Suffolk County Council

**Agenda Item 6**

# Health Scrutiny Committee, 14 March 2017

## 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. Children and adolescent emotional health and wellbeing - single point of access and funding
2. The production of Education, Health and Care Plans
3. Ofsted/CQC Joint local area inspection of provision for Special Educational Needs and Disability
4. Public Health services review
5. Suffolk Information Partnership and warm handovers
6. Dementia Together
7. Colchester Hospital University NHS Foundation Trust & Ipswich Hospital NHS Trust: Briefing on Long-Term Partnership

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## 1. Children and adolescent emotional health and wellbeing - single point of access and funding

1.1 At the meeting on 19 January 2017, during its consideration of the emotional wellbeing of children and young people, the Committee requested:

a) an update on progress with the development of a single point of access for child and adolescent mental health referrals in Suffolk, including information on timescales, challenges faced and details of what would, and would not be delivered through the single point of access;

b) mapping of the total funding pot available to support children and young people's emotional health and wellbeing in Suffolk and how this had been allocated to address levels of need.

This information is provided below.

**a) Access – Emotional Wellbeing Hub (Single Point of Access)**

1.2 The vision for the multi-agency Emotional Wellbeing Hub for East and West Suffolk is that no child, young person (0-25) or their family/carer will be turned away without being offered appropriate help, information or advice. Working with system partners, parents/carers and young people the key principles of the hub will be:

- Timely, effective help for all children & young people and their families/carers to their presenting need;
- No Bounce;

- Don't have to re-tell story;
- Consistent and responsive response;
- Hand-on to services.

1.3 The two key partners in this development are Norfolk and Suffolk Foundation Trust (NSFT) and Suffolk County Council's Children and Young People's directorate. There have been a number of workshops, visits and design events on this initiative over the past year and the pace of delivery for this Transformational work has been a challenge. This has been discussed at previous meetings of Health Scrutiny Committee and through the Children's Trust.

1.4 In response to this a new implementation Board has been established, co-chaired by Debbie White, Director of Operations, NSFT and Allan Cadzow, Service Director for Children and Young People Services, Suffolk County Council, which is meeting monthly to oversee the work of the implementation workgroup.

1.5 A multi-agency workshop is scheduled for March to agree the operational model in detail and this will then enable a final business case and service specification to be presented by the workgroup to the April Board with the aim of the Hub being operational in Autumn 2017.

**b) Financials**

1.6 Please find on the next two pages the indicative financial plan. NHS England has recently confirmed the funding to 2020 which shows a year on year increase 2016/17: £1.6m, 2017/18: £1.8m, 2018/19: £2.1m and £2.3m. In line with NHS England monitoring and assurance process, we have ring-fenced these monies to the Transformation Plan which includes a Memorandum of Understanding with the Council to fund agreed areas of spend including Community and Workforce Development and the Implementation of the Single Point of Access.

**For further information, please contact: Jo John, Transformation Lead for Child and Adolescent Mental Health Services; Tel: 07908 456984. Email:** jojohn@suffolk.nhs.uk**,**

## CAMHS Transformation Plan

| Project | Scheme | Organisation to be paid | 2016/17 Actual | 2017-18 Plan | 2018-19 Plan | 2019-20 Plan |
|---|---|---|---|---|---|---|
| 1 | Children's Ambassador | Suffolk County Council | £30,000 | £30,000 | £0 | **£30,000** |
| 2 | Eating Disorders (Recurrent) | Norfolk & Suffolk Foundation Trust | £299,000 | £372,000 | £372,000 | **£372,000** |
| 3 | Project management | West Suffolk CCG | £125,000 | £127,000 | £129,000 | **£129,000** |
| 4 | Workforce development | Suffolk County Council | £0 | £0 | £0 | **£0** |
| 5 | Single Point of Access Implementation (Recurrent) | Suffolk County Council | £0 | £0 | £200,000 | **£350,000** |
| 6 | Behavioural pathway - ADHD service (Recurrent) | Norfolk & Suffolk Foundation Trust | £204,000 | £140,000 | £140,000 | **£140,000** |
| 7 | CYP IAPT - Wellbeing 4YP Counselling | Norfolk & Suffolk Foundation Trust 4YP | £0 | £0 | £0 | **£0** |
| 8 | Family and Carers Support project - SPCN | SPCN | £10,000 | £10,000 | £10,000 | **£10,000** |
| 9 | Digital Technology - websites development | Suffolk County Council | £0 | £0 | £0 | **£0** |
| 9 | Digital Technology - Online Chat 4YP pilot | Suffolk County Council (as above) | £0 | £0 | £0 | **£0** |
| 10 | Crisis (Recurrent) | | £0 | £360,000 | £600,000 | **£600,000** |
| 11 | Belhaven (Mar'17-Sept'17) | Priory | £0 | £250,000 | £250,000 | **£250,000** |
| 12 | Suffolk Community Foundation Trust Grant | Suffolk Community Foundation Trust | £54,000 | £100,000 | £100,000 | **£100,000** |
| 13 | Perinatal (Recurrent) | Norfolk & Suffolk Foundation Trust | £0 | £0 | £0 | **£266,000** |
| 14 | SALT | SCH | £46,000 | £0 | £0 | **£0** |
| 15 | Children in Care (Recurrent) | To be sourced | £0 | £60,000 | £60,000 | **£60,000** |
| 16 | CYP IAPT | | £0 | £0 | *£0* | **£0** |
| 17 | AANT | | £0 | £0 | £0 | **£0** |
| | Total | | **£768,000** | **£1,449,000** | **£1,861,000** | **£2,307,000** |
| | | | | | | |
| | Allocation received from NHSE to CCGs | | £1,591,966 | £1,816,337 | £2,136,867 | £2,350,554 |
| | | | | | | |
| | Underspend/-overspend | | £823,966 | £367,337 | £275,867 | £43,554 |
| | | | | | | |
| | | Recurrent spend /over recurrent budget | £823,966 | £367,337 | £275,867 | £43,554 |

**MOU Year 1 2015-16 £355,750**

| Project | Scheme | Organisation to be paid | 2016/17 Actual | 2017-18 Plan | Total |
|---|---|---|---|---|---|
| 4 | Workforce development | Suffolk County Council | £42,000 | £70,000 | £112,000 |
| 9 | Digital Technology - websites development | Suffolk County Council | £12,000 | £26,000 | £38,000 |
| 9 | Digital Technology - Online Chat 4YP pilot | Suffolk County Council (as above) | £9,000 | £24,000 | £33,000 |
| 16 | CYP IAPT | | £3,139 | £130,000 | £133,139 |
| 17 | AANT | | £17,000 | £20,000 | £37,000 |
| | Total | | £83,139 | £270,000 | £353,139 |

**MOU Year 2 2016-17 £823,000**

| Project | Scheme | Organisation to be paid | 2016/17 Actual | 2017-18 Plan | Total |
|---|---|---|---|---|---|
| 5 | Single Point of Access Implementation (Recurre | Suffolk County Council | £0 | £455,000 | £455,000 |
| 13 | Perinatal (Recurrent) | Norfolk & Suffolk Foundation Trust | £0 | £266,000 | £266,000 |
| 12 | Suffolk Community Foundation Trust Grant | Suffolk Community Foundation Trust | £0 | £100,000 | £100,000 |
| | Total | | £0 | £821,000 | £821,000 |

**MOU Year 3 2017-18 £366,000**

| Project | Scheme | Organisation to be paid | | 2018-19 | Total |
|---|---|---|---|---|---|
| 13 | Perinatal (Recurrent) | Norfolk & Suffolk Foundation Trust | £0 | £266,000 | £266,000 |
| 4 | Workforce development | Suffolk County Council | £0 | £70,000 | £70,000 |
| 1 | Children's Ambassador | Suffolk County Council | £0 | £30,000 | £30,000 |
| | Total | | £0 | £366,000 | £366,000 |

Where IAPT = improving access to psychological therapies & AANT = Analysis of additional needs screening tool

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## 2. The production of Education, Health and Care Plans

2.1 At its meeting on 19 January 2017, the Committee also requested details of what was being done to ensure relevant agencies were meeting the statutory requirement to participate in Education, Health and Care (ECH) needs assessments and the production of ECH Plans for people aged 18-25. This information is provided below:

### Background

2.2 Education, Health and Care Plans (EHCPs) were introduced in the 2014 Children and Families Act. EHCPs have taken over from Statements of Special Educational Needs and provide the statutory protection for children and young people who require additional provision beyond that available within mainstream.

2.3 The statutory requirements for referral, assessment and drafting of EHCPs is the same for all age groups including 18-25 year olds. The key difference for this age group is that their EHCPs belong to them and not their parents or guardians.

2.4 The purpose of an EHCP is to effectively bring together education, health and care agencies to align planning and ideally commissioning of support. Local authorities are required to co-produce plans with families.

2.5 To date Suffolk has struggled to meet the statutory timescales (20 weeks) for drafting new EHCPs and transferring existing statements into EHCPs. Work undertaken as part of the Special Educational Needs and Disbilities (SEND) Reform Programme and SEND self-assessment had recognised a number of structural weaknesses in the EHCP process. These included:

- timely assessment information gathered from education, health and social care professionals;
- clear accountability lines for ensuring that assessment information was appropriately requested and returned to the SEN team;
- lack of understanding of EHCPs and professionals' requirements to deliver against the identified outcomes.

### SEND Inspection findings

2.6 Between the 12 and 16 December 2016 Ofsted and the Care Quality Commission (CQC) inspectors carried out an inspection of Suffolk's provision and services in support for children and young people with SEND. The inspection, while recognising recent progress and leaders' understanding of and capacity to deal with issues surrounding implementing 2014 Children and Families Act reforms, was highly critical in its findings of the progress made to date.

2.7 As a result, Suffolk becomes the third area out of the 20 inspected to date that is required to submit a Statement of Action. The statement of action must detail how we intend to accelerate the progress of our implementation of the SEND reforms. Progress against the statement of action will be monitored by Ofsted for one year at which time they will either sign off our progress or initiate a further inspection.

2.8 A key area for development for Suffolk is in how effectively we produce timely, quality EHCPs. The inspection outcomes letter noted the following as areas for development:

- *the poor quality and timeliness of assessment for, and transition to, EHC plans, including the seeking of advice from professionals and agencies where necessary*
- *The co-production of EHC plans, where services and families work together to identify, plan and review provision, is too dependent on the variable quality and knowledge of individual practitioners and providers.*
- *Health professionals are not involved quickly enough in determining the level of children's and young people's need or in planning the necessary support for them.*
- *The lack of information sharing means that requirements for the co-production of EHC plans are not met (Ofsted/CQC Joint Area SEND Inspection in Suffolk outcome letter; February 2017)*

**Moving Forward**

2.9 In order to address the issues surrounding professional input into EHCPs (as well as the other areas outlined above) a full review of the EHCP process has been underway since November of 2016.

2.10 Central to the ECHP process moving forward will be a digital EHCP hub which will allow professionals and families to see what stage the plan is at, who has had information requested from them and what the response has been. This transparency and clarity will allow families the confidence that their plans are progressing.

2.11 The digitised EHCP process will also significantly reduce the bureaucratic burden of developing the plans. This will allow us to significantly speed up turn-around time from decision to assess to issuing the plan. With the process streamlined we will be better placed to increase our capacity to effectively co-produce plans with families and young people, while also improving the percentage of plans produced within 20 weeks (currently around 45% with a target of 70% once the process is in place).

2.12 In addition to the EHCP online hub the lines of accountability between services are being formalised with named responsible officers from each service being identified to be accountable for returning requests for assessment.

2.13 Contracts with health providers are being redrafted by Clinical Commissioning Group (CCG) partners to include a requirement to contribute towards EHCPs

2.14 There is a workforce development strategy being developed to identify training needs of health and social care professionals in particular so that they understand what their responsibilities in relation to EHCPs are, and how they can effectively contribute both to the plans and to the outcomes for children and young people cited in the plan.

2.15 Development of more multiagency working in assessment panels and review meetings to reduce unnecessary contact points and duplication of information for families and young people.

2.16 The new digital platform is due to go live in a pilot phase in September 2017 although the other refinements are being put in place from March.

**For further information, please contact: Richard Selwyn, Assistant Director Commissioning, Children and Young People's Services, Suffolk County Council, Tel: 01473 264732, Email** Richard.Selwyn@suffolk.gov.uk

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## 3. Ofsted/Care Quality Commission (CQC) Joint local area Inspection of provision for Special Educational Needs and Disability

3.1 Following the local area inspection to judge the effectiveness of Special Educational Needs and Disability (SEND) services and provision in Suffolk, a report was published jointly by Ofsted and the Care Quality Commission (CQC) on 17 February 2017, and is available online here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592289/Joint_local_area_SEND_inspection_in_Suffolk.pdf

3.2 In a joint statement, Suffolk County Council and the three Suffolk Clinical Commissioning Groups (CCGs) responded to the report as follows:

*"We fully accept the findings of the report and apologise that the local area's services and provision have not effectively met the needs of children and young people in our county. Transforming these services is our priority.*

*Prior to the Ofsted and Care Quality Commission inspection, we identified that significant improvements needed to be made to the way children and young people with special educational needs and disabilities and their families access support.*

*We have been working in partnership with the Suffolk Parent Carer Network to introduce a number of changes covering education, health and social care, and we are beginning to see the positive impact of these. The number of Statements to be transferred to Education Health Care Plans (EHCPs) has reduced and production of new EHCPs has increased.*

*We recognise that it is not just about the speed of production but also improving the quality of the EHCPs produced. We are investing in training across all partners and providers focussing on improving co-production of EHCPs.*

*Whilst the report recognises the early steps taken to make improvements, it clearly highlights that there is still much more work we need to do and we agree with these findings. Since the inspection, together with the Suffolk Parent Carer Network, we have identified three key areas of focus to bring about the rapid improvements that are needed. We are working together to improve access to information, improve the SEND journey and develop the services and provision available locally.*

*The three NHS Clinical Commissioning Groups (CCGs) in Suffolk (NHS Great Yarmouth and Waveney CCG, NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG) have recruited Designated Clinical Officers for SEND who are working closely with both the local authority and health providers to improve the Education Health and Care Plan Process.*

*Waiting times for child and adolescent mental health services are beginning to reduce and children with complex care needs are being well cared for by the community nursing teams.*

*Suffolk County Council has a good track record of turning poorly performing services around; 89% of our schools are now judged 'Good' or 'Outstanding'. This rate has been increasing faster than the national average over the last two years and marks a more than 20% increase since the council's Raising the Bar programme (which aims to improve educational attainment) began.*

*We all want children and young people in Suffolk to reach their full potential. Working together we have full confidence that we will be able to implement the same turnaround to ensure that children, young people and their families can access the support they need, when they need it."*

**For further information about the inspection please contact Allan Cadzow, Service Director for Children and Young People Services, Suffolk County Council; Tel: 01473 260938, Email:** allan.cadzow@suffolk.gov.uk

3.3 On 28 June 2017 the County Council's Education and Children's Services Scrutiny Committee will be considering this matter, to provide Members with the opportunity to understand and scrutinise the outcome of the inspection and the subsequent action plan.

**For further information about this meeting please contact: Paul Banjo, Scrutiny Officer; Email:** paul.banjo@suffolk.gov.uk**, Tel. 01473 265187.**

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## 4. Public Health Services Review

4.1 The Public Health grant for Suffolk has reduced year on year since 2015/6 (when the Department of Health reduced the grant by 6.2%) and will continue to reduce until 2020/21. From 2020/21 the government has suggested that the grant from the Department of Health will cease and all public health services provided by local authorities will be funded through business rates. For 2015/16 and 2017/18 Public Health achieved savings without affecting commissioned services. However, currently Public Health is reviewing all services, focusing on the effectiveness of services in achieving required outcomes. The reductions in funding over this period will require the overall value of contracts to reduce by approximately 18% by 2019/20 and core public health staffing funding to reduce by 23%.

4.2 Currently plans are being developed with providers using contract performance monitoring and quality measures including service user feedback, health needs assessments and service reviews. For 2017/18 two decisions have been agreed with providers that will cause a reduction in the current level or type of service delivered.

**County-wide Peer Support Breast Feeding Contract**

4.3 The County-wide Peer Support Breast Feeding Contract will end on 31 March 2017. A full review of "healthy child" services was completed early in 2016 and included reviewing outcomes, interviews with staff, focus groups with mothers and also an online survey widely circulated to those who have had contact with health visitors and school nurses. It took into account wider priorities including the Health and Wellbeing Board priority that every child has the best start in life. Breast feeding is of benefit to mothers and babies and Public Health are committed to supporting women to breast feed. However the Peer Support Service has covered different areas of the county over the past 5 years and the evaluation has shown that it has not resulted in increases in breast feeding rates – which was why it was commissioned. A core role of health visitors is to support mothers in breast feeding and this will continue, as will support from midwives. Staff in these services are being given additional training to be more proactive and we will continue to monitor breast feeding rates closely.

**Psychosexual service**

4.4 The psychosexual service delivered by Cambridge Community Health Service will be decommissioned. The rationale for this was that the service delivery was not evidenced based and no outcomes were evident:

- The service in Suffolk has historically been part of specialist sexual health service but is not a mandated service;
- The current service is not available across the whole of Suffolk for historical reasons and is not available in neighbouring counties;
- The evidence base is weak but what is available suggests a programme of 6 sessions is the most cost effective option;
- A review of 2 years' data showed that only 6% of clients complete the recommended 6 sessions;
- Of those that did not complete the recommended number of sessions 46% attended 2 or 1 sessions which is unlikely to produce benefit;
- 28% attended more than 6 sessions and 2% attended over 21 sessions which accounted for 12% of total counselling time in the period of the audit.

4.5 The service receives relatively low activity, 742 attendances in 2015/16 (equating to 285 patients) and 640 attendances in the first three quarters of 2016/17 (equating to 235 patients).

4.6 Patients presenting with psychosexual needs to the sexual health service will be signposted to alternative provision for support, that are already in place within the county.

**0-19 Heathy child service in Waveney**

4.7 As part of the work on future service transformation, the decision has been taken to undertake a business case review of the delivery of the 0-19 heathy child service in Waveney. The contract is with East Community Healthcare and was transferred to Public Health from NHS England in October 2015. The contract ends in April 2017 but was extended in July 2016 following the announcement of a review into the mandated visits for health visitors by Public Health England. Public Health have been reviewing possible models for future service delivery alongside further financial modelling to ensure the sustainability of the services in a difficult financial climate. As a local authority, Suffolk County Council (SCC) has a statutory duty of best value to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness." The business case will be used to determine whether the service will be brought into SCC to be provided by CYPS alongside the 0-19 services to the rest of Suffolk, or be procured on the open market.

4.8 If requested, more information about potential plans for Public Health commissioned services can be presented for consideration to the Health Scrutiny committee at its next meeting.

**For further information, please contact Dr Amanda Jones, Assistant Director of Public Health, SCC, Tel: 01473 260052, Email:** amanda.jones@suffolk.gov.uk

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## 5. Suffolk Information Partnership and warm handovers

5.1 This information item gives some background to the Suffolk Information Partnership (SIP) and how they are promoting their warm handover referral system to support vulnerable people and develop partnership working between the statutory and voluntary and community (VCS) sectors in Suffolk.

5.2 The SIP was formed in 2011 to enable Adult and Community Services and strategic VCS partners to work together, share knowledge and skills and improve the information that each organisation provides to the public. Since then the Partnership has grown to include the CCGs, Community Action Suffolk, Healthwatch Suffolk and a number of VCS organisations. The SIP receives no funding and its success comes from a passion to provide good, clear information, avoid duplication and the commitment of members to work together.

5.3 A few years ago members felt that whilst many people were happy to be signposted to organisations and services that could give further support, they felt that vulnerable customers were unlikely to make that contact themselves and needed some help. The Partnership set up a secure online referral system in 2013, which has been supporting customers and providing a robust, easy process for ACS practitioners and partners ever since. To make a warm handover the practitioner or partner completes the online form giving the person's details, situation and needs. They then choose the organisation(s) that the referral goes to and it is delivered instantaneously. The process is underpinned by a Data Exchange Agreement, so customers are responded to quickly and offered services and support. Regular partnership meetings, a quarterly newsletter and toolkit supports the process by keeping everyone updated with changes to organisations and services and ensuring referrals are appropriate.

5.4 Customers benefit from the referral as they do not have to repeat their story to multiple organisations and they are given information and support quickly. Partners have also seen an increase in their confidence and knowledge of local services and have been able to give the person being referred a wider range of services, such as benefits, debt and employment advice, social activities and home adaptations because of the diversity of the partners involved. In 2016 over 1,000 referrals were received by the partners. This included ACS, but also referrals from VCS partner to VCS partner, so reducing demand for ACS's services.

5.5 Building on the success of the Partnership and credibility of the referral process the SIP is now keen to open the warm handover to new partners. This year they have already added the Fire Service Prevention Team and soon the Local Area Co-ordinators. They are also talking to Suffolk Community Health (SCH) and hope they will join shortly. With ACS and SCH working together in the Integrated Neighbourhood Teams the benefits for them to be able to refer patients swiftly and securely to voluntary and community organisations are huge. The Partnership is embarking on an exciting year and hopes to have more new partners by 2018.

**For further information, please contact: Kate Turner, Suffolk Information Partnership Co-ordinator; Tel: 01473 260878, Email:** kate.turner@suffolk.gov.uk**..**

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## 6. Dementia Together

### Introduction

6.1 Co-production with people with dementia, their families, carers and service providers has delivered consistent feedback that, although there is a comprehensive range of services and organisations serving the needs of Suffolk people affected by dementia, people are overwhelmed by the differing offers. The user is unclear on how they differentiate, how they can be accessed, which organisation is delivering the offer and which are most appropriate to their needs.

6.2 The dementia pathway is too complex, disjointed and impersonal, and does not focus enough on maintaining independence and building resilience.

### New service

6.3 Ipswich and East Suffolk Clinical Commissioning Group, West Suffolk Clinical Commissioning Group and Suffolk County Council went out to tender earlier this year with a new service specification aiming to move towards a service model that:

- complements the Integrated Health and Social Care principles of delivering secondary and tertiary prevention;
- is locality focused;
- delays or mitigates crisis;
- empowers service users;
- improves and simplifies access to advice and information;
- encourages independent, community-based 'living well' and improved outcomes;
- enables people with Dementia and their carers to move through the system as required.

6.4 The tender has now been awarded to Sue Ryder as lead provider working with Norfolk and Suffolk Dementia Alliance (SDA), Dementia Friendly Communities (DFC) and Dementia Action Alliances (DAA) in Suffolk and other enabling health and social care organisations to deliver the Peri Diagnostic Dementia Service.

6.5 The new service, called Dementia Together, will commence on 1 April 2017.

### Summary of service aims

6.6 The overall aim of the service is to help people with dementia and their carers to easily identify and access the support they need so that they can plan for their future, avoid crises and live well with dementia for as long as possible in their usual place of residence within supportive communities. They will have the knowledge and ability to sustain independent living and when required, will be assisted to access locally available help through just one contact via a single point of access. They will be advised on the support they need and helped to the right place, where there will be no organisational barriers and will receive a timely response.

6.7 People contacting Dementia Together only have to tell their story once. The service then works with local community services to provide co-ordinated, responsive support for individuals at every step of the way – whether that is information about dementia, connecting with others who understand, or planning for the future.

6.8 If the person consents, basic contact information will be taken and they will be offered a call back by a Dementia Navigator at a time convenient to them who will undertake a telephone assessment. If there are immediate concerns or complexities which would indicate that a face to face assessment would be more appropriate this will be offered.

6.9 Other referrals received by professionals to the service will be triaged based on information provided. The triage levels are set out below.

6.10 **Level 1 – Curious:** Anyone who may simply have a question or is seeking information about dementia. They may or may not have a diagnosis, but at the present time the condition is not causing them great concern or impacting greatly on their daily lives.

6.11 **Level 2 – Concerned:** Dementia is clearly having detrimental impact on quality of life for patient and or main carer. This may be due to deteriorating cognitive function or other health concerns e.g. changing behaviours, eating, continence, or frailty. It might also be due to circumstances changing, leading to clear risks of isolation, living alone, being suddenly housebound or being unable to access transport. Support networks may have withdrawn e.g. due to employment problems, transport and financial issues. It also looks out for where a carer might be starting to break down or crises developing.

6.12 **Level 3 – Crisis:** Physical or mental health deterioration requiring urgent specialist health professional intervention. It also includes sudden main carer breakdown, where the cared for person is reliant, and an urgent review of care and support involvement of Suffolk Social Care evident. Clear safeguarding issues, raising serious urgent concern about the welfare of the patient are also included.

6.13 Dementia Together will provide interventions at Level 1 and Level 2, and will refer onwards to the appropriate organisation for Level 3 intervention.

6.14 In addition Dementia Together recognises a level of 'Coping'. Any interventions will aim for a 'steady state' where:

a) person is aware of the condition; and
b) it is well managed and they are living as well as possible.

People may move between these levels during the journey of their condition, the aim being to keep people for as long as possible or enable them to return to 'Coping'.

**The Dementia Together service will offer**

**Information:**

6.15 A single (freephone) telephone number, responding to referrals, people already registered with the service and anyone (including health and social care professionals) who wish to seek advice and information. Telephone information, advice and support will be available seven days a week (Monday to Friday, 9am – 6pm and Saturdays & Sundays, 10am – 4pm). A Level 2 Navigator will always be available to ensure high quality consistent advice and information.

6.16 A Web Based Information System managed by Sue Ryder Hub. Our aim, with consent, is to register all referrals on to our information system which will contain all relevant information in order to support ongoing effective navigation, so the person does not have to continually tell their story. The system will register all

contacts and data necessary for the effective monitoring and evaluation of the service. The design of the information system is more or less complete and work on building it will take place in the next two weeks to allow for testing and for any adaptations to take place during the final two weeks of March.

6.17 Information Prescriptions as a basic will be offered to all referred, followed up after six weeks (with consent) to see if followed through and impact.

6.18 Website – a standalone dedicated website containing trusted information and advice regarding prevention and living well with dementia. This is being designed by Purple Tuesday and will be hosted and maintained by the Norfolk & Suffolk Dementia Alliance.

6.19 Local Information Stations appropriately located and easily accessible within the community and updated by DAAs/DFCs and/or local Level 1 Navigators. These will provide the standard service-wide information sheet about the service, general trusted information about dementia, details of local advisors and information on local relevant services, dementia friendly groups and events. East of England Co-op will provide Information Stations in their stores. The Co-op will also provide information and advice to thousands of people at flagship shows, eg the Suffolk Show.

**Navigation**

6.20 Local Dementia Navigators (Level 1) – A personalised local contact for people who are affected by dementia to provide trusted basic information and signposting to enable people to cope and live well in their local communities. Hosted by local DAAs/DFCs, they will have a clear link to both the Level 2 Navigator working in their geographical area (who will provide informal supervision, guidance and support) and to the Hub (for updating of information system and triage to level 2). Volunteers will need to meet role criteria and undertake competencies and training. Promotion of this volunteering opportunity and recruitment is underway.

6.21 Dementia Navigators (Level 2) – Hosted by Sue Ryder, will become involved when the needs of the client are clearly more complex, a full holistic assessment is indicated or a home visit is needed. These staff will be able to give high quality information, advice and education assessment and assistance with care planning. Certain staff members from both the Alzheimer's Society and Suffolk Family Carers are eligible for Transfer of Undertakings and Protection of Employment (TUPE) and discussions are taking place.

**Peer Support**

6.22 The service will grow a range of affordable and flexible Peer Support Opportunities which meet the varying needs of the whole population, people with dementia and their carers. We will ensure that there is a focus in year 1 evaluation to inform development of effective peer support models in year 2 through co production, but will begin with the following range of options in year 1:

6.23 Facilitated Peer Support usually to meet the needs of a particular group on a short term basis, with a view that members of the group can move on to more informal networks or in some cases the group become self-supporting. We recognize a need for a newly diagnosed group and younger persons with

dementia group. These will be facilitated by Level 2 Navigators or suitably trained professionals within partner organisations.

6.24 Local Peer Support Groups (cafes or activity groups). An update of our dementia mapping has confirmed that there will be a serious reduction in provision from 1 April, due to lack of continued funding for the Alzheimer's groups and Sue Ryder Synergy Cafes beyond 31 March. Sue Ryder and the Alzheimer's Society are also looking at ways to transition cafes and groups. The DAAs/DFCs and other Dementia Hubs, eg The Gatehouse in Bury St Edmunds and The Bridge Project in Sudbury, are assisting with this process. Volunteer led peer support groups will receive monthly input from the Level 2 Navigators. We have also allocated a small funding pot which DAAs/DFCs can apply to use to develop local peer support (or to promote Level 1 Navigation).

6.25 Peer Support Workers. Identifying people with dementia and who have a positive attitude to living with dementia to become a peer support worker.

6.26 Care Planning. Dementia Together will appropriately promote My Care Wishes – paperwork to support people with long term conditions to plan for their care. At Level 2, specific care planning support will be offered following a holistic assessment.

6.27 Education – Healthy living, carer resilience, living well with dementia. We will refer into any existing health education programmes (eg One Life Suffolk), make links with other organisations delivering education and use community venues to host education group sessions. Level 2 Navigators will provide an element of this through attendance at local dementia cafes/peer support groups.

6.28 Education and Awareness in local communities – DAAs will have this as an objective in local plans. This will involve increasing awareness and knowledge in local schools, businesses, etc. The service will support via training where required of local navigators.

6.29 Hard to Reach Groups - We anticipate the current support available will not meet their needs. Year 1, we will hold tailored workshops targeting these groups to listen and identify what barriers and possible solutions. Our aim is to encourage local navigators within black and minority ethnic (BME) communities and other hard to reach groups.

**Signposting and Onward Referrals**

6.30 The helpline coordinators and navigators will hold clear information on all available support services across the county via the website. The Hub and Level 2 Navigators will be able to make warm handover referrals to appropriate organisations.

6.31 Navigators will make introductions and ensure the individual is able to participate.

6.32 Signposting will be pro-active and, with consent, Navigators will keep in touch with their service users to monitor the effectiveness of this.

**Mobilisation Period**

6.33 During the current Mobilisation Period we have:

- Set up a Project Implementation Group which meets on a fortnightly basis and includes commissioners.

- Drawn up Contracts with our Material Contractors and Memorandum of Understanding with our other partners.
- Clarified key performance indicators and Outcomes and are working with the University of Suffolk and our Information Analyst around quality monitoring and an evaluation framework.
- Met with each of the DAAs/DFCs and local Dementia Hubs to explain the service more fully and promote Level 1 Navigation and Peer Support Groups.
- Met with both Alzheimer's Society and Suffolk Family Carers to discuss the smooth transfer of services and TUPE of staff. This process is continuing.
- Implemented a recruitment process for additional Helpline Operators for the service.
- Engaged with a long list of key stakeholders and this process is continuing.
- Completed an update of our mapping of dementia services in Suffolk which took place in June 2016.
- Dealt with media and prepared marketing materials.
- Been working with Purple Tuesday on the design of the information system and look forward to testing this later this month.
- Agreed with the Norfolk & Suffolk Dementia Action Alliance re the training they will be providing and also looking at induction and other essential training requirements.
- Been developing operational policy and procedures and documentation.

**For further information contact: Jo Marshall, Sue Ryder Care, email jo.marshall@suerydercare.org and/or Hannah Newman-May, Redesign Project Officer for West Suffolk and Ipswich and East Suffolk CCGs email hannah.newman-may@westsuffolkccg.nhs.uk.**

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## 7. Colchester Hospital University NHS Foundation Trust & Ipswich Hospital NHS Trust: Briefing on Long-Term Partnership

### 7.1 Preamble

In May 2016 the Boards of Colchester University Hospital NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) committed to entering a Long-Term Partnership (LTP) to respond to challenges faced by the local health systems.

The LTP is now developing an Outline Business Case (OBC) which will be considered by both Trust Boards in summer 2017.

A Strategic Outline Case was published in February 2017 which examines many different scenarios for a partnership of the two organisations. Groups of clinicians and managers at the Trusts and in the local health systems considered the benefits of each scenario, feeding into a recommendation to the Trust boards. This was to continue to evaluate three of these scenarios in the next stage of planning (an Outline Business Case).

These scenarios are:

- A merger of the two Trusts with full integration of clinical services
- A merger of the two Trusts with some integration of clinical services
- An acquisition of one Trust by another

As a comparison, the scenario of 'no change' is also being considered.

A merger or acquisition would not necessarily require clinical services to move, but may mean that services would work together more closely, for example, sharing best practice in delivering high quality care. The Trusts aim to have completed their Outline Business Case in summer 2017. Engagement with staff and stakeholders will enable the IHT and CHUFT Boards to come to an informed decision about precise options to include in a Full Business Case (FBC) for public consultation at a later stage.

### 7.2 Ambition and objectives

The ambition for the LTP is:

***For CHUFT and IHT to work together to secure sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex***

Four objectives have been defined which align with the strategic challenges:

1. To improve quality and patient outcomes
2. To deliver better value for money
3. To sustain and improve access to services to meet the needs of our populations, and
4. To develop a sustainable, skilled workforce

### 7.3 Clinical strategy

The IHT/CHUFT LTP is an integral element of the Sustainability and Transformation Plan (STP) for Suffolk and North East Essex. The STP was developed through a partnership of local health and social care organisations and built after taking into account a wide range of evidence including the feedback from system-wide public involvement exercises previously undertaken by Clinical Commissioning Groups (CCGs). To move CHUFT and IHT forward to become more sustainable and improve quality, they need to act together. That is why developing the LTP is a key programme in its proposed acute services reconfiguration work stream.

The Trusts are developing the LTP to meet the following essential design principles:

- Continue to operate as district general hospitals
- Focus on delivering acute services, and delivering them well
- Develop specialist services where there will be a demonstrable improvement in care for patients from improved access and/or outcomes

- Continue to provide A&E services on both acute hospital sites
- Continue to have obstetric-led maternity services on both sites
- Have a 24/7 undifferentiated acute medical take at both sites
- Have at least one paediatric assessment unit/paediatric intensive care unit
- Maximise clinical synergies and adjacencies
- Enhance teaching and training to develop the future clinical workforce
- Move at pace to minimise the disruption caused through uncertainty and maximise the speed by which improvements are made

Over the coming months both Trusts will be engaging extensively with staff to ensure their involvement in shaping the clinical strategy.

### 7.4 Engagement and communications strategy

A communications and engagement strategy detailing how we will seek to involve patients, stakeholders and the wider public in the development of the OBC is being finalised to support the LTP. The strategy has had input from Healthwatch Suffolk and Healthwatch Essex and has been shared with Essex County Council Health Overview and Scrutiny Committee and Suffolk County Council Health Scrutiny Committee.

The aims and objectives of our communications and engagement strategy draws on NHS guidance which set four tests for service reconfiguration. These are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from commissioners.

**Aim**

To ensure the OBC, and any potential partnership solutions that would represent significant change to the ways in which IHT and CHUFT configure or deliver their services, are developed in partnership with key stakeholders and responsive to their views and needs.

**Objectives**

1. To provide meaningful opportunities for key stakeholders to help shape and influence potential scenarios for partnership and service change and development
2. To minimise uncertainty or confusion for patients and their carers, staff, partners and residents
3. To build and sustain confidence in the ability of both organisations to deliver high quality and safe healthcare during the transitional phases and beyond
4. To promote a positive reputation for CHUFT/IHT in the effective management of change and as deliverers of safe, caring and high quality care for residents
5. To ensure the Trusts meet their full statutory responsibilities to consult and engage on significant service change.

**Principles**

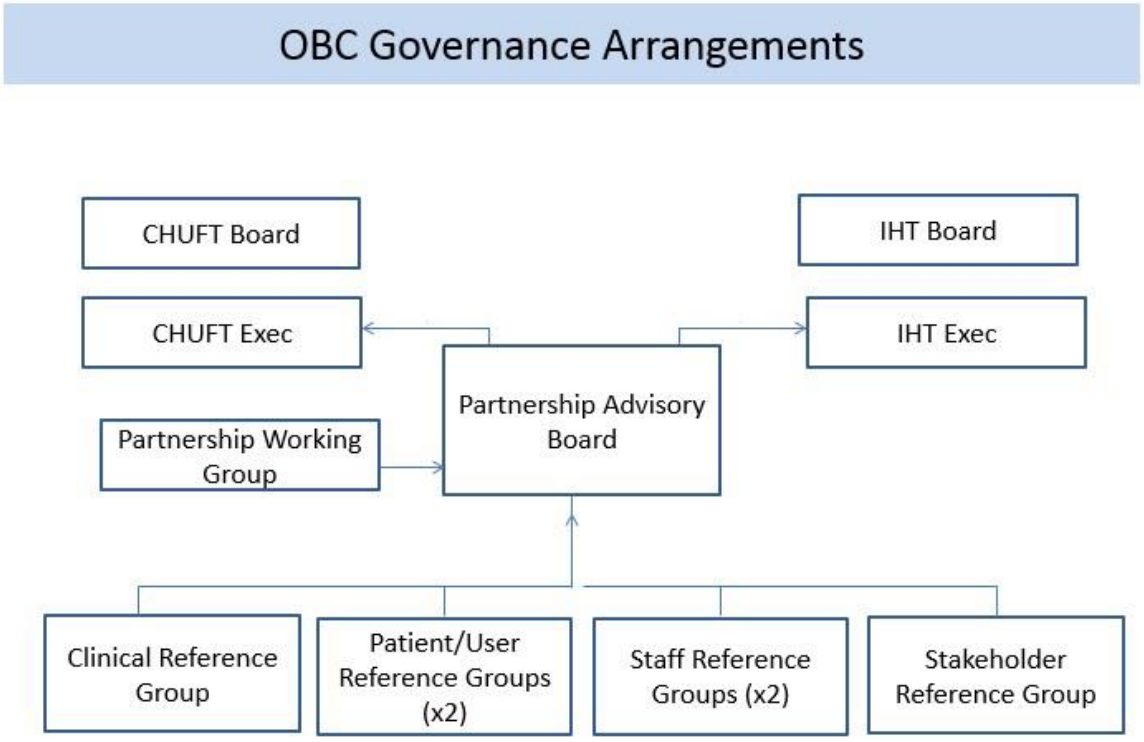
- **Proactive, targeted and integrated communications**
- **Strong relationship management -** promptly picking up and addressing key concerns as the OBC programme develops and ensuring easier access to any additional help or information partners may need

- **Change ambassadors -** We will identify and seek to work with ambassadors – that is people and organisations that share the IHT/CHUFT Long-Term Partnership's ambition and who are keen to help communicate its story to relevant audiences
- **Active use of networks to minimise confusion, reduce engagement overload and make best use of resource**
- **Regular information giving** – internally and externally and rapid response to feedback

We have developed a communications and engagement strategy to ensure there is ample opportunity for meaningful engagement. This includes ongoing engagement with Healthwatch Suffolk and Healthwatch Essex and the creation of a number of advisory and reference groups. These groups will offer their views and advice, including recommendations, which will be considered by the Partnership Advisory Board. For more information on each advisory and reference group, please see appendix 2.

**For further information or to request a copy of the Draft Long Term Partnership Communication Plan, please contact: Mr Stephen Hall, Freshwater on behalf of the Colchester and Ipswich Hospitals Long Term Partnership, Tel: 0207 0671595**

**Appendix 1: Outline Business Case Governance Arrangements**



## Appendix 2: Advisory and reference groups

**A Stakeholder Advisory Group** – The purpose of this group is to secure for the OBC the system knowledge and expertise necessary to ensure it is informed by and responsive to the views and needs of our partners in the North East Essex and Suffolk health and social care system. Also to see that the OBC aligns effectively with local commissioning, health, social care and well-being strategies.

The Stakeholder Advisory Group will provide its advice directly to the Partnership Advisory Board and draw its membership from key partners in health, local government and social care.

**Patient and User Advisory Groups (two, one for each hospital)** - The purpose of these groups is to enable the OBC to identify and take into account the potential implications and impacts of potential scenarios for change on patients and service users, as part of the evidence used to inform decision making.

We also propose to enable the Patient and User Reference Groups to meet and work together and be supported to visit and learn more about each other's hospital, services and issues.

**Clinical Reference Group** - This group will ensure any proposed service changes are clinically led and based on robust clinical evidence and best practice. It is proposed that members are drawn from clinical and allied professions and come from both hospitals, CCG's, Public Health, the East of England Ambulance Trust, the Local Medical Committees and GP Federations.

**Staff Partnership Reference Groups (one for each hospital)** - The purpose of these groups will be to help inform and influence the OBC development by contributing their ideas, advice and feedback about the affect and impact of OBC activities and their impact on staff. Their considerations will also help test, guide, facilitate and develop effective internal communication and engagement.