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

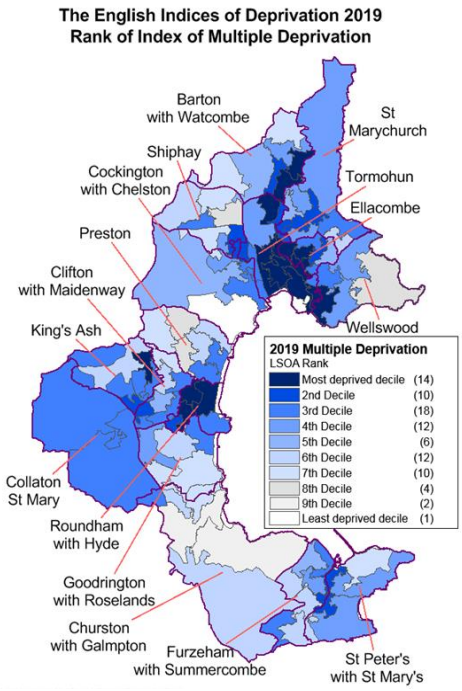
The specific conditions, which have been met as part of the planning process, are as follows:

- 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.

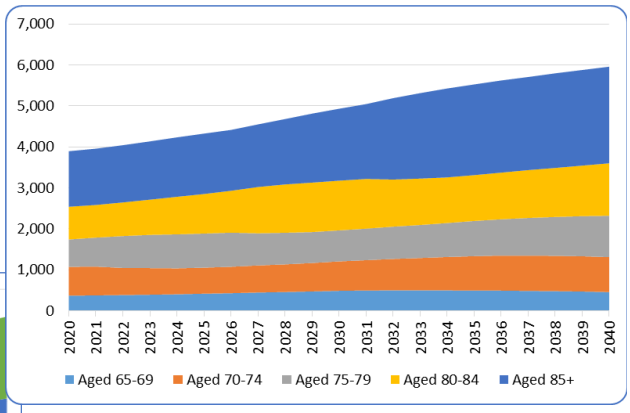
Torbay GP registers show higher percentages of patients having depression, diabetes, coronary heart disease, hypertension, asthma, COPD, epilepsy and rheumatoid arthritis, compared to the rest of England.

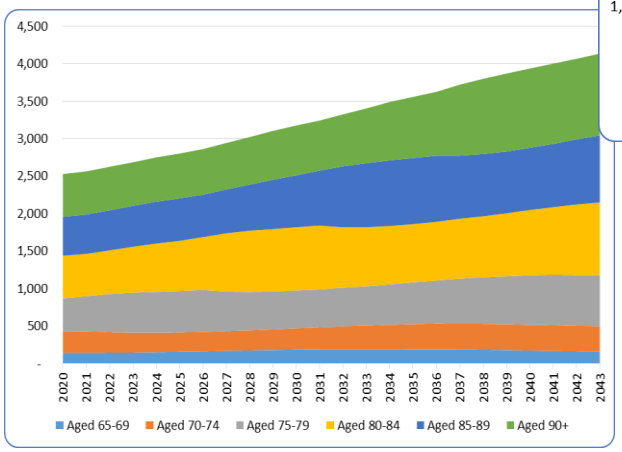
Multiple long-term conditions are associated with much higher healthcare costs, unplanned hospital admissions, delayed transfers of care and long-term institutionalisation. In 2015, 54% of people over 65 had multiple long term conditions, and it is likely to be increasing in the bay.

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.

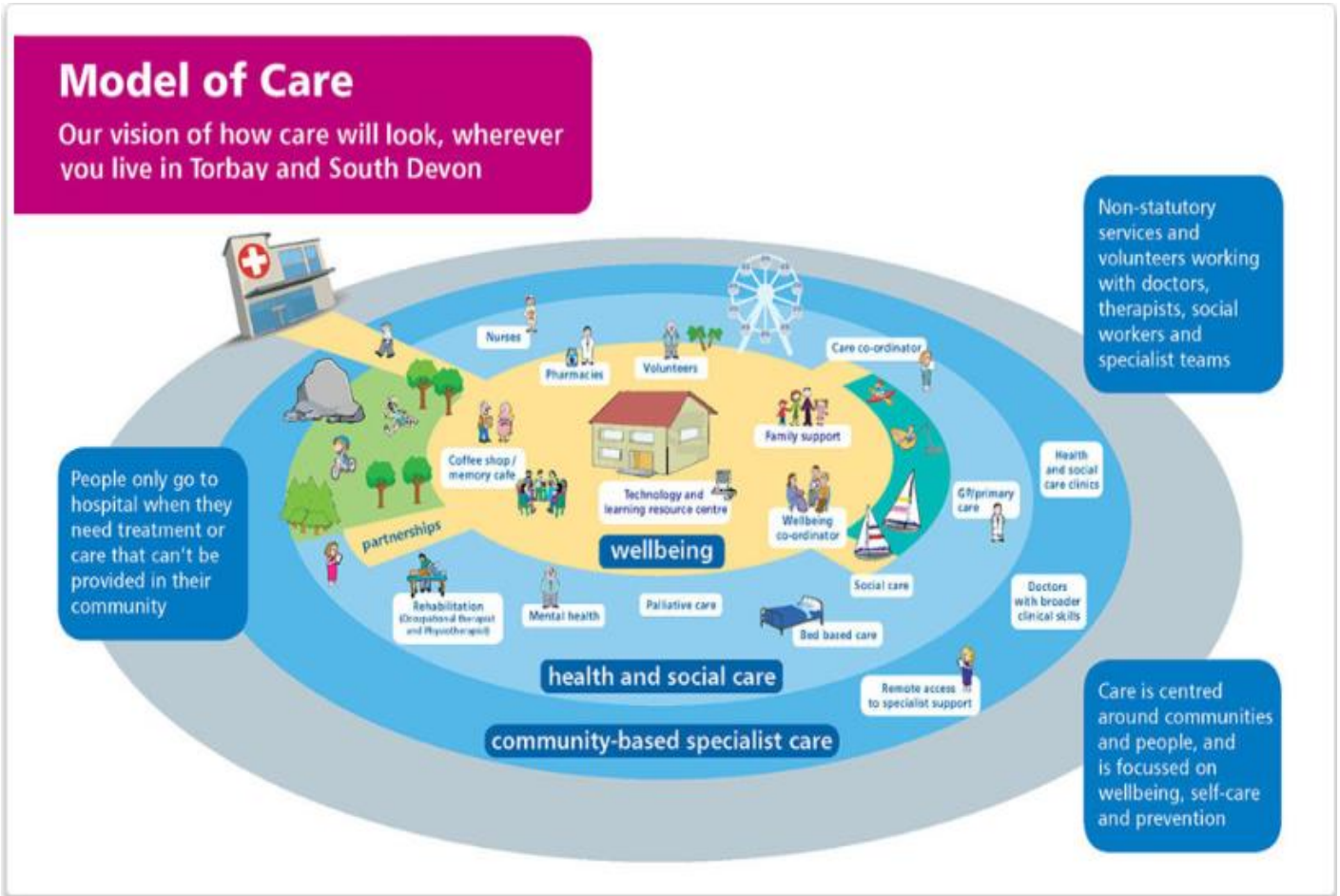
As mentioned above, Torbay has an ageing population which is also growing faster than the national average, increasing future demand for health and care services. If local services assist individuals to identify their strengths and link them in with appropriate support, there is potential to help them 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