Health and Wellbeing SUFFOLK

Agenda Item 10

Suffolk Health & Wellbeing Board, 21 July 2016

A committee of Suffolk County Council

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:

1. Health and Care Integration

Better Care Fund (BCF) 2015/16

1.1 The Quarter 4 submission for the BCF was sent in to the Department of Health in May. The dashboard for the metrics is as follows:

Better Care Fund Measure	Target Achieved (Y/N)	Direction of Travel during year
Measure 1 – Non-elective admissions to hospital	N	Worsened
Measure 2 – Delayed transfers of care	N	Worsened
Measure 3 – Permanent admissions to residential and nursing care homes	Y	Improved
Measure 4 – Effectiveness of reablement (Local Measure)	N/A*	Improved
Measure 5 – Dementia diagnosis rate	N	Improved
Measure 6 – Support to manage long term health conditions	N	Improved

Note no previous comparator data for local measure National measure will be reported in Quarter 1*

1.2 A more detailed dashboard which shows data over the whole period and broken down by clinical commissioning group (CCG) area, as well as showing delayed transfers of care by hospital and attribution is available from Jo Cowley – jo.cowley@suffolk.gov.uk

1.3 The Quarter 4 return included summary narratives for the whole BCF year. The following sections reproduce text from the Suffolk return.

What have been your greatest successes in delivering your BCF plan for 2015/16

1.3.1 Development of Connect sites - Integrated Neighbourhood Teams, working with their local Neighbourhood Network. Two early adopter sites set up in 2015/16 in Sudbury and IP3/4 - with teams co-located in Connect Sudbury.

1.3.2 Out of Hospital Team (Lowestoft) evaluation and metrics demonstrated that this was a successful model that could help support independence, reduce hospital admissions, and be a better use of resources.

1.3.3 Joint Health and Wellbeing Strategy refreshed to include integration as a cross cutting theme, giving it more focus in the Board's work.

What have been your greatest challenges in delivering your BCF Plan for 2015/16

1.3.4 Pace of change has been slow, partly because of the need to align a number of different organisations, systems and cultures.

1.3.5 It has been difficult to attribute benefits of services changes to the BCF programme.

1.3.6 Multiple governance is a challenge, making sure the right people go to the right meetings and that communication flows work round our organisations.

Brief narrative on year-end overall progress, reflecting on the first full year of the BCF

1.3.7 The first year of the BCF has seen the delivery of integrated care move in Ipswich & East and West Suffolk from a planning phase into a delivery phase. The Health and Care model has been put into action in two early adopter sites, and a roll out plan agreed to set up Integrated Neighbourhood Teams in 13 locations across East and West Suffolk. The learning from the early adopter sites, along with co-produced work with partners is informing the next round of commissioning for healthcare services in the community (proactive care), as well as the development of the urgent care (reactive) model for 2017 onwards.

1.3.8 In Waveney particular emphasis has been given to consolidating the Out of Hospital Team model (with independent evaluation showing that the model reduces non elective hospital admissions). Recommendations from a community consultation in 2015/16 are being used to drive forward out of hospital care.

1.3.9 Pressure on both local government and the NHS have led to an increase in delayed transfers of care, and there are joint plans to address this across both our systems.

Better Care Fund 2016/17

1.4 The BCF Plan for 2016/17 was submitted in May, showing our planned activity for the coming year and how the pooled fund would be spent to support reablement, community care and support for people to remain living in their own homes. The Plan was signed off on behalf of the Health and Wellbeing Board at the end of May. We are waiting to hear now if the plan has been approved. Meanwhile the activity outlined in the plan continues to progress through our integration programmes across Suffolk.

1.5 For a copy of the 2106/17 Better Care Fund Plan please contact Jo Cowley.

For further information please contact: Jo Cowley, Business Development Specialist, Suffolk County Council; Email: jo.cowley@suffolk.gov.uk, Telephone: 01473 265202.

Update from Integration Programmes

Connect

1.6 The roll-out plan for Connect in East and West Suffolk has been agreed and is now being put into action. There will be a total of thirteen Integrated Neighbourhood Teams established to provide co-ordinated and effective care for people in their locality. In nine of the thirteen areas project groups have been established with the other four project groups being planned. The project groups have been asked to put into place a suite of tools and working arrangements, including a shared care and support plan, joined up approaches to staff training and development, and development of local service directories to enable health and care practitioners to have knowledge of the full range of services options for local people. In addition areas are encouraged to find ways of working together to deliver better outcomes for people in their patch. Some examples of this include

a) exploring co-location of teams, or where this is not currently practical, hotdesking

b) Home First co-ordinating more closely with Care Co-ordination Centre to better co-ordinate care for customers.

c) Joint visits to customers to ensure care and support plans are comprehensive and co-ordinated

d) Joint training (for example in Making Every Contact Count) and workplace shadowing.

1.7 The option to refurbish Sidegate Lane as a site for the Connect East Ipswich team is no longer feasible because of cost. However, the team are continuing to work more closely together including shared Lunch and Learn sessions, a shared directory of services and workplace shadowing.

1.8 One of the early successes of joint working has been in Eye where Occupational Therapists (OTs) have collaborated to reduce duplication. Each week lead OTs from health and social care are able to identify at least one customer where they were both due to take action, but where only one intervention is required. This has freed up more time for other customers.

1.9 The Connect model is underpinned by a number of enablers. One of these is Digital and IT, and the Local Digital Roadmaps which have recently been submitted to the Department of Health will support integrated working.

For further information about the Connect programme please contact Rachel Bottomley, Commissioner HASCI, Adult and Community Services, Email: Rachel.bottomley@suffolk.gov.uk, Telephone 01473 264741

Waveney

Out of Hospital Teams

1.10 Out of Hospital Teams are seen as an integral part of the drive towards a Great Yarmouth and Waveney integrated care system. Following the successful establishment of Out of Hospital Teams in Lowestoft and Yarmouth, a Sole Bay Out of Hospital service is currently being recruited to, and will be delivered through the Sole Bay GP Practice. This includes a beds with care provision within a local care home. The Sole Bay Out of Hospital Team will cover the registered population in Southwold and Reydon.

1.11 Plans for a Beccles, Bungay and Kessingland Out of Hospital Team are being finalised. The service will be delivered through an expansion of the established Lowestoft Out of Hospital Team.

Most Capable Provider (MCP)

1.12 Rather than continuing to commission individual services through an open competitive tender process, NHS Great Yarmouth and Waveney CCG has opted to use a Most Capable Provider (MCP) procurement route to transform services within the community. By embarking on this path, we hope to help create more integrated care and support for our patients, while offering greater stability in the local health economy.

1.13 The CCG has identified a number of services around which a single service specification will be drawn up, these are referred to as 'Bundles'. An invitation, requesting the identified most capable provider to submit and offer for Bundle one 'Out of Hospital System' has now been released, with a deadline of 5 August for submission. The CCG is hoping to make a decision in relation to this first Bundle in October 2016.

Sustainability Transformation Plan (STP)

1.14 The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV).

1.15 These blueprints, called Sustainability and Transformation Plans (STPs), are place based, multi-year plans built around the needs of local populations. The intention is that STPs will help drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021.

1.16 The Waveney district of Suffolk, is part of the Norfolk and Waveney (N&W) footprint in relation to the Sustainability Transformation Planning process. Check point documentation for the Norfolk and Waveney footprint was submitted to NHS England on 30 June 2016.

For further information please contact: Bob Purser, Head of Joint Commissioning, Waveney; Email bob.purser@nhs.net, Telephone 01502 719513

Back to top

2. West Suffolk System Resilience Group

Meeting Wednesday 01 June 2016

2.1 Members received an update report on system performance:

a) Delayed Transfers of Care (DToCs) in West Suffolk NHS Foundation Trust (WSFT) have increased significantly, with the highest number of lost bed days attributable to social care funded domiciliary care. WSFT is continuing conversations with Adult Community Services (ACS) and the Clinical Commissioning Group (CCG) to potentially develop an NHS solution for the care market.

b) There has been an increase in the number of ambulance handovers within 15 minutes. This pathway is being reviewed.

c) Chronic Obstructive Pulmonary Disorder activity dipped again for April, but the team is now fully recruited to. A review needs to be undertaken to understand why referrals are declining into the service.

2.2 Jon Green, Executive Chief Operating Officer of WSFT, presented an update of WSFT's A&E performance. NHS Improvement requested that WSFT did not report their A&E performance until issues with e-Care had been resolved. Reporting recommenced on 16 May 2016, which demonstrated a drop in performance of approximately 10% (82.5% for second half of May). A detailed recovery plan is being drafted for this.

2.3 Members discussed potential rapid intervention trials that could be implemented in west Suffolk in the next 4 or 5 weeks to reduce demand on the system. It was noted that the demand is system-wide and it is important to ensure patients are not just moved to another area that is also under pressure, i.e. from WSFT to Primary Care.

2.4 The 'ideas to trial' report for a DToC 'Doing Things Differently' week (week commencing 13 June 2016) was discussed. There has been good representation from providers at meetings to develop the plan for this. It is likely that the CCG will submit an amended DToC improvement trajectory based on learning achieved throughout the 'Doing Things Differently' week.

Next Steps:

2.5 The next steps are:

a) Details of an A&E 111 pod being trialled in Blackpool will be considered as a possible way of encouraging individuals to choose a different pathway.

b) A communications strategy will be developed by the CCG aimed at patients who are not engaging with the system appropriately.

c) The proposed rapid interventions will be discussed at the ICS Transformation Group with a view to taking this forward.

For further information please contact: Becky Turner, Redesign Project Support Officer, NHS West Suffolk CCG; Email: Becky.Turner@westsuffolkccg.nhs.uk, Telephone: 01284 758 030.

Back to top

3. Integrated Care Network (ICN) – Ipswich and East Suffolk

3.1 The Integrated Care Network System Resilience Group met on Tuesday 14 June 2016 and agreed to support and proceed with the joint progression of the System Wide Demand Management Plan. The aim of the plan is to better manage planned care demand and covered overall framework and a number of pathways and activities. The ICN also supported the redesign of the existing Crisis Action Team (CAT) service, incorporating a 'standard domiciliary care support' option within the service. This is however subject to the inclusions of a core set of agreed measurable key performance indicators and delivery timescales. Further support was agreed for the Frailty Assessment Base (FAB) to be included within the CAT / FAB business case.

For further information please contact: Jacqueline Morris, Redesign Business Officer – Integrated Care, NHS Ipswich & East Suffolk CCG; Email: jacqueline.morris@ipswichandeastsuffolkccg.nhs.uk, Telephone: 01473 770 131.

Back to top

4. Annual Reports of Clinical Commissioning Groups

4.1 The Suffolk clinical commissioning groups (CCGs) have now published their annual reports for 2015/16. These are available at the following links:

Great Yarmouth and Waveney CCG:

http://www.greatyarmouthandwaveneyccg.nhs.uk/page_sa.asp?fldKey=94

Ipswich and East Suffolk CCG

http://www.ipswichandeastsuffolkccg.nhs.uk/Library/Library.aspx?udt_1166_param_category=Annual%20Reports

West Suffolk CCG

http://www.westsuffolkccg.nhs.uk/annual-report/

For further information please contact: Linda Pattle, Democratic Services Officer, Suffolk County Council; Email: linda.pattle@suffolk.gov.uk, Telephone: 01473 260771.

Back to top

---

5. Healthwatch Suffolk Annual Report

5.1 Healthwatch Suffolk has published its annual report for the year 2015/16. The report shows the difference that has been made throughout the year for people using health and social care services in Suffolk, how Healthwatch Suffolk has involved local people in its work and put people in touch with information and support.

5.2 The report is available in a range of formats via the following link:

http://www.healthwatchsuffolk.co.uk/news/healthwatch-suffolk-strengthens-its-influence-in-201516-to-make-a-difference-for-suffolk-residents

5.3 A short video highlights reel has also been created and is available to view now on YouTube: https://www.youtube.com/watch?v=Ox5eZkzDec8

5.4 2015/16 has seen Healthwatch Suffolk continue to raise its profile in the county, reaching more people for their views than ever before. A number of notable outcomes from its work include the following examples:

- Ipswich Hospital revised its policy to allow birthing partners to stay with mum overnight so that they might provide much needed support with baby care and emotional wellbeing (Healthwatch Suffolk is in the process of publishing this report jointly with the Ipswich Hospital NHS Trust)
- Healthwatch Suffolk visited seven care homes to talk to residents about their care and treatment. Recommendations were made which have led to a good number of improvements in services.
- Healthwatch Suffolk influenced the decision to slow down the implementations of new domiciliary care services in the county so that people could have more time to make better decisions about how they wanted their care to be delivered.

- West Suffolk Hospital improved support and information for carers and implemented actions to address concerns about poorly coordinated care for patients at the end of life.
- Ipswich Hospital took action to address negative feedback about the way it had treated a patient with end term cancer.
- The Care Quality Commission worked closely with Healthwatch Suffolk to hear the views of local people when inspecting local services.

For further information please contact: Michael Ogden, Information Services Manager, Healthwatch Suffolk; Email: michael.ogden@healthwatchsuffolk.co.uk, Telephone: 01449 703 949.

Back to top

6. Transformation Challenge Award update

6.1 In 2014 Suffolk Public Sector Leaders (SPSL) submitted a successful bid to Department for Communities and Local Government's (DCLG) Transformation Challenge Award. DCLG described the fund as: "available to support English local authorities transform their operation, make changes to their business processes and work with the wider public sector to improve services for local people". Therefore, SPSL viewed it as an opportunity to enhance the direction of travel for collaboration and integration across the public sector.

6.2 The bold and ambitious bid was successful in securing £3,323,125. It was signed up to by leaders from all councils, Clinical Commissioning Groups and Police. The bid was guided by the shared vision that: "collaboration and better alignment between organisations is key to the transformation and delivery of effective and efficient public services which provide better outcomes for individuals and communities" along with the following underpinning principles:

- Doing what's right for Suffolk
- Better outcomes with less money
- Integrated Suffolk System
- More resilient people and communities

6.3 The funding was received in April 2015 and since then, leaders, managers and frontline staff have come together across a range of work streams that report to SPSL (community resilience; data and intelligence; medium term financial planning; health, care and safety; growth and workforce development). It has been used to build capacity for change and to unblock barriers to collaborative/integrated approaches. Examples include:

- Additional capacity (backfill of post) and technical expertise to speeding up planning system, unlocking sites for growth
- A system-wide data insight and intelligence coordinator to: understand current analysis/evaluation capacity, highlight gaps and develop a network of analysts for better sharing and joined up approaches.
- Early roll out of South Waveney out of hospital model to prevent emergency admissions and support people to live at home.

- Local Area Co-ordinators to support people to engage with community resources to build local resilience and connections to prevent need for statutory services

6.4 Given the importance of integrated working to the Health and Wellbeing Board's remit and the recent refresh of the Board's Joint Health and Wellbeing Strategy, an update on progress for how the TCA funding is being used to deliver the Board's priorities the collaborative approach seemed appropriate.

For further information please contact: Caroline Davison, Head of Policy, Suffolk County Council; Email: caroline.davison@suffolk.gov.uk, Telephone: 01473 264400.

Back to top

---

7. Strengthening commissioning of sport and physical activity for improved mental health and wellbeing outcomes

7.1 This report updates the Suffolk Health and Wellbeing Board (SHWB) on the progress of Suffolk's national commissioning programme supported by Sport England. The project, led by the Most Active County team, aims to help the sport and physical activity sector engage more effectively in the Suffolk mental health commissioning environment:

- Improving the understanding of the needs of commissioners and the commissioning process;
- Improving understanding and endorsement of the role of sport and physical activity can play in delivering better outcomes for mental health and wellbeing;
- Appraising the current service offer and identifying how it might be re-shaped with other potential delivery partners to deliver improved outcomes.

7.2 An outcomes framework and logic model for the project has been produced, reflecting the priorities of the Joint Health and Wellbeing Strategy (JHWS), Joint Strategic Needs Assessment (JSNA), and the Suffolk Mental Health strategy and commissioning plan. The model also reflects the available evidence around mental health and physical activity.

7.3 The overarching strategic outcome from this process was that more people with mental health problems should become more active, and improve their mental and physical health. The main intermediate outcome was that more people with mental health problems should be included in local initiatives which included physical activity and active recreation. The key service outcomes were that local networks should work together more effectively to focus on promoting better access, reduced stigma and increased engagement in these activities.

7.4 Liam Hughes, our Sport England Commissioning Programme expert advisor, has met with key individuals across the sectors, undertaken a mapping exercise and undertaken key consultation meetings with stakeholders.

7.5 As a result of these consultations, the proposition moving forward is to initially focus on two key periods of transition, in two localities - from adolescence into adult life (in Ipswich), and from working age into retirement (in Stowmarket and

its hinterland). These were recognised as periods of high risk for both inactivity and mental distress.

7.6 An action plan has now been developed in two phases. Firstly, further consultation and relationship building with key commissioners and local networks is underway to enable local programme plans to be developed. Secondly, later in 2016, we will move into implementation mode for local plans, testing concepts and evaluating.

7.7 Liam Hughes will share his findings from the project and explore the next steps with the SHWB at the Partnership meeting on 21 July 2016. More detailed information on the outcomes framework, mapping exercise report, and action plan proposals are available on request.

For further information please contact: Richard Hunt, Head of Service Development (Culture, Libraries, Sport and Communities), Suffolk County Council; Email: richard.hunt@suffolk.gov.uk, Telephone: 01473 264626.

Back to top

8. Carers Strategy 2016 - 2021

8.1 At its meeting on 14 May 2015, the Board received the findings of a Carers Joint Strategic Needs Assessment and the resulting actions, as set out in a report entitled Unpaid Carers - Strategic Analysis and Support Plans The Board noted the findings and agreed to receive a progress report in due course.

8.2 Attached at Appendix A is a progress report on the Carers Strategy 2016 – 2021.

8.3 The refreshed Strategy represents the Family Carers Partnership Board's continued commitment to unpaid Carers of all ages. It is focussed on an asset based approach with a more preventative focus to helping unpaid Carers, that enables them to continue to provide the crucial support that they do (should they wish to continue caring), in balance with their health and wellbeing needs.

8.4 It includes a recognition that unpaid Carers need a period of adjustment and support when their caring role changes due to the admission of the person they care for to a permanent residential facility, or when their role ceases on bereavement. In addition it recognises that there may, in certain circumstances, be a conflict of interest between the unpaid Carer and the person they support.

8.5 The Strategy sits alongside the Strategy for Young Carers and Young Adult Carers and acknowledges the transition from Young Carers services to Adult Carers services at any point between the ages of 14 – 25 at an appropriate time for that young person.

8.6 The Strategy reinforces that unpaid Carers are everyone's business throughout the public, private and voluntary sector and within the community.

For further information please contact: Karen Keeler, Commissioning Manager, Prevention; Email: Karen.keeler@suffolk.gov.uk, Telephone: 01473 264427.

Back to top