NHS
Torbay and South Devon
NHS Foundation Trust

Review of ICO performance measured against original 5 years business case with a focus on delivery of care model outcomes

1 Introduction

The creation of the Integrated Care Organisation (ICO) in 2015 through the acquisition of Torbay & Southern Devon Health & Care NHS Trust by South Devon Healthcare NHS Foundation Trust was underpinned by a 5 year business case that had at its core a new model of integrated care, designed to empower individuals to take ownership of their own health and care needs. This re-ablement focus and restorative and capacity-building approach focussed on empowering citizens to retain or improve their independence - an important factor in improving the management of demand in the system. The aim was that this strength-based approach would result in a shift of resources from a reactive diagnosis and treatment medical model, to a more holistic, joined-up model of health and social care.

This paper describes what we set out to achieve; the criteria for measuring success; the outcomes we expected to achieve and a high level assessment of what has been delivered so far benchmarked against national trends and set against changing context.

2 What did we set out to achieve?

The **aim** of the integrated care model was for people to stay as active as possible for as long as possible through the course of their lives, supported in taking responsibility for their own health and wellbeing. Instead of assuming ever-increasing dependency or constant decline, the aim was to retain or improve independence and self-worth but also to recognise that there can come a time in life when intensive medical intervention is the best course of action.

The original ICO business case described 5 high level **goals** and 8 national and local **priorities** that applied across the whole system of health and care provision:

High level goals:

1. Improve people's experiences of health and care;
2. People should have a bigger say, not only in the priorities we set and the care we provide, but also to support people in managing their own health and to help people improve their wellbeing;
3. Reduce inequalities in health and care;
4. Continue to support and develop a motivated, flexible workforce with the right staff and right resources in the right place; and
5. Maintain a financially stable and sustainable health and care system.

National and local priorities:

Urgent and emergency care	Community health and social care
Dementia care	Long-term conditions
Joined-up professional practice	Seven day health and care
Troubled families	Substance misuse, (alcohol and smoking)

Underpinning the business case was a belief that the expansion of personal social care and personal health budgets would act as a catalyst to empowering citizens to take greater ownership for managing their own health and care needs.

The business case was informed by **priorities of local people** following a range of public engagement and consultation events where people shared what was important to them:

Table 1: Community Services Engagement Reports: what's important to local people?	
Accessibility of services	Opening hours, public transport and buildings that are fit for purpose. Also, access to information.
Communication and coordination	Joined-up IT systems and information for patients, so people know who to contact.
Education, prevention and self-care	People want to know more about their condition – what it is and how to manage it themselves
Reliability, consistency and continuity of services	People want to know who will come to see them and when they will come. Building relationships with carers is important in making people feel safe.
Support to stay at home	There is a great range of statutory and voluntary services that people consider important to help them stay in their own homes.
Wellbeing and community support	Making more use of voluntary services to help people live at home, using support already in communities – 'neighbourliness.'

To achieve these goals and address the priorities, a number of **work streams** were created to deliver the fundamental changes to the care model being sought by commissioners and local people to deliver what was important to them. These work streams were organised around the principal that *"services should wrap around the person and family to create a single system of health and care delivery"* and included:

Table 2: ICO Integration Work streams	
development of a single point of contact	*a multi-media gateway to both signpost appropriately and to mobilise the appropriate assessment and equipment needed*
realignment of community resources including looking at existing community hospitals and utilising them in a different way	*to further support the self-care and prevention agenda and to help move from a reactive model of care to a proactive model of care*
new frailty pathway	*a whole system pathway of care starting with risk stratification of the most vulnerable patients and integration of community, social care and medical teams to better support the cohort of frail elderly patients.*
introduction of a new Multiple Long Term Conditions service for people with multiple LTCs	*to provide coordinated multidisciplinary management of coexisting medical conditions in one place at one time; outside of the acute setting where possible and avoiding multiple appointments per condition*
outpatient service redesign	*the development of a number of clinical service innovations with the objective of providing care closer to home, self-care and assessment avoiding multiple appointments per condition*
inpatient innovation	*series of clinical service transformation projects with the aim of reducing length of stay or avoiding an admission*

3 What benefits did we expect to see?

Delivery of these work streams was expected to **drive significant change in service utilisation** including a reduction of acute and community hospital beds, a reduction in outpatient appointments and a reduction in A&E attendances with resources freed up to be reinvested in a new model of care to better meet the needs of individuals. Many tangible and qualitative outcomes were anticipated through a shift in resources as a result of the new care model, including improvements in citizens health and wellbeing, enhanced patient experience and staff experience and more resilient services and communities.

In addition to the care model benefits, the physical creation of the ICO via the vertical integration of a high performing small DGH trust with a high performing, international exemplar community health and social care provider was expected to **deliver tangible system benefits** through the following:

Table 3: ICO vertical integration system benefits	
Increasing the pace of service developments	*without organisational boundaries, transactional barriers and conflicting incentives impeding decision-making*
Improving the scale of development opportunities	*With more clear oversight and influence along a much greater proportion of pathways, the scale of ambition can realistically be greater*
Removing boundaries to align incentives and reduce transactions	*where patient benefits and community-wide interests are prioritised above individual organisational concerns; many other benefits to the quality and experience of care, and service efficiency arise from the alignment of incentives and the removal of interfaces between services and reduction of transactions between organisations*
Integrating the workforce to deliver the new care model	*bringing together teams to share a single set of values, maximise their effectiveness in delivering organisational goals and provide the best quality for service users*
Delivering financial return on investment	*maximising the benefits arising from delivering integrated care at pace through organisational consolidation, optimising the economies of scale through management integration, and offering greater value for money through better contracting arrangements*
Enabling change and mitigating risk through a Risk Share Agreement	*building on the principles of the Better Care Fund to pool the resources available and align financial incentives across the community in the best interests of service users. The intention was to balance the risks across the key local partner organisations, and incentivise all signatories to make best use of resources for the local community*

Integrating the health and care workforce was expected to **deliver significant workforce benefit**:

- fewer staff working on the acute hospital site;
- greater numbers of staff working in community settings;
- changing ratios between registered and non-registered staff in community settings, moving away from a very profession-centric workforce to one of skilled care workers;
- new generic roles in community settings at both a professional and care worker level;
- new professional roles for physicians' associates and surgical care practitioners;
- holistic approaches to care in all settings; and
- more specialist medical support in community settings.

By creating the ICO and delivering the planned service developments the following **financial benefits** were anticipated:

Table 4: ICO creation: anticipated return on investment	
Back office and supporting function cost reduction	(£1.9m)
Care model cost reduction	(£12.4m)
Care model investments in community settings	£6.1m
Net cost reduction	**(£8.2m)**

Note: In the business plan and accompanying Risk Share Agreement the financial benefits were phased across the first three years, with most of the care model benefits accounted for in years two and three. There would be a deficit anticipated in the first two years**,** moving to a surplus by year three. Cash reserves would be maintained and were expected to be generally improving by year five.

4 What were the key tests to demonstrate success?

The following **criteria** describe the agreed **key tests** included in the business plan to demonstrate the ICO's success in delivering the integrated care model:

- maintain and improve the **quality of health and care outcomes** delivered for the community it serves, reflecting the changing nature of the community's needs;
- move the balance of services away from reactive to proactive, with a **greater focus on prevention and self-management**;
- provide services in the most appropriate locations, as **close to patients' homes** as possible – central to this was an intention to review and redesign community hospitals;
- **reduce interfaces** between separate health and care services, within and without the ICO;
- meet all **mandatory performance and financial targets**;
- **manage increasing demand within a restricted cost base**, with greater flexibility to invest resources for the benefit of the community;
- develop an appropriately **skilled and dedicated workforce**; and
- ensure that service users and commissioners feel **engaged** with existing services and future service developments.

5 What were the expected activity and financial outcomes of the care model?

The following tables are taken from the original business case and set out the anticipated activity and financial impact of the care model. This was the anticipated position at the time of submission (February 2015) and was the basis on which the ICO creation and acquisition was assessed by the regulator with an expectation the ICO would be established on 1 April 2015.

Table 5: ICO creation: care model activity impact

Service line	Demand scenario	Baseline 2014/15 FOT	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
A&E attendances	**Demand without ICO**	**80,972**	**81,931**	**83,537**	**85,142**	**86,748**	**88,353**	**89,959**
	ICO impact	-	(8,485)	(25,454)	(33,938)	(33,938)	(33,938)	(33,938)
	Demand with ICO	**80,972**	**73,447**	**58,083**	**51,204**	**52,810**	**54,415**	**56,021**
Non-elective admissions	**Demand without ICO**	**34,713**	**35,071**	**35,416**	**35,780**	**36,158**	**36,550**	**37,001**
	ICO impact Care Homes	-	(188)	(563)	(750)	(750)	(750)	(750)
	ICO impact LTCs	-	(927)	(2,782)	(3,709)	(3,709)	(3,709)	(3,709)
	ICO impact MH	-	(36)	(107)	(142)	(142)	(142)	(142)
	ICO impact emergency	-	(102)	(307)	(409)	(409)	(409)	(409)
	Demand with ICO	**34,713**	**33,818**	**31,658**	**30,770**	**31,148**	**31,540**	**31,991**
Outpatient attendances	**Demand without ICO**	**408,594**	**412,479**	**422,172**	**431,864**	**441,557**	**451,249**	**460,942**
	ICO impact	-	(7,493)	(22,478)	(29,971)	(29,971)	(29,971)	(29,971)
	Demand with ICO	**408,594**	**404,987**	**399,694**	**401,893**	**411,586**	**421,278**	**430,971**

Table 6: ICO creation: care model financial impact

	Activity Changes			Savings		Investments		
Element	**Bed reduction**	**ED attendance reduction**	**Outpatient appointment reduction**	**Pay £**	**Non pay £**	**Pay £**	**Non pay £**	**Net impact**
Acute Frailty	24	4,000	-	893,405	169,743	849,224	-	
Community frailty	-	-	-	175,000	-	310,000	-	
Single Point of Contact	-	-	-	-	-	-	20,000	
Community Localities	-	-	-	383,790	63,980	425,580	610,332	
Community Hospitals	18	3,000	-	2,016,579	1,318,105	-	101,000	
e Acute Innovations	15	24,000	29,500	4,767,850	1,683,171	1,374,420	30,000	
MAAT	8	4,000	-	399,196	65,543	289,312	10,000	
Intermediate Care	-	-	-	-	499,276	-	-	
A&E Investment	-	-	-	-	-	1275,000	-	
Medical skill mix*	-	-	-	-		-	-	
Sub total	**65**	**35,000**	**29,500**	**8,635,820**	**3,799,818**			
TOTAL				**12,435,638**		**6,055,804**		**6,379,834**

The tables reflect an expectation that as a result of the vertical integration and introduction of the new care model the following impact would be realised:

- **a reduction in A&E attendances** – from 80,972 in 2014/15 to 56,021 by March 2021
- **a reduction in non-elective admissions** – from total of 34,713 in 2014/15 to 31,991 by March 2021
- **a reduction in outpatient attendances** – from 408,594 in 2014/15 to 401,893 by March 2021
- **a reduction in beds** – 65 beds would be taken out as a result of the care model changes

together with anticipated savings of £12.4m in response to investment of £6.05m – a return on investment of £6.3m.

6 What has been delivered?

Due to delays in national decision making, the ICO go live originally planned for 1 April 2015 was delayed with go live date actual being 1 October 2015. Therefore at the time of producing this report the ICO has been operating as an integrated care organisation for nearly 3 years.

For the purpose of measuring progress against the original care model activity and financial impact outcomes, the tables that follow use the latest full year outturn position (2017/18) as the review point.

During the period 2014/15 to 2017/18 the overall population of Torbay and South Devon grew by 1.98%. The over 65s – the population that the new model of care was particularly targeted at – grew by 7.24%.

Set against this growing population context, the following tables demonstrate that when comparing 2017/18 against the 2014/15 base year, population growth was accommodated and service utilisation changed as follows:

- **total A&E attendances reduced by 3.7%** compared to a national increase of 5.7%
- **A&E attendances by the over 65s reduced by 1.5%** compared to a national increase of 13.8%
- **Total bed days used reduced by 21.2%** compared to national reduction of 2.1%
- **Bed days used by the over 65s reduced by 27.8%** compared to national reduction of 2%
- **Total outpatient attendances reduced by 3.5%** compared to national increase of 10.9%
- **Outpatient attendances for the over 65s reduced by 0.9%** compared to national increase of 13.2%

Table 7: Context: National trends and population change 2014/15 – 2017/18 actual

	All A&E Attendances %	65+ A&E attendances %	Bed days used %	65+ Bed days used %	OP Attendances %	65+ OP Attendances %
National trend	**5.7**	**13.8**	**-2.1**	**-2.0**	**10.9**	**13.2**
ICO change	**-3.7**	**-1.5**	**-21.2**	**-27.8**	**-3.5**	**0.9**
Population growth	**1.98**	**7.24**	**1.98**	**7.24**	**1.98**	**7.24**

Table 8: ICO creation: care model activity impact actual against plan

Population context:

- From 2015/15 to 2017/18 whole population grew by 1.98% from 284,720 to 290,364
- From 2014/15 to 2017/18 the care market target segment (over 65 population) grew by 7.24% from 69,222 to 74,236

Service line	Demand scenario	Baseline 2014/15 FOT	2017/18 plan	2017/18 actual
	Demand without ICO	**80,972**	**85,142**	
A&E attendances	**ICO impact**	-	(33,938)	
	Demand with ICO	**80,972**	**51,204**	**75,061**

Comment:

- 2017/18 actual activity reduced by 7.3% against the business case 2014/15 FOT baseline
- 2017/18 difference from plan was an additional 23,857 attendances
- Nationally A&E attendances increased overall by 5.7% between 2014/15 and 2017/18 compared to the ICO activity which saw a reduction in A&E attendances of -3.7%
- Nationally A&E attendances for over 65s increased by 13.8% between 2014/15 and 2017/18 compared to ICO activity which saw a reduction in A&E attendances for over 65s of -1.5%

Service line	Demand scenario	Baseline 2014/15 FOT	2017/18 plan	2017/18 actual
	Demand without ICO	**34,713**	**35,780**	
	ICO impact Care Homes	-	(750)	
	ICO impact LTCs	-	(3,709)	
Non-elective admissions	ICO impact MH	-	(142)	
	ICO impact emergency	-	(409)	
	Demand with ICO	**34,713**	**30,770**	**37,159**

Comment:

- 2017/18 actual activity increased by 7% against the business case 2014/15 FOT baseline
- 2017/18 difference from plan was an additional 6,389 attendances

Service line	Demand scenario	Baseline 2014/15 FOT	2017/18 plan	2017/18 actual
	Demand without ICO	**408,594**	**431,864**	
Outpatient attendances	ICO impact	-	(29,971)	
	Demand with ICO	**408,594***	**401,893**	**412,038**

Comment:

- 2017/18 actual activity increased by 1% against the business case 2014/15 FOT baseline
- 2017/18 actual activity ahead of plan by 10,145 attendances

Note: this table does not include the additional investment in social care (£9m in Torbay 2017/18) and additional efficiencies made in the ICO in 2017/18 which exceeded the Trust's total £42m savings and income target to deliver its overall control total.

Care model: financial impact

The financial impact of the first 3 years of the care model (see following tables) is calculated as:

- **Total £13.23m recurrent cash releasing system savings generated** of which £6.4m reinvested in care model
- **Further efficiencies, associated with avoiding growth in expenditure** of £19.9m
- Total **£69.35m** system benefit derived during this period, including cost avoidance calculation using national trends and PBR and other, general efficiencies delivered by the Trust.

Table 9: ICO care model: actual financial impact 2017/18 and 2018/19 forecast

Care model development	ICO Business Case Target £m	Savings Actual 2017/18 £m	Forecast savings 2018/19 £m	Grand total Recurrent savings £m	Comment
Further acute beds – frailty/front door	1.06	0.00	0.00	**0.00**	*16 further acute beds for front door removed from plans*
Recurrent care model/intermediate care/MAAT	4.92	5.52	1.51	**7.04**	
Acute outpatient innovations	3.00	0.00	0.00	**0.00**	*OP Innovations work is absorbing growth and reducing waiting lists - not cash releasing*
Acute inpatient innovations	3.45	1.93	0.00	**1.93**	
Other Trust recurrent integration related savings above original ICO schemes	0.00	4.06		**4.06**	
Non recurrent community other	0.00	1.64			*these were investments in the IC teams that slipped due to vacancies in 2017/18*
Subtotal delivered Trust	**£12.44**	**£13.15**		**£13.03**	
Primary care savings - prescribing		0.20		0.20	
TOTAL delivered across CCG & ICO	**£12.44**	**£13.35**		**£13.23**	

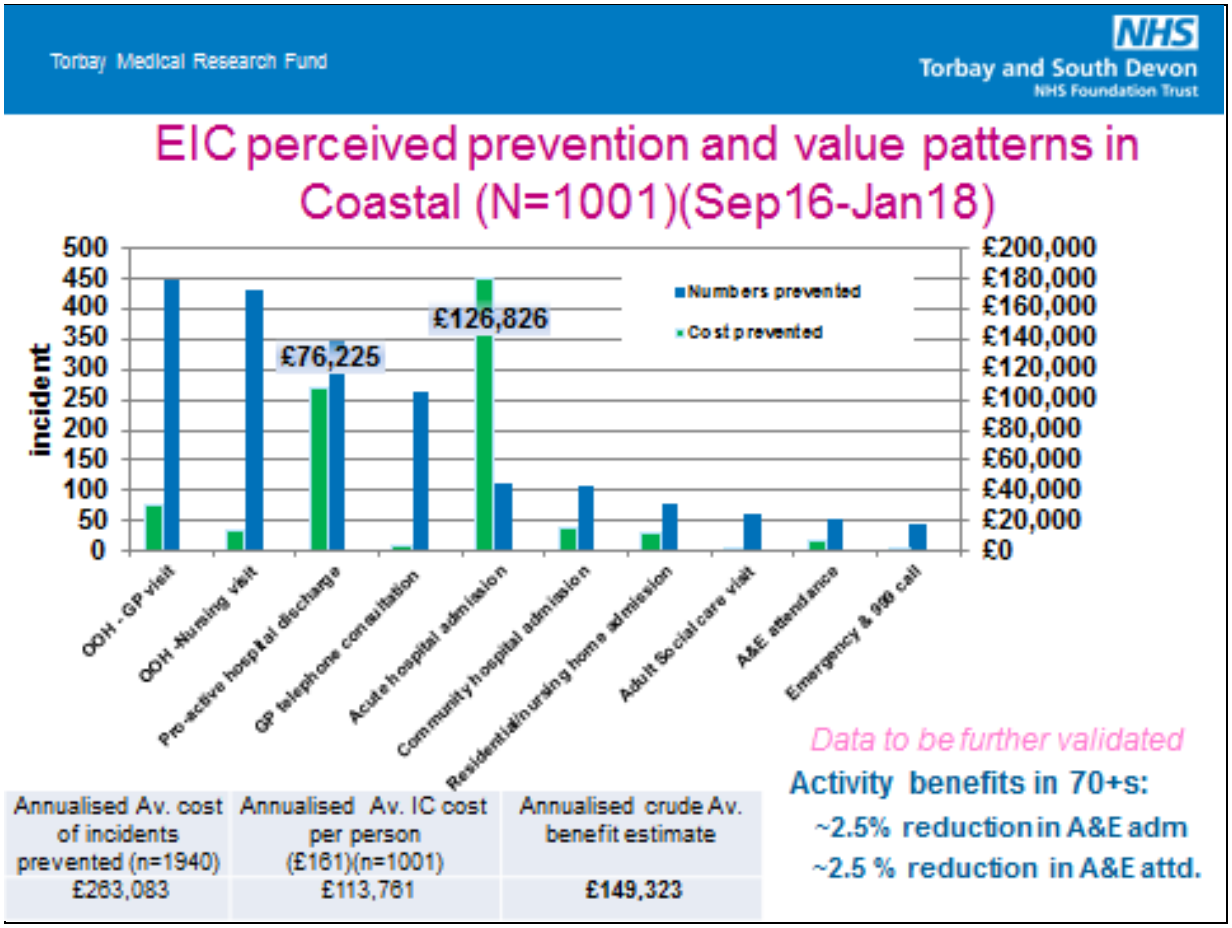
Table 10: ICO care model: system benefit calculation 2015/16-2017/18

Service utilisation indicator	£
A&E attendances less than national average (PBR value)	974,255
Bed day reduction compare to national position (PBR value)	9,941,926
Outpatient reduction compared to national average (PBR value)	9,050,831
Care model (excluding bed savings)	4,060,000
- Other care model	742,000
- Care Model MATT	1,640,000
- NR Community	200,000
- Primary care prescribing	1,900,000
- Back office merger savings	
ICO system efficiencies, excluding care model and additional commissioner income	40,842,500
Total	**69,351,512**

Additional economic impact of elements of the care model have been estimated by independent Researchers in Residence from the Universities of Plymouth and Exeter who have been evaluating the impact of enhanced integrated care in the Coastal locality for the period Sept 2016-Jan 2018.

They have calculated the potential value of savings accrued through prevention of hospital admissions, avoidance of A&E attendances and proactive hospital discharges as an annualised benefit of £149k for that locality when costed against tariff for expected activity without the care model.

Their analysis also demonstrates benefits to the wider health system, particularly general practice, and not just the acute and community services.



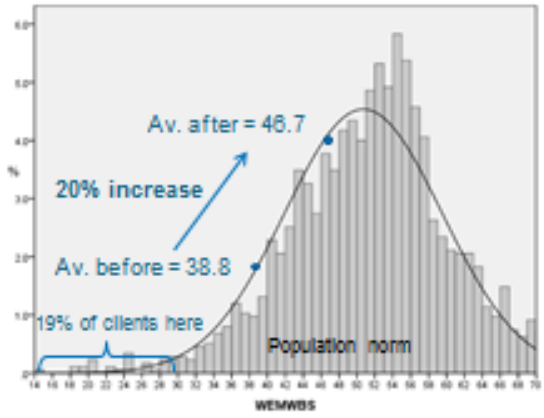
Care model: Qualitative impact

The Researchers in Residence have also undertaken a qualitative study of the wellbeing coordination (WBC) service – a key care model programme. Through their evaluation they have demonstrated:

- **WBC programme has helped over 1,500 people over 50 years ≥2 LTCs,** many frail and elderly in the first year
- **Health and well-being improved significantly,** with many positive stories of lives turned around
- **a statistically significant improvement in quality of life** for the cohort of citizens interviewed using both the Warwick Edinburgh Mental health and Well-being scale (WEMWBS) and Patient Activation Measures (PAM)
- **a positive impact on frailty** with a significant improvement in independence reported using the Rockwood score scale

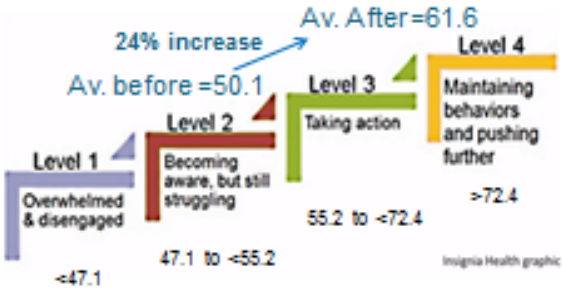
Impact on health and well-being and activation

Warwick Edinburgh Mental Health and Well-being scale (WEMWBS)



There was a statistically significant improvement in quality of life (n=92)

Patient Activation Measure (PAM)



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Impact on frailty

Rockwood score scale

Dependency for ADLs

Av. score 4.71

41% reduced
1-2 levels

Av. score 4.35

Independence

Care model: client satisfaction

The 2016/17 Adult Social Care (ASC) Survey (latest published benchmarked data available) showed that at 68.4% service user satisfaction in Torbay was higher than England, South West and comparator group averages, and in the top quartile of England Local Authorities.

Note: 2017/18 data demonstrates a further improvement to 69.2% .

Table 11: ICO Care model: client satisfaction

ASCOF Measure	2016/17 S. West ave	2016/17 Comparator group ave	2016/17 England ave	2016/17 Torbay
(3A) Overall satisfaction of people who use service with their care and support	67.4%	66.6%	64.7%	68.4%

Care model: workforce impact

The original ICO business case assumed that the shape and size of the integrated work force would change as a result of the creation of the new integrated care organisation and implementation of the care model and corresponding new ways of working.

The following table sets out the original indicative projection for overall establishment figures for the ICO after all organisation and service changes in the first five years with a planned 13.5% reduction in staff over seven years.

Table 12: ICO Original business case - workforce transformation projections

Staff group	2014/15 (Baseline)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Consultants	184	183	176	170	169	167	165	165
GP	9	9	9	9	9	9	9	9
Dental	11	11	11	11	11	11	11	11
Junior Medical	227	226	222	221	220	220	220	220
Nursing, midwifery & health visitors (exclude HCAs)	1,818	1,786	1,759	1,667	1,640	1,629	1,624	1618
Other clinical staff -social workers	234	234	234	234	234	234	234	234
Other clinical staff costs (include HCAs)	473	475	444	358	323	311	305	299
Scientific, therapeutic & technical	582	575	562	562	546	531	523	515
Non clinical staff	1,831	1,754	1,729	1,684	1,649	1,614	1,594	1574
Total	**5,369**	**5,252**	**5,144**	**4,916**	**4,800**	**4,725**	**4,683**	**4644**

The following table demonstrates by the end of March 2018 the workforce had reduced overall from 5,369 (2014/15 baseline year) to 5,101 – albeit not to the full extent of the original assumptions of a planned reduction to 4916.

Workforce - by staff group

Staff in Post by staff Group

Table 1

Staff Group	2015 / 09	2016 / 03	2016 / 09	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03
Add Prof Scientific and Technic	274.87	270.11	282.27	295.47	297.23	296.89	294.47	298.28	286.21	286.06	278.68	286.70	281.92	292.11	289.95	297.48
Additional Clinical Services	1,016.24	1,039.05	1,058.88	1,073.29	1,070.59	1,075.01	1,076.72	1,068.81	1,070.32	1,068.69	1,059.85	1055.60	1,059.49	1,091.59	1,079.62	1,080.69
Administrative and Clerical	1,345.55	1,342.79	1,340.26	1,292.95	1,268.78	1,265.77	1,267.43	1,258.83	1,259.13	1,256.09	1,244.10	1244.19	1,230.87	1,250.64	1,252.45	1,241.09
Allied Health Professionals	403.03	398.12	397.08	405.45	401.10	402.55	400.26	401.56	403.33	403.50	396.19	395.15	391.76	404.09	403.18	398.95
Estates and Ancillary	389.95	389.27	399.86	392.86	380.83	378.78	375.22	375.56	372.50	368.07	363.74	368.03	365.91	368.77	368.04	362.10
Healthcare Scientists	92.69	91.59	93.75	91.85	92.27	91.47	90.47	91.13	88.13	89.13	94.23	85.93	86.93	85.77	85.77	84.17
Medical and Dental	425.99	414.22	437.41	435.50	456.88	452.43	451.28	488.13	468.13	467.03	465.11	463.99	458.94	465.75	468.89	469.83
Nursing and Midwifery Registered	1,182.09	1,197.97	1,192.73	1,196.66	1,178.26	1,174.32	1,173.08	1,161.42	1,161.89	1,166.97	1,168.77	1160.94	1,154.69	1,168.25	1,177.70	1,166.40
Students	5.69	5.09	3.90	1.50	2.50	2.00	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	5,136.11	5,148.21	5,206.14	5,186.13	5,148.43	5,139.21	5,130.91	5,145.74	5,111.65	5,105.54	5,070.66	5,060.52	5,030.52	5,126.97	5,125.60	5,100.71

Table 2

Staff Group	2015 / 09	2016 / 03	2016 / 09	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03
Bands 1 - 7	4461.09	4492.38	4531.51	4525.20	4467.81	4462.16	4456.01	4434.46	4421.27	4418.27	4385.30	4376.00	4353.44	4453.69	4473.39	4418.62
Band 8 and Above	249.02	241.61	237.22	225.36	223.74	224.62	223.62	223.15	222.15	220.25	220.25	220.53	218.13	207.53	183.33	212.26
M&D	425.99	414.22	437.41	435.57	456.88	452.43	451.28	488.13	468.23	467.03	465.11	463.99	458.94	465.75	468.89	469.83
Grand Total	5,136.11	5,148.21	5,206.14	5,186.13	5,148.43	5,139.21	5,130.91	5,145.74	5,111.65	5,105.54	5,070.66	5,060.52	5,030.52	5,126.97	5,125.60	5,100.71

Table 3

Staff Group	2015 / 09	2016 / 03	2016 / 09	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03
Bands 1 - 7	86.86%	87.26%	87.04%	87.26%	86.78%	86.83%	86.85%	86.18%	86.49%	86.54%	86.48%	86.47%	86.54%	86.87%	87.28%	86.63%
Band 8 and Above	4.85%	4.69%	4.56%	4.35%	4.35%	4.37%	4.36%	4.34%	4.35%	4.31%	4.34%	4.36%	4.34%	4.05%	3.58%	4.16%
M&D	8.29%	8.05%	8.40%	8.40%	8.87%	8.80%	8.80%	9.49%	9.16%	9.15%	9.17%	9.17%	9.12%	9.08%	9.15%	9.21%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 4

Staff Group	2015 / 09	2016 / 03	2016 / 09	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03
Non-Executive Directors	14.00	6.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	8.00	8.00	8.00
Grand Total	14.00	6.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	8.00	8.00	8.00

Table 5

Staff Group	2015 / 09	2016 / 03	2016 / 09	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03
Chief Executive	2.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Clinical Director - Medical	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Director of Nursing	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Finance Director	2.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Other Directors	3.00	4.50	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Grand Total	9.00	8.50	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00

Notes: In addition to the 9.00 WTE Executive Directors shown above in 2015/09 there were 2 further
Senior Managers as TSDHCT acting in Executive Director Roles and remunerated accordingly.
A further 2 Directors from SDHFT at 2015/09 were also covering Director Roles at TSDHCT
At 2015/09 the role of Medical Director at TSDHCT was vacant
In total across SDHFT and TSDHCT there would normally have been a compliment of 14.00WTE Executive Directors
Medical and Dental staff numbers from April 2017 includes the adjustment for hosting a cohort of GP Trainees
Total year reductions to date are 84.82 as at the end of March against the 162.99 target by the end of March 2018 which is 99.43 behind original plan

The tables opposite show the WTE in post figure by staff group back to September 2015, the month before the Integrated Care Organisation (ICO) commenced, up to March 2018.
Table 1 shows current whole time equivalent staff in-post by staff group from September 2015 (prior to the ICO commencing) to February 2018.
Table 2 shows the number of staff by pay bands. Those staff in Band 8 are predominantly in management roles.
Table 3 shows the same pay bands by ratio.
Tables 4 and 5 show the number of Non-Executive Directors and Executive Directors over the same period.

This difference reflects changing circumstances including:

- the delayed go live date which coincided with increased demand in the system compared to when the workforce modelling was developed for the original business case;
- changed requirements in terms of new junior doctors contract implementation;
- growth in demand particularly in cancer related specialties; and
- quality improvement requirements in response to CQC safety concerns e.g. Emergency Department staffing, safe staffing on wards and specialling has grown with the more complex patient groups including mental health related complications.
- other workforce growth areas outside of the care model eg Torbay Pharmaceuticals expansion and other income generation areas.

Overall savings were made to a greater extent in non-pay related rather than the 70: 30 split assumed in the business case assumptions.

7 Conclusions

Whilst the care model benefits realised by the end of year 3 may not be to the level originally forecast in some areas due to changing circumstances, the qualitative and quantitative results that are emerging do demonstrate positive impact and return on investment and include:

- **Health and well-being has improved significantly,** with many positive stories of lives turned around with significant improvements in independence reported. At 68.4% client satisfaction with adult social care in Torbay was higher than England, South West and comparator group averages, and in the top quartile of England Local Authorities in 2016/17. Latest 2017/18 demonstrates a further improvement to 69.2%.
- **40% of people cared for at home** enabling a reduction of 99 beds
- **Delayed transfers of care** remain amongst lowest in Country
- **Fewer people admitted to a care home as their permanent residence -** for those funded by adult social care aged 65+
- **Workforce shape changed** and overall headcount reduced from 5,369 (2014/15 baseline year) to 5,101
- **Service utilisation significantly improved overall, when nationally have seen an increase in demand** - eg total bed days used reduced by 21.2% compared to national reduction of 2.1% with bed days used by the over 65s reduced by 27.8% compared to national reduction of 2%
- **Total £13.23m recurrent cash releasing system savings generated** of which £6.4m reinvested in care model and **£19.9m of cost avoided by reducing demand** which, when added to general efficiencies delivered over the period derive a **total benefit calculated at £69.35m.**