Better Care Fund Plan 2023/25
Devon Health & Wellbeing Board (Devon County Council footprint)

Bodies involved strategically and operationally in preparing the plan

The Devon Integrated Care System (ICS) – *Community First Strategic Framework* outlines how One Devon (the collective of voluntary sector and care and health services), work together to provide the best opportunity for effective community service delivery. This aims to meet our citizen's needs, to maintain independence, to manage their long-term health conditions, to support them during a crisis where additional support of care and/or health services may be required and to provide the care they need as and when their health deteriorates.

Multiple organisations and local citizens helped to develop the framework which reflects the holistic, multi-organisational collaborative approach we wish to replicate in the future development of our community services. This strategic framework acts as the backbone for building stronger effective partnership working across our voluntary sector, local authority and NHS partners.

Key contributors to our *Devon Community First Strategic Framework* included:

> Devon County Council, Torbay Council, Plymouth City Council, NHS Devon Integrated Care Board, Royal Devon University Healthcare NHS Foundation Trust, Torbay and South Devon NHS Foundation Trust, Livewell Southwest, The Devon Primary Care Committee, Devon Partnership Trust, University Hospitals Plymouth, Devon Voluntary Community Social Enterprise Reference Group, The Mental Health and Learning Disability and Autism Provider Collaborative, North Devon Local Care Partnership Delivery group and Executive group, East Devon Local Care Partnership Delivery group and Executive group, South Devon Local Care Partnership Delivery group and Executive group, West Devon Local Care Partnership Delivery group and Executive group, Plymouth Devon Local Care Partnership Delivery group and Executive group, Devon ICS End of Life Care group, The Devon Virtual Voices Panel and University of Plymouth.

This list is not exhaustive and acts as only an indication of the wide range of organisation, groups and committees supportive of the development of this area.

How we have gone about involving stakeholders

For the development of the BCF 2023/5 plan, a BCF business group, with engagement with a range of key stakeholders including local authority and NHS colleagues, have met regularly to understand the planning requirements, to be responsive to direction from the BCF Leadership Group and coordinate the narrative and supporting template responses required.

This process has ensured involvement and both direct and indirect representation from the various stakeholders highlighted above, supporting the *One Devon ICS - Community First Strategic Framework*.

Stakeholders have been involved in the development and adoption of the *One Devon ICS Community First Strategy*. They have been engaged through a series of meetings developing the draft plan and its final adoption. Engagement meetings in each locality via the Local Care Partnership structure have taken place with representation from primary, community, acute, mental health, local authority and VCSE organisations; and focus groups have taken place to ensure public representation. The feedback from the engagement meetings has been reviewed and considered for inclusion within the strategy.

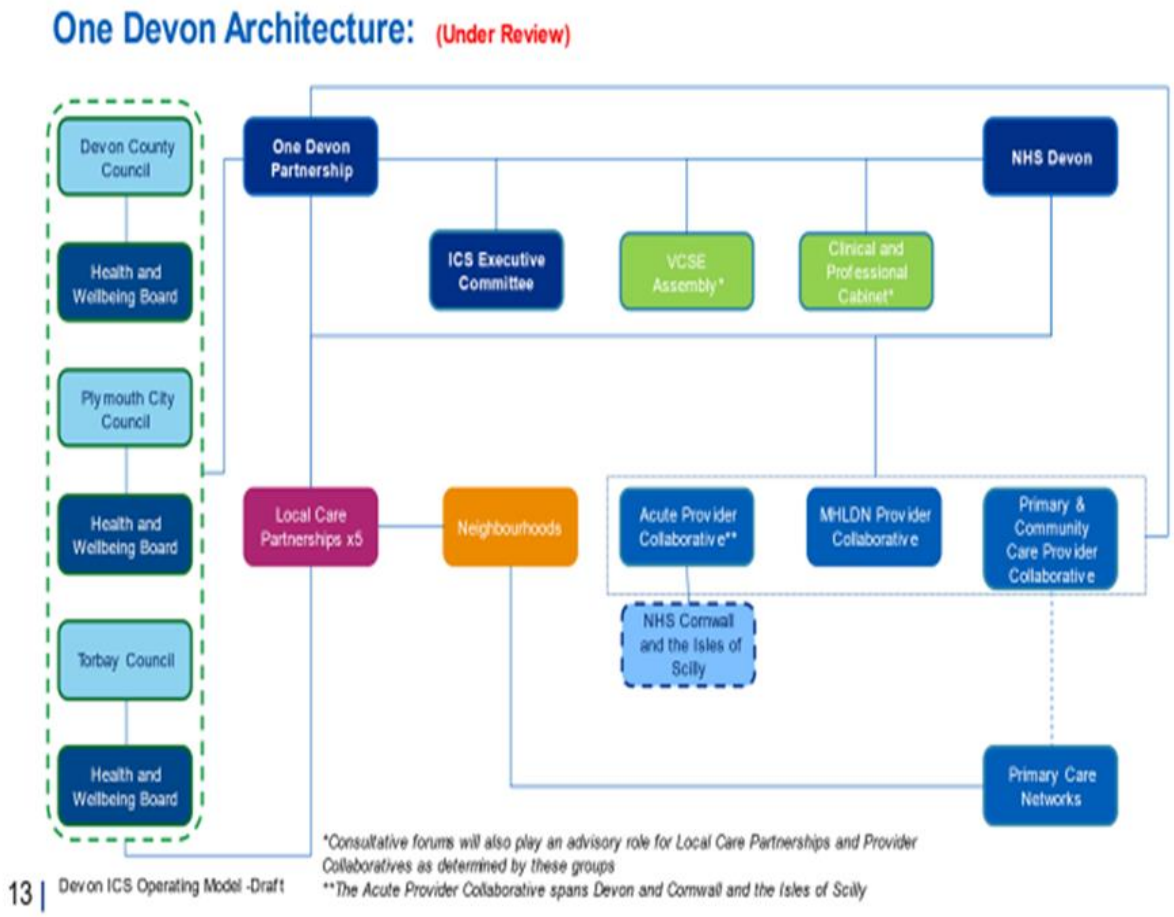
These local care partnerships now provide valuable insight into opportunities and challenges at place level. With wide local representation are well placed to support the delivery of the Community First framework against the key local priorities.

Local partner organisations are already integrated as a delivery arm for services across acute and community health and social care and through feedback from our ICS System discharge and flow meetings, we have engaged with acute and community colleagues in the design and monitoring of our BCF planning metrics and via the System Delivery and Improvements Group, where provider Trusts are represented at Chief Operation Officer level.

The Devon Health and Wellbeing Board receive quarterly reports regarding the BCF including performance against the national metrics, rationale for planned spend; and examples of BCF investment and the impact that has had at service level.

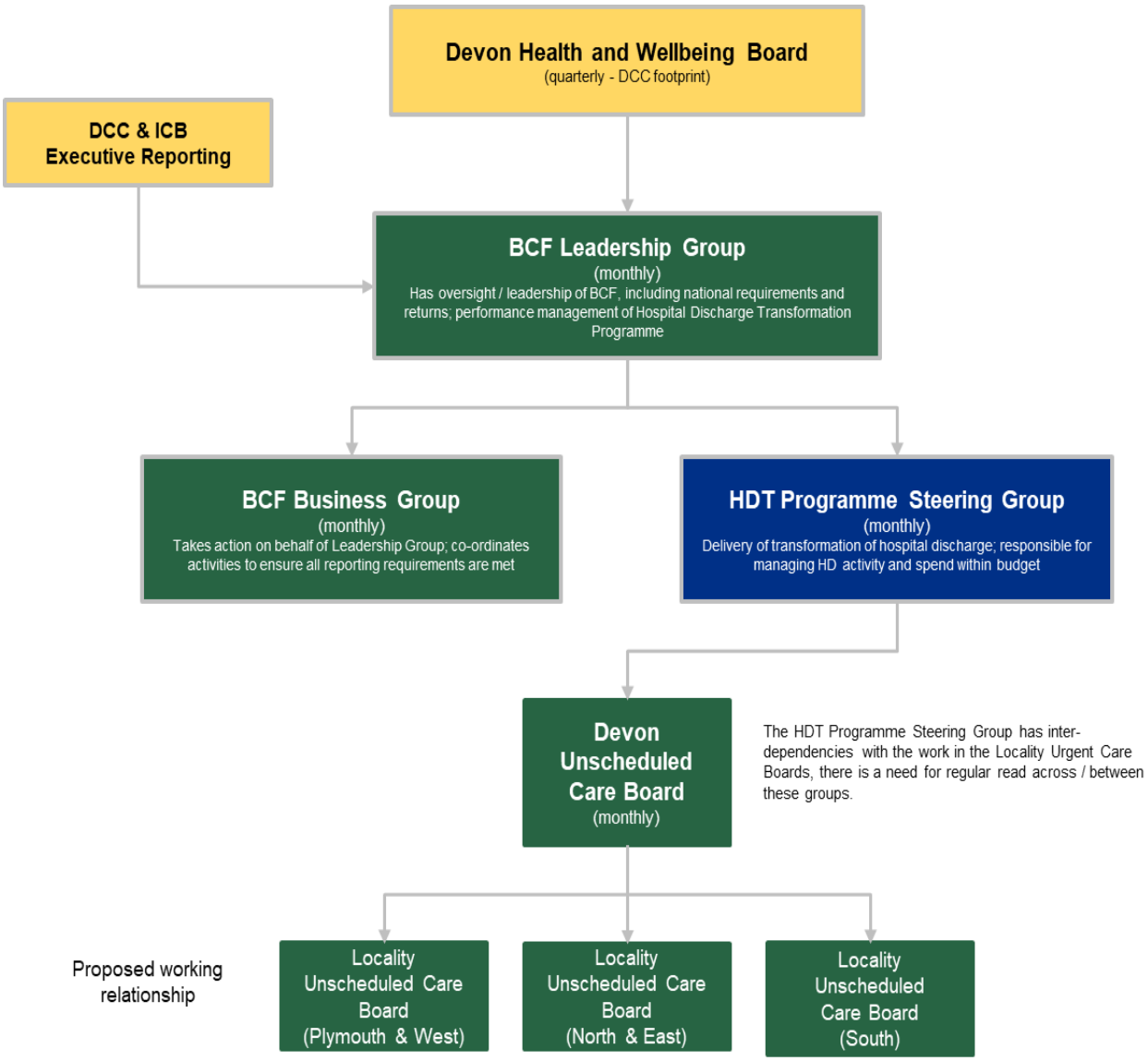
Governance of the BCF

There are five established local care partnerships (LCPs) that when combined, form the whole of the One Devon Integrated Care System, as shown below in the One Devon Architecture. Four of these are within the Devon Health & Wellbeing Board footprint.



The governance arrangements for Devon's Better Care Fund (DCC footprint) are being revised, as shown below, with the BCF Business Group and the Hospital Discharge Transformation (HDT) Programme Steering Group directly linked and reporting to the BCF Leadership Group.

In addition, the HDT programme will report to the Devon Unscheduled Care Board with strong working relationships with each localities unscheduled care boards.



N.B. Plymouth not covered by the Devon Health & Wellbeing Board

Executive Summary

Devon has a strong history of integrated working and can be proud of the many benefits that this brings to residents, our services and the ICS.

Several of our community services are now being provided by, or in partnership with, local acute trusts bringing many benefits to people, services, and the system. The establishment of the Integrated Care Partnership in Western Devon is an excellent example of our organisations working in more integrated ways towards common goals. Benefits from integration that we are now seeing include, improved collaboration between services, the opportunities for the standardisation of pathways across different sectors, and development of new ways of working for our collaborative workforce and importantly delivering better continuity of care for our local population.

In the coming months we will continue our journey of development as an ICS and within our Local Care Partnerships to harness the opportunities that these afford for further integration and partnership working, whilst embedding our overall Devon ICS Strategy and Forward Plan.

The BCF plan will support the *One Devon Joint Forward Plan* and the delivery of the 5-year (2022-27) *One Devon Community First Strategic Framework* and begin to address the inconsistencies in access and availability in our communities, as we learn from them and with them understand what matters and how best the BCF funding stream can meet their needs. A focus of the Community First Strategy is on preventative, proactive and personalised care to support people to live as independently as possible with greater connection to their local community ensuring people spend more time at home, wherever their home may be, rather than in a hospital bed. Community services supported by the BCF funding stream, play a pivotal role in keeping people well and managing acute, physical, and mental health and long-term illness.

A key system priority remains addressing the urgent care and system flow challenges frequently being experienced across the Devon ICS and the impact delayed discharge has on whole system flow, including for others timely access to services they may need. The success of delivering the *Devon Urgent and Emergency Recovery Plans* relies heavily on ensuring the integrated community services supported by the BCF remain responsive to the continued high demand and be able to enhance the support at times of greater pressure or demands across the care pathway. Transformation of these services, focusing initially on hospital discharge, will bring significant improvements to the experience of all those transitioning through our integrated health and social care services. The *Hospital Discharge Transformation Programme Steering Group* leads this, with Chair and Vice-Chair roles and membership from both DCC and ICB. The membership of this group will work in collaborative partnership at a locality and

Devon County Council footprint level and provide oversight and design of a new hospital discharge model in 2023.

The provision within our intermediate care services will look to the national *Intermediate Care Framework* delivery principles (awaiting national publication) to guide transformation, with a clear ambition in supporting individuals to remain independent for longer, recognising as these principles do, the need for local flexibility and innovation to account for local needs. This framework combined with high impact change model and the use of demand modelling using the improving patient flow between acute, community and social care (IPACS) tool, will ensure we establish clear pathways through the patient journey, from ward to exit from intermediate care pathways by, where necessary, the implementation of alternative best practice models of care.

The Devon BCF plan 2023/2025 responds to this with transformation of service provision explicably linked to best practice, available demand and capacity modelling. This reflects local needs and on-the-ground intelligence, that when combined support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways. The aim is to reduce pressure on urgent care through services that enable people to stay well, safe and independent at home for longer.

Our ambition is to ensure community services, including the voluntary sector, are recognised as being integral to our system response, with well thought out planning regarding the steps needed to achieve the vision, co-production of services with our system stakeholders and local communities, and in ensuring that they are funded to sustain delivery and outcomes in the longer term.

We will continue to build on our achievements to date and are now in a unique position to be able to understand and evaluate the different models of integration and to share learning about what works well in being able to meet the needs of the local population, by focussing on care outside of the hospital setting.

We also recognise the importance for us as a Devon ICS to be able to demonstrate the financial benefits of integrated working and how this model supports the flow of activity away from the hospital and crisis-management services, and supports funding out into the community, to create a more robust and resilient offer.

The work supported in the various BCF schemes will enhance both integration and partnership working and with it all the benefits that brings, whilst also building resilience for future on-going delivery of excellence across Devon.

National condition 1: Overall BCF Plan and approach to integration

As with previous years, the BCF for 2023/5 has been developed jointly by DCC and NHS Devon colleagues and will continue to facilitate collaborative working across partners and stakeholders within the Devon ICB – DCC footprint. This mirrors the collaboration seen in developing the *One Devon 5-year Joint Forward Plan* (due for publication July 2023.)

BCF delivery enables integration across partners within services that adds value by joint delivery, integration of workforce/teams, development and delivery of joint strategies and delivery plans, and joint commissioning. This will be strongly seen in this BCF cycle with the hospital discharge transformation by partners from both the DCC and ICB leading on identified workstreams.

Other examples of collaboration and integrated approaches include:

- Joint strategies development and delivery by integrated teams from partners including carers; mental health; older people with mental health needs; learning disabilities; children and young people; older people with physical disabilities.

- Joint delivery arrangements between the local authority and health providers including services focus on complex care teams to support people when they are most vulnerable and working closely with primary care using a strength-based approach. These are multi-disciplinary teams that focus on the frailest and most vulnerable, identified by risk stratification, with care coordinated around the individual. These services have been developed in local "place" and are designed to support people to remain safe, well and independent at home, as part of our collective home first approach.

- Jointly commissioned services: examples: Integrated Children's Services; the Community Equipment Service; Personal Care; dementia support workers; Rapid Response teams; and Social Care Reablement service.

- Partnership engagement – risk sharing: examples: collaboration and engagement between Devon County Council and eight district councils, in relation to delivery and planning for Extra Care and other housing developments, Disabled Facilities Grants and Planning.

Launched last year, the Devon Community First Strategy 2022-27 sets out our five-year ambition to be commission and deliver community services that:

1. Have adequate investment and are commissioned for outcomes that are important to the people using our services, utilising data to build a deeper understanding of the value being delivered rather than solely guiding the decision making.

2. Encourage and enable people to be an active participant in their health and care when they are well, and equipping them with the skills, knowledge, technology, and confidence to better self-manage when they are unwell, so they can live well for as long as possible on their own terms, promoting People Led Change.

3. Deliver person-centred, coordinated care that focuses on people's strengths and what matters to them.

4. Improve integration of the workforce to enable greater collaborative working across organisational boundaries, the sharing of data across multiple systems via linked records and moving towards single records and plans of care, that people can access and contribute to.

5. Build community capacity at neighbourhood level, informed by local needs so people have better access to the responsive services they require, closer to home and at the time they need them.

6. Provide proactive, reliable, resilient, safe, and sustainable community services that support people to stay in their usual place of residence or stay there for as long as possible, avoiding unnecessary hospital admissions and accelerating discharges after an acute stay.

The *One Devon - Healthy Aging Commissioning Handbook* developed locally, sets out evidence and pragmatic guidance in the form of a toolkit for local care partnerships to support the design of their strategic plan for supporting older people, with a population health focus that is adapted to local need. This is being worked through at locality level to best understand the population and its needs being able to focus resources where most needed and to narrow the inequality gaps identified.

In addition, our services will be looking to the Intermediate Care Framework delivery principles (awaiting national publication) to guide transformation with a clear ambition in supporting individuals to remain independent for longer, recognising as these principles do, the need for local flexibility and innovation to account for local needs. This transformation will be key to ensuring sustainability within our hospital discharge offer, including discharge-2-assess and establishing a locality appropriate model for a home first model of service delivery and best practice, to ensure most efficient use of resources available.

The *Devon Acute 100-day discharge challenge* ten interventions continue to be monitored and reported, with steady improvements being seen in all domains. It is recognised that further improvements are required and this BCF cycle provides the opportunity to place additional focus on the “revision of intermediate care strategies to optimise recovery and rehabilitation” domain.

The *Hospital Discharge Transformation Programme* will seek to address the significant challenges currently being experienced across all the Devon acute sites with daily patient flow. The identified workstreams will provide an end-to-end review of past and current performance for all pathways 1-3, which is then used to inform future needs for which modelling can be applied and then implemented, through transformation of hospital discharge, home first - discharge to assess, short-term intermediate care service delivery and care-home market sustainability.

It is critical that our system establishes a financially sustainable model that fulfils future demand. The ultimate impact of this will evolve, with the tangible outcomes including:

- Clarity on service capacity, performance and utilisation
- Development of “right” size to meet expected future demand (this could be for bedded capacity or supporting services)
- Provision and delivery based on evidence based best-model modelling
- Agreed joint commissioning responsibilities / ownership.

National condition 2: Enabling people to stay well, safe and independent at home for longer

Integral to our *One Devon Joint Forward Plan* is primary and community care integration, with our vision and ambition to deliver an integrated model of care to support all people at home (includes prevention, anticipatory care, whole life course, and best practice pathways). In addition, we have the commitment to deliver the required recovery of the Urgent and Emergency Care position.

The integrated model of care described in the Devon GP strategic framework (2022), aligns with the output of the Fuller Stocktake, which focusses on the development of integrated multi-disciplinary neighbourhood teams at place. Our Community Care comprises of all our community health and social care services and voluntary sector and community organisations as contributory partners in integration.

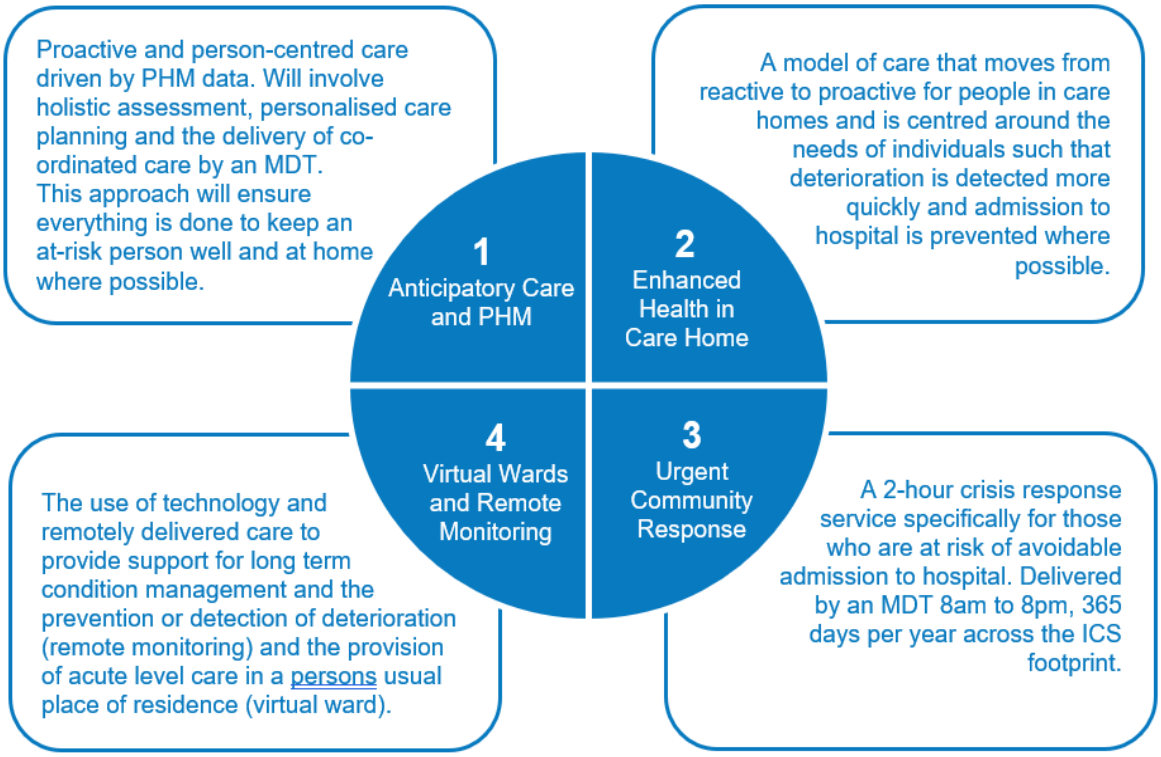
At local level our *Devon Community First Strategy* describes the aims of building community capacity at a neighbourhood level, focussing on proactive, reliable, resilient, safe and sustainable community services. One of our objectives, that forms part of the forward plan, is to have a primary and community collaborative across Devon that will enable further integration across social care, mental health and VCSE organisations, by designing a model which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes.

The ten components of our *Devon Community First Strategy* follow the ten areas of our *Integrated Care framework* which describes our approach to deliver truly integrated care in community services.

The strategy itself forms the first component of the map, by which we will realise our vision and deliver integrated care across the Devon ICS, as shown below.

As the BCF is an integral enabler to this vision, investment continues to be particularly focused on the discharge to assess model that is adaptable and builds resilience at “place”, ensuring more and the most appropriate use of capacity for all the integrated community-based health, social care, and mental health services.

A key priority for all services is the driving ambition for care closer to home, supported by timely discharge and enhanced by virtual wards support. Our community approach seeks to support keeping people at home, wherever that may be and importantly when safe to do so. The four guiding components of this approach are summarized below.



These four components promote our ambition of delivering proactive care, supported by population health data collation and analysis from our One Devon data set, to deliver care closer to home that meets the needs of the local population.

We recognise that crisis does occur, we must equip our services and workforce with the support and expertise needed for the safe delivery of all care and will be increasingly doing so, supported by digital solutions to enhance the care, monitoring and safety of those in our care. An example of this is the piloting of a 24/7 nurse-led remote consultation service for care homes, to seek timely support and advice for their residents.

By reviewing the changing demand for and capacity within our existing services, several elements have been identified with related programmes and projects, including those shown below:

Element	Actions	Enablers
Understanding demand and supply	• Understand projected need • Market availability, supply of care home support and care home beds • Admission avoidance • Community reablement • Capacity and case management	• Population health management • UCR 2-hour response and 2-day support • Anticipatory care • Virtual wards
Improvements in discharge practice	• Transfer of care quality improvement group • Trusted assessor roles • Locality improvement plans	• Population health management • UCR 2-hour response and 2-day support • Anticipatory care • Virtual wards
Capacity Creation	• Market engagement and development • Market rates • Block purchase / commissioning arrangements	• Personal health budgets • Complex care market development • Enhanced health in care homes • Pathway 2 – short-term bed configuration
Discharge 2 Assess model	• Clear performance measures • Consistent process application across ICS	• Strategic Discharge 2 Assess review

BCF planning has included key partners from across DCC and the respective localities. Most significantly, the BCF investment across the DCC footprint supports and secures on-going provision for social care and maintains this capacity together with integrated multi-agency community teams, made up of community nurses, social care and therapy professionals. BCF funding also helps secure community support contracts with VCSE, support for dementia cafes, learning disability review teams and mental health out of area placements across the county. In addition, at locality level, BCF funding supports many additional roles, linked to the improvement and coordination of out-of-hospital services, such as a rapid response and reablement service in Northern locality, the Care Service team in Southern and Eastern localities and home-based intermediate care roles in Western locality.

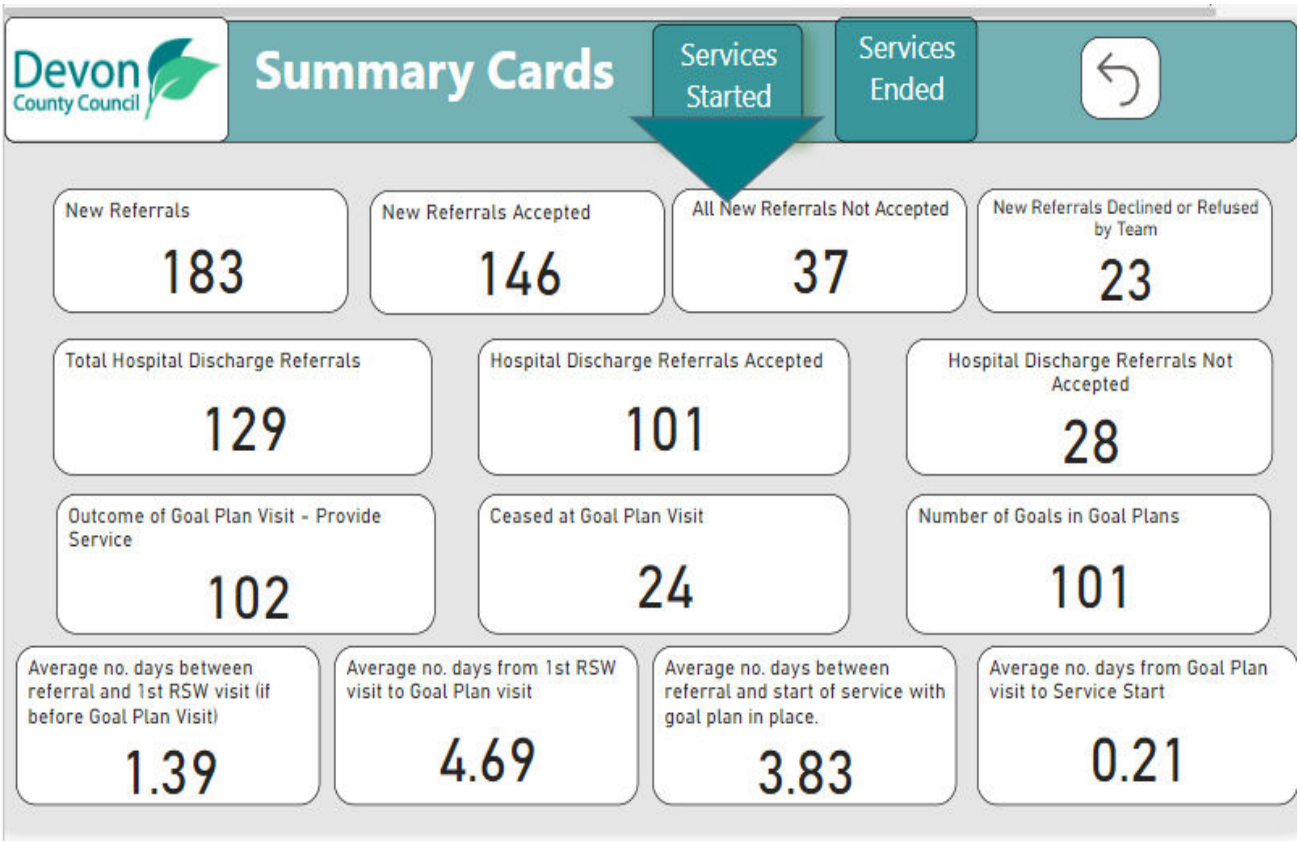
We have used learning from last year's referral rates, demand, activity and unfolding trends, to provide estimates for future demand and capacity needs within our community care services. We recognise there is an inconsistency in data recording and therefore data quality, which limits our ability to forecast details of expected community reablement demand and capacity. As there is no statutory

requirement to record these data fields and without substantiated data/evidence, we base our forecast on the known data, recognising that this will understate the Devon position.

The chart below shows data as of the end of April 2023, headlines include:

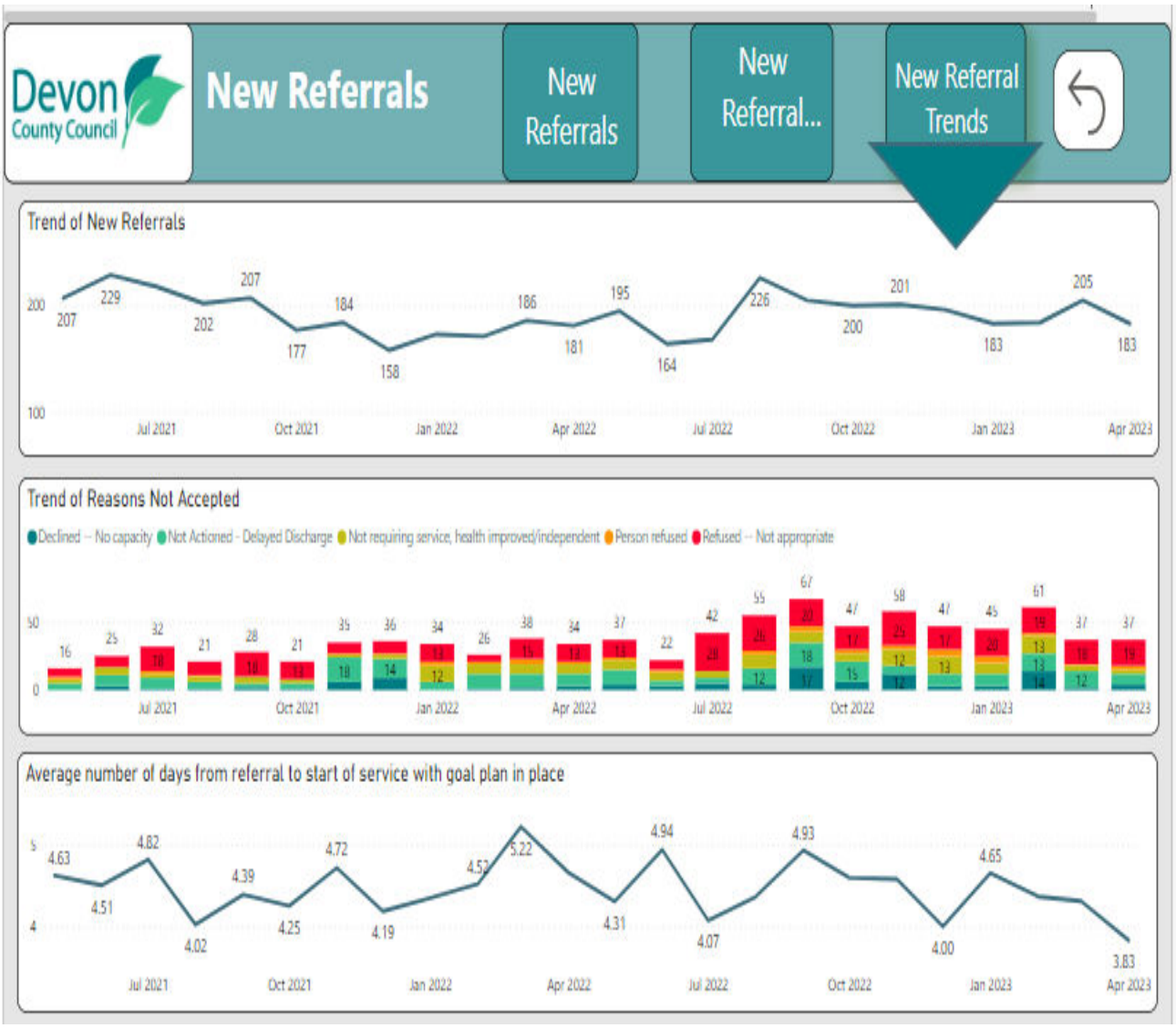
- 183 new referrals to Social Care Reablement Service, of which 146 (78%) were accepted.
- Most new referrals are because of hospital discharge 129 (70.5%).
- Of the 129 hospital discharge new referrals received, 101 (78%) were accepted.

(Note due to inconsistency of recording across localities this data is understated)



With regards to new referrals received, the trend over time is at best variable, typically between 180-200 new referrals per month of which hospital discharge is the main source.

Capacity is also variable, depending on requirements to put backfill arrangements in place for unfulfilled community care packages.

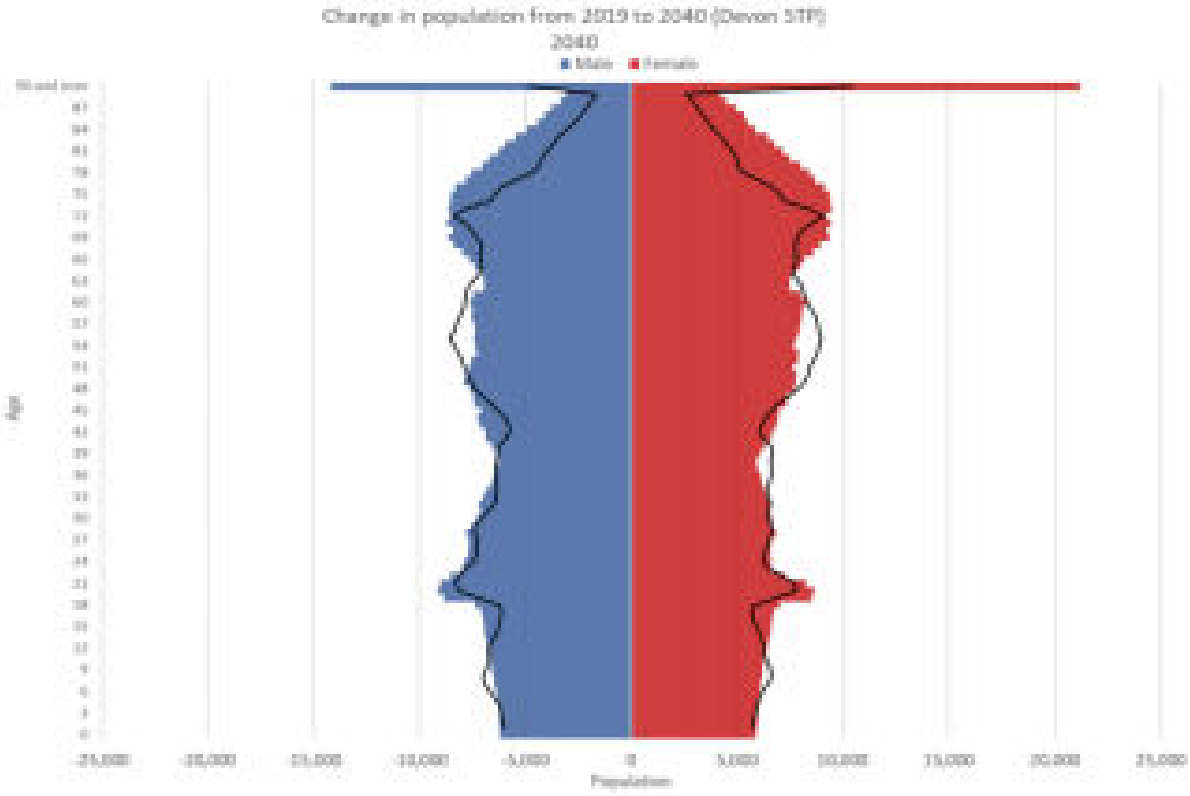


The Hospital Discharge Transformation Programme aims to reduce delayed discharges for those patients via pathways 1,2 and 3, through transformation of out-of-hospital services, whilst working in tandem to optimise in-hospital processes and practice, to see a reduction in all pathway length of stay. These services will be augmented by ensuring join-up with the wider local community support networks through roles such as community flow coordination, to optimise a person's independence and integration with their local community network of informal support.

National Condition 3: Provide the right care in the right place at the right time

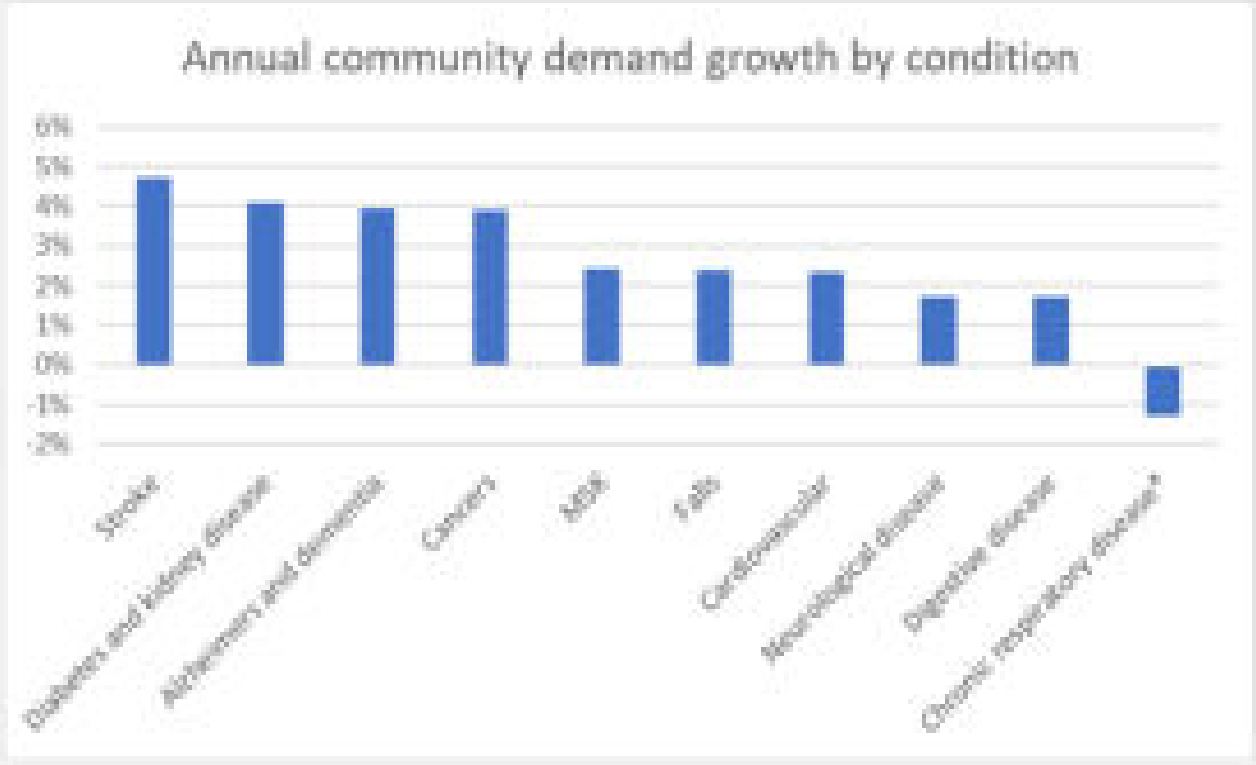
The demand modelling used to inform the *One Devon Community First Strategy* shows a predicted annual growth across the sectors of our health and care system, over the next ten years. Overall annual growth, which includes population and disease prevalence growth plus other non-demographic demand (for instance demand growth linked to new developments and public expectation), will average 2.9% over the next decade from 2022.

The growth in community services is disproportionately impacted by our ageing population, and the increase in people living with multiple comorbidities. The diagram below shows that overall, Devon has an aging population with predicted significant growth expected (diagram shows from 2019 (black line) to 2040 (shaded areas)) within the next 20 years.



Whilst life expectancy may have plateaued, the overall gap in life expectancy and healthy life expectancy has increased, meaning more people are and will be living in poorer health. In addition, because of an aging population, there is an increased number of people living with multiple co-morbidities.

The expected growth in demand in Devon for community services due to an aging population, is expected primarily in those conditions associated with increasing age and is anticipated to include increased growth of those with stroke, Alzheimer's & dementia, cancers, musculoskeletal presentations including pain associated with osteo-arthritis, falls and cardio-vascular disease conditions. As a result, the modelling indicates the following growth in demand for community services for many of these conditions associated with older age, with six of these conditions anticipating at least a 2% increase in demand.



In autumn 2022, the Devon ICS undertook a demand and capacity modelling review of the acute bed base within our main acute hospital providers. For the winter of 2022 alone, there was a general and acute bed deficit of nearing 500 beds. A targeted programme of improvement and transformation is already underway to off-set this deficit, including significantly reducing the number of people with no-medical-criteria-to-reside in our acute hospital bed base.

Community services are recognised as playing a pivotal role in supporting people to stay at home, avoid hospital admissions and return to the community as safely as possible after an hospital stay. The community services funding stream, via the BCF, plays a critical role in the systems target of halving the number of people in our acute hospital beds base, who have no-criteria-to-reside.

Our priorities align with the *High Impact Change Model*. We have adopted the national discharge to assess model across Devon and monitor the delivery of the time to transfer standards daily and, working as a Devon system, to share learning and make improvements where required through our System Flow programme. Through detailed analysis of daily performance, we maintain our focus on pathway 1- 3 discharges.

As part of Urgent and Emergency Care recovery, discharge, length of stay, capacity, and no criteria to reside are stringently monitored. Whilst Devon performs well in comparison with our southwest regional ICBs, we recognise far-reaching improvements are required outside the “usual” considerations for urgent care, to ensure future service and financial sustainability. A focus on arriving at a care market solution is critical, as is developing a workforce model that meets future needs and demand.

Care market business continuity, workforce and market sufficiency are the key challenges that we continue to work with all partners to improve.
The implementation of the 10 standards of the national 100-day challenge for community services, has enabled improvements in our discharge to assess delivery. Each area has taken ownership of delivering their own local plans for addressing; demand reduction for pathways 1-3, efficiencies within each pathway and capacity creation for each discharge pathway.

We have engaged with the care market to listen to their experience of discharge and to act on these, by co-producing a *Transfers of Care Quality Improvement Programme* to improve discharge to care homes. We are using the learning from patient experience and PITCH reports, received through the Patient Safety and Quality Teams, to shape our improvement actions.

Through co-production with the Devon Care Home Collaborative, we are developing a shared workforce plan. Key projects include ‘Proud to Care’, Devon-wide recruitment portal and information hub, ‘LoveCare’- to endorse the need for improved investment in adult social care to reward and value the workforce, securing parity with the NHS and achieving sufficiency in the market.

We continue to focus on supporting early discharge planning, by expanding the reach of the discharge hubs and proactively supporting people home from hospital. This involves improving patient flow through the hospital, further developing a 'one team' approach, driving forward our plans for integration including the voluntary sector, mental health services and the independent sector

and further developing the home first approach and maximising impact from the enhanced health in care homes workstream. This focus is seen in our continued investments in many areas including:

- multi-agency discharge teams
- enhancing our urgent and intermediate care / reablement services to build both capacity and skills
- extending hours of service across the system but particularly in community teams to move towards embedding a 7-day service and avoid peak admission and discharge times,
- increasing the scope and availability of residential and nursing care placements through discretional purchase of beds to increase capacity
- building on the skills of staff within care homes but also investing in the support we wrap around through such things as enhanced therapy support and proactively targeting primary care support to the sector
- extending the capacity of trusted assessors
- building the scope and reach of our community equipment and telecare and assistive technology opportunities.
- Partnership and investment in the VCSE to support admission avoidance and to facilitate discharge.

These multi-agency services also play a vital role in our hospital admission avoidance offer, including the provision of urgent response services at times of crisis, which are anticipated to support those with chronic ambulatory care sensitive conditions to be safely managed and supported in a community space and wherever possible in their own residence.

Established Care Home support teams working closely with the primary care offer from the Enhanced Health in Care Home multi-disciplinary teams service, ensure care homes are supported both with proactive care and crisis support when needed. Further support, from a pilot to be expanded to sixty care homes across Devon with a 24/7 nurse-led virtual consultation, aims to support the triage and safe, timely allocation of appropriate resources and will see care homes working closely with the wrap-around community services, with greater in-hours planning to support reduced in-hours duplication and out-of-hours activity.

Additional equipment to aid care homes to manage residents following a fall, is being rolled-out to fill identified gaps in access to raiser equipment. The coordination and/or communication of the various projects and programmes set up to support care homes, is considered essential to make best use of our valuable resources and minimise duplication.

We recognise that the increasing unit cost of equipment will need to be resourced through the BCF, and that we will continue to monitor this expenditure across the Devon footprint. However, we also recognise and will continue to support, the role

equipment and tech can play in supporting individuals to remain within their own home and its importance in minimising demand, especially for long term residential placements.

The iBCF and Better Care Fund allocation within the Devon Health and Wellbeing Board, has been invested to ensure the duties of the Care Act are further enhanced. Investment has been targeted to support the further escalation and prevention of long term health and social care needs. The integrated teams are geographically arranged to provide holistic support with primary care services and are closely aligned to primary care networks and local VCSE services. At the heart of this approach is person centred care and support planning, which enables proactive care and support to be put in to place and to sign post to approach agencies.

This integrated approach also addresses the needs of clients who require an urgent community response to:

1. Avoid admission to hospital
2. Enable swift step down from hospital and support the individual with community rehabilitation services, thus ensuring the longer-term recovery in the community.

A key focus of the Care Act is to ensure an appropriate provider market is sourced to meet the needs of the population. Investment has been made within accommodation based care and support and residential care providers. Investment has been made in areas of need, to guarantee a range of community-based provision is available to meet individual need. These providers work seamlessly with community based integrated teams.

Supporting Unpaid carers

BCF funding for carers is pooled with the Devon County Council's contribution to the Carers Strategic Budget. This pooled budget is £3.886 million, held within the Better Care Fund.

The largest item of expenditure is the Caring Well in Devon (CWiD) contract at £2.258 million.

The core contract covers information, advice, awareness work, the development of peer and community support for carers, delivery of direct support, training, delivery of Carer Passports and Contingency Planning, and the delivery of "Carer Support Management" (CSM), the Care Act statutory duties delegated to "Devon Carers" through the contract.

Carer direct payments are generated through the CSM service and administered by Devon County Council (in 2022/3 these were £141k and a similar sum is anticipated for 2023/24).

The CWiD contract has also been varied to provide:

- Administration of an enhanced Breaks fund which last year (2022/3) provided targeted Breaks payments of more than £324k to carers, recognising the impact of Covid 19. This is expected to be £200k+ in 2023/4.

- Provision of a volunteer provided sitting scheme, to extend opportunities for carers to take short breaks from caring.

- The delivery of our HSJ Award-winning Carers Hospital scheme, preventing admissions at the hospital front door and facilitating discharges in all four acute hospitals and related community hospitals. This is the subject of an additional allocation from the BCF of £820.7k. The evidence submitted for the Award is shows effectiveness and impact including:

    - Between April 2020 and December 2021 over 4,000 carers would simply not have been recognised, and would have gone without support, until another crisis

    - The service identifies carers early in their caring journey, protects their health and wellbeing and effectively meets and de-escalates needs.

    - Without this service around 1,000 carers a year would be facing a discharge on Pathway 0 with no support, and at the point of or in actual crisis, including suicide attempts.

- The Scheme now has capacity of 450 cases per month and regularly exceeds this.

In addition to the CWiD contract, the pooled budget provides funds to children and families for a support service to Young Carers (£250k, with an agreed uplift of £12k this year), transfers to Adult Care and Health in respect of Care Act duties (£537k), a Carers Employment Advice and Support service (£46.7k) and smaller items such as Carer access to the HOPE scheme (Help Overcoming Problems Effectively), access to IT for Carers and funding Carer Passports (NHS LTP).

Impact 2022/23 - Highlights

The Carers' Service ("Devon Carers")

- Supported 26,917 carers, of whom 6070 were new to the service.
- Achieved quarter on quarter growth in users of webpages (10286 in Q4), developing more significant community and employer support for carers signing up the first Carer Friendly Towns, and gaining increasing traction with employers (having signed up John Lewis and the Devon Partnership NHS Trust, with a further 8 employers in the final quarter alone)
- Assisted 2313 carers through facilitation of Peer Support
- Administered breaks for 1744 carers
- Answered 13,354 calls from carers, handled around 1,300 email contacts and 1,640 webchats.
- Provided training to 324 carers
- Issued 6070 Carer Passports
- Completed 3871 carer assessments/reviews, of which 2714 were new assessments.

This is only a snapshot of the service which provides a rich mix of services including training to professionals, Carer Alert Cards, Contingency Planning and support to locality integrated planning.

The pooled budget also supports the recruitment, support and facilitation of our Carer Ambassador Scheme. Carer Ambassadors are our strategic volunteers who facilitate two-way communication with wider groups of carers and are active collaborators in co-production, including co-production of the CA scheme. There are currently 79 active Carer Ambassadors.

The Carer Ambassador role is a broad one and individual CA's fulfil it by different means, according to their skills interests and situations. These means range from influencing policy and development, up to national level, to local informal carer support and identification. Some CA's have negotiated useful links with Primary Care locally. However, the integration of the carers' perspective and agenda in LCP's and PCN's is still in a very developmental phase, with some moving faster than others. This is a priority for development for our Joint Programme, the ICB, the commissioned Carers Support Service (Devon Carers) and for the cohort of CA's, with CA's both pushing for opportunities and taking them up as they arise.

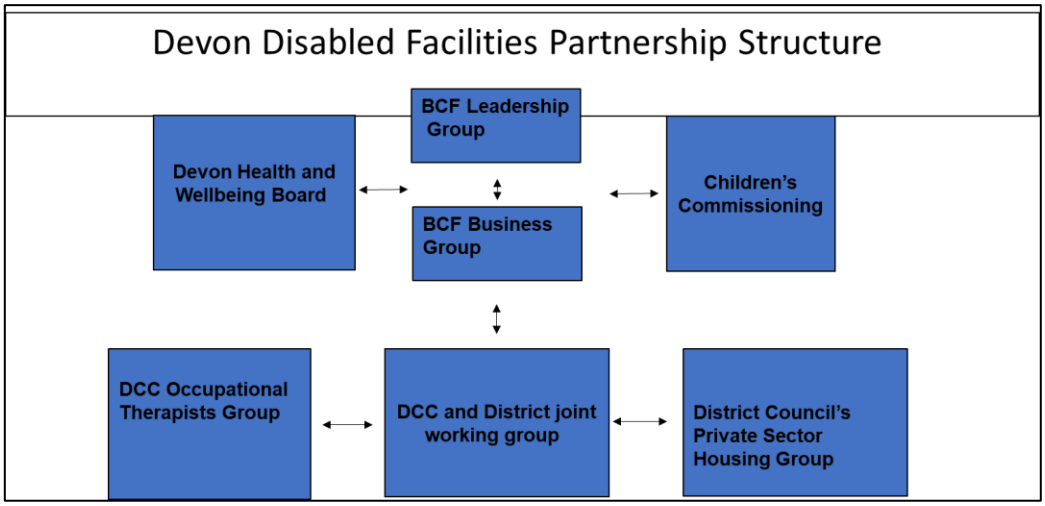
The impact of this service for carers is regularly monitored, including through movement on a locally co-produced Carer Outcomes Wheel which has been in use for some years and is a core part of the local Protocol for Carer Assessments (Carer Health and Wellbeing Checks).

Our latest report of impact on outcomes of Carer Support Management, shows improvements in some areas when measured against the Carer Outcomes Wheel, though the continuing impact of the Pandemic, the shortage of replacement care and the cost of living problems, as well as the local issue we are working to better understand and counter of carer social isolation and loneliness, means the positive impact is not as strong as before the Pandemic. The service is also monitored for inclusion and for reach into the most deprived and most isolated areas and are positive and improving on all measures. 1447 carers known identify as non-white (7.3%). 623 statements of appreciation were received.

Disabled Facilities Grant (DFG) and wider services

Governance of Devon's DFG

Devon's DFG delivery arrangements are driven by a Housing, Health and Social Care partnership that reports directly into BCF Leadership Group, and that liaises as needed with our Health and Wellbeing Board and Children's Commissioning Group.



The development of DFG proposals and plans (including this plan) is led by a DCC and District joint working group. The group is supported by DCC's management information systems, to input performance and budget data into a shared on-line tool that supports joint planning and budget allocation. For the 2023/24 year ahead, Devon has scheduled in a series of County (Health and Social Care) and District (8 Housing Authorities) partnership meetings which agree how the DFG is allocated, and to model options for how these resources could be reprioritised either during the 2023/24 or 2024/25.

For the year ahead, agreement has already been reached on two features:

1. Last year's district council underspends are pooled at year end, and re-allocation happens against a formula based on the previous year's actual spend in each district. This means that for 2023/24, each housing authority will have the greatest opportunity of meeting all the needs in their area in the timeliest way possible and that access to housing assistance will be as fair as possible.

2. Devon County Council will continue to top slice £312k from the DFG that will be allocated to districts. This will be used to deliver modular ramps, through our countywide Community Equipment contract, thereby providing advantage in timeliness and cost.

With the Government allocation for 2023/24 having been set at the same level as 2022/23, Devon's projections for numbers of people supported and use of the DFG have been modelled against last year's position:

DFG and RRO Activity	Total people supported 2022/23	Projected Spend	Projected % of budget
Mandatory DFG	627	£4,527,314.00	54.9%
Stairlifts	479	£2,418,183.76	29.3%
Ecoflex	94	£201,570.00	2.4%
Moving fund	6	£27,048.00	0.3%
Safety applications	80	£226,552.00	2.7%
Hoarding/dementia approved	9	£14,255.00	0.2%
DCC top slice modular ramps	43	£312,000.00	3.8%
Top up funding	N/A	£518,448.24	6.3%
Total	**1338**	**£8,245,371.00**	**100.0%**

The final allocations to individual district councils were agreed in June 2023.

However, the DCC and District Housing working group will take forward our draft shared workplan:

ID	Theme	Next Steps or Aims and Purpose
1	Planning best use of any additional "Next steps to put People at the Heart of Care" DFG funding.	Await further NHSE announcement of grant conditions and develop proposal for allocation and spend. The focus of our thinking will be led by best practice examples for promoting independence at home and we will consider the potential of TECS to help deliver flexible and timely services supporting home from hospital.
2	Reviewing and revising the DFG performance and financial data sets in line with latest Foundations advice and more specific BCF requirements	First work through BCF leadership group to clarify requirements, and then use partnership to look at prevention of admission to residential care, preventing an avoidable admission to the hospital, prevention of slips, trips, and falls, support to allow

		discharge to the usual place of residence, support to re-able and rehabilitate, and counting the number of people helped with assistive technology including telecare and other community-based equipment.
3	Review Housing Assistance Policy Home adaptation grants - MIDDEVON.GOV.UK	Continue the ongoing review and incorporate changes in central Government guidance along with other local improvements as proposals become agreed.
4	To explore options for different levels of DCC top slice	Opportunity to extend scope of modular ramps to get quick and better outcomes for people
5	Reviewing the 'people supported' and use of DFG split across different activities.	The partnership will debate/develop/agree options for prioritising different options, or continuing with historic pattern of use
6.	Reviewing the policies around putting DFG into Lendology The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RR)) allows a portion of DFG funding for discretionary services. Devon's Housing Assistance Policy allows for discretionary services, these have been around 'Lendology' and are detailed within Home adaptation grants - MIDDEVON.GOV.UK 7 of Devon's 8 district councils have drawn down a total of £350,000.	The partnership will debate/develop/agree options for a consistent policy and practice around Lendology – and use that in advising customers

In terms of how Devon's DFG links to the strategic aims of the wider Health, Housing and Social Care aims, the partnership has collaborated on and is led by the following strategic intentions:

Integrated Adult Social Care
Devon's health and social care strategies are underpinned by the principle of promoting independence and supporting people to remain at home for as long as possible. The role of DFG in helping achieve those aims is reflected in our vision for Adult Social Care, published across three strategies: *Living Well in Devon* (for people 18 – 64 years), *Ageing Well in Devon* (65 years and over) and *Caring Well in Devon* (for unpaid carers) at Adult Social Care Vision and Strategies - Have Your Say (devon.gov.uk).

Housing
The wider approach of Devon's public sector partners (health, social care and housing) is set out within DCC's Housing Strategy at https://www.devon.gov.uk/care-and-health/document/a-joint-strategic-approach-to-supporting-people-to-live-independently-in-devon-2020-to-2025/

This sets out how we work in partnership to drive the delivery of care, health and wellbeing in communities across Devon so that people feel safe, healthy, connected, able to help themselves and each other. The strategy reflects that care and support needs change over time and so might the housing and accommodation they choose to help live as independently as possible.

Regular Housing Forums with each of the eight district councils enable connection with planning and housing leads and links with the Housing Commission. These arrangements are informed by evidence from needs assessments for each district council area.

The Housing Assistance Policy
Home adaptation grants - MIDDEVON.GOV.UK is an important delivery tool for this strategy. This policy sets out the areas on which Devon's partners will focus the available resources to improve housing conditions, and how the different grants available will be fairly and efficiently managed to mitigate hazards in the home and avoid unnecessary injuries, episodes of ill-health, and harm to mental health. The policy reflects the Better Care Fund priorities that aim to achieve the following outcomes:

- Reduced admissions to residential and nursing care homes
- Reduce delayed transfers of care
- Reduce avoidable emergency admissions
- Increase dementia diagnosis rates

Devon's *Housing Assistance Policy* covers the full range of grants available to people and is supported by accessible web pages for the public on each organisation's own websites. During the 2023 year we intend to develop a more accessible summary of *Devon's Housing Assistance Policy*, as part of our workforce training tools.

Equality and Health inequalities

The One Devon ICS partners all play leading role in tackling health inequalities, through building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Health inequalities and how to address these across Devon have featured highly in the development of the Joint Forward Plan including the *One Devon Primary Care* and *Community First* strategies and the People Led Change publications. CORE20Plus5 remains the focus of NHS Devon's combined health inequalities and prevention plan and continues to strengthen leadership and system-wide awareness of health inequalities through a range of activities. For example: the national piloting of the CORE20PLUS5 Connectors model is now delivering regular drop-in café style services and have developed a bespoke drop-in service for podiatry for our homeless population, in response to priorities voiced by our local population.

As our Local Care Partnerships develop, we continue with support and investment ensuring population health is embedded in all local programmes in support of a local place-based model, that narrows the health inequality gaps for Devons population.

Embedding Health Inequalities across the Devon system is being delivered through several actions, including:

- Working closely with our workforce development programme, NHS Devon will deploy Health Inequalities awareness to all staff. This will ensure the workforce:
  - Have a collective understanding of what health inequalities are, and how they can affect the population of Devon.
  - Are more confident in asking individuals to share personal information about themselves that will assist us in ensuring that factors such as where they live, their ethnic background and other characteristics are not resulting in unacceptable differences in access, experience and outcome.
  - Are confident in identifying health inequalities.
  - Are confident in taking positive action to tackle any identified health inequalities experienced by the people they meet.

- We continue working closely with our colleagues in Communications & Engagement NHS Devon to raise awareness of health inequalities within our population. This will support our population to feel safe and confident to share information about themselves.

- In 2022/23 NHS Devon revised the Quality and Equality Impact Assessment (QEIA) and is now integral in ensuring health inequalities consideration is fully considered in all proposals for change. This refreshed

tool will ensure inequalities from the perspectives of those affected by them are mitigated through co-design with the relevant inclusion health groups. Importantly, not only does this tool make it easier to identify potential inequalities brought about by change, but it also connects those completing the assessment with best practice and easy to understand, tangible examples of how to mitigate against inequalities.

We have prioritised Population Health, as reflected in changes to our governance structure, encompassing the strategic progression of the Health Inequalities, Population Health Management and Prevention Agendas.

There have already been significant improvements in the capacity and leadership of the Population Health programme. This includes new appointments of a Non-Executive Director, with the responsibility for Health Inequalities; a whole-Devon Senior Responsible Officer (SRO) for Digital Inequalities and Head of Health Inequalities and Prevention. There is increased support to, and engagement with, the HEE funded Health Inequalities Fellows network in Devon and dedicated project management capacity, to support localities in taking action to deliver the priorities they define to achieve the aims of our Equally Well aspirations.

The focus on Population Health and its potential to inform local gaps and needs, has been mirrored amongst our local care partnerships, who maintain the need for population health knowledge, data and lived experience insight, to drive collaboration amongst members. As an example, earlier this year all localities are engaged in the first tranche of population health management projects using local data from the One Devon Data Set, to inform targeted ventures reducing variation in our populations well-being. The One Devon Dataset is now being used to "test" how, by combining comparable data from across partner organisations, we as partners can be better informed as to the characteristics of our population, at an increasingly granular level, which can then influence opportunities to be taken in narrowing of health inequality gaps. One example is a test site using a multi-agency approach in using a population health management logic model, to develop an alternative option for a bespoke population prescribed, dependency forming medication.

In addition, the delivery of whole-Devon improvements include:

- Establishing stronger links with our network of Health Education England HI Fellows.
- Building upon the work of Devon Communities Together cultural awareness programme that describes a mutual understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population.

In 2022, NHS Devon undertook a homeless health needs assessment within each locality, to give both a local, and aggregated whole-Devon view. The outcome from this will be used to inform future commissioning requirements of Primary Care services, to support the homeless population and ensure inequalities that may exist in the current provision are addressed across Devon.

Investment in prevention priorities continues both in whole-Devon workstreams, and in interventions at place via our annual prevention funding.

Data and insight relating to the characteristics of the population who are, and importantly, are not, accessing our support and services remains a challenge for Devon. NHS Devon's Population Health Management programme is linked with the Health Inequalities team. The Population Health Management Programme has the overall aim of having a systematic population health analysis at system, place and neighbourhood level, enabling LCPs, PCNs and partners including mental health and local authority, to understand their population's needs, including the wider determinants of health, and design interventions to meet them.

As an end state, all LCPs and PCNs routinely utilise PHM to develop targeted interventions for identified 'at risk' cohorts.

Ultimately having a comprehensive dataset in the form of a sole source of truth, has potential to inform the use and evidence the impact of the BCF, ensuring better outcomes for the population as well those facing inequalities in accessing services.