### GOVERNING BODY

<table>
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<tr>
<th>Agenda Item No.</th>
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<tbody>
<tr>
<td>Reference No.</td>
<td>IESCCG 0-04</td>
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<td>Date.</td>
<td>28 January 2020</td>
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<table>
<thead>
<tr>
<th>Title</th>
<th>Ipswich and East Suffolk Alliance</th>
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<tr>
<td>Lead Director</td>
<td>Maddie Baker-Woods, Chief Operating Officer</td>
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<tr>
<td>Author(s)</td>
<td>Maddie Baker-Woods, Chief Operating Officer</td>
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<tr>
<td>Purpose</td>
<td>To provide an update of the actions that the Ipswich and East Suffolk Alliance has taken, to date, towards the Alliance’s vision and objectives</td>
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#### Applicable CCG Clinical Priorities:

<table>
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<tr>
<th>No.</th>
<th>Priorities</th>
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<tbody>
<tr>
<td>1.</td>
<td>To promote self care</td>
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<td>2.</td>
<td>To ensure high quality local services where possible</td>
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<td>3.</td>
<td>To improve the health of those most in need</td>
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<td>4.</td>
<td>To improve health &amp; educational attainment for children &amp; young people</td>
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<td>5.</td>
<td>To improve access to mental health services</td>
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<td>6.</td>
<td>To improve outcomes for patients with diabetes to above national averages</td>
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<td>7.</td>
<td>To improve care for frail elderly individuals</td>
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<td>8.</td>
<td>To allow patients to die with dignity &amp; compassion &amp; to choose their place of death</td>
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<tr>
<td>9.</td>
<td>To ensure that the CCG operates within agreed budgets</td>
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#### Action required by Governing Body:

To consider and note the progress in delivery of the Ipswich and East Suffolk Alliance Strategy
Ipswich and East Suffolk Alliance
Progress Report
December 2019

Our Alliance in Action
Working Together with You
Introduction

An Alliance – ‘a group of organisations working together with common purpose’

Our Alliance includes: Suffolk County Council; East Suffolk and North Essex Foundation Trust; Norfolk and Suffolk Foundation Trust; Suffolk GP Federation; and Ipswich and East Suffolk CCG working with our District and Borough Councils, community and voluntary sector partners. Our mission is ‘to work seamlessly together with you’.

Our plans have been built on discussions with the public and staff, together with partnership working between our organisations over many years. We have drawn on local evidence of need, understanding of national policy and the ambition of our wider Integrated Care System Partnership. Together we are bound by a vision of Ipswich and East Suffolk as a ‘place of strong communities in which everyone is able to stay well, take control over their mental and physical well-being and, when support is needed, receive joined up health and care’

Together we serve over 400,000 people.

This, our first Progress Report, aims to demonstrate the action we have taken together – as an Alliance – to progress towards our vision and objectives. It includes descriptions of how we have worked, case studies of the benefits we have achieved with and for individuals, and headlines of our progress overall in numbers. It concludes with our proposed Next Steps.
# Contents

This report includes:

<table>
<thead>
<tr>
<th>Section</th>
<th>Page no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Plan on Page</td>
<td>4</td>
</tr>
<tr>
<td>Our Area, Our Profile, Challenges, Assets and Opportunities</td>
<td>5</td>
</tr>
<tr>
<td>What people told us our priorities should be</td>
<td>10</td>
</tr>
<tr>
<td>Our Shared Values</td>
<td>11</td>
</tr>
<tr>
<td>Our Objectives</td>
<td>12</td>
</tr>
<tr>
<td>A Report on Progress against our Commitments to Action:</td>
<td></td>
</tr>
<tr>
<td>(1) Service Transformation Actions</td>
<td>13</td>
</tr>
<tr>
<td>(2) Connecting Actions</td>
<td>36</td>
</tr>
<tr>
<td>(3) Enabling Actions</td>
<td>57</td>
</tr>
<tr>
<td>How are we doing in numbers?</td>
<td>66</td>
</tr>
<tr>
<td>Where Next?</td>
<td>71</td>
</tr>
</tbody>
</table>

Tide Mill at Woodbridge
**Our Vision:** Ipswich and East Suffolk is a place of strong communities in which everyone is able to stay well, take control of their mental and physical health and wellbeing and, when support is needed, receive integrated health and care services.

**Our Mission:** To work seamlessly together with you.

<table>
<thead>
<tr>
<th>Ambitions and Objectives</th>
<th>Programmes of Work</th>
<th>Enabling Actions</th>
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<tbody>
<tr>
<td><strong>ICS Higher Ambitions</strong></td>
<td><strong>Alliance Objectives</strong></td>
<td><strong>Connecting Actions</strong></td>
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<tr>
<td>• Reducing the health gap</td>
<td>• To help people to prevent ill health and manage their own care</td>
<td>• Enabling you to stay well</td>
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<td>• Zero suicides</td>
<td>• To deliver planned, responsive, joined up health and care services</td>
<td>• Joining up in communities</td>
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<td>• Preventing and treating obesity</td>
<td>• To deliver innovative solutions supported by technological and digital infrastructure</td>
<td>• Creating One Team</td>
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<td>• Improved end of life care</td>
<td>• To provide services as close to people’s homes, as possible</td>
<td>• Changing how we invest</td>
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<td>• Ageing and living well alone</td>
<td>• To create One Team to facilitate the best holistic care and to retain and attract the best talent</td>
<td>• Reducing inequalities</td>
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<tr>
<td>• No patient diagnosed with cancer through an unplanned admission</td>
<td>• To reduce duplication and waste</td>
<td>• Planning long-term</td>
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**Transforming Services**
- Joined up care
- Planned care
- Mental health and Learning Disabilities
- Cancer
- Children and Young People
- Primary care
- Maternity
- End of Life

**Connecting Actions**
- Enabling you to stay well
- Joining up in communities
- Creating One Team
- Changing how we invest
- Reducing inequalities
- Planning long-term

**Enabling Actions**
- Alliance development
- Workforce
- Digital
- Estates
- Communication and engagement

**Our Values:** Collaboration - Co-ordination - Creativity - Community-focus - Creating One Team - Cost-effectiveness

**Our Members:** East Suffolk and North Essex NHS Foundation Trust; Suffolk County Council; Norfolk and Suffolk NHS Foundation Trust; Suffolk GP Federation, working with Ipswich and East Suffolk CCG, our wider district and borough councils, voluntary and community partners
Our Area

Our area is one of fast-paced change in our busy port alongside major new home building, infrastructure programmes and changing make-up of some communities in Ipswich as well as gradual change in our villages and rural communities. Our area includes:

- Ipswich, the County and University Town of Suffolk
- Felixstowe, Britain’s largest container port next to Martlesham, a global centre for British Telecom
- Stowmarket, home of the Museum of East Anglian Daily Life
- Woodbridge and Wattisham Garrisons
- Aldeburgh, Leiston and our coastal communities
- Framlingham and Saxmundham
- Eye, Mendlesham and rural mid-Suffolk
Our Alliance is one of three within our wider **Suffolk and North East Essex Integrated Care System**, which provides strong leadership and support for the delivery of local plans. Our Alliance includes **eight localities** in which we are working to join up health and care with wider voluntary and community partners to deliver our vision of strong communities.
Our Health and Wellbeing Profile

By 2039, **1 in 3** Suffolk residents will be aged 65 and that will mean the ratio of people of working age and over 65 will be **1:1**

**55.7%** of our population has a Long Term Condition (**53.5%** in England)

**18.5%** of people have a caring responsibility. This is not just parents

**32%** of people are in semi-skilled or unskilled occupations in our area as compared with **25%** in England

**24.3%** of people have no qualifications compared to **22.5%** in England

The 3 biggest causes of death for people less than 75 are:

- Cancer (**206.4 per 1000, 74.6 preventable**)
- Cardiovascular (**102.2 per 1000, 40 preventable**)
- Respiratory (**25.9 per 1000, 10.9 preventable**)

Ipswich has 12 areas in the top **10%** most deprived areas of England

**21.6%** of homes are social rented in Ipswich as compared with **17.5%** in the rest of England

**22%** of children in Ipswich live in poverty
We have identified four major challenges:

The care and quality gap - Demand for health and care services is growing. In the next 20 years, 1 in 3 people in our area will be aged over 65 and the ratio of non-working to working aged people will be 1:1. The number of individuals with Special Educational Needs and Disabilities is also rising.

The health and well-being gap - There are inequalities. The 2019 Index of Multiple Deprivation, published since our initial strategy, shows that our area ranks 124 out of 191 in England, where 1 is the most deprived area. Our deprivation score was 17.4 in 2015 compared to 17.7 in 2019. 5% of small areas are in the 10% most deprived nationally – this is the same as in 2015. The most deprived area is Priory Health; the least deprived is Martlesham. The drivers remain, as before: living environment; education, skills and training; and barriers to accessing housing and other services. There is inequality in access, experience, and outcomes.

The finance gap - Our finances are stretched. Over the last eighteen months, we have learnt a great deal more about each organisation’s position through open-book accounting and a spirit of collaboration. Whilst our position remains exceptionally challenging, this understanding has helped us to manage our position.

The workforce gap - Our workforce is shrinking. In the next five years many members of our current workforce may reach or be over the retirement age and recruitment may be unable to match demand. Our plans and delivery to close this gap have progressed significantly within individual professional groups and in creating “One Team – Ipswich and East Suffolk” but workforce remains a top priority for us.
These challenges are not insurmountable. Ipswich and East Suffolk has many assets and opportunities, which we have been building on:

1. The **quality of our health and care services is generally good**, in many areas outstanding, and there is a clear plan for services which need improvement.

2. Our towns and villages have many **vibrant community and voluntary sector** organisations who work actively with us and our local authority partners.

3. We have **excellent clinical and professional leaders** in all of our organisations who are increasingly working together collaboratively.

4. We have a **strong track record in working, in partnership**, across organisations and most importantly with local people to make services better whilst managing costs and cutting waste.
What people tell us our priorities should be

Over many years our organisations have listened to the public’s views and ideas about health, care and community services. This includes a year-long exercise in developing the Suffolk Health and Care Review.

There are five key themes:

1. **Self-care** - support to take personal responsibility for health and wellbeing.
2. **Access to services and information** - through signposting and simple language.
3. **Prevention and Re-ablement** - ways to stay healthy and stay in control.
4. **Integration** - joined up care so people only have to tell their story once and have a single, personal plan
5. **Stop waste** - Focus scarce resources on areas of care that make most difference to patients.
Our Shared Values

The way we work together and with you, matters to us hugely.

Together we have evolved six shared values - the six ‘Cs’:

1. Collaboration – working in partnership
2. Co-ordination
3. Creativity; innovation
4. Community-focus
5. Creating One Team - Combined Clinical and Care Leadership
6. Cost effectiveness

Since we agreed our strategy, there have been challenging issues, familiar to every area to test how we live our values including:

- System financial pressures; the need for end of year agreements, prioritisation of transformation funds and negotiation of new contracts and variations;
- An 8% - 10% growth in demand for most partners’ services compared to previous years;
- Implementation of new services;
- Quality challenges in individual organisations or services; and
- New national policies to implement at pace.

Our firm foundation of collaboration and wider value set have enabled us to work together to respond to these and other issues as they have arisen.
## Our Objectives

<table>
<thead>
<tr>
<th>Number</th>
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<td>7</td>
<td>To move resources from acute to community and home settings.</td>
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<td>8</td>
<td>To develop a vibrant, sustainable Alliance between providers and with commissioners.</td>
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Working together with you
Service Transformation Actions

We have three major Commitments to Action to deliver our objectives.

1. **Service Transformation Actions**: joined up care, close to home; planned care; mental health and learning disabilities; cancer; maternity; children’s and young people’s services; primary care; and end of life care.

2. **Connecting Actions**, which involve every Alliance partner and are needed to deliver every transformation programme:
   
   i. Enabling you to stay well - prevention; self-care; re-enablement.
   ii. Joining up in our communities - physical, mental health and well-being.
   iii. Creating ‘One Team’ - joining up clinicians and professionals across our Alliance.
   iv. Changing how we invest our resources - eradicating waste; balancing our system books; shifting investment to prevention.
   v. Reducing inequalities - in outcomes and experience.
   vi. Planning for the long term - the next 20 years.

3. **Enabling actions**: Organisational development; workforce; digital; estates and communication.
Service Transformation Actions

There are eight main transformation programmes that we are focused on to deliver our target outcomes.

They are:

1. Joined up care
2. Planned care
3. Mental health and learning disabilities
4. Cancer
5. Children’s and young people
6. Primary care
7. Maternity
8. End of life care

Each of these transformation programmes engages at least two Alliance partners and associates. Some of the programmes are Suffolk-wide such as mental health. Some are ICS-wide e.g. cancer but delivered locally.

“We are making excellent progress in joining up care – in and out of hospital – to meet individuals physical and emotional needs. We must now build on these firm foundations and take the next bolds steps together to deliver our vision.”

Neill Moloney, Managing Director, East Suffolk and North Essex NHS Foundation Trust
Our Ambition
Everyone receives the right level of joined-up care for their needs, avoiding the inappropriate use of urgent and emergency care.

Our Plan
Our Joined-up or Integrated Care programme has well-established Alliance-wide governance and delivery plans. Our focus is:
• Helping people to avoid unnecessary admissions
• Avoiding falls and fractures
• Care home quality and management
• High Intensity User support
• Trusted assessment between professionals
• Responsive home care
• Family carer support

Our Progress
Excellent examples of progress include:

Admissions avoidance: The REACT team (Reactive Emergency Assessment Community Team) combines consultant geriatrician, nurse, therapist and social care colleagues. It goes from strength to strength; now reducing emergency admissions by up to 20 per day. In late 2019, REACT was further boosted when the Dementia Intensive Support Team (DIST) joined to deliver a seven-day service.
Care Homes
A multi-disciplinary team across our Alliance is working to ensure the very best possible care for people in residential and nursing homes. The virtual team including social care colleagues, GPs, geriatricians, dieticians, nurses and pharmacists are working with local homes to ensure continuous improvement in delivery of care including nutrition, wound management as well as access to GP and hospital care, when needed. This year a team of pharmacists and technicians has been part of a national Medicines Optimisation in Care Homes (or MOCH) programme; they review medicines and appliances and make changes, where necessary to reduce the risk of harm and ensure residents have optimal care.

**MOCH Pharmacists – So much more than just medicines!**

A 92 year old woman who had recurrent falls had a review with the one of the MOCH pharmacists. Performing observations, he noted she was wearing class 3, the highest grade of stockings, which seemed to restrict blood flow to the legs. The woman had always worn them but the Pharmacist suggested that she tried an alternative for just two weeks - she had no falls in that 2 week period!

Falls and Fractures
Following strategy development in 2018, our focus has been on (1) identifying people at risk of a fall; (2) promoting healthy ageing and prevention; and (3) ensuring a timely response in crisis. In Felixstowe, a new frailty clinic is now live with support from local clinicians and patients. By the end of this year, all care homes will also have access to a very special new inflatable cushion to help patients safely up when they fall and a tool or algorithm, known as I Stumble, which helps carers assess patients for injury. In other areas, these two innovations have reduced significantly the time patients lie on the floor and unnecessary ambulance call-outs.
High Intensity Users
In June 2019 an Alliance group of 111, Out of Hours GPs, the Ambulance Service, A&E and NSFT colleagues formed a High Intensity User Group with the aim to support individuals with a very high number of attendances at all services for non-medical reasons. The reasons why people may very frequently use urgent services include addiction, drugs or alcohol, homelessness, loneliness or the inability to cope with a long term condition. Our model builds on national best practice and is enabled by a co-ordinator who identifies patients, supports planning, finds a lead individual and partner for each person and monitors their progress. The service is person-focused and non-judgemental, avoiding any stigmatisation. The Team works together to understand underlying causes and holistic solutions.

Turning Round Together
A gentleman in his late 50s was a family man and had a successful career. A series of personal events left him alone and spending all of his money on alcohol and drugs. He drank daily and failed to attend planned appointments or take his medication. He regularly phoned and contacted 111 and attended A&E, often via ambulance and mainly out of hours, when he was in crisis. He had involvement with the Police and was at risk of losing his home.

The HIU group found that the gentleman was pleasant and affable and wanted to make changes to his life when he engaged with support services. They identified a lead from the hospital who worked with him to meet his health and care needs with joined-up services. He also has the offer of regular one to ones with his GP.

Urological issues were expedited for the gentleman to improve his quality of life and enable him to plan trips out on his mobility scooter. Adaptations were made to his home, which was also refurbished. Social care provided daily care. He was given Blister packs for prompts to encourage medication compliance. This has resulted in the gentleman becoming stable. He is still drinking but a lesser amount and his contact with urgent care has reduced dramatically. Ongoing support of community services will aid his recovery by providing continuity of care.
Planned Care

Our Ambition
A seamless journey of ‘right first time’ planned care from a diagnostic to opinion and advice and to treatment or procedure, where needed including the very best support in self care and management.

Our Plan
Our focus is on key specialities: (1) Cardiology, (2) Muskuloskeletal including Pain and Rheumatology (3) Ophthalmology (4) Gastroenterology (5) Stroke; (6) Diabetes.

Our Progress
For each speciality we have progressed three sets of action:

- Using integrated information – ESNEFT and CCG colleagues have been working very closely together to understand current challenges and discuss new models for local integration between acute, community and primary care services
- Using medical technologies that change clinical pathways and speed up care – transforming diagnosis and treatment
- Investing in staff - this year, a particular focus has been on developing new relationships and alignment between GPs and consultant colleagues at Ipswich and Colchester hospital sites

“Delivering excellence in planned care for patients depends on partnership – the essence of our Alliance; Partnerships between primary and secondary care clinicians and between patients and clinicians. Integrated information and technology support these relationships to ensure we are making the best possible decisions and delivering timely, compassionate care.”

Crawford Jamieson, Medical Director, East Suffolk & North Essex NHS Foundation Trust
**Confident COPD Patients**

A patient experienced a severe chest infection, which following a visit to her GP, resulted in her being given a diagnosis of borderline Chronic Obstructive Pulmonary Disease (COPD). On Christmas Day she became very unwell with a severe cough and difficulty breathing that meant she had to use a rescue pack, which she had been given. A visit to the doctor resulted in her use of a nebuliser after which she returned home and was off work for four weeks.

Having visited a COPD nurse, the patient was invited to attend a pulmonary rehabilitation course, led by ESNEFT, which introduced her to the ‘My COPD’ App that she now uses on a daily basis to gain knowledge and to monitor her progress. She finds the App extremely useful and has needed far less visits to her GP. The consultant is able to access the information that the patient collects; in due course, the plan is that her GP will be able to see this too.
Our Ambition is shared with Family 2020 for Suffolk

All children and families in Suffolk have the right to: be safe; have the best education; physical and emotional health; successful preparation for adulthood and employment.

Our Plan

With leadership from Suffolk County Council, Alliance partners have worked in partnership with children, young people and their families to develop three pillars of a plan:

- Understanding and anticipating families’ needs - including a single assessment.
- Reaching out and responding - early help focused on individuals.
- Joining up - a single point of access.

We have seven priorities for action to achieve this: (1) Emotional health and well-being; (2) Special Educational Needs and Learning Difficulties; (3) Speech, Language and Communication; (4) Neurodevelopmental pathways; (5) Community services; (6) Urgent need and (7) Childhood obesity

“We’re making really good progress in building trusting relationships between parents, carers and professionals in health, care and education who are dedicated to keeping our children safe, healthy, happy and well-prepared for adulthood. We now need to sustain this energy and secure the resources we need to tackle unjust inequalities, which some of our children face and give every child the best start in life”

Allan Cadzow, Service Director for Children & Young People’s Services, Suffolk County Council
Children and Young People

Our Progress

1. **Emotional Health and Wellbeing.** Our strategy and progress to improve adults’ and children's’ emotional health and wellbeing is described in the mental health section of this report. Developed by Suffolk-wide Alliance partners, one very specific programme to support our youngest children, their mums and families is a specialist perinatal mental health service delivered by NSFT. This offers direct support and interventions for women with severe and moderate perinatal mental health presentations including pre-conception advice, through birth to when the baby is a year old. A charity “Get Me Out of the Four Walls” has been commissioned to deliver a peer support network for new parents experiencing isolation.

**Case study**

The Perinatal Mental Health team continues to work with mum and baby and will do for a year. “The support and care she still receives from them has been great and has enabled her to thrive as a mother.” Service users mother, 2018

2. **Support for People with Special Educational Needs and Disabilities.** Alliance partners across Suffolk including Suffolk County Council, NSFT and the CCGs are working with Suffolk Parent Carer Network and wider partners to make important significant improvements to our education and health offer to children and young people with special educational needs and disabilities. Over the last 12-months, joint action has resulted in reductions in waiting times for some services. New pathways will now enable speech and language therapist and specialist teachers to offer better and more timely advice and support to meet each individual’s needs. Business case being developed for neurodevelopmental pathway which will focus on need rather than diagnosis and will offer early intervention and access to support. The County Inclusion and Support Service and then Special Educational Needs Co-ordinator network have also been strengthened. Progress has been made in reducing the number of outstanding Education, Health and Care plans; now the priority is ensuring that new needs are met within 20-weeks and that plans are of the highest quality. Progress is being made and all Alliance partners are committed to ensuring that pace is sustained or increased, as necessary and that our focus is beyond plans and pathways to sustained, real difference to individuals’ and families lives.
3. **Accessible and timely speech and language therapy** has the potential to change the lives of many very vulnerable children’s physical, social and emotional well-being. Listening to concerns from specialist services, parents and carers led to a new way forward. Over 18 months, a steering group made up of Suffolk Parent Carer Network, alongside the two Suffolk CCGs, Suffolk County Council and providers started to ask key questions about new ways to access services. By engaging with parents and carers, the group began to understand where the issues and opportunities could be. Three parent and carer sessions were held across the county to gain feedback on the model. After collating and testing, the clinical commissioning groups were able to agree more funding to pay for more therapists and training for teachers.
Our Ambition
Our ambition is that mental health and emotional wellbeing is everyone’s business and that by working in partnership we will deliver a new model of care.

Our Plan
Since May 2018 Ipswich and East Alliance has been part of #averydifferentconversation across Suffolk with patients, carers, families and professionals to discuss and shape the future of our mental health and emotional wellbeing. The Mental Health & Emotional Wellbeing Strategy (January 2019) includes the following principles:

• Physical and mental health will be integrated
• Mental health and emotional wellbeing is everyone’s business
• Additional investment will be made in safe, effective and evidence based care
• The workforce within our system, including experts by experience, are our most valuable asset and the key to future success – we will support them
• Co-production is essential at every stage.

“NSFT is very pleased to be actively working with health, care and wider partners of the Ipswich and East Suffolk Alliance, enabling us to join up care in our communities.”

Jonathan Warren, Chief Executive Officer, Norfolk and Suffolk NHS Foundation Trust
Key features of our future service provision will be:

• **Place based commissioning and provision of mental health**, defining new ways of organising ourselves around ‘place’ and ‘locality’.

• **System-wide leadership and culture** - mental health being everyone’s business and engendering a culture of partners across Suffolk working together to integrate mental, physical and social care provision within our localities and Alliances.

• **Early Help** to build individual and community resilience - increased focus and investment in prevention and self-care.

• **A Primary Care and Community Mental Health Service** - a community-based mental health service model wrapped around primary care within localities and integrated as part of our Integrated Neighbourhood Teams. Increased specialist mental health support and expertise will be delivered into primary care and the community to improve timely access and intervention.

• **Crisis System Model** - we will work together to prevent mental health issues escalating, whilst recognising the need for the core mental health services including a 24/7 Crisis Resolution and Home Treatment Team service (CRHTT) with telephone advice, Psychiatric Liaison Services and Early Intervention in Psychosis service.

• **Integrated Children’s Model** (0-25 years) – we are building on the Suffolk Children’s Emotional Health and Wellbeing Plan (Year 3) and Emotional Wellbeing Hub development to evolve a fully integrated children’s model across physical, mental health, education and social care.
Mental Health and Learning Disabilities

Our Progress

In the past 12 months whilst we have been developing our strategy and plans, a number of practical initiatives have been progressed:

- **Primary Care Education** - a number of evening education sessions have taken place covering Dementia, Children’s Emotional Wellbeing, Consultation skills, Personality Disorder and Depression and Anxiety each attended by between 40 and 70 GPs and other community colleagues. There is a huge appetite to learn.

- **Living Life to the Full** - This new digital offer of support is now available to all of our GP Practices offering self-help materials for conditions including depression and anxiety and access, if needed, to the Suffolk Wellbeing Service.

- **Investing in voluntary and community services**, including Dementia Together, Survivors in Transition, Suffolk MIND (Suffolk Waves and Night Owls) supporting Personality Disorder.

- **Improving Access to Psychological Therapies for Long Term Conditions** – This is described with our actions ‘Helping you to stay well’.

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**Development: Mental Health Evening Learning Sessions**

“Very informative….so engaging and so interesting. Have learnt a lot that I will take with me through my work and personal life. Thank you.”

“It was an invaluable learning opportunity”

“Very practical. Amazing input and insights from the Patient Perspective...one of the most inspiring and emotive speakers I have ever heard.”

“Really inspired me to try something different”.

---

ARE YOU...
LIVING LIFE TO THE FULL?

6 WEEKS THAT CAN CHANGE YOUR LIFE
Mental Health and Learning Disabilities

- **Crisis Resolution and Home Treatment Teams.** £2.1m investment is being made to deliver 24/7 mental health crisis services; enabling any resident to access support when they need it including home based assessment and support by March 2021.

- **Early Intervention in Psychosis Services.** A £1m investment has been made in a Suffolk wide team that supports residents who suffer from psychosis.

- **Early Adopter** sites in Ipswich and Saxmundham, Leiston and Framlingham. These sites will lead the way in developing and delivering the changes that the strategy envisages. Suffolk Mind and our co-production partners, Suffolk Family Carers, Suffolk Users Forum and Suffolk Parent Carer Network are working alongside NSFT, local GP practices, Suffolk County Council and ESNEFT colleagues, to engage everyone in the changes we all want. This work is beginning by building an in-depth understanding of need and support (assets) in these communities.

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### Making Some Noise About Mental Health

Supported by Alliance Transformation funding, Noise Solutions is a music based mentoring programme delivered by professional musicians rather than specialist mental health workers. The programme helps young people to gain confidence and improve their self-esteem. In the first five weeks of the two-hourly, ten-week programme, participants are given the opportunity to create music using state-of-the-art software, either at home or in school, with a focus on making them feel good at something quickly. This could be hiphop, rock, grime, drum ‘n’ bass or acoustic singer/songwriter material. The next five weeks are spent in a commercial recording studio to help hone the young person’s sense of competency and achievement and bolster their confidence and sense of worth. Every aspect of the process is captured using audio and visual aids to create a digital story that can then be shared with the people who are important to them. Since being funded, Noise Solutions has helped over 20 young people with highly complex needs struggling to engage with traditional talking therapy approaches.

*Charted in a video, one young man explains how he felt able to apply to attend college after taking part and is now at university. The mother of another participant tells how the programme has given her child joy for the first time in two years.*
Primary Care

Our Ambition
Safe, local, high quality care delivered by local practices working together with partners seamlessly to care for patients effectively and at a sufficient scale that enables an enhanced range of local services.

Our Plan
90% of all healthcare is delivered by GP-led primary care. Locally, as nationally, practices have faced intense challenges in meeting demand as numbers of GPs and Nurses, in particular have decreased. Our Plan is focused on primary care and its role within the wider health and care community; it has five interwoven strands:

1. New models of care including working at scale through collaborations to enable resilience and transformation and in new partnerships with other providers.
2. New consultation types with GP-led multi-disciplinary teams.
4. A set of workflow efficiency measures to release time to care - 10 High Impact Actions.
5. Recruitment, retention and returner programmes for GPs and Nurses, and growth of a wider multi-disciplinary team.

Our Progress
We have been progressing these plans for over three years; in the last 18 months, they have begun to accelerate and mature. All practices in Ipswich and east Suffolk are members of the Suffolk GP Federation, which delivers services, individual practice services and collective services, such as GP+ directly.

Extra Access to Primary Care in a Crisis
A 57 year old man who was working in Suffolk suffered an acute medical problem. As he was working away from home and had no way of getting back to see his GP he considered attending A&E. However, having heard about the GP+ service, he registered as a temporary resident at a local practice and asked for an appointment. This was made for the same evening at a surgery about 8 miles away from where he was staying. The man shared that the appointment was on time, the GP was helpful and unhurried and explained the nature of the condition, what was required and provided a prescription. She also explained where to find a pharmacy open at that time of the evening. GP+ provides thousands of additional appointments each year, in the evenings and weekends including bank holidays for people living in or visiting our area.
New models of care with collaboration
In 2018 practices were supported in working together in smaller groups to trial new models of care and ways of delivering services through, for example, shared recruitment of pharmacists or paramedics; collective partnerships with local voluntary sector organisations; joint training and education; and shared management.

One group of 12 practices, of which 10 are in Ipswich and East Suffolk, has now formed a single partnership, Suffolk Primary Care, with a clear mission and values based on delivering compassionate, high quality care and nurturing and supporting staff. Suffolk Primary Care is pursuing innovative, ambitious plans for sharing clinical, management and administrative resources as one team, whilst ensuring each local practice is anchored in its community with local partners.

Practical examples include:
• Neighbouring Norwich Road and Chesterfield Drive practices combining elements of GP training with joint weekly tutorials enabling trainees to enjoy shared learning and an improved experience and allowing trainers to focus on areas of expertise.
• A central clinical administration team of 12 staff provides support to all practices including protocol-led coding of clinical correspondence, referral management and patient enquiries. The team works from two hub sites in Stowmarket and Felixstowe.

“The Ipswich and East Suffolk health and care system is facing many well publicised challenges. Suffolk GP Federation is an eager member of the Ipswich & East Suffolk Alliance and can see its positive benefits for patients and our workforce”

David Pannell, Chief Executive Officer, Suffolk GP Federation CIC
Organisational collaborations have paved the way for practices’ response to the new national Primary Care Network (PCNs) contract. All practices are now within one of 11 Networks; with a vibrant Clinical Director community, now meeting and learning together.

Networks are developing local strategies and priorities for action; assessing their ‘maturity’ as groups and mapping their development path; recruiting new staff; and providing additional opening hours. In one group in Ipswich, for example, one practice has extended evening appointments and one has extended its offer on a Saturday. This Network’s shared pharmacist offers a minor illness clinic in one of the practices and conducts medicines reviews in the other; which meets the needs of both and provides a diverse and rewarding role for the new pharmacist.

The CCG is piloting contracts at PCN level alongside national offers, for example, trialling a new proactive service for vulnerable housebound patients.
Maternity (ICS-wide with local delivery)

Our Ambition
To offer services to women and their babies that are as safe as the best in England, striving to adopt best practice and learn when things go wrong.

Our Plan
Our maternity plan is ICS-wide with local implementation. It responds to three key national programmes: ‘Better Births’; ‘Saving Babies Lives’ and ‘Neonatal Health and Safety’. There are four key programmes, supplemented by prevention and self-care.

1. Implementing Saving Babies Lives Care Bundle
2. Offering all women Personalised Care Plans
3. Offering three choices of antenatal, intrapartum, postnatal care and birthing choices
4. Increasing access to specialist perinatal mental healthcare

Our Progress
Excellent local progress includes:
• Creation of a forerunner, Continuity of Carer community team in Stowmarket and hospital based team in Ipswich, which enable women to see their named midwife/team members throughout pregnancy, birth and postnatal care. Delivering this has been a major yet very rewarding change to the way people work. An official launch and celebration of change took place in Hadleigh on 31 May 2019.
• Introducing a specialist midwife in Ipswich and East Suffolk who supports women to stop smoking during their pregnancy
• Reviewing how we support women who are risk of stillbirth or premature birth, and ensuring that all of our units deliver the Saving Babies Lives care bundle
• Reviewing how we provide special care for babies. We have improved our care pathways, reducing the number of full term babies needing special care.
• Completing a digital maturity review of our maternity systems, and developing a strategy for the delivery of patient accessible notes and dynamic, personalised care plans.
• Working with public health colleagues in Suffolk County Council to develop a Healthy Pregnancy Plan, and establishing services to optimise the health of pregnant women and their babies
• Establishing an Alliance Maternity forum where all stakeholders come together to plan, transform and review service models for maternity and very young children
Maternity (ICS-wide with local delivery)

Supported by the ICS, Ipswich and East Suffolk Maternity Voice Partnerships and Healthwatch have developed a year-long service user survey, to measure the satisfaction with all elements of maternity services. The results and actions needed will be discussed in summer 2020.

**Continuity of Care ... Delivering Positive Pregnancies**

A young woman who had lost a previous baby at 21 weeks gestation was very worried when she became pregnant again this year. She had received pregnancy bereavement counselling following her loss, but had ongoing mental health issues. For clinical reasons, a caesarean was planned for the delivery of her baby. The Beech team provided her with the continuity she needed. By seeing the same midwife through the majority of her pregnancy, she trusted the midwifery team, and began to feel safe for her next baby. This relieved her anxiety and ensured she had a positive birth and recovery.

A pregnant woman shared, “I had a very difficult birth with my first baby, and to be honest I was not looking forward to having another baby. With support from the Maple Team this changed into something to look forward to. I was able to contact someone 24 hours a day if I needed to, but knowing that the support was there was enough. I had a midwife that I knew and trusted for the whole experience.

“I had had a difficult time breastfeeding my first baby and so had decided to bottle feed this baby. However, with the encouragement and support from my midwife I managed to breast feed this time. The team helped me talk to other Mums, we developed a WhatsApp group to support each other, and the midwife support worker was available to help us post-natally. I did not feel as isolated as before, I felt part of a group of friends that all cared about each other.”

“**Our Continuity of Care models are changing women’s experiences of pregnancy, birth and antenatal care. Choice and continuity give confidence to mums, and their partners, and support the best, safe start in life for their babies.**

Lisa Nobes, Director of Nursing and Clinical Quality, Ipswich and East Suffolk Clinical Commissioning Group
Our Ambition shared with the ICS is that:

No patient is diagnosed with cancer through an unplanned hospital admission. 100% of patients take up the offer of breast, bowel and cervical screening.

Our Plan

We are working with patients, living with and beyond cancer, carers, patient-advocates, health care providers and clinicians to exchange knowledge and ideas of how we can improve cancer services. Our aim is to ensure that patients, relatives, carers and the public, along with the workforce are actively involved in the design, delivery and assessment of cancer services, in order to shape services and improve health.

Our current plan is four-fold:

1. Earlier and faster diagnosis
2. Personalised care for patients
3. Increasing support to patients on their cancer journey
4. Meet waiting time standards

“We have made fantastic progress so far in developing our local Alliance including ensuring that we truly look at the issues that matter for our local population.”

Richard Watson
Deputy Chief Executive and Director of Strategy and Transformation, Ipswich and East Suffolk Clinical Commissioning Group
Cancer (ICS-wide)

Our Progress

This year:

1. Faster diagnosis pathways have been introduced for prostate, lung, colorectal, and oesophago-gastric potential cancers to meet the 28-day faster diagnosis standard so that patients have cancer confirmed and therefore treated or ruled out as quickly as possible.

2. Primary care has been supported to introduce the Faecal Immunochemical Test (FIT) to enable earlier diagnosis of bowel cancer – this was launched in May and is being evaluated by the University of Cambridge.

3. Personalised care is being offered first to breast, prostate and colorectal patients to ensure that they receive all elements of the recovery package including holistic needs assessments, health and well-being support and end of treatment summaries. Patients are supported to follow self-management pathways.

Patient story

A 67 year old retired gentleman had long standing constipation and lower abdominal bloating, which had been attributed to irritable bowel syndrome or diverticular disease. He developed lower abdominal discomfort but had no weight loss or rectal bleeding and he had had a negative bowel screening a year earlier. He was not anaemic and his symptoms did not qualify him for a fast track referral for cancer, under current NICE guidance. However, following NICE NG30 a Faecal Immunochemical Test (FIT) was performed by his GP, which turned out to be positive. He was referred urgently for a colonoscopy, which revealed an early adenocarcinoma of his colon, which was subsequently completely removed at surgery. There was no evidence of invasive local spread and so his surgery was deemed curative. Without FIT testing the gentleman may have experienced delay and possibly a more adverse outcome.
End of Life Care

Our Ambition
To support every individual, their family and carers in planning for, and realising their wishes in the final stage of their life.

Our Plan
There are four key elements of our plan:

i. Identifying people in the final stages of life
ii. Developing places of excellent end of life care and investing in people who care
iii. Improving hospital care
iv. Opening debate

Our Progress

• **Identifying people in the final stages of life** and improving, with consent, information sharing to ensure people’s wishes are fulfilled. New, simple end of life care planning documentation known as My Care Wishes has been prepared and is now offered by all organisations to help people plan ahead.

• **Developing places of excellent end of life care and investing in people who care** - accrediting care homes skilled in end of life care management; recruiting new specialist care co-ordinators; and recruiting Hospice nurses for in-reach and assessment. Since January 2018, a new community based model of end of life care has been piloted in East Suffolk to support people to die in their preferred place of care. There has been considerable investment via the Better Care Fund in additional community staffing to support patients at home and enhancing existing St Elizabeth Hospice ‘One Call’ 24/7 advice and support line to co-ordinate care for patients.

10 Care Homes have achieved a special end of life care accreditation. The pilot has been extended by the CCG until end of March 2020. A new approach to engaging local people in supporting individuals and their loved ones in their own homes is being tried in some of our most remote rural communities of Hollesley, Orford and Alderton by the Peninsula Practice.
End of Life Care

• **Improving in-hospital care** including post death care within the mortuary and through extending specialist palliative care nursing. Improvements in discharge processes at hospital have been made to support patients at the end of their life through daily, joint working between the Complex Discharge Team and CCG’s Continuing Healthcare Team, working closely with care homes and domiciliary providers to set up care packages and placements to support preferred place of care patient wishes

• **Opening debate** - creating a wider discussion about end of life care with the public. Alliance partners in Ipswich and East Suffolk and across the ICS are working together to open conversations about dying. During ‘Dying Matters Week, our GPs, Suffolk County Council and voluntary sector partners all engaged in a single campaign.

**Speaking Out about Dying**

Jane O’Riordan from Ipswich offered to speak out during Dying Matters awareness week. Jane began volunteering with Cruse Bereavement 18 months ago after watching a lady she had befriended die a “hideous” death away from her home, which was the one place she wanted to be. Since then, Jane has given her time to offer emotional support to help others cope with grief and loss.

“Death is such an unfashionable subject that no one wants to discuss,” said Jane, “but if you do talk about it, it becomes so much less of an issue... We think that talking about death is going to make us die more quickly, but that simply isn’t true. Speaking to your loved ones, preparing and writing things down are so, so important.”
We have developed six priority Connecting Actions, which involve every Alliance partner:

1. **Enabling you to stay well** (prevention; self-care; re-ablement).
2. **Joining up in our communities** - physical, emotional health and wellbeing.
3. **Creating ‘One Team’** - joining up clinicians and professionals across our organisations.
4. **Changing how we invest our resources** - eradicating waste; balancing our system books; shifting investment to prevention.
5. **Reducing inequalities** - in outcomes and experience.
6. **Planning for the long-term** - the next 20 years.

“The Ipswich and East Suffolk Alliance has driven positive cultural change across our services for the benefit of our population. Increasingly it is looking at addressing the wider determinants of health and so its partnerships are growing to help address this significant challenge.”

Ed Garratt
Chief Executive Officer, Ipswich & East Suffolk CCG and Executive Lead for the Suffolk and North East Essex Integrated Care System
Our Ambition
People living in Ipswich and East Suffolk live well for longer: A revolution in prevention, self-care and re-ablement.

Our Plan
Over the past 12-months we have developed and begun to implement concrete plans in partnership to:

1. Enable people who have a long term condition to understand and plan how to stay well for longer.
2. Enable everyone to keep physically and mentally active.
3. Plan services to detect and treat conditions which can change the way you live; Frailty; Hypertension, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease and Diabetes.
4. Enable everyone who becomes unwell to return to independent living, with or without support.

Our Progress
We have been very practical; trying and testing at least one major initiative for each area. All of our actions are being closely monitored and evaluated to determine long-term support.

“Public Health Suffolk is very pleased that the Ipswich & East Suffolk Alliance has prioritised prevention and reducing health inequalities and working collaboratively with us and wider partners to improve the health and wellbeing of our population. We are particularly grateful for the support of the Alliance to the ‘One You’ campaign.”

Padmanabhan Badrinath
Consultant in Public Health Medicine, Ipswich and East Suffolk Locality, Public Health Suffolk, Suffolk County Council
Connecting Action 1 – Enabling you to stay well

1. Living well with a long-term condition

- **Improving access to psychological therapies** – A £2.6m investment has been made to expand access to psychological support particularly for people with long-term condition such as diabetes, heart failure and COPD. By March 2021 we will have increased the access rate from 19% to 25% at Ipswich Hospital.

- **Flu Pledge** – This year, for the first time, with leadership from Public Health Suffolk, all Alliance partners have signed up to a Flu Pledge, aiming to keep patients, the public and staff well. We will report against our progress throughout the season.

Ipswich and East Suffolk Alliance
Flu Pledge

We collectively pledge that preventing & managing seasonal Flu is a key priority for us, and we will help to support the vaccination programme within our own organisations as well in the wider community, to ensure that we protect, detect, respond and recover from seasonal flu in Suffolk.

- Dr Mark Shenton
  Chair, Ipswich and East Suffolk CCG
- Jonathan Warren
  CEO, Norfolk & Suffolk NHS Foundation Trust
- Kirsten Allerson
  CEO, Suffolk Family Carers
- Neil Motson
  Managing Director/Deputy CEO
  East Suffolk and North Essex NHS Foundation Trust
- Allen Colby
  Corporate Director for Children and Young People
  Suffolk County Council
- Kathy Nixon
  Strategic Director, Babergh Mid Suffolk District Council
- David Pannell
  Chief Executive, Suffolk GP Federation
- Paul Little
  Director for Integrated Health and Care, Suffolk County Council & East Suffolk and North Essex NHS Foundation Trust
2. Keeping Physically and Mentally Active

- **The How Are You Suffolk? campaign.** This new initiative is being personalised to each of our localities, ‘How are you Stowmarket?’ ‘How are you Ipswich?’ ‘How are you Felixstowe?’ It uses innovative, local marketing techniques as well as traditional channels, such as light displays, to generate curiosity and draw people to the [www.suffolkhowareyou.co.uk](http://www.suffolkhowareyou.co.uk) website, which encourages people to think about and access local health and wellbeing services and activities.

- **Park Run Practices including It’s OK to Walk.** Suffolk County Council, working with the CCG and Parkrun, have encouraged 18 of our 40 practices to become Parkrun practices to date. Parkrun encourages walking, running, volunteering and meeting people. Local GPs, nurses and Patient Participation Groups are working together to encourage people to take part. In March 2019, the NHS led a ‘takeover day’ at the Ipswich Parkrun in the stunning Borough Council managed Christchurch Park. The goal remains for all practices to have the Parkrun medal and to grow their patient’s enjoyment and sustained engagement with their local park and exercise.
3. Detecting and treating conditions which can change the way you live

• **Healthy Living Pharmacies** – This Suffolk-wide programme has been developed in partnership between the Local Pharmaceutical Committee, CCG and Public Health Suffolk, supporting pharmacies in building their relationships within their communities – both with the public and with primary care partners. It builds all Pharmacy teams’ knowledge of wider Alliance priorities, for example, in providing training to enable supportive conversations with patients diagnosed with cancer and allows for flexible focus on issues that are a priority for Integrated Neighbourhood Teams. All Boots pharmacies within the area have joined the programme alongside many local contractors.

• **Reducing the risk of Type 2 Diabetes** – Working with Suffolk County Council Communities Team, local residents in Holbrook and Shotley developed a project for local people at high risk of Type 2 Diabetes, often called pre-diabetic. 17 local people joined a programme of education with OneLife Suffolk adult weight management, with sessions at Holbrook Sports Centre and advice from local practice nurses delivering part of the DESMOND course usually offered to people once they are diagnosed. Professionals and people with lived experience of diabetes also offered advice. 90% of people finished the course. 80% lost over 5% of their body weight – an average of 17lbs. Those who had their blood sugar measured showed a good reduction and everyone took part in a new physical activity and said that they felt their health and wellbeing had improved. From small acorns grow big oaks – the programme is now being adapted and adopted in the Eye INT area.
Connecting Action 2 – Joining up in our communities

Our commitment to you
We will listen, support, inform and understand what you want to achieve and help you reach your goals.

Our Ambition
People living in Suffolk will be aware of and able to access services available in their community.

Our Plan
Integrated Neighbourhood Teams – joined up community, social and mental health care teams working with GP Practices, voluntary and community sector partners in each of eight Connect localities - were part of the vision of the Suffolk Health and Care Review. We are focused on four key outcomes:

1. Fewer people need unplanned care and support (reduction in crisis)
2. Greater numbers of people have access to and are supported by activity outside of statutory services
3. Resources in the delivery of community based health and care are used more efficiently
4. The on-going costs of supporting people are reduced as people’s independence is increased.

Ipswich and East Suffolk Integrated Neighbourhood Teams

Eye and North West
Stowmarket
South Rural
Ipswich West
Ipswich East
Saxmundham and North East
Woodbridge
Felixstowe
Connecting Action 2 – Joining up in our communities

Our Progress

In the previous year, our focus was on joining together social care and community teams, in developing mutual understanding of different professional roles and where, through joint knowledge, information and trust, an individual’s needs could be better met and team time could be used more effectively by working together. This year, Paul Little became the first, joint area Director for Social and Community Care.

With Paul’s leadership, an Alliance-wide Development Group has been set up with its name and functions purposely focused on enabling local practitioners and clinicians. In spring 2019, the Group, agreed a plan for the next 12 months.

The plan has 11 key elements; our progress against each is summarised overleaf.

“We are so lucky in East Suffolk to have the Alliance. We focus on the whole system; health, care, district and borough Councils and the voluntary sector to name a few, all working together trying to do the best for the people that we serve. Things are by no means perfect, but there is real commitment from all to try our very best to make things better and better, developing new approaches that the whole system can get behind and deliver. With a really clear focus on keeping people independent and well we can deliver ever better support for people that need it and a system working as efficiently as we possibly can. It’s a real privilege to be part of this effort.”

Paul Little,
Director for Integrated Health and Care
Suffolk County Council & East Suffolk and North Essex Foundation Trust
Connecting Action 2 – Joining up in our communities

1. **Development of Core Leadership Teams** to provide a focal point for planning and oversight of INT and Connect teams. Alignment is now complete for social care, community, GP and social prescribing colleagues and will shortly be complete for mental health too. The Teams met altogether in October as a springboard for the next phase in their local work.

2. **Alignment and engagement of Primary Care Network Clinical Directors with INTs** - Clinical Directors have been aligned to their Integrated Neighbourhood Teams; there are some differences in geographies of PCNs and INTs and we are working pragmatically to ensure that our focus is on individuals’ needs within our communities and to manage these issues.

3. **Delivery of Joint Strategic Needs Assessment for each INT** - Public Health Suffolk has now produced Local Based Needs Assessments for each of the eight Integrated Neighbourhood Team areas. Each document profiles information about people’s health and wellbeing within the area including age, education, vaccination rates, mental health, long term physical conditions and the reasons why people are admitted to hospital. The assessments suggest possible areas of focus from the data, which supplemented by local professionals and members of the communities’ knowledge, will help guide priorities for action. The assessments are helping us to focus the right services in the right places. All assessments can be found at: [https://www.healthysuffolk.org.uk/jsna/pbna](https://www.healthysuffolk.org.uk/jsna/pbna)

4. **Mobilisation of Social Prescribing for each INT** – This is complete and detailed in a case study below.

5. **Appointment of business, administrative and programme management support to each INT** – This is now complete with the appointment of two new business support colleagues within Suffolk County Council and programme management colleagues aligned from within the Clinical Commissioning Group. Our next step is to align Alliance Board member sponsors to each area.

6. **Provision of sample Terms of Reference** for an INT and Connect Group to complement a Primary Care Network’s Agreement – This is in progress but not yet complete

7. **Development of a delivery plan** – This is underway in every area. They currently range from a focus on a single ‘mission critical issue’ to a broad and holistic plan. Each area will be supported in further development and delivery planning.
8. **INT operational financial strategy** – to be developed with consideration to PCN, core operational and transformation funding requirements – This will be assessed on the basis of the plans created.

9. **Estates** – delivering the next moves – The Eye Integrated Neighbourhood Team of community and social care and mental health colleagues is now fully co-located at Hartismere Hospital, with a dedicated space for social prescribing on site too. Potential locations for joint bases for social care and community teams have been found in Felixstowe, Stowmarket, Leiston and Woodbridge and sites are being sought in Ipswich and South Rural.

10. **Further development of an Organisational Development Support Offer** – Many individuals and core Integrated Neighbourhood Team social and community care colleagues have been taking part in personal and group development activities. Our next step – once all members of the Core Leadership Teams are in place – is to co-create a tailored organisational development plan for each Team.

11. **Communications and access to information** – This work is on-going.

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**Working together to raise awareness of alcohol support services**

The local Integrated Neighbourhood Team in Stowmarket and Needham Market was asked to consider shared customer/patient concerns and common areas of pressure to their services or gaps in local provision. Collectively they recognised that alcohol was a key issue and that services were undersubscribed and generally not very well taken up.

The Team arranged an Alcohol Awareness event in October in central Stowmarket with GPs, community and social care colleagues working hand-in-glove with voluntary and wider partners. The public attendance was excellent. Over 10 local providers were on hand with information about their services, and able to offer help, advice and support.

It was agreed that the event was a complete success. A number of patients, specifically targeted from their own GP practice attended as well as members of the public that were either interested in the services for themselves or someone they cared for. New multi-professional relationships were formed, which now provide the springboard for the next steps in planning and delivering services together and joining up in the Stowmarket community.
Social Prescribing

Social prescribing - offering an alternative opportunity to medical or other statutory care in the local community - can help to prevent ill health or aid recovery. In Ipswich and East Suffolk a number of successful pilots have paved the way to a roll-out this year across our eight Integrated Neighbourhood Teams. Social prescribing link workers – known locally as Community Connectors – receive referrals, have a conversation with an individual and support to them in engaging in a local activity. Our Community Connectors are all hosted by voluntary sector organisations who are uniquely placed to understand someone’s need and to find the right opportunity for them. The hosting organisations were selected through a formal procurement process and include: Suffolk Family Carers, The Shaw Trust, Citizen’s Advice and Access Community Trust.

Everyone’s needs are different, so each Community Connector has a wide list of local, free activities and a budget to source additional or new options. A mobile service is also operational. Since March, 200 people have been supported through the social prescribing programme in Ipswich. The reasons for referral by a GP to the Community Connector include for benefits advice, bereavement support, housing help, loneliness, unemployment and money worries. Connectors provide direct advice and help individuals to find support with Suffolk Mind, a Solicitor, the Disability Advice Service, an Open Spaces project, the Jobcentre and a Witness Advice Service.

The programme has been governed by an Alliance-wide Social Prescribing Steering Group of GPs, patients, voluntary sector organisations, ESNEFT, Suffolk County Council and District and Borough partners. There is on-going learning from the set-up and operation of the programme including: developing understanding of the opportunities and benefits of social prescribing, management of referral processes and ensuring the highest standards of information governance. The University of East Anglia has been asked to evaluate our programme.
One gentleman, seen by a Community Connector, was in a very distressed state and had been calling the Samaritans. He also advised that he was in danger of self-harm. He had been suffering from depression for 20 years and had an alcohol dependency. He had resigned from his job recently due to an allegation of bullying. Since that time he had had no income and was finding it difficult to get out of his flat and this increased his sense of anxiety and depression.

The Community Connector met with the individual and helped him to get support from Suffolk Mind. He was then helped by Citizens Advice to complete his application for Universal Credit and to ask for an advanced payment. The Community Connector also helped to explore his passion for art and drawing and talked through a list of possible groups, which he decided he was happy to explore on his own in an area he was familiar with. The individual recently called the Community Connector to let them know that he had secured a new job.

“Our social prescribing strategy was developed in partnership, building on local experience and using national evidence. The most important features are that our service is individual, and local. Our community Connectors are the linchpin between voluntary, community and statutory services. The case studies we are collating tell you all you need to know about how social prescribing is changing lives.”

Kirsten Alderson
Chief Executive Officer, Suffolk Family Carers
Our commitment is to invest in the people who work with you; to retain, develop and attract the best talent.

Our Ambition
Seamless care delivered by seamless teams.

Our Plan
Creating One Team, delivering joined up care has been an absolute priority over the last 18-months. Our approach has been multi-faceted; working within localities, as described in the section ‘Joining Up in our Communities’ as well as across our Alliance.

Our Progress
One example of pan-Alliance working is our One Clinical Community development programme. Two leadership development programmes were held in Ipswich and East Suffolk between September 2018 and March 2019 and a further programme is now underway. Participants include GPs, consultants, psychiatrists, psychologists and Public Health leaders. A dedicated parallel programme for nurses brought together colleagues from primary care, NSFT and ESNEFT.

All participants developed their own leadership skills, gained insight into each other’s working lives and identified how collaboration could improve outcomes for patients, themselves and all organisations. Specific work was focused on mental health, children and young people, the frail elderly and diabetes care.

“‘Seamless care, delivered by seamless teams’ is at the very heart of our mission. Joint appointments and co-location have an important role to play BUT our most important action is to invest in training and development of individuals and multi-professional teams so that they work together.

“The feedback we have had from our One Clinical Community leadership programmes shows how working lives and patient care have been transformed by learning and growing as ‘One Team’.”

Mark Shenton
Chair, Ipswich and East Suffolk Clinical Commissioning Group
Connecting Action 3 – Creating ‘One Team’

Taking part in the One Clinical Community Leadership Programme was one of the highlights of my professional year. To see so many diverse clinical leaders, both emerging and established, coming together to tackle the major challenges facing our local area was inspiring. It was evident from the outset that our commonalities were far greater than any traditional barriers between us, and this philosophy stands us in good stead to move forward with true alliance principles.”

Dr Imaad Khalid, Clinical Executive GP
Connecting Action 3 – Creating ‘One Team’

Multi-disciplinary Teams in Our Communities

In our Section ‘Joining up in our Communities’ we have described our progress in developing Core Leadership Teams in each of our eight Connect areas. In some areas, prior to progressing to the Team’s leadership for strategic planning, colleagues across social care, community health and primary care had re-invigorated very practical joint working focused on patients with complex needs using a Multi-disciplinary Team (MDT) Meeting approach. Woodbridge is an excellent example, which has now been supplemented by the Independence and Wellbeing Practitioners from the Social Care Team being linked to each Surgery within the area. The idea is two-fold. Firstly, to build relationships with the surgery as part of our wider INT, attending the MDT. Secondly, to attend the surgery two weeks after each MDT to make contact with any patients that the GPs have low level concerns about. Urgent concerns with high risks still follow the Customer First referral process. The patients are sometimes already known to Social Care colleagues and the conversations are aimed at preventing a crisis situation. The Independence and Wellbeing Practitioners have an asset based conversation to understand the situation and to help individuals find a solution for themselves. If this isn’t something that can be achieved, then the practitioner will help with some short term re-ablement. As appropriate, the practitioners can also forge links with social prescribing community connectors.

Creating One Physical and Mental Health Team to Support Patients with a Serious Mental Illness

An NSFT nurse completed a health check for a gentleman with a serious mental illness, who had not been responding to multiple letters from his local practice, despite their best efforts. His blood pressure was raised, and his blood results and presenting symptoms were showing serious concern leaning towards an undiagnosed diabetic illness with very high blood sugars. A discussion between the Psychiatrist and Nurse resulted in agreement that the patient should attend A&E. The nurse took the gentleman to the hospital and stayed with him all Friday afternoon until he was triaged and then admitted. His blood sugars remained very high and he was treated for this immediately and admitted for further monitoring. He stayed in hospital and was visited by the mental health nurse for continuity of care and to ensure that some support was in place. He is now diagnosed with Type 1 Diabetes and will require insulin to manage his blood sugar. The Home Treatment Team will support him with his physical and mental health over the coming weeks alongside support in returning to his Practice.
Connecting Action 4 – Changing how we invest our resources

Our commitment is to invest our resources transparently and in line with our strategy and values.

Our Ambition
To build on our financial transparency; reduce waste; invest in our people; and increase our investment in prevention, self-care, re-ablement and out of hospital care.

Our Plan
Our ambition is to eradicate waste; balance our system books; and shift investment to prevention.

Our Progress
Over the last 18-months, our focus has been four-fold:

• To understand the financial picture across our Alliance
• To start to work more closely together – in an open book style
• To focus on making the best use of resources – the Ipswich and East Suffolk £
• To maximise investment for the provision of health and care services – including attracting national resources

The CCG, which receives most of the health funds for Alliance partners from national government, has shared its full financial picture; the different sums it receives and how they are spent to enable an understanding by all partners of the relative expenditure in different services and providers. We have acknowledged that this does not cover the whole picture of health and care, with significant elements including social care needing to be included. We have also identified the need to scope the interplay between other public sector and voluntary sector partners on the wider determinants of health, and the vital role of this investment in preventing ill-health.

An Alliance Financial Performance Committee is now operational. This group brings together financial expertise with clinical and practitioner experience to secure oversight of NHS financial control totals at Alliance level. It delivers a strategic view of the flow and use of resources across all organisations and works to smooth barriers to system wide decision-making and increasing the impact of our expenditure and achievement of our ambitions.
In 2018/19 the CCG asked the Alliance to manage a Transformation Funding investment of £1.8million and in 2019/20 of £3.4million focused on:

- Joined up and end of life care
- Mental health and emotional wellbeing
- Creating One Team
- Digital transformation
- Prevention

Alliance partners, working as part of our wider ICS, have leveraged significant funding from national streams and will continue to do so.

By working in partnership, all NHS bodies in the Alliance were able to live within the financial control totals set by NHS regulators in 2018/19 and we are working towards this in 2019/20. For our NHS providers in 2018/19 this meant access to the Provider Sustainability Funding allocated to their organisations and a share of unearned sums from other areas that did not achieve their control totals.

“Balancing our books in a way which delivers high quality, joined up services is an essential part of the Alliance’s business. We are all custodians of the public purse – spending every £ wisely is everyone’s job; by working together to achieve the best possible value for money, eradicate waste and make bold decisions, we can make a real difference to the lives of people we serve today and in the future.”

Jane Payling
Director of Finance, NHS Ipswich and East Suffolk Clinical Commissioning Group
Our Ambition
People will be treated fairly. Outcomes will be equal.

Our Plans
Reducing inequalities in experience and outcomes is a priority for our Alliance. Our plan set out five initial actions that we would take; it is important to note that whilst these actions are described in a dedicated way here with some specific targeted initiatives, our intent is that inequalities are addressed in each and every programme of work.

1. Develop a full understanding of where inequalities exist; how and where to make a difference.
2. Identify the data measures to monitor outcomes to prevent and continue improving reducing inequalities.
3. Equality and Diversity Impact Assessments will ensure new models of care are fully inclusive
4. Work with our communities to develop plans to address inequalities and ensure sustainability.
5. Develop targeted interventions to reduce inequalities.

“Public Health Suffolk is pleased that tackling inequalities and preventing ill health is a key priority for the East Suffolk Alliance which has signed up to the Flu pledge and actively supporting health promoting initiatives such as “How are you Suffolk?” We look forward to continuing to be part of the Alliance in preventing ill health and promoting wellbeing for the population of East Suffolk”.

Stuart Keeble
Director of Public Health
Public Health, Suffolk County Council
Connecting Action 5 – Reducing Inequalities

Our Progress

Some of our most targeted actions are shared here:

**Lofty Heights** is a small Community Interest Company which, working with Ipswich Hospital, community and social care colleagues, gives people the answer to their question, “*My care has been excellent but when can I go home?*” For some people, their ability to get home is delayed by the lack of physical space – a need to move some furniture to enable a new bed or frame or bathroom equipment to be safely in place; for others, who may have been hoarding, more fundamental clearing and cleaning is needed to enable people to ‘get home’. Some people are able to pay for support and others are not. With Alliance funding, Lofty Heights has been able to offer a universal service. Between June 2018 and May 2019, Homeward Bound received 127 referrals; 43 required a home assessment. Initially the service was only supported to offer up to four hours of help but in recognition of more complex cases requiring decluttering of between two and five days with significant waste disposal, the approach was changed with need and time left to Lofty Height’s discretion. It is estimated that for these complex cases individuals have been able to get home between 7 and 14 days quicker than they otherwise would. The service is now being further funded in Ipswich and East Suffolk and in West Suffolk too.

**Emergency Food**

Recognising that low income and poor nutrition are key causes of ill health, in winter 2018/19, the CCG in partnership with Suffolk Community Foundation created an Emergency Food Fund. The Fund offered grants of up to £10,000 for: emergency food deliveries; holiday hunger projects; distributing food to older people in need; homeless and vulnerable food programmes; breakfast and similar clubs. £65,000 was initially awarded to 10 local foodbanks and voluntary organisations involved in feeding nearly 1300 people across Suffolk.

*In Whitton, which is one of the 10% most deprived wards in the country where a high number of families live in poverty with children receiving free school meals, the Youth Partnership provided holiday activities and meals as well as a Movie Club with food on a Saturday morning. About 30 children have attended each day in the holidays.*

“A young lady, who is one of our regulars from Whitton Primary School chose a quiet moment to ask the volunteer kitchen staff if she could take some leftover food home for the rest of her family. A package was put together and our 9-year old went home with it – says it all really.”
Connecting Action 5 – Reducing Inequalities

Other projects underway or shortly to start, supported by Alliance Transformation or Realising Ambitions funding include:

- **Housing First** – an Ipswich Borough Council, voluntary sector and CCG project to support homeless individuals into new accommodation
- **Black and Ethnic Minority Health Awareness Programme** – a set of prevention and self-care projects being developed in partnership between GPs and community groups
- **Proactive Health and Care for Housebound Individuals in Winter** – this is a pilot in one Primary Care Network area; nurse led health reviews will be offered to patients who either temporarily or permanently are unable to go to a health centre
- **Time to Talk** – a befriending service for lonely and isolated individuals
- **Bridging the Gap** – engaging people with mental health issues and dementia at Woodlands
- **Suffolk Refugees** - an asylum mental and physical health support programme
Our commitment is to be fit-for-the future; to have built a foundation to enable us to manage and deliver care for our future communities, working with you to think and plan long-term.

Our Ambition
We will prepare and plan our services ready to serve our communities for the next 20 years.

Our Plans
1. We will understand what our communities will need and want. Over the next 12 months we will identify the data sets required for this.
2. We will develop services that can meet the needs of our community sustainably.
3. We will be innovative, embrace technology and be proactive in our approach.
4. We will develop our organisation, principles, workforce and infrastructure in readiness for our future plans.
Connecting Action 6 – Planning for the long term

Our Progress

Over the last 18 months the Alliance has embraced a mind-set of ‘thinking and planning long-term’.

- Public Health Suffolk has engaged us all with Suffolk 2030, which shares a picture of our future: of our age, health and wellbeing as well as economic profile in ‘doing nothing’ scenarios.
- Our district and borough council colleagues have involved us in their Local Plan development; in discussions about scenarios for new growth and changing communities.
- Our digital leaders have shown how we can improve patients’ and the public’s experience and manage demand by adopting new technologies.
- Our workforce colleagues have used national models to predict long-term needs and accelerated work in schools and colleges to promote health and care careers.
- British Telecom in Martlesham welcomed us to their Hothouse with inspirational national speakers to consider how our planned care services could be transformed.

We have been informed by the NHS Long Term Plan and contributed to our local Integrated Care System Five Year Plan. Our whole Integrated Care System is now a national Wave 2 Population Health Management System. This support will enable us to advance the collation of data across our system to plan individual and our whole communities’ health, care and wellbeing needs.

This thinking and action is a step-change for our Alliance partnership and individual organisational partners. Our next Delivery Plan will include actions and milestones that continue this proactive approach to the future.

“Thinking and planning long-term together with our communities is essential. The potential for us to collaborate in designing our physical environment and holistic collective services to meet the needs of our residents today and in years to come is immense. We’re making a great start together!”

Kathy Nixon
Strategic Director, Babergh & Mid Suffolk District Council
Enabling Actions

Organisational Development

Workforce

Digital

Communications and Engagement

Estates
**Enabling Action 1 – Organisational Development**

**Our Ambition**

Our ambition is to develop a vibrant, sustainable Alliance between providers, commissioners, voluntary and community partners, which will enable us to “work together with you”.

**Our Plan and Progress**

Over the past two years, the Alliance has been led by a Board of Chief Executives and Directors from each of our organisations. Our combined strategic and operational knowledge and experience has enabled us to develop plans, make decisions and ‘get on and do’ together.

We have built on a highly participative and effective set of service transformation boards for Planned Care, Integrated Care and Primary Care and established new ones for Social Prescribing and Prevention and in support of Integrated Neighbourhood Teams.

We have worked closely with colleagues across our whole Integrated Care System and with our partner Alliances in North East Essex, for example, on programmes of work, where ESNEFT is a joint partner, such as for maternity services, and with West Suffolk, where Suffolk County Council is a partner, such as for mental health and children’s services.

We are currently creating an Integrated Quality Committee to understand risks across our system and to look at how an individual and their family and carers needs are met holistically, for example, from initially going to the GP through to a time in hospital and return to home with care – whether from a statutory or voluntary sector partner. Currently, we just look at how we perform as individual organisations but we want to change this and see the world through an individual’s eyes and experience.

We have established a Financial Performance Committee, which is looking at how we are spending the money entrusted to us across all partner organisations – to see how we can secure best value and balance the books in our area, as a whole.

We are working to develop further local focus within wider ICS digital, workforce and estates programmes. We plan to take additional steps in evolving our governance to enable delivery of our plans. We will publish our next Delivery Plan in spring 2020.
Our Ambition

Our ambition is to be positive, proactive and pragmatic; working in partnership to plan and implement new joined-up recruitment, retention and development opportunities.

Our workforce is vital. We, like our neighbouring Alliances, face significant recruitment, retention and development challenges, if we are to deliver our new models of care.

Our Plan and Progress

We are proactive in every element of the further development and delivery of the ICS-wide Five Workforce Ambitions:

• **Joint planning.** Alliance partners are engaged in collating local workforce data and in locality as well as ICS-wide planning forums.

• **Shared resources.** Alliance partners have been proactive and pragmatic in agreeing how to share resources to deliver better services and more rewarding job opportunities. Examples within this report include: the new joint Social Care and Community Managers for six INT-Connect localities; the shared management and clinical administration team created by Suffolk Primary Care for 13 practices; as well as joint commissioning posts between Suffolk County Council and the Suffolk CCGs for example, for Children and Young People’s Service Development.

• **Recruitment, retention and development.** Ipswich and East Suffolk has a proud tradition of recruiting new talent from local Modern Apprenticeships to internationally sourced medical and nursing teams and to developing individuals and teams within and across our organisations. This is a key focus for our local workforce group.

• **Developing new ways of working.** This includes One Clinical Community and Multi-disciplinary Teams, as illustrated in our section Creating ‘One Team’.

• **Valuing and supporting improved health and wellbeing.** Alliance partners are working together and learning from one another in how to improve staff wellbeing. This includes: partnerships with Suffolk Mind to understand and develop staff’s individual and collective emotional wellbeing; growing volunteering opportunities to increase staff’s connection with the communities we all serve and to build teams; and flexible working opportunities to enable people to achieve the best possible work-life balance.
**Our Ambition**

Our Alliance is supporting the further development and delivery of the ICS and wider regional digital strategies including:

1. Developing whole system leadership and co-ordination of investment in digital programmes with shared priorities and objectives focused on person-centred care.

2. Breaking down barriers between organisations and development of common secure technology infrastructure that enables information to flow between pathways and helps staff to use time effectively.

3. Creating further capacity and capability through collaboration, managing supply more effectively; innovating to help people to self-care.

4. Expanding our strategy to develop an at-scale population management approach.

**Our Additional Local Plans and Progress**

In addition to these wider ICS regional strategies and investment programmes, our Alliance has committed £500,000 in 2019/20 to key local priorities. They were selected on the basis that they are:

- Aligned to ICS and local priorities, enabling joined up care;
- Transformative; and
- Sustainable.

The programmes are:

- Development of a Master Patient Index at ESNEFT
- Development of the Strategic Outline Business Case for ESNEFT’s Electronic Patient Record
- SystmOne for acute and physiotherapy
- NHS Mail support for care homes
- SystmOne links to Suffolk County Council
Enabling Action 3 – Digital

My Care Record – Sharing for Seamless, Safe Care
Over the last three years we have been working to encourage patients to allow their electronic record to be shared between health and care professionals to enable the best possible seamless, safe care. We have been doing this through information leaflets, advertising in healthcare and other settings and in conversations at public events. Over that time the percentage of people ‘signing up’ has increased from 10% to nearly 65%. However we know that nationally only about 2% of people do not wish their records to be shared and so, learning from trials elsewhere we are now investing in My Care Record, a programme, which after due promotion enables people to ‘opt-out’ rather than need to ‘opt-in’.

“IES Alliance is a true collaboration, where our community and the people we serve are at the heart of every discussion. Our shared determination to improve the integration of health and care services is key to innovation and service improvement.”

Shane Gordon, Director of Strategy, Research and Innovation
East Suffolk & North Essex NHS Foundation Trust
Our Ambition

Our strategy and detailed plans will be underpinned by excellence in:

- Working in partnership
- Involving
- Engaging
- Informing

. . . the public, people who use our services and people who work in our services.

We will ensure our:

- Our feet are on the street - we are reaching out to people
- We seek out new technologies - push our normal boundaries . . . to get people involved and provide information.

This will be a whole Alliance priority with dedicated resource in support.
In May 2019 we prepared a holistic communications plan with a clear monthly focus of positive messages about the issues we are tackling and the action that we can all take, with stories of how together we are making a difference.

<table>
<thead>
<tr>
<th>Month</th>
<th>Topics</th>
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<tbody>
<tr>
<td>May</td>
<td>• Dying Matters</td>
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<tr>
<td>June</td>
<td>• Gangs</td>
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<td></td>
<td>• Better Births</td>
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<tr>
<td>July</td>
<td>• Active Schools</td>
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<td></td>
<td>• Patient Conference</td>
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<tr>
<td>Aug/Sep onwards</td>
<td>• Mental health in schools</td>
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<td></td>
<td>• Flu</td>
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<td>• Mental health liaison</td>
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<td>September</td>
<td>• Organ Donation</td>
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<td></td>
<td>• Suicide prevention</td>
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<tr>
<td>October</td>
<td>• Mental Health</td>
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<tr>
<td></td>
<td>• Restart a Heart Day</td>
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<tr>
<td>November onwards</td>
<td>• Choose Well this Winter</td>
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<tr>
<td>January</td>
<td>• Better Births</td>
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<tr>
<td>March</td>
<td>• Return, reuse, recycle</td>
</tr>
<tr>
<td>May</td>
<td>• Suffolk Show</td>
</tr>
<tr>
<td></td>
<td>• Dying Matters</td>
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</table>
Our Ambition
Our estate is critical to delivery of our goals. An ICS-wide strategy is currently being developed in line with the Naylor Review and local One Public Sector Estate principles. We are keen to play a highly active role in its development; ensuring we address local critical challenges.

Our Plan
We are focused on:
• Alignment with local clinical strategies, specifically including service integration in localities.
• Maximising value for money, specifically including our plans to eradicate waste and to change our investment profile from urgent and acute care to primary and community care and prevention.
• Addressing backlog maintenance.

Our Progress
Three key projects which have been progressed by Alliance partners, working together and within the ICS framework, over the last 18 months are:

Urgent Treatment Centre at the Ipswich Hospital site
A new centre is planned at Ipswich Hospital, which will offer treatment for a range of urgent but not life-threatening conditions, freeing up the Emergency Department (ED) to focus on providing care for the most critically ill and seriously injured patients. The centre will be built alongside a new ED, simplifying services by providing a single front door that all patients will use before they are triaged by clinical staff and directed either to the Urgent Treatment Centre or ED depending on which service will best meet their needs. The building will also be home to a new MRI and CT scanner.

Artist impression of the new Urgent Treatment Centre, ESNEFT Ipswich Hospital Heath Road site
Co-location of Health and Social Care Teams
The Eye Integrated Neighbourhood Team of community, social care and mental health colleagues is now fully co-located at Hartismere Hospital.

GP Practice Co-location in Partnership with Ipswich Borough Council
Two GP practices in Ipswich - Chesterfield Drive and Deben Road, both members of Suffolk Primary Care - are working in partnership with Ipswich Borough Council to develop a new healthcare facility on the North West fringe of the town on the old Tooks Bakery site. Together they will serve more than 25,000 patients currently registered with the Practices as well as new residents on the site and the Ipswich Garden Suburb. Ipswich Borough Council will be providing the capital needed for the development and will be the landlord once the building is completed.
Our Ambition

We need to know what progress we are making towards our vision and objectives. In our original strategy we included a set of measures for children and adults. They were presented in four categories:

i. Outcomes
ii. Processes
iii. Experience
iv. Resources

Our Plan

When we established our strategy we did not have a baseline – or starting point – for every measure. They also have a range of review periods; for example, we measure four hour A&E target on a daily basis; smoking rates are published on an annual basis; the Index of Multiple Deprivation is published every four years. In terms of resources, whilst we have developed a far better understanding of overall NHS investment by the CCG and within individual providers services, there is still significant work to do to include local authority and other spend and to break this down between localities and adults and children’s services as well as to benchmark our investment with other areas.

Our Progress

We set out below progress against the four categories of metric and, as appropriate, where there has been change. As we develop our next Delivery Plan we will work with ICS partners to consider whether these or other metrics may be better to judge our progress.
### Outcomes

<table>
<thead>
<tr>
<th>Healthy Life Expectancy Suffolk</th>
<th>Inequality of Life Expectancy in Suffolk</th>
<th>Suicide Rate by 100,000 people in Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>M 63.2yrs F 65.1 years</td>
<td>M 7 years F 4.4 years</td>
<td>M 15.2 F 4.7</td>
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<table>
<thead>
<tr>
<th>Smoking Prevalence</th>
<th>Physically Active</th>
<th>Overweight or Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich 17%</td>
<td>Ipswich 67.6%</td>
<td>Ipswich 68.4%</td>
</tr>
<tr>
<td>East Suffolk 13%</td>
<td>East Suffolk 65.2%</td>
<td>East Suffolk 62.7%</td>
</tr>
<tr>
<td>Mid Suffolk 14.7%</td>
<td>Mid Suffolk 66.2%</td>
<td>Mid Suffolk 68.7%</td>
</tr>
<tr>
<td>Babergh 10.4%</td>
<td>Babergh 62.7%</td>
<td>Babergh 62.2%</td>
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<thead>
<tr>
<th>Ipswich Hospital</th>
<th>East Suffolk</th>
<th>Mid Suffolk</th>
<th>Babergh</th>
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<tbody>
<tr>
<td>17%</td>
<td>13%</td>
<td>14.7%</td>
<td>10.4%</td>
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### Processes

<table>
<thead>
<tr>
<th>IAPT in Ipswich &amp; East Suffolk</th>
<th>Accident &amp; Emergency</th>
<th>Referral to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>% people (18+) who have</td>
<td>Ipswich Hospital A&amp;E 4</td>
<td>Ipswich Hospital 18 week</td>
</tr>
<tr>
<td>completed IAPT moving to</td>
<td>hour standard 88.8% year</td>
<td>referral to treatment 81.4%</td>
</tr>
<tr>
<td>recovering 51%</td>
<td>to date</td>
<td></td>
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| Delayed Transfer of Care      | Primary Care          | Learning Disabilities   |
| (DTOC)                        | GP Primary care Quality outcomes 98.8% | LD Health Checks completed Q1 & Q2 34.4% |
| DIOC (Ipswich Hospital)       | GP Primary care Quality outcomes 98.8% | LD Health Checks completed Q1 & Q2 34.4% |
| 4.8% (October 19)             | GP Primary care Quality outcomes 98.8% | LD Health Checks completed Q1 & Q2 34.4% |

### Experience

<table>
<thead>
<tr>
<th>Ipswich Hospital</th>
<th>NSFT</th>
<th>Care Homes in Ipswich &amp; East Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC rating -</td>
<td>CQC rating -</td>
<td>CQC rating: Overall</td>
</tr>
<tr>
<td>Overall: Good</td>
<td>Overall: Inadequate</td>
<td>Outstanding: 12</td>
</tr>
<tr>
<td>Caring: Good</td>
<td>Caring: Good</td>
<td>Good: 62</td>
</tr>
<tr>
<td>Requires improvement: 9</td>
<td>Requires improvement: 9</td>
<td>Requires improvement: 9</td>
</tr>
<tr>
<td>Inadequate: 2</td>
<td>Inadequate: 2</td>
<td>Inadequate: 2</td>
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<tr>
<th>Staff survey</th>
<th>Primary Care IESCCG</th>
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<tbody>
<tr>
<td>ESNEFT Morale ~60%</td>
<td>GP Patient Survey: Overall experience 86%</td>
</tr>
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</table>
### How are we doing in numbers?

<table>
<thead>
<tr>
<th>Children</th>
</tr>
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<tbody>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td><strong>Smoking</strong>&lt;br&gt;Smoking status at time of delivery (Suffolk)&lt;br&gt;10.30%</td>
</tr>
<tr>
<td><strong>Obesity</strong>&lt;br&gt;Prevalence of obesity at Year 6 in Suffolk&lt;br&gt;Three year average 17.2%</td>
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<thead>
<tr>
<th>Processes</th>
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<tbody>
<tr>
<td><strong>Dental</strong>&lt;br&gt;Suffolk admissions for dental caries&lt;br&gt;206.2 per 100,000</td>
</tr>
<tr>
<td><strong>Self-Harm Hospital Admissions</strong>&lt;br&gt;Hospital admissions for self-harm (10-24 years)&lt;br&gt;450.8 per 100,000</td>
</tr>
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<table>
<thead>
<tr>
<th>Experience</th>
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<tbody>
<tr>
<td><strong>Children's services</strong>&lt;br&gt;Suffolk County Council Children’s Services - Outstanding</td>
</tr>
<tr>
<td><strong>Schools</strong>&lt;br&gt;Suffolk Schools Ofsted ratings – Outstanding 13.7%&lt;br&gt;Good 66%</td>
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<tr>
<th>Children and Adults</th>
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<tbody>
<tr>
<td><strong>Resources</strong></td>
</tr>
<tr>
<td><strong>NHS Budget 19/20</strong>&lt;br&gt;Acute commissioning £286m</td>
</tr>
<tr>
<td>Primary care £67.6m</td>
</tr>
<tr>
<td>Mental health £57.8m</td>
</tr>
<tr>
<td>Community £49.4m</td>
</tr>
</tbody>
</table>
How are we doing in numbers?

ADULT

<table>
<thead>
<tr>
<th>OUTCOMES</th>
<th>Source</th>
<th>URL</th>
<th>Data referring to</th>
<th>Comparing with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Life Expectancy</td>
<td>PHE Fingertips</td>
<td><a href="https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0">https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0</a> gid/1000049 pat/6 par/E1200006 ati/202 are/E10000029 iid/90366 age/1 sex/1</td>
<td>2015/17</td>
<td>N/A</td>
</tr>
<tr>
<td>Inequality of Life Expectancy</td>
<td>PHE Fingertips</td>
<td><a href="https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0">https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0</a> gid/1000049 pat/6 par/E1200006 ati/202 are/E06000055 iid/90366 age/1 sex/1</td>
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All data accessed on 10 Dec 2019

How are we doing in numbers?

References

ADULT

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## CHILDREN and RESOURCES (Adult & Children)

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This Progress Report describes the action that we have taken, to date, towards our vision and objectives. It demonstrates the practical difference we are making to individuals’ health and wellbeing and to staff’s working lives. Crucially, it describes how our we have lived our values of:


We now need to prepare our next five year Delivery Plan focused on our local needs and ambitions within the context of the Suffolk and North East Essex System Strategic Plan. As we do this, we will: take learning from our journey to date and consider existing actions, which require particular focus; consider actions, which it may be appropriate to stop or reduce; as well as new actions, which may be needed. We will develop our plan through our established and emerging Alliance partnership workstreams. We will give particular attention to the different needs and goals of our eight Connect localities.

Our plan will be published in Spring 2020.

For further details, please contact:

Maddie Baker-Woods
Chief Operating Officer
Ipswich and East Suffolk Clinical Commissioning Group and Alliance

01473 770000
Maddie.baker-woods@ipswichandeastsuffolkccg.nhs.uk
Working together with you