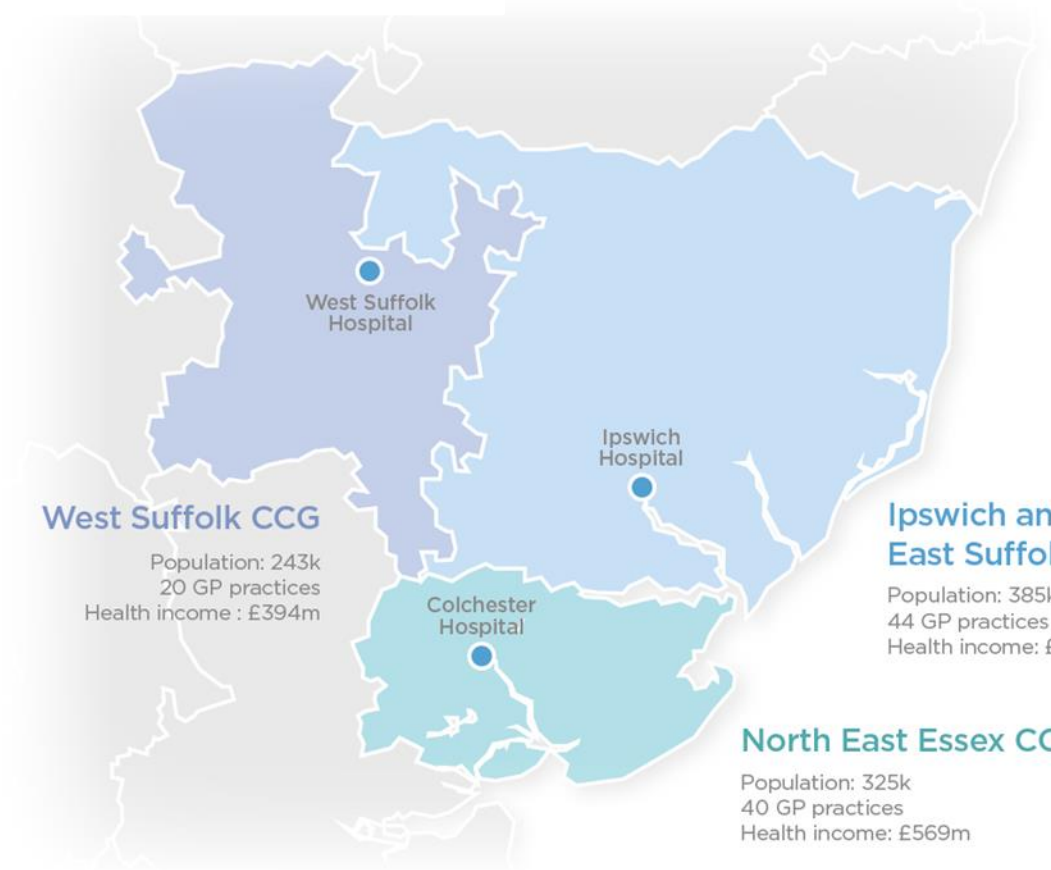
Suffolk and North East Essex
Sustainability and Transformation Plan

Our Health and Care System



- 953,000 population
- 2 County Councils
- 7 District and Borough Councils
- 3 Clinical Commissioning Groups (CCGs)
- 104 GP practices
- 2 GP Federations
- 3 Acute trusts
- 2 main Mental Health providers
- 2 main Community Health providers
- 8 Community Hospitals
- 1 Ambulance Trust
- 2 local Healthwatch
- 2 local Medical Committees
- 177 Dental practices
- 184 Pharmacies
- 193 Optometrists
- Significant contribution from the voluntary sector & hospices

£2.3bn System health and care income 2016/17

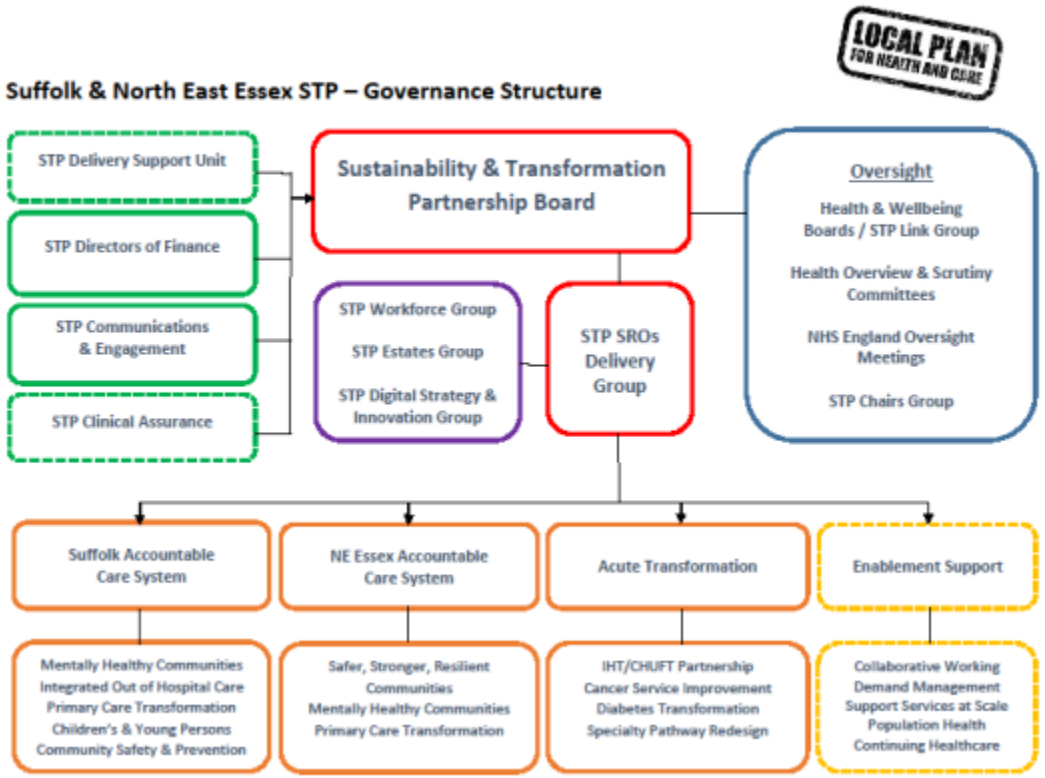
£2.4bn Health and care expenditure 2016/17

£84.8m System health deficit 2016/17

Income based on 2015/16 place based allocations

Our Vision: people across Suffolk and North East Essex live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing

Our Governance



Suffolk and North East Essex STP

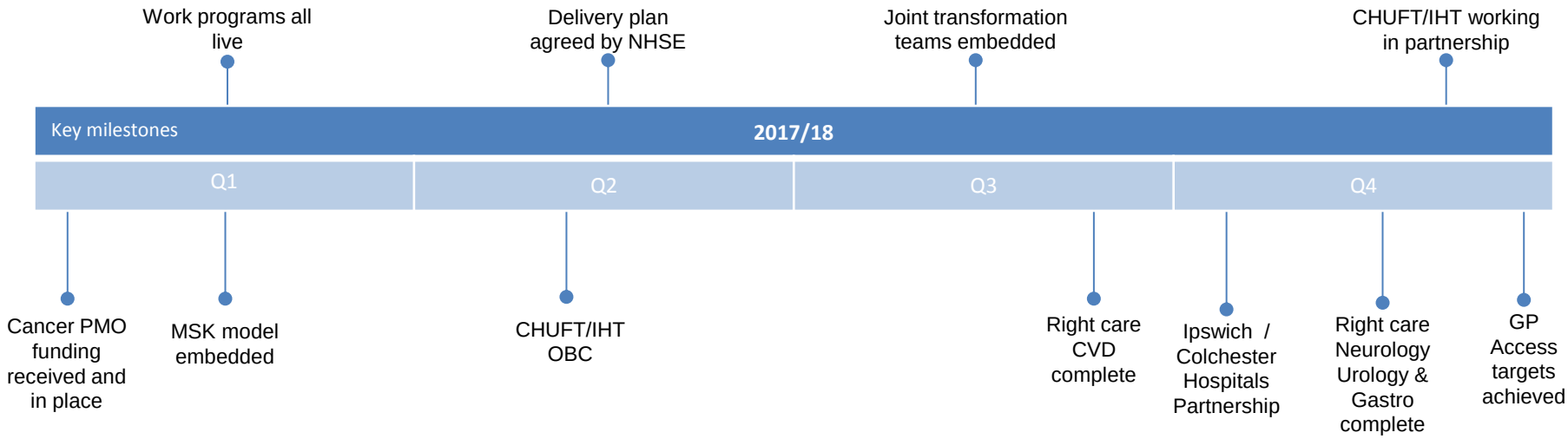
Our Key Programmes

Objectives

- Re-shaping acute care to respond to resilient community work stream outputs
- Aligning clinical systems and processes across all three sites where possible / appropriate
- Reducing variation across the acute sites

Success so far …

- £1m successful bid for diabetes
- £2.4m successful bid for GP streaming
- New CHUFT leadership team
- Improved A&E performance by all
- New models of care live (e.g. MSK)



Acute Hospital Reconfiguration

FBC by January 2018

- Delivery of CHUFT and IHT partnership
- 6 Networked specialities: stroke, cardiology, endoscopy, oncology, orthopaedics, urology

Urgent and Emergency Care

New models by March 2018

- 111 and OOHs SPA
- GP access in A&E
- Hospital at home delivery

Speciality Pathway Transformation

New model live by March 2018

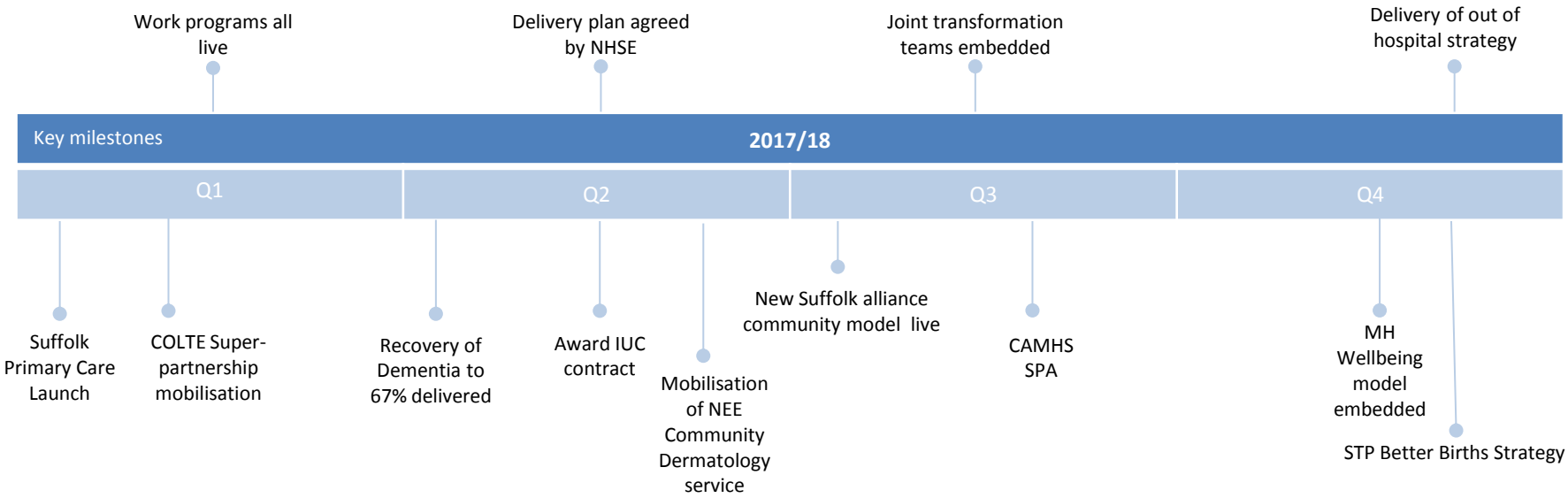
- Right care
- Provider specific pathways

Objectives

- Shaping primary and community care to reduce demand for acute hospital and “bed based” care systems
- Working with partner organisations to improve safety, resilience, and strengthen communities
- Reduce need for follow up by the acute hospital through better management and “safe landing” within primary and community care
- Reduce primary care variation, including for prescribing and referrals

Success so far …

- New community model agreed
- Alliance providers for community services
- Launch of super partnerships
- ‘Green’ GP 5YFV plan
- LD OOA placements ahead of trajectory



Community Alliances

New contracts by October 2017

- Integrated community services
- Care homes
- D2A
- Integrated Urgent Care

Mentally Healthy Communities

New models by March 2018

- Prevention and early intervention
- Recovery
- Crisis
- Learning Disability

Primary Care Transformation

New model live by April 2017

- PC at scale
- Workforce
- Estates
- Reducing variation

Children's & Young People Transformation

New model live by March 2018

- CAMHS SPA
- Acute Paediatrics DM
- Maternity

Vision and 7 Golden Threads of our GP Forward View

Vibrant, sustainable primary care at the heart of high quality, integrated health and care services

1. **New models of care** – enabling primary care collaboration; delivering joined up care in localities
2. **Workload** – reducing workload; optimising patient care
3. **Workforce** – caring for every professional, caring for patients
4. **Access** – enhancing patient access to GP-led services; promoting and supporting patients in self care
5. **Infrastructure** – creating environments for future care needs, enabling digital connectivity for patients and professionals
6. **Investment** – stimulating transformation, delivering High Impact Changes
7. **Leadership, governance and management** – Co-producing strategy and plans with clinical leadership, patients, public and partners; enabling excellence in delivery with management support

Deben Health Group –seven practices –: Saxmundham, Wickham Market, Framlingham, Aldburgh, Framfield House, Little St Johns (both Woodbridge), Alderton working collaboratively to share support functions; develop their clinical and managerial processes together; look at how they can work better together as a group to refer and offer new services (e.g. social prescribing) to patients within their locality.

We are working with alliance partners to integrate care

Discharge to Assess

- Glastonbury Court care home beds open
- Initial findings suggest two thirds of patients discharged home without requiring placement

Admission Prevention Service

- Early Intervention Team – multi-agency team including voluntary sector partners
- Facilitating discharges and admission prevention

Support to get home service

- Joint project between WSFT, Social Care and Community

Trusted Assessor model

- Currently in Glastonbury Court
- To be rolled out across other care homes

New models of community care – 'Buurtzorg'

- Buurtzorg pilot to be rolled out in Haverhill in October 2017
- Led with Social Care and Community services


HAVERHILL news

cambridge-news.co.uk/haverhill

Nursery wins top Ofsted rating

Families hunt for eggs in meadow

Property guide inside

Dutch care at home system to be tested

Treat for little princesses

Questions

STP Delivery Guide setting out the outcomes the local health and care plan will achieve. (Available here: http://www.healthwatchsuffolk.co.uk/neesuffolkstp/)