2025_2026 Population Health Northern LCP Funding – Q3 update

One Northern Devon were allocated £233,000 of Population Health funding from the ICB for the 25_26 financial year and chose to allocate it as follows:

Item no.	Health Inequality Programme	Allocation	Comments
1	High Flow	£108,000	As allocated.
2	Community Flow	£65,000	Part-funded CF for one year with £52,224 from OND
3	Hospital Discharge fund	£10,000	As allocated.
4	School Mental Health support	£10,000	£6,843 supported Place2Be provision in this financial year. It is requested that the remaining £3,157 is allocated to supporting the provision in the next academic year (January agenda item).
5	Primary Care Outreach	£12.000	£10,000 allocated to Belle's Place, Ilfracombe £2,000 allocated to peer mentors Harbour Bideford drop-in
6	Closing the Gap	£28,000	Foundational work has taken place across all partner agencies. £18,900 has been ringfenced for partners to use to progress their plans and £9,100 to extend the clinical leadership.
7	FAME	£10,000	£20,000 allocated by the ICB centrally, OND matched this with £10,000 (so not technically from our PHM budget)

1. High Flow - £108,000

HIU Flow (North) – Q3 board précis

HIU Flow provides a Team Around the Person approach for adults (18+) who attend ED more than expected (typically 5+ times/month or 20+ times/year), supporting "what matters" and coordinating across services to improve wellbeing and reduce health inequalities. The report notes an average of 2.6 FTE caseworkers in Q3.

- 38 people supported in Q3, including 18 new clients.
- 100% of people progressed in at least one goal; 97 goals supported in total (almost 2 goals per person).
- Self-reported outcomes: 88.8% reduced loneliness (where relevant), 57.1% improved wellbeing, and 86.6% reported a positive experience at end of support.

What support was delivered

The team recorded 378 practical outputs in Q3, focused mainly on accommodation (153), physical health (123), and money/finance (52), with additional work on mental and emotional wellbeing (22) and protection from harm (20). Outcomes are logged on case closure; 164 outcomes are recorded across closures, with the largest outcome area being physical health (71).

Impact on service use and cost

25% reduction in non-elective admissions & -4.5% change in ED attendances (noting small sample effects in the 3-month view).

Estimated cumulative savings of £34,312 (3-months) and £161,841 (12-months) using RDUH reference costs.

Who was reached

Wide age spread (largest group 65+ at 31.6%, and 25–34 at 26.3%) and 29% of people supported this quarter live in the most deprived national IMD decile.

Key issues and learning (Q3)

Recurring barriers include long waits for specialist input for complex conditions; digital exclusion limiting GP access (contributing to crisis routes); system blind spots around learning needs and advocacy; and the tension between person-centred practice and performance/data pressures. Learning includes recognising the "unseen work" responding to enquiries, and the value of staying alongside people while other services cannot respond.

More information can be found in this report.

2. Community Flow - £65,000 (plus £52,224 match-funding)

Community Flow (North) – Q3 board précis

Community Flow in North (2.8 FTE) supports people to leave hospital safely and rebuild Independence through practical, person-centred community support.

Q3 reach and headline impact

- 136 people supported in Q3, including 88 new people.
- 53 instances of safer and more speedy discharge supported.
- 68 instances of potentially avoided future readmission; 67 instances of potentially avoided readmission within six weeks.
- 48 people discharged solely due to Community Flow intervention.
- £9,692.79 of grants/funds secured for individuals this quarter.
- Year-to-date (since April 2025): 273 people supported.

What support was most needed

Q3 activity was concentrated on accommodation, mental and emotional wellbeing, community connection, physical health and money/finance support (362 outputs for North in Q3).

Key issues and barriers (Q3)

Recurring barriers affecting discharge and recovery: transport constraints; limited local support networks; time-intensive grant processes; the loss of quicker-response discharge funding; and complex home situations (including unsanitary conditions) that can delay progress. Loneliness and reduced befriending capacity in Torridge is also noted.

More information can be found in this report.

3. Hospital Discharge fund - £10,000

This fund is used to support patients who no longer have a medical need to be in hospital to return safely and reduce risk of readmittance due to unsuitable living conditions. It is used mostly on accommodation needs such as deep cleans, furniture removal and replacement, decluttering or white goods eg. washing machine.

The Flow team have also secured in excess of £16,000 of charitable funding to support patients to further supplement accommodation requirements as well as activities to support health and wellbeing - leisure classes etc.

Most recent example of description of using funds to support a patient discharge:

Bedroom: *In the main bedroom, clothing was decluttered and clothing things put away. The mattress was replaced.*
Lounge: *Sofa was replaced and room was decluttered.*
Bathroom*: Now free of Biohazards.*
Kitchen*: has been decluttered and cleaned. We washed a huge amount of very soiled dishes and rotten food. The fridge was challenging- emptied and deep cleaned*

4. School Mental Health Support -

Place2Be delivered a substantial targeted mental health offer across the 2024–25 academic year, supporting **56 children and young people** through **216 targeted sessions**, alongside **parent partnership (44 sessions)** and other activity (**18 sessions**).

Impact and outcomes

- **Teacher SDQ:** Change: 53% improved**,** 42% deteriorated**,** 5% same**.** For those severe pre-counselling: 60% improved**;** 50% clinical recovery**.**
- **Teacher impact statements:** 63% “a bit/much better”; 64% improved classroom learning (where difficulties identified); 57% fewer difficulties for teacher/class (where identified).
- **Parent SDQ:** pre shown as 100% severe; change 75% improved / 25% deteriorated**;** 13% clinical recovery.
- **Parent impact**: 100% “a bit/much better”, 100% Place2Be helpful, 83% improved homelife (where difficulties identified).

Key presenting needs (moderate/severe ratings)

Most common *moderate* needs include **low self-esteem (41%)**, **mood swings (41%)**, **emotional difficulties (36%)**, **general anxiety (36%)**, **family tensions (32%)**, **separation anxiety (32%)**. Highest *severe* category shown is **attention difficulties (23%)** (with several others at 18%).

Safeguarding (dashboard totals)

All-time safeguarding dashboard shows highest totals for **self-harm (22)** and **suicide ideation (22)**, plus **access to appropriate adult (19)** and **child violence (19)**, followed by smaller counts across other categories.

More information can be found in this report.

5a. Primary Care Outreach - Belle's Place

Belle's Place is a long-standing community hub in Ilfracombe supporting people experiencing multiple disadvantage, including homelessness/rough sleeping, insecure or temporary accommodation, addiction/substance misuse, mental ill-health, social isolation/exclusion, and wider hardship (including low literacy and distrust of statutory services). It provides essential practical support alongside trusted access to health and statutory services, aiming to help people engage before needs escalate to crisis.

Service offer

Belle's Place provides a blend of essential needs support, access to health and wellbeing, and wraparound advice/signposting:

- Essential needs/crisis prevention: hot food 5 days/week (up to 39 meals per day), foodbank links (independent and Trussell Trust), showers/toiletries, warm clothing, tents and sleeping bags.
- Health and wellbeing access: primary care outreach clinic (GP/health screening), mental health support (including monthly Devon Mind presence) and CMHT, sexual health (C-Card, STI/HIV advice, condoms/lube), oral health support (hygiene advice and dental referrals with a self-referral pathway), podiatry, Hep C Trust screening/treatment support, and a newly established needle exchange (uptake building).
- Drugs, alcohol, housing and statutory services: Together drug/alcohol support (50+ clients currently on the programme), regular housing officer support including temporary accommodation for 30+ people in Ilfracombe, probation and social services access, plus practical advocacy (online access, forms, signposting).
- Wider community support: weekly barber and school uniform shop, delivered in a compassionate, respectful environment designed to sustain engagement.

Reach and demand

- Drop-in use averages 29 attendances per day, operating 5 days/week, 52 weeks/year (approximately 7,540 drop-in attendances per year)
- Support outside drop-in averages 3 requests per day (e.g., food bank vouchers/parcels, clothing, equipment, signposting).
- School uniform support: Summer 2020 (72 families), Summer 2021 (104 families), Summer 2022 (250 families), plus around 4 uniform requests per week through the year;
- Wider outputs include completion of 400+ Household Support Fund applications and C-Card provision with 11 young people currently using the service.

Evidence and impact

- Primary care access: Combe Coastal Surgery has run a primary care outreach clinic twice monthly at Belle's Place for the past 3 years; improved reach to people with high health need who have previously not engaged well with health services, enabled by trust between Belle's Place staff and service users.
- Drugs and alcohol: 50+ clients currently engaged with the Together programme.
- Oral health: support enabled 6 referrals to dental services, improved trust/engagement to support advice and treatment.
- Sexual health: since August 2022, 8 people engaged with sexual health outreach; C-Card active with 11 young people.
- Harm reduction/BBV: needle exchange newly established; Hep C Trust screening has supported people through treatment

Key conclusions

Belle's Place:

- reaches a high-need cohort with historically low engagement with statutory services;
- improves access by removing barriers (trust, stigma, literacy, chaotic lifestyles, fear of services);
- is likely contributing to earlier intervention (and therefore reduced crisis presentations) through the outreach clinic model; and
- functions as a high-throughput preventative community asset given the volume and consistency of use.

There are challenges to ongoing commissioning/funding while there are concerns about premises suitability, health and safety, and governance. The proposed direction is:

- governance transfer to Town Council / One Ilfracombe (or similar) to provide stable oversight, admin and compliance, and increase commissioning confidence;

More information can be found in this report.

5b. Primary Care Outreach – Peer Mentors

Peer mentor-led rough sleeper drop-in (Harbour Bideford, Torridge) – précis for board

Purpose

To run a peer mentor-led rough sleeper drop-in in Bideford that provides low-threshold, trusted support for people experiencing homelessness, while also strengthening the recovery journey, confidence and wellbeing of the peer mentors leading the offer.

Model and partners

The drop-in is hosted by TTVS at Harbour Bideford each Tuesday and is led by a peer mentor team from The Lighthouse Bideford. The Lighthouse provides a residential recovery programme for men for up to two years, and the peer mentors are all in recovery.

Why peer mentors are central

Peer mentors use their lived experience and recovery expertise to engage people who may not trust or readily access statutory services. They report that leading the drop-in gives them pride, purpose and a sense of value through helping others, and provides a practical setting to build skills and confidence in a supported environment.

Link to the January 2025 public health pilot and what it showed

This current drop-in builds directly on the outreach pilot delivered in January 2025, which explored barriers and preferences for primary care access for people experiencing homelessness in Torridge. The report from that pilot highlighted persistent barriers to accessing primary health care, and indicated that people benefited from peer-led, low-threshold outreach. The Tuesday drop-in is an extension of that approach, responding to feedback that attendees valued the peer-led model and wanted it to continue.

What the funding is for

The funding supports the peer mentors who make the Tuesday drop-in possible. This includes supporting their health and wellbeing so they can sustain the role safely and effectively. One practical example is support towards gym memberships: peer mentors use exercise as a key recovery tool from chemical dependency, but many are currently paying for memberships themselves, which significantly reduces their monthly budgets. Funding would help stabilise and

sustain the peer mentor contribution that underpins the drop-in.

Why this is a good use of small funds

The public health report from the January 2025 pilot provides a clear rationale for investing in low-threshold, trusted outreach approaches for this group, given the barriers to primary care access and the importance of engagement models that work in real life for people experiencing homelessness. Supporting peer mentors is a small-cost, high-leverage way to maintain the conditions that enable this type of outreach to function consistently and effectively.

Intended outcomes

- Continued engagement of people experiencing homelessness through a trusted weekly drop-in.
- Improved navigation into primary care and other support, addressing the access barriers identified in the public health report.
- Strengthened recovery, confidence and wellbeing for peer mentors through purposeful contribution, skills development and improved ability to sustain healthy routines.

More information can be found in this report.

6. OND Closing the Gap Programme

Purpose and approach

Devon Community Foundation was commissioned by NHS Devon to assess the social value and impact of investment linked to Closing the Gap, considering effectiveness, efficiency, sustainability, equity, relevance and impact.

What Closing the Gap is

Closing the Gap is a long-term (ten-year) systems change programme in the One Northern Devon LCP footprint, aiming to reduce health, economic and social inequalities—especially in the most deprived 30% of communities—by embedding an equity focus on access, experience and outcomes across partner organisations, and shifting culture from top-down, risk-averse approaches toward co-production and community-led solutions.

Progress to date

CtG has completed the “Discover” and “Define” phases of a double-diamond approach, with implementation still emerging. Early progress is primarily cultural and developmental rather than measurable in conventional health indicators, including:

- building a shared cross-sector vision;
- strengthening understanding of inequity in access/experience/outcomes;
- prompting partners to examine what they know about disadvantaged service users and barriers;
- beginning to share learning and shift from risk narratives toward trust.

The partnership also reached a pragmatic position on defining the target cohort: broadly the most deprived 30% of Northern Devon LSOAs (IMD deciles 1–3) while recognising the limitations of IMD for rural deprivation and allowing partner insight beyond geography.

Strengths and risks highlighted

Strengths include:

- an unusually diverse and enthusiastic coalition (relative to other Devon LCPs),
- clear ambition
- strong leadership with good analytical capability

However, at this stage the programme is still in its early days and therefore fragile, with "hub and spokes" dynamics and reliance on key individuals in organisations creating sustainability risk. Resource constraints particularly affect VCSE participation, and there are challenges in translating "system change" language into frontline practice across sectors. There are tensions between prevention/equity ambitions and commissioning/funding realities, plus complexity in agreeing evaluation approaches that fit the nature of systems and cultural change.

Key recommendations / suggestions

The evaluation suggests the partnership should:

- strengthen peer learning by unlocking and sharing existing practice assets (including the Ilfracombe Poverty Truth Commission and Lottery-funded VCSE work);
- proactively feed CtG insight into Integrated Neighbourhood Team development (including potential linkage with the Eastern LCP Social Health model);
- develop a shared outcomes framework that captures cultural change and learning (without forcing rigid, standardised metrics);
- invest in a medium-term coordination role to maintain the partnership, oversee evidence collation and iterative peer learning, and free senior leaders to focus on strategic/system-level influence.

More information can be found in the evaluation report.

7. FaME (Falls Management Exercise)

FaME is an evidence-based, progressive 24-week falls management exercise programme delivered by specialist postural stability exercise instructors in the community (supported by volunteers). It aims to build strength, improve balance**,** and develop skills and confidence including getting down to and up from the floor, with home exercise between sessions**,** plus an educational and social component.

Who it is for

Inclusion: typically 55+, at risk of falls / fear of falling; able to follow instructions; able to walk independently (with or without an aid); able to rise from a chair; able to monitor effort safely; willing to attend weekly and complete home exercise.
Exclusion: higher-risk or unresolved clinical issues that need assessment/management first (e.g., frequent/unexplained recent falls not yet assessed), uncontrolled conditions awaiting review, recent injurious fall without assessment, or other contraindications to exercise.

Where it is delivered and why those places

Locations were selected using local falls data (including SWAST "pick-ups following falls"), focusing on areas including EX39, plus central Barnstaple (EX31) and central Ilfracombe (EX34)**.** Current delivery includes Ilfracombe, Barnstaple and Westward Ho!

Current delivery position (roll-on/roll-off model)

- Programme model: roll-on roll-off, with the first starters now at week 14 of 24**.**
- Current attendance:
    - Ilfracombe: 12
    - Barnstaple: 11
    - Westward Ho!: 11
    - Total currently attending: 34
- Withdrawals: 7 total
    - 2 caring responsibilities
    - 1 asked to leave (inappropriate behaviour)
    - 4 due to participants' own health problems
- Waiting list: 16 people; assessments booked to fill gaps as they arise.

Funding / operational notes

- Current funding does not include transport or refreshments (both can materially affect access and engagement).
- Refreshments are being funded through donations**,** which are currently meeting costs.

Statistics

- 61 referrals (53 self-referrals; 8 from health/community professionals)
- 44 joined the programme; 18 (44%) had fallen in the previous 6 months
- Age range 63–92; wide range of deprivation (IMD)
- 33 completed the 6-month programme **(**75% completion**)**
- 9 people reported a single fall during the programme; no ambulance call-outs reported.

Illustrative impact

A case example shows functional and activity gains during the programme (e.g., Timed Up and Go improved by 8.4 seconds**,** 30-second sit-to-stand improved 6 → 10**,** improved flexibility, progressed resistance levels), with one fall at home during the programme but able to get up independently and no further falls since May (year not specified), moving from no regular activity to meeting CMO physical activity guidelines**,** and continuing into ongoing community balance classes.

More information can be found in this presentation.