Local Government Association

Case study

Torbay

April 2016

The journey to integration: learning from seven leading localities

Summary and lessons learnt

- Impact: Torbay halved the growth rate of health and social care costs compared to the national average between 2007/8 and 2010/11. At the same time it has delivered significant improvements in terms of experience, activity and outcomes.

- Place: the commissioning structure in Torbay was initially simple through the care trust arrangements, but has become more complex following the 2012 health reforms and split of commissioning and provider functions. The population is relatively complex, with a large proportion over 65 and high admissions for cancer, stroke and dementia.

- Focus: the programme focuses on the top 10 per cent of the at-risk population (including multi-morbidity). The target population consists of older people and those with long term conditions (LTCs).

- Care model: the development of the 'Mrs Smith' narrative encouraged patient-centric care. The Torbay integrated care strategy focuses on the benefits for service users and continuous care at home being the priority, with additional services to support this. Prevention, emergency admission avoidance, rapid discharge and rehabilitation are all included in the range of services. The delivery model is based around integrated health and social care teams managed in zones around localities and GP practices. This compelling narrative and focus on benefits for the service user are critical to achieving engagement and change across the system.

- Information management: Torbay has a well-developed flow of information in the system, with data sharing agreements in place across providers and laboratories in all five zones.

- Commissioning and payment: Torbay initially created a pooled budget which successfully aligned interests. Recent reforms, which dismantled the care trust responsible for this pooled budget, required a change of direction. Significant resources have been directed at integrated care development and subsequent evaluation has taken place which demonstrates significant improvements in terms of experience, activity and outcomes.

- Workforce: Torbay created health and social care coordinators who are practical, hands-on and IT-capable people who help give other medical professionals confidence that the packages of care they allocate to a patient would be put in place effectively. The new roles had a large impact in bringing about change across the workforce and facilitating teamwork across providers. The trust developed leadership and training programmes to support the new positions. Torbay shows that simple and inexpensive innovations such as health and social care coordinators can have a significant positive impact. Working from the bottom up, bringing frontline teams together and aligning them with general practices and their registered populations is important to success.

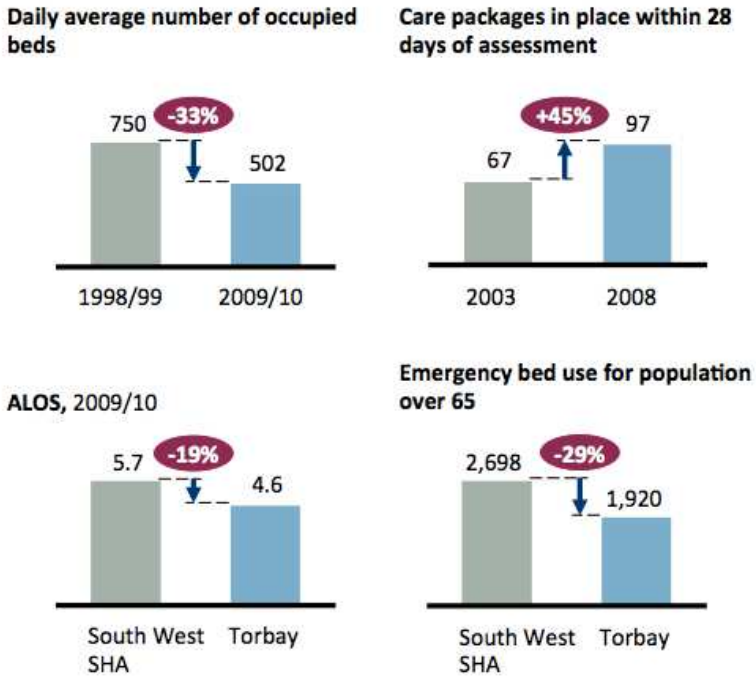
- Governance: Torbay introduced a single management team for integrated care and created a joint manager of operations, both which significantly improved governance. Torbay has developed an integrated care organisation, which integrates the acute trust with health and social care.

- Leadership: Torbay has been integrating health and social care for almost 15 years, with strong executive and clinical leadership throughout which is fully embedded in the programme. Making successful and significant changes takes time and requires persistence by local leaders in overcoming obstacles and challenges. Clear leadership and vision are crucial and creation of a compelling narrative is highly effective in securing engagement. In this case, leadership was mainly on the part of providers of health and social care services, with commissioners having a lesser role.

1 Impact

The programme in Torbay has an impressive impact on outcomes. Exhibit 1 shows four measures of this success – with improvement in occupied beds and care package placement over the decade between 1998/9 and 2009/10 and lower average length of stay (ALOS) and emergency bed use against South West peers.

Exhibit 1: measureable impact in Torbay



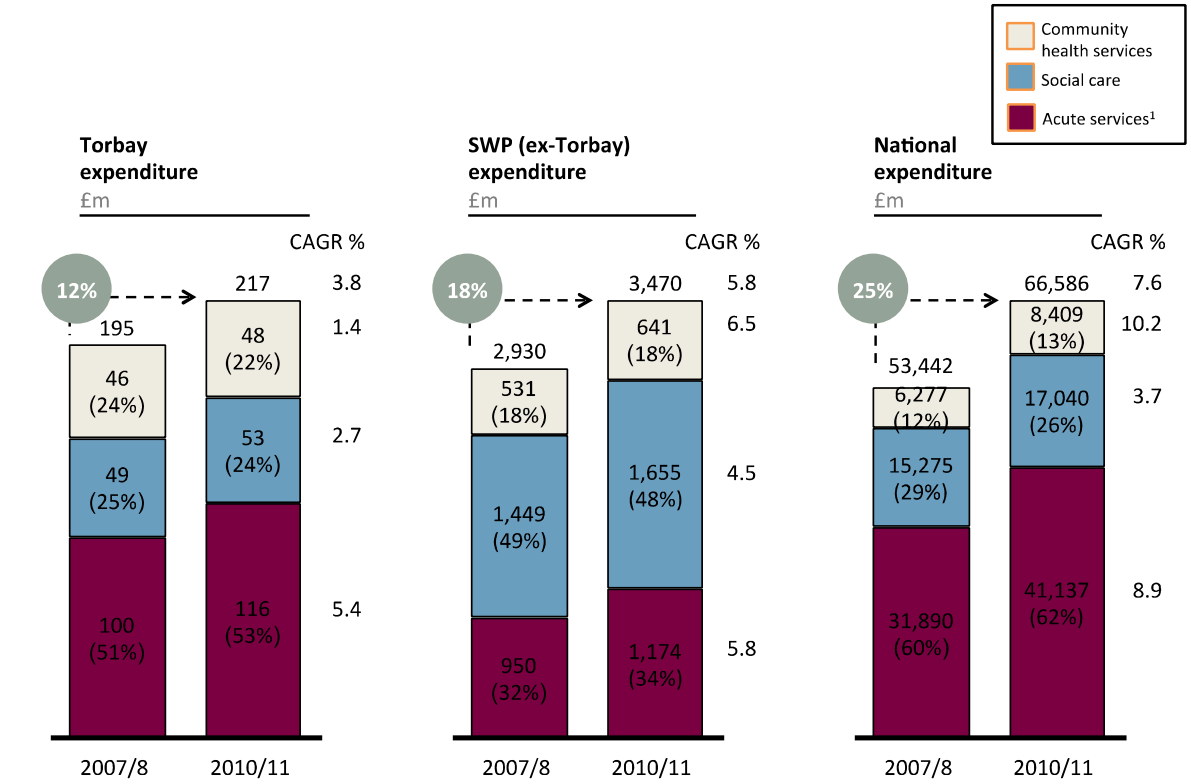
Source: Ben Richardson, The Impact of the Torbay Model

In addition, delayed transfers of care from hospital were reduced to negligible levels. Further, 144 fewer people were living in residential and nursing homes since 2007/08 and the standardised admissions ratio for Torbay became the third lowest in the South West.

There are significant impacts in terms of cost. Exhibit 2 shows Torbay delivered dramatically lower cost growth in comparison to both its peers and nationally. The bars represent spend by community health, social care and acute, (with the percentage of total underneath each respective absolute value) while

the percentages beside the chart and in a bubble above show the growth between 2007/08 and 2010/11.

Exhibit 2: Cost growth in health and social care expenditure – Torbay, peers and national



1 General & acute spend and A&E (excludes maternity and mental health)

Source: NASCIS 2010/11; FIMS 2010/11; L&B 2010/11; Carnall Farrar analysis

2 Place and context

Torbay covers a region of around 140,000 [7] registered patients. The Torbay and Southern Devon Health and Care Trust (formed in 2012) serves a total population of 250,000. As Exhibit 3 shows, the Torbay region has significant health challenges. It is in this context that one of the first integrated programmes targeting older people and those with chronic conditions was developed.

Exhibit 3: Torbay context[1,2,3,4]

Emergency admissions and Delayed Transfer of Care (DToC) data available for Devon region only.

	South Devon and Torbay CCG	National median	Top quartile
% pop 65+	23.0	16.9	12.1
IMD score	21.9	21.5	13.7
Emergency admissions per 1,000	26.4	25.5	21.6
DToC per 1,000	10.0	8.4	5.0
Stroke %	2.47	1.79	1.48
COPD %	2.19	1.80	1.42
Cancer %	2.84	2.17	1.87
Diabetes %	6.19	6.26	5.71
Dementia %	0.96	0.63	0.54
Mental Health %	0.92	0.81	0.73
Obesity %	10.24	9.66	8.12

Top quartile
2nd quartile
3rd quartile
Bottom quartile

3 Focus

Torbay's integrated care programme focuses primarily on older people. A 'Mrs Smith' (Exhibit 4) narrative has been developed, based on an 80 year old patient using fragmented services while requiring multiple health and care services. It has been used to display and contrast the current and ideal pathway for an older person navigating the local health and social care system. The programme also focuses on those patients suffering from chronic conditions, in need of palliative care and those with disabilities. In designing the model, a strong emphasis was placed on promoting independence and self-care, including prioritising the provision of care in the home.

[1] Better Care Atlas, NHS England (2014/15)
[2] National General Practice Profiles, Public Health England (2012) [accessed at http://fingertips.phe.org.uk/profile/general-practice]
[3] Quality and Outcomes Framework Data (2013/14)
[4] Integrated Care Value Case – Torbay, England, Local Government Association (2013)

Exhibit 4: Ideal Mrs Smith model

4 Care model

Health and social care coordinators bring teams together and provide consistency for patients. Although these employees have no formal professional training they work closely with professionals and zone managers. Their role is as a single point of contact to streamline and control the referral process. They have access to both health and social care records and are therefore aware of all the details of a patient's condition and care. This gives them knowledge of the complex, unstable and intermediate care cases within their zone which they proactively coordinate care for within the multi-disciplinary team (MDT). The coordinators work closely with nurses, allied health professionals and social care staff to arrange and modify care packages.

The care coordinators appointed are practical, hands-on and IT-capable people who help give other medical professionals confidence that the packages of care they allocate to a patient would be put in place effectively. Some 'care coordinators' already existed in Torbay, but advertisements were put out to recruit additional coordinators from a range of backgrounds. Confidence, communication and practical skills were prized in the search for new recruits, while the local trust would provide training. The trust developed training packages, which later became accredited. In total the amount of coordinators grew to 24 across the five zones.

Mandy Seymour, Chief Executive of South Devon Health and Care Trust emphasised: "Health and social care coordinators are pivotal in the new system…Staff have to feel confident patients will get the care and equipment they need".

Discharge coordinators are based in wards to help facilitate timely discharge. These coordinators help to speed up the process and involve families and patients earlier. Tasks include checking newly admitted patients, their history and their previous and current care packages. They also attend MDT meetings and help develop future care plans for each patient and discuss the proposed care plan with the patient. The coordinators also liaise with social workers to make sure the package is ready and notify the zones of any packages of care put in place for a patient so that they can provide continuity and review the patient's needs in four weeks.

Torbay also invested in intermediate care and reviewed the role of community hospitals to prompt a more active intermediate care service. As part of the service a crisis response hotline was set up to

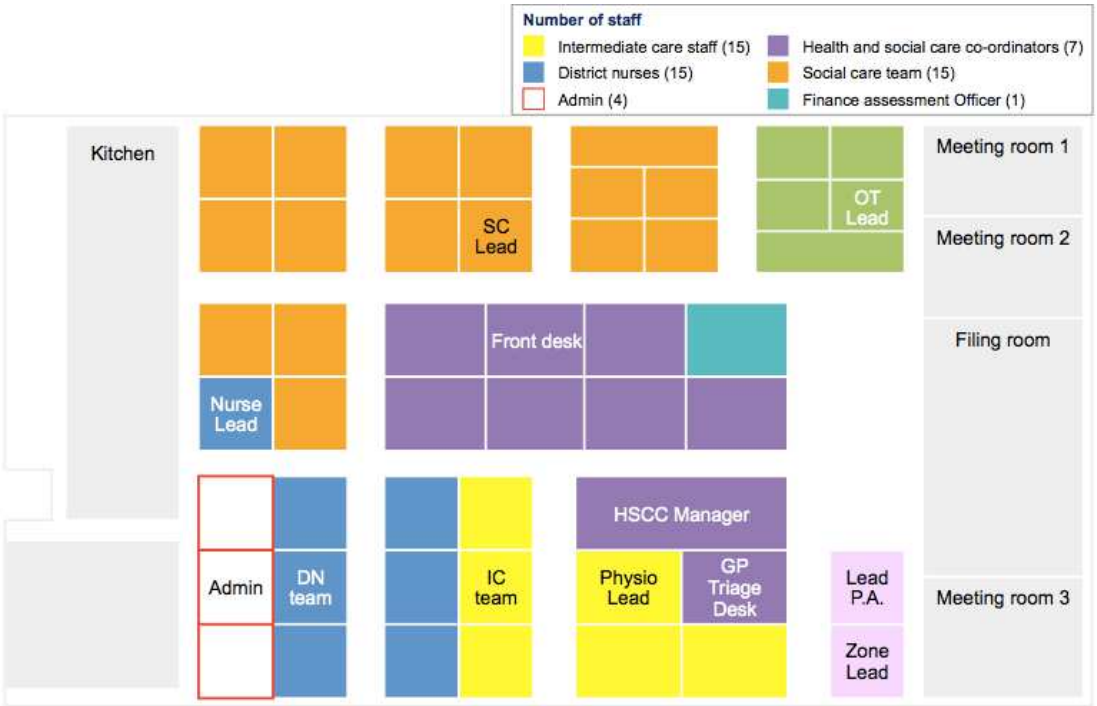
react to emergencies. Emergency calls would go to a health and social care coordinator who would liaise with all parties required (eg ambulance, nursing home etc). If a patient was in a crisis, a nurse, physiotherapist and occupational therapist would conduct a needs assessment on the same day. The team would hold handover meetings, assessing whether further support is required or if the care offered should be reduced. Team members would visit selected patients that required follow-up and inform the health and social care coordinator of any action needed.

Care planning was also developed. GPs identify patients most at risk of unscheduled admissions. These patients are allocated a case manager and given individual care plans. These plans include treatment objectives, planned interventions and recommended actions in situations of crisis. Teams meet regularly, often daily, to review the most complex cases.

Five zones were established with an integrated health and social care team, led by a single manager. Each zone had a single point of contact and uses a single assessment process. One telephone number is used for patients and GPs to call for any community care or in the case of a crisis – which is linked to GP practices. This enables collaboration and fosters relationships between the same groups of people.

Staff members across the teams in each zone are located in the same room, in an open plan office space, which facilitates exchange and collaboration. A typical floor plan is shown in Exhibit 5. This shows the health and social care coordinators in the centre of the office at the front desk, ensuring they can be accessed by everyone in the office readily – streamlining their own ability to coordinate the various services.

Exhibit 5: Typical zone floor plan



Shared information is a key enabler in the programme. Each zone has access to information from all providers and laboratories. This information is accessible on computers in each zone. The information sharing between primary, community and social care has reduced delay and provides near real-time information for clinicians and carers.

6 Commissioning and payment model

Another vital enabler of the programme was the development of a pooled health and social care budget for the then provider, Torbay Care Trust, of £225 million. This removed financial barriers to integration, including conflicts and confusions about budget responsibility and allowed a coordinated approach to providing integrated care.

This model was pursued initially, and facilitated success, but was dismantled as a result of the 2012 government reforms. These reforms caused the unpicking of the care trust, the separation of payment and provision elements and the separation of social care and healthcare budgets. “There is no question in my mind that as a result of this we have had to make more siloed decisions. As a consequence, I am afraid that some of the wrong decisions have been made,” added Mandy Seymour. Moving forwards Mandy states that “The Integrated Care Organisation (ICO) will hopefully bring it all together again, as it was under the Primary Care Trust (PCT) and the risk share between the Clinical Care Group (CCG), Torbay Council and the ICO will mean all parts of the system will share benefits and pains of economic performance.”

7 Workforce

The trust grouped various teams from a range of services and found around five health and social care coordinators from their original staff. The trust then improved these teams by training them with their own development packages that later became accredited. The zones were created and piloted on a small scale and then scaled up across the whole of Torbay, until there were five zones and 25 health and social care coordinators.

The creation and integration of zones supported teamwork and allowed a wide range of services to be effectively coordinated via a single point of access. The provision of one telephone number for patients and GPs per zone and the use of health and social care coordinators reduced the time taken to make care decisions. Recruitment targeted people with practical, communication and IT skills as well as a mind-set to get things done. The creation of this non-medical post was important to enable teams to work together efficiently and also because it created a post that could work across medical and non-medical systems. In addition, new social worker posts were funded from NHS money. This alleviated concerns from social care staff about budget limitations.

Prior to this change people were working in a fragmented manner, service by service, with communication done by letter or referral, never speaking face to face. GPs would do referrals without knowing which patient they were sending on and whether equipment or care would be properly

allocated and actioned. Through the process of implementing the care coordinator and zone model, staff realised that there were areas of respective case loads that they had in common and discussions that usually would have lasted hours could be done in minutes. People started to work together as a team. The role of nurses and therapists developed and closer links were established with the acute hospitals and care of the elderly specialists.

8 Governance

In 2005, Torbay Council and Torbay PCT reached a formal agreement to establish Torbay Care Trust which was fully responsible for commissioning and providing health and care services. The local authority kept its statutory accountability for adult social care.

A governance structure was created that facilitated effective leadership – with a single management team for integrated care and a joint manager of operations. Middle management was integrated further following this appointment – with social workers joining the local professional executive committee and the creation of a post of professional lead for social work.

9 Leadership and journey

The programme was supported by strong leadership and a clear vision constructed around the ‘Mrs Smith’ narrative. This narrative allowed services users, carers and staff to connect with a narrative they were familiar with (for example – with older family members) and as a result recognise the problems faced by older people in the current system. The messages from the leadership team flowed down to staff and patients, and the narrative helped create an aligned vision for health and social care which was structured around the needs of the patient.

Some of the key milestones in the Torbay integrated care programme have been:

- 2003 – following visits to Kaiser Permanente by CEO and senior PCT staff, integration plans are triggered
- 2004 – Brixham pilot project brought health and social care workers into a single team
- 2005 – PCT and adult social services combined to form care trust, a single budget formed
- 2006 – integrated care programme extended to whole region
- 2012 – Health and Social Care Act separates commissioning and provision and creates Torbay and South Devon Care Trust
- August 2015 – integration of acute trust, health and social care.

Evolution of the system

While the initial model was developed by Torbay PCT to cover its population of 140,000, it has been extended to cover the catchment of Torbay and Southern Devon Health and Care Trust as a result of the segregation of commissioning and provision by reforms. The trust has a catchment of 380,000 people and has had to cope with significant financial pressures and higher scrutiny as a result of the split with commissioning. For the first time in many years delays have been seen in the system, which is largely due to cuts in the adult social care budget that plays a vital role in discharging and reabling patients.

The model has evolved in a number of ways. There are now fewer zones with larger geographic catchments, with the original five zones reduced to two. There has been an increased focus on personalisation – primary care has nominated clinical leads and business leaders for each locality who develop locality plans to meet the specific needs of their population. Care of the elderly consultants have been brought into locality planning, with GPs pooling their patients and deciding whether consultant input is needed to target certain patients. This part of the model is being developed as a 'frailty hub' that uses an early warning tool to target the top 1 to 2 per cent of the population.

Primary care commissioners, who used to operate separate IT systems, now use the same system and share information including up-to-date medical history and shared health and social care records. The acute trust and the community and social care provider merged in October 2015 to become an ICO, which will have aligned financial incentives to overcome the barrier of separated commissioning and provisioning arrangements. The ICO will share risk with the CCGs and Torbay Council, meaning that all parts of the system will share benefits and pains of performance. Mandy Seymour commented that the ICO is intended to "bring it all together again, ensuring the alignment of incentives and a joined-up approach to delivery of care and support to patients".

An important change under the ICO would be the pursuit of a Care Direct Plus Model used by Devon County Council. This involves the set up of single point of access coordination centres that accept all referrals and signpost as necessary. Only patients with complex or in-depth issues would be referred on to the zone. Although this would have been seen as an unnecessary step in the original Torbay model, this provides significant workforce savings by filtering out unnecessary calls and allowing the larger catchment of the Health and Care Trust to be catered for more easily.

10 Bibliography

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