Wednesday, 01 December 2021

Meeting of the Health and Wellbeing Board

Thursday, 9 December 2021
2.00 pm
Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board
Councillor Jackie Stockman (Chairwoman)
Pat Harris, Healthwatch Torbay
Liz Thomas, NHS England
Matt Fox, NHS Devon Clinical Commissioning Group
Jo Williams, Director of Adults Services
Nancy Meehan, Director Children's Services
Lincoln Sargeant, Director of Public Health

Co-opted Members of the Board
Jo Hammond, Devon Partnership NHS Trust
Pat Teague, Ageing Well Assembly
Ian Ansell, Torbay Safeguarding Children Board
Alison Brewer, Primary Care Representative
Julie Foster, Torbay and Southern Devon Health and Care NHS Trust
Tara Harris, Divisional Director of Community and Customer Services
Alison Hernandez, Police and Crime Commissioner
Adel Jones, Torbay and South Devon NHS Foundation Trust
Chris Forster, Torbay Community Development Trust
Tanny Stobart, Imagine This Partnership
Mike Page, Department for Work and Pensions
Neil Ralph, Devon and Cornwall Police

Download this agenda via the free modern.gov app on your iPad, Android Device or Blackberry Playbook. For information relating to this meeting or to request a copy in another format or language please contact:
Lisa Antrobus, Town Hall, Castle Circus, Torquay, TQ1 3DR

Email: governance.support@torbay.gov.uk - www.torbay.gov.uk

HEALTH AND WELLBEING BOARD
AGENDA

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

2. Declaration of interest

2(a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

2(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

3. Urgent items
To consider any other items that the Chairman/woman decides are urgent.

4. Torbay Joint Health and Wellbeing Strategy (Pages 4 - 6)
To consider an update on the development of the Torbay Joint Health and Wellbeing Strategy.

5. Torbay Joint Health and Wellbeing Strategy Outcomes Framework update, November 2021 (Pages 7 - 14)
To consider a report on the above.

6. Multiple Complex Needs - Partnership Approach (Pages 15 - 17)
To consider a report on the partnership approach to Multiple Complex Needs.

7. Better Care Plan 2021/22 (Pages 18 - 41)
To consider a report that details how the Better Care Fund will be used in 2021/22.

8. **Digital Business Case for Electronic Patient Record for Torbay and South Devon NHS Trust** (Verbal Report)

9. **Director of Public Health - Annual Report** (To Follow)
To note the Director of Public Health Annual Report.

10. **Torbay and Devon Safeguarding Adults Partnership 2020-21 Annual Report** (Pages 42 - 55)
To note the Annual Report of the Torbay and Devon Safeguarding Adults Partnership.

11. **Work Programme** (Pages 56 - 61)
To note the work programme for the forthcoming 12 months.

Meeting Attendance
Torbay Council continues to operate in a Covid-19 secure manner in order to protect staff and visitors entering Council buildings and to help reduce the spread of Covid-19 in Torbay. This includes social distancing and other protective measures (e.g. wearing a face covering (unless exempt), signing in and using hand sanitiser). Our public meetings will continue to operate with social distancing measures in place and as such there are limited numbers that can access our meeting rooms. Also, to help prevent the spread of the virus, anyone attending meetings is asked to take Covid lateral flow test the evening before - if you have a positive test result, please follow the Government's guidelines and do not attend the meeting.

If you wish to attend a public meeting, please contact us to confirm arrangements for your attendance.

Title: Torbay Joint Health and Wellbeing Strategy

Wards Affected: All

To: Health and Wellbeing Board **On:** 9th December

Contact: Maria van Hove
Telephone:
Email: maria.vanhove@torbay.gov.uk

1. Purpose

To update members on the development of the strategy.

2. Recommendation

Members are asked to endorse the priorities and the process for developing the strategy.

3. Supporting Information

Torbay's health and wellbeing strategy will focus around the priority areas identified in the June and September Health and Wellbeing Board workshops.

Focus areas are:

1. Good mental health
2. A good start to life
3. Healthy ageing
4. Complex needs
5. Digital inclusion

Following on from these workshops, Torbay's Public Health team is working with partners from across the system on developing specific goals for each priority area, together with outcomes that will be monitored throughout the year.

The above priority areas will be underpinned by five cross-cutting areas, four of which were also identified by the Health and Wellbeing Board at the June and September meetings:

1. Housing
2. Physical activity
3. Tackling inequalities
4. Climate Change and environmental sustainability

5. Supporting carers

Housing has emerged as a fundamental enabler through subsequent work with priority area leads and is therefore proposed as an important underpinning area which should feature in the Strategy.

The table below shows the timeline for strategy development.

The draft Strategy will be shared with Board members at the end of January 2022 to enable members to comment on the draft before submission to Council Cabinet. The pre-consultation Strategy will be discussed in detail in the March Health and Wellbeing Board meeting, and the final Strategy document will come to the June meeting after public consultation.

Step	**Date**
Draft to Health and Wellbeing Board members	31 January 2022
Draft Strategy submitted	24 Feb 2022
Torbay Council Senior Leadership Team approve draft Strategy for Cabinet	1 March
Torbay Council Informal Cabinet approve draft for consultation	8 March 2022
Health & Wellbeing Board meeting discuss consultation draft & agree delivery mechanisms	17 March 2022
Launch of 6 week public consultation	22 March 2022
Final post consultation Strategy submitted to Health & Wellbeing Board meeting	09 June 2022
Final strategy approved by Torbay Council Senior Leadership Team	21 June 2022
Final Strategy approved by Informal Cabinet for recommendation to Council	28 June 2022
Strategy approved by Council	21 July 2022

4. Relationship to Joint Strategic Needs Assessment

4.1 Priorities of the JSNA are reflected in the strategy.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 This paper outlines the development of the revised Joint Health and Wellbeing Strategy 2022-26.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 This is the proposal for updating the strategy that the Health and Wellbeing Board endorses.

Appendices

Background Papers

The following documents/files were used to compile this report:

- Torbay Joint Health and Wellbeing Strategy 2018-22: Joint Health and Wellbeing Strategy - Torbay Council

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Torbay Joint Health and Wellbeing Strategy Outcomes Framework update, November 2021		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	Thursday 9 December
Contact:	Claire Truscott, Public Health Intelligence Analyst		
Telephone:	01803 208377		
Email:	claire.truscott@torbay.gov.uk		

1. Purpose

1.1 November 2021 update of the Joint Health and Wellbeing Strategy Outcomes Framework

2. Recommendation

2.1 The following narrative and table is considered for information purposes, with issues discussed

3. Supporting Information

3.1 The table below includes measures for each of the priorities of Torbay's Joint Health and Wellbeing Strategy 2018-22 - Thriving Lives. The main issues shown by this table are below:

3.1.1 **Prevention: Work together at scale to promote good health and wellbeing and prevent illness**

The **life expectancy gap** (1 and 2) represents the range in years of life expectancy from most to least deprived. For males the gap is widening- rising for 5 periods to 11.5 years, in the worst quintile in England. For females the figure remains in the 2nd worst quintile at 7.7 years.

The rate of **hospital admissions for alcohol related conditions (broad definition)** (4) is where either the primary diagnosis or one of the secondary diagnoses is an alcohol-related condition. This is a new method of calculation taking account of the latest academic evidence and more recent alcohol-consumption figures. The four periods reported show Torbay as significantly higher than the England figure, with 1,974 per 100,000 the outcome for 2019/20.

3.1.2 **Enable children to have the best start in life and address the inequalities in their outcomes**

There is a steady decrease in **smoking in pregnancy** rates (6) at 11.0%. Ten years earlier it was 20.9%.

Measures 10 and 11 on **school achievement** come from the Department for Education. Statistics for 2019/20 were cancelled due to Covid-19.

The proportion of **children scoring at or above the expected level at 2-2 ½ years** (9) has decreased since the previous year from 91% to 84%, which is now not significantly different to England.

In March 2021 the rate of **Children in Need** (14) increased to 562.7 per 10,000, the highest in 6 years and significantly worse than England.

The rate of **Children Looked After** (15) in March 2020 is on a general increasing trend at 140 per 10,000 and significantly worse than England.

HPV vaccination of 13-14 year old females (17)- the 2nd completing dose- has decreased to worse compared to the goal. Due to Covid-19 the delivery of the school immunisation programmes was paused which has had a big impact on HPV vaccinations in the 2019/20 academic year.

3.1.3 **Building emotional resilience in young people**

The hospital admission rate for **self-harm in 10-24 year olds** (19) remains significantly worse than England in 2019/20 although on a generally reducing trend in the last 4 periods.

3.1.4 **Create places where people can live healthy and happy lives**

The percentage of **adults classified as overweight or obese** (24) has increased from 59.8% to 67.0% in 2019/20 but is similar to England. This is the highest in the 5 periods recorded.

3.1.5 **Support those who are at risk of harm and living complex lives, addressing the underlying factors that increase vulnerability**

Successful completion of alcohol treatment (28) (not re-presenting within 6 months) has decreased and is now significantly worse than England.

The rate of **hospital admissions for alcohol related conditions (narrow definition)** (29) is where the primary diagnosis is an alcohol- related condition. This is a narrower definition than measure 4 and as with measure 4 uses a new method of calculation. In 2019/20 Torbay has been significantly higher than England in the four periods reported.

3.1.6 **Enable people to age well**

The proportion of social care users who reported that they **had as much social contact as they would like** (30) has decreased from 50.8% to 35.3% in 2020/21. The survey took place from January – March 2021 so results could be lower due to Covid-19 restrictions. Torbay is one of only 18 Local Authorities who completed the survey this year and the other results were in the 30s and early 40s.

In 2020/21 the percentage of **flu vaccinations of at risk individuals** (34) has increased to 54.8% which is much closer to the goal of 55% than in previous periods**.** The percentage of **flu vaccinations of those aged 65+** (35) has increased sharply and is now better compared to the goal of 75% (Torbay is 79.8%). The increase for both indicators follows the England trend.

The rate of **emergency admissions due to falls** (37) for those aged 65+ has further decreased to significantly less than England for the 2nd period in a row, a positive outcome.

3.1.7 **Promote good mental health**

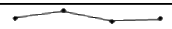
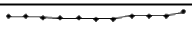
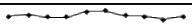
Torbay's **suicide rate** (43) of 18.8 per 100,000 in 2018-20 has levelled off and slightly decreased since the last two periods where it was 19.5 and then 19.0. It has been significantly worse than England for the most recent 5 periods.

Below is the Joint Health and Wellbeing Strategy outcomes table for November 2021 which contains the measures referred to above.

3.2 Joint Health and Wellbeing Strategy Outcomes Table- Torbay, November 2021

Number	Measure	Time period	Type	Torbay	Similar areas[1]	Devon wide (STP[2])	England	Trend of previous figures	RAG rating compared to England/goal[3]	Direction of travel since previous figure
Prevention: Work together at scale to promote good health and wellbeing and prevent illness										
1	Life expectancy gap in males	2017-19	Years	11.5	10.7	7.2	9.4		Worst quintile	
2	Life expectancy gap in females	2017-19	Years	7.7	8.6	4.8	7.6		2nd worst quintile	
3	Adult smoking rate	2019	%	15.0%	13.7%	14.7%	13.9%			
4	Alcohol related ill health- Hospital attributable admissions (Broad definition- new method)	2019/20	Per 100,000	1,974	2,094	1,506	1,815			
5	Mortality rate from preventable conditions	2017-19	Per 100,000	169.5	161.3	135	142.2			
Enable **children** to have the best start in life and address the inequalities in their outcomes										
6	Smoking in pregnancy rate- at time of delivery	2020/21	%	11.0%	13.8%	11.0%	9.6%			
7	Baby's first feed breastmilk	2018/19	%	73.3%	64.4%	73.1%	67.4%			
8	Children in relative low income families	2019/20	%	17.6%	19.4%	15.9%	19.1%			
9	Children who score at or above the expected level in all 5 areas at 2 - 2.5 years (Ages and Stages Questionnaire)	2020/21	%	84.0%	80.6%	88.4%	82.9%			
10	Early years good development (at the end of reception)[4]	2018/19	%	70.8%	70.8%	71.4%	71.8%			
11	Difference between school % of disadvantaged pupils and national % of other pupils achieving an expected score in reading, writing and maths (Key Stage 2)[4]	2019	%	17% lower	South West- 25% lower	23% lower	N/A		N/A	
12	Pupils with statement of Special Educational Needs (SEN) support	2020/21	%	11.7%	13.0%	13.4%	12.2%			
13	Children overweight or obese in year 6[5]	2019/20	%	34.6%	35.9%	30.9%	35.2%			
14	Children in Need rate	2021	Per 10,000	562.7	395.8	306.5	321.2			
15	Children in care/ looked after rate	2020	Per 10,000	140	97	68	67			
16	Population vaccination coverage- MMR for two doses (5 years old)	2020/21	%	91.6%	91.7%	92.6%	86.6%			

Number	Measure	Time period	Type	Torbay	Similar areas[1]	Devon wide (STP[2])	England	Trend of previous figures	RAG rating compared to England/goal[3]	Direction of travel since previous figure
17	Population vaccination coverage- HPV vaccination coverage for two doses (females 13-14 years old)	2019/20	%	71.4%	71.0%	70.4%	64.7%			
Build emotional resilience in **young people**										
18	School pupils with social, emotional and mental health needs	2019/20	%	3.74%	3.21%	3.86%	2.70%			
19	Self harm rates- hospital admissions (10-24 years)	2019/20	Per 100,000	700.7	545.5	650.1	439.2			
Create **places** where people can live healthy and happy lives										
20	Physically active adults	2019/20	%	69.1%	64.5%	71.8%	66.4%			
21	Parkrun for adults- Number of participants[6]	2019	Number	4,975	Local figures				N/A	
22	Parkrun for juniors- Number of participants[6]	2019	Number	605	Local figures			No trend- previous year is from Nov18	N/A	No comparable figure
23	Thriving place index- Scorecard results for local conditions	2021	Score 0-10	4.37	4.71	5.07	N/A		Low - Medium	
24	Overweight or obese adults	2019/20	%	67.0%	67.6%	61.9%	62.8%			
Support those who are at risk of harm and living **complex lives**, addressing the underlying factors that increase vulnerability										
25	Domestic abuse crimes and incidents	2020/21	Number	3,507					N/A	
26	Homelessness rates (New relief duty cases)[7]	2020/21	Per 1,000 households	12.7	Local figures				N/A	
27	Successful drug treatment	2019	%	5.9%	4.8%	4.8%	5.6%			
28	Successful alcohol treatment	2019	%	29.6%	36.9%	30.2%	37.8%			
29	Harmful alcohol use- Hospital admissions for alcohol related conditions (Narrow definition- new method)	2019/20	Per 100,000	732	640	489	519			
Enable people to **age well**										
30	Proportion of people who use services who reported that they had as much social contact as they would like	2020/21	%	35.3%	No data[8]				N/A	
31	Proportion of carers who reported that they had as much social contact as they would like (biennial survey)[9]	2018/19	%	32.4%	34.5%	27.2%	32.5%			

Number	Measure	Time period	Type	Torbay	Similar areas[1]	Devon wide (STP[2])	England	Trend of previous figures	RAG rating compared to England/goal[3]	Direction of travel since previous figure
32	Feel supported to manage own condition	2018/19	%	58.6%	59.7%	62.2%	58.4%		Not calculated	↓
33	Fuel poverty	2019	%	10.5%	13.5%	11.1%	13.4%		Not calculated	↑
34	Population vaccination coverage - Flu (at risk individuals)	2020/21	%	54.8%	55.1%	56.4%	53.0%		🔴	↑
35	Population vaccination coverage - Flu (aged 65+)	2020/21	%	79.8%	81.8%	82.1%	80.9%		🟢	↑
36	Population vaccination coverage - Shingles vaccination coverage (aged 71 years)	2018/19	%	44.5%	49.2%	49.1%	49.1%	No trend- new indicator	🔴	No previous figure
37	Emergency hospital admissions due to falls in people aged 65 and over	2019/20	Per 100,000	1,792	2,302	1,765	2,222		🟢	↓
38	Hip fractures in people aged 65 and over	2019/20	Per 100,000	558	600	543	572		🟡	↑
39	Dementia- estimated diagnosis rate (aged 65 and over)	2021	%	59.9%	61.8%	56.6%	61.6%		🔴	↓
Promote good **mental health**										
40	Self reported wellbeing- low happiness score	2019/20	%	8.0%	9.1%	6.4%	8.7%		🟡	↓
41	Campaigning uptake/impact			To be added						
42	Training numbers			To be added						
43	Suicide rate	2018-20	Per 100,000	18.8	12.0	12.3	10.4		🔴	↓

[1]Amalgamation of values for similar areas - The children and young people's sections use the National Foundation for Educational Research (NFER) Children's Services Statistical Neighbours for Torbay. The rest of the table uses the Chartered Institute of Public Finance and Accounting (CIPFA) statistical nearest neighbours for Torbay.

[2]Sustainability and Transformation Partnership

[3]RAG (Red, amber, green) rating:

🔴 Torbay value is statistically significantly worse than the England value/ worse compared to the goal

🟡 Torbay value is not statistically significantly different to the England value/ similar compared to the goal

🟢 Torbay value is statistically significantly better than the England value/ better compared to the goal

[4]Statistics release for 2020 cancelled due to Covid-19

[5]2017/18 value not published for data quality reasons

[6]Parkruns only took place Jan-Mar in 2020 due to Covid-19 so no figures included for 2020

[7]Rates are locally calculated using Office for National Statistics household projections

[8] Due to Covid-19, the 2020-21 Adult Social Care survey was voluntary for councils to participate. Only 18 councils (including Torbay) chose to take part so data is not available for the majority of other areas and the England outcome cannot be calculated

[9] The Survey of Adult Carers in England (SACE) is biennial and was due to take place in 2020-21. Due to the impact of Covid-19, the survey was postponed until 2021-22

Key

No.	Name of measure/ Benchmarking against goal/ Source
1	A02a- Inequality in life expectancy at birth (Male) - Public Health Outcomes Framework
2	A02a- Inequality in life expectancy at birth (Female) - Public Health Outcomes Framework
3	C18- Smoking prevalence in adults (18+)- current smokers (Annual Population Survey) - Public Health Outcomes Framework
4	Admission episodes for alcohol-related conditions (Broad) - Hospital Episode Statistics, NHS DIgital, calculated by Public Health England
5	E03- Under 75 mortality rate from causes considered preventable (2019 definition) - Public Health Outcomes Framework
6	C06- Smoking status at time of delivery - Public Health Outcomes Framework
7	C05a- Baby's first feed breastmilk - Public Health Outcomes Framework
8	B01b- Children aged under 16 in relative low income families - Public Health Outcomes Framework
9	C08a- Percentage of children achieving a good level of development at 2-2½ years- Ages and Stages Questionnaire (ASQ-3) - Public Health Outcomes Framework
10	B02a- School Readiness: percentage of children achieving a good level of development at the end of Reception - Public Health Outcomes Framework
11	Difference between school % of disadvantaged pupils and national % of other pupils achieving an expected score in reading, writing and maths (Key Stage 2)- Department for Education
12	Percentage of pupils with Statement of Needs (SEN) support (All schools)- academic year- Department for Education
13	C09b- Year 6: Prevalence of overweight (including obesity) - Public Health Outcomes Framework
14	Children in need: Rate per 10,000 children aged under 18- data as of 31 March of the year- Department for Education
15	Children in care: Children looked after at 31 March (rate per 10,000 population aged under 18 years)- data as of 31 March of the year- Department for Education
16	D04c- Population vaccination coverage- MMR for two doses (5 years old). Benchmarking against goal- <90%= red, 90%-95%= yellow, ≥95%= green - Public Health Outcomes Framework
17	D04f- Population vaccination coverage- HPV vaccination coverage for two doses (females aged 13-14 years old). Benchmarking against goal- <80%= red, 80%-90%= amber, ≥90%= green - Public Health Outcomes Framework
18	Percentage of school pupils with social, emotional and mental health needs (School age) - (State funded primary, secondary and special school pupils with SEN/ Statement or EHC with primary need of social, emotional or mental health) Department for Education
19	Hospital admissions as a result of self-harm (10-24 years) - Hospital Episode Statistics, NHS Digital, produced by Public Health England
20	C17a- Percentage of physically active adults - Public Health Outcomes Framework

No.	Name of measure/ Benchmarking against goal/ Source
21	5k Torbay adult parkrun (Saturday mornings) - Torbay Council
22	2k Junior parkrun (Sunday mornings) - Torbay Council
23	Thriving Places Index- Scorecard for local conditions- https://www.thrivingplacesindex.org/
24	C16- Percentage of adults (aged 18+) classified as overweight or obese - Public Health Outcomes Framework
25	Domestic abuse crimes and incidents- Torbay Council Community Services
26	Homelessness rates: New homeless cases at Relief stage- Torbay Council Housing Options team
27	C19a- Successful completion of drug treatment- opiate users - Public Health Outcomes Framework
28	C19c- Successful completion of alcohol treatment - Public Health Outcomes Framework
29	C21 - Admission episodes for alcohol-related conditions (narrow definition) - Public Health Outcomes Framework
30	1i(1)- Proportion of people who use services who reported that they had as much social contact as they would like - Adult Social Care Outcomes Framework
31	1i(2)- Proportion of carers who reported they had as much social contact as they would like - Adult Social Care Outcomes Framework
32	2.1- Feel supported to manage own condition - NHS Outcomes Framework
33	Proportion of households in fuel poverty - Department for Business, Energy and Industrial Strategy
34	D05 - Population vaccination coverage - Flu (at risk individuals). Benchmarking against goal- <55%=red, ≥55%= green - Public Health Outcomes Framework
35	D06a - Population vaccination coverage - Flu (aged 65+). Benchmarking against goal- <75%= red, ≥75%= green - Public Health Outcomes Framework
36	D06c- Population vaccination coverage - Shingles vaccination coverage (71 years old). Benchmarking against goal- <50%= red, 50%-60%= amber, ≥60%= green - Public Health Outcomes Framework
37	C29 -Emergency hospital admissions due to falls in people aged 65 and over - Public Health Outcomes Framework
38	E13- Hip fractures in people aged 65 and over - Public Health Outcomes Framework
39	E15- Estimated dementia diagnosis rate (aged 65 and over)- as in March of the year. Benchmarking against goal- <66.7%(significantly)= red, similar to 66.7%= amber, >66.7%(significantly)= green - Public Health Outcomes Framework
40	C28c- Self-reported well-being- people with a low happiness score (Annual Population Survey) - Public Health Outcomes Framework
41	Campaign uptake/ impact
42	Training numbers
43	E10- Suicide rate - Public Health Outcomes Framework

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Multiple Complex Needs – Partnership Approach
Wards Affected:	All
To:	Health & Wellbeing Board **On:** 9th December 2021

Contact: Bruce Bell
Telephone: 07917 242503
Email: bruce.bell@torbay.gov.uk

1. Purpose

1.1 During January 2021, discussions took place with stakeholders from Torbay Council, the NHS, Police and Probation services with a view to submitting an Expressions of Interest bid for funding from the Ministry of Housing, Communities & Local governments 'Changing Futures: Changing systems to support adults experiencing multiple disadvantage' Programme.

1.2 Though the bid was unsuccessful, the conversations informing the submission highlighted differences in the perspectives of complexity across the system; the challenges posed for different services in meeting the needs of people with complex lives; as well as how best to meet these needs.

1.3 While the procurement of the Multiple Complex Needs (MCN) Alliance is an essential programme of work, it is limited to Torbay Council. The conversations with stakeholders confirmed that a system-wide approach is also required if the aims and objectives of the MCN Alliance are to be realised.

1.4 The Innovations Unit (IU) has been commissioned by Torbay Council to undertake two strands of work [1] to develop the Community Safety Partnership Board; and [2] to work with stakeholders to develop a collective understanding of 'people with complex lives'. It is the latter strand that this paper is concerned with.

1.5 For strand 2, the IU will be working with the Torbay system in developing a shared understanding of complexity. The expected outputs/deliverables will be [1] agreeing shared priority areas of focus within the definition; [2] common principles for new ways of addressing priority areas identified through the process; and [3] a clear understanding of roles and responsibilities in providing support.

1.7 This will be achieved through a series of workshops that are developed collaboratively between the IU, a Design Group comprising of stakeholders from across the system and a 'Lived Experience Thematic Group'. In addition, there will be telephone-based interviews with some key stakeholders.

1.6 Given the partnership nature of this programme of work there is a benefit to having system-wide governance. The Torbay Health and Wellbeing Board is best placed to provide this.

2. Recommendation

2.1 That the Health and Wellbeing Board agrees to provide governance and oversight for this piece of system-wide work.

2.2 That the Health and Wellbeing Board establishes and chairs a sub-group comprising representatives from the Board and any additional members it would view as pertinent. The purpose being to [1] support and influence the direction of travel; [2] oversee outputs from this work; and [3] support/drive any agreed actions that derive from this work.

3. Supporting Information

3.1 Four workshops will be run in the coming weeks (dates to be finalised):

- *Workshop 1:* Defining complexity and the principles to address it.
- Workshop 2: What the data tells us and the realities of complex lives.
- *Workshop 3*: Developing the vision in practice: outcomes, principles, practice model and values.
- Workshop 4: Feedback to the Governing Board on insights gathered.

3.2 The Health and Wellbeing Sub-Group would act as the Governing body receiving the feedback.

4. Relationship to Joint Strategic Needs Assessment

4.1 A common definition of complex lives is where are two or more features are present of substance misuse, homelessness, mental distress or ill-health, domestic abuse, criminal justice involvement.

4,2 All these aspects have been identified by the 2020-21 Joint Strategic Needs Assessment as being of a significant concern in Torbay. Commonly profiles are worse in Torbay than the South West and/or England averages.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 Priority 5 in Torbay's Joint Health and Wellbeing Strategy (2018-22) is concerned with 'supporting those who are at risk of harm and living complex lives,

addressing the factors that increase vulnerability. This commits partners to working together to provide an integrated system based on what is important to those who have complex lives to achieve the strategy's outcomes.

5.2 The development of this system-wide partnership approach as outlined in this paper is a central to the achievement of the strategy's aspirations.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 There is a need to ensure continuance of the 'complex lives' agenda in future iterations of both the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

6.2 For the Joint Health and Wellbeing Strategy it would be beneficial to expand the scope to include the wider system approach to complex lives to include the work outlined in this paper.

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Better Care Plan 2021/22		
Wards Affected:	All		
To:	Health & Wellbeing Board	**On:**	09 December 2021
Contact:	Jenny Turner		
Telephone:			
Email:	Jenny.turner3@nhs.net		

1. Purpose

1.1 The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

1.2 The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

1.3 The Better Care Fund is a pooled fund derived some a series of funding sources. One element of the funds is the Improved Better Care Fund which in itself has several elements and there are different conditions attached to the provision and expenditure of funds within it.

1.4 The attached report details how the Better Care Fund will be used in 2021/22.

2. Recommendation

2.1 The Board is asked to support:

1. A commitment to transformative care learning from the initiatives and taking the momentum from successes to date to deliver improvements in patient experience of care (including quality and satisfaction), improvements across the health of populations, and reducing the per capita cost of health care and deliver the goals of the NHS Long Term Plan.
2. The recognition of the pace of change required with the demographic, workforce and care demand drivers being faced.
3. The proposals made in the accompanying report, for them to be taken through due governance, to deliver a transformation in Torbay's care

provision for the wellbeing of the population including those working and caring within it.

3. Supporting Information

3.1 See Appendix 1 Torbay Better Care Fund Narrative 2021/22
3.2 See Appendix 2 Torbay Better Care Fund Template 2021/22

4. Relationship to Joint Strategic Needs Assessment

4.1 The demand and costs to the system relating to the key challenges evidenced in the JSNA 2018-2020 will increase unless transformative action is applied to those challenges. The transformation that is taking place with the new model of care responds to these challenges and the constant endeavour to improve client and patient experience. Working in an integrated way is key to achieving transformation and addressing the wider determinants of health.

4.2 Better Care Fund, and particularly the iBCF, is there to support the development of an integrated system and seamless transfers of care with a stable and supported provider market delivering services that reduce the pressures on the NHS. This remains a focus with reference to transforming care to meet the challenge of an optimised care system designed through improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care, as well as reducing demand and costs in social care.

4.3 The BCF and iBCF recognise the JSNA's prevention opportunities: the upstream-downstream opportunities to reduce costs, and as health improvement opportunities to prevent the need for treatment services are more cost effective than treating people, to tertiary prevention that aims to prevent the worsening or repeat need for treatment

5. Relationship to Joint Health and Wellbeing Strategy

5.1 Within the BCF narrative and ASC Improvement Plan schemes in progress there are many that will support the preventative and early intervention strategies. With the projected demand on services and the recent workforce reports from Health Education England (190,000 more staff 2027) and Skills for Care (700,000 more staff by 2030) excluding the factor associated with a compound effect of annual turnover requiring in excess of 1 million new workers in the current 'as-is' system, it is clear that the support must be focussed on accelerating a transformation to a new model of care. This requires the engagement of and delivery models with an increasingly broad range of stakeholders and the community themselves. The development of a care-force beyond a workforce requires a shift in tasks and costs. Along with this is the care of those that are caring. Wellbeing and the devolvement of action to an up-skilled and technologically enabled care-force with solid infrastructure and oversight is essential.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 Nothing is needed to change in future versions of the JSNA and/or JHWS as a result of what the Better Care Fund Board are asking the Health and Wellbeing Board to do in relation to the Better Care Fund 2021/22 Plan

Appendices

Appendix 1 – Torbay Better Care Fund Narrative

Appendix 2 – Torbay Better care Fund Template

Background Papers

The following documents/files were used to compile this report:

NHS Long Term Plan, http://www.longtermplan.nhs.uk/

Better Care Fund, https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

2018-2020 Joint Strategic Needs Assessment for Torbay, http://www.torbay.gov.uk/DemocraticServices/documents/s50293/JSNA%20Appendix%201.pdf

Torbay Better Care Fund Narrative
2021/22

1. Introduction

The Better Care Fund brings together health and social care funding. Organisations across the Devon Integrated Care System (ICS) are in agreement in terms of having a sustainable health and care system which will improve the health and wellbeing of the population, of which the Better Care Fund is a mechanism to assist in achieving this aim.

As such, this narrative plan, together with the planning template, have been created by system partners including Devon Partnership NHS Trust, agreed by:

- Torbay Council
- NHS South Devon and Torbay Clinical Commissioning Group
- Torbay and South Devon NHS Foundation Trust

and then formally approved by the Torbay Health & Wellbeing Board with oversight by Torbay Adult Social Care Transformation Board and the Adult Social Care Improvement Board.

There are specific conditions in terms of use of funding and the metrics by which the plan will be measured, with a particular focus on avoidable admissions, length of stay, discharging to normal place of residence, residential admissions and reablement. There are also conditions in terms of working together across organisational boundaries and in agreeing proposals for the use of the funding, which have been addressed by creating a collaborative and co-designed plan with associated schemes.

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

The funding is used to improve performance in the following five areas:

1. Avoidable admissions: overall plan for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive admissions.
2. Length of Stay: plan for reducing the percentage of hospital patients with a length of stay over 14 days and 21 days.
3. Discharge to normal place of residence: plan for improving the percentage of people who return to their normal place of residence in discharge from acute hospital.

4. Admissions to residential and nursing homes: plan for reducing rates of admissions to residential and nursing homes for people over the age of 65.
5. Effectiveness of reablement: plan for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation

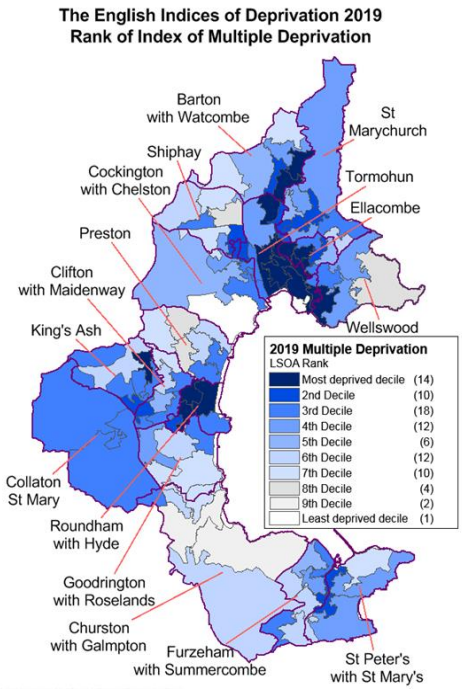
The specific conditions, which have been met as part of the planning process, are as follows:

- Plans to be jointly developed and agreed;
- A clear narrative for the integration of health and social care;
- A strategic, joined up plan for DFG spending;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services;
- An agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach
- Agreed expenditure plan for all element of BCF
- Stretching metrics with clear, ambitious plans to deliver.

2. Background and context to the plan

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

Torbay has a resident population of 136,264 people.



Within Torbay 27% of the population live in the top 20% 'most deprived in England' areas which are shown by the darker shades blue on the map. Pale areas are amongst the least deprived.
In our most affluent areas residents can expect to live on average more than six years longer than those living in our more deprived communities.

People in more deprived communities tend to experience multiple long-term conditions and generally have poorer health outcomes.

Torbay is ranked as the most deprived local authority in the SW region and COVID-19 is expected to weaken the economy further, as it is heavily dependent on tourism.

Disability-free life expectancy measures the average number of years a person would expect to live without a long lasting physical or mental health condition or disability that would limit their daily activities. In Torbay, disability-free life expectancy at birth is lower for both men and women than in England as a whole.

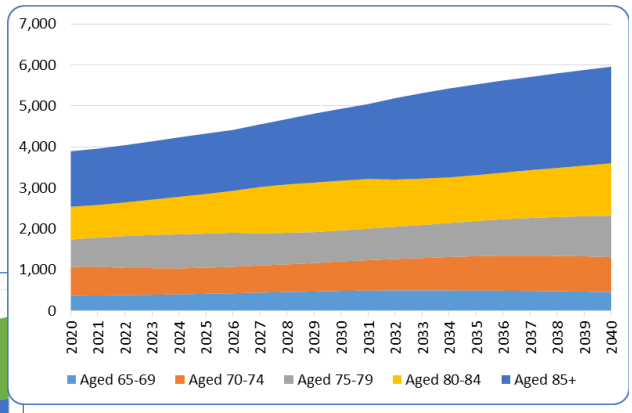
Torbay GP registers show higher percentages of patients having depression, diabetes, coronary heart disease, hypertension, asthma, COPD, epilepsy and rheumatoid arthritis, compared to the rest of England.

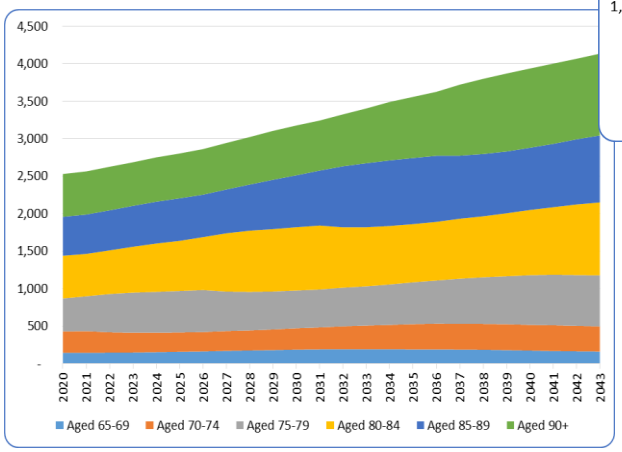
Multiple long-term conditions are associated with much higher healthcare costs, unplanned hospital admissions, delayed transfers of care and long-term institutionalisation. In 2015, 54% of people over 65 had multiple long term conditions, and it is likely to be increasing in the bay.

27% of Torbay's population are aged 65 or over, compared to just 18% of population across England. By 2040, this is expected to rise to one in three (34%) of Torbay's population.

As our population ages, we expect the number of frail people, people with physical restricted mobility, slowness, low physical activity, and people with dementia to increase over the coming years, and require support from health and social care services.

Frailty estimates for Torbay show that over the next 10 years frailty rates will increase by 25% to over 5000 people.





Prevalence data estimates for Torbay show that over the next 10 years, the number of people living with dementia will increase by over 30% to 3300 people.

People with poor physical health are at higher risk of experiencing common mental health problems, and those people with mental health problems are more likely to experience poor physical health.

One-in-four adults will experience mental illness during their lifetime. Measures such as depression rates in primary care, and hospital admissions for self-harm and suicides, are higher in Torbay compared to wider England average.

Other issues affecting levels of need are prevalence of learning disability. A learning disability can be mild, moderate or severe, and affects the way a person understands information and how they communicate. The percentage of GP patients known to have a learning disability is higher across Torbay compared to England.

Inappropriate admissions and unnecessarily long periods in hospital can be harmful, for older people in particular. The longer older people remain in hospital, the harder it is for them to regain their independence and return home, and the more likely they are to be readmitted.

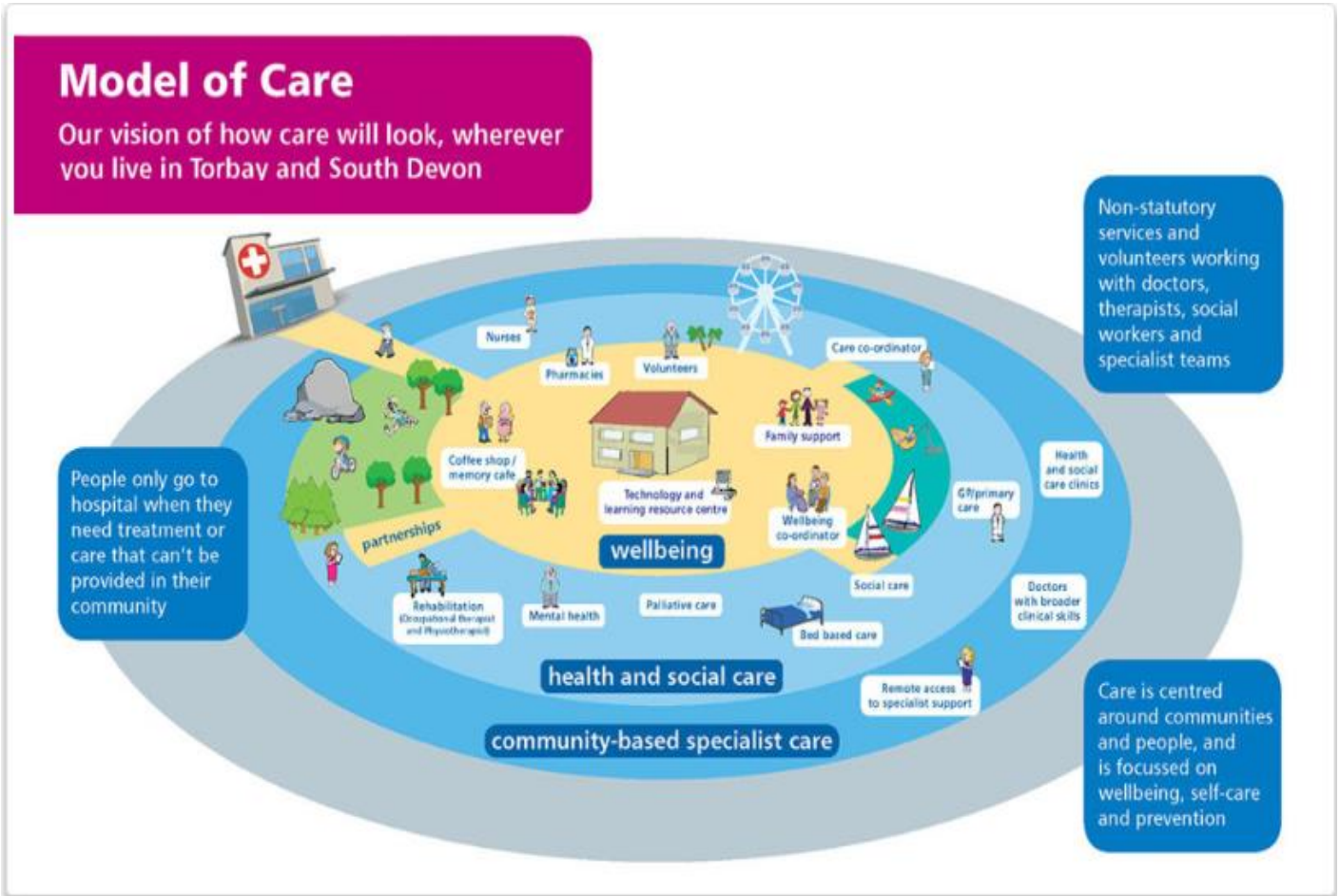
As mentioned above, Torbay has an ageing population which is also growing faster than the national average, increasing future demand for health and care services. If local services assist individuals to identify their strengths and link them in with appropriate support, there is potential to help them remain independent and less reliant on care. We also need to recognise that some of the support that people require can be delivered within their community and by the voluntary sector.

People with mental health conditions and those with disabilities do not always have access to the level of support they need, which impacts on their general health and wellbeing. The additional funding has been incorporated into schemes to address this inequity.

The Better Care Plan provides an opportunity to assist and support in the work which is already being undertaken.

3. Approach towards integration of health and social care

Within Torbay, there has been ongoing work to implement an integrated care model. This model provides a fully integrated health and social care system involving joined-up services which deliver education and advice about how to maintain independence and stay well, with mental health and wellbeing as high a priority as physical health and wellbeing. It also aims to take a person-centred approach and build wider support around people, through making the best use of what is already available to them at home and in the community.



The creation of the Integrated Care Organisation in October 2015 - Torbay and South Devon NHS Foundation Trust, was strongly supported and encouraged by both the Clinical Commissioning Group and the local authorities and this has resulted in a more effective patient journey for thousands of people.

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

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

South Devon and Torbay has a respected reputation for partnership working and for innovating to find more effective ways of delivering quality care. Relationships between statutory and voluntary sector organisations are well founded and there is a shared ambition to tackle problems. This extends to positive working with provider organisations whose reach is broader than South Devon and Torbay.

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

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

Adult Social Care:

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

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

We know that the demand on the adult care system in Torbay is high and it will only continue to increase due to our aging population and areas of social deprivation. This is one of the reasons why we need to change the way we currently deliver our social care

and work towards fully adopting a community led approach where our communities can be supported to flourish. Our commitment to engage with and work with our voluntary and community partners as well as people who use services to co-design the plan will enable us to develop a robust service delivery that is fit for the future and for the people of Torbay. We are also encouraging a culture within teams of embedding continual improvement. We are focussing on achieving positive shared outcomes for people receiving Social Care support and reflecting this via monitoring our own performance and seeking feedback from all involved so we can learn from experience.
We are reminding people of the core values of social care, including:

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

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

Providing Safe Quality Care and Best Experience:

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

Focus on Mental Health

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

Focus on the Transition team

We have developed a specialist team to work with young people who are being referred through to our service from our colleagues in Children's services. This team has developed from having two skilled and un-registered practitioners to include a Social Work Lead and two additional experienced Social Workers. Close links have been developed with Children's services, Education and Mental Health services. There are now regular review meetings to consider a young person's aims, hopes and aspirations

when they reach 14 and 16 years old. The transition team work within a strengths-based approach aligning their assessments and support with the preparing for adulthood guidelines promoting health, education, employment, independence and community inclusion. The team work flexibly to ensure their care plans are outcome based which includes reviewing a situation when it is right for the young person rather than on an annual basis.

Focus on Learning Disability

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

- An increase of 50 units of self-contained supported living, sheltered housing and/or Extra Care for people with learning disabilities, in line with the Housing Strategy 2017. One third of people over 45 with a moderate or severe learning disability, and one third younger adults (under 35 years) are living with parents. We want to ensure there is appropriate accommodation and choice, so people can have planned transitions towards independent living, and avoid unnecessary entry into residential care wherever possible.
- Increased Quality Assurance support for supported living providers and the consequent improvement and monitoring of the quality of support and tenancies.
- A reduction in the number of working age adults with LDs in long-term residential settings (currently just over 70 adults). Residential settings by their nature, do not usually maintain or increase self-determination, control, citizenship, or enable community inclusion and natural circles of support.
- The development of an outcomes commissioning framework for the development of Daytime activities/services which offer more choice, develop community inclusion and deliver more aspirational outcomes. Greater housing choice - particularly self-contained Supported Living, sheltered housing, Extra Care and access to general needs housing.

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

Focus on Autistic Spectrum Conditions and Neurodiversity

During 2019, in recognition of the need to focus on post-diagnostic support in Torbay for people with Autistic Spectrum Condition (ASC), a multi-stranded ASC post-diagnostic project was launched, which included the following:

- A new accessible information and advice service, to help improve access to employment, education and welfare benefits.
- The development of Peer Support for people with ASC through seed funding of small groups (one for adolescents and one for adults)

- Employment of a 0.4FTE specialist ASC Social Worker

Focus on Dementia

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

Focus on Homelessness

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

Focus on carers

We know that people do not always see that they are a Carer, so we try to make it as easy as possible for Carers to be identified, whether at GP surgeries, through other professionals that may work with Carers, and through our campaigns such as Carers week. As of January 2021, just under 1200 Carers of Adults had received an assessment and/or a health and wellbeing check this year, which is 34% of people receiving Adult Social Care services against an annual target of 36%.

Up to end Jan 2021 416 carers have received support to have a Carers Break (which during the Lock-Downs were used for on-line craft courses, garden benches, gardening materials – anything identified by the carer to give them a break from their caring role

Improved wellbeing through partnership:

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

Supported Living Provision

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

The Supported Living framework introduced in April 2018 provides a greater focus on assisting improvement alongside our statutory assessment function. The framework is intended as a focal point for joint working between partnership organisations and reflects Torbay's integrated health and care service delivery model. The framework supports Torbay in moving towards a more enabling environment with measurable outcomes in promoting people's independence, quality of life and health and well-being.

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

Enhanced Intermediate Care

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

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

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

We work with the Joint Emergency Team in the Emergency Department (ED) to prevent an unnecessary admission into the hospital when they present in ED.

We have recently started doing a virtual multi-disciplinary team meeting with the Care Home Visiting Service, Older Mental Health Services, dietician, pharmacist and Health Care for the Older Person Consultants. This happens weekly and we refer any people in our Intermediate Care service who we feel would benefit from this specialised group of clinicians. This results in the person receiving suggested care by the consultants without having to attend an appointment. This service has been extended so that the localities can discuss any people who are either in their own home or a care home placement. This has promoted proactive treatment for these people
The average age of people benefitting from this service is 83 years old. The deeper integration of these services has helped ensure people have shorter stays in hospital. The implementation of a 'discharge to assess at home' pathway has further developed the ability of the organisation to care for people at home and we always work towards the ethos that 'the best bed is your own bed'.

Extra Care Housing

Extra Care housing combines care and support to maximise the independence of Torbay's population whose Long-Term Condition or diagnosis means they require ongoing care and / or support to maintain independent living, for as long as possible, in their own community-based home. Our Extra Care service is multi-generational supported living benefitting from 24/7 on-site staffing.
Demand for Extra Care Housing continues to outstrip supply. To address this the Council has purchased a site in Torquay to increase capacity. A dedicated Capital housing officer has been recruited by the Council to work in partnership with TDA and Torbay and South Devon NHS Foundation Trust in developing these sites. The Extra Care project group membership includes multi-disciplinary representation and the voluntary sector whose aim is to develop housing which:

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

Wellbeing services with the Voluntary Sector

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

- By Facilitating/supporting alliances/partnerships within the community to improve resilience

- By working more openly and collaboratively with the Voluntary sector on an equal footing via forums such as the Voluntary Sector Steering group and via the use of the Adult Social Care precept for 20/21.

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

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

The VCSE sector has been agile, creative, and person-centred in its response to community need; which has positively influenced culture within Adult Social Care and the way in which we are improving our services. For example, as part of the Three-Year Plan, we are redesigning our "Front Door" (the way in which people access our services) in Adult Social Care. This is not only being informed by the development of the Community Helpline, but VCSE partners are actively involved in the redesign work. This approach is fully aligned to the Care Act (2014), which recommends greater integration and collaboration with local partners, for the benefit of community wellbeing.
A new Steering Group has been created with representatives from across the VCSE and statutory sectors; which will help to guide and shape developments. A VCSE Forum has also been set up, to make it easier for organisations within the sector to connect with a common purpose; providing greater opportunities for collaboration, and a stronger voice in the local system.

Technology Enabled Care Services (TECS)

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

This contract has supported people from managing medications independently through to allowing people to access their community with TEC phones linked to 24/7 care for

emergencies. The provider NRS have been developing a new system to support people being discharged from hospital through until their assessment has been completed in their home while having access to a care line. Work has started with public health to use TEC to support people with diabetes and mental health so that they are able to manage and live full lives.

The Hope Programme

The HOPE (Help to Overcome Problems Effectively) Programme is an evidence based 6-week self-management course based on positive psychology, mindfulness and cognitive behavioural therapy, built on 20 years of research from Coventry University. It brings together people with similar needs and experiences in a safe space across 6 weeks. Participants are given the tools to build their knowledge, skills and confidence whilst helping each other. The groups are run by trained facilitators – professionals or volunteers.
Across Torbay and extending into wider Devon, the HOPE programme continues to go from strength to strength with over 1,400 participating in the programme to date. We celebrated our Third Birthday on 13th November 2020

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

Health and wellbeing coordinators and PCN link workers

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

Falls and frailty prevention work

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

b) Approach to Collaborative Commissioning

Torbay has had integrated services since 2005 which were extended in 2015 to encompass a whole system integration with the creation of the Integrated Care Organisation (ICO) Torbay and South Devon NHSFT. Arrangements include aligned

commissioning posts across the local authority and the CCG, pooled funding arrangements which are managed through agreed collaboration as to how these are spent. We have developed a Local Care Partnership Delivery Group which brings together operational and commissioning leaders across our system including the local authority, CCG, public health, Primary Care Networks and the voluntary sector. This group is responsible for aligning system plans and evolving strategy into operational plans. The Integrated Care Model sets out our system wide ambition to have a maturing integrated offer at neighbourhood and place, bringing together primary care networks, mental health, social care and hospital services to meet population needs.

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

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

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

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

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

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

The process for developing PCNs in Torbay is being supported by the local care partnership delivery group. There are 3 PCNs in Torbay and these are co-terminus with

the council boundary. We have worked in partnership with PCNs to support the development of their pharmacists and social prescribing link workers.

A VCSE strategy has been developed across Torbay. It contains a mix of place-based agencies and those that operate across a wider theme and area due to their specialist nature. The VCSE is a key part of the integrated model of care and will help to deliver the BCF priorities in the following ways: social prescribing, self-care, building resilient communities, by helping with transport, enabling hospital discharge to take place by supporting people with volunteers or befriending, looking after pets whilst people are in hospital, and wellbeing co-ordinators will be linking to community assets.

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

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

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

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

4. Strategic, joined up approach for DFG spending

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

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

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

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

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

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

digital technology where possible. A recruitment programme is in place to increase workforce for STS.

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

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

6. Stretching metric with clear and ambitious plans to deliver

Metric Name	Numerator	Denominator	Data Source	Frequency of Update	Improvement area
Percentage of inpatients who have been in hospital for longer than 14 days	Number of inpatients staying over 14 days in an acute setting	Total number of discharged patients from an acute setting	SUS	Monthly with 6 weeks lag	Improve flow challenges
Percentage of inpatients who have been in hospital for longer than 21 days	Number of inpatients staying over 21 days in an acute setting	Total number of discharged patients from an acute setting	SUS	Monthly with 6 weeks lag	Improve flow challenges
Percentage of hospital inpatients who have been discharged to usual place of residence	Number of patients discharged to usual place of residence	Total number of discharged patients from an acute setting	SUS	Monthly with 6 weeks lag	To monitor & improve use of home first principle and inform service planning.
Avoidable admissions Unplanned hospitalisation for chronic ambulatory care sensitive conditions (2.3.i)	Hospital Episode Statistics (HES) Admitted Patient Care (APC), provided by NHS Digital – National Statistics	Mid-year population estimates for England published by the Office for National Statistics (ONS) annually – National Statistics. Available in June following end of reporting year	NHS Outcomes Framework: 2.3.i – Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHSD)	Yearly, released in February 22 following the financial year-end	Reducing time spent in hospital by people with long-term conditions

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

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

Actual 18/19 905
Actual 19/20 901.7
Actual 20/21 568.0
Plan for 21/22 based on actual for actual for 19/20 – 901.7

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

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

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

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

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

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

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

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

April 19 – Aug 21 14 days 11%, 21 days 5.5%
Target from draft ICS dashboard 10% and 8% for South Locality
Actual 21/22 YTD 14 days 13%, 21 days 7%
Plan for 21/22 is 13% for 14 days and 7% for 21 days

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

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

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

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

April 19 – Aug 21 90.6%
Plan for 21/22 based on actual for 21/22 five months
Actual 21/22 YTD 90%
Plan 21/22 is 90%

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

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

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

		19-20 Plan	19-20 Actual	20-21 Actual	21/22 Actual YTD	21/22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	451	516	417	239	
	Numerator	164	189	155	90	
	Denominator	36,399	36,612	37,143	37,143	

Plan for 21/22 – 478

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

Torbay Council and Torbay & South Devon NHS Foundation Trust has jointly commissioned two new extra-care housing schemes with the express outcome of reducing admissions for older people to general residential care (we have projected a reduction of 200 commissioned residential care beds by 2030) in Torbay and extending the length of time older people can remain independent before requiring residential care with nursing. The first scheme of 80 units is at the design stage and has involved the University of Stirling's Dementia Design Centre to ensure that our admission reduction approach includes maximising independence at home for people with varying degrees of dementia. Start on site is scheduled for June 2022, with completion and mobilisation in December 2023. The second scheme of 100 units has a more complex development schedule due to the nature of the site but will be completed and mobilised in late 2024. Further to this, we are respecifying our existing extra-care schemes (108) to increase the capability of the service to divert older people with care needs away from residential care; this will be mobilised in March 2022 and is expected to a further reduction of 12 admissions a year.

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

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at	Annual (%)	76.5%	80.3%	77.8%	

home 91 days after discharge from hospital into reablement / rehabilitation services	Numerator	173	269	140	
	Denominator	226	335	180	

Plan for 21/22 – 77.8%

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

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

Final Version – 30/11/21

Torbay & Devon Safeguarding Adults Partnership

2020-21 Annual Report

DRAFT v0.10

Torbay and Devon Safeguarding Adults Partnership

Contents

Section 1: Chair's Foreword

1.1 Paul Northcott – Chair of the Torbay and Devon Safeguarding Adults Partnership

The merger of both the Torbay and Devon Safeguarding Adults Boards into the TDSAP has presented a unique opportunity to strengthen the partnership and build on the previous successes that have been achieved in both areas. I would like to thank the two previous Chairs and the senior managers for all of their commitment and vision in progressing the merger.

Joint working opportunities have enabled us to progress the work that has been detailed in this report whilst also enabling us to plan for the challenges that we will encounter in the future.

The new priorities for the partnership will ensure that we focus on those areas that will improve safeguarding practice and ensure that we are effectively working together to deliver services that meet the needs of vulnerable individuals and the wider community. Community and service user engagement continues to be developed and is seen by the partnership as essential in building on the progress that has been achieved and informing future practice.

1.2 Julie Foster – Former Chair of the Torbay Safeguarding Adults Board

Like many other organisations across the world, Torbay Safeguarding Adults Board has had to adjust the way it operates during the current pandemic. Meetings have had to be convened virtually and some of our activities suspended temporarily whilst pressing priorities to safeguard a much wider population were actioned.

The responsiveness and flexibility of our partners has been fantastic and, despite the need to work differently, safeguarding adult's activity has continued relentlessly and those at risk from harm have been protected. Steps have been taken to publicise the help available in cases of both domestic and financial abuse - issues which caused a particular concern during lockdown. We have also taken steps to monitor the impact of very busy health and care systems on hospital discharge and care at home to ensure adults at risk do not fall through gaps.

It is to the credit of our senior managers that the plans to develop a new Safeguarding Adults Partnership between Devon and Torbay have reached fruition during the past year. Torbay is keen to maintain its own identity and has its own particular opportunities and threats, but it makes sense to build on our close links with Devon to provide a consistent approach across the area and to reduce the duplication and resource requirements of two separate Boards

1.3 Siân Walker – Former Chair of the Devon Safeguarding Adults Partnership

The pandemic had a massive impact on all of us, especially on vulnerable people living in Devon's communities. Whilst, like others, we had to adjust the way we worked, the Devon Safeguarding Adults Board continued to function well, adapting to more regular updates from statutory partners from the Council, Police. NHS and the voluntary and community sector. This provided information and data which enabled us to take immediate action where appropriate. The Board continued to function with virtual meetings but work behind the scenes changed as Board Support staff were deployed to front line services, importantly to resource services to support effective safeguarding. We maintained a good overview and I felt assured that safeguarding remained a top priority by all partners. I worked alongside other Safeguarding Chairs in the south-west so we could all learn from one another, adapt and be agile to these new circumstances. I ensured that we maintained our ability to respond well to the very many circumstances in which people found themselves, both citizens and professionals across the partnership.as we supported them all in their Covid response. Plans were progressed during this time to merge the Devon & Torbay Safeguarding Adults Boards, something which I fully supported in the knowledge that our partners worked across both Council areas, and it enabled a more dynamic and efficient way of working.

I was delighted, after chairing the Devon Safeguarding Partnership for 5 years, to leave it in a far healthier position. I am grateful for the opportunity I had to work across our county and delighted to hand over to Paul Northcott with the newly merged Partnership Board.

Section 2: Our Role and Purpose

The Torbay & Devon Safeguarding Adults Partnership (TDSAP) is the collective name for the partners that work with the Board to safeguard adults across Torbay and Devon.

The **Torbay & Devon Safeguarding Adults Partnership (TDSAP)** was founded in the final quarter of 2010/21 by Devon County Council and Torbay and South Devon NHS Foundation Trust as a requirement of the Care Act 2014. It provides strategic leadership for adult safeguarding across Torbay & Devon. Prior to the creation of the TDSAP there were two separate Boards operating in Torbay and Devon; the Devon Safeguarding Adults Partnership and the Torbay Safeguarding Adults Board.

The TDSAP is completely independent, with an independent chair.

The core objective of the Partnership, set out in section 43(2) of the Care Act 2014, is to help and protect adults in its area in cases where an adult has care and support needs and;

- They are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, they are unable to protect themselves from either the risk of or the experience of abuse or neglect

The TDSAP acts as the key mechanism for agreeing how agencies work together to safeguard and promote the safety and wellbeing of adults at risk and/or in vulnerable situations. It does this by co-ordinating what each of the TDSAP members does and makes sure that they do it effectively.

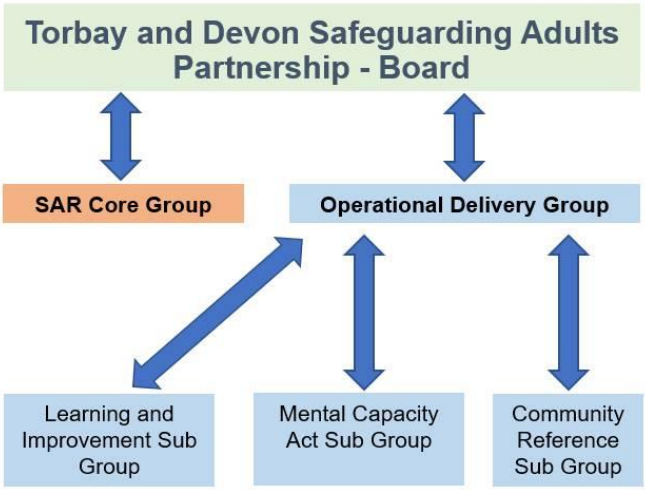
The TDSAP multi-agency partnership, aims to promote awareness and understanding of abuse and neglect among service users, carers, professionals, care providers and the wider community. It works to generate community interest and engagement in safeguarding to make sure that **'safeguarding is everyone's business'**.

The TDSAP also commissions Safeguarding Adults Reviews for people who have experienced poor safeguarding outcomes, to ensure that lessons are learned for the future.

Section 3: Our Structure

The TDSAP established the below structure to undertake the work on behalf of the Partnership. These meetings are supported by the Partnership Business Manager and Partnership Co-Ordinator. Each sub-group has an established Terms of Reference.

When required, Task & Finish groups are established to deliver key elements of work commissioned by and reported to the Partnership. These Task and Finish groups comprise of representatives nominated by Partnership members who have sufficient knowledge and skills to contribute to the required task.



TDSAP Organisational Structure

Section 4: Our Partnership Members

The TDSAP has representatives from the following organisations; Torbay & South Devon NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Royal Devon & Exeter NHS Trust, University Hospitals Plymouth NHS Trust, NHS Devon Clinical Commissioning Group, NHS England/Improvement, Torbay Council, Devon County Council, East Devon District Council, Devon Partnership Trust, Livewell Southwest, South Western Ambulance Service Foundation Trust, Devon & Cornwall Police, HM Prison & Probation Service, Devon & Somerset Fire & Rescue Service, Care Quality Commission, Living Options, Healthwatch, Trading Standards, Housing and The Department of Work and Pensions.

Section 5: Safeguarding Adult Reviews

The Torbay & Devon Safeguarding Adults Partnership (TDSAP) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.

The TDSAP must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. Boards may also arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Consistent SAR themes from 2020/21 referrals include:

- Mental Health
- Suicide
- Self-Neglect
- COVID Lockdown Impact

The SAR Core Group continues to meet quarterly and has done so throughout the COVID pandemic. The Core Group is attended by representatives from partner organisations including CCG, NHS, Local Authorities and the Police.

SAR Activity During 2020/21:

- There have been 24 SAR referrals during the period of 2020-2021.

- 10 SAR referrals were received by Devon Safeguarding Adults Partnership. 3 SAR referrals were received by Torbay Safeguarding Adults Board. 11 SAR referrals were received by the TDSAP.

- There have been 4 SAR Learning Events across Torbay and Devon

Further information on TDSAP SARs, including copies of previously published SARs, please visit our website.

For more information on how to raise a concern please visit our website.

Section 6: TDSAP Sub-Groups

6.1 Community Reference Group

The newly formed Joint TDSAP Community Reference Group (CRG) includes people recruited from local Voluntary, Community and Social Enterprise (VCSE) and people with lived experience of the safeguarding process, across the TDSAP area.

The CRG has grown from strength to strength undertaking co-production, consultation and engagement work. Methods to gather intelligence have included focused task and finish groups, on-line and telephone surveys and varied user led dialogue. The CRG has provided new ways for people who have been through safeguarding processes to input directly into the work of the partnership.

The CRG provides feedback on key priorities for future work, is raising awareness of safeguarding with the adult population and two-way communication channels with representatives within and across the VCSE.

During 2021 the CRG brought the voice of the service user into the Annual Partnership Development Day and ensured that the voice of the people we support, remains central to the planning of future partnership priorities.

6.2 Learning & Improvement Sub-Group

The Learning and Improvement Subgroup has continued to undertake and complete key areas of work, despite meeting less frequently than usual in 2020/21 due to partner agencies responding to health and social priorities related to the COVID 19 pandemic. These areas of work include the Partnership reviewing, retendering and awarding a contract to provide a comprehensive range of safeguarding adults and mental capacity act training. The majority of the training during the year, was delivered virtually due to the COVID 19 pandemic. The safeguarding adults training strategy has remained a key focus following its approval last year. Assurance was sought from partners regarding individual progress in order to develop a partnership wide implementation plan.

6.3 Mental Capacity Act Sub-Group

Over the previous 12 -month period the work of the Mental Capacity Act Subgroup experienced some disruption as a consequence of the Covid19 pandemic response. Although some of the sub group meetings were stood down, to allow partners to concentrate on their COVID 19 pandemic responses, the existing work plan was regularly reviewed and updated once the group was in a position to reconvene.

There is renewed energy amongst our partners for collaborative working wherever possible and a recognition that there continues to be an ongoing need to increase legal literacy across operational staff groups to protect the wellbeing and rights of people we support across Torbay and Devon.

The priority work will continue to be focussed on the following areas:

- Increasing understanding and application of Legal Literacy across partner organisations
- The Liberty Protection Safeguards which are expected to come into force in 2022.
- The use of lawful restrictive measures
- The Mental Capacity Act 2005 learning outcomes from SARs

The group continues to work in tandem with the Learning and Improvement Sub Group and the interaction between these 2 sub-groups is regularly reviewed to ensure this organisational arrangement is fit for purpose to help deliver the strategic priorities of the partnership.

6.4 Operational Delivery Group

The Operational Delivery Group (ODG) oversees all of the above sub-groups and reports directly to the Partnership Board. In 2021/21, following a review of the Safeguarding Insight Data, the ODG established four Task and Finish groups to review the data and suggest areas for improvements. The four groups focused on; Care Homes, Types of Abuse, Blue Light Services and Health Referrals.

The Partnership has been supporting the Local Authorities to help inform a national picture in relation to the COVID 19 pandemic, the results of which are shared back to local authorities and our Partnership.

The ODG continues to review and consider developing areas of adults safeguarding to ensure that partners are well informed to respond to emerging themes and trends.

Section 7: TDSAP Priorities 2020/21

Prior to the establishment of the TDSAP in Dec 2020, the Torbay Safeguarding Adults Board and the Devon Safeguarding Adults Partnership had separate strategic priorities held within their own business plans.

Former Torbay Safeguarding Adults Board (TSAB)

The TSAB Business Plan was for the period 2018-2021and included the below priorities:

1. Embedding Making Safeguarding Personal
2. Learning from Safeguarding Adult Reviews
3. The Interface Between Safeguarding Adults at Risk and Domestic Abuse / Sexual Violence
4. Preventative and Creative Solutions
5. Mental Capacity Act
6. Market Shaping and Commissioning

Former Devon Safeguarding Adults Partnership (DSAP)

The DSAP Business Plan for 2020-2021 included the below priorities:

1. Safeguarding within the Covid-19 Pandemic:
   - To work in partnership to ensure continuity of safeguarding adults business.

2. Living Well:
   - The DSAP Board aims to support partners to deliver preventative actions, to safeguard those with care and support needs through learning together and delivering change.

Copies of both of the above business plans can be found on our partnership website.

Section 8: Our Work During 2020/21

COVID-19 had a significant impact on both Safeguarding Adults Boards and the newly merged Board and the core work that continued during the pandemic. A decision was made, in consultation with partners, to re-prioritise and strategically pause some work, to enable partners to concentrate on their pandemic response as a priority.

Despite adopting a focus on statutory assurance and support, the Boards continued to maintain their Care Act 2014 obligations for safeguarding adults with regular assurance gained from their key safeguarding partners.

Partners provided assurance reports to the Independent Chairs including updates on their COVID 19 crisis response. This approach ensured that partners provided proportionate strategic overview during the pandemic.

In December 2021 the Devon Safeguarding Adults Partnership and the Torbay Safeguarding Adults Board merged to form the TDSAP. This included a successful process to appoint a new Independent Chair to the TDSAP. The merger was completed in Quarter 4 of 2020/21 and since then the TDSAP has been working to ensure their policies and procedures are aligned across the new partnership.

The TDSAP has undertaken a review of Safeguarding and Mental Capacity Act training to ensure the offer from the TDSAP is up to date and in line with legal literacy. The TDSAP increased safeguarding training capacity for partners to meet increased demand following an awareness campaign launched in 2020.

The TDSAP undertook a review of the referral process for SARs as a result of an increased number of SARs being received. An evaluation criteria was introduced to ensure the process is as effective and efficient as possible.

Learning from SARS continues to be a priority piece of work for the TDSAP going into 2021/22 and beyond, as detailed in the Strategic Priorities 2021/2024.

Section 9: Looking Ahead

The Strategic Priorities for the TDSAP have been agreed and published in the 2021-2024 TDSAP Business Plan.

A copy of the strategic priorities can be found by clicking here: Strategic Priorities 2021/2024

The priorities are detailed below:

Strategic Priority	What we will do to deliver this priority
To embed the learning from Safeguarding Adult Reviews (SARs) into organisational practice	• Partners will contribute to the SAR process and play a key role to identify the relevant learning • We will embed a process to identify immediate learning and implement this swiftly • We will ensure the learning is SMART with key success criteria in place • Partners will provide strong evidence to assure the TDSAP that sustained improvements have been embedded • Promote multi-organisational communication, ensuring cooperation as an underlying key principle • Develop swift and dynamic processes for delivery of Safeguarding Adults Reviews • Each Safeguarding Adults Review will have an underlying principle to 'Focus on the Learning' for each organisation • We will regularly monitor, identify and resolve reoccurring SAR themes to prevent reoccurrence

Strategic Priority	What we will do to deliver this priority
To work with partners to better understand and reduce the risk of 'Hidden Harm', especially in the context of COVID 19	• Support and encourage all safeguarding partners to focus on the 'Hidden Harm' that is usually out of sight from public view and often not recognised or reported • Ensure that the emphasis is on having a culture of 'spotting early signs' to prevent risks escalating • Use COVID 19 data and information to seek assurance that partners are all uncovering and responding to hidden harm • Ensure that all safeguarding partners who work with people who have needs for care and support, exercise professional curiosity and take appropriate action • Embed the theme of 'professional curiosity' within multi agency case audits (MACA) • Develop and deliver a multi-organisational workshop and awareness campaign for partners and service representatives to better understand, encourage and support professional curiosity and escalation within their organisations
To improve outcomes for people with needs for care and support by finding the right solution for them	• To seek assurance that partners and service representatives work together to establish more effective coordination to achieve person centred solutions • Work with partners and service representatives to better understand and embed a creative approach to finding effective solutions for people with complex lives • We will develop and share key data and information to help develop effective communications and co-ordination between partner organisations, including strengthening links with the districts and community safety partners • We will focus on preventative strategies to better understand how we can avoid the need for safeguarding intervention • We will work with service representatives and commissioning partners to better understand people's needs and support them to achieve their desired outcomes • To have regular assurance from partners that people are safeguarded during and after the COVID-19 pandemic and that attention to safeguarding continues in accordance with statutory

	responsibilities, recognising that some people will be put at greater risk as a consequence of the pandemic
Strategic Priority	**What we will do to deliver this priority**
Improving Involvement and Engagement with people in receipt of safeguarding services	• We will build on past Safeguarding Awareness Campaigns by targeting communications within our communities to raise further awareness of safeguarding • We will learn from COVID 19 experiences and use this feedback to shape future engagement • We will work with key partners to improve the interface with children's services especially for those who transition to adult services • To seek assurance that all partners are involving and listening to people about their experience of safeguarding • Ensuring that all people are listening to, valuing and responding to relatives, friends and people in communities • The partnership will have a focus on 'Making Safeguarding Personal' to ensure that safeguarding is person-led and outcome-focussed • We will continue to invest and engage with community groups to ensure the 'voice of the person' is central to partnership working

Title: Health and Wellbeing Board Work Programme 2021-22

Wards Affected: All

To: Health and Wellbeing Board **On:** 9 December 2021

Contact: Maria van Hove & Julia Chisnell
Telephone: 07584 175711
Email: maria.vanhove@torbay.gov.uk
Julia.Chisnell@torbay.gov.uk

1. Purpose

To update members on the Health and Wellbeing Board Work Programme

2. Recommendation

To endorse the Health and Wellbeing Board Work Programme for 2021-2022

3. Supporting Information

For the last three years the Health and Wellbeing Board has structured its work programme around the principles of areas to watch, areas to sponsor and areas of focus:

Areas of focus are areas where the Board has direct involvement & debate to assure itself of the detail of delivery. The Board will be seeking a commitment to action from partner members.

Areas to sponsor are areas that the Board actively promotes but leaves other organisations & partnerships to deliver, seeking assurance of outputs and outcomes. The Board will encourage integration & partnership working to deliver the system priorities.

Areas to watch are areas where the Board is interested but only needs to keep a watching brief on delivery through oversight of key outcomes, & where other organisations or partnerships are delivering the system priorities

The Health and Wellbeing Board work programme focuses on the priority areas identified in the workshops in June and September 2021, with the proposed addition of Housing. Tackling inequalities was also highlighted as a priority at the workshops. Rather than identifying this as a separate workstream, all programme areas will take a population approach, identifying and addressing fundamental inequalities.

Areas of focus	**Areas to sponsor**	**Areas to watch**
Improving mental health and wellbeing	Increasing physical activity	NHS delivery of population health outcomes & the NHS Long Term Plan
Improving outcomes for children and families (including trauma informed approach)	Tackling the climate emergency	Infection control & anti-microbial resistance
Improving outcomes for people with multiple complex needs	Supporting carers	Economic regeneration strategy
Promoting healthy ageing	Sufficient and sustainable housing	NHS recovery of elective services & patient experience
Promoting digital	Identifying and supporting	Turning the Tide of

inclusion	those experiencing domestic and sexual violence and abuse	Poverty & the COVID recovery programme

The Health and Wellbeing Board meets quarterly. At each meeting, time is set aside for a workshop, or spotlight session, to facilitate progress in one of the identified areas of focus. Alongside these spotlight sessions, the Health and Wellbeing Board will receive updates and presentation on other work areas identified as areas to sponsor or areas to watch.

Each priority area has an identified lead officer and lead member who will be responsible for assuring delivery and reporting on progress. The Board will receive flash reports on progress on each area on a quarterly basis.

An executive delivery group is being established to meet between Board meetings to review delivery and identify areas for escalation to the Board for support or resolution. The executive group will keep business on track and ensure the work programme is delivered. Membership will include priority area leads and Local Care Partnership colleagues, to ensure consistency across the local strategic agenda.

The table below includes major items for the formal Board and the spotlight workshop sessions during 2022. There will be additional formal items for approval and update brought forward during the year. The timetable will be reviewed quarterly by the executive group and at each Health and Wellbeing Board meeting.

Partners are asked to ensure papers requiring Health and Wellbeing Board approval are notified in advance so they can be included in the forward plan.

There will also be an ‘emerging issues’ process for partners to highlight emerging topics that are of importance to members and require multi-agency awareness and action.

Date	Item	Lead Officer(s)/ Organisation	Purpose
December 2021	**Business items:** Update on Health and Wellbeing strategy development Health and Wellbeing Board work programme 2021-22 Director of Public Health Annual Report	 Director of Public Health Director of Public Health Director of Public Health	 Endorsement of priority areas and process For agreement To receive and note the content and recommendations.
	Spotlight session: • Children and young people's mental health		For update and discussion
March 2022	**Business items:** Peninsula Health Protection Annual Report 2020/21 Joint Strategic Needs Assessment Flash monitoring reports: areas of focus, sponsor & watch	 Julia Chisnell Simon Baker Workstream leads	 For information For information & to note the key findings for the population For information & escalation of risks & issues
	Spotlight session (tbc): • Joint Health and Wellbeing Strategy • Outcomes for children and families	 Julia Chisnell & Maria van Hove Nancy Meehan	 For discussion For update and discussion

Date	Item	Lead Officer(s)/ Organisation	Purpose
June 2022	**Business items:** Flash monitoring reports: areas of focus, sponsor & watch	 Workstream leads	 For information & escalation of risks & issues
	Spotlight session (tbc): • Outcomes for people with multiple complex needs • Promoting physical activity	 Bruce Bell & Tara Harris Kirsty Parker-Calland	For update & discussion
September 2022	**Business items:** Peninsula Pharmaceutical Needs Assessment Flash monitoring reports: areas of focus, sponsor & watch	 Simon Baker / Ian Tyson Workstream leads	 For information For information & escalation of risks & issues
	Spotlight session (tbc): • Healthy ageing • Climate emergency activity • Housing	 John Arcus Tara Harris	For update & discussion
December 2022	**Business items:** 2022/23 Health and Wellbeing Board work programme Flash monitoring reports: areas of focus, sponsor & watch	 Lincoln Sargeant Workstream leads	 For information and endorsement For information & escalation of risks & issues
	Spotlight session (tbc):		For update & discussion

Date	Item	Lead Officer(s)/ Organisation	Purpose
	• Digital inclusion • Supporting carers • Domestic & Sexual Violence & Abuse	Bruce Bell, Adel Jones Katy Heard	

4. Relationship to Joint Strategic Needs Assessment

Priorities of the JSNA are reflected in the work programme.

5. Relationship to Joint Health and Wellbeing Strategy

The Health and Wellbeing Board work programme exists alongside the Joint Health and Wellbeing Strategy to complement and add to the work outlined in the strategy.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

No implications at this point

Appendices

Background Papers:

The following documents/files were used to compile this report:

- Health and Wellbeing Board Work Programme 2020-2021
- Outputs of Health and Wellbeing Board workshops June and September 2021