Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund

Draft Narrative Plan 2022-3

Torbay Health and Wellbeing Board

Cover

Health and Wellbeing Board(s)

Torbay

Introduction

The Better Care Fund brings together health and social care funding to support organisations across the One Devon Integrated Care System (ICS) in building toward a sustainable health and care system which will improve the health and wellbeing of the population, with the Better Care Fund a mechanism to assist in achieving this aim.

This document is the draft plan for which Torbay Health & Well-being Board are accountable within the new One Devon, Integrated Care System architecture. This plan has been developed for Torbay but sits in the context of and contributes toward delivery against the Devon system Integrated Care Strategy through the integrated approach and joint commissioning arrangements in the South Local Care Partnership.

The intention being that a more place-based approach continues to develop with partners which includes influencing and shaping the further development of system-wide strategies and delivering improved outcomes for our local communities. Learning from good practice which already exists and further developing models which have been developed with much work with voluntary and community organisations to respond to the needs of our communities through a different 'front door' for Adult Social Care and support Torbay's vision to deliver a more strengths-based approach, promoting maximum independence and wellbeing.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

This narrative plan, together with the BCF Planning and Capacity and Demand templates have been drafted by local system partners, overseen by the newly created Adult Social Care Continuous Improvement Board, feeding through the Health & Wellbeing Executive to the Health & Wellbeing Board, and supported by the main statutory organisations as in previous years. These being Torbay Council, NHS Devon Integrated Care Board and Torbay and South Devon NHS Foundation Trust.

Key stakeholders involved in the emerging Local Care Partnership include those organisations highlighted above as well as Devon County Council, the Southern Primary Care Collaborative Board, Devon Partnership Trust, Voluntary & Community sector leads for Torbay & South Devon, Directors of Public Health/Consultants (Devon County Council & Torbay Council), Devon Local Pharmaceutical Committee and Devon Local Optical Committee.

How have you gone about involving these stakeholders?

For this submission, the BCF Leads have engaged with a range of key stakeholders including local authority and NHS colleagues specifically to develop the narrative and supporting templates.

The initial delegated sign off for the draft submission was from the Director of Adult & Community Services for Torbay Council on behalf of the Health and Wellbeing Board for Torbay, with this submission being approved through the Chief Executive, Torbay Council. The Health and Wellbeing Board will then oversee the development of the BCF Plan 2022-23 and approve any subsequent BCF Planning submission (dependent on timescales). As part of the Devon-wide system sign-off process, the BCF plans for each of the three Health and Wellbeing Boards has been reviewed and signed off by the NHS Devon Integrated Care Board Executive.

The continuation of the Better Care Fund arrangements requires effective partnership working to ensure the delivery of these schemes and associated outcomes using an integrated local system approach which will be facilitated through the emerging South Local Care Partnership which covers the Torbay & South Devon footprint. This plan will be shared with this group in October.

The approach to integrated commissioning at 'place' is developing and the development of the Local Care Partnership arrangements will support as a key driver of local strategy and agreeing and delivering against key local priorities. The local Integrated Care Organisation (NHS Provider) already delivering services across acute and community health and social care.

This development of even closer alignment and approaches to joint working and the existing governance architecture ensures system wide support and oversight of their delivery, across statutory partners and all key local stakeholders.

The development of the Community First Strategy for the Devon Integrated Care System has also supported this approach with consultation and engagement across each of the five Local Care Partnership areas and with representation from primary, community, acute, mental health, Local Authority, VCSE organisations and small groups to represent the public.

In Torbay, the Better Care Fund and Improved Better Care Fund resources are delegated to Torbay and South Devon NHS Foundation Trust as an integrated care organisation responsible for the delivery of health and social care services in Torbay. The Adult Care Strategic Agreement between Torbay Council and Torbay and South Devon NHS Foundation Trust governs the delivery of Adult Social Care, April 2020 to March 2023 and includes delivery of services and outcomes agreed through the Better Care Fund.

Executive summary

The most significant development since the previous plans were developed and submitted has seen the inception of the NHS Devon Integrated Care Board following in the footsteps of NHS Devon Clinical Commissioning Group and the wider partnership arrangements for the system known as One Devon, which came into being with effect from 1st July 2022.

The five local care partnership geographical arrangements sit as part of this system architecture along with Provider Collaboratives for Acute and for Mental Health, Learning Disability and Neurodiversity and Collaborative Board arrangements for Primary care in each local system.

The local system has been under increased pressure during the last couple of years and a key priority focus remains in relation to urgent care and system flow. The BCF plan is a key contributor responding to this with schemes that support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways with the aim to reduce pressure on urgent care through services that enable people to stay well, safe, and independent at home for longer.

The local system is developing its approach to a small number of priorities through the Local Care Partnership (LCP), with the BCF plan being key to enabling across many of these and with further work to develop a proposal for supporting further local system integration particularly in relation to community services.

These are set in the context of:

- Further development of Local care partnerships.
- PCN/Community services at “place” alongside Health and wellbeing centres
- ICS strategy for community first / community urgent care / Primary Care (GP)
- National developments, inc. Fuller report and national model of rehabilitation
- EPR convergence, wider digital technology adoption e.g., remote monitoring

And include:

- Establishing an integrated approach to responding to urgent care needs in Torbay - primary care, minor injury, social care, 0-19, drugs and alcohol, mental health and CFHD.
- Develop approach to integrated health and wellbeing services in South Devon
- Transformation and continuous improvement in delivery of Adult Social Care Services.

The Devon ICS Community First Strategy sets out our vision and direction of travel for community services over the next five years (2022 to 2027). Community services play an important role in keeping people well and managing acute, physical, and mental health and long-term illness. The key focus of this strategy is on preventative, proactive and personalised care to support people to live as independently as possible with greater connection to their local community ensuring people spend more time at home rather than in a hospital bed and at the same time avoid or at the very least delay the need for long-term residential care.

We want community services, including the voluntary sector, to be far more prominent in our system with well thought out planning regarding the steps we need to take to achieve the vision, co-production of services with our system stakeholders and the public, and in ensuring that they are adequately funded to sustain delivery and outcomes in the longer term.

Devon has a strong history of integrated working, and today several community services are now being provided by, or in partnership with, local acute trusts bringing many benefits to people, services, and the system. Our work towards integration thus far has improved collaboration between services, the opportunity for the standardisation of pathways which cuts across different sectors, and potential to use the workforce in a different way, providing better continuity of care for people. Future developments are likely to include extension of traditionally acute based specialists out into the community, bringing more of the medical expertise to support people in their own homes and out of a hospital setting.

Whilst our history for integration is strong, is has not been delivered consistently across the county. This strategy describes our ambitions and visions at a system level in order that we can increase the consistency and equity of access, experience and outcomes for people using community services. Those ambitions will develop and be implemented at a local level, such that they truly serve their local population and make the best use of existing and future community assets.

The high-level draft Income & Expenditure summary is set out below:

Selected Health and Wellbeing Board:	Torbay

Income & Expenditure

Funding Sources	Income	Expenditure	Difference
DFG	£2,128,689	£2,128,689	£0
Minimum NHS Contribution	£13,119,732	£13,119,732	£0
iBCF	£8,837,572	£8,837,572	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£24,085,993**	**£24,085,993**	**£0**

The templates completed in support of this narrative document and Better Care Fund plans for 2022-23 appear at the end of this document and set out in further detail the expenditure and associated metrics toward submission.

The refreshed Torbay Joint Strategic Needs Assessment has also just been published and is available here: http://www.southdevonandtorbay.info/media/1285/2022-2023-torbay-jsna.pdf

The Joint Strategic Needs Assessment describes the health and wellbeing needs of our population, and the drivers that influence health and wellbeing, like housing, employment, and education. The draft Health and Wellbeing Strategy seeks to tackle these difficult issues through agencies working together to bring about real, sustainable change.

It has been prepared in collaboration with Health and Wellbeing Board partners over the last nine months and identifies 5 priorities areas, and 6 cross-cutting areas,

which all member organisations feel are critically important for improving the health and wellbeing of Torbay residents. Importantly, this year working closely with colleagues in the new Integrated Care System, and especially those in the South Local Care Partnership, to make sure our priorities are clearly aligned.

The Health and Wellbeing Strategy responds to the areas of greatest need given the levels of deprivation and poorer outcomes in some parts of Torbay:

- children living in challenging circumstances and losing out on educational opportunities
- lack of high-quality housing with secure tenure
- people living with poor mental health
- older people experiencing loneliness and isolation.

All these needs have been exacerbated by the pandemic, and all of them hit our most disadvantaged communities the most.

During this last period teams across the Local Authority and NHS have devoted significant capacity to supporting providers in the Torbay Care Market. This included timely and flexible use of government support funding, within the prescribed grant conditions, across a range of COVID funding such as the Infection Control, Testing and Workforce Grants. Without this support we would not have maintained market capacity during this time. The Better Care Fund has supported this Integrated approach and way of working with the market and work continues to further improve these arrangements.

The local Market Position Statement and Blueprint is the local source document for market strategy. The document aims for enhanced capacity via additional Supported Living and Extra Care capacity using Housing based care models. Also, the document has a strong focused on quality Nursing Care and Dementia which reflects system priorities and is evidenced by demographic data in the Joint Strategy needs Assessment (JSNA).

Despite the challenging backdrop, looking ahead to plans during the current financial year which are proceeding with Extra Care Housing Schemes at Torre Marine, Torquay, and Crossway in Paignton. We are working with providers as well to bring forward new Supported Living capacity in the community for people with Learning Disabilities or Mental Health conditions as an alternative to bed-based care.

The Trust and Council also commence work with two providers in relation to two potential schemes one for Rehabilitation capacity and one for Dementia beds across the footprint of the local Integrated Care system. This local system is the Local Care Partnership which includes NHS, VCSE, Primary Care Networks, Mental Health providers and two Local Authorities (Torbay & Devon County Council).

The Better Care Fund has and continues to along with our approach support focus on priority areas through the application of the funding available. These are in 3 broad areas which are developed further throughout the document, but seek to

- Promote independence (Alternative ‘front door’ with VCS, use of DFGs and assistive tech etc, and reablement).
- Through our approach to joint commissioning, develop strong and sustainable care markets which meet the needs of those in our communities.
- Supporting carers and their families.

Governance

NHS Devon is one of 42 integrated care boards across the county and took over the statutory functions of clinical commissioning groups (CCGs) on 1 July 2022. It is the organisation responsible for the majority of county's NHS budget, and for developing a plan to improve people's health, deliver high-quality care and better value for money. Our aim is to improve people's lives in Devon – wherever they live – to reduce health inequalities and make sure we can deliver these services for the long term.

Diagram 1.1

The local system for Devon is comprised of NHS Devon, responsible for commissioning NHS services and joining up care and the One Devon Partnership developing the strategy and working together as NHS, local councils, voluntary sector, and many other stakeholders as per the diagram (1.2) below:

Diagram 1.2

Within the One Devon Partnership there is a representative from each of the five Local Care Partnerships, with our Local Care Partnership being the South LCP. This is where most of the service changes will happen and covers around 300,000 people.

As part of the Devon-wide system sign-off for the under the new Integrated Care System (ICS) governance framework the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB Executive Board.

The Local Care Partnership is developing to provide system leadership and clinical oversight to the integrated commissioning arrangements. It provides focus and direction for integrated commissioning, ensuring collaborative planning and performance monitoring. It also provides assurance to the governance arrangements of both NHS Devon and Torbay Council. To ensure collaboration in our local system, much of the development work will take place through the Local Care Partnership with stakeholders and partners represented and co-ordination toward sign off by the Torbay Health and Wellbeing Board through the Adult Social Care Continuous Improvement Board.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

This section will also include

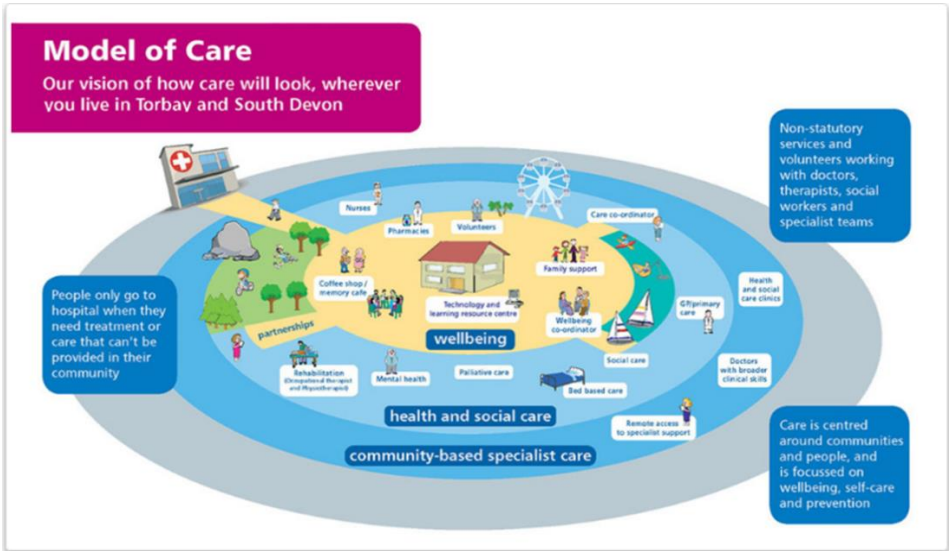
Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe, and independent at home for longer
- Provide the right care in the right place at the right time

The One Devon Integrated Care Partnership will lead the development of the strategy which builds upon existing foundations and supports more integrated approaches to delivering health and care. This will help to provide focus on and drive the change required to tackle the challenges the system faces such as reducing disparities in health and social care; improving quality and performance; preventing mental and physical ill health; maximising independence and preventing care needs.

Within Torbay, there has been ongoing work to implement an integrated care model that puts a strengths-based approach at its heart. This model provides a fully integrated health and social care system involving joined-up services which deliver education and advice about how to maintain independence and stay well, with mental health and wellbeing as high a priority as physical health and wellbeing. It also aims to take a person-centred approach and build wider support around people, through making the best use of what is already available to them at home and in the community. A significant programme of work with our VCSE partners has delivered a new 'front door' to adult social care with an emphasis on making the most of individual and community resources as part of our strengths-based approach.



The creation of the Integrated Care Organisation in October 2015 - Torbay and South Devon NHS Foundation Trust, was strongly supported and encouraged by both the Clinical Commissioning Group and the local authorities and this has resulted in a more effective patient journey where fewer people in Torbay experience delays in moving between hospital and home and waits for care at home remain short - in stark comparison to many other areas in the current year.

Our vision is to have excellent, joined up care for all. Torbay already has a model of integrated health and social care teams built around geographical clusters and primary care practices, with a single point of access. These teams provide functions to enable:

- Proactive identification of people at risk and admission to hospital or inappropriate care settings.
- Integrated assessment and personalised support planning for people with long-term conditions and/or complex care needs.
- Urgent reactive care to people in crisis to avoid immediate risk of admission.

South Devon and Torbay has a respected reputation for partnership working and for innovating to find more effective ways of delivering quality care. Relationships between statutory and voluntary sector organisations are well founded and there is a shared ambition to tackle problems. This extends to positive working with provider organisations whose reach is broader than South Devon and Torbay. This is well supported by the framework the Better Care Fund has provided but is also being taken forward through the approach to creating Local Care Partnerships which seek to cement some of this working and further enhance what we can deliver together.

The Better Care Fund sits within this longstanding programme of integration through the creation of the ICO and the continued development of a new model of care.

Joined up approach to integrated, person-centred services across health, care, housing, and public sector services locally

Adult Social Care:

Torbay and South Devon NHS Foundation Trust and Torbay Council are working together on an Improvement Plan with partners to progress Adult Social Care delivery and opportunities for transformation using a strengths-based approach in Torbay. Much has been learnt from the Covid Pandemic and new ways of working with our community have developed as a result. Members of staff alongside service providers from the private and voluntary sector as well as people who have lived experience and their carers were invited to join us in several facilitated conversations focused on creating a shared Vision of the future for Adult Social Services

Our shared vision is: **Thriving communities where people can prosper**
Our mission statement is: **Our residents can have a place to call home in a community they can be part of, while being empowered to achieve what matters most to them, through the best care and support available.**

We know that the demand on the adult care system in Torbay is high and it will only continue to increase due to our aging population and areas of social deprivation. This is one of the reasons why we need to change the way we currently deliver our social care and work towards fully adopting a community led approach where our communities can be supported to flourish. Our commitment to engage with and work with our voluntary and community partners as well as people who use services to co-design the plan will enable us to develop a robust service delivery that is fit for the future and for the people of Torbay. We are also

encouraging a culture within teams of embedding continual improvement. We are focussing on achieving positive shared outcomes for people receiving Social Care support and reflecting this via monitoring our own performance and seeking feedback from all involved so we can learn from experience.

We are reminding people of the core values of social care, including:

- being part of the community,
- supporting people to build their own capability,
- enabling people to live their lives as independent as possible.

The Adult Social Care Improvement plan (ASCiP) seeks to support the vision of developing thriving communities in Torbay by delivering the strategic priorities, deepening integration with partners and promoting a strength-based approach throughout all conversations. This will be achieved by working in collaboration with partner agencies and by valuing skills, knowledge and potential in all individuals and their communities.

Providing Safe Quality Care and Best Experience:

Working across our system with partners to deliver high quality care that meets best practice standards, is timely, accessible, personalised, and compassionate. It will be planned and delivered in partnership with those who need our support and care to maximise their independence and choice.

Focus on Mental Health

In under 65 MH we have been working with providers to ensure that all clients live in the least restrictive environments that promote their independence. We have been working to develop the local supported living framework and to identify ways to support people in their own homes. Torbay Public Health have engaged with local voluntary sector providers to help improve access to voluntary sector and community assets to support people to achieve positive mental wellbeing. We continue to work with partners and our communities to ensure that the people of Torbay receive a good offer in terms of mental health support both through the Community Mental Health Framework and more broadly.

Focus on the Transition team

We have developed a specialist team to work with young people who are being referred through to our service from our colleagues in Children's services. This team has developed from having two skilled and un-registered practitioners to include a Social Work Lead and two additional experienced Social Workers. Close links have been developed with Children's services, Education and Mental Health services. There are now regular review meetings to consider a young person's aims, hopes and aspirations when they reach 14 and 16 years old. The transition teamwork within a strengths-based approach aligning their assessments and support with the preparing for adulthood guidelines promoting health, education, employment, independence, and community inclusion. The team work flexibly to ensure their care plans are outcome based which includes reviewing a situation when it is right for the young person rather than on an annual basis.

Focus on Learning Disability

Much of 2020/21 was spent evaluating and preparing for the launch of Torbay's Market Position Statement to achieve the following outcomes:

- An increase of 50 units of self-contained supported living, sheltered housing and/or Extra Care for people with learning disabilities, in line with the Housing Strategy 2017. One

third of people over 45 with a moderate or severe learning disability, and one third younger adults (under 35 years) are living with parents. We want to ensure there is appropriate accommodation and choice, so people can have planned transitions towards independent living, and avoid unnecessary entry into residential care wherever possible.
- Increased Quality Assurance support for supported living providers and the consequent improvement and monitoring of the quality of support and tenancies.
- A reduction in the number of working age adults with LDs in long-term residential settings (currently just over 70 adults). Residential settings by their nature, do not usually maintain or increase self-determination, control, citizenship, or enable community inclusion and natural circles of support.
- The development of an outcomes commissioning framework for the development of Daytime activities/services which offer more choice, develop community inclusion, and deliver more aspirational outcomes. Greater housing choice - particularly self-contained Supported Living, sheltered housing, Extra Care, and access to general needs housing.

The Torbay Learning Disability Partnership Board (LDPB), which was launched in December 2019 will continue to be supported by 8 Ambassadors who act as Learning Disability self-advocates. The Ambassadors ensure that people with learning disabilities are involved in decisions about all new services, strategies, and policies.

Focus on Autistic Spectrum Conditions and Neurodiversity

During 2019, in recognition of the need to focus on post-diagnostic support in Torbay for people with Autistic Spectrum Condition (ASC), a multi-stranded ASC post-diagnostic project was launched, which included the following:
- A new accessible information and advice service, to help improve access to employment, education, and welfare benefits.
- The development of Peer Support for people with ASC through seed funding of small groups (one for adolescents and one for adults)
- Employment of a 0.4FTE specialist ASC Social Worker

Focus on Dementia

- The Care Home Education and Support Team (CHEST) continues to form an integral part of the Older People Mental Health service in Torbay despite the enormous challenges that the ongoing Covid pandemic has brought upon Health and Social Care services. Although CHEST core business needed to be suspended in the initial months of the pandemic it soon became apparent that people with Dementia both in Care Homes and in the Community still required the specialist input provided by the team. The CHEST method focusses on a strengths-based, holistic, person-centred, and collaborative non-pharmacological approach to look at the person and how they are trying to communicate their needs. Medication although helpful can never be the only solution and we work with providers and people's loved ones and formal carers to adapt interventions thus easing a person's distress.
- CHEST colleagues focused on re-building and strengthening relationships with Care Homes, which in turn boosted staff morale. Although there has been no official survey undertaken this year, there has been some informal feed-back from different homes stating that they find the CHEST involvement to be invaluable, particularly in terms of the quick response it provides. Many homes appreciate the ability to refer to CHEST directly.
- As previously referenced, are proceeding with Extra Care Housing Schemes at Torre Marine, Torquay, and Crossway in Paignton, and working with providers to bring forward new Supported Living capacity in the community for people with Learning Disabilities or Mental Health conditions as an alternative to bed-based care and a potential scheme to realise additional dementia capacity.

Focus on Homelessness

An integrated team consisting of a social worker, drug and alcohol treatment worker, housing staff, outreach team and the new Housing First team have worked to remove barriers for people who are homeless to access housing, health, and care services. The Housing First teamwork with those whose needs have not been previously met; housing people straight from the streets into the community and providing intensive support to help people maintain their accommodation. The Housing First team is working well with the Homeless and Vulnerability locality team with good effect. The teamwork across 7 days a week and have a case load of only 5 people to ensure that they can provide the levels of support that people need.

Focus on carers

The BCF contributes towards payment of staffing to deliver service and towards the carer's personal budgets such as a break from caring to improve their health and wellbeing. There are statutory duties for both LAs and the NHS to ensure that services are provided for family and friend carers, via Care Act 2014 and recently passed Health and Care Bill 2022. Every year, more and more people take on a caring role. The enormous contribution of the country's carers not only makes an invaluable difference to the people they support, but it is also an integral part of our health and social care system, and it deserves to be better recognised. The economic value of their contribution is huge – and the UK's health and social care system is heavily and increasingly reliant on it. An impact assessment published by the Department of Health (October 2014) estimated that each £1.00 spent on supporting carers would save councils £1.47 on replacement care costs and benefit the wider health system; Carers UK estimate that care provided by friends and family saves the state £132 billion each year.

We know that people do not always see that they are a Carer, so we try to make it as easy as possible for Carers to be identified, whether at GP surgeries, through other professionals that may work with Carers, and through our campaigns such as Carers' week and Carers' Rights Day. In 2021-22, 1,930 Carers of Adults received a Carers' assessment / health and wellbeing check, which is 52% of people receiving Adult Social Care services against an annual target of 36%.

In 21-22, 704 carers received support to have a Carers Break, and the positive impact on their Health and Wellbeing was significant. Link to Carers Personal Budgets evaluation.. This has been especially important at a time when Replacement Care (Respite) Services have been limited.

Improved wellbeing through partnership:

We will work with our local partners in the public, private, voluntary and community sectors to tackle the issues that affect the health and wellbeing of our population. We will work in partnership with individuals and communities to support them to take responsibility for their own health and wellbeing.

Supported Living Provision

Supported housing provides crucial help to some of our most vulnerable people. It can have an enormous positive impact on an individual's quality of life: from their physical and mental health to their engagement with the community and reducing social isolation.

The Supported Living framework introduced in April 2018 provides a greater focus on assisting improvement alongside our statutory assessment function. The framework is intended as a focal point for joint working between partnership organisations and reflects

Torbay's integrated health and care service delivery model. The framework supports Torbay in moving towards a more enabling environment with measurable outcomes in promoting people's independence, quality of life and health and well-being.

During the year we identified significant gaps in the market for people with a mental health diagnosis resulting in a tender, specifically for this client group, being published in the summer of 2020. As a result, we have increased the number of Supported Living Providers on our framework and are working with them to increase capacity and develop services.

Enhanced Intermediate Care

We have invested in Enhanced Intermediate Care services to help people stay independent at home longer. Intermediate care also aims to avoid hospital admission if possible and delay people being admitted to residential care until they absolutely need to. Intermediate Care is a key requirement in facilitating early discharges from hospital.

We work to ensure Enhanced Intermediate Care is fully embedded working with GPs and Pharmacists as part of the health and wellbeing teams within Torquay, Paignton and Brixham. We also have a dietician in the Torquay locality who has been invaluable during any Covid Care Home Outbreaks

We have developed stronger links with the ambulance service and the acute hospital which means that the person experiences a more seamless service between settings.

We work with the Joint Emergency Team in the Emergency Department (ED) to prevent an unnecessary admission into the hospital. The Frailty Team are also based in the T&SD ED working alongside JETS to identify and support the Health of the Older Person (HOP) clients through to outpatient, acute HOP in-patient or IMC beds as appropriate. This links into the agreed Frailty Virtual Ward arrangements, with recruitment underway. There is also an In-reach B7 Occupational Therapist from the T&SD Complex Discharge Team, with those above enabling/supporting safe discharges and collaboration with the VCSE discharge teams.

We have recently started doing a virtual multi-disciplinary team meeting with the Care Home Visiting Service, Older Mental Health Services, dietician, pharmacist, and Health Care for the Older Person Consultants. This happens weekly and we refer any people in our Intermediate Care service who we feel may benefit from this specialised group of clinicians. This results in the person receiving care without having to attend an appointment. This service has been extended so that the localities can discuss any people who are either in their own home or a care home placement, promoting proactive treatment.

The average age of people benefitting from this service is 83 years old. The deeper integration of these services, supported by investment through the Better Care Fund has helped ensure people have shorter stays in hospital. The implementation of a 'discharge to assess at home' pathway has further developed the ability of the organisation to care for people at home and we always work towards the ethos that 'the best bed is your own bed'.

Extra Care Housing

Extra Care housing combines care and support to maximise the independence of Torbay's population whose Long-Term Condition or diagnosis means they require ongoing care and / or support to maintain independent living, for as long as possible, in their own community-based home. Our Extra Care service is multi-generational supported living benefitting from 24/7 on-site staffing.

Demand for Extra Care Housing continues to outstrip supply. To address this the Council has purchased a site in Torquay to increase capacity. A dedicated Capital housing officer has been recruited by the Council to work in partnership with TDA and Torbay and South Devon NHS Foundation Trust in developing these sites. The Extra Care project group membership includes multi-disciplinary representation and the voluntary sector whose aim is to develop housing which:

- Promotes independence, quality of life, health and well-being and offers choice and diversity.
- Creates mixed communities which integrate well.
- Supports people in their own home.
- Build homes which adapt to individuals' changing needs.
- Diverts people from more institutionalised care.

The Extra Care Scheme is in Torre Marine, but we have a second one planned for Crossways. a scheme in Torquay which is in the planning system and a second plan for central Paignton as part of a regeneration scheme.

Wellbeing services with the Voluntary Sector

During 20/21 the statutory sector in Torbay further developed its well-being offer by working more closely in an enduring partnership with the Community and Voluntary Sector in Torbay. Jointly with the Voluntary Sector we have responded to the challenges of the pandemic:

- By Facilitating/supporting alliances/partnerships within the community to improve resilience
- By working more openly and collaboratively with the Voluntary sector on an equal footing via forums such as the Voluntary Sector Steering group and via the use of the Adult Social Care precept previously.

During the pandemic Voluntary Sector partner organisations responded flexibly and used resources in a creative fashion. Their added value to the social care offer was noted and their place and benefit to the Health & Social Care system, and Adult Social Care can only build in strength as we move forward with the Adult Social Care Improvement Plan.

The development and implementation of the Adult Social Care Three Year Plan has been very much informed by our "Community Led Support" work in Adult Social Care, which preceded it. This focused on working in a different way with the community, and a more person-centred approach to wellbeing. This work has been further developed and reinforced through the pandemic, with a more open, collaborative approach being taken to joint working, improving relationships, and understanding between the sectors. Initiatives have been truly community-led and asset-based, with statutory services taking a more facilitative, supporting role.

The VCSE sector has been agile, creative, and person-centred in its response to community need, which has positively influenced culture within Adult Social Care and the way in which we are improving our services. For example, as part of the Three-Year Plan, we are redesigning our "Front Door" (the way in which people access our services) in Adult Social Care. This is not only being informed by the development of the Community Helpline, but VCSE partners are actively involved in the redesign work. This approach is fully aligned to the Care Act (2014), which recommends greater integration and collaboration with local partners, for the benefit of community wellbeing.

Building upon this ethos, there is now an extension of this work to be piloted within the Emergency Department, with a VCSE model at the front door to support the clients who

have attended, with a community-based connector to facilitate and signpost other pathways of support. This could be both for this attendance but also to support with advice/appointment booking/connection to other services to reduce or mitigate the need for attendance for that issue in the future or support another part/area of their lives (mental health and well-being/social/carers issues/non-acute health related problems).

A new Steering Group has been created with representatives from across the VCSE and statutory sectors, which will help to guide and shape developments. A VCSE Forum has also been set up, to make it easier for organisations within the sector to connect with a common purpose, providing greater opportunities for collaboration, and a stronger voice in the local system. The VS in conjunction with the Council are planning a community response to the Cost-of-Living crisis via a procured Alliance approach.

Technology Enabled Care Services (TECS)

A Technology Enabled Care Service (TECS) is available across Torbay. Commissioned in 2018 by Torbay and South Devon NHS Foundation Trust, the service is provided by NRS Healthcare located in Paignton. TECS provides solutions to individuals to keep them safe and independent in their own homes for longer, potentially delaying any need for formal service interventions. NRS Healthcare offer a private purchase option so that people can choose different ways to support how they access the community and live as independently or care for loved ones. For those who are eligible following a Care Act Assessment, TECS will be considered before other packages of care are put in place.

This contract has supported people from managing medications independently through to allowing people to access their community with TEC phones linked to 24/7 care for emergencies. The provider NRS have been developing a new system to support people being discharged from hospital through until their assessment has been completed in their home while having access to a care line. Work has started with public health to use TEC to support people with diabetes and mental health so that they are able to manage and live full lives.

The Hope Programme

The HOPE (Help to Overcome Problems Effectively) Programme is an evidence based 6-week self-management course based on positive psychology, mindfulness, and cognitive behavioural therapy, built on 20 years of research from Coventry University.
It brings together people with similar needs and experiences in a safe space across 6 weeks. Participants are given the tools to build their knowledge, skills and confidence whilst helping each other. The groups are run by trained facilitators – professionals or volunteers. Across Torbay and extending into wider Devon, the HOPE programme continues to go from strength to strength with over 1,400 participating in the programme to date. We celebrated our 4th Birthday on 13th November 2021

As we continue to adapt our day to day lives towards a new normal amidst the Covid-19 pandemic, the HOPE programme has had to evolve as well. Since April, facilitators have been delivering the HOPE programme using Microsoft Teams and finding out the best ways to modify the face-to-face programme to an online one. This meant a two-month hiatus from April – June 2020, but since then we have been delivering 'Virtual HOPE'. This has increased our spread and reach, with people not having to travel to a HOPE venue but can access in the comfort of their own homes. We have also been able to offer more evening courses to support people who have working responsibilities.

Health and wellbeing coordinators and PCN link workers

Provide effective links into the voluntary and community sector- both these roles base their approach on discussions focussing on what matters to each person. Making Every Contact Count is more established and provides support to people around behaviour change related to tobacco, hypertension, alcohol, being overweight or physically inactive.

Falls and frailty prevention work

Is being driven by the locality Ageing Well and Frailty Partnership working across the system.

a) Approach to Collaborative Commissioning

Torbay has had integrated services since 2005 which were extended in 2015 to encompass a whole system integration with the creation of the Integrated Care Organisation (ICO) Torbay and South Devon NHSFT. Arrangements include aligned commissioning posts across the local authority and NHS Devon, pooled funding arrangements which are managed through agreed collaboration as to how these are spent. We have developed a Local Care Partnership Delivery Group which brings together operational and commissioning leaders across our system including the local authority, NHS Devon, public health, Primary Care Networks, and the voluntary sector. This group is responsible for aligning system plans and evolving strategy into operational plans. The Integrated Care Model sets out our system wide ambition to have a maturing integrated offer at neighbourhood and place, bringing together primary care networks, mental health, social care, and hospital services to meet population needs.

b) Overarching Approach to support people to remain independent at home

The key elements of our plans to support people to remain independent at home are connecting people with things that help them to lead healthy lives, supporting people to stay well and independent at home, proactively working to avoid dependency and escalation of illness, connecting people with expert knowledge and clinical investigation, providing easy access to urgent and crisis care and embedding end of life care at all levels.

The key priorities are population health management through data driven planning and delivery of care to achieve maximum impact, social prescribing, and community asset-based approaches. There is an Integrated Care Model Programme aiming to deliver these ambitions by bringing together several projects which aim to bring greater integration of health and social care provision. These include workstreams on: Enhanced Health provision in Care Homes, Ageing Well and Frailty, Community Urgent Response, transforming the delivery of social care, enhanced discharge, and our community mental health framework. The aim is to work as a system to meet the health and wellbeing needs of the population.

The programme includes working in partnership with primary care services and our voluntary and community sector.

The process for developing PCNs in Torbay is being supported by the local care partnership delivery group. There are 3 PCNs in Torbay and these are co-terminus with the council boundary. We have worked in partnership with PCNs to support the development of their pharmacists and social prescribing link workers.

A VCSE strategy has been developed across Torbay. It contains a mix of place-based agencies and those that operate across a wider theme and area due to their specialist nature. The VCSE is a key part of the integrated model of care and will help to deliver the

BCF priorities in the following ways: social prescribing, self-care, building resilient communities, by helping with transport, enabling hospital discharge to take place by supporting people with volunteers or befriending, looking after pets whilst people are in hospital, and wellbeing co-ordinators will be linking to community assets.

c) Reducing health inequalities and inequalities for people with protected characteristics

Learning from the pandemic has highlighted an increase nationally in health inequalities. The Devon ICS has responded by creating a health inequalities group focused on understanding and developing plans to reduced health inequalities. Responses and plans to this challenge are Devon-wide e.g., Disability strategy, Carers Strategy, Promoting Independence Policy as well as local LCP place as well specific plans at local place-based LCP level utilising PHM approaches.

Quality is the golden thread that runs through all aspects of our integrated commissioning and service delivery. We have created a system-wide quality, equality, and performance group to ensure that QEIAs are undertaken for all services to understand impact on all sectors of society but with reference to those with protected characteristics. All QEIAs will subsequently be subject to a system scrutiny panel to provide assurance that all elements of quality impact are understood, and risk assessed. All commissioning-led decisions in respect of service redesign are robustly and openly challenged and must be able to demonstrate that key impacts on quality of care have been appropriately considered through use of the agreed QEIA assessment process. Our Quality and Equality Impact Assessment (QEIA) tool aims to review impact through both an evidence/narrative account and a guided rating scale: measurable outcome scores of impacts on safety, treatment quality and experience.

The approach in Torbay is to work closely with public health colleagues to reduce health inequalities and inequalities for people with protected characteristics. As part of the development of plans we have assessed the areas where there are greatest health inequalities, and the Adult Social Care Transformation Plan includes approaches to reduce these. Areas of particular focus include suicide prevention, looked after children and older people's mental health.

Strategic, joined up approach for DFG spending

Approach to integration with wider services – using DFG to support housing needs of people with disabilities or care needs and arrangements for strategic planning for the use of adaptations and technologies.

The approach to using the DFG to support the housing needs of people with disabilities or care needs is supported by the Torbay Council Housing Strategy 2020-25 https://www.torbay.gov.uk/council/policies/community-safety/housing-strategy/, which recognises the need for its Strategy to support the Community and Corporate Plan and recognises the significance of housing within the wider determinants of health, particularly in helping to alleviate the pressure on Adult Social Care and Health services. The strategy enables the co-ordination several housing and health related priorities including, aids and adaptations for disabled people, home improvements; access to community equipment and assistive technology to enable independence at home, speed up hospital discharge/reduce readmission, prevent escalation of need e.g., accidents and falls and support maintenance of physical and mental well-being.

As part of this year's Better Care Fund, we have set aside a small amount to invest in a Strategic Review of our approach in relation to DFGs.

Torbay's housing strategy aims to deliver homes fit for the future at each stage of life to meet the needs of an increasing aging population; higher proportion of older people; higher proportion of population with disability; increased referrals for Disabled Facilities Grants; higher proportion of one person households; higher proportion of households aged over 65 living alone (from Housing and Health Needs Assessment). As part of improving quality of homes and providing homes fit for the future, there will be the development of additional extra care housing units. The local partnership arrangements including, an integrated ASC and housing strategy team, ensure effective partnership with local housing providers, local communities; large and small private sector bodies, the broader public sector; and our local community and voluntary sector.

Agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach

Planning for a patient's discharge from hospital is a key aspect of effective care and some will have ongoing care needs that must be met in the community. Meeting the ongoing care may involve specialised equipment at home or daily support from carers to complete the activities of daily living. Planned of the patient's return home, to ensure that there is no gap in the provision of care between the discharge from hospital and the initiation of community services is widely recognised. The flow of information about the patient must also be handed over from the hospital team to the community team so an informed plan of care can be put into place. Discharge planning is vital: poor discharge planning may lead to reduced quality of patient outcomes and delayed discharge planning can cause patients to remain in hospital longer than necessary.

The Complex Discharge Hub with a single system co-ordinator supports the discharge of patients on Pathways 1-3 from the acute hospital and decides the pathway, destination and level of care required to support the appropriate prescription of care from acute settings. The approach uses triage and liaison with Short Term Services (STS) and independent providers. The hub works across 7 days with an MDT workforce with the aim that the level of support provided enhances patients' independence utilising digital technology where possible. A recruitment programme is in place to increase workforce for STS.

The new Trusted Assessor roles at T&SD working from within the hospital on behalf of care providers to support appropriately assessed and supported discharges to those environments, facilitating and supporting close working relationships and collaboration with them, but also the primary link for P0 clients to support a smooth discharge back to their usual place of residence if it is a care environment. The control team also undertake a daily review of all P0 patients with a LoS >7 days to ensure that if they require any help or support from the Discharge Hub, that this is escalated and reviewed.

There is a complex discharge daily sit rep meeting to check and challenge the approach towards complex discharges which maintains oversight of actions to be completed to facilitate discharge. This meeting includes voluntary sector colleagues to increase understanding of voluntary sector services and ensure appropriate input to support discharge. Increased collaboration between therapy and discharge teams is aiming to create a team ethos and improve everyone's understanding of each other's challenges and pressure. Aiming for a Joint therapy team being established across acute, community and social care – sharing the assessment burden.

The team are working with hospital wards to develop ways of managing people's care within the hospital that avoids multiple moves across in-patient wards and embeds the ethos of home first.

a) Avoidable admissions: overall plan for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive admissions.

The indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, convulsions and epilepsy and high blood pressure. The rate is the standardised rate per 100,000 population of emergency admissions for chronic ambulatory care sensitive conditions.

Plans include extending urgent community response offer, the use of surgical and medical receiving units 24/7 and extending the enhanced health in care homes offer.

In terms of frailty - in response to Torbay and South Devon NHS FT joining the Acute Frailty Network programme for a year, greater Healthcare of the Older Person clinical presence has been embedded at the Front Door. The workforce currently consists of a Consultant and Registrar with a Frailty Advanced Nurse Practitioner starting in January and a Frailty Discharge Coordinator out to advert. This team is working closely with the already established Joint Emergency Team. The emphasis is on Same Day Emergency Care and admission avoidance. Other focuses include system wide frailty identification and the roll out of a Comprehensive Geriatric Assessment.

We also have plans in place covering admission avoidance for people with Long Term Conditions, specifically respiratory and diabetes:

- **Respiratory**
  PCN's piloting a COPD pathway by working with community teams and referring into intermediate care. Weekly MDTs with specialist nurses available to support. Successfully seen as an enabler to support discharge.
  Respiratory 'hot' clinics in place by December 2021, to avoid unnecessary admissions by allowing rapid access to respiratory physicians and specialist nurses, enabling stable patients to be managed in the community.

- **Diabetes**
  Following results from an audit in September 2021, where 100% of required acute diabetic foot referrals were made, a B3 podiatry post is in place providing education, foot touch tests and next steps to all wards within TSDFT.
  Individuals can still self-refer to the National Diabetes Prevention Programme (NDPP) until March 2022. 92% of PCN referrals, for the period April 2020 to October 2021, are for NDPP.

  TSDFT continuing the roll out of CONNECT Plus app which has been co-designed with NHS clinicians and patients to make it easier to manage multiple conditions together and in one place. Its range of features provides 24/7 access to clinically assured information that helps patients to be better educated about their conditions. CONNECT Plus empowers patients by enabling them to monitor progress, manage their medication, handle numerous appointments, and better care for themselves from the comfort of their own homes. This means that patients will need fewer appointments, make fewer calls to the department, and it becomes much easier to run patient-initiated follow-up programmes.

b) Length of Stay: plan for reducing the percentage of hospital patients with a length of stay over 14 days and 21 days.

Percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days

- Model for Winter to include forensic review completed on all patients with a LOS greater than 10 days by the Clinical site Manager with a physical presence on wards to discuss patients with MDT workforce. The aim is to support a reduction in patients moving to >14 days with a focus on the patients with a criteria to reside and what needs to happen to bring care decisions forward.

- Weekly MDT meeting including mental health teams, complex Discharge. Reviewing all patients with no CTR and LOS > 14 days. Supported shared understanding of each other's challenges and pressures.

c) Discharge to normal place of residence: plan for improving the percentage of people who return to their normal place of residence in discharge from acute hospital.

Percentage of hospital inpatients who have been discharged to their usual place of residence.

Home First strategy throughout the hospital. Plans include that any patient not on Pathway 0 or not returning to their usual place of residence with usual package of care is assessed by ward staff and then referred into discharge hub.

The discharge hub undertakes multidisciplinary triage and decides the pathway, destination, and level of care. Return to usual place of residence is supported by multi-agency intermediate care teams and short-term services.

d) **Admissions to residential and nursing homes: plan for reducing rates of admissions to residential and nursing homes for people over the age of 65.**

Adult Social Care Improvement Plan is engaged with improving ASC, focussing on strength-based approach, efficiency, effectiveness, innovation, and cashable savings. This plan includes ambitions to reduce admissions to residential and nursing care, increase the use of extra care housing and increase the number of people supported to stay in their own home.

Torbay Council and Torbay & South Devon NHS Foundation Trust has jointly commissioned two new extra-care housing schemes with the express outcome of reducing admissions for older people to general residential care (we have projected a reduction of 200 commissioned residential care beds by 2030) in Torbay and extending the length of time older people can remain independent before requiring residential care with nursing. The first scheme of 80 units is at the design stage and has involved the University of Stirling's Dementia Design Centre to ensure that our admission reduction approach includes maximising independence at home for people with varying degrees of dementia. Start on site is scheduled for June 2022, with completion and mobilisation in December 2023. The second scheme of 100 units has a more complex development schedule due to the nature of the site but will be completed and mobilised in late 2024.

Further to this, we are respecifying our existing extra-care schemes (108) to increase the capability of the service to divert older people with care needs away from residential care; this will be mobilised in 2022 and is expected to a further reduction of 12 admissions a year.

e) **Effectiveness of reablement: plan for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation**

Our plans include using our multi-agency Intermediate Care Teams and enabling short term services to support people after discharge from hospital. These teams have close links with social prescribers and our voluntary sector partners so that people continue to be supported after initial, intensive short-term intervention.

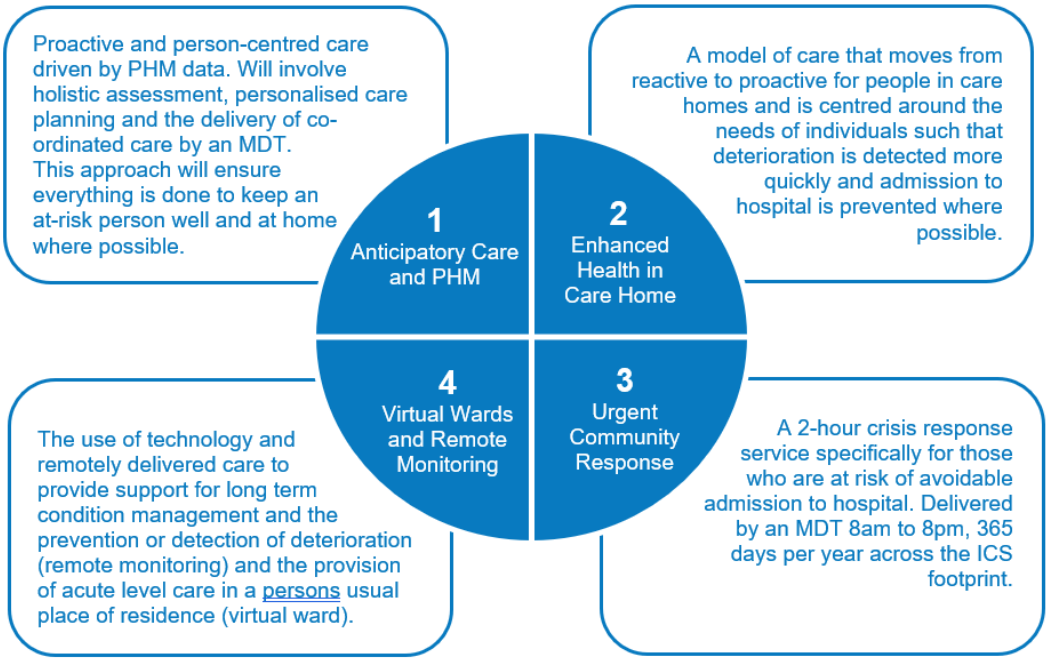
Torbay Council and Torbay & South Devon NHS Foundation Trust are at the early stages of jointly commissioning a 20-24-bed residential hospital step-down and reablement service, working in partnership with an existing Torbay care home provider alongside an embedded NHS multidisciplinary therapy team in the same building. Mobilisation of this service would be late 2022 and it is anticipated that 96-124 older people would go through the service annually, improving flow through the integrated health and care system and significantly improving post-discharge outcomes, including a reduction in unplanned hospital readmissions.

Community First Strategy

The ten components of our Community First strategy follows the ten areas of our Integrated Care framework which describes our approach in Devon to deliver truly integrated care in community services. The strategy itself forms the first component, being the map by which we will realise our vision and deliver integrated care across Devon ICS. As BCF is an enabler to this vision, investment will be particularly focused in 2022/2023 on the discharge to assess model and more appropriate use of capacity for integrated community-based health, social care, and mental health services, with a greater focus on care closer to home, supported by timely discharge and virtual wards.

Our community approach to keeping people at home

The diagram below highlights four key areas which directly seek to keep people at home (in their usual place of residence) when it is safe to do so. This strategy aims to move us to a place where we can increasingly have the resource, infrastructure, and clinical skill to support people with higher acuity needs in the community. In addition to the programmes below, there are several more specific services areas that support the avoidance of unnecessary admissions for people. A good example of this currently is the Devon ICS End of Life review, of which a focus is on giving people the increased ability to die in their preferred place and reducing avoidable admissions.



Our priorities align with the High Impact Change Model (have completed a self-assessment on managing transfers of care), and we have adopted the national discharge to assess model across Devon and are monitoring the delivery of the time to transfer standards daily and working as a Devon system to share learning and make improvements where required through our System Flow programme. It is important here that existing good practice in Torbay and indeed other parts of the system are considered as such as part of the approach in the wider system and we don't impact good progress.

Through detailed analysis of daily performance, we recognise that our main challenges are with pathway 2 and 3 discharges. Care market business continuity, workforce and market sufficiency are the key issues that we are grappling with. We are currently undertaking a piece of work, as one of the 10 points of the national 100-day challenge, to understand our discharge demand and capacity and are modelling this for each of our five localities. From this modelling work we will then draft a local plan for each area addressing; demand reduction for pathways 1-3, efficiencies within each pathway and capacity creation for each discharge pathway.

We continue to focus on supporting early discharge planning by expanding the reach of the discharge hubs and proactively supporting people home from hospital, improving patient flow through the hospital, further developing a 'one team' approach, driving forward our plans for integration including the voluntary sector, mental health services and the independent sector

and further developing the home first approach and maximising impact from the enhanced health in care homes workstream. This can be seen in our continued/new investments including through the Better Care Fund in such areas as:

- In-reaching B7 into ED to collaborate and link with JETS/Frailty/acute teams
- new Trusted Assessor / Admiral nurses working directly with the private care providers for transfers of care but also focussing Pathway 0 patients that are resident within a care environment to ensure they return to their usual place of residence
- Assistant Practitioners review all Pathway 1 from the Rapid Team, and they re-triage the Pathway 2 to ensure their prescription of care is correct and if it can be de-escalated
- multi-agency discharge teams
- enhancing our urgent and intermediate care / reablement services to build both capacity and skills
- extending hours of service across the system but particularly in community teams to move towards embedding a 7-day service and avoid peak admission and discharge times,
- increasing the scope and availability of residential and nursing care placements through discretional purchase of beds to increase capacity
- building on the skills of staff within care homes but also investing in the support we wrap around through such things as enhanced therapy support and proactively targeting primary care support to the sector
- building the scope and reach of our community equipment and telecare and assistive technology opportunities.

The Better Care Funding and our approach to integrated working are contributing to a number of existing schemes and supporting the development of others which are helping to address our local pressures, including capacity in the community, pressure of the complex caseload and the use of bed-based care.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Healthy people are at the core of healthy societies. Yet health is more than just the absence of disease. The World Health Organisation defines health as “a state of complete physical, mental and social well-being”. When it comes to health, accessible and high-quality health care is important, but as little as 10% of a population’s health and wellbeing is linked to access to health care. Many other factors, such as the home and the community we live in, our environment,
work, education and money, influence whether we are healthy and happy. It is therefore crucial to address these and create an environment that enables people to be as healthy as they can.

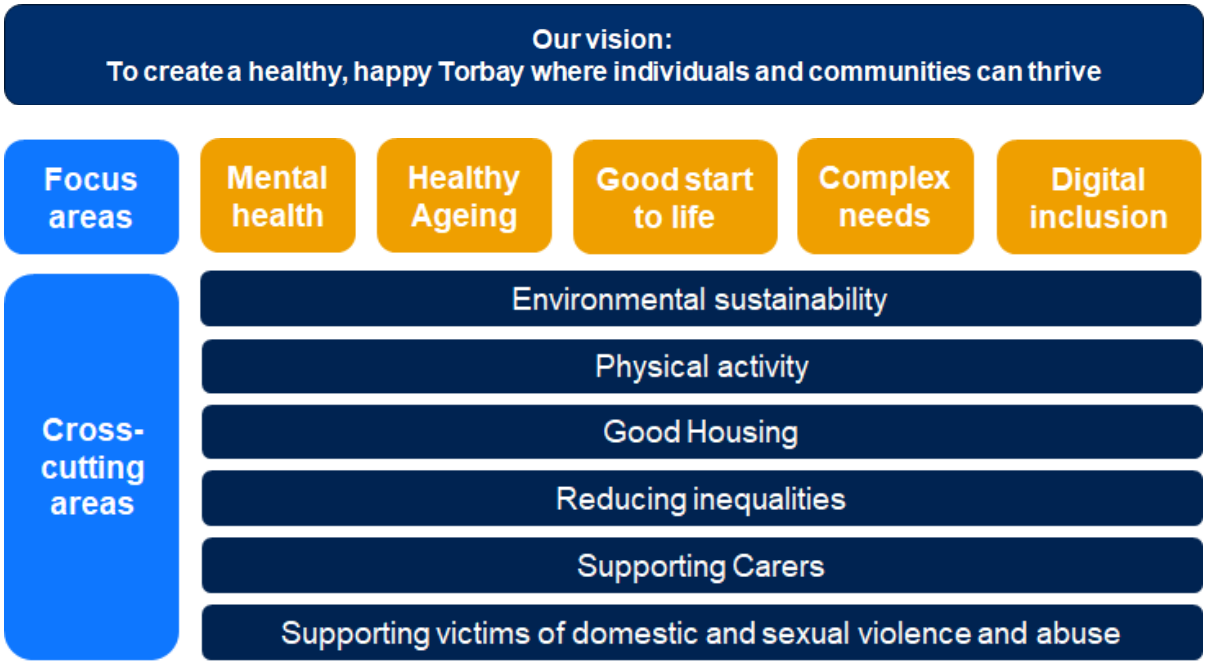
The circumstances in which we live, our daily activities and our social lives affect our physical and mental health and wellbeing. At the same time, having a physical illness or mental health problem can have a significant impact on our social and working lives and our wellbeing. Everyone in our community should have the opportunity for good health and wellbeing. To increase the health and wellbeing of the people in Torbay we need to work across all sectors and organisations to address the factors that influence these. This Joint Health and Wellbeing Strategy sets out our focus areas and key actions to improve lives in Torbay over the next four years.

Torbay offers a great quality of life for individuals and families, with a great natural environment on the English Riviera, a wide range of outdoor activities, excellent schools and a growing arts and cultural sector. But in common with other coastal communities, Torbay faces major challenges. Some of these are listed below. For more detail consult Torbay Council’s Joint Strategic Needs Assessment.

The Strategy in summary

The Joint Health and Wellbeing Strategy lays out the plan to improve the health and wellbeing of the population in Torbay between 2022 – 2026. Five focus areas and six cross cutting areas identify priorities for collective system action over the next four years.
The Health and Wellbeing Board has selected priority areas that relate to all aspects of health and wellbeing, without duplicating existing work or losing focus by spreading efforts too widely.

The Joint Health and Wellbeing Strategy provides a framework for the Health and Wellbeing Board to promote and monitor progress in the areas identified to be most important. It also provides a direction for the commissioning of services in other areas and identifies medium and long-term goals. The goals outlined in the following sections of the strategy will provide a basis for the Health and Wellbeing Board to monitor progress on each priority area.



The goals and actions laid out in Torbay's Health and Wellbeing strategy will be delivered by Torbay Council, constituent members of the Joint Health and Wellbeing Board and partners, in accordance with the table below.

The Health and Wellbeing Board has agreed 'areas of focus', 'areas to sponsor' and 'areas to watch'. Areas of focus match the focus areas of the Strategy. These are where the Board will take a more active direction and oversight of delivery. Areas to sponsor and watch are the underpinning areas where the Board is not the lead for delivery but requires assurance from partners that progress is on track.

For each area of focus there is a lead strategic group who will oversee delivery. There will also be an annual delivery plan sitting beneath the Strategy, defining actions year on year.

To ensure we achieve our aims in the agreed priority areas, an outcomes framework sets out the indicators and measures against which progress will be measured. Progress reports will be presented at the quarterly Health and Wellbeing Board meetings. In addition to this, the Health and Wellbeing Board will hold a spotlight session on each work area to examine progress in more detail through the year.

Specific focus and approach

When we published our last JSNA, in 2020, we highlighted the widening inequalities gap in the ten years since the Marmot Report, Fair Society, Healthy Lives, was published. During the last two years of the COVID-19 pandemic, those inequalities have only widened further. Those most adversely affected by both the direct and indirect impacts of the pandemic are the most vulnerable in our communities, living in the areas of highest deprivation. People in poorer health were more likely to become seriously ill with COVID-19, those in temporary work were more affected by job insecurity through lockdown, and those living in crowded or poor-quality accommodation were more likely to find it difficult to cope with disrupted schooling.

The spotlight on COVID section showcases some of the impacts: numbers of our population claiming universal credit have increased significantly; instances of domestic or sexual violence and abuse rose in all parts of the country during the national lockdowns; NHS

waiting lists have burgeoned, and the number of people in contact with mental health services has increased substantially. The Torbay Food Alliance, and the Torbay Community Helpline, supported thousands of people with practical day to day help. This reflects both the acute needs of our population, and the great community spirit and heart of our community organisations and our volunteers.

As we move, we hope, from the acute phase of the pandemic to living with endemic disease, we now face the enormous challenge of enabling all members of our communities to recover health and wellbeing. Clearly this is inextricably linked with recovering financially, having a stable job and a secure home, being socially connected, and feeling truly part of a community. As a Council we are leading work to tackle the COVID deficit through our Turning the Tide on Poverty programme. This builds on the Marmot principles of healthy start in life; fair employment and good work for all; healthy standard of living; sustainable communities; and preventing ill-health. The chapters of the JSNA set out what we will need to tackle in each of these areas.

However, the situation has changed rapidly and repeatedly due to the Covid-19 pandemic and response, followed more recently by the Cost-of-Living Crisis being experienced due energy increases and changes to taxation and benefits being implemented in April 2022.

The Task and Finish Group discussed the themes identified within the Marmot Report 'Fair Society, Healthy Lives'. Marmot published a further report 'Build Back Fairer' examining the impact of the Covid-19 pandemic and the national measures taken to manage it on health inequalities. Further recommendations were made on short-, medium-, and long-term measures that should be taken to mitigates these adverse impacts (see Appendices). Turning the Tide on Poverty describes the approach in Torbay to embed these Marmot themes and recommendations.

The Torbay Covid-19 Recovery Board reviewed and updated the impact assessments and agreed to align the Covid-19 Recovery Strategy with Turning the Tide on Poverty work streams in revising approach to recovery planning. There are now key strategies and plans in place to deliver on these themes including the Economic Strategy currently under development and the Joint Health and Wellbeing Strategy which is out for consultation. In addition, there is a Strategic Housing Strategy and Children's Improvement Plan in place both overseen by Boards.

National policy has also influenced the situation with a shift in the pandemic response to Living with Covid and statements of Levelling Up missions. It was important that while responding to and implementing national policy that we were reviewing the situation on the ground in our local communities.

A series of multi-sector workshops have been held, to explore how as a local system we can address key issues driving health inequalities. These were guided by the policy objectives recommended in the Marmot review. The workshops were held around four inter-dependent themes:

- Best Start: Give every child in Torbay the best start in life and enable them to maximise their capabilities and control over their lives
- Fair Employment: Maximise opportunities for people in Torbay to access good, fair work which pays a living wage
- Ill Health Prevention: Strengthen the role of ill-health prevention in Torbay

- Healthy Standard of Living: Ensure that rented accommodation in Torbay is of a good standard that supports good health.

Reducing inequalities

Health inequalities describe differences in the opportunities that people have to lead healthy lives. Health inequalities do not only exist in life expectancy, but also in access to and availability of care, behaviours that impact health and social determinants of health such as housing. Due to the impact of inequalities on health outcomes, reducing inequalities is an important goal in the NHS Long Term Plan, and should be a key aim of any public health policy in Torbay.

In Torbay, we have very affluent areas, but also quite deprived areas that struggle with poor housing, poverty, insecure jobs, low wages. Inequalities have also worsened during the pandemic, meaning that this is now more important than ever.

Ask from other service areas:

- Every time a service changes a quality and equality impact assessment should be completed
- All employees should be trained to recognise the needs of minority and ethnic groups
- Introduce a Rural Proofing for Health Toolkit into the service delivery of local health and care systems
- Ensure that digital care pathways are developed in ways which increase inclusion

Inequalities

Inequalities are variances between different groups within society that are both avoidable and unfair. They develop out of the conditions that we are born, grow, live, work and age in. These conditions impact in different ways as well as in different combinations, which manifest in such a way as to be either beneficial or detrimental to people's lives, such as health behaviours, health status and wellbeing.

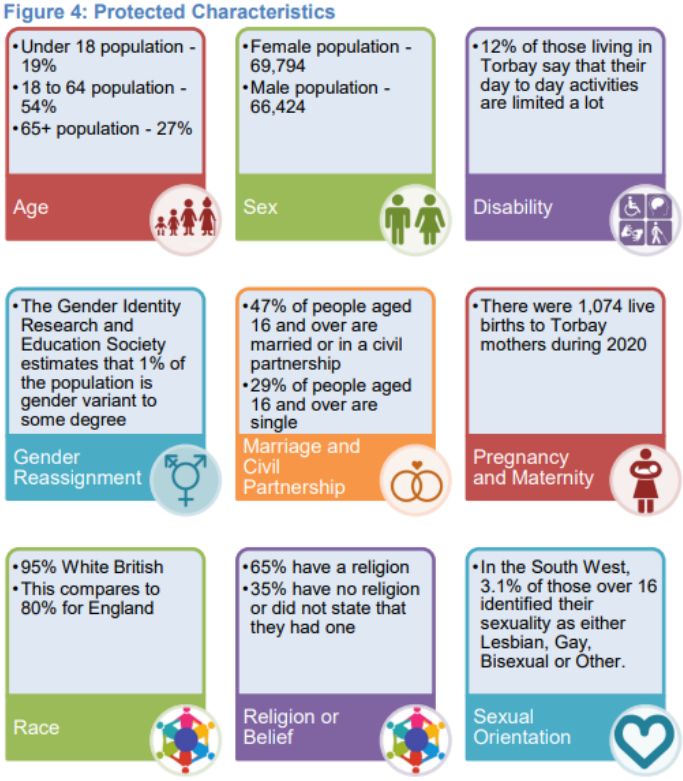
Inequalities can exist between population groups in a geographic community in different ways, with many individuals and groups intersecting across two or more of these (Figure 3).

Figure 3: Inequalities and intersection

- Socio-economic groups and deprivation: *Examples include those who are unemployed, on low incomes or people living in deprived areas.*
- Protected characteristics: The Equality Act protects people against discrimination because of the nine protected characteristics that we all have. *Examples of protected characteristics are sex, race, sexual orientation, and disability.*
- Vulnerable groups in society: These are groups of people who because of certain factors mean they are more at risk than others in society and/or marginalised in society. *Examples include people with a disability, people with substance misuse problems, prisoners, and homeless people. Inclusive health groups can be an alternative term that is often used for this population group.*

Protected Characteristics

Figure 4: Protected Characteristics



Protected characteristics are the nine characteristic groups protected under the Equality Act 2010, these are listed in Figure 4. Under the Act, people are not allowed to discriminate, harass or victimise another person because they have any of the protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic.

Torbay's population includes an increasing number of people with lived experience of health and wellbeing challenges. As this population ages, the need for health and care services is estimated to increase substantially in the future. Torbay needs health and care services that promote the health and independence of people in the community and take older citizens' needs and preferences into account.

Physical, mental, and social wellbeing are closely connected and any programme to support healthy ageing needs to promote these together. There is also a need to understand and to tackle people's experiences of social isolation, discrimination, and exclusion. We need to work together to overcome these complex challenges and see this as an opportunity for engagement and learning about health and wellbeing for us all, right across the life course.

Together we want to transform the way we approach this, focusing on the strengths, skills and experience we can all contribute to society as we age, and enabling us as individuals to take steps to promote and improve our own health and wellbeing with each new decade.

What are our goals?

Every individual:

- Understands the process and is aware of ways for preventing and living with ill-health
- Has their choices and ambitions acknowledged and promoted
- Is able to choose the level of support that will enable them to live independent and socially connected lives
- Is respected for their life experiences and abilities
- Is treated with dignity in all health and care services

To make this happen we will

- Adopt a whole community approach inclusive of all ages and cultures, and require the same of our partners
- Ensure health and care services are shaped by people with lived experience and from diverse backgrounds
- Enable trusted relationships that fully support peoples' wellbeing
- Promote and support the wellbeing of carers
- Promote services that are accessible, inclusive, and effective
- Ensure support is targeted at prevention and is determined by need, not age
- Actively challenge discrimination
- Ensure that when care is needed it is accessible, compassionate and of high quality
- Enable communities to support safe, healthy, active, socially connected, intergenerational living
- Develop housing provision that is suitable and adaptable for people as they age, promoting independent living.

Devon Integrated Care System

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities, and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation.

The key headlines from the developing Equality, Diversity and Inclusion strategy are that One Devon is moving towards a new approach to inclusion that prioritises co-production and working with community partners to understand the needs of our diverse communities in Devon. Inclusion should be at the heart of our organisational culture and is set to be the foundation of joint working within the One Devon and NHS Devon. Since the last BCF Plan, NHS Devon implemented a new Equality, Diversity, and Inclusion Team, which includes an Equality, Diversity and Inclusion Project Manager and System Equality, Diversity, and Inclusion Lead.

ICSs have a leading role in tackling health inequalities, through building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level. CORE20Plus5 remains the focus of NHS Devon's combined HI and prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including the participation in the national piloting of both the

CORE20PLUS5 Connectors model; the support and investment we continue to make in the work of our Local Care Partnerships (LCP's); and our ambition to be a pilot area for the HEE Health Inequalities eLearning programme.

Embedding Health Inequalities across the Devon system is being delivered through a number of actions, including:

- Working closely with our workforce programme, NHS Devon will aspire to deploy Health Inequalities awareness to all staff. This will ensure the workforce:
    - Have a common understanding of what health inequalities are, and how they can affect the population of Devon.
    - Are more confident in asking patients to share personal information about themselves that will assist us in ensuring that factors such as where they live, their ethnic background and other characteristics are not resulting in unacceptable differences in access, experience, and outcome.
    - Are confident in identifying health inequalities.
    - Are confident in taking positive action to tackle any identified health inequalities experienced by the people they meet.
- Working closely with our colleagues in Communications & Engagement NHS Devon will aim to raise awareness of health inequalities within our population. This will support patients in being confident in why it is safe and relevant to share information about themselves.
- In 2022/23 NHS Devon revised the Quality and Equality Impact Assessment (QEIA) which will be launched across Devon to ensure HI is fully considered in all change. A "soft launch" within NHS Devon in Q3 will inform final revisions prior to a phased, wider rollout for completion by Q4 2022/23. This refreshed tool will view inequalities from the perspectives of those affected by them through co-design with the relevant inclusion health groups. Importantly, not only will this tool make it easier to identify potential inequalities brought about by change, but it will also connect those completing the assessment with best practice and easy to understand, tangible examples of how to mitigate against possible inequalities.
- Revisions to our governance structure for health inequalities will give increased focus supporting the Health Inequality priorities our LCP's, and the PCN's within them, have described, alongside the delivery of whole-Devon improvements.
- Establish even stronger links with our network of Health Education England HI Fellows.
- Build upon the work of Devon Communities Together cultural awareness programme that describes a common understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population.

By November 2022, NHS Devon will have completed a homeless health needs assessment within each locality to give both a local, and aggregated whole-Devon, view. The homeless

HNA will also be used to inform future commissioning requirements of Primary Care services to support the homeless population and ensure inequalities that may exist in the current provision are addressed across Devon. From a study undertaken in 2020 to understand attendance and discharge experiences of no fixed abode and addiction patients at local hospitals.

Currently work is being undertaken on Devon's overarching primary care and Community First strategies, People Led Change and the expectation is that addressing health inequalities will be a prominent feature of that work (strategy production July 2022).

Investment in prevention priorities continues both in whole-Devon workstreams, and in interventions at place via our £2m annual prevention fund.

Devon approaches 22/23 having made significant improvements in the capacity and leadership of the Health Inequalities programme. Through:

- The appointment of a Non-Executive Director with the responsibility for Health Inequalities
- Alignment of the HI, Prevention and Health Inequalities agendas under the portfolio of the Deputy Director of Commissioning of Out of Hospital.
- Identification of a whole-Devon SRO for Digital Inequalities
- Appointment of a Head of Health Inequalities and Prevention
- Increased support to, and engagement with, the HEE funded Health Inequalities Fellows network in Devon.
- Dedicated project management capacity in place to support localities in taking action to deliver the priorities they will define to achieve the aims of our Equally Well aspirations.

NHS Devon's Population Health Management programme is closely linked with the Health Inequalities team. The Population Health Management Programme has the overall aim of having a systematic population health analysis at system, place, and neighbourhood level, by 2023/24 enabling LCPs, PCNs and partners including mental health and local authority, to understand their population's needs, including the wider determinants of health, and design interventions to meet them. As an end state, all LCPs and PCNs should be routinely utilising PHM to develop targeted interventions for identified 'at risk' cohorts. The One Devon Dataset (ODD) is in the process of being developed. The dataset will allow all data to be accessible in one place, with various organisations able to access the data.

Using the data made easily accessible by the One Devon dataset will enable us to inform the Better Care Fund schemes, ensuring better outcomes for the population as well those facing inequalities in accessing services.

Better Care Fund Submission Templates:

Please find the associated templates required in support of this narrative document embedded below:

BCF 2022-23 Planning Template v

BCF Demand & Capacity Template -