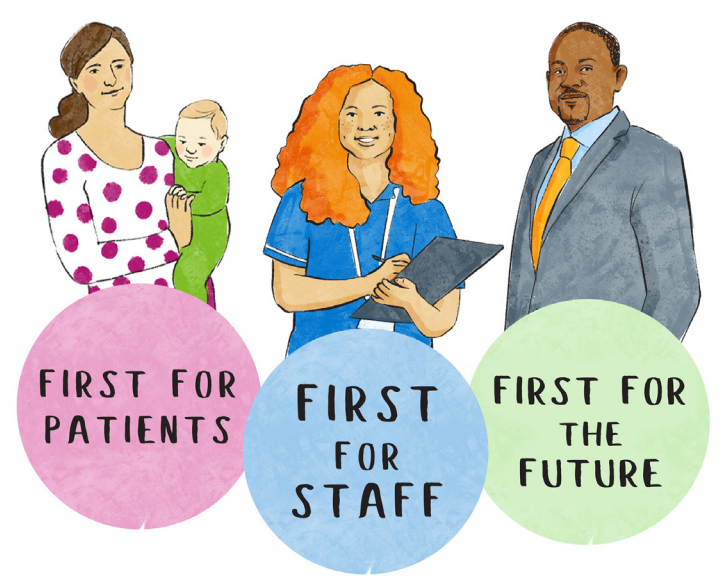
NHS
West Suffolk
NHS Foundation Trust

Prevention, health inequalities and personalised care strategy

West Suffolk NHS Foundation Trust

2023 - 2031



Putting you first

Introduction

West Suffolk NHS Foundation Trust (WSFT) provides hospital and adult community services to a largely rural geographical area with a population approaching 280,000 people. The catchment area extends beyond Thetford in the north and Sudbury in the south, to Newmarket to the west and Stowmarket to the east. The trust also provides integrated community services for children and young people who live in Ipswich and East Suffolk. Overall, the trust serves populations in the west and east of Suffolk and in parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The trust employs nearly 5000 staff who work from a range of different bases including hospitals, health centres, community hubs, GP surgeries, patients' homes and their own homes.

The trust is a member of a place-based partnership in the West Suffolk Alliance, within the Suffolk and North East Essex Integrated Care System.

Vision and values

Our vision

In 2021, the trust published a new five-year strategy, First for our patients, staff and the future. It lays out how the trust will deliver its vision of the best quality and safest care for our local community, in the aftermath of the Covid-19 pandemic and in an increasingly joined-up landscape, where the NHS, community services, councils and the voluntary sector are working closer together than ever before.

Vision:
To deliver the best quality and safest care for our local community

Ambition: First for patients	Ambition: First for staff	Ambition: First for the future
• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes.	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development.	• Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology.

Powered by our First Trust Values
Fairness • Inclusivity • Respect • Safety • Teamwork

The First for the Future ambition includes the aim to **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities**, which speaks directly to the population we serve:

Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities

By wellbeing we mean looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make you better when you are ill, and to support you to help keep yourself well in the first place.

- We will adapt our services to do more to increase everyone's wellbeing and prevent ill health
- We will recognise and value the role you play in managing your own health and wellbeing, involving you in conversations and decisions about your health and care, moving from 'what's the matter with you?' to 'what matters to you?'
- We will maximise our social impact as an anchor institution rooted in our local community – providing training and employment opportunities for local people, buying from local businesses, supporting local charities and community groups
- We will minimise our environmental impact with our Green Plan

This prevention, health inequalities and personalised care strategy has been created to help achieve the first three goals on the list. The Green Plan is managed and governed separately. The Green Plan is published here.

Our values

Alongside our vision and ambitions, we share five core values which reflect the culture we are striving to create across the Trust.

Our FIRST trust values are:

- Fairness – We value fairness and treat each other appropriately and justly
- Inclusivity – We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation
- Respect – We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves
- Safety – We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement
- Teamwork – We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

The FIRST values have been used to help create the prevention, health inequalities and personalised care strategy. Following the prevention, health inequalities and personalised care strategy will help us adhere to the values that we share.

Why do we need a prevention, health inequalities and personalised care strategy?

The needs of our local population, the nature of healthcare, the healthcare workforce and the ways in which clinical and non-clinical services are delivered have changed immeasurably over the last decade, even before the radical changes and unique challenges brought about by the Covid-19 pandemic.

The NHS Long Term Plan (NHS England, n.d.) clearly states that the NHS can and should take more action on prevention, health inequalities and personalised care to help improve the population's health and allow itself the best possible chance of meeting growing demand.

In Suffolk, we have known for some time that the growth in demand for healthcare services is unsustainable. In 2017, Suffolk County Council published analysis that showed that by 2037, another 2 hospitals the size of West Suffolk Hospital would be needed if the trend in hospital admissions didn't change (Suffolk Public Health & Communities, 2017). We are experiencing this rise in all our services, be it more district nurse visits, more children's community clinics, or more A&E attendances, for example.

WSFT is helping to tackle this crisis by joining up care within the trust and with other local organisations as a member of the West Suffolk Alliance[1] and Suffolk and North East Essex Integrated Care System[2]; through the Joint Forward Plan[3], the Alliance Live Well framework[4], our clinical and care strategy[5] and the Future System Programme[6]. It is starting to bear fruit; repeating the analysis in 2022, Suffolk County Council now estimates that only 1.5 new hospitals would be needed by 2042 (Suffolk Public Health & Communities, 2022). This is excellent progress, but it also shows that joining up care and shifting the emphasis away from a reliance on hospital specialists cannot be the whole answer.

The trust has an important and powerful role to play in helping people not to get sick in the first place, and making sure that when they do need our help, everyone gets the care they need fairly and tailored to their circumstances.

We can play this role alongside local residents, communities, councils and employers. By changing the trend, we will help our friends, families and neighbours in west Suffolk and the surrounding areas to enjoy fairer, happier, healthier lives. They will also have a better experience of our care and get more benefit from our care when they do need to visit us.

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[1] https://www.sneeics.org.uk/working-together/working-together-in-place-based-alliances/west-suffolk-alliance/
[2] www.sneeics.org.uk
[3] https://suffolkandnortheastessex.icb.nhs.uk/wp-content/uploads/2023/06/15427-SNEE-ICB-Joint-Forward-Plan-2023-2028-PROOF_20.pdf
[4] https://www.sneeics.org.uk/live-well/
[5] Please see https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-21-July-2023.pdf pages 77-104
[6] Please see www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.apsx for more information

We are building on strong foundations

This is not our first prevention, health inequalities and personalised care strategy. In 2017, we published our first strategy (West Suffolk NHS Foundation Trust, 2017/18) and talked about our aspiration to truly be a national health service, not just a national illness service (box 1).

Box 1: Our track record

We have been training staff in health coaching since it began being used in England in 2014. The programme has been independently evaluated by the Institute of Employment Studies (Institute for Employment Studies, 2018) and Healthwatch Suffolk (Healthwatch Suffolk, 2023).

Our catering team have held an Eat Out, Eat Well award for the fresh, healthy food it serves since 2016

WSFT's volunteer service was recognised by Helpforce in 2017 for the wide range of volunteering opportunities it offered (Helpforce, 2019). Volunteering encourages good mental health and is one of the Five Ways to Wellbeing (NHS Confederation & New Economics Foundation, 2011)

Our asset-based approach to staff health and wellbeing, with a particular focus on mental wellbeing, was shortlisted in the staff engagement category of the Health Service Journal Awards 2017

WSFT was the first acute trust in the East of England to employ a public health specialist in 2018

All healthcare support workers have been trained in Making Every Contact Count as part of their Care Certificate since 2018

We have provided free membership for staff at the local leisure centres run by Abbeycroft Leisure since 2021

We have worked with several organisations over the years to provide stop smoking advice, weight management classes, and exercise-on-referral schemes for patients and staff

Prevention, health inequalities and personalised care have also become established as core components of high-quality care (box 2). The objectives this strategy sets are not nice-to-haves; they are part of our day-to-day responsibility to the people that we serve.

Box 2: Regulatory and contractual requirements

The Care Quality Commission assesses NHS trusts with four relevant key lines of enquiry:

E5. How are people supported to live healthier lives and, where the services is responsible, how does it improve the health of its population

C2. How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?

R1. How do people receive personalised care that is responsive to their needs?

R2. Do services take account of the particular needs and choices of different people?

The NHS standard contract 2022/23 (NHS England, 2022) has 6 relevant sections:

Service condition 8: Unmet need, Making Every Contact Count and Self-Care

Service condition 10: Personalised care

Service condition 13: Equity of access, equality and non-discrimination, including the trust's duties under the Equality Act 2010

Service condition 18: Green NHS and Sustainability, including the trust's responsibility to procure for Social Value (UK Government, 2020)

Service condition 19: Food standards and sugar-sweetened beverages

Schedule 2M: Development plan for personalised care

Schedule 2N: Health inequalities action plan

It is important that the trust focusses on its unique role in prevention, health inequalities and personalised care, working *with* partners but not duplicating other organisations' efforts. The NHS Providers Population Health Framework for Healthcare Providers (NHS Providers, 2019) is invaluable as a reference resource and a source of standards (Figure 1).

Figure 1: NHS Providers Population Health Framework for Healthcare Providers


COLLABORATIVE
WORKING
Prevention and health improvement
Interventions with patients
Workforce health
Healthy environment and culture
Strategy and policies
Population healthcare and health services
Value
Population view of healthcare
Using data and evidence
Effectiveness, quality and safety
Community role and wider determinants
Reducing health inequalities
Equitable access
Sustainability
Employment practices
Procurement
Health protection
Emergency planning
Screening
Immunisations
Infection prevention and control

How this strategy has been created

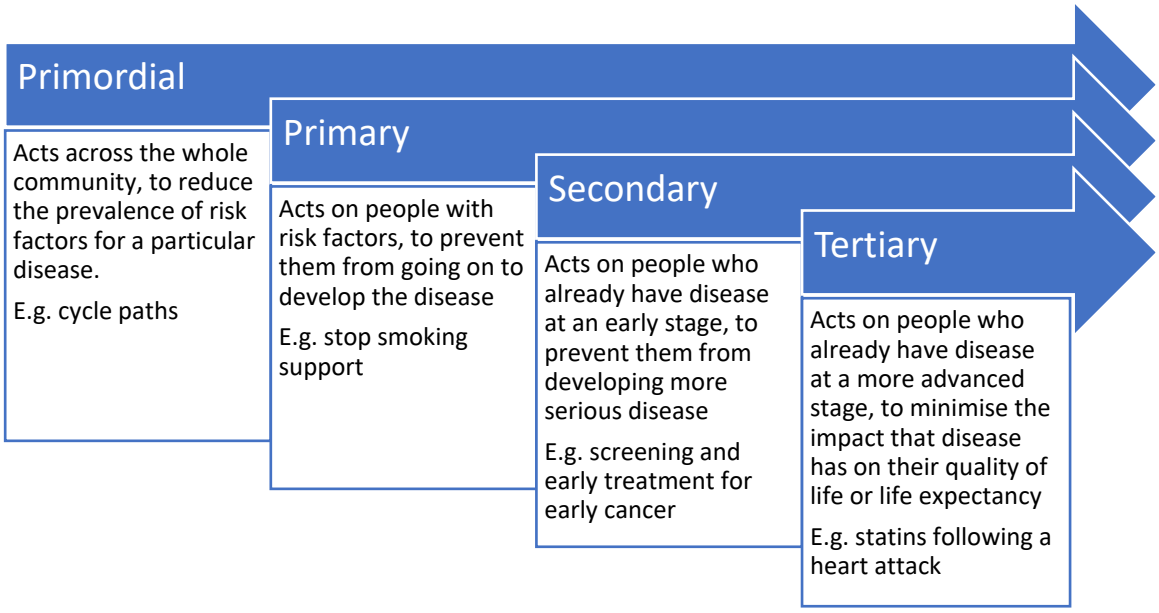
Over the next three chapters, prevention, health inequalities and personalised care will be defined as topics and set in the context of the national and local policy. For each topic, an analysis of strengths, weaknesses, opportunities and threats (SWOT) has been performed, comparing WSFT's current approaches with the evidence base for best practice (page 12, page 20, and page 27).

On the basis of the SWOT analyses, SMART objectives have been set (page 29) and an asset-based approach has been used to define an action plan for 2023-25 in the first instance (page 32).

Progress will be measured using well-designed metrics (page 34) and a continuous improvement ethos will be followed. We will review the content of the strategy on an annual basis to make sure it is up to date with best practice and we will refresh the action plan to reflect what we have achieved and what we are finding difficult.

Prevention

Prevention can be categorised into four levels:



The terms prevention and health improvement are often used interchangeably. There are several schools of thought on the prevention topics that the trust could prioritise:

- The NHS Long Term Plan focuses on smoking, obesity, alcohol, air pollution and antimicrobial resistance
- The Population Health Framework for Providers adds in workplace health and healthy premises
- The SNEE Joint Forward Plan prioritises healthy behaviours, naming tobacco, alcohol, drugs, weight, physical activity, and sleep as risk factors that need attention

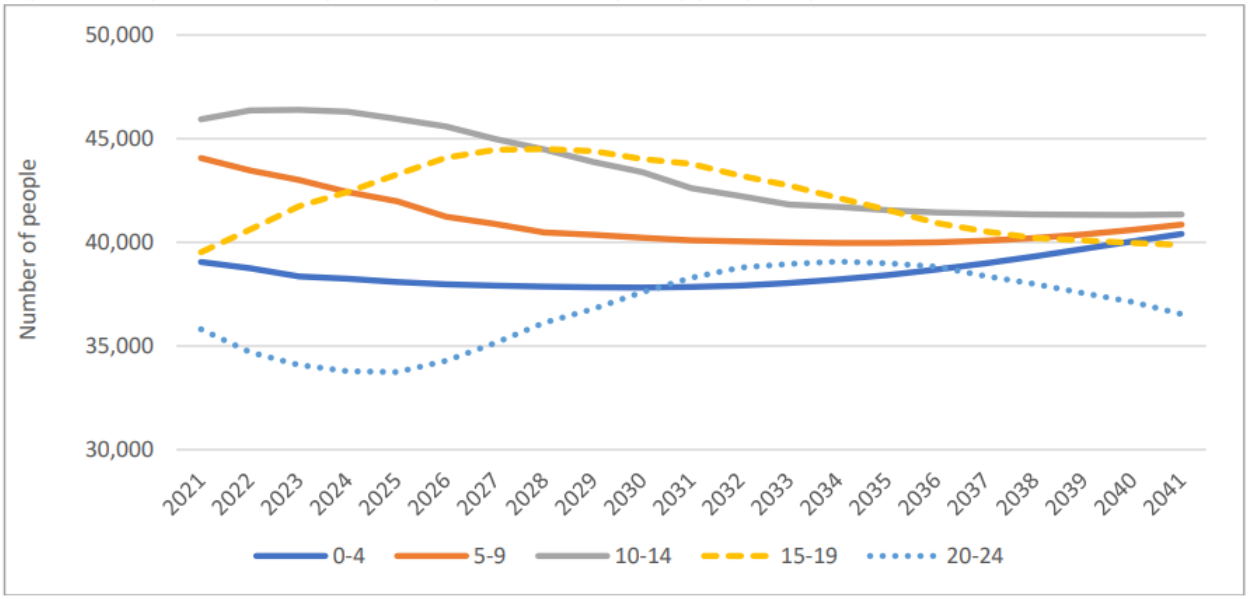
What do we know?

Our local population – population forecasts for the WSFT catchment area for district general hospital and adult community services

Age group	2021	2031	
0-14	41,025	39,689	↓ 3.3%
15-64	139,788	138,812	↓ 0.7%
65-74	27,331	30,393	↑ 11.2%
75+	26,353	33,841	↑ 28.4%
Total	234,497	242,735	↑ 3.5%

Our local population – population forecasts for the WSFT catchment area for children and young people's community services

Figure 2: Population change among children and young people aged 0-24 in Suffolk (2021 to 2041)



Source: The State of Children in Suffolk 2022 (Suffolk Public Health & Communities, 2022)

Risk factors

Obesity = 32% children and 61% of adults overweight or obese

Smoking = 16% adults smoke

Loneliness = 18% adults feel lonely

Physical activity = 29% adults physically inactive

People's experience of their health

17% people do not enjoy good health

16.5% people's day to day activities limited by a health condition or disability, including 8.5% of children and young people aged 24 or younger

Disease prevalence

People are not defined by their illnesses, but the health and care services they require are. Amongst our local population:

1 in 8 people are diagnosed with depression

1 in 126 live with a severe mental illness

1 in 6 children and young people have a probable mental health disorder

1 in 6 adults have high blood pressure

1 in 13 with asthma

1 in 44 with COPD

1 in 82 with heart failure

1 in 50 have had a stroke or transient ischaemic attack

1 in 12 have diabetes

1 in 113 have dementia

1 in 200 have a learning disability

1 in 23 have cancer

And for many people these diagnoses co-exist; increasingly people in our communities are living with multiple long-term conditions over many years.

The benefits of prevention

Healthy behaviours, social connection and healthy environments improve people's health and wellbeing.

For example:

Primordial:

Access to green and open spaces such as parks, gardens and woodlands improves mental health and happiness and reduces the risk of heart disease, obesity, cancer and musculoskeletal conditions (The King's Fund, 2023)

Primary:

Drinking less than 14 units of alcohol a week reduces a person's risk of heart disease, stroke, cancer, liver disease, injury, self-harm, and harm from risky behaviours. People who drink within the recommended limit enjoy better mood and memory and they sleep better (NHS, n.d.)

Secondary:

Recently diagnosed type 2 diabetes can be put into remission by weight loss in people who are overweight or obese (Lean, et al., 2019)

Tertiary:

Stopping smoking at or after the time of diagnosis improves survivorship from a number of different cancers (Toll, Brandon, Gritz, Warren, & Herbst, 2013). An average smoker will also save around £2000 a year by quitting (NHS, n.d.).

How are things now?

The SWOT analysis on prevention is shown in Figure 3.

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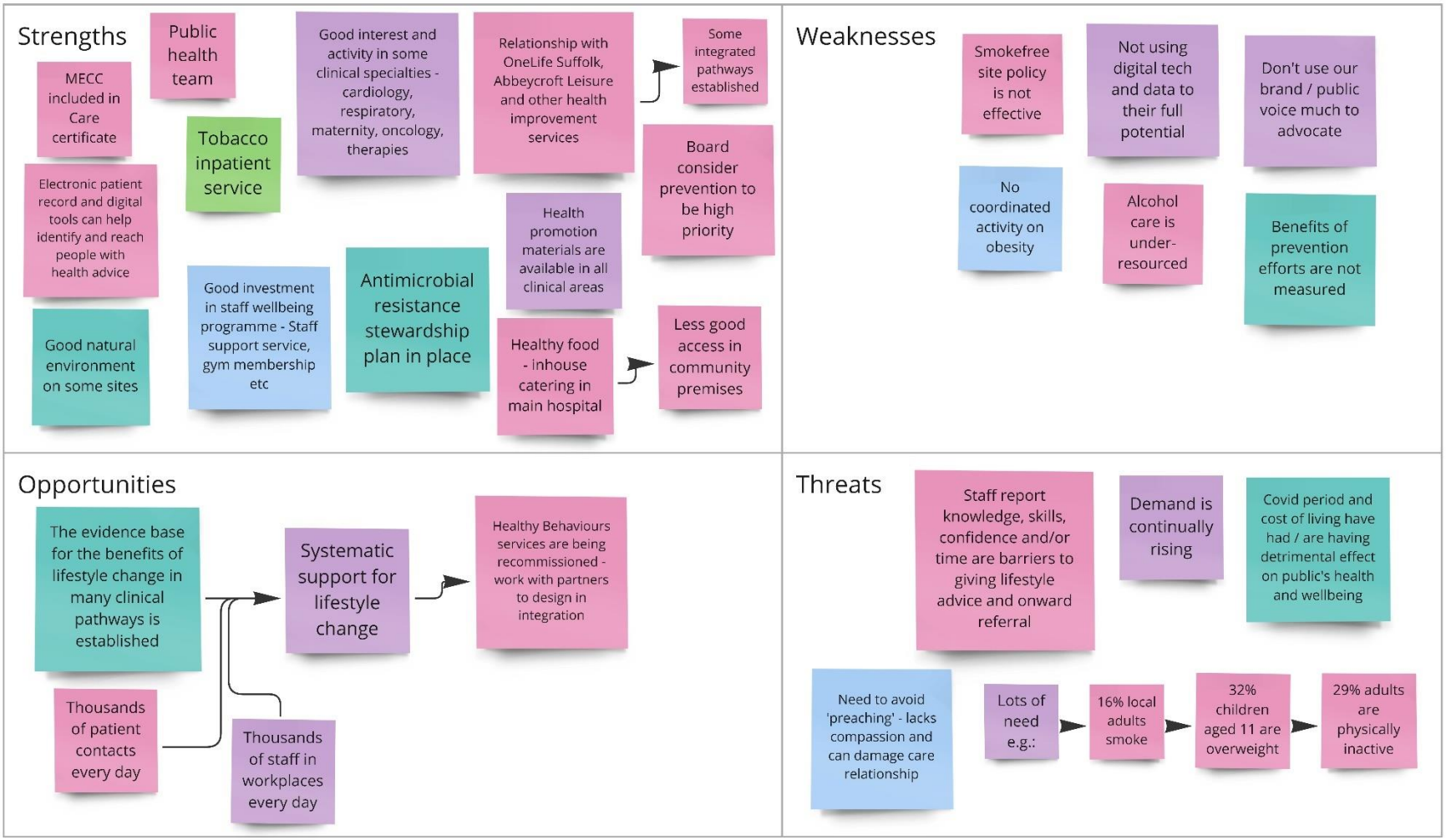
Figure 3: SWOT analysis for prevention



In summary

WSFT does some good work on prevention and there is a big opportunity to scale it up so that every service user and staff member can benefit if they wish. The challenge will be in doing so in a way that makes it realistic to achieve.

Health inequalities

Health inequalities are **unfair and avoidable** differences in health across the population, and between different groups within society.

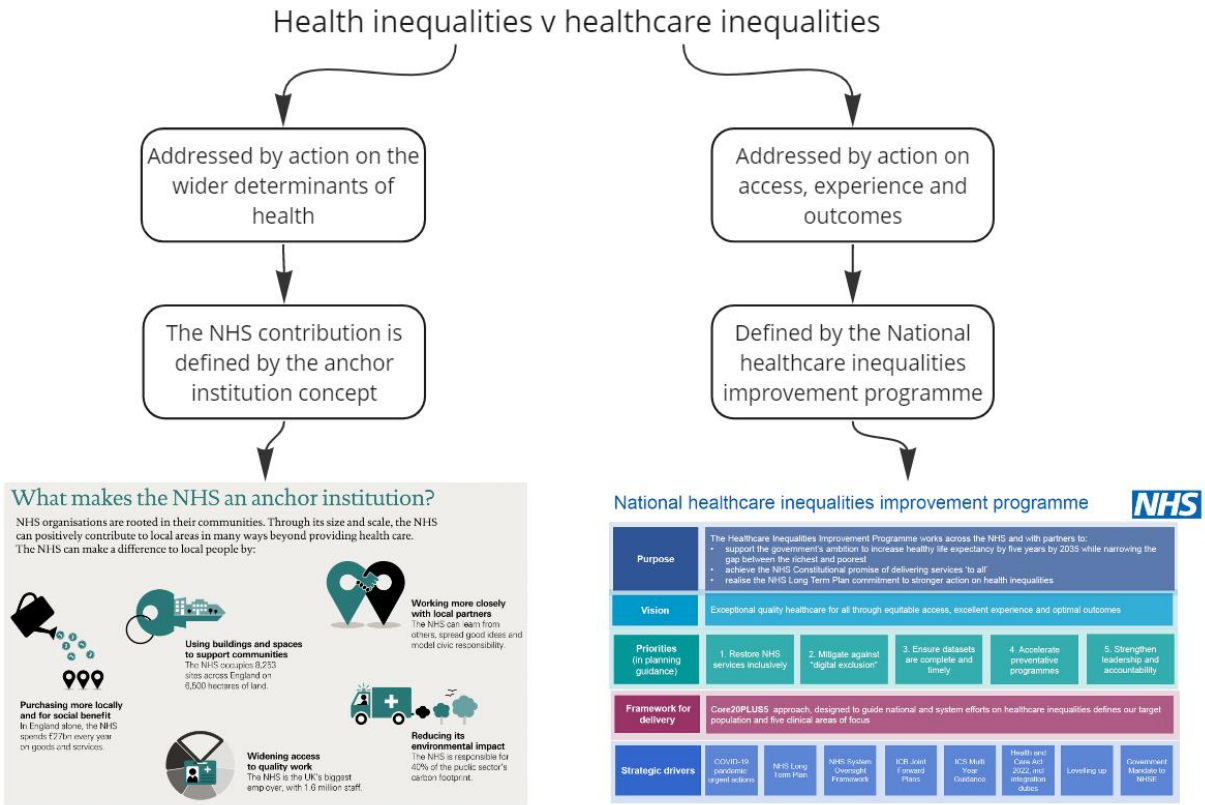
They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing.

Within this wider context, **healthcare** inequalities are about the **access** people have to health services and their **experience** and **outcomes**.

NHS England (NHS England, n.d.)

NHS trusts have a role and responsibility to improve both health inequalities and healthcare inequalities (Figure 4).

Figure 4: Frameworks guiding the actions NHS trusts can take to improve health inequalities and healthcare inequalities (Reed, Gopfert, Wood, Allwood, & Warburton, 2019), (Future NHS, n.d.)



Health inequalities

It is widely accepted that only about 20% of health is down to healthcare (The Health Foundation, 2018). Thirty percent is achieved through healthy behaviours; and the other 50% is down to what are called the 'wider determinants of health' (Figure 5). They include economic factors like household income, social factors like high quality education and environment factors like good housing.

Not only do the wider determinants of health have a direct effect on disease and illness – such as damp housing causing respiratory illness in children – they also influence how much control

people have over their social interactions and their lifestyle 'choices' – illustrated in the famous Dahlgren and Whitehead rainbow in Figure 6.

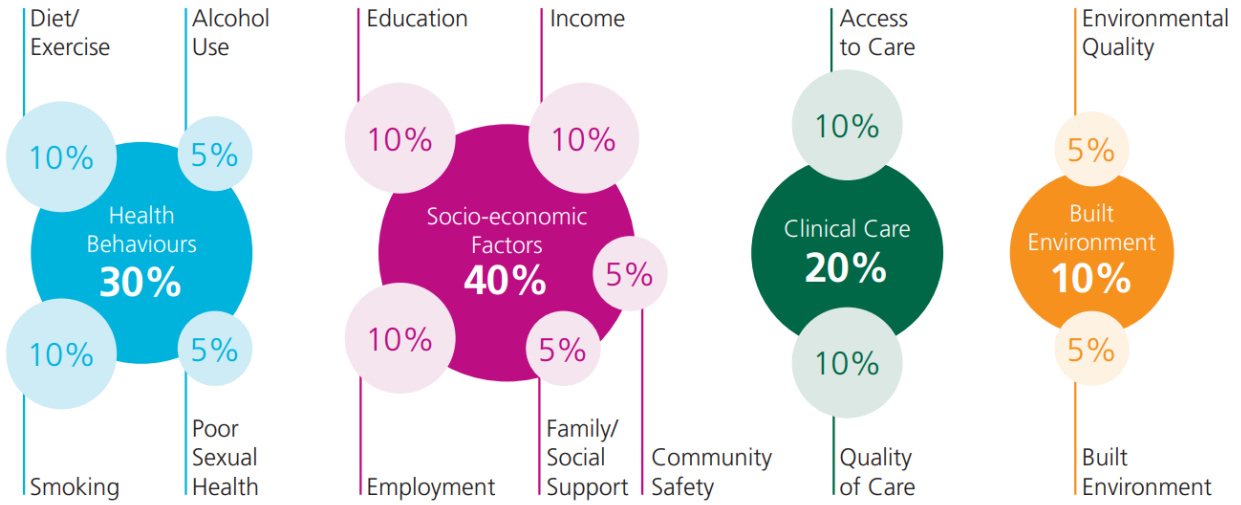


Figure 5: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute County Health Rankings model for determining the wider determinants of population health (Suffolk and North East Essex Integrated Care Board, 2023)

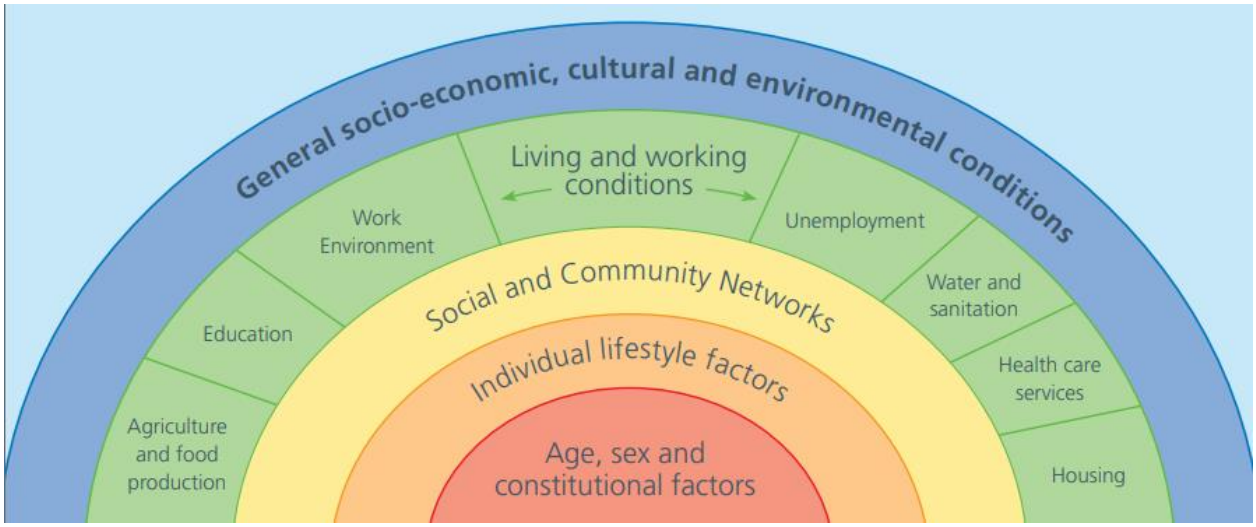


Figure 6: The factors that influence an individual's health and wellbeing – the Dahlgren-Whitehead rainbow (after (Dahlgren & Whitehead, 2006)

As Michael Marmot wrote in his landmark review of health inequalities in England in 2010 (University College London, 2010), "inequalities in health arise because of inequalities in society" (page 16). The wider determinants of health - good housing, good work, healthy food, good education, green space and clean air to name just a few - are not distributed evenly. The Marmot Review showed how this affects life expectancy, quality of life, and the national economy.

WSFT can help reduce health inequalities in the local population in a number of different ways:

- How it acts as an employer
- How it uses its purchasing power
- How it collaborates with local organisations and communities

- How seriously it takes its responsibility to help tackle the climate emergency.

Large organisations which can have a sizeable impact on the health and wellbeing of their local population, through the wider determinants of health, are referred to as ‘anchor institutions’.

It is important to make sure that the impact is had in such a way that it definitely reduces inequality, though, rather than exacerbating it.

The Health Foundation convenes a learning network to help NHS bodies increase their anchor impact. SNEE ICS has an ICS Anchor Charter to which all ICS members are signatories.

Healthcare inequalities

If health inequalities are caused by the unfair disadvantages that are created beyond the boundaries of our organisation, health**care** inequalities are caused by the unfair disadvantages that are created within it.

Not everyone finds our services equally accessible; not everyone experiences the same quality of care from us; not everyone gets the same benefit from the care we provide.

These are difficult truths to accept. No member of the NHS workforce sets out to provide care inequitably and no organisation sets out to deliver services in a way which is unfair.

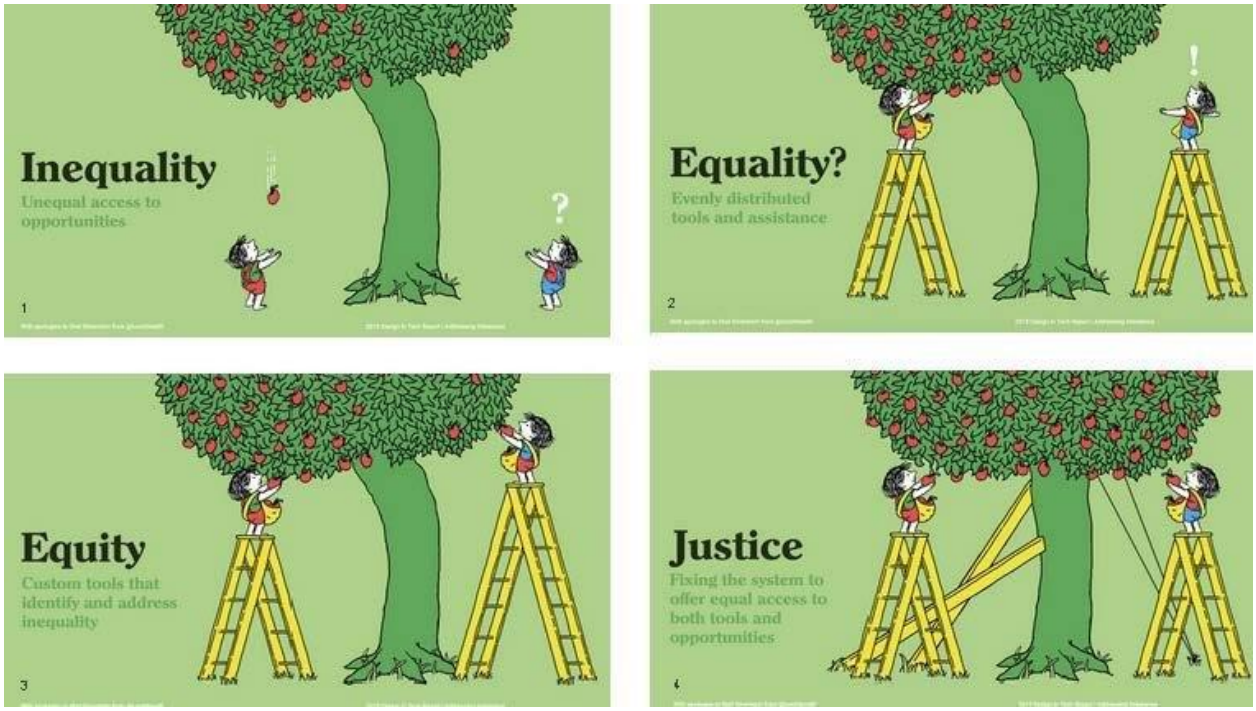


Figure 7: Equality, equity and justice (Ruth)

The problem arises from the intention to treat everyone equally, when, as Marmot explained, their needs are not equal in the first place (Figure 7). Language, literacy, culture, financial resources, and many other wider determinants of health have a heavy influence on:

1. The effectiveness of the interactions between individual patients and their healthcare professionals
2. How easily patients and their carers can navigate our buildings, our websites, the various roles and responsibilities of our services, and how we connect into rest of NHS and beyond.

The take-home point is this:

If we are not actively trying to reduce healthcare inequalities, we are almost certainly inadvertently widening them.

The national healthcare inequalities improvement programme (HIIP) has been set up specifically to help NHS organisations understand and start to address healthcare inequalities. It breaks this vast topic down into a set of focussed, manageable, impactful first steps.

The priorities that are laid out in the HIIP are:

1. Restoring NHS services inclusively (focusing on elective waiting lists)
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely (focusing on ethnicity data first)
4. Accelerating preventative programme (including the Core20PLUS5 approach – see below)
5. Strengthening leadership and accountability

Objectives and key lines of enquiry have been developed for each priority. The objectives are provided in Appendix 1 and our position against them is summarised in the SWOT analysis in Figure 12.

The Core20PLUS5 approach is a method for identifying the population groups who are most affected by healthcare inequalities and the clinical interventions that will have the greatest impact on improving those inequalities quickly. Tailored versions of Core20PLUS5 have been created for adults (Figure 8) and for children and young people (Figure 9).

Figure 8: Core20PLUS5 approach to healthcare inequalities for adults (NHS England, n.d.)

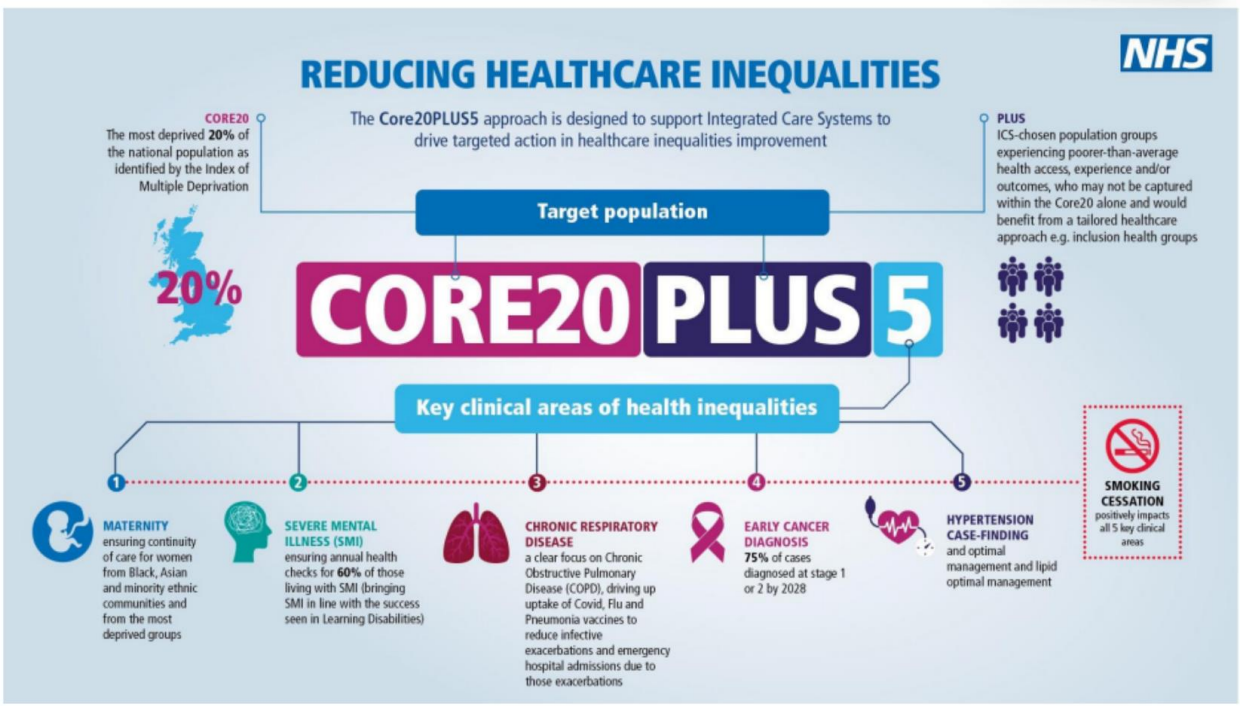
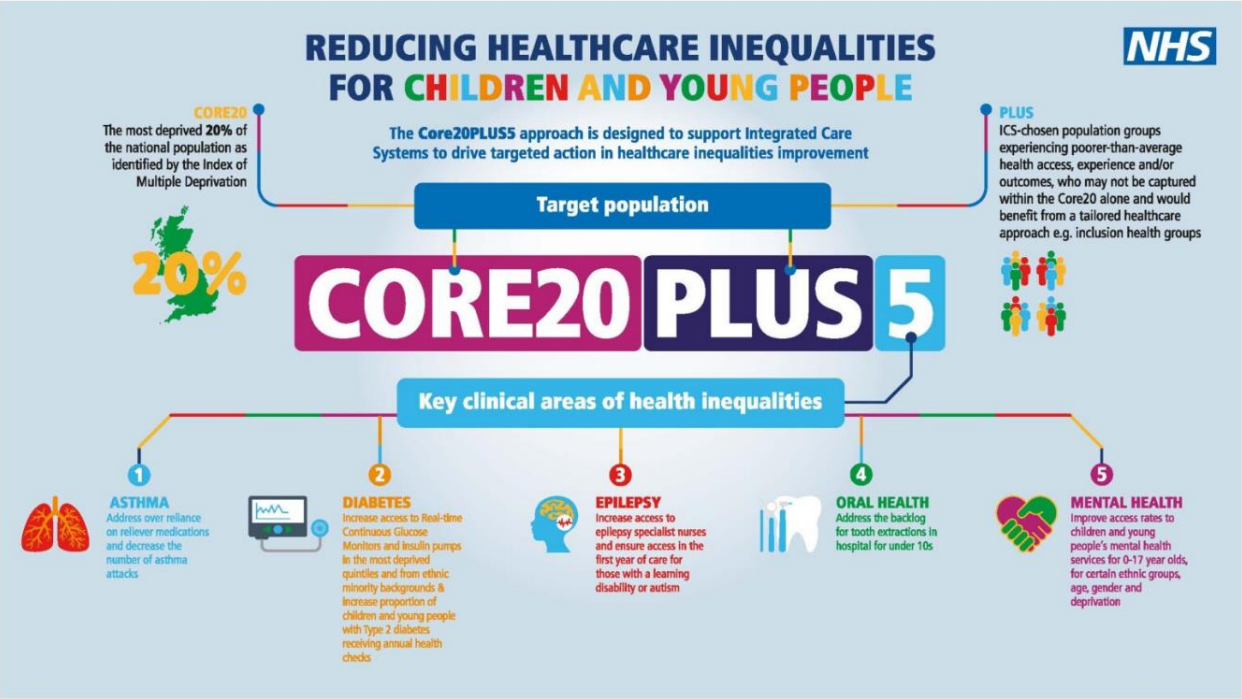


Figure 9: Core20PLUS5 approach to healthcare inequalities for children and young people (NHS England, n.d.)

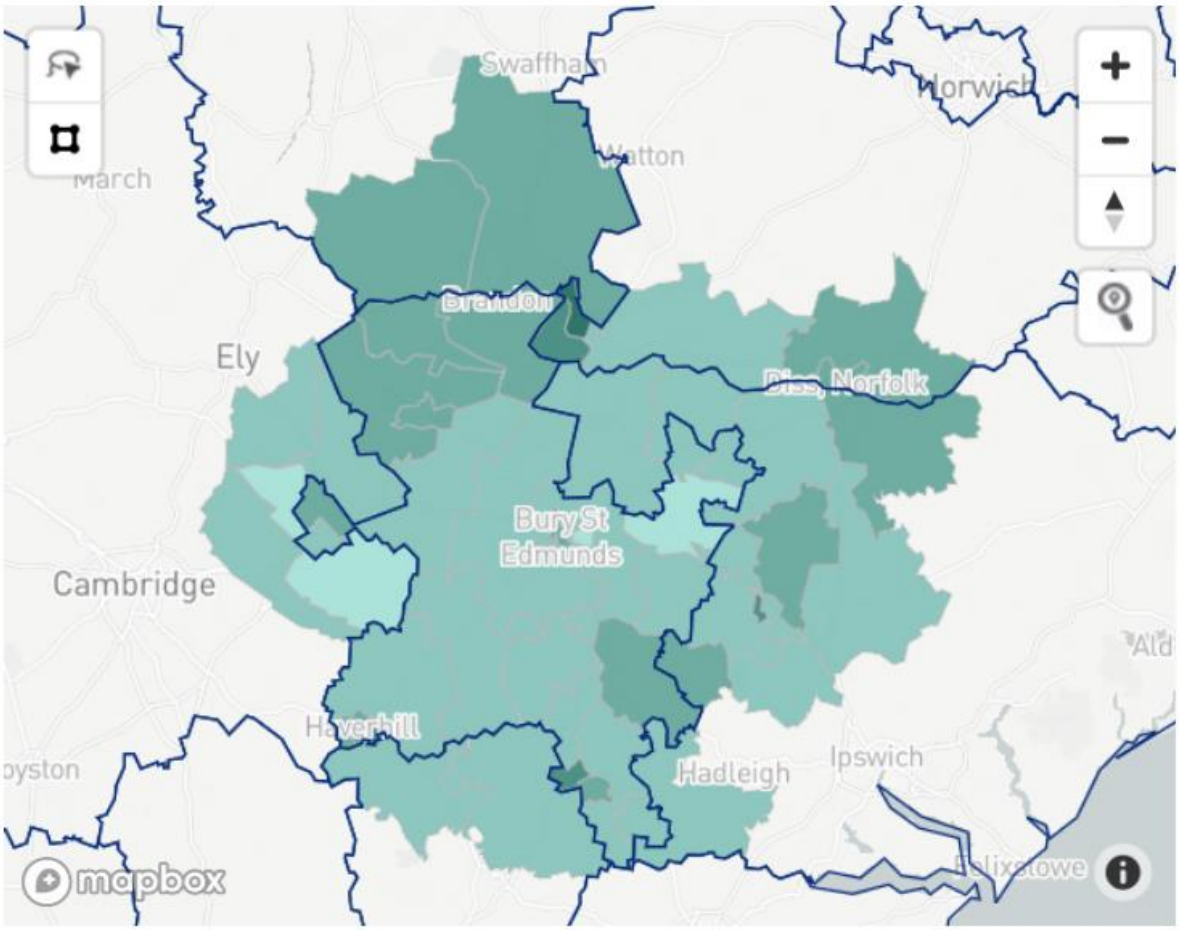


What do we know?

In the WSFT catchment area, there are a lower number of people living in deprived areas than the national or regional average (Figure 10), with four neighbourhoods in the 20% most deprived nationally.

Figure 10: WSFT catchment area (defined by hospital admissions) by deprivation quintile (OHID, 2022)

IMD Quintile of Hospital Catchment



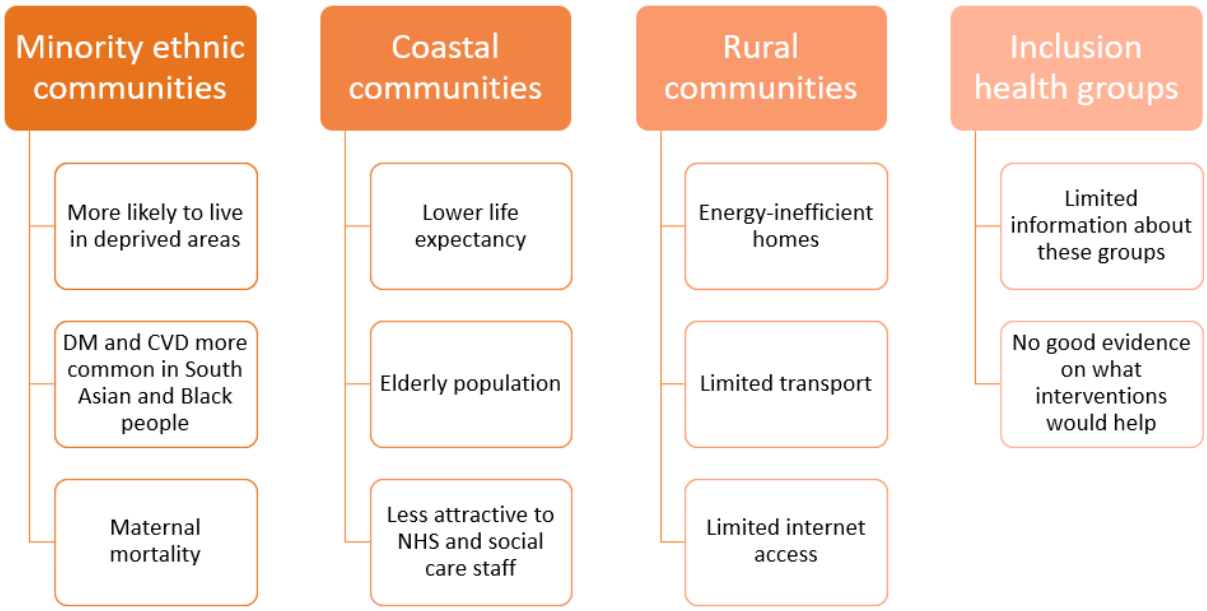
Q1 - Most Deprived
Q2
Q3
Q4
Q5 - Least Deprived

SNEE ICS has defined the PLUS populations as follows:

- People from minority ethnic groups
- Coastal communities
- Rural communities
- People and groups facing the sharpest health inequalities (groups at risk of disadvantage or “inclusion” health groups) e.g., migrants, travellers, those who are homeless, those in prison and sex workers
- People with learning disabilities and/or autism
- People with more than one health condition

West Suffolk does not have a coastline but otherwise a large proportion of our population will be covered by at least one of these categories. The nature of some of the disadvantages they face is shown in Figure 11.

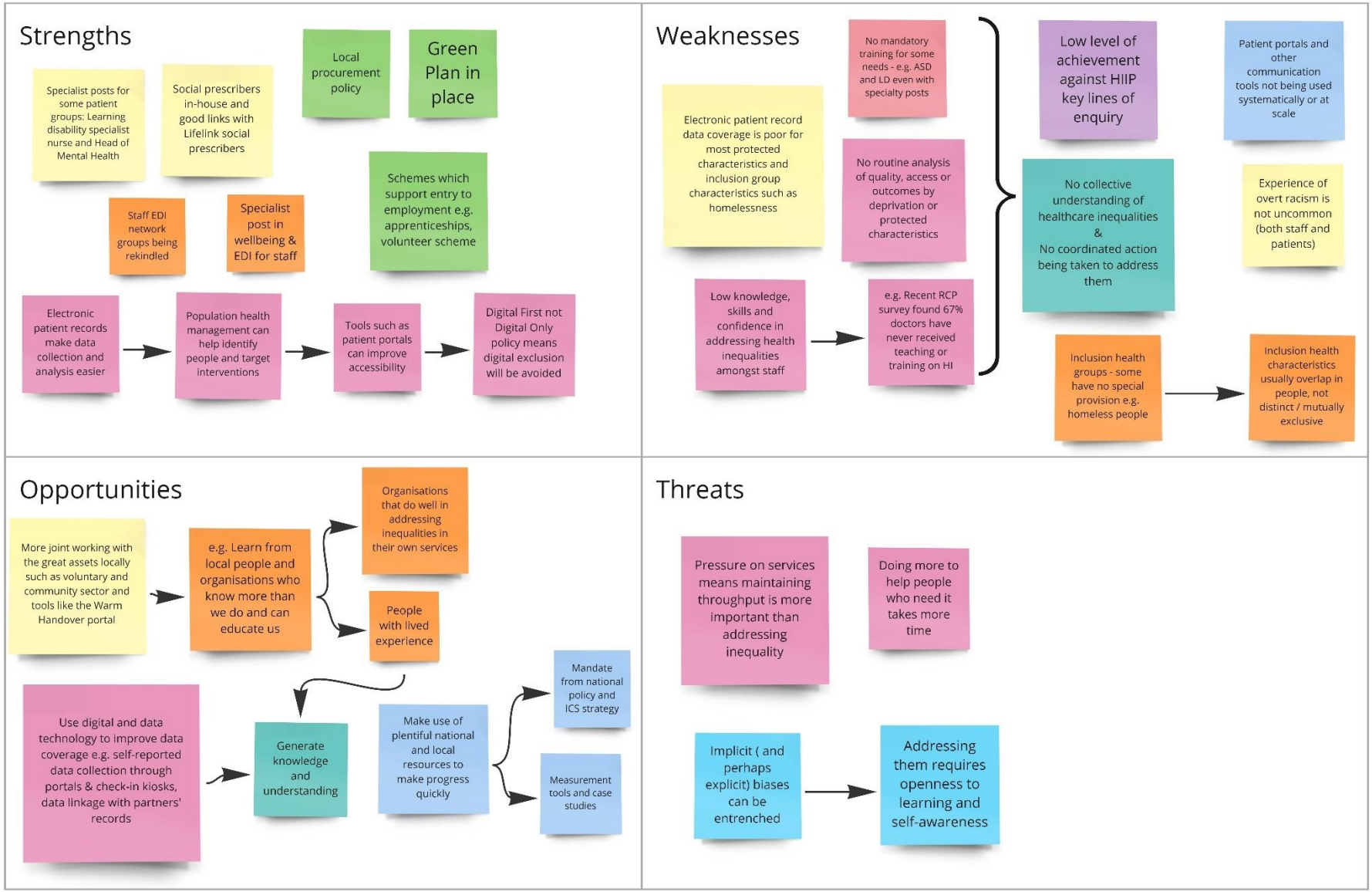
Figure 11: Characteristics that make the PLUS groups more susceptible to inequalities (courtesy of Maisie Fitzgerald, University of Cambridge)



How are things now?

The SWOT analysis on health inequalities and healthcare inequalities is shown in Figure 12.

Figure 12: SWOT analysis on health inequalities and healthcare inequalities



Whilst the electronic patient record could be a really useful tool for collecting data about people's characteristics and analysing who is subject to health inequalities, its use is impaired at the moment by the poor recording of protected characteristics and inclusion groups.

In February 2023, amongst the individual patient records:

- 100% had age, sex and ethnicity recorded

But only:

- 37% had religion recorded
- 0.33% had gender identity recorded
- 0.26% had sexual orientation recorded
- 0.07% were recorded as having a severe mental illness, compared to 0.95% in the GP register[7]
- 0.2% are recorded as having a learning disability, compared to 0.5% in the population[8]
- 0.24% are recorded as having a disability of any kind, compared to a prevalence of 16% in the population[9]

And:

- People from minority ethnic groups are under-identified – for example 2% are recorded as being in the Asian and black ethnic groups compared to 3.5% in the 2021 census
- People in inclusion health groups are difficult to identify because the information is not systematically gathered or recorded.

In summary

The trust takes its role as an anchor institution seriously and is making a good contribution to reducing health inequalities locally. There is a long way to go however on healthcare inequalities. Our ability to understand our population's different needs and characteristics and the pattern of healthcare inequalities is low. That said, there are many things that could help us, including the electronic patient record, the active voluntary, community and faith sector locally and our expanding patient engagement channels. There is the potential to make significant progress quickly.

The PLUS populations are very broad in our catchment area so we will focus first on the 20% most deprived neighbourhoods, people in minority ethnic groups and people with learning disabilities and autism, followed by inclusion health groups.

[7] Severe mental illness profile for NHS West Suffolk CCG, QOF prevalence (all ages), 2021/22 (OHID, n.d.)
[8] Learning disability profile for Suffolk, QOF prevalence (all ages), 2019/20 (OHID, n.d.)
[9] West Suffolk district, People disabled under the Equality Act: day-to-day activities limited a lot or a little (ONS, 2023)

Personalised care

Personalised care means people have choice and control over the way their care is planned and delivered. It is a change in relationship between people, professionals, and the system advocating collaboration and recognising people as active participants in their life and therefore care. It is based on ‘what matters to them’ and their individual strengths and needs as opposed to ‘what is the matter with them’.

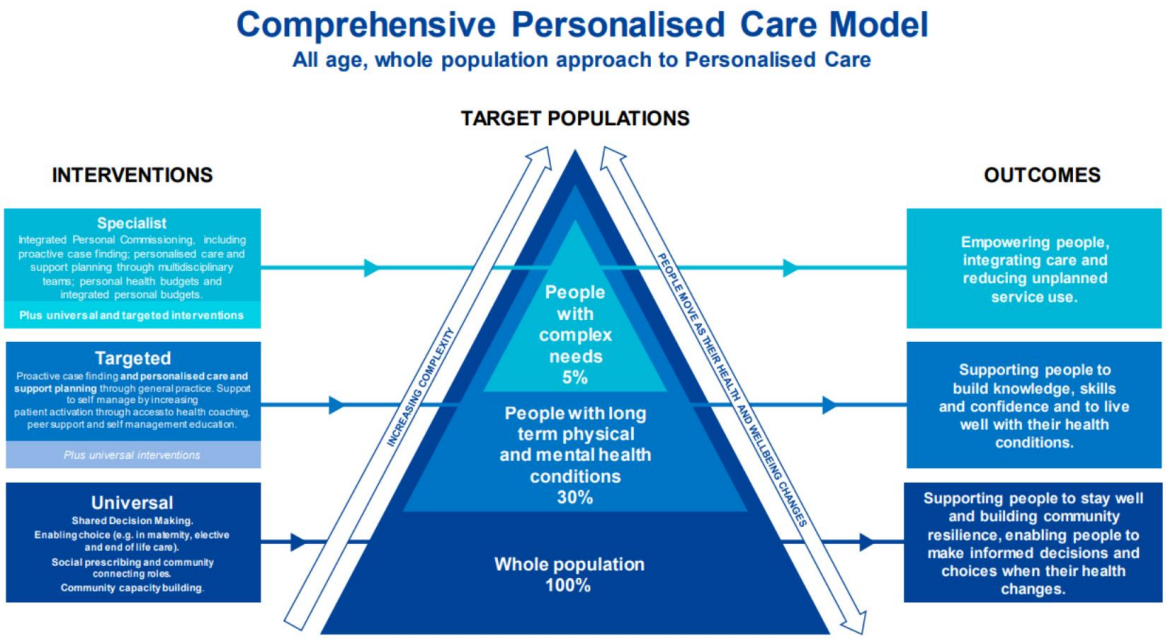
There are six pillars of personalised care. All are based on the principle of ‘what matters most’ to the individual (NHS England, 2019):

1. Patient choice – the right to make choices about health and care delivery
2. Shared decision making (SDM) – partnership between clinician and patient to ensure decisions are right for individuals
3. Patient activation and supported self-management – encourage, support, and empower living well with long-term physical and mental health conditions
4. Social prescribing and community-based support – connecting people to practical, social, and emotional support by introducing their local activities, services, and groups
5. Personalised care and support planning – joint holistic planning of treatment, management, and care with patient and/or advocate and health and care professionals
6. Personal health budgets – financial support to fulfil identified elements of the personalised care and support plan allowing more choice and control over how needs are met.

The NHS Comprehensive Personalised Care Model in Figure 13 illustrates how an all-age, whole population approach to personalised care can be achieved by using different types of interventions for different groups of people:

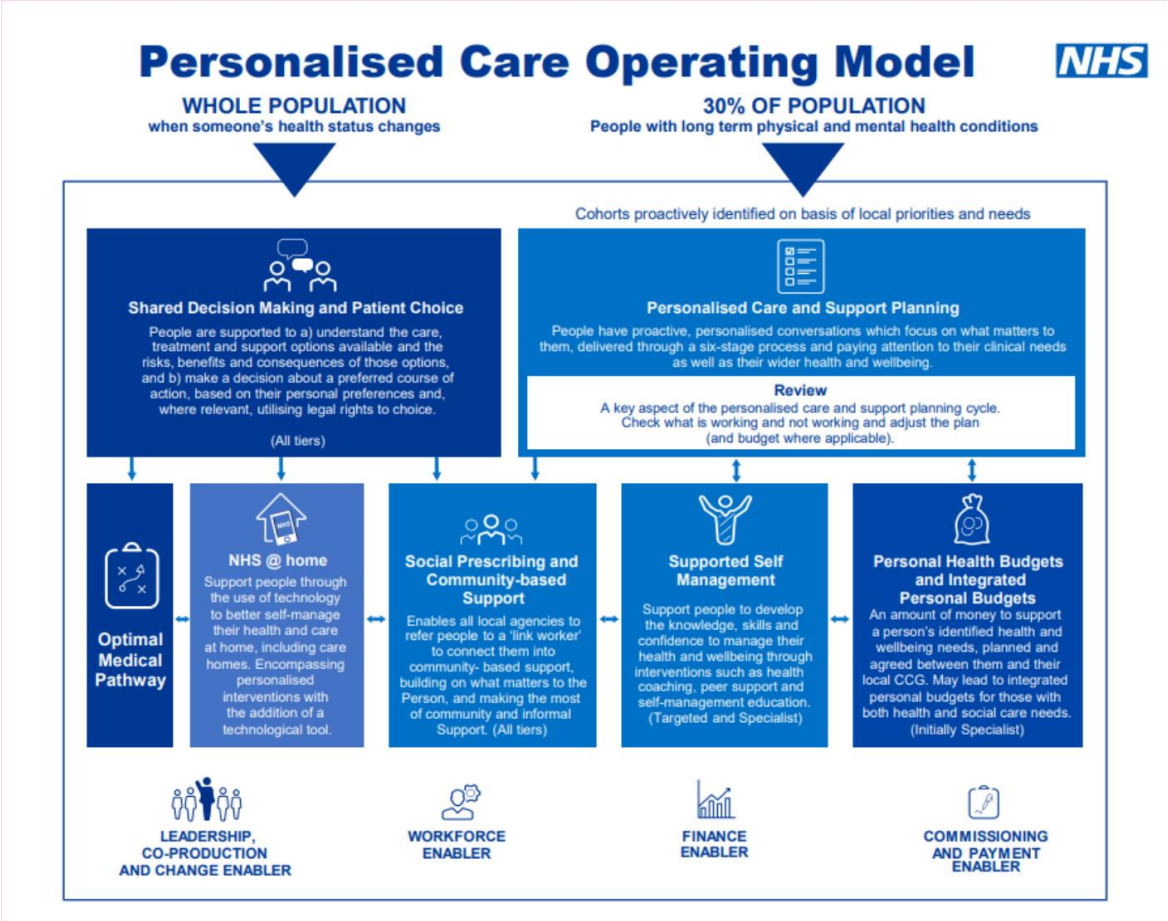
- universal interventions, such as shared decision making, which should be available to the whole population
- targeted interventions, such as health coaching, for people with long-term physical and mental health conditions
- specialist interventions, such as personal budgets, for people with the most complex needs.

Figure 13: NHS Comprehensive Personalised Care Model (NHS England, 2019)



Turning the Comprehensive Personalised Care Model into reality takes a whole-system, population approach including leadership, co-production, workforce, finance, and commissioning (Figure 14). Ultimately, personalised care will allow integration of services to be holistic around the person including health, social care, public health and wider specialist and community-based support.

Figure 14: NHS Personalised Care Operating Model (NHS England, 2018)



What do we know?

We know that individual health and care needs are becoming more complex and increasingly difficult for health and care services to manage using what can be described as 'round hole, square peg' approaches. Individuals are different, and one-size does not fit all (NHS England, 2019). Evidence tells us that by using a personalised approach to health and care, people's experience is better (round peg, round hole) and therefore their health and wellbeing outcomes improve. The NHS Long Term Plan states that 'personalised care will become business as usual across the health and care system' (NHS England, n.d.).

A briefing by The Health Foundation on the potential for 'reducing emergency admissions' through 'unlocking the potential of people to better manage their long-term conditions' highlights that people with long-term conditions spend most of their time managing treatment, medication, symptoms, and their health themselves with less than 1% of this time is spent with health professionals (Deeny, Thorlby, & Steventon, 2018). The briefing concludes that by equipping people with the knowledge, skills, and confidence to self-manage long-term conditions, it is likely to reduce demand on health and care services. It further concludes that use of health coaching to support patients more in self-management is needed, along with the Patient Activation Measure® (PAM) to assist health and care professionals in tailoring care to meet patient needs better, the impacts of which could be significant.

In addition to this, the briefing advocates social prescribing and peer support opportunities to help people more with self-management.

The evidence-base supporting personalised care continues to grow. Examples include:

- a review of over 1,000 papers concluding that peer support reduces loneliness and increases knowledge and confidence (Nesta & National Voices, 2015)
- a systematic review found that people in receipt of personal budgets prefer this to alternatives and are more satisfied, have better quality of life and fewer problems (Fleming, et al., 2019)
- of 9,000 people tracked across the health and care system, those with more confidence managing long-term conditions use their GP less and are less likely to need an emergency admission to hospital (Deeny, Thorlby, & Steventon, 2018).

There are several case-studies provided by NHS England to illustrate the impact personalised care can have on individuals. One case study describes how art, which was supported by social prescribing saved someone's life. By finding comfort, connection, and peace in art, it became a therapeutic tool allowing the person to change their perspective from being a mental health patient to an active person living a good life in society (NHS England, n.d.).

How are things now?

There is a wide range of activity underway at WSFT to increase personalised care across the six pillars. A baseline assessment of this has been completed using an NHS England maturity matrix template. The assessment rates 33 areas from starting to thriving across the six pillars and enablers specified in the operating model for personalised care delivery. The results are provided in Table 1 below and confirms that the trust is mostly in an emerging/developing position of implementation. Eight areas required a yes (n=3) or no (n=5) response, so have been excluded from the results in Table 1.

Table 1: Personalised care maturity matrix results

Key	Description	Score
Starting	Lack of leadership Not using national or local data Not considered/no emerging plans No collaboration Lack of knowledge of topic	**5**
Emerging	Leadership lacks authority Limited use of national & local data Limited thinking about how to scale up Minimal collaboration Limited knowledge of topic	**9**
Developing	Leadership in place Use of national or local data in part Teams/services/system developing clear vision Some understanding of current & future Population health needs Evidence of or plans in place towards delivering national priorities	**9**
Maturity	Strong leadership Using national or local data to inform plans Teams/services/system implementing new or redesigned care Evidence of tangible progress consistently improving delivery	**1**

Thriving	Leadership that champions at every level and project stage Demonstrating improvement in outcomes Full population health management capability Evidence of delivering national priorities Collaborative approach when issues emerge	**1**

The initiatives underway across the trust and identified through completion of the maturity matrix in March 2023 are described in Table 2. The scale of their reach is given where quantifiable.

Table 2: Current initiatives towards each of the six pillars of personalised care

Patient choice	In 2022, the trust invested in an electronic consent platform to enable better choice discussions and more accurate recording of consent processes in acute care
Shared Decision Making	Over the last six months, a shared decision making (SDM) template based on guidance from the General Medical Council has been created for the hospital electronic patient record (eCare) alongside a proposed requirement for acute and community trust colleagues to complete Personalised Care Institute SDM e-learning to encourage better quality SDM in a systematic and structured way.
Patient activation and supported self-management	In the last 12 months, 1,208 Patient Activation Measure® (PAM) surveys have been administered across 13 acute and community-based health and care services helping to tailor support to meet specific individual needs. Since the beginning of 2018, at least 640 health and care colleagues have been trained by the WSFT health coaching training service, enabling delivery of quality-assured health coaching skills[10] and enabling more opportunity for supported self-management in the population.
Social prescribing and community-based support	In September 2022, a pilot for hospital-based social prescribing began on one ward. The social prescriber contacted over 250 inpatients by March 2023 and plans to extend the service to more wards during 2023. Each integrated neighbourhood team (INT) benefits from a social prescriber being assigned to the locality to support people in the community.
Personalised care and support planning	Since 2012 people with long-term and life limiting illness have accessed a 'my care wishes' physical yellow folder. This is a personalised care and support plan to record individual wishes on treatment, admission to hospital and care options. Throughout 2023, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) will be added to 'my care wishes', and the acute electronic patient record as an individual's personalised care and support plan. The ReSPECT plan supports an open conversation about a person's condition, priorities for future care and treatment options in an emergency.
Personal health budgets	Acute personal health budgets were introduced in 2022. These are small amounts of money to support discharges home or into the community.

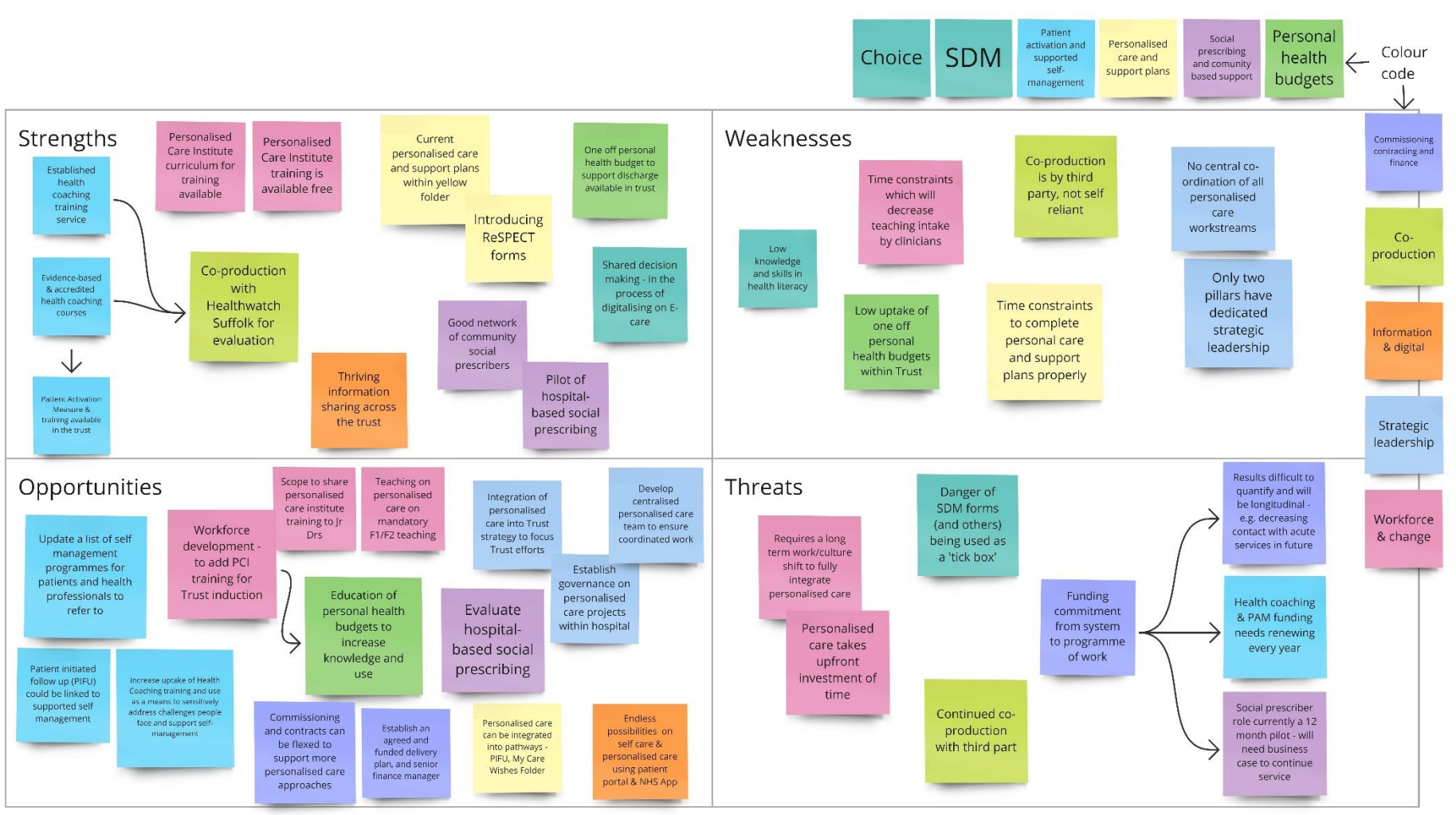
[10] The WSFT health coaching training service delivers accredited training licensed from and quality assured by TPC Health www.tpchealth.com

	Between January and March 2023, across the provision of personal health and integrated budgets, 154 people have been supported.

The SWOT analysis on personalised care is shown in Figure 15.

This highlights that the trust has existing strengths across the pillars of personalised care and therefore opportunities to build on this good work to date. Recognising our weaknesses and any threats in developing co-ordinated implementation of personalised care will allow us to plan and develop our implementation strategy taking these into account.

Figure 15: SWOT analysis on personalised care



The trust's role

The trust has an extensive role to play in the implementation of personalised care across both our acute and community services. We are uniquely placed to lead a personalised approach in all our daily contacts across the west Suffolk population. However, we must recognise that implementation of the personalised care comprehensive model is an enormous process and culture change which will take time and therefore need a phased introduction to ensure the best possible quality and outcomes for patients and staff.

There are some areas of the six pillars of personalised care, where the trust can do more than others. Already well-established programmes of work are underway for pillars two and three of personalised care: shared decision making and patient activation and supported self-management. These both have designated clinical leads identified who are responsible for driving the change needed to crystallise these elements into health and care practice across the trust. Exploratory use of acute personal health budgets to support discharge and social prescribers dedicated to meeting inpatients social needs are successfully underway. Further development of personalised care and support plans for individual wishes is planned throughout 2023.

The trust has a unique role in supporting the delivery of personalised care to our population, based on the comprehensive model. Each pillar of personalised care will need to be incorporated into core practice throughout the trust over the next few years, however, we recognise that this will need to be broken down and implemented gradually over time in a structured and systematic way to ensure alignment with the best outcomes for patients and the workforce alike.

Based on the work that the trust already successfully delivers and developments underway, over the next three years we will focus on:

1. Fully integrated consent and shared decision making in every patient contact by training colleagues in these core skills
2. Continuing to develop and grow the use of health coaching and offer PAM® across the trust in specified pathways of care, in line with the evidence-base
3. Evaluation of the effectiveness, impact, and outcomes of hospital-based social prescribing to support decisions on whether investment here should continue
4. Expanding awareness and use of acute personal health budgets to establish where they have the biggest uptake

In summary

WSFT has been a pioneer in personalised care with its early adoption and ongoing commitment to health coaching. Several other initiatives are also in place and there is a substantial investment being made overall. The initiatives are being pursued in siloes though; there is no coordinated approach to personalised care across the trust. The opportunity lies in systematising the approach and joining-up the good work underway to achieve the greatest possible impact for the population.

Objectives

To achieve our goal to **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities**, we need to convert it into a set of objectives and SMART actions.

Prevention, health inequalities and personalised care are each big and broad topics which will require system-level effort. To make sure the Trust's contribution is effective, the objectives for this strategy have been set on the basis of two principles:

- Firstly, the Trust must do what only it can uniquely do: embed prevention, health inequalities and personalised care into its own services and employment and business practices
- Secondly, the Trust should collaborate with partner organisations where it can add significant value to the impact of collective activities.

Taking into account the national and local priorities, the evidence base and the SWOT analyses for each of the three topics, the prevention, health inequalities and personalised care strategy will pursue 12 objectives.

Prevention

For patients:

P1: We will embed prevention in all clinical and care pathways. This objective is shared with the Clinical and Care Strategy 2023-2031[11].

- We will work with partners to created integrated pathways so patients can get the help they need with tobacco, alcohol, drugs, weight management, physical activity, and sleep
- We will use our data and digital technology to its full potential to make the pathways tailored, easy and efficient to use
- Staff will have the knowledge, skills, confidence and time they need to give lifestyle advice and direct patients to the help that is available

For staff:

P2: We will maintain and improve our healthy workplaces for everyone to enjoy. This objective is shared with the Estates and Facilities Strategy 2023-2028[12], the Workplace Strategy and the Wellbeing Work Plan.

- We will use a compassionate approach to reduce smoking on all our sites
- All staff will have access to healthy food at work
- Staff who are sedentary at work will be able to be more physically active
- Staff who are active at work will be able to get good rest

[11] See Trust open board meeting pack – 21 July 2023, pages 77-104. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-21-July-2023.pdf (Accessed 22 October 2023)
[12] See Trust open board meeting pack – 31 March 2023, pages 201-284. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-31-March-2023.pdf (Accessed 20 July 2023)

- All staff will know where they can get help for themselves and their families with tobacco, alcohol, drugs, weight management, physical activity, and sleep

For the public:

P3: We will use our platform to promote healthy behaviours and the help that is available to our local population. This activity will be done in a coordinated fashion with our partners.

Health inequalities

For patients:

HI1: We will understand our population better, the inequalities they are subject to and the nature of their needs.

HI2: We will use this knowledge to reduce the healthcare inequalities we create by:

- Addressing the Core20PLUS5 priorities, jointly with local partners
- Removing the barriers that make it harder for some people to use our services than others
- Tailoring how care is provided to meet people's different needs better

HI3: We will routinely measure the inequalities in our key access and outcome metrics and demonstrate continuous improvement.

For staff:

HI4: We will perform our role as an anchor institution to the best of our ability, by:

- Being a great employer and widening access to good work, as set out in the People and Culture Plan[13]
- Promoting and celebrating the diversity of our staff and encouraging a sense of belonging, as set out in the Inclusion Work Plan[14]

For the public:

HI5: We will perform our role as an anchor institution to the best of our ability, by:

- Buying more goods and services locally and for social benefit, as set out in the Estates and facilities management strategy[15]
- Reducing our environmental impact, as set out in the Green Plan[16].

Personalised care

For patients:

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[13] See Trust open board meeting pack – 26 May 2023, pages 55-59. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-26-May.pdf (Accessed 20 July 2023)
[14] Available at https://www.wsh.nhs.uk/CMS-Documents/EqualityandDiversity/New-Docs/Inclusion-Strategy-and-Action-Plan.pdf
[15] See Trust open board meeting pack – 31 March 2023, pages 201-284. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-31-March-2023.pdf (Accessed 20 July 2023)
[16] Available at https://www.wsh.nhs.uk/CMS-Documents/Corporate-information/Green-Plan-2021-25-FINAL.pdf

PC1: We will adopt structured and systematic shared decision making across our treatment pathways

PC2: We will implement health coaching skills and offer PAM® in acute and community pathways which are evidence-based

PC3: We will use hospital-based social prescribing and acute personal health budgets to support timely discharge and reduce re-admissions

For staff:

PC4: Staff will be able to access accredited training across the spectrum of personalised care

Action plan 2023-25

The first actions that we will take are listed in the table below, numbered with reference back to the objectives they apply to. Actions which are followed by an amber **(A)** are actions which will rely on collaboration with Alliance partners. Actions which are followed by a green **(A)** mean the resources created will be shared with Alliance partners. Actions which are followed by a blue **(B)** have been adopted as Trust Board strategic objectives in 2023/24.

Number	Action
P1.1	Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas. **(B)**
P1.2	Participate in the design and delivery of the new Suffolk healthy behaviours service, led by the district, borough and county councils. The new service will go live on 01 October 2023. **(A)**
P1.3	Maintain the existing exercise referral pathways in 2023/24 and work with Abbeycroft Leisure to achieve the best impact for patients. Align them with the new health behaviours service from April 2024 onwards. **(A)**
P2.1	Revise the smokefree site policy, using co-production and human factors to devise a compassionate approach that will reduce smoking on the West Suffolk Hospital site. Demonstrate a measurable reduction in smoking on site by September 2024.
P3.1	Undertake 2 public health campaigns each year, one of which will always be a stop smoking campaign.
HI1.1	Improve the coverage and accuracy of the recording of protected characteristics in the electronic patient record: • Increase the accuracy of ethnicity data by 50% compared to Census 2021 data for people living in the West Suffolk Alliance and Breckland catchment geographies by March 2025 • Double the number of people identified as having a learning disability by April 2024
HI1.2	Conduct research and generate knowledge about health inequalities and healthcare inequalities in the WSFT catchment population. Publish the research in formats that can be understood by the trust board, all staff and all members of the community by April 2024. **(A)**
HI2.1	Using the knowledge created, collaborate with our West Suffolk Alliance partners to define the actions that WSFT will take to address the Core20PLUS5 clinical priority areas, for both adults and children & young people, by June 2024. **(A)**

PC1.1	Begin phased implementation of shared decision making in day surgery in August 2023.
PC2.1	Introduce health coaching techniques and patient activation into 4 specialist areas by March 2025.
PC3.1	Evaluate the effectiveness, impact and outcomes of hospital-based social prescribing and personal health budgets by December 2025.
Overarching.1	Expand and promote the WSFT PHIPC training curriculum, curating national and local resources so all members of staff can gain the knowledge and skills they need in order to take action on prevention, health inequalities or personalised care **(A)** • Train 1000 colleagues in prevention, health inequalities or personalised care each year **(B)** • Offer 304 training places across health coaching and patient activation for staff employed by WSFT and colleagues working in a West Suffolk integrated neighbourhood team or a VCFSE partner[17] • Offer a PHIPC fellowship for 10 fellows in 2024/25 to learn more advanced skills and apply them in their service or department
Overarching.2	Apply the PHIPC approach holistically in at least one clinical or care service each year to improve outcomes and generate learning. In 2023/24 the public health team will work with the maternity service to: • Offer expectant people and their households a smoke-free pregnancy pathway including focused sessions and treatments • Regain UNICEF Baby Friendly Stage 2 accreditation and improve families' experience and outcomes with infant feeding • Understand and start to tackle the local pattern of health inequalities in maternal and neonatal outcomes

[17] VCFSE: voluntary, community, faith and social enterprise sector

How the prevention, health inequalities and personalised care strategy will be monitored

The prevention, health inequalities and personalised care strategy acts a sub-strategy to the trust's overall strategy First for our patients, staff and the future.

The senior responsible officer for the prevention, health inequalities and personalised care strategy is the medical director.

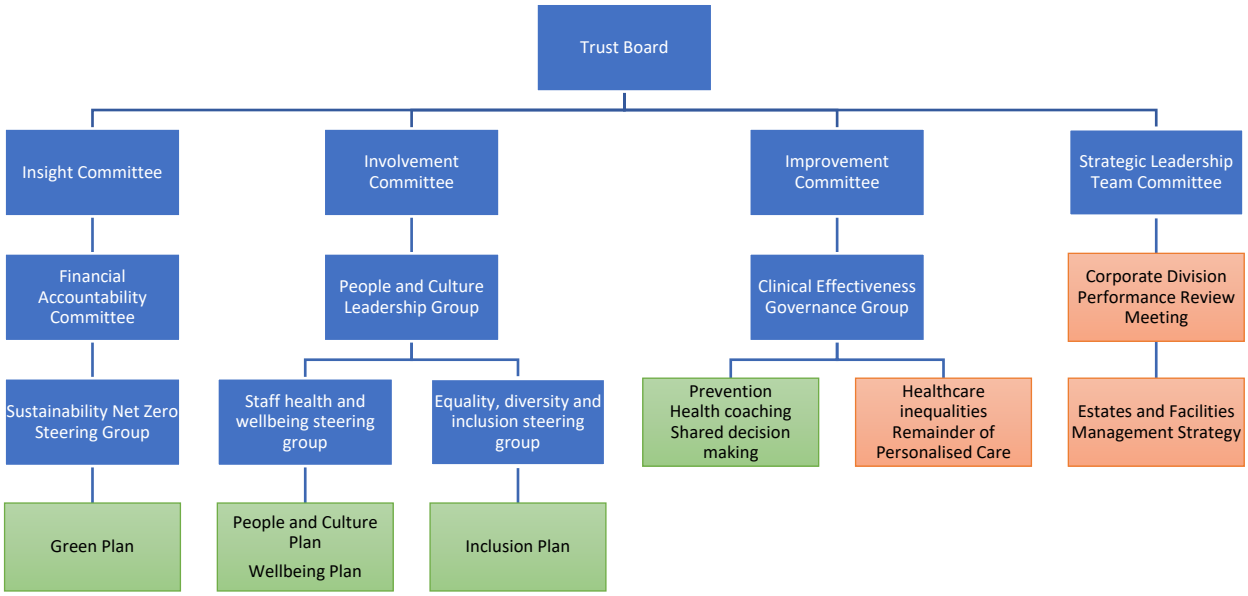
The current governance arrangements for prevention, health inequalities and personalised care are fragmented (Figure 16), however all parts of it work well for their purpose. There are three gaps currently but solutions have been identified for each:

1. There is a significant gap in that there is no existing governance for healthcare inequalities. Healthcare inequalities have a natural fit with clinical effectiveness so the Clinical Effectiveness Governance Group will extend its role to include it.

2. The Clinical Effectiveness Governance Group also provides assurance for two of the pillars of personalised care (health coaching and shared decision making) but not the other four. The governance of all six pillars will be combined and brought under CCEG's remit.

3. The Estates and Facilities Management Strategy does not have a route to board-level oversight at the moment. This will be achieved by extending the performance review approach which is used for the clinical divisions to cover the corporate division too.

Figure 16: Existing service-to-board governance of prevention, health inequalities and personalised care. Orange boxes indicate new governance which will be created. Green boxes indicate existing governance.



Each workstream is also connected into the West Suffolk Alliance Live Well framework and/or SNEE ICS governance structure, creating integrated governance with our partners and encouraging joint working.

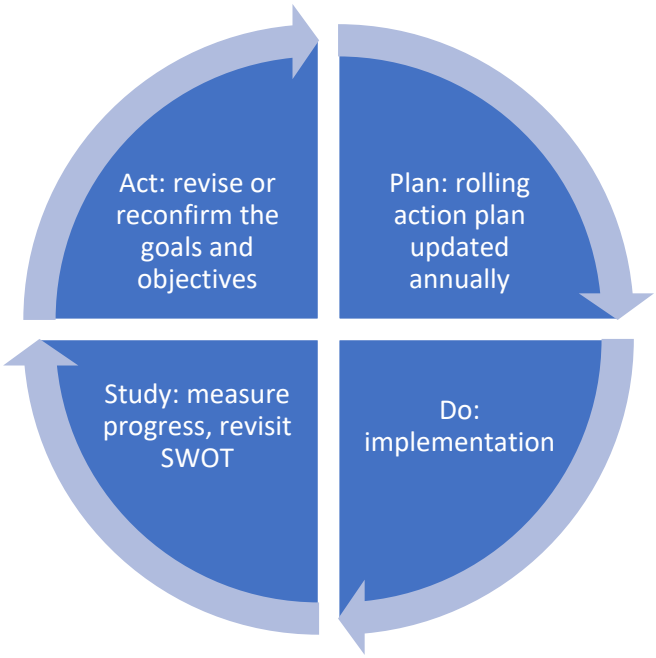
How progress will be measured

As one of the First for the Future goals, how well we **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce inequalities** will be assessed annually by our partners (please refer to page 25 of the trust strategy).

A set of outcomes and indicators have been defined which will allow our partners to make a meaningful assessment of our progress against the strategy without creating a large additional reporting burden (Appendix 2).

We will use the principles of continuous improvement to celebrate achievements, adapt to things that change and keep our ambition high (Figure 17). The objectives and the action plan will be reviewed each year, following the annual assessment, and new indicators will be added as required. The first review will be conducted in quarter 3 of 2024/25, with the action plan updated by 01 February 2025.

Figure 17: A continuous improvement approach to the prevention, health inequalities and personalised care strategy


Act: revise or reconfirm the goals and objectives
Plan: rolling action plan updated annually
Study: measure progress, revisit SWOT
Do: implementation

Appendix 1

National health inequalities improvement programme objectives of relevance to NHS trusts

Priority 1: Restoring NHS services inclusively
1.1 Systems use waiting list data to identify inequalities and ensure performance reports are broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations. 1.2 Systems develop and publish equality and health inequalities impact assessments (EHIAs) for elective recovery plans. 1.3 Systems' elective recovery plans give regard to the 8 elective recovery principles in fulfilment of the health inequalities criteria. 1.4 Systems use recovery data to identify inequalities and put SMART action plans in place to address identified inequalities. 1.5 Systems prioritise service delivery by taking account of the bottom 20% by IMD and Black and minority ethnic populations for patients on and not on the waiting list, including through proactive case finding. 1.6 Systems evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts.
Priority 2: Mitigating against digital exclusion
2.1 Systems ensure that providers offer face-to-face care to patients who cannot use remote services. 2.2 Systems ensure that more complete data collection is carried out, to identify who is accessing face-to-face, telephone or video consultations, broken down by relevant protected characteristics and health inclusion groups. 2.3 Systems ensure that they take account of their assessment of the impact of digital consultation channels on patient access.
Priority 3: Ensuring datasets are complete and timely
3.1 Systems continue to improve collection and recording of ethnicity data, across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.
Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)
4.1.1 Systems have clear plans for implementation of the Core20PLUS5 approach and accountability is assured through board performance reporting. 4.2.1 Systems have identified the most deprived 20% of the national population within their area. 4.2.2 Systems use this information when planning health services and interventions designed to reduce health inequalities.

4.3.1 Systems use local data, including that provided by the local joint strategic needs assessment, to identify their 'PLUS' populations.

4.3.2 Systems use this information when planning health services and interventions designed to reduce healthcare inequalities.

4.4.1 Systems ensure continuity of care for women from ethnic minority communities and from the most deprived groups in keeping with the NHSE LTP goal, taking into account the Building Blocks as communicated by the Maternity Transformation programme.

4.4.2 Systems have appropriate staffing levels to safely implement continuity of care for women from ethnic minority communities and from the most deprived groups.

4.6.1 Systems monitor uptake of covid, flu and pneumonia vaccine uptake rates in people with COPD, including those from ethnic minority, deprived and locally identified 'PLUS' groups.

4.6.2 Systems have plans in place to improve uptake of Covid, flu and pneumonia vaccines in people with COPD, particularly in the most deprived and locally identified 'PLUS' groups.

4.7.1 Systems have plans in place to improve early cancer diagnosis rates, particularly in the most deprived and the locally identified 'PLUS' groups.

4.8.1 Systems have plans in place to improve (i) hypertension case finding and optimal management, and (ii) lipid optimal management, particularly in the most deprived and locally identified 'PLUS' groups.

4.9.1 Systems have plans in place to improve smoking cessation rates, particularly in the most deprived and locally identified 'PLUS' groups.

4.10.1 Systems take a culturally competent approach to increasing covid and flu vaccination uptake in groups that have a lower uptake than the overall average (as at March 2021).

Priority 5: Strengthening leadership and accountability

Systems and providers have a named executive board-level lead for tackling health inequalities.

Systems and providers access training and the wider support offer.

The system SRO for health inequalities works with the board and partner organisations to use local population data to (a) identify the needs of communities experiencing inequalities in access, experience and outcomes (b) ensure that performance reporting allows monitoring of progress in addressing these inequalities.

Health inequalities improvement dashboard (HIID) and use of data

The system is using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

The system uses the HIID, and other tools where appropriate, to drive insights and interventions aimed at reducing inequalities.

Appendix 2

Specific measures for 2023-25 action plan

Number	Action	Measure	Source
P1.1	Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas. **(B)**	Number of people supported to stop smoking Percentage who live in the 40% most deprived lower super output areas Number of people who successfully quit for 4 weeks Percentage who live in the 40% most deprived lower super output areas	Tobacco dependence service
P1.2	Participate in the design and delivery of the new Suffolk healthy behaviours service, led by the district, borough and county councils. The new service will go live on 01 October 2023. **(A)**	Hours of specialist expertise contributed to the design process	Public health team
P1.3	Maintain the existing exercise referral pathways in 2023/24 and work with Abbeycroft Leisure to achieve the best impact for patients. Align them with the new health behaviours service from April 2024 onwards. **(A)**	Number of referrals into the integrated health and leisure pathways Number of successful completers Percentage who live in the 40% most deprived lower super output areas	Abbeycroft Leisure
P2.1	Revise the smokefree site policy, using co-production and human factors to devise a compassionate approach that will reduce smoking on the West Suffolk Hospital site. Demonstrate a measurable reduction in smoking on site by September 2024.	*Placeholder: Number of people smoking on the West Suffolk Hospital site (monthly spot audits)*	*To be developed*
P3.1	Undertake 2 public health campaigns each year, one of which will always be a stop smoking campaign.	Appropriate measures of campaign reach e.g. website hits, newsletter readership, social media impressions	Determined by campaign design

HI1.1	Improve the coverage and accuracy of the recording of protected characteristics in the electronic patient record: • Increase the accuracy of ethnicity data by 50% compared to Census 2021 data for people living in the West Suffolk Alliance and Breckland catchment geographies by March 2025 • Double the number of people identified as having a learning disability by April 2024	Accuracy of ethnicity data compared to Census 2021 data Number of people identified as having a learning disability For both measures, the denominator is the eCare record for the West Suffolk Alliance and Breckland registered populations	Information service (Protected characteristics report)
HI1.2	Conduct research and generate knowledge about health inequalities and healthcare inequalities in the WSFT catchment population. Publish the research in formats that can be understood by the trust board, all staff and all members of the community by April 2024. **(A)**	*Placeholder: Measure of understanding amongst the target audiences*	*To be developed*
HI2.1	Using the knowledge created, collaborate with our West Suffolk Alliance partners to define the actions that WSFT will take to address the Core20PLUS5 clinical priority areas, for both adults and children & young people, by June 2024. **(A)**	*Placeholder: Core20PLUS5 indicators*	*In development*
PC1.1	Begin phased implementation of shared decision making in day surgery in August 2023.	*Placeholder: Proportion of people admitted to the day surgery unit who have a recorded shared decision in Concentric*	*To be developed*
PC2.1	Introduce health coaching techniques and patient activation into 4 specialist areas by March 2025.	Number of new services using health coaching and patient activation in their care pathways	Health coaching team
PC3.1	Evaluate the effectiveness, impact and outcomes of hospital-based social prescribing and personal health budgets by December 2025.	*Placeholder: Appropriate measures will be identified*	*To be developed*

Overarching.1	Expand and promote the WSFT PHIPC training curriculum, curating national and local resources so all members of staff can gain the knowledge and skills they need in order to take action on prevention, health inequalities or personalised care **(A)** • Train 1000 colleagues in prevention, health inequalities or personalised care each year **(B)** • Offer 304 training places across health coaching and patient activation for staff employed by WSFT and colleagues working in a West Suffolk integrated neighbourhood team or a VCFSE partner[18] • Offer a PHIPC fellowship for 10 fellows in 2024/25 to learn more advanced skills and apply them in their service or department	Number of colleagues who have undertaken a training activity listed on the prevention, health inequalities and personalised care training curriculum	Public health team (collated from several sources)
		Number of training places offered in health coaching and patient activation Number of training places taken up Proportion of training places taken up by INTs and VCSFE organisations	Health coaching team
		Fellows' evaluation of the PHIPC fellowship scheme	Public health team
Overarching.2	Apply the PHIPC approach holistically in at least one clinical or care service each year to improve outcomes and generate learning. In 2023/24 the	Proportion of women who were smoking at the time of booking, who are smokefree at the time of delivery	Maternity team

[18] VCFSE: voluntary, community, faith and social enterprise sector

	public health team will work with the maternity service to: • Offer expectant people and their households a smoke-free pregnancy pathway including focused sessions and treatments • Regain UNICEF Baby Friendly Stage 2 accreditation and improve families' experience and outcomes with infant feeding • Understand and start to tackle the local pattern of health inequalities in maternal and neonatal outcomes	Percentage of babies whose first feed is breastmilk Percentage of babies receiving any breastmilk at time of discharge	Infant feeding team (via LifeQI)
		Placeholder: Measures of inequality in maternal and neonatal outcomes	*To be developed*

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