been under increased pressure at times due to national contingency plans being implemented over Christmas and New Year due to the national crisis e.g. the floods in the North of England.
- The CCG has commissioned the Out of Hours Primary Care service to put in place additional clinicians over the busy Christmas and New Year period.
- The CCG has also commissioned the Out of Hours Primary Care service to provide additional primary care clinicians in its base next to A&E to allow for streaming of patients with a minor illness to a GP.
- The CCG has commissioned a further 5 CHC discharge to assess beds within Waveney and also 2 beds with care in a care home within Reydon.
- During peak periods the CCG has arranged for additional transport services to support discharge from the acute trust.

Whilst it is anticipated that the system will be under periods of peak pressure particularly during the winter, it should be noted that this is reflective of the national picture. Through the implementation of the systems operational plans and initiatives the GYW health and social care system continues to work collaboratively with the focus to ensure the best interests of the patients are met.

Appendix 2

Ipswich and East Suffolk and West Suffolk – Implementation update

Progress this period

East and West Suffolk

There are many synergies between the Connect East Ipswich and Connect Sudbury early adopter sites, and work stream leads are working across the two sites wherever possible. This allows for the maximum learning and opportunities to test different aspects of the model in ways that work specifically for each locality. Plans are underway to develop the transformation team so that it can work more effectively as an integrated team, with agreed partnership plans supporting the delivery of integrated care within East and West Suffolk. Overarching progress on the Connect work streams includes:

1.

- Suffolk County Council (SCC) in conjunction with the CCG has developed a core set of metrics to measure the baseline of activity in the Sudbury and East Ipswich localities. These metrics have now been discussed with the various work stream leads, formulated and approved by the Connect project groups. The next stage is to start populating the data for each metric. Recruitment will commence in January for a data intelligence specialist to coordinate this data activity across both Connect sites.

- Suffolk Public Health have now scoped and developed the approach to conduct a rapid review of the Connect implementation across both Connect areas. The initial report should be ready for review in January 2016.

- The co-location of the Adult and Community Services (ACS) team into the Sudbury Health Centre was completed on 3 September. Suffolk County Council's corporate property programme board and Ipswich and East Suffolk CCG's Governing Body have approved development of the health and wellbeing centre proposal for 214 Sidegate Lane. A survey of the building and grounds has been carried out in preparation for the submission of a 'change of use' planning application. If successful, this will provide shared office accommodation for ACS and Suffolk Community Healthcare (SCH) teams together with multi-use clinic space, flexible meeting/activity space and hot-desking opportunities for the wider Connect members such as police and Voluntary and Community Sector (VCS).

- The current Integrated Neighbourhood Team lead has been withdrawn from her role across the Connect sites by SCC to work on other work areas. This is a risk to the project, but local SCC and SCH leadership with CCG support will be provided to ensure that the team developments continue at pace. This will include accelerated

INT developments such as enhanced referral management, review of access and linkage to specialist teams in West Suffolk and East Ipswich. In addition, there is no resource currently to lead the Integrated Rehabilitation and Reablement aspect of the Connect work. This is being reviewed and managed within SCC.

- As part of the workforce development initiative, Think Big, Connect Sudbury and East Ipswich have commenced planning how the concept will be used to better integrate the INTs and VCS. It is anticipated that workshops will take place in Feb/March with key operational staff to development fresh and innovative thinking.

- Recruitment of two Local Area Coordinators is now complete for Connect Sudbury. Imogen Sherwood (Sudbury Town) and Cally Boardman (Sudbury Rural) have been successful and appointed. These roles will play a fundamental part in linking statutory services and VCS organisations through the support of vulnerable people in the community. It is expected that the team will be ready to receive introductions in the New Year. A communications plan is being developed to ensure that all teams are aware of their roles and know how to access. The recruitment process for Local Area Coordinators for East Ipswich will commence in January

- Positive project group meetings held on 3 December in Ipswich and 8 December 2015 in Sudbury, which demonstrated good progress in the INT and Neighbourhood Network (NN) areas of the programme. Participation and engagement for both early adopter sites remains high.

- Work has commenced to consider how the Connect programme can be extended across the rest of the East and West Suffolk area in alignment with the commissioning intentions. The outcome of this work will go to the Health, Care and Safety Joint Commissioning Group which oversees the Connect developments from a system perspective.

Winter planning activity

This activity has been agreed in Ipswich and East Suffolk for the winter period

1. **Crisis Action Team (CAT)** - 24/7 multi- agency very short term intensive admission avoidance scheme. Aimed at avoiding A&E attendances, ambulance conveyances, 0 LOS and 1+ LOS (length of stay). 6 month pilot project
2. **Frailty Assessment Base (FAB)** - The Frailty Assessment Base is located at Ipswich Hospital and provides multidisciplinary advice and assessment for frail older people. This is a new service staffed by senior consultants, therapists, nurses, pharmacists and dieticians. It provides Comprehensive Geriatric Assessment for frail older patients at risk of acute admission. This service will provide direct access to senior specialists will facilitate timely, proactive multidisciplinary

assessment and intervention which will help prevent acute deterioration, hospital admissions and maintain independence.

The service commenced on 5 October 2015 and will run 10am-6pm Monday to Friday initially.

3. **Acute Readmission Avoidance Scheme (ARAS**) - A 6 month winter scheme which commenced 12/10/15 which is run and managed by Ipswich Hospital Trust (IHT)and provided by The British Red Cross. The scheme has the following aims:
    - To support vulnerable people being discharged from hospital, coordinate support services to ensure that all appropriate assistance is in place to prevent hospital readmissions.
    - The Scheme offers support within an intensive 72 hour window for patients ensuring that there is adequate provision from existing support services in place when handing over at the end of service term.
    - The service will see a minimum of 15 patients per week, facilitating earlier discharge and readmission avoidance.
4. **Community Reablement Beds -** A winter scheme commencing from 9 November 2015, to provide up to 24 community reablement beds (virtual and real) in Stowmarket, Ipswich and Felixstowe to provide step up, step across and step down care to medically stable patients who have a short-term low level reablement need.
5. **Hospital Ambulance Liaison Officer (HALO)** - IESCCG have committed baseline winter funds for support to the ambulance service with funding pre-committed to HALO schemes to support the reduction in handover and turnaround delays. Ambulance turnaround delays are identified as a system priority for 2015/16 and the provision of HALOs located in the Emergency Department at IHT will support and tackle handover delays
6. **Prime Minister's Challenge Fund – Ipswich Primary Care Hub** - NHS England have (through the Prime Minister's Challenge Fund) commissioned GP appointments from 6:30pm – 9:00pm on weekdays and 12 hours a day on Saturday, Sunday and Bank Holidays. These will be available to both grass roots GPs, A&E triage nurses, the ambulance service and (subject to enablement later this year) NHS 111.
7. **Town Pastors – Ipswich** - To support and care for intoxicated and other vulnerable people who otherwise may end up needing NHS care via ambulance, paramedic or A&E services. To ensure that all Town Pastors (who are all volunteers) know when and how to access services along with the correct uses of health services including 111, GP, pharmacy etc. so they can advise accordingly. To provide a watchful eye and appropriate support in Ipswich town centre on a Friday and Saturday night.
8. **Suffolk Family Carers – Moving and Handling** - Suffolk Family Carers: Moving and Handling Training for 90 carers focused on falls prevention.

9. **Suffolk Family Carers – Respite on Prescription -** The aim of the project is to provide a period of respite for patients to allow their carers to attend hospital appointments or undergo surgery for the remainder of 2015/16
10. **Ipswich Hospital –** IHT are leading on a number of internal schemes to increase efficiencies and flow to create further capacity, these include:
    - Plan to use Kesgrave ward as a medical escalation ward from 1st October – 31 March. This involves planning to have the ward fully functional and staffed across the winter period to accommodate the expected increase in medical activity
    - Different use of Gipping ward to enable 6 day case spaces for gynaecology patients on Stour ward
    - Use of Stour ward – conversion of current day room to accommodate a further 4 beds
    - Completion of the Clinical Investigations Unit move from Raedwald to the 1st floor maternity block. . This change expects to provide an additional overall bed capacity of 4 beds
      commenced on 2nd November 2015
    - Plan to use Bramford ward for medical escalation 1 January – 31 March (12 beds)
    - Increased geriatrician input into community hospitals, reducing community hospital LOS, together with actions from community Red to Green for Quarters 3 & 4. Commenced on 20 October
    - Emergency Department - 'LEAN' process review undertaken. 17 staff and patients interviewed, collation of improvement opportunities and process changes identified and worked through in a workshop facilitated by Emergency Care Intensive Support Team. Trialling of changes to take place in Emergency Department (ED) Red to Green week commencing 5 October. This will include recording and monitoring of revised ED professional standards to understand any bottlenecks and continually improve processes

14. **Delayed Transfers of Care (DTOC) Plan** - A bi-weekly high level Winter Resilience Group was established to develop and implement an action plan to tackle the increase in DToC's. A detailed action plan encompassing a number of short and long term actions have been identified across the system, targeting areas impacting on DToC performance.

This activity has been agreed in West Suffolk for the winter period:

1. **Chronic Obstructive Pulmonary Disorder (COPD) service -** The winter 2014/15 review highlighted that the COPD and pulmonary rehab service experienced a decrease in referrals which did not reflect the increased levels of respiratory illness in the population or the rise in COPD emergency

admissions. The COPD service, as did many of the community services, experienced an increase in the number of interventions per patient indicating that acuity may have been driving most of their activity. The CCG has worked with the service provider to undertake a deeper analysis of the service model and has since made a number of pathway changes which will produce an improved proactive response to case management and a reactive response as part of an integrated admission prevention service. Work is in progress and the revised operational pathway is planned to be launched in late September 2015.

The level of demand last winter was unprecedented across the system. The System Resilience Group (SRG) agreed that the efficacy of the flu vaccination was most likely to be an underlying cause and agreed that the local plan for 2015/16 would require additional focus to ensure confidence does not affect uptake this winter. It was felt the management of frailty was also key in managing respiratory related emergency admissions and this is a major focus of this year's plan.

2. **Frailty** - The number of frail elderly emergency admissions had risen exponentially over winter 2014 with respiratory and other infections such as Urinary Tract Infections presenting as the tipping point and the primary diagnosis for admission but with underpinning multiple co-morbidities. The priority areas of action have included:
   - Identifying the very highly complex frequent service users – through case note review of frequent service users we have identified the top 100 cases which are now being proactively case managed in the community. For the frail cohort of service users the Interface Geriatrician takes a lead role in supporting the community case manager and patients' GP to develop a shared care plan and supports the multi disciplinary team review. The system has developed a pull-based discharge pathway for individuals whose plan at home has failed and they have subsequently been admitted into hospital.
   - Frailty assessment – as part of CQUIN (Commissioning for quality and innovation payments) we have co-developed a frailty pathway for all over 75 year olds who are admitted as an emergency
3. **Care Homes** - The work with care homes has expanded in 2015/16 following a successful launch in 2014 and is a key part of the system plan. Supported by the Interface Geriatrician, End of Life Consultant at West Suffolk Foundation Trust (WSFT), sessional pharmacists and the GPs, the Care Home Clinical Team work closely with care home staff, residents and families to undertake clinical reviews and develop shared care plans. This year we expect to completely roll out the approach to all 47 of the care homes in west Suffolk and evaluate the impact of the Recognizing the Deteriorating Patient toolkit. The impact of this care home approach is already demonstrating a 50% reduction in care home emergency admissions from those care homes already worked with.
4. **Integrated Admission Prevention – Early Intervention Team -** The successful implementation of the Early Intervention Team at WSFT in 2014/15 on reducing emergency admissions has informed the decision by the West Suffolk System Forum to utilize most of the Operational Resilience Funding to extend the model of working out into the community as part of an integrated community facing enhanced admission prevention service. The new Team will operate under a single management structure but includes services from the acute trust, community services, social care, Age UK Suffolk and mental health services. The full model is expected to be launched on 12 October.

The existing community admission prevention service is being re-engineered in a number of ways including: pathway changes to separate planned and unplanned demand, increased training for core teams, changed alignment of core/aps team interfaces, reduction in existing pathway duplication/delays and workforce/skills re-profiling. This work is supported by new operational policies and procedures. The impact of the work will improve urgent response capacity, benefit recruitment and retention and ensure core community functions are not compromised.

The team will also have direct access to a number of existing community beds which will be designated for admission avoidance purposes. This will enhance the integrated model described above and will be a critical part of its success. The team will 'pull' together the interface geriatricians, and other services/organizations to develop and agree the management plan for patients so that they receive a safe and viable alternative to acute admission.

5. **Additional step down and step up community beds** - The operational resilience funding has supported the commissioning of up to 7 additional community beds which will be used for step up purposes accessed via the Early Intervention Team and step down reablement or rehabilitation from WSFT. These beds will be operational from 1 October 2015 to 31 March 2016.

6. **Enhanced Hospital Ambulance Liaison Officer -** The HALO role played an important part at WSFT last winter in supporting delivery of ambulance handover. The CCG has supported use of the resilience funding again this year to reintroduce this role at WSFT and we are enhancing the role to work alongside the Early Intervention Team in supporting crews to refer to the community team. Utilisation by East of England Air Ambulance Service Trust (EEAST) of community alternatives to conveyance has been inconsistent and it is planned that this critical role will provide education and challenge to crews where a conveyance could have been avoided. The role will promote the admission prevention response and provide feedback to crews on referral activity.

Appendix 3

Update from the Suffolk Informatics Partnership

1. The Suffolk Informatics Partnership (SIP) board continue to meet regularly, and have a number of active subgroups supporting the aims.

2. Good progress being made by the Clinical Information Assurance sub-group::-
   - addressing barriers to digitally enabled Information (Records) Sharing
   - progressing digital enablement (inc commitments to 'throw out the fax)'

3. There are emerging plans being developed for a pan-public sector IT Infrastructure that enables seamless co-location; led by the ICT sub-group

4. The principles and critical success factors for 'Improving Population Health and Wellbeing by use of Insight, Intelligence & Innovation' (iPHWi^3) have been agreed, we are developing a sub-group around the existing 'Suffolk Information Forum'.

5. Agreements have been reached around aligning the SIP governance to TCA (Transformational Challenge Award) and ICO (Integrated Care Organisations) that avoid duplication, and ensure 'pan-system' collaboration.

6. The SIP Acceleration Programme Manager has been appointed, and is working with partner agencies gaining clarity on existing organisational plans, and pan-system acceleration opportunities.

7. Progress is being made around the 'Suffolk Digital Roadmap' (as defined in 'Personalised Health and Care 2020'); the Suffolk 'footprint' is being led by West Suffolk CCG and includes all health & care providers, commissioners and support agencies involved in health & care across Ipswich & East Suffolk CCG and West Suffolk CCG), with formal links between Great Yarmouth & Waveney CCG (part of the Norfolk 'footprint'), and the CCGs in Cambridgeshire & Essex. This has been approved by NHS England.

8. The NHS England Digital Maturity Index (self assessments) are being completed by all major providers across the Suffolk footprint

9. Digital Maturity analysis, the SIP Acceleration programme, provider SWOT analysis, ICO aims, and Commissioner Health & Care redesign will all inform the development of the Suffolk Digital Roadmap.

10. The Suffolk Digital Roadmap will be further developed over the coming months, will seek formal sign off by the Health & Wellbeing Board, and aims to be published in June 2016. It is clear that NHS England's early ambitions from each Roadmap are focussed on 'paper free at the point of care'

11. It is anticipated that there will be additional investment from NHS England to implement local roadmaps; at this stage we have no further details, other than it is expected to be 'match funding'. Suffolk will need to carefully consider how to effectively invest to achieve the most benefit across the system (as generally until now, investment has been 'infra-organisation').

Appendix 4

Update from the Suffolk Workforce Forum

The Suffolk Workforce Forum met on the 25th November and received a Progress Report presentation detailing the items below. It was noted that the Workforce Transformation Lead post has been recruited and Steve Griffee will be commencing on 4th January 2016.

The next Suffolk Workforce Forum meeting is scheduled for the 14th January and will receive progress update reports on Talent for Care, Suffolk Crisis Action Team and Local Enterprise Partnership.

Integrated Care Principles - The Integrated Care Principles developed in consultation with Suffolk Health and Social Care colleagues, were presented to the Connect project groups in November who approved them for ratification. On December the 3rd they were presented to the Norfolk & Suffolk Health Education East -Chief Executive Board who supported their role out.

Workforce Profiling - All Suffolk Health & Social Care organisations have completed the workforce profiling template and the data has been collated into a report. This data will be extremely useful in helping to meet the requirements of implementing the five year forward view especially in relation to "Place Based Planning".

Rotational Apprenticeship Scheme - The Integrated Rotational Apprenticeship Project continues at pace with 4 apprentices in Ipswich and 4 in Bury St Edmunds rotating through a Hospital, Community and Social Care setting.

The Ipswich cohort will be starting their second placement on Monday 1st February and will be attending a Care Certificate Ceremony with their current placement host at the end of January to celebrate completing the standards.

The West Suffolk cohort will be starting their second placement on Tuesday 1st March.

Victoria Fennell and Emma White will be working closely with the Participating Organisations to evaluate the project and will be collecting case studies from the apprentices and mentors to promote the programme for future cohorts.

It is hoped that Suffolk will be able to run the programme again this autumn with some Primary Care and Mental Health Services involvement alongside Social Care and the Acute Trusts.

Integrated Workforce Development

Workforce Information Sharing Portal (WISP) - Over one hundred areas of best practice have been added to the portal and further functionality developed which enables specific search criteria to be utilised. This has been praised by users, enabling them to access best practice and prevent reinvention of wheels!

Local Enterprise Partnership: Developing a Sector Skills Action Plan - A paper was taken to the Directors of Nursing Group at the Norfolk and Suffolk Workforce Partnership. They fully support our work and believe it aligns with their priorities. They were happy with our proposed areas for focus, are keen to work with us on all parts of the action plan and especially on support and promotion of registered nurses in nursing homes where they had some really good ideas. They will send their comments and suggestions on the details of our proposals in the next few weeks and they will ensure that this goes to the Chief Executive Board (Trusts, CCGs, Community Health, Local Authorities) with a recommendation that this work is supported.

Integrated Healthy Lifestyle Service - The Integrated Healthy Lifestyle Service (IHLS) contract has been awarded to Leeds Beckett University. This provider leads a partnership arrangement with; MoreLife, Quit 51 and Tobacco Free Futures. The new IHLS will be delivered across the whole of Suffolk from 1st April 2016 and will incorporate some new services together with a broad range of existing provision

Appendix 5

Section 75 agreement pooled funds

CONTRIBUTION SUMMARY	National £bn	IESCCG £m	WSCCG £m	GYWCCG £m	SCC £m	HWBB £m
2014/15 NHS transfer to social care						
Section 256	1.10	8.1	4.4	2.5	-	14.9
Carer's break funding	0.13	0.8	0.6	0.3	-	1.7
CCG reablement funding	0.30	1.9	1.3	0.7	-	4.0
Local Authority Capital funding	0.13	-	-	-	1.8	1.8
Disabled Facilities Grant	0.22	-	-	-	2.7	2.7
	1.88	10.9	6.3	3.5	4.5	25.2
2015/16 additional funding transfer into BCF						
Performance related (emergency admissions)	0.30	0.7	0.4	0.6	-	1.7
NHS Commissioned out of hospital services	0.70	5.9	3.7	1.9	-	11.5
Other Transfer	0.90	5.4	3.8	2.4	-	11.7
	1.90	12.0	8.0	4.9	0.0	24.9
Total Funding	**3.78**	**22.9**	**14.2**	**8.4**	**4.5**	**50.0**

EXPENDITURE SUMMARY	IESCCG Pool £m	WSCCG Pool £m	GYWCCG Pool £m	HWBB Pool £m
Integrated Neighbourhood Teams	7.6	4.9		12.5
Access to Specialist Services and Support	0.9	0.6		1.4
Admission prevention	2.9	1.9		4.8
Reablement	9.1	5.2		14.4
Support for Carers	0.9	0.6	0.3	1.7
Contingent on Emergency Admissions reduction	0.7	0.4		1.1
Supporting independence by provision of community based interventions			4.0	4.0
Integrated Community Teams and Out of Hospital Teams			1.5	1.5
Urgent Care Programme			1.6	1.6
Support for people with dementia and older people with mental health problems			0.7	0.7
Care Act implementation	0.9	0.6	0.3	1.8
Local Authority Capital funding	0.9	0.6	0.3	1.8
Disabled Facilities Grant	1.4	0.7	0.7	2.7
Total Expenditure	**25.1**	**15.5**	**9.4**	**50.0**

Appendix 6

Better Care Fund - National Conditions

Condition	Q4 Submission Response	Q1 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	
1) Are the plans still jointly agreed?	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	No - In Progress	No - In Progress	No - In Progress	31/03/2017	See below for commentary on the protection of social care services
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	No - In Progress	No - In Progress	31/03/2016	This condition has been met in Waveney and is in progress in the rest of Suffolk.
4) In respect of data sharing – confirm that:					
i) Is the NHS Number being used as the primary identifier for health and care services?	No – In Progress	Yes	No – In Progress	31/03/2018	We have revised our judgement on this since the Q1 return in Waveney the condition has been met. In the rest of Suffolk all organisations have the NHS numbers on their systems but are not routinely using it as the primary identifier.
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for	No – In Progress	Yes	Yes		

information sharing in line with Caldicott 2?					
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No – In Progress	No – In Progress	No – In Progress	31/03/2016	This approach is being tested and rolled out in our integrated team developments – the Out of Hospital Team model in Waveney and the Connect sites in the rest of Suffolk.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Yes	Yes		

Protection of Social Care –Systems agreement was reached at the end of 2014 as to how this national condition would be met, alongside transfer of the former section 256 funding and funding allocated to help offset the financial impact of the Care Act.

However, plans were reliant on 2015/16 savings in the NHS being identified through joint work that would then be passed to Suffolk County Council for the protection of social care. The amount generated through this activity is unlikely to much above £1m in this year, out of an anticipated £5.4m, resulting in a financial shortfall for the County Council.

This situation and the position over the next couple of years (where a further £4.6m in addition to the £5.4m per annum is needed to safeguard social care services) should be seen in the light of further anticipated reductions to Suffolk County Council budgets and the financial position of the three CCGs in Suffolk. We intend to rethink the scope of the BCF to address this in BCF 2016-17.

Appendix 7

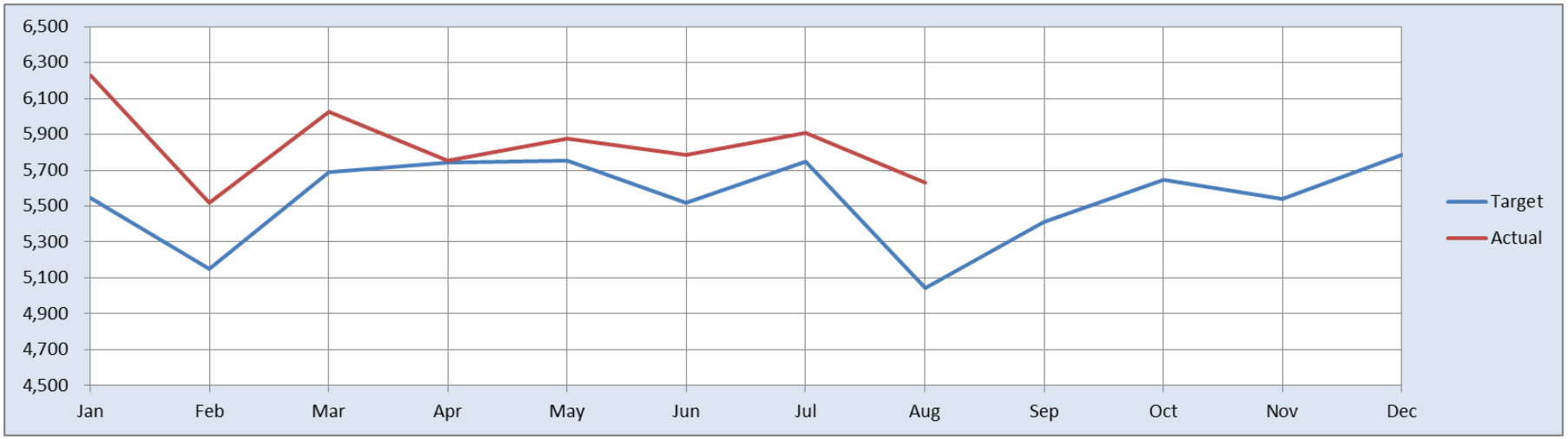
Better Care Fund Metrics – Quarter 2 2015/16 (July - September)

Measure 1 – non-elective admissions to hospital

This measure tracks the number of people who have been admitted to hospital in an emergency. The aim is to reduce this number through better support in the community. Hospitals outside of Suffolk are shown where there have been admissions of Suffolk residents. The Better Care Fund target is for the whole of Suffolk, but the numbers have been broken down to show the different performance for each hospital.

Note – no September figures available at the current time.

Graph showing total number of non-elective admissions across the whole of Suffolk against the BCF target.



Metric and Target		Jan	Feb	Mar	Q4	Apr	May	June	Q1	July	Aug	Sept	Q2
Total non-elective admissions in to hospital (general & acute), all ages, per 100,000 population	Actuals	6,228	5,520	6,024	17,772	5,754	5,874	5,786	17,414	5,910	5,631	0	11,541
	Target	5,544	5,151	5,690	16,385	5,741	5,753	5,517	17,011	5,746	5,043	5,413	16,202
Target reduction -3.5% vs baseline	*variance*	*12.3%*	*7.2%*	*5.9%*	*8.5%*	*0.2%*	*2.1%*	*4.9%*	*2.4%*	*2.8%*	*11.7%*	*-100.0%*	0
IPSWICH AND EAST SUFFOLK CCG	*Actuals*	3,430	3,041	3,323	9,794	3,184	3,116	3,076	9,375	3,141	2,957	0	6,098
	Target	2,927	2,707	2,976	8,611	3,013	2,969	2,772	8,753	3,024	2,535	2,819	8,378
	variance	502	334	347	1,183	171	147	304	622	117	422	-2,819	-2,280
WEST SUFFOLK CCG	*Actuals*	1,826	1,624	1,761	5,210	1,663	1,849	1,740	5,252	1,828	1,777	0	3,606
	Target	1,639	1,583	1,704	4,927	1,781	1,795	1,779	5,356	1,755	1,630	1,637	5,023
	variance	186	40	57	284	-118	54	-39	-104	74	147	-1,637	-1,417
GREAT YARMOUTH AND WAVENEY CCG	*Actuals*	900	788	862	2,550	830	830	892	2,552	860	820	0	1,680
	Target	907	796	936	2,638	875	914	893	2,682	894	811	888	2,592
	variance	-7	-8	-73	-88	-45	-85	-1	-130	-33	9	-888	-912
CAMBRIDGESHIRE AND PETERBOROUGH CCG	*Actuals*	10	9	11	30	11	11	11	32	11	10	0	22
	Target	10	9	10	29	10	11	10	31	10	10	10	30
	variance	0	0	1	2	0	0	1	2	1	1	-10	-8
NORTH EAST ESSEX CCG	*Actuals*	39	36	42	118	44	44	44	132	44	41	0	85
	Target	38	36	40	114	40	41	39	120	39	35	37	110
	variance	0	1	2	3	4	3	5	12	5	6	-37	-26
SOUTH NORFOLK CCG	*Actuals*	24	21	24	69	23	25	23	70	25	25	0	50
	Target	22	20	23	66	23	23	23	69	25	22	22	69
	variance	1	1	1	3	0	1	0	1	1	3	-22	-19

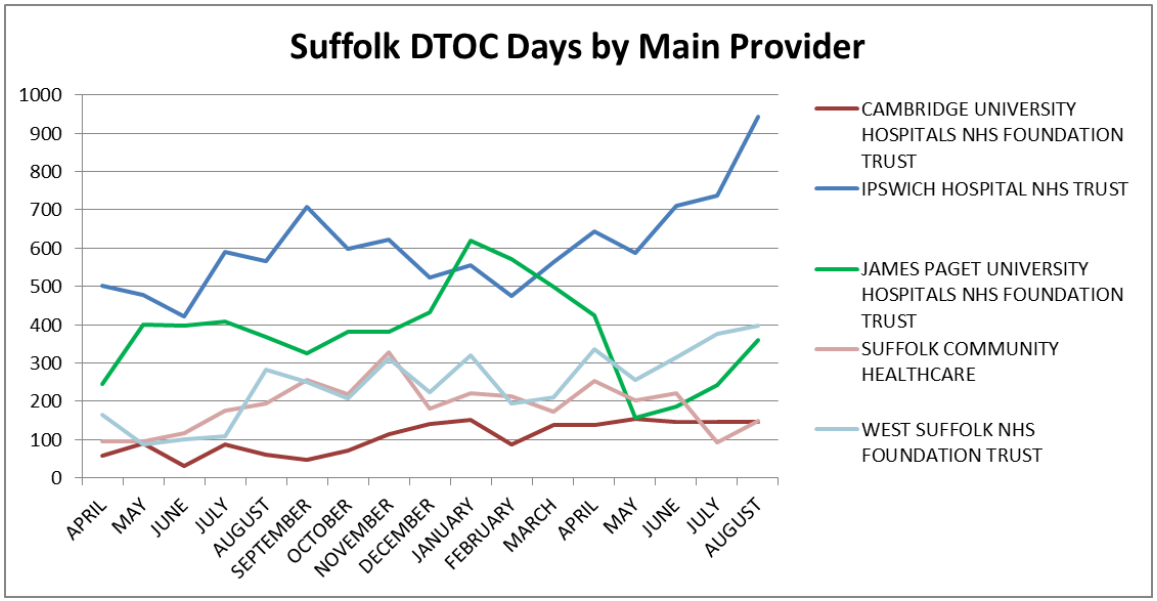
Measure 2 – Delayed transfers of care - This measure looks at delayed transfers of care for Suffolk residents, from all hospital settings. The aim is to reduce delayed transfers of care. Note - the totals do not include delays from NSFT hospitals, so the position

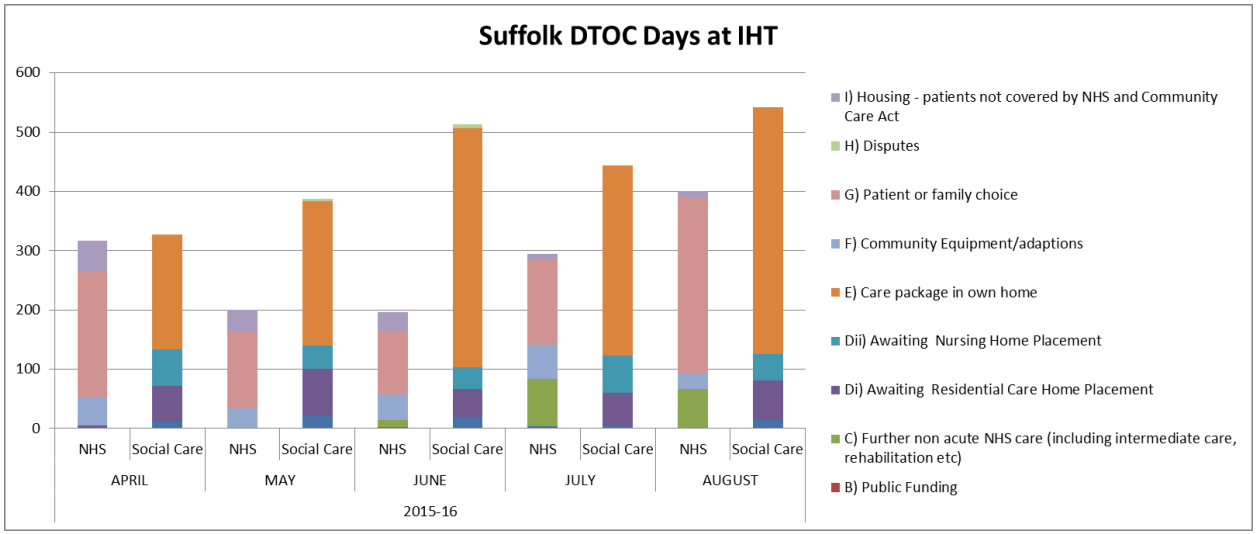
across Suffolk is more acute than is indicated by the figures. Further information has been provided this quarter to give the attribution for the delays across Suffolk and for each acute trust.

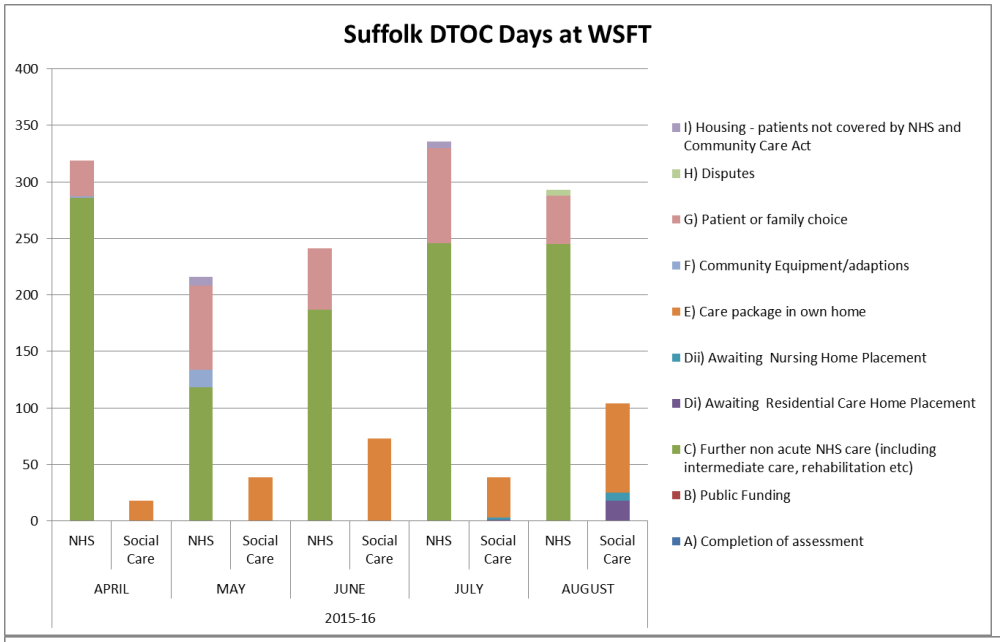
Metric and Target		Jan	Feb	Mar	Q4	Apr	May	June	Q1	July	Aug	Sept	Q2
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	Actuals					374	237	281	892	288	347		635
	Target					266	266	266	797	268	268	268	803
Target reduction -4.5% vs baseline	*variance*					*40.9%*	*-10.8%*	*5.9%*	*12.0%*	*7.5%*	*29.7%*	*-100.0%*	*-20.9%*

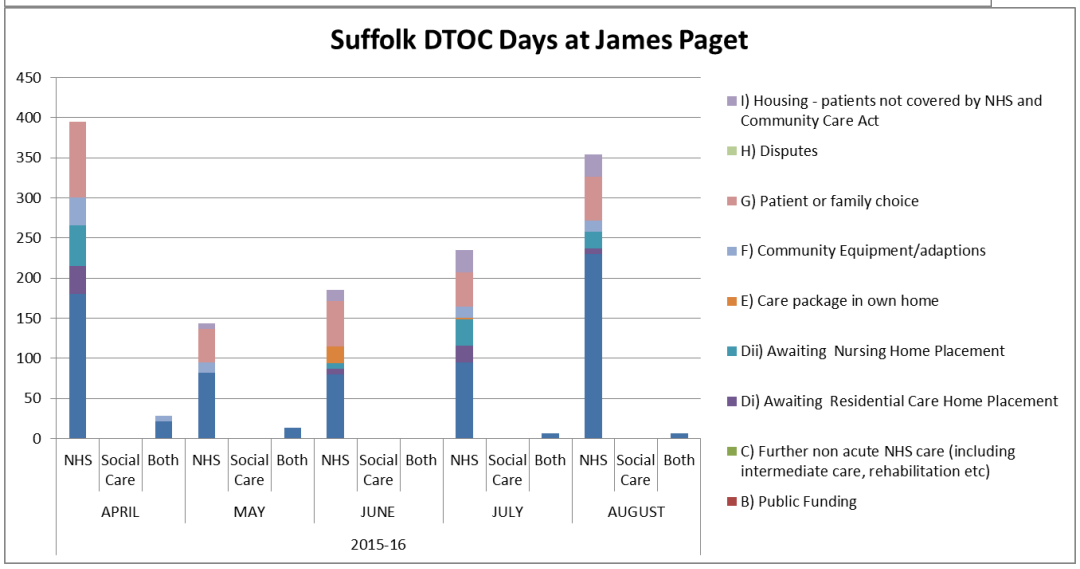
Delayed Transfer of Care Days - Suffolk Total

	NHS	Social Care	Both	Total
2014-15				
APRIL	923	558	58	1539
MAY	1161	617	112	1890
JUNE	1133	562	6	1701
JULY	1226	612	53	1891
AUGUST	1369	750	68	2187
SEPTEMBER	1348	815	42	2205
OCTOBER	1395	674	44	2113
NOVEMBER	1401	805	72	2278
DECEMBER	1324	666	71	2061
JANUARY	1651	754	44	2449
FEBRUARY	1244	584	64	1892
MARCH	1204	676	89	1969
2015-16				
APRIL	1439	707	68	2214
MAY	945	442	14	1401
JUNE	963	687	14	1664
JULY	1127	569	7	1703


Suffolk DTOC Days by Main Provider
1000
900
800
700
600
500
400
300
200
100
0
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
AUGUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
IPSWICH HOSPITAL NHS TRUST
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
SUFFOLK COMMUNITY HEALTHCARE
WEST SUFFOLK NHS FOUNDATION TRUST


Suffolk DTOC Days at IHT
600
500
400
300
200
100
0
NHS
Social Care
APRIL
MAY
JUNE
JULY
AUGUST
2015-16
I) Housing - patients not covered by NHS and Community Care Act
H) Disputes
G) Patient or family choice
F) Community Equipment/adaptions
E) Care package in own home
Dii) Awaiting Nursing Home Placement
Di) Awaiting Residential Care Home Placement
C) Further non acute NHS care (including intermediate care, rehabilitation etc)
B) Public Funding


Suffolk DTOC Days at WSFT
400
350
300
250
200
150
100
50
0
NHS
Social Care
APRIL
MAY
JUNE
JULY
AUGUST
2015-16
I) Housing - patients not covered by NHS and Community Care Act
H) Disputes
G) Patient or family choice
F) Community Equipment/adaptions
E) Care package in own home
Dii) Awaiting Nursing Home Placement
Di) Awaiting Residential Care Home Placement
C) Further non acute NHS care (including intermediate care, rehabilitation etc)
B) Public Funding
A) Completion of assessment


Suffolk DTOC Days at James Paget
450
400
350
300
250
200
150
100
50
0
NHS
Social Care
Both
APRIL
MAY
JUNE
JULY
AUGUST
2015-16
I) Housing - patients not covered by NHS and Community Care Act
H) Disputes
G) Patient or family choice
F) Community Equipment/adaptions
E) Care package in own home
Dii) Awaiting Nursing Home Placement
Di) Awaiting Residential Care Home Placement
C) Further non acute NHS care (including intermediate care, rehabilitation etc)
B) Public Funding

Measure 3 – permanent admissions to residential and nursing care homes

This measure looks at the number of older people who are admitted permanently to residential or nursing care. The target for this measure is to keep the number per 100,000 of the population static (despite the proportion of older people in the population rising). The results for the first two quarters are showing that a greater proportion of people where admitted than the target set in the Better Care Fund plan.

Metric and Target		Apr	May	June	Q1	July	Aug	Sept	Q2
Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000 population	Actuals				598				
	Target				597				1,837
Target - no increase in number of admissions vs 2013/14 levels	*variance*				*1*				
Number of permanent admissions	Actuals	85	88	76	249	119	86	99	304
	Target	89	74	65	228	93	84	90	267
	variance	-4	14	11	*21*	26	2	9	*37*

Measure 4 – effectiveness of reablement

This measure looks at how effective reablement services are by checking whether older people are still at home 91 days after being discharged from hospital. This measure is only captured once a year, so for the purposes of this report a proxy measure has been shown. This proxy measure is the number of successful social care tier 2 (short term enablement) interventions. The aim is to increase the effectiveness of reablement and other services in the community supporting people are a stay in hospital, so that less people are either readmitted to hospital, or move permanently into residential or nursing care homes. Although the percentage is increasing it is still below target.

Metric and Target		Apr	May	June	Q1	July	Aug	Sept	Q2
Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Actuals				63.7%				67.7%
	Target				78.9%				78.9%
Target improvement +5% vs baseline	*variance*				*15.20%*				*11.22%*

Measure 5 – dementia diagnosis rate

Dementia is often undiagnosed meaning that people do not get the early help or treatment that they need. The aim is to increase the rate of diagnosis. The rate for August is estimated as it is only published by letter. This shows good improvement. Once all data available this will be recalculated.

Metric and Target		Jan	Feb	Mar	Q4	Apr	May	June	Q1	July	Aug	Sept	Q2
Local metric: Estimated diagnosis rate for people with dementia - percentage and number	Actuals			56.7%	56.7%						63.3%		
	Target			67.0%	67.0%				67.0%		67.0%		67.0%
National target	*variance*			-10.3%	*-10.3%*						-3.7%		0.0%
IPSWICH AND EAST SUFFOLK CCG	*Actuals*			55.3%	55.3%				0.0%		62.0%		0.0%
	Target			67.0%	67.0%				0.0%		67.0%		0.0%
	variance			-11.7%	-11.7%				0.0%		-5.0%		0.0%
WEST SUFFOLK CCG	*Actuals*			58.4%	58.4%				0.0%		64.9%		0.0%
	Target			67.0%	67.0%				0.0%		67.0%		0.0%
	variance			-8.6%	-8.6%				0.0%		-2.1%		0.0%
GREAT YARMOUTH AND WAVENEY CCG	*Actuals*			54.9%	54.9%				0.0%		63.0%		0.0%
	Target			67.0%	67.0%				0.0%		67.0%		0.0%
	variance			-12.1%	-12.1%				0.0%		-4.0%		0.0%

Measure 6 – support to manage long term health conditions

- This measure is based on a question in the GP survey
- The actual % is going up but we don't have updated actuals. These are only published twice yearly so not due again until January.
- Change in percentage not statistically significant in Ipswich and East and Waveney CCG areas.

Metric and Target		Jan	Feb	Mar	Q4	Apr	May	June	Q1
Patient/Service User metric: support from local services or organisations to help manage long-term health condition(s)	Actuals								70.54%
	Target								73.20%
Target improvement +1% vs baseline (72.7%)	*variance*								*-2.66%*