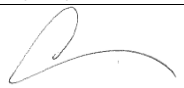
BCF Narrative South Devon and Torbay CCG and Torbay Council:

Signatories

Local Authority	Torbay Council
Clinical Commissioning Group	NHS South Devon and Torbay Clinical Commissioning Group
Boundary Differences	NHS South Devon and Torbay CCG will also contribute to Devon County Council BCF submission. Arrangements have been put in place to ensure clarity of schemes and plans for each BCF submission.
Date agreed at Health and Well-Being Board:	
Date submitted:	

Signed on behalf of the Clinical Commissioning Group	South Devon and Torbay Clinical Commissioning Group
By	Simon Tapley
Position	Director of Commissioning
Date	21/03/16
	

Signed on behalf of the Council	Torbay Council
By	Caroline Taylor
Position	Director of Adult Social Care
Date	

Signed on behalf of the Integrated Care Organisation	**Torbay and South Devon NHS Foundation Trust**
By	Paul Cooper
Position	Chief Finance Officer
Date	

Signed on behalf of the Health and Wellbeing Board	**Torbay Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Derek Mills
Date	

Engaging with Local Providers

Our Pioneer programme, Integrated Care Organisation business case, Vanguard programme and proposed new model of care have been developed with the active support, involvement and engagement of South Devon Healthcare NHS Foundation Trust, Torbay and Southern Devon Health and Care NHS Trust, Devon Partnership NHS Trust, South Western Ambulance Services NHS Foundation Trust, Virgin Care, Torbay Council, Devon County Council, NHS England, Torbay Community Development Trust, the five General Practice localities and our public.

In 2013/14 we began CCG wide engagement with a range of statutory, private sector, voluntary and community sector organisations as well as the public to help us to shape our new model of care. Further engagements with all sectors will be based on new models of care and payment mechanisms to ensure the right care is delivered at the right time in the right place at the right cost. New models of financing will be achieved with the support of local authority and health partners to bring about investment in the system.

Multi-provider forums are held which are interactive; these disseminate and collect information, challenge and solutions with the market.

Local Agreement on Funding Arrangements

In 15/16 we have a risk share which contains acute, community, placed people and adult social care- our new model of care. Our planning return template shows the funding contributions and how they have been applied. We are working with the ICO and Torbay Council to agree the same risk share for 16/17 subject to affordability.

Our Vision for Health and Care Services

South Devon and Torbay is a geographically diverse area. Its population ranges across the deprivation span and its health and social care system is financially challenged, not least because of its ageing population and the proportion those over 85. These challenges are increased – especially in urgent and emergency care - by the annual additional pressure on services of holidaymakers and tourists.

The area has a respected reputation for partnership working and for innovating to find more effective ways of delivering quality care. Relationships between statutory, independent sector 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.

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 Torbay Council and has resulted in a more effective patient journey for thousands of people.

In Torbay the model for integrated community health and adult social care was developed in 2005, with the creation of Torbay Care Trust. This model has been recognised both nationally and internationally as an excellent model of care, with a single assessment process, single care record, single information technology system and multi-disciplinary frontline teams supported by a single management structure. The role of the care coordinator in these teams, ensuring seamless care for patients, has since been replicated in many other areas.

In 2013 South Devon and Torbay became one of 14 national Pioneer sites for integration. The joint bid from the health and care community set out an ambitious goal of whole-system integration, extending beyond health and social care to encompass acute care, mental health and the voluntary sector and personal support, underpinned by the creation of an Integrated Care Organisation (ICO). The ICO formed in 2015 through the merging of South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Care Trust to create a single entity for delivery to become Torbay and South Devon NHS Foundation Trust which further widens the current model of health and social care to include acute health care provision. Our vision for integrated health and care extends beyond the local authority boundary of Torbay into the whole CCG area, into South Devon which is within the scope of Devon County Council. The Better Care Fund sits within this longstanding programme of integration through the creation of the ICO and the development of a new model of care. We widened our scope further in 2015 when our health and care community become one of only eight groups across the country to be named as a Vanguard site for taking a pioneering new approach to urgent care and we have developed proposals to increase access to urgent care services and develop the infrastructure to support patients to choose wisely.

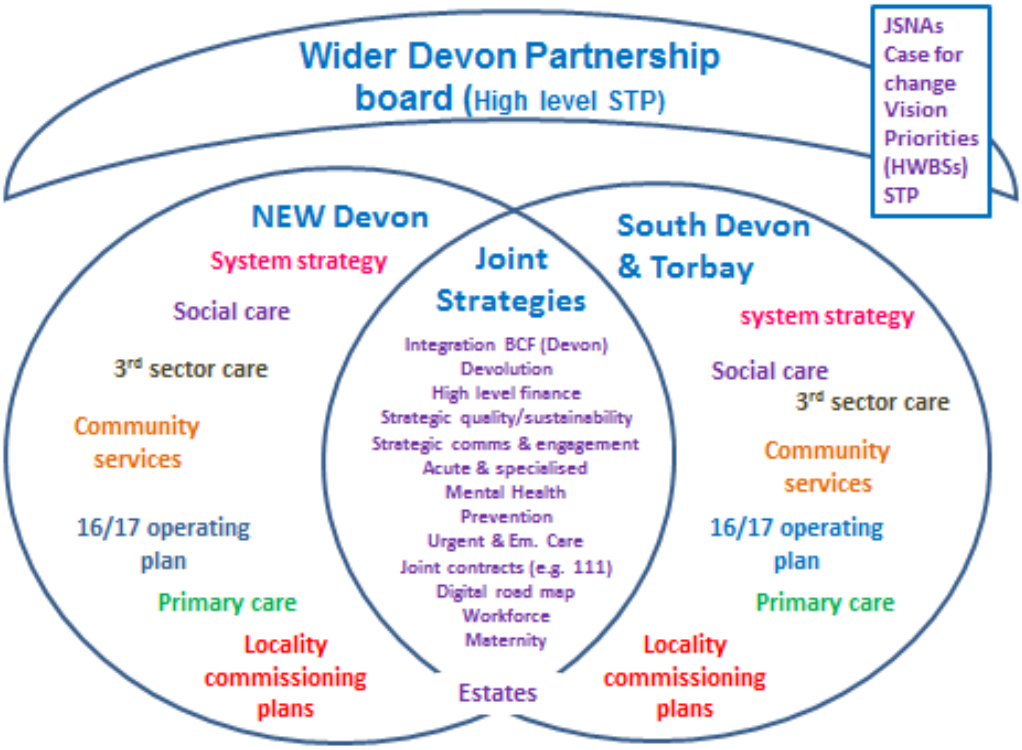
Our Vanguard approach integrates seamlessly with the planning footprint identified in line with NHS England's 16/17 planning guidance and the requirement for a 'Place based', system wide 'Sustainability and Transformation Plan' (STP) responsive to our communities.

- Strategic direction – the creation of the integrated care organization (ICO), with a high percentage of patient flow to one provider, supports the shared vision and outcomes for future health and social care across the existing CCG boundary, underpinned by good stakeholder relationships.
- Major Service reconfiguration – children's community health services, CAMHS transformation and rehabilitation, re-ablement and recovery require a wider network approach across Devon and engagement with key stakeholders is already underway.
- Urgent and Emergency Care – our Vanguard is largely contained within our CCG boundary but we work closely with other commissioning organisations in relation to the wider footprints covered by partner provider services such as 111 and 999.
- Primary Care, including primary care estates planning – the majority of patient flow happens within our CCG boundary, supporting our primary care services development plans and our locality based community service model.

- Integration of community health and social care services –The Better Care Fund as an integral component of our STP
- Mental Health services – achieving the vision for mental health services as set out in the Five Year Forward View will require our working in a wider mental health planning network reaching well outside our CCG boundary across our Devon footprint including addressing low level mental health
- Prevention and self-care – embracing national initiatives will be helped by working with for example our local authority and voluntary sector partners in small communities which can help drive cultural change.
- IT – our NHSE supported digital road map is co-terminus with the CCG and ICO geographical boundary.

  Assistive Technologies – using the latest developments to increase independence and safeguards for people with fast response mechanisms and light touch approaches to ensure minimal but timely interventions

The diagram below demonstrates the inter-dependencies driving our STP



The key inter dependency of the successful implementation of the Better Care Fund has been the creation of the Integrated Care Organisation and the implementation of the new model of care reflected within risk share and contractual arrangements agreed between all partners as well as being progressed at a pace to deliver on outcomes.

Whilst the BCF plan in 14/15 focused in detail on four schemes:

- Single point of contact (SPOC)
- Frailty services

- Multiple Long Term Conditions
- Community Care (Locality Teams and Community Hospitals)

There are also a number of other population groups such as carers and children as well as preventative public health interventions and mental health that have detailed programmes of work associated with them which play a significant part in the whole system change across the health and care sector.

All of this is supported by the work of Integrated Personal Commissioning for which we are a pilot area. This is putting even greater control in the hands of the clients and patients. As a joined up system the opportunity is greater for us to be able to support them in identifying, accessing and benefitting from a wider range of options which will increase their wellbeing and support their reduced reliance on the system.

Key Principles

At the core of our vision for integrated health and care are these principles:

- People will direct their own care and support, receiving the care they need in their homes or their local community
- Key services will be available when and where they are needed, seven days a week
- Joined up IT and data sharing across the entire health and care system will enable seamless care
- We will promote self-care, prevention, early help and personalised care
- We will have a flexible and responsive care workforce across the community

Programmes of work across organisations are aligned to help deliver these core aims, and form the basis of this BCF plan are already underway within the Integrated Care Organisation and by our five Locality Commissioning Groups:

- Single Point of Contact (SPOC)
- Community care
- Wellbeing Co-ordination
- Long Term Conditions Management

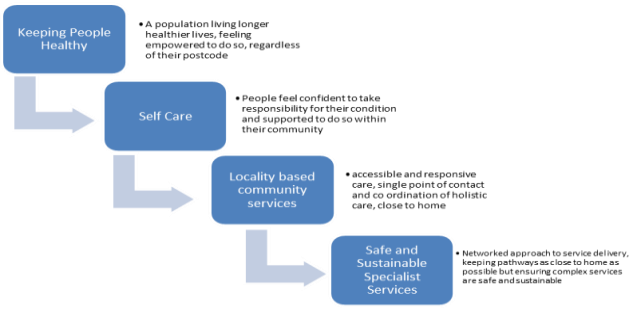
The CCG's five year strategic commissioning plan is based on the Joint Strategic Needs Assessment. Close links between CCG and public health specialists, who are integral to CCG commissioning, ensure the alignment of priorities and focus between health and local authority plans. This includes the Children and Young People's plan and early help strategy, and joint commissioning strategies for dementia, carers, learning disability, mental health and housing-related support.

The **Joint Strategic Needs Assessment** (JSNA) has developed from a reference document into an interactive tool, available to partners to interrogate the data according to service need. The JSNA has highlighted those areas that needed priority attention. For learning disability, suicides, and alcohol, we have segmented and condition-specific in depth profiles at a geographical ward and neighbourhood level. A joint information intelligence virtual team has been established among health, local authority (including education) and police to facilitate information sharing that can then be translated into strategy.

The Better Care Fund lines up with the existing priorities set out in the **Health and Wellbeing strategy** which takes the life course approach and identifies priorities which support a system of self-care for people with long term conditions, and promote both independence and mental health.

We have also defined how we will review our services to understand further the direction for our transformational change. **This will form four phases of care:**

1. Keeping people healthy
2. Self-Care
3. Locality based Community Services
4. Safe and Sustainable specialist service



Case for Change and Evidence Base

As with other areas in the UK, we face a number of health and wellbeing issues in South Devon and Torbay. The statistics show that two out of every three adults are overweight, with one in four being deemed obese. In primary schools one in five children is obese by the time they reach Year 6.
We also have an ageing population with one in four adults aged over 65 and this statistic is increasing. Torbay in particular also has a high number of households which fall into the poverty category and there are high rates of alcohol related admissions to hospitals and mortality due to corresponding liver disease.

But far outweighing the long term public health challenges we face, our very immediate challenge is that of financial balance and creating a sustainable financial position to enable the delivery of our Sustainability and Transformation Plan covering an extended footprint. Through the STP we will work with NEW Devon CCG, Torbay Council and Devon County Council to meet the national challenges of:

- Closing the health and wellbeing gap
- Closing the care and quality gap
- Closing the finance and efficiency gap

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.

We believe that services should be based on populations in local communities and centred on the individual's needs within those communities. Services should be built on people's needs not organisational imperatives; this serves as a mantra for the formation of Local Multi- Agency Teams (LMATs) as centres of wellbeing where our population can receive co-ordinated support in relation to prevention, self-care, social care and medical support from primary and community care. All our partners, including our neighbouring CCG, NEW Devon, are in agreement that we need to retain the locality focus of our integrated, multi provider community to enable us to take on these 'national challenges'.

Delivery of the Torbay Better Care Fund Plan in 2016/17

In 2015/16 we started to develop and test a new model of care in Teignmouth and Dawlish, and in Dartmouth. In these towns, input from the League of Friends, town councils, Patient Participation Groups, the voluntary sector and others has helped to shape an emerging model of care. We have also had meetings with stakeholders in towns in each of our localities to discuss the principles of this new approach.

During 2015/16 we developed our emerging model of care which sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs. It is founded on joined-up care across the whole community. We want to be able to provide care as close to home as possible, supporting people to remain independent and in their own homes, reducing reliance on bed-based services, with local communities actively helping to support the wellbeing needs of the local population.

The development process throughout 2015/16 has encompassed the clinical case for change underpinned by a financial evaluation of several options for the most sustainable model which have been developed with stakeholder feedback at every stage.

We recognise that one size will not fit all, that there will be differences in health, demography and geography, as well as variation in the availability of other services such as residential and nursing care. The proposed model of care will reflect these differences while being able to deliver consistent, high-quality care.

The emerging model is evolving in the light of comments received. We will consult formally across our whole area in 2016/17 so that people have the opportunity to have their say on the proposed model of care, reflecting on what it will mean for health and care in their own area.

Figure 1.0 The New Model of Care will deliver:

Theme	Objective	How will this be achieved? (throughout 2016/17)	Measures of success
Improved patient and carer experience	To ensure that frail elderly patients are supported to live well in the community, managed at the level of care appropriate to their needs, and to reduce reliance on statutory agencies To enable patients and carers to better navigate the health and care system in order that the local health and social care systems work as a whole to respond to and meet the needs of people who use health and care services Single point of access – patients with complex or long-term conditions will be able to access care through one route and telephone number, delivered by local multi-agency teams.	Local Multi Agency Teams – one per locality, seeing community teams co-located and working with primary care, with secondary care outreach services delivered as close to home as possible. Wellbeing co-ordinators, appointed from the voluntary sector under an SLA with the Wellbeing Partnership in Devon and the CVS in Torbay, with honorary contracts with the ICO will help patients and carers navigate the system, ensuring they need tell their story only once. This SPOA is already being successfully piloted in Torquay, and it will further develop in line with the newly-commissioned 111 service.	Increase in number of ASC users who have as much social contact as they would like (national measure) Increase in number of carers who have as much contact as they would like (national measure) 70% calls dealt with at first point of contact, 30% passed on correctly
Maximised Independence	To enable people to take control of their own health and wellbeing by leveraging the prevention strategy, maximising use of the voluntary and community sector for signposting and support, with a focus on wellbeing and health promotion. This will result in a reduced reliance on statutory services	Wellbeing coordinators will help patients and carers navigate the system, utilising their extensive knowledge of community support. GPs will be funded to provide medical cover to support the LMAT functions,	

	LMATs will enable multiple organisations to work together with local communities, to provide exceptional standards of care and support that will ensure elderly patients are able to remain healthy and receive care in their own home to a far greater extent.	and in particular the intermediate care placements. We will begin conversations with end of life care providers to encourage new ways of working between the LMATs and End of Life Care Providers to ensure seamless pathways of care. District councils will be fully involved, in particular housing and leisure services to allow truly holistic care and support.	
Minimised hospital admissions	To build on our proactive risk stratification process - identifying those most in need and ensuring they are able to be appropriately managed in community settings, thereby reducing the number of avoidable admissions to an acute hospital bed.	The LMATs will link with primary care, with shared records supporting our existing MDT proactive case management The Intermediate Care service will merge with the rapid response and crisis response teams, providing one co-ordinated community response team at the heart of the LMAT in every locality. This includes embedded nursing and therapy services. We will contract with the private care home market to maximise intermediate care bed availability, linking closely with both LAs to ensure market stability and resilience. We will work in partnership with care home	Increase in patients supported by intermediate care, either as step up or step down support. <45% bed based care provision >50% reduction in community bed days Significant increase in support in South Devon, to bring it in line with numbers supported in Torbay One care home one practice Increase in care home patients with advanced care plans recorded (TEPs)

		providers and local authority social care to develop new shared models of care and support, including medical reviews, medication reviews and rehabilitation services. Increased skills sets within the workforce to focus on activities to be undertaken versus role based/silo working	

Prevention:
In response to some of the challenges we face as a population, the CCG in 2015-16, has, as its primary focus, developed a Joint Prevention Strategy which brings together the work of our two Public Health teams. Working with our partners in Devon we have mapped the level of community resilience to give us a better understanding and view of where our prevention work needs to focus and what our aims are.

We have profiled demand across social care and lifestyle services forming a baseline for both our Self Care Vanguard work in Torbay and South Devon, and the Devon County Council 'demand management' programme of which we will be part of. The demand work provides us with a common set of goals against which we will develop our implementation.

Our profile work has included not only the more traditional review of the JSNA but also includes, household profiling, goal setting, motivational interviewing and consumer preferences.
This will give us better understanding of the person, circumstances, holistic need and motivation, buying behaviour, their social circle, skills, knowledge etc. which will help us to understand how to frame and motivate individuals using more than just existing market segmentation.

Self-care:
Our self-care work remains a priority area for us. The successful urgent care Vanguard bid provides us with the opportunity to use the learning from our previous self-care work to drive this forward All contacts with our system will support people to increase their levels of knowledge, skills and confidence in adopting healthy behaviours and lifestyles, managing their own health and health care, resulting in significant increases in upstream prevention; reduced demand on our urgent and emergency care services; ensuring patients are cared for at the most appropriate part of the system; and bringing about a sustained reduction in health inequalities. Health and care professionals will have a high awareness of, and confidence in, self-care, voluntary sector services, local community assets and peer support. We will achieve all of this by:

- Providing open access to a comprehensive and accurate Directory of Services;
- Using techniques such as social marketing to identify and target sections of the population with "call to action to self-care" messages that they will relate to and that will 'activate' them to self-care;

- Encourage people to make full use of the multimedia rich online tools, information and advice we will make available or signpost them to, bringing about a 'channel shift' in how people choose to interact with our services towards self-service options;
- Adopting system-wide approaches to patient & clinical activation to self-care; shared decision making; and evaluation; and
- Working with the voluntary sector to create and maintain vibrant social network for health at both local community and system level.

Workforce:
An integrated workforce planning group has been established across the local health and care community and a workforce planning day took place in February 2016. This has been the first step towards creating an integrated workforce plan for South Devon and Torbay. This work will both seek to address current workforce concerns locally as well as constructing a strategic vision and a plan for an integrated workforce. Links have also been made with social care at a regional level to look at opportunities for standardising approaches to workforce development and maximise the interactions by all health and care staff in developing good outcomes for the individual being cared for.

To support the event work is also underway to create a local health community 'workforce infographic' which will provide us with a baseline level of understanding of our current workforce landscape and provide a summary picture of where our individual organisational workforce plans will take us in the future. We also hope to take an innovative approach to our workforce planning offering flexibility across our entire health and care system.

The outputs of the workforce planning group will form part of our STP deliverables with phase leads aligning service objectives to those described as part of the integrated workforce strategy.

Carers:
Torbay operates a whole system approach to Carers services prioritising early identification and support of Carers through a 'universal' offer of support, which provides information and advice, assessment and access to practical and emotional support for all Carers (not subject to eligibility). There are Carers Support Workers at key points in the Carers journey including in all GP surgeries, in the Discharge team at the Acute Hospital and in specialist community teams. Our services for carers aim to reduce hospital admissions and the time those cared for spend in hospital because carers are more involved in decision-making, supported to care during hospital stay and on discharge. We anticipate this will also lead to a reduction in readmissions.

We are in contact with 28% of the population of Carers based on the 2011 Census data. The refreshed Carers Strategy 'Measure Up' 2015-2017 encompasses previously piloted programmes such as the work done pre discharge and follow up 48 hours after discharge from community hospitals to identify early on problems and reassurance to patients and carers; Carer awareness training for community staff to assist in the early identification of Carers; Health and Wellbeing Checks carried out in GP practices by Carers support workers to identify what early support is needed and signposting or systematic referral on for more complex cases; specific focus on vulnerable groups with support worker focus on substance misuse problems and mental health problems.

With the implementation of the Care Act 2014, a pool of 'trusted assessors' in primary care and the voluntary sector were trained to deliver 'light touch' Carers Assessments - the Carers Health and Wellbeing checks. They then work as enablers to help Carers find their own solutions and access community support. Carers Trust Phoenix are the voluntary sector partner who deliver these checks,

and have a good background of community engagement, and linking Carers into mutual support. This approach aims to develop community capacity, self-care and mutual support for carers. As part of the Ageing Better Big Lottery funding, both Carers Trust Phoenix and Mencap have received additional funding to develop projects for older Carers - Circles of Support and Mutual Caring.

Torbay has an interagency strategy for Young Carers under 25 (2013 – 16) with a 3 year Action Plan and a joint agency Steering Group. It is in the process of being refreshed with almost all of the targets having been achieved well ahead of schedule. This Strategy is based on whole family working and there are specific requirements and targets for adult services teams to identify Young carers and address their needs. There is significant attention to raising staff awareness across the health and social care system about the needs of young carers and their needs are promoted across Health and Social Care with the Carers Policy and Action Plan.

Torbay's Carers Services are Care Act compliant, but the biggest challenge is to thoroughly embed the ethos of whole family working and enhanced Carer support throughout adult services including mental health. On-going awareness training and social care audits will continue to ensure standards are met.

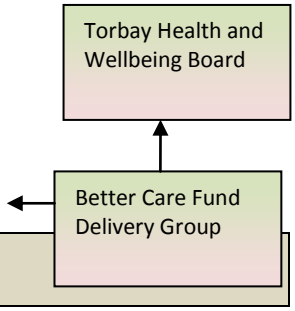
The Care Act also promotes support to Carers who are in employment or wish to return to employment and this will be an area of focus over the coming year. Working together with our partners in Devon, an employment event for Carers is being organised. This will include employment rights for Carers, building confidence and skills promotion of Carers wishing to begin employment and advice about becoming self-employed / running a small business, which often gives flexible working opportunities for Carers. Carers Services will also be ensuring that its services are more accessible to working Carers.

Overarching Governance Arrangements

Governance structures for integration have a firm grounding in the existing health and social care pooled arrangements.

There are already existing structures such as the Risk Share Oversight Group and Contract Review Meeting where agreements have been brokered around risk-sharing, changes to financial flows and other significant 'unblocking' changes to the way in which care is delivered in South Devon and Torbay. Through this collective debate full consideration has been given to the risks as well as the benefits of commissioning from one integrated organisation with all partners in agreement as to supporting the model and in deed the interface that further opportunities present with other providers in the future such as mental health and children social care as well as improved effectiveness and improved efficiency. The Better Care Fund Delivery Group has been established as a means of reporting on risks and progress of those projects specifically related to the BCF.

The Health and Wellbeing Board has a key role in integration and provides the strategic oversight with responsibility for sign off of relevant plans and scrutiny of implementation. The governance arrangements for the BCF are described below:



Meeting the National Conditions :

Maintaining Provision of Social Care Services:

The creation of an Integrated Care Organisation for acute as well as community health and social care services will increase our ability to deliver better care through pooled funding.

The local schemes identified in this plan are supported by integrated delivery and commissioning across health and social care. They are focused on preventing admission to acute and higher levels of care and reducing reliance on statutory services by increasing resilience through building on the assets of communities improving access to early advice and information to support people to manage their own conditions and remain independent for longer. These schemes sit alongside other initiatives promoting and supporting the independence including, our community equipment service, a home improvement agency, use of adaptations and assistive technology and a new care and support 'Living Well @ Home' service.

Additionally, the Community Development Trust has secured £6 million of Big Lottery funding to enable the Ageing Well Initiative which will play a pivotal role in our new model of care.

Torbay compares favourably with other authorities in terms of the rate of people in and entering residential/nursing care (see section below: admissions to residential and care homes).

We will be working with providers to support shifting care into the community and people's homes, by offering a broader range of care options, primarily provided within neighbourhood settings. Part of this work will involve us engaging with existing care home owners and potential investors in the sector to design what residential and nursing homes might look like in the future, to better fulfil the needs of our ageing population. This approach will be facilitated by implementation of the recently approved Torbay Housing Strategy 2015 - 2020.

It is likely there will be a continued reduction in long-term placements in residential care and later admission to long-term nursing care. However, by working in partnership with providers we can help people stay healthy and reduce social isolation and loneliness.

Torbay's figures for self-directed support are also better than the regional and England averages. In 2014/15 the proportion of people using social care who receive self-directed support (adults aged over 18 receiving self-directed support) was 90.1% (compared with a SW average of 79.2% and an England average of 83.7%).

Needs are recognised to incorporate not only the care provided by existing system partners such as domiciliary care agencies and care homes but also housing, support functions. Early identification and addressing low level mental health are keys to the success in reducing and managing system demand on more complex and acute end services.

The integrated nature of the Torbay system enables a whole system approach which provides the ability to view patients and clients across the pathway of their care in total. In line with the Care Act, projects locally work to ensure that the determinants of wellbeing are addressed using national eligibility criteria, to ensure that there is support for people to maintain meaningful relationships and purpose. A system approach to guide-ed and enablement conversations structures the interactions at the multiple touch points for patients across the system.

Torbay has a sound record in reducing the numbers of people going into long term care whilst it is also able to demonstrate the use of the community assets within these homes in contributing to its enviable DToC figures because of the development and use of intermediate care beds in these settings. The use of this approach is to be further expanded through the development of LMATs across the CCG footprint.

The Living Well@Home programme of work, increased skills sets within frontline care delivery staff and increased data gathering and reporting will all contribute to early intervention and prevention. The strategic partnership arrangement with a prime contract for community care enables coordinated connectivity with the projects in Ageing Well progamme. It also progresses the community development led by organisations such as the British Red Cross which is accelerating new ways of working to create links within communities and reduce reliance on long term care interventions from both health and social care.

In 15/16 we have a risk share which contains- acute, community, placed people and adult social care. We are working with the ICO and Torbay Council to agree the same risk share for 16/17 subject to affordability.

Delivery of 7 Day Services to Support Discharge:

We consider that seven day services are a key driver of quality and we are committed to providing seven-day health and social care services, with the optimal pathway of care available for the patient regardless of the day of the week to support patients to be safely discharged and to prevent unnecessary admissions at weekends.

We recognise that not all services are necessary to be delivered seven days a week, and in 15/16 the ICO has piloted seven day working within some areas of care to help inform which additional services would be needed both to meet the needs of the population and to facilitate flow through the whole health and care system seven days a week. Early findings have evidenced the value of therapy staff working in community hospitals at weekends, and shift patterns are being examined to see how best to achieve this. These pilots will ensure we will see a continued roll out of six/seven day provision across key services and through on-going evaluation, with fully joined-up services across the health and care system providing continuity of care and support seven days a week.

Through the formation of the Integrated Care Organisation in 15/16 and the development of the new model of care in 16/17 resources will shift from inpatient beds to high quality, value-for-money care provided in people's homes. The broad model of the workforce will be one of joined up professional practice, integrated team working and the flexible delivery of care in the most appropriate settings. We will see a shift in the current workforce configuration to more community-based teams, delivering seven-days-a-week services.

Our new model of care includes working towards fully joined up seven day provision, of which Primary Care is a key element. Key to delivering this will be the creation of federated of General

Practice so that care will be provided to a population rather than to the registered Practice list. Federation will enable practices to work together to provide different care models, including extension of existing services into periods of the week where General Practice is currently restricted or unavailable. As part of this collaborative approach we will optimise the current workforce capacity by exploring technology based solutions that complement traditional face to face consultations, so that not only is access extended in terms of timings but also in terms of styles. To allow federated working and improve quality of patient interactions with other health and social care providers we will extend the ability to share patient records (where consent to do so exists) across providers, thus delivering better informed consultations and improved outcomes.

Data Sharing and the Use of the NHS Number:

All our health and social care services use the NHS number as the primary identifier. The further development of ICO will see the delivery of improved outcomes in an integrated Information Management and Technology (IM&T) infrastructure.

Across the new care model shared records and interoperability of systems are essential at all stages of the pathway to avoid duplication of work, errors and inefficiencies to enable and align to the four phases or care for our STP development. 2015/16 saw the establishment of a working group across NEW Devon SD&T, Kernow and Somerset CCGs to develop the vision of the 'Five Year Forward View' in a consistent way. This will include our submission of the digital roadmap implementation plan in 2016/17 to take us to a paperless state by 2020.

Shared health records that interoperate with other provider systems will improve patient care as they move from one part of the system to another. Clear, consistent information, with the ability to access past medical history, medications and allergies together with the more detailed information in the GP record, will improve clinical decision making. This will result in more personalised, timely care and a reduction in admissions and re-admissions. Real time access to high quality information reduces the risk of clinical decision making. This has the benefit of reducing unnecessary admissions due to the lack of useful clinical information such as blood results, clinic letters and care plans Technology and on-line services are increasingly being used in all aspects of life. Using the same approaches and giving on-line access to patients for their own health and care records will help them to manage their care, strengthening their ability to self-care and giving them more control. In 2015/16 an 'information sharing toolkit' has been established as a platform to support the Vanguard and LMAT work initially but will have wider benefit. This toolkit has been nationally recognised and is utilised by the Information Governance Alliance.

Enabling patients and health professionals to easily navigate relevant services digitally either on the internet or from a mobile device will allow users a better-informed choice of service and increase the potential for efficient resource usage. It will give them information in 'real time' and would enable them to make choices before having to rely on emergency services.

Through the use of the patient held record, patients and carers will be more engaged in their own care plan, with a record of their own wishes and wellbeing objectives supported by the ability to update their own information when required, ensuring its relevance.

By ensuring systems used within our community and by our neighbours work to the same standards, we will increase choice. Organisations will be able to work with systems that suit them whilst relying on the interoperability standards to enable information to be available as and when necessary to the right people at the point of care.

Integration between the relevant systems will allow professionals to work with the patient to achieve objectives that are important to them and ultimately their plan of care will become more meaningful, impacting more effectively on their quality of life.

As part of the Vanguard workstream in 2016/17 home technologies and signposts to advice and support will become more substantial. Monitoring of outputs from these systems will allow proactive intervention to reduce ill health and potential admissions especially of those at the highest risk.

Joint Assessments and Accountable Lead Professional:

Torbay 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.

These teams work in partnership with primary care and include representation from the voluntary and community sector.

We have a strong track record of proactively seeking to identify those patients at risk of hospital admission, and working jointly to reduce this risk through an integrated and personal approach to care. We use a risk stratification tool, the Devon Predictive Model, to identify patients at risk of hospital admission in the next 12 months. The top 0.5% of our population are pro-actively case-managed on our monthly community virtual wards. The virtual ward teams use the predictive tool to objectively identify patients who are then pro-actively and holistically case-managed by a multi-disciplinary team, including primary care, community and rehab teams, palliative care, mental health, social care and the voluntary sector. Each patient is allocated a named case-manager who then co-ordinates their care and support. We have built on this highly-successful model to incorporate the features of the Unplanned Admissions Enhanced Service for primary care with 2% of our population then being proactively case-managed.

We will continue to work to integrate mental health with other clinical services so that mental health is a core part of this assessment.

Through the development of the new model of care we are working with the five GP localities to establish ways of working to ensure that medical cover is available to support Local Multi-Agency Teams and community hospitals.

Agreement on the Consequential Impact on Providers

Statutory agencies are not able to deliver our vision for integration alone. To set out the opportunities and to encourage a diverse market we have developed a market position statement for Torbay focusing on adult provision and with the development of the inclusion of children's services to facilitate market innovation and development in line with the Care Act.. The statement provides an analysis of how well current service supply will meet future demand. It provides clear messages to the market on the vision for seven-day integrated care services in Torbay with reduced reliance on long term bed based care. It outlines how provision needs to change to create a diverse

and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help, and focusing on personal outcomes and choice.

Agreement to Invest in NHS Commissioned Out-of-Hospital Services

In 15/16 we have a risk share which contains- acute, community, placed people and adult social care- our new model of care. We are working with the ICO and Torbay Council to agree the same risk share for 16/17 subject to affordability.

Agreement on Local Action Plan to Reduce Delayed Transfers Of Care

In 15/16 we have a risk share which contains- acute, community, placed people and adult social care- our new model of care. We are working with the ICO and Torbay Council to agree the same risk share for 16/17 subject to affordability. The section below on DTOC provides more detail on performance.

Non-elective Admissions (General and Acute)

Within Torbay, non-elective admission rates of non-elective admission are above national and regional averages.

There has been extensive work between commissioners and providers in the development of the risk share agreement and business case for the ICO which is consistent with this BCF plan. And therefore there has been agreement in terms of modelling the impact of the schemes on non-elective admissions as well as across a number of other areas of activity both across the acute, community and social care providers.

The BCF plan and schemes that are focused on reduction of Non-elective admissions are developed, implemented and monitored via the Systems Resilience Group which include the progress of our urgent and emergency care Vanguard.

Admissions to residential and care homes

The rate of permanent admissions to care homes in older age groups is below regional and national averages and is falling over time. In 2014/15 permanent admissions to residential and nursing care homes, per 100,000 population in Torbay was 606.3 (compared to averages of 678.2 in the SW and 668.8 in England). The forecasted figure for 2015/16 is predicted to fall further to 600.

As part of the new model of care we will be working in partnership with care homes on a range of initiatives. These include:

- Asking care homes to notify the GP when a 999 call has been made, also linking with the ambulance service to try to prevent unnecessary conveyances to hospital as part of their "Right Care, Right Time, Right Place" strategy;
- Changing working arrangement in practices to enable visits to be made earlier in the day, to try to prevent overnight admissions occurring simply because of the time of day; and
- Working towards 'one care home, one practice'; extending the medication review pilot already underway
- A focus on falls prevention, training provided to care home staff by the Fall Prevention Lead
- The expansion of the use of the care homes to support intermediate and respite care as a feature of the new model of care

In addition to this the CCG, ICO, Torbay Council and Devon County Council are working with care homes to develop a future fees model, which will refocus the health and care system around enabling individuals to achieve their personal outcomes and goals. This includes greater use of outcomes-based contracts to drive greater partnership working between commissioners, the ICO and care homes.

Whilst the care homes fees are a live issue in Torbay as they are across the country, work is in progress to move towards outcomes based working with the homes. The engagement of Torbay homes and willingness to contribute to system improvement has been previously evidenced by their response to a social care CQUIN where such indicators as Essence of Care, nutrition and hydration, safeguarding, and resident feedback/innovation were included.

The success of our neighbouring authority Devon County Council in its work with its care home partners is being learned from, adapted and adopted.

The focus on outcomes based working and new models of care will ensure that the correct funding flows so that the delivery contributes positively to the Sustainability and Transformation Plan. This commitment will enable investment by homes to produce a community asset both physical and workforce that is flexible and fit for future.

Effectiveness of Reablement

In 2014-15, reablement services were effective for 77.2% of older people who received the service in Torbay, compared to 83.0% in the South West, 84.0% in the local authority comparator group, and 82.1% for England. Rates are lower than other areas of Devon.

In 2014-15 3.5% of older people discharged from hospital in Torbay were offered reablement services this was in line with the South West (3.5%), and slightly above the local authority comparator group (3.3%) and England (3.1%) rates. Coverage rates increased on 2014-15 levels.

Reablement service effectiveness at 91 days is currently broadly in line with regional and national rates.

Our new model of care will deliver community-based services as described in figure 1.0 to manage more people in a proactive way to prevent hospital admission, reduce delayed discharges and reduce admissions to long term care.

Delayed Transfers of Care (DTOC)

Torbay had an average of 97.0 days of delayed transfers of care 100,000 population aged 18 and over per month compared with 315.4 in the South West, 172.9 in the local authority comparator group and 270.4 in England for the latest available full year (2014/15). The rate increased from 85.6 in 2012/13 to 97.0 in 2014/15. For the period April to November 2015 delayed transfers of care continued to be a challenge to the local health and care system, however whilst performance has declined Torbay is the second lowest authority in the South West and much lower that the regional and England average for delayed discharges. Similarly, for this period Torbay is the best rated in the South West and much lower than regional and England averages for DTOC.

Delayed transfers of care are more likely affect groups who are more frequently hospitalised, with higher rates in older age groups, and a greater number of females affected. Persons living alone and those who are socially isolated are more likely to be affected by delayed, as are those with more complex support needs. Our new model of care will deliver community-based services as described in figure 1.0 to manage more people in a proactive way to prevent hospital admission, reduce delayed discharges and reduce admissions to long term care. This will include the adoption of a 'Discharge at home to assess' model of care whereby patients leave hospital as soon as they are medically fit to have their support needs assessed on arrival at home by members of the community intermediate care and social care teams, enabling them to access the right level of home care and support in real time. The model builds on the integration experience in Torbay with 'zone' teams and care provided in Torbay and Southern Devon. The experience of Pioneer enabled us to undertake

small tests of change in the form of a 'hubs' for frailty and children's services which have contributed to the development of the model of care. All GP practices within the CCG are signed up to the proactive care locally enhanced service which means that 5% of the population have a personalised care plan and a named care coordinator.

We provide intermediate care, both home-based and in care homes – and these services will expand as part of our model of care. Through the merging of rapid response and crisis response teams, that provide personal care services for a limited period of time, admissions will be prevented and to prompt discharge will be supported. Social care reablement and intensive home support services, personal care with a reablement focus, for up to six weeks to enable a return to full independence.

The new model of care will offer an enhanced single point of contact primarily developed to reduce reliance on the statutory sector to local MDTs which will be enhanced by support from primary care, the voluntary sector, mental health and hospital consultants to deliver more preventative care and support within the community and improve patient flow.

In 16/17 we will be exploring the opportunities for risk sharing arrangements for the provision of community equipment and minor adaptations which are an integral aspect of delivering effective care in the community – preventing DTOC and supporting reablement.

Our vision for health and care has been informed and shaped by the development of locality plans via engagement with GP localities and their local public which have recommended that system wide resources should be deployed in the best way, including community investment, in order to provide and maximise alternatives to hospital admission through health and social care activities.

We have also developed proposals to address the function of our community hospitals and MIU's as part of the new model of care e.g. for the provision of community services, intermediate care and step up/step down beds in order to provide solutions to our system wide pressures. In the spring of 2016/17 we hope to launch public consultation on our proposals.