Living Well Together

one ilfracombe

our future, our choice

Programme name: One Ilfracombe – Living Well Together

Programme initiation request from: One Ilfracombe Living Well Together Team

Approved by One Ilfracombe Board at: 20th March 2015 Board meeting

Document contains:

1. Programme initiation request
    - Programme proposal summary – vision & values
    - What need does the programme address?
    - What are the objectives of the programme?
    - What One Ilfracombe objectives does the project support?
    - Whose need does the project primarily address?
    - What outcomes are expected for these stakeholders?
    - Who is needed on the team to enable successful delivery
    - What is the cost of the programme and how will costs be met?
    - What is the estimated start and finish date?
    - Significant risks
    - Programme conforms to One Ilfracombe principles
2. Appendix 1 – Terms of Reference for Living Well Together development team
3. Appendix 2 – Programme fit with partners' strategic objectives
4. Appendix 3 – Target groups at risk of escalation to next level of need
5. Appendix 4 – Key Performance Indicators
6. Appendix 5 – 2015 Timetable

Programme proposal summary

Vision

To improve health and wellbeing in Ilfracombe by creating a new and innovative service that is seamless, holistic and responsive. Making best use of the statutory, community and voluntary provision, it will support people at an early stage to reduce escalation and the need for crisis intervention.

Values (shared principles, standards and goals)

One Ilfracombe Principles

1. Gain better understanding of the problem being tackled from individuals directly affected.
2. Redesign the service around the person, not the agency
3. Focus on prevention and reducing demand
4. Develop a co-ordinated, multi-agency, multi-disciplinary approach & central point of contact
5. Foster community responsibility & support volunteers to help design & provide the solution
6. Establish (social, economic and environmental) value for money
7. Explore the potential for One Ilfracombe to be the deliverer and commissioner of services

In addition to the One Ilfracombe principles above, the Living Well Together team will aim to contribute to the reduction of health inequalities by ensuring that services are delivered for the whole community but with a scale and intensity that is proportionate to their level of disadvantage.

All will have an equal voice on the team, regardless of sector, and the involvement of service users and front-line staff will be actively encouraged.

What need does the programme address? [1]

Ilfracombe

Low wages, seasonal employment

Highest rate in Devon of working age sickness (twice Devon rate at 8.5%)

High rate of private rented accommodation, much of it sub-standard

Highest rate in Devon of 65+ residents receiving residential-nursing care

Relatively isolated, poor transport links

Highest rate in Devon of adults with mental health condition receiving community based care (almost twice Devon rate)

Significantly higher rate of alcohol-related admissions

Significantly higher rates of cardio-vascular related hospital admissions

Significantly low rates of immunisation

Result:

Life expectancy lowest in Devon

Highest deprivation index in Devon; central ward in top 5% most deprived wards in country.

£84 million spent annually on public services

Service users

I have to tell my story many times to multiple agencies.

I don't always know who I should talk to about my issues. I don't know what help is out there

There are a lot of services I am involved with, but no single person or service seems to be co-ordinating it all

I feel like I'm only able to get help when I'm in a real emergency

I don't know enough to make an informed choice so rely completely on experts

Result:

I can't get the support I need early enough so end up in crisis needing urgent support from services

Services

Reduced budgets, increased demand

No mechanism to join up services delivered by different agencies

Opportunities to highlight risk or needed support by other services are missed

There is variable recognition and understanding of what support the community and voluntary services can offer

Result:

Our emergency intervention is unscheduled and costly and does not allow us to be as effective as we could be

[1] Data taken from Joint Strategic Needs Assessment Ilfracombe Town Profile 2013-14 and One Ilfracombe Virtual Bank

What need does the programme address? (continued)

Care (see box below) is best delivered safely and efficiently in homes and communities by taking a neighbourhood, multi-agency approach.

- People want to receive safe, supportive care as close to home as possible and delivering this results in better health outcomes
- Residents have described how they 'tell their story' many times to a variety of different staff and providers and don't fully understand their options
- Increasing demand. The ageing population and associated conditiwons as dementia as well as increase in mental health disorders for all ages is well documented.

"Care"

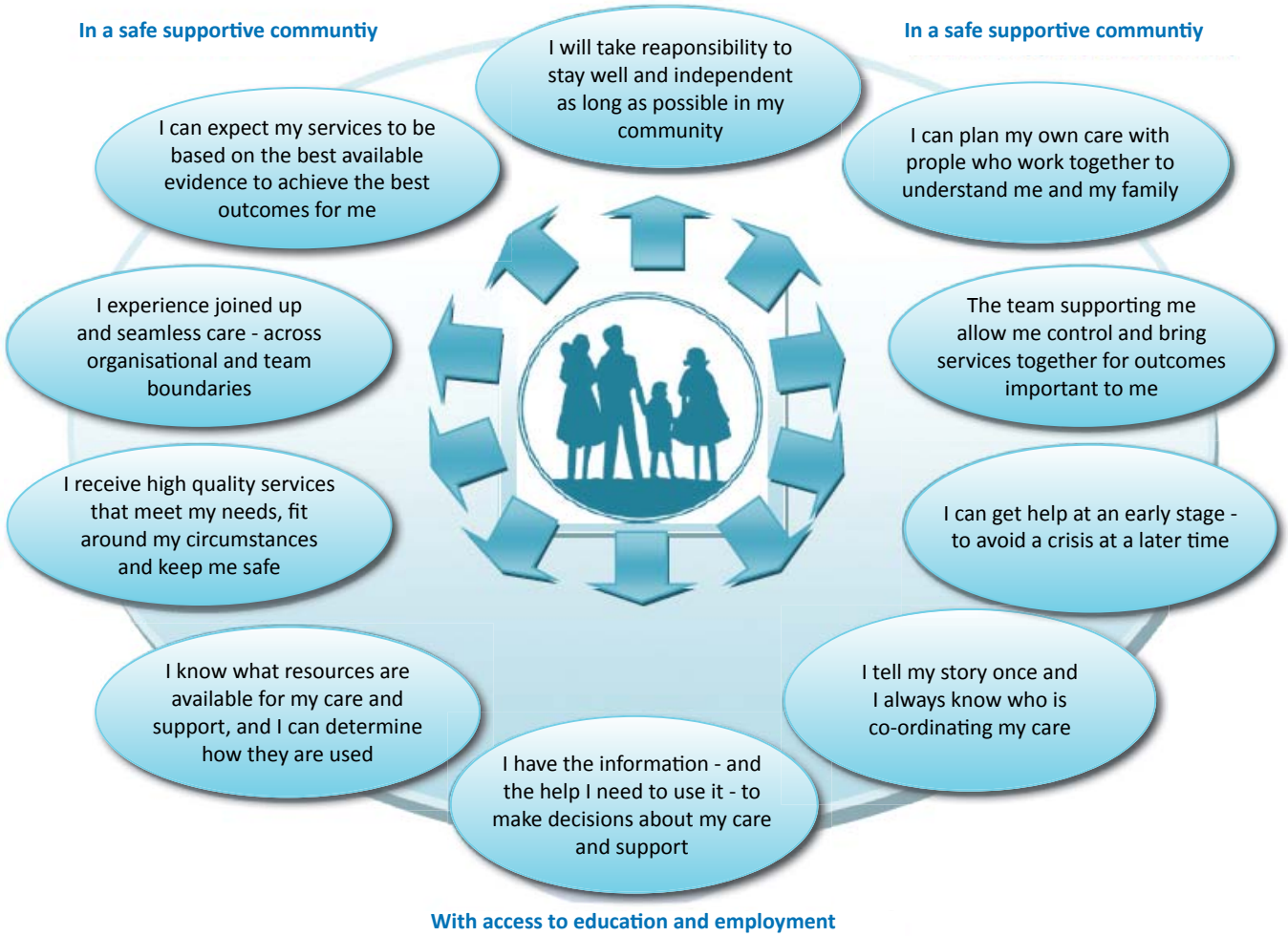
For the purposes of this document, we are defining care as the provision of what is needed for the overall health and wellbeing of an individual. It includes non-clinical support.

- Financial pressures. Our partners recognise the need for change and are committed to finding more efficient models of delivery and investing in prevention
- There is growing evidence that supporting people early and at every stage improves their wellbeing and reduces crises.
- The health of a community and individual residents relies on the services of non NHS partners (such as those providing education, housing, employment, social, personal safety, financial advice etc).
- Services will be restructured to actively mitigate Ilfracombe's rurality and poor transport infrastructure.
- While there has been much improvement in integrating health & social care services, the overall multi-agency health & wellbeing provision remains disjointed and will be improved by doing things differently.
- The people of Ilfracombe are an important asset and their expertise continues to be under-utilised

What are the objectives of the programme?

- To develop and implement a Joint Strategy for creation of a local "health and wellbeing" service that is constantly improving its integration and effectiveness;
- To support people to live as full and independently as possible for as long as possible by:
  - providing services people need
  - in the way they that is right for them
  - and that reduces the health inequalities that currently exist between Ilfracombe and the rest of Devon.
- To join up services more effectively to meet the needs of the service user, reflecting the approach of the One Ilfracombe Town Team which promotes the concept that 'any partner's door is the right door' for access into health and wellbeing services
- To support and make best use of the local charitable, voluntary and community sector provision together with the non-NHS services that contribute to a person's health and wellbeing including education, housing, employment, personal safety and benefit services. These will be brought into a co-ordinated overall service provision with statutory health, mental health and social care.
- To have co-design and co-production with service users, carers and families at the heart of the service and the emphasis will be on prevention, self-management and supporting communities to help themselves.
- To use this work will be used as a basis for influencing future commissioning.

For service users this will mean:



"Building services around people and their communities is the key to successful public service transformation. The experiences of people that use your services need to be the starting point, with local partners jointly accountable to their communities for the delivery of those services"

- Public Service Transformation Network

The redesign will be a continuous development towards a trusted model for integrated health and wellbeing that is:

- **Ambitious** – for the people of Ilfracombe. Our strong desire to achieve real change and improvement will ensure we challenge the status quo and avoid being constrained by process, history and organisational boundaries.
- **Safe** – patient safety will not be compromised
- **Trusted** – service users will be able to trust in the care provision
- **Holistic** – multi-agency and multi-sector, removing duplication and identifying gaps in provision
- **Personalised** for the service user; enabling a package of support options that can address individual need
- **Empowering** – greater choice for individuals and carers and clear pathways they can confidently and positively engage with supporting greater management of their wellbeing. Personal budgets will be more effectively used to support independence.
- **Local** – a Health & Wellbeing Hub that enables easier access to a wide range of support
- **Accessible** – the 'one door' approach, providing entry into the network of provision at whichever partner's door an individual presents. An integrated referral system will be developed
- **Effective** – as a result of the above, the care being offered by all providers will be more effective.
- **Validated** – user outcomes will be monitored and evaluation will be embedded in every stage.
- **Consistent** – a consistent approach across the partnership in both assessment and access to reosurces
- **Scaleable and replicable** – a collaborative model of practice which can be replicated.

Which One Ilfracombe objectives does the project support?

Increased numbers of older people living independently (Living Well)

Increased life expectancy (Living Well)

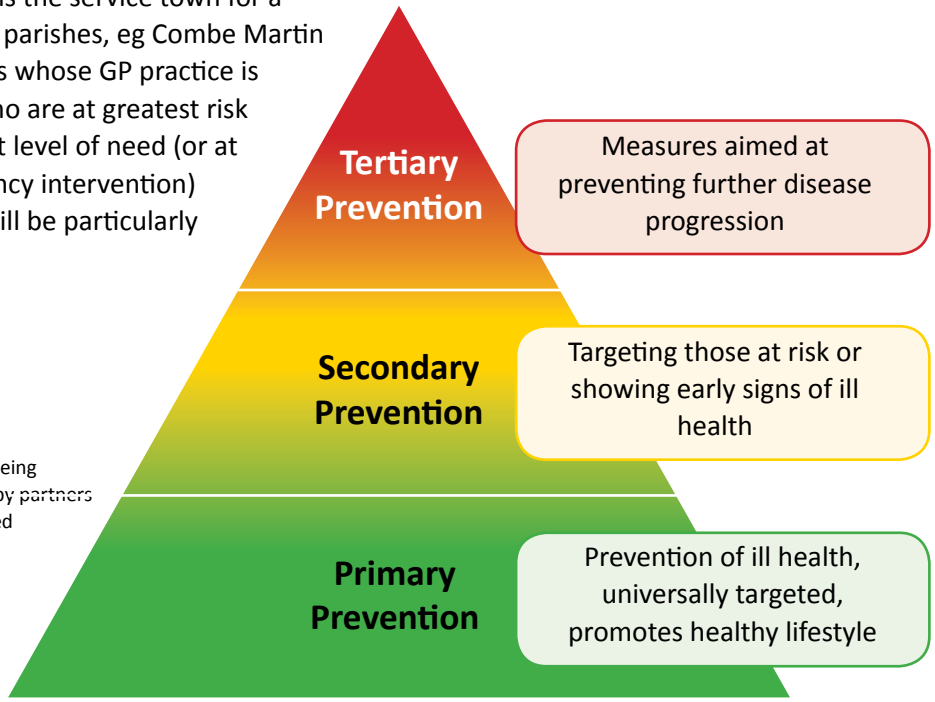
More young people and families reaching their full potential (Living Well)

More Ilfracombe residents in work (Ilfracombe Works)

Whose need does the project primarily address?

For evaluation purposes the project's primary beneficiaries will be the people living within the parish of Ilfracombe who access its health and wellbeing services.

It is recognised however, that the beneficiaries will be wider as Ilfracombe is the service town for a number of surrounding parishes, eg Combe Martin and Mortehoe residents whose GP practice is in Ilfracombe. Those who are at greatest risk of escalating to the next level of need (or at risk of needing emergency intervention) in the diagram below will be particularly benefited:



Types of Health & Wellbeing interventions provided by partners at different levels of need

What outcomes for these stakeholders are expected, what are the KPIs and when & how will these be monitored by the Board?

We will take an outcomes-focussed approach to demonstrate value for money using an evaluation methodology supported by New Economics Foundation. The added value of this model is that it is not only used to 'prove' but importantly to 'improve' the programme of work. We will establish and report on how much expected benefits as outlined in Appendix 4 (KPIs and Evaluation Plan) will have been achieved.

The KPIs for residents/service users have been agreed (and will be confirmed as part of the SROI process). These can be found in the Stakeholder Outcomes table in Appendix 4.

For each project initiated, we will identify beneficiaries and for each, capture the baseline situation. Once implementation has begun, we will ask those who have agreed to be surveyed throughout the process, whether each of the outcomes has improved. This could be carried out quarterly depending on the speed of implementation.

Additionally, partners will be identifying what their own organisations need to measure in terms of success and these will also form part of the KPIs to be monitored by the board.

Who is needed on the Project Team to enable successful delivery?

A Development Team has been identified to drive the implementation of the programme (see Living Well Together Development Team Terms of Reference)

A core operational team is also required made up of:

Project Co-ordinator (One Ilfracombe – Charmain Lovett)

Project Support (One Ilfracombe – Hannah McDonald)

Communications (Katherine Allen, NDHT)

Community Engagement (Sarah Hiscock, ITC / Julia Knight ITC / Nellie Guttmann NDHT)

Evaluation (One Ilfracombe / ITC)

Data/statistics (partners)

Change Management – (Martyn Dowdall, NDHT / Paul Pilkington, DPT)

What is the cost of the project including in-kind contributions of time?

EXPENDITURE

Expenditure description	In kind	Revenue
Staff costs – Programme Development Team January 15 – Dec 15	£36,000	
Staff costs – Core Operational Team March 15 – Feb 16	£33,500	£38,000
Staff costs – Community Connector		£16,000
Project costs		£5,000
Total	**£69,500**	**£59,000**

How will the costs be met?

INCOME

Income description	In kind	Revenue
LWT Programme Team	36,000	
LWT Core Operational Team	33,500	
NEW Devon CCG – Core Operational Team costs		£10,000
NEW Devon CCG – Community Connector costs		£5,000
DCC – Community Connector		£11,000
Northern Devon Healthcare Trust		£15,000
Total	**£69,500**	**£41,000**

Further funding will be sought as the programme develops and it becomes clear what needs to be done to achieve the outcomes.

What is the estimated return on this investment?

The return on investment will be calculated for each intervention that is initiated as part of the Living Well Together programme and reported back to partners and the One Ilfracombe board.

What is the estimated Start & End date?

January 2015: Partner strategic agreement and core skills commitment

February 2015: Agree case for change, discover baseline, agree focus for transformation

Mar 2015: Agree Programme Vision, evaluate findings, agree project areas to initiate*

April – May 2015: Plan first project using LiA approach, service user engagement for project 2

June – Staff engagement conversations

July – Nov agree project teams and 12 week cycles for implementing change

Nov/Dec – LWT review progress, evaluation, learning. Plan next phase.

*Projects initiated will have their own plan setting out clearly the vision and what is aimed to achieve and specific evaluation measures.

See Appendix 5, 2015 Timetable for more detail

Evaluation takes time and should be proportionate to the project. What kind of evaluation does this project require?

Given the ground-breaking and significant nature of this programme, it is suggested that a full Social Return on Investment evaluation and Cost Benefit Analysis is carried out and funding has been requested to support this.

Significant risks

- Lack or organisational agreement over data sharing protocols
- Integration of IT systems will be beyond the budget of this programme and will have to be sourced separately if this is found to be the preferred option.
- A risk register will be created for the programme and risks notified to the board

Programme conforms to One Ilfracombe Principles

Any project proposal will have to show that it conforms to the principles defined in the One Ilfracombe Operational Plan if it is to be successfully approved by the Board.

What is the current service provision?
This will be mapped as part of the project. Partners have been given templates and these will provide the currrent service model and it will be placed on the Virtual Hub.

Are there any evident gaps?
Once the service provision is mapped, and residents have been consulted the project team will report on any gaps identified.

Are there any evident areas of service duplication?
Once the service provision is mapped, the project team will report on any service duplication.

Are there any opportunities for innovative approaches to delivery?
Throughout engagement with staff and residents, innovative ideas will be encouraged.

Are there opportunities for One Ilfracombe to be commissioned around this project?
One Ilfracombe has the right structure to deliver a programme of this magnitude successfully. The CCG and NDHT will be asked to commission One Ilfracombe to project-manage.

Are there opportunities for One Ilfracombe to be a central point of contact?
The Virtual Hub and Health & Wellbeing Hub will be promoted and health & wellbeing services could all be badged under One Ilfracombe similar to the way the Town Team works.

Will the project prevent or reduce public service demand?
Yes. The KPIs to monitor this are currently being developed.

How could the project be co-delivered with the community?
Community representatives are part of the Development Team. The community will be extensively consulted throughout. The One Ilfracombe Good Neighbour scheme as well as health & wellbeing volunteering opportunities will be promoted.

Appendix 1: Living Well Together Development Team Terms of Reference

Revised 9.03.15

Purpose

1. To drive and oversee the planning and implementation of the TCS programme
2. To create a Programme Initiation Request (PIR) and seek sign-off from their organisation
3. To keep their organisations informed of progress, notify of changes, issues or risks and seek sign-off at appropriate stages
4. To keep the One Ilfracombe(OI) board informed of progress, and notify changes, issues or risks at appropriate stages
5. To consider what in-kind or other resources could be allocated to the programme
6. To be innovative and prepared to work differently to improve the way services are delivered
7. To ensure the programme conforms to the seven OI principles
8. To hold partners to account for delivery of the programme
9. To ensure staff delivering services for Ilfracombe are involved and signed up to the new way of working

Meetings

Monthly at the Ilfracombe Centre

Membership

Andrea Davis (Chair)	One Ilfracombe Living Well Champion
Ron Ley	Chairman, One Ilfracombe
Andrea Beacham	Programme Manager, One Ilfracombe
Dr John Womersley	Chairman, Northern Locality, NEW Devon CCG
Andy Robinson/Rob Sainsbury	Director of Finance & Performance/ Director of Operations, NDHT
Dr Andrew Moore/Ann Richards	Clinical Director/DAS, IAPT Provider Manager, Devon Partnership Trust
Eric Hayes	Tyrrell Hospital League of Friends and Ilfracombe Access Group
Cllr George Squires	Mayor of Ilfracombe
Dr Stephen Hunt	GP, Waterside Practice, Ilfracombe Medical Centre
Dr Sean Ross	GP, Warwick Practice, Ilfracombe Medical Centre
Neil Blackburn	Group Commander, Devon & Somerset Fire & Rescue Service
Stephen Roberts/Rachel McCarty	Chief Executive/Director of Care, North Devon Hospice
Janice Donovan	Ilfracombe Town Council Living Well Champion
Keri Storey/Chris Thomas	Assistant Director Health & Social Care / Cluster Manager, NDHT/DCC
Jeremy Mann	Head of Environmental Health & Housing, North Devon Council
Elaine Fitzsimmons	Associate, Northern Localilty NEW Devon CCG

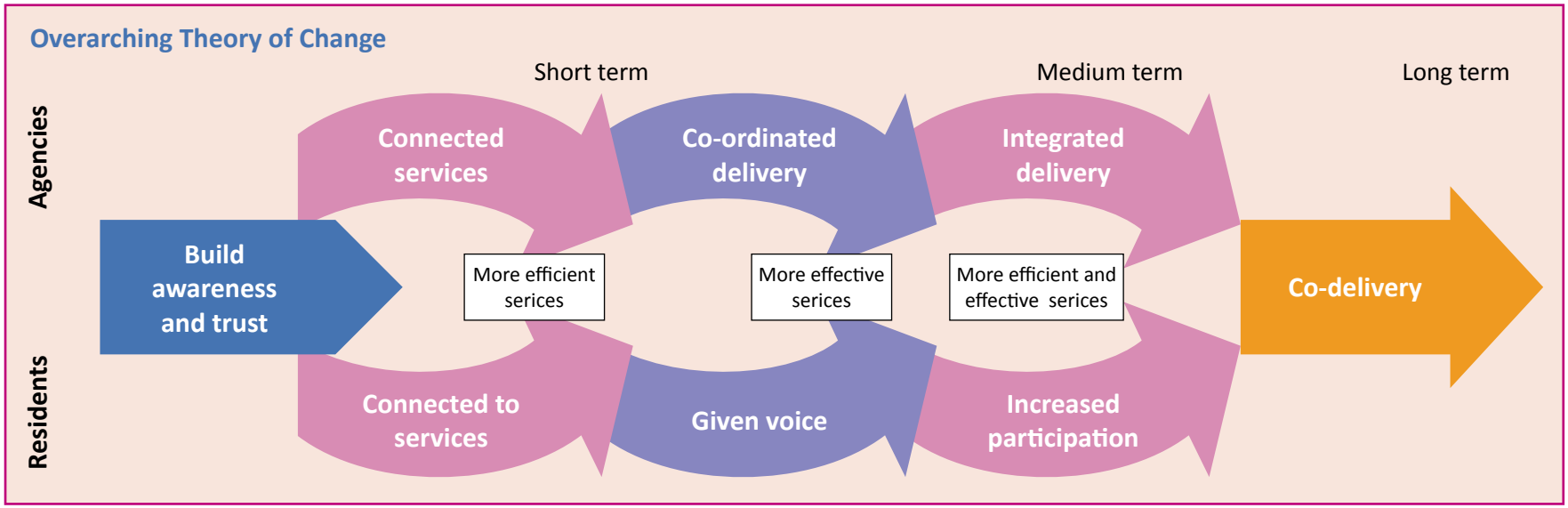
John Green	Chair, Patient Participation Forum, Warterside Practice
Jaine Keable	Westbank Friends
Tracey Polak/Martin White	Assistant Director of Public Health/ Public Health Specialist, DCC
Marc Rostock	Director of Neighbourhoods, North Devon Homes
Kerry Turton	Independent Care Sector representative
Ann Oliver	Jobcentre Plus
Rebecca Bennett	Virgin (CAMHS)

Invitees

As and when appropriate to the work being planned, other agency representatives will be invited to attend meetings or become part of Task & Finish groups. These will include representatives from education providers, addiction services, DCC place services, probation service, disability services etc.

Appendix 2: How does the Living Well Together programme fit with partners strategic objectives?

One Ilfracombe Theory of Change



One Ilfracombe Living Well priorities:

One Ilfracombe Health & Wellbeing priorities 2013-15

(the priorities below all contribute to the overall objective of increased life expectancy for Ilfracombe residents)

	Focus on childrend & families	Healthy lifestyle choices	Health & Wellbeing in older age	Strong & supportive community
Priorities	1. More young people and families reaching their full potential 2. Education outcomes and skills	1. Integrated pathway for self-care	1. Increased numbers of older people living independently • Dementia Friendly	1. Social isolation 2. Supported at home
Actions	1a TFS programme 2a Reducing unemployment due to ill health in Pathways to Work project 1b Raise aspirations through Cadet and Education to Work projects	1a Social prescribing to include self-management within integrated package 1b community Connector 1c Vertual Hub of local & general information 1e Physical Hub - potential Tyrrell Hospital	1a Engagement 1b Improved awareness 1c Improved services 1d Improved diagnosis 1e Virtual Hub of local & general information 1e Promote healthy lifestyle advice 1f community Connector 1g Physical Hub - potential Tyrrell Hospital	1a Engagement 1b connect Online 1c Neighbourhood Health Watch 1d Community Connector 1e Virtual Hob of local & general information 1f Physical Hub - potential Tyrrell Hospital

Devon Health & Wellbeing strategic priorities 2013-16 (in addition to those listed above)

Priorities	• Poverty • Domestic & Sexual Violence • Pre-school education outcomes • Transition	• Alcohol misuse • Contraception & sexual health • Screening • Physical activity, healthy eating & smoking cessation • High blood pressure	• Falls • Carers support • End of life care integrated pathway	• Mental health & emotional health & wellbeing • Living environments • Housing • Offender health • Protected characteristics JSNA

NHS

Five year forward plan. Includes:

Public health & prevention, community involvement and social movement

Devon & Somerset Fire & Rescue Service priorities:

Public Safety

- Effective and Efficient working

Operational objectives:

- To reduce the risks to people from fire in the home, targeting those most at risk and promoting safer behaviour
- To work with partners to deliver programmes to improve social well-being and antisocial behaviour in the community through engagement with young people and vulnerable adults

North East & West Devon CCG (Northern locality) priorities:

- To adopt an asset based approach to helping individuals and communities to help themselves, with a greater emphasis on prevention & reducing reliance on statutory services
- To commission consistently great services that deliver the defined outcomes we are setting out to achieve
- To positively shift resources from parts of the system where change is needed to those parts that can bring most benefit

- To bring about a new model of out of hospital care that maximises the benefits of the Better Care Fund
- To target our attention to achieving impact on inequalities and services for people who are most vulnerable
- To strategically join up the key actions we know will make a real and sustainable difference to integration

North Devon Hospice

- Enhance community based care to improve patient and carer access
- To seek to ensure that patients achieve their preferred place of care (PPC)
- To develop services closer to a patient's home: Hospice2Home
- To develop and lead a co-ordinated approach to end of life care (EoLC)
- Build partnerships to enhance our capability
- To broaden, improve and enhance services to meet the future needs of our beneficiaries
- Provide leadership through education
- To be the centre of excellence for End of Life Care

Northern Devon Healthcare Trust

Vision:

We will deliver local integrated health & social care to support people to live as healthily and independently as possible, recognising the differing needs of our local communities across Devon.

Strategic objectives:

- We will be recognised for delivering care of the highest quality, measured in terms of clinical effectiveness, patient safety and the patient experience
- We will ensure access to a sustainable range of services that are delivered locally through established partnershops and clinical networks with other organisations
- We will maximise the benefits derived from an integrated model of health & social care that provides the right care at the right time in the right place at the level of the individual
- We will recruit and develop a flexible and multi-skilled workforce fully engaged in turning the vision into a reality
- We will efficiently and effectively run our services; generating surpluses to reinvest for our local community and underpinning all we do with systems and processes which deliver safe, high quality services.
- We will be the local provider of choice; trusted by the public and commissioners to meet their needs

Delivery strategies:

- Re-shaping community services
- Improving emergency care
- Improving hospital productivity

Ilfracombe Town Council

Strategic objective 18 – to improve the health & wellbeing of Ilfracombe's residents.

Key actions:

- Identify and alleviate the underlying causes of Ilfracombe's health inequalities, recognising that the determinants of health outcomes include factors such as their living conditions, work and socio-economic position
- To support One Ilfracombe in the creation of a Health and Wellbeing partnership that includes the community and voluntary sector provision alongside the NHS and non-NHS public services such as Jobcentre Plus, Education Providers, the Fire Service and Housing Providers.
- To create health & wellbeing services that are seamless, whichever the provider
- To support the disproportionately high number of people off work due to sickness into some form of employment that will be beneficial to them

- Map current health and wellbeing services
- Engage with the community to find out what works well and what can be improved
- Create a programme that focuses on prevention activities
- Support delivery of services that promote healthy lifestyle choices
- Ensure carers are well-supported

Devon Partnership Trust

In everything we do, we ask ourselves 'is this service good enough for my family'?

The services must be Safe, Timely, Personalised, Recovery-focused and Sustainable. These five objectives will underpin all of our work as we continue to improve services.

Strategic business objectives:

- To consolidate and improve the quality, responsiveness, efficiency and cost effectiveness of our services. This is about being brilliant at the basics, such as care planning, record keeping and risk assessment.
- To expand current services and improve care for people whilst delivering overall savings for the local health economy. This is about re-affirming our organisation as the provider of choice and extending our sphere of influence.
- To provide an integrated health and social care service by working with new and existing partner organisations.

Values:

- Valuing and respecting people
- Enabling and supporting our staff
- Listening to people
- High quality clinical and managerial leadership
- Promoting respect and compassion
- Being inclusive
- Working with people in delivering their care
- Promoting personal recovery in everything we say and do.

Devon County Council Adult Social Care

The Care Act gives DCC the following responsibilities:

Promoting wellbeing, focus on prevention and providing good information and advice

- Reducing and delaying care needs
- Maximising opportunities for independence
- Providing control for the individual (and carers) specifically by the use of personal budgets

Appendix 3: Target groups at risk of escalation to next level of need

North Devon Hospice:

- Patients requiring urgent palliative care with complex symptoms not being managed
- Patients/families unable to cope in current care setting
- Patients newly diagnosed with life limiting illness
- Patients and families of those with life limiting illness requiring access to groups/counselling and/or education

Devon & Somerset Fire & Rescue Service:

- Alcohol
- Smoking
- Mental health conditions
- Limited mobility
- Drugs
- Poor housekeeping
- Social isolation/living alone

Ilfracombe Town Council (the Ilfracombe Centre):

- Debt
- Risk of eviction from private rented accommodation

Independent Care Home provider:

- Patients unable to have respite or permanent care in the preferred location (leading to social isolation and reduced wellbeing)
- Lack of day care facilities
- Lack of support/education to people with care responsibilities
- Lack of communication between hospital to residential homes leading to a disorganised and poor patient experience upon discharge
- Lack of communication regarding after-care planning upon discharge which leads to a poor patient experience

Devon Partnership Trust

- Known history of mental illness
- Chronic physical health conditions
- Drug and alcohol misuse
- Social isolation
- Housing/accommodation problems
- Unemployment
- Life Stresses (e.g. bullying, job loss, divorce, debt, bereavement)
- Pregnancy
- Traumatic experience (past and present, including child abuse, domestic violence, combat stress/veterans)
- Poverty/low socio-economic status

Warwick & Waterside GP Practice

- any episode of acute mental or physical ill health which results in an individual losing their capacity to function at their normal level
- any worsening of chronic mental or physical ill health which results in an individual losing their capacity to function at their previous level
- any change in an individual's home, work or social circumstances which induces an incapacity, or perception of incapacity, to cope with their circumstances
- loss of, or perceived loss of, capacity of carers (family or employed) to continue to cope with the needs of a dependent individual

DCC Adult Social Care

- People at risk of harm (in line with DCC safeguarding responsibilities)
- Carers (Act has new rights for Carers to assessment)
- Risk of personal loss of independence
- Risk of care market failure (need to ensure resilience in the provision of at home care or care home beds)

NDC

- People living in unhealthy housing (presence of Catagory 1 Hazards, Housing Act 2014)
- People living in unsafe housing (eg children with limited space, lots of stairs etc)
- People living in unsuitable housing (unaffordable housing or housing which has not been adapted to meet the needs of a disabled person)
- People at risk of becoming homeless due to complex needs and/or other social factors
- People at risk of harm due to self neglect
- People who are rough sleeping
- People who are in financial crisis

Appendix 4: Key Performance Indicators

Which of the following forecast evaluation steps have been completed and which ones do the Project Team need to build into the Project Plan?

Stage		Completed by	When
1.	**Establishing scope and identifying stakeholders**		
1.1	Established scope of analysis	LWT Team	27.2.15
1.2	Identified stakeholders	LWT Team	27.2.15
1.3	Decided how to involve stakeholders		
2.	**Mapping outcomes**		
2.1	Description		
2.3	Valued inputs		
2.4	Quantified outputs		
2.5	Clarified outcomes/intended outcomes with stakeholders		
3.	**Evidencing outcomes and giving them a value**		
3.1	Decided which outcomes to measure		
	Agreed appropriate indicators		
3.2	Agreed how data will be collected and when		
3.3	Estimated how long outcome will last		
3.4	Valued the outcome (agreed financial proxies)		
4.	**Establishing impact**		
4.1	Calculated deadweight and displacement		
4.2	Assessed attribution		
4.3	Deducted drop-off		
4.4	Calculated impact		
5.	**Calculating the SROI**		
5.1	Projected value of outcomes over period it will last		
5.2	Calculated the net present value		
5.3	Calculated the ratio		
5.4	Completed sensitivity analysis		
5.5	Calculated payback period		
6.	**Reporting, using and embedding**		
6.1	Reported to stakeholders		

Status	Date
Project agreed by board	
Project not agreed by board	
Comments/amendments from board	

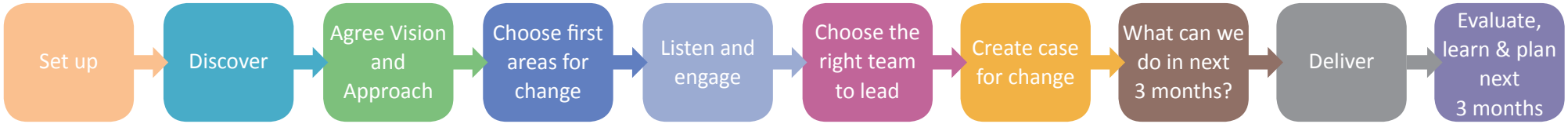
Intended outcomes

Stakeholder	***Role and activities***	***What happens to them?***
For Ilfracombe people and those who access Ilfracombe's services	Engage with programme (one-to-one interviews, surveys etc) to explain how well the current system delivers the final outcomes. Confirm the outcomes described are the desired ones. Representatives to co-design the new delivery model Take an active role in managing own healthcare utilising new opportunities to increase awareness of care pathways	***Final outcomes to be measured:*** • I can plan my own care with people who work together to understand me and my family • The team supporting me allow me control and bring services together for outcomes that are important to me • I can get help at an early stage – to avoid a crisis at a later time • I tell my story once and I always know who is co-ordinating my care • I have the information – and the help I need to use it – to make decisions about my care and support • I know what resources are available for my care and support, and I can determine how they are used • I receive high quality services that meet my needs, fit around my circumstances and keep me safe • I experience joined up and seamless care – across organisational and team boundaries • I can expect my services to be based on the best available evidence to achieve the best outcomes for me • I will take responsibility to stay well and independent as long as possible in my community • As a carer, I feel recognised and valued; and have the support I need to enable me to carry out my care responsibilities so they are not detrimental to my own health and wellbeing
For health and social care providers:	Andy, Elaine, Chris to confirm what KPIs they will want to see measured	• Admission avoidance • Prompter discharge • Improved service quality • Reduced demand for care home provision • Something about reduced escalation to higher cost, more acute levels of care/ unplanned admissions? Need to reference that prevention objective.
For commissioners:	Elaine/Ian Hobbs/Gavin Thistlethwaite to confirm what KPIs they will want to see measured	• Increased ability to commission safe sevices • Reduction in avoidable harm • Reduction in waste by commissioning only needed services • Increased understanding of the whole 'service' available • Resources match local need • Duties under the Care Act fulfilled • Impact on local health inequalities through effective co-ordination of services that impact on the wider determinants of health

For voluntary and community services	Pat/Eric to confirm what KPIs they will want to see measured	• Our work sits within an overall strategy and plan for health & wellbeing improvement alongside the public sector • We are more sustainable as our service is better promoted and better used
For non-NHS public services	Jeremy, Neil, Ann to confirm what KPIs they will want to see measured	• We work more effectively due to partnership working with the other agencies whose work impacts on our own priorities
For the State:	Andrea B to speak to Robert Rutherfoord about which are the most appropriate KPIs	Public Health Outcomes Framework – 2013-2016 Outcome 1: Increased health life expectancy Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities) • Objective 1: Improvements against the wider factors which affect health & wellbeing and health inequalities • Objective 2: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities • Objective 3: The population's health is protected from major incidents and other threats, whilst reducing health inequalities • Objective 4: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.

Appendix 5: 2015 Timetable

Programme Stages



Progress in each stage

Set up - Jan 15

1. Programme team agreed

2. Commitment to programme from partner organisations made

3. Core skills within partnership network

Discover – Feb 15

1.Agree focus for transformation

Those at risk of escalation to next level of need; those at risk of needing crisis intervention

Discover – Feb 15

2a. Review current situation: Ilfracombe

Low wages, seasonal employment

Highest rate in Devon of working age sickness (twice Devon rate at 8.5%)

High rate of private rented accommodation, much of it sub-standard

Highest rate in Devon of 65+ residents receiving residential-nursing care

Relatively isolated, poor transport links

Highest rate in Devon of adults with mental health condition receiving community based care (almost twice Devon rate)

Significantly higher rate of alcohol and cardio-vascular related hospital admissions

Result:

Life expectancy lowest in Devon

Highest deprivation index in Devon; central ward in top 5% most deprived wards in country. £84 million spent annually on public services

Discover – Feb 15

2b. Review current situation: Individual

I have to tell my story many times to multiple agencies.

I don't always know who I should talk to about my issues. I don't know what help is out there

There are a lot of services I am involved with, but no single person or service seems to be co-ordinating it all

I feel like I'm only able to get help when I'm in a real emergency

I don't know enough to make an informed choice so rely completely on experts

Result:

I can't get the support I need early enough so end up in crisis needing urgent support from services

Discover – Feb 15

2c Review current situation: Services

Reduced budgets, increased demand

No mechanism to join up services delivered by different agencies

Opportunities to highlight risk or needed support by other services are missed

There is variable recognition and understanding of what support the community and voluntary services can offer

Result:

Our emergency intervention is unscheduled and costly and does not allow us to be as effective as we could be

Agree Vision – Mar 15

To improve **health and wellbeing** in Ilfracombe

by creating a **new and innovative service** that is **seamless**, **holistic** and **responsive**.

Making best use of the **statutory**, **community** and **voluntary** provision, it will **support people** at an **early stage** to reduce escalation and the need for crisis intervention.

ONE ILFRACOMBE APPROACH

Get a better understanding of the problem from the individuals affected

Redesign the service around the person, not the agency

Focus on prevention and reducing demand

Develop a co-ordinated, multi-agency, multi-sector, multi-disciplinary approach and central point of contact

Foster community responsibility and support volunteers to help design and provide the solution.

Establish value for money

Explore potential for One Ilfracombe to be the commissioner of services

Define – Mar 15

1 Evaluate findings

By considering understanding gained from:

Current **town** statistics

Customer feedback

Organisational feedback

alongside the **agreed approach**, focus down to initial target areas for change to allow prototyping and robust evaluation

DO WE KNOW ENOUGH?

Q. Have we discovered enough to have a crystal clear definition of what needs to change?

A. Whilst the LWT programme is extensive, there are some distinct elements that could be taken forward immediately. It is suggested that **the following projects are implemented immediately**:

1. Provide an 'any door is the right door' service into Ilfracombe's health & wellbeing services to enable a joined-up approach with care and support co-ordinated across organisational boundaries and people only need to tell their story once
2. Create a multi-sector early support system that builds resilience and allows support for individuals to be triggered earlier to deliver the best outcomes

Move into Action – April 15
Project 1: Any Door is the Right Door

Move into action. Communicate with staff to explain the new process. Agree leadership by committed sponsor groups.

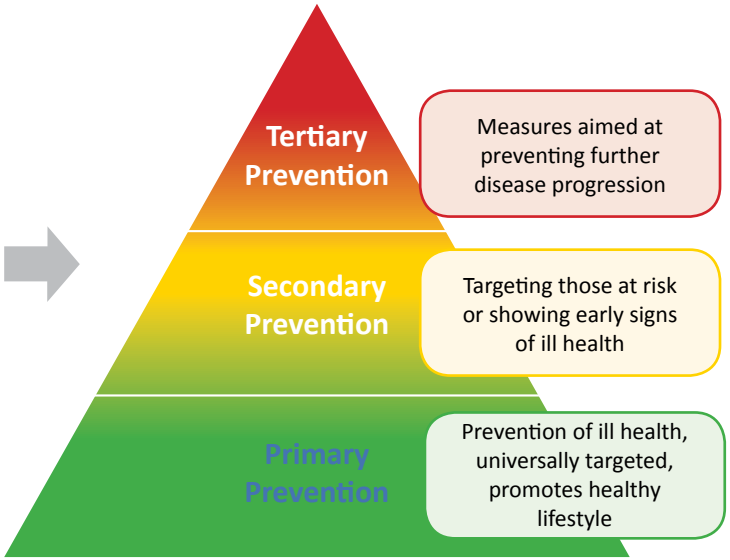
Appoint project team of around 5-10 people. Create powerful case for change. Who would be the most fantastic mix of people across the usual boundaries to involve and agree big impact changes? Arrange LiA conversation and focus on what can be done in the next 12 weeks. Ensure customer experience is measured and progress reported to the LWT team.

See **Any Door is the Right Door** doc
To be agreed at April LWT meeting

Project 2: Multi-sector early support system

More targeted engagement with service users is needed to understand at where we are currently missing opportunities to provide earlier support and whether they believe they would achieve better outcomes if this was provided.

REDUCING ESCALATION AND PREVENTING CRISIS



Define – Mar 15

2a. Agree focus areas/target groups

Partners identify risk factors for escalation/crisis

Agree from this which are the **most common risk factors** that would benefit from a multi-agency, multi-sector approach.

Discover – May 15

3. Map existing approach for focus areas/target groups identified

Who does what now and how?

Mapping template to be completed for chosen service areas.

Discover – May 15

3. Identify issues and failings in the system for the focus areas/target groups identified

Engage with customers to:

Understand how well the system currently works for them

Understand when it is that support could be provided to prevent a situation arising/worsening

Understand what success looks like to them

Understand the barriers and enablers to achieving this

Discover – May 15

3. Understand how money currently flows around the system for the focus areas/target groups identified

Use One Ilfracombe's Virtual Bank to understand the money flow

Move into Action – Jul 15

Agree project team

Create powerful case for change

Focus on what can be done in 12 week cycles

Arrange LiA conversation