West Suffolk Alliance Strategy 2018-2023

All about people and places

May 2018 - Edition 1

Introduction

In September 2016 health and care partners formed the West Suffolk Alliance. We have committed to work together to improve the health and care system in West Suffolk for all people whether they be a child, part of a family or a single adult. Our belief is that by working together in an Alliance we can have an impact on wellbeing, care and physical and mental health outcomes for people.

Our focus within the Alliance is on **people and places.**

The strategy for our Alliance is to move from working as individual organisations towards being a fully integrated single system, with a shared vision, clear local priorities, able to both provide an improved service for people in West Suffolk and also to tackle the sustainability issues faced by the system together.

Delivery of our strategy is a critical element of the wider Suffolk and North East Essex Sustainability and Transformation Partnership Plan.

We have developed four interrelated ambitions. These demonstrate how as Alliance partners we will make progress together. They do not displace our own organisational priorities, but rather show the added value from Alliance working. This strategy is backed up with a Five Year Delivery Plan.

This strategy consolidates the development work across the health and care system that has taken place since the Health and Care Review in 2014. It is based on consultation and engagement sessions where we have spoken to local people about what matters to them and their families. Our commitment to coproduction will mean that as we develop our plans further we will work with people and staff to get their input both on the direction of travel and on specific changes that might be proposed.

West Suffolk Alliance members

Suffolk County Council (in particular Adult and Community Services, and Health, Wellbeing and Children and Young People Services)

West Suffolk Foundation Trust (hospital and community health provision)

The Suffolk GP Federation

Norfolk and Suffolk Foundation Trust (mental health services)

Working closely with the **West Suffolk Clinical Commissioning Group**

The Alliance sees the partnership with the Ipswich and East Alliance, and with wider stakeholders as crucial, including District and Boroughs, the Ambulance Service, independent care providers and the voluntary and community sector, employers, education providers and business.

West Suffolk in numbers

1 hospital - West Suffolk Hospital

24 GP surgeries

30 health beds in community

4 health centres

49 care homes

1 hospice

1 inpatient mental health unit

29 Home care providers registered in west Suffolk

3 District and Borough Councils

Over **2,000** voluntary and community groups

6 Integrated Neighbourhood Teams /Connect sites

West Suffolk population is **227,800**

2016 ONS estimate

89 schools

What are the big challenges for people in West Suffolk?

The health and wellbeing gap

Overall the population of West Suffolk is generally healthy with high life expectancy.[1] However, it is estimated that 1 in 6 adults smoke,[2] 6.7% of people have diabetes, nearly 10% of adults have a Body Mass Index of 30 or over, and there is much higher incidence of osteoporosis than in England as a whole.[3] These factors have a significant impact on wellbeing and health, incidence of disease and healthy life expectancy.

The care and quality gap

The challenge in West Suffolk is from a combination of the forecast rise in population (11.6% between 2017 and 2037)[4] and the anticipated larger proportion of residents who have multiple long term conditions including dementia. For example the number of people living with dementia is likely to almost double in the next 20 years and most of these new cases will be in people aged over 85. The system will need to be responsive to the changing demographics of West Suffolk over the next 20 years.

The funding and efficiency gap

It is imperative that the Alliance works collaboratively to develop new models of health and care. Current arrangements will not address the rising needs for services, and the associated costs of these. Nor will they deal with the anticipated reduction in the ratio of working to non-working people and the impact on both our workforce and the numbers of people that will require health and care provision.

> ***Our staff are critical for getting moving - they care about services for people in West Suffolk, and they know what needs to be fixed. We must harness that knowledge and passion.***
>
> **Dr Stephen Dunn**
> Chief Executive, West Suffolk Foundation Trust

[1] http://webarchive.nationalarchives.gov.uk/20160109203331/http:/www.ons.gov.uk/ons/dcp171776_356961.pdf
[2] https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health
[3] https://fingertips.phe.org.uk/profile/prevalence/data#page/1/gid/1938132820/pat/46/par/E39000031/ati/152/are/E38000204/iid/90443/age/239/sex/4
[4] https://www.healthysuffolk.org.uk/uploads/Population_Projections_FINAL.pdf

What are the assets and opportunities for West Suffolk?

West Suffolk has many assets and opportunities to help overcome these challenges and enable delivery of our vision:

- Our towns and villages have many vibrant community and voluntary sector organisations who provide invaluable activities and services and work actively with us and our local authority partners.
- We have excellent clinical and professional leaders and staff in all of our organisations who are increasingly working together.
- We have a strong track record in working in partnership - across organisations and most importantly with patients to make services better whilst managing costs and cutting waste.
- Communities and politicians are in support of retaining and building services locally.

CQC rate the quality of our health and care services as good, in many areas outstanding, and there is a clear plan for services which need improvement.

- West Suffolk Hospital is rated as 'outstanding.'
- 22 GP practices are rated 'good' and the other 2 are rated 'outstanding.'
- SCC Children's Services are rated good in all aspects.
- Over 80% of our care homes and home care services are rated 'good' or 'outstanding.'
- Mental health services require improvement and are working with partners to deliver agreed improvements and explore future service models.
- Special Education Needs and Disability services for children and young people were rated as 'inadequate' but are now recognised by the Department for Education and Ofsted as making good progress.
- 87% of schools in Suffolk are judged 'good' or 'outstanding' by Ofsted.

"Mrs Proctor was full of praise for the carers she had when she came out of hospital. She said they went over and above to support her recovery. One of them came to her in the snow at 10.00pm at night. She felt she could not fault the care they gave."

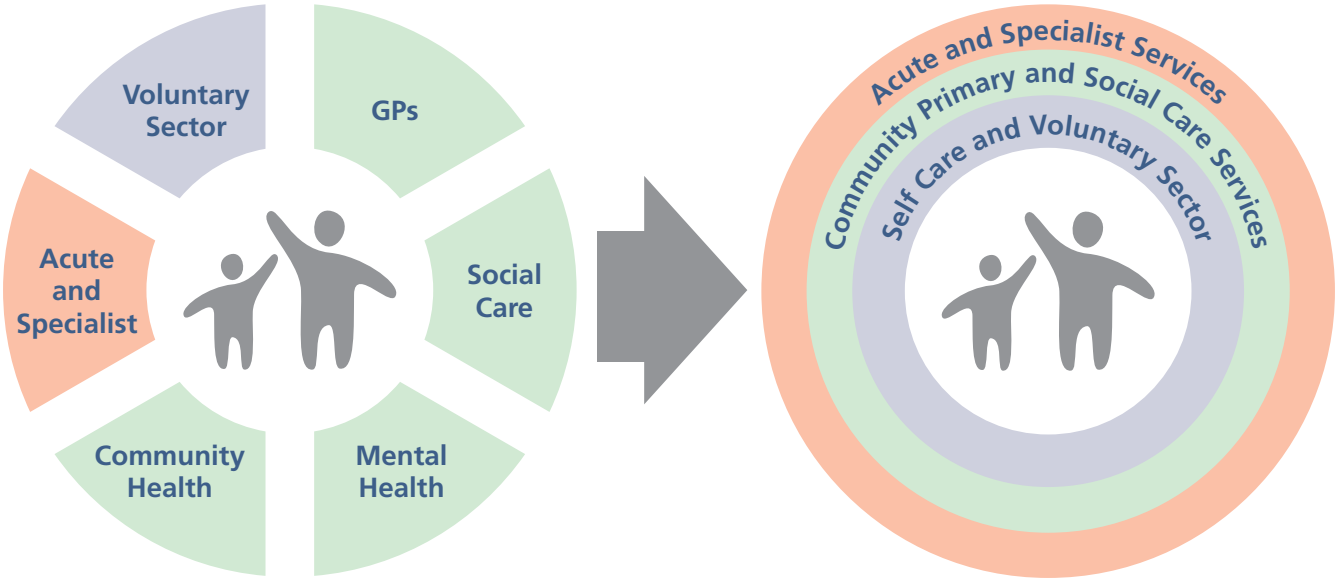
"Walter wrote to thank the Brandon Community Healthcare Team for all the care and attention they had given him. It had been difficult at times, but the family has come through and the team are brilliant."

A key relationship for us is with the Sustainability and Transformation Partnership, as we are delivering large elements of their programme.

Pete Devlin
Operations Director, Suffolk, Norfolk and Suffolk Foundation Trust

Our vision

Co-ordinating services around the individual - so that if feels like one service



From this

'I have to tell my story multiple times to different people.'

'I'm left waiting for services whilst they argue over who pays.'

'I don't get a say in my treatment.'

'When I'm discharged from a service, I'm not sure where to go next.'

To this

'I completed an integrated care plan, setting out who will provide care and support to me and when.'

'I receive more care in or near to my home, and haven't been to hospital for ages.'

'I feel fully supported to manage my own conditions and live independently.'

Joining up services around the needs of people

Case Study: Why taking a co-ordinated approach is important

The Alliance has committed to joining up services around the needs of people. This case example shows how we need to work better with partner agencies to support people to stay well and living in their own communities. The case study highlights that individuals with complex needs require coordinated input and support from system partners. At times this can be difficult to achieve, particularly when people do not want to engage with services. However, it is important that we commit to this coordinated approach as fragmented care impacts individual quality of life and makes additional demand on the services offered by system partners.

Mark is in his early twenties and has a diagnosed mild learning disability. He was admitted to a specialist hospital placement after concerns about his challenging behaviour and contact with the criminal justice system.

His stay in hospital was for over a year and whilst in hospital there were problems with aggression towards staff and damage to property. During the admission Mark was also diagnosed with a personality disorder. Mark was assessed as having capacity to consent to his care and support plan. As risk and challenge increased, the level and intensity of support was increased. Eventually Mark had two people to support him 24 hours a day.

Despite having this intensive support there were multiple serious incidents of self harm, aggression to staff and involvement with criminal justice and multiple safeguarding referrals. After an assault on a staff member that led to Mark's arrest, the support provider withdrew their service due to the level of risk he posed to staff members.

Mark has continually refused help from Mental Health Services, and does not engage with any support or treatment offered. Attempts to refer Mark to specialist residential placements have been unsuccessful either because providers are worried about risk or because he will not engage.

As a result of the assault and the offending committed whilst in receipt of 2 to 1 support Mark received a custodial sentence and is now in prison. Social care staff are working with colleagues across the mental health trust, probation and the clinical commissioning group to consider next steps and plan for prison discharge. There is also a need to look at the skills and capacity of our provider sector require to support people with behaviour that challenges services and who pose a risk to themselves and others.

Connect

The Connect programme is central to the delivery of our strategy - **All about people and places.** People's health and wellbeing are influenced by a large number of factors. The Connect programme aims to harness the statutory, voluntary and community sectors to work together to develop a co-ordinated approach in our localities, to improve the health and wellbeing of individuals and communities. We already have many examples of joint working, for example with the District and Borough Councils, with the police force and with local community organisations but we plan to focus on this much more during the following year.

Integrated Neighbourhood Teams are a core element within each Connect area and work across a defined group of GP practices. They are made up of health and care staff, and will provide co-ordinated joined up care for people and proactive support for those most at risk of deteriorating health. INTs have been established in **Haverhill, Bury Town, Bury Rural, Sudbury** and **Mildenhall,** with a team in **Newmarket** to be developed. There are of course strong links to specialist provision, and to the local and regional hospital network, but the aim is to pull in more and more specialist support through the INT so that people can be supported to manage their health and care needs in their own homes, in their local community.

Case study -
Mildenhall Integrated Neighbourhood Team

Collaborating and working in an Alliance way

"It's brilliant sitting next to community health Occupational Therapists. I can pop over and talk to them instead of making referrals. The person we are working with gets a much better service."

Suffolk County Council Home First OT

The development of the Integrated Neighbourhood Teams (INT) is a key feature of model in West Suffolk. In Mildenhall the health and social care team are now co-located and have been working closely together over the past six months to develop a shared approach to their caseload through implementing trusted assessment and care coordination.

The health and social care therapists, nurses and Home First teams now work more closely holding weekly Multi-Disciplinary Team reviews of their caseloads ensuring the care to the individual is coordinated and without duplication. The INT work in Mildenhall will now move on to focus on bringing shared access to the two main IT systems and how equipment budgets can be aligned.

Staff have embraced the ideas of Freedom to Act and Freedom to Speak Up and we have added Freedom to Integrate in order to support our teams to work more collaboratively.

As Alliance partners we have agreed the following values:

We will:

- Focus on **people and places** in West Suffolk integrating services around people's homes, neighbourhoods and communities. We will give priority to what works for families, individuals and communities and will be bold and ambitious about what can be achieved.
- Create a **financially sustainable system** through managing demand differently and through committing to using the West Suffolk pound in the best way locally, reducing duplication and waste.
- Address **health inequalities** across West Suffolk focusing on prevention, accessibility, integration, effectiveness and sustainability of services to ensure that existing health inequalities in West Suffolk are reduced.
- Strive for the **best quality services** based on the outcomes we have agreed, within the resources available.
- Design things together and **collaborate** working with people, communities and partner organisations in West Suffolk. We will agree collectively how we do things so that we only do them once and support each other through change as our organisations adapt, building trust and having frank and honest discussions when needed.
- Be **innovative** redesigning our services using the experience of people and front line staff, and looking at national and international evidence. We will coproduce our changes designing effective and integrated services which meet people's needs.

This is about evolution, not revolution - learning what we can do together, and making sure the budgets we each hold support doing the right thing clinically and professionally.

Dr Nick Jenkins
Medical Director, West Suffolk Foundation Trust

Our commitment is to deliver the following four interconnecting ambitions. Action on these ambitions is taking us from where we are now to where we want to be in 2023.

1. Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Building local integrated working, across all ages and across both physical and mental health.

2. Focusing with individuals on their needs and goals

Looking at how we co-ordinate services to help people of all ages keep well, get well and stay well.

3. Changing both the way we work together and how services are configured …

… so that health and care services are sustainable into the future and work well for people.

4. Making effective use of resources

We will use the West Suffolk pound in the best way locally, reducing duplication and waste. All our organisations face challenging finances and if we work together we can use our resources better.

We strongly believe that working as an Alliance will lead to better services for people in West Suffolk.

Allan Cadzow
Director for Children and Young People, Suffolk County Council

Ambition 1 - Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Our future vision

We want to reduce health inequalities and keep people healthy at home by treating them earlier. We want to stop people from becoming unwell by giving them the right support close to home, with hospitals only needed for specialist care. Our communities should be safe and healthy and should support wellbeing and prevent ill health, alongside a health and care system that is organised with an increased focus on prevention.

We want to provide more integrated services, driving efficiency and high quality care. This requires local leadership and a willingness to work across all aspects of our systems to do what is right for people of all ages and with both physical and mental health.

Our partners are keen to play a full part in the delivery of this Strategy and we recognise the critical importance and range of the opportunities they bring.

Action we are taking to achieve this

1. We are introducing different ways of working that help people to manage health and care problems earlier. For example, through proactive risk stratification and follow through, good information and advice and care co-ordination. We also want expertise, experience and efficiencies to be shared widely so that everyone in West Suffolk can benefit equally from the same high standards of specialist care.

2. We are developing local integrated teams so that people's whole needs are looked after rather than each element in isolation. We want GPs, social work staff, nurses and other health professionals, the voluntary sector and others to work together to co-ordinate and deliver care locally.

3. We are exploring how we can jointly deliver short term care to people in a crisis that gives them the help they need to stay out of hospital and long term care.

4. Our teams will be given opportunity to innovate and set priorities for change, with local leadership to bring together all elements of our system to work together, and transform services so that they meet local need. We see the engagement of GPs as critical in making this a success.

5. We recognise the wider influences on wellbeing and health - environment, infrastructure, housing, education and employment. The Alliance will work with the private, voluntary and wider public sector to ensure that our communities can thrive.

Ambition 1 - Strengthening the support for people to stay well and manage their wellbeing and health in their communities

Case Study: Partnership working in Haverhill

The LifeLink project in Haverhill addresses social needs by equipping individuals and families with the tools they need to become more resilient and address their current issues. In addition it provides a space for people to build new relationships and support networks through connecting people - linking lives together.

To date the LifeLink Coordinators have worked with 95 individuals/families helping and providing them with a space to talk through their current situation, needs, interests and aspirations. Both coordinators are trained in coaching techniques, allowing the participant to lead the conversation and realise their own solutions. The LifeLink Coordinators simply listen, ask the right questions and then support them in accessing certain groups, support services and provision.

We have seen very quickly the positive impact this is having on the lives of participants and their loved ones, with a clear uplift in emotional wellbeing and connectivity within the town. We have invested in a wider evaluation with a focus on a reduction on reliance on GP services and prescription drugs, this data will take longer to collate, however some participants have indicated that they no longer feel the need to see their GP or take antidepressants.

It became very clear that social prescribing can support an individual's journey back into employment or volunteering. We therefore teamed up with Department of Work and Pensions and Suffolk County Council Skills Department and rolled out Moving Towards Work with the understanding that this would sit alongside LifeLink to support those furthest from the labour market. A lot of learning has come from this collaboration which will be applied to future endeavours. Partnership working has been key to the success of this project to date and will continue to be at the centre of how we continue to develop this project within Haverhill.

The first twelve months

- We will build our Connect programme across all six localities, setting up locality delivery groups, embedding the locality lead role, with shared decision making, plan with local priorities and common data set.
- Develop new volunteer roles in the community through the Helpforce programme
- Continue to roll out the Making Every Contact Count programme
- Understand who is most at risk from poor health and health crisis and target support to keep them well.
- Develop the SEND local offer so that young people have access to up to date local information to support them to live good lives.

People will start to notice that they can access both health and care together through any of our Alliance organisations.

Ambition 2 - Focusing with individuals on their needs and goals

Our future vision

We believe that if our services can be focused on an individuals needs and goals that this will both work better for people in West Suffolk, and be a more efficient use of resources.

This means changing the way we work, giving people more information and choice, and being more flexible in our responses. It means working closely across our professions, including with non health and care organisations, and with families and family carers so that people get co-ordinated, integrated care.

Action we are taking to achieve this

1. We want to test out new ways of delivering health and care services that break down traditional organisational boundaries. The Buurtzorg Test and Learn site in Barrow is exploring how district nurses can support people through providing more holistic care, and encouraging independence. If the test is successful we would roll out this model across other areas of West Suffolk.

2. We are exploring ways to create person centred plans with people, so that they have one outcome focused plan that explains how services and other supports will help them to meet their wellbeing and health needs, whether they have a physical or mental health problem, whatever their age, or if they are a carer for someone. Wherever possible we will support these plans with a personal budget.

3. When people get help it will be co-ordinated. We will check with people if we can share records across relevant professionals, backed up by trusted assessment, so that they do not have to keep repeating their story.

4. We aim to support self care and self management, handing control back by using health coaching, assistive technology, digital offers as default and through making better use of community pharmacies and social prescribing.

5. Feedback from people who use our services will be used to inform our redesign options, and how we spend our West Suffolk pound.

Ambition 2 - Focusing with individuals on their needs and goals

Case Study: Buurtzorg Test and Learn

Buurtzorg is a Dutch model of care that has been successful in supporting people who have nursing and personal care needs and who are living in their own homes. In West Suffolk, the Neighbourhood Nursing and Care Team are testing a model inspired by Buurtzorg to see how it can work alongside our Integrated Neighbourhood Teams and wider health and care system.

Buurtzorg is very different from our current model of care, as individual nurses do both nursing and personal care tasks. They also work with family, friends and local community groups, alongside other formal professionals, to put in a wide range of supports and options for people so that they can become more independent and live a good life. The evidence is that this approach leads to a reduction in care needed over time and to fewer hospital stays.

It is very early days with the "Test and Learn" and there are challenges trialling a radically different model of care within our existing system.

However, the team have already identified benefits to working in this way, for example:

- Helping families to identify where additional benefits such as Attendance Allowance are due.
- Providing personal care as well as nursing and health care.
- Monitoring blood sugars and supporting better self care.
- Developing "What if" plans so that everyone knows what will happen in a crisis with the person with the health problems or with their family carer.
- Linking people in with local community groups and activities.

The first twelve months

- Develop integrated pathways between acute and primary care.
- Take the lessons from the Buurtzorg Test and Learn to develop a model that works for people in West Suffolk.
- Develop the use of technology and exploit our digital expertise.
- Introduce care co-ordination, trusted assessment and start to develop a shared single customer plan.
- We will streamline and co-ordinate services for children and young people with ADHD, autism and behavioural issues so that they don't have to go through different pathways to receive services.

People will have conversations with health and care staff that are much more holistic and which address people's own priorities.

Ambition 3 - We will change both the way we work together and how services are configured

Our future vision

We want people in West Suffolk to start well, live well, age well and die well - and this means prioritising the prevention of ill health, whether physical or mental, as well as recognising the multiple factors that lead to ill health and deterioration of health.

We believe that working as Alliance partners we have the flexibility and freedoms to use our collective resources to make this happen. Our workforce are key to success and will be at the forefront of this work.

Our priorities for change will be driven by local need so that time and energy goes into sorting out the things that matter most to people in their area and which will make the biggest difference to health inequalities.

Action we are taking to achieve this

1. We are developing a Five Year Delivery Plan which shows how we will deliver the outcomes we have agreed as a system. We have agreed to move away from a focus on our own organisations to delivering what works best for people in West Suffolk.

2. Health and care system leaders are meeting together regularly with other partners, such as district and borough councils and the police, to plan how we deliver our vision for people in West Suffolk and to track action against our delivery plan.

3. We will share this draft strategy more widely with people in West Suffolk, with our staff and with partner organisations so that we can listen to what people think about our plans and use these to improve and strengthen our delivery going forward.

4. Our intention is to move towards an Integrated Care System, where we can truly use our resource flexibly to meet local need, acknowledging that this will take time to develop. Steps on the way will include moving contracts held by Alliance partners under the control of the Alliance and ensuring we have fully engaged GPs in West Suffolk.

5. We are expanding our collaboration with partner organisations such as the voluntary and community sector and the district and borough councils so that we can work together, bringing housing, environment, volunteering and other important factors into the mix, recognising their impact on wellbeing and health.

Ambition 3 - We will change both the way we work together and how services are configured

Case Study: Special Education Needs and Disabilities - working together for improvement

The development of Suffolk SEND strategy for 2017-20 was led by the Suffolk Parent Carer Network (SPCN) and involved partners from health, care and education. Together we developed a shared vision, aims and priorities forming the basis of the strategy. These encompassed inspection findings, but also took account of the wider evidence base we had from SPCN, our staff and local stakeholders. Once the priorities were agreed we jointly developed the objectives that set out the scope of the work. Each priority has co-accountable leads from health, education and social care supported by a critical friend from SPCN. These teams developed the action plans that sit beneath each objective and provide the detailed programme of work that will enable us to deliver the strategy. In parallel we consulted on the strategy, including the objectives, and have incorporated the feedback from the respondents into our final version of both strategy and action plans. There was strong support for the new strategy, with over 80% of the 109 respondents agreeing with the vision, aims and objectives, and 88% agreeing that the priorities identified were the right ones.

We have cross referenced the Ofsted/CQC findings from the inspection against the strategy objectives and action plans to ensure that all the matters raised by inspectors have been addressed within the action plans we have developed. Through this approach we have swiftly been able to develop a new SEND Strategy for Suffolk, while at the same time responding to the inspection findings. We have one integral plan of action to deliver the change we need and are now ready to begin our long term programme.

The first twelve months

- We will develop a Five Year Delivery Plan that shows our priorities and specific actions over the next twelve months. There will be a senior lead for each area of our plan.
- We will set up and deliver an engagement plan to share the draft strategy and the delivery plan.
- We will finalise the outcomes framework and measures and will start to monitor our system together, taking action where we are not making sufficient positive progress.

People who work in our system will no longer experience organisational barriers to change.

Ambition 4 - We make effective use of resources

Our future vision

Between Alliance partners we spend more than £340 million on health and adult social care services in West Suffolk. This does not include the cost to the wider economy of poor health and wellbeing. We believe that we can use our resources even more effectively if we work together, including eventually being able to shift resources between organisations.

This will help us to maintain services whilst demand on our system is growing, whether this be for GPs, social care, mental health services or acute and community health services.

Alongside this we see a greater role for people and our communities, taking charge of - and responsibility for - managing their own health and wellbeing, whether they are well or ill. We will invest more in preventing ill health and aim to replace high cost interventions with lower cost case management.

Action we are taking to achieve this

1. Our Delivery Plan will reverse the current trend that is leading to higher hospital spend by increasing the proportion of our health and care budgets that is spent in the community, and this, alongside a local approach to commissioning in West Suffolk, will help us to achieve value for money.

2. We will work to get a whole system understanding of health and care resources in West Suffolk and how we use them as a key step towards becoming an Integrated Care System.

3. We will work together to address the financial pressures within each of our Alliance organisations.

4. We will develop and implement plans for:
   - Information Technology and Digital Solutions
   - Estates
   - Comms and engagement
   - Workforce
   - Organisational development
   - Communications

5. We will to take every opportunity to use our assets together to reduce duplication and drive out inefficiency. For instance, we plan to share public sector buildings aiming for community hubs in each of our localities, as part of a wider strategy to consolidate corporate functions, and we are looking at how we can share data and create single patient records. We are reviewing pathways to reduce the waste caused by hand offs and reassessment.

Ambition 4 - We make effective use of resources

We will have plans for the following areas that support delivery of effective services on the ground

IT and digital
We will develop the use of technology and exploit our digital expertise. We have a head start in West Suffolk as we are running one of the sixteen Acute Global Digital Exemplar programmes in England. We would like to use technology to deliver benefits to people (for example access to records, self help information, digital monitoring and new innovations such as robotics) and to our organisations (for example shared care records, and a single data reporting view). We are piloting GovRoam in Newmarket Hospital early Summer 2018.

Estates
Making shared use of our public sector estates will help us to achieve a number of our ambitions. Our staff tell us that it will help them to develop Integrated Neighbourhood Teams, plus it will be a more efficient use of resources.

Workforce
Our workforce is our most important asset and we want them to feel a strong ownership of the West Suffolk Alliance Strategy and plan. Our delivery plan will be driven by them along with people who use our services and their carers, which will ensure that our organisational cultures develop in response to system and pathway changes.

Organisational Development
We will recognise talent across our organisations and ensure that career pathways are flexible, including with independent care providers. We have obtained external funding to help us with this work, which is being carried out throughout Suffolk. We want to explore joining up our workforce where this makes sense, across clinical and non-clinical teams. We are putting in place initiatives that will ensure that West Suffolk is an attractive place to work.

Communication
People in west Suffolk expect us to work across barriers and boundaries, and we will need to use their experience and stories to develop our plans and to show where this have changed for the better. Our communications strategy will also be key to creating an Alliance culture, where staff feel part of an integrated system and a priority is ensuring the messages and priorities for the Alliance are cascaded throughout our organisations and with partners.

Our organisations retain their own decision making and accountability, but we put our Alliance principles into action and make sure that decisions are taken with these in mind.

Mike Hennessey
Director of Adults and Community Services, Suffolk County Council

Joining up services around the needs of people

Case Study: Sharing information to make a real difference

On the evening of Sunday 1st April, which was a bank holiday weekend, an acutely unwell lady was brought to West Suffolk Hospital Accident and Emergency Department. She had a stage 4 ovarian cancer, and was very vague about her history and not able to give information about her condition or treatment. We were able to determine that she was under the care of a consultant at Addenbrooks Hospital, but as it was Sunday evening of course there was no one around involved in her care to speak to.

However a recent innovation at West Suffolk Hospital is that we are able to access Addenbrooks Hospital care records. Because of this we were able to see an up to date treatment plan and the results of her most recent scan. Access to this information meant that we were able to expedite her treatment with the right medication and care plan without the need for another CT scan or any other diagnostic tests in order to work out what do next. This meant her stay in hospital was only short and we were able to stabilise her condition, relieve her pain, and discharge her the next day. Importantly we were able to update her patient notes so that her own GP and her own consultant were made aware of what had happened and had live information on her condition and the treatment we had provided.

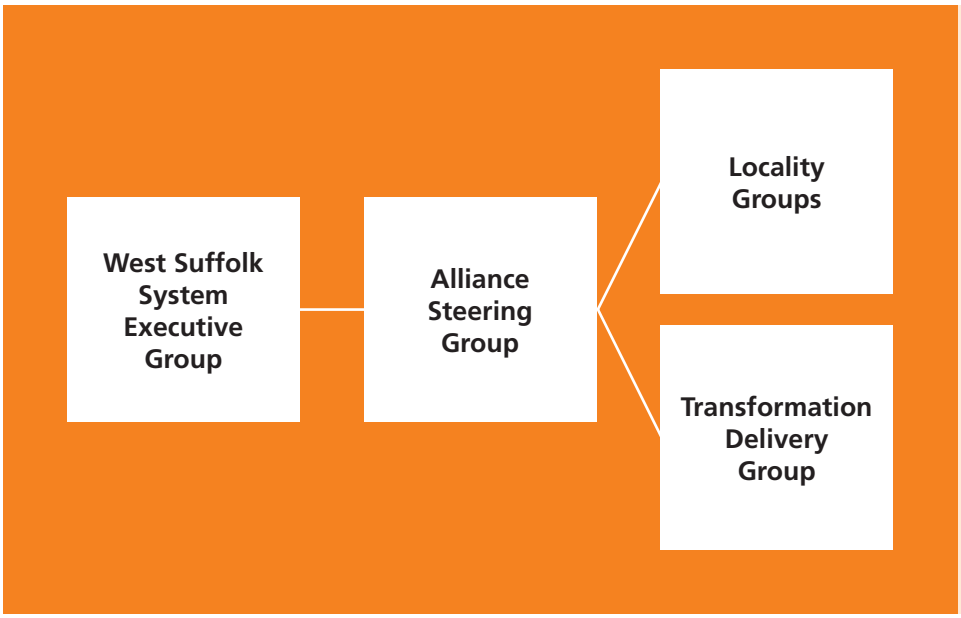
We want to change our health and care system so that it works for people - their lives and ambitions. This is the starting point for the changes we want to make.

Kate Vaughton
Chief Operating Officer, West Suffolk Clinical Commissioning Group

West Suffolk Alliance forums for discussions and decision

Our Alliance is driven by a System Executive Group comprising director and clinical lead representatives from West Suffolk Hospital, Suffolk County Council - Adult and Children's Services, Norfolk and Suffolk Foundation Trust, Suffolk GP Federation, West Suffolk Clinical Commissioning Group, our district and borough, voluntary sector and patient representative groups. Our nominated lead represents our Alliance at STP level.

Wider system governance



Working with:

Ipswich and East Suffolk Alliance

Childrens Alliance

Mentally Healthy Communities Board

Suffolk Commissioners Group

Suffolk Health and Wellbeing Board

Suffolk and North East Essex Transformation Partnership

West Suffolk Alliance Strategy - in context

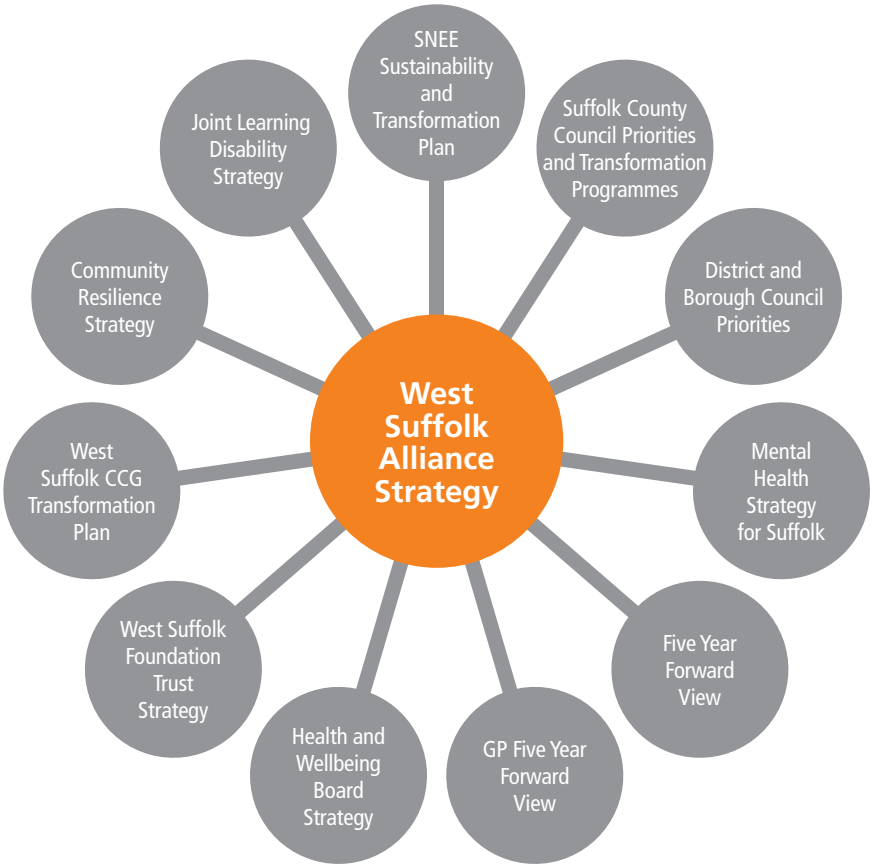
The West Suffolk Alliance Strategy is part of a wider network of plans and strategies and builds on these to show how we will add value through Alliance working.

The Strategy is intended to show how we will deliver key aspects of the Suffolk and North East Essex Sustainability and Transformation Partnership Plan.

It also recognises that to improve the wellbeing, health and independence of people in West Suffolk a wide number of partners must be involved.

The Strategy should be read alongside our Five Year Delivery Plan. This shows the programmes and projects that we are collaborating on together to turn our vision into reality.

Some programmes are led across both Alliance areas on behalf of both East and West Alliance and there are interconnected programmes with North East Essex Alliance partners.



West Suffolk System outcomes

Together we have developed a set of system outcomes around eight domains:

1. Local people have an excellent experience of care and support

2. Health and Care inequalities will be reduced

3. Reduction in the incidents of avoidable harm

4. Money is used for best effect across the health and care system

5. Local people are supported to stay well

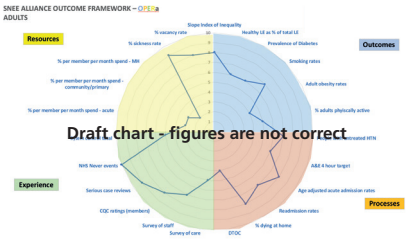
6. Local people with health and care needs are supported to avoid deteriorating health and manage crisis

7. Local people's health and wellbeing is optimised after a period of ill health or injury

8. Local people are supported to have a good death

Progress against these outcomes will show how we are moving forward as a system, and will help us to work together as Alliance partners, not just as individual organisations.

This work is still under development - so the radar chart shown below is an illustrative example of how we would plot our progress. We aim to have measures developed at Alliance level as well as at a locality level.



System outcomes - OPERa framework

OUTCOMES - Health and care outcomes for our population

• Health and care inequalities will be reduced	• The Slope Index of Inequalities narrows
• Alliance activity focuses on effective prevention	• The length of healthy life expectancy, and the proportion of healthy life expectancy within total life expectancy, increases
• Local people are supported to stay well	• Self care, PAM, A&E attendances, 111, Early help metrics (SC)
• Local people with health and care needs, including those with chaotic lifestyles, are supported to avoid deteriorating health and managing crisis	• Unplanned age standardised acute admission rates reduce; chaotic lifestyle metric from RE
• Local people's health and wellbeing is optimised after a period of ill health or injury	• The proportion of eligible people entering reablement and rehabilitation services increases; effective whole system reablement % increases
• There is a reduction in incidents of avoidable harm	• Serious incidents/case reviews within health and care reduce

PROCESSES - We maximise the opportunities available to us through Alliance working to improve health and care processes

• Alliance working leads to a culture change of acting in the interests of the system, not those of constituent organisations	• All Alliance partners can demonstrate effective culture change through business cases, prioritisation decisions and case studies
• Health and care teams and pathways are effectively integrated, increasing efficiency and reducing duplication	• Key Alliance care pathways demonstrate increased efficiency by improving outcomes, reducing cost, increasing throughput etc.
• The Alliance develops a shared vision and values which actively guide decision making	• All Alliance partners can demonstrate use of Alliance vision and values in decision making and case studies
• There is shared control and rapid decision making in all parts of the Alliance system	• All Alliance partners agree that governance arrangements are timely and effective
• The Alliance benefits from shared back office functions through making savings from reduced duplication of functions	• Savings from combined back office Alliance functions are achieved
• The Alliance develops population-level business intelligence across line of business systems to guide targeted, risk-based, interventions	• Effective targeted interventions are introduced based on population insight from combined clinical systems
• The incidence of markers of poor use of Alliance resources reduces (e.g. elective cancellations, readmissions, etc.)	• System DTOCs reduce

System outcomes - OPERa framework

EXPERIENCE - Local people have an excellent experience of care and support

• Local people give positive and consistent feedback about their personal experience of care and support, and their experience of care and support for their loved one	• The proportion of of local respondants who agree with the Alliance's measured 'I statements*' in relation to their own/their loved ones care and support is high, and increases over time; CQC findings; safeguarding volumes
• Local people are supported to have a good death	• Performance against defined key measures in this area (Family and carer feedback; % dying in preferred place of death including home; use of advance care planning) is high and improves over time

RESOURCES - Resources are used for best effect across the Alliance

• Services are delivered within the combined Alliance financial envelope	• System achieves annual budgets/ agreed control totals as per the STP, including efficiency requirements
• Financial flows work to incentivise services which intervene early to improve outcomes and manage need and demand	• PMPM (Per member, per month) spend on unplanned acute care decreases as a proportion of total spend
• The Alliance workforce are motivated, skilled and enabled to work flexibly including within integrated teams	• Staff survey, roster coverage levels, % of workforce with multiple skills, 'trusted assessor' working, caseloads
• The Alliance workforce is sustainable with a larger pool of trained people available to cover hard to fill vacancies and 'strength in depth' making it easier to recruit and manage demands of flexible workforce (particularly GPs)	• The Alliance develops a sustainable workforce and sickness and vacancy rates in key risk staff groups are low and decrease over time

For more information

West Suffolk System Executive Group meeting in April 2018

> ***We have not created new organisations through alliance working. Rather we are developing ways to allow existing organisations to come together to work far more closely and effectively than ever before.***
>
> **Dr Paul Driscoll**
> Chair, Suffolk GP Federation

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