Improvement East

Section 1: Project overview

Project title	LAAs and LSPs - Supporting Joint Strategic Needs Assessment, Community Engagement and Social Inclusion

Lead authority	Suffolk County Council
Lead officer contact details	Graham Gatehouse, Director of Adult and Community Services, Suffolk County Council (Mr Gatehouse has now left this post)
Partner authorities involved	JIP Core Group Eleven DASS (East of England) Department of Health East of England RIEP Regional SHA SCIE Care Quality Commission GO East NHS East of England IDeA Skills for care CSED
Project description, purpose and outcomes	**Part One : JSNA Gap analysis** **Purpose** In collaboration with our regional partners to develop a gap analysis with accompanying recommendations -to cover the link between evidence-based local needs, and how these translate into coordinated partnership action and improved population level outcomes through the mechanism of the LAA/LSP. **Outcomes:** The work will define a JSNA model of best practice to take forward the JSNA related work of the Priority Councils. The model will focus on a revised process to include: 1. **Revised communication strategies** designed to identify stakeholders and their requirements from the JSNA at an early stage to ensure outputs are fit for purpose 2. **A programme management approach** to replace the present project management models, including revised Job Descriptions, structures and Boards to ensure governance and communication is effective and efficient 3. **Revised feedback protocols** to ensure members of the public have access to JSNA outputs and have the opportunity to comment and review 4. **Forecasting methodologies** reviewed to provide analysts with the capacity to develop forward looking (3 – 5 years)

	documents 5. **Themed based JSNA development** – breaking up the main document to meet the needs of stakeholders and interest groups 6. **Knowledge Portals** incorporating health and social care information / knowledge resources and toolkits, designed to meet the needs of end users. Also incorporating communities of practice, blogs, social networking functionality 7. Finally, a coherent Knowledge Management Strategy to ensure evidence is effective in driving improvement strategies across partnerships, inclusive of information audits, process definition, communication protocols, leadership requirements, resource allocation and evaluation tools. The final report and recommendations will be thoroughly tested against the needs of commissioners, stakeholders and key partners via a 2 month period of discussion, refinement and development following the 3rd Feb event and prior to submission of final report end of March 2010. The draft final report will be disseminated to all key stakeholders prior to regional dissemination **Part Two: Connected Care in Brandon** There is broad agreement about the direction of public service reform, with the emphasis on locally-based solutions, community empowerment and personalisation of services, to engage with the hardest to reach members of society. Connected Care fits with this agenda. Turning Point (a national charity) was commissioned by the JIP, the Department of Health Eastern Region Social Care and Partnerships Team, Suffolk County Council and NHS Suffolk to carry out a Connected Care pilot project in Brandon. Turning Point works with communities and commissioners to develop more responsive, joined-up services. They promoted evidence-based best practice for community engagement and community-led commissioning and support health, housing and social care commissioners to develop Connected Care services locally Connected Care engaged the local community in Brandon in the process of developing responsive, joined-up health and social care. Focusing on people living in the Brandon East and Brandon West wards, a programme of research was undertaken, by local people, into the community's experience of using services. They adopted a mixed research methodology for the Connected Care audit. This included a questionnaires with 632 local residents, semi-structured interviews with 19 local residents and two focus groups

	with people living across Brandon area who currently use services. They targeted people with particular conditions, issues and those who feel they have unmet support needs living in different parts of the community In total they engaged with just under 10 per cent of the population of the two Brandon wards. The data analysis was undertaken by researchers at Turning Point. The quantitative data collected through the questionnaires, it was analysed using SPSS a quantitative data analysis package. The qualitative data from the interviews and focus groups was coded to identify recurrent themes, case studies and examples of good practice using the qualitative data analysis package NVIVO. The community researchers were involved in identifying key issues to guide the analysis at the start of the process and also validating the findings once the analysis had been completed. Key findings from the analysis suggested Social Capital: The people of Brandon want to develop the community's social capital. They wanted more activities available to them and do not feel that enough activities are provided for young people or elderly people. They feel powerless to influence decisions in Brandon and social cohesion issues. An underdeveloped voluntary sector in Brandon also means there is little opportunity for voluntary organisations to network and build relationships with each other. Health and social Care: Overall we found that people living in Brandon are satisfied with many aspects of the services that they use, particularly health services. Reactions to social care and housing services were more mixed. People particularly wanted to receive more support from social care services around more practical low-level support services Access to services: Access to services was an issue raised time and time again throughout the course of the research. The most common barriers cited by the community were the location of services, the lack of public transport, waiting times, making appointments and opening hours, unfriendly reception staff and cultural barriers such as language. The people of Brandon want services to be more accessible to them. They want services located where possible in Brandon, they want longer opening times and shorter waits for appointments. They want friendly front line staff welcoming them into a service, more access to translators and information provided in languages other than English. Information: Information is a really important resource and whilst the majority of people in Brandon feel comfortable about finding information on health services, there are some real problems

	regarding access to information when one needs social care support. People in Brandon want to have clearer information about the services available in the local area as well as information on healthy living made easily available. Better coordination Brandon the community clearly identified a need for services to be better coordinated. People feel that services should work more closely with each other so that they don't have to continuously repeat their story to every professional they meet. Ideally, people want services based together in the same building so that services are more accessible. People also want to be able to see the same workers and build up a relationship with their GP's and carers Next steps The next stage of the Connected Care project is to use the findings from the audit to drive forward service improvement. This programme needs to reflect the community's priorities and ensure that the community is engaged in commissioning and service delivery. Connected Care will need to build on and complement the existing initiatives and services that already exist in Brandon. These services, in turn, need to provide a joined up response to people's needs. An overall recommendation for agencies stems from the recognition that the Connected Care project is an opportunity for commissioners to develop Brandon as a model of best practice for the provision of health and social care services to a rural community which can be replicated elsewhere in the region, and provide a feedback mechanism to government departments on best practice. A number of events will be held over the coming months. This will include an event to feedback the research findings to the community and an event to bring frontline health and social care workers together to improve joint working. There will also continue to be Connected Care steering group meetings to bring commissioners, providers and representatives from the local community together to develop a response to the research, based on the findings presented in this report. **A JIP film has been made about connected care and this will be available on the JIP web site by 31st March 2010**

Section 2: Final status

Original budget	The total budget for this project was £68,000
Actual total cost	Due to the time of submission of this paper the JIP are only able to make an estimate of final costs as all of the invoices have not yet been submitted The current estimate for the LSP, LAA, JSNA costs is approximately £55,000

	- £60,000. This means that everything was delivered under budget!
Cost savings and efficiencies achieved	**Part One** Efficiency saving are envisaged over a three year period. These will result from More effective use / access / dissemination of data (it is estimated by the Audit Commission that policy / strategy managers can use up to 85% of their time resolving data queries instead of identifying the key messages and applying these to their local context) It is estimated developing a knowledge management approach to JSNA development will produce a 50% return on the investment **Part Two: Connected Care** Early intervention and a more integrated approach is not only better for the service user, it also leads to big cost efficiencies. There is a growing body of evidence to suggest that integrated health and well-being services, in particular early intervention and prevention, can realise significant financial benefits. Studies have illustrated that integrated early intervention programmes can generate resource savings of over £2.50 for every £1 spent. (see Turning Point web site) Connected Care helps partnership working: As Local Authorities and PCTs are building links, working together, and in some cases actually merging, Connected Care focuses on finding out where the links are missing and providing solutions to bringing services closer together for the good of all. Connected Care is about knowing how to do things differently Turning Point help to provide solutions to integrated health and social care that aim to combine and co-ordinate all the services required to meet the assessed needs of the individual.

Original estimated end date	Part One: 31st March 2010 Part Two: December 2009
Actual end date	31st March 2010 No Variance

Section 3: Achievements and learning

Were the original objectives achieved?	Part One: All objectives have been achieved. Extra objectives have been added as the project has progressed to include: 1. Developing a model of best practice for producing JSNA

	resources 2. Producing a Toolkit of resources to allow practitioners to develop their capacity and capability locally Part Two: All objectives have been achieved.
Were the end users/clients satisfied with the project?	Part One: There was an overwhelming positive response to 3rd Feb Feedback Day to the JSNA Regional Network (where key issues were identified and improvement strategies agreed) Part Two: The JIP Cross cutting work stream made a film about the connected care process with the community. There was clear evidence that the community were pleased with both the connected care process and the film. However, it will be up to NHS Suffolk and Suffolk County Council to ensure that the work is taken forward. As they are a central part of the steering group we envisage that this should happen.
Lessons learned: project planning	Part One: The project was effectively managed and driven forward. In terms of key lessons learnt these include: 1. Developing more effective linkages with ADASS 2. Developing earlier links with the JSNA Network may have saved time. Part Two: The connected care process is an evidence based process- so although it was a pilot for our region it was a tried and tested method. It is envisaged that it will be used in other settings across the region as it contributes towards a deeper understanding of the JSNA . Connected Care brings the voice and views of the community to increase understanding of the needs and aspirations of service users. It has the potential to deliver 'more for less' through a cost benefit model of service integration and deliver service transformations that improve the experience of local residents whilst prioritising available investment.
Lessons learned: effectiveness of project	Part One: The effectiveness of the project will be judged by how comprehensively the recommendations are accepted and implemented by senior managers across the region. Part Two: There is a lack of social capital in Brandon which is associated with the limited number of activities, a feeling of powerlessness to influence decision making, and an underdeveloped voluntary sector. People in Brandon face difficulties accessing services due to the town's rural location and poor public transport provision. People in Brandon want to have clearer information about the services available in the local area as well as information on healthy living made easily available. There is also some confusion over social care provision in the area due to a lack of clear information.

	The community would like to see services and staff work more closely with one another. There is great support for bringing more services to Brandon and for them to be conveniently located under one roof.
Were any unexpected opportunities identified and realised?	Part One: A key opportunity was identified and realised in relation to a link with IDeA who provided project support and facilitated key parts of the project, including links with other regions, evaluating Forecasting methodologies, and developing communication strategies. Part Two: The process of connected care helped to build the confidence of the community researchers and they are potentially key people to help to embed change within their own community~ Turning Point had recognised this and is building this new community capacity into plans for the next steps (Turning Point are currently bidding to other agencies to move this project forward)
What went right?	Part One: Most of the project went right, it followed established process in defining issues, analysing and recommending improvements in a structured process, involving all key stakeholders. Part Two: Turing Point employed a skilled researcher to lead the community processes and the whole project was evidence based so the community engagement process was very effective and the community researchers spoke to people in their own community that they usually did not talk to! Significantly, the project included views from people with learning disabilities, people who are drug dependant, people from minority communities as well as elders in the community.
What went wrong?	Part One: More time spent on early partnership engagement may have been productive. Part two: As far as JIP has been informed Connected Care proceeded as planned.
Were risks identified and mitigated?	Part One: Key risk: the report is ignored by decision makers Mitigation: developing a business case which stressed efficiencies gained from new ways of working. Also addressing the key issue of linkages between data and commissioner activity. Part Two: Suffolk NHS and Suffolk CC do not respond to the findings of the Connected Care process in Brandon. Mitigation: Turing Point have already bid for funding to move the project forward. Also Suffolk CC and Suffolk NHS are still active on the steering board.
What could have been done to improve the project?	Part One: N/A Part Two: greater commitment from Brandon Council would have been useful

Section 4: The future

Would the project merit evaluation in the future?	Part One: The project's success criteria will be set out and clearly defined in the final report. Evaluation would be a useful next step but would need to take place at key stages over a 2 year period, involving key stakeholders across a range of agencies. Part Two: Given the high level of engagement and commitment by the community, an external evaluation would be useful to see if Suffolk CC and Suffolk NHS did make changes to their services in response to the findings of the project
Has learning been shared? How will it be?	Part One: The final report will be accompanied by a Toolkit of resources to enable project managers to implement the main recommendations in a structured and consistent manner across the region. Part Two: A film has been made about connected care in Brandon and this will be available on the JIP web site by the 31st March 2010. Turing Point is taking the project forward (with funding from other sources)

Section 5: Improvement East performance

Please comment on the effectiveness of Improvement East throughout the project	Part One and Two: Improvement East has always supported the work of the JIP and the staff are quick to offer information, support and advice, as requested.

Section 6: Cluster evaluation

Comments from the Cluster:	*This section to be completed by the relevant Improvement East Cluster Group.*