WEST SUFFOLK ALLIANCE
about people & places

West Suffolk Alliance Delivery Plan 23/24

Improving health through partnership

May 2023

Document Control & History

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0.1	31/03/23	Rebecca Jarvis	Draft for comment
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1.0	03/05/23	Rebecca Jarvis	Final Document
2.0	18/05/23	Rebecca Jarvis	Revised final document

Contents

1. Executive Summary

Executive Summary

This Plan

- Focuses on what collective action we can take to improve the health and well-being of the West Suffolk population in 2023/24
- Is a partnership agreement and complements other planning documents including those that are organisation specific, county-wide or ICS-wide
- uses the Live Well framework to organise our partnership work in line with the SNEE ICB Joint Forward Plan
- Selects a smaller number of achievable priorities to focus our partnership efforts and contributes to the Live Well outcomes
- will continue to evolve as we develop, agree and review how to measure the impact of the action we plan to take
- provides the foundation to assess our progress during 2023/24. A formal 6 month progress review will take place in November 2023.

West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

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	Key Workstreams	Priority actions in 2023/24	By When	Sponsor
Start Well 	• Collaboration • Insight and Intelligence • Resources	• A system wide partnership group • Understand wider system shared challenge • Develop a coproduced decision making structure • Early education programmes.	• July 2023 • July 2023 • October 2023 • October 2023	**Garry Joyce** Deputy Director of Transformation Children and Young People SNEE ICB
Feel Well 	• Sleep • ADHD • Carers	• Improved data and information regarding sleep • Create resources to help improve awareness • Lived experience involvement approach. • Understand carer needs and plans for improvement in carer support. • Joint plan to improve ADHD service. • Create "Wait Well" resources and services • Improve early identification in primary care	• July 2023 • Sept 2023 • July 2023 • November 2023 • November 2024 • February 2024 • March 2024	**Vanessa Wragg** Deputy Service Director, NSFT **Belinda Danso - Langley** - Service Director Suffolk Care Group, NSFT
Be Well 	• Healthy Behaviours • Dentistry	• Development of a new model of healthy behaviours • Work with key stakeholders to develop locally designed programmes. • Improve alignment. • Understand the dentistry landscape especially the challenges and issues including: ➢ Identify opportunities to transform and integrate dental services into our local system ➢ Work collaboratively with other domains to improve dental outcomes.	• October 2023 • March 2024 • March 2024 • November 2023	**Ian Gallin** Chief Executive West Suffolk Council **Kathy Nixon** Deputy Chief Executive Babergh and Mid Suffolk District Councils

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	Key Workstream/s	Priority actions in 2023/24	By When	Sponsor
Age Well 	• **Community Model of Care**	• Further development of Integrated Neighbourhood Teams and alignment with Primary Care • Community Nursing and Therapy Demand and Capacity review • Strengthen the Home and Reablement first Model of Care	• December 2023 • November 2023 • October 2023	**Clement Mawoyo** Director of Integrated Adult Health and Social Care West Suffolk **Sandie Robinson** Deputy Director Transformation SNEE ICB
Stay Well 	• Demand Management • Urgent Community Response • Discharge and Flow • Direct Access • Diabetes	• Enhancing our Urgent Community Response to deliver >10% increase in admission avoidance • Focus on improving discharge to improve flow and reablement outcomes • Explore direct access pathway opportunities • Redesign the end to end diabetes pathway	• October 2023 • October 2023 • February 2024 • March 2024	**Nicola Cottington** Chief Operating Officer West Suffolk NHS Foundation Trust **Dr David Brandon** Associate Medical Director SNEE ICB
Die Well 	• Co-ordinated 24/7 care • Personalised Plans • Compassionate Communities	• Further development of the End of Life Model of Care • Access to 24/7 specialist support • Integrated and collaborative training and support package for staff • RESPECT rolled out • Accessible dashboard of those within the last year of life • Digital solution identified for offering two-way care planning communication between person end of life and support network • Die well information campaign planned	August 2023 August 2023 March2024 March 2024 March 2024 March 2024 March 2024	**Susan Wilkinson** Chief Nurse West Suffolk NHS Foundation Trust

West Suffolk Alliance Delivery Plan Summary - Enablers

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

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Vision & Key Workstreams		Priority actions	By When	Sponsor
Workforce	**Support organisations to build workforces that enable them to effectively serve populations by taking a system approach to** • Implement an Education and Training Digital Passport • Improve Equity to International Recruitment Opportunities for Alliance Stakeholders	For each workstream there will be a focus on; • Improving supply • Upskilling staff • Creation of new roles	• March 2024	**Ewen Cameron** Chief Executive West Suffolk Foundation Trust
Digital & data	**A shared planned approach for the use of digital and data at place across the system.** • Promotion and adoption • Evaluation	• Design an approach that promotes and facilitates the adoption and usage of use cases, dashboards, digital technologies and innovation with all partner organisations. • An agreed evaluation model for comparing different dashboards/ technology offerings to assist the GIRFT (getting it right first time) principle	• November 2023 • March 2024	**Craig Black** Executive Director of Resources West Suffolk Foundation Trust **Dr Molly Thomas-Meyer** (Public Health Suffolk)
Estates	**Create and manage one public estate that is driven by service needs; run and planned as one system** • Optimise use of existing estate • New Hospital Programme • Plan for population growth	• Use Haverhill locality as an exemplar to: ➢ Identify service and clinical requirements ➢ Be clear on all assets available in each locality ➢ Be a proactive partner with District and Borough Councils • Pilot single management of shared buildings • Ensure system decision making governance in place for shared spaces • Support estates requirements flowing from Future Systems programme • Estates domain operational group to engage with each locality	• November 2023 • Review January 2024 • July 2023 • March 2024 • January 2024	**Peter Wightman** West Suffolk Alliance Director
Localities	**Enable coordination at a locality level** • Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives	• Prioritise Haverhill Locality in the first instance whilst supporting the other Localities to maintain a level of engagement and development	• November 2023	**Chris Abraham** (Suffolk Community Action CX)

2. Context – Strategic & Local

West Suffolk Alliance – part of SNEE

the *statutory committee where partners set the health and well being strategy*
Suffolk and North East Essex

the NHS *statutory body* that plans and buys healthcare services for the local population.

the *local mechanism* for delivering integrated care and services for the population of West Suffolk

All partners developing a single collective <u>STRATEGY</u> to improve health and wellbeing outcomes for SNEE.

Integrated Care Strategy 23-28

The NHS working with partners to <u>PLAN</u> how best to invest the NHS budget to deliver the Integrated Care Strategy for the population.

Joint Forward Plan 23-28

Local partners working together to co-ordinate <u>DELIVERY</u> of services and initiatives in places, communities and neighbourhoods.

Alliance Delivery Plan 23-24

ICP – Integrated Care Strategy

OUR **INTEGRATED CARE STRATEGY** IN SIX NUMBERS

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

1

ONE MILLION PEOPLE

We are **ONE** team with a shared vision of the best possible health outcomes being a reality for every **ONE** of the **ONE** million people that we all serve.

2

TWO COUNTIES

We work flexibly with wider partners across the **TWO** counties of Suffolk and Essex

3

THREE LOCAL ALLIANCES

We co-ordinate delivery as locally as possible through our **THREE** local place-based alliances

4

FOUR COLLECTIVE AMBITIONS

We are united around our **FOUR** collective ambitions:

- the **best health and wellbeing** a genuine reality for all
- the opportunity of **health equality** for everyone
- everyone able to '**Live Well**' – Start Well, Be Well, Stay Well, Feel Well, Age Well, Die Well
- a genuinely **'Can Do' Health & Care System** that people can trust.

5

FIVE EQUAL SECTOR PARTNERS

We believe in parity between all **FIVE** sectors in the ICS – NHS, primary care, social care, public health and the voluntary community social enterprise and faith (VCSEF) sector.

6

SIX 'CAN DO' VALUES

The way we work together as a 'Can Do' Health and Care System is underpinned by our **SIX** core values: Collaborative, Creative, Courageous, Compassionate, Cost Effective, Community Focused

ICB - Joint Forward Plan

The ICBs five year plan, the Joint Forward Plan (JFP), clearly sets out how the ICB plans to contribute to the implementation of the ideas set out in the Integrated Care Strategy as well as our county based Health and Wellbeing Strategies and the national NHS Plan.

Like the ICB Strategy, the Joint Forward Plan also utilises the Live Well Model.

Identified priority areas within the JFP include;

- Health Inequalities
- Children and Young People
- Mental Health
- Healthy Behaviours
- Access to Care
- Early Intervention
- Frailty
- End of Life Care

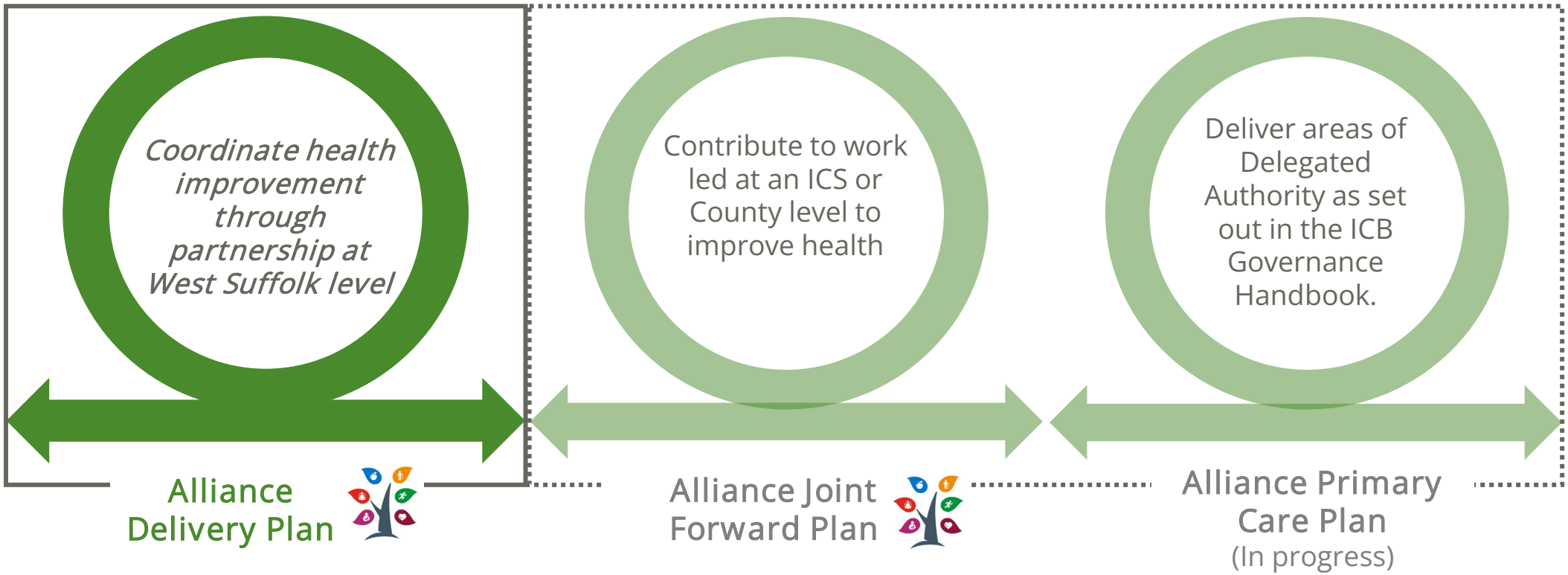
All three alliances in Suffolk and North East Essex are using the Live Well model to shape their Alliance Local Delivery Plans.

You can find the details of the Joint Forward Plan in Appendix 1.

West Suffolk Alliance Delivery Plan

This plan focuses on 2023/24 actions related to improving health through partnership working.
The Alliance Committee has two other functions which are described in other documents

Alliance roles



You can find the details of the ICB Governance Handbook in Appendix 1.

West Suffolk Alliance Partners

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NHS & Council Statutory Bodies
- Suffolk and North East Essex ICB
- West Suffolk NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Suffolk County Council
- West Suffolk District Council
- Babergh and Mid Suffolk District Councils

Service Providers
- GP teams and Primary Care Networks
- Dentists, pharmacists & optometrists
- Suffolk GP Federation
- Care Market
- Allied Health Professionals CIC
- West Suffolk College
- Abbeycroft Leisure

Voluntary Community Faith and Social Enterprise
- Community Action Suffolk
- Healthwatch Suffolk
- Multiple local & national VCSFE Partners including:
- St. Nicholas Hospice Care
- Abbeycroft Leisure
- Home Start
- Reach Haverhill

Integrated neighbourhood teams in 6 localities

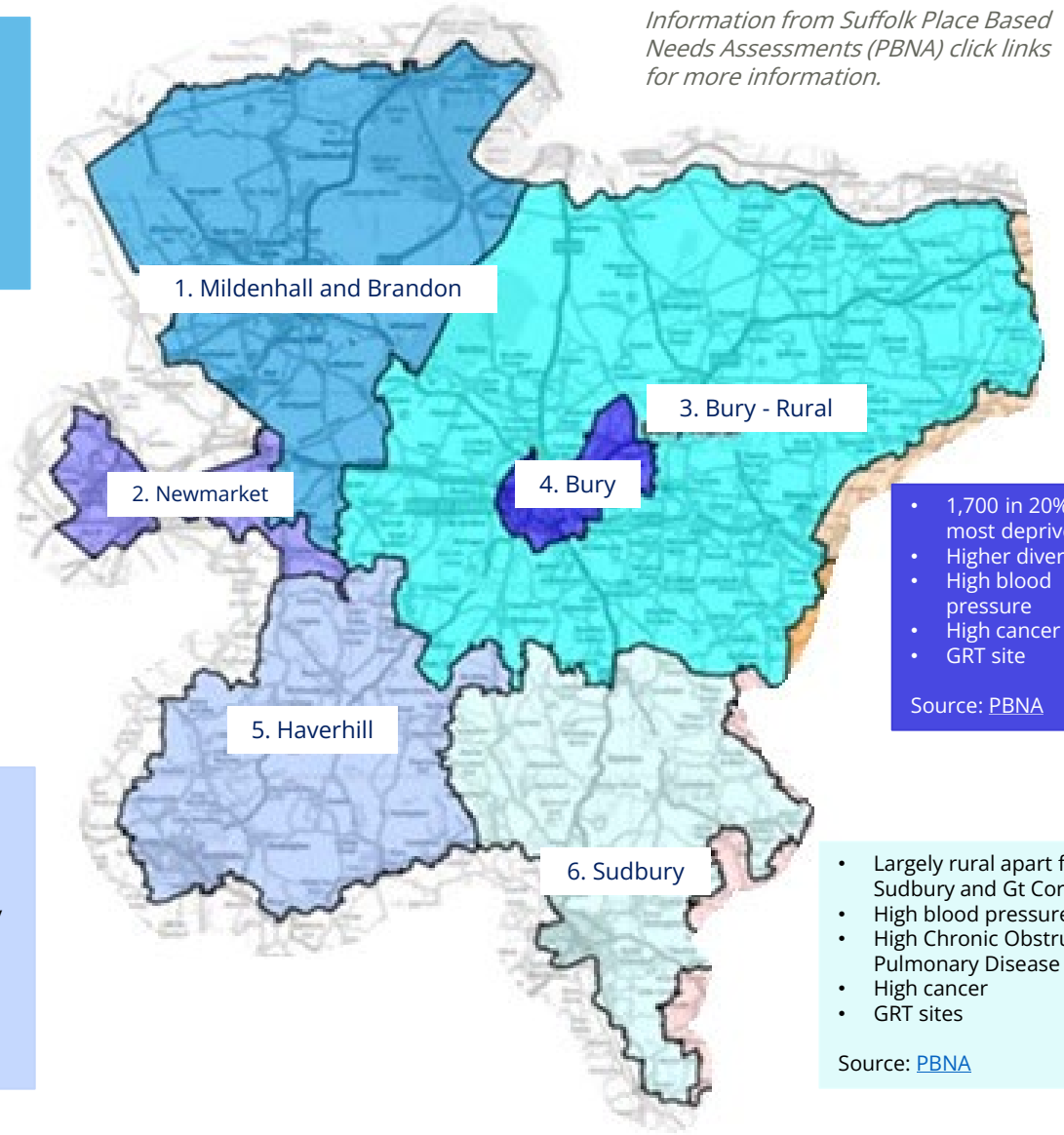
Local Geography & Need

West Suffolk population:

- Total: 274,000 with the largest age group being 50 – 54.
- It is expected that our population will grow by 7% in general and 34% in older people over the next 20 years.
- Largest population growth areas are expected in Bury and Haverhill.
- 3.2% aged 85+ (vs 2.5% national)
- 1,685 people in West Suffolk live in the most deprived 20% areas in England.
- 8.1% are affected by income deprivation.
- 6.6% of working age people are affected by employment deprivation.

Our local plans uses public health information like this and the Core20PLUS5 data to evidence our required areas of focus in the Alliance Delivery Plan.

Information from Suffolk Place Based Needs Assessments (PBNA) click links for more information.



- Higher diversity
- Armed forces personnel
- Higher births
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High smoking
- High cancer
- GRT sites

Source: PBNA

- Higher diversity
- High smoking
- Higher births

Source: PBNA

- Rural populations (excluding central Haverhill)
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High smoking
- High cancer
- GRT site

Source: PBNA

- Rural
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT sites

Source: PBNA

- 1,700 in 20% most deprived
- Higher diversity
- High blood pressure
- High cancer
- GRT site

Source: PBNA

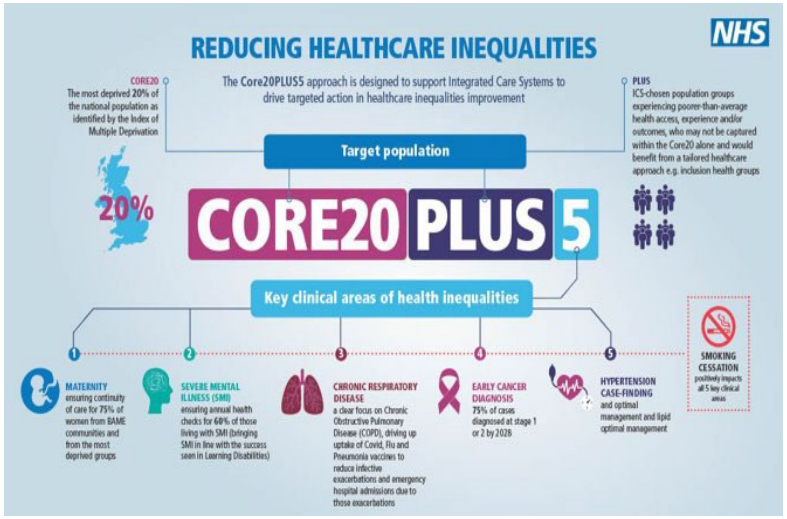
- Largely rural apart from Sudbury and Gt Cornard
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT sites

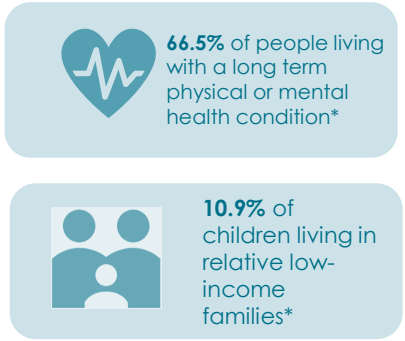
Source: PBNA

Please note, the boundaries of Bury and Bury Rural have changed since this work was completed.

Reducing Health Inequalities in West Suffolk

VISION: Work with partner organisations and communities across West to reduce inequalities using the Core20Plus5 framework, focussing on raising awareness and action to support everyone to Live Well, with specific actions to support our most vulnerable communities.





Everyone should have the opportunity to have and maintain good health and wellbeing. We know this does not always happen, and certain communities and populations experience health inequalities based on a range of factors. Some areas of need in West are:

We need to support the health needs of the approx. 1700 people in West Suffolk who live in areas that are ranked among the most deprived 20% in England** . They are likely to experience health inequalities and poorer physical and mental wellbeing. While there is not always data available on all the Core20Plus5 populations at a very local level, there are some specific ways in which we can support our Core20Plus5 key areas in West:

- Increase by nearly double the number of individuals with SMIs who receive health checks.
- Boost vaccination rates to prevent influenza.
- Reduce smoking prevalence by two thirds to meet upcoming government ambitions
- Increase early detection of cancer rates by 16 percentage points
- When looking at West Suffolk – nearly 19,000 people are estimated to have undiagnosed hypertension.
- Nearly 12,000 people in West Suffolk are estimated to diagnosed with hypertension but not having their blood pressure optimally managed.

Data Source: Census 2021, west alliance profile, Public Health Outcomes Framework 2020/21, State of Suffolk Report 2019
* = west Suffolk district boundaries not alliance boundaries
** Source: DCLG Index of Multiple Deprivation 2019 & ONS 2020 population estimates.

The new ICB **Health Inequalities & Prevention Committee** has outlined key principles which will support our approach in West:

- Reducing Health inequalities by levelling up is core business for everybody.
- We will match resources to need.
- We are data informed and evidence based.
- We do this work through Community - Centred Approaches and Coproduction
- We target our efforts through a Core 20 Plus 5 and prevention frame.
- We use our position as Community Anchors to tackle the 'causes of the causes'
- Our services and communication are digitally inclusive.
- Key Public Health priorities are hypertension and smoking, and we will look to develop specific initiatives in West with partners.

The Health Inequalities Plan for West Suffolk Alliance

1. We will develop proposals for an approach to Health Inequalities and Prevention for West Suffolk Alliance, aligning with the principles above. This will include evidence-based actions for key stakeholders to consider, and articulating outcomes. This will align and build with the ICB Committee plans which are underway and will look to increase engagement across partners to enact the agreed approach.
2. We will promote data including Population Health Management initiatives to support ongoing aims.
3. We will work with the Alliance Live Well domain/enabler groups and West based organisations to enact actions
4. We will develop some targeted work on hypertension and smoking -- given their key key role in preventing ill health.
5. Live Well Delivery Group: we will work with this central group to support embedding operational actions.
6. Reporting : we will provide quarterly updates on workstream progress to the Alliance Committee.

Wider Determinants of Health - Focus on Education

In partnership with West Suffolk College, we want to leverage education to collaborate with our Primary, Secondary and Further Education school's network and connect with CYP and families to improve the health of the people of West Suffolk

Relative contribution of the determinants of health

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

Together we will will:

- **Deliver early education programmes** for families via primary school awareness .
- Work with Education to **increase understanding of support methods for emotional wellbeing and mental health** via primary and secondary schools, as well as adults via post-18 provision.
- Use primary and secondary schools, as well as post 16 providers to **engage young people and families in understanding the risks associated with poor habits, diet, and physical activity.**
- Use post-18 providers to **educate on the provision and level of support available to those dealing with frailty and dementia**.
- **Increase knowledge base of opportunities available to support end of life** via post 18 education providers.

Primary Care Networks

We have 25 practices organised into 6 primary care networks

120 additional roles staff in place and set to increase further in 23/24

Role type	Number
Care Coordinator	41
Social Prescriber	17
Clinical Pharmacist	16
Mental Health Practitioner	12
Paramedic	12
Pharmacy Technician	8
Trainee Nurse Associate	6
Nursing Associate	2
First Contact Physiotherapist	6
	120

PCN	Practices in the PCN	Patient numbers
Blackbourne	Botesdale Health Centre	9,756
	Stanton Surgery	5,328
	Woolpit Health Centre	15,551
	Ixworth Surgery	9,080
Bury St Edmunds	Angel Hill Surgery	14,125
	Guildhall & Barrow Surgery	12,834
	Mount Farm Surgery	15,109
	Swan Surgery	12,654
	Victoria Surgery	10,885
Forest Heath	Brandon Medical Practice	5,239
	Forest Surgery	7,610
	Lakenheath Surgery	5,376
	Oakfield Surgery	7,395
	Orchard House Surgery	12,024
	Reynard Surgery	10,019
	Rookery Medical Centre	13,937
Sudbury	Hardwicke House	24,336
	Siam Surgery	11,218
WGGL	Glemsford Surgery	4,683
	Guildhall – Clare Surgery	5,319
	Long Melford Practice	8,991
	Wickhambrook Surgery	5,268
Haverhill	Unity Health Care	17,781
	Haverhill Family Practice	17,530

West Suffolk summary - strengths, progress & opportunities

	Strengths & progress	Opportunities to improve
Well Being	Public health focus at WSFT; staff well being offers; leisure services; social prescribing	Opportunities for diet, exercise and mental health improvement
Primary Care	Comparatively stable GP teams	Variation in access experience contacting GP Teams GP team Workload & workforce pressure Severe dental access problems
VCSFE sector	Established relationships and commissioned services and funded activities	Greater partner awareness and understanding of the VCFSE Improved collaboration and partnership working with VCFSE Increased resilience support for the VCFSE sector
Health & social care integration	Joint leadership roles and aligned teams	Scope for further prevention and move to home based model PCNs and INTs not well aligned
Mental health	Talking therapies	Community mental health teams and PCNs
Hospital & community integration	Integrated NHS trust	Planning for and resourcing "left shift"
Estate	Mildenhall, Sudbury, Newmarket & Brandon hubs	Hospital needs replacement Primary care capacity & hub opportunities in Bury and Haverhill
Joint approach to commissioning & change	Alliance Committee with delegated powers. Live well domain working has started	Live well domain maturity
Finance	SNEE system in balance	Overspending at WSFT & primary care medicines budgets

3. Our Delivery Approach

Working in partnership with people and communities

Creating together through the power of collaboration.

"To achieve real impact, we need systems to look beyond those who are typically involved – building partnerships across traditional boundaries and working with people, communities and those who represent them to create real change"

Working in partnership with people and communities: statutory guidance

(2022)

People and Places are the centre of everything we seek to do in West Suffolk Alliance.

West Suffolk Alliance recognises that by working in partnership with people and communities is critical if we are to create service which offer personalised care, work for everyone and deliver the best outcomes.

Our approach seeks to actively develop partnerships and networks with our communities to enhance transparency, accountability and collaboration to build enduring relationships.

West Suffolk Alliance will develop a local people and communities delivery plan to ensure the people of West Suffolk act as an important **reference** point and ensure that we don't lose sight of the ultimate goal of improving people's lives through health and care.

Our people of West Suffolk are experts by lived experience and will create **qualitative** information evidence base to overlay with our data led approach and meaningfully challenge the proposals we seek to develop.

Our partners will seek to see the solutions we **develop** through the eyes of our communities ensuring compassionate led leadership remains at the heart of West Suffolk Alliance.

Ten Principles of working with people and communities

The Alliance is committed to following the Guiding Principles of working with people and communities. By using these principles within our Alliance we know we are contributing to an *equitable engagement approach with our partners, people and communities.*

1. Centre decision-making and governance around the voices of people and communities
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by health inequalities
5. Work with Healthwatch and the voluntary, community and social enterprise sector
6. Provide clear and accessible public information
7. Use community-centred approaches that empower people and communities, making connections what works already
8. Have a range of ways for people and communities to take part in health and care services
9. Tackle system priorities and service reconfiguration in partnership with people and communities
10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

Organise our partnership working around 6 live well domains and 4 Enablers

In West Suffolk we have identified four enablers that are integral to the successful delivery of the Alliance Delivery Plan.

- a. Workforce
- b. Digital & Data
- c. Premises
- d. Localities

We aim to collaborate by

Having a clear purpose	Acting efficiently and inclusively	Working also at ICP and County level as needed	Being flexible & adapting
• **Focus on a set of shared outcomes** agreed and reported at Alliance level with a shared approach to evaluation of both quality and impact **Use data & insight** to understand the key challenges for population health • **Focus on actions dependent on partnership** (not replicate organisation specific responsibilities)	• **Mandated to act** by the Alliance • **Leading on behalf of each other** where appropriate • Seek help where there are blocks • **Meetings;** map, align and streamline current groups to minimise bureaucracy • **Co-produce** with involvement of relevant partners, person centred solutions	• Recognise the relationship with **ICB programmes and County Leads** to recognise interdependencies and make connections • Import and export **best practice** • Clear where **delivery lead sits at County & ICB level**	• Ensure we review and learn from how we are working to **adapt as we learn**, innovate and deliver • Recognise overlaps & **interdependencies** exist • **Evaluate** quality & impact of delivery where succeeding & failing

Distributed Leadership Model as of 09/05/23

WEST SUFFOLK ALLIANCE
about people & places

Committee Member (Mandated Authority)

Alliance Partner (From local organisations)

Delivery Support (Health Resource)

Domain	Sponsor	Strategic Lead	Change Co-ordinator
Start Well	Gary Joyce (ICB/SCC)/Angela Whatley (SEND with WS College)	Tara Spence (HomeStart - VCSFE)	Jamie Mills/Helen Bowles
Feel Well	Vanessa Wragg/Belinda Danso-Langley (NSFT)	Jon Neal (Suffolk Mind - VCSFE)	Hannah May
Be Well	Ian Gallin (WSC) /Kathy Nixon (B&MS)	Helena Jopling (WSFT)	Jennie McCrory/Trisha Stevens
Stay Well	Nicola Cottington (WSFT)	Dr David Brandon Associate MD (ICB alliance)	Renu Mandal and Lucy Webb
Age Well	Clement Mawoyo (ASC)	Sandie Robinson (ICB Alliance)	Lesley Standring and Michelle Glass
Die Well	Sue Wilkinson (WSFT)	Sharon Basson (St Nicholas Hospice)	Cara Twinch
Enabler Domains			
Estates	Peter Wightman (ICB Alliance)	WSC/BMS Chris Todd	Daniel Turner
Workforce	Ewen Cameron (WSFT)	Phill Stittle (WSC)/Mark Smith (AHPS CIC)	Graham Seward and Paul Firth
Digital	Craig Black (WSFT) and Molly – Thomas Meyer (PH)	Liam McLaughlin (WSFT)	Nicola Chalk and Phil Nice
Locality Development	Chris Abraham (CAS - VCSFE)	Sandie Robinson (ICB alliance)	Sarah Hedges

4. The Plan

The potential is exciting but integrating and moving to a prevention approach is challenging

Our domain groups are at different stages of development

Establish the team and relationships
Building networks

Leadership

Resources

Build a shared understanding of key issues and opportunities

Stories & data

Setting priorities and realistic goals and measurable objectives

Implementation

Communicating & coordinating

Overcome obstacles

Reviewing

WSA Live Well Framework – Problem Statements

Overarching aim in all domains : Health Inequalities
Need to systematically identify and allocate resources towards improving access, experience, and outcomes of healthcare to reduce health inequalities.

Be Well
Decreasing healthy behaviours and access to dentistry services.

Feel Well
Need more collaborative approaches for whole person physical and mental health improvement.

Start Well
Inequitable health outcomes during pregnancy and birth and long waits for children and young persons mental health services.

Age Well
An ageing population with increases in demand on all services and increasing complexity.

Stay Well
Demand for health and social care services is rising with a quarter of the population experiencing long-term conditions.

Die Well
Need to increase the numbers of people who have control and clear death wishes while providing a 24/7 service/.

Workforce | **Digital & Data** | **Premises** | **Localities**

Start Well

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Start Well: Giving children and young people the best start in life in West Suffolk			
Domain Workstream	**Focus Areas**	**Key Deliverables**	**Intended Impact**
Collaboration	1. **Building collaboration with system partners** across West Suffolk to provide a wider focus on CYP and families agenda 2. **Identify areas where we need to collaborate further** to deliver our local priorities for CYP and families. This will include colleagues from education, district and borough councils and safeguarding partnerships 3. **Early education** for families via primary school awareness programmes	• A system wide partnership group, with representation from key sector leads across West Suffolk • Establish and deliver early education programmes across West Suffolk	Partners across West Suffolk Alliance working together to agreed shared action focused on on giving CYP the best start in life
Insight and intelligence	1. Gather **data and insight** to better understand strengths and need to promote Start Well, address wider determinants of health and reduce inequalities	• Establish local challenges with health, social care and Education colleagues with leads with input from service users	Better understanding of needs and key action plan setting out local shared outcomes
Resources	1. **Identify resources and community assets** to support the delivery of agreed outcomes across the Start well domain 2. **Agree collective outcomes, identify indicators and prioritise actions** for system wide improvements that will make the greatest impact in West Suffolk for CYP & families	• Develop a coproduced decision making structure for the Start Well domain	Shared platform to enable decision making at place and allocation of resources with the mandate to deliver

Feel Well

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Feel Well: Supporting the mental wellbeing of our local population of West Suffolk

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
Sleep	1. **Increase the number of people who say they feel rested after sleep.** 2. **Increase awareness of the importance of sleep** across West Suffolk. 3. **Create guidance** for people working in the system to have the confidence to ask people about their sleep and provide information on the tools to improve it.	• Support research, data collection and monitoring to target improved sleep outcomes. • Create resources to help improve awareness and also access to practical support for both patients and staff within West Suffolk.	Reduction in the negative health and social impact of living with poor sleep experiences.
ADHD	1. **Reduce wait times and improve experience** of ADHD services. 2. **Support patients and their families/ carers to "Wait Well"** though Improved accessible resources and signposting to local and national support services. 3. **Improve early diagnoses** to reduce risk of suicide and/ or development of wider mental health conditions.	• Review ADHD service processes and create plan to improve service access and wait times across West Suffolk. • Create "Wait Well" resources and services in areas such as peer support, exercise, diet etc. • Ensure people with lived experience are shaping the delivery of any future services and provisions. • Work with primary care to help early identification and referrals.	Improve the outcomes of people living with ADHD through timely diagnosis and treatment. JFP: Achieve a 5% year-on-year increase in number of adults supported by community mental health services
Carers	1. **Understand how local mental health services can better support carers** both with their carers responsibility and the impact on their own health and wellbeing. 2. Ensure all mental health services have **clear processes for identifying and working with carers.** 3. **Support carers to feel properly informed and empowered to care by Improving information sharing** between carers and the related health and care organisations.	• Work in partnership with the Integrated Care Academy (ICA) to understand and improve carer needs. • Develop and provide guidance to services on how to ensure carers should be included in patient care. • Review information sharing practices and ensure they meet the needs of carers and safeguarding requirements .	Reduce the burden that mental health services unintentionally place on carers of people with mental health needs.

Note: The Suffolk Mental Health charter describes the full range of actions being taken with regards to mental health improvement including those contributing to further JFP targets

- Achieve a year-on-year reduction in hospital admission for mental health.
- Tackle health inequalities by ensuring at least 90% receive a full annual physical health check and follow-up intervention.
- And strengthening community mental health teams between NSFT and PCNs

Be Well

WEST SUFFOLK ALLIANCE
about people & places

Be Well: Empowering adults to lead healthy lifestyles in West Suffolk			
Domain Workstream	**Focus Areas**	**Key Deliverables**	**Intended Impact**

Healthy Behaviours	1. **Improve opportunities to help people lead healthy lifestyles** across key areas including;
	    1. Reduction in **smoking** and tobacco dependency
	    2. Increasing **physical activity**
	    3. Maintaining a **healthy weight**, reduce obesity, eat healthy foods and drinks.
	2. **Creating an aligned and collaborative new approach** to Healthy Behaviours across West Suffolk to increase uptake and reduce health inequalities.
		• Development of a new model of healthy behaviours provided via a digital resource and locally delivered programmes, courses, advice and support.
		• Work with Public Health, District and Borough Councils, VCFSE partners, acute, primary and community care services and the health and care workforce, including social prescribers, to develop locally designed programmes.
		• Align the current healthy behaviours pathways in West Suffolk, to the new delivery model.
			Improve health outcomes for the people of West Suffolk preventing ill health and need to access health services where possible.

Dental Health	1. **Improve access to dental services** for the people of West Suffolk. 2. **Reduce health inequalities and locality variation** in access to services. 3. **Increase awareness of the importance of good dental health** in relation to wider physical and mental health needs. 4. **Improve healthy behaviours in relation to dentistry.**	• To have a better understanding of the commissioning arrangements for dentistry after the transfer of Dental services to ICBs as part of Pharmaceutical, Ophthalmic, Dental (POD) services. • To better understand the challenges and issues facing dentistry, including a lack of access, a lack of access routes for specialist dentistry and a lack of prevention and health promotion. • To understand how the West Suffolk Alliance can be involved in opportunities to transform and integrate dental services into our local system • To provide support, as part of a joined up approach with the other Live Well domains and domain enablers, to promote good dental health and reduce dental caries	*Improve the dental health of the people of West Suffolk.*

Age Well

WEST SUFFOLK ALLIANCE
about people & places

Age Well: Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives In West Suffolk

Domain workstream	Focus Areas	Key Deliverables	Intended Impact
Strengthen the model of care at Locality level to ensure the delivery of reablement and responsive care at INT level is optimised	1. We will review and re-baseline the **Maturity Matrix for each INT** to identify the development priorities aligned to support delivery of the Model of Care 2. We will have a **clear understanding of the capacity and demand for** agreed services within each INT including community nursing, community therapy and domiciliary care. 3. We **will implement a 7 day locality offer of home and reablement** first at all 6 localities with 24/7 wrap around support	• **INT development plan in place to address opportunities for further maturity to deliver the enhanced model of care ahead of winter 2023** • **Demand and Capacity review completed and plan in place to inform operational alignment and future planning** • **Enhanced Home first business case approved using National Discharge Funding and outcomes through BCF plan agreed** • **Virtual Ward business case approved and alignment of key pathways to Model of Care in place** • **Pathways for frailty, EOL and UCR refreshed to improve resilience of Model of Care to support more people at home**	**Increase in number of people supported in their crisis at home (10% above 22/23 baseline)** Reduction in waiting times for therapy by x% Increase in number of pathway 1 discharges by x% against 21/22 baseline **Quantify demand** and capacity across INTs to inform strategic, financial and workforce planning Improved **reablement** outcomes for people, improved flow and reduced demand across the system,

Stay Well

WEST SUFFOLK ALLIANCE
about people & places

Stay Well: Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives in West Suffolk

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
Demand management	**Understand the demand profile across our UEC** system and respond accordingly to profile, working collaboratively	• Establish data required for the UEC demand profiling.	Better understanding of demand profile for UEC
Urgent Community Response.	**(UCR) model embedded within the responsive service** of the INTs in collaboration with the Age Well domain priorities	• **UCR enhanced to include wider offer of support to deliver growth in admission avoidance activity including accepting more activity from Community Hub** • **Wrap around model of UCR in place to support localities to keep more people at home through their crisis**	Consistently meet or exceed **70%**-two hour urgent community response standard. **10% growth UCR activity**
Discharge and flow	**Focus on improving discharge processes and community response to improve flow and reablement outcomes**	• **Map, using the 100 day challenge approach, the current discharge pathway against the high impact areas to identify opportunities for improvement.** • Re-launch Criteria Led Discharge (acute & Community beds) • Specialist Virtual Ward Pathways to assist with early discharge. • Review of data for delays in discharge for patients no longer with a Criteria to Reside and introduce regular audits of this data. • Capacity & demand review of specialist community services to optimise responsiveness to referrals to ensure timely transfer of care.	Reduction in general and acute bed occupancy to 92% or below. Planned discharge across 7 days of the week.
Direct access	**Reduce unnecessary GP appointments and improve patient experience** by streamlining direct access and setting up local pathways for direct referrals. Phase 1 focus is to design a direct access pathway for breast lumps for women over 50	• Work with primary and secondary care to explore direct access pathway opportunities for breast lumps for >50 years • Develop plan to increase GP direct access to diagnostics where feasible • List of potential additional direct access pathways	Direct access pathway for breast lump for >50 developed and implemented
Diabetes	**Design an integrated diabetes service** in West Suffolk	• Gather information on current service provision • Identify national best practice models • Identify opportunities for non NHS system partners to play a part in supporting people with Diabetes • Set up workshops to scope the design of an integrated diabetes service	Improved percentage of patients with diabetes control achieved (aligned to targets set by NICE)

Die Well

WEST SUFFOLK ALLIANCE
about people & places

Die Well: Giving individuals nearing end of life choice around their care

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
Seamless and coordinated end of life and bereavement care and support for people and their families 24/7 through a collaborative, cohesive appropriately trained workforce.	1. **Develop an End of Life Model of Care** that focuses on providing compassionate, well communicated care for those end of Life or bereaved. 2. **Support staff to have difficult conversations**, supporting advance care planning and death literacy 3. **Training and support rollout** - difficult conversations, What Matters to you? Personalised Care and Support Plan, etc 4. **Rollout of RESPECT** 5. **Source a solution for identifying people in their last year of life** 6. **Identify a solution for an accessible person owned record of their wishes**, which includes their preferred place of death and preferred choices. 7. **Plan the campaign** with earlier availability of information to support die well conversations	• Model of care agreed and supported at the Die Well Domain group • Specialist end of life telephone and face to face support available 24/7 • Integrated and collaborative training and support package for staff • RESPECT rolled out • Accessible dashboard of those within the last year of life • Digital solution identified for offering two-way care planning communication between person end of life and support network • Die well information campaign planned	Progress achieved towards 70% of individuals supported to remain at home or in a community setting (as the patient wishes) by March 2024

4. Key Enablers

Workforce

WEST SUFFOLK ALLIANCE
about people & places

VISION: To support organisations to build workforces that enable them to effectively serve populations

Key Info: Our partners are Suffolk County Council, Public Health and Communities; District and Borough Councils; acute, community and mental health trusts; Primary Care, West Suffolk Alliance

Workstream	Domain Actions	Milestones	Intended impact
Implement an Education and Training Digital Passport	**Supply** • Work with stakeholders to create a shared Alliance training programme available to the workforce regardless of organisation **Upskilling** • Produce a joint induction package that can be utilised by Alliance stakeholders to onboard the workforce • Work with alliance partners to produce a set of common principles for training and education • Work with stakeholders to develop a career conversations framework **New roles** • Proactively collaborate with the Education Sector within the Alliance footprint to develop content of existing courses and establish new courses to meet the qualification needs of the workforce	**Supply** • Current training offers mapped using themes of mandatory, CPD etc. **Upskilling** • Gather information on provider' inductions so as to identify essential requirements, commonalities and best practice • As above • Career Framework for Alliance produced **New roles** Share workforce data and liaise with education institutions to tailor courses to meet workforce need	Knowledge, skills and expertise utilised from within the West Suffolk System Visible career pathway across the system Joined up workforce planning
Improve Equity to International Recruitment Opportunities for Alliance Stakeholders	**Supply** Support stakeholders to make the process of international recruitment less challenging and more co-ordinated such as pastural care and coaching **Upskilling** Produce a joint induction package that can be utilised by Alliance stakeholders to onboard the workforce **New roles** Implement a joint, cross sector leader's network and forum	**Supply** • Subject matter expert forums implemented, with representatives from across the Alliance, to identify current challenges **Upskilling** Gather information on provider' inductions so as to identify essential requirements, commonalities and best practice **New roles** • Work with communications team to produce guidance document outlining aims of a leaders network • Send open invitation to leaders across the Alliance to join network and forums	Joined-up workforce planning Increased supply and improved capacity

Digital & Data

WEST SUFFOLK ALLIANCE
about people & places

Vision - A shared planned approach for the use of digital, data and innovation at place, across the system.

Key Info – PHM to be the driver for data provision and consideration for innovation and digital technologies and inclusion to be a default consideration for all new and redesigned services.

Workstream	Domain Actions	Milestones	Impact
Promotion and Adoption	Design an approach that promotes and facilitates the adoption and usage of use cases, dashboards, digital technologies and innovation with all partner organisations.	• Create an agile environment/deployment process which allows data, digital technology and innovation to respond quickly to a localised /specific need. • Promote digital technologies, data tools and innovation as the way forward for service re(design), decision making and targeted approaches. • Understand all data, digital and innovation options, identifying any gaps that there may be in order to improve provision.	• A faster reaction in response to NHS England funding/alternative funding provision and changes. • A significant reduction in deployment delays. • Committed investment into cultural change/behaviour change(including Human Resources documentation and shared partnership agreements and priorities.) • Committed investment to a "pool resource" to be used for technology solutions/innovation/artificial intelligence. • A proven model of delivery which can be used to scale up delivery at pace as desired. • Increased adoption of community based, preventive care. • Maximised use of existing digital technologies, data platforms and innovation through appropriate promotion, training and co-design of new tools. • Work with partnership organisations and Human Resource teams to make digital, data and innovation everyone's priority as part of job descriptions and mandatory training. • An embedded process to ensure people/communities are involved in the co-design of innovation and digital and data services, with innovation, digital and data becoming the norm for service (re) design tools from point of bid to implementation. • A full gap analysis of missing technologies and data provision with an action plan to reduce this gap through sourcing new innovations, technologies, datasets, dashboards etc in response to community/clinical demands.
Evaluation Model	An agreed evaluation model for comparing different dashboards/ technology offerings to assist the GIRFT (getting it right first time) principle	• To be clear on our return on investment and the impact our interventions have had at place • Develop a common evaluation approach to measure quality and impact of the actions agreed in the ADP • Lessons learned and full evaluations to become the norm in all new projects and programmes in order to fully understand the needs and implications of digital technologies and data provision.	• Identified cost analysis, improved statistics and an overall healthier and happier population as a result of service improvements and redesigns that have been implemented. • Increase number of lived experiences and case studies at the forefront of all our work. • An increased number of innovation, new technology and digital alternatives to face to face consultations, leading to more efficient and appropriate use of clinical staff time. • An increased number of pilot projects and programmes turning into business as usual due to successful evaluations promoting the benefits of larger scale rollout. • A reduction in technologies and use case offerings where the appropriateness and needs of the services have not been considered first.

Premises

WEST SUFFOLK ALLIANCE
about people & places

VISION: Create and manage one public estate that is driven by service needs, run and planned as one system

Key Info: Our partners are Suffolk County Council, Public Health and Communities; District and Borough Councils; acute, community and mental health trusts; Primary Care, West Suffolk Alliance

Workstream	Domain Actions	Milestones	Intended Impact
Optimise use of existing estate & enable co-location of linked services where possible and appropriate	• **Identify service and clinical requirements** within each locality to support estate development and optimisation plans – Live Well domains • **Be clear on all assets available** in each locality and their use including VCSFE & wider opportunities such as high street • **Use Haverhill locality as an exemplar:** Reoccupation of health centre and other sites in Haverhill based on integrated service visions & occupation principles • Pilot single management of shared buildings (e.g. reception, bookings, utilisation) • **Ensure system decision making governance in place for shared spaces**	*Live Well accommodation visions:* Work with each of Live Well Domains to identify service and clinical requirements across all localities October 23 Asset Map including their use – December 23 initial review & then ongoing through appropriate governance Haverhill • Decisions May/June 23 • Occupation & Communication June/July 23 • Review January 24 Review and ensure in place September 23	• Supports integration vision • Increased capacity reducing need for new estate • Greater value for money

New hospital programme	• Support estates requirements flowing from **Future Systems programme** including:
	  • Outline Business Case produced in line with national timetable when published
	  • As part of this, work with services to define services moving to a community setting
		• Date TBC
		
		• Quantification of intended service transfer and estates requirement date TBC
			• Enables appropriate shift to community setting
			• Address essential standards issues

Planning for population growth	• Be a proactive partner with District and Borough Councils as part of their **local plan development process**, ensuring health provides input on population mitigation measures • Estates domain operational group to engage with each locality to understand service development need to meet with existing and planned population growth and to start development of longer term alliance based strategic mitigation measures. –	• Summer 2023 • ongoing aim to complete all localities during 23. • Early priorities Haverhill and Bury	

Locality

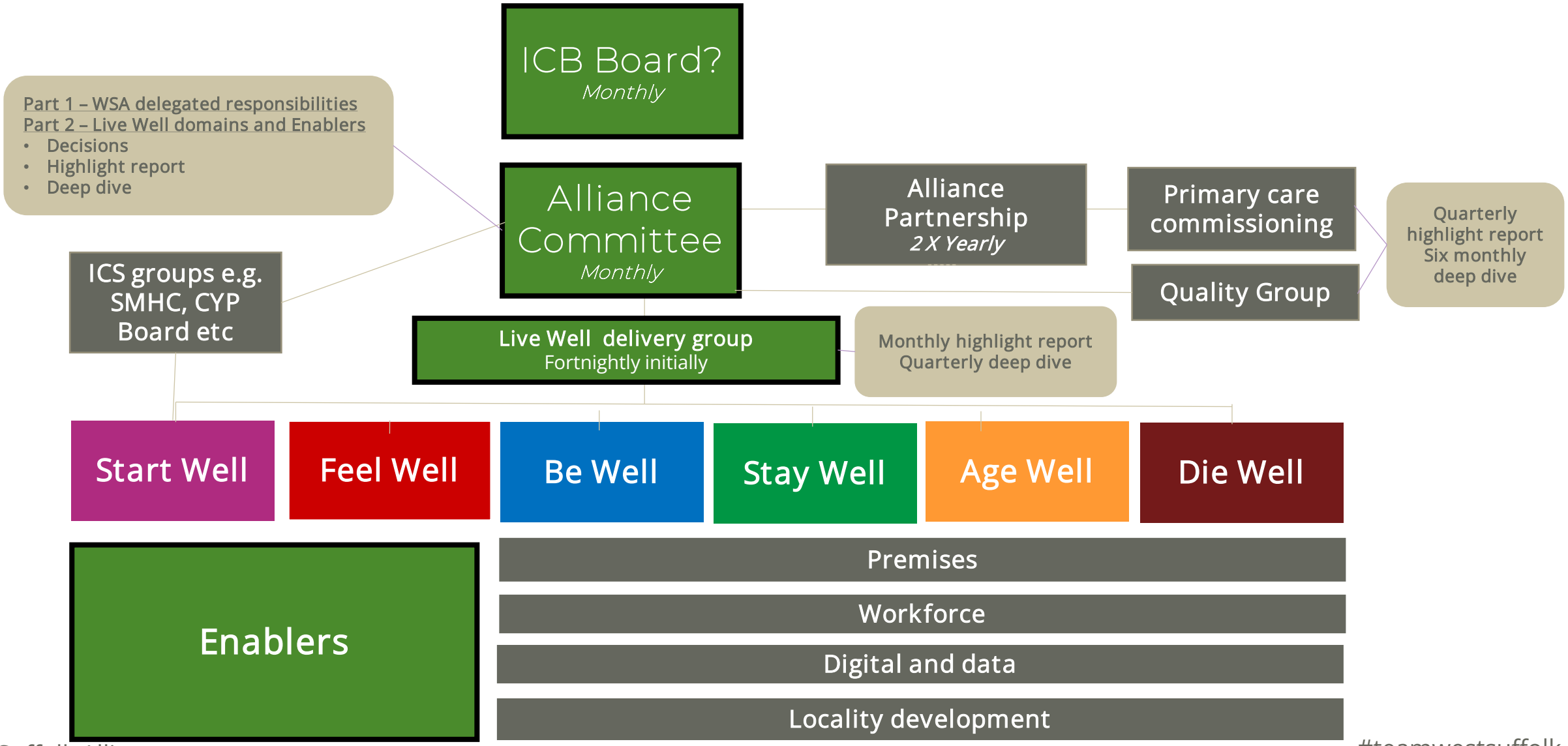
Vision: Strengthen the infrastructure at place to enable local communities and services to strengthen their role in delivering the very best for the local people and for communities to flourish. Provide a vehicle for the Domain priorities to be supported and delivered.

Key Info: *In scope* = Localities and the supporting mechanisms to achieve sustainability. *Out of scope* INT, PCN and service specifics.

Workstream	Domain Actions	Milestones	Impact
Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives	Prioritise Haverhill Locality in the first instance whilst supporting the other Localities to maintain a level of engagement and development	• Support each locality to have a meeting structure in place which brings diverse partner organisations together to consider what good looks like locally, network, share learning, develop & implement local actions and build trust & sustainability • Align local and Alliance governance structures in a simplified way • Support partners to develop a leadership structure, which facilitates locality integrated/coordinated working • Understand funding sources available at a locality level: ➢ Map and develop at Alliance level the funding pots and alignment of governance associated with spending ➢ Develop a proposal for how funding is aligned to a locality level • Collate community discovery work to understand the needs/diversity in the community and look at them from a ABCD approach to develop the locality actions • Support each locality to have a closed loop cycle of engagement and communication • Develop a clear and simple locality strategy, which communicates: ➢ the aspired change behaviours required to facilitate integrated/coordinated working at place level ➢ the engagement/communication plan for localities ➢ A plan for sharing of information/resource regardless of organisational boundaries ➢ A plan for shared place based, person-centred, fit for purpose funding opportunities • Identify the barriers to integrated working at a locality level including alignment or principles of how physical boundaries can work across PCNs and Integrated Neighbourhood Teams • Align actions required with other domains and enablers	• Locality meetings functional within all 6 localities • Governance structures in place, linking localities with the Alliance/ICB • Agreed locality leadership structure in place across partners • Place based shared funding proposal taken to the Alliance Committee and Locality Boards (where in place) • Clear and accessible database in place for aligning intelligence from all localities and providers/community • Closed loop communication stream between people – locality - West Suffolk Alliance in place and functional • Locality strategy signed off by all Alliance Committee partners • Paper identifying the barriers to locality working submitted to the Livewell delivery group

6. Implementation

Governance & Reporting



Appendix

Joint Forward plan target indicators

We will assess our performance in delivering our commitments over the next five years by measuring performance against one or more target indicators in each domain. These are the lead key performance indicators that we wish to 'target' improvements in, with a particular focus on reductions in health inequalities. Delivery against the target indicators will be achieved through a broad programme of work detailed in full in the JFP and supporting annexes.

Start well:

- Reduce the neonatal mortality rate by end of 2023/24 and reduce each year thereafter, addressing inequalities by prioritising reduction in unwanted variation in neonatal mortality
- By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS) or 18 weeks for Neurodevelopmental Diagnostic (NDD) Services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas
- Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas

Stay well:

Access to care

- Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices
- No one waits more than one year for elective care by March 2025
- Increase by 10% each year the number of cases seen by the urgent community response service;
- By 2028, 95% of patients attending A&E services wait no longer than 4 hours
- Reduce the number of acute hospital bed days utilised by people without a criterion to reside that are discharged on complex pathways (1-3)

Early intervention, prioritising early diagnosis and treatment for people living in the 20% most deprived areas

- Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028
- 80% of people with high blood pressure are identified and treated by 2028
- More than 85% of people with Atrial Fibrillation are identified and 90% of those at high risk of stroke are treated by 2028

Joint Forward plan target indicators (2)

Feel well:

- Achieve a 5% year-on-year increase in the number of adults supported by community mental health services
- Achieve a year-on-year reduction in hospital admission rate for mental health conditions
- Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028

Be well:

- Halt recent increases in the number of overweight and obese children in reception and year 6 by 2028 and maintain prevalence below the national average
- Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030
- Increase each year the number of units of NHS dental activity delivered

Age well:

- Reduce each year the rate of emergency hospital admissions due to falls amongst the population aged over 65
- Reduce each year emergency acute hospital bed use (bed days per capita) for those over 65 years old
- Achieve the national 66.7% dementia diagnosis rate by October 2024 and an increase in dementia annual care plan reviews completed each year

Die well:

- Increase each year the percentage of people identified as approaching the end of life

Health Inequalities (cross cutting):

- By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups

Links to referenced documents

- Integrated Care Partnership – Integrated Care Strategy 23-28
- Integrated Care Board – Joint Forward Plan 23-28
- ICB - Governance Handbook