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

Supplementary Information Appendix July 2023.

Planning requirement: 1

A jointly developed plan that all parties can sign up to

The Devon Better Care Fund Plan forms an integral part of the wider One Devon ICS and fulfils a strong local response for the needs of the population served by the Devon County Council and of the Devon Health & Wellbeing Board. In addition, the BCF is seen as an enabler to deliver a local response to the following strategic documents:

1. Devon ICS 5 Year Joint Forward Plan One Devon plan and strategy
2. Devon ICS Community First Strategic Framework
3. Devon ICS Urgent and Emergency Recovery Plan
4. NHS Operating Plan
5. Devon County Council Strategic Plan Devon CC Strategic Plan
6. Devon County Council – Promoting Independence – our vision and strategies for adult social care in Devon. Promoting-independence

Throughout the development of this BCF plan, communications and contributions to/from partners from across the Devon County Council footprint were maintained through various routes including as an example within local care partnership work-plans and their respective up-date reporting cycles.
Key stakeholders involved in the development of the Devon BCF plan include:

- Devon County Council
- NHS Devon
- Local Care Partnerships – who's membership includes (not limited to): acute trusts, primary care collaborative and One Communities representation, district councils .

Devons eight district councils, including in their role as housing authorities, are key partners in the development and delivery of the strategies shown above and the BCF plan. This reflects the importance that local services and housing make to health and social care outcomes at a local community level. Details of the agreement reached on the use of BCF funding for Disabled Facilities Grants is contained in the BCF Narrative and Spending Template plans.

The narrative plan also provides information on the arrangements for close working with district councils.

Local Housing Forums build a common understanding of how to deliver solutions for those who require housing with support. More specifically they:

- Build relationships between district councils and social care and health.
- Share strategic objectives, market position statement and needs assessments.
- Promote collaboration on local planning and strategy development and the needs of specific client groups and help influence local developments.
- Take advantage of S106 opportunities and the relationships that district councils have with developers.
- Reach agreement on key spending including the BCF funding for Disabled Facilities Grants.

At local 'place' levels district councils are members of Local Care Partnerships and contribute to working groups e.g. Health Inequalities steering group and projects such as Fuel Poverty. At county level they are also represented at senior levels on the One Devon Partnership and 'Team Devon' and the Health & Wellbeing Board, which is accountable for the BCF.

A Housing Commission, under the chairmanship of Lord Richard Best and consisting of a range of academic, political and sector leads, has been established for 2023/24. The commission will conduct an in-depth analysis of the various local housing markets and related socio-economic profiles, and model demographic change, to make the case for a step change in social and housing policy and pragmatic solutions to be delivered locally, moving into the next decade.

How have you gone about involving these stakeholders?

Development of the BCF 2023/5 plan was undertaken by the Devon BCF Leadership Group and BCF Business Group. The BCF planning process has involved engagement from the range of key stakeholders including Devon County Council (including integrated adult social care commissioning leads, housing, and DFG leads), NHS Devon locality commissioning and partner provider organisations.

The BCF groups have met regularly to understand and respond to the requirements of the BCF and the planning process and have provided the oversight and engagement with the range of stakeholders to jointly develop and contribute to the Devon BCF plan.

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.

The wide engagement across the Devon footprint will ensure cross organisation and sector agreement and ownership to the strategic direction and investment outlined within the Devon BCF Plan.

For this BCF planning submission, the additional modelling undertaken for the Hospital Discharge Transformation Programme will see significant transformation to schemes supported by the BCF and within the programme provides an additional accountability and reporting framework through the Unscheduled Care Boards as the collaborative working forum.

The Local Care Partnerships and the Unscheduled Care Boards have been and will continue to be engaged in the BCF Planning and its delivery.

Likewise, the Devon Health and Wellbeing Board will continue to 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 local level.

Planning requirement: 3
Strategic joined up plan for Disabled Facilities Grant (DFG) spending

The BCF plan 2023/5 details the rationale for the planned use of the DFG that has been agreed with Devon's eight district council housing authorities. The resulting financial allocations are listed in the Spending Plan template. Operationally there is join up between health and social care and the application of DFG within the eight District Council footprints. Health and social undertaken comprehensive person centred, culturally sensitive health and social care reviews which focuses on personal outcomes, positive risk taking and identify are of support. The review identifies the need for aids and adaptations to support an individuals continued independence. Support is provided by the health and social care workforce to access Disabled Facilities Grant and ensure DFG spend is contributing to BCF outcomes.

Planning requirement: 4

How services support independent living; remaining in own home (links to demand planning in community in Spending Plan template)

Devon has adopted the National Institute for Health and Care Excellence (NICE) core principles of intermediate care, including reablement. Devon delivers Intermediate Care via is multi-disciplinary health and social care teams working in neighbourhoods. The professional practice of the team delivers the core principles of intermediate care by:

- Ensuring all practitioners develop goals in a collaborative way the optimises independence and wellbeing and adopts a culturally sensitive person-centred approach.
- Delivered as part of Devon's core service delivery this ensures good communications through a multi-disciplinary team meetings and with service users and their families / carers.

The principles of ensuring collaborative, culturally sensitive and positive risk taking are embedded throughout service delivery and are expected within commissioned services who support health and social care delivery within the community. This is embedded within our current approach to intermediate care and will also be incorporated into our plans as mentioned throughout our BCF narrative plan.

The principles underpinning the national Intermediate Care Framework are embedded within the delivery of the community intermediate care schemes supported by the BCF funding. These services are focused on supporting individuals to remain independent for as long as is possible within a supported a safe environment, recognising as these principles do, the need for local flexibility and innovation to account for local needs. The hospital discharge transformation programme 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.

Admission avoidance activity is provided in part by the urgent community response (UCR) services. This in northern and eastern localities for example, is provided by the integrated community health and social care teams hosted by the Royal Devon University Hospital Trust and funded through the BCF scheme for rapid response/urgent community response (see Spending Plan template, expenditure tab). Whilst monthly referral numbers received have varied since November 2022 (max: 106 (December '22); min: 51 (February 23)) the national target of 70% to achieve the response within 2 hours is consistently exceeded. The responsiveness and flexibility within this scheme provide support for residents to remain in their own home and supports avoidable admissions through swift access to a network of services offered by the integrated teams. Stronger links and referral pathways are being developed for optimal utilisation of the local virtual ward models for both respiratory and frailty presentations.

The Devon BCF provides opportunity to fund local "place" based schemes in direct response to the local population needs. As an example, funding a "home and settle" service which has volunteers being the first contact with an individual on discharge from hospital who could otherwise be alone. This contact ensures the individuals has all they need to remain safe in the initial hours of transition to home and support could be as simple as a phone call to check all is OK or for

checking has milk for a cup of-tea and that food supplies have been replenished. This check could also help support to apply for additional allowances to meet longer term needs.
Recognising the responsibility to support the unpaid carer provision, the BCF has been used to provide recuperative placements which provide respite for both the individuals and their family / usual support network so supporting individuals to remain in their own home.
The Devon BCF also provides the revenue pool of £6.9 million for our Community Equipment provision which supports residents to remain in their own homes and supports safe care solutions for individuals and those providing their care. Included in this is a commitment to supporting assistive technology and looking to increase use and access to digital solutions for quality care and safety.

Planning requirement: 6.
Right Care, Right Place, Right Time.

<u>Creating capacity to meet demand.</u>

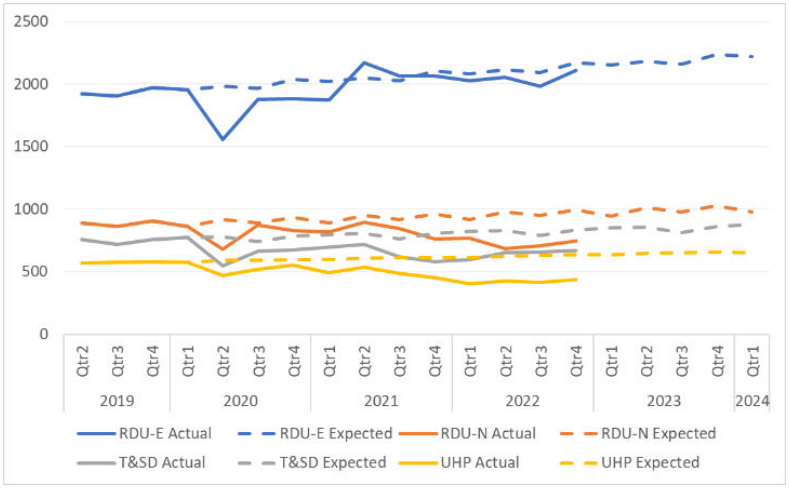
Through the Devon-system wide Discharge and Flow group we have assessed progress against the High Impact Change Model and the 100 day challenge, key areas of focus include monitoring and responding to system demand and capacity, home first discharge to assess; and improved discharge to care homes. In February 2023 the ICS presented to the National team key discharge improvement activity which forms the basis of our system plan through to Winter 2023. We have established a Hospital Discharge and Transformation Programme for the Devon footprint that supports delivery of the HICM that aims:

- To work in collaborative partnership at a locality and DCC-footprint level.
- To provide oversight and design of a new hospital discharge model for the DCC footprint by 01/09/23.
- To utilise the IPACs model to improve understanding for demand and capacity (see below)
- To agree the model and best use of resources for delivery, escalating to the BCF Leadership Group and Devon Unscheduled Care Board where decisions cannot be made.
- To provide assurance to the BCF Leadership Group and Devon Unscheduled Care Board; and escalate risks in a timely fashion.

There is also an established Devon Transfer of Care workstream that seeks to improve the quality of discharge to the care market, especially care homes.

A range of stakeholders including, lead commissioners, finance leads, performance analysts and senior leadership managers from both NHS Devon ICB, local integrated acute hospital and community service providers and Devon County Council came together to understand the data and intelligence focusing on patient flow through acute, community and social care. Example below of modelling data for discharges.

Discharges (per Q) to P1 -3 beds by Provider – Actual vs Predicted Activity:



- John Bolton Model predicts discharges to be split between:
  - P0 50%
  - P1 45%
  - P2 4%
  - P3 1%
- Devon Demand Model predicts growth per year of:
  - P1 3.1%
  - P2 4.4%
  - P3 3.1%
- Modelling of P1 -3 capacity will utilise expected activity based of Devon Demand Model predicted growth.

- SUS data filtered to: Non-Elective patients; aged 65+; to Exclude 0 day Lengths of Stay; to exclude where the discharge destination = 79 - Patient Died or Stillbirth'; to include Devon's 4 main acute provider sites only; and to include Devon CC council area (based on GP practice) only.

This launched the Hospital Discharge Transformation Programme to design and jointly agree the totality of investments for the Additional Discharge Fund to enhance capacity within the future model of delivery. With an overarching focus for Hospital Discharge – the key workstreams include homecare capacity to support discharge, enhanced community reablement offer and supporting the sustainable care home market, to ensure services capacity can meet the predicted demand.

Improving Patient Flow.

The Improve patient flow between acute, community and social care (IPACS) model has been adopted as the basis for the Devon CC footprint hospital discharge transformation programme. This will support the strategic, operational and cultural transformation of all partners delivering services within the scope of the programme. This will enable capacity allocation to follow complex discharge pathways and consider total cost, patient experience and outcomes. the involvement of analytics to synthesis and present back data to the project leads will enable the cultural shift and demonstrate the value and importance of system-wide working and collaboration across partners and organisations. It is planned to utilise the IPACS model to look at our approach both for the full Devon CC footprint as well as examining any local variations that might need different consideration. The IPACS modelling tool will be used in conjunction with John Bolton Model outputs, applied to our local data, enabling us to work through assumptions and theories and allowing us to interrogate multiple

potential outcomes before deciding on a more fully considered commissioning approach.

Homecare – community services (pathway1)

Pathway 1 IPACS model outputs currently identify the projected upper capacity required will increase to between 744 and 766 patients between the months of November 2023 to January 2024 (projected average of 670 in preceding months). P1 accounts for 45% of discharge activity and work is currently underway as part of a system wide Hospital Discharge programme. The programme deliverables include detailed capacity and demand plans to support discharge during winter 23/24, also informing the Devon wide Discharge Strategy due to launch April 24.

Homecare has seen an improving position in workforce numbers, in the main attributable to international recruitment (IR). Whilst IR presents its own challenges in relation to commercial viability (scale and volume to sustain hours required), it is supporting market capacity. As a result, the gap in terms of capacity required to meet full demand has reduced significantly. With the notable shift in capacity over the last 6 months, it has been important that this has been recognised and to consider appropriate actions and adapt to the new market and workforce position. A pause on awarding any new spot contracts for home care is enabling a period of consolidation to work with current contracted providers (recent and existing) to support safe induction and growth whilst also seeking to address remaining capacity requirements in the shorter term.

The BCF and hospital discharge fund has been utilised to fund key initiatives to support people to be in the right place.

- Live in Care: Contracted staff capacity to provide short–term care by DCA staff living in the individual's home to support early discharge from hospital where an intensive level of care and support was indicated by the hospital discharge team.
- DCA Block contracts were established for the provision of care and support to people at home by DCA's in areas of the County where capacity is often limited due to the risks of fluctuation in demand or availability of workforce.
- Agency – Block contracted volume of additional staffing resource to provide the inhouse care delivery teams with additional capacity. The DCA Agency supported the highest number of people at c. 200 people per week and 255 people at its highest demand.

Care Homes

Pathway 2 IPACS model outputs currently identify the projected upper capacity required will be up to 211 patients per month between the months of November 2023 to January 2024. It is anticipated that around 180-190 block beds will be commissioned to meet the demand for winter 23/24, with the ability to flex to the upper limit of 211 beds. This includes only beds provided within the private social

care sector and does not include community hospital beds (which equates to around 200 beds across the Devon County Council Footprint). The commissioning programme alongside understanding the demand for these beds, also will aim to understand the acuity and complexity of the care required. This will feed into discussions around pricing within the set budget. The programme will also involve active co-production with the social care market to shape a final proposal. Early indications identify that the outcome is likely to include a significant proportion of block booking of beds across North, East and South Devon with a continued spot purchase approach in West Devon.

Pathway 3 IPACS model outputs currently identify the projected upper capacity required will be up to 40 patients per month between the months of November 2023 to January 2024. The council completed the market sustainability improvement fund capacity plan, and this identified that on average the nursing market has approx. 20% capacity at any given time and the over 65s market has capacity of 40% at any given time (in total this equates to circa 2000 beds). Whilst this would indicate a sufficient market there is some key concerns as set out as below

- DCC's forecasted demand modelling indicates that by 2025, there will be 8% increase on current levels of commissioned activity in nursing beds and by 2030 this will be 22%. There is not the nursing home capacity to meet this demand and we need to develop further modelling. The ICS is exploring opportunities with strategic providers to develop capacity in the DCC footprint. We are also exploring a significant new build with the ICB and Torbay to develop capacity jointly.

- It is expected the residential market will suffer some fragility over the next two years due to the risk factors of under 80% occupancy, high use of agency staff and small standalone providers. In the next three years there are 1,490 additional beds planned through proposed new builds, and 230 additional beds through planned extensions. However, current build and labour costs as well as financing costs may prevent this growth. The other factor to consider with new builds is affordability and that these builds are largely aimed at the low needs luxury market which is not compatible with social care requirements for affordable complex care. The council is working with local providers and district to develop more affordable housing options for older people.

The BCF and hospital discharge fund has been utilised to fund key initiatives to support people to be in the right place, the block purchase pathway 2 care home beds had good outcomes for people, there was a reduction in the use of care home beds for long term residential placements as result. This model also supported a reduction in the number of people needing packages of home care.

A capacity gap was identified in the ability and willingness of care homes to take individuals that have expressive behaviour. Several factors contribute to this

including poor assessment, lack of workforce and people's needs in transition may be higher initially presenting risk issues to the care home provider. The council established a hospital discharge team to commission and fund agency staffing that sup-ported complex individuals to be discharged from Hospital into care homes (short term 1:1 care and support). This increased capacity as care homes accepted discharges which they would not have ordinarily taken. Time to transfer reduced from 12 to 6 days under this initiative.

This has had a longer-term success with homes expanding their offer there has been a development in the complex care market. 66% of discharged patients remained in the care home without needing ongoing 1:1 support, this also helped to demonstrate to this cohort of providers they were able to support this client cohort.

Care homes are further supported through the care home visiting teams with training and support through an on-going education programme which provides training and support in areas including early recognition of deterioration (RESTORE), falls training in the reducing risk of falls and management of falls, and hydration and nutrition awareness. Collaborative work with primary care colleagues provides additional support through the enhanced health in care homes projects which also is supporting the roll-out of a virtual nurse-led consultation offer to over 60 of our larger care home establishments across Devon. Recently additional lifting equipment for homes without access to such equipment which will reduce long-lays and for non-injurious falls, with the support of visiting teams will reduce need for conveyance to secondary care, supporting residents to remain in their place of residence.