Overview & Scrutiny
Confidence in your Council

Priorities and Resources Review Panel 2015/2016

Members
Councillors Bent, Darling, Davies, Hytche, Kingscote, Pentney, Stockman, Thomas (J) and Tyerman

(Contact MeetingContact 01803 207063 or e: scrutiny@torbay.gov.uk)

Tuesday, 13 January 2015 at **9.30 am**
to be held in the **Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR**

Agenda

1. **Apologies**
To receive apologies for absence, including notifications of any changes to the membership of the Committee.

2. **Adult Social Care** (Pages 1 - 145)
Councillor Scouler, Caroline Taylor and Richard Clack (Torbay and Southern Devon Health and Care NHS Trust)

TORBAY COUNCIL

Adult Social Care

1. **What will adult social care look like in Torbay in 2015/2016 and onwards?**

The strategy for adult social care continues to be that we support those people who are eligible for social care support as part of an integrated approach with the NHS. There are a number of schemes across the NHS and Social care that are part of a re-design of pathways to ensure people are supported to improve their health and well being , and that this can be achieved on the reduced amount of public taxation available to support these public services. Social care is under great pressure nationally , and that national picture is reflected in Torbay.

2. **What is the current position in relation to the savings proposals which were considered in September 2014? Has consultation been undertaken? Have Equality Impact Assessments been completed? Will the savings be realised in 2015/2016?**

The savings proposals are as outlined in September. Where required consultation has been undertaken and EIAs completed. As outlined in previous debate, adult social care is a statutory duty of the local authority so services can be delivered differently to achieve required outcomes, but cannot be ceased. As outlined previously there is a spectrum of risk to achieving the full savings and ensuring quality outcomes are maintained. The ASA is attached for consideration. The current outturn position for adults services commissioned from the trust is £232k over budget.

3. **What has been the result of exploring "further joint working, share commissioning, new income and efficiencies" with the NHS and others? When will benefits be realised from this exploration?**

This area is still under exploration. There are benefits to be realised in development of new income and further risk mitigation, through gain share or other mechanisms but requires more time. The delivery of the ICO understandably continues to be the priority for delivery in our local system. The Better Care Fund did not become a source of new monies and has been refocused by government on prioritising reductions in acute emergency admissions.

4. **What is the current position in relation to the changes to voluntary sector blocks contracts which were agreed in February 2014? Which organisations are providing services and how sustainable are those services moving forward? What impacts are being felt in the community as a result of these changes?**

The voluntary sector block contracts have been reduced in accordance with decisions taken in Feb 14. This has meant that access to advocacy for people with mental illness and mental capacity issues has been reduced and services which support people with complex physical and mental health needs are ending. However, the Care Act 2014 and the increase in Deprivation of Liberty applications require greater levels of statutory advocacy services to be in place . Options for meeting this requirement are being considered at present.

The impact on the system of support for adults was more impacted by the closure of some supporting people contracts. That has already been considered by scrutiny in October 14.

5. How does the Community Development Trust and the Ageing Well initiative fit with the future provision of health and social care services?

Both of these elements are a key part of our future system of health and social care. The CDT is represented on the joined up board for pioneer to ensure that Torbay's voluntary sector is at the heart of future thinking for health and care. The Aging Well initiative will allow innovation to take place in a number of areas and we know that combating social isolation is key to older people's overall sense of well being. As the project progresses there will be an opportunity to review outcomes and question how further changes can be made in the NHS and local authority provision to mainstream the benefits achieved.

Caroline Taylor
DASS

Annual Strategic Agreement

Between

Torbay Council, South Devon and Torbay Clinical Commissioning Group and Torbay and Southern Devon Health and Care NHS Trust

for the delivery of Adult Social Care

April 2015 to March 2016

Contents

Appendices

1. Purpose and Scope of this agreement

This agreement sets out the way in which Torbay Council and South Devon and Torbay Clinical Commissioning Group (CCG) will commission services from Torbay and Southern Devon Health and Care NHS Trust (TSDCT) and South Devon Healthcare NHS Foundation Trust (SDHFT) on the basis that in 2015 both trusts will be in the form of an integrated provider (ICO-integrated care organisation) referred to in this document as 'the Trust'.

The commissioning agreement reflects the evolving relationship between commissioners and providers. NHS reforms have indicated that commissioning is separate from provision. Commissioning is locally delivered by the CCG and undertaken jointly with the local authority. Strategic commissioning has returned to the Council to ensure joint commissioning with NHS commissioners. There is a developing maturity of relations which is reflected in our local areas status as a 'pioneer' of integration. These relationships are reflected in this Agreement in as far as they impact on arrangements between the Council/CCG and the Trust(s).

All organisations are committed to working in partnership with NHS, Local Authority, other providers and the third sector to develop the model of integrated care for which Torbay and South Devon is renowned. This includes our commitment to drive integration to a new level, including further structural integration and extended organisational care pathways between health and social care services. We will use the opportunities of the Better Care Fund and our Pioneer status to pool budgets and increase joint commissioning across all our health and care providers and ensure there is a diverse range of care and support services available.

Where specific service specifications are required to ensure clarity and accountability for specific functions, or to ensure successful and timely delivery of the work outlined, these will be developed separately.

1.1 Overall context and strategy

National agenda

The Care Act 2014 represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support. For the first time, the Act will put a limit on the amount anyone will have to pay towards the costs of their care from April 2016. The Act also delivers key elements of the government's response to the Francis Inquiry into events at Mid Staffordshire hospital, and demands increasing transparency and openness and will help drive up the quality of care across the system. The Act strengthens previous commitments to an integrated approach across organisations and health and social care boundaries, including a requirement of continuity during transition between children's and adult services. Locally the implementation of the Care Act is one of the significant elements of delivery in 2015 across our local system.

NHS England has produced a five year forward view (October 2014). This document sets out a clear direction for the NHS- showing why change is needed and what it will look like. It supports patients being in control of their own care, and supports combined budgets with local government as well as personal budgets. It supports integration between GPs and hospitals,

physical and mental health, health and care. It described a strategic direction which is in line with local plans and our Health and Wellbeing Board strategy.

It also stresses a radical upgrade in prevention and public health. Public Health England has been created and public health commissioning responsibilities has moved to local government. Our local strategy reflects those ambitions to improve the health and support of our local population through prevention and self care and community support, wherever possible.

The health and care agenda has been the focus of concerns nationally about safety and quality and the national question of how we pay for care in an increasing older population with more complex care needs have been partly answered by Dilnot reforms. CQC as the regulator are taking a more robust and focused approach to inspections. However, the overall costs of providing and supporting our local population for health and care remain an ongoing challenge.

Locally
The joint commissioning and delivery of services underpins the direction of travel which the Council and NHS set out since the recent NHS reforms.

The local context is shaped by the expectation of an Integrated Care Organisation (ICO) as well as the success of being a national 'pioneer' for further integration and innovation.

The CCG, Torbay Council, and the Trust and other providers will continue to pursue a strategic direction designed to maximise choice and independence for those requiring adult health, social care and support.

1.2 Financial context

Funding arrangements for NHS and Adult Social Care (ASC) are under great pressure and although there has been welcome reform though the Care Act with the expectation of government funding to support these new costs, as well as one off contributions to support winter demands, it does not ease the overall pressures on the NHS and councils to provide safe and quality services within less resource.

The CCG, the Council and the ICO have an intention to 'pool' financial resources as the best way of meeting increasing demands, on the basis of a risk share. The document is still being finalised but will be included once agreed.

Through the establishment of the ICO, and by pooling funding under a risk share agreement, we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we expect to see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

1.3 Health and Wellbeing Board

The vision of Torbay's Health and Wellbeing Board is for a Healthier Torbay: Where we work together to enable everyone to enjoy a healthy, safe and fulfilling life. The Board has identified three outcomes to be delivered to achieve this vision:

- Children have the best start in life
- A healthy life with a reduced gap in life expectancy
- Improved mental health and wellbeing

There are a number of priorities under each outcome. The Board will challenge commissioners and providers of services in Torbay about how well they are working together to meet these priorities and will be looking for information about the actions which are needed to improve the health and wellbeing of everyone in Torbay.

1.4 Quality

National: CQC (Care Quality Commission) The Commission will make sure health and social care services provide people with safe, effective and compassionate high-quality care and encourage care services to improve.

They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care.

CQC principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to themselves that they expect of others
- We promote equality, diversity and human rights.

The CQC will change what they look at when they inspect so that the following five questions about services are tackled:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs

Local: Torbay and Southern Devon Health and Care NHS Trust

The Trust will provide quality assurance of both its own business activity and that of the services it commissions on behalf of the community. A Quality Assurance Framework has been developed and is in use. The framework includes the following elements:

- Living Well at Home, a new way of delivering high quality and sustained support plans to people living at home, will replace the traditional domiciliary care provision in Torbay. A prime contractor will be in place from 1 April 2015 to manage the provision on our behalf. This will give us the opportunity to work with the independent sector in partnership and move from 'time and task' to outcomes based contracting on the basis of 'what matters most' to Mrs Smith and her family. It is intended to drive up quality, ensure safeguarding is addressed and to link individuals into their local communities to enhance wellbeing and social isolation.
- The Care Home Self-Assessment and Management Tool known as the Quality Effectiveness Safety Trigger Tool (QuESTT) is established and is completed by the home electronically on a monthly basis, with direct access to a Trust database to complete this.
- A business and finance audit tool to be completed on an annual or bi-annual basis - this will replace the current documentation.

Further mechanisms to learn from experience will be put in place in order to ensure key messages are cascaded to staff from serious case reviews.

1.5 Learning Disabilities and Autism Commissioning

Ultimately seeking a more regional approach (in line with '*Living Well with a Learning Disability in Devon 2014-16*') but for the ASA for next year the focus will be as laid out in TSDH&CT's Operational Commissioning Strategy (2014-16) which has been adopted. This will also form the workplan and focus for the Learning Disabilities Partnership Board (LDPB) and the workplan and focus for the Autism Partnership Board. In addition to this, it will be a requirement that the actions resulting from the Learning Disability Self Assessment Framework findings and the Autism Self Assessment Framework findings will be incorporated into this.

The schedule is in support of the Learning Disability Operational Commissioning Strategy (2014-16) and confirms the direction of effort being undertaken by the resources applied to it.

Outcomes required 2015/16:

- Delivery of the Learning Disability Operational Commissioning Strategy
- Running and support of the Learning Disabilities Partnership Board.
- Production of the action plan from the Learning Disability Self-Assessment Framework.
- Running and support of the Autism Partnership Board.

- Completion and delivery of the Autism Self-Assessment framework 2015 and the subsequent action plan development and delivery
- Contract Management of Learning Disability/Autism Providers.
- Monitoring of Learning Disability Providers through Commissioning Strategy Meetings as required.
- Ensuring that people with Learning Disability/Autism are safeguarded.
- Supporting people with Learning Disability/Autism in Torbay to have greater choice over their activities, including accessing employment.
- Supporting more people with Learning Disability/Autism in Torbay to live in their own community, in their own home.
- Ensuring good planning and support for people with Autism.
- Ensuring good support for carers of people with a learning disability
- Increase the number of or arrangements in place to promote and provide personal budgets including the development of integrated personal commissioned budgets (target to be agreed)
- Engagement with strategic health and care commissioners by providing knowledge and expertise in support of the development of market provision specific to those with complex health and social care needs

1.6 Safeguarding

The Trust will continue to deliver the delegated responsibilities of Torbay Council regarding Safeguarding Adults.

Care Act 2014; this new legislation puts Safeguarding Adults into a statutory framework for the first time from April 2015. This puts a range of responsibilities and duties on the Local Authority with which we will need to comply.

This includes requirements in the following areas:

- Duty to carry out enquiries
- Co-operation with key partner agencies
- Safeguarding Adults Boards
- Safeguarding Adult Reviews
- Information sharing
- Supervision and training for staff

Accountability for this will sit with the Torbay Safeguarding Adults Board (SAB). This is a well-established group that will provide a sound basis for delivering the new legislative requirements. The Board will incorporate the requirements into its terms of reference and Business Plan for 2015/16, ensuring that all relevant operational and policy changes are in place for April implementation.

- Regular performance analysis from all partner agencies will be reported to the SAB to give a clear picture of performance across the agencies. The Council will ensure high level representation on the Board by the DASS and Executive Lead for Adult Social Care.

- In order to maximise capacity Torbay SAB will work closely with the Devon SAB with an increased number of joint sub committees and shared business support.
- In addition to this, in order to provide internal assurance that the Trust is fulfilling its Safeguarding Adult requirements, the Board will have a sub-committee which will oversee performance. This will have a particular focus on training and performance activity. This group will operate across TSDHCT and SDHCT as part of the anticipated ICO establishment.
- The Safeguarding Adult function and process was the subject of a **Peer Review** (ADASS and LGA) in June 2014. The focus of this was on governance and accountability in a changing organisational environment and on keeping people safe in their own homes. The review produced valuable feedback which will inform the SAB Business Plan.
- The Council has signed up to the national initiative of **Making Safeguarding Personal**. This is an exciting initiative designed to measure Safeguarding Adult performance by outcomes for the individual, rather than the current reliance on quantitative measurement of timescales for strategy meetings and case conferences. Work will be done through SAB during 2015/16 to implement these new measures in Torbay.

Children and Family Act 2014

Alongside the Care Act 2014, this is a new piece of legislation which will amend a range of issues affecting children and young people. It complements the Care Act's ' whole family' approach to needs assessment and will require Adult Social Care Services to work in close partnership with Children's Services to develop pathways around transition to adulthood, a key aspect of the Special Education Needs and Disability (SEND) reforms which are incorporated into this legislation. There is also a need to develop protocols for carrying out other work relating to children, e.g., parenting assessments, which are often a requirement in care proceedings where parent/carers have disabilities.

Multi-agency Safeguarding Hub (MASH)

- Since August 2014, the Single Point of Contact (SPOC) for safeguarding adults has been co-located with the police as part of a pilot service. This is yielding positive results in terms of timeliness of triage for incoming alerts and joint work between Adult Social Care and the Police. Work is also in progress to establish a MASH for adults and children, a very welcome venture given our aspiration to develop a whole family approach.
- The Trust and Torbay Council are working together with the CCG to implement an action plan based on the recommendations from the inquiry into **Winterbourne View**. Work will continue on this plan to ensure that future milestones are met for returning individuals to their home area (when safe) and to review our contracts with providers to ensure that they reflect and are monitored on the principles and requirements of Safeguarding Adult policy and best practice.
- In order to ensure that a number of initiatives around the protection of vulnerable people are co-ordinated and that learning is disseminated from these, the SAB has established **Keeping People Safe,** a new sub group. This will meet quarterly during 2015/16.

- There will be a continued focus on ensuring that all staff have the appropriate level of training for their role, as set out in the Torbay Safeguarding Adults Multi-Agency Training Policy, with the target of 90% achievement set by the Board.

1.7 Service Development Activity

The service development activity to be undertaken by the Trust in the period 2015/16 will be framed by national and local policy drivers including:

- Enactment of the Care Act reforms: These reforms will be implemented in accordance with national frameworks and timescales during 2015/16 and 2016/17.
- Locally the formation of the ICO and developments within the Pioneer project will drive a range of service developments which will need to both shape and be shaped by the requirements of this ASA.
- More immediately, but still within the context of the above longer term developments, the level of financial reductions the Trust has been asked to plan for in the period 2015/16 will require a sea change in the level of services and how those services are provided. These changes will need to be fully endorsed by the Council, as the commissioning authority, and some may also require full public consultation.

Whilst many of the service development areas are interdependent in terms of delivering quality services within the resources available the key priorities in 2015/16 will be to:

- Ensure the regular (at least annual) reassessment of the Community Care Support needs of all people receiving care in their own home to ensure the consistent application of all current policy and eligibility criteria, including FACS, RAS and the Cost Choice and Risk Policies. Where appropriate this will include ensuring that any short breaks provided accord with the person's needs and any appropriate charging policies.
- Ensure the annual reassessment of the financial circumstances of everyone receiving a chargeable social care service to ensure that charging policies are being applied consistently and equitably.
- Ensure that where short break care is necessary to meet a person's assessed needs it is funded as part of their personal budget.
- Jointly develop activity measures for social care workforce, including safeguarding and DoLs.
- Implement the final phase of the Occombe House development.
- Bring forward proposals for service delivery which will ensure that assessment and care planning processes, and all back office functions, are managed in the most cost effective way. These proposals will be developed through quarter 4 of 2014/15 with implementation planning taking place in quarters 1 and 2 of 2015/16.

Additionally there is an assumption which is built into CIP plans in relation to adult social care that the number of people needing support in care homes will continue to fall. The number of people supported in care homes fell by an average of 4.5%

over the period April 2007 to September 2012, the plans in this agreement are based on this trend continuing but at a rate of 6% per annum.

1.8 Commissioning Intentions and Associated Work plan
Commissioning priorities 2015-16:

The Council and the CCG have developed a joint approach to strategic commissioning for adult care services and will ensure it is aligned with NHS commissioning for health outcomes and public health outcomes in line with the joint outcomes framework. The intention is to work with the CCG to further integrate commissioning governance and support for health, adult social care, support, housing, public health and children linked to the Health and Wellbeing Board and the pioneer programme over the year. This will increase the potential to further streamline and make best use of resources across organisations to support the commissioning function.

To ensure the effective and efficient delivery of services it is vital that colleagues in commissioning and provider functions work closely together to share intelligence in regard to demand, build capacity and resilience in the market place, ensure that quality is monitored and that provider capability is matched to the needs of service users. This work will be pursued in line with the principles of the Pioneer project and the establishment of the ICO will be an enabler in this process with CCG staff also being aligned with ICO workstreams to jointly develop the Service Development Plans.

Whilst the Council and CCG will work together to deliver strategic or macro commissioning priorities the Trust will continue to deliver a range of micro commissioning responsibilities including:

- The assessment of need and commissioning of care packages to meet assessed needs on an individual basis.
- Monitoring and pooling of intelligence in regard to the quality of services provided by all providers of adult social care services in Torbay.
- Instigating safeguarding processes where these are necessary and escalating circumstances where providers are not complying with agreed improvement plans to commissioners for decision in regard to contract enforcement and if necessary contract cessation.

The Council and CCG have worked together to develop a market position statement for adult social care, which is in line with the commissioning intentions of both the Council and the CCG. The resulting service developments will be implemented by working in conjunction with providers with the objective of securing more cost effective system wide solutions, which take account of the resources available. A work programme to underpin the delivery of these changes will be agreed between the Council, the CCG and the Trust and monitored through the governance arrangements for this Agreement.

1.9 Consultation, Engagement and Involvement Process

As the Accountable Authority the Council will lead consultation processes where the need for change is being driven by the needs and requirements of the Council. The Trust is committed to supporting the consultation and engagement processes the Council undertakes in relation to service changes recognising the Council's statutory duty and good practice.

As a provider the Trust will engage all stakeholders in service redesign and quality assurance including, playing an active role with Torbay Council Health Overview and Scrutiny Committee. Additionally the Trust will be engaged with the CCG Locality Teams where the primary focus will be on consultation in regard to NHS services.

Where service changes will result in variation in the level or type of service received by individual service users, the Trust will comply with statutory guidance on the review/reassessment of care needs and ensure that those service users affected are given appropriate notice of any changes.

The Council, the Trust and the CCG will continue to support the role of Healthwatch and the community voluntary sector in involving people who use services in key decisions as well as service improvement and design.

The Council also expects the Trust to engage actively with service users and the voluntary sector in Torbay in developing new service solutions. This will apply irrespective of whether the service changes are driven by the necessities of the current financial environment or the need to ensure the continual evolution and development of services.

1.10 Mental Health

The Council has **statutory responsibilities** for providing services to people with mental health problems under the Mental Health Act 1983 and NHS and Community Act 1990 which are delegated to the Trust. These include:

- Approval and provision of 'sufficient' numbers of Approved Mental Health Practitioners (AMHP)
- Aftercare under section 117
- Guardianship under section 7
- Care management services

The Trust delegates many of these responsibilities to Devon Partnership NHS Trust (DPT), along with the budget. A number of issues have been identified around the sustainability and robustness of some of these arrangements. A visit from CQC and the Mental Health Act Commission in March 2013 focused attention on to this area and reinforced the need to address the issues. These stem from historical complexities around employing organisation, contracts of employment, recruitment and training and volume of referrals and capacity. There are also issues around the commissioning of mental health services and the impact that changes have on staff roles (e.g., reduction in inpatient services).

Issues have been raised both locally and nationally regarding **crisis and acute care** which impact significantly on the role of the Approved Mental Health Practitioner and social care generally. These issues need addressing jointly by health and social care commissioning. There is a need for the Council to put in place arrangements for this function as it is not resourced currently.

DPT is implementing a number of changes across its system in terms of moving towards **mobile working** and 'hot desking'. It has also introduced a psychosis/non psychosis service to replace the geographically based multi-disciplinary teams. These will impact on the way in which social care services are provided and will require a clear resolution which assures that potential risks to individuals and staff associated with these changes are managed.

The following is being addressed:

- Contractual relationship between TSDHCT and DPT in terms of budget accountability and performance.
- Pressures on the Under 65 Mental Health budget arising from increased numbers of eligible clients and the impact of the loss due to budget reductions of Supporting People services, providing 'low level' support.
- Workforce issues and deployment/roles of social care staff (see Section 2 workforce).

The **Care Act** will impact on the way in which social care is delivered to people with mental ill health as for general social work. DPT will need to release assigned social care staff to undertake training as appropriate.

2. Workforce Current Position and issues for 15/16

The provision of an integrated health and social care service through local multidisciplinary teams has proved to be an effective model for delivery, able to respond to customer needs swiftly and able to facilitate rehabilitation and avoidance of residential and hospital admissions. However, the existing model relies on a level of staff resources which will not be sustainable in future given the additional demands and an alternative model is being designed. This will have an impact on how staff are deployed. The future model will require consultation with staff and some realignment of roles.

A workforce plan is being produced which will address future needs making use of data gathered during 2014 on activity and workload.

- **Impact of new legislation on workforce**; the Council and Trust are working together to ensure that there is capacity to meet the new demands from the Care Act 2014 on 1 April 2015. Modelling has demonstrated that a significant number of additional referrals for carers and individual assessments will be received. The new model of care described above is being implemented by the Trust from July 2015 which will aim to streamline the way in which referrals are handled. This will increase efficiency and release capacity in due course to carry out additional work. However, the changes in the law start from 1 April 2015 and additional staff will need to be in post from then, even if not required after the new model beds in.
- **Awareness of spirit of the Care Act**; the Care Act requires a cultural shift to ensure that there is a clear focus on wellbeing, prevention, personalisation and carers needs. It will also require a range of new underpinning systems to ensure that other requirements, such as Eligibility and Deferred Payments, can be managed. Presentations on the Act have been delivered to all teams and will be followed up by a series of seminars in the final quarter of 2014/15 to promote awareness.
- **Role of social worker**; the Act gives the social worker , alongside GPs, a clear role in leadership of the multi-disciplinary response and they will all be required to understand the new way of working and take it forward with their colleagues from other professions.
- **Training Framework**; a framework is being developed which will enable all staff in social care to be clear about the skills and competences required of them and what training they need to undertake. This will enhance the approach taken regarding safeguarding training.

- **Open University Social Work Training**; this training route will be used to support further members of existing staff wishing to qualify. It has proved effective in providing a reliable stream of qualified staff and supports recruitment.
- **Approved Mental Health Professionals/Emergency Duty Service**; the daytime rota is more stable but small staff numbers mean it is vulnerable to staff absences and turnover. EDS is particularly vulnerable, with an ageing workforce which is resisting the changes which need to be made to create a sustainable service. It is also now almost impossible to recruit a social worker with both child care and mental health experience. To address the growing problems, all staff with Council contracts (required prior to change in Mental Health Act 2006) will be transferred under TUPE to the Trust in January 2015 to create a single workforce. This improves the opportunities to develop more sustainable services.
- **MCA/DoLS**; there has been a huge increase in referrals resulting from the case law in March 2014. Staff with Best Interest Assessor qualifications are being sought in order to reduce waiting times.

3 Adult Social Care Performance Management

ASC Outcomes Framework (ASCOF) and Other Key Performance Measures

The Adult Social Care Outcomes Framework (ASCOF) is the Department of Health's main tool for setting direction and strengthening transparency in adult social care. The framework was first published in March 2011 and since then has been kept under constant review to ensure a continued focus on measures that reflect the outcomes which matter most to users of adult social care services and carers.

The ASA includes all the performance indicators incorporated with the ASC Outcomes Framework as well as a number of other metrics that emphasise quality and the inter-dependency of health and social care services. For reporting purposes each indicator is placed within one of the 4 ASCOF Domains and an overview is given below (see **Appendix 2** for the KPIs and benchmarking information).

Additional and new returns will be required under the Care Act for finance, general performance monitoring and safeguarding. The development of these reports during the year as guidance is published will be monitored via the adult Social Care Programme Board.

3.1 Domain 1: Enhancing quality of life for people with care and support needs

This reflects the personal outcomes which can be achieved for individuals through the services they receive. In particular it focuses on the services provided by adult social care and the effect they have on users and carers. It covers issues of personalisation, choice and control, independence and participation.

3.2 Domain 2: Delaying and reducing the need for care and support

The purpose is to achieve better health and wellbeing by preventing needs from increasing where individuals have developed, or are at risk of developing, social care needs. It is aimed at early intervention to prevent or delay needs from arising, and supporting recovery, rehabilitation and reablement where a need is already established or after a particular event.

Many of the outcomes around prevention are achieved in partnership with other services. The measures reinforce partnership working and there is a strong focus on efficiency since one of the outcomes of prevention will be delaying or avoiding clinical intervention or inappropriate care placements. Social care has a key role in avoiding inappropriate care placements which impact negatively on recovery and can be more costly.

3.3 Domain 3: Ensuring people have a positive experience of care and support

The quality of outcomes for individuals is directly influenced by the care and support they receive. A key element of this is how easy it is to find and contact services and how individuals are treated when they receive services. Specific quality data is difficult to come by for this domain but there will be data available from local surveys and complaints.

3.4 Domain 4: Safeguarding people whose circumstances make them vulnerable and protecting them from avoidable harm

This domain covers the fundamentals of the social care system – keeping vulnerable people safe. Although there is a safety net within the registration and inspection system there is a wider aspiration of protecting from avoidable harm and caring for individuals in a safe and sensitive environment that respects their needs and choices. In terms of safety, other than numeric measurements, it is difficult to qualitatively or quantitatively measure events that have not happened. It is recognised more work will need to be done on considering measures for this domain. As with Children's services, safeguarding is in issue for all partners.

3.5 Monthly Performance Reporting

Many of the ASCOF indicators are derived from the annual ASC Survey or Carer's Survey. As such, performance is only reported once per year. The ability exists to benchmark the Council against other local authorities and a formal report is submitted to the Social Care Programme Board and the Adult's Policy Development Group meeting. Where possible, however, performance is measured on a monthly basis (see Appendix 2).

3.6 Joint Strategic Needs Assessment (JSNA)

The Trust will work with the Council and the CCG to develop and use the JSNA as a key source of commissioning information for the Health and Wellbeing Board.

3.7 Benchmarking and Comparisons with other Authorities

The strategic direction of adult social care, as outlined in Section 1, is based on several benchmarking reports published during 2012 as well as NHS and Social Care national information databases.

- Department of Health Use of Resources Annual Report
- Towards Excellence in Adult Social Care (TEASC) Benchmarking Report

The first three given in the list above are national reports; the fourth was a report commissioned directly by Torbay Council. The Dr Foster NHS database and the Audit Commission Toolkit were also accessed to provide comparative information.

Finding	*Comparison*
Adult Social Care Survey 2013/14 - National measures	Social care-related quality of life - Torbay scored slightly below the England average and ranked 86 out of 150 local authorities.
	Control over their daily life - Torbay was in line with the England average and ranked 69 out of 150 local authorities.
	Overall satisfaction of people with their care and support - Torbay scored above the England average and ranked 20 out of 150 local authorities.
	Feeling safe - Torbay scored below the England average and ranked 118 out of 150 local authorities.
	Services have made them feel safe and secure - Torbay scored below the England average and ranked 141 out of 149 local authorities.
Care Homes	Care home placements decreased by 12.5% between April '11 and Apr'14 from 781 to 683 clients, an average of 4.5% p/a.
	The proportion of nursing to residential home clients is not in keeping with other areas owing to an oversupply of residential care places.
Community Based Services	10.7% of clients receiving domiciliary care within Torbay receive less than 2 hours of domiciliary care each week. This is in line with the national average of 9.1%.
	32% of clients receiving domiciliary care receive in excess of 10 hours of domiciliary care each week. This is well below the national average of 46%. This is surprising when taking account of the reduced reliance on care home placements and points towards the effectiveness of intermediate care services within the Bay who support and work closely with complex clients.

3.8 Financial Risk Share and Efficiency:

The existing risk sharing agreement will continue until the new Integrated Care Organisation is formally established and the services currently provided by the Trust transfer into the new organisation. The two Trusts, which will form the ICO, the Council and the CCG have agreed a revised risk share arrangement which will be instituted at the point that the ICO is formally constituted. The document is still being finalised, but is included here in draft form (Appendix 8), to indicate the likely shape and nature of the agreement.

There are a number of risks to the Council and the Trust in delivery of this. The known risks include issues associated with:

- Ordinary residence
- Risk of capacity to deliver changes

- Judicial Review of care home fees
- Increasing pressures in regard to significant increases in the number of DOLS applications.
- Increasing pressures in regard to the volume of safeguarding activity.
- The cost of implementing the Care Act, includes the cost of services delivered, frontline staff and back office functions.
- Community concern
- Acquisition process
- Care Law established by national legal rulings.

4. Spending Decisions and Key Decisions

4.1. This agreement reiterates section 22.3 of the Partnership Agreement, i.e., the Trust may not make decisions unilaterally if they meet the criteria of a 'key decision'.

4.2. Key decisions are made by Torbay Council in accordance with its constitution. In Schedule 8 of the Partnership Agreement a key decision is defined as a decision in relation to the exercise of Council functions, which is likely to:

- result in incurring additional expenditure or making of savings which are more than £250,000
- result in an existing service being reduced by more than 10% or may cease altogether
- affect a service which is currently provided in-house which may be outsourced or vice versa
- and other criteria stated within schedule 8 of Partnership Agreement.

When agreeing what constitutes a key decision, consideration should be given to the level of public interest in the decision. The higher the level of interest the more appropriate it is that the decision should be considered to be key.

5. Social Care Budget 2015-16

The budget outlined below for 2015-16 is allocated to the Trust to meet the performance levels listed in Appendix 1 along with any local adjustments to be agreed before 1st April 2015 between the DASS and the Trust.

	2012-13	***2013-14***	***2014-15***	***2015-16***
Base Budget	*40,035*	*40,339*	*38,273*	*33,429*
*Central Govt Funding**	*2,224*	*2,966*	*2,966*	
Sub Total	***42,259***	***43,305***	***41,239***	***33,429***
JCES	*560*	*499*	*498*	*498*
TOTAL	***42,819***	***43,804***	***41,737***	***33,927***

*** For 2015-16 the funding stream will form part of the Better Care Fund. Planning assumptions for the BCF allocate funding of £2,976K as protected funding Adult Social Care.**

The above figures will require adjustments for:

- potential Care Home increases resulting from Judicial Review
- transfer of staff between the Trust & Council
- additional Care Act responsibilities that come into effect from 1st April 2015
- Independent Living Fund transfer into Local Authorities from 1st July 2015

6. Client Charges for 2015/16

The basis for charging for long stay residential/nursing care services will change with the inception of the Care Act, when sections 14 and 17 of the Care Act and the Care and Support (charging and assessment of resources) rRegulations 2014 will apply. Residential charges to be implemented each April as directed by the Department of Health CRAG (Charging for Residential Accommodation Guide). For non-residential care our policy remains unchanged.

Client contributions are based on an individual financial assessment of the service users financial circumstances, including capital and income. It is not anticipated that the new regulatory framework will in itself alter the level of income collected.

There is no charge for services provided to clients under Intermediate Care or Continuing Care.

Services provided specifically to carers will, in principle, not be subject to a charge but this will be reviewed in view of final guidance on implementation of the Care Act, dependent upon resource allocation. These are services provided directly to the carer (rather than the person that they care for) which include open access services such as Carers Emergency Card and Carers Education Courses, and simple services provided as a result of an assessment including emotional support or one-off direct payments for a carer's break.

The Trust will ensure that all clients in receipt of a chargeable service receive a full welfare benefit check from the FAB team and an individual financial assessment in accordance with Department of Health circular LAC(2001) 32.

The Trust will ensure that individual financial assessments will be updated at least annually (but more frequently where the financial circumstances of an individual service user are known to have changed during the course of the year).

The Care Act 2014 establishes a universal deferred payments scheme which means that people should not be forced to sell their homes in their lifetime to pay for the cost of their care. A deferred payment is, in effect, a loan against the value of the property which has to be repaid either from disposal of the property at some point in the future or from other sources. When the scheme starts in April 2015, all Councils in England will be required to provide a deferred payment scheme for local

residents who go to live in residential or nursing care, own a property and have other assets with a value below a pre-determined amount (currently £23,250). They must also have assessed care needs for residential or nursing care.

As part of the Care Act planning, a deferred payments policy is being formulated and within this the Council has the ability to recover any reasonable costs it may incur in setting up a DPA from the Client, the costs of which may be included in the total deferred or may be paid as and when they are incurred. To this end the regulations identify areas of costs and expenditure that the Trust may seek to recover and how these may be recovered. The Council will also have the capability to charge interest on the balance outstanding on the deferred arrangement on a compound basis, in accordance with the regulations.

7 Roles and Responsibilities

Torbay Council

- **Role of Torbay Council Director of Adult Social Services (DASS) –** has delegated her authority for provision of frontline services to the Trust for the provision of Adult Social Services. She provides strategic leadership of adult social care services and strategic commissioning for adults for Torbay fulfilling the statutory responsibilities of the DASS role. The DASS is accountable for all seven statutory responsibilities of the role but will delegate Professional Practice and Safeguarding and Operational Management responsibilities to the Trust through the Deputy DASS. She delegates aspects of the financial management elements of the role to the Finance Director of TSD and the Executive Head of Finance at Torbay Council, but retains overall accountability for the ASC budget**.**
- **Role of Adult Social Care Executive Lead Member -** to provide political steer to the Trust and the Council in adult social care. To challenge/monitor and drive performance.
- **Executive Head Finance –** to take a lead responsibility on behalf of the Council in relation to the delegated budget.

From 1 December 2014, the Adult Social Care Commissioning Team was transferred under TUPE legislation from TSDHCT to Torbay Council. This move was made to separate the commissioning and provider functions, previously held together in TSDHCT, with the objective of creating an integrated strategic commissioning team for the Council which linked with the CCG, thus establishing joint commissioning arrangements aligning to the proposed Integrated Care Organisation.

The principles and operational arrangements for the relationships between teams and functions of both organisations are described in Appendix 7. It is essential that these arrangements are clear and are kept under review in order to ensure that both organisations continue to work together and identify any issues arising.

The Trust

- **Role of Trust Chief Operating Officer (COO)** – has delegated authority within the Trust to ensure that the requirements of this agreement are met through the effective management and delivery of adult social care services as part of the Trust's integrated Zone based teams. The COO will take lead responsibility for the relationship with the Council.

- **Role of Director of Finance –** to take a lead responsibility within the Trust for managing the budgets allocated to social care services and the monitoring and reporting of performance. This will include the provision of support to the DASS in analysing and interpreting performance, against locally agree KPIs and national benchmarking data, as part of target setting, strategic planning and performance monitoring.
- **Role of Associate Director Adult Social Services –** to provide professional leadership for social care services and lead on workforce planning, implementing standards of care, safeguarding and support the running of the Adult Social Care Programme Board.
- **Role of Head of Complex Care –** to provide advice and leadership in regard to care planning for people with complex needs, the application of statutory guidance in regard to Ordinary Residence, the management of applications for judicial review of decisions in regard to individual care needs assessments and complex or vexatious complaints.
- **Trust Board -** The Adult Social Care Executive Lead Member is a member of the Board of the Trust to oversee the strategic direction of the provider trust.

Social Care Programme Board (SCPB)/CCG Contract Management

The Council and the CCG intend to take a joint approach to the commissioning of services from the ICO. This will include establishing revised governance structures, which will include the Health and Wellbeing Board. The role and remit of the Adult Social Care Programme Board will be revised to reflect these changes during the course of the year.

This SCPB is overseen by the senior officers described above. The Board will drive adult social care work and improvement plans. Its Terms of Reference cover the following areas:

- To assist the development of the strategic direction of adult social care services which supports the new context the Council and Trust face in terms of changing public sector reform and reducing public resources.
- To receive regular reports and review progress against transformation and cost improvement plans differentiating between those areas incorporated within the budget settlement and any cost pressures over and above this.
- To receive reports and review performance against indicators and outcomes included in the Annual Strategic Agreement providing and/or participating in regular benchmarking activities.
- To monitor action plans against any in-year areas of concern, raising awareness to a wider audience, as appropriate.
- To discuss and determine the impact of national directives translating requirements into commissioning decisions for further discussion and approval within the appropriate forums. This will include the initial list of service improvement areas planned for 2014-15 and onwards.
- To discuss and develop future Annual Strategic Agreements.
- Co-ordinate the production of the ‘Annual Account’.
- To develop discussion/briefing documents for use with the following groups or organisations:

• Adults Policy Development Group	• ADASS or other local authorities
• Overview and Scrutiny	• Executive teams within both organisations
• Health and Well-Being Board	• Integrated Governance Committee
• Joint Commissioning Group (Torbay)	

8 Emergency Planning

The South Devon Healthcare Foundation Trust will act as a Category 1 responder in relation to civil and health emergencies where humanitarian assistance is required. SDHFT will provide an appropriate and timely level of support to the Council in such circumstances and provide appropriately trained and competent staff and other resources as required to enable a coordinated response from the incident itself through to and including the recovery phase.

APPENDIX 1

Adult Social Care

Director: Caroline Taylor
Executive Lead: Cllr Christine Scouler

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
Adult Social Care (via Partnership Agreement with Torbay and Southern Devon Health and Care NHS Trust)					
1. Renegotiation of Contracts:		220,000	Nil	April 2015	The objective of this scheme is to secure best value from a range of existing contracts, without affecting service volumes or outcomes, through negotiation of terms and conditions with suppliers. Negotiations with providers affected are on-going and are proving successful as per original proposal.
2. Review of all existing community care support plans		498,000	Nil	On-going process	This is within existing policy and will ensure equity and parity between service users. The scheme has delivered savings in 2014/15, this will continue in 2015/16 partly as a result of the full year effect of the work undertaken in 2014/15 and partly through further review activity with individual service users. There is reasonable confidence that this will deliver savings at the required level.
3. Care Home Placement Numbers & Rates		360,000	Nil	On-going	There has been a year on year reduction in the number of placements which are necessary to meet assessed needs over the last four years. This trend has developed as alternative forms of care have come on stream. There is confidence this trend will continue and the targets will be achieved. However achievement of the target is reliant on this trend continuing and will be determined by the needs of individual service users and therefore be subject to demographic pressure.

APPENDIX 1

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
4. Equitable Application of Non-residential Charging policy	50,000		Nil	April 2015	This is within existing policy and will ensure equity and parity between service users. The scheme started in 2014/15, all relevant service users will have been reviewed by the end of the current financial year, £50,000 will have been delivered in year, this will have a full year effect of £75,000 but as £50,000 of this has been taken as a saving in the current year the impact in 2015/16 will be a saving of £25,000 which will leave a shortfall of £25,000 which will be met through management of in year pressures.
5. Community Alarms (Proposal agreed by Council in Feb 2014)		48,000	Nil	April 2015	This is within existing policy and will ensure equity and parity between service users and has now been subsumed within the review of community care support plans (see 2 above. This is because where alarms continue to be necessary to meet assessed care needs they are funded within the clients personal budget.
6. Learning Disability Development Fund (Proposal agreed by Council in Feb 2014)		17,000	Nil	April 2015	Decision to reduce funding was made by the Council February 2014, consultation completed as part of that decision making processes and this scheme is a continuation of that process.
7. Voluntary Sector Block Contracts (Proposal agreed by Council in Feb 2014)		38,000	Nil	April 2015	Decision to reduce funding was made by the Council February 2014, consultation completed as part of that decision making processes and this scheme is a continuation of that process.

APPENDIX 1

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
8. Service Redesign - Learning Disability Review of remaining day care and respite service including transport arrangements.		525,000	Nil	On-going	Commissioning Strategy and delivery plans are being overseen by the Health and Well Being Board and Health Scrutiny Committee. There is a high level of confidence that the target will be delivered; the detail is being worked up through engagement processes which include people with learning disabilities and representative groups. However delivering this target will require a range of challenging redesign work to be completed on a co-production basis with stakeholders and services users.
9. Service Redesign - Respite Care Review existing arrangements for respite care and introduce a single policy to ensure equitable availability of respite care services according to need.		250,000	Nil	TBC	A consultation process is currently underway on a revised policy (now referred to as short breaks). The consultation process will conclude on the 13th February 2015 and reported to the Council. The Short Breaks Policy and EIA are attached as Appendix 9
10. Service Redesign - St Kilda's To review the proposals for the St Kilda's site to ensure the recommended service solutions represents value for money.		320,000	Nil	Ongoing	The outline business case has been approved by the Trust Board and a contractor has been appointed to work up the design and finalise the cost of building the new facility. The contract is due to be agreed in April 2015 and the new service will come on line in October 2016. Negotiations will soon commence with the current provider of the service to agree an exit strategy which will enable savings to be made in 2015/16.

APPENDIX 1

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
11. Delivery Model 1 - Assessment Process This will involve changing the way that care needs are assessed and services are co-ordinated, including: ▪ Moving to telephone and on-line assessments rather than face to face contacts. ▪ Promoting the self-directed care and personal budgets to enable people to take control of their own circumstances and needs		668,000	Covered by pooled arrangements with NHS	April 2015 to March 2016	The scheme will impact on how care needs assessments are undertaken but not the level of care provided. Development and pilot work is currently underway, with full implementation scheduled for July 2015. The expectation is that the part year effect savings (July 2015 to March 2016) will meet the 2015/16 target.
12. Delivery Model 2 - Emergency Duty Team Review of the way Out of Hours & Emergency Duty services are provided.		274,000	nil	TBC	A range of options are being evaluated, including other providers or extending joint approach with Children's Services and the MASH development. This involves negotiations with staff and trade unions, there is assurance that savings will be made but the final figure and full year effect is not guaranteed at this stage.

APPENDIX 1

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
13. Delivery Model - Quality Assurance To review the way the Trust works with providers of nursing, residential and domiciliary care services to promote and ensure the quality of services.		127,000	nil	April 2016	A saving of £91,000 has been delivered however this has reduced the size and capacity of the team providing this service to the smallest viable critical mass. Further savings are not possible as this would result in the removal of all internal assurance processes which would compromise safeguarding procedures and result in reliance on CQC processes for all on going quality assurance. There will therefore be a shortfall of £36,000 which will be met through management of in year pressures.
14. Movement of clients from residential homes to Extra Care Housing The objective will be to support people to remain, or return to, living independently in their own accommodation.		500,000	TBC	TBC	This is a high level proposal involving housing providers and is in line with the housing commissioning strategy which was agreed by the Health and Well Being Board. As proposals are developed and there is a level of detail upon which there can be consultation with service users and their families this will be completed. The results of the consultation, along with an Equality Impact Assessment, will then be considered in reaching decisions about the future of these services. There is confidence that part year savings can be achieved but the full year effect remains high risk.

APPENDIX 1

Agreed Savings – Outline details	Savings for 2015/16		Implement-ation Cost	Delivery Date	Possible risks / impact of proposals
	Income £	Budget reduction £			
15. Further Joint working, shared commissioning, new income and efficiencies to be explored with the NHS and others.		1,566,000	TBC	TBC	This area is still under exploration. There are benefits to be realised in development of new income and further risk mitigation, through gain share or other mechanisms but requires more time. The delivery of the ICO understandably continues to be the priority for delivery in our local system. The Better Care Fund did not become a source of new monies and has been refocused by government on prioritising reductions in acute emergency admissions.

Benchmark Assessment and KPIs

D R A F T 06/01/15

Appendix 2

Domain & KPI	Frame work	Reporting Frequency	Notes	2015/16 Target Proposed	2014/15 Target	2013/14 Target	2012/13 Target	2014/15 Outturn Forecast*	2014/15 Outturn to Oct14	2013/14 Outturn	2012/13 Outturn	2013/14 England Average	2012/13 England Average
Domain 1: Enhancing quality of life for people with care and support													
ASC 1A: Social care-related quality of life	ASCOF	Annual	Data from annual Adult Social Care Survey. Target set for top quartile	19.2	n/a	n/a	n/a	n/a	n/a	18.8	18.6	19	18.8
ASC 1B: The proportion of people who use services who have control over their daily life	ASCOF	Annual	Data from annual Adult Social Care Survey. Target set for top quartile	79	n/a	n/a	n/a	n/a	n/a	76.7	77.3	76.8	76.1
ASC 1C pt1: proportion of people using social care who receive self-directed support	ASCOF	Monthly	KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15. Target provisonally set and will be reviewed after Q1 15/16 via SCPB and DASS leadership process.	70%	70%	70%	55%	65.0%	51%	62%	58%	62.1	56.2
ASC 1C pt2: proportion of people using social care who receive direct payments	ASCOF	Monthly	KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15. Target provisonally set and will be reviewed after Q1 15/16 via SCPB and DASS leadership process.	10%	10.0%	10.0%	n/a	9.8%	9.4%	10%	10%	19.1	16.8
ASC 1D: Carer-reported quality of life	ASCOF	Annual	Data from biennial from Carers Survey. Target set for top quartile	8.4	n/a	n/a	n/a	n/a	n/a	n/a	8.2	n/a	8.1
ASC 1E: Proportion of adults with a learning disability in paid employment	ASCOF	Annual	KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15. Target provisonally set and will be reviewed after Q1 15/16 via SCPB and DASS leadership process.	4.5%	n/a	n/a	4%	4.4	4.4	4.1	4.9	6.8	7
ASC 1F: Proportion of adults in contact with secondary mental health services in paid employment	ASCOF	Monthly	Data from DPT.	7.1%	5.5%	5.5%	6.0%	1.2%	1.2%	3.1	4.8	7.1	8.8
ASC 1G: Proportion of adults with a learning disability who live in their own home or with their family	ASCOF	Monthly	KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15. Target provisonally set and will be reviewed after Q1 15/16 via SCPB and DASS leadership process.	70%	69.0%	69.0%	60.0%	68.8%	67.3%	66%	69%	74.8	73.5
ASC 1H: Proportion of adults in contact with secondary mental health services who live independently, with or without support	ASCOF	Monthly	Data from DPT.	77%	77.0%	77.0%	70.0%	76.3%	69.5%	66%	77%	60.9	58.5
ASC 1I: Proportion of people who use services and their carers who reported that they had as much social contact as they would like	ASCOF	Annual	Part 1 – services users - Calculated annually from Adult Social Care Survey. Part 2 – carers - Calculated biennially from Carers Survey.	47.1	n/a	n/a	n/a	n/a	n/a	47.1	n/a	44.2	n/a
D40: % clients receiving an annual review	Local	Monthly	This actually measures % reviews that are overdue.	76%	80.0%	80.0%	85.0%	76.4%	80.9%	90%	88%	n/a	n/a
SC-005: No. of overdue reviews	Local	Monthly	Expecting to change to % of reviews more than x months overdue	TBC	500	n/a	n/a	710	623	n/a	n/a	n/a	n/a
SC-007: No. of overdue reviews for out of area placements (snap shot)	Local	Monthly	Expecting to change to 'OOA placement reviews overdue by more than X months'.	TBC	0	n/a	n/a	5	8	n/a	n/a	n/a	n/a
D39: % clients receiving a Statement of Needs	Local	Monthly		90%	95.0%	95.0%	95.0%	90.0%	91.30%	93%	94%	n/a	n/a
NI132: Timeliness of social care assessment	Local	Monthly		74%	70.0%	65.0%	70.0%	74.1%	72.6%	70%	70%	n/a	n/a
NI133: Timeliness of social care packages following assessment	Local	Monthly		90%	85.0%	85.0%	85.0%	94.6%	96.2%	98%	99%	n/a	n/a

Domain 2: Delaying and reducing the need for care and support													
ASC 2A p1: Permanent admissions to residential and nursing care homes, per 100,000 population Part 1 - younger adults	ASCOF	Annual	Reported annually to SCPB as official population updated annually. KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15.until new reporting completed at the end of 2014/15.	BCF?	n/a	n/a	n/a	n/a	n/a	36.3	28.2	14.4	15
ASC 2A p2: Permanent admissions to residential and nursing care homes, per 100,000 population Part 2 - older people	ASCOF	Annual	Reported annually to SCPB as official population updated annually. KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15.	572.6	n/a	n/a	n/a	n/a	n/a	628.6	718.4	668.4	697.2
ASC 2B p1: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services Part 1 - effectiveness	ASCOF	Annual		88.7	n/a	n/a	n/a	n/a	n/a	81.5	81.3	81.9	81.4
ASC 2B p2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services Part 2 - coverage	ASCOF	Annual		BCF?	n/a	n/a	n/a	n/a	n/a	2.9	3.4	3.3	3.2
ASC 2C p1: Delayed transfers of care from hospital and those which are attributable to adult social care Part 1 - total delayed transfers	ASCOF	Annual		346.9	n/a	n/a	n/a	n/a	n/a	3.6	2.7	9.7	9.4
ASC 2C p2: Delayed transfers of care from hospital and those which are attributable to adult social care Part 2 - attributable to social care	ASCOF	Annual		BCF?	n/a	n/a	n/a	n/a	n/a	1.8	1	3.1	3.2
ASC 2D: The outcomes of short-term support: sequel to service	ASCOF	Monthly	New Measure for 2014/15. Unable to report until new reporting developed during 14/15.	TBC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
ASC 2E: Effectiveness of reablement services	ASCOF	n/a	New KPI still under national development.	TBC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
ASC 2F: Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	ASCOF	n/a	New KPI still under national development.	TBC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LI-404: No. of permanent care home placements at end of period	Local	Monthly	Finance will confirm after further budget & CIP work - end Jan14	TBC	644	697	703	641	658	683	717	n/a	n/a
LI-450: Proportion of clients supported in a care home at end of period	Local	Monthly	Data quality improvements during 2014/15 increased outturn. Target should be reset.	from above	18.0%	18.0%	n/a	20.0%	20.4%	21%	18%	n/a	n/a
Domain 3: Ensuring that people have a positive experience of care and													
ASC 3A: Overall satisfaction of people who use services with their care and support	ASCOF	Annual	Calculated annually from Adult Social Care Survey.	68.5	n/a	n/a	n/a	n/a	n/a	68.5	72.6	64.8	64.1
ASC 3B: Overall satisfaction of carers with social services	ASCOF	Annual	Calculated biennially from Carers Survey.	46.4	n/a	n/a	n/a	n/a	n/a	n/a	45.9	n/a	42.7
3E: Improving people's experience of integrated care	ASCOF	n/a	New KPI still under national development. Will be calculated annually from Adult Social Care Survey. Will be calculated biennially from Carers Survey.	TBC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
ASC 3C: The proportion of carers who report that they have been included or consulted in discussions about the person they care for	ASCOF	Annual	Calculated biennially from Carers Survey.	76.6	n/a	n/a	n/a	n/a	n/a	n/a	74.4	n/a	72.9
ASC 3D: The proportion of people who use services and carers who find it easy to find information about services	ASCOF	Annual	Part 1 – services users - Calculated annually from Adult Social Care Survey. Part 2 – carers - Calculated biennially from Carers Survey.	77.3	n/a	n/a	n/a	n/a	n/a	71.8	73	74.5	74.1
NI135: Carers receiving needs assessment, review, information, advice, etc.	Local	Monthly	Local KPI but may need to change KPI defintion changes with new 2014/15 statutory returns. Unable to forecast until new reporting completed at the end of 2014/15. Target provisonally set and will be reviewed after Q1 15/16 via SCPB and DASS leadership process.	40%	35.0%	31.0%	31.0%	46.0%	26.4%	35%	28%	n/a	n/a

Domain 4: Safeguarding adults who circumstances make them														
ASC 4A: The proportion of people who use services who feel safe	ASCOF	Annual	Calculated annually from Adult Social Care Survey.	69.6	n/a	n/a	n/a	n/a	n/a	62.3	58.8	66	65.1
ASC 4B: The proportion of people who use services who say that those services have made them feel safe and secure	ASCOF	Annual	Calculated annually from Adult Social Care Survey.	85.6	n/a	n/a	n/a	n/a	n/a	66.5	65.3	79.1	78.1
ASC 4C: Proportion of completed safeguarding referrals where people report they feel safe	ASCOF	n/a	New KPI still under national development.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TCT11: Safeguarding Calls Triaged within 48 Hours	Local	Monthly	South West Safeguarding Adults Network recommendation. Measures being reviewed regionally so may need to be reset in 2015/16 by via SCPB and DASS leadership process.	90%	n/a	n/a	80%	TBC	48%	81%	81%	n/a	n/a
TCT12b: Proportion of safeguarding strategy meetings held within 7 working days	Local	Monthly	South West Safeguarding Adults Network recommendation. Measures being reviewed regionally so may need to be reset in 2015/16 by via SCPB and DASS leadership process.	80%									
TCT13b: Proportion of Safeguarding case conferences held within 30 working days of strategy meeting	Local	Monthly	South West Safeguarding Adults Network recommendation. Measures being reviewed regionally so may need to be reset in 2015/16 by via SCPB and DASS leadership process.	80%									
TCT14b: % repeat safeguarding referrals in last 12 months	Local	Monthly	Changing measure from number to proportion. Target increased to account for >30% increase in referrals since 2013/14.	8.0%									

* linear forecast from 7 months of data where appropriate
ASCOF KPIS from 'The Adult Social Care Outcomes Framework 2015/16' (Nov14)
Torbay ASCOF figures from statutory returns may differ from those reported in end of year reports due to different processes & deadlines

Appendix 3

Risk Matrix

Analysis of risks set out in ASA: The risk analysis set out in this grid has been completed against the Trust's risk scoring matrix under which a score of 4 or less is regarded low, between 6 and 9 as moderate and 10 to 25 as significant.

Risk	Risk description	Mitigation	Risk Score			Risk Owner
			Impact	Likelihood	Score	
Care Home Fees	Care home fees have been set within a new banding structure for residential care set last year and this has been challenged through JR.	• This challenge is currently being considered for appeal	4	4	16	Council
Acquisition process	The Trust is expected to be acquired by another NHS Foundation Trust in 2015 to form an ICO and this could result in distraction from delivery of this agreement.	• This is mitigated through close working between senior officers in the Council, the Trusts and CCG, the Mayor and Councillors, NHS Chairs and Board members. • The impact of senior staff and board member changes will be mitigated through close working of council, NHS provider and commissioner bodies.	4	4	16	Trust
Ordinary residence	Movement of ordinary residence can create in year pressures and this will be monitored closely through Social Care Programme Board	• Adherence to protocols by front line teams and to assess the needs of individual only users to ensure that ordinary residence does apply to their circumstances. • A revised protocol has been introduced during 2013/14 and is being applied. Operationally application is monitored via the Complex Care Review Panel. • Close monitoring of financial impact through Social Care Programme Board (Monthly reports available and quarterly report to Commissioning for Independence Board.)	4	4	16	Council
The scale of savings required	Savings plans targets are significant and over a two year period will require radical	• Individual assessments / reassessment carried out against FAC criteria and all relevant policy frameworks as part of assessing whether it is safe or appropriate to reduce the level	4	4	16	Shared

Risk	Risk description	Mitigation	Risk Score			Risk Owner
			Impact	Likelihood	Score	
	changes in the range of services available, the level of care that can be provide and the way services are delivered.	and make up of existing care plans. • The Trust, Council and CCG will work with service users and the voluntary sector to secure appropriate input and engagement in redesigning and redeveloping services. • Changes in the nature, level and range of services will be subject to formal consultation as required by national guidance and Council policy.				
Risk of capacity to deliver changes	The requirements of this commissioning agreement are the further changes and savings to back office and assessment processes. Capacity in zone teams may impact on the pace of delivery.	• This is mitigated through assurance from the Trust that operational services at the front end can be delivered in a different way. • ASA KPIs include monthly metrics that will demonstrate any reduction in capacity • Regular updates to OLG, SCPB and/or CIB highlighting any commissioning/service transformation needs/risks.	4	3	12	Shared
Community concern	Concern may be raised in response to implementation of the programme of work outlined in this agreement which may affect the pace of delivery.	This is mitigated through • The close involvement of, and engagement with the individuals involved, their families and carers through the relevant assessment and reassessment processes. • Moderation of decision making in complex cases through the complex care review panel. • Escalation of individual cases to the Social Care Programme Board, support from Council Legal services and briefing for Members where particularly difficult, sensitive or contentious cases arises.	4	3	12	Council
Delivery of Care Act	The care act is an opportunity to improve social care and is expected to be fully funded by Government.	• Close involvement through ADASS and LGA of assessing impact and preparedness for Care Act	4	3	12	Shared
DoLs	The Cheshire West ruling in March 2014 has created significant additional	• Caselaw relating to DoLS has created national pressures, with the Law Commission now reviewing the legislation, with likely changes to the law in 2017. The Council has made additional	4	3	12	Shared

Risk	Risk description	Mitigation	Risk Score			Risk Owner
			Impact	Likelihood	Score	
	applications for Deprivation of Liberty Safeguards. This has resulted in an increasing waiting list without the capacity to process applications within legal timescales.	funding (£60k) available to support this in 14/15. This has improved administration but it has not been possible to identify appropriately qualified best interest assessors to make an impact on waiting times. A local course is being considered to supply more staff and a range of other options are being developed.				
EDS	Vacancies, an ageing workforce, skill set requirements and a need to change working patterns has placed this small service at risk of breakdown.	• A range of options are being developed to put this service on a sound footing. This includes outsourcing the service to another provider, considering a combined day/night rota and splitting children and adult services.	4	4	16	Trust
Dom Care	Pressure in dom care market; difficulty in securing packages of care in timely way with some providers planning to exit the market.	• The Living Well @ Home programme has been designed to stabilise the market.	4	4	16	Shared

Outcome Framework	Indicator ID	Indicator Name
NHS Outcomes Framework	1b	Life expectancy at 75
NHS Outcomes Framework	1.1	Under 75 mortality rate from cardiovascular disease
NHS Outcomes Framework	1.2	Under 75 mortality rate from respiratory disease
NHS Outcomes Framework	1.3	Under 75 mortality rate from liver disease
NHS Outcomes Framework	1.6.I	Infant mortality
NHS Outcomes Framework	1.6.ii	Neonatal mortality and stillbirths
NHS Outcomes Framework	2.2	Employment of people with long-term conditions
NHS Outcomes Framework	2.3.i	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
NHS Outcomes Framework	2.3.ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
NHS Outcomes Framework	2.5	Employment of people with mental illness
NHS Outcomes Framework	3a	Emergency admissions for acute conditions that should not usually require hospital admission
NHS Outcomes Framework	3.1	Patient reported outcomes measures for elective procedures
NHS Outcomes Framework	3.2	Emergency admissions for children with lower respiratory tract infections
NHS Outcomes Framework	4b	Patient experience of hospital care
NHS Outcomes Framework	4.1	Patient experience of outpatient services
NHS Outcomes Framework	4.2	Responsiveness to inpatients' personal needs
NHS Outcomes Framework	4.3	Patient experience of A&E services
NHS Outcomes Framework	4.5	Women's experience of maternity services
NHS Outcomes Framework	5a	Patient safety incident reporting
NHS Outcomes Framework	5b	Severity of harm
NHS Outcomes Framework	5.2.i	Incidence of healthcare-associated infection - MRSA
NHS Outcomes Framework	5.2.ii	Incidence of healthcare-associated infection - C. difficile
NHS Outcomes Framework	5.4	Incidence of medication errors causing serious harm
NHS Outcomes Framework	5.5	Admission of full-term babies to neonatal care
NHS Outcomes Framework	1.4.vii	Under 75 mortality rate from cancer
NHS Outcomes Framework	4.7	Patient experience of community mental health services
NHS Outcomes Framework	3b	Emergency readmissions within 30 days of discharge from hospital
NHS Outcomes Framework	1.5	Excess under 75 mortality rate in adults with serious mental illness
NHS Outcomes Framework	1a	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
NHS Outcomes Framework	2.6.i	Estimated diagnosis rate for people with dementia
NHS Outcomes Framework	3.6.i	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilition services
NHS Outcomes Framework	3.6.ii	Proportion of Older People (65 and over) who were offered rehabilitation following discharge from acute or community hospital
NHS Outcomes Framework	4a.i	Patient experience of GP services
NHS Outcomes Framework	4a.ii	Patient experience of GP out of hours services
NHS Outcomes Framework	4a.iii	Patient experience of Dental services
NHS Outcomes Framework	4.4.i	Access to GP services

NHS Outcomes Framework	4.4.ii	Access to NHS dental services
NHS Outcomes Framework	4.6	Improving the experience of care for people at the end of their lives
NHS Outcomes Framework	5.6	Incidence of harm to children due to 'failure to monitor'
NHS Outcomes Framework	3.5.i	The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days
NHS Outcomes Framework	3.5.ii	The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days
NHS Outcomes Framework	1a.ii	Potential years of life lost (PYLL) from causes considered amenable to healthcare - Children and young people
NHS Outcomes Framework	1a.i	Potential years of life lost (PYLL) from causes considered amenable to healthcare - Adults
NHS Outcomes Framework	2 H	ealth-related quality of life for people with long-term conditions
NHS Outcomes Framework	2.1	Proportion of people feeling supported to manage their condition
NHS Outcomes Framework	2.4	Health-related quality of life for carers
NHS Outcomes Framework	1.4.i	One-year survival from all cancers
NHS Outcomes Framework	1.4.ii	Five-year survival from all cancers
NHS Outcomes Framework	1.4.iii	One-year survival from breast, lung and colorectal cancer
NHS Outcomes Framework	1.4.iv	Five-year survival from breast, lund and colorectal cancer
NHS Outcomes Framework	1.6.iii	Five year survival from all cancers in children
NHS Outcomes Framework	5.1	Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital
Adult Social Care Outcome Framework	1A	Social care-related quality of life
Adult Social Care Outcome Framework	1B	Proportion of people who use services who have control over their daily life
Adult Social Care Outcome Framework	1C	Proportion of people using social care who receive self-directed support, and those receiving direct payments
Adult Social Care Outcome Framework	1D	Carer-reported quality of life
Adult Social Care Outcome Framework	1E	Proportion of adults with learning disabilities in paid employment
Adult Social Care Outcome Framework	1F	Proportion of adults in contact with secondary mental health services in paid employment
Adult Social Care Outcome Framework	1G	Proportion of adults with learning disabilities who live in their own home or with their family
Adult Social Care Outcome Framework	1H	Proportion of adults in contact with secondary mental health services who live independently, with or without support
Adult Social Care Outcome Framework	1I	Proportion of people who use services and their carers, who reported that they have as much social contact as they would like.
Adult Social Care Outcome Framework	2A	Permanent admissions to residential and nursing care homes, per 100,000 population
Adult Social Care Outcome Framework	2B	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

Adult Social Care Outcome Framework	2C	Delayed transfers of care from hospital, and those which are attributable to adult social care
Adult Social Care Outcome Framework	3A	Overall satisfaction of people who use services with their care and support
Adult Social Care Outcome Framework	3B	Overall satisfaction of carers with social services
Adult Social Care Outcome Framework	3C	Proportion of carers who report that they have been included or consulted in discussion about the person they care for
Adult Social Care Outcome Framework	3D	Proportion of people who use services and carers who find it easy to find information about services
Adult Social Care Outcome Framework	4A	Proportion of people who use services who feel safe
Adult Social Care Outcome Framework	4B	Proportion of people who use services who say that those services have made them feel safe and secure
Public Health Outcomes Framework	0.1i	Healthy life expectancy at birth
Public Health Outcomes Framework	0.1ii	Life Expectancy at birth
Public Health Outcomes Framework	0.1ii	Life Expectancy at 65
Public Health Outcomes Framework	0.2iii	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area
Public Health Outcomes Framework	0.2iv	Gap in life expectancy at birth between each local authority and England as a whole
Public Health Outcomes Framework	1.01i	Children in poverty (all dependent children under 20)
Public Health Outcomes Framework	1.01ii	Children in poverty (under 16s)
Public Health Outcomes Framework	1.02i	School Readiness: The percentage of children achieving a good level of development at the end of reception
Public Health Outcomes Framework	1.02i	School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception
Public Health Outcomes Framework	1.02ii	School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check
Public Health Outcomes Framework	1.02ii	School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check
Public Health Outcomes Framework	1.03	Pupil absence
Public Health Outcomes Framework	1.04	First time entrants to the youth justice system

Public Health Outcomes Framework	1.05	16-18 year olds not in education employment or training
Public Health Outcomes Framework	1.06i	Adults with a learning disability who live in stable and appropriate accommodation
Public Health Outcomes Framework	1.06ii	% of adults in contact with secondary mental health services who live in stable and appropriate accommodation
Public Health Outcomes Framework	1.08i	Gap in the employment rate between those with a long-term health condition and the overall employment rate
Public Health Outcomes Framework	1.08ii	Gap in the employment rate between those with a learning disability and the overall employment rate
Public Health Outcomes Framework	1.08iii	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
Public Health Outcomes Framework	1.09i	Sickness absence - The percentage of employees who had at least one day off in the previous week
Public Health Outcomes Framework	1.09ii	Sickness absence - The percent of working days lost due to sickness absence
Public Health Outcomes Framework	1.1	Killed and seriously injured (KSI) casualties on England's roads
Public Health Outcomes Framework	1.11	Domestic Abuse
Public Health Outcomes Framework	1.12i	Violent crime (including sexual violence) - hospital admissions for violence
Public Health Outcomes Framework	1.12ii	Violent crime (including sexual violence) - violence offences per 1,000 population
Public Health Outcomes Framework	1.12iii	Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population
Public Health Outcomes Framework	1.13i	Re-offending levels percentage of offenders who reoffend
Public Health Outcomes Framework	1.13ii	Re-offending levels - average number of re-offences
Public Health Outcomes Framework	1.14i	The rate of complaints about noise
Public Health Outcomes Framework	1.14ii	The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime
Public Health Outcomes Framework	1.14iii	The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time
Public Health Outcomes Framework	1.15i	Statutory homelessness - homelessness acceptances
Public Health Outcomes Framework	1.15ii	Statutory homelessness - households in temporary accommodation

Public Health Outcomes Framework	1.16	Utilisation of outdoor space for exercise/health reasons
Public Health Outcomes Framework	1.17	Fuel Poverty
Public Health Outcomes Framework	1.18i	Social Isolation: % of adult social care users who have as much social contact as they would like
Public Health Outcomes Framework	1.18ii	Social Isolation: % of adult carers who have as much social contact as they would like
Public Health Outcomes Framework	2.01	Low birth weight of term babies
Public Health Outcomes Framework	2.02i	Breastfeeding - Breastfeeding initiation
Public Health Outcomes Framework	2.02ii	Breastfeeding - Breastfeeding prevalence at 6 - 8 weeks after birth
Public Health Outcomes Framework	2.03	Smoking status at time of delivery
Public Health Outcomes Framework	2.04	Under 18 conceptions
Public Health Outcomes Framework	2.04	Under 18 conceptions: conceptions in those aged under 16
Public Health Outcomes Framework	2.06i	Excess weight in 4-5 and 10 - 11 year olds
Public Health Outcomes Framework	2.06ii	Excess weight in 4-5 and 10 - 11 year olds
Public Health Outcomes Framework	2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 - 14 years)
Public Health Outcomes Framework	2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 - 4 years)
Public Health Outcomes Framework	2.07ii	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 - 24 years)
Public Health Outcomes Framework	2.08	Emotional well-being of looked after children
Public Health Outcomes Framework	2.12	Excess Weight in Adults
Public Health Outcomes Framework	2.13i	Percentage of physically active and inactive adults - active adults
Public Health Outcomes Framework	2.13ii	Percentage of active and inactive adults - inactive adults
Public Health Outcomes Framework	2.14	Smoking Prevalence

Public Health Outcomes Framework	2.14	Smoking prevalence - routine & manual
Public Health Outcomes Framework	2.15i	Successful completion of drug treatment - opiate users
Public Health Outcomes Framework	2.15ii	Successful completion of drug treatment - non opiate users
Public Health Outcomes Framework	2.16	People entering prison with substance dependence issues who are previously not known to community treatment
Public Health Outcomes Framework	2.17	Recorded diabetes
Public Health Outcomes Framework	2.18	Alcohol related admissions to hospital
Public Health Outcomes Framework	2.19	Cancer diagnosed at early stage (Experimental Statistics)
Public Health Outcomes Framework	2.20i	Cancer screening coverage - breast cancer
Public Health Outcomes Framework	2.20ii	Cancer screening coverage - cervical cancer
Public Health Outcomes Framework	2.21vii	Access to non-cancer screening programmes - diabetic retinopathy
Public Health Outcomes Framework	2.22iii	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check
Public Health Outcomes Framework	2.22iv	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check
Public Health Outcomes Framework	2.22v	Cumulative % of the eligible population aged 40-74 who received an NHS Health check
Public Health Outcomes Framework	2.23i	Self-reported well - being
Public Health Outcomes Framework	2.23ii	Self-reported well - being
Public Health Outcomes Framework	2.23iii	Self-reported well - being
Public Health Outcomes Framework	2.23iv	Self-reported well - being
Public Health Outcomes Framework	2.24i	Injuries due to falls in people aged 65 and over (Persons)
Public Health Outcomes Framework	2.24i	Injuries due to falls in people aged 65 and over (males/females)
Public Health Outcomes Framework	2.24ii	Injuries due to falls in people aged 65 and over - aged 65 - 79

Public Health Outcomes Framework	2.24iii	Injuries due to falls in people aged 65 and over - aged 80+
Public Health Outcomes Framework	3.01	Fraction of mortality attributable to particulate air pollution
Public Health Outcomes Framework	3.02i	Chlamydia screening detection rate (15-24 year olds) - old ncmp data
Public Health Outcomes Framework	3.02ii	Chlamydia detection rate (15-24 year olds) - CTAD
Public Health Outcomes Framework	3.03i	Population vaccination coverage - Hepatitis B (1 year old)
Public Health Outcomes Framework	3.03i	Population vaccination coverage - Hepatitis B (2 years old)
Public Health Outcomes Framework	3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)
Public Health Outcomes Framework	3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)
Public Health Outcomes Framework	3.03iv	Population vaccination coverage - MenC
Public Health Outcomes Framework	3.03v	Population vaccination coverage - PCV
Public Health Outcomes Framework	3.03vi	Population vaccination coverage - Hib / MenC booster (2 years old)
Public Health Outcomes Framework	3.03vi	Population vaccination coverage - Hib / Men C booster (5 years)
Public Health Outcomes Framework	3.03vii	Population vaccination coverage - PCV booster
Public Health Outcomes Framework	3.03viii	Population vaccination coverage - MMR for one dose (2 years old)
Public Health Outcomes Framework	3.03ix	Population vaccination coverage - MMR for one dose (5 years old)
Public Health Outcomes Framework	3.03x	Population vaccination coverage - MMR for two doses (5 years old)
Public Health Outcomes Framework	3.03xii	Population vaccination coverage - HPV
Public Health Outcomes Framework	3.03xiii	Population vaccination coverage - PPV
Public Health Outcomes Framework	3.03xiv	Population vaccination coverage - Flu (aged 65+)
Public Health Outcomes Framework	3.03xv	Population vaccination coverage - Flu (at risk individuals)

Public Health Outcomes Framework	3.04	People presenting with HIV at a late stage of infection
Public Health Outcomes Framework	3.05i	Treatment completion for TB
Public Health Outcomes Framework	3.05ii	Incidence of TB
Public Health Outcomes Framework	3.06	NHS organisations with a board approved sustainable development management plan
Public Health Outcomes Framework	4.01	Infant mortality
Public Health Outcomes Framework	4.02	Tooth decay in children aged 5
Public Health Outcomes Framework	4.03	Mortality rate from causes considered preventable
Public Health Outcomes Framework	4.04i	Under 75 mortality rate from all cardiovascular diseases
Public Health Outcomes Framework	4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable
Public Health Outcomes Framework	4.05i	Under 75 mortality rate from cancer
Public Health Outcomes Framework	4.05ii	Under 75 mortality rate from cancer considered preventable
Public Health Outcomes Framework	4.06i	Under 75 mortality rate from liver disease
Public Health Outcomes Framework	4.06ii	Under 75 mortality rate from liver disease considered preventable
Public Health Outcomes Framework	4.07i	Under 75 mortality rate from respiratory disease
Public Health Outcomes Framework	4.07ii	Under 75 mortality rate from respiratory disease considered preventable
Public Health Outcomes Framework	4.08	Mortality from communicable diseases
Public Health Outcomes Framework	4.09	Excess under 75 mortality rate in adults with serious mental illness
Public Health Outcomes Framework	4.1	Suicide rate
Public Health Outcomes Framework	4.11	Emergency readmissions within 30 days of discharge from hospital
Public Health Outcomes Framework	4.12i	Preventable sight loss - age related macular degeneration (AMD)

Public Health Outcomes Framework	4.12ii	Preventable sight loss - glaucoma
Public Health Outcomes Framework	4.12iii	Preventable sight loss - diabetic eye disease
Public Health Outcomes Framework	4.12iv	Preventable sight loss - sight loss certifications
Public Health Outcomes Framework	4.13	Health related quality of life for older people
Public Health Outcomes Framework	4.14i	Hip fractures in people aged 65 and over
Public Health Outcomes Framework	4.14ii	Hip fractures in people aged 65 and over - aged 65
Public Health Outcomes Framework	4.14iii	Hip fractures in people aged 65 and over - aged 80+
Public Health Outcomes Framework	4.15i	Excess Winter Deaths Index (Single year, all ages)
Public Health Outcomes Framework	4.15ii	Excess Winter Deaths Index (single year, ages 85+)
Public Health Outcomes Framework	4.15iii	Excess Winter Deaths Index (3 years, all ages)
Public Health Outcomes Framework	4.15iv	Excess Winter Deaths Index (3 years, ages 85+)

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

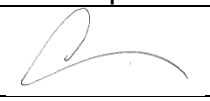
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

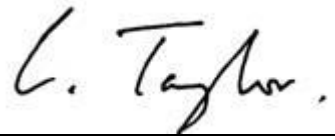
a) Summary of Plan

Local Authority	**Torbay Council**
Clinical Commissioning Groups	**South Devon and Torbay CCG**
Boundary Differences	**South Devon and Torbay CCG covers all of Torbay Local Authority and the South part of Devon County Council.**
Date agreed at Health and Well-Being Board:	**16TH September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£5.2m**
2015/16	**£12.014m**
Total agreed value of pooled budget: 2014/15	**£5.2m**
2015/16	**£12.014m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	South Devon and Torbay Clinical Commissioning Group
By	Simon Tapley
Position	Director of Commissioning
Date	17th September 2014
	

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Torbay Council
By	Caroline Taylor
Position	Director of Adult Social Care
Date	17th September 2014
	

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Torbay Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Chris Lewis
Date	17th September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Aging Well Bid	A Big Lottery funded bid to support a whole system approach to aging well , targeting those most in need and social isolation using an Asset Based Community Development approach. ***Here***
Better Care Fund Plan December 2013	The vision for how we will use the Better Care Fund and pooled health and social care budgets to deliver integrated whole system care for everyone who needs it. ***Here***
CCG Strategic Commissioning Plan 2014-2019	This sets out the ambitions and intentions for the CCG which prioritise integrated planning and delivery to address the challenges faced by health and social care. ***Here***
Dementia Plan and	Plan setting out the need for developing services and opportunities wider in the community for recognising signs and early assessment followed by

An Overview of Dementia	support and care for carers, care in hospital settings and care in residential and nursing homes. Analysis of dementia prevalence and predictive modelling provided by Public Health. ***Here***
ICO Risk Share Agreement	Overview document to facilitate the development of integrated health and social care and the improvement of services, by better aligning financial incentives and budgets. ***(At this time the full agreement remains confidential and commercially sensitive)***
Joined-Up ICT Strategy	The Strategy is a key enabler to delivering the JoinedUp vision for integrated health and care. The delivery of the ICT objectives will depend on five core features. • Interoperability • Best of breed systems • Mobile working (agile) technology • Transformed business and performance information • Contemporaneous use ***Here***
Joint Health & Wellbeing Strategy 2012/3 – 2014/15 (JHWS)	Agreed set of priorities for Torbay covering the life course with three underlying principles of 'First & Most', 'Early intervention', 'Integrated and Joined up approach'. ***Here***
Operational commissioning strategy for people with learning disabilities	This document describes the operational commissioning intentions of Torbay and Southern Devon Health and Care NHS Trust (TSDHCT), for people with Learning Disabilities living in Torbay. It continues the commitment to personalisation and choice from a diverse market place. Rather than directly provide services ourselves, we will commission services on people's behalf and co-ordinate the provision of information and support planning; either directly or through third parties. ***Here***
Living Well at Home	Our strategy for providing support for people to remain living as independently as possible in their own homes, delivered in partnership with the independent sector. ***Here***
Market Position Statement	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 integrated care services in Torbay over 7 days a week, reducing reliance on bed based care. It outlines how provision needs to change to stimulate a diverse and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help to support people manage their conditions through early help and a focus on personal outcomes and choice. ***Here***
Pioneer application	The vision for whole system integrated care in South Devon and Torbay. ***Here***

June 2013	
South Devon & Torbay Integrated and personal Care Organisation Business case	The full business case for the merging of Torbay and Southern Devon Health and Care NHs Trust (TSD) with South Devon Healthcare NHS Foundation Trust (SDH). It sets out the background for the merger and demonstrates why this proposal is the best option for TSD & SDH and for the people they serve. SDH's Trust Board and its council of governors will review this full business case (FBC) to support a final decision regarding commitment to the merger before wider publication. ***(At this time the full business case remains commercially sensitive)***
South Devon and Torbay CCG Engagement report	The report analysing the feedback from our extensive community services engagement process. ***Here***
South Devon and Torbay Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. ***Here***
The Mental Health Commissioning Strategy for Devon, Plymouth and Torbay 2014-2017	This joint strategy (currently in draft) for adults of all ages draws together the mental health commissioning intentions of five commissioning bodies: South Devon and Torbay CCG and NEW Devon CCG Plymouth City Council, Torbay Council and Devon County Council. The Strategy focuses on how we can support good mental health and seek to prevent mental ill health. ***Here***
Torbay and South Devon Integrated Prevention Strategy 2014/15-2019/20	A plan which works towards transforming the NHS from an illness to a wellness service with a focus across 3 areas: Lives People Lead (Key Behaviours); Health Services People Use (Access & Take Up); and Wider Determinants. ***Here***

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

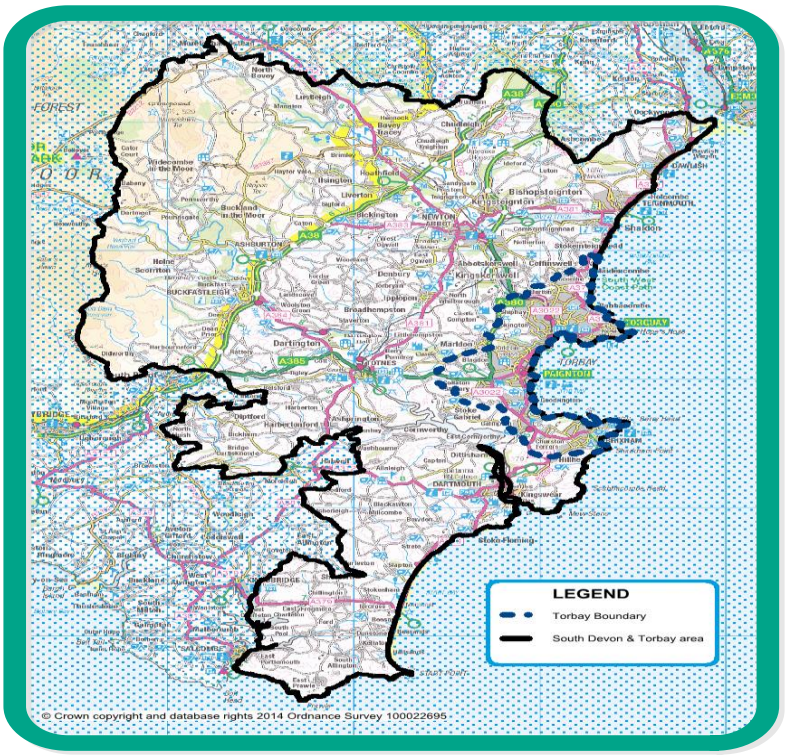
Within Torbay full integration of community health and adult social care was achieved in 2005, with the creation of Torbay Care Trust. This model has been recognised both nationally and internationally as an excellent model of care. It has realised a single assessment process, a single care record, a 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. This is the driver for a new model of excellence for 2018/19.

The bid articulated a vision for integrated care and personal support, underpinned by the creation of an Integrated Care Organisation (ICO) that further widens the current model of health and social care to include acute health care provision. This offers an opportunity for an entirely new approach.

The strategy for delivering on Pioneer and the ICO extends beyond the local authority boundary of Torbay into the whole CCG area, and thereby into South Devon within the scope of Devon County Council. The improvements set out in this submission will therefore form part of the wider system changes across a larger geographical area. The Better Care Fund sits within this longstanding programme of integration.

Map showing Torbay and South Devon:



Our Pioneer programme and ICO business case 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, Rowcroft Hospice and Torbay Community Development Trust. Strategy is agreed and progress monitored by a whole-system JoinedUp Board, working to achieve: "Excellent, joined-up care for everyone."

At the core of our vision for integrated care and personalised support 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

Programmes of work across our organisations are aligned to help us deliver these core aims, and these form the basis of this BCF plan. Our key areas of work to help deliver this vision are included at Annex 1, and include workstreams already underway for the Integrated Care Organisation and by our five Locality Commissioning Groups:

- Single Point of Contact (SPOC)
- Community care
- Frailty Services
- 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.

Statutory agencies are not to sole key to integration, and our vision for community-wide participation expresses this. To set out the opportunities and to encourage a diverse market we have developed a **market position statement** for Torbay with the first phase focusing on adult social care. 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 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.

b) What difference will this make to patient and service user outcomes?

With our local communities, we are resolved to make a major difference to the quality of life of our population, to support people to be as well and independent as they can be, and to provide care with compassion when they cannot. This is why we have integrated services.

In the Torbay of the future, Mrs Smith or her daughter will make a single call for any health or care service. Her GP will be integrated into a community hub, where she can find not just health and social care but personalised support for her mental health and general wellbeing needs, too, all organised with her single named care coordinator. Thanks to information-sharing across all parts of the system, whenever Mrs Smith receives care for one condition it automatically and electronically triggers others that are needed, for support or prevention. Acute hospital interventions are included, but it's a long time since Mrs Smith has been to hospital; hand-held diagnostics come to her in her home, her GP can monitor her vital signs remotely and the last time she did need intravenous treatment she chose to have it in her own home. Together with her family and key health worker, Mrs Smith has planned her end of life care, and has chosen hospice care in her own home. For now, volunteers from the 'neighbourhood connector' scheme have made sure handrails are fitted in her home, and they help her with her garden.

Mrs Smith's 15 year-old grandson Robert won't lose his CAMHS support at his next birthday; his named key worker will be on hand and work closely with the community-hub-based GP and adult mental health services so that he can transfer smoothly. Robert will take control of planning his care, in a way that works for him. He now benefits from peer support, so he is learning ways to manage his emotions, complementing his psychological therapy from the all-age depression and anxiety service. Carer support for his mother is automatically triggered; this means help with her housing difficulties, too. Moreover, Robert is getting support to find a vocational course that will interest him.

Extensive engagement has taken place with our local communities. We have engaged on future community services, on services for young people, on maternity care and on mental health services. The insights gained are reflected in our strategy, and already in changes to services. The key themes coming from the community engagement events held are set out below:

Community Services Engagement Report	
Accessibility of services	Opening hours, public transport and buildings that are fit for purpose. Also, access to information.
Communication & 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 & 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'

We will continue to engage with our local communities and will evaluate the outcomes of all of our services using the key metrics set out in Template 2 of our BCF submission. Each of our schemes have a set of specific Key Performance Indicators to allow us to monitor individual successes and inform future commissioning intentions, with the BCF overarching metrics allowing us to measure performance of our integration workstreams as a whole. The BCF metric workbook is produced to cover Torbay, Plymouth and Devon, allowing us to benchmark and share best practice locally as well as the broader national benchmarking.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Again, we use the example of Mrs Smith to convey the changes that will be delivered over the next five years and what care will look like from the patient perspective.

Mrs Smith has a care plan developed by her named GP. She and her daughter find it much more straightforward to get the services Mrs Smith needs, because her care coordinator arranges them for her, using the single point of access.

Although the community hub is still new, the voluntary sector is well integrated within it. Advice on home insulation grants, pension credits etc is easily accessible, and when her daughter is away Mrs Smith gets visited by the befriending service, which helps her order her groceries online.

Her daughter, as a carer, is able to take up opportunities for respite care knowing that Mrs Smith will be looked after. She needs a break from time to time, but her mental health has also benefitted from easy access to talking therapies, arranged by the care coordinator. This strengthens her resilience, allowing her to care for longer, and Mrs Smith, therefore, to remain at home.

Does Mrs Smith go out to her appointments or have them on the phone? If she goes out, the transport is arranged and provided by her local voluntary organisation, based in the hub. Is her memory affected sometimes? They will also support her with this by taking her to memory cafes. Is she heading for a dementia diagnosis? The one-stop-shop at Torbay hospital provides assessment and diagnosis on the day and when her daughter drove her there, they could book their parking space (April 2014). Then she gets really active support from the Dementia Support Worker operating in her local community.

Mrs Smith's daughter has been feeling isolated through her caring responsibilities and because her husband has died recently. She has started to get a variety of symptoms such as skin problems and stomach pain. She has put on a bit of weight. Her GP refers her to a walking for health group, supported by the Care Trust and run by trained volunteers. A befriender from the caring organisation goes with her to the first couple of walks and she then feels confident to go on her own.. The volunteer walk leader shows the group how to use the outdoor gym equipment in the park.

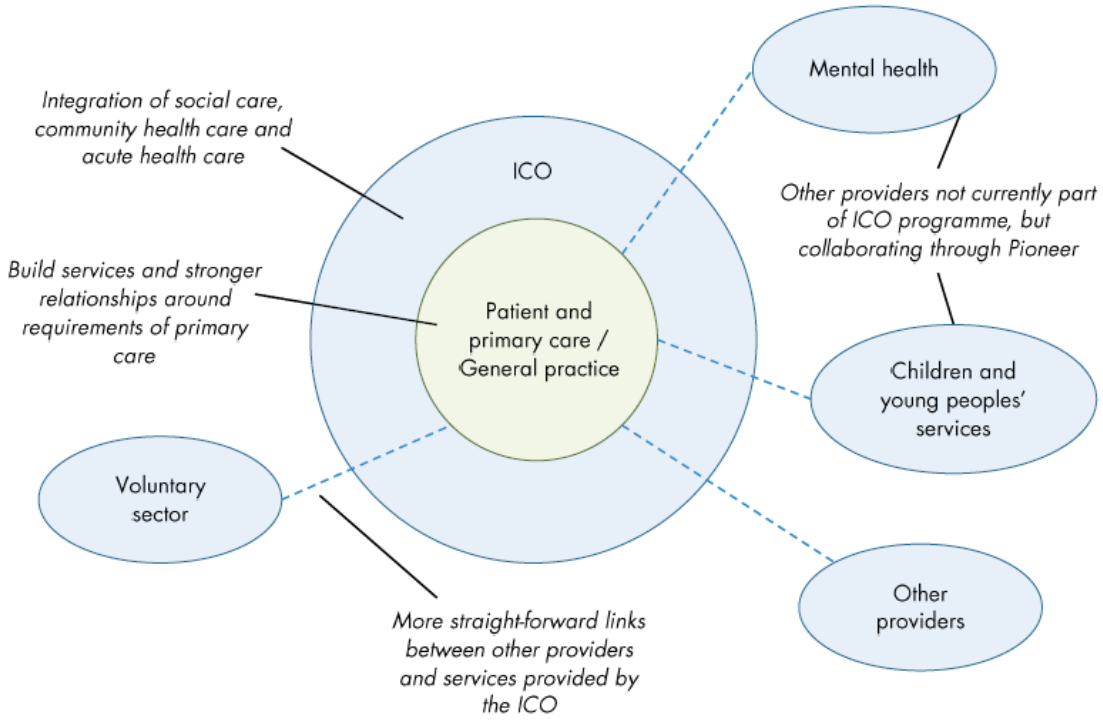
One of the walkers tells Mrs Smith's daughter about a course at the local library which helps older people learn how to use smart phones and tablets. They arrange to go together.

These ambitions are being actively pursued through our Pioneer Programme and Integrated Care Organisation. The Better Care Fund is complementary to this, with many of the service changes outlined above already being developed, irrespective of BCF. However, the BCF has brought a stronger focus and drive towards pooled resources across the system, as the best way to address the challenges and pressures that we currently face in our hospitals and health spend. This spend will have to reduce, as we shift from high-cost reactive to lower-cost preventative services, supporting greater self-management and community based care.

Our social care spend will be going further, as new joint-commissioning arrangements deliver better value and improved care at home, reducing the need for high-cost nursing and care home placements. Across the whole system, the principle is “more for less”.

The new care model moves from assuming an ever increasing dependency or constant decline, to an assumption of retaining or improving independence and self-worth. The model also recognises that there can come a time in life when intensive medical interventions are not the best course of action. The objective of the model is a move from a focus on a reactive diagnosis and treatment model to a proactive, prevention model that recognises the needs of the individual.

Figure 15: Integration of social care, community and acute health care



Each of our organisational plans include schemes to ensure we achieve these improvements, with the four key areas for the BCF outlined in Annex 1. The Better Care Funded work will help to increase independence at home. We will have delivered further extra care housing units, re-commissioned community equipment services and community care and support will be focused on meeting individual outcomes to re-able people quickly and keep them independent and well at home.

Changes are needed to bring about a self-supporting, self-reliant and resilient community that can deal with many of the challenges that would otherwise fall at the door of the statutory sector. One of the first steps is to build the ‘social capital’ needed which will be an inherent part of our integration plan, and requires an active relationship between local communities and voluntary and community sector partners.

The CCG strategic plan sets out the key outcomes and indicators for each of its high level priorities. These are all in line with the vision for integrated care and support. The plan also demonstrates the number of workstreams in place to make integration happen within the context of a flat cash environment and reducing local authority budgets. The workstreams focus on prevention, primary care, community, urgent care, mental health, long-term conditions, learning disability, planned care, medicines, joint commissioning and children’s services.

In conjunction with these ambitions and in alignment with the 'Everyone Counts: Planning for Patients 2014/14 to 2018/19' planning guidance we will be working towards achieving improvements in the following seven ambitions and three key measures:

Additional Years of Life
Quality of life for people with long term conditions
Eliminating avoidable deaths in hospital
Positive experience of care outside hospital
Avoiding hospital through integrated care
Older people living independently
Reducing health inequalities
Improving health (via prevention)
Parity of esteem for mental health with physical health

We have agreed that the additional local indicator for the Better Care Fund is '*Estimated diagnosis rate for people with dementia*.' This has been agreed following a baseline analysis of the suggested metrics and consideration then given to our own local demography, and echoes the priorities already set out in Pioneer and Integrated Care Organisation.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Building on Integration

Our vision is to have excellent, joined up care for all as set out in Section 2 and Section 4 It is worth noting that 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 our community hubs. New community hubs will be 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. The development of each of the initial community hubs has included an analysis of demographic levels of needs overlaid with service response. Combining such intelligence data with primary care level data and our ability to use evidence-based, local, combined predictive modelling means we can confidently identify risk groups who will benefit from a more integrated approach to care delivery.

The SDT CCG footprint:

Within the Torbay and South Devon area **the SDT CCG have established five localities**. These localities are formed around groups of GP practices in areas based on registered populations shown in the table below.

Locality	Population	Average age	65+ pop	Life expectancy High/Low	Average Deprivation Score
Coastal	35,200	46.6	27.3%	85.2/76.3	19.3
Moor to Sea	54,100	45.0	24.1%	86.9/76.7	16.1
Torquay	72,300	42.3	20.8%	86.9/75.8	29.2
Paignton & Brixham	72,600	45.5	26.3%	85.4/74.6	23.9
Newton Abbot	51,600	42.9	21.7%	87.1/76.1	16.2
England		39.4	16.9		21.5

Challenges

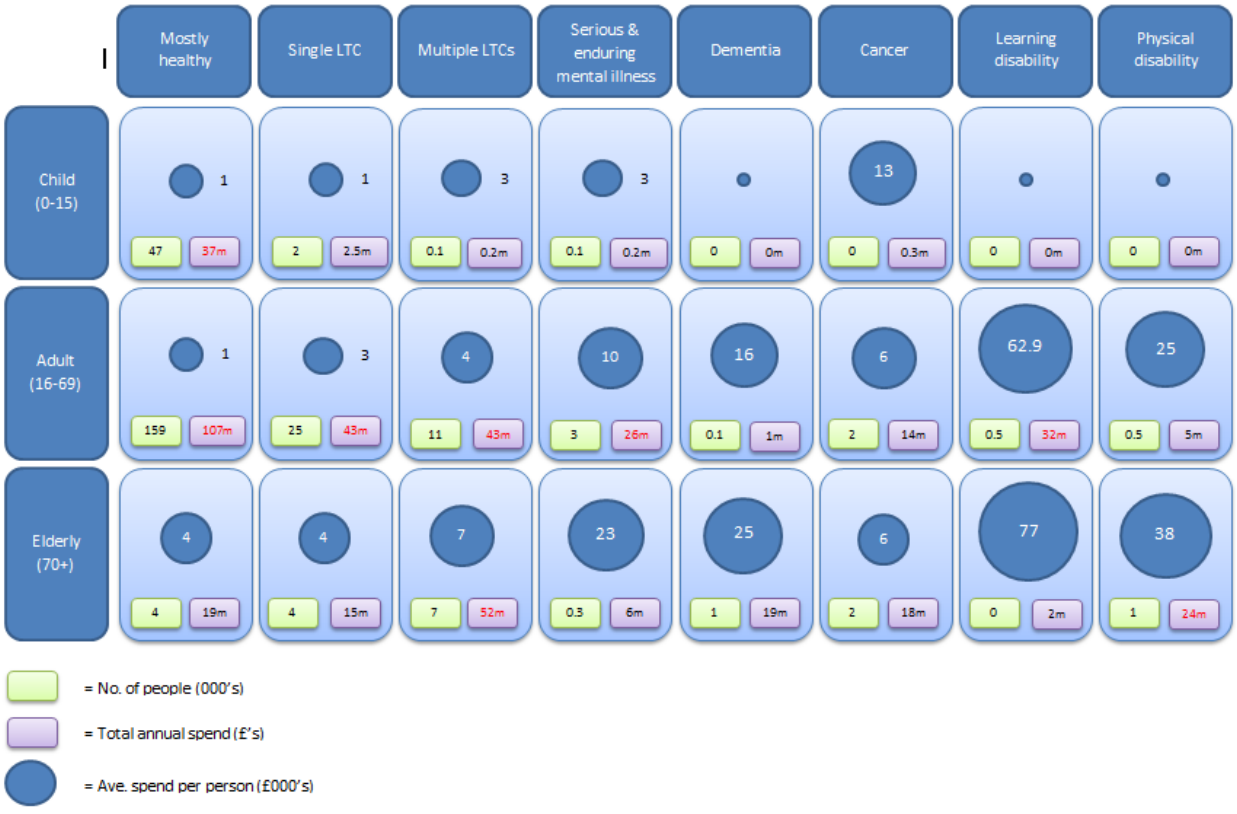
Pressures on the NHS come not only from age, but illness and especially chronic illness; The World Health Organization (WHO) estimates that more than half of the burden of disease among people over 60 is potentially avoidable through changes to lifestyle. The challenge is to prevent ill health and to promote healthy productive years of life. A significant concern for an aging population is dementia, but as much of this is linked to vascular disease, which is declining,

the potential impact might be less than expected. Anticipating the impact the baby boomer generation will have on health and social care is difficult but there is clear evidence that the expectations of Boomers' and their willingness to adopt what's new and better will speed progress in patient-managed technology, such as mobile health, telehealth and telecare.

These empowered citizens will have a significantly different view of how they wish their health and care needs to be met from that which the Public Sector currently provides. We can anticipate that they will be **computer literate** and familiar with using **social networking** sites to keep in touch with family, friends and wider social networks. They will be confident with using the Internet to access information about all aspects of their lives and care from engagement with internet based hobbies to keeping in contact with developments in the world. They will wish to **access much more advice on how to self-care**, and also support for purchasing their own packages of care using personal budgets to meet their personal health and care needs. These packages are likely to be quite complex, potentially involving family, friends and the wider community, alongside a range of public and third sector agencies, all of whom will need to place the citizen at the centre, and work in partnership to deliver the bespoke care package commissioned.

Population Segmentation - Care Spend Estimating Tool

There is significant financial challenge facing the health and care sector as we cope with increasing demand and high quality services while contending with constrained and challenging financial position the local health and social care economy. The Care Spend Estimating tool has been used to map the population groups across conditions to identify where our biggest spend is. From the diagrams below it is clear that single and multiple long term conditions and the elderly cost more per capita and therefore are the key areas of concentration and focus.



Long term conditions: (LTC)
LTC are defined by the World Health Organisation (WHO) as chronic conditions lasting more than 12 months, which require on-going healthcare. These conditions, such as heart disease, diabetes and mental health problems, may not be curable at present but can be controlled through treatment and behaviour change. People with long term conditions account for 29 % of the population, but use 50% of all GP appointments and 70% of all inpatient bed days. Long term conditions fall more heavily on the poorest in society: compared to social class I, people in social class V have 60% higher prevalence of long term conditions and 60% higher severity of conditions. Researchers predict that the prevalence of LTCs will increase by up to 50% by 2031 with massive increase in personal and healthcare cost. The numbers of people with multiple LTCs is high and rising also

With an aging population; we would expect the number of people with dementia in the population to increase. Across South Devon there are currently estimated to be around 5,000 people aged over 65 living with dementia though the diagnosis of Dementia is still incomplete. The prevalence of dementia is expected to rise for at least 10 years. The combination of multiple LTCs and dementia has enormous impact on independence of individuals, service need and cost.

A life course approach to understanding the needs of the population now and in the future would aim to reduce this cost to the public purse by influencing the risks associated with the burden of disease. The ICO is central to this aspiration as it provides the opportunities to identify those at risk of deterioration early at first admission so that supportive care can be provided promptly by teams working across health and social care. To reemphasis our ambition for Mrs Smith's daughter Sue, the ICO will:

- Enrol her on the Community Co-ordinator locality register.
- Sue will be linked up with a Community Volunteer and Family Support worker.
- She will be on the locality carer register so she can access the 'help at home service'.
- She will have the Life Clinic App so she can access information and support straight away.
- Ensure she has access to volunteer support to help with her mum.
- Ensure she has her 6 month wellbeing check and medicines review.
- She will enrol with the local life clinic to learn about supported self-help.
- She will be aware of new services especially for women and the support available.
- We will reduce her dependence on her GP by providing viable alternatives.

Dying Well:
At 94, Mrs Smith knows she is nearing the end of her life but she is close to her family and they are looking after her. She feels OK most of the time but does need more help with everything than she used to.

Across England, the over 85 population is currently around 2.3% and expected to increase to around 2.9% in 2021. In South Devon, the over 85 population is expected to increase from 3.9% in 2012 to 4.8% in 2021. The highest proportion of over 85's live in the seaside communities of Dawlish, Teignmouth (South Devon) and Paignton (Torbay).

It is estimated that approximately 11% of over 65 year olds are frail, defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength. About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

There is a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.
Commissioners and providers are facing the challenge of meeting the complex needs an ageing population now. As we age, our complex health needs increase and we require increased levels

of help and support. At present, our over 85 year old population cost around 10 times that of our population aged 5 to 9 or 10 to 14 for all hospital admissions. On our current trajectory, and assuming today's prices, we may expect the over 85 population to cost the hospital over £1m more in 2020 compared to today. Up from around £7.3m in 2012 to £8.5m in 2020. Estimates suggest that the cost for non-elective care (not adjusting for inflation or other factors) for the over 85's will rise from around £14.5m to £18.5m in 2021 through demographic change alone.

It is clear that meeting the increasingly complex needs of our local population will require a new approach to health and social care. This is especially true for those at the end of life. An estimated 25,000 persons aged 65 and over live alone in Torbay and South Devon; this is around 37% of this age group. This is expected to increase to around 30,000 by 2020. There are approximately 153 nursing, residential and care homes in South Devon. In 2012/13 there were 2743 admissions from local homes via the Emergency Department. Of these 214 died and 92 died within 48 hours. This suggests that work should be undertaken to fully understand the reasons for admission and whether we can improve end of life care so that people are able to die in their preferred place. For Mrs Smith the ICO will:

- Enrol her on the Community Co-ordinator locality register.
- Mrs Smith will be linked up with a Community Volunteer and Family Support worker.
- She will have been offered guided conversations about advance care planning and her wishes for her end of life care will be recorded on her shared care record.
- She will have a tele-health device so she can retain her independence whilst still monitoring her health.
- She will see her volunteer twice a week and has a 'night sitter' sometimes.
- She has a hot meal delivered daily so her daughter doesn't have to cook all the time.

Model of Care

We wish to promote well-being and independence which will see all our providers move away from an institutional bed based model of care to a delivery system that is flexible and responsive to the changing needs of our populations. We have been told, through our locality engagement events, that people want care closer to home with a single-point of access. This is also in line with the evidence we have already collected from three consecutive annual acuity audits and ongoing monthly audits that all clearly state that with additional personal care services 30 - 40% of patients cared for in a community hospital bed could be at home.

An Integrated Care Organisation bringing together providers of community, social care and acute services provides a sound basis from which we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we expect to see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

We are working with the Acute Trust on detailed infrastructure (hospital estate and IT but also the location of services) and workforce plans. A Joined up workforce and integrated IT, which enables multiple professionals to share patient records and treatment plans, are vital in achieving a better quality of service for our patients in the most cost effective way. We are also working with providers of mental health services in our CCG to ensure that mental health professionals, as well as other agencies, are an integral part of our community based teams, which will be co-ordinated through our Community Hubs.

Working with the Care Market

We are also working with independent and voluntary sector providers to stimulate a vibrant and diverse market for services in Torbay. The Aging Better bid and programme led by the Community Development Trust in Torbay will provide a valuable injection of resource and capacity in tackling elderly isolation and engage older people more actively in their communities

In order to enable people to continue to live well and independently in their own homes, we need to ensure our domiciliary care provision can meet that need. In response to this challenges and the increase in demand for services with reducing public sector resources, we will need to deliver an innovative system of care.

We will identify two Prime Contractors,who will co-ordinate, manage and deliver care and support in Torbay. This will cover services such as domiciliary care (personal and non-personal care) as well as other areas of care and support to people in their own homes. It is a significant development in the continued integration of the Torbay system, with the new service starting early in 2015. (full details are attached)

Risk stratification

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 then 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 for 2014/15, working towards the top 2% of our population then being proactively case-managed.

Across South Devon & Torbay CCG the top 2% of patients account for 33.67% of the total emergency admissions and 37.7% of the total cost of emergency admissions. These patients are over 23 times more likely to have had an emergency admission over the last 2 years.

Table: Emergency admissions over last 2 years for both SD&T CCG

Patient group	Total emergency admissions	Patients	Emergency admissions person	% of total admissions
Top 2%	13,579	4,988	2.72	33.67%
Others	26,756	244,238	0.11	66.33%
Total	40,335	249,226	0.16	100.0%

The table above shows that the top 2% of patients had 13,579 total emergency admissions over the last 2 years with an average of 2.72 admissions per patient in South Devon & Torbay CCG. It has been estimated that a 3.5% reduction in non-elective admissions across the Torbay BCF would be a reduction of 570 admissions per year. An 8% reduction in emergency admissions across the top 2% of patients would deliver the target reduction in non-elective activity. A significant proportion of the schemes in the Better Care Fund are targeted at these top 2% of patients. Thus the top 2% of patients as identified via the Devon predictive model represent the biggest opportunity to reduce the level of non-elective activity.

South Devon and Torbay CCG had a standardised admission rate (SAR) of 96.2 in 2013, compared to an average of 94.2 across the South Of England. A 3.5% reduction in non-elective admissions would see us move into the top quartile, and this is our ambition.

Table: Cost of emergency admissions over last 2 years for SD&T CCG

Patient group	Total cost of emergency admissions	Patients	cost /person	% of total cost
Top 2%	£25,790,860	4,988	£5,171	37.7%
Others	£42,604,947	244,238	£174	62.3%
Total	£68,395,807	249,226	£274	100.0%

The total spend across South Devon & Torbay CCGs was £25.7m over the last 2 years on emergency admissions for the top 2% of patients. This corresponds to an average cost per patient of £5,171 over this period for emergency admissions and £8,128 for all PBR related activity.

BCF Schemes

Programmes of work across our organisations are aligned to help us achieve these outcomes, and form the basis of this BCF plan. Our key areas of work are included at Annex 1, and include workstreams already underway for the Integrated Care Organisation and by our five Locality Commissioning Groups. They will also help us meet the challenge of the prescribed metrics set out in the BCF as set out in detail in 4d and Annex 1.

Scheme 1: Single Point of Contact (SPOC) will :

- Increase in citizens sourcing their own health and care solutions (target minimum 10%)
- Reduction in numbers of citizens requiring assessment (target 10%)
- Reductions in non-elective hospital admissions (target initially 15% reduction in inappropriate admissions (net 5%))
- More appropriate treatment/management of patients
- Better utilisation of non-hospital resources
- Promoting self-care
- Increased involvement and utilisation of the Voluntary Sector
- The extension of the SPOC service to provide in-home monitoring is also expected to substantially reduce 30-day, post-acute readmission as well as provide an early warning system for at-risk patients that will enable early intervention prior to a crisis occurring.

Scheme 2: Frailty Services will achieve a :

- Reduction in community bed based care and bed days.
- Reduction in frail elderly admissions from Care Homes
- Increased use of Crisis Response Team / domiciliary care / social care / Intensive Home Support Services.
- Increase 0/1 LOS, decrease 2< LOS day (acute wards).
- Reduction in total no of admissions to acute wards.
- Reduction in numbers of patients admitted to acute from intermediate care beds (with the exception of patients from intermediate care coming in to frailty unit for diagnostics.)
- Increase in no of patients having a CGA and resulting in a managed MDT care plan.
- Fewer patients feeling a loss in independence in acute trust by giving them the autonomy to reable in their own home quickly.
- Increase in patient satisfaction
- Reduction in hospital admissions for patients diagnosed with dementia
- Reduction in predictable end of life deaths in acute setting

Scheme 3: Multiple Long Term Conditions will

- Reduce hospital admissions before and after commencement of the service
- Changes in volume of activity within the multi-LTC service and the specialty LTC services
- Reduction in outpatient appointments for patients
- Reduction in unnecessary hospital admissions as LTC is managed more proactively
- Improved palliative care and less patients dying in an acute trust through the single holistic care plan.

Scheme 4: Community Care (Locality Teams & Community Hospital beds) will deliver:

- Defined register of 3000 patients across Torbay
- Admission times - we would expect to see more earlier in the day and fewer resulting in overnight stays

- Reduction in admissions for the 3000 case managed patients
- A reduction in prescribing and medication costs
- Fewer emergency hospital admissions from care homes
- An increase in the number of high-risk patients who have a care plan
- Fewer 999 calls from care homes
- Improved experience of patients and carers as a result of proactive case management and link to a case manager
- Reduction in placements into long term care
- Increase in the number of patients offered rehabilitation following discharge from hospital
- Reduction in the number of readmissions to hospital within 91 days
- An increase in the number of people with a dementia diagnosis

Without the BCF there is a fundamental risk to a the changes in the model of care not being fully implemented. This would mean that all of the above 4 schemes would be effected in terms of slow growth and realisation of the benefits and in some cases services not going ahead ie. Single point of contact; frailty services; discontinuation of crisis response team etc.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The key inter dependency of the successful implementation of the Better Care Fund plan is on the Integrated Care Organisation and contractual arrangements agreed between partners being approved as well as being progressed at a pace to deliver on outcomes.

Whilst the BCF plan has focused in detail on four schemes there are also a number of other population groups such as carers and children as well as preventative public health interventions and mental health which have detailed programmes of work associated with them and will no doubt play a significant part in the whole system change across the health and care sector.

	DEADLINE	**LEAD**
IMPLEMENTATION OF ICO		
ICO Final Business Case to Organisational Boards	September 2014	SDHFT
ICO Final Business Case Monitor Process initiated	October 2014	SDHFT
Contract Heads of Terms Agreed	February 2014	SDHFT + CCG+ LA
ICO Created	April 2015	
IMPLEMENTATION OF SCHEMES		
Service Development Plans completion	August 2014	JCCG + Operational Leads
Refine segmentation of population further and benefits realisation to effectively target schemes	October 2014	SDHFT + TSDHCT + CCG
Single Point of contact		
Design SPoC Service Model, Scope, Structures And Phasing	September – 31st October 2014	TSDCHT
Workforce Design and Planning/Skill Mixing	September – 30th June 2015	
Full Business Case	September – 31st December 2014	
Standardisation of Workflow and Business Processes	June 2015	
Achieve and Maintain Standardised Practice	Ongoing	
Voluntary Sector Alignment And Investment	March 2015	
Development of Public Information and Online Screening Tool	March 2015	
Communications Strategy	Ongoing	
Staff Engagement	Ongoing	
Service User Engagement	Ongoing	
Stakeholder Engagement	Ongoing	

Live Directory of Services – for Clinicians	June 2015	
ICT Strategy and Infrastructure	June 2015	
Logistics	June 2015	
Formal Consultation with Workforce and Staff Reorganisation	June 2015	
Frailty services		
Service design Scope service models for the following: 1) acute frailty pathway 2) ACU, SSFU, ED MDT. 3) Discharge to Assess. 4) CFU	0-4 months pre-integration	ICO workstream 3 team
Set up Acute Frailty Pathway Development services specifications for: ACU / SSFU / ED MDT / CFU / Discharge to Assess Identify frailty screening tool Implement Comprehensive Geriatric Assessment	4-7 months pre-integration	ICO workstream 3 team
Set up Community Frailty Unit Pilot interface geriatrics with named consultant Establish appropriate diagnostics suite Establish multi-disciplinary ethos	4-7 months pre-integration	ICO workstream 3 team
Review resource within Intermediate Care Identify current service provision Carry out gap analysis and establish resource requirements. Mobilise planned pilot	4-7 months pre-integration	ICO workstream 3 team
Multiple Long Term Conditions		
Design of service complete	December 2014	Dr RG Dyer
Recruitment of staff completed	April 2015	Dr RG Dyer and management lead
Training of staff completed	September 2015	
Commencement of service	September 2015	
Community Care (Locality Teams & Community Hospital beds)		TSDHCT
Review of current MDT structures	Map current structures, services and staff	September 2014
	Create new model of 'proportionate response' for health and social care	September 2014
	Determine staffing requirements for new model	31st December

	Process map current system and develop 'to be' processes	October 2014
	Analyse workloads and workflow within social care and health teams	November 2014
Creation of new structures	Re design current workforce	31st January 2015
	Staff consultation	January 2015 - March 2015
	Implementation	Summer 2015
Agreement on structure of Locality Multi-Agency Teams (LMATs) and locality MDTs	Engagement with key stakeholders associated with LMAT (the voluntary sector, mental health, GPs and acute clinicians); internal review of the composition, structure and organisation of existing MDTs.	31st January 2015
	Fitness for purpose Estate review	31st March 2015
	Redesign of locality structure to support LMAT and redesigned MDTs	31st December 2014
	Redesign, standardise and integration of reablement and crisis services across the footprint	31st January 2015
	Gap assessment of community workforce for Discharge to assess to include Community Hospitals and Derriford	31st January 2015
	Gap analysis of resource, equipment transport for the home, including telehealth/care	31st March 2015

	Workforce development and training requirements identified	28th February	
WIDER COMMISSIONING			
Aging Well Programme commence	October 2014	Community Development Trust	
Living Well @ Home Contract agreed	January 2015	T&SDHCT	
PROJECT MANAGEMENT OF BCF			
Integrate BCF project within ICO and Pioneer Project Programme	September 2014	Pioneer Programme Mgr	
MONITORING AND MANAGING BCF PROGRAMME			
Test and review the mechanisms in place for monitoring and reporting to the Joint Commissioning Group; ICO Board and Pioneer (JoinedUp) Board.	October 2014	JCCG	
Review and update the performance report templates to ensure fit for purpose and ability to respond and escalate action as needed.	October 2014	JCCG	

b) Please articulate the overarching governance arrangements for integrated care locally

Governance Structures

Governance structures for integration have a firm grounding in the existing health and social care pooled arrangements. (A copy of the risk share agreement has been provided as part of supporting documentation).

There are already existing structures such as the ICO programme Board and JoinedUp Health and Care Cabinet (Pioneer Board) which has provided a forum 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 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 will fit in to the strategic and operational monitoring framework established for Pioneer and ICO to ensure escalation is timely and ability to respond is assured across the relevant organisation or area of work.

Project Tracking

Each of the key work streams report on progress against a shared agreed performance metric reporting system through to the Pioneer Board which in turn is also managed through the Joint Commissioning Group made up of Director of Adult Social Care; Director of Children Services; Director of Public Health; CCG Director of Commissioning and supporting senior members of

staff. This group which has helped to develop a shared set of commissioning strategies and a joint work plan to deliver intent for further service developments and improvements across the health and social care system including mental health and children services.

Performance Reporting

Performance reports have already been developed so that metrics can be monitored on a regular basis. This reporting is continually being refined so that it can be used as a key source of assurance for progress against the BCF plan and brings together not only the BCF metrics but the three outcome frameworks (Adult Social Care, NHS and Public Health).
Example of Torbay Dashboard below:

This summary sheet brings together performance 'outliers' across the three outcome frameworks for Adult Social Care, the NHS and Public Health. Local performance summaries are attached to this overview

JOINT OUTCOME FRAMEWORK SUMMARY

	Indicator	Time period	Torbay Value	National Value	Unit of Measure	Trend Chart	Trend Guide
PHOF	0.2iv - Gap in Life Expectancy (Female)	2010-12	-0.6	0.0	Years		Lower is Better
	1.01i - Children in poverty U16	2007-11	23.8	20.6	%		Lower is Better
	1.01ii - Children in poverty U20	2007-11	23.0	20.1	%		Lower is Better
	1.03 - Pupil absence	2010-13	5.8	5.3	%		Lower is Better
	1.11 - Domestic Violence	2011/12	19.4	18.8	Per 1000		Lower is Better
	1.12i - Violent Crime admissions (including sexual violence)	2010-13	69.6	57.6	Per 100,000		Lower is Better
	1.13ii - Re-offending	2010-11	0.8	0.8	Avg per offender		Lower is Better
	2.02i - Breastfeeding Initiation	2010-13	71.1	73.9	%		Higher is Better
	2.02ii - Breastfeeding Prevalence 6-8 weeks after birth	2010-13	36.0	47.2	%		Higher is Better
	2.03 - Smoking at Delivery	2010-13	17.5	12.7	%		Lower is Better
	2.04 - Under 18 Conception	2010-12	39.5	27.7	Per 1000		Lower is Better
	2.06i - Excess Weight Child 4-5 years	2010-13	28.0	22.2	%		Lower is Better
	2.06ii - Excess Weight Child 10-11 years	2010-13	38.5	33.3	%		Lower is Better
	2.13ii - Physical activity	2012-13	34.3	28.9	%		Lower is Better
	2.17 Recorded Diabetes	2010-13	6.4*	6.0*	%		Lower is Better
	2.18 Alcohol admissions	2009-13	817.8	636.9	Yearly admissions		Lower is Better
	2.23i - Self-reported wellbeing (low satisfaction)	2012-13	7.6	5.8	%		Lower is Better
	3.02ii - Chlamydia Diagnoses (15-24) - CTAD Males	2012-13	1859.0	1387.0	Per 100,000		Higher is Better*
	3.03xii - Population Vaccination HPV	2010-13	83.5*	86.1	%		Higher is Better
	3.03xiii - Population Vaccination PPV	2010-13	64.1*	69.1	%		Higher is Better
	3.03xiv - Population Vaccination Flu (65+)	2010-13	69.7*	73.4	%		Higher is Better
	3.03xv - Population Vaccination Flu (At risk individuals)	2010-13	47.8*	51.3	%		Higher is Better
	4.06ii - Liver Disease Mortality (preventable) female	2008-12	21.5	15.8	Per 100,000		Lower is Better
	4.06ii - Liver Disease Mortality (Male)	2008-12	29.6	21.1	Per 100,000		Lower is Better
	4.06i - Liver Disease Mortality	2008-12	23.1	18.0	Per 100,000		Lower is Better
ASCOF	1C(2) - People receiving direct payments	2013	15.7	19.1	%	Not available	Higher is Better
	1E - Adults with learning disabilities in employment	2013	4.1	6.8	%	Not available	Higher is Better
	1F - Adults in contact with mental health services who are in paid employment	2013	3.1	7.1	%	Not available	Higher is Better
	1G - Adults with learning disabilities in stable accommodation	2013	68.4	74.8	%	Not available	Higher is Better
	2A(1) - Permanent admissions to care homes: people aged 18 to 64	2013	36.3	14.4	Per 100,000	Not available	Lower is Better
	2B(2) - Older people receiving reablement services after leaving hospital	2013	2.9	3.3	%	Not available	Higher is Better
	3D(1) - Service users who find it easy to get information	2013	71.8	74.7	%	Not available	Higher is Better
	4A - People who use services and feel safe	2013	62.3	66.0	%	Not available	Higher is Better
	4B - People who say the services they use make them feel safe and secure	2013	66.5	79.2	%	Not available	Higher is Better
ASCOF (Additional indicators)	LI-222 No. of overdue reviews (KPI not in ASA)	2012-13	464.0	N/A	Count	Not available	Lower is Better
	LI-201 Number of people supported through telehealth or telecare	2012-13	881.0	N/A	Count	Not available	Higher is Better
	LI-102 Emergency bed days for over 75s with 2+ admissions to acute hospital	2012-13	14834.0	N/A	Count	Not available	Higher is Better
	LI-240 Carers receiving needs assessment, review, information, advice, etc	2012-13	28.0	N/A	%	Not available	Higher is Better
	LI-800 Percentage of Torbay Care Trust indicators performing on or above target (as per ASA rating)	2012-13	81.0	N/A	%	Not available	Higher is Better

	Indicator	Time period	South Devon & Torbay	National Value	Unit of Measure	Trend Chart	Trend Guide
CCGOF	1.6 - Under 75 Mortality repiratory disease: directly age standardised rate (DSR)^	2012 (calendar)	30.2	27.4	Per 100,000		Lower is Better
	1.8 - Emergency Admissions for alcohol related liver disease: DSR^	2013 (calendar)	26.4	24.1	Per 100,000		Lower is Better
	1.9 - Under 75 mortality from cancer: DSR [CCG tool]	2012 (calendar)	122.1	123.8	Per 100,000		Lower is Better
	2.7 (NHS 2.3ii) - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s: DSR^	2013 (calendar)	301.2	309.0	Per 100,000		Lower is Better
	3.1 (3a of NHS) - Emergency admissions for acute conditions that should not usually require hospital admissions (adults)^	2013 (calendar)	1092.9	1174.2	Per 100,000		Lower is Better
	3.4 - Emergency admissions for children with Lower Respiratory tract infections (Indirectly age standardised rate) [local]	2013-14	322.6	366.5	Per 100,000		Lower is Better
	5.4 (NHS 5.2ii) - Incidence of healthcare - associated infection - C.Difficile (rate) [CCG tool and HSCIC]	2013-14	29.9	23.8	Per 100,000		Lower is Better

	Indicator	Time period	South Devon & Torbay	Target for Period	Benchmark	Unit of Measure	Trend Guide
tional indicators)	People who have had a stroke who spend 90% of their time on a stroke ward (SDHFT)	April 14 - May 14	68.5	80.0	83.8	%	Higher is Better
	Patient-Reported Outcome Measures (PROMS) for Groin Hernia: adjusted average reported health gain	April 13 - Dec 13	0.1	0.1	0.1	Score	Higher is Better
	Friends & Family Test response rate for A&E (SDHFT)	April 14 - May 14	3.5	15.0	18.5	%	Higher is Better
	Friends & Family Test Score for A&E (SDHFT)	April 14 - May 14	44.0	54.0	54.0	Score	Higher is Better
	Madatory L1 Training - Child Protection - SDHFT	April 13 - Dec 13	63.8	89.0	Not available	%	Higher is Better
	Number of CAS Alerts not closed within the deadline	April 14	6.0	0.0	Not available	Count	Higher is Better
	Number of over 52 week waiters (referral to treatment waiting times for non-urgent consultant-led treatment)	April 14 - May 14	1.0	0.0	Not available	Count	Higher is Better
	Patients waiting longer than six weeks from referral for a diagnostic test	April 14	1.9	1.0	1.2	%	Lower is Better
	Maximum 62 days wait for first definitive treatment following a consultant's decision to upgrade (SDHFT)	April 14	66.7	85.0	93.0	%	Higher is Better
	All patients who have operations cancelled on or after the day of admission (SDHFT)	April 14 - May 14	1.4	0.8	0.6	%	Lower is Better
	No urgent operation to be cancelled for a 2nd time (SDHFT)	April 14 - May 14	4.0	0.0	Not available	%	Lower is Better
	Cancelled patients not treated within 28 days of cancellation - month in arrears (SDHFT)	April 14 - May 14	4.0	0.0	Not available	%	Lower is Better

Key Messages

High levels of poor health related behaviours across the lifecourse and especially in children. In particular:

Maternal and early years health:

High levels of smoking in pregnancy
Low levels of breastfeeding

School age children:

Higher levels of obesity
Higher levels of pupil absence

Adults:

Low levels of physical activity
Low levels of reported wellbeing
High levels of alcohol misuse
High degree of risk taking behaviour in young adults leading to sexually transmitted infection and teenage conception

Determinants driving poor health:

High levels of Poverty
High levels of child Poverty
High levels of fuel Poverty

High levels of Violence
Increasing domestic violence but decreasing violent crime admissions

Changes to Indicators:

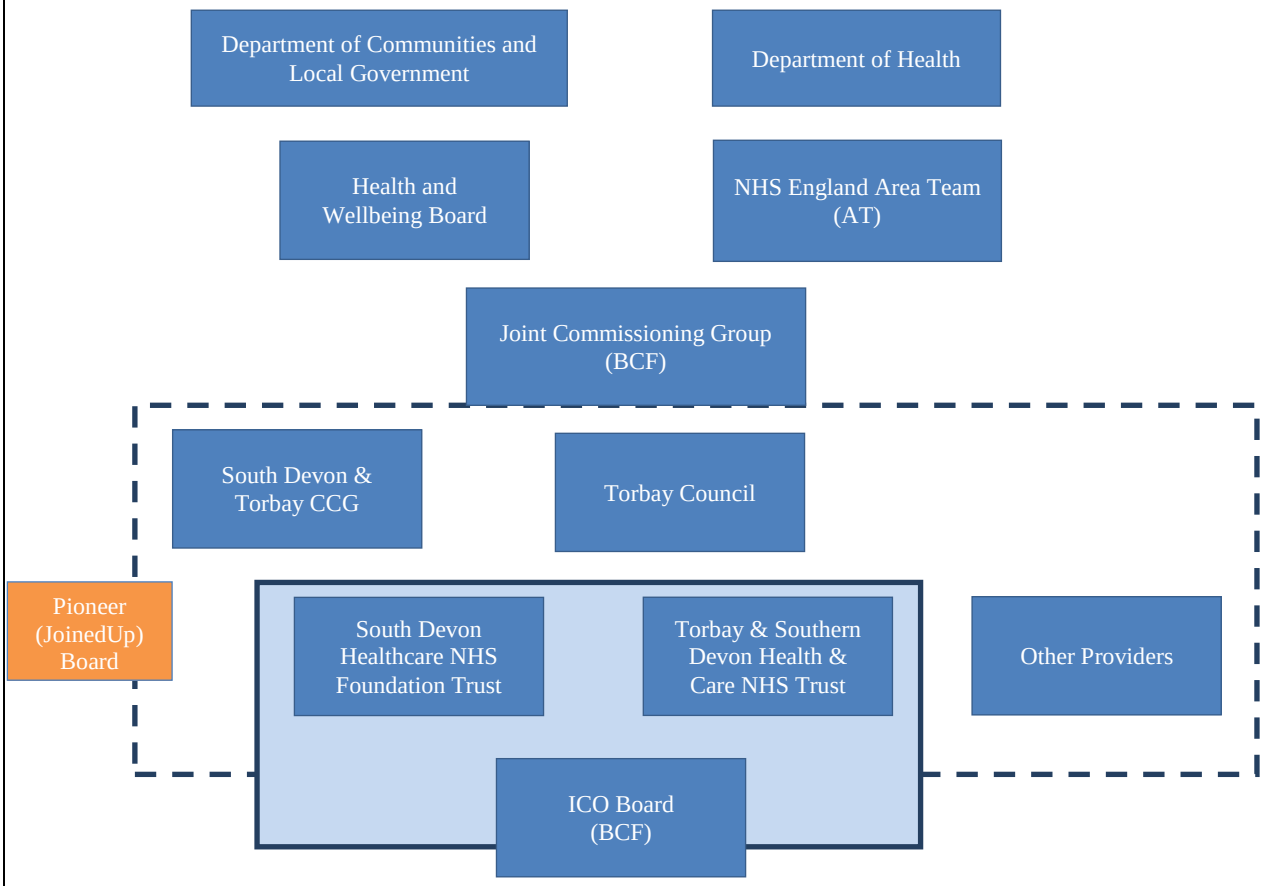
1.04 Youth Justice Entrants and 1.17 Fuel Poverty were significantly worse for Torbay previously. Figures are now better and as a result these indicators have been removed from this summary.

Trend Data Information

Quality Framework & Assurance

Quality outcome measures are key to the evaluation and monitoring process for the Pioneer programme and ICO. Through the contract monitoring process we can monitor providers and seek assurance in delivering the recommendations from the Francis report as well as involve patient and staff experience which will also inform the further development of projects in taking forward the integration work across adults and children and improve patient outcomes.

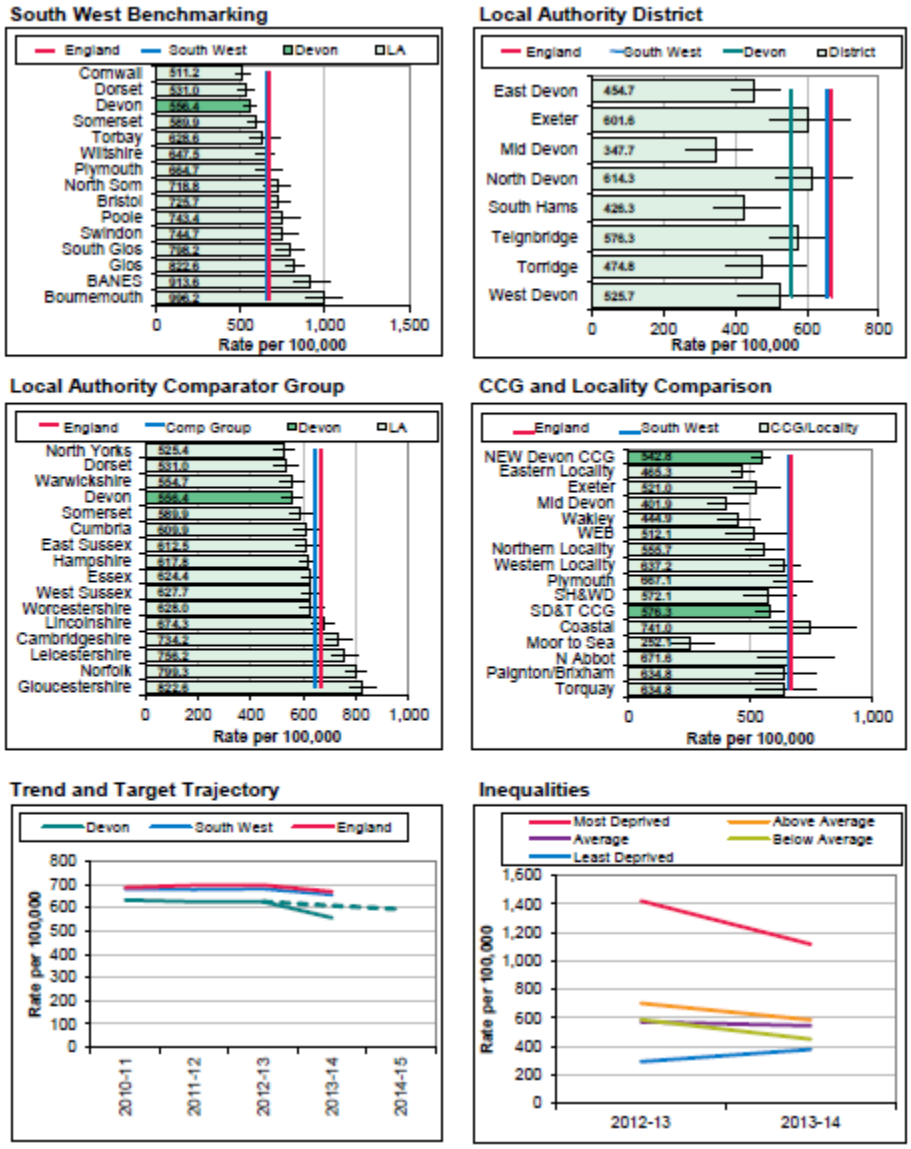
Governance arrangements have been strengthened ensuring the ICO and Pioneer remain the focus of integration with a reporting line to the Health and Wellbeing board.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Within the partners to the BCF both providers and commissioners have an identified lead staff member for the BCF in terms of both completion for submission as well as ongoing operational delivery. The governance and monitoring mechanism is established to ensure there is both strategic and operational management oversight of performance and ability to flag early warning of delays or risks so that remedial and appropriate action is sanctioned. This is established through the monthly Joint Commissioning Group and the development of the integrated outcomes framework which tracks performance against the trajectories of the agreed service streams as well as comparison with localities wider than Torbay.

Example below: Permanent Admissions to Care Homes (over 65s).



The BCF projects are those already identified within the Pioneer Programme and Integrated Care Organisation Business Plan and therefore have a reporting mechanism both operationally and strategically at Director and Executive level ensuring there is a mechanisms in place for escalation and sanctioning of action at the different organisational levels .

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref No.	Scheme
1	Single Point of Contact (SPOC)
2	Frailty Services
3	Multiple Long Term Conditions
4	Community Care (Locality Teams & Community Hospitals)

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

BCF RISK LOG - TORBAY

RISK ID	NAME	RISK DESCRIPTION	LIKELIHOOD	IMPACT	RISK SCORE	BCF CONDITIONS	BCF INDICATORS	OWNER	MITIGATING ACTIONS
BCF001		ICO - Heads of Terms agreement delayed and ICO not created on time due to delays and Monitor set backs	3	5	15	Impact on acute sector;	Delayed Transfers of care; avoidable emergency admissions ; reablement; Admissions to Res/Nursing.	John Lowes + Mandy Seymour	Joint working across providers and commissioners in development of full Business Case and full support.
BCF002		Shifting of resources to fund new joint interventions and schemes destabilise current service providers, particularly in the acute and community sector.	2	4	8	Impact on acute sector	Delayed tranfers of care; avoidable emergency admissions; reablement; Admissions to Res/Nursing; Service user experience	Paul Cooper + Richard Clack	Financial planning has been undertaken jointly across the organisations to understand the level of resource within the health and care sector. Our plans have been developed in partnership with our providers as part of our integration programme, allowing for a holistic view of impact across the provider landscape. We will continue to actively engage and involve providers in all key strategic decisions during this process to manage change effectively including finance colleagues in determining the levels of risk and balance.
BCF003		Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	3	4	12	Sign off by HWB, Protecting social care services; 7 day services; Data Sharing; Joint Assessment; Impact on acute sector; dementia diagnosis;	Delayed tranfers of care; avoidable emergency admissions; reablement; Admissions to Res/Nursing; Service user experience	Simon Tapley + Cathy Williams + Paul Cooper	Contingency planning is undertaken as part of the business plan and implementation phase. There are weekly meetings to escalate concern and pressure to the system among senior managers providers and commissioners.
BCF004		Over reliance on small number of staff already leading on system change projects to deliver BCF bureaucratic process and submission returns as well as risk to duplication of effort.	3	3	9	Sign of by HWB.	Delayed tranfers of care; avoidable emergency admissions; reablement; Admissions to Res/Nursing; Service user experience	Liz Davenport + Simon Tapley + Cathy Williams + Paul Cooper	Join up between BCF; Pioneer and ICO with key people identified as project/area leads.
BCF005		Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	3	5	15			Liz Davenport + Simon Tapley + Cathy Williams	We have modelled our assumptions using a range of available data, including that based on previous performance and national guidance. We will continue to test and refine these assumptions as part of our on going review and evaluation process. In reality this has been judged as a medium to high risk as there is potential for delays in implementation however we have plans in place to deal with this and is managed through the Joint Commissioning Group.
BCF006		The introduction of the Care Bill will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently	5	5	25	Protecting social care	Admissions to Res/Nursing; Service user experience	Caroline Taylor	We will remain well-informed of policy and legislative developments and will continue to refine our assumptions around this as part of our planning process and as more of our plans begin to deliver. We believe there will be potential benefits that come out of this process, as well as potential risks.
BCF007		Care Bill impact on Carers support services in not being able to meet the predicted demand which may effect patient level outcomes.	3	4	12	Protecting social care	User experience	Caroline Taylor + Simon Tapley	Measure Up Carers Strategy is being refreshed taking account of care bill implications as well as current service user and stakeholder views.
BCF008		Progress of implementation and ability to effect change is hampered by inability to reach agreement between organisations due to Geographical boundaries of local authorities and CCG	2	3	6	Sign off by HWB, Protecting social care services;		Simon Tapley + Paul O'Sullivan	Joint commissioning forums in place between senior and director level managers. Early and continuing discussion of BCF, ICO and Pioneer is on agendas with key members of staff engaged. Escalation reporting mechanisms at each level to ensure swift resolution where necessary.
BCF009		There is a risk that the foucs on developing the ICO detracts from the implementation of 7 day services	2	5	10	7 day services	Delayed Transfers of care; avoidable emergency admissions ; Admissions to Res/Nursing; Patient and services user experience	Simon Tapley + Paul Cooper	ICO Board and SRG will proivde the governance steer to maintain focus on progressing BCF.
BCF010		Progress in keeping on target for achieving metric measures.:	2	4	8	Delayed Transfer of Care from hospital		Caroline Taylor + Cathy Williams	Monitoring of the metrics will be reported to the Joint commissioning Group as part of the wider joint outcomes performance report. Services in place to contribute to achieving the expected performance includes:
			3	4	12	Emergency Admissions		Simon Tapley + Paul Cooper + Cathy Williams	robust plans in place such as Crisis Response; Reablement; Care Coordination will ensure that emergency admissions is not only held at current levels but over the agreed trajectory achieve the required reduction.
			3	4	12	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes		Caroline Taylor	Work streams in place with Complex Care Team with Brokerage; Reablement; Crisis response will continue to address this risk
			3	4	12	Proportion of older people (65 and over) who were still at home 91 days afteer discharge from hopsital into reablement/ rehabilitiation services		Caroline Taylor + Cathy Williams	Several of the work streams identified for Reablement; community equipment and assistive techology will continue to address this and will be monitored via the Joint Commissioning Group.
			3	4	12	Estimated diagnosis rate for people with dementia		Simon Tapley	Good progress has been made with improving the diagnosis rate of people with dementia through primary care awareness and education; dementia advisors; public engagement programme; screening on admission (over 75yrs). Activity needs to be increased and extended to work with care homes and community providers in identyfing people with dementia. Information from GPs for dementia diagnosis rate is only available at year end via NHS England. This has been escalated.
BCF011		Increased financial pressures across the range of service areas but particularly from growth in high cost complex patients; CHC and EoL.	4	4	16	Protecting social care services; 7 day services; Impact on acute sector; dementia diagnosis	Dealyed transfers of care; avoidable emergency admissions; reablement; Admissions to Res/Nursing;	Simon Bell + Paul Cooper + Richard Clack	Risk share agreement proposed and being further developed which would result in overspends against the ICO Plan being distributed between Commissioner (SD&T CCG & TC) and Provider (SDHFT, TSD) in proportion to the terms of the agreement i.e. 50%/50%. (Current working asumption is that the Commissioner share would be split with CCG anticipating 40% and LA 10%).

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The delivery of the Integrated Care Organisation remains the cornerstone of our Pioneer Programme and delivery of the BCF ambition.

Our local provider of community services, Torbay & Southern Devon Health and Care NHS will be acquired by South Devon Healthcare NHS Foundation Trust to form the Integrated Care Organisation, which will provide acute, community and social care services. Through the acquisition and by pooling almost £240m of funding, we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we expect to see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

As illustrated in our operational plan, for the first two years of the BCF we aim to slow the growth in emergency admissions in line with meeting the BCF required target of 3.5%, but over the five year period the plan of the Integrated Care Organisation is to reduce admissions by significantly more which is consistent with those of our providers.

The aim of our risk management process is to provide a systematic and consistent framework through which our priorities are pursued. This involves identifying risks, threats and opportunities for achieving these objectives and taking steps to mitigate the risks and threats. An integrated approach will be taken so that lessons learned in one area of risk can be quickly spread to another area of risk.

The value identified for the BCF is £12.014m. In terms of the broader Integrated Care Organisation there is a risk share agreement approved by all partners; CCG; Torbay Council; South Devon Healthcare Foundation Trust and Torbay & Southern Devon Health and Care NHS Trust. The purpose is

- To facilitate the development of integrated health and social care and the improvement of services, by better aligning financial incentives with:
  - A shift away from incentivising activity volume growth (in acute services)
  - A shift towards incentivising improved overall system capacity and the use of alternatives to acute admission (including development of community based care)
- To simplify and ease contractual processes and negotiations, to make time for more productive and developmental activities
- To maximise the use of health and social care funds for care, rather than organisational and administrative processes.

It will operate by:

- Services and cost plans will be reviewed annually, and the rolling contract renewed by the risk share oversight group. Mutually agreed changes will be accounted for as the rolling contract is refreshed each year. This will include review of future government funding plans, and 'horizon scanning' of likely cost and demand pressures.
- Financial and service performance against plan, along with review of performance and quality standards will be formally reviewed in the bi-monthly meeting of a contract review group. This will be chaired by an executive director of the CCG. All parties to the risk share agreement will be members of this contract review group.

The quantity of the pooled fund that is at risk in the Better Care Fund is £1,025,766 and is set out in the Part 2 plan template. This has been derived at from clear analysis and modelling of costs and impact.
The funding is allocated within the following activity areas:
Disabled Facilities Grant to Districts
Social Care Capital Grant
Reablement
Carers
Care Bill
Protecting Adult Social Care
Other Reablement/Section 256
BCF Implementation 14/15
Integrated Care Organisation

The model used for costing of the ICO and assumptions in terms of finance and activity can be found in the supporting documentation titled **"Outcome measures financial costings HP 240614".** The core fundamentals are based on reducing the numbers of bed days, spells and episodes of acute and community bed based care and length of stay. With target settings of 20% in bed days as well as emergency attendances and outpatients.

The risks identified to the delivery of the Better Care Fund in relation to phased and full implementation. Each risk has been identified and scored from discussion with each of the interested stakeholders. A number of schemes developed are essential elements of the plan to realise the benefits in 2014/15 and beyond.

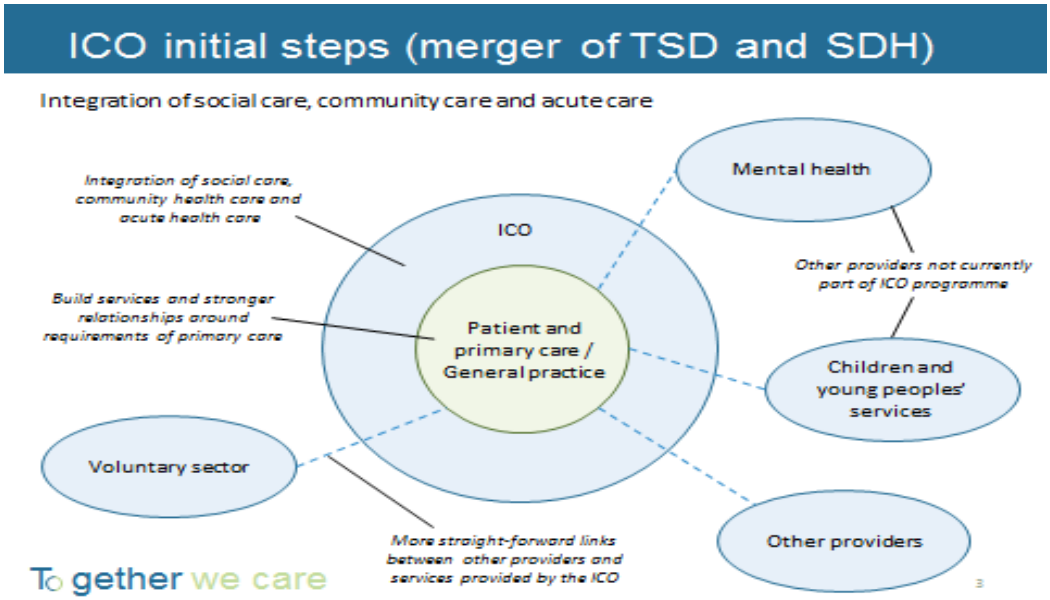
The current most significant risk identified by the partners to BCF is in relation to public sector financing and the pressures and demands from influencing demographic and economic factors. This being recognised there may well be a level of acceptance of 'slowing down' the system to accept slower performance in order to re adjust the delivery plan and meet expectations whilst maintaining an acceptable performance level and longer term goal.

The health and well being board has been consulted on both the Better Care Fund as well as receiving updates on the developing Integrated Care Organisation. Members have been advised as to the actions, spend and risks associated.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The predicator for the BCF is our pioneer programme and implementation of the Integrated Care Organisation. The model of care of the ICO set out below is supported by 8 work streams as well as ensuing an alignment of strategic plans across the community which will impact on the how and where care is delivered and role and choice of the patient



The ICO model will contribute to a system wide move away from a 'disease based model' of service delivery to one of 'proactive prevention'. The model will require greater collaboration between health and social care professionals and carers as we direct our efforts toward moving the person down the dependency triangle from unsafe, crisis and acute interventions that create dependence to safe, preventative interventions that promote independence. The ICO provides the opportunity to align the health and social care workforce to deliver one model of care.

In developing the BCF plan a number of related strategies and initiatives have been recognised as contributing to taking forward further integration and delivery of key performance metrics and outcomes. These initiatives include:

Aging Well
The Torbay Community Development Trust has been awarded Big Lottery funding to support a whole system approach to aging well, targeting those most in need using an Asset-Based Community Development approach. The project highlights the need for a holistic approach to preventing isolation as well as robust and targeted solutions for those who have become isolated. The projects the bid will support will also take a preventative wellbeing focus and will include social prescribing and guided conversations to set personal goals, introducing a NESTA match-funded 'My Support Broker' project.

Dementia Plan
Dementia is a condition that imposes a good deal of distress on those who are living with it and for their families. It is especially important for us here in Torbay because we have a large and growing population of older people. The plan sets out the need for developing services and opportunities wider in the community for recognising signs and early assessment followed by support and care for carers, care in hospital settings and care in residential and nursing homes. Working with partners in statutory, community, voluntary and independent organisations, commissioning intentions will focus on:

Prevention

- Maintain the profile of public information linked to healthy lifestyles and ageing well

Raising awareness and understanding

- Support and enable the development of dementia friendly communities
- Targeted awareness raising activity for example with schools

Early diagnosis and support

- Promote access to workforce development in understanding dementia
- Ensure equity of access to Memory Assessment, diagnosis and Intervention groups
- Develop and maintain a network of support for peer support groups (Memory Cafes) and other opportunities to reduce isolation through the Prevention Strategy
- Monitor and maintain Alzheimer's Society dementia advisor service
- Ensure people with dementia and their carers have a voice through targeted involvement activity

Living well with dementia

- Enhance personalisation and person centred planning including access to personal budgets, supporting people to remain at home or as close to home as possible
- Promote closer integrated working between primary, community and secondary care and between statutory, voluntary and independent sectors around the needs of individuals.
- Ensure the needs of carers for people with dementia are encompassed within a refreshed carers strategy, including access to regular and reliable respite options
- Maintain a focus on quality of care for people with dementia in acute and community hospitals
- Drive up quality and dementia specific capacity within care homes; extra care housing; domiciliary care
- Improve end of life care

Integrated Personal Commissioning

We have submitted an expression of interest to be a demonstrator site for Integrated Personal Commissioning . This provides a great opportunity to bring both health, social care and voluntary sector together to offer a truly joined up budget for individuals and one which both TSDHCT as part of the ICO and in partnership with the Aging Well would already be in a strong position to develop. A potential cohort of patients that this might be piloted could be learning disability which would fit with the re commissioning of learning disability support services ***(Operational Commissioning Strategy for people with learning disability)*** as well as those people with long term conditions.

Joined Up IT

Our joined up IT strategy supports not only frontline practitioners with single IT and health records but will also encourage organisations to provide innovative IT solutions to improve patient outcomes. An example of this is the adoption of clinical portal technology to overcome the disparity between different clinical systems, creating a tailorable patient health record, accessible to the right people at the right time, wherever needed.

Living Well @ Home

A competitive dialogue (CD) process is underway to procure two Prime Contractors, who will co-ordinate, manage and deliver care and support in Torbay. This will cover services such as domiciliary care (personal and non-personal care) as well as other areas of care and support to people in their own homes. It is a significant development in the continued integration of the Torbay system. The requirements of the Prime Contractors will be to

- Manage the market for capacity and quality.
- Record activity for trend analysis, stratification of client groups and early intervention or preventative care.

- Work with the integrated system in Torbay to expand the breadth of care and support skills available from the care market and to increase the number of care workers.
- Improve the recognition and profile of care work in Torbay.
- Collaborate with system partners and sharing best practice.
- Release resources within the community in a coordinated way.
- Ensure Wellbeing is at the heart of all that is done, with a focus on enablement and outcomes to achieve this.
- Deliver high quality care to 1000+ clients.
- Make the care experience for recipients seamless.

Market Position Statement
This provides an analysis of how well current service supply will meet future demand. It provides clear messages to the market on the vision for integrated care services in Torbay over 7 days a week, reducing reliance on bed based care. It outlines how provision needs to change to stimulate a diverse and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help to support people manage their conditions through early help and a focus on personal outcomes and choice.

Mental Health
This joint strategy draws together the commissioning intentions of five commissioning bodies: South Devon and Torbay CCG and NEW Devon CCG Plymouth City Council, Torbay Council and Devon County Council.

The key areas for development are:

- Prevention
- Personalisation
- Integration
- Improving health and wellbeing
- Supporting recovery
- Improving access

The engagement and involvement of those with lived experience and carers underpins every stage of the commissioning, delivery and monitoring of mental health services.

The Torbay and South Devon Integrated Care Pioneer Service in primary care psychiatry is recognised in the Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities Investing in the Evidence, with a view to further development and piloting elsewhere in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf

Personal Health budgets
Personal Health Budgets and Direct Payments are a key driver in promoting independence and choice among patients currently in receipt of Continuing Health Care. Torbay was an original pilot site for PHBs, and already has established processes in place aligned with direct payment systems. As we extend the roll out of personal health budgets to people with continuing healthcare needs as well as those with long term conditions, we will need to develop solutions away from the more traditional models of personalised care and support, testing out more web based support planning and brokerage services.

Torbay and South Devon Integrated Prevention Strategy – 2014/15- 2019/20
A plan which works towards transforming the NHS from an illness to a wellness service with a focus across 3 areas:
Lives People Lead (Key Behaviours);
Health Services People Use (Access & Take Up);
Wider Determinants.

There are two drivers to improve the health and well-being of the people of Torbay and South Devon; ***to reduce the number of people dying early*** (what we call premature mortality) and ***to reduce the gaps in life expectancy*** across our area (focusing on Health Inequalities).
If we look at both these areas it will help us focus our priorities around the prevention, self- care and personal responsibility agenda across the whole life course.

To deliver this we need to develop new commissioning models which are community led and incorporate:

- greater use of a model of volunteering whereby those with direct experience of issues become the volunteers.
- a model where commissioning is informed by patient experience
- a focus on workforce culture and transformational training that unpacks the relationship between care giver and receiver.

Summary
As we have already mentioned the fundamental alignment of the BCF is to the Integrated Care Organisation which has 8 work streams with multi agency representation recognising interdependencies across the health and care sector. The work streams are:

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

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

We can confirm that the plans in this BCF submission are included in the CCG 2 year operation plan and our 5 year strategic plan, as demonstrated through-out this submission.

The CCG and local authority are very much partners in the development of the Integrated Care Organisation, with the BCF a key means of delivery and catalyst for more integration which is a key strand within each of our organisational plans.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Our plans for primary care co-commissioning are structured around seeking a high degree of delegation to CCG. This will maximise the opportunities available to us in seeking to contract with primary care providers in a manner which means entire patient pathways are available as defined within our commissioning intentions.

In saying this we are mindful that provision of complementary and robust pathways within primary and community settings maximises the likelihood of delivering patient tailored care. Such care will be delivered within or close to the patients usual place of residence, and where possible on a proactive basis, decreasing the likelihood of providing reactive care with default approaches

leading to higher than necessary admission rates.

This is an aspiration articulated within our commissioning intentions and which therefore is core to both out plans for primary care as well as BCF.

Locally primary care development and redesign is overseen by means of the Primary Care Redesign Board (PCRB) which includes all commissioners of Primary Care Provision within its membership, as well representation from local Health and WellBeing Boards.

All undertakings relating to co-commissioning rote through PCRB with oversight from the Peninsula wide Primary Care Commissioning Overview Group (PCCOG) chaired by NHS England.

Work stream prioritisation for co-commissioning had been mindful of BCF plans, as illustrated by extending scope of Unplanned Admissions DES to align efforts to work underway to achieve cohesive approach across health and social care for the most vulnerable members of our population. In addition, Prime Ministers Challenge Fund resources have been deployed to address identified needs of the same patient cohort in a manner which complements BCF and related work streams.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

We have been working closely with our partners, in particular the Health and Wellbeing Boards of Torbay and Devon providing local leadership to deliver a sustainable health and care system. The Health & Wellbeing Boards have been integral to developing this plan and bringing together the alignment of priorities, across partner organisations, for the benefit of our communities. Through our Pioneer status, and the national support which comes with this, we will continue to build on this work to deliver the significant changes which are needed.

The National Voices narrative, built around the key statement *'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'* has been adopted across organisations, and complements the success of the model of Mrs Smith as a representative user of adult social care and health services. Creation of an Integrated Care Organisation in South Devon and Torbay and implementation of the Pioneer Plan will extend this model to young people and families, with even closer working with communities through creating community hubs where services will be linked together with a single point of access, so that care takes a whole person approach to meeting need and promoting independence in the community outside hospital and closer to home.

There is a strong commitment of a wide range of partners and organisations to this programme of works and our success to date is now being built upon to drive integration to a new level, including further structural integration and extended organisational care pathways between social care services and the local acute trust. We will use the opportunities of the better care fund and pioneer status to pool budgets and increase joint commissioning across all our health and care providers and ensure there is diverse range of care and support services available.

Our JSNA describes our local demographics and we have analysed local demand and supply in our market position statement (link below).

http://www.torbay.gov.uk/index/yourservices/adults/marketpositionstatement.htm

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Torbay already has an excellent track record of integrating health and social care services, as evidenced by the impact of local social care services on reduced lengths of stay and bed numbers.

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, there has been an investment in excess of £300,000 in a Community Development Trust to support the development and coordination of the third sector in Torbay, and to access funding streams and grants through a collaborative approach across organisations and partners. This will leverage both skills and resources which is evidenced in one current initiative - Fulfilling Lives: Better Ageing which has attracted £6 Million of Big Lottery funding over the next few years.

We will continue to review the pooling arrangements for the BCF alongside the wider pooled budget for the Integrated Care Organisation, to consider whether additional resources will be invested within this pooled fund in order to work towards our shared vision.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

As can be seen in Template 2 (Tab 2 & 3) the value of £2,976 is allocated to the protection of adult social care continuing activity around assessment, care provision and reablement in keeping people in their own homes.

The creation of an Integrated Care Organisation for acute as well as community health and social care services in April 2015 will increase our ability to deliver better care through pooled funding of almost £340 Million.

£400,000 has been identified in 2015/16 for the implementation of the new Care Act duties. However at this early stage in costing the impact of the Care Act locally there are new costs relating to increased assessments, deferred payments and additional carer services in the region of £3m.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Torbay's existing model of integrated health and social care delivery means we are well-placed to meet the new duties in the Care Act . We have established a single NHS and council Care Bill Project Board to oversee implementation with project plan and work packages (which incorporate the BCF) and cover the following areas:

- Social Care Workforce Change
- To Identify potential impacts on current workforce by April 2015 and ensure that by April 2016 skills, configuration and capacity are sufficient to meet new demand and legal duties.

Care Funding & Finance
By April 2016 - Identify local self-funders, estimate cost of meeting their care costs and calculate implementation costs.
By April 2015 - Estimate likely increase in requests for a deferred payment locally, review existing arrangements (workforce capacity, IT, Finance) for deferred payments and estimate implementation and related costs.

Pathways & Business Process
By April 2015 - Estimate the volume of additional assessments and the cost. Review our assessment process to ensure it focuses on prevention and wellbeing. Review support and arrangements for young people and their families during transition and update procedures and training. Consider how assessments will be carried out for local self- funders.
By April 2016 - Estimate time needed to assess self-funders ahead of go live date Consider ways of conducting proportionate assessments including, for self-funders and review financial processes, information and advice systems and IT.

Market Management & Commissioning
By April 2015 - Re-design commissioning arrangements including capacity, skills and leadership. Refresh market position statement to clearly identify strength/weaknesses in local provision to meet the Care Bill requirements.
By April 16 - Review engagement/dialogue with local providers and service users and start a conversation with local providers about the potential impact of the reforms.

Public Information & Advice
By April 2015 - Re-design existing advice and information services to ensure there is adequate funding and capacity so that good quality financial information & advice independent of the local authority is available and people know how to access it.

v) Please specify the level of resource that will be dedicated to carer-specific support

The following budget is part of the joint arrangement that we have in commissioning and provision for carers services which includes both health and social care resources.

Direct access services available to all carers	£222
Preventing breakdown in carers mental & physical health	£129
Targeting specific groups of carers	£115
Development of flexible breaks and enabling services	£107
Carer Involvement	£4
Management, development and administration	£133
Total	**£710,000**

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 more than 26% of the population of Carers based on the 2011 Census data. The refresh of the Carers Strategy 'Measure Up' 2015-2017 will encompass effective 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 highlighting the amended assessment paperwork to identify 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 focuse on substance misuse problems and mental health problems.

The plan for April 2015 is to create a pool of 'trusted assessors' in primary care and the voluntary sector to deliver Carers Assessments, working as enablers to help Carers find their own solutions and access community support. This approach aims to develop community capacity, self care and mutual support arrangements for carers. Examples of this capacity are Crossroads Care SW Carers Enabling service and Carers 4 Carers telephone befriending service. As part of the Ageing Better Big Lottery bid we have included two capacity building projects that specifically target Carers – Circles of Support and Mutual Caring. These will run for 2 years from April 2015.

Duties to address the needs of Parent Carers have been introduced into the Care Act and we are expecting detailed regulations and guidance in January 2015. It is intended to focus on support for Parent Carers in the next Torbay Interagency Carers strategy Measure Up 2015 – 17, which is currently being consulted on and is timetabled for endorsement by the Health and Wellbeing Board in December 2014.

Torbay has an interagency strategy for Young Carers under 25 (2013 – 16) with a 3 year Action Plan and a joint agency Steering Group. This 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 specified in a joint Carers strategy with the local Hospitals Trust.

Torbay is confident the Carers Services will be compliant with the Care Act although recognises capacity to meet the demand may well be challenging. We work with reference to national tools and good practice ie 'Making it Real for Young Carers' and we have a service that is able to respond to requests for assessments. We have considered draft regulations on young carer assessments. These set out the, matters to be determined and considered and they will become statutory guidance potentially through amendment to `Working Together'.

Carers services will have a direct impact on all four BCF schemes particularly in relation to the extension of the carer support CQUIN to hospital as well as community health and social care services reduces the time cared for spend in hospital because carers are more involved in decision-making and supported to care during hospital stay and on discharge. Impact should be a reduction in readmissions.
Preventative approach with health and wellbeing check will reduce number of carers who

experience breakdown in their caring role due to impact on their health and well being. Community and voluntary sector capacity in supporting carers will be increased

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change to original forecast.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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. We are committed to providing seven-day health and social care services, supporting patients being discharged and preventing unnecessary admissions at weekends. We already have several community services provided 7 days a week across Torbay:

Service	Torbay 7 day service	Comments
District Nursing	Yes	
Intermediate care	Yes	Intermediate care minimum level service at the weekend in Torbay. Staff also cover Paignton and Brixham hospitals for new therapy referrals or people at risk of deterioration
Social Work	No (see below)	
Emergency Duty Service	Yes Out of hours	
Early stroke discharge and neuro team	No	
ME/CFS	No	
MSK physio	No	
Hospital discharge	Yes	Discharge Coordinators cover A&E Sat /Sun
Intensive Home Support Service	Yes	
Crisis Response Team (dom care)	Yes	
Older peoples mental health	No	
Health Visitors	No	

Alcohol and drug services	No	
Lifestyles / Public Health Promotion	Yes	Weekend working sat am for smoking cessation and other times if events are on
CAMHS	emergency duty service plus protocols with A&E	
Community hospitals	Yes	
St Kilda Rowcroft Hospice at Home	Yes Yes	

We recognise that not all services are necessary to be delivered seven days a week, and we have pilots underway 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, as informed by those pilots 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.

The plan to deliver 7 day services is included in the Service Development and Improvement Plans with both our acute and community providers, and this will be further progressed with the contract with the Integrated Care Organisation from 2015. The two SDIPs are pasted below and action plans with milestones are in the process of being agreed by the service leads. The action plans will be monitored at our monthly Contract Review Meetings:

Provider/s	**TSDHCT**
Redesign Group	**CSTG**
Lead Clinician	**David Greenwell**
Lead Commissioner	**Solveig Sansom**
CQUIN name	**7 day services**
Description of CQUIN	**This proposal mirrors the top POAP priority for community services:** • Key community services to enable 7 day delivery to be identified, tested and costed. • Full evaluation of the effectiveness of weekend working, informed by the outcome of the engagement events to determine where weekend working is best rolled out to facilitate 7 day flow throughout the whole system.

Numerator (how will the evidence be collected and quantified)	• **No of six and seven day services pilots conducted and evaluated** • **Key community services to enable sustainable 7 day delivery to be identified, tested and costed**
Data source	• **TSD 7 day services steering group minutes** • **Report and action plan**
Outcome benefits	**Improved patient flow throughout the whole system. Same quality of care delivered every day.**
What will success look like?	Identified key community services operating at least 6 days a week, eliminating the pressures in the system on Mondays and Fridays
Which of the CCG objectives does this CQUIN support (see POAP)	**To achieve fully joined-up and cost-effective seven-day services**

a)SEVEN DAY SERVICE AND OUTSTANDING ACTIONS TO DELIVER HIGH IMPACT INNOVATIONS IN ACCORDANCE WITH NHS ENGLAND GUIDANCE	
b) Implementation of 7 day working	Development of mechanisms to measure baseline and progress
	Identification through self-assessment of measurement gaps
	Where required agreed performance trajectories

Rowcroft Hospice already delivers seven day services for both their inpatient unit and their hospice at home service, and were featured in the “Every Day Counts” paper produced by NHSIQ. We recognise that there is a risk that the focus on the formation of the ICO may detract from the delivery of the plans for 7 day services and to mitigate this risk the SDIP progress is monitored at monthly contract review meetings.

Through the formation of the Integrated Care Organisation we expect to see resources 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 integrated business plan includes working towards fully joined up 7 day provision, of which Primary Care is a key element. Key to delivering this will be continuing the work which is underway to develop General Practice Federations so that care will be provided to a population rather than to the registered Practice list. This will enable a federation of 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.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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.

The ability for multiple professionals to share patient records and treatment plans is vital to achieving a better quality of service for local people in the most cost-effective way. Integrated models of care can only be supported by IM&T that is not limited by traditional organisational boundaries. Complex 'whole-system' care pathways rely on immediate information sharing between all clinical and 'web of care' participants. The ICO and Pioneer see IM&T as a as a key enabler supported by the Joined-Up ICT Strategy.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The GP clinical systems we use are ITK compliant and any future systems will be to link in. The community use PARIS and this is using more open API's. This will further boosted when moving to PARIS version 5.1. NHS mail is used for email correspondence within the NHS including CCG staff and Adult Health and Social Care in Torbay and GCSX is used by Devon County Council for secure email. We also ensure that our 3rd sector partners use secure email when exchanging emails with PID.

CCG staff work with data held on a secure drive (hosted by South Devon Health Informatics Service) with role-based access granted for each of the work area folders – e.g. staff working in Finance cannot see the Safeguarding data.

All solutions requiring interoperability are procured as such and will contain contractual references to ensure compliance with the necessary standards.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The CCG enters into service agreements using the NHS Standard Contract. In the event that this is found to be lacking in IG / Confidentiality requirements, an additional bespoke clause will be inserted for signature by the contracted party.

The CCG enters into data sharing agreements to ensure the secure and legal processing of personal data.

The CCG published its IG Toolkit (version 11) on 30 September 2013 at level 2 for all requirements. The supporting evidence has been audited by Audit South West and also by the HSCIC.

The CCG has been granted Accredited Safe Haven (ASH) status in order to process personal data for specified purposes; this has been authorised by the Secretary of State and agreed by the Confidentiality Advisory Group (CAG) who ensure that the Caldicott2 guidelines are adhered to.

The CCG delivers face-to-face Information Governance training for all staff, which includes the caldicott2 guidelines.

Torbay Council has achieved PSN (Public Services Network) data governance compliance and is working towards level 2 of N3 Connecting for health compliance.

Anyone with an N3 connection needs to complete the IG toolkit and be compliant. For General Practice this is a requirement set out in the recent GP Excellence in IT operating model (Published in April 2014) and will be addressed through this.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

We have outlined in the Case for Change Section (3) the segment of our population of highest risk of hospital admission as well as an explanation of the approach used to identify this group. This section adds further detail to the process we have adopted.

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. This has been supported through a ‘Locally Enhanced Service’ initiative to incentivise input from Primary Care. There is a willingness to build upon the successes of this project to widen the scope and scale and meet the expectation of the ‘accountable GP’ initiative, as set out within ‘Everyone Counts; Planning for Patients 2014/15 to 2018/19’.

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 then 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 for 2014/15, with 2% of our population then being proactively case-managed.

The King's Fund identify the recommended strategy for each strata of risk as follows:

Relative Risk	% of Patient Population	Emergency Admissions	Outpatient Attendances	A&E Attendances	Interventions
Very High Relative Risk	0.5%	18.6 x average	5.8 x average	8.5 x average	Case Management
High Relative Risk	0.6% - 5%	5.5 x average	3.8 x average	2.9 x average	Disease Management
Moderate Relative Risk	6% - 20%	1.7 x average	1.9 x average	1.4 x average	Supported Self Care
Low Relative Risk	21% - 100%	0.5 x average	0.6 x average	0.8 x average	Prevention & Promotion

We also have a Frequent User Panel, which looks at our top 10 frequent users of A&E every month. This panel includes representation similar to that of the virtual wards, but also includes the ambulance service, the fire service and the police.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

As described above, we already have monthly community virtual ward meetings – multi-agency meetings to discuss the list of patients at risk of admission, as risk-stratified by the Devon Predictive Model. The model is evidence-based and combines data from both primary and secondary care, and has been in use for four years. Up until April 2014, this process covered 0.5% of our patient population, with each of those allocated a case manager / lead professional as appropriate, with multi-disciplinary input from the rest of the team as required.

For 2014/15, NHS England has developed a new enhanced service for primary care which builds on the virtual wards and risk stratification already in place in Torbay. All of our GP practices have signed up to this new service, which will see the number of patients proactively case-managed and with their own care co-ordinator rise to 2% of the population.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

As at 31st March 2014, over 0.5% of our population had a joint care plan in place as part of the virtual ward. Each of our practices has signed up to the NHS England Proactive Care service, which will see this number increase to a minimum of 2% from September 2014. These numbers are monitored monthly using patient read codes and by practice reporting quarterly.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

We have undertaken an extensive public engagement process for our community services, taking three months and including 21 public events across the CCG footprint plus additional meetings with staff, district councils, the voluntary sector and local groups. A number of key themes were common to each event, and we have used these to inform our plans for community services for 2014/15 and beyond. Local people are involved in the steering groups which co-ordinated these events, and will also continue to be involved in developing these plans. We received feedback from over 1200 people during the three month process. Full details are included in our engagement report, attached, but in summary:

We went to every town and many villages across our CCG footprint, inviting people to talk with us - in person, by completing a survey or returning a leaflet.

- 21 public events
- 7 meetings with individual groups
- 7 community staff events
- 823 members of the public attended
- 471 additional written and online responses were received

We followed a similar engagement process to look at how mental health and support services work in our area. The experience of people who use mental health services, their families and carers should directly influence the commissioning process, so we have embarked on a rolling programme of engagement events and individual engagement to collect feedback as follows.
1. General focus on adult mental health (June 2013)
2. Urgent care, inpatients and community services (August 2014)
3. General focus on adult mental health (December 2014)
4. Time to talk, about reducing the stigma of mental health (February 2014)
5. Dementia (May 2014)

The core messages from all of these events have been instrumental in the development of this plan and our vision for integrated care and support, and we will continue to engage and consult with the public as we begin to implement it.

We recognise that a “one size fits all” approach will not work, and for this reason each of the CCG five localities has developed a steering group made up of local people. These groups initially helped to inform and run the full engagement process, but will continue to meet and act as expert reference groups as our plans are implemented and further developed.

Our local Healthwatch are represented on each of the steering groups and were wholly involved in the engagement process.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Our main health and care providers are:

- South Devon Healthcare Foundation NHS Trust
- Torbay & Southern Devon Health and Care NHS Trust
- Torbay Council
- Torbay Community Development Trust
- Rowcroft Hospice
- Devon Partnership NHS Trust

Our plan reflects a number of existing programmes, the development of which have included our health and care providers as active participants, including our voluntary and community sector. Providers continue to be engaged in the development of our on-going and future plans.

We have a long history of including our providers in service planning and reviews, and have a number of multi-disciplinary Clinical Pathway Groups, which in turn feed into senior level multi-disciplinary Service Redesign Boards. In addition to this, the Joint Commissioning Group retains the strategic lead for the oversight of the BCF plans. The Social Care Programme Board for Torbay provides the senior management forum for oversight of the Annual Strategic Agreement through which the Council delegates commissioning and delivery of Adult Social Care to the NHS.

The Better Care Fund has been discussed with the Health and Wellbeing Board and plans for its further development and links with Pioneer and the Integrated Care Organisation are regular agenda items.

As the first cohort of Integration Pioneers, both commissioners and providers have formed a programme board - including the community provider (Torbay and Southern Devon Health and Care NHS Trust), the acute hospital (South Devon Healthcare Foundation Trust), our mental health provider (Devon Partnership Trust), Council-provided Children Services along with Virgin Healthcare, South West Ambulance Service, the voluntary sector (Torbay Community Development Trust) and Rowcroft hospice – which will oversee our programme of integration and pooled funds. Given the opportunities that the Better Care Fund presents this is seen as integral to the planning and implementation of our plans as integration Pioneers and the priorities for the Integrated Care Organisation which will increase our ability to deliver better care through pooled funding of almost £240M.

This plan recognises the importance of early help and prevention and the role of adult social care services in keeping people independent at home, as well as the vital contribution of local communities and the voluntary sector in reducing loneliness and isolation by providing both formal and informal support to frail and vulnerable people. These services make a positive difference by reducing reliance on bed based care and supporting reablement and recovery through outcomes based care and support

Ultimately, the predicator for the BCF plan is our Pioneer programme and the implementation of the Integrated Care Organisation, and the four key schemes detailed at Annex 1 include all of our key providers.

ii) primary care providers

Our extensive engagement process outlined in section 8a was led by our GP colleagues. The plans referred to within this document reflect those developed by our GPs in each of their localities, in response to that engagement. The redesign board which oversees the engagement process is chaired by a Torbay GP.
Locally primary care development and redesign is overseen by means of the Primary Care Redesign Board (PCRB) which includes all commissioners of Primary Care Provision within its membership, as well representation from local Health and WellBeing Boards.

All undertakings relating to co-commissioning rote through PCRB with oversight from the Peninsula wide Primary Care Commissioning Overview Group (PCCOG) chaired by NHS England.

Work stream prioritisation for co-commissioning had been mindful of BCF plans, as illustrated by extending scope of Unplanned Admissions DES to align efforts to work underway to achieve cohesive approach across health and social care for the most vulnerable members of our population. In addition, Prime Ministers Challenge Fund resources have been deployed to address identified needs of the same patient cohort in a manner which complements BCF and related work streams.

iii) social care and providers from the voluntary and community sector

Our extensive engagement process outlined in section 8a was also undertaken in partnership with Torbay Council and Healthwatch Torbay. The plans referred to within this document reflect those developed by our GPs in each of their localities, in response to that engagement, and in partnership with those organisations.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

There has been extensive work between commissioner 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.

As a result there are plans in place for each of the schemes to achieve a reduction in admission, but most significantly length of stay, in 2015/16 on the baseline set in 2014/15.

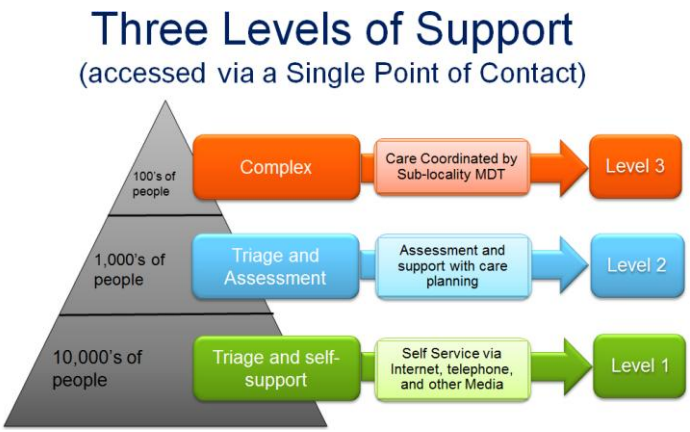
The plan for an integrated care organisation will result in a less pronounced impact on budget with a single budget and contract agreed for both acute, community and adult social care. However this, and the delivery of the wider BCF, is dependent on receiving approval from Monitor to the ICO business case being submitted October 2014.

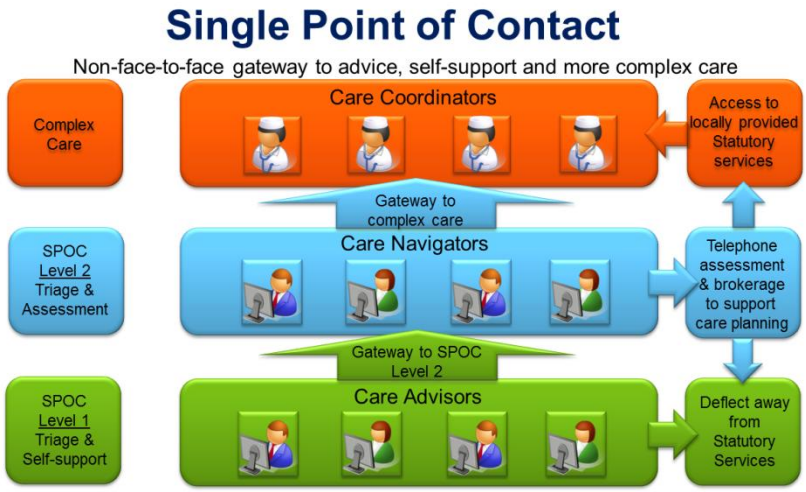
Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – SCHEME 1: SINGLE POINT OF CONTACT

Scheme ref no.
SCHEME 1
Scheme name
Single Point of Contact and Live Directory of Commissioned services
What is the strategic objective of this scheme?
To establish a gateway (Single Point of Contact) for citizens including carers to access information and advice about health and social care and which enables escalation as appropriate for citizens with more complex needs, but with a primary aim being to support citizens in helping themselves wherever possible. To provide a Live Directory of Services that enables Clinicians to identify alternatives to hospital admission in real time, thereby preventing avoidable admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are three key components associated with this proposal: 1. To Provide a Single Point of Contact (SPOC) gateway to integrated health and social care information, advice and support for citizens and 2. To establish a SPOC for Clinicians and other Care Professionals that supports them in identifying and referring patients to appropriate services in real time (24x7), thereby preventing avoidable non-elective admissions. 3. Over time, it is expected that the SPOC will provide in-situ remote monitoring to support citizens in their own homes. The SPOC for citizens builds on the successful Care Direct Plus service that has been operating successfully within Southern Devon for the past 3 years, and which provides a Gateway to Social Care information, advice and support augmented by Health Care Professionals. Building on this model we will: 1. Extend the service to cover both Southern Devon and Torbay 2. Enhance the Service to provide a fully integrated single gateway to both Health and Social Care advice and support for the citizens of Southern Devon and Torbay 3. Redefine the scope of the service to provide a much more comprehensive approach to supporting citizens in helping themselves by sourcing and resourcing their own solutions wherever possible This model is fundamentally a call centre through which all health and care enquiries are directed. Depending on the complexity of the enquiry, skilled Care Advisers will advise the citizen on how to source their own solutions (Level 1 response) or, where it is clear that the situation cannot be resolved in this way the citizen will be escalated to the next level of response (Level 2). Level 2 will involve telephone triage and for social care needs, eligibility assessment (FACS; for non-complicated cases brokerage will also be provided. Where issues are complicated and cannot be resolved over the telephone, or where a

face-to-face assessment is considered essential to the needs of the citizen, then the case will be referred to the Multi-Disciplinary Team (MDT) Care Coordinator in the patients locality, who will organise and coordinate in-home assessment by the appropriate professionals.





The second component of the new model is the creation of a Live Directory of Commissioned Services for Clinicians, the purpose of which is to:

1. Make available to clinicians and other professionals access to a comprehensive directory of statutory and non-statutory services available in Real Time, and
2. Facilitate real-time patient resource matching and e-referral. This will enable the rapid identification of alternatives to Hospital admission where a patient does not require acute level care but needs an alternative service to be available quickly if an avoidable admission is to be prevented.

These initiatives align with our aspirations within Pioneer to create ways to prevent unnecessary access to or deployment of statutory services and to reduce hospital admissions by creating smarter responses at the front-end of our services.

The model complements the work also underway to redesign the role and function of Multi-Disciplinary Teams operating at Locality Level and which it is intended will be enhanced by increased collaboration with and support from the voluntary sector, mental health and hospital consultants to deliver more preventative care and support within the community.

The third component of the new model, which will be introduced in a subsequent phase, is the extension of the SPOC service to incorporate in-home monitoring of patients using tele-health/tele-care other monitoring devices or regular telephone contact as appropriate to the risk stratification of the citizen.

All of these plans are part of the business case for the development of the Integrated Care Organisation within South Devon and Torbay (encompassing the acute trust and community provider) which will have all of the system wide resources to deploy in the best way, including community investment, in order to provide and maximise alternatives to hospital admission through health and social care activities.

These plans also form part of a wider strategy to build social capital and that will harness the resources of local communities and the voluntary sector in key aspects of delivering services, and especially in relation to enabling self-help and support.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain is through the development of the ICO and the risk share agreements therein between health and social care supporting system wide management of this within Torbay and Southern Devon.
Therefore;
Torbay and Southern Devon Health and Care NHS Trust (Lead)
South Devon Healthcare NHS Foundation Trust
South Devon and Torbay CCG
Torbay Council
Devon County Council
The Voluntary Sector

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Care Direct Plus Service has been operating for over 3 years and provides a Single Point of Contact (SPOC) gateway to Senior citizens requiring information, advice and support for social care, and more recently augmented by health care professionals who now advise and address those enquiries which have a health related issues. There is therefore an existing and proven evidence base for extending this model. CDP currently undertake over 60% of assessments and facilitate associated brokerage over the phone, which is likely to substantially reduce the number of in-situ assessments currently undertaken across Torbay (thereby substantially reducing costs and waiting times). Expanding CDP will also generate economies of scale from which both Councils will benefit.

Enhancing the CDP service to enable a much greater focus on supporting citizens to source their own solutions is a Pioneer and JoinedUp objective (local health economy strategy), and expected to reduce the number of assessments required and the number of citizens who access statutory services (prime objectives of both Councils).

There is considerable empirical and academic evidence identifying that some 30% of patients admitted to hospital non-electively do not require Acute Level Care, however in the absence of rapid access to alternatives, acute hospital admission is often the only safe thing to do. The Live Directory of Commissioned Services will give Clinicians and other Professionals access to real-time information on the available alternatives 24x7 and, when coupled with real time patient resource matching and e-referral is expected to result in a significant reduction in avoidable admissions (a major objective of whole system – CCGs, Providers and Councils).

There are a not insignificant number of documented texts – reports, academic papers, pilots, experiments and trials which support the approach being proposed including:

1. Butler D, (2013) 'Test of change (introduction of integrated health and social care coordinators) End of Pilot Evaluation'
2. De Silva D (2011) Helping people help themselves: our view of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation
3. Purdy S (2012) Avoiding hospital admissions: what does the research evidence say? London: the King's Fund. www.kingsfund.org.uk/publications/avoiding-hospital-admissions
4. 'South Devon & Torbay: Proactive case management using the community virtual ward and the Devon predictive model'
5. Case Study examples: Patient resource matching and e-referral (to support Live Directory of Commissioned Services) http://stratahealth.co.uk/resources/case-studies/
6. Case study examples: NHS North West London, Torbay, Towers Hamlets
7. Naylor et al (2013) 'Long term conditions and mental health – the cost of co-morbidities'
8. Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' Quality Watch, The Health Foundation, Nuffield Trust
9. Poteliakhoff E, Thompson J (2011). Emergency bed use: what the numbers tell us. London: The King's Fund.
10. Shepperd S, Doll H, Angus R M, Clarke M J, Iliffe S, Kalra L, Ricauda N A, Tibaldi V, Wilson AD (2009). 'Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data'. Canadian Medical Association Journal, vol 180, no 2, pp 175–82.
11. Oliver D, Foot C, Humphries R (forthcoming). Making our health and care services fit for an ageing population. London: The King's Fund.
12. 'Case management: what it is and how it can be best implemented'
13. Goodwin N, Sonola L, Thiel V, Kodner D (2013). Co-ordinated care for people with complex chronic conditions. London: The King's Fund.
14. Proactive care partnership: http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Increase in citizens sourcing their own health and care solutions (target minimum 10%)
Reduction in numbers of citizens requiring assessment (target 10%)
Reductions in non-elective hospital admissions (target initially 15% reduction in inappropriate admissions (net 5%))
More appropriate treatment/management of patients
Better utilisation of non-hospital resources
Promoting self-care
Increased involvement and utilisation of the Voluntary Sector
The extension of the SPOC service to provide in-home monitoring is also expected to substantially reduce 30-day, post-acute readmission as well as provide an early warning system for at-risk patients that will enable early intervention prior to a crisis occurring.

Specific BCF benefits as detailed in Template 2:

Reduction in non-elective admissions

Reduction in delayed transfers of care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will baseline as many of the key performance metrics as possible but may also need to supplement this with audits.
Key markers will include:
Number of citizens whose enquiry is resolved at Level 1 response (without access to assessment)
Change in the number of citizens requiring assessment
Change in the number of non-elective admissions
Change in/Number of patients requiring a Level 3 response (referral to Locality MDT)
Number of citizens whose admission is prevented by referral to an alternative service
Reductions in non-elective hospitals admissions

What are the key success factors for implementation of this scheme?

1. Agreement of key stakeholder (DCC and Torbay Council) on the adoption (in Torbay) and expansion of the CDP model across Torbay and Southern Devon.
2. Involvement of/collaboration with other key Providers in developing the Single Point of Contact model, in particular Primary Care, Mental Health, Voluntary Sector, third and independent sectors
3. Development of an appropriate (online/internet based) advice and information service (for direct use by citizens or Level 1 response) in collaboration with DCC and Torbay Council. This will also require substantial engagement with Voluntary Sector, third and independent sectors, to maintain contemporaneous information.

4. Development of new scripts, processes and associated training for CDP staff to deliver the proposed model of service
5. Reviewing and addressing the impact of the new model of service on field staff and developing the Multi-Disciplinary Team concept accordingly
6. Identifying the best accommodation options for the expanded CDP service
7. Identifying and implementing the technology necessary to support the Live Directory of Commissioned Services (for use by clinicians and other professionals), patient resource matching and e-referral, and the cooperation of the CCGs in requiring every commissioned service to maintain a Live Service Status.

ANNEX 1 – SCHEME 2: Frailty Care Model Scheme

Scheme ref no.
SCHEME 2
Scheme name
Frailty Care Model scheme
What is the strategic objective of this scheme?
To support the holistic care of older persons in Torbay by taking a whole system overview of the pathway of care. Aim being to shift from a 'reactive' care model to a 'proactive' care model, focussing on enabling and empowering citizens, carers, community to support themselves and provide varying care settings dependent upon the individual's needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model of care involves greater collaboration between citizens, carers, voluntary sector, health and social care in community and acute settings to support older persons within Torbay. The pathway of care will shift resource and expertise across the system rather than patients always having to attend an acute hospital for specialist treatment which is often a detrimental setting for their needs.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
South Devon & Torbay Clinical commissioning Group (CCG), Joined-up cabinet, 7 Locality Commissioning groups (LCGs) Torbay and Southern Devon Health and Care Trust, Torbay Council and South Devon Healthcare NHS Foundation Trust are all working strategically as part of both the Integrated Care Programme and Pioneer to create a seamless system of care for older persons, placing them in the centre/in control and ultimately shifting the care pathways from a reactive/crisis response driven pathway to an enabling/self-care and proactive pathway.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
1) **"Redesigning acute care for older people seven days a week – so who said that seven day services are more expensive?"** Sheffield Teaching Hospital NHS Foundation Trust http://www.nhsiq.nhs.uk/media/2422335/sheffield_emergency_cs_final.pdf Impact for Patients:- • Faster assessment at the emergency 'Front Door' by multi-disciplinary assessment teams enabling a focus on what needs to be done to get patients back home as soon as clinically appropriate and discharge care packages put in place to enable patients to be assessed at home, shortening overall pt pathway • Patients are seen by Geriatric Medical Consultants on average more than 10 hours sooner that in the previous system which provides earlier clinical decision making and consistent quality of care

- Patients admitted at weekends have a greater equality of service

Impact to overall system:-

- Speedier senior assessment of patients
- More timely access to specialist input
- Lower bed occupancy
- Higher percentage of pts on the 'right' wards for their needs.
- Faster turnaround for diagnostic tests and a clear care plan provided.
- Increased consultant and multi-disciplinary presence seven days a week

2) Sheffield Teaching Hospital NHS Foundation Trust

"Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources." Kate M Silvester, Mohammed A Mohammed, Paul Harriman, Anna Girolami, Tom W Downes. Publishes electronically 12 November 2013

http://ageing.oxfordjournals.org/content/43/4/472.full.pdf+html

Describes a patient flow analysis of older emergency patients to identify and address delays in ensuring timely care without additional resources. They undertook three distinct changes 1) Discharge to Assess initiative, 2) Seven Day Working 3) establishment of a Frailty Unit. Risk of hospital mortality and average bed occupancy fell without affecting re-admission rates or requiring additional resources.

3) The primary care paradox: New designs and models Nuffield Trust and KPMG

http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/primary-care-paradox/Documents/primary-care-paradox-v1.pdf

In the article they identify four new design principles that may help frame future developments in primary care:

1) access and continuity
2) patients and populations
3) information and outcomes
4) management and accountability

Saltman and others (2006) 'have argued that the intermediate territory between self-care and specialist/hospital care is changing, with primary care playing an increasing part in coordination and integration of care that is provided by different services. These new roles, together with elements of specialist care that can now be delivered in primary care settings, can be thought of as 'extended primary care'. They are the focus of recent developments in many European countries, often seeking to bridge the divide between generalist first contact care, specialist services and disability or home care.'

Case Study: Hartola Health Station, Finland

Finnish health and care services are organized around municipalities, which vary in size, with an average population of 5,800. National policy aims to merge smaller municipalities and reduce the total number from over 300 to around 70. The health station in Hartola illustrates the range of services available in 2013 for a population of 3,500, with 5,000 extra summer visitors .

• Municipality-owned health station (linked since 2012 to a cluster of municipalities): comprehensive primary care including preventive care, some specialist and welfare services. Two full time GPs.

• Also offers: home care, dementia unit, diagnostics, social welfare support, community hospital, specialized geriatrics and psychiatry.

• Uses doctors, nurses, allied health professionals, private ambulance staff, administrative personnel, private laboratory company.
• Electronic patient record.
• Introducing the Chronic Care Model into primary care as the 'health value model'.

4) Geriatric Medicine, Dr Zoe Wyrko, Consultant Geriatrician Royal College of Physicians 2013
https://www.rcplondon.ac.uk/sites/default/files/geriatric_medicine.pdf

The paper sets out the role Geriatricians can play in the future of the whole system, recognising the distinct needs of older persons including the fact that they usually have complex social needs related to their chronic medical conditions.
Dr Wyrko suggests that 'to provide integrated holistic care for older people, geriatric medical services should cross the boundary between primary and secondary care. Care pathways should consider the physical and psychological needs of normal ageing, together with the crises and potential deterioration associated with acute illness.'
Pg 120 also sets out a useful table indicating the 'Medical and paramedical services supporting the assessment and rehabilitation of older people

5) Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. NHS England 2014
http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in community bed based care and bed days.
- Reduction in frail elderly admissions from Care Homes
- Increased use of Crisis Response Team/domiciliary care/social care/Intensive Home Support Services.
- Increase 0/1 LOS, decrease 2< LOS day (acute wards).
- Reduction in total no of admissions to acute wards.
- Reduction in nos of pts admitted to acute from int care beds (with the exception of pts from int care coming in to frailty unit for diagnostics.)
- Increase in no of pts having a CGA and resulting in a managed MDT care plan.
- Less patients feeling a loss in independence in acute trust by giving autonomy to reable in own home quickly.
- Increase in patient satisfaction
- Reduction in hospital admissions for patients to be diagnosed with dementia
- Reduction in deaths in acute trust

Specific BCF benefits as detailed in Template 2:

Reduction in non-elective admissions
Reduction in permanent residential admissions

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Measuring set KPIs Seeking staff feedback Seeking patient feedback Analysing trend in complaints from pts 65< Analysing trend in compliments from pts 65<
What are the key success factors for implementation of this scheme? That patients don't have to repeat their story to lots of different staff members That patients/carers feel more empowered/enabled to make decisions about '*What matters to them'* A reduction in admissions from acute wards and an increase in utilisation of voluntary, community health and social care resources

ANNEX 1 – SCHEME 3: Multiple Long Term Conditions

Scheme ref no.
SCHEME 3
Scheme name
Multiple Long Term Conditions
What is the strategic objective of this scheme?
A new service for people with multiple LTCs to allow coordinated multidisciplinary management of coexisting medical conditions in one place and at one time.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Individuals with multiple LTCs such as Heart failure, Atrial Fibrillation, Diabetes, CKD, hypertension, Chronic Obstructive Pulmonary Disease (COPD), obesity and depression will be managed by one team without the need for referral to multiple specialist teams. The service will operate at a number of locations in community settings with co-location of all health professionals (Doctor, nurse, therapists, specialist nurses, social services and voluntary and charitable sectors). Simple diagnostics (near patient testing, blood tests and where possible simple radiology) will be available at the time of consultation. This service will function in all localities in Torbay and South Devon and across all sectors. Carers support workers
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
South Devon and Torbay Clinical commissioning Group (CCG), Joined-up cabinet, 7 Locality Commissioning groups (LCGs) Torbay and Southern Devon Health and Care Trust, Torbay Council and South Devon Healthcare NHS Foundation Trust are all working strategically as part of both the Integrated Care Programme and Pioneer to create a seamless system of care.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• Care Planning; Improving the Lives of People with Long Term Conditions. Royal College of General Practitioners 2011 • Delivering better services for people with long-term conditions. Building the house of care. Kings Fund 2013 • Patient centred coordinated Care. Nationalvoices.org.uk • The Importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings: Evidence from South Somerset's Symphony

Project. Centre for Health Economics Research Paper 96. 2014.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Hospital admissions before and after commencement of the service
- Changes in volume of activity within the multi-LTC service and the specialty LTC services
- Reduction in outpatient appointments for patients
- Reduction in unnecessary hospital admissions as LTC is managed more proactively
- Improved palliative care and less patients dying in an acute trust through the single holistic care plan.

Specific BCF benefits as detailed in Template 2:

Reduction in non-elective admissions

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Assessment of patient satisfaction with the service and other experience

- Assessment of professional satisfaction with the service and other experience

What are the key success factors for implementation of this scheme?

1. Multi-condition care planning. Involvement of the voluntary sector in determining holistic service needs for individuals and providing links to local means of support. Planning of priorities for the care of individuals taking account of all medical conditions and social needs.
2. Comprehensive clinical review by medical and nursing staff, providing a consistent approach to the management of all of a person's medical problems. Assessment of 'Patient Activation' and use of Motivational Interviewing and other proven techniques in management of LTCs.
3. Support of self-management as a keystone of the service. Use of Patient Knows Best (PKB) to facilitate self-management and virtual consultation.
4. The development of mentoring relationships between service staff and appropriate specialist teams allowing up to date and highest quality care without the need for physical referral to multiple specialist teams.
5. A flexible approach to locus of care. The team will be able to move between primary care, this intermediate service and the hospital as required, e.g. liaising with staff when the service user is admitted to provide information to the hospital team and contributing to discharge planning and seamless movement back in to the service after an inpatient episode.
6. Clear relationships with other programmes which might be needed from time to time, e.g. cardiac rehabilitation, weight management services.
7. Clear links with Well-being services including commissioned 'Living Well, Feeling Better', which could be co-located
8. Clear links with 'Virtual wards' for those at high risk of admission and with End

of Life services when appropriate.
9. Linkage with the local De-escalation guidelines in development
10. Regular (3-4 times per year) educational sessions for service staff attended by consultants from all LTCs and specialist nurses. Discussion of cases and themes and new directions in LTC management.
11. Audit of service outcomes and user satisfaction surveys.

ANNEX 1 – SCHEME 4: Community Care: Locality Teams and Community Hospitals

Scheme ref no.
4
Scheme name
Community Care: Locality teams and Community hospitals
What is the strategic objective of this scheme?
To redesign community based services in order to manage more people in a proactive way to prevent hospital admission, reduce delayed discharges and reduce admissions to long term care. This includes the enhancement of the current primary care service to provide a single multi-disciplinary assessment service.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model of care builds on the successful integrated model of Care provided in Torbay and Southern Devon. It also links through to our aspirations within Pioneer in terms of developing local 'hubs ' for the provision of integrated care, for example the children and young people's hub and the frailty service. The service model will link an enhanced single point of contact primarily developed to reduce reliance on the statutory sector (as described in another scheme) 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. This will link through to the enhanced virtual wards and the development of one GP practice per care home. The development of the Torbay's 'Big Team' will deliver improved GP case management for virtual ward patients for the top 2% of most vulnerable patients – approximately 3,000 patients. This will offer an enhanced service along with extra nurses and HCAs linking though to existing Community Matrons and intermediate care teams to prevent hospital admissions. This scheme will also focus clinical interventions earlier in the day, more pro-active care for patients most at risk of admissions, improve and enhance quality of medical care for care home patients and improve discharge planning for patients in acute and community hospitals. The overarching plan links to the development of locality plans which have been developed through a 'bottom up' approach driven through locality engagement driven by the CCG. All of these plans are part of the business case for the development of the Integrated Care Organisation within Torbay (encompassing the acute trust and community provider) which will have all of the system wide resources to deploy in the best way, including community investment, in order to provide and maximise alternatives to hospital admission through health and social care activities. In addition to this there are plans to utilise our community hospitals to provide solutions to our system wide pressures within health and social care. This will include a change in function of our community hospitals, e.g. for the provision of community services, intermediate care and step up/step down beds.

Additional locality schemes which link to this include:

- Working with care homes to ask them 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
- Care Homes – working towards one care home, one practice; extending the medication review pilot already underway; mentoring of care home staff by GPs and annual reviews of care home residents.
- Torquay Children, Young People and Families Hub – building community assets, development of volunteer workforce, social prescribing and guided conversations
- Carers support workers within GP surgeries providing health and wellbeing checks as well as hospital liaison providing support for discharge and assessment of need.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain will be through the development of the ICO and the risk share agreements therein between health and social care supporting system wide management of this within Torbay.

South Devon and Torbay CCG (commissioners)
Torbay and Southern Devon Health and Care NHS Trust
South Devon Healthcare Foundation Trust
Torbay Council
GP practices in Torbay
Pharmacy / medicines management
Devon Partnership Trust
Torbay Community Development Trust (voluntary sector)
Rowcroft Hospice
South West Ambulance Service Foundation Trust

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

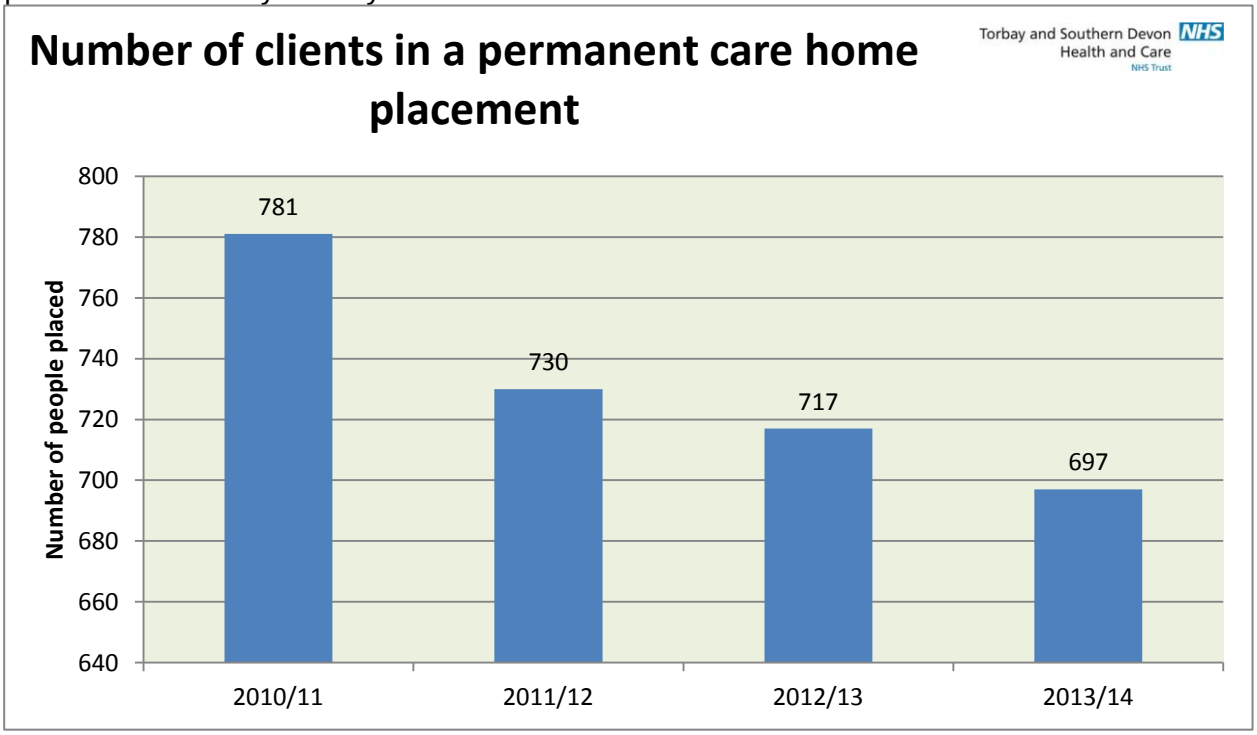
An extensive engagement process was undertaken in November and December 2013, with the public and other stakeholders including Healthwatch Torbay – from this it was clear that people want continuity of care and to maintain their relationship with "their" GP. They also wanted better co-ordination of their care and to avoid hospital admissions, with treatments closer to home where possible.

We have also taken into account information and regular surveys from South Devon Healthcare Foundation Trust and have also engaged with local care homes, Rowcroft hospice, mental health colleagues and Devon Doctors (OOH service providers) for their input.

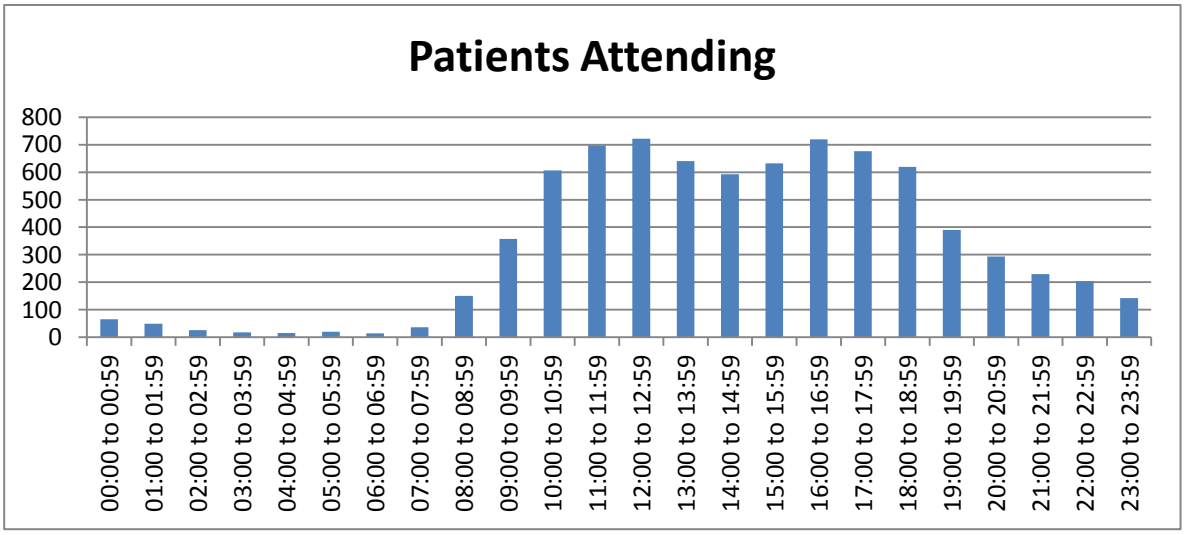
We have extensive evidence of the success of the virtual ward model, using risk stratification to identify patients at risk of admission, and then proactively case managing them via a multi-

disciplinary team.

Since the introduction of intermediate care, we have seen the number of permanent care home placements reduce year on year:



Our rationale for moving GP visits to earlier in the day is based on the pattern of admissions to Torbay hospital – if we can ensure frail older patients in particular are referred for rapid assessment earlier in the day when services are available, they are less likely to be admitted to hospital overnight. This will also link with our plans for extended access to primary care (8am – 8pm) and for seven day services.



We also looked at examples of best practice elsewhere, including the Northamptonshire Integrated Frail and Elderly Pathway and the Kings Fund Report from March 2014: http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

http://www.kingsfund.org.uk/sites/files/kf/Integrated-care-summary-Sep11.pdf

http://www.slideshare.net/kingsfund/chris-ham-on-making-integrated-care-happen-at-scale-and-pace

http://www.slideshare.net/NuffieldTrust/peter-colclough-paul-mears-integrated-care-in-torbay?related=1

http://www.helesangels.org.uk/

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Defined register of 3000 patients across Torbay
- Admission times - we would expect to see more earlier in the day and fewer resulting in overnight stays
- Reduction in admissions for the 3000 case managed patients
- A reduction in prescribing and medication costs
- Fewer emergency hospital admissions from care homes
- An increase in the number of high-risk patients who have a care plan
- Fewer 999 calls from care homes
- Improved experience of patients and carers as a result of proactive case management and link to a case manager
- Reduction in placements into long term care
- Increase in the number of patients offered rehabilitation following discharge from hospital
- Reduction in the number of readmissions to hospital within 91 days
- An increase in the number of people with a dementia diagnosis

Specific BCF benefits as detailed in Template 2:

Reduction in non-elective admissions
Reduction in permanent residential admissions
Increased effectiveness of reablement
Reduced delayed transfers of care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Expected Outcome	Measure	Benchmark	Links to other schemes
Defined register of 3000 patients across Torbay	Practice read codes	n/a – straightforward number of patients read-coded	Proactive Care DES (NHS England)
Admission times - we would expect to see more earlier in the day	Times of admissions – provided by SUS	Compare to same time the previous year	7 day services

and fewer resulting in overnight stays			
Reduction in admissions for the 3000 case managed patients	Devon predictive modelling outcome report – produced quarterly NB – this will be a measure of this cohort of patients rather than individuals	Compare to same time for the same cohort the previous year	Proactive Care DES (NHS England)
A reduction in prescribing and medication costs	Prescribing database: 4000 patients in care homes £200,000 est. per annum 30,000 less prescriptions written 5-17% reduction in hospital admissions	Other locations e.g. North East estimate £170 saving per care home review which would be £680,000 so we may have underestimated	Nice guidance for care home reviews, CHUMS report, All Wales Medicines Strategy group on frail patients and polypharmacy
Fewer emergency hospital admissions from care homes	SUS data	Compare to same time for the same cohort the previous year	SWAST "Right Care, Right Place, Right Time"
An increase in the number of high-risk patients who have a care plan	Practice read codes	Compare to same time the previous year	Proactive Care DES (NHS England)
Fewer 999 calls from care homes	SWAST data (already monitored by Older People Clinical Pathway Group)	Compare to same time the previous year	SWAST "Right Care, Right Place, Right Time" and ICO SPOC scheme
Improved experience of patients and carers as a result of proactive case management and link to a case manager	Annual Social Care Survey: How many users of care and support services said they were 'extremely satisfied' or 'very satisfied' with their care and support	Compare to same time the previous year	Proactive Care DES (NHS England)
Reduction in placements into long term care	Social care data	Compare to same time the previous year	
Increase in the number of over 65s who are still at home 91 days after discharge from hospital into reablement / rehabilitation services	SUS data Intermediate Care dashboard	Compare to same time the previous year	
Reduction in the number of	SUS data	Compare to same time the previous	

readmissions to hospital within 91 days		year	
An increase in the dementia diagnosis rate	QOF data	Compare to same time the previous year	Dementia strategy

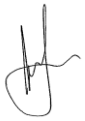
- Metrics and performance will be monitored by the CCG Business Planning and Performance Group which meets monthly, with headline reporting to the monthly CCG / ICO contract review group.
- Progress will also be monitored by our JoinedUp Board (exec representatives from the health and care system, including the voluntary and community sector) and the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

- Local agreement across a range of stakeholders on the use of community hospital beds, in particular the public and GPs
- Ability to manage emerging pressures within the health and social care system to manage pressures over winter
- Engagement from care homes

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Torbay Health and Wellbeing Board
Name of Provider organisation	South Devon Healthcare NHS Trust
Name of Provider CEO	Dr John Lowes
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	16156
	2015/16 Plan	15591
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-565

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes, subject to approval of the creation of the ICO.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, subject to approval of the creation of the ICO.

Commissioning roles and responsibilities for Adult Social Care between the Trust and the Council after transfer of Adult Social Care Strategic Commissioning Team to Council

The Adult Social Care (ASC) Commissioning Team is transferring under TUPE to Torbay Council on 1 Dec 2014, thus transferring responsibility for strategic commissioning to the Council from this date. This is in line with the report commissioned from the Institute of Public Care (IPC) in January 2013, although recommendations regarding transfer of some procurement and contracting functions have not been considered to date.

The new arrangements will require very high levels of ongoing communication and co-operation between organisations, particularly between Commissioning in the Council and Safeguarding Adults, Procurement and Business Support and Quality in TSDHCT. This cannot be emphasised strongly enough as any failures in this respect will impact on and create risk around the safety of vulnerable adults, financial savings and service development and stability. This interface will be managed through the Social Care Programme Board.

Role	Description	Responsibility	Rationale	Day to day
Strategic Commissioning	Commissioning cycle; needs analysis, market facilitation strategy, the setting of overall contractual frameworks and strategic decommissioning. Setting overall outcomes, planning and investment against plans plus the review of the efficacy of this investment. Negotiating and agreeing the terms of a contract for services.	ASC Commissioning Team, Council	New legislation and role of H&WB give 'appropriate responsibility' and accountability back to LA; allows it to commission for wider priorities and community agenda across different services, eg, housing. Market facilitation	Safeguarding Adults Whole Homes and some exceptional individual cases; Care Home fees; overarching contracts and frameworks;LWAH strategic partnership; provider forum; Decisions on contract enforcement and decisions to de-list or suspend business where the council is the contracting Authority
Strategic Procurement	Developing ASC Services. Ensuring public sector procurement	TSDHCT Procurement	Close links to strategic commissioning	Present contracts with the Care Trust are covered with

	compliance. Establishing the overall contractual frameworks Tendering, negotiating and agreeing the terms of contracts. Management of contract variation orders. Strategic management of contract compliance	Team For existing contracts management and re-procurement only. Additional resource needed for new services.	required enabling good communication especially around process and the specification of outcomes	the TSDHCT resource and this will continue in respect of these service areas unless resources or budget are transferred to the council, as these are within the establishment and funding that the Care Trust receives from Torbay Council Where there are new services introduced such as Extra Care or further voluntary sector development, the procurement may well be with the council, however budgets and personnel may have to be reviewed at that time
Operational Contract Management, compliance and monitoring	On-going management of the contract including payment and monitoring. Addressing issues directly with providers. Responsibility for Provider of Concern processes. Providing market intelligence and report information to Strategic Commissioners.	Business Support and Quality Team, TSDHCT	Close links to procurement desirable. Key is good communication and cooperation	These responsibilities will be held on a day to day basis in working with providers to improve quality and manage concerns, but where all processes are exhausted the issues will be escalated to strategic commissioners for decisions on contract enforcement and decisions to de-list or suspend business where the council is the contracting Authority

Individual service negotiating, contracting/procurement	Focussing on the client at an individual level for contracted care.	Zone Teams, TSDHCT	Located near to actual service delivery. Smaller 'transaction' costs and quicker addressing of problems from client side with care monitoring and delivery	As stated
Individual service/care monitoring	Monitoring the individual outcomes, objectives and quality of care being delivered by the care manager.	Zone Teams, TSDHCT	Located near to actual service delivery. Smaller 'transaction' costs and quicker addressing of problems from client side with care monitoring and delivery	As stated
Care management (provision) or care delivery	Delivering the service to the client	Zone Teams, TSDHCT	This is actual delivery so needs to stay wherever the provider side is located	As stated
Financial monitoring, performance and quality assurance Is this of viability of provider or services delivered?	At both strategic service level and individual contract level – a financial/ performance management support function. Financial and performance information to be called off and provided to Strategic Commissioners.	Shared need to be clear which teams are doing what otherwise we will have confusion !	Finance functions already integrated and possibly no clear advantage to move	Robust and clear processes for transfer of relevant information and reports, etc, eg monthly performance made available to team. Governance of this to be through SCPB.

JF 24.11.14

South Devon Healthcare NHS
NHS Foundation Trust

Torbay and Southern Devon Health and Care NHS
NHS Trust

Acquisition of Torbay and Southern Devon Health and Care NHS Trust by
South Devon Healthcare NHS Foundation Trust

In partnership with Torbay Council and South Devon and Torbay Clinical Commissioning Group

Risk-Share Agreement

WORK-IN-PROGRESS DOCUMENT

Contents

1 Purpose of agreement

- To facilitate the development of integrated health and social care and the improvement of services, by better aligning financial incentives with:
  - A shift away from incentivising activity volume growth (in acute services)
  - A shift towards incentivising improved overall system capacity and the use of alternatives to acute admission (including development of community based care)
- To simplify and ease contractual processes and negotiations, to make time for more productive and developmental activities
- To maximise the use of health and social care funds for care, rather than organisational and administrative processes.
- To maintain levels and quality of service despite reducing real terms resourcing.
- To reduce the volatility arising from individual organisations' exposure to demand and cost changes.
- To support a long-term contract for services between the parties; and support Heads of Terms for agreements between the parties and any regulatory authorities.

2 Parties to agreement

- Commissioners
  - South Devon and Torbay Clinical Commissioning Group *(Lead: Simon Bell)*
  - Torbay Council *(Lead: Paul Looby)*
- Providers (ICO)
  - South Devon Healthcare NHS Foundation Trust *(Lead: Paul Cooper)*
  - Torbay and Southern Devon Health and Care NHS Trust *(Lead: Richard Clack)*

3 Key principles behind risk-share

1. A financial and service baseline will be agreed for a period of five years, on a rolling basis. Variance from this baseline will trigger the risk-share mechanism.
2. The risk share mechanism focuses on variance in actual costs incurred by the ICO. For the purposes of this risk-share agreement the cause of variance in costs (i.e. demand or efficiency) is not important – the impact will be shared regardless of origin.
3. Variances from planned cost in the ICO will be shared between the parties in agreed proportions. The impact of negative and positive variances will be mirrored.
4. Variances from plan will be calculated on the total income and expenditure position of the ICO. This includes all commercial activities and all NHS commissioned services. Therefore variances arising in services commissioned by NHS England (including specialised services), New Devon, Public Health will also trigger implementation of the risk share agreement.
5. As part of this agreement, and by committing to a five year funding envelope defined by current baseline adjusted for expected growth / contraction in their allocations going forward, Commissioners are committed to maintaining planned levels of spend for the duration of this agreement. This envelope recognises that prevailing national economic conditions plan for a real terms decrease. Any downward change to planned resource availability will require re-specifying service commitments to be deliverable within available resources. Any upward change to planned resource availability will also require joint consideration of the service commitments. Such allocation changes, in either direction will, other than by agreement be limited to the overall percentage change applied to the relevant Commissioner's overall allocation.

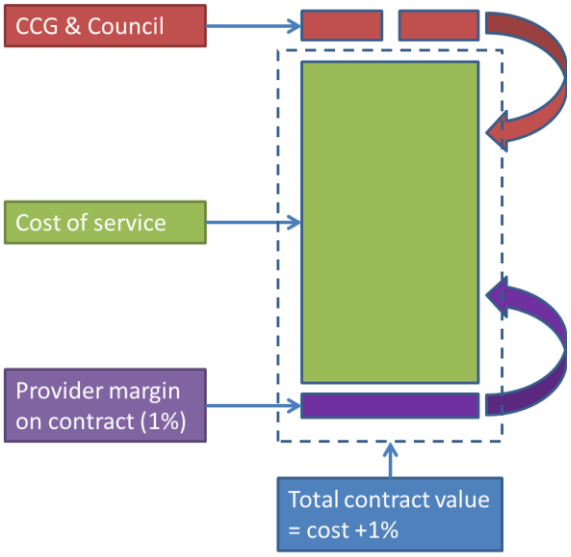
6. Enhancements to elective care pathways delivered by the ICO will deliver a better patient experience and it is therefore expected that patient choice will support the ICO's market share in this area. The impact of patient choice will be accommodated through funding transfer arrangements as part of this agreement. These could increase or decrease the ICO income and will be calculated with reference to the planned and actual level of elective activity delivered in the ICO.
7. The planned ICO costs include a sufficient margin on income to provide a 1% surplus to the ICO over the five years of this agreement. This surplus may be reduced by adverse cost variances shared through this agreement.
8. This agreement requires a long term commitment from all parties. The initial five year duration for the agreement is set to enable the ICO to recover set up costs and to deliver the 1% target surplus on a sustainable basis. Beyond this point it is recognised that parties may wish to reduce the duration to three years.
9. All parties should seek to minimise costs to the system as a whole where possible and to maximise the utilisation of all public expenditure.
10. Sufficient transparency around the cost base of the ICO and CIP plans, along with associated transparency around commissioner (financial and commissioning) plans will be a prerequisite for the successful operation of the risk share agreement.
11. Where parties have a responsibility to commission services, set prices, or enter into agreements which may affect the cost of the ICO, these responsibilities will be exercised with due regard to the risk share agreement, and the parties to it. Early and sufficient transparency around such arrangements will be the expectation.
12. The impact of unplanned changes to commissioner funding envelopes will be managed in accordance with key principle five above.

4 Description of risk-share mechanism

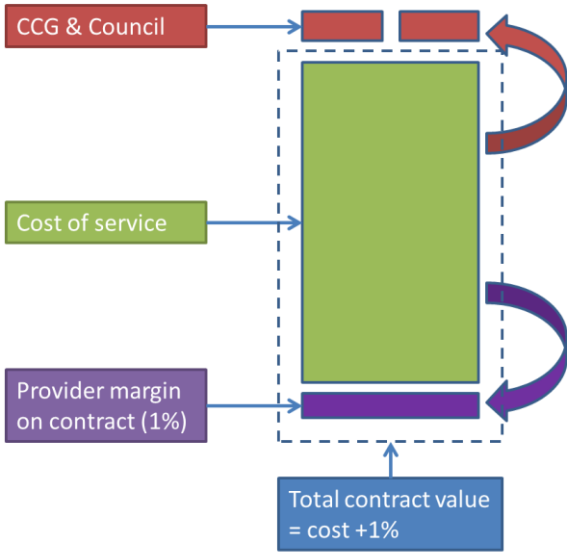
1. **Agree baseline**: A planned level of service commitment and ICO spend on these services will be agreed for an initial five year fixed period. The agreement will move to a rolling three year period beyond this point
2. **Commit resources**: Commissioners will agree to commit the necessary resources to meet the baseline level of service as described in current plans, allowing for a 1% surplus for the ICO.
3. **Deliver service efficiencies**: The ICO will deliver agreed levels of efficiency improvements throughout the period.
4. **Manage variance**: Any variance between actual costs (plus 1%) and the plan will be shared according to the following proportions:
5. **Changes to risk share contributions:** Changes to risk share contributions will normally only arise where they follow a shift in baseline resource between commissioning organisations not already described in current plans. Changes in baselines already described in current plans will not give rise to alterations in the risk share contributions set out above.

Party	Indicative baseline contract value	Share	Practical application
ICO (currently SDH and TSD)	£248.0m	50%	Overspend: All costs incurred within ICO Underspend: All costs incurred within ICO
TSDCCG	£204.8m	41%	Overspend: Share of variance is paid to ICO Underspend: Share of variance is withheld from ICO
Torbay Council	£43.3m	9%	

This is represented diagrammatically:



To agreed proportions (CCG 41%; TC 9%, ICO 50%), participants fund any deficits in the ICO position



To agreed proportions (CCG 41%; TC 9%, ICO 50%), participants gain from any surpluses in the ICO position

5 Scope of risk-share mechanism

Contract between the current SDH and CCG	
Elective services (planned)	In
Non-elective services (urgent)	In
All other services (e.g. PTS)	In
Contract between the current TSD and CCG	
Continuing healthcare (live cases)[1]	In
Continuing healthcare (retrospective cases)	Out
Community health services	In
Contract between the current SDH and Torbay Council	
Public health	In
Contract between the current TSD and Torbay Council	
Public health	In
Adult social care	In
Other relevant factors[2]:	
Other sources of income to SDH	In
Other sources of income to TSD	In
Supporting people	Out
Joint equipment store	Out
Devon social care	Out
West Devon contract with New Devon CCG	In
Additional non-clinical service resource allocations e.g. Consultant Merit Awards, etc.	In
Impact of Care Act and other regulatory changes	In

[1] Note that there is a question regarding whether this covers both South Devon and Torbay. Torbay Council has said that this should only include Torbay residents, while the CCG expect it to cover Southern Devon too. Either

way there will be a requirement to continue managing the distinction between health and social care for South Devon patients, unlike for Torbay patients where the commissioning is fully integrated. Need assurance that proportion of people receiving CHC is aligned between Torbay Council and DCC.

[2] Any surplus or deficit the ICO makes from activities outside the scope of the risk share agreement may be factored into the agreement (and therefore effect the financial position of all parties) by mutual agreement of the parties as described in Section 7 (page 6).

6 Definition of baseline

The baseline will be defined as follows:

Service commitments

- The services provided by SDH and TSD at the end of 2014/15 will define the baseline range of services to be provided by the ICO once formed.
- The level of activity provided within each service will not be explicitly measured as part of this risk share agreement, as payments will not be made on an activity basis. However, activity will be recorded and reported as per other regulatory requirements, and for the purposes of service analysis and improvement (in concert with commissioners and national initiatives).
- Although income will not be linked to activity, should costs exceed income an understanding the driver(s) for a deficit will be essential to help identify solutions. Many of the costs in the ICO will continue to be linked to levels of demand, understanding variances between planned and actual demand will therefore be a requirement of this agreement.
- Both commissioners five year financial plans are described explicitly in the ICO final business case (FBC) and form a key component of the baseline.
- The ICO will meet the requirements of all statutory performance frameworks for these services. These frameworks are as follows:
  - The Monitor risk assessment framework
  - The "Single Outcomes Framework" which is currently under development by the parties.
- The specification and mode of delivery of services may be changed by the ICO (undertaking relevant consultation where necessary) in order to better meet the needs of the community while continuing to deliver against the above frameworks.
- Shifts in services, either into or out of the ICO will result in a cost change to the baseline of the ICO but will otherwise not affect the operation of the agreement (except insofar as they are so material they would trigger other aspects of the agreement). In other words, where commissioners incur net costs or savings as a result of the shift in service, these will be borne by the commissioners.

Service costs

- The cost baseline will be defined and agreed for the services described above over the initial 5 year period. This will set out a profile of the total cost of ICO health and care services for the relevant population for this period and analysed by commissioner.
- The initial cost will be determined by the indicative resource availability information provided by the commissioners in advance of this agreement, which has been informed by historic service costs alongside key service changes for 2015/16.
- This cost baseline will be set out in the ICO final business case (FBC) and reviewed by Monitor and the Trust Development Authority (TDA).
- As a general principle the ICO will be supported to make a 1% surplus on its services, and a 1% margin will be applied on the total planned service cost within this agreement. Changes to surplus can however be considered as part of level 2 and level 3 risk share considerations (below).
- Arrangements for the appropriate recovery of VAT in line with current arrangements between the Council and Torbay and Southern Devon Health and Care NHS Trust insofar as they will relate to the on-going services provided by the ICO will be considered alongside this arrangement. Further guidance

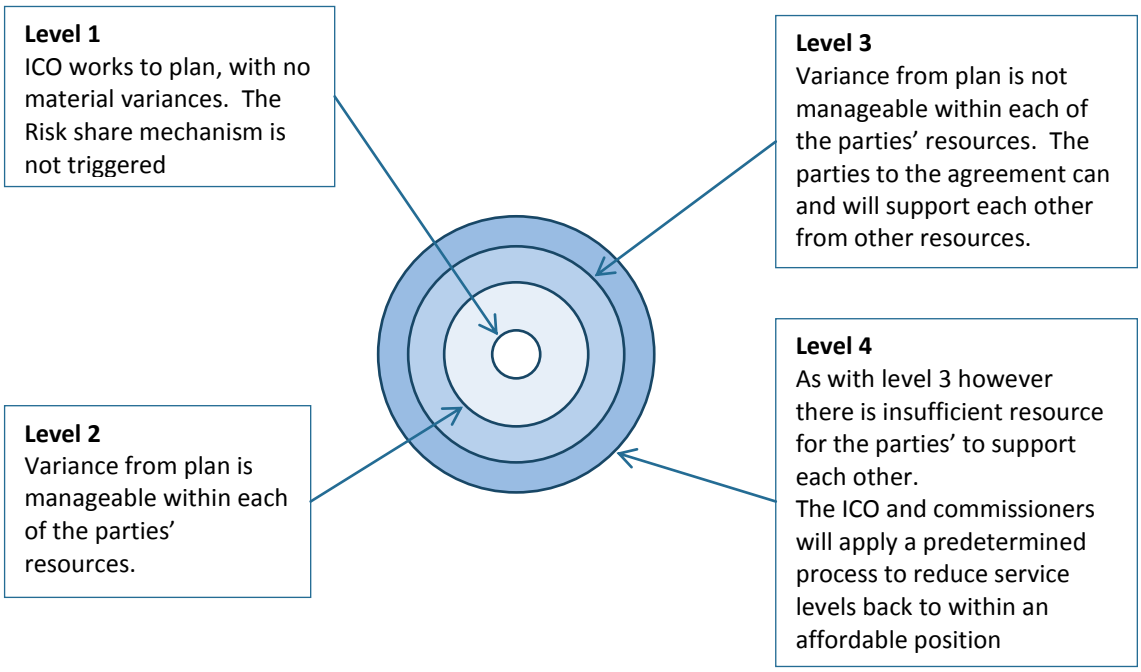
on the VAT implications of Better Care Fund, and in particular as it relates to this arrangement, will be considered alongside this arrangement.

Financial Mechanism

- Payments for the delivery of services (as per the agreed capitation baseline) will be made monthly.
- Variance between actual costs and the baseline will be reviewed in arrears on a quarterly basis. If actual costs are higher than the agreed baseline then the relevant additional share will be paid to the ICO for the quarter, in accordance with agreed risk share proportions. If actual costs are less than the agreed baseline then that month's contract payment will be reduced to account for underspend in the quarter, in accordance with agreed gain share.
- This mechanism to apportion the variance will apply at each of the levels 2, 3 and 4 of extraordinary measures that are described in section 7 below.

7 Cooperation and extraordinary measures

The core mechanisms within this risk share agreement aim to incentivise a reduction in cost of health and care across the community, and reduce the risk to individual parties through sharing the impact of adverse (or positive) financial performance between the parties.



These mechanisms (reference to legally binding is unnecessary as the whole agreement is intended to be legally binding) are summarised as "Levels 1 & 2" below:

Level	Description	Action
Level 1	Agreed plan is met with no material variance	Contract sums are paid on a monthly basis.
Level 2	Variance from plans is manageable within normal flexibilities available to parties	The risk share mechanism is applied as described herein, with variations applied on a quarterly basis.

It is possible that external events or extraordinary pressures may lead to a situation where one or more parties to this agreement struggle to meet their contractual commitments. This is a particular risk in the public sector where new rules or budget changes can be imposed without warning and in a short time period.

The parties have agreed to operate in a spirit of cooperation to meet challenges to the local community over the life of this agreement. As such the parties will consider flexibilities they may have in order to support each other.

The following table (describing escalation levels 3 and 4) indicates how the parties will aim to support each other in such circumstances.

Level	Description	Action
Level 3	One party raises concerns meeting their obligations within the agreement. The other parties have capacity to support the troubled party. These issues may be raised by the risk share oversight group which meets on a quarterly basis.	Support may be provided through the following routes (this list is not exhaustive): ○ Mutual agreement to flexible management of financial commitments within the contract period. ○ Consideration of how services and funds that are out of scope of the risk share agreement (see page 2) but have a potential impact on other parties could contribute towards the wider group's sustainability. ○ Consideration of other (potentially third party) routes of support that could be drawn upon to support the wider group's sustainability.
Level 4	One party raises concerns about meeting their obligations within the agreement. The other parties do not have capacity to support the troubled party. These issues will be raised by the risk share oversight group. It is anticipated that this would occur infrequently (for instance as part of an annual review) and with significant notice.	Solutions may be drawn from the following routes, which would only be considered where other options have been exhausted, and where the parties agree the chosen option would be a "least harm" approach (this list is not exhaustive): ○ Consideration of potential changes to service scope or specification in order to reduce costs while meeting statutory demands. ○ Consideration of potential for one or more parties to compromise delivery of expected performance or financial standards on a temporary basis, alongside a plan to resolve the situation and put the agreement onto a more sustainable position.

8 Treatment of funds released through "underspends"

The parties anticipate that in the absence of special circumstances, any underspend achieved by the ICO should be pooled, and an appropriate cross-party body would be involved in deciding how such funds are invested in future health and care services. A group such as the "Pioneer Board" or "JoinedUp Cabinet" may be appropriate for this role.

In circumstances where one or more parties are under extreme financial pressure, the parties agree that any of such parties may need to retain underspends for internal use.

9 Legal basis of agreement

This agreement will take the form of a contract between the parties with an initial term of five years, leading to a three year contract renewed annually on a rolling basis beyond the first five years.

This agreement is designed to sit alongside and complement the existing contracts for services between the two provider trusts (that will become the ICO) and the commissioners. It will not override any of the service quality or administrative elements of those contracts, but will supersede all financial components of these contracts.

10 Governance/control

A risk share oversight group will be created, with initial membership based on the group developing this agreement and including appropriate NHS non-executive and Council elected member representation. They will act to ensure the risk share mechanism operates to deliver the expected flexibilities as described. They will have a particular responsibility to consider the medium term operation of the risk share agreement and provide early advice around likelihood of maintaining risk at level 1 or 2 of the agreement and consider and recommend actions where this is not the case.

Services and cost plans will be reviewed annually, and the rolling contract renewed by the risk share oversight group. Mutually agreed changes will be accounted for as the rolling contract is refreshed each year. This will include review of future government funding plans, and 'horizon scanning' of likely cost and demand pressures.

Financial and service performance against plan, along with review of performance and quality standards will be formally reviewed in the bi-monthly meeting of a contract review group. This will be chaired by an executive director of the CCG. All parties to the risk share agreement will be members of this contract review group.

Each respective organisations statutory responsibility and internal governance mechanisms remain unaffected by this agreement.

11 Dispute resolution

All parties are expected to operate in good faith and with transparency with regard to the agreement. Where disputes around the operation of this agreement arise it is expected that the risk share oversight group will, in the first instance, seek to understand the dispute and either agree remedies or else agree and describe the parameters of the dispute for further consideration.

As it will be important in terms of on-going operation of the agreement to seek to resolve all disagreements locally where the risk share oversight group cannot reach agreement, a special meeting of Chief Executive Officers of the parties will be convened to consider the dispute as described by the risk oversight group and agree a solution.

In the unlikely event that parties to the agreement consider that external mediation is required to resolve a dispute, and with due consideration for the likely impact on the on-going success of the agreement, an external mediation provider will be appointed and all parties to this agreement agree to be bound by the final judgement reached.

The external mediator will be the Centre for Effective Dispute Resolution. The costs of the mediation will be borne by the parties to this agreement equally.

12 Contract Termination

This agreement has been put in place as a medium to long term means of managing the risks relating to volatile funding arrangements alongside increasing demand for care. There is also an expectation that this agreement will help to facilitate service reconfiguration over the course of the agreement.

This agreement should ensure that the first step for any party who wishes to change or withdraw from the agreement should be to sit down with the other parties to understand the circumstances and identify an appropriate solution that best meets the needs of the local population and balances the interests of the parties. Therefore there is no explicit premature termination clause within this agreement.

The duration of this agreement is set to allow sufficient time for the ICO to make the necessary service changes and investments and to achieve the resulting efficiencies. The modelling has indicated that this will be achieved of the first 5 years of the ICO and this period has therefore been agreed as the initial duration of the contract. At the end of the initial 5 year term the contract term will revert to a rolling 3 years.

During this time all efforts will be made to support each other in the event that individual parties' become financially distressed. However if one party is not in a position to continue the agreement the notice period is 12 months. This period of time is required for the other parties to the agreement to conclude their own exit plans. At the end of this notice period the default contractual terms set out in the NHS standard contract will apply. For the acute aspects of the business this will be payment by results (PbR) and for the community aspect of the business the traditional cost plus contract terms will apply to the extent PbR tariff have not been developed.

Force majeure

There may be a small number of exceptions to the above, which account for circumstances where there is a very serious catastrophe or event that threatens the health of the local population on a large scale or the existence of any of the parties as a going concern.

One of the partners shall not be deemed in default of this Agreement, nor shall it hold the other Parties responsible for, any cessation, interruption or delay in the performance of its obligations (excluding payment obligations) due to earthquake, flood, fire, storm, natural disaster, war, terrorism, armed conflict, or other similar events beyond the reasonable control of the Party provided that the Party relying upon this provision:

- gives prompt written notice thereof, and
- takes all steps reasonably necessary to mitigate the effects of the force majeure event.

For clarity most changes in government policy or funding would not be covered by this force majeure clause. We can reasonably anticipate that there will be changes in policy and funding in the life of this agreement and such changes should not signal an end to the relationships described in this agreement. The purpose and spirit of this agreement is to:

- Recognise the level of uncertainty in health and care services and the existence of local risk
- Ensure that the parties collaborate to prepare for and manage such risks for the medium-long term
- Share the financial impact of any residual risk and benefit

13 Operation of agreement before ICO approval

Parties to this agreement can opt to operate within the parameters of this agreement prior to the formal start date of the ICO. This would be in order to maximise the benefit to service improvement and efficiency ahead of a formal approval.

Where this is the case, the risk share mechanism described in section 4 will be operate as described but any additional commissioner contribution to excess costs will be allocated proportionately to each provider organisation according to relative share of baseline. It would be expected however, that organisations will seek to use resource collectively in order to maximise the benefit to service improvement and efficiency.

14 External references

This risk share agreement will be referenced within the following documents:

- The Business Transfer Agreement
- Contracts for services between the ICO and TSDCCG and Torbay Council
- The SDH Final Business Case
- The TSD Divestment Business Case.

Appendix 9

Torbay and Southern Devon Health and Care NHS Trust

Policy for the Provision of Short Breaks

Contents

1 Policy Statement

1.1 This policy underpins Torbay and Southern Devon Health and Care NHS Trust's (TSDHCT) (The Trust) commitment to supporting carers to continue in their valuable role by ensuring access to a range of services which provide eligible carers with a break from their caring role. This includes short breaks in a variety of forms.

1.2 This policy recognises that a carer is someone who provides unpaid help and support to a relative or friend who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.

1.3 Access to social care funded short breaks is based on assessment and will be provided for people whose needs are eligible under Care and Support (Eligibility Criteria) Regulations 2014.

1.4 Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, TSDHCT will carry out a carer's assessment. Where an adult provides care under contract (e.g. for employment) or as part of voluntary work, they should not normally be regarded as a carer, and so TSDHCT will not to carry out the assessment.

1.5 As per the requirements of The Care Act 2014, Carers' assessments will seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. The carer's assessment must also consider the outcomes that the carer wants to achieve in their daily life, their activities beyond their caring responsibilities, and the impact of caring upon those activities.

1.6 There may be instances where the adult being cared for does not have eligible needs, so does not have their own personal budget or care plan. In these cases, the carer must still receive a support plan which covers their needs, and how they will be met. This would specify how the carer's needs are going to be met (for example, via replacement care to the adult needing care), and a personal budget may be provided for the costs of meeting the carer's needs.

1.7 Short breaks/replacement care are considered as part of the Resource Allocation System, and provided directly or via a Personal Budget/Direct Payment.

1.8 Short breaks encompass a wide range of different short term services. The common factor is not what service is provided but its purpose - to provide a break or the carer which helps them to sustain the caring relationship and which is a positive experience for both the carer and the person with care needs.

1.9 Adult Social Care and Health funding can be used to provide short term solutions through a variety of options to the carers of people with learning disabilities, people with mental health problems, people with physical disabilities, people with substance misuse issues, older people and other vulnerable adults across TSDHCT. This policy outlines how we will move towards a

consistent and equitable way of all client groups in the provision of Social Care and Health funded short breaks.

1.10 Current policy for the provision of adult health and social care is aimed at promoting the maximum possible choice and control for service user and their carer(s). This policy sets the mechanism by which a carer's need for short breaks can be met best through services provided to the service user and/or a personal budget provided directly to them.

1.11 This policy rests upon a general assumption and expectation that short breaks are replacement care, replacement care may be needed to enable a carer to look after their own health and wellbeing alongside caring responsibilities, and to take a break from caring. In these circumstances, where the form of the replacement care is essentially a homecare service provided to the adult needing care that enables the carer to take a break, it should be considered a service provided to the cared-for person, and thus must be charged to them not the carer

1.12 Services provided to the service user are subject to financial assessment. This is undertaken as outlined by the Fairer Contributions Policy and the Fair Access to Care Services Policy Eligibility Framework and Guidance.

2 Scope

2.1 The assessment of need forms the basis on which the Trust responds to requests for assistance and is concerned with exploring a person's presenting needs and determining their eligibility for services. As part of the Assessment and Support Planning process, the need for short breaks or other appropriate services to enable the carer to continue caring may be identified. A carer's need can be considered separately via a carer's assessment, or jointly in the same assessment as the service user.

2.2 Carers can be eligible for support in their own right. The national eligibility threshold for carers is also set out in the Care and Support (Eligibility Criteria) Regulations 2014. The threshold is based on the impact a carer's needs for support has on their wellbeing.

2.3 The need for these services, as with any community service or activity, must be identified as part of the assessment of a person's needs and any subsequent review(s) and can only be provided where the person is eligible for a service as set out in the Department of Health's Guidance on Fair Access to Care Services

2.4 The amount of money allocated to meet a service user's eligible needs is established by the Resource Allocation System. TSDHCT considers on an individual basis if this is sufficient to meet a person's needs. The amount may be re-considered if there is compelling evidence that more money is required due to complexity of need or other circumstances identified at assessment. The Cost, Choice and Risk Policy (attached as appendix one) will be used to aid decision making in these circumstances.

2.5 The amount of money allocated through the Resource Allocation System is referred to as the 'Personal Budget'. The service user, and their carer, will then have choices in how their care needs are met within this personal budget. These choices will be considered in discussion with the service users, and their carer, to agree the type, range and amount of services that will be provided from this personal budget.

2.6 The cost of short breaks will be taken into account, in the resource allocation and personal budget processes, by calculating the likely annual cost of the short breaks and dividing this by 52 to calculate an assumed weekly cost (eg short breaks totalling £520 per year would have an assumed weekly cost of £10)

2.7 Where an individual requests a Direct Payment to meet their assessed needs for care, the same principles will apply as to those people opting to received support directly from Adult Social Care. The cost of short breaks will only be included in the Direct Payment where it is considered that the carer or service user is eligible for this support.

2.8 The provision of short breaks is subject to a charge under TSDHCT's Non-Residential Charging Policy. This policy may be reviewed from time to time, and changes may affect the charge which will be made for the provision of respite.

2.9 Short breaks can be offered in a wide variety of ways including:

- Breaks in specialist short break units (specialist guest houses, community flats, purpose-built or adapted houses);
- Breaks in care homes;
- Breaks in the home of another individual or family who have been specially recruited (such as adult placement schemes);
- Breaks at home through a care assistant or sitting service;
- Facilitated access to clubs, interest or activity groups;
- Holidays;
- Supported breaks for the person with care needs and their carer together;
- Peer support groups (e.g. For young carers);
- Breaks in supported accommodation;
- Breaks using self-directed support, for example, direct payments or managed care.

2.10 When a person has been assessed as eligible, Short Breaks can be funded by the Continuing Healthcare Funding Stream. In these circumstances decisions will be made the principles of reasonableness, fairness and equity. These services are not chargeable and all references to charging and social care legislation do not apply. However, the same principles of good practice and supporting carers will be central to the support planning in these cases.

3 Legal Framework

3.1 The Care Act 2015

The Care Act replaces all the social care act legislation governing carer's rights.

The act comes into force in April 2015. With respect to supporting carers, it requires councils to assess any carer who appear to have needs for support.

The council must consider whether a carer is willing to care, the impact on their needs on wellbeing, the outcomes a carer wishes to achieve and if the provision of support could contribute to the achievement of these outcomes. It requires adult services to assess the needs of young carers and to ensure they extend carer's rights to the carers of disabled young people in transition.

4 Aims of the policy

The aims of this policy are to ensure that TSDHCT does as much as it can to support carers to sustain their caring role and help maintain their health and wellbeing. It intends to ensure equity of access to short breaks; to reflect national and local priorities and to underpin any future proposals for changes to the existing arrangements for access to and the provision of TSDHCT funded short breaks.

5 Principles and Provision

5.1 Following an assessment of need TSDHCT will only fund short breaks for FACS eligible needs identified at assessment.

5.2 Service Users and Carers will be encouraged to use their personal budget to purchase services best suited to them, chosen from a range of services.

5.3 Short breaks are an integral part of a whole support plan, and should not be treated as an 'add on' or 'separate' service. This principle is an essential component of TSDHCT's approach to its provision and will ensure fair access to short breaks.

5.4 This policy recognises that a reasonable charge will be applied for the provision of TSDHCT funded services. Such a charge will be calculated in accordance with a financial assessment under the TSDHCT Non-Residential Charging Policy.

6 Implementation

6.1 This policy will be applied from 1st April 2015 to any new adult health & social care service users. Existing service users will be informed individually when this policy will affect them; this would usually be at the time of their annual review or when their needs are reassessed.

6.2 Some existing service users may lose their eligibility for short breaks, or see it reduced, under this policy. However this will only happen following a full reassessment of a person's needs and circumstances. These cases will be considered sympathetically and the transition to new arrangements will be agreed with the individual carer, user and assessor.

7 Monitoring, Review and Reassessment

7.1 Any impact this policy has had on the ability of carers to continue in their caring role, and to maintain their health and wellbeing, will be considered by assessing officers at a review or reassessment of the individual's needs.

7.2 An individual or their authorised representative can request a review of their social care assessment at any time. This should be undertaken at least annually.

If the individual disagrees with the assessment and wishes this to be reconsidered, then they should tell the operational team who carried out the assessment. If they are unable to resolve matters this way then they should contact TSDHCT's complaints team.

8 Complaints

TSDHCT's Complaints Policy welcomes and responds positively to all comments, compliments and complaints as a means of demonstrating its commitment to working in partnership with individuals and carers.

Budget Proposals 2014/15 and 2015/16: Equality Impact Assessment (EIA)

Officer Name:	**Joanna Davies**	**Position:**	**Operational Change Lead**
Business Unit:	**Operational Change**	**Directorate:**	**Operations**
Executive Lead(s):	**Cathy Williams**	**Date:**	**22/12/14**

The council and its partners are facing a significant challenge in the savings it needs to make over the next couple of years. This Equality Impact Assessment (EIA) has been developed as a tool to enable business units to fully consider the impact of their proposals on the community. As a council we need to ensure that we are able to deliver the savings that we need to make while mitigating against any negative or adverse impacts on particular groups across our communities.

This EIA will evidence that the Council have fully considered the impact of the proposed changes and has carried out appropriate consultation on those changes with the key stakeholders. This EIA and the evidence provided within it will allow Councillors to make informed decisions as part of the decision-making process regarding the council's budget.

Executive Lead / Head Sign off:

Executive Lead(s)	**Cathy Williams**	**Executive Head:**	**Steve Honeywill**
Date:		**Date:**	

Summary from Overall Budget Proposals:
Copy from Overall Budget Proposal template

Proposals – Outline	**Savings for 2014/15 and 2015/16**		**Implementation Cost** *Include brief outline + year incurred*	**Delivery** *When will this proposal realise income / savings*	**Risks / impact of proposals** • *Potential risks* • *Impact on community* • *Knock on impact to other agencies* • ***If statutory service please state relevant legislation section and Act together with any statutory guidance issued.***	**Type of decision**		
	Income £ 000's	**Budget reduction £ 000's**				**Internal**	**Minor**	**Major**
Because of changing needs and The Care Act 2014, TSDHCT needs to refresh our policy for short break provision for all adults under one policy and then consider how best to implement this – ensuring we are appropriately supporting the carers with the highest needs and ensuring equitable, value for money provision.					There is potential for negative response/publicity at the consultation phase. This could be viewed in the wider context of budgetary pressures however, our arrangements do require review and need to provide fairer outcomes and equity across the board.			

Section 1: Purpose of the proposal/strategy/decision

No	Question	Details
1.	**Clearly set out the proposal and what is the intended outcome.**	The proposed Short Breaks Policy (The Policy) will be finalised by February 2015; it aligns current practice and the changes required under The Care Act. The Policy defines what a carer is under the legislation and ensures that The Council's legal duties are exercised appropriately. New arrangements for short breaks will be developed following consultation of The Policy and a subsequent options appraisal for the commissioning and delivery of services to meet the needs of carers in a person centred way.
2.	**Who is intended to benefit / who will be affected?**	The Short Breaks Policy underpins Torbay and Southern Devon Health and Care NHS Trust's (TSDHCT) (The Trust's) commitment to supporting carers to continue in their valuable role by ensuring access to a range of services which provide eligible carers with a break from their caring role. It affects all people who potentially may use short breaks – everyone receiving a care package in the community and their carers.

Section 2: Equalities, Consultation and Engagement

Torbay Council has a moral obligation as well as a duty under the Equality Act 2010 to eliminate discrimination, promote good relations and advance equality of opportunity between people who share a protected characteristic and people who do not.

The **Equalities, Consultation and Engagement** section ensures that, as a council, we take into account the Public Sector Equality Duty at an early stage and provide evidence to ensure that we fully consider the impact of our decisions/proposals on the Torbay community.

Evidence, Consultation and Engagement

No	Question	Details
3.	**Have you considered the available evidence?**	*Consider data and research already available locally and nationally. Your assessment should be under-pinned by up-to-date and reliable, factual information about the different groups the proposal is likely to affect. For instance, population profile, satisfaction data, deprivation statistics and how this helps to build a picture around your proposal.*
4.	**How will / have you* consulted on the proposal?** **delete as appropriate*	*Have you carried out any consultation on your proposal and if so how? Focus groups / survey / events? Remember that it may be important to also consult on any alternative options. Also include who will you / have consulted with and if applicable which specific groups you will / have consulted with (i.e. groups who may be specifically affected by your proposal, specific equality or hard to reach groups).*
5.	**Outline the key findings**	***TO BE COMPLETED ONCE CONSULTATION UNDERTAKEN**: Include feedback on your proposal including where you have consulted on any alternative options. Also include response rates, number of attendees to events / focus groups, outline of specific interest groups consulted. Use bullet points to summarise the key conclusions.*
6.	**What amendments may be required as a result of the consultation?**	***TO BE COMPLETED ONCE CONSULTATION UNDERTAKEN**: Has feedback from the consultation and engagement process identified any changes required to the proposal? Have you had to alter your decision and look at alternative options?*

Positive and Negative Equality Impacts ***TO BE UPDATED ONCE CONSULTATION UNDERTAKEN***

No	Question	Details		
7.	**Identify the potential positive and negative impacts on specific groups**	*It is not enough to state that a proposal will affect everyone equally. There should be more in-depth consideration of available evidence to see if particular groups are more likely to be affected than others – use the table below. You should also consider workforce issues. If you consider there to be no positive or negative impacts use the 'neutral' column to explain why.* ***EVERY BOX MUST BE COMPLETED – if there is no impact please state either 'No Positive Impact' or 'No Negative Impact'.***		
		Positive Impact	**Negative Impact**	**Neutral Impact**
	Older or younger people		x	
	People with caring responsibilities		x	
	People with a disability		x	
	Women or men			x
	People who are black or from a minority ethnic background (BME)			x
	Religion or belief (including lack of belief)			x
	People who are lesbian, gay or bisexual			x
	People who are transgendered			x
	People who are in a marriage or civil partnership			x
	Women who are pregnant / on maternity leave			x
	Socio-economic impacts (Including impact on child poverty issues and deprivation)			x

No	Question	Details		
	Public Health impacts (How will your proposal impact on the general health of the population of Torbay)			x
8a.	**Cumulative Impacts – Council wide** (proposed changes elsewhere which might worsen the impacts identified above)	*Are any cumulative impacts identified across your service area from proposals in other departments OR from other service areas? Please explain what these might be (you may need to revisit this section once proposals have been further defined)* *NONE*		
8b.	**Cumulative Impacts – Other public services** (proposed changes elsewhere which might worsen the impacts identified above)	*Are any cumulative impacts identified across your service area from proposals in other public services or partner organisations? Please explain what these might be (you may need to revisit this section once proposals have been further defined)* *NONE*		

Section 3: Mitigating action ***TO BE UPDATED ONCE CONSULTATION UNDERTAKEN***

No	Action	Details
9.	**Summarise any negative impacts and how these will be managed?**	*Outline each negative impacts identified relating to equalities in question 7 and how each impact will be managed / monitored so that they are reduced / eliminated or mitigated. What ways can the negative impact be minimised?* ***There is potential negative impact to frail older people, carers and people with a disability*** ***This negative impact is the same, that overall care packages will be reduced by a strict adherence to the new policy's proposal that all short breaks be costed from within the RAS. This means that people with learning disabilities, in particular, will find that a vacancy based generous allocation of short break vouchers will reduce.*** ***The mitigation of this action is a commitment that all assessments are person centered, and allocated amounts based on need – with flexibility dependent on individual circumstances.***

Section 4: Monitoring ***TO BE UPDATED ONCE CONSULTATION UNDERTAKEN***

No	Action	Details
10.	**Outline plans to monitor the actual impact of your proposals**	The policy's impact on individuals will be monitored at individual review. New arrangements for short breaks will be developed following consultation of The Policy and a subsequent options appraisal for the commissioning and delivery of services to meet the needs of carers in a person centred way.

Section 5: Recommended course of action – ***TO BE COMPLETED WHEN ALL SECTIONS COMPLETE AND EIA FINALISED***

No	Action	Outcome	Tick ✓	Reasons/justification for recommended action
11.	**State a recommended course of action** *Clearly identify an option and justify reasons for this decision. The following four outcomes are possible from an assessment (and more than one may apply to a single proposal). Please select from the 4 outcomes and justify the reasons for your decision*	***Outcome 1: No major change required -*** *EIA has not identified any potential for adverse impact in relation to equalities and all opportunities to promote equality have been taken*		
		Outcome 2: Adjustments to remove barriers *– Action to remove the barriers identified in relation to equalities have been taken or actions identified to better promote equality*		
		Outcome 3*:* ***Continue with proposal*** *- Despite having identified some potential for adverse impact / missed opportunities in relation to equalities or to promote equality. Full justification required, especially in relation to equalities, in line with the duty to have 'due regard'.*	✓	The new policy is designed to address inequalities and operational difficulties in current policy and practice. We also need to address concerns in practice issues and concerns from carers: • A lack of provision in the residential market – this

				leads to problems with short break users finding a vacant bed to place their relative and means that forward planning is extremely difficult • Review of the existing short breaks voucher system which experiences problems in its application, due to inconsistencies in its application and provision problems (above) • Meeting the needs of very complex people, including those in receipt of Continuing Health Care • The use and efficiency of The Baytree Short Breaks Unit (in house provision).
		Outcome 4: Stop and rethink *– EIA has identified actual or potential unlawful discrimination in relation to equalities or adverse impact has been identified*		

Adult Social Care

Director: Caroline Taylor
Executive Lead: Cllr Christine Scouler

Adults and Older People – Residential and Nursing Home Provision

<table>
<tr><th>What is provided?</th><th>Why is it provided?</th><th>What drives demands?</th><th>Budget Reference</th></tr>
<tr>
<td>Provides accommodation, care and support to clients unable to live at home. They may also have chronic/complex needs which prevent them from being cared for safely at home or within another setting.</td>
<td>To proactively support the individual in maintaining and/or developing their activities of daily living skills.
To ensure the client, working closely with carers and the zone team maintains links with family and community.
To promote the health and welfare of the individual resident receiving the service.</td>
<td>The service is provided to people who can no longer be supported to live at home and/or have chronic and complex needs which prevent them from being care for safely at home or in another setting (858 in total – includes full cost clients and short stay placements).
<table>
<tr><th>Placement Numbers</th><th>Older People</th><th>Mental Health (under 65)</th><th>Learning Disability</th><th>TOTAL</th></tr>
<tr><td>Residential Care</td><td>591</td><td>60</td><td>114</td><td>765</td></tr>
<tr><td>Nursing Care</td><td>91</td><td>2</td><td>0</td><td>93</td></tr>
<tr><td>Total</td><td>682</td><td>62</td><td>114</td><td>858</td></tr>
</table>
</td>
<td>103-107</td>
</tr>
</table>

Adults and Older People – Domiciliary and Day Care Services

<table>
<tr><th>What is provided?</th><th>Why is it provided?</th><th>What drives demands?</th><th>Budget Reference</th></tr>
<tr>
<td>Domiciliary care provides tailored support within a client's home to meet their individual needs. The person is visited at various times of the day or, in some cases, care is provided over a full 24-hour period. Day care provides a range of meaningful social activities aimed at sustaining a person's capacity to live independently.</td>
<td>The reasons for the service are reflected in the expected outcomes, including:
• Extended Client choice in the way their care needs are met
• Clients live more independent and healthy lives
• A wide range of responsive and accessible personal and non-personal care services are provided, with an emphasis on prevention and enabling independence
• High quality support for people with long-term needs is provided</td>
<td>
<table>
<tr><th></th><th>TOTAL</th><th>Older People</th><th>Mental Health (under 65)</th><th>LD</th><th>Total</th></tr>
<tr><td>Domiciliary Care</td><td>824</td><td>689</td><td>40</td><td>95</td><td>824</td></tr>
<tr><td>Day Care</td><td>231</td><td>122</td><td>2</td><td>107</td><td>231</td></tr>
<tr><td>Direct Payment</td><td>380</td><td>241</td><td>16</td><td>123</td><td>380</td></tr>
<tr><td>Total</td><td>1,435</td><td>1,052</td><td>58</td><td>325</td><td>1,435</td></tr>
</table>
</td>
<td>103-107</td>
</tr>
</table>

Learning Disabilities

<table>
<tr><th>What is provided?</th><th>Why is it provided?</th><th>What drives demands?</th><th>Budget Reference</th></tr>
<tr><td>Organisations within Torbay will work together to ensure that people with a learning disability will be able to enjoy the same basic rights as anyone else. People will be housed and supported to find work that is suited to them. They will also be able to enjoy time with friends and family and take part in the culture and community of Torbay.</td><td>To support clients to live in their own homes rather than living in residential care.
To support clients into employment.
To support clients with learning disabilities to play an active role within the community.</td><td>
<table>
<tr><th>Demand</th><th>TOTAL</th></tr>
<tr><td>Domiciliary & Day Care & Direct Payments</td><td>325</td></tr>
<tr><td>Care Homes</td><td>114</td></tr>
<tr><td>In-House services</td><td>90</td></tr>
<tr><td>Total</td><td>529</td></tr>
</table>
<table>
<tr><th>Ordinary Residence</th><th>2012/13</th><th>2013/14</th></tr>
<tr><td>People moving into Torbay</td><td>28</td><td>6</td></tr>
<tr><td>Pending</td><td>n/a</td><td>4</td></tr>
<tr><td>Projected to year end</td><td>n/a</td><td>2</td></tr>
<tr><td>People moving out to other areas</td><td>-2</td><td>-5</td></tr>
<tr><td>Balance</td><td>+26</td><td>+7</td></tr>
</table>
</td><td>103-107</td></tr>
</table>

Mental Health Services

What is provided?	Why is it provided?	What drives demands?	Budget Reference
To support people during acute/severe and enduring mental health problems using appropriate residential, nursing, domiciliary and day care services as well as provide specialist advice to other frontline teams. Mental health services for people under the age of 65 are co-ordinated by Devon Partnership Trust; services for people aged over 65, and suffering with dementia, are co-ordinated by the Trust.	Dementia is one of the biggest challenges facing health and social care at present and has been highlighted as one of the most important areas for focus. In Torbay our age profile means that this is even more an issue than most areas.	**No. Care Home Clients** Community Mental Health Team – under 65: 62 Older People Mental Health Team: 214 **Total: 276**	103-107

Support to carers

What is provided?	Why is it provided?	What drives demands?	Budget Reference
Information, advice and emotional support to carers which also prevents the breakdown of their physical or mental health. Flexible breaks and other support is available which is not dependent on accessing statutory services. The service enables an appropriate response to most needs and an effective referral mechanism for more complex cases.	The Torbay model of carers support combines low cost, direct access for carers to information, advice and support; encouragement of self care/self assessment; improvement in self help networks in the community, together with targeted support. This universal offer enables an appropriate response to most needs and effective referral for the more complex cases. Early identification and targeting 'hidden carers' reduces crisis responses and supports a shared and integrated approach across the health and social care system	• Torbay Carers Register supported 3570 carers in 2013-14 (524 new carers joined the Register) • 4466 carers were supported through their GP surgery in year to 01/04/14 (up from 4303 at 01/04/13) • Average of 240 new enquiries per month were made to Signposts Information Service • At 01/04/14 182 Young Adult Carers had received support from the service and 293 carers under 25 were known to adult teams • 2013-14 target for carers assessments exceeded – target 31%, achieved 35.3%	103-107

Partnership Commissioned Services

What is provided?	Why is it provided?	What drives demands?	Budget Reference
A range of community services are commissioned particularly for housing related support for Torbay's vulnerable people with a local connection, who need support to remain living independently. Services intervene early to prevent the greater financial and social cost of acute responses to incidents such as, threatened homelessness, poor mental health and domestic abuse.	There is no statutory requirement these services but the programme plays a key role in delivering the Council's statutory duties in relation to homelessness and children, families and young people, crime and disorder and public health.	Client groups include older people, homeless families, people with learning disability and physical/sensory disability, young people and ex-offenders.	102

Community Equipment Service

What is provided?	Why is it provided?	What drives demands?	Budget Reference
The Community Equipment Service is jointly commissioned by Torbay Council and Southern Devon CCG. The service provides complex aids for daily living (including, specialist beds, mattresses, hoists and syringe pumps) and minor adaptations (such as grab rails and ramps). It also provides the administration for the Simple Aids for Daily Living (including, walking frames, shower stools and bath boards) aids service which is provided by a range of local retailers.	The equipment and adaptations provided enable children and adults to remain independent avoiding delayed hospital discharge, admission into residential and nursing care and support end of life care at home.	Demand is driven by the need to safely discharge people from hospital and intermediate care with the equipment adaptations they will need to remain independent as well as ensuring people can remain independent at homer following illness or disability. This is new service so there is no historical data available. In April there were 297 clients who received community equipment. In May this increased to 611 clients	100

Service Title: Adult Social Care

Manager: Caroline Taylor

Business Unit: Adult Social Care

Director: Caroline Taylor

Brief Description of Service:

Torbay Council currently commissions Torbay and Southern Devon Health and Care NHS Trust (formerly Torbay Care Trust) to co-ordinate the delivery of Adult Social Care in Torbay. The provision of these services is governed by an Annual Strategic Agreement (ASA). The Council is the lead body in the operation of an equipment store for the purchase and distribution of items to support social care. The expenditure split over services within Adult Social Care (ASC) is an indicative split based on 14/15 estimates.
In addition Section 256 monies have not been included because the method of allocation has not yet been announced (£3m 14/15).
Supporting People supports the promotion of the independence of vulnerable people based on the commissioning of housing related support from a range of providers.

Service provides:-	No of Staff (**FTE)	Employee Direct Costs	Premises	Supplies & Services	Contribut'n to Reserves	Other	Total Expenditure (*ATL)	Fees, Charges & Sales	Govern't Grant Income	Contribut'n from Reserves	Other	Total Income (*ATL)	Net Expenditure (*ATL)
		£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000
107 ASC - Commissoning & Delivery	0	0	0	2,181	0	0	2,181	0	0	0	0	0	2,181
104 ASC - Learning Disability	0	0	0	9,596	0	0	9,596	0	0	0	0	0	9,596
105 ASC - Mental Health	0	0	0	2,780	0	0	2,780	0	0	0	0	0	2,780
106 ASC - Other Social Care	0	0	0	6,227	0	0	6,227	0	0	0	0	0	6,227
103 ASC - Physical & Sensory	0	0	0	12,888	0	0	12,888	0	0	0	0	0	12,888

Service provides:-	No of Staff (**FTE)	Employee Direct Costs	Premises	Supplies & Services	Contribut'n to Reserves	Other	Total Expenditure (*ATL)	Fees, Charges & Sales	Govern't Grant Income	Contribut'n from Reserves	Other	Total Income (*ATL)	Net Expenditure (*ATL)
		£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000	£`000
100 Joint Equipment Store	0	0	0	996	0	0	996	-498	0	0	0	-498	498
102 Supporting People	7.6	140	0	1,573	0	0	1,713	-288	0	-222	0	-510	1,203
TOTAL	**7.6**	**140**	**0**	**36,241**	**0**	**0**	**36,381**	**-786**	**0**	**-222**	**0**	**-1,008**	**35,373**

Note: *ATL = 'Above the Line' budget is the net budget that an officer is responsible for, which excludes reallocated support services **FTE = Full Time Equivalent