Integrated care and support: a bid for pioneer status

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

National Voices
People shaping health and social care

South Devon and Torbay Clinical Commissioning Group
South Devon Healthcare NHS Foundation Trust
Torbay and Southern Devon Health and Care NHS Trust
Torbay Council
Devon Partnership NHS Trust

Supported by:

Devon Health and Wellbeing Board
Torbay Health and Wellbeing Board
Devon County Council
Rowcroft Hospice
South Devon and Torbay Strategic Public Involvement Group
Northern, Eastern and Western Devon Clinical Commissioning Group

This bid is submitted with the backing of our neighbouring Northern, Eastern and Western (NEW) Devon CCG.
As a pioneer, we would work closely with NEW Devon and our joint partners to extend the learning across a combined population of more than 1.2 million people, rapidly sharing and exchanging best practice and innovation to achieve integration at pace and scale.

TORBAY COUNCIL

NHS

> "With our local communities, we are resolved to make a major difference to the quality of life of our population, to break – permanently – the cycle of disadvantage which curtails the opportunities of one generation after another, to support people to be as well and independent and fulfilled as they can be, and to care with compassion when they cannot. To do this, we need to join up with each other to make our care seamless and put more power in the hands of those who need our care and support."

Introduction

We have a strong track record of collaboration across our whole area. The model of integrated health and social care in Torbay has won national and international recognition and brought many to our door seeking to learn from us. For several years, care has been viewed from the perspective of how it will be experienced by "Mrs Smith" and her family and carers. But we have only just begun, and our ambition for coordinated care is huge.

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

But the Mrs Smith we know so well now has a grandson, Robert, who at 15 is living with his mother in a deprived ward in the market town of Newton Abbot. Robert has been struggling with his mental health, drinking alcohol and taking drugs at times, getting in trouble with the police and "failing" at school. He has been receiving support from the Child and Adolescent Mental Health Services but soon he will be 16, when normally he would lose all his familiar professional contacts as he moves into adult services. Robert isn't planning to stay at school but his work prospects aren't good. Recently, he has been self-harming. We will return to Robert in a moment…

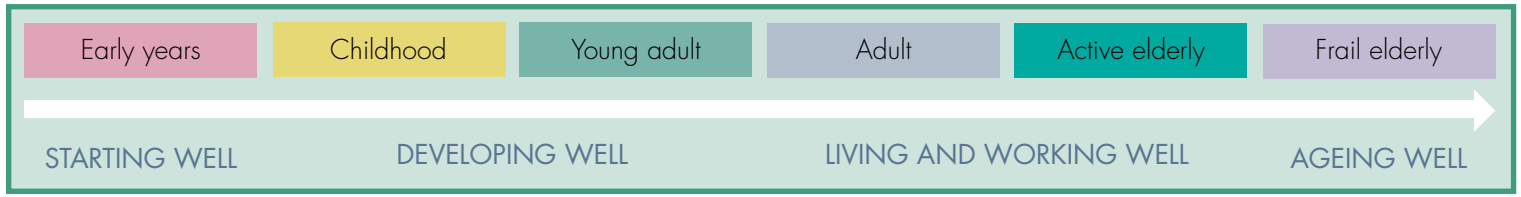
It is well known across England, and across South Devon, that the population is ageing. Today, nationally, 2.2% of the population is 85 or over. Torbay reached this 31 years ago. By 2021, the rate for England will be 2.9%, but 4.9% here.[1] For Mrs Smith, integrated health and care has delivered. Waits for physiotherapy have dropped from 8 weeks to 48 hours. Waits for occupational therapy have fallen from 2 weeks to 2 days, for urgent equipment from 4 weeks to 4 hours. Multiple calls were once needed to reach a social worker, district nurse, physio or OT; now it takes just one. Torbay Hospital has one of the lowest lengths of stay in the country, enabling acute hospital beds to be reduced from 750 to under 500. It has the lowest rate of emergency admissions in the South West.

But there are important challenges surrounding young people and families too. Numbers of children on protection plans or in 'looked-after' care in Torbay are among the highest in the country. Inequalities mean a 7-year life expectancy gap, 17 years more for some of expected ill-health, and a cost to our system of £150+ million. On Dartmoor we see rural isolation, with poor transport links and more difficult access to services. Suicide rates are falling in Torbay but those of self-harm are not. Housing problems for many are acute. There is much to do to reduce alcohol misuse.[2]

The challenge is this: the principles that enabled our integrated health and social care for adults to flourish must now be extended across the whole community. The seamless, multi-disciplinary working, the strong relationships, the culture of holistic care, the care coordinator, must all be offered too – across two local authorities – to our families with troubles and to our young people. To Robert.

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

We are proud of our progress so far but we now need support as we tackle the rapid, whole-system transformation required to make our vision a reality. Pioneer status would give us vital expertise in change management, open access to international learning to guide a major system redesign, national support for pushing at the boundaries and for flexibility where that would ease the path for integration, and leverage for tackling very difficult issues head on. In return, we make a firm commitment to share our gains to help integration flourish across the country.



Introduction continued...

We believe in integration in South Devon and Torbay and will use it to make that "major difference" for our population, with excellent, joined-up care, now and in the future.

As a joined-up health and care community, South Devon and Torbay has left behind the disease-based and reactive model, with an agreed vision to focus on wellbeing, prevention, self-care and reablement, always striving for maximum independence – so that over their life course the people of South Devon and Torbay can start well, develop well, live and work well, age well and die well.

We see a reformed and vibrant primary care model integrated with the community in the widest sense – with the whole spectrum of health and care but also with the voluntary and community sector which can do so much to offer support for self-care and peer support and help get services right. At the centre is a smaller acute hospital offering leading-edge, highly specialist care – not when all else fails, but only when all else could never have succeeded.

To achieve this, we have innovative schemes running across the spectrum of this life course. You will find them at the village hall and in the district hospital, in the nursery and the care home. They are parts of the jigsaw we are putting together to create one picture – of seamless, joined-up care in which people won't fall through the gaps because the gaps will have been closed.

Shared values are the starting point for this. In January 2012, leaders of the whole health and care community launched the Joined Up Health and Care Cabinet, with the agreed commitment to deliver "High-quality, reliable and joined-up health and care which puts people first". Professional bonds are strong, a culture of drive and collaboration well established and common goals approved.

This will be where we drive the shift in emphasis and resources towards our young people and families, so that the patterns of lifelong reliance on care can be broken, wherever that's possible. This is a long-term plan; it is a sustainable service model leading to active and resilient communities being better able to support their older people.

The Cabinet itself is being re-shaped, with a voice for people using services. It is establishing a programme board and recruiting a project lead for delivering the transformation that Cabinet leaders have already mapped for years one to five, following the life course.

Starting well: early years

At the Joined Up Health and Care Cabinet we are lengthening and broadening our care pathways, to formalise prevention and early intervention and address inequalities through the 'Proportionate Universalism'[3] approach, with evidence-based action across all the social determinants. As disadvantage starts at birth and accumulates through life, the focus for integrated work in the early years is therefore on those with significant needs.

"We will drive the shift in emphasis towards our young people and families so that the patterns of life-long reliance on care can be broken."

Poor family skills lead to poor outcomes for children. Within the universal health visitor service in Torbay, the Family Health Partnership team delivers an intensive, evidence-based support programme to some of our most disadvantaged and vulnerable first-time young parents. Currently, 50-75 families are targeted; this needs to be extended.

With budgets taut and certain to remain so, we need to work to maximum effect with our communities, using an assets-based approach. The Watcombe/Hele Project aims to support the community to better meet its own needs, using its own strengths – guided by the Munro principle that "preventive services can do more to reduce abuse and neglect than reactive services."[4] Here, the 0-19 specialist community public health nursing team works alongside street wardens, community policing, education and the community group Hele's Angels in one of the most deprived areas of Torquay. Together, they address the issues the community itself identifies as priorities. Families with problems are identified earlier, safeguarding issues are spotted and flagged, and carers identified for support. Vital links with schools and housing providers have been strengthened. The pilot is already building community capacity – a mother starting a network group for families has asked that a health visitor offer regular support at drop-in sessions. If outcomes are good, we will build on this by rolling out the Watcombe/Hele Project to targeted communities across the whole area.

"The people helping me have been my lifesavers. I shall never, ever forget them."

Patient, alcohol service

Developing well: childhood and the young adult

To drive overall improvement in our children's services, we have reviewed our Child and Adolescent Mental Health Services (CAMHS) in Torbay and have agreed the outcomes we believe are needed to better meet the needs of children, young people and their families. We will now check these with people using the services. We want young people to get the support at their GP practice, which will have specialist oversight, training and professional leadership. Each cluster of GP practices and schools will have a dedicated primary care mental health worker, together with targeted screening, a seemless transition for young people to adult services, and a fast-track to the specialist service where needed, with a return to primary care after a time-limited intervention. Appropriate preventive programmes can be delivered in the classroom.

We will consider CAMHS provision in South Devon, to build on improving access, including to psychological therapies, providing excellent support for children in the care of the local authority and others with more complex needs. We also plan an all-age learning disability service in Torbay with lifelong support.

Self-harm is still largely a hidden problem. In Torbay we see a significantly high standardised rate for emergency admissions[5] for self-harm, but there are more who attend A&E but are not admitted – and likely to be more still who do not go to A&E. This comes at a significant cost to young people, families, employment, and health and social care – with an annual repetition rate of 15% and the risk of suicide 30-50% higher than in the general population. Our integrated public health response is improving public and professional awareness of the support available. We are developing consultation models for other frontline staff such as teachers, and putting in place peer support, time-limited intervention and care planning for young people like Robert, together with better access to psychological therapies.

KPIs:

- Reduce self-harm attendances by 10% a year
- Improve experience of people using the service by: to be agreed with service users.[6]

Excessive drinking and the associated rise in crime and violence has an impact across communities, within families, and on individuals. On national measures for alcohol admissions, Torbay scores significantly worse than average, including among the under 18s.[7] We have newly-redesigned integrated alcohol services, but

"We are extending our holistic alcohol service from Torbay into South Devon."

alongside these we invested in an intensive, holistic alcohol service for those with alcohol dependence and particularly high attendance at hospital, who often present with poor physical and/or mental health.

A targeted case worker works intensively with a small cohort, delivering a wide range of interventions including detox, referral to mental health or GP services, talking therapies and practical help with benefits or housing. This initiative was nominated for a national award for best service redesign with the best outcomes. The investment of just £40,000 was recouped in year one.

KPIs:

- Rate of increase of alcohol related hospital admissions: 0%
- Attainment of personal goals set with individuals for the outcomes they want
- Experience against National Voices measures

Many young people have disabled or ill adults relying on them for care. The Census 2011 indicates about 900 self-identified young carers in South Devon and Torbay but greater numbers are likely to be shouldering this responsibility.

Health and wellbeing checks for young carers are being further developed. In South Devon, they run alongside the current Common Assessment Framework for children. A model policy for closer working with schools is being tested so that more young carers are identified. In Torbay, a joint strategy for young carers under 25 (2012), developed with carers, represents a bold approach to developing joined-up support services for young carers and their families.

Our local authorities are also exploring the potential of 'social investment bonds' for early intervention for children. These are based on the commitment from Government to use a proportion of the savings from improved social outcomes to 'repay' the non-Government investors which fund these early intervention activities. An evidence-based financial model is being researched.

> "Quite a week for diabetes! It really feels like we have huge support at a senior management level to sort out diabetes in a way that we've talked about for ten years. Really exciting."
>
> Dr Robert Dyer, consultant in diabetes mellitus, Torbay Hospital, 2011

Living and working well – adults and the active elderly

The economy and opportunities for work are clearly critical, and we are all, as organisations, conscious of our duties as major employers to offer apprenticeships, work experience and training. We recognise, though, that economic hardships have an impact on health and wellbeing, which makes active support essential in these middle and later years.

Integration will be vital in actively managing long-term conditions. Our diabetes service is the model for our vision: an approach that identifies problems early in primary care and intervenes when there's the best possible chance of keeping people well, before they end up at the hospital door. It brings together consultants, specialist nurses and primary care in a community-based model founded on education.

The number of people with diabetes is increasing year on year in Southern Devon.[8] These patients are living longer, with more complications – factors that were leading to increasing referrals to secondary care. In our outreach model, primary care is seen as the base for all patients, with specialist services being made accessible as needed. Comprehensive guidelines are written by and for primary care staff. There is a strong joint formulary, and simple but cost-effective guidance on insulin prescribing.

Outcomes include a reduction in major amputations from 10.2/10,000 to 4.3, reduction in admissions for hypoglycemic emergency, low rates of diabetic retinopathy, a 50% reduction in admissions for heart attack and a rate of admissions for acute coronary syndromes now below the national average.

We will further integrate with end of life care, as this work has highlighted a one-year mortality in patients with high blood-sugar levels who have multiple hospital admissions.

This preventive/early intervention model will be extended next to chronic obstructive pulmonary disease, and then for each long-term condition area as appropriate.

An important factor in long-term conditions is the effect they may have on mental wellbeing. The close link between physical and emotional health is well established. As well as depression, medically unexplained symptoms (MUS) may be seen.[9]

We are developing more integrated primary, secondary, psychiatric, health psychology and psychological therapy service care pathways, so that people with MUS and significant psychiatric comorbidity are more likely to be identified and given appropriate psychological interventions and support.

KPIs:

- Reduce the numbers of frequent attenders to secondary care with MUS by >10%
- Experience against National Voices measures

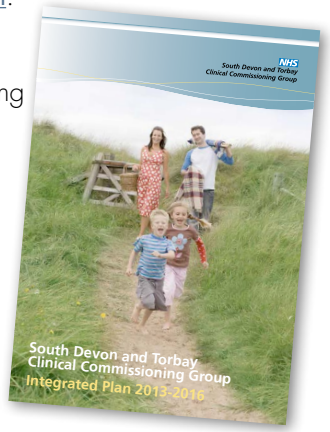
Social care reablement in Devon has been highly successful in promoting independence for people who may otherwise have needed longer-term personal care at home. As at April 2013, results from the six-week interventions show:

- 79% needing no further assistance from the council in terms of care provision, with 71% of these still remaining unaided 18 months later
- 12% having ongoing personal care at home at a reduced level from the standard service level
- 9% needing ongoing personal care at home beyond the standard service level

We will develop enhanced services on this model in our South Devon area, and – working with the County Council – take the learning to our Torbay area.

In 2009 Devon County Council became a demonstrator site for health and wellbeing checks for carers, and has been blazing a trail ever since with its integrated approach with primary care, social care and the voluntary sector. The check is a carer-led consultation, covering all-important outcome areas such as safety and warmth at home, work, education, leisure and support needs and incorporating the carer assessment, formally delegated by the council to primary care. A modified form of this check has been adopted for use in the voluntary sector.

Devon Carers, the jointly-funded, jointly-commissioned carers' support service, was designed with carers and has won national recognition as providing quality services. Self-care is a priority in the CCG Integrated Plan. To build on our Co-Creating Health work, we are procuring an evidence-based self-care service that supports people to achieve their own goals.



> "As a former PCT Board member in a different area I have been really struck by the considerably higher priority that is being given to mental health at the Governing Body of the CCG. I think this reflects the impact of having senior GPs at the table when commissioning decisions are made."
>
> Nick Ball, non-executive director, South Devon and Torbay Clinical Commissioning Group

Ageing well and dying well – keeping frail, elderly people at home

If we are to help people stay in their own homes – wherever possible, for as long as possible and as far as possible until they die – then we need, among other things, to marshal and mobilise the support of the voluntary sector. We need to work more closely with the voluntary sector and with local communities themselves to develop further capacity to complement that of public sector services and to promote self-help and independence for people living at home.

In South Devon, 'village agents' and Neighbourhood Health Watch schemes are spreading, and in Torbay we are developing the concept of neighbourhood connectors, to work in every neighbourhood. They will help combat social isolation – the blight of old age – and enable older people (and families with particular vulnerabilities) to engage in a wide range of activities. The connectors will act as a bridge to any other services required. Torbay Council has recently endorsed and supported the creation of a Community Development Trust, bringing together community leadership and voluntary organisations to tackle some of the wider issues that local communities themselves identify. There is now an opportunity to add clinical leadership and support to this structure, both strategically, by commissioners, and operationally, by NHS providers working on a locality basis.

The corporate social responsibility resource of our local business and professional organisations also remains largely untapped.

The virtual ward helps keep people in their own homes through a holistic approach. Every GP practice in South Devon joins up with the inter-disciplinary health and care teams, and uses predictive modelling to identify patients at risk of admission. As they are actively case managed to reduce that risk, the wider support each person has available is also considered – be that family, neighbours, religious or spiritual support. If we don't know, we find out. Each patient has a dedicated case manager, an active care plan and details of these are visible on the out-of-hours system. Full data for virtual ward patients in 2011/12 showed a sizeable reduction in admissions for that cohort of patients – down by 25%.

> "Our case manager is marvellous, caring, kind and helpful. She is knowledgeable and I am able to talk to her about any concerns. If I didn't have Angela, I would have no-one else to turn to."

We have been chosen by The King's Fund as a demonstrator site to study further the care coordination of people with complex needs. The virtual ward has changed the culture: an emergency admission for a person with a known long-term condition is seen as a failure.

Scale: For 2013/14 the CCG has increased its investment. The approach will be extended to a broader cohort of patients (the 5% most at risk, from the 0.5%), introducing integrated specialist input, for example through the use of virtual clinics.

In East Devon, Section 256 monies used by Devon County Council have brought about a successful hospital at home scheme, and we want to extend this to South Devon. Patients needing stepped up medical care can be admitted directly by their GP, or are discharged to their own home from community hospitals or the acute hospital, with continuing oversight from the care of the elderly consultant where appropriate. Hospital lengths of stay have been reduced, care is personalised and patient experience is exceptionally good. Doctors and families particularly welcome the scheme for people with dementia.

The overwhelming impact of dementia is not medical, but on a person's ability to function independently within their family, community and society. We are, therefore, supporting the spread of dementia-friendly communities as the absolute cornerstone of our response, signing up local businesses and others with the help of our volunteer dementia champions.

Working with people who use services, the two Devon CCGs and Devon County Council have developed a dementia care pathway which defines the supports available from pre-diagnosis to end of life. No-one in future will feel abandoned after diagnosis. Commissioned services are also undergoing dramatic redesign. In Torbay, the local memory clinic has been relocated to Torbay Hospital to serve as a 'one stop shop' for both diagnosis and post-diagnosis interventions, such as group therapy and the legal advice that's often much needed. Acute hospital psychiatric liaison services are being developed on the West Midlands RAID model to reduce inappropriate admission and reduce bed stay durations. GPs are now facilitating access to anti-dementia drugs, and people with dementia and their carers will get active community support through a newly-commissioned dementia advisor/support worker service.

"I was working with the GP but we couldn't get my mother to agree to access services. Through the case manager, we were able to get a benefits check, get voluntary sector services involved and a care package in place. Dealing with one person increased my mother's confidence and she finally agreed to have essential medical tests."

Carer

Ageing well and dying well – keeping frail, elderly people at home continued...

The next step is a pilot to integrate and extend out-of-hours support to match peak demand, with community psychiatric and district nursing, social care and medical services working together. The goal is to improve quality of life. Torbay has the second highest percentage of people with dementia in England but our rates of admission to psychiatric care and of antipsychotic prescribing are now among the lowest in the country.[10]

KPIs:

- Reduce hospital admissions by 10% a year
- Improve experience of person with dementia/families by: measures to be determined at engagement
- Experience of individual, families and carers against National Voices measures

With providers and the community, Torbay is developing an integrated housing strategy, including best use of equipment, home improvements, disabled facilities grants, but also support and care within people's own homes, particularly for frail, elderly people. Intermediate care in Torbay has helped bring social-care use of care homes, age standardised, to within the best 10% in the country. The number of publicly-funded residents in South Devon is still comparatively high for the county and we need to expand services in the community.

We are keen to support a Devon County Council initiative to develop extra-care housing to promote person-centred care and support, and accommodation for rent and sale. At Newton Abbot, 50-60 flats are being built. Centrally located and used as a 'hub,' they will provide an oasis where the older and more vulnerable members of the community can meet, interact socially and be assured of care and support, round the clock. We support extending this model to other towns with poorer transport links.

We have 222 care homes in South Devon and Torbay and they are home to 3,892 older people. Care can be excellent, but is not uniformly so. We see about 1,500 unplanned hospital admissions from care homes every year, with around 400 ambulance 999 calls a month. Of these, one in six is discharged the same day, and one in five has a one-day length of stay. All of this indicates that many residents could be treated instead in their home, without the unwelcome disruption of an unplanned trip to hospital.

We launched a jointly-funded secondary care outreach pilot in December 2012. Nurses from the hospital Medical Admissions team provide an integrated approach between hospital and care home. They offer an acute nursing service, with advice, guidance and nursing support, and some acute nursing treatments such as intravenous treatments and blood transfusions.

After an all-stakeholder event, our five locality commissioning groups agreed integrated plans with pharmacy and mental health to avoid unplanned admissions, avoid over (or under) medication, improve end of life care, and support the homes with improved education and clinical skills. Each home will be linked with a named GP practice, to improve care planning and people's continuity of care, if they want this. Medicines will be reviewed to maximise safety and minimise safeguarding worries.

Emergency admissions from care homes cost the CCG around £4 million a year. Preventing 474 admissions in year one by bringing the admission rate from the top 20 homes in line with the average will save £1.254 million.

Improving integrated end of life care is a goal for all, not just for those in our care homes. Nationally, 70% of people do not die where they choose – in South Devon and Torbay that figure averages 48%. However, there is still work to be done.[11]

In line with the 2013 Cochrane Review[12], the CCG has supported a 24/7 hospice at home service. Our valued provider, Rowcroft Hospice, delivers this through a team of specialist nurses and senior healthcare assistants, with a rapid response service and dedicated night drivers.

In the first year, the Rowcroft at Home service cared for over 400 patients, 84% of whom died at home, with 7% supported to stay at home until they could be admitted to their preferred place of care to die. 69% of referrers advised that referral had prevented admission to hospital. Carers have reported a reduction in the burden and anxiety of caring; patients have reported improved quality of life, dignity and self-worth. We are now exploring with Rowcroft ways of extending the numbers of people supported, and palliative care teams across the system will join up – from hospice to hospital to community.

KPIs:

- Increase the number of people supported to die at home if that is their wish
- Support the reduction in hospital deaths by 10% per year
- Support a 25% reduction in the average length of stay in hospital for patients in the last two weeks of life

> "Never in my wildest nightmare did I imagine that I would be trapped in a paralysed body unable to speak. First and foremost I wanted to maintain my independence and I have every intention of enjoying the rest of my life. Integrated care in the community gives me my last piece of freedom. Priceless!"
>
> Bob Brewis, diagnosed with motor neurone disease

Recreating the system

Bringing about lasting improvements in the life chances and wellbeing of our population will entail far-reaching and urgent change. Strategic leadership for our integration plans will be through the South Devon and Torbay Joined Up Health and Care Cabinet, and through Devon's Joint Strategic Commissioning Group, which includes Northern, Eastern and Western Devon CCG. The Health and Wellbeing Boards will be regularly updated, and provide system-wide leadership for addressing inequalities and the wider determinants of health.

We will take an assets-based approach, drawing on the existing strengths of our communities to build their resilience and capacity. At the same time, we need to mould the system to the people using our services, so they can move through it seamlessly and in a way that they themselves can control.

All this has great implications for our highly-valued workforce. Redesigning this is a task we have just begun, and with which we will need external support. Our professional staff will need to work and co-create in an entirely innovative way. We are thinking about how to change, merge, blend and redesign the traditional roles of nurses and allied healthcare professionals around the needs of Mrs Smith, her daughter and her grandson as they access health and care throughout their lives. Our recent contribution to the first draft of the Centre for Workforce Intelligence integrated workforce paper (2013) will enable us to think through a methodology for bringing together the future workforce around the needs of people using services. We'll be using analysis, policy review, workforce modelling (with accurate information on current structures) and scenario planning, all with the detailed involvement and engagement of our staff.

> "Our valued staff will need to work and co-create in an entirely innovative way."

New ways of measuring performance – no longer by activity – will require new ways of collecting and evaluating data. We are working with the University of Exeter on solutions to this complex task.

In readiness for the new system, the Joined Up Cabinet will stretch an ambitious joined up IT programme over Torbay's whole Joined Up endeavour. Incorporating the principles of Patient Knows Best, this will see leading-edge systems spanning the whole healthcare community, linking health and social care, primary care, mental health care, hospital care and residential care, with meticulous governance and consents.

We see this as streamlining processes, adding assurance about patient safety, improving patient care and ultimately helping avoid unnecessary admissions to hospital. There are three strands:

E-prescribing: a patient's prescribing and medication record visible not just in the hospital but across the whole community including mental health, hospice providers, pharmacy, and ambulance service – increasing patient safety. We have won a £3.7 million Government grant for this; the only area to bid jointly as an entire healthcare community.

E-booking: that will allow the clinician to input directly into an electronic system that knows the pathways and will make all the associated bookings, eg for diagnostics, pre-admission and surgery. If, for instance, blood test results make scheduled surgery inappropriate, it will be rescheduled, with no administrative interface. Moreover, the patients themselves will be able to make changes from home; they can alter a pre-admission outpatient appointment without, as now, throwing out the schedule for surgery, and they will be able to track their own progress through the pathway.

VitalPAC: the vital signs recording and monitoring system already allows clinicians to record observations on a hand-held device at the bedside, with built in reminders and alerts. We will extend this across primary care, health and social care and into care homes, so that clinicians can monitor their patients remotely, and vice-versa. Specialist oversight will support increasingly sophisticated decision making, including about admissions from care homes. All will be visible to patients.

Integration of organisations is not the goal – but can be an enabler. Currently South Devon Healthcare NHS Foundation Trust is the sole bidder for the community services run by Torbay and Southern Devon Health and Care NHS Trust. It has put forward, in its acquisition bid, the case for creating a single Integrated Care Organisation, underpinned by a highly-detailed Integrated Business Plan detailing a reduction of workforce and efficiency savings. A key commissioner requirement of this process was that it should deliver more for less. That principle remains across our system.

> "In particular I wanted to thank the A&E consultant who handled the situation quickly and skilfully. Also the senior house officers, healthcare assistants, nurses and domestics all did a fantastic job looking after her. Everything happened smoothly and promptly and I was kept informed throughout by the team."
>
> Husband of a patient cared for at Torbay Hospital

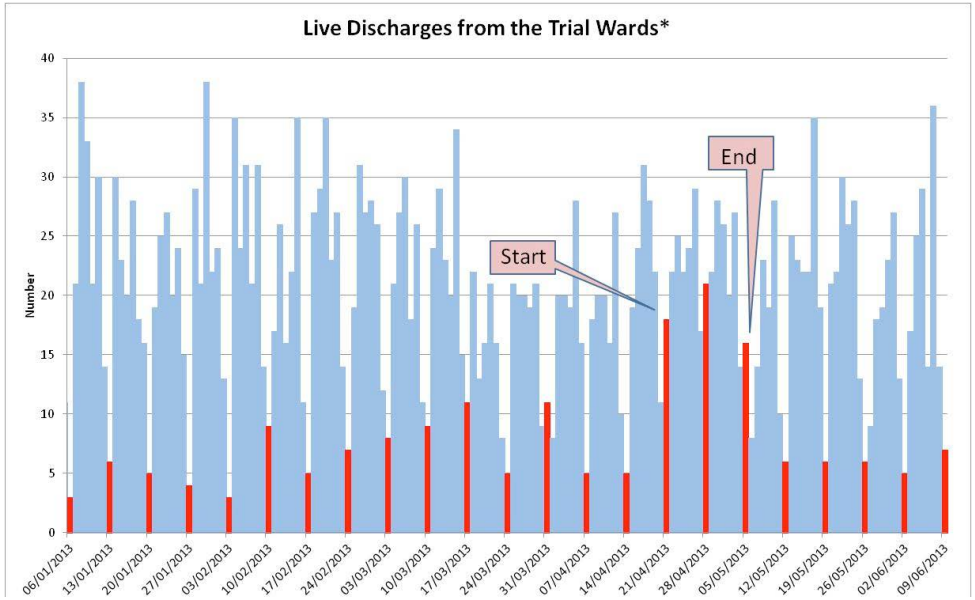
Recreating the system continued...

On finance, we already have, locally, a good record of not getting in the way of excellent ideas for service change: we collectively agree approaches to payment for services that promote high quality, innovative care while maintaining financial stability for all organisations. While we do work with national payment systems, we have worked with them flexibly, never allowing tariff alone to drive our working together. In future, we need even more flexibility to pool budgets so that together, across the integrated system, we can design, commission and provide the very best services for our population. As a pioneer site, we would pursue this with the benefit of the external support offered. And whether or not this acquisition takes place (outcome July) the key benefits outlined must be retained. Among them is the vast scope for improving patient flow – the key not only to safe, effective and efficient care, but directly linked to people's outcomes and their experience.

Real quality of care will require our integrated system to be responsive seven days a week – in the acute hospital, community hospitals and across all the relevant components of the multi-disciplinary teams in the community. The challenge is vast, but without it, patients end up in the wrong parts of the system – producing outliers on wards, patients being admitted to the acute hospital when they could have been cared for in the community and, ultimately, delays in patients getting where they need to be – back home.

Torbay Hospital already sees excellent patient flow – getting the front door right and transferring people onwards or home safely. Its occupancy rates, at 89.5%, are among the best in the country. Its seven day services include radiology, physicians, surgery and physiotherapy, but it still sees significant variation in performance over the seven day period.[13] Click to see charts.

Test of change – Sunday working



This spring a pilot of Sunday working was run for three consecutive weekends on five wards (conducting 'business as usual' rather than a weekend service). It extended the working of general physicians with special interest in the fields of care of the elderly, respiratory medicine and gastroenterology, trainee doctors, therapists, ward clerks, patient transport services and discharge coordinators. After each weekend, emergency beds were available on the Monday, and there was "an atmosphere of calm" in the hospital. There were significant qualitative and quantitative improvements in system performance over the whole week.

Notably, in a period when soaring demand on A&E made national headlines, Torbay Hospital continued to meet its 4-hour wait requirement, staying at >95% despite the pressure.

> "The professionals involved with my care talk to each other. We all work as a team."

In health and care, the multi-disciplinary approach is well established. In Torbay this sees teams in designated 'zones' bringing together community nursing, adult social care and intermediate care, including community pharmacy, occupational therapy and physiotherapy, with a clinical active case coordinator (or community matron) and an integrated health and social care coordinator. People needing services have a single point of access – one phone call

…pleasantly surprised by 'come and meet CCG' meeting in Torquay tonight. Others could learn from the positivity & transparency…

…having once worked in a PCT, actually now believe that CCGs can make a far improved difference. Tonight my faith is restored in the NHS…

Recreating the system continued…

is all that's needed. Seven day services include district nursing, out of hours emergency duty service, crisis/rapid response domiciliary care, with, in Torbay, intermediate care, discharge coordinators in A&E, intensive home support service, and, in South Devon, reablement. This needs extending.

The metrics for seven day working have been identified as: experience as against National Voices measures; patient survey; the SHMI mortality indicator; readmissions; average length of stay, including combined acute and community stays; staff survey; pathway cost; and recruitment to organisations. KPIs are still to be developed.

Central to our model for joined up care is the community hub. We are now extending its scope, integrating the learning disability service this year, along with a community psychiatric nurse and dementia support worker. We will consider with Devon County Council the further development of a new community hub in Newton Abbot in South Devon, using the single point of access via Care Direct Plus, and seeing closer integration with primary care. This hub model would, in common with that in Torbay, have direct mental health service support and a key focus on dementia friendly initiatives. A frailty service and an urgent care centre integrated with primary care and the out of hours service are also being considered for Newton Abbot community hospital – Devon's newest and best equipped. Key planned outcomes: fewer hospital admissions, increased early diagnosis of dementia and support for carers of people with dementia.

We have, too, been exploring ways of integrating working between primary care and the multi-disciplinary health and social care team. GPs and the community team are helping the same people, the same patients. Rising demand on primary care risks poorer service and experience for patients. There are obvious benefits if resources are shared, in terms of time, efficiency and quality of care. GPs greatly value the single point of contact and health and care coordination in the zones, but it is clear that there are gaps – school nursing, Child and Adolescent Mental Health Services, and health visitors are more difficult to access.

We have agreed, so far, the need for single clinical leadership and a single management structure across the local primary care and community services. This could include pooled and flexible use of resources running alongside clinical integration; for the patient this would mean being seen by the most appropriate person – not necessarily their GP – at the right time. This approach would help in managing long-term conditions. For primary care, there is the advantage of having contingencies at times of high demand or emergencies. A key enabler has also emerged for this model: prompt access for GPs to diagnostics.

"GP practices are developing provider networks so they can work effectively to improve health."

As the principal point of contact with health services for most people, primary care is an essential part of the jigsaw in whole system, person centred integration. To keep commissioning local, South Devon and Torbay CCG has five locality commissioning groups (LCGs) with coherent boundaries reflecting the common characteristics of the population served. The LCGs monitor and manage practices' commissioning performance (referrals, A&E attendances, urgent admissions) but everyone acknowledges that the practices' ability to perform well is directly related to the quality of provider services available. The 37 practices are therefore now developing GP provider networks so that they can work collaboratively to deliver patient care and share more specialist skills and resources. With greater scale, these networks – or federated practices – can work together more effectively to improve whole population health.

We know there's a lack of capacity for the increasing demand in general practice, evidenced locally[14] and nationally[15]. The age profile of our GPs means recruitment is not keeping pace with the retirement of the existing workforce. Action is needed, and our innovative solutions are developing. We have commissioned the University of Exeter to model capacity and demand in primary care and will use the results to develop a primary care strategy in conjunction with the NHS England Area Team.

We have also supported 22 of our 37 practices so far to adopt the Dr First or Productive Primary Care schemes that streamline and improve access for patients; early feedback tells us is greatly welcomed.

> "First comes thought; then organisation of that thought, into ideas and plans; then transformation of those plans into reality. The beginning, as you will observe, is in your imagination."
>
> Napoleon Hill, 1883-1970

Recreating the system continued...

Feedback has also been overwhelmingly positive for the National Voices narrative which we have used at all our recent Meet the CCG engagement events. We recognise that while we can claim to meet some of the "I" statements on what coordinated care looks like, we are nowhere near offering, consistently and across the board, the kind of inclusive, joined up care that puts those using services in control. The narrative will now form the basis of all our engagement; we will evaluate the response and use it, with National Voices' guidance, to develop criteria for our commissioning, building these requirements into our service specifications and performance monitoring. Providers have an excellent record on involvement and engagement and they, too, will be determining KPIs on the validated measures expected later this year.

We have already taken an entirely new approach to engagement, with our CCG Strategic Public Involvement Group (SPIG). Working with networks in the community, we went on a journey with partners in the voluntary sector, involvement networks and the-then LINks, to discover such a body should look like. Importantly, SPIG self-nominated, selected their own members from within their networks, and selected and elected their own Chair and Vice-Chair. As a result, we have wide networks back into the community. SPIG is working with us to ensure they influence commissioning at the most strategic levels. We think we've broken the mould in enabling our community to tell us how they want us to engage, and will, therefore, put SPIG and our two Healthwatch organisations in the driving seat in taking forward the work on the National Voices narrative.

We invite provocative, insightful and field-leading speakers to Torbay and South Devon to take part in seminars we call the 'Excite, Ignite, Imagine' series. But the words have wider resonance across our system, encapsulating our search for innovation and better, different ways of improving health and care for our communities. We are using the learning from other high performing systems such as Jönköping in Sweden to develop our own 'Qulturum' where innovation, improvement, education and research come together to support the delivery of an integrated care system. In our state-of-the-art innovation, education and research facility we are actively working with our academic partners, University of Exeter and research institute PenCLAHRC, to undertake operational research – using techniques such as simulation with clinical teams,

patients, families and carers to redesign care pathways. We are making our innovation processes open and accessible, crowd-sourcing opinion from across our care community via multiple platforms. Our groups such as Catalyst and iTorch gather staff inspiration and help instigate change.

The hospital's Hiblio is a pioneering digital TV service for healthcare, promoting concise health information and education to the public and clinicians alike. We are extending it with training DVDs for carers on topics such as preventing pressure ulcers. It also includes a medical education channel with transferrable mandatory training, and specialty-specific information for clinicians.

We search out ideas from all parts of the country and the world, working closely with the Association of British Healthcare

Industries, British In-Vitro Diagnostics Association and others. Our default setting is to share our own ideas and learning, too. As a pioneer site, we would use all our networks; our natural starting point would be the large geography and population of NEW Devon CCG, where integration is already a priority and where we both want to see system level partnership working across the Devon County Council footprint. We already arrange learning exchange visits with other care communities, and would formalise this programme. We are also active in NHS Clinical Commissioners and our Academic Health Science Network, have links with the International Foundation for Integrated Care and highly-valued ties with The King's Fund and The Nuffield Trust.

With the support of the pioneer programme and the external expertise it offers, we are confident we can achieve the transformation of our health and care system we are aiming for. We do not believe that making our existing system 'better' can be the answer – the system itself needs to change. None of us underestimates the challenge but we are ready for it. South Devon and Torbay is committed to making a lasting difference to the care and support of our local population.

References

[1] Office of National Statistics, Interim Subnational Projections, 2011

[2] Haines, D., (2013) Joint Strategic Needs Assessment, South Devon and Torbay

[3] Marmot, Professor Sir M., (2010) Fair Society, Healthy Lives, Institute of Health Equity

[4] Munro, Professor E., (2011) Munro Review of Child Protection, Department of Education

[5] In adults of 341/100,000 (national average 207) and for under 18s of 139/100,000 (national average 123)

[6] All Devon Partnership NHS Trust mental health projects integrate mental and physical healthcare and are designed around the NHS Change model of co-production involving patients, carers and stakeholders.

They align with the Peninsula Academic Health Science Network and CLAHRC priorities and will be subject to bids to these groups for full evaluation of patient experience, outcomes and against best practice guidelines.

[7] Local Alcohol Profiles for England (LAPE), North West Public Health Observatory

[8] Yorkshire and Humber Public Health Observatory, 2012

[9] Data analysis in Devon in 2010 showed that of 300 consecutive patients referred to a neurology clinic, 60% had MUS, 15% had a psychiatric disorder, 16% (48) attended A&E from 1 to 12 times a year with their complaint and of those 54% (26) were admitted.

[10] North West Public Health Observatory, Community Mental Health Profiles 2013

[11] End of Life Clinical Pathway Group, South Devon and Torbay Clinical Commissioning Group, performance data

[12] Gomes, B., Calanzani, N., Curiale, V., McCrone, P., Higginson, I.J., Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD007760. DOI: 10.1002/14651858.CD007760.pub2

[13] In Torbay, there is no "Friday effect" on mortality rates as reported in June 2013 by the Imperial Group. Analysis of all elective procedures, a basket of intermediate to major elective operations, elective colorectal resections and elective major joint replacements shows no significant day-of-operation effect on mortality in the last five years, and a possible effect in the five preceding years.

[14] Oxenbury, Dr J., (2013). Practice Managers Survey Results: workforce information for South Devon & Torbay.

[15] Lueddeke, G.R., (2012). Transforming Medical Education for the 21st Century: megatrends, priorities and change. Radcliffe Publishing Ltd: London; Howard, Professor, J., (2013). General practice and primary care task force review. East of England Multi-Professional Deanery.

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