Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	South Devon and Torbay Clinical Commissioning Group
By	Simon Tapley
Position	Director of Commissioning
Date	19th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Torbay Council
By	Caroline Taylor
Position	Director of Adult Social Care
Date	19th September 2014

<Insert extra rows for additional Councils as required>

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

c) Related documentation

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

Document or information title	Synopsis and links
Pioneer application June 2013	The vision for whole system integrated care in South Devon and Torbay here
South Devon & Torbay Integrated and personal Care Organisation Business case	The full business case for the merging of Torbay and Southern Devon Health and Care NHs Trust (TSD) with South Devon Healthcare NHS Foundation Trust (SDH). It sets out the background for the merger and demonstrates why this proposal is the best option for TSD & SDH and for the people they serve. SDH's Trust Board and its council of governors will review this full business case (FBC) to support a final decision regarding commitment to the merger before wider publication.
Better Care Fund Plan December 2013	The vision for how we will use the Better Care Fund and pooled health and social care budgets to deliver integrated whole system care for everyone who needs it.
CCG Strategic Commissioning Plan 2014-2019	This sets out the ambitions and intentions for the CCG which prioritise integrated planning and delivery to address the challenges faced by health and social care.
South Devon & Torbay CCG Commissioning Template	Planning document setting out ambitions for improving a range of key outcomes here
South Devon and Torbay CCG Engagement report	The report analysing the feedback from our extensive community services engagement process here

South Devon and Torbay Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy 2012/3 – 2014/15 (JHWS)	Agreed set of priorities for Torbay covering the life course with three underlying principles of 'First & Most', 'Early intervention', 'Integrated and Joined up approach'.
Living Well at Home	Our strategy for providing support for people to remain living as independently as possible in their own homes, delivered in partnership with the independent sector.
An Overview of Dementia	Analysis of dementia prevalence and predictive modelling provided by Public Health.
Aging Well Bid	
Mental Health Strategy	
Learning Disability Strategy	
Market Position Statement	The statement provides an analysis of how well current service supply will meet future demand. It provides clear messages to the market on the vision for integrated care services in Torbay over 7 days a week, reducing reliance on bed based care. It outlines how provision needs to change to stimulate a diverse and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help to support people manage their conditions through early help and a focus on personal outcomes and choice.

2) VISION FOR HEALTH AND CARE SERVICES

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

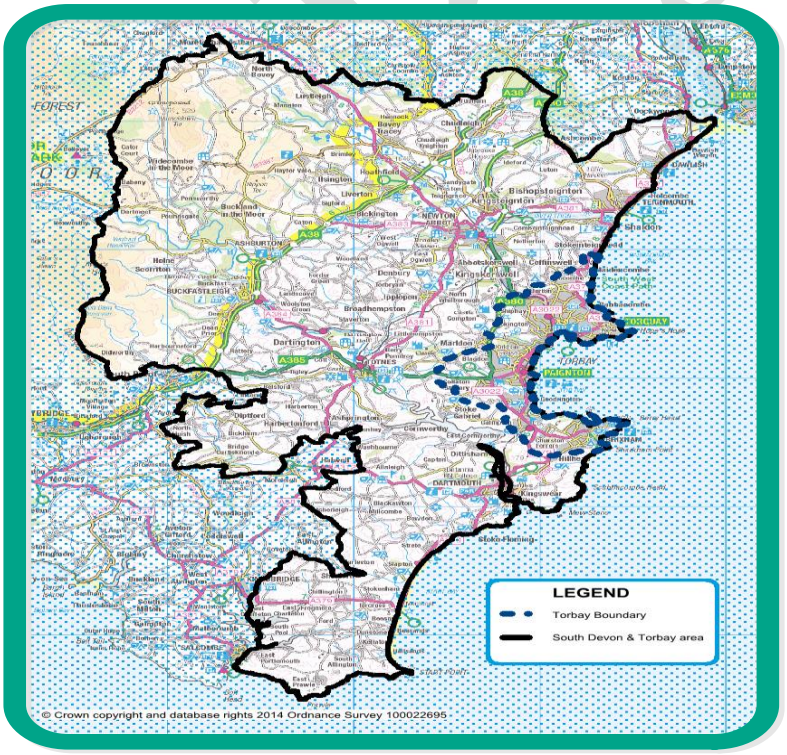
Within Torbay full integration of community health and adult social care was achieved in 2005, with the creation of Torbay Care Trust. This model has been recognised both nationally and internationally as an excellent model of care. It has realised a single assessment process, a single care record, a single information technology system and multi-disciplinary frontline teams supported by a single management structure. The role of the care coordinator in these teams, ensuring seamless care for patients, has since been replicated in many other areas.

In 2013 South Devon and Torbay became one of 14 national Pioneer sites for integration. The joint bid from the health and care community set out an ambitious goal of whole-system integration, extending beyond health and social care to encompass acute care, mental health and the voluntary sector. This is the driver for a new model of excellence for 2018/19.

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

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

Map showing Torbay and South Devon:



Our Pioneer programme and ICO business case have been developed with the active support, involvement and engagement of South Devon Healthcare NHS Foundation Trust, Torbay and Southern Devon Health and Care NHS Trust, Devon Partnership NHS Trust, South Western Ambulance Services NHS Foundation Trust, Virgin Care, Torbay Council, Devon County Council, NHS England, Rowcroft Hospice and Torbay Community Development Trust. Strategy is agreed and progress monitored by a whole-system JoinedUp Board, working to achieve: "Excellent, joined-up care for everyone."

At the core of our vision for integrated care and personalised support are these principles:

- People will direct their own care and support, receiving the care they need in their homes or their local community
- Key services will be available when and where they are needed, seven days a week
- Joined up IT and data sharing across the entire health and care system will enable seamless care
- We will promote self-care, prevention, early help and personalised care

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

- Single Point of Contact (SPOC)
- Community care
- Frailty Services
- Long Term Conditions Management

The CCG's five year strategic commissioning plan is based on the Joint Strategic Needs Assessment. Close links between CCG and public health specialists, who are integral to CCG commissioning, ensure the alignment of priorities and focus between health and local authority plans. This includes the Children and Young People's plan and early help strategy, and joint commissioning strategies for dementia, carers, learning disability, mental health and housing-related support.

The **Joint Strategic Needs Assessment** (JSNA) has developed from a reference document into an interactive tool, available to partners to interrogate the data according to service need. The JSNA has highlighted those areas that needed priority attention. For learning disability, suicides, and alcohol, we have segmented and condition-specific in depth profiles at a geographical ward and neighbourhood level. A joint information intelligence virtual team has been established among health, local authority (including education) and police to facilitate information sharing that can then be translated into strategy.

The Better Care Fund lines up with the existing priorities set out in the **Health and Wellbeing strategy** which takes the life course approach and identifies priorities which support a system of self-care for people with long term conditions, and promote both independence and mental health.

Statutory agencies are not to sole key to integration, and our vision for community-wide participation expresses this. To set out the opportunities and to encourage a diverse market we have developed a **market position statement** for Torbay with the first phase focusing on adult social care. The statement provides an analysis of how well current service supply will meet future demand. It provides clear messages to the market on the vision for seven-day integrated care services in Torbay with reduced reliance on bed based care. It outlines how provision needs to change to create a diverse and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help, and focusing on personal outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

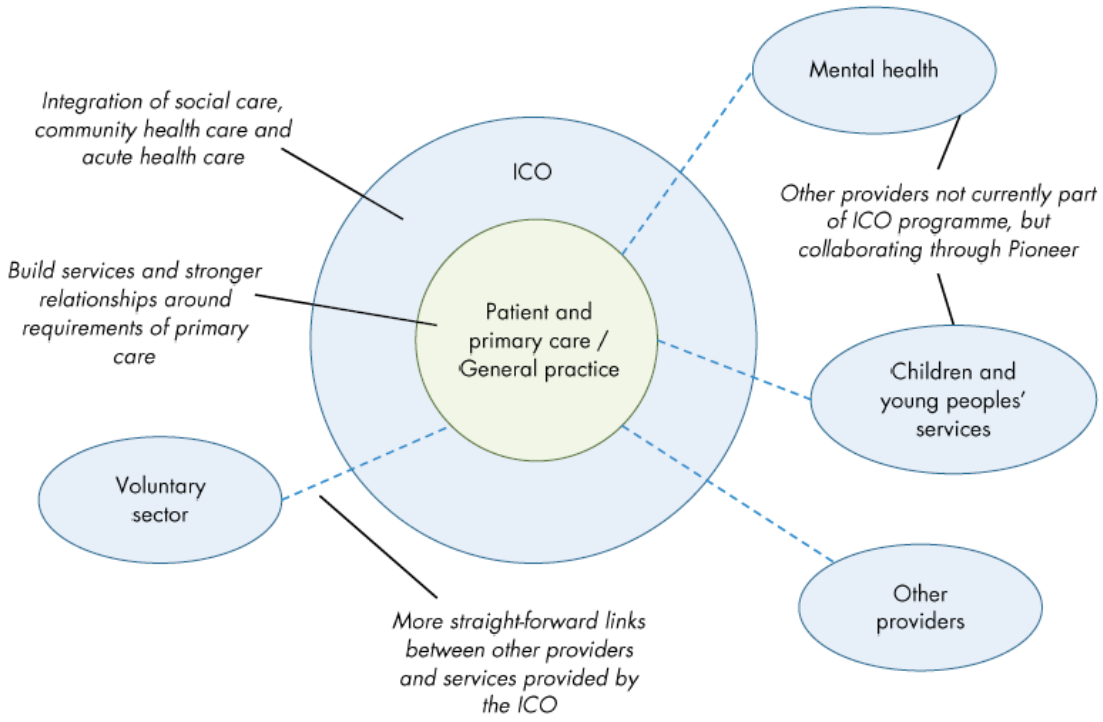
One of the walkers tells Mrs Smith's daughter about a course at the local library which helps older people learn how to use smart phones and tablets. They arrange to go together.

These ambitions are being actively pursued through our Pioneer Programme and Integrated Care Organisation. The Better Care Fund is complementary to this, with many of the service changes outlined above already being developed, irrespective of BCF. However, the BCF has brought a stronger focus and drive towards pooled resources across the system, as the best way to

address the challenges and pressures that we currently face in our hospitals and health spend. This spend will have to reduce, as we shift from high-cost reactive to lower-cost preventative services, supporting greater self-management and community based care. Our social care spend will be going further, as new joint-commissioning arrangements deliver better value and improved care at home, reducing the need for high-cost nursing and care home placements. Across the whole system, the principle is "more for less".

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

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



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

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

The CCG strategic plan sets out the key outcomes and indicators for each of its high level priorities. These are all in line with the vision for integrated care and support. The plan also demonstrates the number of workstreams in place to make integration happen within the context of a flat cash environment and reducing local authority budgets. The workstreams focus on

prevention, primary care, community, urgent care, mental health, long-term conditions, learning disability, planned care, medicines, joint commissioning and children's services.

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

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

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

3) CASE FOR CHANGE

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

Our vision is to have excellent, joined up care for all.

We believe that services should be based on populations in local communities and centred on the individual's needs within those communities. Services should be built on people's needs not organisational imperatives; this serves as a mantra for the formation of our community hubs. New community hubs will be centres of wellbeing where our population can receive co-ordinated support in relation to prevention, self-care, social care and medical support from primary and community care. The development of each of the initial community hubs has included an analysis of demographic levels of needs overlaid with service response. Combining such intelligence data with primary care level data and our ability to use evidence-based, local, combined predictive modelling means we can confidently identify risk groups who will benefit from a more integrated approach to care delivery.

Pressures on the NHS come not only from age, but illness and especially chronic illness; The World Health Organization (WHO) estimates that more than half of the burden of disease among people over 60 is potentially avoidable through changes to lifestyle. The challenge is to prevent ill health and to promote healthy productive years of life. A significant concern for an aging population is dementia, but as much of this is linked to vascular disease, which is declining, the potential impact might be less than expected. Anticipating the impact the baby boomer generation will have on health and social care is difficult but there is clear evidence that the expectations of Boomers' and their willingness to adopt what's new and better will speed progress in patient-managed technology, such as mobile health, telehealth and telecare.

These empowered citizens will have a significantly different view of how they wish their health

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

Torbay has a model of integrated health and social care teams built around geographical clusters and primary care practices, with a single point of access. These teams provide functions to enable:

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

The SDT CCG footprint:

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

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

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

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

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

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

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

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

Risk stratification

We use a risk stratification tool, the Devon Predictive Model, to identify patients at risk of hospital admission in the next 12 months. The top 0.5% of our population are then pro-actively case-managed on our monthly community virtual wards. The virtual ward teams use the predictive tool to objectively identify patients who are then pro-actively and holistically case-managed by a multi-disciplinary team, including primary care, community and rehab teams, palliative care, mental health, social care and the voluntary sector. Each patient is allocated a named case-manager who then co-ordinates their care and support. We have built on this highly-successful model to incorporate the features of the Unplanned Admissions Enhanced Service for primary care for 2014/15, working towards the top 2% of our population then being proactively case-managed.

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

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

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

The table above shows that the top 2% of patients had 13,579 total emergency admissions over the last 2 years with an average of 2.72 admissions per patient in South Devon & Torbay CCG. It has been estimated that a 3.5% reduction in non-elective admissions across the Torbay BCF would be a reduction of 544 admissions per year. An 8% reduction in emergency admissions across the top 2% of patients would deliver the target reduction in non-elective activity. A significant proportion of the schemes in the Better Care Fund are targeted at these top 2% of patients. Thus the top 2% of patients as identified via the Devon predictive model represent the

biggest opportunity to reduce the level of non-elective activity.

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

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

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

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

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

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

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

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

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

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

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

There is a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.
Commissioners and providers are facing the challenge of meeting the complex needs an ageing population now. As we age, our complex health needs increase and we require increased levels of help and support. At present, our over 85 year old population cost around 10 times that of our population aged 5 to 9 or 10 to 14 for all hospital admissions. On our current trajectory, and assuming today's prices, we may expect the over 85 population to cost the hospital over £1m more in 2020 compared to today. Up from around £7.3m in 2012 to £8.5m in 2020. Estimates suggest that the cost for non-elective care (not adjusting for inflation or other factors) for the over 85's will rise from around £14.5m to £18.5m in 2021 through demographic change alone.

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

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

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

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

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

Scheme 2: Frailty Services will achieve a :

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

Scheme 3: Multiple Long Term Conditions will

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

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

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

4) PLAN OF ACTION

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

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

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

	DEADLINE	**LEAD**
IMPLEMENTATION OF ICO		
ICO Final Business Case to Organisational Boards	September 2014	SDHFT
ICO Final Business Case Monitor Process initiated	October 2014	SDHFT
Contract Heads of Terms Agreed	February 2014	SDHFT + CCG+ LA
ICO Created	April 2015	
IMPLEMENTATION OF SCHEMES		
Service Development Plans completion	August 2014	JCCG + Operational Leads
Refine segmentation of population further and benefits realisation to effectively target schemes	October 2014	
WIDER COMMISSIONING		
Aging Well Programme commence	October 2014	Community Development Trust
Living Well @ Home Contract agreed	January 2015	T&SDHCT
PROJECT MANAGEMENT OF BCF		
Integrate BCF project within ICO and Pioneer Project Programme	September 2014	Pioneer Programme Mgr
MONITORING AND MANAGING BCF PROGRAMME		
Test and review the mechanisms in place for monitoring and reporting to the Joint Commissioning Group; ICO Board and Pioneer (JoinedUp) Board.	October 2014	JCCG
Review and update the performance report templates to ensure fit for purpose and ability to respond and escalate action as needed.	October 2014	JCCG

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

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

There are already existing structures such as the ICO programme Board and JoinedUp Health and Care Cabinet (Pioneer Board) which has provided a forum where agreements have been brokered around risk-sharing, changes to financial flows and other significant 'unblocking' changes to the way in which care is delivered in South Devon and Torbay. Through this collective debate full consideration has been given to the risks as well as the benefits of commissioning from one integrated organisation with all partners in agreement as to supporting the model and in deed the interface that further opportunities present with other providers in the future such as mental health and children social care as well as improved effectiveness and improved efficiency.

The Health and Wellbeing Board has a key role in integration and provides the strategic oversight with responsibility for sign off of relevant plans and scrutiny of implementation. The governance arrangements for the BCF will fit in to the strategic and operational monitoring framework established for Pioneer and ICO to ensure escalation is timely and ability to respond is assured across the relevant organisation or area of work. Each of the key work streams report on progress against a shared agreed performance metric reporting system through to the Pioneer Board which in turn is also managed through the Joint Commissioning Group made up of Director of Adult Social Care; Director of Children Services; Director of Public Health; CCG Director of Commissioning and supporting senior members of staff. This group which has helped to develop a shared set of commissioning strategies and a joint work plan to deliver intent for further service developments and improvements across the health and social care system including mental health and children services. Performance reports have already been developed so that metrics can be monitored on a regular basis. This reporting is continually being refined so that it can be used as a key source of assurance for progress against the BCF plan and brings together not only the BCF metrics but the three outcome frameworks (Adult Social Care, NHS and Public Health).
Example of Torbay Dashboard below:

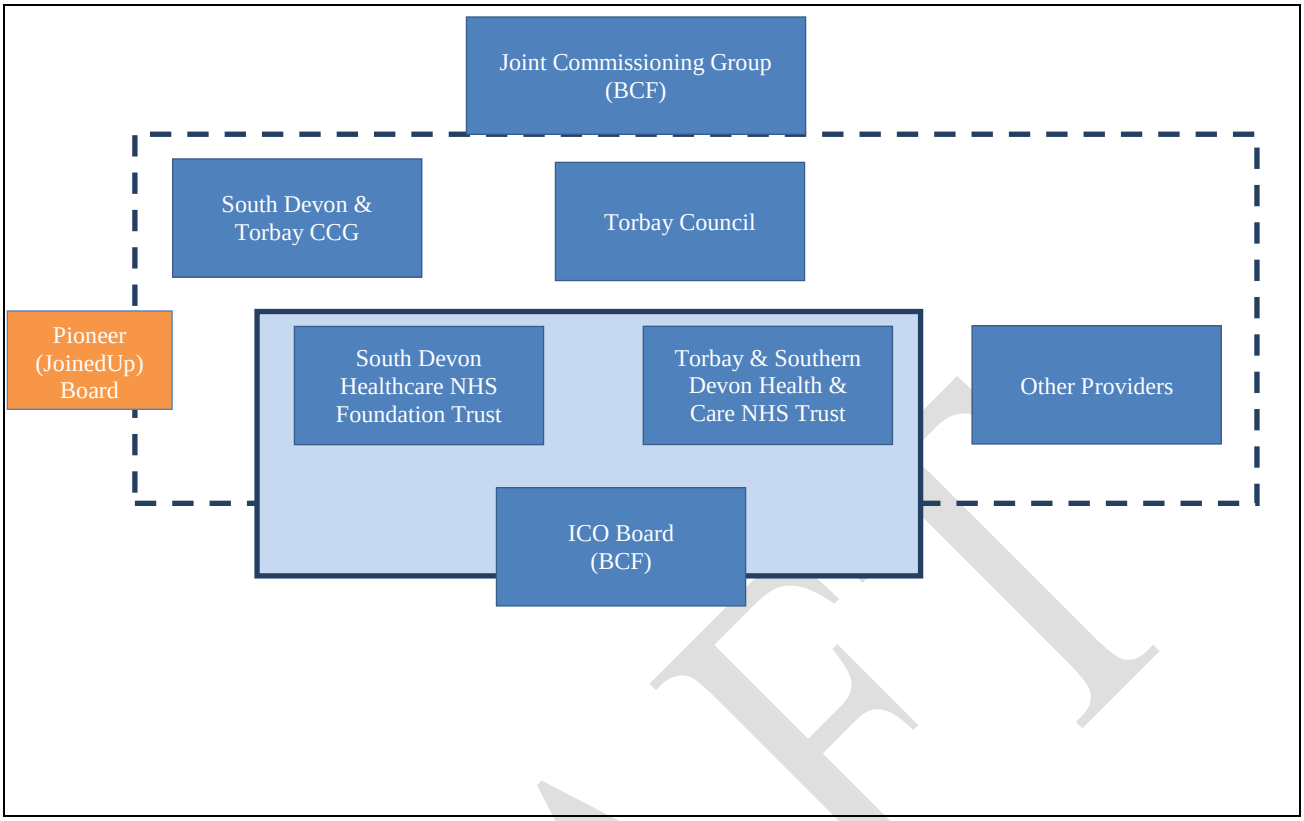
Governance arrangements have been strengthened ensuring the ICO and Pioneer remain the focus of integration with a reporting line to the Health and Wellbeing board.

Department of Communities and Local Government

Department of Health

Health and Wellbeing Board

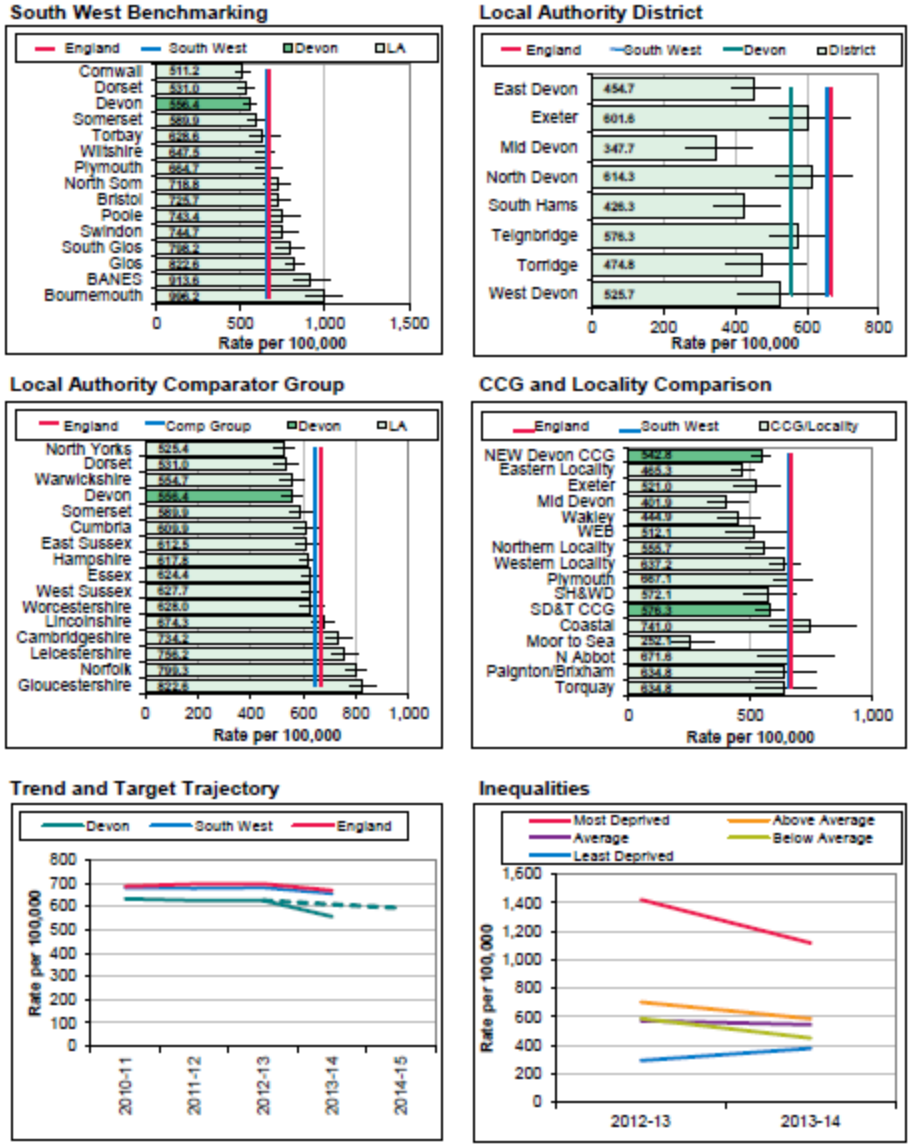
NHS England Area Team (AT)


Joint Commissioning Group (BCF)
South Devon & Torbay CCG
Torbay Council
Pioneer (JoinedUp) Board
South Devon Healthcare NHS Foundation Trust
Torbay & Southern Devon Health & Care NHS Trust
Other Providers
ICO Board (BCF)

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

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

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



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

d) **List of planned BCF schemes**

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
ICO - Heads of Terms agreement delayed and ICO not created on time due to delays and Monitor set backs	3	5	15	Joint working across providers and commissioners in development of full Business Case and full support.
Shifting of resources to fund new joint interventions and schemes destabilise current service providers, particularly in the acute and community sector.	2	4	8	Financial planning has been undertaken jointly across the organisations to understand the level of resource within the health and care sector. Our plans have been developed in partnership with our providers as part of our integration programme, allowing for a holistic view of impact across the provider landscape. We will continue to actively

				engage and involve providers in all key strategic decisions during this process to manage change effectively including finance colleagues in determining the levels of risk and balance.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	3	4	12	Contingency planning is undertaken as part of the business plan and implementation phase. There are weekly meetings to escalate concern and pressure to the system among senior managers providers and commissioners.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	3	5	15	We have modelled our assumptions using a range of available data, including that based on previous performance and national guidance. We will continue to test and refine these assumptions as part of our on going review and evaluation process In reality this has been judged as a medium to high risk as there is potential for delays in implementation however we have plans in place to deal with this and is managed through the Joint Commissioning Group.
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently	5	5	25	We will remain well-informed of policy and legislative developments and will continue to refine our assumptions around this as part of our planning process and as more of our plans begin to deliver. We believe there will be potential benefits that come out of this process, as well as potential risks.
Progress of implementation and ability to effect change is hampered by inability to reach	2	3	6	Joint commissioning forums in place between senior and director level managers. Early and continuing discussion of BCF, ICO and Pioneer is on

agreement between organisations due to Geographical boundaries of local authorities and CCG				agendas with key members of staff engaged. Escalation reporting mechanisms at each level to ensure swift resolution where necessary.
Progress in keeping on target for achieving metric measures.:				Monitoring of the metrics will be reported to the Joint commissioning Group as part of the wider joint outcomes performance report. Services in place to contribute to achieving the expected performance includes:
• Delayed Transfer of Care from hospital	2	4	8	Current performance is good. Retaining focus on this and ensuring impact from Community equipment and assistive technology; Care Coordination Carers support; Reablement; Intensive Home support continues.
• Emergency admissions	3	4	12	Robust plans and focus of services such as Crisis Response; Reablement; Care Coordination will ensure that emergency admissions is not only held at current levels but over the agreed trajectory achieve a reduction of 3.5%.
• Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	3	4	12	We are confident that a number of work schemes in place such as Complex Care Team with Brokerage; Reablement; Crisis response will continue to address and reduce this risk.
• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.	3	4	12	We are confident that a number of work schemes in place such as Reablement; Community Equipment and Assistive technology will continue to address this and will be monitored by the Joint Commissioning Group.
• Estimated diagnosis rate for people	3	4	12	Good progress has been made with improving the diagnosis rate of people with dementia through Primary care

with dementia				awareness and education; Dementia advisors; Public engagement programme; Screening on admission (over 75yrs). Activity needs to be increased and extended to work with care homes and community providers in identifying people with dementia which we feel is achievable over the BCF period.
There is a risk that the focus on developing the ICO detracts from the implementation of 7 day services	2	5	10	7 day services are included in the Service Development and Improvement Plans of both organisations, and these are monitored monthly at contract review meetings.

b) Contingency plan and risk sharing

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

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

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

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

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

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

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

It will operate by:

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

The quantity of the pooled fund that is at risk in the Better Care Fund is £979,965 is set out in the Part 2 plan template. This has been derived at from modelling and clear analysis and modelling of costs and impact.
The funding is allocated within the following activity areas:
Disabled Facilities Grant to Districts
Social Care Capital Grant
Reablement
Carers
Care Bill
Protecting Adult Social Care
Other Reablement/Section 256
BCF Implementation 14/15
Integrated Care Organisation

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

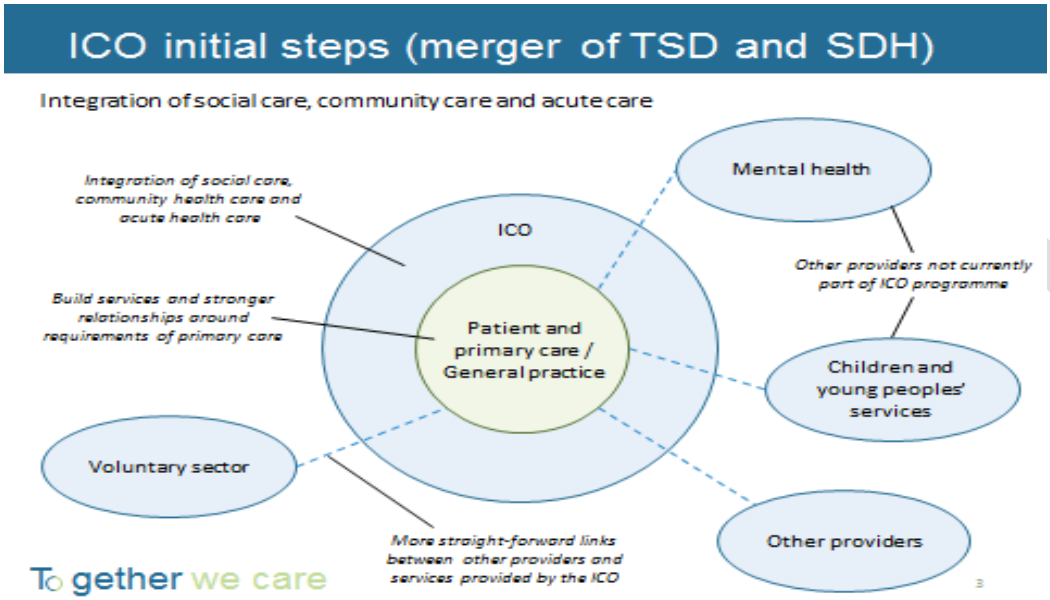
The current most significant risk identified by the partners to BCF is in relation to public sector financing and the pressures and demands from influencing demographic and economic factors. This being recognised there may well be a level of acceptance of 'slowing down' the system to accept slower performance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

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

6) ALIGNMENT

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

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



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

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

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

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

funded 'My Support Broker' project.

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

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

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

Mental Health and LD strategies
Our joint commissioning strategies between health and social care in setting out the key priorities to improve mental health services and services for people with a learning disability.

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

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

Ultimately, the predicator for the BCF plan is our Pioneer programme and the implementation of the Integrated Care Organisation. The model of care of the ICO is supported by eight key work streams, ensuring an alignment of strategic plans across the community which will impact on the how and where care is delivered and role and choice of the patient. Our four key themes set out in Annex 1 are evolved from these 8 ICO workstreams:

- Community health and social care

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

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

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

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

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

We have been working closely with our partners, in particular the Health and Wellbeing Boards of Torbay and Devon providing local leadership to deliver a sustainable health and care system. The Health & Wellbeing Boards have been integral to developing this plan and bringing together the alignment of priorities, across partner organisations, for the benefit of our communities. Through our Pioneer status, and the national support which comes with this, we will continue to build on this work to deliver the significant changes which are needed. The National Voices narrative, built around the key statement *'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'* has been adopted across organisations, and complements the success of the model of Mrs Smith as a representative user of adult social care and health services. Creation of an Integrated Care Organisation in South Devon and Torbay and implementation of the Pioneer Plan will extend this model to young people and families, with even closer working with communities through creating community hubs where services will be linked together with a single point of access, so that care takes a whole person approach to meeting need and promoting independence in the community outside hospital and closer to home. There is a strong commitment of a wide range of partners and organisations to this programme of works and our success to date is now being built upon to drive integration to a new level, including further structural integration and extended organisational care pathways between social care services and the local acute trust. We will use the opportunities of the better care fund and pioneer status to pool budgets and increase joint commissioning across all our health and care providers and ensure there is diverse range of care and support services available. Our JSNA describes our local demographics and we have analysed local demand and supply in our market position statement (link below). http://www.torbay.gov.uk/index/yourservices/adults/marketpositionstatement.htm	

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

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

The local schemes identified in this plan are supported by integrated delivery and commissioning across health and social care. They are focused on preventing admission to acute and higher levels of care and reducing reliance on statutory services by increasing resilience through building on the assets of communities improving access to early advice and information to support people to manage their own conditions and remain independent for longer. These schemes sit alongside other initiatives promoting and supporting the independence including, our community equipment service, a home improvement agency, use of adaptations and assistive technology and a new care and support 'Living Well @ Home' service. Additionally, there has been an investment in excess of £300,000 in a Community Development Trust to support the development and coordination of the third sector in Torbay, and to access funding streams and grants through a collaborative approach across organisations and partners. This will leverage both skills and resources which is evidenced in one current initiative - Fulfilling Lives: Better Ageing which has attracted £6 Million of Big Lottery funding over the next few years. We will continue to review the pooling arrangements for the BCF alongside the wider pooled budget for the Integrated Care Organisation, to consider whether additional resources will be invested within this pooled fund in order to work towards our shared vision.	

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

The creation of an Integrated Care Organisation for acute as well as community health and social care services in April 2015 will increase our ability to deliver better care through pooled funding of almost £340 Million. £400,000 has been identified in 2015/16 for the implementation of the new Care Act duties. However at this early stage in costing the impact of the Care Act locally there are new costs relating to increased assessments, deferred payments and additional carer services in the region of £3m.	

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

Torbay's existing model of integrated health and social care delivery means we are well-placed to meet the new duties in the Care Act . We have established a single NHS and council Care Bill Project Board to oversee implementation with project plan and work packages (which incorporate the BCF) and cover the following areas: Social Care Workforce Change To Identify potential impacts on current workforce buy April 2015 and ensure that by April 2016 skills, configuration and capacity are sufficient to meet new demand and legal duties. **Care Funding & Finance** By April 2016 - Identify local self-funders, estimate cost of meeting their care costs and calculate implementation costs. By April 2015 - Estimate likely increase in requests for a deferred payment locally, review	

existing arrangements (workforce capacity, IT, Finance) for deferred payments and estimate implementation and related costs.
Pathways & Business Process
By April 2015 - Estimate the volume of additional assessments and the cost. Review our assessment process to ensure it focuses on prevention and wellbeing. Review support and arrangements for young people and their families during transition and update procedures and training. Consider how assessments will be carried out for local self-funders.
By April 2016 - Estimate time needed to assess self-funders ahead of go live date
Consider ways of conducting proportionate assessments including, for self-funders and review financial processes, information and advice systems and IT.
Market Management & Commissioning
By April 2015 - Re-design commissioning arrangements including capacity, skills and leadership. Refresh market position statement to clearly identify strength/weaknesses in local provision to meet the Care Bill requirements.
By April 16 - Review engagement/dialogue with local providers and service users and start a conversation with local providers about the potential impact of the reforms.
Public Information & Advice
By April 2015 - Re-design existing advice and information services to ensure there is adequate funding and capacity so that good quality financial information & advice independent of the local authority is available and people know how to access it.

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

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

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

Torbay operates a whole system approach to Carers services prioritising early identification and support of Carers through a 'universal' offer of support, which provides information and advice, assessment and access to practical and emotional support for all Carers (not subject to eligibility). There are Carers Support Workers at key points in the Carers journey including in all GP surgeries, in the Discharge team at the Acute Hospital and in specialist community teams. Our services for carers aim to reduce hospital admissions and the time those cared for spend in hospital because carers are more involved in decision-making, supported to care during hospital stay and on discharge. We anticipate this will also lead to a reduction in readmissions.
We are in contact with more than 26% of the population of Carers based on the

2011Census data. The refresh of the Carers Strategy 'Measure Up' 2015-2017 will encompass effective previously piloted programmes such as the work done pre discharge and follow up 48 hours after discharge from community hospitals to identify early on problems and reassurance to patients and carers; Carer awareness training for community staff highlighting the amended assessment paperwork to identify carers; Health and Wellbeing Checks carried out in GP practices by Carers support workers to identify what early support is needed and signposting or systematic referral on for more complex cases; specific focus on vulnerable groups with support worker focuses on substance misuse problems and mental health problems. Torbay has an interagency strategy for Young Carers under 25 (2013 – 16) with a 3 year Action Plan and a joint agency Steering Group. This is based on whole family working and there are specific requirements and targets for adult services teams to identify Young carers and address their needs. There is significant attention to raising staff awareness across the health and social care system about the needs of young carers and their needs are specified in a joint Carers strategy with the local Hospitals Trust. Torbay is confident the Carers Services will be compliant with the Care Act although recognises capacity to meet the demand may well be challenging. We work with reference to national tools and good practice ie 'Making it Real for Young Carers' and we have a service that is able to respond to requests for assessments. We have considered draft regulations on young carer assessments. These set out the, matters to be determined and considered and they will become statutory guidance potentially through amendment to `Working Together'.	

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

There has been no change to original forecast.	

b) 7 day services to support discharge

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

We consider that seven day services are a key driver of quality and we are committed to providing seven-day health and social care services, with the optimal pathway of care available for the patient regardless of the day of the week. We are committed to providing seven-day health and social care services, supporting patients being discharged and preventing unnecessary admissions at weekends. We already have several community services provided 7 days a week across Torbay:

Service	Torbay 7 day service	Comments
District Nursing	Yes	
Intermediate care	Yes	Intermediate care minimum level service at the weekend in Torbay. Staff also cover Paignton and Brixham hospitals for new therapy referrals or people at risk of deterioration
Social Work	No (see below)	
Emergency Duty Service	Yes Out of hours	
Early stroke discharge and neuro team	No	
ME/CFS	No	
MSK physio	No	
Hospital discharge	Yes	Discharge Coordinators cover A&E sat /sun
Intensive Home Support Service	Yes	
Crisis Response Team (dom care)	Yes	
Older peoples mental health	No	
Health Visitors	no	
Alcohol and drug services	no	
Lifestyles / Public Health Promotion	yes	Weekend working sat am for smoking cessation and other times if events are on

CAMHS	emergency duty service plus protocols with A&E	
Community hospitals	Yes	
St Kilda Rowcroft Hospice at Home	Yes Yes	

We recognise that not all services are necessary to be delivered seven days a week, and we have pilots underway to help inform which additional services would be needed both to meet the needs of the population and to facilitate flow through the whole health and care system seven days a week. Early findings have evidenced the value of therapy staff working in community hospitals at weekends, and shift patterns are being examined to see how best to achieve this.

These pilots will ensure we will see a continued roll out of six/seven day provision across key services, as informed by those pilots and through on-going evaluation, with fully joined-up services across the health and care system providing continuity of care and support seven days a week.

The plan to deliver 7 day services is included in the Service Development and Improvement Plans with both our acute and community providers, and this will be further progressed with the contract with the Integrated Care Organisation from 2015. Rowcroft Hospice already delivers seven day services for both their inpatient unit and their hospice at home service, and were featured in the “Every Day Counts” paper produced by NHSIQ. We recognise that there is a risk that the focus on the formation of the ICO may detract from the delivery of the plans for 7 day services and to mitigate this risk the SDIP progress is monitored at monthly contract review meetings.

Through the formation of the Integrated Care Organisation we expect to see resources shift from inpatient beds to high quality, value-for-money care provided in people's homes. The broad model of the workforce will be one of joined up professional practice, integrated team working and the flexible delivery of care in the most appropriate settings. We will see a shift in the current workforce configuration to more community-based teams, delivering seven-days-a-week services.

Our integrated business plan includes working towards fully joined up 7 day provision, of which Primary Care is a key element. Key to delivering this will be continuing the work which is underway to develop General Practice Federations so that care will be provided to a population rather than to the registered Practice list. This will enable a federation of practices to work together to provide different care models, including extension of existing services into periods of the week where General Practice is currently restricted or unavailable. As part of this collaborative approach we will optimise the current workforce capacity by exploring technology based solutions that complement traditional face to face consultations, so that not only is access extended in terms of timings but also in terms of styles. To allow federated working and improve quality of patient interactions with other health and social care providers we will extend the ability to share patient records (where consent to do so exists) across providers, thus delivering better informed consultations and improved outcomes.

c) Data sharing

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

All our health and social care services use the NHS number as the primary identifier. The further development of ICO will see the delivery of improved outcomes in an integrated Information Management and Technology (IM&T) infrastructure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Torbay has a model of integrated health and social care teams built around geographical clusters and primary care practices, with a single point of access. These teams provide functions to enable:

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

These teams work in partnership with primary care and include representation from the voluntary and community sector.

We have a strong track record of proactively seeking to identify those patients at risk of hospital admission, and working jointly to reduce this risk through an integrated and personal approach. This has been supported through a 'Locally Enhanced Service' initiative to incentivise input from Primary Care. There is a willingness to build upon the successes of this project to widen the scope and scale and meet the expectation of the 'accountable GP' initiative, as set out within 'Everyone Counts; Planning for Patients 2014/15 to 2018/19'.

We use a risk stratification tool, the Devon Predictive Model, to identify patients at risk of hospital admission in the next 12 months. The top 0.5% of our population are then pro-actively case-managed on our monthly community virtual wards. The virtual ward teams use the predictive tool to objectively identify patients who are then pro-actively and holistically case-managed by a multi-disciplinary team, including primary care, community and rehab teams, palliative care, mental health, social care and the voluntary sector. Each patient is allocated a named case-manager who then co-ordinates their care and

support. We have built on this highly-successful model to incorporate the features of the Unplanned Admissions Enhanced Service for primary care for 2014/15, with 2% of our population then being proactively case-managed.

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

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

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

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

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

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

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

As at 31st March 2014, over 0.5% of our population had a joint care plan in place as part

of the virtual ward. Each of our practices has signed up to the NHS England Proactive Care service, which will see this number increase to a minimum of 2% from September 2014. These numbers are monitored monthly using patient read codes and by practice reporting quarterly.	

8) ENGAGEMENT

a) Patient, service user and public engagement

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

We have undertaken an extensive public engagement process for our community services, taking three months and including 21 public events across the CCG footprint plus additional meetings with staff, district councils, the voluntary sector and local groups. A number of key themes were common to each event, and we have used these to inform our plans for community services for 2014/15 and beyond. Local people are involved in the steering groups which co-ordinated these events, and will also continue to be involved in developing these plans. We received feedback from over 1200 people during the three month process. Full details are included in our engagement report, attached, but in summary: We went to every town and many villages across our CCG footprint, inviting people to talk with us - in person, by completing a survey or returning a leaflet. • 21 public events • 7 meetings with individual groups • 7 community staff events • 823 members of the public attended • 471 additional written and online responses were received We followed a similar engagement process to look at how mental health and support services work in our area. The experience of people who use mental health services, their families and carers should directly influence the commissioning process, so we have embarked on a rolling programme of engagement events and individual engagement to collect feedback as follows. 1. General focus on adult mental health (June 2013) 2. Urgent care, inpatients and community services (August 2014) 3. General focus on adult mental health (December 2014) 4. Time to talk, about reducing the stigma of mental health (February 2014) 5. Dementia (May 2014) The core messages from all of these events have been instrumental in the development of this plan and our vision for integrated care and support, and we will continue to engage and consult with the public as we begin to implement it. We recognise that a “one size fits all” approach will not work, and for this reason each of the CCG five localities has developed a steering group made up of local people. These groups initially helped to inform and run the full engagement process, but will continue to meet and act as expert reference groups as our plans are implemented and further developed. Our local Healthwatch are represented on each of the steering groups and were wholly involved	

in the engagement process.	

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Our main health and care providers are: • South Devon Healthcare Foundation NHS Trust • Torbay & Southern Devon Health and Care NHS Trust • Torbay Council • Torbay Community Development Trust • Rowcroft Hospice • Devon Partnership NHS Trust Our plan reflects a number of existing programmes, the development of which have included our health and care providers as active participants, including our voluntary and community sector. Providers continue to be engaged in the development of our on-going and future plans. We have a long history of including our providers in service planning and reviews, and have a number of multi-disciplinary Clinical Pathway Groups, which in turn feed into senior level multi-disciplinary Service Redesign Boards. In addition to this, the Joint Commissioning Group retains the strategic lead for the oversight of the BCF plans. The Social Care Programme Board for Torbay provides the senior management forum for oversight of the Annual Strategic Agreement through which the Council delegates commissioning and delivery of Adult Social Care to the NHS. The Better Care Fund has been discussed with the Health and Wellbeing Board and plans for its further development and links with Pioneer and the Integrated Care Organisation are regular agenda items. As the first cohort of Integration Pioneers, both commissioners and providers have formed a programme board - including the community provider (Torbay and Southern Devon Health and Care NHS Trust), the acute hospital (South Devon Healthcare Trust), our mental health provider (Devon Partnership Trust), Council-provided Children Services along with Virgin Healthcare, South West Ambulance Service, the voluntary sector (Torbay Community Development Trust) and Rowcroft hospice – which will oversee our programme of integration and pooled funds. Given the opportunities that the Better Care Fund presents this is seen as integral to the planning and implementation of our plans as integration Pioneers and the priorities for the Integrated Care Organisation which will increase our ability to deliver better care through pooled funding of almost £240M. This plan recognises the importance of early help and prevention and the role of adult social care services in keeping people independent at home, as well as the vital contribution of local communities and the voluntary sector in reducing loneliness and isolation by providing both formal and informal support to frail and vulnerable people. These services make a positive difference by reducing reliance on bed based care and supporting reablement and recovery through outcomes based care and support Ultimately, the predicator for the BCF plan is our Pioneer programme and the implementation of	

the Integrated Care Organisation, and the four key schemes detailed at Annex 1 include all of our key providers.	

ii) primary care providers

Our extensive engagement process outlined in section 8a was led by our GP colleagues. The plans referred to within this document reflect those developed by our GPs in each of their localities, in response to that engagement. The redesign board which oversees the engagement process is chaired by a Torbay GP.

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

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

c) Implications for acute providers

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

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

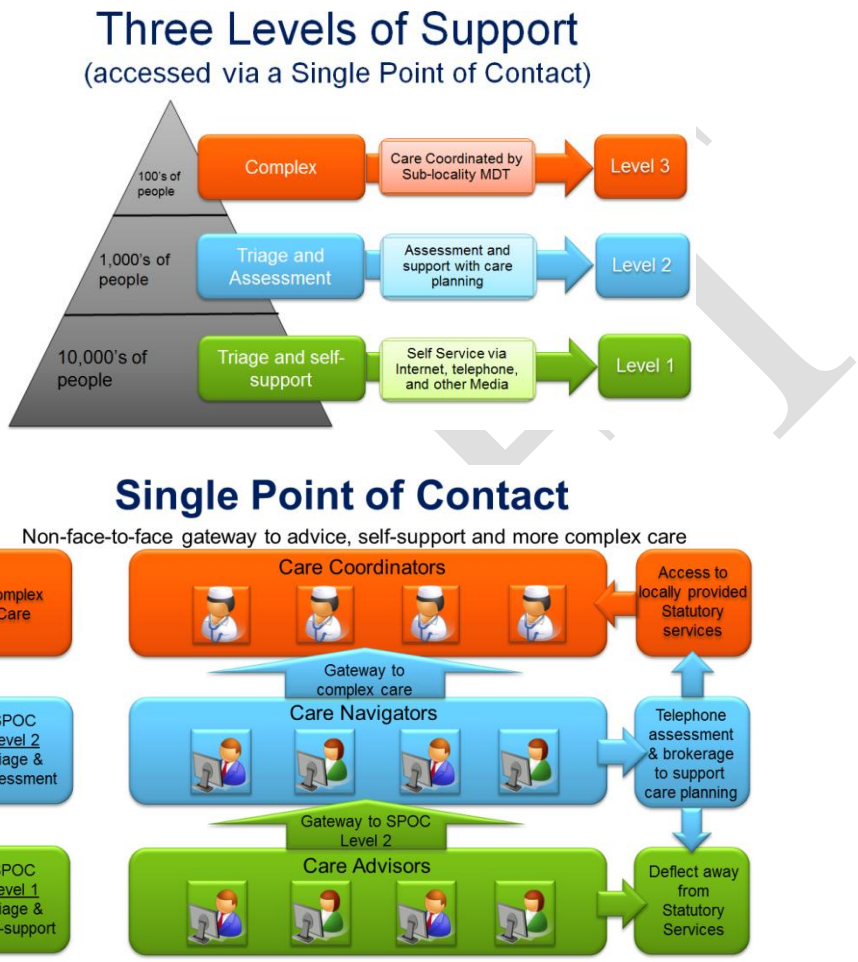
Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – SCHEME 1: SINGLE POINT OF CONTACT

For more detail on how to complete this template, please refer to the Technical Guidance

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

Where issues are complicated and cannot be resolved over the telephone, or where a face-to-face assessment is considered essential to the needs of the citizen, then the case will be referred to the Multi-Disciplinary Team (MDT) Care Coordinator in the patients locality, who will organise and coordinate in-home assessment by the appropriate professionals.



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

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

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

The model complements the work also underway to redesign the role and function of Multi-Disciplinary Teams operating at Locality Level and which it is intended will be

enhanced by increased collaboration with and support from the voluntary sector, mental health and hospital consultants to deliver more preventative care and support within the community.

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

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

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

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

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

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

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

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

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

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

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

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

complex chronic conditions. London: The King's Fund.
14. Proactive care partnership: http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactive care_coastal_leaflet.pdf

Investment requirements

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

Impact of scheme

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

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

Feedback loop

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

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

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

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

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

ANNEX 1 – SCHEME 2: Frailty Care Model Scheme

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
SCHEME 2
Scheme name
Frailty Care Model scheme
What is the strategic objective of this scheme?
To support the holistic care of older persons in Torbay by taking a whole system overview of the pathway of care. Aim being to shift from a 'reactive' care model to a 'proactive' care model, focussing on enabling and empowering citizens, carers, community to support themselves and provide varying care settings dependent upon the individual's needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model of care involves greater collaboration between citizens, carers, voluntary sector, health and social care in community and acute settings to support older persons within Torbay. The pathway of care will shift resource and expertise across the system rather than patients always having to attend an acute hospital for specialist treatment which is often a detrimental setting for their needs.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
South Devon & Torbay Clinical commissioning Group (CCG), Joined-up cabinet, 7 Locality Commissioning groups (LCGs) Torbay and Southern Devon Health and Care Trust, Torbay Council and South Devon Healthcare NHS Foundation Trust are all working strategically as part of both the Integrated Care Programme and Pioneer to create a seamless system of care for older persons, placing them in the centre/in control and ultimately shifting the care pathways from a reactive/crisis response driven pathway

to an enabling/self-care and proactive pathway.

The evidence base

Please reference the evidence base which you have drawn on

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

1) **"Redesigning acute care for older people seven days a week – so who said that seven day services are more expensive?"** Sheffield Teaching Hospital NHS Foundation Trust

http://www.nhsiq.nhs.uk/media/2422335/sheffield_emergency_cs_final.pdf

Impact for Patients:-

- Faster assessment at the emergency 'Front Door' by multi-disciplinary assessment teams enabling a focus on what needs to be done to get patients back home as soon as clinically appropriate and discharge care packages put in place to enable patients to be assessed at home, shortening overall pt pathway
- Patients are seen by Geriatric Medical Consultants on average more than 10 hours sooner that in the previous system which provides earlier clinical decision making and consistent quality of care
- Patients admitted at weekends have a greater equality of service

Impact to overall system:-

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

2) **Sheffield Teaching Hospital NHS Foundation Trust**

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

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

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

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

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

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

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

Saltman and others (2006) 'have argued that the intermediate territory between self-care

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

Case Study: Hartola Health Station, Finland
Finnish health and care services are organized around municipalities, which vary in size, with an average population of 5,800. National policy aims to merge smaller municipalities and reduce the total number from over 300 to around 70. The health station in Hartola illustrates the range of services available in 2013 for a population of 3,500, with 5,000 extra summer visitors .
• Municipality-owned health station (linked since 2012 to a cluster of municipalities): comprehensive primary care including preventive care, some specialist and welfare services. Two full time GPs.
• Also offers: home care, dementia unit, diagnostics, social welfare support, community hospital, specialized geriatrics and psychiatry.
• Uses doctors, nurses, allied health professionals, private ambulance staff, administrative personnel, private laboratory company.
• Electronic patient record.
• Introducing the Chronic Care Model into primary care as the 'health value model'.

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

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

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

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

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

• Reduction in community bed based care and bed days. • Reduction in frail elderly admissions from Care Homes • Increased use of Crisis Response Team/domiciliary care/social care/Intensive Home Support Services. • Increase 0/1 LOS, decrease 2< LOS day (acute wards). • Reduction in total no of admissions to acute wards. • Reduction in nos of pts admitted to acute from int care beds (with the exception of pts from int care coming in to frailty unit for diagnostics.) • Increase in no of pts having a CGA and resulting in a managed MDT care plan. • Less patients feeling a loss in independence in acute trust by giving autonomy to reable in own home quickly. • Increase in patient satisfaction • Reduction in hospital admissions for patients to be diagnosed with dementia • Reduction in deaths in acute trust
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Measuring set KPIs Seeking staff feedback Seeking patient feedback Analysing trend in complaints from pts 65 Analysing trend in compliments from pts 65<
What are the key success factors for implementation of this scheme? That patients don't have to repeat their story to lots of different staff members That patients/carers feel more empowered/enabled to make decisions about '*What matters to them'* A reduction in admissions from acute wards and an increase in utilisation of voluntary, community health and social care resources

ANNEX 1 – SCHEME 3: Multiple Long Term Conditions

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
SCHEME 3
Scheme name
Multiple Long Term Conditions
What is the strategic objective of this scheme?
A new service for people with multiple LTCs to allow coordinated multidisciplinary management of coexisting medical conditions in one place and at one time.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Individuals with multiple LTCs such as Heart failure, Atrial Fibrillation, Diabetes,

CKD, hypertension, Chronic Obstructive Pulmonary Disease (COPD), obesity and depression will be managed by one team without the need for referral to multiple specialist teams.
The service will operate at a number of locations in community settings with co-location of all health professionals (Doctor, nurse, therapists, specialist nurses, social services and voluntary and charitable sectors). Simple diagnostics (near patient testing, blood tests and where possible simple radiology) will be available at the time of consultation.
This service will function in all localities in Torbay and South Devon and across all sectors.

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

South Devon and Torbay Clinical commissioning Group (CCG), Joined-up cabinet, 7 Locality Commissioning groups (LCGs) Torbay and Southern Devon Health and Care Trust, Torbay Council and South Devon Healthcare NHS Foundation Trust are all working strategically as part of both the Integrated Care Programme and Pioneer to create a seamless system of care.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Care Planning; Improving the Lives of People with Long Term Conditions. Royal College of General Practitioners 2011
- Delivering better services for people with long-term conditions. Building the house of care. Kings Fund 2013
- Patient centred coordinated Care. Nationalvoices.org.uk
- The Importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings: Evidence from South Somerset's Symphony Project. Centre for Health Economics Research Paper 96. 2014.

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

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

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

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

Assessment of patient satisfaction with the service and other experience • Assessment of professional satisfaction with the service and other experience
What are the key success factors for implementation of this scheme? 1. Multi-condition care planning. Involvement of the voluntary sector in determining holistic service needs for individuals and providing links to local means of support. Planning of priorities for the care of individuals taking account of all medical conditions and social needs. 2. Comprehensive clinical review by medical and nursing staff, providing a consistent approach to the management of all of a person's medical problems. Assessment of 'Patient Activation' and use of Motivational Interviewing and other proven techniques in management of LTCs. 3. Support of self-management as a keystone of the service. Use of Patient Knows Best (PKB) to facilitate self-management and virtual consultation. 4. The development of mentoring relationships between service staff and appropriate specialist teams allowing up to date and highest quality care without the need for physical referral to multiple specialist teams. 5. A flexible approach to locus of care. The team will be able to move between primary care, this intermediate service and the hospital as required, e.g. liaising with staff when the service user is admitted to provide information to the hospital team and contributing to discharge planning and seamless movement back in to the service after an inpatient episode. 6. Clear relationships with other programmes which might be needed from time to time, e.g. cardiac rehabilitation, weight management services. 7. Clear links with Well-being services including commissioned 'Living Well, Feeling Better', which could be co-located 8. Clear links with 'Virtual wards' for those at high risk of admission and with End of Life services when appropriate. 9. Linkage with the local De-escalation guidelines in development 10. Regular (3-4 times per year) educational sessions for service staff attended by consultants from all LTCs and specialist nurses. Discussion of cases and themes and new directions in LTC management. 11. Audit of service outcomes and user satisfaction surveys.

ANNEX 1 – Community Care (Locality Teams & Community Hospital beds)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
SCHEME 4
Scheme name
Community Care: Locality teams and Community hospital beds
What is the strategic objective of this scheme?
To redesign community based services in order to manage more people in a proactive way to prevent hospital admission, reduce delayed discharges and reduce admissions to long term care. This includes the enhancement of the current primary care service to provide a single multi-disciplinary assessment service.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The model of care builds on the successful integrated model of Care provided in Torbay and Southern Devon. It also links through to our aspirations within Pioneer in terms of developing local 'hubs ' for the provision of integrated care, for example the children and young people's hub and the frailty service.

The service model will link an enhanced single point of contact primarily developed to reduce reliance on the statutory sector (as described in another scheme) to local MDTs which will be enhanced by support from primary care, the voluntary sector, mental health and hospital consultants to deliver more preventative care and support within the community. This will link through to the enhanced virtual wards and the development of one GP practice per care home. The development of the Torbay's 'Big Team' will deliver improved GP case management for virtual ward patients for the top 2% of most vulnerable patients – approximately 3,000 patients. This will offer an enhanced service along with extra nurses and HCAs linking though to existing Community Matrons and intermediate care teams to prevent hospital admissions. This scheme will also focus clinical interventions earlier in the day, more pro-active care for patients most at risk of admissions, improve and enhance quality of medical care for care home patients and improve discharge planning for patients in acute and community hospitals.
The overarching plan links to the development of locality plans which have been developed through a 'bottom up' approach driven through locality engagement driven by the CCG.

All of these plans are part of the business case for the development of the Integrated Care Organisation within Torbay (encompassing the acute trust and community provider) which will have all of the system wide resources to deploy in the best way, including community investment, in order to provide and maximise alternatives to hospital admission through health and social care activities.
In addition to this there are plans to utilise our community hospitals to provide solutions to our system wide pressures within health and social care. This will include a change in function of our community hospitals, e.g. for the provision of community services, intermediate care and step up/step down beds.

Additional locality schemes which link to this include:

- Working with care homes to ask them to notify the GP when a 999 call has been made, also linking with the ambulance service to try to prevent unnecessary conveyances to hospital as part of their "Right Care, Right Time, Right Place" strategy
- Changing working arrangement in practices to enable visits to be made earlier in the day to try to prevent overnight admissions occurring simply because of the time of day
- Care Homes – working towards one care home, one practice; extending the medication review pilot already underway; mentoring of care home staff by GPs and annual reviews of care home residents.
- Torquay Children, Young People and Families Hub – building community assets, development of volunteer workforce, social prescribing and guided conversations

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

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

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

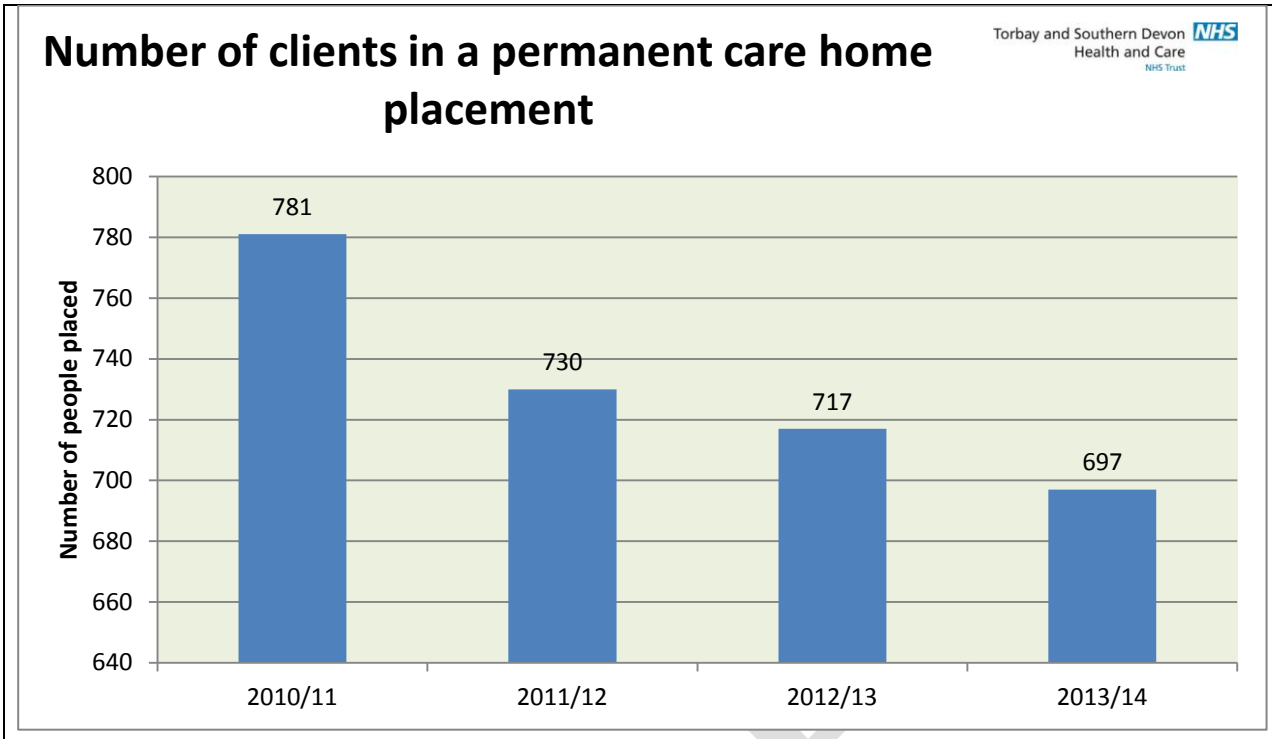
The evidence base
Please reference the evidence base which you have drawn on

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

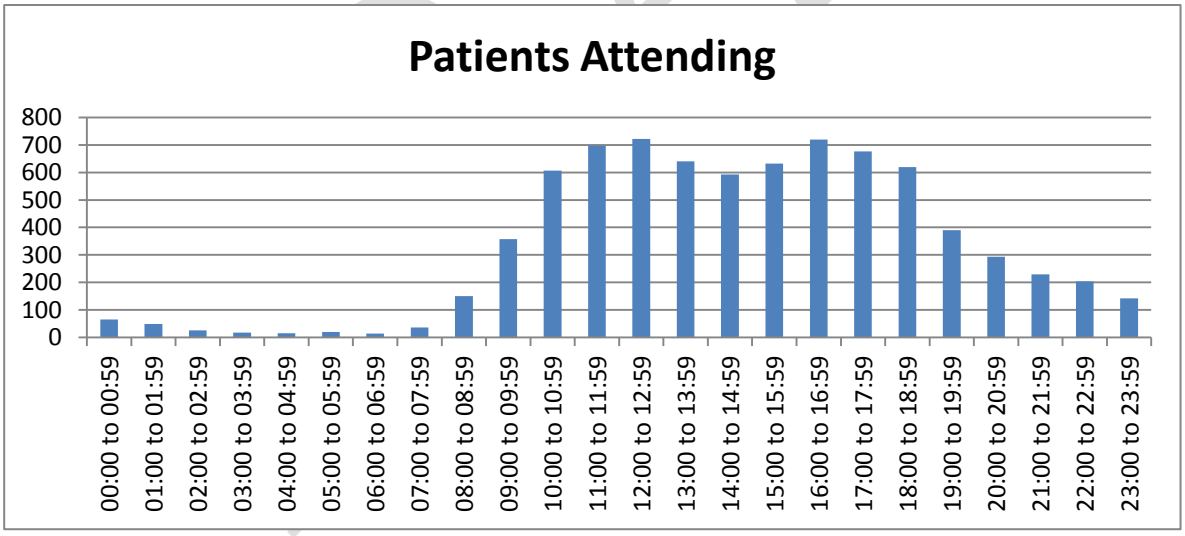
An extensive engagement process was undertaken in November and December 2013, with the public and other stakeholders including Healthwatch Torbay – from this it was clear that people want continuity of care and to maintain their relationship with "their" GP. They also wanted better co-ordination of their care and to avoid hospital admissions, with treatments closer to home where possible.
We have also taken into account information and regular surveys from South Devon Healthcare Foundation Trust and have also engaged with local care homes, Rowcroft hospice, mental health colleagues and Devon Doctors (OOH service providers) for their input.

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

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



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



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

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

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

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

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

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

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

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

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

Expected Outcome	Measure	Benchmark	Links to other schemes
Defined register of 3000 patients across Torbay	Practice read codes	n/a – straightforward number of patients read-coded	Proactive Care DES (NHS England)
Admission times - we would expect to see more earlier in the day and fewer resulting in overnight stays	Times of admissions – provided by SUS	Compare to same time the previous year	7 day services
Reduction in admissions for the 3000 case managed patients	Devon predictive modelling outcome report – produced quarterly NB – this will be a measure of this cohort of patients rather than	Compare to same time for the same cohort the previous year	Proactive Care DES (NHS England)

	individuals		
A reduction in prescribing and medication costs	??	??	??
Fewer emergency hospital admissions from care homes		Compare to same time for the same cohort the previous year	SWAST "Right Care, Right Place, Right Time"
An increase in the number of high-risk patients who have a care plan	Practice read codes	Compare to same time the previous year	Proactive Care DES (NHS England)
Fewer 999 calls from care homes	SWAST data (already monitored by Older People Clinical Pathway Group)	Compare to same time the previous year	SWAST "Right Care, Right Place, Right Time" and ICO SPOC scheme
Improved experience of patients and carers as a result of proactive case management and link to a case manager	Annual Social Care Survey: How many users of care and support services said they were 'extremely satisfied' or 'very satisfied' with their care and support	Compare to same time the previous year	Proactive Care DES (NHS England)
Reduction in placements into long term care	Social care data	Compare to same time the previous year	
Increase in the number of over 65s who are still at home 91 days after discharge from hospital into reablement / rehabilitation services	Intermediate Care dashboard?? TSD dashboard??	Compare to same time the previous year	
Reduction in the number of readmissions to hospital within 91 days	SUS data	Compare to same time the previous year	
An increase in the dementia diagnosis rate	QOF data	Compare to same time the previous year	Dementia strategy

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

What are the key success factors for implementation of this scheme?
• Local agreement across a range of stakeholders on the use of community hospital beds, in particular the public and GPs • Ability to manage emerging pressures within the health and social care system to manage pressures over winter • Engagement from care homes