

South Devon and Torbay Pioneer Programme – Profile

1.1 What is your area like?

The area served by South Devon and Torbay Clinical Commissioning Group (CCG) stretches from the south Devon coastline to Dartmoor, covering 286,000 people with 35 GP practices. Southern Devon is a rural area four times the size of Torbay and is made up of small towns, villages and hamlets; Torbay is more urban.

About 25% of the population of South Devon and Torbay is aged over 65. Today, in England, 2.2% of the population is 85 or over. Torbay reached this level 31 years ago. By 2021, the rate for England will be 2.9%, but 4.9% in Torbay. South Devon's population is ageing, too, at a much faster rate than the national average. Inequalities in life expectancy result in a seven-year life expectancy gap and 17 years more for some of expected ill-health. In South Devon and Torbay this could represent a cost to our system of £150m-plus per year. Our pioneer and integrated work also addresses inequalities at the other end of the life course including numbers of children on protection plans or in looked after care, which in Torbay are among the highest in the country.

On Dartmoor we see rural isolation, with poor transport links and more difficult access to services. Suicide rates are falling in Torbay but those of self-harm are not. Housing problems for many are acute. There is much to do to reduce alcohol misuse. In the moorland area of south Devon we see higher than average rates of fuel poverty.

1.2 What are you aiming to achieve?

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

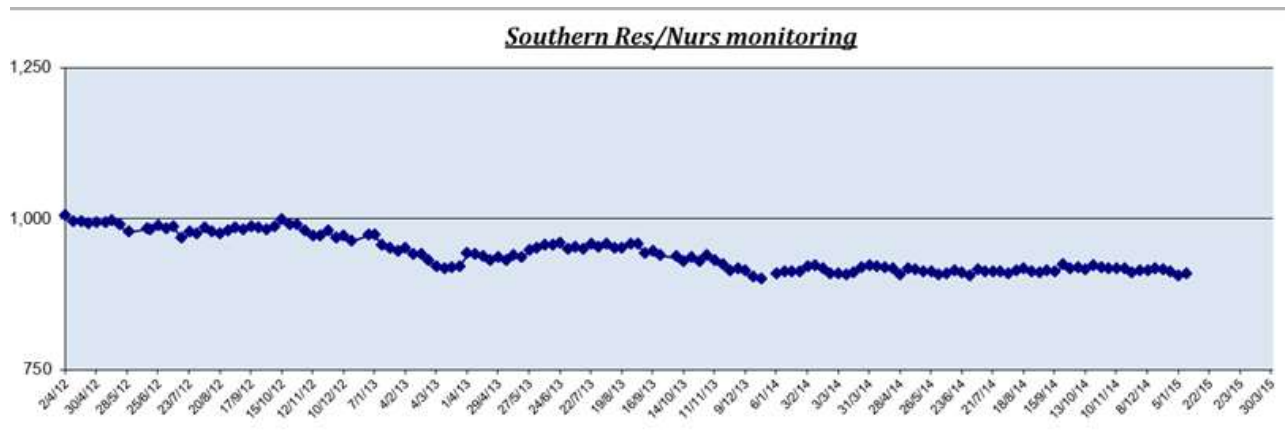
We foresee a reformed and vibrant primary care model integrated with the community in the widest sense – with the whole spectrum of health and care but also with the voluntary and community sector offering support for self-care and peer support. At the centre is a smaller acute hospital offering leading-edge,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

For some years before the integration pioneers' programme started, we had been working towards integrated care and we are beginning to see results.

- The number of residents supported by Torbay Local Authority in residential care placements as on 31 March of the year reduced from 739 in 2011 to 663 in 2014
- The number of residents supported by Torbay Local Authority in nursing care placements as on 31 March of the year reduced from 90 in 2011 to 74 in 2014

- The number of Torbay Local Authority supported permanent admissions to residential and nursing care in the 18-64 age group reduced from 49 admissions in 2010/11 to 29 in 2013/14
- The number of hospital admissions from care homes in South Devon and Torbay has reduced to 769 admissions so far in 2014/15 from 849 admissions in the same period in 2012/13 – a reduction of 9.42%

The graph below, from Devon County Council, shows the reduction in long-term care home placements since the introduction of joined up intermediate care in southern Devon (includes western area):



The above is a snapshot indicating that the care being delivered to our imaginary representative, 'Mrs Smith', is changing.

More widely, we are proud of our progress so far, but we now need to tackle the rapid, whole-system transformation required to make our vision a reality for all our residents. Our current challenge is to extend our integrated health and social care for adults across the whole community. We want to offer everyone the same seamless, multi-disciplinary working, strong relationships, culture of holistic care and care co-ordinators across two local authorities.

1.3 What have been the highlights of your first year?

Shared values are the starting point for integrated working. In January 2012, leaders of the whole health and care community formed the JoinedUp Health and Care Cabinet, with the agreed commitment to deliver 'high-quality, reliable and joined-up health and care which puts people first'. The cabinet includes a voice for people who use services. We have established a JoinedUp programme board to take forward and oversee the implementation of ideas from the JoinedUp Cabinet; and we have recruited a programme lead for delivering transformed services.

Our plan for the first year of the pioneers programme had four elements:

- Establishing a children's hub, for children and their families
- Setting up a Newton Abbot frailty hub
- Taking action to make mental health integral and mainstream within our integration programme

- Building the resilience of the community and voluntary sector

1.4 Details of the year

1.4.1 The Newton Abbot Frailty Hub

The hub provides services for the top 2% of high-risk patients (around 1,000), identified by means of a predictive model, building on our well-established virtual wards. The aim is to support people to live and age well, with multi-agency wrap-around support. The hub will be working next year with the community and voluntary sector to identify and support 'pre-frail' patients as well. See case study: [Newton Abbot Frailty Hub](#).

1.4.2 Mainstreaming mental health

The medical director of our mental health trust is a member of the JoinedUp Board. Progress to date includes:

- Introducing GP link workers between GP surgeries and community mental health teams (CMHTs) and closer relations between mental health consultants and GP practices
- All in-hours referrals now come through a single point via the Devon Referral Service and work is under way to ensure a single point of access for out of hours referrals.
- A multi-agency integrated psychological therapies group with representation from people with experience of using psychological therapies meets monthly to design improved access to and patient experience of, psychological therapies
- A series of engagement events with people and carers who use adult mental health services in response to which the following services were commissioned:
 - A crisis house providing short-term intensive support. See case study: [Corner Retreat Crisis Service](#)
 - Step-down beds
 - A court liaison and diversion service
 - A street triage pilot working with the police
 - A perinatal mental health service
 - An integrated dementia care pathway

1.4.3 The children and families hub

The hub focuses on a number of deprived neighbourhoods in the locality. It has clear governance arrangements developed through the community-led Health and Neighbourhood Development (HAND) Group. There are three workstreams:

- **Single point of access** This brings existing resources together with a single access point for information and advice, a call centre drawing on a shared directory of services, an e-hub gateway and a shared website with App functionality. A 'social prescribing' model started on 12 January 2015 targeting overweight and obese children in the 5-11 years range. See Case Study: [Developing Social Prescribing](#).

- **Building community capacity** Funding has been secured to create a neighbourhood development plan focusing on reducing social isolation and improving the health and wellbeing of children and families living in poverty. A 'Timebank' scheme with members of the community sharing their skills and experience as buddies and peer supporters has been launched.
- **Workforce** Plans to co-locate public health nursing and the lifestyles service (commissioned by public health to support self-care and management of conditions) with peer support in surgeries, community centres and schools are in development. A successful funding bid allows us to train community voluntary sector staff in guided conversations and we have submitted a further funding bid for non-professional care co-ordinators.

To support primary care, we are developing the physician's associate model with Plymouth University and exploring the use of pharmacists to support patients with long-term conditions. Working closely with Health Education England South West, we've achieved significant funding to transform the workforce. For example: accelerated learning to consider strategic reform, and local funding to develop 'care coaches' to guide local people towards community wellbeing assets.

1.5 What has been the most exciting aspect?

Cross-organisational leadership is a hallmark and significant strength for South Devon and Torbay integration plans. Building on the success of our strategic, 'blue-sky' Clinical Cabinet (a unique group existing since 2011), we formed the Pioneer Board (known as the JoinedUp Board). The board includes chief executives, medical directors and their equivalents across the public and voluntary sectors of the patch and they are absolutely focused on delivery of the pioneer (JoinedUp).

We now have two major lead groups for the pioneer. The cabinet retains a strategic and innovative approach and includes a very wide range of clinical and non-clinical people from across our system, and the JoinedUp Board takes lead accountability for areas of work, and for connecting with other organisations, such as housing, the Department for Work and Pensions and criminal justice. We used the pioneer systems leadership funding grant to offer specific strategic development to the JoinedUp Board in 2014, and this has significantly contributed to the shared vision and drive for Pioneer in South Devon and Torbay.

We are also pleased that the commitment to collaboration has resulted in a risk sharing agreement between the CCG, Torbay Council, the hospital trust and the community health and care trust. With the CCG taking delegated responsibility for commissioning the South Devon aspect of social care for Devon County Council. We believe that this will facilitate the development of integrated health and social care across South Devon and Torbay and the improvement of services by aligning financial incentives with our overall objectives

Working with people in the community has been very rewarding. We are working with Torbay Community Development Agency on their Ageing Better Big Lottery

programme which will reduce loneliness and isolation by building on the strengths of our communities to support each other through guided conversations and time banks. Patients and service users are involved in co-production and design of services and their evaluation through groups such as Torbay Voice, Experts by Experience (South Devon and Torbay group of patients and service users), carers' services and Teignbridge CVS.

1.6 What has been the most challenging aspect?

While the development of an integrated care organisation is a building block to our pioneer programme plans, there is little doubt that the cost of integration may prove a challenge to investment in other areas, at least in the first two years. This relates not only to the project costs of set-up, but also to the cost of managing integrated services until such time as transformation really does release savings.

We have found it very difficult, in the context of financial pressures, to keep 'business as usual' going while introducing new ways of working and delivering services. We would like to have seen more allowance in the pioneer programme made for double running of services.

Seven-day working is a central tenet of our pioneer aims. This will be difficult to achieve without national resolution of changes to the consultant contract, which is key to local change. Similarly, we find that some national workforce policies (for example community placements for F2 doctors) do not well support seven-day working. We would welcome national support to ensure that future workforce planning and policy is more joined up.

Being a pioneer has however, helped us to work at a national level on overcoming IT and information governance. Locally there is an IT sub group of the JoinedUp Board. This group makes recommendations on an integrated approach to IT and information and oversees an information sharing group and implementation of a work plan which drives the development of an integrated IT system.

Following an extremely successful information sharing event, a cross-organisation information sharing toolkit will be launched in February. Data sharing agreements are already in place to support the Newton Abbot Frailty hub, flu clinics and Devon Doctors to work effectively and have the information they require when they need it.

1.7 What are you planning to do next year?

- Prioritising prevention and promoting independence, for example by rolling out our frailty service to all localities
- Developing our whole model of care towards becoming an integrated care organisation, using the Better Care Fund and pooled budgets to support this work

1.8 What is your advice for areas starting on their own integration journey?

It is absolutely vital to establish joined-up leadership and explicit commitment to integration at the most senior level from the start. In South Devon and Torbay this has been greatly helped by the development of a narrative about what real integration could mean for ordinary people who use services. We have used the longstanding example of an imaginary, representative, elderly Mrs Smith and introduced her carer daughter and troubled teenage grandson Robert to help shape our vision and as a constant reminder of who will benefit from improved and integrated services.

It is very important to have a single programme of work that pulls together all the projects that will lead to integration. Otherwise there is a danger of gaps, duplication and confusion.

We believe our efforts in taking the workforce with us have been well worthwhile. It is important that frontline staff own and 'buy-in' to the JoinedUp programme because without them the programme will not succeed. This includes finding ways to give staff permission to innovate and work differently, for example by relaxing the key performance indicators to which they work. We have also worked with specific staff groups, using coaching methodology, to embed the way we want to do business.

Contact: Fran Mason, Senior Manager, Pioneer and JoinedUp

Email: franmason@nhs.net