Thursday, 24 August 2023

Meeting of the Health and Wellbeing Board

Thursday, 22 June 2023
2.00 pm
Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board

Pat Teague, Ageing Well Assembly
Ian Ansell, Torbay Safeguarding Children Board
Alison Brewer, Primary Care Representative
Tara Harris, Divisional Director of Community and Customer Services
Pat Harris, Healthwatch Torbay
Matt Fox, NHS Devon Clinical Commissioning Group
Jo Williams, Director of Adults Services
Adel Jones, Torbay and South Devon NHS Foundation Trust
Nancy Meehan, Director Children's Services
Lincoln Sargeant, Director of Public Health
Chris Forster, Torbay Community Development Trust
Tanny Stobart, Imagine This Partnership (Representing the Voluntary Children and Young People Sector)
Anthony Reilly, Devon NHS Partnership Trust
Paul Northcott, Adult Safeguarding Board
Sarah Newham, Department for Work and Pensions
Roy Linden, Devon and Cornwall Police
Councillor Bye
Councillor David Thomas

HEALTH AND WELLBEING BOARD
AGENDA

1. Apologies
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

2. Minutes (Pages 4 - 24)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 9 March 2023.

3. Declaration of interest

3(a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

3(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

4. Urgent items
To consider any other items that the Chairman/woman decides are urgent.

5. Update on Membership and Terms of Reference (Pages 25 - 26)
To receive a verbal update in respect of the membership and terms of reference of the Health and Well Being Board, as approved by Council on 25 May 2023.

6. Torbay Joint Strategic Needs Assessment 2023/24 (Pages 27 - 208)
To consider the 2023/2024 update report of the Joint Strategic Needs Assessment (JSNA).

7. Torbay Drug and Alcohol Partnership Report (Pages 209 - 212)
To consider the report on the new Drug and Alcohol Partnership for Torbay.

8. **Smokefree Devon Alliance Strategy 2023 - 2028** (Pages 213 - 223)
To consider the report on the Devon Smokefree Alliance Strategy 2023 – 2028.

9. **Devon Integrated Care Joint Forward Plan** (Pages 224 - 455)
To consider the report on the Joint Forward Plan.

10. **Integrated Care Board and Local Partnership Business Programme Update**
To receive a verbal update in respect of the Integrated Care Board and Local Care Partnership business programme

11. **Turning the Tide on Poverty and Cost of Living Work Programmes Update**
To receive a verbal update on the Turning the Tide on Poverty and Cost of Living work programmes.

Meeting Attendance
Please note that whilst the Council is no longer implementing Covid-19 secure arrangements attendees are encouraged to sit with space in between other people. Windows will be kept open to ensure good ventilation and therefore attendees are recommended to wear suitable clothing.

If you have symptoms, including runny nose, sore throat, fever, new continuous cough and loss of taste and smell please do not come to the meeting.

Minutes of the Health and Wellbeing Board

9 March 2023

-: Present :-

Pat Teague, Tara Harris, Pat Harris, Matt Fox, Councillor Jackie Stockman, Lincoln Sargeant, Tanny Stobart, Paul Northcott and Councillor Cordelia Law

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8. Apologies

Apologies were received from Nancy Meehan, Director of Children's Services, Torbay Council; Alison Hernandez, Police and Crime Commissioner; Anthony Reilly, Devon NHS Partnership Trust and Sarah Newham, Department for Work and Pensions.

Acting Superintendent Nigel Yelland attended in place of Chief Superintendent Roy Linden.

Chris Winfield and Chris Knights attended in place of Adel Jones, Torbay and South Devon NHS Foundation Trust.

Sharon O'Reilly attended in place of Jo Williams, Director of Adult and Community Services.

9. Minutes

The Minutes of the Health and Wellbeing Board held on 8 September 2022 were confirmed as a correct record and signed by the Chairwoman.

The Chairwoman referred to the current membership and the Board held no objection to the suggestion that co-opted members could become full members of the Board.

10. Peninsula Health Protection Annual Report 2021/22

Members noted the Peninsula Health Protection Annual Report 2021/22 which was outlined by Julia Chisnell, Consultant in Public Health with Torbay Council. The Board was informed of the key considerations which were:

- Health protection
- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections and antimicrobial resistance
- Emergency planning and response

The Board was pleased to note that as a result of assistance from Outreach Teams and community engagement in promoting vaccination clinics, vaccination uptake had improved. Cancer screening had been on a recovery trajectory following the pandemic and was now back to pre-pandemic levels. However, more in-roads were required in respect of MMR vaccinations as uptake needed to improve. Currently the statistics showed a 91% uptake in the last quarter, falling to 87% currently. This was being treated as a priority with a focus on school age vaccinations.

In response to questions, the Board was informed that with the increase in cancer screening there were challenges to be addressed but that these were manageable at present and that NHS England and NHS Trust colleagues were working together to address these challenges.

It was recognised that there were pressures on the NHS generally and that the NHS and Public Health continued to work together to resolve those pressures particularly in relation to waiting lists.

Progress on actions detailed in the Peninsula wide priorities for 2022/23 will be included in the next annual assurance report.

11. Torbay Joint Health & Wellbeing Strategy 6 monthly monitoring reports

The Board noted the second progress report on implementation of the Torbay Joint Health and Wellbeing Strategy. Julia Chisnell, Consultant for Public Health, Torbay Council, informed the Board that the programme was on track.

Members were provided with a summary of progress by priority programme area relating to mental health and well-being; good start to life; supporting people with complex needs; healthy ageing; digital inclusion and were informed of changes in the data indicators since the September 2022 report.

Risks and issues were highlighted in respect of the ageing programme and digital programme funding which was coming to an end. A case was being developed in respect of the ageing programme and the digital funding programme was cutting back its delivery as the current fixed-term funding ends in March 2023. The networking aspect of the programme will continue but for 2023/24 there will be no commissioned delivery programmes to support people to get online.

More work on cross cutting areas would be carried out over the next few months, bringing people together to improve connections between these areas of work and the health and wellbeing agenda.

In response to questions, Members were informed that refugees and migrants were being supported and that there was extra work in relation to the mental health programme to address the mental health concern. A difficulty identified was how long migrants or refugees stayed in the area and this could affect their route of support.

Members were reassured that mental health was covered in the overall Strategy and a lot of work was being undertaken with faith communities and skills resources training, for example and there were a lot of opportunities for change.

12. Building a Brighter Future - New Hospitals Programme update (Torbay & South Devon NHS Foundation Trust strategy)

The Health and Well Being Board received a presentation from Torbay and South Devon NHS Trust.

The Strategic Outline Case for £497 million had been submitted to the New Hospital Programme national team for consideration. Meanwhile, site enabling plans were being progressed so that the estate would be ready for construction as soon as possible.

Members were informed that the four key principles within the Strategic Outline Case were:

- reprovision of medical beds and emergency surgery beds in the hospital;
- separation of planned and unplanned services;
- non-clinical services to be moved off the hospital site;
- emergency department and same day emergency care services to be completely upgraded.

The Board were updated in relation to funding; what the site could look like and plans for that; current key milestones and progress achieved over the last 12 months, which included a new acute medical unit, new endoscopy unit and new theatres. Next steps were outlined and the team were working hard to ensure allocation of funds were confirmed following which the aim was to complete the site enabling full business case by June 2023.

In response to Members questions it was confirmed that the vast majority of key services would be unaffected by the acute services review. However, if there were other service shifts, they would be taken into account. A lot of work had been done around capacity modelling and not making the hospital too small for future needs. The bed modelling already carried out required input from community colleagues to ensure that there were facilities for enabling discharge and levering use of digital technology so that patients could be managed closer to their home. At present the model proposed 350 medical beds although there was other bed capacity on site that could potentially be used, but not necessarily for acute provision.

Accommodation for key workers had also been considered and off-site solutions were being explored. Concerns were raised that managing traffic flow around the site would present a challenge and assurance was given that this was considered in the planning.

In respect of the site, net carbon standard was a compulsory requirement to meet environmental building standards. There would still be a fossil fuel heated element and although there would be upgrade work on a concentrated area, there was also

an aspiration to become net zero carbon across the site, however, this would not be achievable straight away.

By consensus the Board resolved:

1. the contents of the report were noted;

2. confirmed its continued support of Torbay and South Devon's New Hospital Programme;

3. that a further update should be provided to the Board in 12 months' time following which 6 monthly updates will be provided.

13. Devon Integrated Care Strategy System

The Director of Public Health, Lincoln Sargeant and the Deputy Programme Director, NHS Devon, Jenny Turner outlined the submitted report and provided a presentation.

The Board were informed that the One Devon Interim Integrated Care Strategy had been developed on behalf of the One Devon Partnership by the Devon Plan Working Group. The Partnership brought together the NHS, local authorities, the voluntary sector and other partners across Devon.

Existing Health and Wellbeing Board strategies were considered when creating the Integrated Care Strategy which reflected work and engagement carried out over time with people in the community. Twelve key challenges had been identified for Devon and the Strategy provided a broad direction of travel in addressing these.

Integrated Care Boards and partner trusts had a duty to prepare a draft Joint Forward Plan in response to the Integrated Care Strategy before the start of 2023/2024. The Joint Forward Plan Guidance specified that the date for publishing and sharing the final Plan is 30 June 2023, however it was likely that this would be achieved earlier.

The draft Joint Forward Plan outlined how the 21 strategic goals would be delivered and cover four broad areas:

- Mental Health, Learning Disability and Neurodiversity;
- Primary and Community Care Model;
- Acute Services Sustainability Programme
- Children and Young People Care Model;

In respect of the report Members commented that:

- the content for children and young people while focused on education did not include much on children's health services such as mental health. However, it was recognised that the Integrated Care Strategy consider health in its

broadest sense and that the Joint Forward Plan would provide more detail on health services;

- clarity was needed around how safeguarding fits into the overall strategy and plan;
- the workforce difficulties faced by the NHS in Devon and wider challenges such as employment opportunities for residents are two separate issues;
- what would change as a result of the plan in terms of outcomes for local people?
- community engagement and involvement were essential and should also include the parent/carers' forums;
- how would the plan's performance be monitored going forward and what role would Torbay's Health and Wellbeing Board play in that?

Overall, Members welcomed the draft plan and its strategic goals which presented an opportunity for change where that was needed. It was noted that an event was planned for 23rd March for members of the 3 Health and Wellbeing Boards in Devon to review the details of the Joint Forward Plan.

By consensus Members resolved that:

1. the draft Joint Forward Plan takes proper account of the Joint Local Health and Wellbeing Strategy;

2. the minutes of the Board meeting on the 9 March 2023 will constitute the response in writing of the Health and Well Being Board and its opinion in respect of (1).

14. Integrated Care Board & Local Care Partnership business programme update

The Board noted a verbal updated provided by Derek Blackford, Locality Director, South & West, NHS Devon Integrated Care Board.

Members were informed that the One Devon Partnership were attempting to better understand partnerships in the wider system and there was more work to be done in that respect including the One Devon Integrated Care Strategy. The work on behalf of Torbay and South Devon could be improved and it was important to understand all of the good work which was already underway. The question was whether enough support has been provided for people to network and to understand what the Integrated Care Board and Local Care Partnership was attempting to deliver and that would be the focus of efforts moving forward. There would also be a focus on whether the Local Care Partnership for South Devon and Torbay had included all the right stakeholders and communities, to identify those who were missing and should be included. Thought was also being given as to how to raise the profile of what the Local Care Partnership was attempting to deliver and amplify the value in what it was trying to achieve. It was essential to have the right support and priorities and work would be taken forward within the Joint Forward Plan.

15. Turning the Tide on Poverty & Cost of Living work programme updates

The Board noted a verbal update provided by Lincoln Sargeant, Director of Public Health, Torbay Council.

Members were informed that the Council adopted a strategic approach in terms of supporting the most vulnerable and most at risk from adverse events like the pandemic and cost of living crisis. The focus over the winter had been the cost of living crisis and the Council had done a lot of work together with partners on implementing a series of measures to ameliorate fuel and food poverty such as the provision of 'warm banks' and food banks.

There were good insights into how best to begin to address the wider issues and interesting opportunities for the future with development around the food strategy with expanding provision through fixed and mobile food banks to developing more social supermarkets.

Work had been carried out recently with Torbay Council, South Devon College and the Torbay and South Devon NHS Trust as major public sector employers in Torbay. A staff survey had been carried out which provided valuable insights around the challenges faced by staff and how the employers could respond better, particularly for those on lower incomes.

There was positive news in that the Council had received confirmation of £2.4 million from the fourth round of the Household Support Fund and had been allocating that funding in a manner to reach a wider range of people who are struggling to make ends meet. There is a Cost of Living Incident Management Team that meets fortnightly and were now discussing how to move from crisis stage to address medium and longer term considerations in order to build resilience for individual, families and communities.

It was recognised that further funds were being allocated to help social supermarkets and food alliances to assist more people in the community who do not qualify for other support or benefits.

Chairwoman

One Devon
Integrated Care Strategy and Joint Forward Plan
Torbay Health and Wellbeing Board

Minute Item 12

#OneDevon

The Ask:

- The Health and Wellbeing Board is asked to **review the strategic goals** set out within the Integrated Care Strategy.
- The Guidance states that the draft Joint Forward Plan must be shared with each Health and Wellbeing Board, and they must be consulted on whether the draft takes proper account of the JLHWS. Each Health and Wellbeing Board must respond in writing with their opinion and the final JFP must include a statement of the final opinion of each Health and Wellbeing Board consulted. **The Health and Wellbeing Board is asked to confirm the process for their response.**

One Devon

12 Devon Challenges

There are 12 key challenges facing Devon, some of which are common across other areas of the country, but others that reflect the unique make up of our county.

1. An ageing and growing population, with increasing long term conditions, co-morbidity and frailty

2. Climate Change

3. Complex patterns of urban and rural deprivation

4. Housing quality and affordability

5. Economic Resilience

6. Access to services including socio-economic and cultural barriers

7. Poor health caused by modifiable behaviours and earlier onset of health problems in more deprived areas

8. Varied education, training and employment opportunities, workforce availability and wellbeing

9. Unpaid care and associated health outcomes

10. Changing patterns of infectious diseases

11. Poor mental health and wellbeing, social isolation and loneliness

12. Pressure on services (especially unplanned care)

Strategic Goals

In response to the 12 Challenges and through ongoing engagement with stakeholders across the Devon System, a set of high level strategic System goals were developed that support the vision of the ICS - ***equal chances for everyone in Devon to lead long, happy and healthy lives*** - and that align to the four aims of an ICS.

The partnership will need to work closely with all sectors, including primary care, carers, VCSE, public health, housing, employers and education to deliver them.

There is also one over-arching strategic goal: **One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money. *By 2025 we will have: adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.***

For each goal where appropriate measures exist, a more specific target measure has been appended to the goals, for delivery within a defined timescale. This will allow the Integrated Care Partnership (ICP) to monitor the extent to which the actions put in place to achieve the strategic goals are impacting. The targets are measured from a baseline of 2021/22, unless otherwise detailed against a goal.

Improving Outcomes in population health and healthcare

Every suicide should be regarded as preventable and we will save lives by adopting a zero suicide approach in Devon, transforming system wide suicide prevention and care.

By 2024: each LCP will have a suicide prevention plan.

We will have a safe and sustainable health and care system.

By 2025 we will: deliver all our quality, safety and performance targets within an agreed financial envelope

People (including unpaid carers) in Devon will have the support, skills, knowledge and information they need to be confidently involved as equal partners in all aspects of their health and care.

By 2028 we will: extend personalised care through social prescribing and shared decision making and increased health literacy

Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death early and disability

By 2028 we will have: decreased the gap in healthy life expectancy between the least deprived and most deprived parts of our population by 25% and decreased the under 75 mortality rate from causes considered preventable by 25%

Children and young people (CYP) will have improved mental health and well-being

By 2024/25 we will have: at least 15,500 CYP aged (0-18) accessing NHS-funded services, 100% coverage of 24/7 crisis and urgent care response for CYP and 95% of children and young people with an eating disorder able to access eating disorder services within 1 week for urgent needs and 4 weeks for routine needs

People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.

By 2025 we will reduce the level of preventable admissions by 95%

Tackling inequalities in outcomes, experience and access

People in Devon will have access to the information and services they need, in a way that works for them, so everyone can be equally healthy and well.

By 2028 we will increase the number of people who can access and use digital technology and improved access to dentists, pharmacy, optometry, primary care

Everyone in Devon will be offered protection from preventable infections.

By 2028 we will have: increased the numbers of children immunised as part of the school immunisation programmes by 10%, increased the uptake of those eligible for Covid and Flu vaccines by 10% and reduced the number of healthcare acquired infections by 10%.

Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place

By 2028 we will have: increased the number of people dying in their preferred place by 25% and those who want it will have advanced care planning in place

The most vulnerable people in Devon will have accessible, suitable, warm and dry housing

By 2028 we will have: decreased the % of households that experience fuel poverty by 2% and reduced the number of admissions following an accidental fall by 20%

In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience.

By 2026 Devon's workforce across the multiple organisations will be supported, empowered and skilled to deliver fully inclusive services for everyone, and Devon will be a welcoming and inclusive place to live and work where diversity is valued and celebrated;
By 2027 Devon's workforce will be representative of local populations; and
By 2028 our estates, information and services will be fully inclusive of the needs of all our populations

One Devon

Enhancing productivity and value for money

People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency.

By 2026 patients will report significantly improved experience when navigating services across Devon.

We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.

By 2028 we will have: a unified approach to procuring goods, services and systems across sectors and pooled budget arrangements

People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care.

By 2028 we will have: provided a unified and standardised Digital Infrastructure

We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.

By 2028 we will have: vacancies amongst the lowest in England in the health and social care sector

Helping the NHS support broader social and economic development

People in Devon will be provided with greater support to access and stay in employment and develop their careers.

By 2028 we will have:

- *Reduced the gap between those with a physical or mental long term condition (aged 16-64) and those who are in receipt of long term support for a learning disability (aged 18-69) and the overall employment rate by 5%;*
- *Decreased the number of 16-17 year olds not in education, employment or training (NEET) by 25%;*
- *Increased the number of organisations with Gold award status for the Defence Employer Recognition scheme.*

Children and young people will be able to make good future progress through school and life.

By 2027 we will have: increased the number of children achieving a good level of development at Early Years Foundation Stage (school readiness) as a % of all children by 3% and 60% of Education, Health and Care Plans (EHCPs) will be completed within 20 weeks.

We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change, supports healthier living (including promoting physical activity and active travel).

By 2028 we will: be on-track to successfully deliver agreed targets for all Local Authorities in Devon being carbon neutral by 2030 and the NHS being carbon neutral by 2040

Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people

By 2024: Local Care Partnerships will have co-produced with local communities and community groups in their area, a plan to empower and support groups to be more resilient.

Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably

By 2028 we will have; directed our collective buying power to invest in and build for the longer term in local communities and businesses

Guidance - preparation of 5 Year Joint Forward Plan (summary)

- **JFP principles:**
  1. Fully aligned with the wider system partnership's ambitions;
  2. Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments;
  3. Delivery focused, including specific objectives, trajectories and milestones as appropriate.
- JFP to be prepared by **ICBs and partner trusts with system partners**.
- ICBs and partner trusts have a duty to prepare a first JFP before **1 April 2023**, but the date for publishing and sharing with NHS England, ICPs and H&WBs is **30 June 2023.**
- ICBs must **consult with those for whom the ICB has core responsibility** (people who are registered with a GP practice associated with the ICB, or unregistered patients who usually reside in the ICB's area), **with HWBs** and with anyone else the ICB considers appropriate.
- JFP should describe how the ICB and partner trusts intend to arrange and/or provide NHS services to **meet their population's physical and mental health needs**.
- Systems are encouraged to use the JFP to develop a **shared delivery plan** for the Integrated Care Strategy and JLHWSs, that is supported by the whole system.
- ICBs and trusts will continue to **separately submit operational and financial information** as part of the national planning process.

High Level Timeline

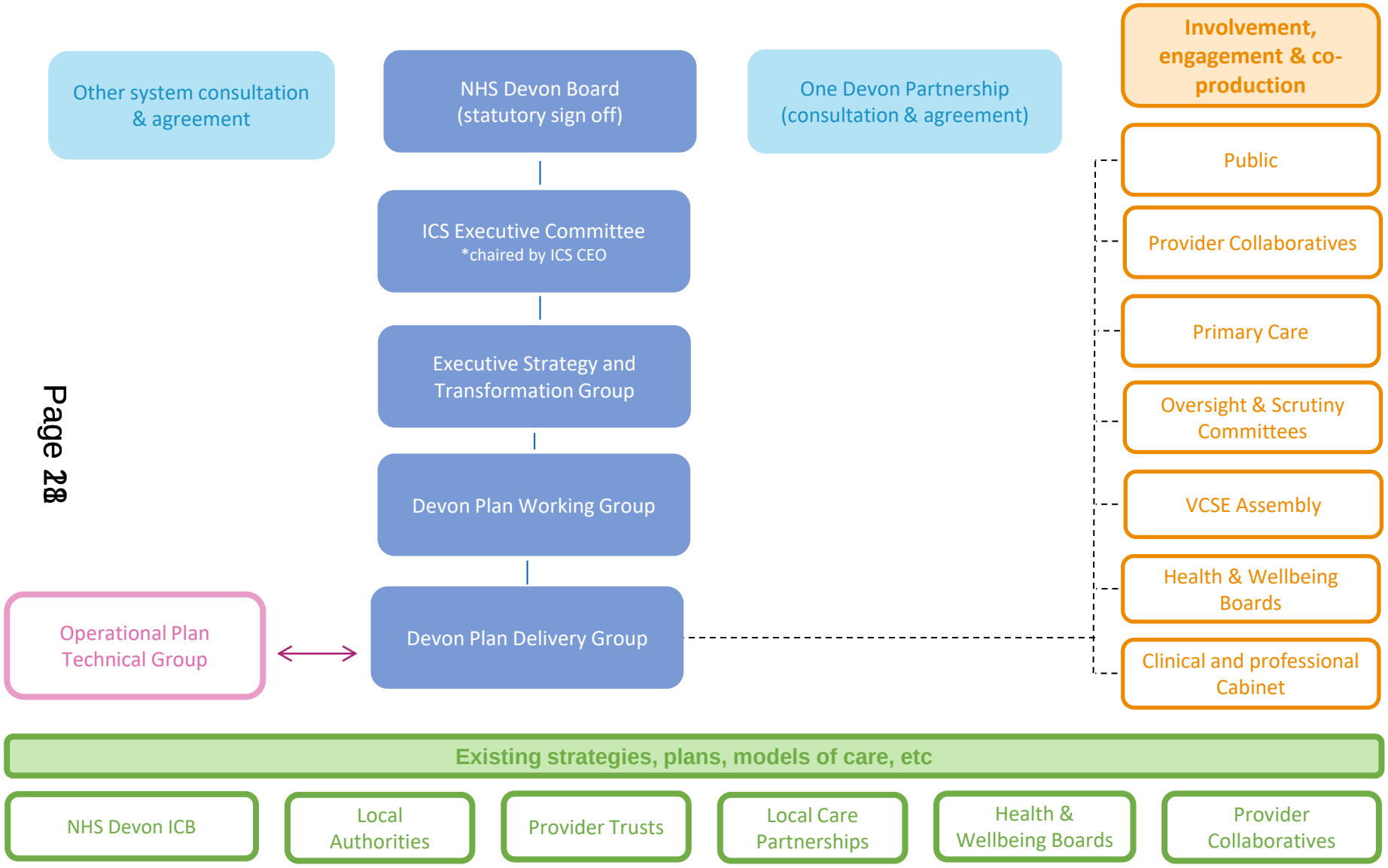
Activity	Deadline	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	24/25	25/26	26/27	27/28
Guidance published	23 /12/ 23																				
Agree scope, structure and format of JFP	31 /01/ 23																				
Agree governance and sign off process	31 /01/ 23																				
Produce engagement plan	31 /01/ 23																				
Confirm leads for pillars, priorities and enabling work streams	31 /01/ 23																				
Stocktake and gap analysis for each pillar, priority and enabler, of current plans against strategic goals and national commitments	31 /01/ 23																				
Identify key questions for public engagement	31 /01/ 23																				
Co-production of JFP content with partners	28 /02/ 23																				
Confirm Devon Outcomes Framework	28 /02/ 23																				
Change Leaders Event	23/03/23																				
Joint Health and Wellbeing Board event	23/03/23																				
Draft JFP to stakeholders	31 /03/ 23																				
Further engagement on draft JFP, inlcuding HWBs	Apr/May																				
Finalise content of Devon Plan documents	31 /05/ 23																				
HWB opinions finalised	31 /05/ 23																				
Sign Off by One Devon Partnership	01/06/23																				
Formatting and production of accessible versions	30 /06/ 23																				
Sign off on the complete Devon Plan	30 /06/ 23																				
Devon Plan Published	30 /06/ 23																				
Implementation and monitoring of delivery																					

Involving system partners

February -	**Subject leads collaborating with partners:** to collate relevant content
Ongoing -	**Devon Plan Working Group:** to inform the JFP process and content
Ongoing -	**Discussion at system meets** (JT and AW attending a range of system meetings) to update partners and open dialogue
10-17 March -	**System partners feedback tool:** to enable cross system input into content to inform and strengthen the draft JFP
23 March -	**Change Leaders Event:** to enable system VSL to check, challenge and inform the draft JFP, increasing ownership
23 March -	**H&WB Boards Event:** to enable political representatives to feed into the plan and gain support for the direction of travel
TBC May -	**Joint OSC masterclass** (led by NHS D team): to socialise the plan, provide an opportunity for members to feed-in and strengthen understanding
	LCP led local partner discussions

One Devon

JFP Governance

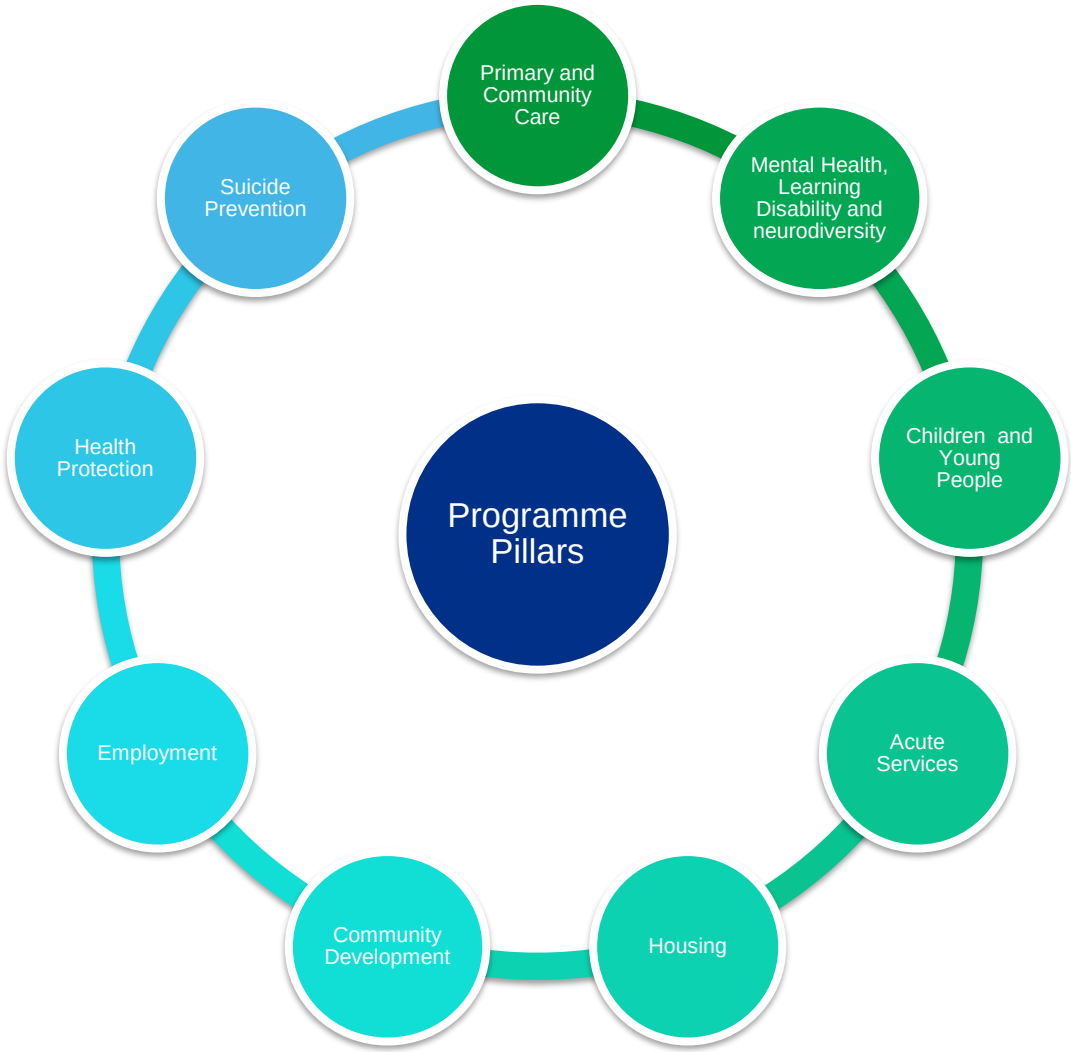


Notes:

The Delivery Group and Operational Plan Technical Group have some shared membership to ensure alignment

The NHS Devon Board has statutory responsibility to sign off the JFP prior to publication on 30 June 2023

Devon's Joint Forward Plan Pillars



Enablers

- System Development
- Workforce
- Digital and Data
- Estates and Infrastructure
- Finance
- Communications and Involvement
- Research, Innovation and Improvement
- Equality, Diversity and Inclusion
- Climate Change
- Population Health

One Devon

Proposed structure of the Joint 5-year Forward Plan

Joint 5-year Forward Plan purpose: A plan proposing how the ICB is going to exercise their functions, including proposals for health services, and action on the ICB's general duties and financial duties.

1. Executive summary	2. What is the Joint 5-year Forward Plan	3. Ambitions for health services	4. Priorities	5. Delivering a sustainable NHS in Devon	6. Enablers	7. Further development of the Joint Forward Plan
1. Summary of priorities and enablers	1. National context/guidance (include SOF4) 2. Health Response to ICS 3. Other plans in the system response to ICS 4. Purpose of the 5-year Joint Forward Plan 5. Who is involved? 6. Role of NHS Devon within the ICS 7. What has fed into this 5-year Joint Forward Plan?	1. Exec summary from strategy 2. Principles – the way we do things together in Devon 3. Highlight 12 challenges 4. Strategic goals 5. Which ones would NHS have a lead role	1. Transformation Roadmap 2. What are NHS Devon's priorities – ICB strategic objectives 3. NHS Priorities - 4 pillars 4. Wider system priorities – 5 pillars 5. Timeline for delivering priorities – high level milestones **6. Year one detail (operating plan narrative)** 7. How we will measure delivery	1. Devon Operating Model 2. LCP accountability framework 3. Getting the system in balance - £, performance, workforce 4. Role of the NHS in wider sustainability 5. How is the ICB going to exercise their functions?	1. Address 9 areas referenced in Conditions for Success section of Integrated Care Strategy from an NHS health services specific angle: • System Development • Workforce • Digital transformation • Estates • Finance • Communications • Research and innovation • Data and information sharing	1. Opinions of 3 HWBs and future work 2. Future engagement and contact details 3. Future iterations 4. Outcomes Framework development 5. Delivery plan – governance framework

The Ask:

- The Health and Wellbeing Board is asked to **review the strategic goals** set out within the Integrated Care Strategy.
- The Guidance states that the draft Joint Forward Plan must be shared with each Health and Wellbeing Board, and they must be consulted on whether the draft takes proper account of the JLHWS. Each Health and Wellbeing Board must respond in writing with their opinion and the final JFP must include a statement of the final opinion of each Health and Wellbeing Board consulted. **The Health and Wellbeing Board is asked to confirm the process for their response.**

Terms of Reference – Health and Well Being Board
as approved by Adjourned Council on 25 May 2023

Health and Wellbeing Board 1. To encourage those who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in its area. 2. To provide advice, assistance and support, as it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 (arrangements between NHS bodies and local authorities) of the National Health Service Act 2006 in connection with the provision of such services. 3. To encourage those who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board. 4. To encourage those who arrange for the provision of any health or social care services in its area and those who arrange for the provision of any health-related services in its area to work closely together. 5. To exercise the functions of Torbay Council and South Devon and Torbay Clinical Commissioning Group under sections 116 (health and social care: joint strategic needs assessments) and 116A (health and social care: joint health and wellbeing strategy) of the Local Government and Public Involvement in Health Act 2007, namely: • Preparation of a Joint Strategic Needs Assessment; and • Preparation of a Joint Health and Wellbeing Strategy. 6. To assess needs for pharmaceutical services in Torbay and publish a statement of its first assessment and of any revised assessment. 7. To provide the Council its opinion on whether the local authority is discharging its duty under section 116B (duty to have regard to assessment and strategies) of the Local Government and Public Involvement in Health Act 2007.	Leader of the Council or their nominee: Cllr David Thomas Director of Adults and Community Services; Director of Children's Services; Director of Public Health; A representative of Healthwatch Torbay; A representative of Devon Clinical Commissioning Group; A representative of NHS England; Cabinet Member for Children's Services; Torbay and South Devon NHS Foundation Trust; Devon Partnership NHS Trust; Torbay Community Development Trust; Chairman of Safer Communities Torbay; Chairman of Torbay Safeguarding Children Board; Chairman of Torbay Safeguarding Adults Board; Representative from Devon and Cornwall Police; Assistant Director for Community and Customer Services; Representative of the Ageing Well Assembly; Representative of Primary Care; Representative of the Department for Work and Pensions;

8.	To exercise the statutory duty to promote co-operation between Torbay Council, its relevant partners and other partners or bodies as the Council considers appropriate, to improve the well-being of children in the area.	Representative of Torbay Schools.
9.	To consider the annual report of the Torbay Safeguarding Children's Board.	
10.	To make any decisions that legislation or government guidance reserves to Health and Wellbeing Board's and/or proposes that Health and Wellbeing Boards would be appropriate forum for such decisions to be made.	

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Torbay Joint Strategic Needs Assessment 2023/24		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	Thursday 22 June
Contact:	Simon Baker, Public Health Specialist - Intelligence		
Telephone:	01803 207311		
Email:	simon.baker@torbay.gov.uk		

1. Purpose

1.1 2023/24 update of the Joint Strategic Needs Assessment (JSNA)

2. Recommendation

2.1 The following narrative is considered for information purposes, with issues discussed. A slide presentation will be made to the board.

3. Supporting Information

3.1 The JSNA is divided into 19 main sections based on subject matter. This is a change from previous years when the JSNA was split by the life course for younger people, working aged people and older people. This decision was made to absorb the significant amount of additional information included in this JSNA along with aiding the navigability of the document. These 19 areas are listed in the remainder of the document:

3.1.1 Demographics

The **Life expectancy gap at birth** remains significant. Over the 5 year period from 2017 to 2021 there is an 11 year gap between the life expectancy of males and 6 year gap for females in the most and least deprived areas of Torbay. The gap for males increased with the addition of Covid period data.

The **average age** of a Torbay resident is 49 years (England 40). 27% of the **current population are aged 65 and over**. This is currently projected to rise to 33% in the next 10 years. Torbay's **population is projected to rise** to 153,000 by 2043 compared to its current level of 139,000.

Almost 1 in 4 Torbay residents have **conditions or illnesses that reduce their ability to carry out day-to-day activities** (England 17%), rates are higher in Torbay even allowing for the older population structure.

3.1.2 Index of Multiple Deprivation

Torbay is ranked as the **most deprived upper-tier local authority in the South West** with approximately 27% of the population classified as living in areas that are amongst the 20%

most deprived in England. The most deprived areas are concentrated in central Paignton and Torquay.

Relative deprivation compared to England was highest in relation to **Employment deprivation**, that is those who have been involuntarily excluded from the labour market.

For 2019, just over 1 in 6 people in Torbay were classified as **income deprived**, this rose to more than 1 in 5 for children being affected by income deprivation.

3.1.3 Children & Young People's Education and Health

There is a very significant **gap in academic achievement** between those eligible for free school meals and those who are not eligible for free school meals. For 2021/22, the percentage of Torbay pupils achieving a good pass at GCSE for English and Maths was 74% for those not eligible for free school meals as opposed to 32% for those who were eligible.

Torbay has consistently had higher rates of children with special educational needs receiving an **Education, Health & Care Plan** than England.

Torbay has a significantly **worse hospital admission rate** for self-harm, alcohol and dental decay amongst our younger population than England. Rates for self-harm and alcohol admissions are much higher among females than males.

Under 18 conceptions have fallen significantly over the last decade and are approximately a third of the rate at the start of the last decade, there have also been significant falls over the same period in the number of **mothers who smoke** at the time of delivery.

MMR rates are higher than England but are below the 95% target, **HPV vaccination rates** fell significantly over the COVID-19 period from approximately 80% to 60% for females aged 13 to 14 in 2020/21.

3.1.4 Children's Social Care

Rates of **Cared for Children** are almost twice as high as England at 31st March 2022 but rates have fallen from peak of 2019.

Rate of children subject to a **child protection plan** at 31st March 2022 fell significantly compared to the previous 3 years. Rates of **Children in Need** remained significantly higher than England at 31st March 2022. **Most common factors** recorded in a Child in Need assessment were Mental Health and Domestic Abuse.

Levels of **persistent absenteeism** (missing 10% or more of possible sessions at school) are much higher among Children in Need or those with a child protection plan than the general school population. During 2021, rates were more than three times higher than the rate in the general school population.

3.1.5 Adult Social Care

Torbay is consistently an outlier in needing to support **higher levels of need in its 18 to 64** population.

Rates of **support requests for new clients** and **long-term support being met by permanent admission to residential and nursing homes** rose substantially during 2021/22.

The number of **carers** supported by Torbay Council stood at 1,430 in 2021/22, this is the largest number in the last 5 years.

34% of carers and 40% of users felt that they had as much **social contact** as they would like in 2021/22. For carers this was higher than the England rate and for users, rates were broadly in line with England although rates for users had fallen significantly compared to previous surveys. 2021/22 figures are likely to be affected by the isolation of the COVID-19 period.

3.1.6 Economy and Employment

Torbay has a **lower proportion of working age people** (57%) compared to England and this is forecast to fall over the next 20 years to approximately 50% of the population.

The **average (median) full-time salary** for residents 2022 was £28,770. This compares to £31,726 across the South West and £33,208 for England, employees in Torbay were also more likely to work **part-time**. The Annual Population Survey (2017 – 2022) shows fewer working age people in Torbay (78%) were classified as **economically active** compared to the South West (81%) and England (79%).

Rates of **unemployment claimants** are lower than England after a significant spike during the COVID-19 lockdowns in 2020 and early 2021 when rates were much higher than England.

There is significantly better **Full Fibre and Ultrafast** broadband coverage than the England average.

3.1.7 Housing

More than 1 in 4 (27%) Torbay households **privately rent** which is significantly higher than England. This is combined with the lowest proportions of **socially rented** accommodation in the South West. **Significant house price rises** have exacerbated affordability issues around buying a property.

By the end of 2021/22, 35% of Torbay dwellings had an **Energy Performance Certificate (EPC)** rating of C or better. Grades C or better are seen as the target to reach but this can be difficult in older properties. This puts Torbay 50th from bottom compared to 331 local authority districts.

Torbay has been set a challenging central government **target of 600 net additional dwellings a year** for the next 18 years. Over the last 21 years, that level of additional dwellings has occurred on 1 occasion.

On average, 146 households were in **temporary accommodation** each quarter between July 2021 and June 2022.

3.1.8 Environment and Climate Change

Torbay's **carbon dioxide and general greenhouse gas emissions** are reducing and remain lower than England.

By the end of 2021/22, 35% of Torbay dwellings had an **Energy Performance Certificate (EPC)** rating of C or better. Grades C or better are seen as the target to reach but this can be difficult in older properties. This puts Torbay 50th from bottom compared to 331 local authority districts.

Torbay's **waste reuse, recycling and composting rate** has reduced in the 3 years from 2018/19 to 2020/21 and is lower than the South West and England.

3.1.9 Sexual and Reproductive Health

The provision of **long-acting reversible contraception (LARC)** in Torbay has been higher (better) than England for the last 8 years. However, **abortion rates** remain significantly higher than England.

Under 18 conception rates are on a decreasing trend and are approximately a third of the rate at the start of the last decade, although still higher than the England figure they are statistically similar in the 2 most recent years.

The all new **sexually transmitted infection** diagnosis rate, testing rates and the percentage of testing positivity are consistently lower over the last decade in Torbay than England. May indicate low levels of infections or other issues such as lack of testing of 'at risk' groups.

Torbay proportion of 15 to 24 year olds screened for **chlamydia** has been significantly higher than England (better) for 7 years.

3.1.10 Substance Misuse and Dependency

Prevalence of **smoking** in adults has fallen over the last decade from over 20% to 15% to be broadly in line with England, tobacco use has also fallen significantly among children over the last 15 years.

Torbay has consistently had significantly higher hospital admission rates than England or South West in relation to **alcohol**, Torbay has had a higher percentage of people successfully complete structured alcohol **treatment** over the last decade than England or South West.

At the end of the last decade, there was a significant rise in the number of recorded **drug misuse** deaths in Torbay. This is reflected across England. Torbay has a higher percentage of estimated opiate and/or crack cocaine users in **treatment** than England or South West.

3.1.11 **Crime, Domestic Abuse and Anti-Social Behaviour**

Rates of reported **violent crime** are higher in Torbay than England although the gap has narrowed.

Levels of reported **acquisitive crime** in Torbay such as burglary, theft and shoplifting have fallen over the last 5 years to 2021/22.

In line with national trends, far fewer children are entering the **youth justice system**.

National Crime Survey data indicates that 29.3% of women and 14.1% of men in England and Wales have experienced **domestic abuse** at some time since the age of 16.

3.1.12 **Weight, Exercise and Diet**

Over 1 in 4 reception and 1 in 3 Year 6 pupils in Torbay are either **overweight or obese**. For reception aged children this is higher than England, for those in Year 6, it is broadly in line with England. Amongst adults, the rate is approximately 6 in 10 for Torbay.

Torbay has a higher reported rate of hospital admissions for **eating disorders** than England.

More than 7 in 10 children report being **physically active or fairly active**, just under 7 in 10 adults report being physically active.

The gap in **healthy life expectancy** between the most and least deprived areas in England was 18.8 years for females and 18.2 years for males.

3.1.13 **Oral Health**

In Torbay, 49% of children were not seen by an **NHS dentist** in the year up to June 2022 and 59% of adults were not seen in the last 2 years. This is significantly lower (better) than England. COVID-19 restrictions on dentists will have reduced the number of patients seen in the period. Also, this will not include patients seen by private dental practices.

Torbay has higher levels of **dental decay in 3 and 5 year olds** than the South West and England.

The rate of **hospital tooth extractions for dental caries (tooth decay)** in those aged 0 to 19 has been significantly higher in Torbay than the South West and England, rates are significantly higher in more deprived areas.

Oral cancer registrations and mortality are at higher levels in Torbay. In line with England, mortalities of males are double that of females.

3.1.14 **Mental Health**

Prevalence of **depression and of mental illness** (schizophrenia, bipolar affective disorder and other psychoses) of Torbay GP patients is higher than England.

Torbay has higher percentages of **school pupils with social, emotional and mental health needs** than England.

Rates of Torbay **adult social care** clients with **mental health** as a primary support reason who are receiving long-term support are significantly higher than England.

Hospital admissions for **self-harm** remain significantly higher in Torbay. However, the overall rate of emergency admissions for all ages is on a reducing trend.

Torbay **suicide** rates have been significantly higher than England, they are gradually reducing from their peak in 2016-18 but remain much higher than England.

3.1.15 **Older People**

65 and over population has risen in Torbay by 21% (just over 6,300 people) between the 2011 and 2021 Census and is currently projected to be 33% of the Torbay population within a decade (currently 27%).

Healthy life expectancy of 11 years for the 65 and over population is in line with England.

Level of **pension credit** claimants among those aged 65 and over is higher in Torbay (13%) than England (11%).

Hospital admissions for **falls** in those aged 65 and over are generally lower than England.

In the Active lives survey across England, those aged 65 and over were more **satisfied**, **happy and less anxious** than those aged 16 to 44.

3.1.16 **Unpaid Carers**

2021 Census showed just over **14,900 unpaid carers in Torbay** which equates to 1 in 9 of the population aged over 5 years. Of these carers, 5,185 provided 50 hours or more of unpaid care. An unpaid carer was defined as giving unpaid help or support to anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age.

Rates of unpaid carers are higher in Torbay than England across all age groups in the Census. **13.5% of females are unpaid carers, 9.0% of males are unpaid carers**.

Almost 1 in 6 people classified as **disabled under the Equality Act** are unpaid carers.

Almost 1 in 2 adult carers known to local social services care for 100 hours or more per week. Carers known to local social services were most likely to look after people with a physical disability, long-standing illness or problems connected to ageing.

3.1.17 **Preventable Mortality**

Definition of preventable mortality relates to deaths that are considered preventable if, all or most deaths from the underlying cause could mainly be avoided through effective public health and primary prevention interventions.

Rate of **deaths from causes considered preventable** in the under 75 age group are higher in Torbay than England and South West, they are much **higher within the more deprived areas** of Torbay when compared to the less deprived.

The most common cause of death in Torbay that was considered preventable in the **under 75 age group** was Cancer, accounting for over 1 in 3 preventable deaths. Just over 50% of these cancer deaths related to lung cancer.

The most common cause of death in Torbay that was considered preventable in the **under 50 age group** was Liver Disease, in particular alcoholic liver disease.

Rate of preventable deaths among the under 75 age group is **much higher among males when compared to females** in Torbay.

3.1.18 **Eye Health**

Torbay is estimated to have a higher rate than England of people living with **sight loss that has had a significant impact on their daily lives**. Rate of Torbay new sight loss certifications have been significantly higher than England for the last 7 years.

Certifications for **age-related macular degeneration** and **glaucoma** are at higher levels in Torbay than England.

The rate per 100,000 of those aged 75 and over registered as **sight impaired or severely sight impaired** in Torbay was lower than England in March 2020. The register has fewer people in the younger age groups, but rates are higher in Torbay than England.

More than 40% of people registered as sight impaired or severely sight impaired in Torbay have **additional disabilities**.

3.1.19 **Diabetes and Heart Disease**

9,679 Torbay GP patients had recorded **Diabetes** in 2021/22 equating to 7.8% of those aged 17 and over at those GPs. 92% of these cases relate to Type 2 diabetes.

Rates of **emergency hospital admissions** and **under 75 deaths** from **coronary heart disease** are much higher in the most deprived areas of Torbay when compared to the least deprived.

18% of Torbay GP patients are known to have **hypertension**, many people do not realise they have this condition so this will be a significant understatement.

Smoking prevalence has fallen over the last decade. It remains significantly higher among the long-term unemployed population or those who work in routine or manual occupations.

Just over 6 in 10 adults are **overweight or obese** in Torbay.

TORBAY JOINT STRATEGIC NEEDS ASSESSMENT 2023/24

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Foreword from the Chair of the Health and Wellbeing Board

It is my pleasure to introduce the 2022/23 Torbay Joint Strategic Needs Assessment (JSNA).

The JSNA is a key document for Torbay Council and our partners. It enables us to build a picture of the needs of our communities, covering all aspects of people's lives. Our last JSNA was published in the latter part of the COVID-19 pandemic. We are now in a position to review the impact of the pandemic on our community, and to refocus our efforts to drive improvements in health outcomes for our population.

The JSNA this year follows a different structure. In addition to the population overview, there are separate chapters setting out greater detail on specific issues such as social care, education, housing, employment, oral health and substance misuse. We hope that you will find the JSNA an effective resource to support the development of strategic, commissioning and health promotion plans.

The JSNA highlights some significant demographic and health challenges we face in Torbay. We continue to age, as a population, faster than the South West as a whole. Inequalities in health status and outcomes are clear. We have high levels of cared for children, special educational needs, self-harm and suicide. In common with other areas, we face continuing issues around obesity (in all ages), smoking, heart disease, and people living with multiple long term health conditions.

There are also some positive trends. Rates of children subject to child protection plans have fallen, under 18 conceptions are reducing, and prevalence of smoking has fallen although it remains a health concern. We also have significant natural assets in our environment. We have a very strong community and voluntary sector. And we have engaged communities, keen to support each other to promote physical, mental and social wellbeing.

As a new administration in Torbay, we are determined to work in partnership to harness the strengths of our communities to address the health and wellbeing challenges we jointly face. We look forward to working with you all to this end.

David Thomas
Chair
Torbay Health and Wellbeing Board

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JSNA Key Challenges

Key challenges facing the population and the organisations that serve the population are highlighted below.

- The recovery from COVID-19 and the cost of living crisis. The social and economic effects of the pandemic and the recent inflationary leaps in the cost of living, particularly around gas, electricity and food prices have disproportionately affected those who live in the most deprived areas of our communities. Costs around fuel are exacerbated by old housing stock which is often energy inefficient.

- There is significant variation in health and wellbeing across the bay. In our most affluent areas residents can expect to live on average over eight years longer than those living in our more deprived communities. There are also significant gaps in healthy life expectancy between the most affluent and deprived areas.

- Inequalities have been widening as relative deprivation worsens; Torbay is ranked as the most deprived local authority in the South West.

- Torbay's economy is ranked among the weakest in England. Average wages continue to be significantly below the regional and national average with less of the population in full-time employment than England.

- The number of cared for children within the local authority remains among the highest in England.

- Torbay schools have a significantly higher proportion of their pupils requiring special education needs support through an Education, Health & Care Plan when compared to England.

- Torbay has far higher levels of need when compared to England that requires support from Adult Social Care in the 18 to 64 population.

- The 2021 Census showed that there were 14,900 unpaid carers in Torbay. 5,185 of these provided 50 hours or more of care. These unpaid carers require support to help deliver this care and to look after their own health and wellbeing.

- We have an ageing population with 1 in 3 Torbay residents expected to be 65 and over by the middle of the next decade. The number of those who are of working age is projected to fall over the next 20 years to approximately 50% of the population from its current rate of 57%.

- There are many opportunities for the people of Torbay to be supported to improve their lifestyles. At present:
  - Over 6 out of 10 adults in Torbay are overweight or obese. Over 1 in 4 reception and 1 in 3 Year 6 children are overweight or obese.
  - Around 1 in 6 adults in Torbay smoke.
  - There are high levels of suicide and self-harm in the population.
  - There are high levels of vulnerability in the population, including groups with specialist needs and high levels of mental ill health.

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This document is part of the JSNA in Torbay, a significant part of the JSNA are the electoral ward profiles which can be found at JSNA Narratives - South Devon and Torbay Knowledge and Intelligence

There is also a range of topic based analyses relating to different aspects of health and wellbeing. All information can be found on our webpages: Sharing knowledge and intelligence to understand the needs of the community - South Devon and Torbay Knowledge and Intelligence

Introduction

Background

A Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of the local community.

The JSNA helps local leaders to work together to understand and agree the needs of the local population. JSNAs, along with health and wellbeing strategies enable commissioners to plan and commission more effective and integrated services to meet the needs of the population. Local Authorities and Integrated Care Boards have equal and explicit obligations to prepare a JSNA, under the governance of the health and wellbeing board.

The approach to the JSNA in Torbay is to provide a collection of narrative and data interpretation to support the community, voluntary sector and statutory organisations across Torbay. This provides a central, consistent range of data that can be accessed to support commissioning strategies and funding bids across all sectors within Torbay.

Helping people to live longer and healthier lives is not simply about NHS healthcare received through GPs or at hospital. It is also about the wider social determinants of where we live and work, things such as Crime, Income, Housing and Education. The collective action of agencies is needed today to promote the health of tomorrow's older population. Preventing ill health starts before birth and continues to accumulate throughout individuals' lives.

Structure

The document is part of a wider suite of documents and presentations that make up the JSNA for Torbay, these include breakdowns of information to smaller areas of Torbay such as wards and MSOAs. As well as the JSNA, there are specific topic based summaries relating to fields such as alcohol and suicide. This information is collated at the following website http://www.southdevonandtorbay.info/

Information sources

Information that makes up this document comes from an array of public sources and occasionally from private organisational sources, these will be credited throughout the profile. A significant amount of information is gathered at the Office for Health Improvement and Disparities (OHID) website called 'Fingertips'. This site contains a large amount of information on its 'Public Health Outcomes Framework', there are also multiple useful profiles relating to subjects such as Mental Health, Alcohol and Tobacco. The site is available at Public health profiles - OHID (phe.org.uk) and shows Torbay's position relative to other local authorities.

Population estimates used

This JSNA has been produced over a period when multiple different population estimates have been available and used for different measures. The 2021 Census population, 2020 ONS population

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estimates and 2021 ONS population estimates are the basis of measures downloaded throughout the production period of the JSNA. This should not lead to a material difference in the vast majority of measures within the JSNA, however it should be noted that populations before 2020 will be revised late in 2023 which could lead to alterations in historical data, again this is unlikely to lead to a material change in the vast majority of cases.

Document overview

Previously the JSNA has been written by life course, for instance last year the JSNA was divided into 4 chapters called Population overview, Starting and developing well, Living and working well and Ageing well.

For this JSNA, it was decided to significantly increase the number of measures within the document. Because of this increase in measures and to improve the navigability of the document it was decided to split the document by subject as shown on the contents page. For example, Sexual and Reproductive Health measures are to be found in a single chapter rather than across multiple life course chapters.

References to quintiles throughout the document relate to populations being broken down into fifths. For instance most deprived quintile is the most deprived fifth of the population across England.

Wider determinants of health

It is not possible to change some of our individual determinants of health, such as our age and genetic makeup. However, there are other factors that we can try to influence in regard to the wider determinants of health. Wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health.

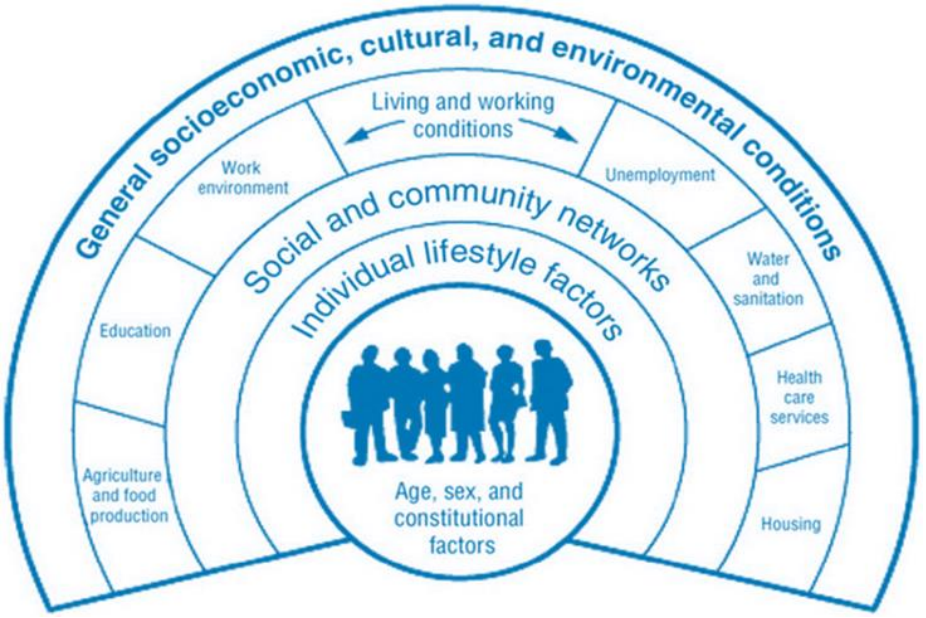
These include the following influences which are presented in Fig 1:

- Individual lifestyle factors – Smoking, alcohol, physical activity and diet.
- Social and community networks – Relationships with family, friends and the wider community.
- Living and working conditions – Includes access and opportunities in relation to jobs, housing, education and welfare services.
- General socioeconomic, cultural and environmental conditions – Includes disposable income, taxation and the availability of work.

Influencing these areas, across the life course, is required to reduce inequalities such as the gaps in healthy life expectancy.

Fig 1: Wider determinants of health

Source: G.Dahlgren, M.Whitehead – Policies and strategies to promote social equity in health



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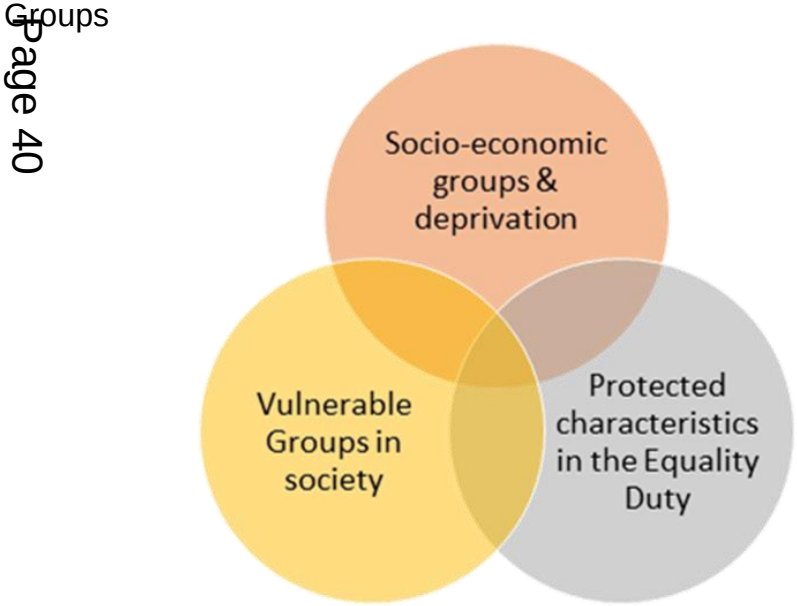
Inequalities

Inequalities are variances between different groups within society that are both avoidable and unfair. They develop out of the conditions that we are born, grow, live, work and age in. These conditions impact in different ways as well as in different combinations, which show themselves in such a way as to be either beneficial or detrimental to people's lives, such as health behaviours, health status and wellbeing.

Inequalities can exist between population groups in a geographic community in different ways, with many individuals and groups intersecting across two or more of these (Fig 2).

Fig 2: Inequalities and intersection



- Socio-economic groups and deprivation: Examples include those who are unemployed, on low incomes or people living in deprived areas.
- Protected characteristics: The Equality Act protects people against discrimination because of the 9 protected characteristics that we all have. Examples of protected characteristics are sex, race, sexual orientation and disability.
- Vulnerable groups in society: These are groups of people who because of certain factors mean they are more at risk than others in society and/or marginalised in society. Examples include people with a disability, people with substance misuse problems, prisoners and homeless people. Inclusive health groups can be an alternative term that is often used for this population group.

Comparisons

The Chartered Institute of Public Finance and Accountancy (CIPFA) has developed an approach to aid benchmarking and comparing similar local authorities. These are known as nearest neighbours. Torbay's nearest neighbours are presented below. Within this report, Torbay will be compared to a 'comparator group' in data tables at the end of most sections, the statistic shown is the average of the nearest neighbours. Torbay is also shown in Fig 3 for comparison.

There are 2 chapters relating specifically to children and young people where a different 'comparator group' is used. The 2 chapters are 'Children & Young People's Education and Health' and 'Children's Social Care' where Torbay is compared to Children's Services Statistical Neighbours (Fig 4).

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Fig 3: CIPFA comparators for Torbay
Source: CIPFA, IMD 2019, 2021 Census

Local Authority	% of population living in 20% most deprived areas (IMD 2019)	% of population aged 65 & over (2021)
Bournemouth, Christchurch and Poole	11.5%	21.6%
Bury	23.7%	18.3%
Calderdale	30.6%	19.0%
Darlington	30.2%	20.4%
Dudley	28.6%	20.4%
Isle of Wight	13.8%	29.2%
North East Lincolnshire	36.7%	20.9%
North Tyneside	21.0%	20.5%
Northumberland	20.3%	25.4%
Plymouth	30.2%	18.5%
Redcar and Cleveland	35.8%	23.3%
Sefton	30.9%	23.2%
Southend-on-Sea	23.5%	19.1%
Stockton-on-Tees	29.6%	18.9%
Wirral	35.8%	22.0%
Torbay	27.5%	26.7%

Fig 4: Children's Services statistical neighbour comparators for Torbay
Source: IMD 2019, 2021 Census

Local Authority	% of child population living in 20% most deprived areas (IMD 2019)	% of population aged 17 & under (2021)
Bournemouth, Christchurch and Poole	14.5%	18.3%
Isle of Wight	21.4%	16.8%
Norfolk	17.9%	18.3%
North East Lincolnshire	45.5%	21.0%
Plymouth	31.8%	19.5%
Redcar and Cleveland	44.2%	20.0%
Rotherham	37.5%	21.2%
Southend-on-Sea	28.1%	21.1%
Telford and Wrekin	27.5%	22.3%
Wigan	29.4%	20.7%
Torbay	30.1%	18.1%

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Demographics

Overview

- Torbay has a significantly older age profile than England, an average age of 49 years compared to 40 years across England. 27% of Torbay residents are aged 65 and over.

  Source: 2021 Census

- Current predictions indicate that 1 in 3 Torbay residents will be aged 65 and over by 2033.

  Source: NOMIS

- Almost 1 in 4 Torbay residents have conditions or illnesses that reduce their ability to carry out day-to-day activities.

  Source: 2021 Census

- There are significant differences in life expectancy between those in the most and least deprived areas of Torbay.

  Source: Primary Care Mortality Database, ONS mid-year population estimates

- For the first time, data was collected by the Census in respect of the sexual orientation and gender identity of Torbay residents.

  Source: 2021 Census

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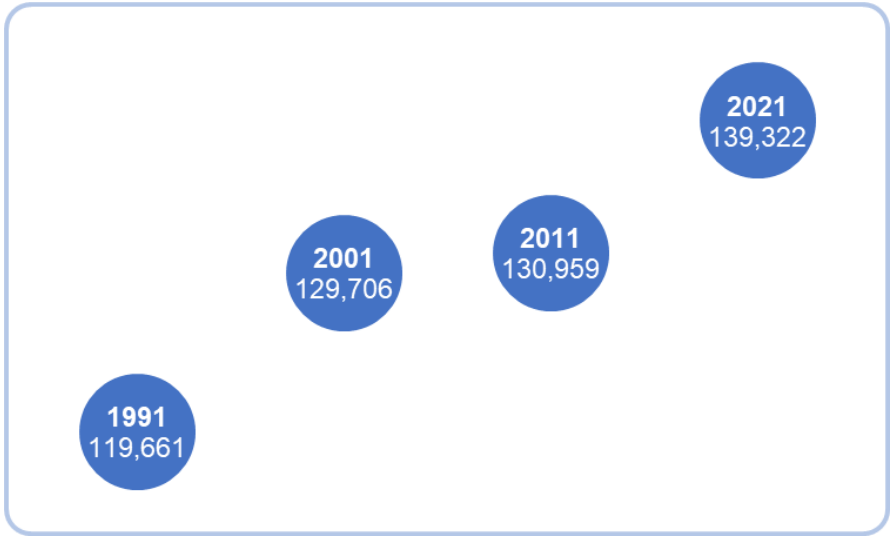
Population

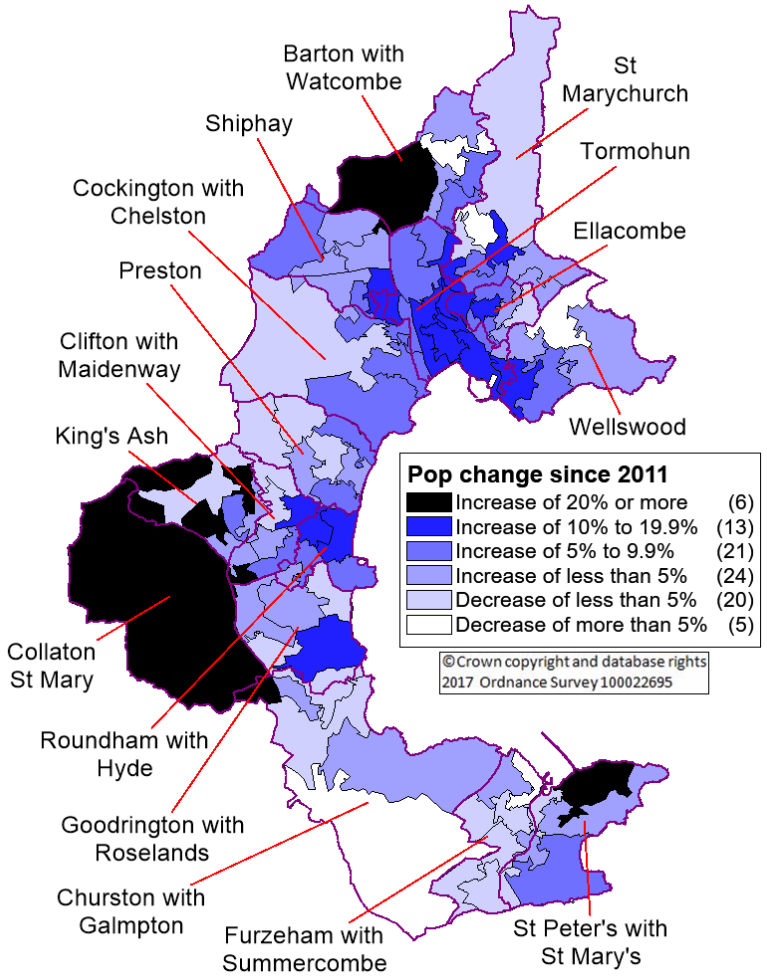
According to the 2021 census, 139,322 people lived in Torbay within 62,992 households. This is an increase of 6.4% when compared to the 2011 population of 130,959. Torbay's population has increased by approximately 20,000 since 1991 (Fig 5). The average (median) age of a Torbay resident according to the 2021 Census was 49 years, this compares to 44 years in 2001.

Fig 5: Torbay Population by Census Year
Source: Census



The increase in population is different across Torbay (Fig 6), 28% of small areas called LSOAs within Torbay fell in population between 2011 and 2021. 19 small areas rose by 10% or more including 6 areas that had population rises over 20%, 1 particular area in Collaton St Mary saw the biggest rise as its population more than doubled, rising by 112%. The next highest rise was 24%. According to the 2021 Census, 12,087 Torbay residents moved to Torbay from inside the UK in the year up to March 2021, this was almost 2½ times the rate before the 2011 Census. This covers the period of the first COVID-19 lockdowns and the subsequent 'race for space' that may have led many to move to areas in the countryside or by the sea.

Fig 6: Population change across Torbay from 2011 to 2021
Source: Census



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Protected Characteristics

Protected characteristics are the 9 characteristic groups protected under the Equality Act 2010. Under the Act, people are not allowed to discriminate, harass or victimise another person because they have any of the protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic. The 9 protected characteristics are listed below.

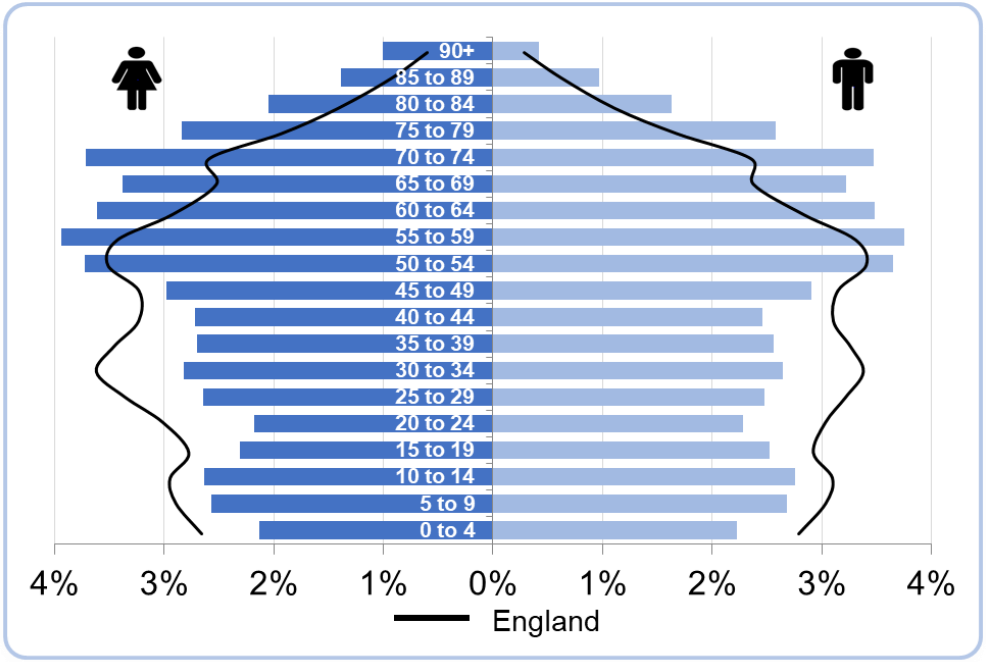
- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

The Census provides data on many of these characteristics that can be difficult to collate at a Torbay level outside of the Census, so a summary of Protected Characteristics data will be provided over the next few pages.

Protected Characteristic - Age

Torbay's population profile shows a significantly older demographic than England. Torbay has significantly larger proportions of those aged 50 and over than England, conversely it has significantly smaller proportions of those aged under 50, in particular those aged 20 to 44 (Fig 7). Torbay's average age of 49 years compares to 40 years for England and 44 for the South West. This age profile can lead to significantly higher demand for health and care services tailored towards an older population. Torbay has a significantly smaller proportion of working age population (higher dependency ratio) when compared to England and the South West.

Fig 7: Population Profile – Torbay
Source: Census 2021



Between 2011 and 2021, the largest proportionate increases in population have occurred in the 70 to 79 and 50 to 59 year age groups, the largest fall was in the 40 to 49 year age group.

Between 1991 and 2021, the largest proportionate increase in population occurred in the 90+ and 50 to 59 year age groups. 2 age groups have seen their population fall, those aged 20 to 29 and those aged 40 to 49 (Fig 8). Please note that population by age band equates to 139,324 (Overall Census population for Torbay given as 139,322).

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Fig 8: Population by age band – Torbay
Source: Census

Age Band	1991	2021	Change
0 to 9	12,666	13,371	+5.6%
10 to 19	13,316	14,223	+6.8%
20 to 29	14,944	13,343	-10.7%
30 to 39	13,398	14,926	+11.4%
40 to 49	15,813	15,423	-2.5%
50 to 59	13,100	20,977	+60.1%
60 to 69	14,379	19,078	+32.7%
70 to 79	13,428	17,575	+30.9%
80 to 89	7,541	8,421	+11.7%
90+	1,076	1,987	+84.7%
ALL AGES	**119,661**	**139,324**	**+16.4%**

Protected Characteristic – Disability

For the 2021 Census, Torbay residents were asked if they had any physical or mental health conditions or illnesses which have lasted or are expected to last 12 months or more. If they answered yes, there was a further question 'Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?'. This definition, where people answer yes to both questions is in line with the disability definition in the Equality Act 2010.

23.8% of Torbay residents answered that their day-to-day activities were limited a little or a lot (Fig 9). This was significantly higher than England (17.3%) and South West (18.6%), the difference was particularly marked in those stating that their day-to-day activities were limited a lot. Data was also provided that took account of differing age structures in local authorities, such as Torbay's population being older than average. Allowing for this, Torbay still had higher rates than England and the South West of those deemed to be disabled under the Equality Act 2010.

Please note rates have not been compared to the 2011 Census as the question was asked slightly differently and included a statement to include problems related to old age which was removed for 2021.

Fig 9: Population by disability status - Torbay
Source: Census 2021

Status	Number	Percentage
Disabled under Equality Act	**33,224**	**23.8%**
Day-to day activities limited a lot	15,258	11.0%
Day-to day activities limited a little	17,966	12.9%
Not disabled under Equality Act	**106,099**	**76.2%**
Long term condition but day-to-day activities are not limited	9,981	7.2%
No long term conditions	96,118	69.0%

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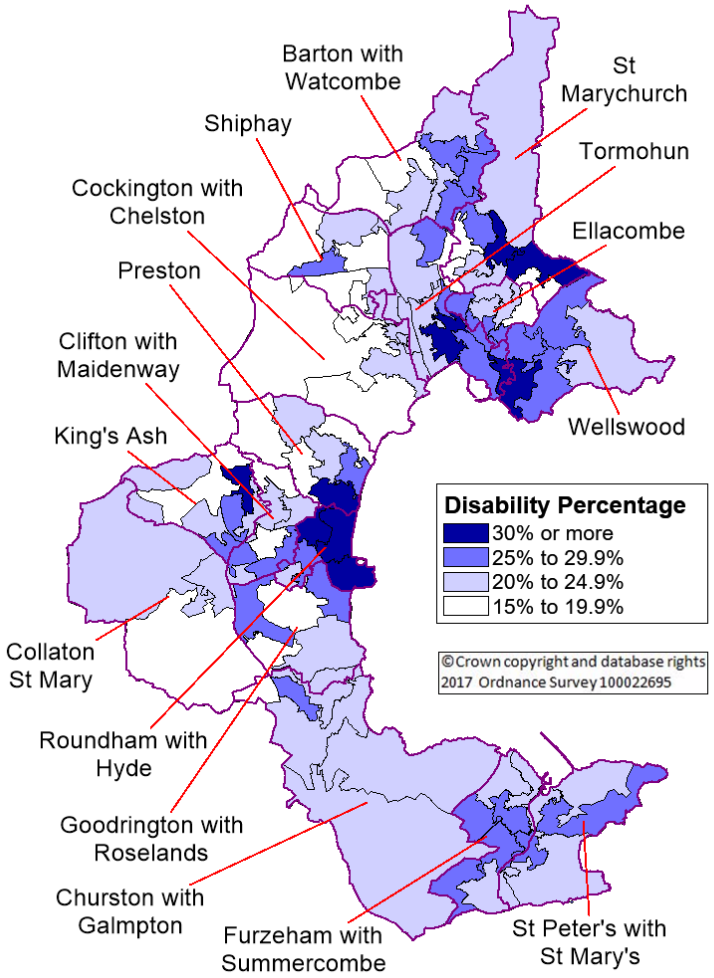
There are significant concentrations of people whose day to day activities are limited a little or a lot in central Paignton, central Torquay and Babbacombe/St Marychurch (Fig 10).

Fig 10: Population defined as disabled by area - Torbay
Source: Census 2021



Protected Characteristic – Gender Reassignment

The 2021 Census was the first Census to ask questions around the gender identity of those aged 16 and over. 94.4% of Torbay's 16+ population answered questions around gender identity, of those who answered, 0.4% stated that their gender identity was not the same as the sex registered at birth (Fig 11). This was similar to the South West and lower than England (0.6%). As of February 2023, data has not been made available by age group to see potential differences between younger people and their older counterparts.

Fig 11: Gender Identity of those who answered in Census - Torbay
Source: Census 2021

Status	Number (16+)	Percentage
Gender identity the same as sex registered at birth	109,984	99.6%
Gender identity different from sex registered at birth but no specific identity given	151	0.1%
Trans woman	94	0.1%
Trans man	102	0.1%
All other gender identities	102	0.1%

Protected Characteristic – Marriage and Civil Partnership

Of those Torbay residents aged 16 and over at the 2021 Census, 44.2% were married or in a registered civil partnership, this was down slightly on 2011 when the percentage stood at 46.9%. For those who have never married or never registered a civil partnership

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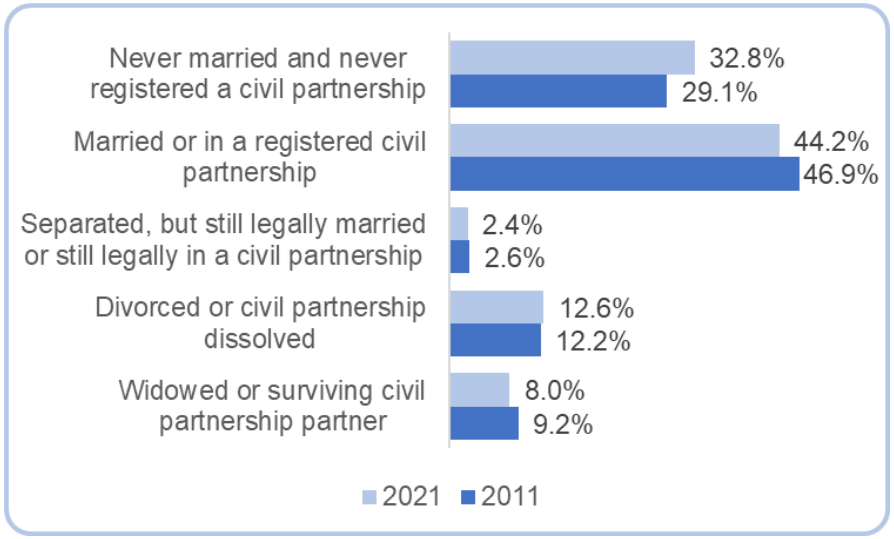
at the 2021 Census, this stood at 32.8% which is slightly up on the 2011 figure of 29.1% (Fig 12).

The proportion of those who have never married or never registered a civil partnership is lower in Torbay than England, the levels of those divorced or widowed is higher in Torbay than England.

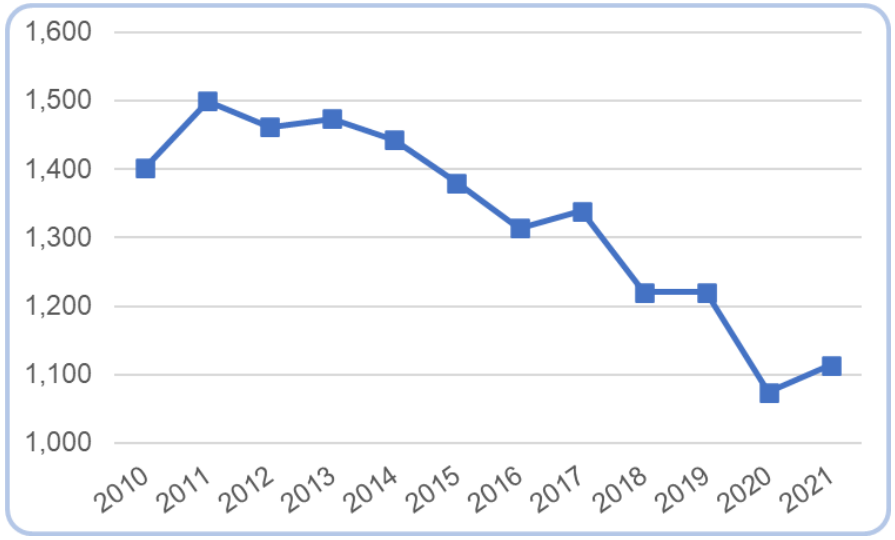
Fig 12: Marriage and Civil Partnership Status - Torbay
Source: Census



Protected Characteristic – Pregnancy and Maternity

Over the period 2010 to 2021, the rate of live births (as a proportion of females aged 15 to 44) has been slightly but significantly higher in Torbay (average of 63.7 per 1,000) than England (60.2) and the South West (58.4). There has been a notable fall in the numbers of live births since the middle of the last decade across all geographical areas (Fig 13).

Fig 13: Live Births – Torbay
Source: ONS Births in England and Wales



Protected Characteristic – Race

96.1% of Torbay residents classified themselves as White for the 2021 Census (2011 – 97.5%), 92.1% as White British (2011 – 94.8%). There were rises in the 4 other broad ethnic classifications in Torbay. Torbay has a higher rate of those who classify themselves as White than the South West and England (Fig 14). Those who do not classify themselves as White are significantly more likely to live in areas of Torbay classified as being amongst the 20% most deprived areas in England.

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Fig 14: Percentage of Ethnic group
Source: Census 2021

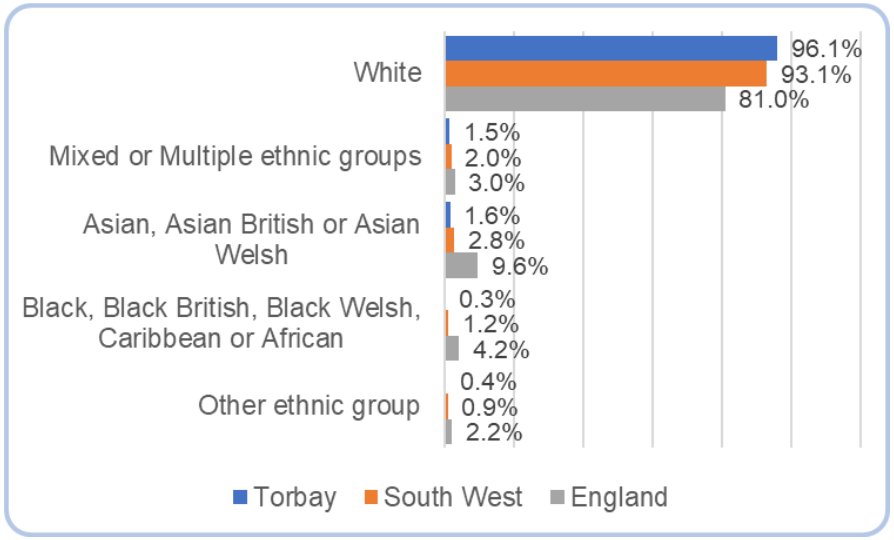
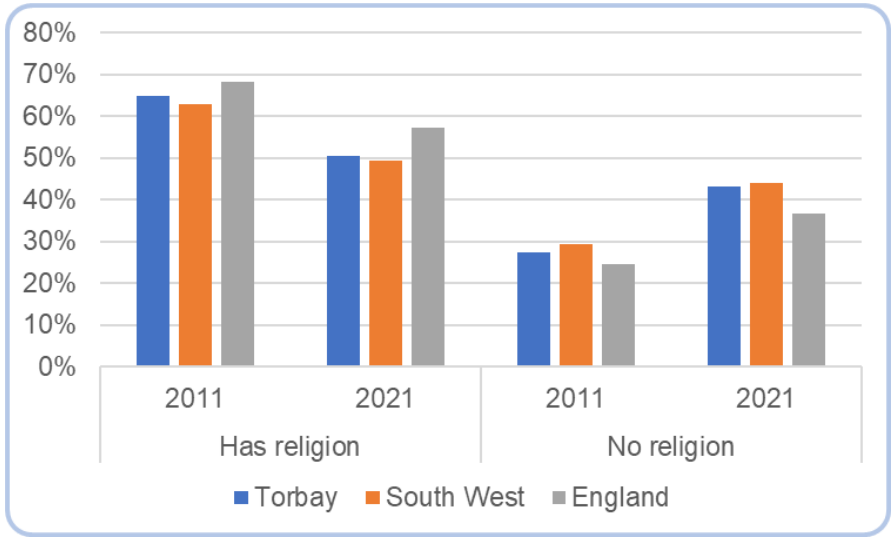


Fig 15: Percentage who have or do not have a religion
Source: Census



Protected Characteristic – Religion or Belief

The number of Torbay residents who state that they have a religion in the 2021 Census has fallen significantly from 64.8% in the 2011 Census to 50.5%. Those in Torbay who state that they have no religion has risen from 27.5% to 43.2% in the same period, 6.3% of Torbay residents did not answer the question on the 2021 Census. These movements are largely mirrored across the South West and England. 48.5% of Torbay residents classified themselves as Christian, down from 63.3% in 2011 (Fig 15).

Protected Characteristic – Sex

51.3% of Torbay's population for the 2021 Census was female, this was a slight fall from 2011 when it was 51.8%. Female to male ratios within Torbay change significantly once you get to those residents aged 80 and over (Fig 16).

Protected Characteristic – Sexual Orientation

The 2021 Census was the first Census to ask questions around the sexual orientation of those aged 16 and over. 92.6% of Torbay's 16+ population answered questions around sexual orientation. Of those who answered, 3.4% of people identified as Gay or Lesbian, Bisexual, or 'All other sexual orientations' which includes people who identify as Pansexual, Asexual, Queer or other sexual orientation (Fig 17). Figures for Torbay were similar to England and South West who also recorded a rate of 3.4%. Figures were slightly higher than

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previous regional estimates of those who identified as Gay or Lesbian, Bisexual or 'All other sexual orientations'.

Fig 16: Sex by age group – Torbay
Source: Census 2021

Age Band	Female	Male	Female %	Male %
0 to 9	6,546	6,825	49.0%	51.0%
10 to 19	6,874	7,352	48.3%	51.7%
20 to 29	6,718	6,625	50.3%	49.7%
30 to 39	7,680	7,246	51.5%	48.5%
40 to 49	7,945	7,479	51.5%	48.5%
50 to 59	10,670	10,306	50.9%	49.1%
60 to 69	9,734	9,339	51.0%	49.0%
70 to 79	9,135	8,440	52.0%	48.0%
80 to 89	4,794	3,627	56.9%	43.1%
90+	1,400	587	70.5%	29.5%
ALL AGES	71,496	67,826	51.3%	48.7%

Fig 17: Sexual Orientation of those who answered in Census - Torbay
Source: Census 2021

Status	Number (16+)	Percentage
Straight or heterosexual	104,729	96.6%
Gay or Lesbian	2,035	1.9%
Bisexual	1,344	1.2%
All other sexual orientations	298	0.3%

Life expectancy and Healthy life expectancy

Life expectancy for females and males at birth in Torbay has been lower than England for the last 3 and 6 time periods respectively (Figs 18 and 19). Over the last decade, life expectancy at birth within Torbay has remained largely flat and female life expectancy has been approximately 4 years higher than males, it should be noted that 2020 encompasses the first 9 months of the COVID-19 pandemic.

There are very significant differences in life expectancy between different areas of Torbay, the gap is particularly pronounced among males. When we look at local Torbay data for the 5 year period 2017 to 2021, there is an 11 year life expectancy gap between males who live in the least and most deprived areas and a 6 year gap for females (Fig 20). It should be noted that Torbay has a relatively small population in the least deprived quintile of England so numbers are a little more volatile, the period also includes 21 months of the COVID-19 pandemic which was known to be particularly dangerous to those with pre-existing conditions which are more likely to exist in more deprived areas and males.

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Fig 18: Life expectancy at birth - Females
Source: Fingertips

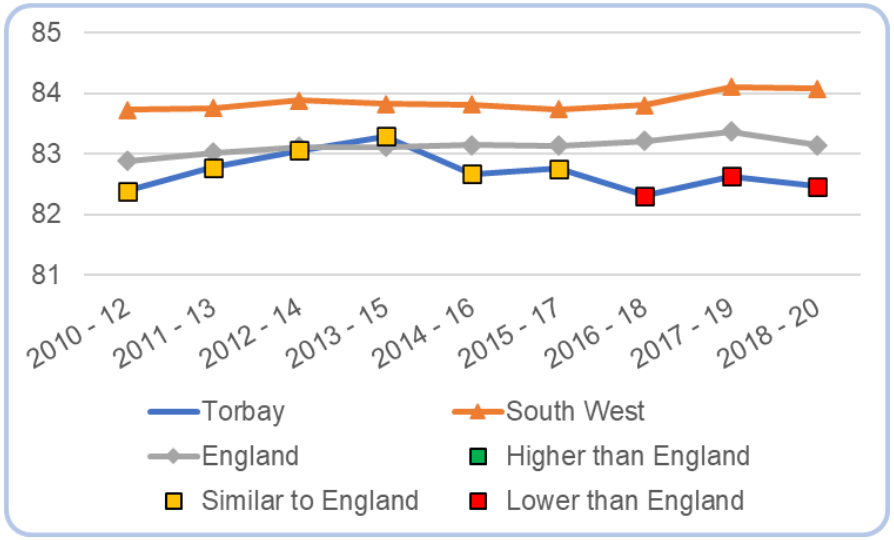


Fig 19: Life expectancy at birth - Males
Source: Fingertips

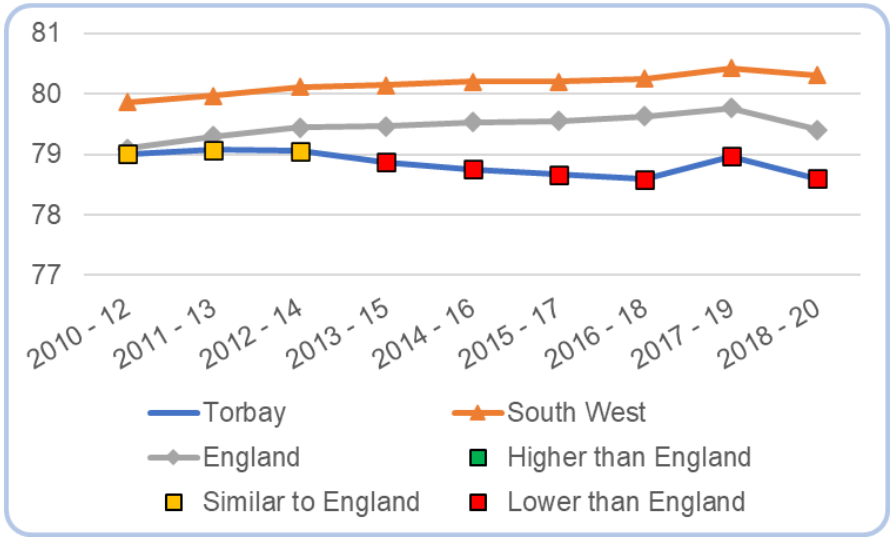
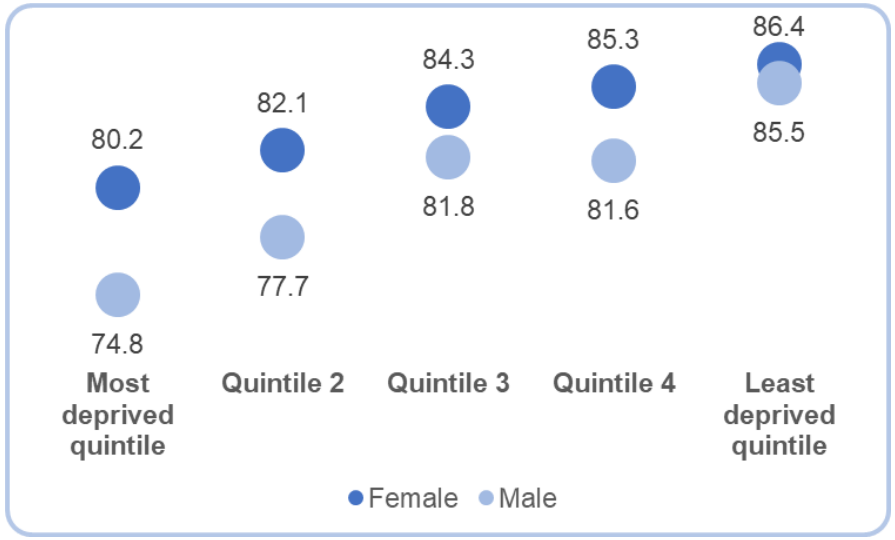


Fig 20: Life expectancy at birth – Torbay (2017 to 2021)
Source: Primary Care Mortality Database, ONS mid-year population estimates



Whilst females in Torbay have a life expectancy at birth approximately 4 years higher than males over the last decade, their healthy life expectancy has been broadly similar to males over the same period in Torbay (Figs 21 and 22). For 2 of the last 5 time periods, healthy life expectancy for females in Torbay has been significantly lower than England. For 2018 – 20, this implies that females in Torbay could expect to live for 20 years whilst not being in good health, for males it would be approximately 14 years. Healthy life expectancy is based on self-reported good or very good health from the Annual Population Survey and registered deaths.

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Fig 21: Healthy life expectancy at birth - Females
Source: Fingertips

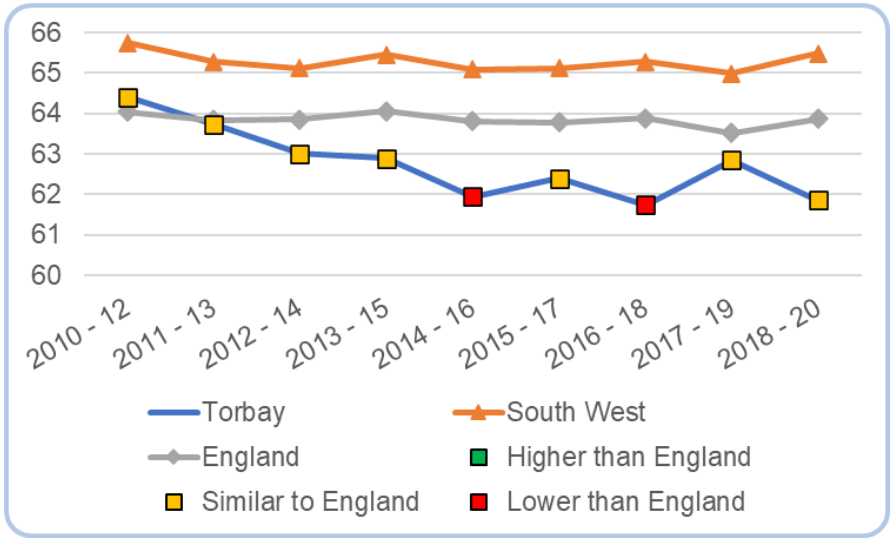
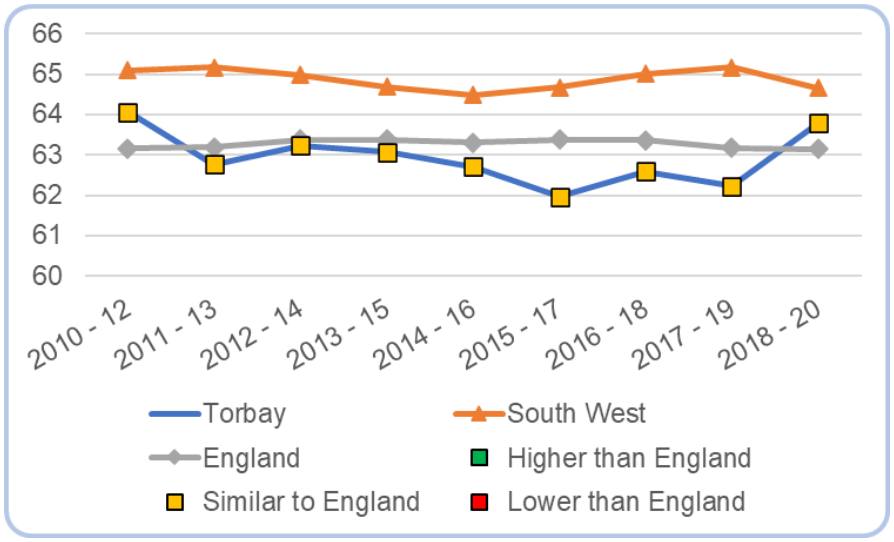


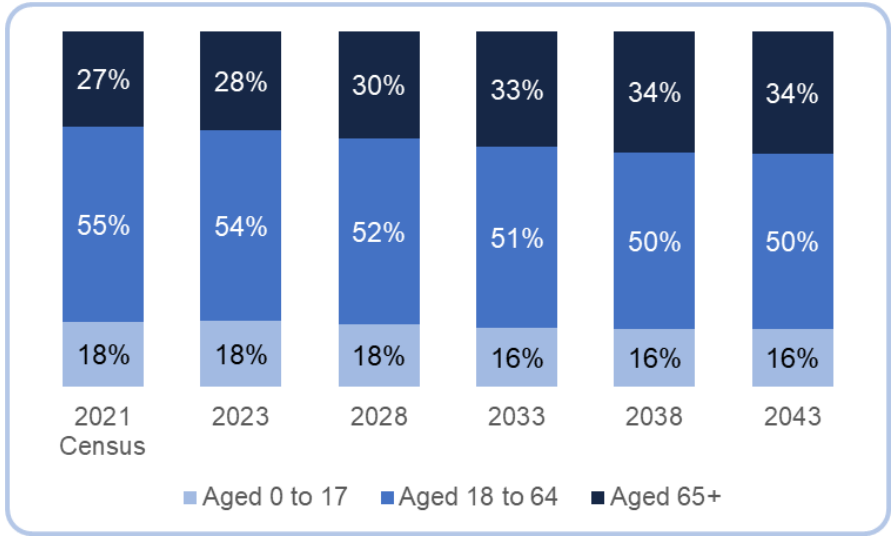
Fig 22: Healthy life expectancy at birth - Males
Source: Fingertips



Population Projections

Torbay's population is currently projected to rise from 139,322 in the 2021 Census to 153,088 by 2043. It should be noted that projections are likely to be updated over the next year in light of the 2021 Census. The proportion of the population aged 0 to 17 is projected to fall from 18% to 16% by 2043. Those aged between 18 and 64 are projected to fall from 55% to 50% by 2043, the proportion of those aged 65 and over is expected to rise from 27% to 34% by 2043 (Fig 23).

Fig 23: Population projections – Torbay
Source: NOMIS



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Average Age (2021)	Years	49	43	44	40	🔴	↑
Dependency Ratio (2021)	Ratio %	71.4%	61.6%	61.9%	55.8%	🔴	↑
Day to Day activities limited (2021)	%	23.8%	20.3%	18.6%	17.3%	🔴	Not comparable
Gender identity not the same as sex registered at birth (2021)	%	0.4%	0.4%	0.4%	0.6%	Not relevant	First time collected
BAME Population (2021)	%	3.8%	7.7%	6.9%	19.0%	Not relevant	↑
Have a religion or belief (2021)	%	50.5%	54.5%	49.5%	57.3%	Not relevant	↓
Gay or Lesbian, Bisexual or other sexual orientations (2021)	%	3.4%	3.2%	3.4%	3.4%	Not relevant	First time collected
Life expectancy at birth - Female (2018 - 20)	Years	82.5	82.4	84.1	83.1	🔴	↓
Life expectancy at birth - Male (2018 - 20)	Years	78.6	78.7	80.3	79.4	🔴	↓
Healthy life expectancy at birth - Female (2018 - 20)	Years	61.9	61.9	65.5	63.9	🟡	↓
Healthy life expectancy at birth - Male (2018 - 20)	Years	63.8	61.8	64.7	63.1	🟡	↑

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Index of Multiple Deprivation

Overview

- Torbay is ranked as the most deprived upper-tier local authority in the South West.
- Approximately 27% of population classified as living in areas that are amongst the 20% most deprived in England.
- Most deprived areas are concentrated in central Torquay and Paignton.
- Relative deprivation compared to England highest in relation to those involuntarily excluded from the labour market (Employment deprivation).
- Just over 1 in 6 people in Torbay were classified as income deprived, this rose to more than 1 in 5 for children being affected by income deprivation.
- Best performing of the 7 sub-domains relates to Crime deprivation.

All above sourced from 2019 English Indices of Deprivation

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Deprivation Categories

The Index of Multiple Deprivation (IMD) which was last undertaken in 2019 measures relative levels of deprivation in 32,844 small areas called Lower Super Output Areas (LSOA), in England. For example, a better rank in relation to Crime does not mean that Crime levels are falling, it could mean that Crime is not rising as quickly as other local authorities.

The Index is made up of the following deprivation sub-categories:-

- Income (22.5%)
- Employment (22.5%)
- Education, Skills and Training (13.5%)
- Health and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment (9.3%)

Income has 2 sub-categories relating to:-

- Children
- Older People

Torbay Rank of Deprivation

For 2019, Torbay was ranked as the 38th most deprived upper-tier local authority out of 151 for 2019 (Fig 24). An upper-tier local authority is either a unitary authority or a county council.

For 2019, Torbay was ranked as the most deprived upper-tier local authority out of the 15 upper-tier local authorities in the South West, Torbay has been in this position since 2007.

24 of Torbay's 89 LSOAs were classified as being amongst the 20% most deprived in England, this was down from 28 in 2015. The 24 areas equated to approximately 27% of the 2019 population (Fig 25).

Fig 24: Local Authority Deprivation rank for Upper-tier local authority – Torbay (1 = Most deprived)
Source: English Indices of Deprivation 2019

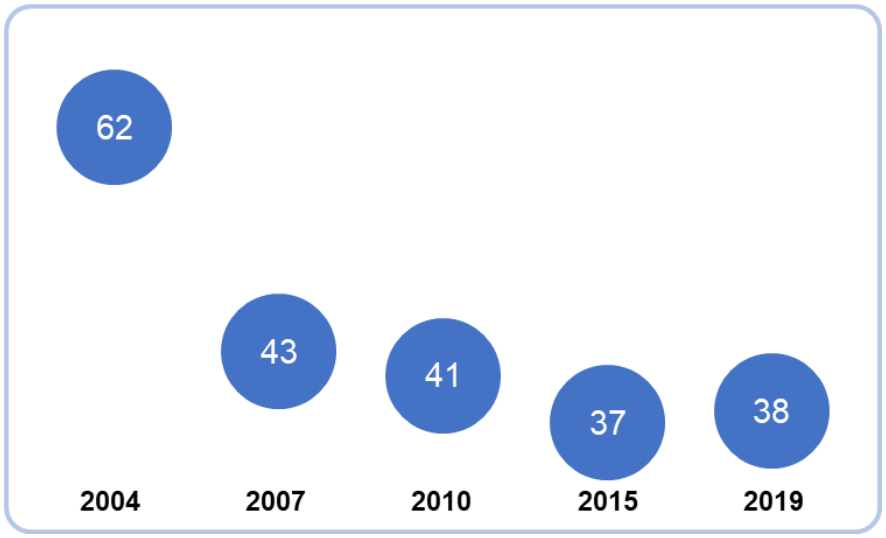
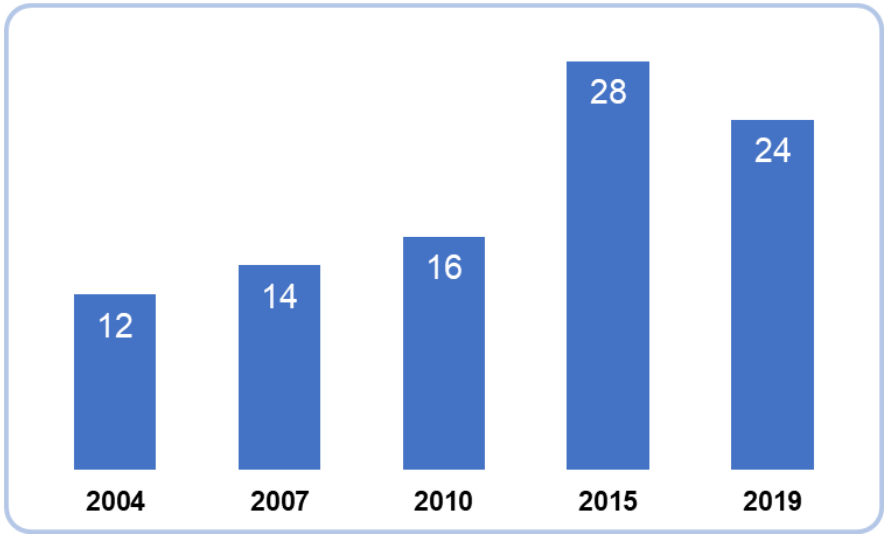


Fig 25: Torbay LSOAs classified as being amongst the 20% most deprived areas in England
Source: English Indices of Deprivation 2019



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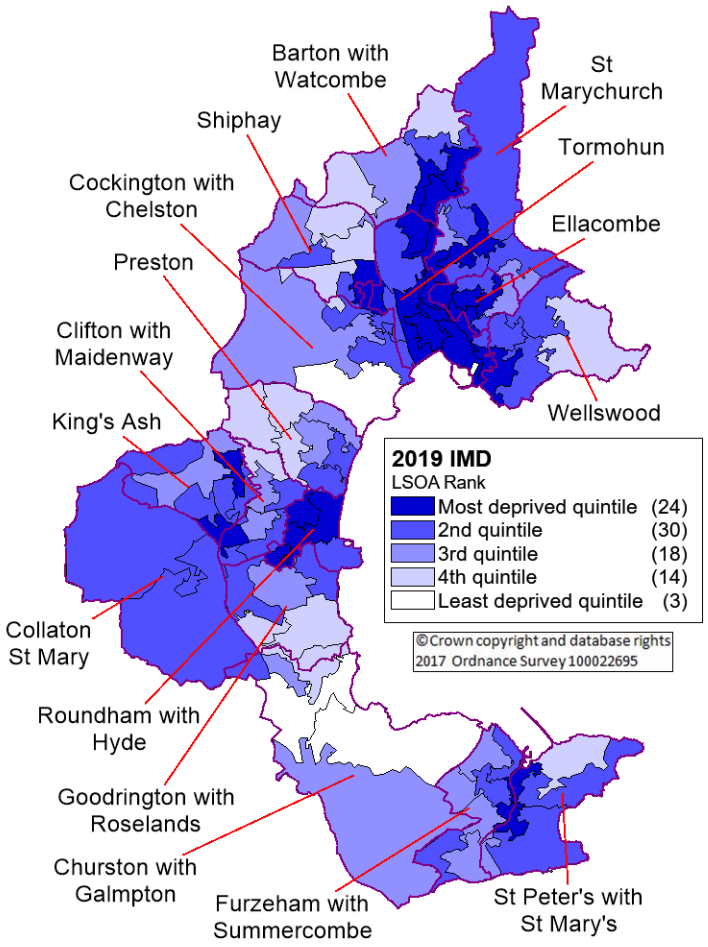
Index of Multiple Deprivation

The most deprived areas within Torbay are concentrated within central Torquay, Hele and up to the Barton areas. There is also a concentration of deprived areas within central Paignton (Fig 26).

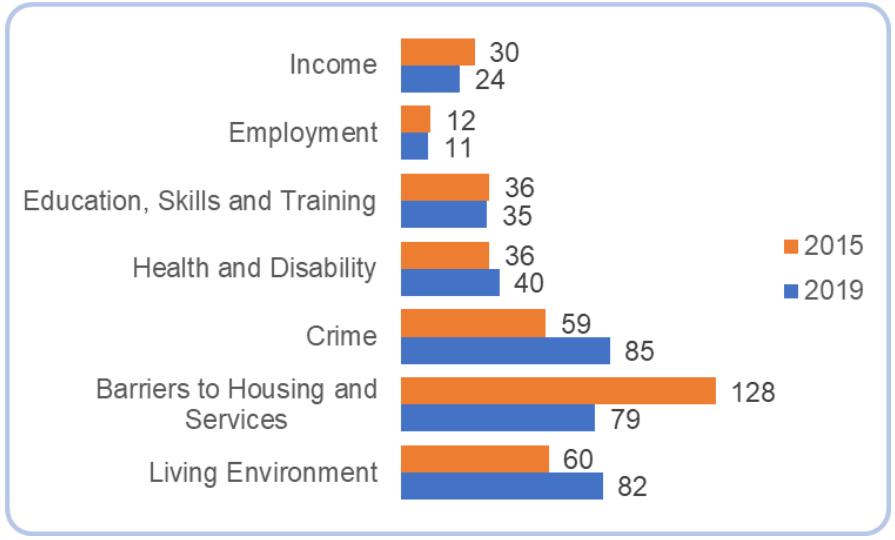
Fig 26: Rank of Index of Multiple Deprivation
Source: English Indices of Deprivation 2019



Deprivation by sub-domain

There are multiple sub-domains within the Index of Multiple Deprivation, a comparison of the change from 2015 to 2019 is given below (Fig 27). The most significant improvements from 2015 to 2019 were in the sub-domains of Crime and Living Environment, the most significant relative worsening related to Barriers to Housing & Services. The worst relative sub-domain continued to be related to Employment. Ranked out of 151 upper-tier local authorities.

Fig 27: Sub-domain of IMD rankings (1 = most deprived)
Source: English Indices of Deprivation 2019



Income Deprivation

Income deprivation relates to the proportion of the population experiencing deprivation relating to low income, it includes measures for those in receipt of income-based benefits. Compared to 2015 Torbay's ranking worsened slightly from 30th in 2015 to 24th in 2019. For 2019, it was calculated that just over 1 in 6 people (17.4%) within Torbay were income deprived. Income deprivation is largely concentrated within central Torquay, Ellacombe, Barton, central

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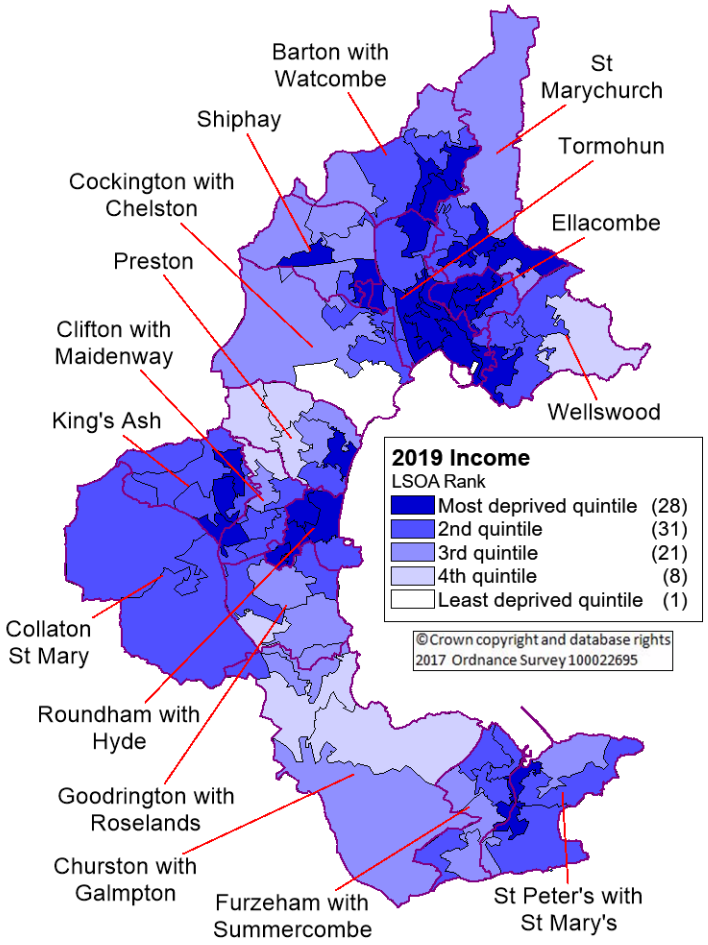
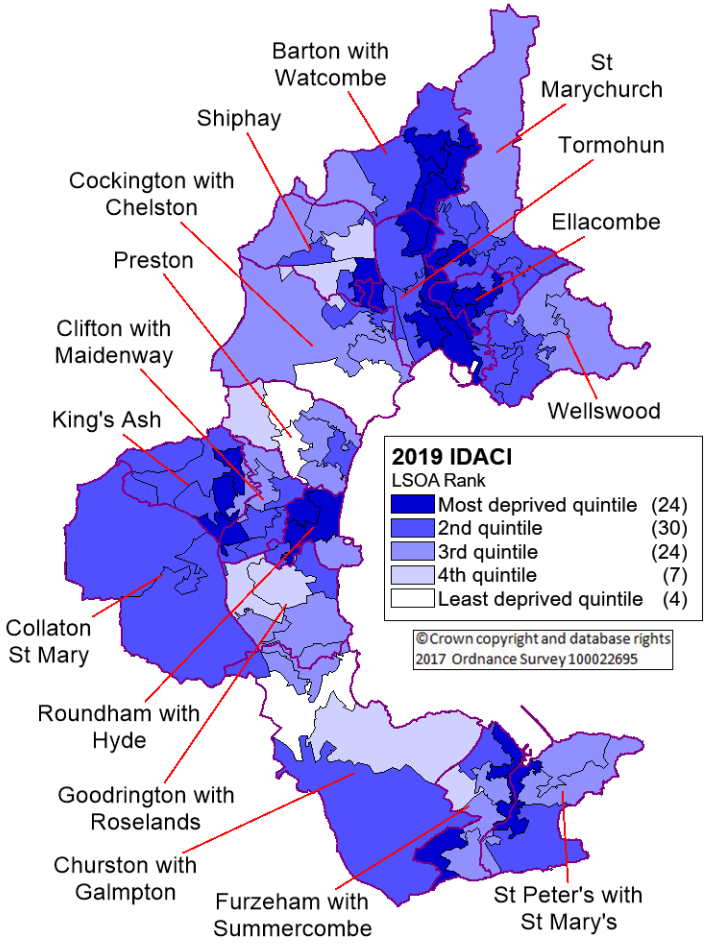
Paignton, King's Ash and central Brixham (Fig 28). Torbay has the highest level of income deprivation amongst upper-tier local authorities in the South West.

Fig 28: Rank of Income Deprivation
Source: English Indices of Deprivation 2019



Income deprivation has 2 further sub-domains related to the effects on children (0 to 15) and older people (60+). Over 1 in 5 (22.0%) of children aged 0 to 15 were affected by income deprivation (Fig 29), with geographical areas of deprivation similar to Income deprivation.

Fig 29: Rank of Income Deprivation Affecting Children (IDACI)
Source: English Indices of Deprivation 2019



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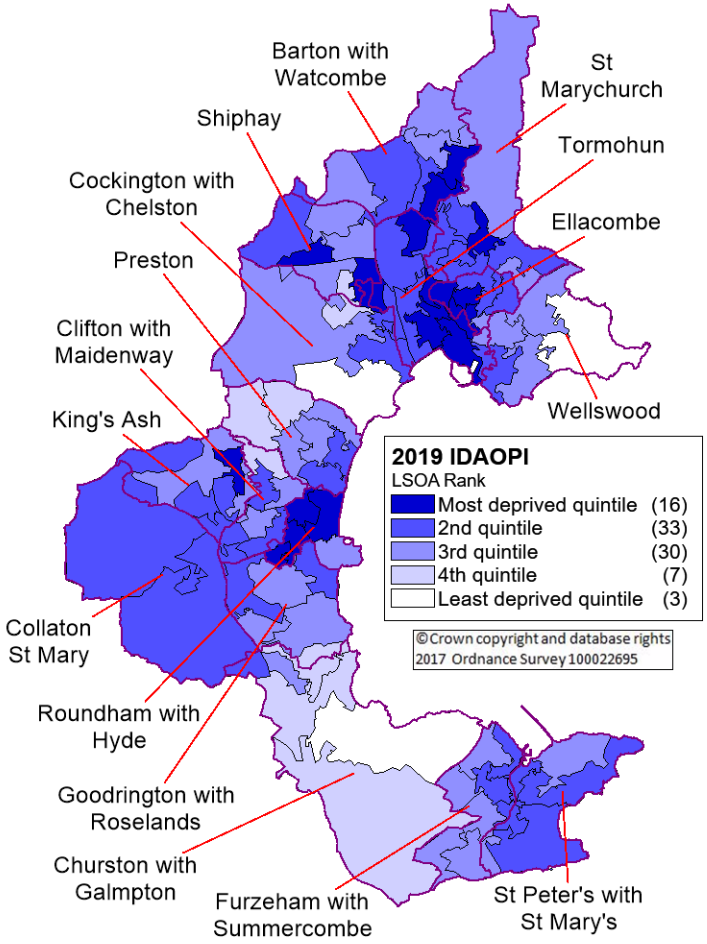
Just over 1 in 6 (17.5%) of people aged 60 and over were affected by income deprivation (Fig 30). Compared to children, the number of the most deprived areas is fewer, but the concentrations are in similar areas.

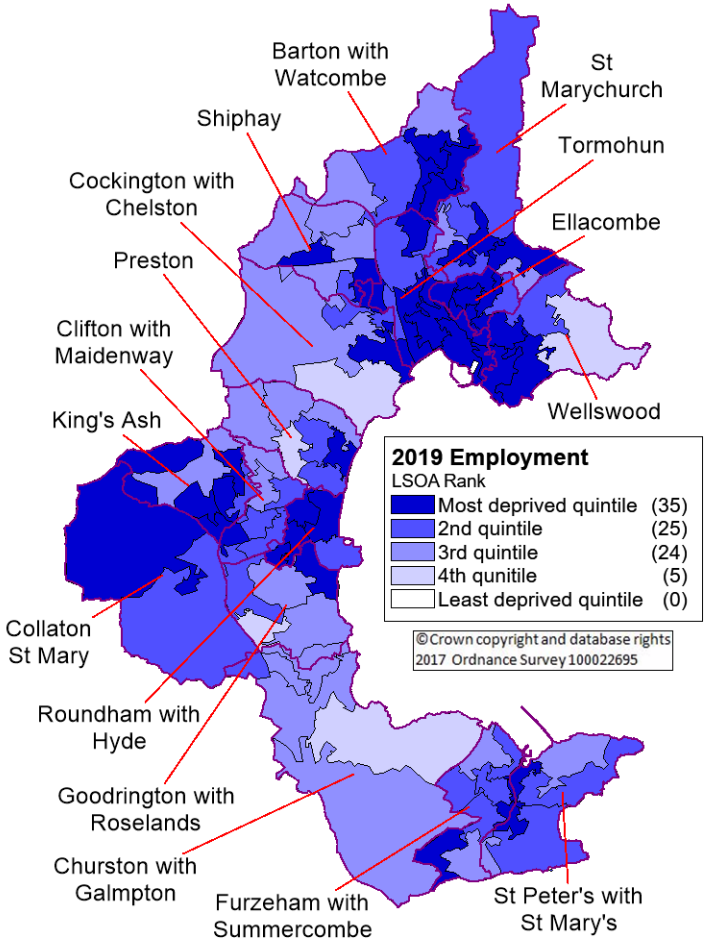
Fig 30: Rank of Income Deprivation Affecting Older People (IDAOPI)
Source: English Indices of Deprivation 2019



Employment Deprivation

Employment Deprivation measures the proportion of the working age population involuntarily excluded from the labour market (sickness, unemployment, disability or caring responsibilities). At 11th lowest in England this was Torbay's worst performing sub-domain (Fig 31).

Fig 31: Rank of Employment Deprivation
Source: English Indices of Deprivation 2019



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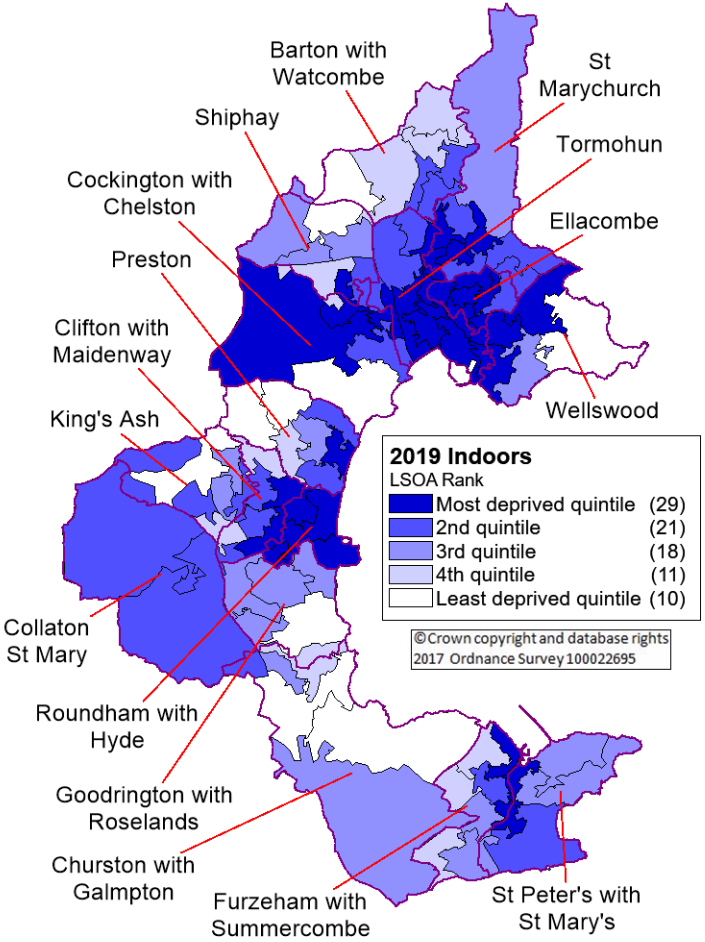
Indoor Deprivation

Indoor deprivation is a section of the Living Environment sub-domain. Indoor deprivation measures the quality of housing, specifically the proportion of houses that do not have central heating or fail to meet the Decent Homes standard (Fig 32).

Fig 32: Rank of Indoor Deprivation

Source: English Indices of Deprivation 2019

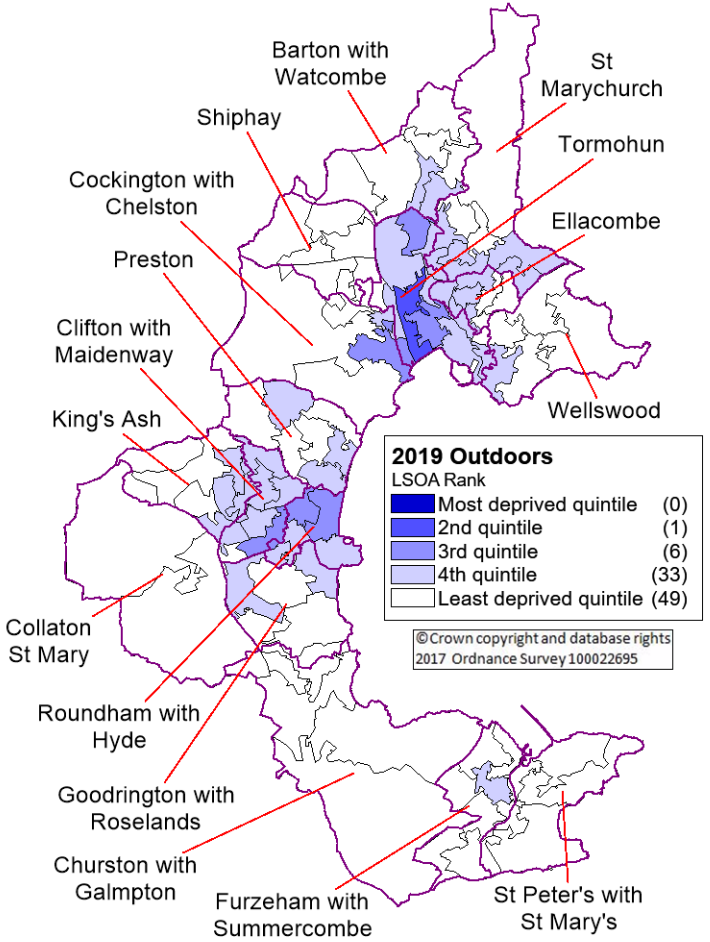


Outdoor Deprivation

Outdoor deprivation is the other section of the Living Environment sub-domain. It measures air quality and road traffic accidents involving injury to pedestrians and cyclists. No-one within Torbay lives in an area within the most deprived quintile (Fig 33).

Fig 33: Rank of Outdoor Deprivation

Source: English Indices of Deprivation 2019



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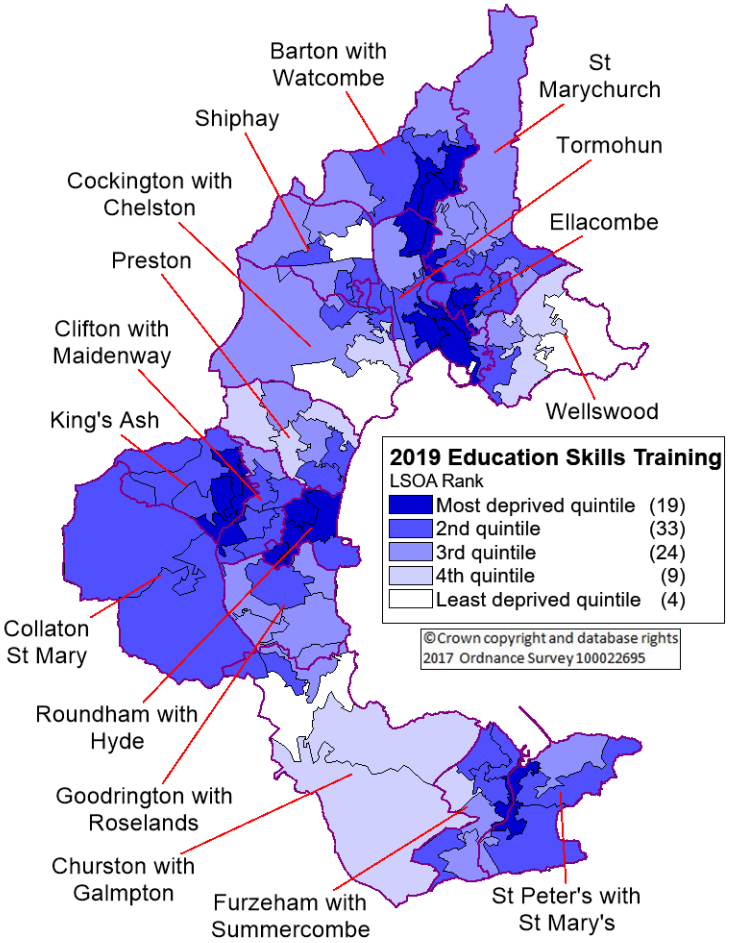
Education, Skills & Training Deprivation

The Education, Skills & Training sub-domain is based on Key Stage 2 and GCSE attainment, absence rates and those entering higher education. It also looks at working age adults with no or low qualifications and those who cannot speak English well (Fig 34).

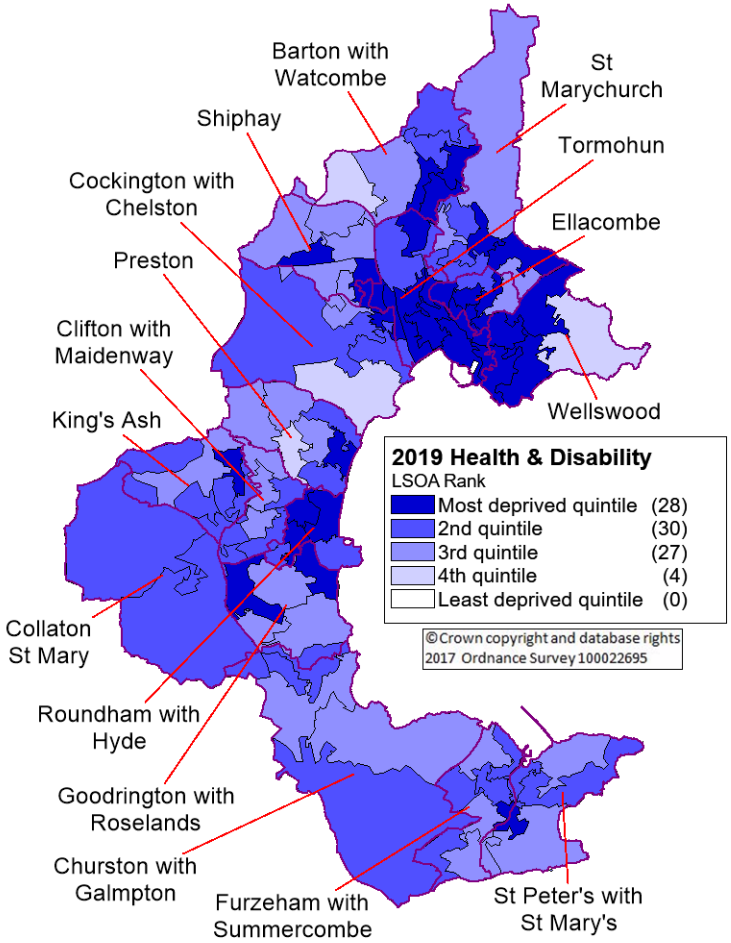
Fig 34: Rank of Education, Skills & Training Deprivation
Source: English Indices of Deprivation 2019



Health & Disability Deprivation

The Health & Disability sub-domain is based on measures such as premature death, emergency admissions to hospital, rates of disability, and mood and anxiety disorders. Deaths, admission rates and disability were adjusted to take account of age profile (Fig 35).

Fig 35: Rank of Health Deprivation & Disability
Source: English Indices of Deprivation 2019



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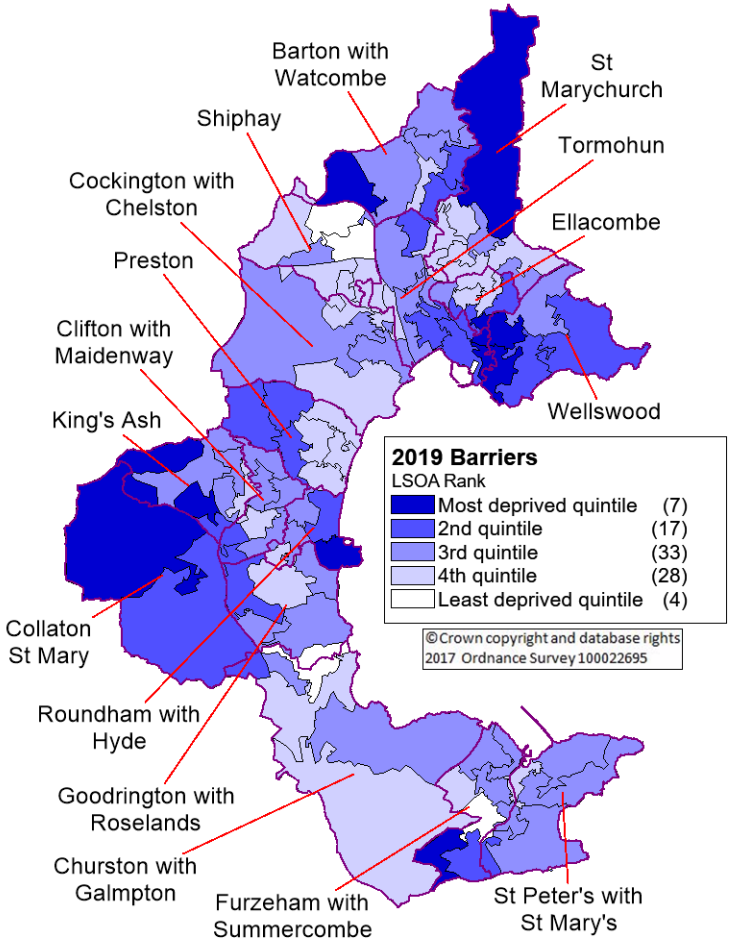
Barriers to Housing & Services Deprivation

The Barriers to Housing & Services sub-domain relates to the physical and financial accessibility of housing and local services. It includes distances to post offices, primary schools, shops and GPs, Housing affordability/overcrowding and homelessness (Fig 36).

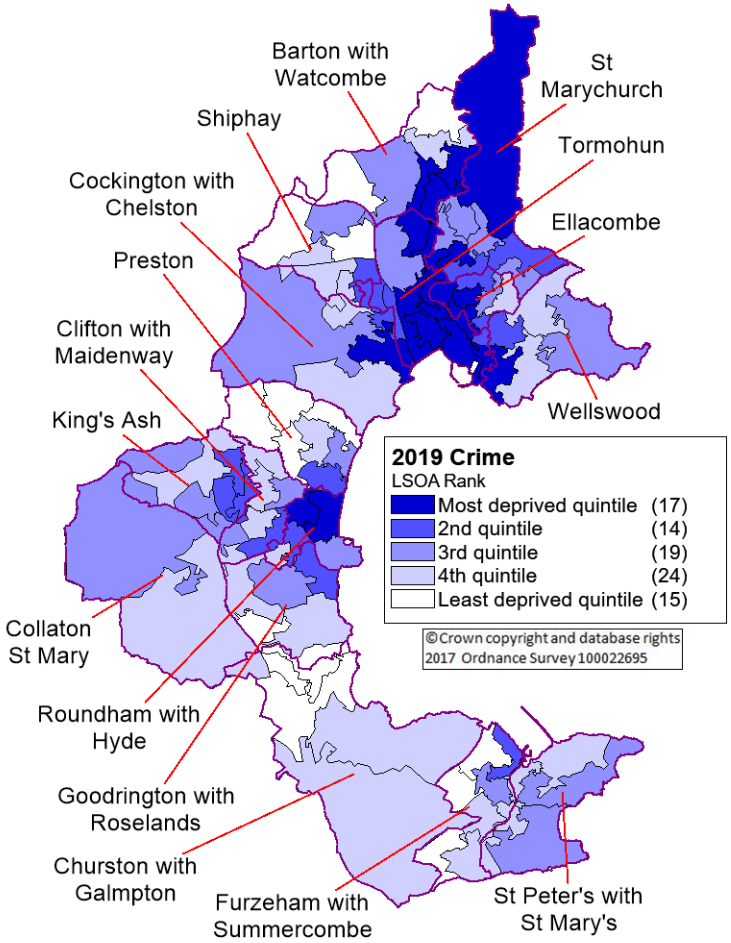
Fig 36: Rank of Barriers to Housing & Services Deprivation
Source: English Indices of Deprivation 2019



Crime Deprivation

The Crime sub-domain relates to the rate of violence, burglary, theft and criminal damage. The most Crime deprived areas relate to Torquay (Fig 37). Town centres will have higher levels of recorded crime due to the concentration of licensed premises.

Fig 37: Rank of Crime Deprivation
Source: English Indices of Deprivation 2019



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Children & Young People's Education and Health

Overview

- Very significant gap in academic achievement between those eligible for free school meals and those who are not eligible for free school meals.

  Source: Fingertips and Department for Education – explore education statistics

- Torbay has a significantly higher proportion of primary and secondary school pupils with an Education, Health & Care Plan.

  Source: Department for Education – explore education statistics

- MMR rates are higher than England but are below the 95% national target, HPV vaccination rates have fallen significantly over the COVID-19 period.

  Source: Fingertips

- Under 18 conceptions have fallen significantly over the last decade, there have also been significant falls in the number of mothers who smoke at the time of delivery.

  Source: Fingertips

- Torbay has a significantly worse hospital admission rate for self-harm, alcohol and dental decay amongst our younger population. Rates for self-harm and alcohol admissions are much higher among females than males.

  Source: Fingertips

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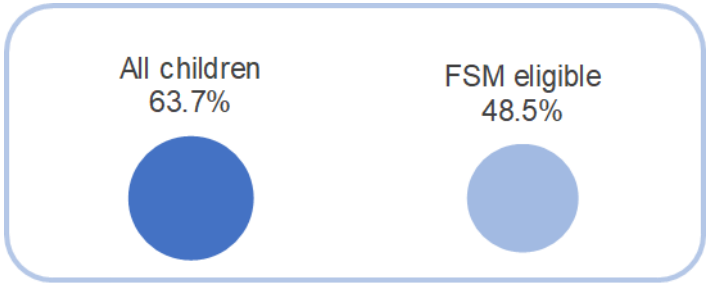
Education

Education is a key determinant of a child's future life, a good education increases the likelihood of higher earnings, better housing and material resources. These are also related to better health outcomes.

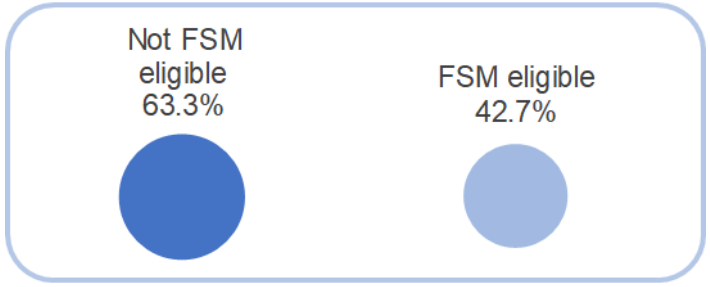
The percentage of children achieving a good level of development at the end of reception (aged 5 years) is similar in Torbay to regional and national levels. Significantly more females than males both locally and across England achieve a good level of development. Within Torbay and nationally, there are significant differences in those achieving a good level of development between all children and those who are eligible for free school meals (FSM), this shows how differences in social backgrounds can emerge early in life (Fig 38).

Fig 38: Percentage of children achieving a good level of development at the end of Reception – Torbay (2021/22)
Source: Fingertips



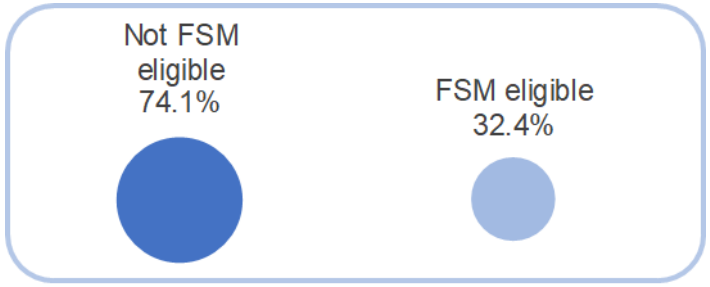
The percentage of children meeting the expected standard in reading, writing and mathematics at Key Stage 2 (age 7 to 11) is broadly similar in Torbay to levels in the South West and England. Looking at Torbay, there are significant differences in those meeting the expected standards between those who are eligible for free school meals (FSM) and those who are not eligible for free school meals. During 2021/22, those at state schools who were not eligible for free school meals in Torbay were almost 50% more likely to reach the expected standard in reading, writing and mathematics (Fig 39).

Fig 39: Percentage of children meeting expected standard in reading, writing and maths at Key Stage 2 – Torbay (2021/22)
Source: Department for Education – explore education statistics



At GCSE level there is further evidence of the gap between those children who are eligible or not eligible for free school meals. For 2021/22, those at state schools who were not eligible for free school meals in Torbay were more than twice as likely to achieve a 9-4 pass (equivalent of A to C) in English and Mathematics at GCSE (Fig 40).

Fig 40: Percentage of pupils achieving a 9-4 pass in English & Maths – Torbay (2021/22)
Source: Department for Education – explore education statistics



Young people who are not in education, employment or training (NEET) are at greater risk of poor health, depression or early parenthood. It is required that all young people remain in education,

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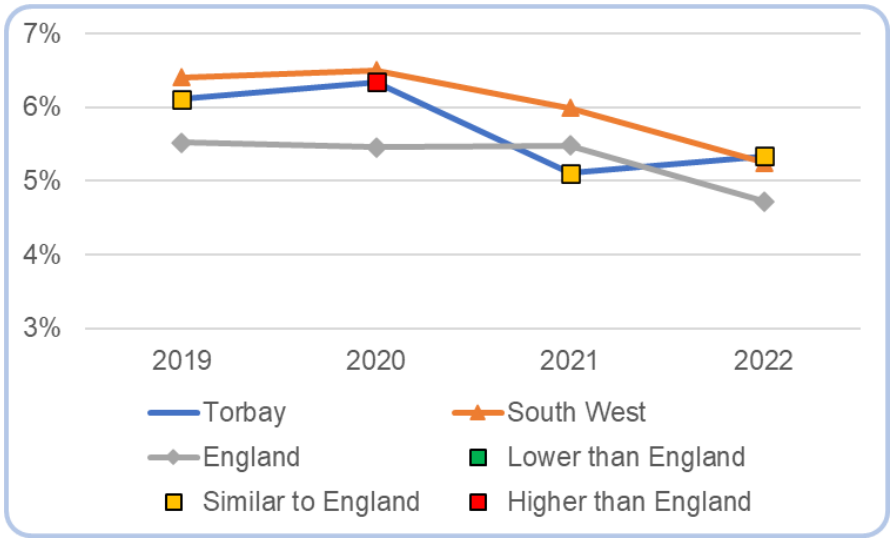
employment or training until the end of the academic year in which they turn 17. For 2022, 159 (5.3%) of 16 to 17 year olds were classified as not in education, employment or training (NEET), this is broadly in line with the regional and national averages (Fig 41).

Fig 41: Percentage of 16 and 17 year olds not in education, employment or training
Source: Department for Education – explore education statistics



Special Educational Needs and Disabilities (SEND) can affect a child or young person's ability to learn. They can affect their:

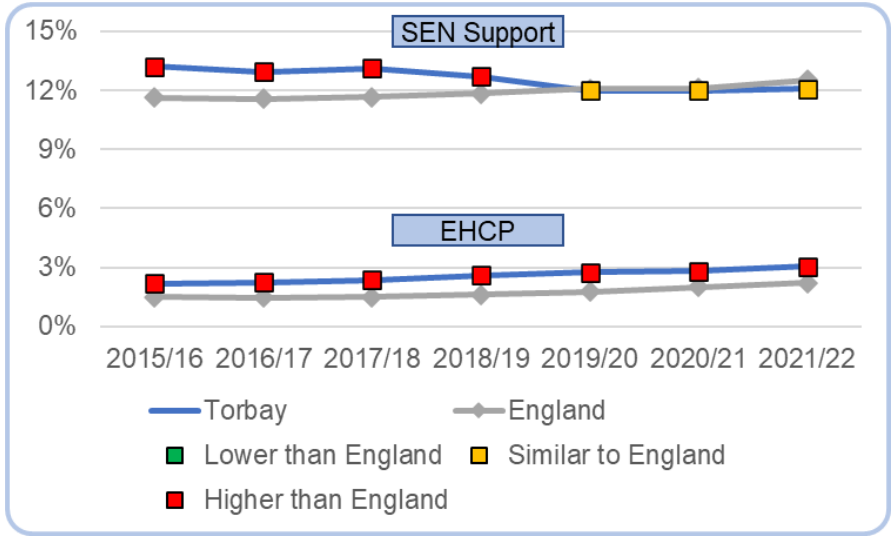
- Behaviour or ability to socialise, for example they struggle to make friends.
- Reading and writing, for example because they have dyslexia.
- Ability to understand things.
- Concentration levels, for example because they have ADHD.
- Physical ability

Children assessed as having special educational needs usually receive either:-

1. SEN Support - Support plans which must be provided by mainstream schools, this may involve the teacher receiving advice and support from external specialists.
2. Education, Health & Care Plan (EHCP) – This is for when SEN Support is not enough, is a legal document which outlines the needs and additional help that will be required.

Over the last decade, Torbay has had a higher level of school children at its primary and secondary schools with diagnosed SEND than England. For Torbay primary and secondary schools, the number of children with an Education, Health & Care Plan (EHCP) is significantly higher than England, for those with SEN Support, rates have been broadly in line with England since 2019/20 (Fig 42). Rates of recognised special needs are significantly higher in males and among those who are eligible for free school meals.

Fig 42: Percentage of state primary and secondary Torbay school pupils with EHCP and SEN Support
Source: Department for Education – explore education statistics



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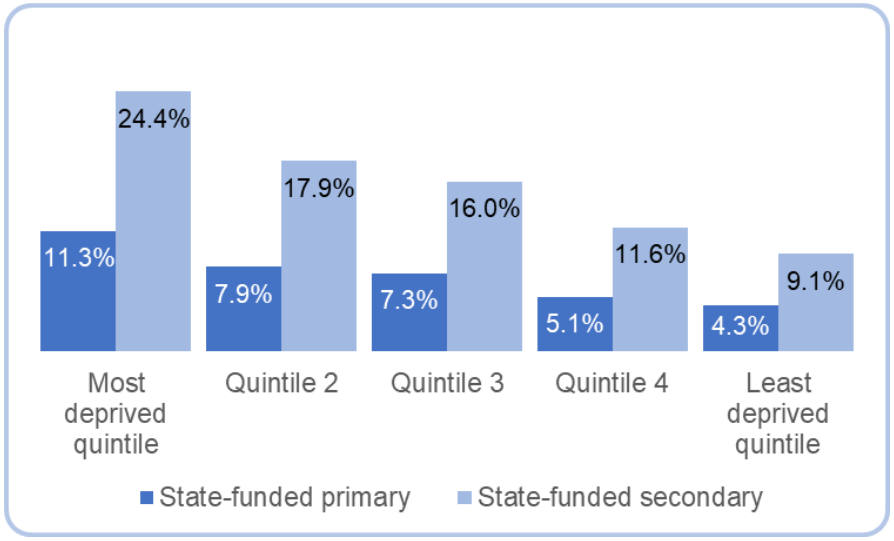
A pupil is identified as a persistent absentee if they miss more than 10% of more of their possible classes. Rates of persistent absenteeism are more common in secondary schools when compared to primary schools, Torbay secondary schools have consistently had higher rates of persistent absenteeism than the South West and England.

Looking at the period 2016/17 to 2020/21, we find that those children who live in the most income deprived areas have a much higher rate of persistent absenteeism than those who live in the least deprived areas. This has been a common pattern across primary and secondary education (Fig 43). This level of absenteeism will increase the chances of poor academic achievement and a limiting of choices for those children after compulsory education.

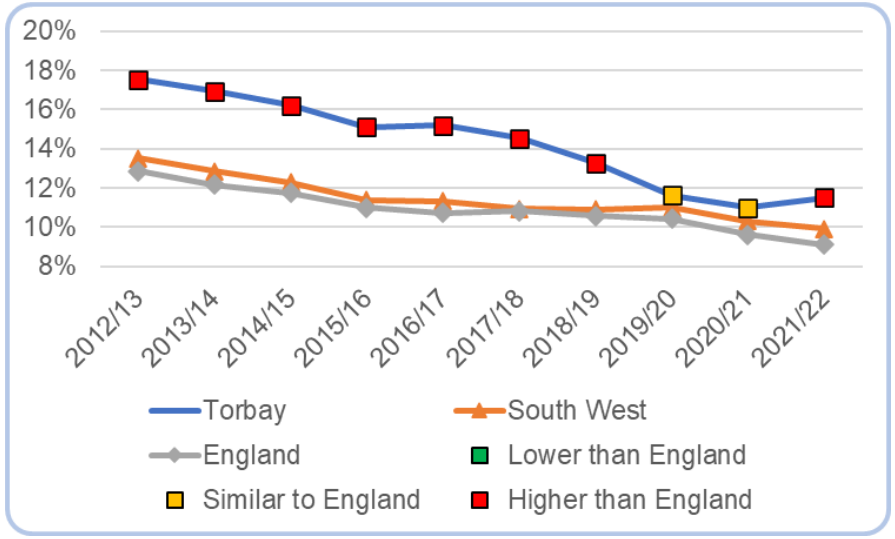
Fig 43: Percentage of state primary and secondary school pupils classified as persistent absentees – Torbay (2016/17 to 2020/21)
Source: Department for Education – explore education statistics



Health – Early Years

Smoking during pregnancy has significant well known detrimental effects for the growth of the baby and health of the mother. The percentage of women smoking at the time of delivery has fallen significantly over the last decade in Torbay from 17.5% in 2012/13 to 11.5% in 2021/22. For 2021/22, the Torbay rate increased slightly from the previous year and was significantly higher than England after 2 years of being broadly in line, however the gap is much smaller than during the previous decade (Fig 44). Across England, mothers who live in the most deprived areas are almost twice as likely to smoke at the time of delivery than those who live in least deprived areas.

Fig 44: Percentage of women smoking at time of delivery
Source: Fingertips



Breast milk provides the ideal nutrition for infants in the first stages of life. Data around breastfeeding at 6 to 8 weeks after birth is frequently not published for large numbers of geographical areas due to significant data issues. For 2021/22, 44% of Torbay mothers were

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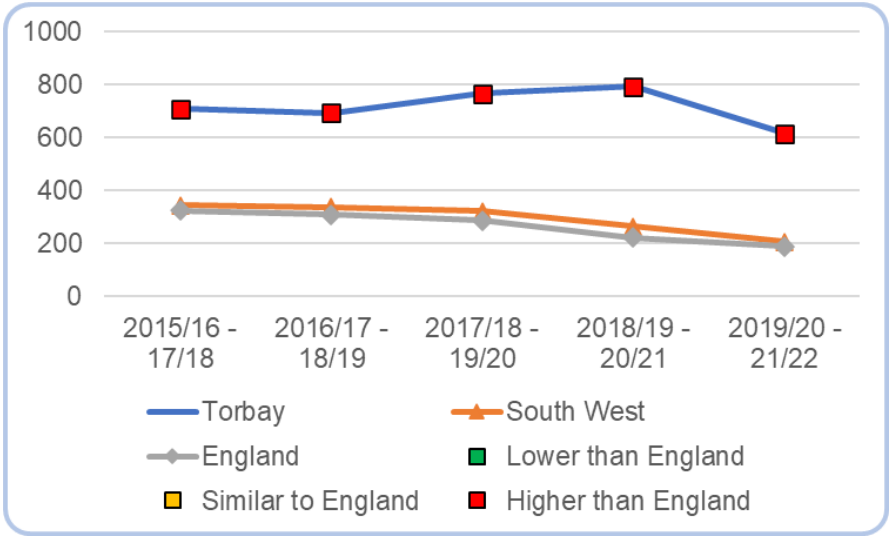
breastfeeding at 6 to 8 weeks after birth, this was significantly below the England figure of 49%. This is broadly consistent with the pattern for 2016/17 and 2018/19 when Torbay figures were previously published.

Infant mortality relates to the number of infant deaths aged under 1 year, Torbay's rates are broadly in line with England over the 12 year period 2009 to 2020, there were 70 deaths of infants under 1 year during those 12 years. Looking at national data, infant mortality rates are more than twice as high in the most deprived areas of England when compared to the least deprived.

Hospital admissions for dental caries (tooth decay) in Torbay for 0 to 5 year olds have consistently been more than double the South West and England average (Fig 45). The consistently high rates of hospital admissions for dental caries could indicate an issue with some children not accessing high street dental services or being unable to access them quickly when emergencies arise. Across England, there are very large differences in rates between the least and most deprived areas. For the period 2018/19 to 2020/21 across England, those aged 5 and under in the most deprived areas were 6 times more likely to have a hospital admission for tooth decay than those in the least deprived areas.

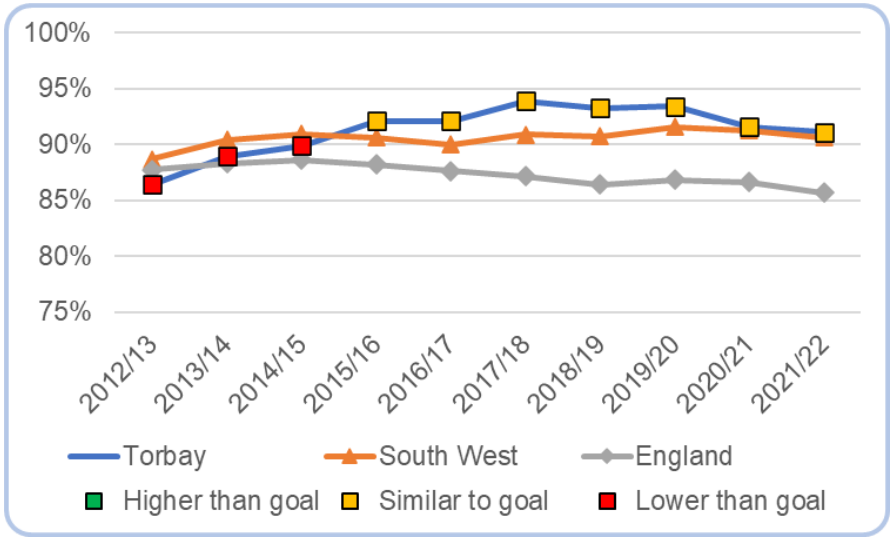
Fig 45: Hospital admissions for dental caries, aged 5 and under, per 100,000

Source: Fingertips, Hospital Episode Statistics for 2019/20 to 21/22



The MMR vaccine provides a safe and effective vaccine that protects against measles, mumps and rubella. The first MMR is usually given within a month of a child's 1st birthday with the second given between the 3rd and 5th birthday. The target (goal) rate for this vaccination is 95%. For receiving the second dose of MMR, Torbay has been rated as amber (between 90% and 95%) for the last 7 years. For 2021/22, Torbay has a rate of 91.1%, this is in line with the South West rate and significantly above the England rate of 85.7% (Fig 46). There has been a slight fall over the last 2 years in the rates of MMR vaccination but they are still above those levels seen in the first half of the last decade. Torbay's rate of the first dose having been administered by the age of 5 is 96.6% for 2021/22.

Fig 46: MMR vaccination coverage for 5 year olds (2 doses)
Source: Fingertips

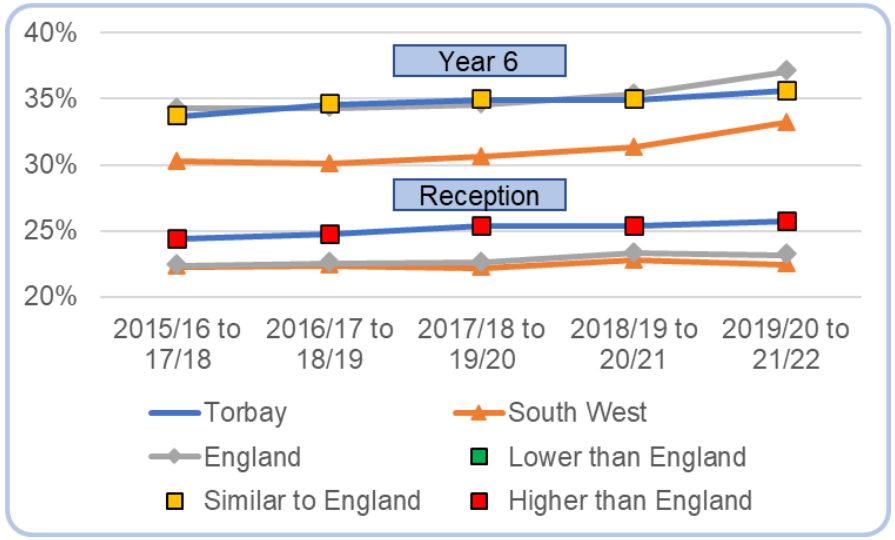


Health – Weight and Activity

The National Child Measurement Programme aims to measure the height and weight of Reception (aged 4 to 5) and Year 6 (aged 10 to 11) children at English schools.

The prevalence of overweight (including obese) Reception aged children in Torbay was approximately 1 in 4 (25.7%). Torbay has consistently had higher levels than the South West and England (Fig 47). For Year 6 children in Torbay, approximately 1 in 3 (35.6%) children were overweight or obese, this rate has been consistent with levels across England but above South West levels (Fig 47). Overweight (including obese) rates among Year 6 children have risen slightly faster than Reception aged children. Across England, rates of overweight (including obese) children are significantly higher in more deprived areas. For 2021/22, rates of overweight (including obese) children in the most deprived decile in England were 26.9% and 46.0% for Reception and Year 6 children respectively as opposed to 16.9% and 26.3% in the least deprived decile.

Fig 47: Percentage of overweight (including obese) children
Source: Fingertips



The Active Lives Children's Survey asks a number of questions around children's level of activity.

One question relates to the daily level of sport and physical activity undertaken by children aged 5 to 16 over the last week. Children can be active (an average of 60+ minutes per day), fairly active (30 to 59 minutes) or less active (less than 30 minutes). Torbay respondents show just over 1 in 2 as active and just over 1 in 4 as less active during 2021/22 (Fig 48). These figures are higher than England but there is a significant amount of volatility from year to year at a local level.

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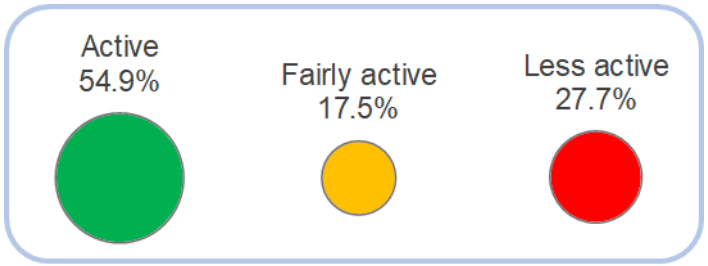
Fig 48: Percentage of children aged 5 to 16 by level of physical activity – Torbay (2021/22)
Source: Fingertips



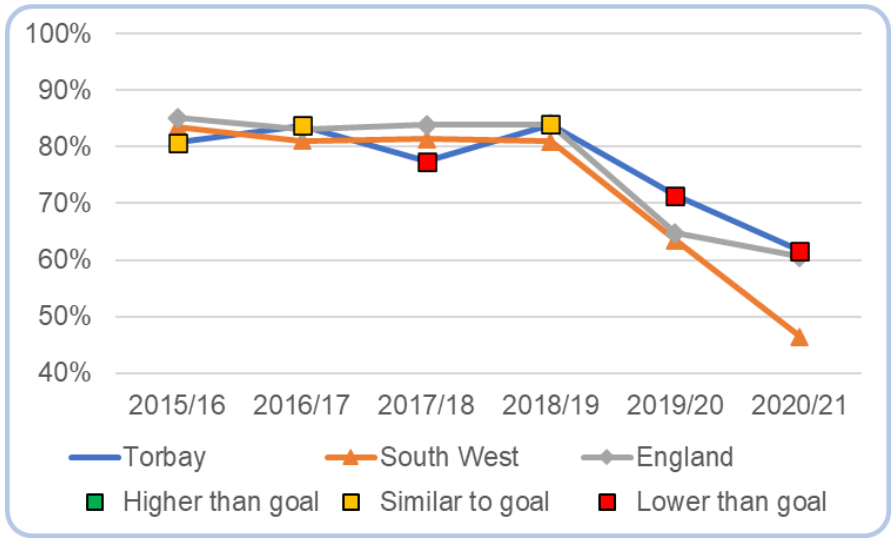
Health – Sexual Health

HPV is usually asymptomatic and for most people does not cause problems. Some types of HPV, however, can cause cancers including cervical, vulval, anal and some types of head and neck cancer. (NHS- HPV).

A two-dose immunisation programme is offered to 12 to 14 year-olds, initially for females but extended to males from 2019. Due to the COVID-19 pandemic there were impacts on coverage in the 2019/20 and 2020/21 academic years across England. These years saw decreases in the percentage of 13 to 14 year old girls receiving two doses of the HPV vaccine (Fig 49) in Torbay, the South West and England. All areas are below the goal of 90% vaccination, Torbay achieved 61.6% in 2020/21 (England- 60.6% and South West- 46.4%).

From September 2019 boys were offered the HPV vaccine. The first dose was received by 64.5% of 12 to 13 year old boys in 2020/21 which was an increase on 49.0% the year before. Torbay is below the England figure in both years.

Fig 49: Percentage receiving the HPV vaccine for two doses, females aged 13 to 14 years
Source: Fingertips



Chlamydia causes avoidable sexual and reproductive ill health and in England is the most commonly diagnosed bacterial sexually transmitted infection (STI) with rates higher in young adults than in other age groups (OHID Fingertips, Public Health Profiles).

The chlamydia detection rate (Fig 50) is a measure of control activity (i.e. screening) in the population, not morbidity. A higher detection rate indicates higher levels of screening. The detection rate has reduced in Torbay over the years although 2020 and 2021 will have been affected by the COVID-19 pandemic. The rate is higher than the South West and England in 2021 at 1,475 per 100,000 compared to 1,334 in England. Females have a higher detection rate than males, as is the case in England.

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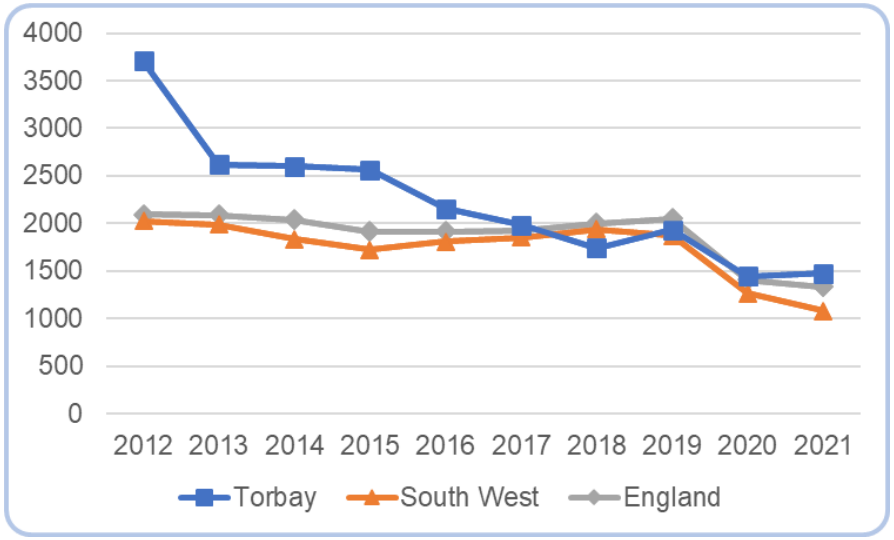
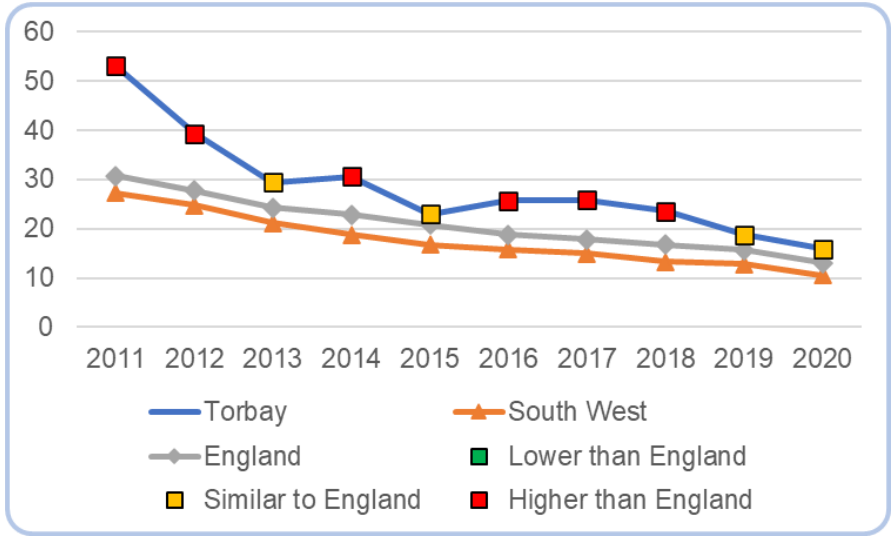
Fig 50: Chlamydia detection rate, aged 15 to 24, per 100,000
Source: Fingertips



Inequality in health and education is a cause and consequence of teenage pregnancy for young parents and their children, and children of teenage mothers are more likely to live in poverty (UKHSA, 2023).

Under 18s conception rates (Fig 51) include pregnancies that result in one or more live or still births or a legal abortion. The national trend is of a falling teenage pregnancy rate and Torbay has followed this trend since the peak in 2008. Rates are still higher than England but statistically similar in 2019 and 2020 at 15.9 per 1,000 in 2020 compared to 13.0 in England. The majority of under 18s conceptions are in 16 and 17 year olds- for example- under 16s represented 3 of the 32 under 18s conceptions in 2020.

Fig 51: Under 18s conception rate per 1,000 female population aged 15 to 17
Source: Fingertips



Health – Self-harm, Alcohol

Hospital admissions as a result of self-harm among 10 to 24 year olds in Torbay have been significantly higher than England. It should be noted that because of the numbers involved (fewer than 200 admissions on average per year in Torbay), it is possible for a handful of individuals with significant levels of admissions to skew the figures. However, the pattern of Torbay having significantly higher rates than England is consistent (Fig 52).

There are very large differences between females and males, across England, rates are consistently between 3 to 4 times higher for females than males. This is also shown in Torbay where the number of admissions for females is almost 4 times higher than males over the 5 year period 2017/18 to 2021/22 (Fig 53).

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Fig 52: Rate of hospital admissions as a result of self-harm, aged 10 to 24, per 100,000 (Age standardised)
Source: Fingertips

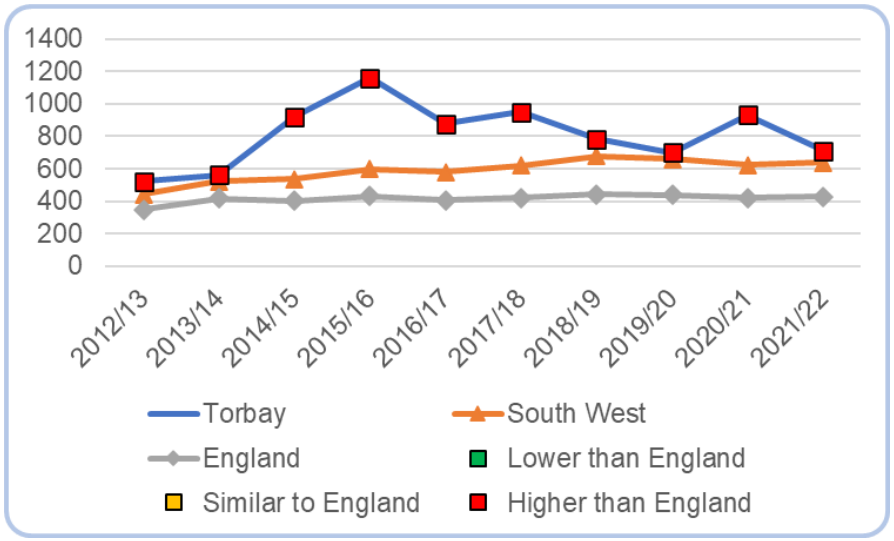
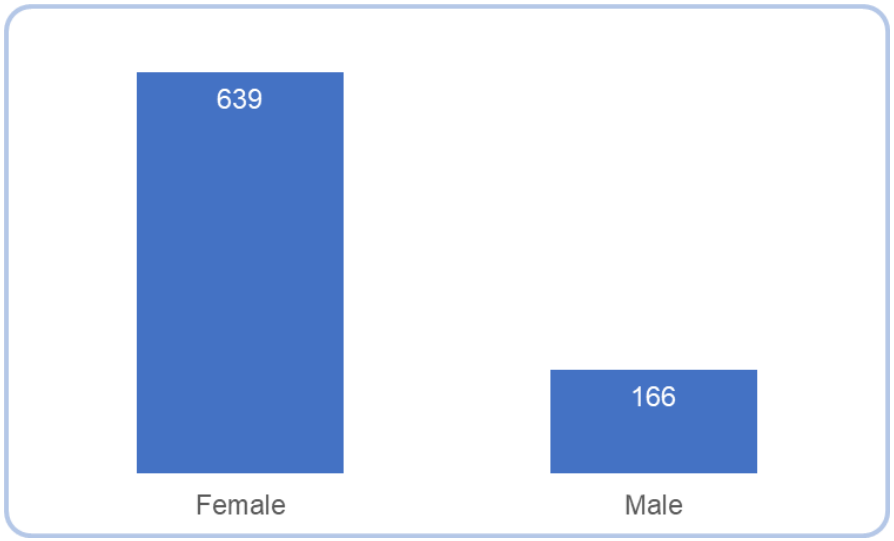
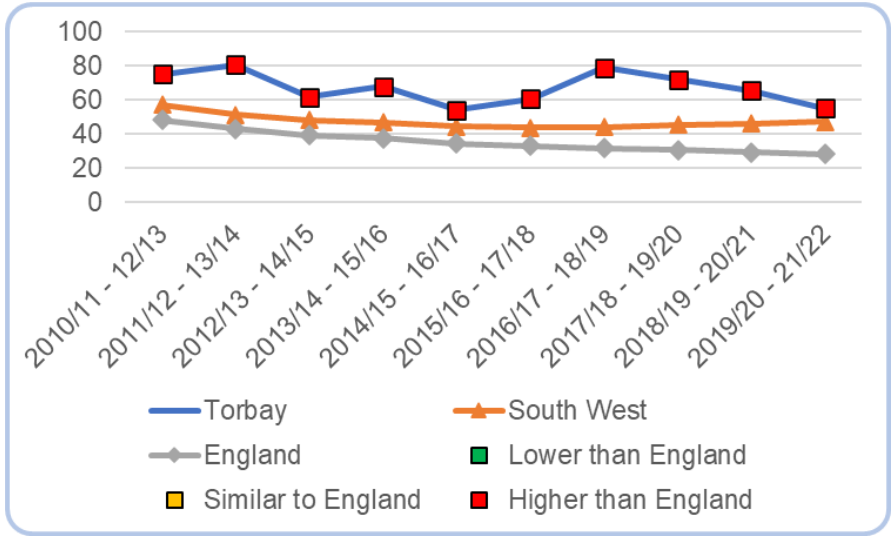


Fig 53: Hospital admissions as a result of self-harm, per 100,000 population aged 10 to 24 – Torbay (2017/18 to 2021/22)
Source: Fingertips



The rate of admissions of under 18s for alcohol specific conditions within Torbay has consistently been above South West and England rates (Fig 54). An alcohol specific condition is a hospital diagnosis code that is wholly attributable to alcohol. Since the middle of the last decade there has been a significant fall in admissions amongst males in Torbay (58 admissions for 2009/10 to 2014/15, 29 admissions for 2015/16 to 2020/21). Female rates have remained steady over the same period (63 admissions for 2009/10 to 2014/15, 67 admissions for 2015/16 to 2020/21).

Fig 54: Hospital admissions for alcohol-specific conditions, per 100,000 population aged under 18
Source: Fingertips, Hospital Episode Statistics for 2021/22



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Children meeting expected standard in reading, writing and maths at Key Stage 2 (2021/22)	%	57.6%	55.9%	57.1%	58.9%	🟡	↓
16 & 17 years not in education, employment or training (2022)	%	5.3%	4.8%	5.3%	4.7%	🟡	↑
Children with SEN - State primary & secondary schools (2021/22)	%	15.1%	15.6%	16.0%	14.8%	🟡	↑
Mothers smoking at time of delivery (2021/22)	%	11.5%	12.0%	9.9%	9.1%	🔴	↑
MMR vaccination coverage for 5 year olds (2 doses) (2021/22)	%	91.1%	91.0%	90.6%	85.7%	🟢	↓
Overweight (inc obese) children - Reception and Year 6 (2019/20 - 21/22)	%	30.9%	30.2%	28.1%	30.5%	🟡	↑
2 doses HPV coverage - Females aged 13 to 14 (2020/21)	%	61.6%	63.8%	46.4%	60.6%	🟡	↓
Under 18s conception rate (2020)	Rate per 1,000	15.9	16.3	10.5	13.0	🟡	↓
Hospital admissions as a result of self-harm, aged 10 to 24 (2021/22)	DSR per 100,000	711.1	503.4	640.2	427.3	🔴	↓

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Children's Social Care

Overview

- Rates of Cared for Children are almost twice as high as England but rates have fallen from peak of 2019.

  Source: Department for Education – Children looked after in England

- Rates of children subject to a child protection plan at 31st March fell significantly compared to previous 3 years.

  Source: Department for Education – Characteristics of children in need

- Rates of Children in Need remain significantly higher than England and our statistical neighbours.

  Source: Department for Education – Characteristics of children in need

- Levels of persistent absenteeism much higher among Children in Need or those with a Child Protection Plan than the general school population.

  Source: Department for Education – Outcomes for children in need, including children looked after

- 2 most common factors recorded in a Child in Need assessment were Mental Health and Domestic Abuse.

  Source: Department for Education – Characteristics of children in need

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Cared for Children

Children's Social Care come into contact with the most vulnerable children in our society, the most serious cases are 'Cared for Children' who are in the care of the local authority, these children may be living with foster parents, in residential children's homes or in residential schools/secure units. The number of cared for children within Torbay has fallen from its peak in 2019 but numbers remain significantly higher than those of Torbay's statistical neighbours (those local authorities who are used as comparators for Torbay), the South West and England (Fig 55).

Children who are the subject of a Child Protection Plan

The level of cases below that of 'Cared for Children' relates to children who are the subject of a child protection plan. The plan is drawn up by the local authority and sets out how a child can be kept safe, how things can be made better for the family and what support they will need. Numbers have consistently been significantly higher than our statistical neighbours, South West and England over the last 5 years although rates fell significantly in 2022 (Fig 56).

Children in Need

A 'Child in Need' is a child who is thought to need extra help from children's services if they are to achieve or maintain a 'reasonable standard of health or development', this includes all disabled children. Numbers of those who are a 'Child in Need' have consistently been significantly higher over the last 5 years when compared to our statistical neighbours, South West and England, numbers have been climbing since 2019 (Fig 57).

Fig 55: Rate of Cared for Children per 10,000 at 31 March

Source: Department for Education – Children looked after in England

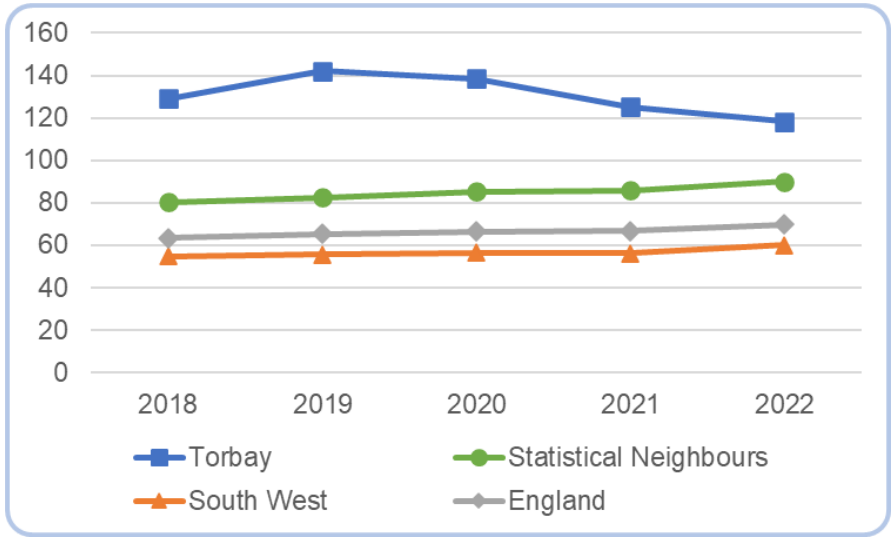

Fig 56: Rate of children who are subject to a child protection plan per 10,000 at 31 March

Source: Department for Education – Characteristics of children in need

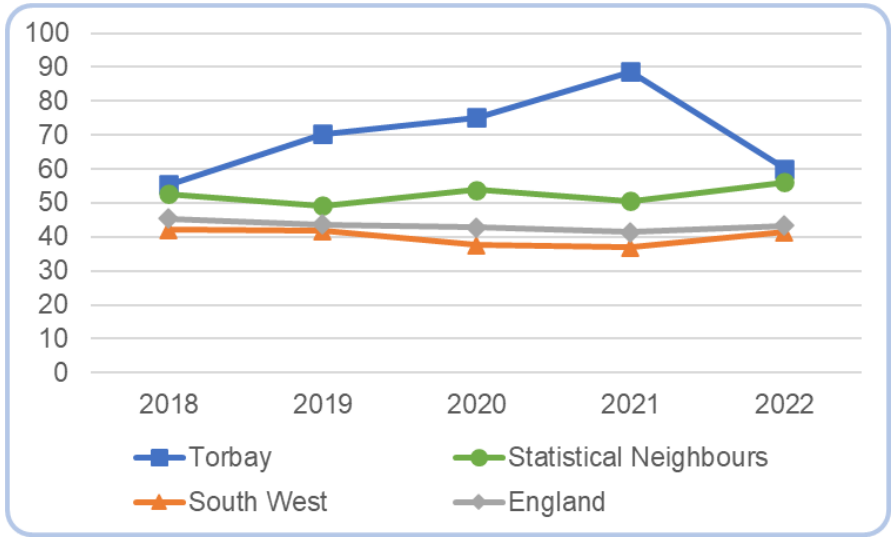

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Fig 57: Rate of Children in Need per 10,000 at 31 March
Source: Department for Education – Characteristics of children in need

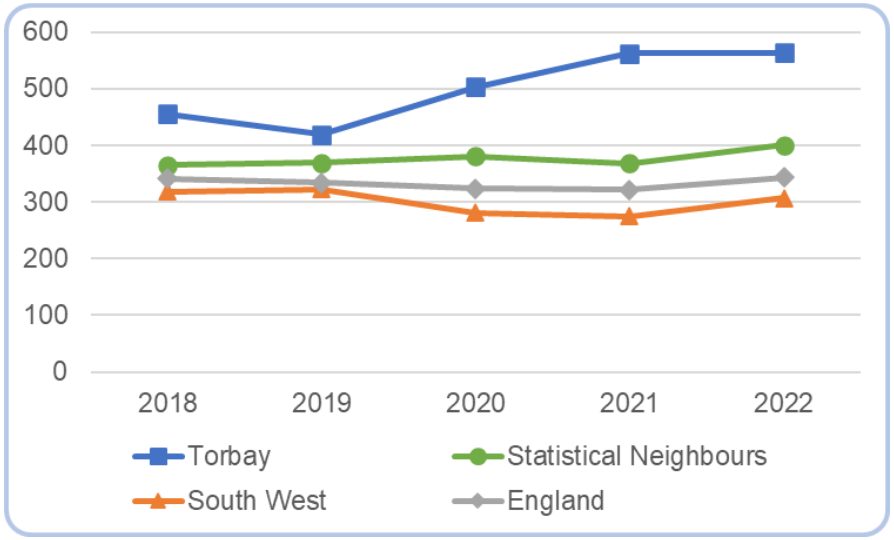
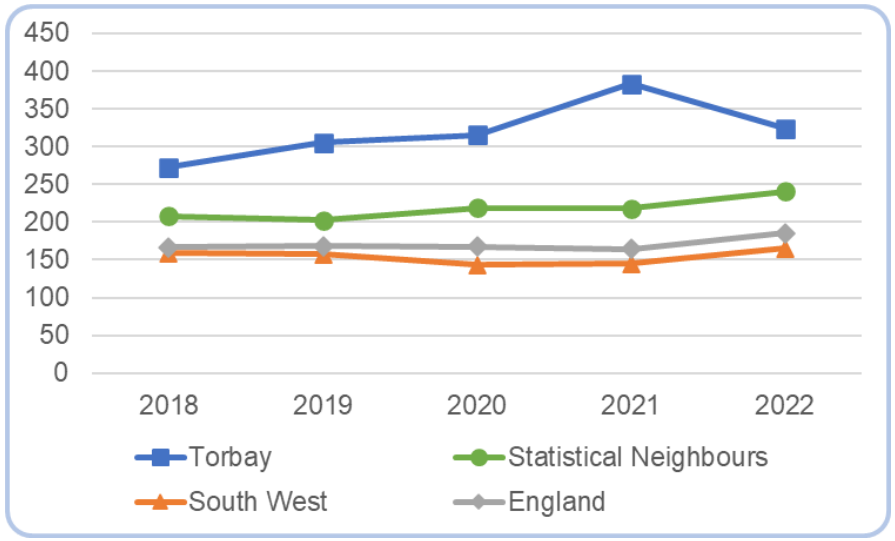


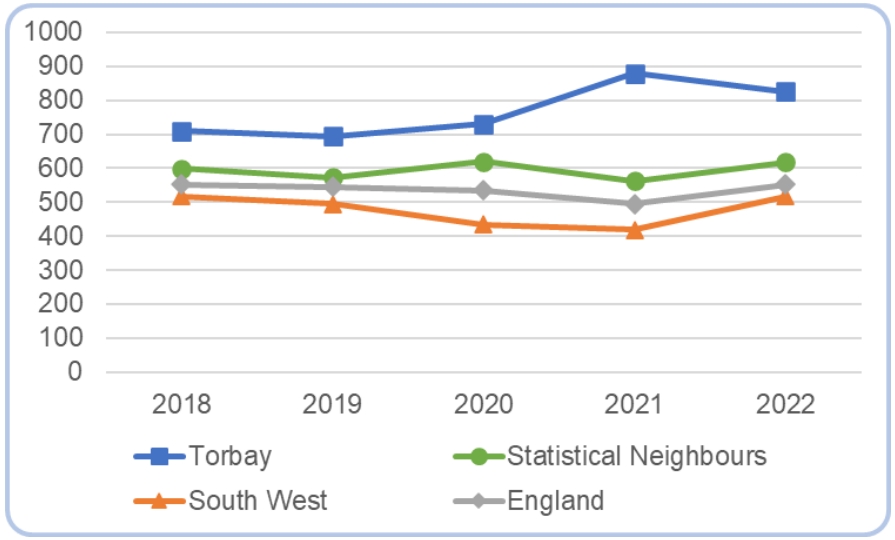
Fig 58: Rate of Section 47 referrals per 10,000 which started during the year
Source: Department for Education – Characteristics of children in need



Section 47 referrals

A Section 47 enquiry is carried out to ascertain if any and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. Rates of Section 47 referrals have consistently been significantly higher than our statistical comparators, South West and England over the last 5 years, rates have fallen from their 2021 peak (Fig 58).

Fig 59: Rate of referrals per 10,000
Source: Department for Education – Characteristics of children in need



Referrals to Children's Social Care

The rate of referrals to the children's social care in Torbay continues to be high, rates have fallen by 7% in the last year but remain significantly higher than statistical neighbours, South West and England (Fig 59).

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Cared for Children with Special Educational Needs

Over the period 2017 to 2021, almost 2 in 3 cared for children in Torbay had recognised special educational needs, these were evenly spread between those who required an 'Education, Health & Care Plan (EHCP)' and those who required 'SEN Support'. An EHCP is a legal document which outlines the needs and additional help that will be required for a child, SEN Support is a lower level of support provided by mainstream schools for those with recognised special educational needs. Rates within Torbay for cared for children with an EHCP are significantly higher than statistical neighbours and England, rates are broadly in line with the South West (Fig 60). Rates within Torbay for cared for children with SEN Support are significantly higher than England but broadly in line with Statistical neighbours and South West (Fig 61).

Fig 60: Percentage of Cared for Children with an EHCP (2017 to 2021)

Source: Department for Education - Outcomes for children in need, including children looked after

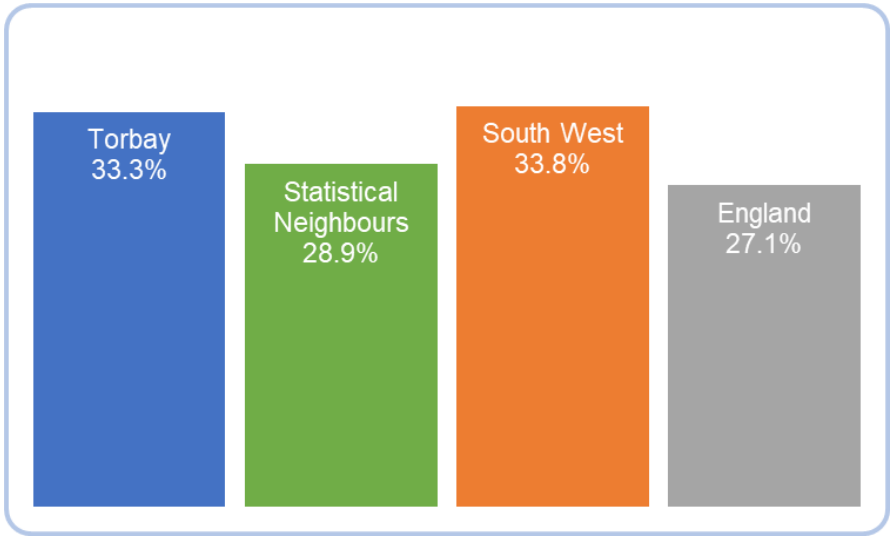
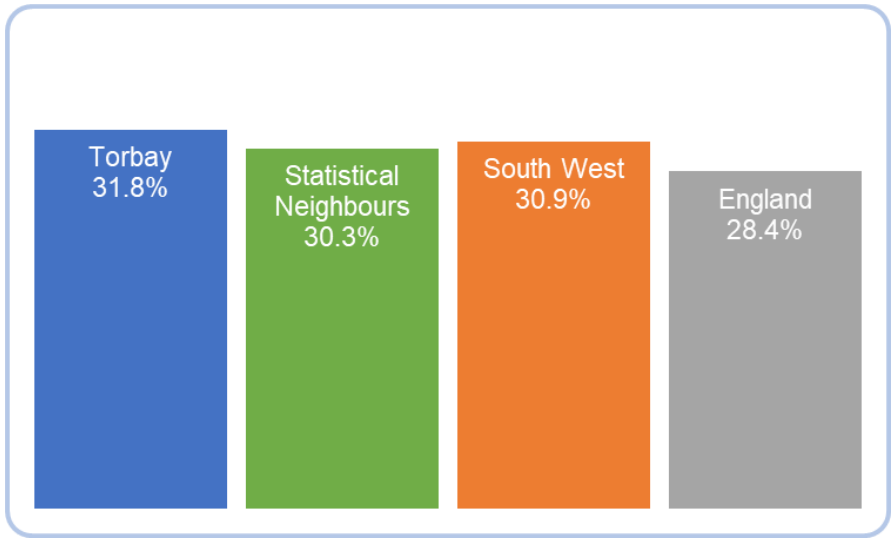


Fig 61: Percentage of Cared for Children receiving SEN Support (2017 to 2021)

Source: Department for Education - Outcomes for children in need, including children looked after



Children in Need achieving a 9-4 pass in English & Maths

A 9-4 pass at GCSE is the equivalent of an A to C pass. For the latest year available (2021), the percentage of children in need receiving a 9-4 pass in English & Maths was 23.6%, across all Torbay pupils the rate was 72.0%, it should be noted that pass rates for this group fluctuate significantly from year to year. Although for 2021, rates were below statistical neighbours, South West and England, they have been higher in 3 of the previous 4 years (Fig 62). Rates across the last 5 years have always been less than half those of the whole school population (Fig 63).

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Fig 62: Percentage of Children in Need achieving a 9-4 pass in English & Maths
Source: LAIT

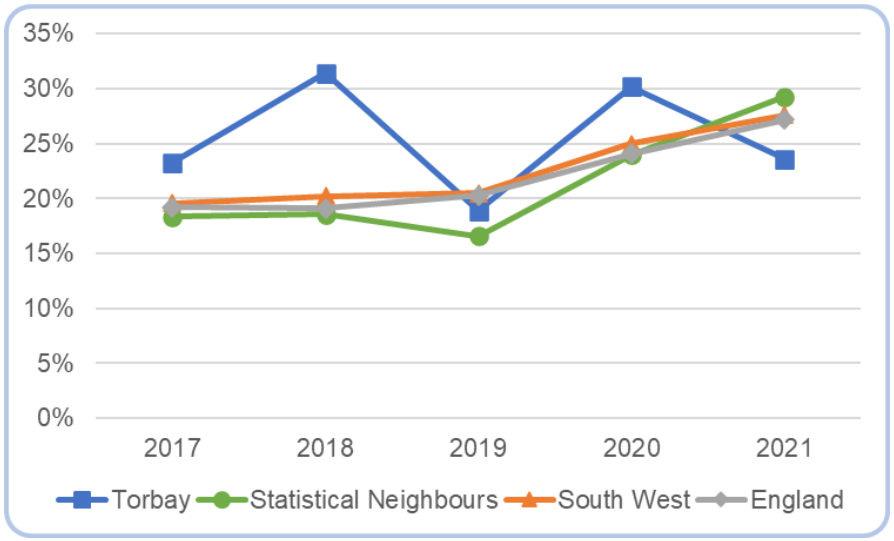
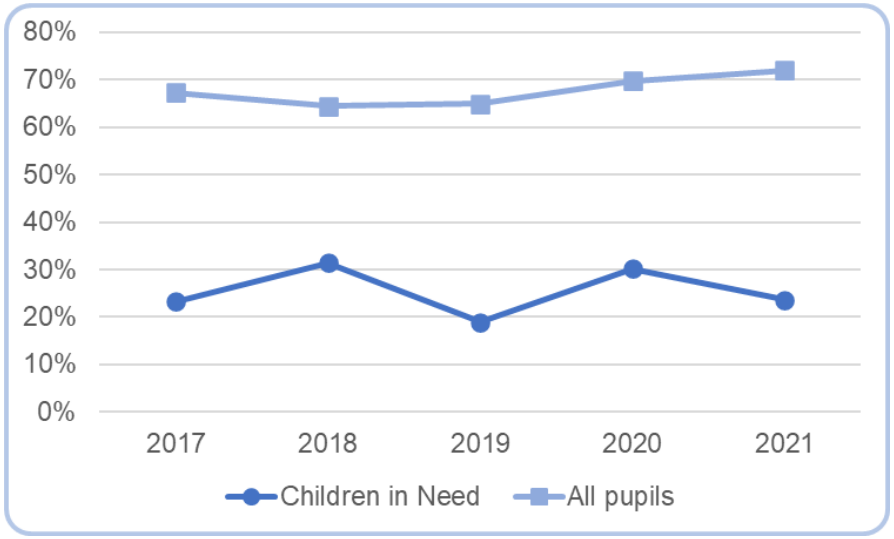


Fig 63: Percentage of Torbay children achieving a 9-4 pass in English and Maths (Children in Need and All pupils)
Source: LAIT



Persistent Absentees – Children in Need & Child Protection Plans

A child is defined as being a persistent absentee if they miss 10% or more of their possible sessions. Rates of persistent absenteeism are much higher among Children in Need & Children with Protection Plans than the general school population over the last 4 years of recorded data (Figs 64 and 65). Rates rose significantly in 2021 as absences due to COVID-19 were included. During 2021, the percentage of Children in Need who were persistently absent was 49.1%, for those with a Child Protection Plan it was 61.4%, among the general state school population it was 15.2%.

Fig 64: Percentage of Children is Need who were persistently absent (2017 to 2019 and 2021)
Source: Department for Education - Outcomes for children in need, including children looked after

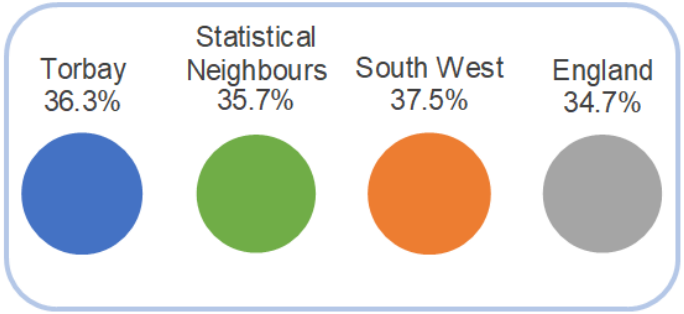
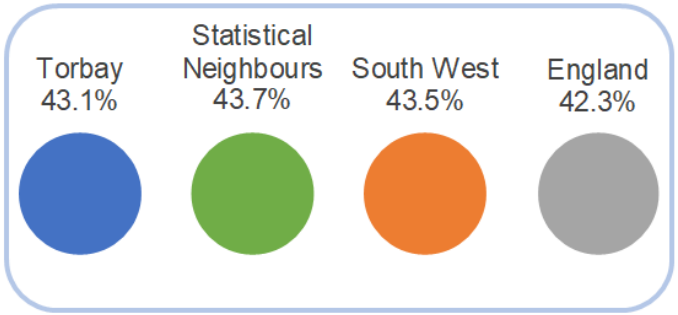


Fig 65: Percentage of those with a Child Protection Plan who were persistently absent (2017 to 2019 and 2021)
Source: Department for Education - Outcomes for children in need, including children looked after



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Children in Need Assessment Factors

When a child receives an assessment, a number of factors are often identified at the end of that assessment. During the period 2018 to 2022 there were 8,712 episodes with an assessment factor for Torbay children, each episode can have multiple factors recorded, the 10 most commonly recorded factors are shown below, the factors can relate to the parent/carer or child (Fig 66).

Fig 66: 10 most common factors in Children in Need assessment for Torbay (2018 to 2022)
Source: Department for Education – Characteristics of children in need

Factor	How often recorded
Mental Health	4,849
Domestic Abuse	4,428
Alcohol Misuse	2,009
Drug Misuse	1,931
Emotional Abuse	1,752
Neglect	1,431
Learning Disability	1,374
Physical Disability	1,148
Socially unacceptable behaviour	748
Physical Abuse	718

A good source of further information around Children's Social Care is the Local Authority Interactive Tool (LAIT) at Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk).

Please note that the 2022 population figures used by the Department for Education at the time of extraction in January 2023 were drawn from the 2021 Census and as such may not yet be fully reflected in the LAIT figures.

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Cared for Children (2022)	Rate per 10,000	118	90	60	70	🔴	↓
Children who are subject to a Child Protection Plan (2022)	Rate per 10,000	60	56	41	43	🔴	↓
Children in Need (2022)	Rate per 10,000	564	400	307	343	🔴	↑
Section 47 referrals started during year (2022)	Rate per 10,000	324	241	165	185	🔴	↓
Referrals (2022)	Rate per 10,000	825	617	518	552	🔴	↓
Cared for Children with an EHCP (2017 to 2021)	%	33%	29%	34%	27%	🔴	↑
Children in Need achieving a 9-4 pass in English & Maths (2021)	%	24%	29%	28%	27%	Not possible to calculate	↓
Children in Need persistently absent (2021)	%	49%	46%	47%	42%	🔴	↑
Child Protection Plan persistently absent (2021)	%	61%	55%	54%	53%	🟡	↑

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Adult Social Care

Overview

- Torbay is an outlier in needing to support higher levels of need in the 18 to 64 year population.
- Rates of support requests for new clients rose significantly in 2021/22.
- The rate of long-term support being met by permanent admission to residential and nursing homes for those aged 65 and over rose substantially during 2021/22.
- The number of carers supported by Torbay Council stood at 1,430 in 2021/22, this is the largest number in the last 5 years.
- 85% of people who used services stated that those services make them feel safe and secure.
- 34% of carers and 40% of users felt that they had as much social contact as they would like in 2021/22.

All above sourced from Adult Social Care Activity & Finance Report

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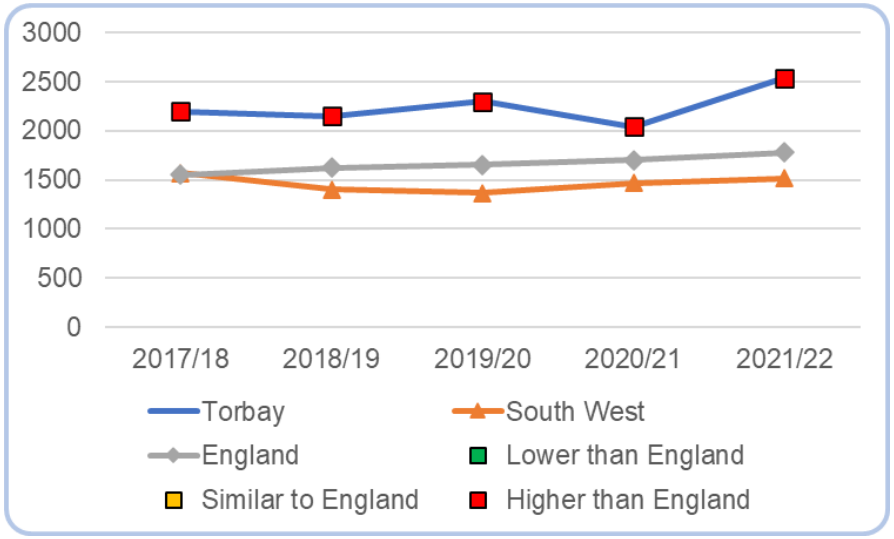
Adult social care is provided to adults with physical, mental and learning difficulties. This can be provided through helping someone to wash, get dressed or cleaning the living areas. It can be provided in the home or in residential care and nursing homes.

There are a number of documents related to Adult Social Care in Torbay at Adult Social Care in Torbay - Torbay and South Devon NHS Foundation Trust

Requests for support for new clients

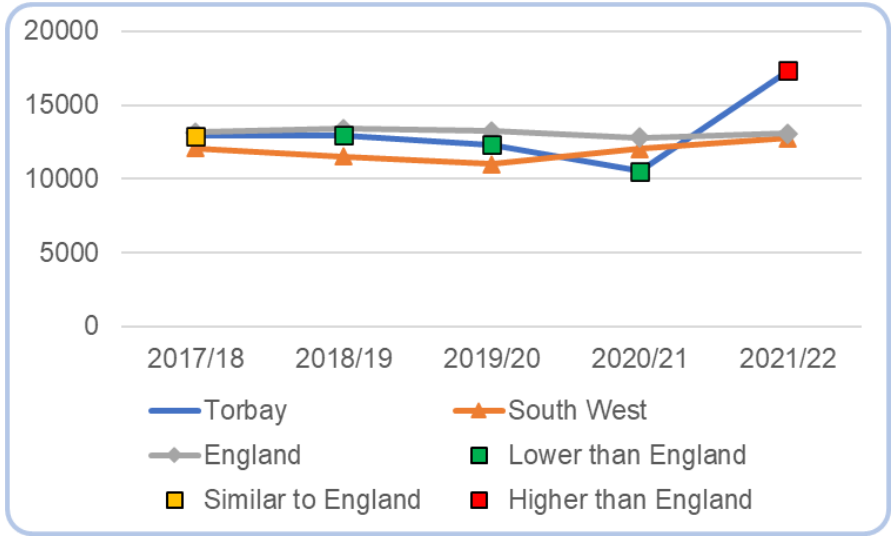
Torbay has a rate of requests for adult social care support for new clients aged 18 to 64 over the last 5 years that were consistently significantly higher than England, 35% higher over 5 years (Fig 67). Rates were also much higher than the South West although broadly in line with our statistical comparators. In the last 5 years there were 8,400 of these requests for Torbay residents aged 18 to 64.

Fig 67: Rate of requests for adult social care support for new clients aged 18 to 64 per 100,000
Source: Adult Social Care Activity & Finance Report



For those aged 65 and over, rates were slightly lower than England for the 3 years before a large uplift in 2021/22 (Fig 68). Rates were higher than the South West over the last 5 years but significantly below our statistical comparators. In the last 5 years, there were approximately 24,100 of these requests for Torbay residents aged 65 and over.

Fig 68: Rate of requests for adult social care support for new clients aged 65+ per 100,000
Source: Adult Social Care Activity & Finance Report



Long-term support – 18 to 64

Rates of long-term support for those funded by Torbay Adult Social Care are significantly higher for those aged 18 to 64 than the England average over the last 5 years (Fig 69). Over the last 5 years the rate has been 82% higher for Torbay than England, it is also significantly higher than the South West and our statistical comparators.

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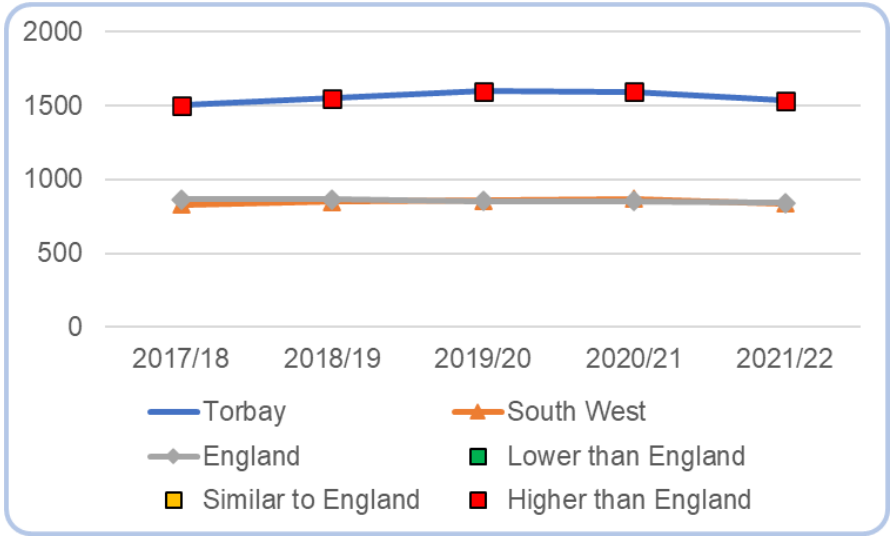
Rates are consistently higher over the last 5 years among 18 to 64 year olds within Torbay, when compared to England, in the major primary support reasons of Learning Disability (60% higher than England), Physical Personal Care (172% higher than England) and Mental Health (73% higher than England). They are also significantly higher than the South West and our statistical comparators.

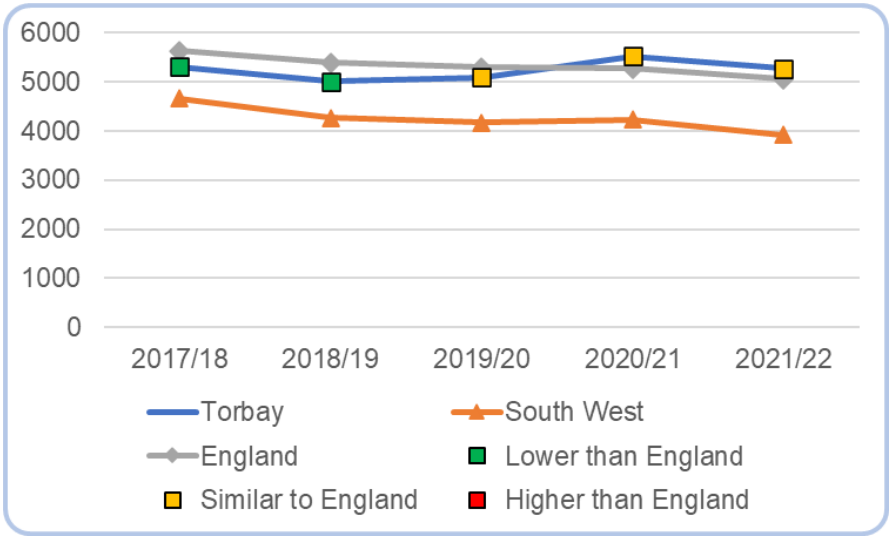
Fig 69: Rate of long-term support for those aged 18 to 64 per 100,000
Source: Adult Social Care Activity & Finance Report



Long-term support – 65+

Rates of long-term support for those funded by Torbay Adult Social Care are broadly similar for those aged 65+ when compared to the England average over the last 5 years (Fig 70). Rates are significantly higher than the South West but significantly lower than our statistical comparators. Within this, there are significant variations from England in some areas, those aged 65+ with a primary support reason of Learning Disability and Mental Health had much higher rates in Torbay whilst those with a primary support reason of Memory & Cognition had significantly lower rates than England.

Fig 70: Rate of long-term support for those aged 65+ per 100,000
Source: Adult Social Care Activity & Finance Report



For rates of long-term support being met by permanent admission to residential and care homes for those aged 65 and over, Torbay had broadly lower rates than England until 2021/22 (Fig 71). For 2021/22, 287 older people were permanently admitted, this is more than 100 above the average of the previous 4 years.

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Fig 71: Rate of long-term support met by permanent admission to residential & nursing care homes aged 65+ per 100,000
Source: Adult Social Care Activity & Finance Report

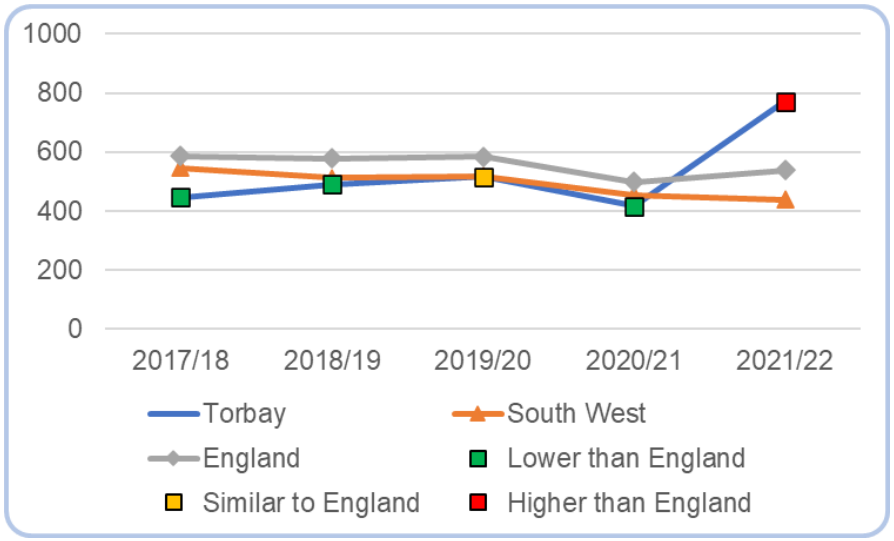
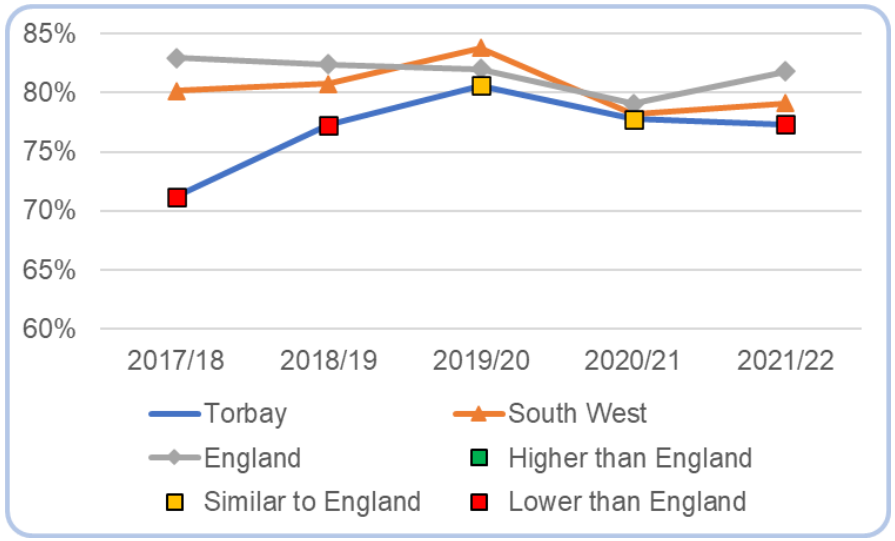


Fig 72: Percentage still at home 91 days after discharge from hospital into reablement/rehabilitation services, aged 65+
Source: Adult Social Care Activity & Finance Report



Still at home 91 days after discharge – 65+

Over the last 5 years, Torbay has broadly had a lower rate of older people (65+) still at home 91 days after discharge from hospital into reablement and rehabilitation, although the trend until 2021/22 had been closing (Fig 72). Rates are also slightly lower than the South West and our statistical comparators. For 2021/22, of the 375 older people offered rehabilitation following discharge from a hospital, 290 remained at home 91 days later (77.3%). Numbers during 2020/21 were approximately half of the other 4 years due to COVID-19.

Carers and users feedback

For 2021/22, the number of carers supported by Torbay Council during the year was 1,430, this was the highest number in the last 5 years. 2021/22 was the first time since 2018/19 that carers reported whether they had as much social contact as they would like in the Adult Social Care Activity & Finance Report. For Torbay, 34% of carers stated that they had as much social contact as they would like which was broadly in line with the last survey in 2018/19. Rates were higher than England and much higher than the South West figure of 24%. Data around the Personal Social Services Survey of Adult Carers in England, 2021-22 is included in the Unpaid carers chapter of this document. Personal Social Services Survey of Adult Carers, 2021/22

Adult Social Care users were also asked if they had as much social contact as they would like. For Torbay, 40% said Yes, this was

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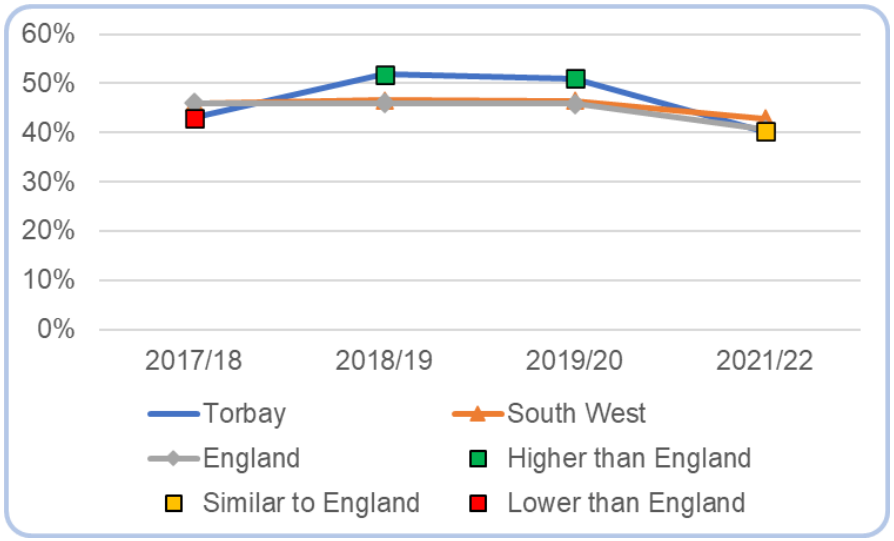
significantly down on figures in 2018/19 and 2019/20 when rates were just over 50%. Rates were broadly in line with England and the South West (Fig 73). Very few authorities collected figures for the 2020/21 return so that year has been removed from the graph.

Fig 73: Percentage of adult social care users who have as much social contact as they would like (No data for 2020/21)
Source: Adult Social Care Activity & Finance Report



The proportion of people who used services who said that those services made them feel safe and secure was 85% in Torbay during 2021/22. This is part of a gradual improvement in this measure since 2018/19. For 2021/22, rates were broadly in line with England and slightly below the South West and our statistical comparators (Fig 74).

During 2021/22, there were 1,000 safeguarding concerns raised and from those 280 Section 42 safeguarding enquiries were instigated (Fig 75).

Fig 74: Percentage of people who use services who say those services have made them feel safe and secure (No data for 2020/21)
Source: Adult Social Care Activity & Finance Report

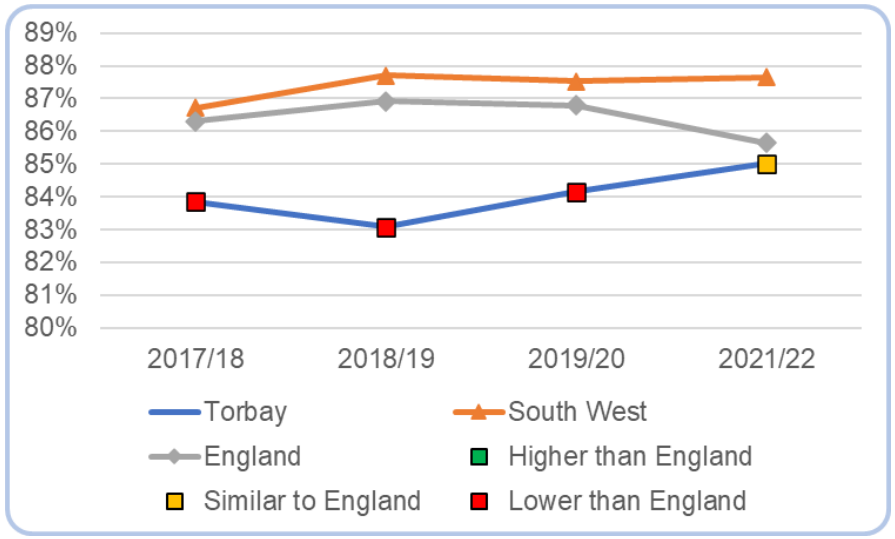
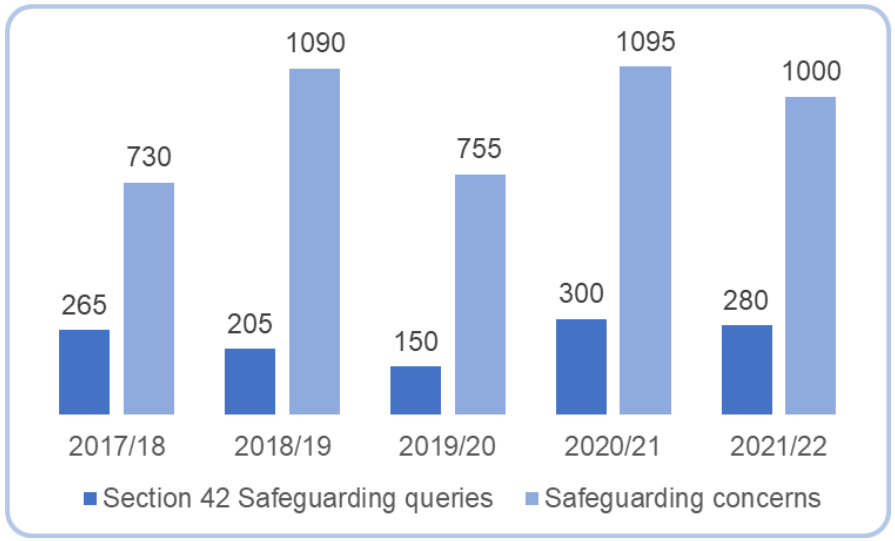


Fig 75: Number of safeguarding concerns and Section 42 enquiries – Torbay
Source: Safeguarding Adults Return



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Requests for support for new clients - 18 to 64 (21/22)	Rate per 100,000	2,541	2,200	1,516	1,782	🔴	↑
Requests for support for new clients - 65+ (21/22)	Rate per 100,000	17,321	15,361	12,761	13,059	🔴	↑
Long term support - 18 to 64 (21/22)	Rate per 100,000	1,534	1,006	837	842	🔴	↓
Long term support - 65+ (21/22)	Rate per 100,000	5,278	5,562	3,917	5,054	🟡	↓
Long term support met by permanent admission to nursing & residential homes - 65+ (21/22)	Rate per 100,000	773	590	439	538	🔴	↑
At home 91 days after discharge into rehabilitation & reablement services - 65+ (21/22)	%	77%	86%	79%	82%	🔴	↓
Adult social care users who have as much social contact as they like (21/22)	%	40%	43%	43%	41%	🟡	↓
Carers who have as much social contact as they like (21/22)	%	34%	30%	24%	28%	🟢	↑
Services have made them feel safe and secure (21/22)	%	85%	88%	88%	86%	🟡	↑

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Economy and Employment

Overview

- Torbay has a lower proportion of working age people compared to England and this is forecast to fall over the next 20 years to approximately 50% of the population.
  Source: NOMIS (ONS population estimates and projections)
- Lower level of economically active 16 to 64 years olds than England and South West.
  Source: NOMIS (Annual Population Survey)
- Lower level of unemployment claimants than England average.
  Source: NOMIS (Claimant Count)
- Average earnings significantly lower than regional and national average.
  Source: NOMIS (Annual Survey of hours and Earnings)
- More of the workforce is in a part-time job compared to England and South West.
  Source: Census 2021
- Fewer residents hold a degree level qualification than England and South West.
  Source: Census 2021
- Better Full Fibre and Ultrafast coverage than England average.
  Source: Ofcom Connected Nations

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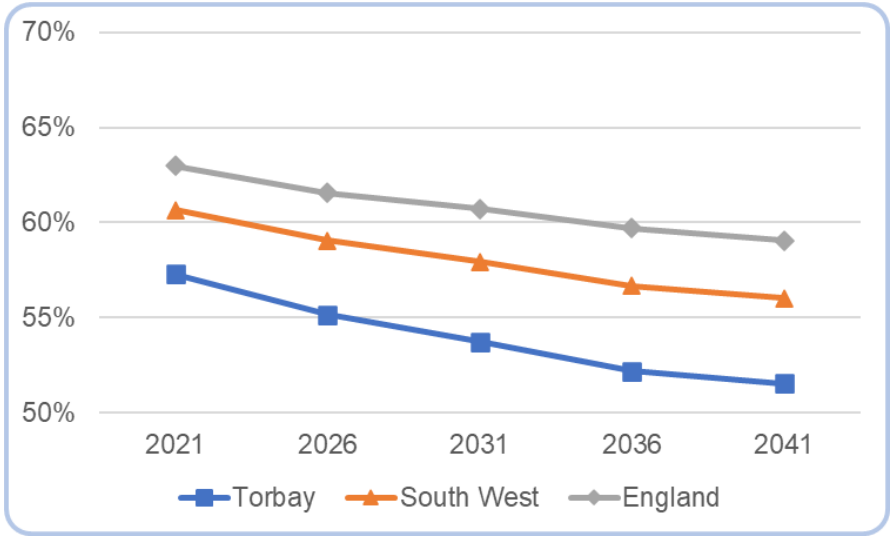
The levels and quality of employment underpin a community. A person who cannot find adequate employment which pays them enough to live without overwhelming financial worries is likely to have an increased risk of physical and mental ill health. Those with higher incomes can expect to have a higher life expectancy and more of that will be in good health.

Demographics

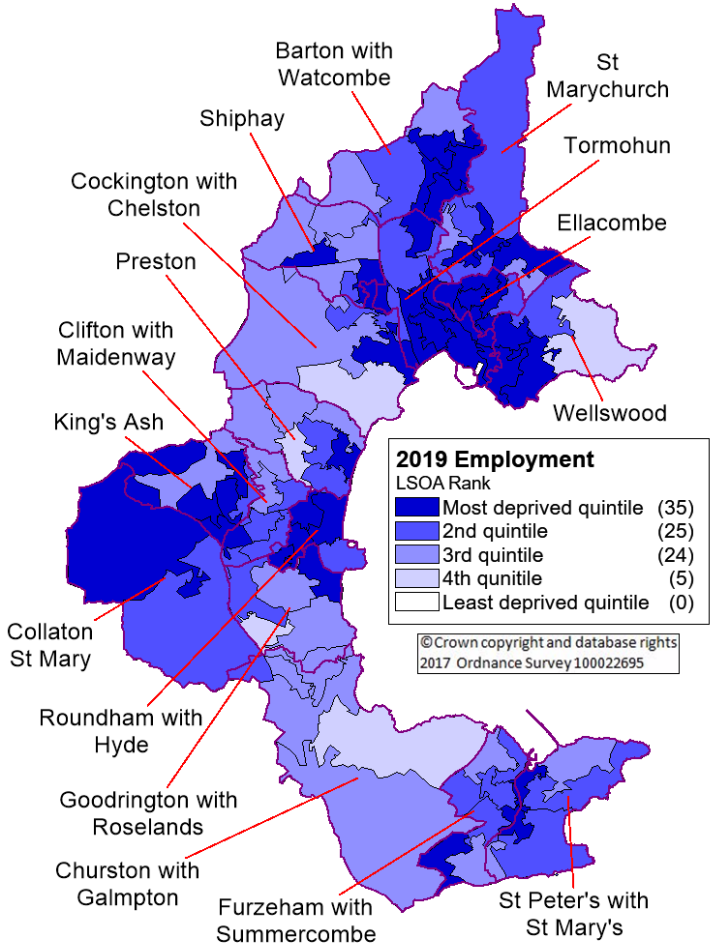
The 2021 ONS mid-year population estimates show that approximately 57% (a slight rise from 2020 due to significant one-off migration of working age people during the COVID-19 pandemic in the 'race for space') of Torbay's population is aged between 16 and 64, this is significantly lower than the England average of 63%. Current projections indicate that Torbay's 16 to 64 year old population is set to fall to approximately 52% by 2041 (Fig 76). This wider fall in the working age population could potentially exacerbate worker shortages and have an adverse effect on tax receipts.

Fig 76: 16 to 64 population as a share of total population
Source: NOMIS (ONS Population estimates & projections)



Employment Deprivation from the 2019 Index of Multiple Deprivation measures the proportion of the working age population involuntarily excluded from the labour market (sickness, unemployment, disability or caring responsibilities). At 11th worst in England this was Torbay's worst performing sub-domain (Fig 77).

Fig 77: Rank of Employment Deprivation
Source: English Indices of Deprivation 2019



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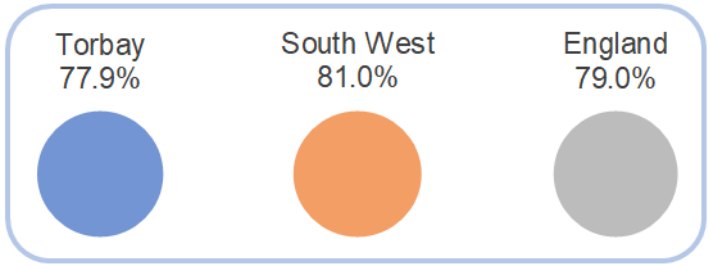
Economic activity

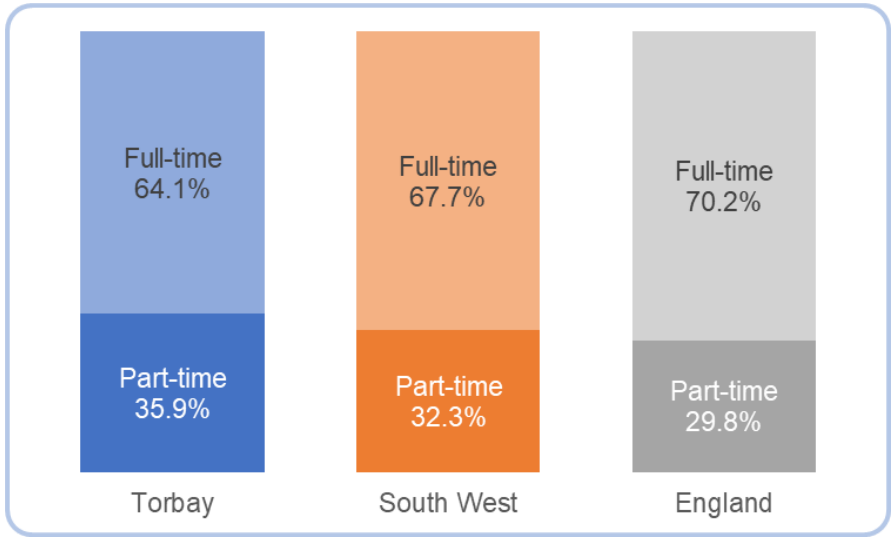
Over the last 5 years, the proportion of those aged 16 to 64 classified as being economically active (in employment or actively seeking employment) has been lower than the South West and England by a statistically significant margin (Fig 78), although in line with our statistical comparators. Male economic activity is a little higher than female economic activity in Torbay but male rates are below England male rates whilst female economic activity rates are in line with England female rates.

Fig 78: Percentage of 16 to 64 economically active (July 2017 to June 2022)
Source: NOMIS (Annual Population Survey)



The 2021 Census showed that 64.1% of Torbay residents classified themselves as a full-time worker (30 hours or more), this was significantly lower than the England average of 70.2% (Fig 79). The Office for National Statistics conducts a Business Register & Employment Survey which shows lower rates of full-time employment for Torbay over the same period (59.5%). The difference is due to the Census asking workers how many hours they work, the Business survey asks businesses about employee hours. Also, the Census asks all residents rather than a sample survey.

Fig 79: Percentage of full-time and part-time workers (2021)
Source: Census 2021



The unemployment claimant rate in Torbay rose significantly along with the rest of the country during 2020, rates have broadly halved from their 2020 peak to current periods (late 2022). Rates for Torbay remain slightly lower than England but above the South West average (Fig 80). The unemployment count does not show the broader picture of those who would like to find paid employment but are unable to because of caring responsibilities, sickness or disability. As of November 2022, 2,500 people in Torbay were claiming unemployment benefit.

During 2022, approximately 11,000 households each month were claiming Universal Credit which equates to just over 1 in 6 households (Source: Stat Xplore). Universal Credit is still in the process of being fully 'rolled out' to the population, within the next couple of years it is hoped that Universal Credit will be fully rolled out and will replace the individual legacy benefits. This will allow for full comparison across geographies and from year to year.

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Fig 80: Percentage of those claiming unemployment benefit as a proportion of residents aged 16 to 64
Source: NOMIS (Claimant Count)

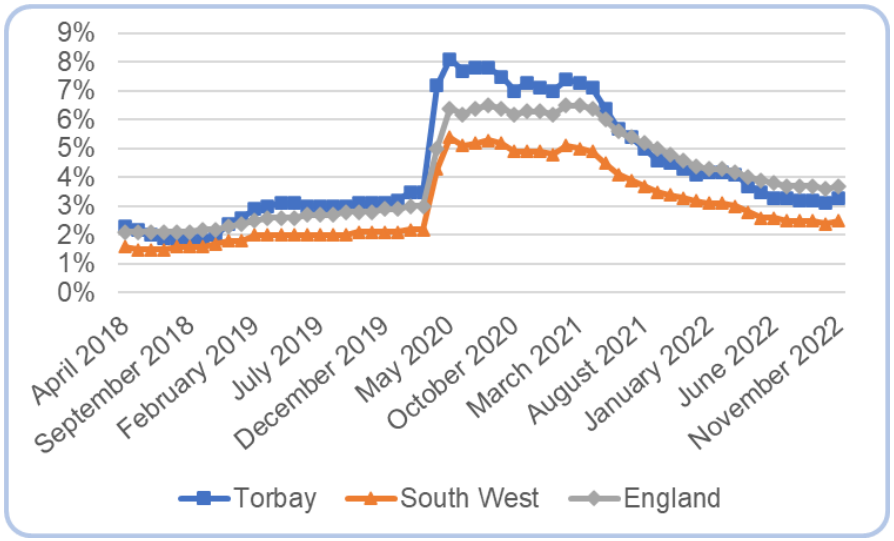
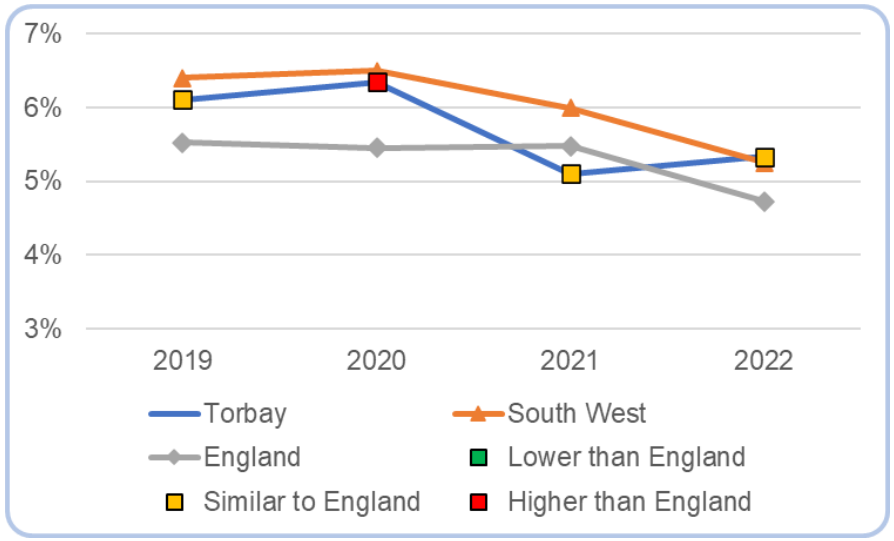


Fig 81: Percentage of 16 and 17 year olds not in education, employment or training
Source: Explore Education Statistics.gov.uk



Young people who are not in education, employment or training (NEET) are at greater risk of poor health, depression or early parenthood. It is required that all young people remain in education, employment or training until the end of the academic year in which they turn 17. For 2022, 159 (5.3%) of 16 to 17 year olds were classified as NEET, this is broadly in line with the regional and national averages (Fig 81).

Workforce

The 2021 Census asked about a person's employment and information is derived about the economic sector in which someone works. Numbers may differ from the Annual Population Survey, however given the that it is a survey it does not give numbers for all sectors as the sample size is too small, so for this document we will use the 2021 Census figures (Fig 82). The largest employment sector is Human health and social work (20.5%) followed by the Wholesale and retail trade (16.5%), Construction (10.3%), Education (8.7%) and Accommodation and food service (8.6%). Compared to the 2011 Census, the most significant rises in employment were in Human health & social work from 9,874 to 12,091 and Construction from 5,116 to 6,048. The most significant fall was in Accommodation and food service which fell from 5,837 to 5,042. It should be noted

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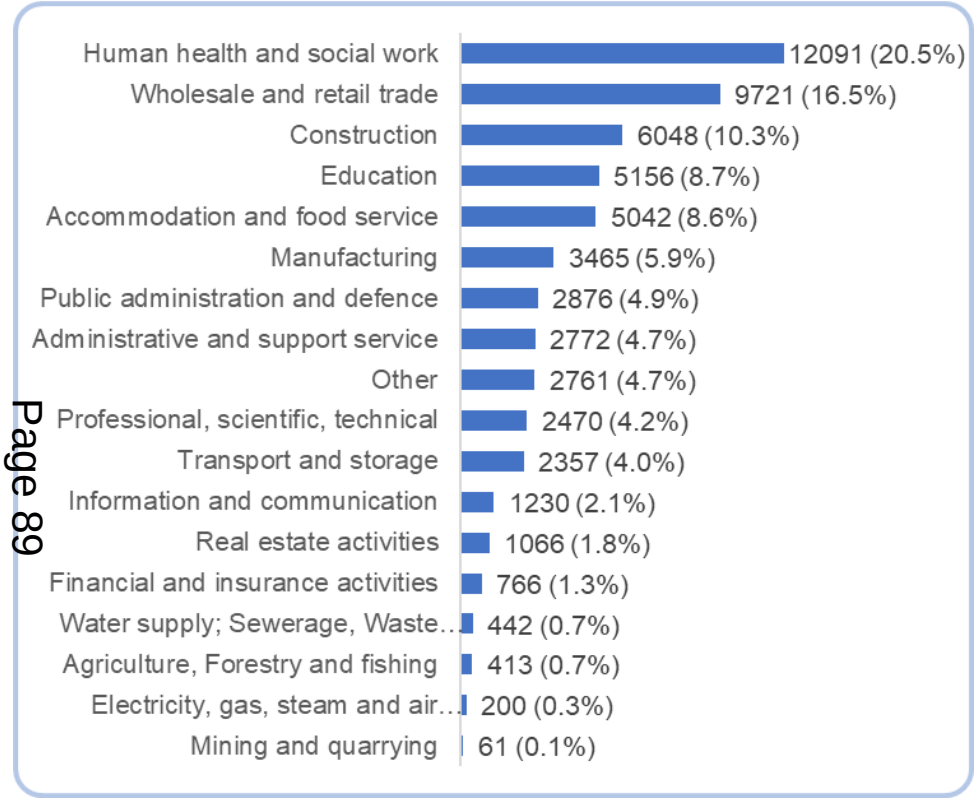
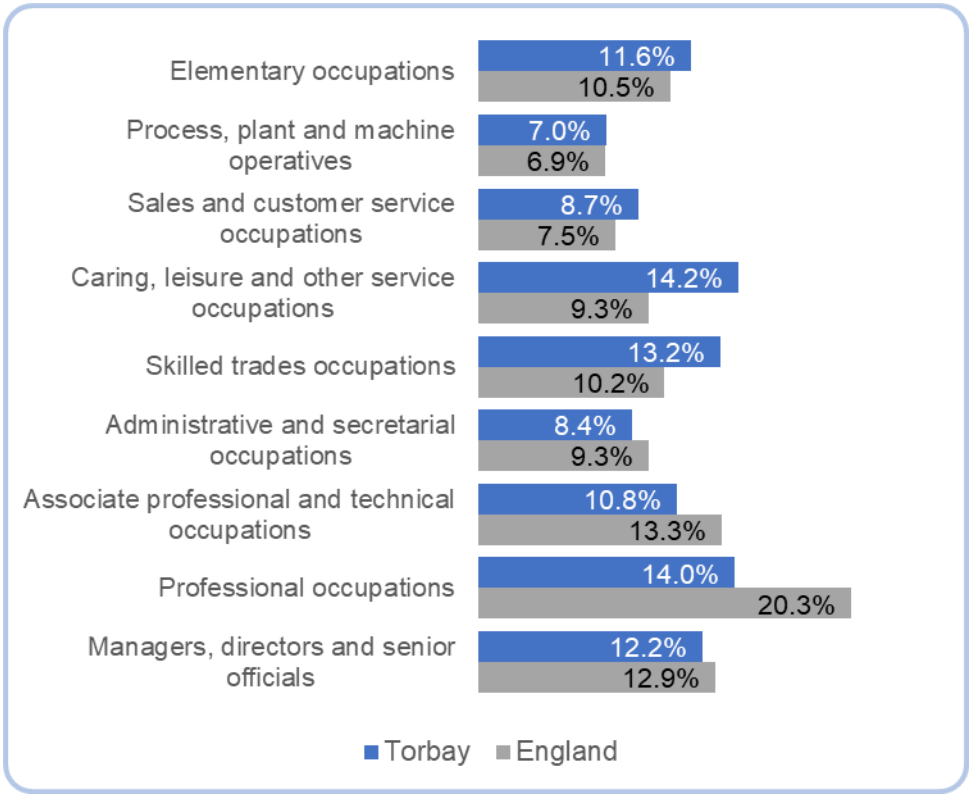
that accommodation and food service businesses were very significantly affected by the COVID-19 pandemic.

Fig 82: Workforce within each employment sector (2021)
Source: Census 2021



The 2021 Census was also used to derive data relating to the occupational groups that people belonged to. The largest proportion belonged to 'Caring, leisure and other service occupations' at 14.2%, this was significantly higher than the England average of 9.3%. The second highest proportion related to 'Professional occupations' at 14.0%, this was significantly lower than the England average of 20.3% (Fig 83). All these groups were further divided into sub-groups, the largest of these were those in 'Caring Personal Services' with 5,261 which equates to 8.9% of Torbay's workforce, followed by 'Sales Assistants and Retail Cashiers' (5.8%) and 'Construction and Building Trades' (4.4%)

Fig 83: Workforce within each occupation group (2021)
Source: Census 2021



Torbay has consistently had lower average salaries than the national and regional average. The results of the 2022 annual survey of hours and earnings showed that median full-time annual salaries in England were 15.4% higher than those for **Torbay residents** (Fig 84) and 30.5% higher in England than those for people who **worked in Torbay** (Fig 86), the South West average was 10.3% higher than

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those for Torbay residents and 23.2% higher than for those people who worked in Torbay.

The hourly rate of pay for workers (Full and Part time) was significantly higher in England and the South West when compared to Torbay, the difference was particularly marked in relation to full-time workers (Figs 85 and 87).

Fig 84: Average (Median) Full-time salary (2022) - **Residents**
Source: NOMIS (Annual Survey of Hours and Earnings)

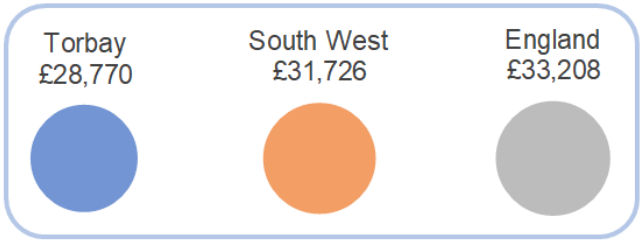


Fig 85: Average (Median) Hourly Rate (2022) - **Residents**
Source: NOMIS (Annual Survey of Hours and Earnings)

Area	All workers	Full-time	Part-time
Torbay	£12.16	£13.34	£10.50
South West	£14.37	£15.78	£11.36
England	£14.87	£16.48	£11.15

Fig 86: Average (Median) Full-time salary (2022) - **Workplace**
Source: NOMIS (Annual Survey of Hours and Earnings)

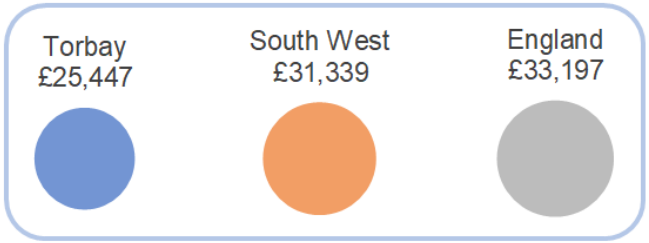
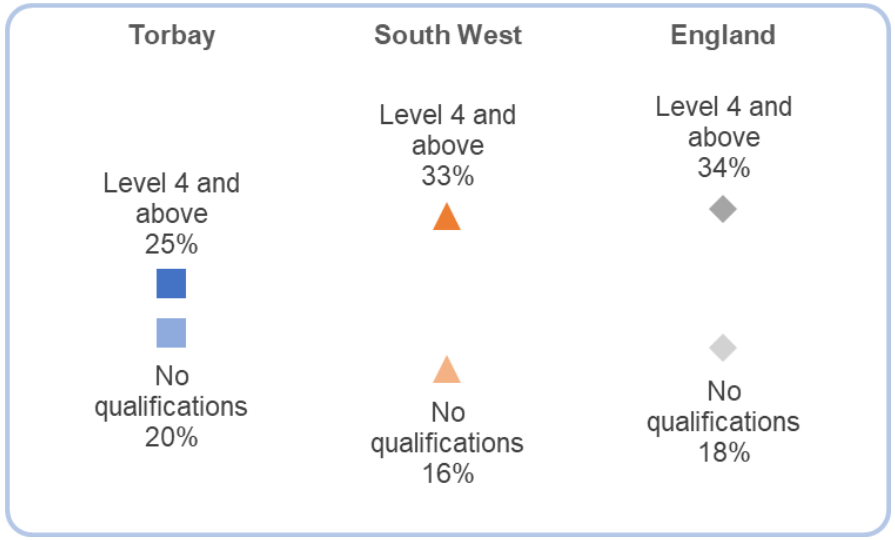


Fig 87: Average (Median) Hourly Rate (2022) - **Workplace**
Source: NOMIS (Annual Survey of Hours and Earnings)

Area	All workers	Full-time	Part-time
Torbay	£11.62	£12.76	£10.39
South West	£14.20	£15.50	£11.30
England	£14.86	£16.48	£11.14

The 2021 Census asked for the highest qualification level of those aged 16 and over. 20% of Torbay residents had no qualifications which was higher than South West and England averages. Torbay also had a significantly lower proportion of residents with a Level 4 qualification (degree level) or above (Fig 88). These gaps are broadly similar to the gaps seen in the Annual Population Survey of 16 to 64 year olds.

Fig 88: Highest level of qualification (2021)
Source: Census 2021



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There continue to be significant gaps amongst those aged 16 to 64 in the overall employment rate and those with a physical or mental long term health condition which was 11.3 percentage points in 2021/22 (Fig 89) and Learning Disabilities which was 67.5 percentage points in 2021/22 (Fig 90). The physical or mental long term health condition gap is broadly similar to England, the Learning Disability gap has improved over the last 3 years but remains large.

Fig 89: Gap in employment rate between those with a physical or mental long term health condition and the overall employment rate – Percentage points
Source: Fingertips

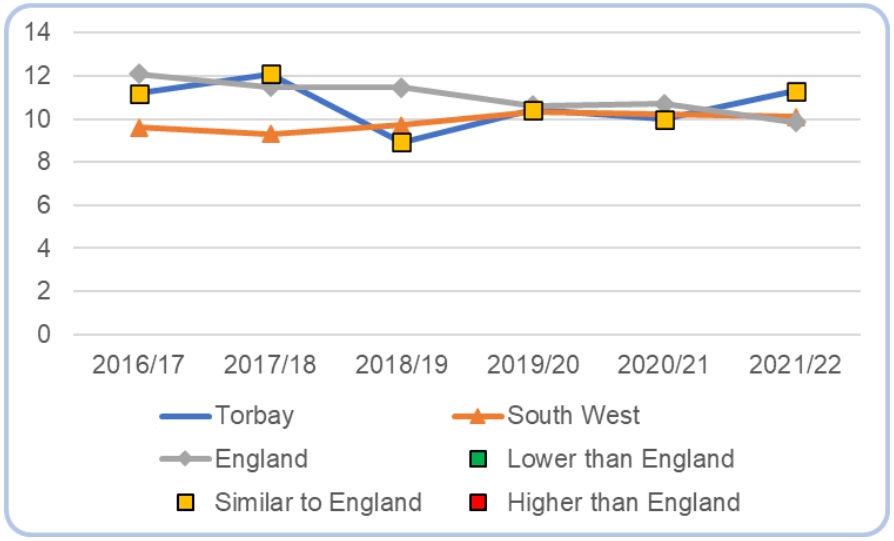
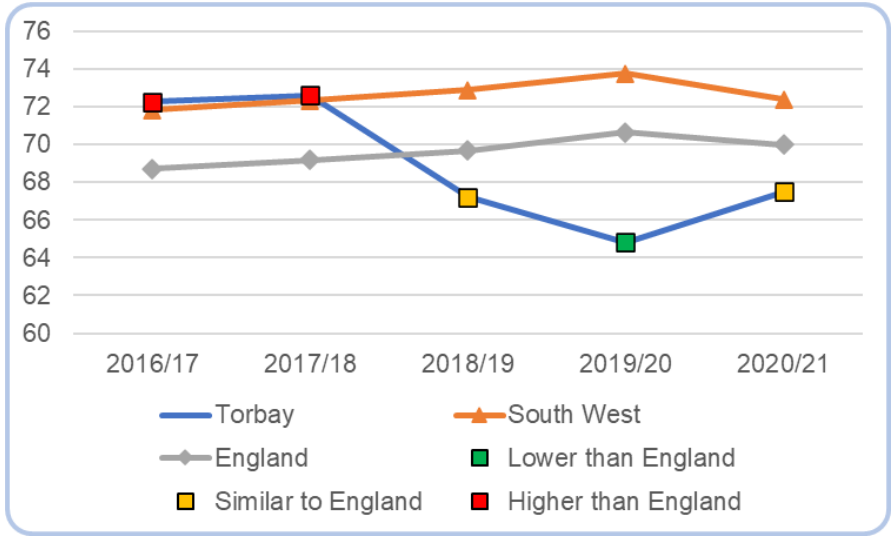


Fig 90: Gap in employment rate between those in receipt of long term support for a learning disability and the overall employment rate – Percentage points
Source: Fingertips



Just over 1 in 6 children under 16 lived in a low income family during 2020/21, the rate was lower than England for 2020/21 but remained higher than the South West (Fig 91). Relative low income is set as 60% of the UK median income, a family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit to be classified as low income. The statistics do not take housing costs into account.

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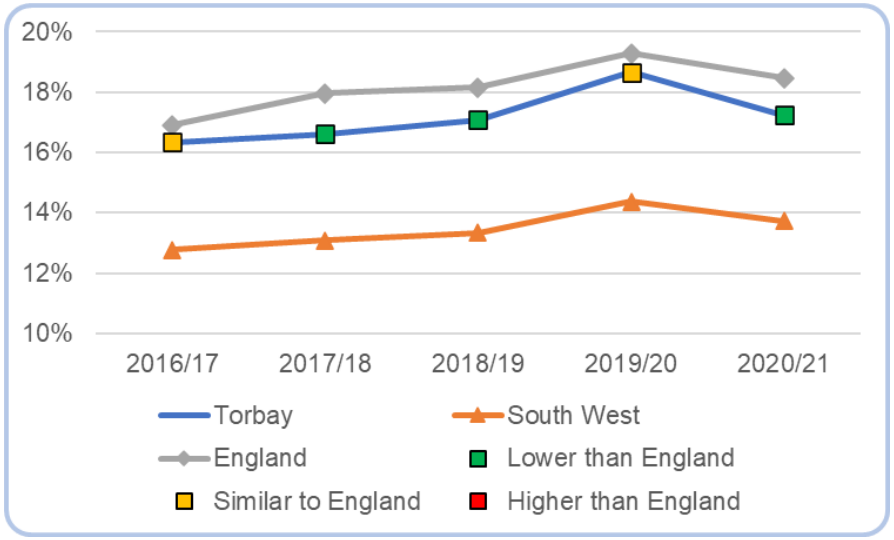
Fig 91: Children in relative low income families
Source: Fingertips



Business, Broadband Connectivity and Insolvencies

The number of active business enterprises in Torbay stood at 4,475 for 2021, this has been relatively consistent over the last 5 years. There were 505 births and 435 deaths of new enterprises within 2021, again this is broadly in line with the previous 5 years (Fig 92). For the 535 new Torbay enterprises born in 2016, 245 (45.8%) survived for 5 years, this is a better rate of survival than England (38.0%) and the South West (37.1%).

Gross Value added is an economic productivity metric that measures the contribution to the economy of each sector (for our purposes, each Local Authority). It is the value of the amount of goods and services that have been produced, less the cost of all inputs and raw materials that are directly attributable to that production. For the last 2 years available (2019 and 2020), Gross Value added per filled job for Torbay has been amongst the lowest in England with only 2 local authorities having a lower GVA per filled job in England.

The GVA data was taken from Subregional productivity: labour productivity indices by local authority district - Office for National Statistics (ons.gov.uk) and relates to Current price (smoothed) GVA (B) per filled job.

Fig 92: Torbay enterprises (2021)
Source: Business Demography (ONS)

As more of our leisure and work is conducted on-line, good broadband connectivity is essential to serve both customers and workers. The latest Connected Nations September 2022 data from Ofcom shows that 97% of Torbay residences have Superfast broadband availability, 84% Ultrafast broadband availability and 74% full-fibre availability. Torbay has a significantly higher proportion of residential premises able to connect to Ultrafast (UK 73%) and Full Fibre (UK 41%). It is a similar story with Commercial premises with Torbay having significantly higher levels of availability of Ultrafast (68% to 50%) and Full fibre (51% to 27%) compared to UK (Fig 93).

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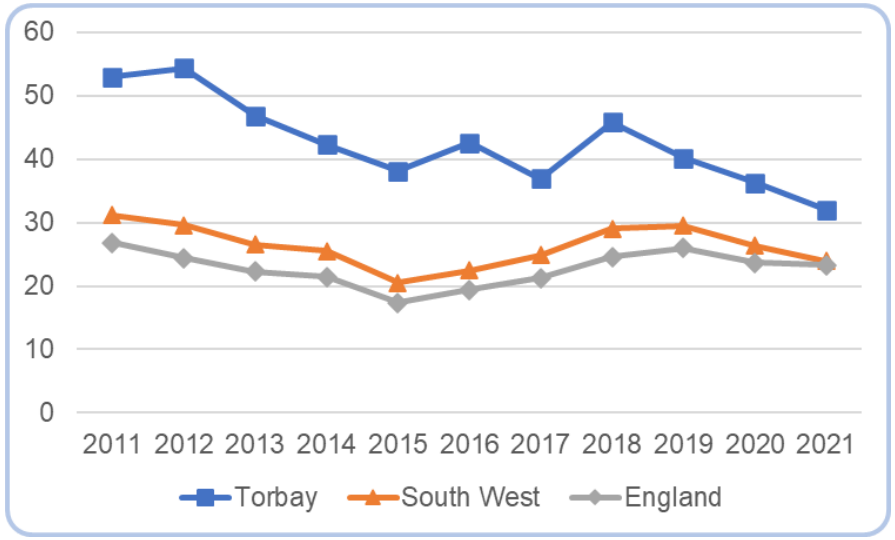
Fig 93: Broadband connectivity availability (September 2022)
Source: Ofcom Connected Nations

Residential	Torbay	UK
Full Fibre	74%	41%
Ultrafast	84%	73%
Superfast	97%	97%
Unable to receive decent broadband	1%	1%
Commercial	**Torbay**	**UK**
Full Fibre	51%	27%
Ultrafast	68%	50%
Superfast	87%	85%
Unable to receive decent broadband	5%	6%

The rate of Individual Insolvencies per 10,000 adults in Torbay reached its lowest level in the last decade during 2021, this is the continuation of a trend over the last 10 years with a drop from 563 Individual Insolvencies in 2011 to 355 in 2021. However, rates are still significantly higher than the South West and England (Fig 94). The make-up of Individual Insolvencies has changed significantly since 2011 with a significant increase in Individual Voluntary Arrangements but falls in Debt relief orders and bankruptcies.

Fig 94: Individual Insolvency Rates per 10,000 adults
Source: Insolvency Service



You may find documents held at the following site useful:-

Economic Regeneration and Tourism - Torbay Council

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
16 to 64 year old population (2021)	%	57%	61%	61%	63%	🔴	↑
16 to 64 year olds who are economically active (Jul 2017 to Jun 2022)	%	78%	78%	81%	79%	🔴	↓
Of those employed, in full-time employment (2021)	%	64%	69%	68%	70%	🔴	↓
Unemployment (Nov 2022)	%	3.3%	3.8%	2.5%	3.7%	🟢	↓
16 and 17 year olds not in education, employment or training (2022)	%	5.3%	4.9%	5.3%	4.7%	🟡	↑
Median full-time salary - Residents (2022)	£	£28,770	£30,827	£31,726	£33,208	🔴	Not relevant
Level 4+ Qualification (2021)	%	25%	29%	33%	34%	🔴	↑
Children in relative low income families (2020/21)	%	17%	21%	14%	18%	🟢	↓
Individual Insolvency Rate (2021)	Rate per 10,000	32	29	24	23	🔴	↓

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Housing

Overview

- More than 1 in 4 (27%) Torbay households privately rent which is significantly higher than England. This is combined with the lowest level of socially rented accommodation in the South West.

  Source: Census 2021

- Significant house price rises have exacerbated affordability issues.

  Source: Office for National Statistics

- By the end of 2021/22, 35% of Torbay dwellings had an Energy Performance Certificate (EPC) rating of C or better.

  Source: Department for Levelling Up, Housing & Communities

- Number of vacant dwellings on a downward trend in Torbay over the last 15 years.

  Source: Council Tax base statistics

- Torbay has been set a challenging target of 600 net additional dwellings a year for the next 18 years. Over the last 21 years, that level of additional dwellings has occurred on 1 occasion.

  Source: Torbay Council Local Plan Update, Department for Levelling Up, Housing & Communities

- On average, 146 households were in temporary accommodation each quarter between July 2021 and June 2022.

  Source: Department for Levelling Up, Housing & Communities

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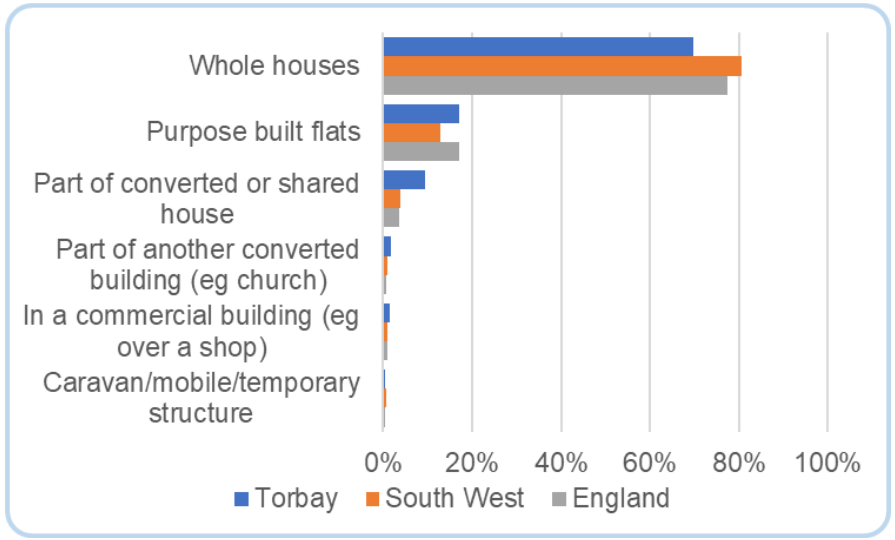
Many parts of the UK have a significant problem in relation to the affordability, availability and quality of their housing stock. Torbay also has significant issues in relation to the points above, these issues will be particularly pronounced among younger and less affluent members of our community.

Households and housing mix

In the 2021 Census, Torbay had just under 63,000 households. 70% of these households lived in a whole house which was significantly lower than the South West and England (Fig 95), Torbay had significantly higher numbers of people who lived in part of a converted or shared house, including bedsits which accounted for 9.3% of households (South West 3.8%, England 3.5%). There were very significant differences between wards, for instance just over 1 in 5 (21%) households in Roundham with Hyde lived in a converted or shared house including bedsits compared to less than 1% in Churston with Galmpton, Collaton St Mary and Barton with Watcombe.

The 2021 Census showed that just over 1 in 3 (35%) of Torbay households consisted of 1 person, this is slightly higher than the South West and England (30%). Just over 1 in 6 (17%) are one person households aged 66 years or over with the highest concentration of 1 in 4 in Wellswood. Tormohun (31%) in central Torquay and Roundham with Hyde (28%) have the most significant proportion of one person households aged 65 and under. Just under 1 in 4 (23%) households in Torbay have dependent children, in King's Ash and Barton with Watcombe this rate is approximately 1 in 3 households. Just over 1 in 20 (5.4%) of Torbay households consisted of 5 or more people, the most significant concentration was in King's Ash (8.6%), Collaton St Mary (8.4%), Barton with Watcombe (7.5%) and Shiphay (6.8%).

Fig 95: Accommodation type of households (2021)
Source: Census 2021



Torbay, in line with England had 69% of its properties classified as underoccupied. Half of Torbay's wards have at least 75% of households underoccupying, rates of under occupation range from 49% of households in Tormohun to 87% in Churston with Galmpton.

Tormohun has the highest rate of over occupation with 228 households (3.6%) being 1 bedroom overoccupied and a further 35 households (0.6%) being 2 or more bedrooms overoccupied.

Almost 2 in 3 households own their property, either outright or with a mortgage. This rate of home ownership in Torbay has been on a steady decline from 78% of Torbay households in 1991 to 65% in 2021. There has been a decline in home ownership across the South West and England but the rate of decline is shallower (Fig 96).

Torbay has high rates of privately rented accommodation, 27% of Torbay households live in the privately rented sector (Fig 97) which is significantly higher than the South West and England rates of

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20%. Roundham with Hyde (47%), Tormohun (45%) and Ellacombe (40%) have the highest rates of households living in privately rented accommodation. Conversely, Torbay has low rates of households living in socially rented accommodation at 8%, this is the lowest rate in the South West.

Fig 96: Percentage of households who own their own home
Source: Census

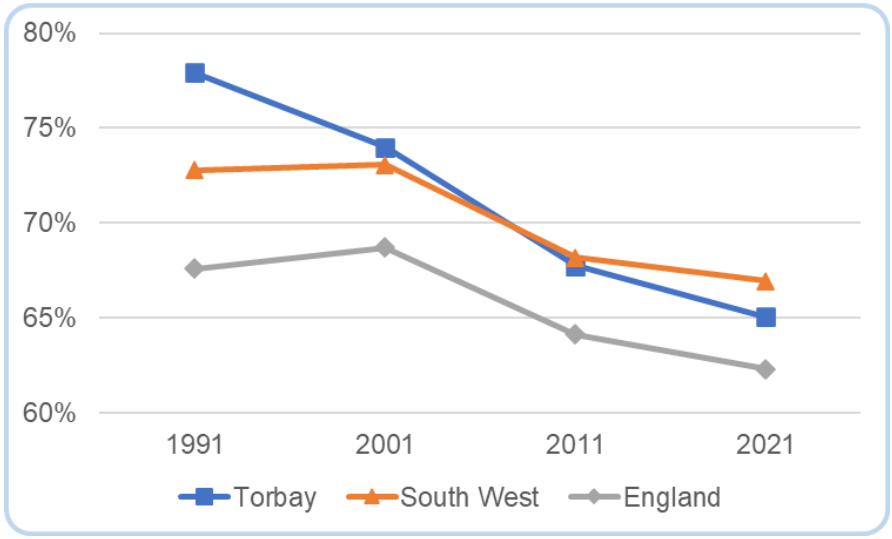


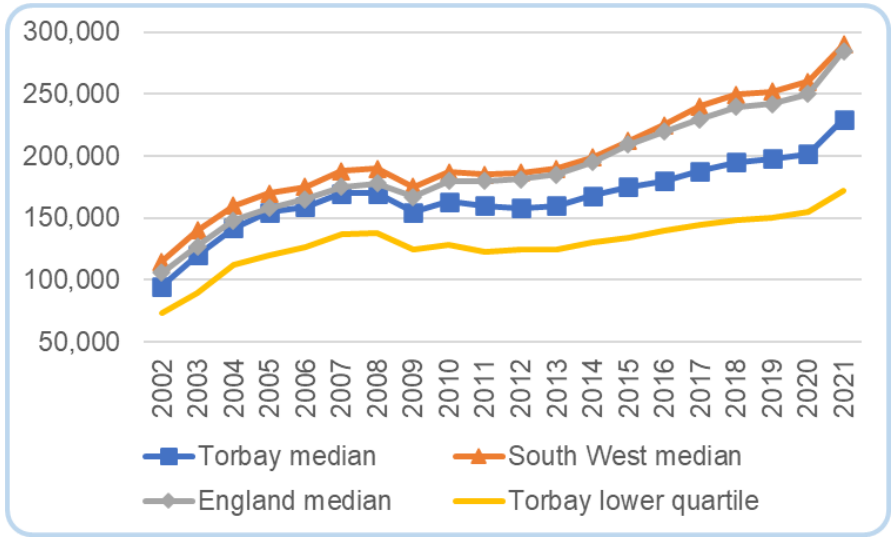
Fig 97: Housing Tenure -Torbay (2021)
Source: Census 2021

Housing Tenure	Number of Households	% of Households
Owned	40,362	64.1%
Shared ownership	622	1.0%
Social rented	5,225	8.3%
Private rented	16,767	26.6%

House prices and rents

Over the last 20 years, the median house price (including flats) in Torbay has risen at a lower rate than the South West and England. For the year ended September 2021, the median house price in Torbay was £230,000 which was a 14% rise on the year before as prices rose after the 2020 COVID-19 lockdowns. The lower quartile house price for the year ended September 2021 was £172,000 in Torbay, lower quartile refers to median of the lower half of house prices. Within Torbay, the lower quartile prices and median prices over the last 20 years have risen by approximately the same rate (Fig 98).

Fig 98: Median and lower quartile house prices (£, year ending September)
Source: Office for National Statistics



House prices by themselves only tell part of the story around housing affordability. A measure of affordability lies in the ratio of lower quartile house prices to lower quartile earnings of residents. Although Torbay house prices are lower when compared to England,

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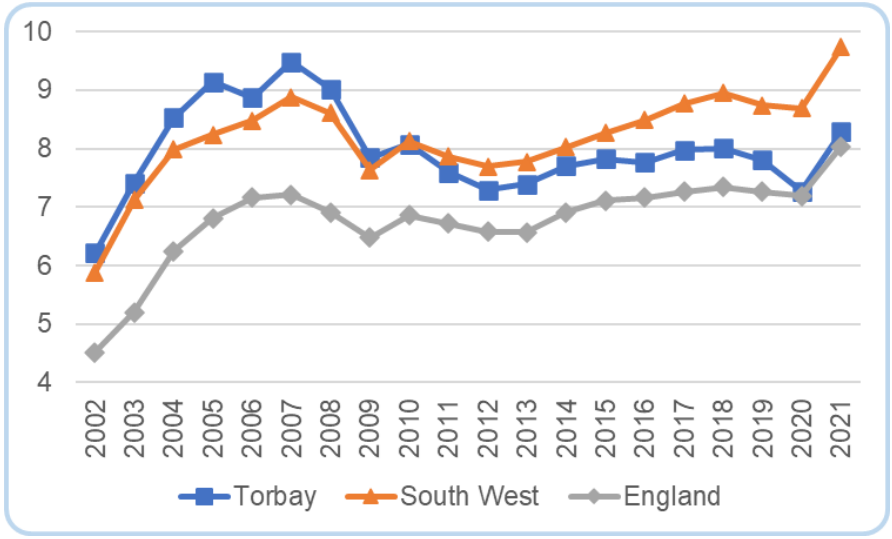
wages are also lower in Torbay which means that over the last 20 years, affordability has been a more significant issue than across England. However, over the last 2 years affordability has been closer to England but significantly better than the South West (Fig 99). For the year ended September 2021, the ratio of lower quartile house price to lower quartile residence-based full-time earnings was 8.29 (South West – 9.74, England – 8.04). It should be noted that these ratios are calculated against those in full-time employment, for a large amount of those who are employed part-time these ratios will be significantly worse.

Fig 99: Ratio of lower quartile house price to lower quartile gross annual residence-based full-time earnings
Source: Office for National Statistics



For many people, buying a house is not currently or is unlikely to ever be a choice they can make due to the affordability of property. 27% of Torbay households currently rent privately which is significantly higher than the South West and England. Whilst overall rents are lower in Torbay compared to the South West and England, it should also be noted that wages are lower. Whilst lower quartile rents were lower in Torbay for studio and 1 bed properties when compared to England, they were in line or higher with respect to 2 and 3 bed properties (Fig 100).

Fig 100: Lower quartile monthly rents (October 2021 to September 2022)
Source: Office for National Statistics Private rental statistics

Area	Torbay	South West	England
Room	£390	£395	£390
Studio	£400	£450	£498
1 bed	£450	£550	£550
2 bed	£625	£685	£625
3 bed	£750	£815	£695
4+ bed	£925	£1,200	£1,100

Housing quality and efficiency

An Energy Performance Certificate (EPC) measures how energy efficient a property is, these are needed for new-build properties and if you wish to sell your property. An EPC is graded from A for the most energy efficient properties to G for the least energy efficient. As well as the environmental need for more energy efficient houses, there is a financial imperative in the face of high energy bills. Grades A to C are seen as the target to reach, although this can be particularly difficult in older properties. By the end of 2021/22, 35.2% of Torbay dwellings were rated as EPC Band C or better, rates were significantly better in flats than houses, new properties being rated A to C was close to 100%. By comparison, 17% of pre-1929 properties

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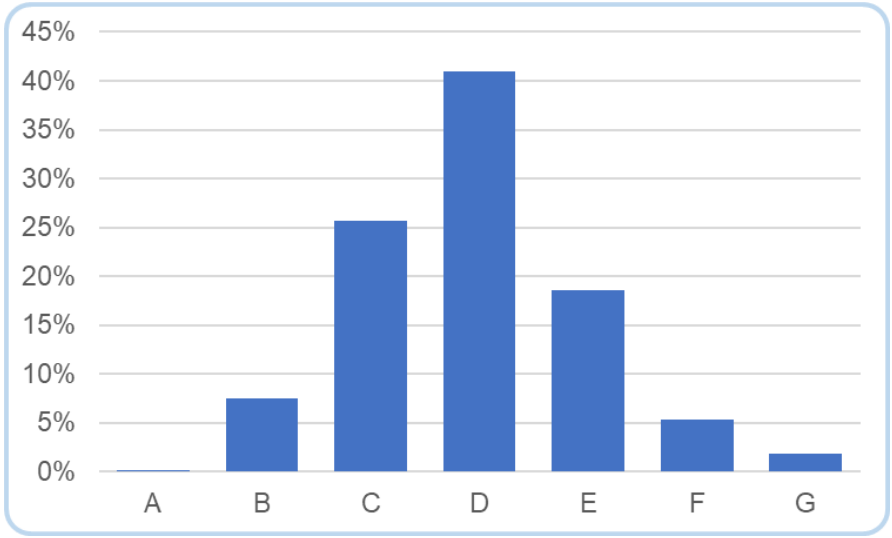
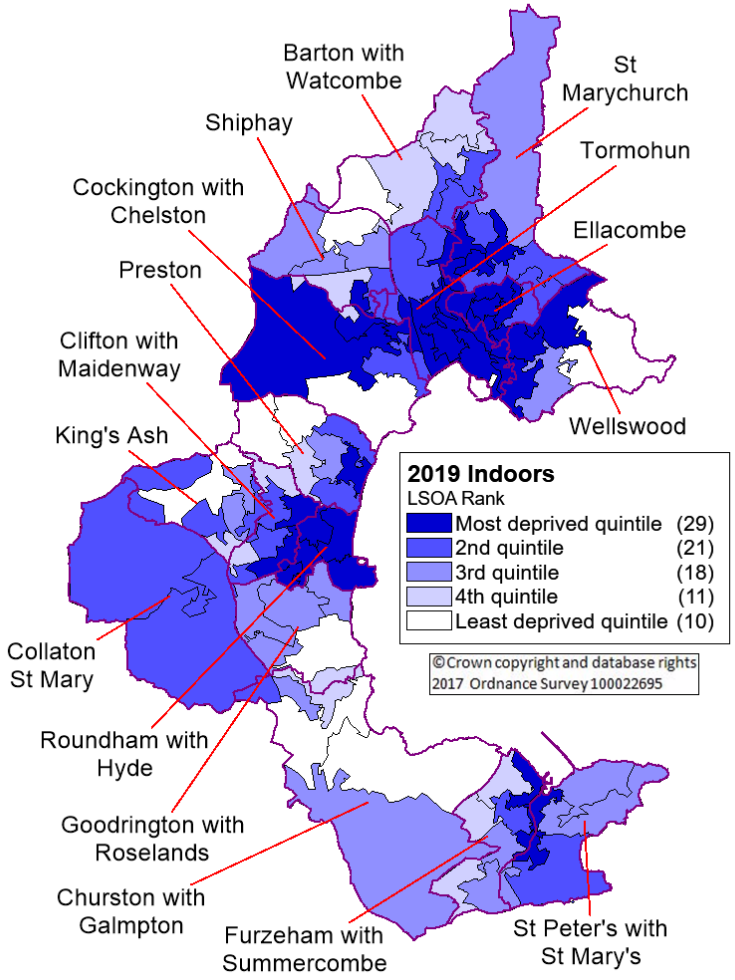
were Band C or better. Socially rented properties were more than twice as likely to be Band C or higher than privately rented or owner occupied. Latest data of the number of EPC lodgements up to the end of 2022 is shown in Fig 101, over 40% of Torbay lodgements returned a Band D.

Fig 101: Percentage of grades for EPC lodgements - Torbay (Up to December 2022)
Source: Department for Levelling Up, Housing & Communities



Indoor deprivation is a sub-section of the Index of Multiple Deprivation 2019. Indoor deprivation measures the quality of housing, specifically the proportion of houses that do not have central heating or fail to meet the Decent Homes standard. There are significant concentrations of indoor deprivation in the central areas of Torquay, Paignton and Brixham (Fig 102)

Fig 102: Rank of Indoor Deprivation
Source: English Indices of Deprivation 2019



1,420 households in Torbay had no central heating according to the 2021 Census. This equates to 2.3% of households (England 1.5%)

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and has fallen from 2,925 households in 2011. Rates were highest in Tormohun (4.4%) and Roundham with Hyde (3.8%).

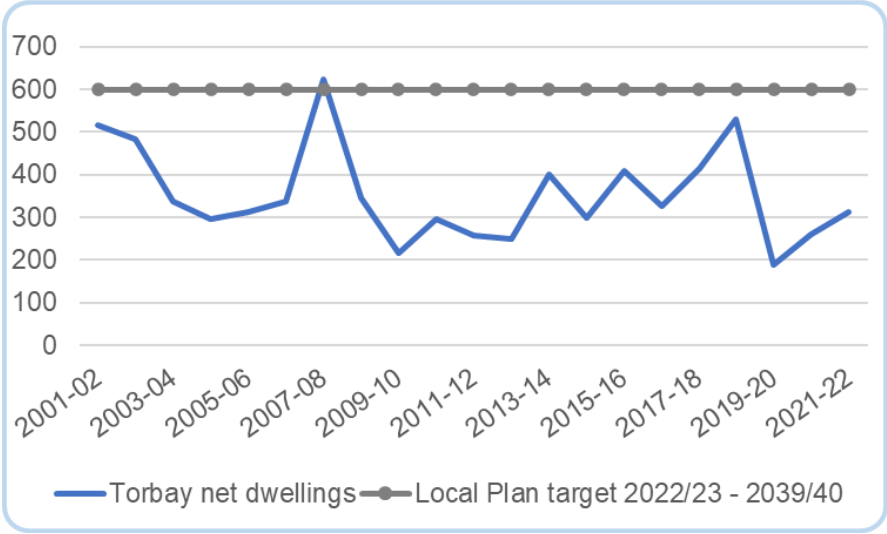
The Department for Business, Energy and Industrial Strategy uses the low income, low energy efficiency methodology to measure fuel poverty. Under this, a household is considered to be fuel poor if they are living in a property with an EPC rating of Band D or worse and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line. As of mid-April 2023, there were no available records at local authority level beyond 2020 which means the available data for Torbay does not take into account the surges in fuel prices over the last year. As of 2020, 1 in 8 of Torbay's households was in fuel poverty which was broadly in line with the South West and England. Across England, fuel poverty is significantly more prevalent amongst those with dependent children than those without. Updates to fuel poverty statistics will be published at Fuel poverty statistics - GOV.UK (www.gov.uk) .

Housing needs and homelessness

On 31st March 2022, Torbay Council had 1,572 households on its housing waiting lists, this is a significant increase compared to 31st March 2019 when there were 1,045 households on the list. However, rates are much lower than the beginning and middle of the last decade. Of the 1,572 households, 808 required 1 bedroom, 382 required 2 bedrooms, 247 required 3 bedrooms and 135 required more than 3 bedrooms. The housing waiting list equates to 2.5% of Torbay households compared to the England rate of 5.1%.

The number of net additional dwellings added to Torbay housing stock during 2021/22 was 312, this is broadly in line with the 5 year and 10 year averages of 341 and 339 respectively. Torbay has been set a target by central government of the minimum number of homes that should be built in Torbay, this figure is 600 dwellings a years, or 10,800 new homes by 2040 Local Plan Update - Torbay Council. This is a significant challenge for Torbay as 600 net additional dwellings in a year has occurred once in the last 21 years (Fig 103).

Fig 103: Torbay net additional dwellings
Source: Department for Levelling Up, Housing and Communities



The Department for Levelling Up, Housing and Communities together with the Ministry of Housing, Communities and Local Government provide data in relation to the additional annual supply of affordable housing. For the 7 years 2015/16 to 2021/22, 397 additional affordable units were completed in Torbay, most of these relating to affordable rent or shared ownership (Fig 104). These statistics consist almost exclusively of those funded through Homes England funded providers or a Section 106 nil grant.

As of October 2022, Torbay had 2,598 vacant dwellings, 1,232 of these have been vacant for at least 6 months which is classified as long-term. Torbay Council Tax base for October 2022 showed 68,056 dwellings on the valuation list, this means 1.8% of Torbay dwellings were long-term vacants, this compares to 1.0% for

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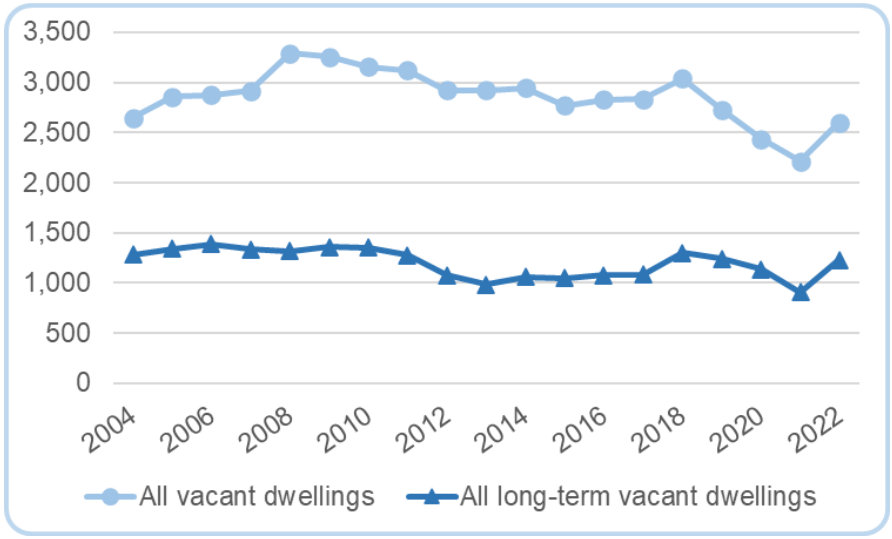
England. Until 2022, vacancy rates in Torbay had fallen for the previous 3 years (Fig 105).

Fig 104: Affordable housing completions – Torbay (2015/16 to 2021/22)
Source: Department for Levelling Up, Housing and Communities

Affordable housing completions type	Number
Affordable Home Ownership	15
Affordable Rent	165
Shared Ownership	175
Social Rent	42
TOTAL	**397**

Fig 105: Vacant dwellings – Torbay
Source: Council Tax base statistics Table 615



Between April and June 2022, 231 out of the 233 Torbay households assessed were owed a homelessness duty, including 155 households owed a relief duty (because they were already homeless), and 76 threatened with homelessness who were owed a prevention duty. Figures were taken from the homelessness tables held at Tables on homelessness - GOV.UK (www.gov.uk) .

The main reasons for the loss of their last settled home for those owed a *relief duty* were:

- End of private rented assured shorthold tenancy – 30%
- Friends or family no longer willing or able to accommodate – 19%
- Domestic Abuse – 16%
- Non-violent relationship breakdown with partner – 15%

These 4 reasons were by far the most common during 2021/22 as well.

By far the main reason for the threat of loss of last settled home for those owed a *prevention duty* was the end of a private rented assured shorthold tenancy (70%). This is much higher than the England average which is around 40%.

79% of households owed a duty had support needs, in many cases multiple support needs, this was significantly higher than the rate of 52% across England over the same period. Of all households owed a duty the 5 most common support needs were:

- History of mental health problems – 52%
- Physical ill health and disability – 43%
- At risk of or had experienced domestic abuse – 19%
- Learning disability – 16%
- History of repeat homelessness – 15%

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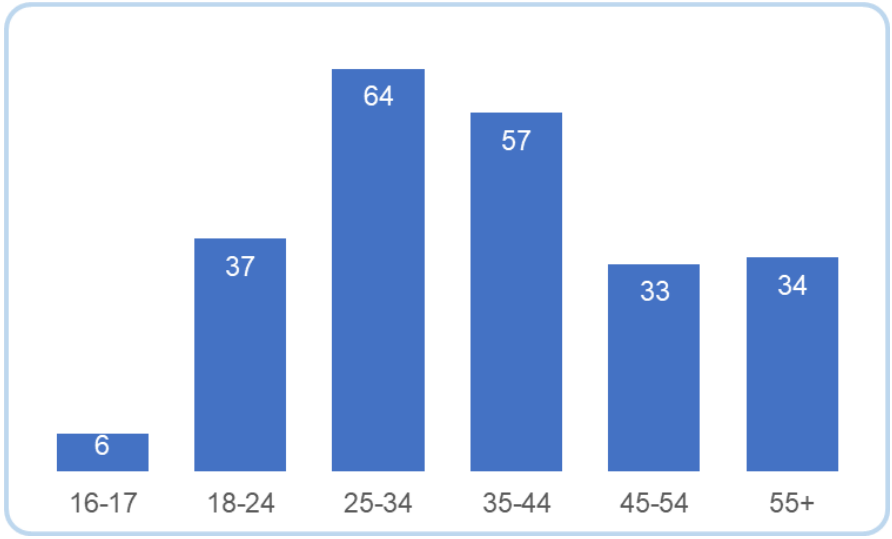
All of these support needs were more common in Torbay than across England over the same period, for instance 26% had a history of mental health problems across England, 18% experienced physical ill health and disability.

Just over half of the main applicants who owed a prevention or relief duty were between 25 and 44 years old (Fig 106)

Fig 106: Age breakdown of those owed a homelessness duty – Torbay (April to June 2022)
Source: Department for Levelling Up, Housing and Communities



Just over 3 out of 4 people owed a relief duty (already homeless) were either single males (54%) or single females (22%). 22% of people owed a relief duty had dependent children (10% were single mothers, 6% single fathers, 6% couples). These figures are similar to 2021/22 although the balance among single parents is usually weighted more heavily towards single female parents.

For those owed a prevention duty the main groups consisted of 49% who were single adults (28% male, 21% female), 18% single female parents with dependent children, 16% couples with dependent children and 12% couples/two adults without dependent children.

The average number of households in temporary accommodation in Torbay (averaged over 4 quarters from 3 months to 30th September 2021 – 3 months to 30th June 2022) was 146, of these 50 were households with children. The most common form of temporary accommodation was bed and breakfast hotels which accounted for 44% of temporary accommodation although this fell to 31% in the quarter to 30th June 2022. For those households with children, they were most likely to be placed in private self-contained accommodation (57%).

Every year, there is a snapshot taken in the Autumn of the number of rough sleepers throughout England on 1 particular night. Over the period 2018 to 2021 the number of rough sleepers counted in Torbay has varied between 16 and 19.

There are a number of documents that provide more detail around Housing in Torbay:-

Local Plan Update - Torbay Council

Housing Strategy - Torbay Council

Ending rough sleeping for good - GOV.UK (www.gov.uk)

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Environment and Climate Change

Overview

- Torbay's population is on average closer to the nearest park, public garden and playing field than the England average but these greenspaces are of a smaller combined size (within a 1000 metre radius).
  Source: ONS (Ordnance Survey Greenspace)
- Torbay waste reuse, recycling and composting rate has reduced in the last 3 years (2018/19 to 2020/21) and is lower than the South West and England.
  Source: Defra
- Torbay's greenhouse gas emissions are considerably lower than England (2020) with the domestic sector as the highest emitter.
  Source: Department for Business, Energy and Industrial Strategy (BEIS)
- Torbay's carbon dioxide emissions are reducing and remain lower than England.
  Source: Department for Business, Energy and Industrial Strategy (BEIS)
- Torbay has much energy inefficient housing, only 35% of dwellings with Energy Performance Certificates are in the higher bands of A-C in 2022, 50th from bottom compared to 331 local authority districts.
  Source: Department for Levelling Up, Housing and Communities
- Torbay's urban forest report, 2022, estimates 18.2% of Torbay as tree canopy cover, compared to 11.8% in 2010 despite a reduction in the number of trees.
  Source: Torbay's urban forest: Assessing urban forest effects and values, survey 2. Treeconomics, using the i-Tree Eco model

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Torbay is a coastal area with a beautiful natural environment. Being outside in greenspaces can positively affect health and wellbeing. Climate change is a global, national and local issue with serious health, social and financial risks and impacts. Deprived groups are more likely to be adversely impacted by lack of decent green and natural space and by climate change.

Greenspace

It is evidenced that being in green environments can help with health and wellbeing, promoting good health and helping with managing health problems and illness recovery. Greenspaces are associated with improvements in mental health and quality of life, as well as promoting community cohesion, reducing loneliness and mitigating the impacts of heat, flooding, noise and air pollution. There is less good quality public greenspace in areas that are the most economically deprived, so people living in deprived areas are less able to gain these health and social benefits. (Public Health England, 2020)

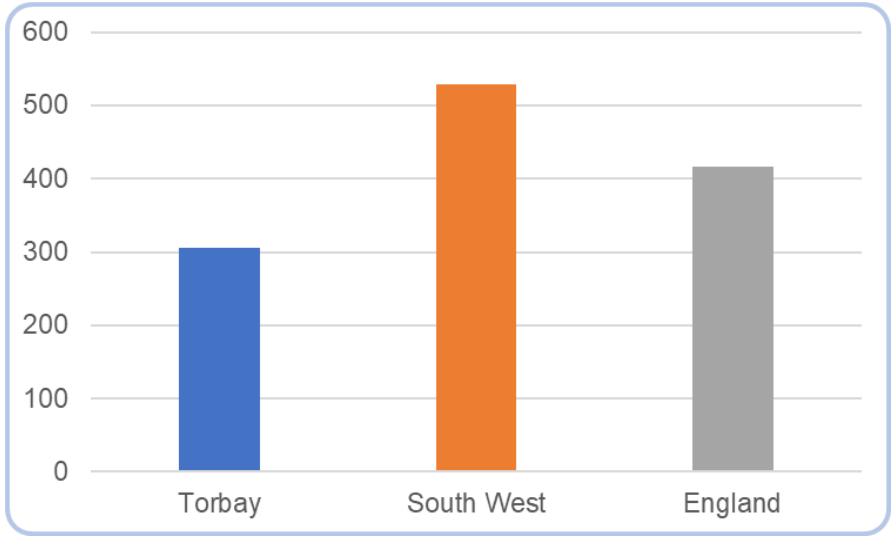
It is becoming more evident that access to blue space (coastline, sea, lakes, rivers, canals etc) can also benefit physical and mental health. This is particularly relevant to Torbay as a coastal area.

Access to Greenspace

The proximity of the population to and the size of these parks, public gardens and playing fields are shown in Figs 107 and 108. Parks and public gardens are very likely publicly accessible but it is possible that playing fields may be private. The data does not include other types of publicly accessible greenspace. The data is weighted by population.

Torbay's population is on average closer to the nearest park, public garden or playing field (Fig 107) than the South West and England, with 305.89 metres distance in Torbay, 417.17 metres in England and higher again in the South West at 528.78 metres.

Fig 107: Average distance to the nearest park, public garden or playing field (metres), 2020
Source: ONS (Ordnance Survey Greenspace)



Per park, public garden or playing field the average population is 5,308 people in Torbay compared to 9,077 in England. The average number of parks, public gardens and playing fields within a 1,000 metre radius is higher in Torbay at 6.34 (3.69 in the South West and 4.43 in England). However, the average combined size of these greenspaces within 1,000 metre radius (Fig 108) is smaller in Torbay at 174,326 metres^2 compared to the 395,568 metres^2 England average.

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Fig 108: Average combined size of parks, public gardens and playing fields within 1,000 metre radius (metres^2), 2020
Source: ONS (Ordnance Survey Greenspace)

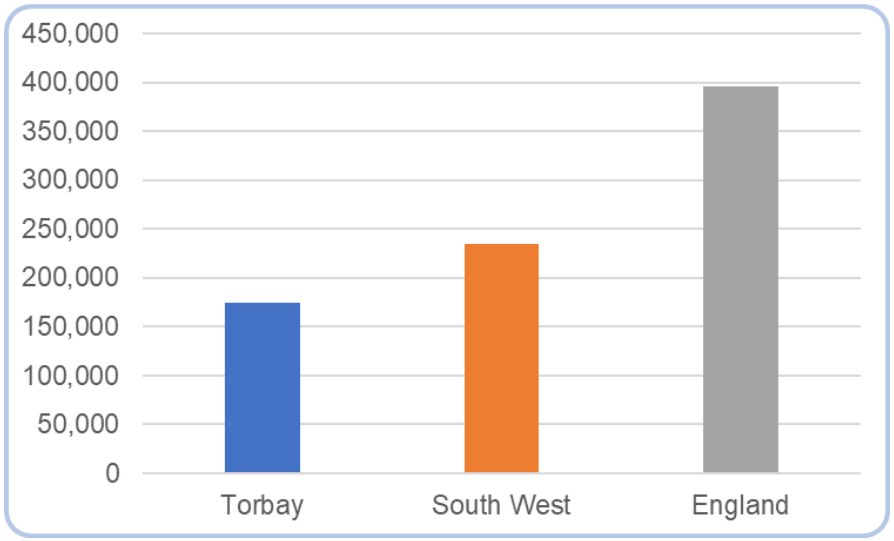


Fig 109: Percentage of houses and flats with a garden, 2020
Source: ONS (Ordnance Survey Greenspace)

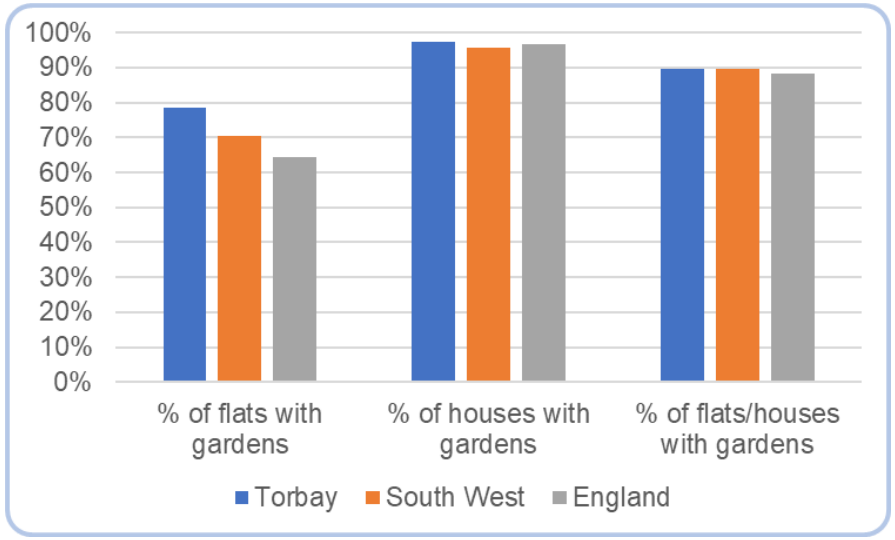
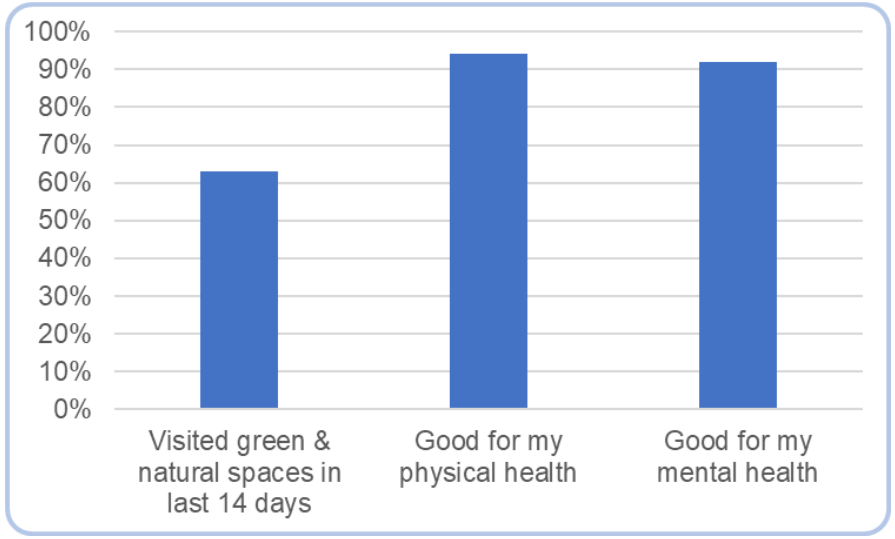


Fig 110: Visiting green and natural spaces, England, 2021/22
Source: People and Nature Survey for England, Natural England



Homes with gardens and visits to green and natural spaces

As has been noted, access to outdoor greenspace is associated with benefits to health and wellbeing. Torbay has a higher percentage of flats with gardens (Fig 109) than the South West and England- 78.5% in 2020 (70.4% in the South West, 64.5% in England). 97.4% of houses have gardens (96.6% in England). Combining houses and flats shows that 89.6% have access to a garden which is very slightly higher than England (88.4%).

The People and Nature Survey for England collects information on people's experiences of and views about the natural environment. In 2021/22, 63% of people said they visited green and natural spaces in the last 14 days (in the previous year 62% said this). Of these people, 94% said it was good for their physical health and 92% for their mental health (Fig 110).

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Those who had not visited green and natural spaces in the last 14 days were asked if they were concerned and worried about certain issues. In 2021/22, the highest number had no concerns and issues- 31%. The biggest concerns/worries were: lack of facilities (toilets, benches, baby changing etc)- 24%, visiting after dark- 23% and anti-social behaviour- 23%.

Waste and recycling

Torbay's waste reuse, recycling and composting rate has been on a reducing trend in the last 3 years (Fig 111) and is lower than the South West and England figures at 36% in 2020/21 compared to 49% (South West) and 42% (England). Torbay household waste collected (ex BVPI 84a measure) is on a generally reducing trend at 428kg per person in 2020/21 while the South West and England increased in 2020/21 to 439kg and 421kg respectively, after decreases in the previous few years.

The disruption caused by the COVID-19 pandemic impacted the generation and collection of waste in 2020/21.

Air pollution

Poor air quality affects physical and mental health. Air pollution can cause or exacerbate health conditions including asthma, stroke, chronic heart disease and chronic bronchitis (Public Health England, 2020). Those who spend their time in polluted areas, especially those with or susceptible to health conditions associated with air pollution, will be affected more.

Fig 112 is a modelled percentage of mortality attributable to long term exposure to particulate air pollution (fine particulate matter). Torbay remained broadly level over the 4 years shown and lower than England. Please note that mortality data will have been affected by the COVID-19 pandemic since March 2020, and air pollution levels year to year will be affected by weather as well as emissions.

Fig 111: Percentage of household waste sent for reuse, recycling or composting (Ex NI192 measure)

Source: Defra

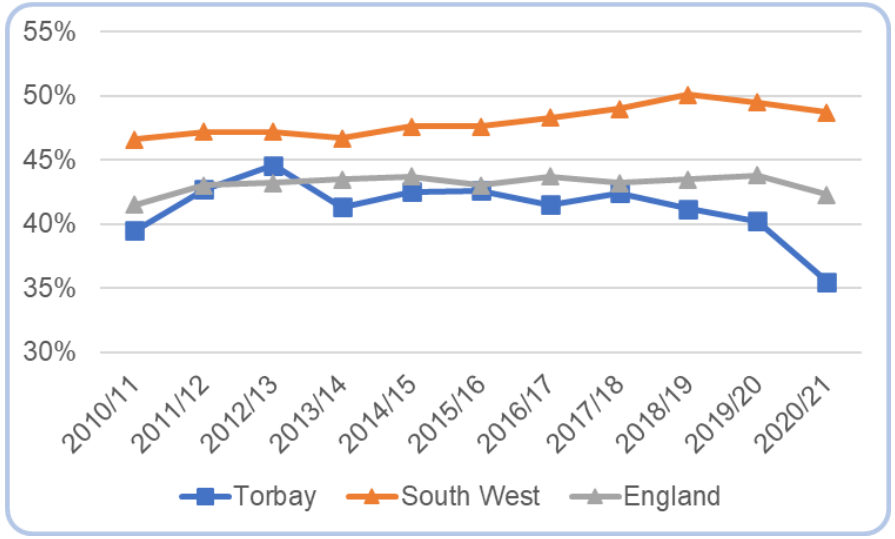
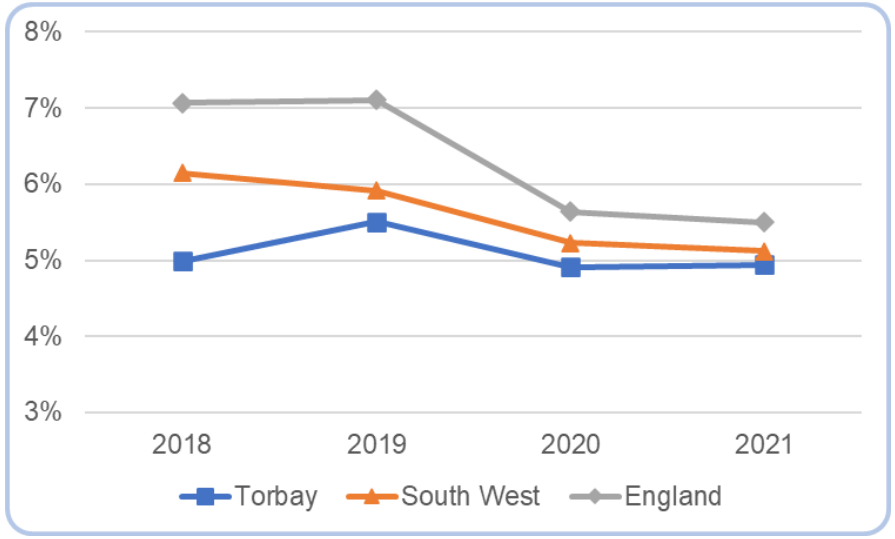


Fig 112: Fraction of mortality attributable to particulate air pollution (new method), age 30+

Source: OHID, Public Health Profiles



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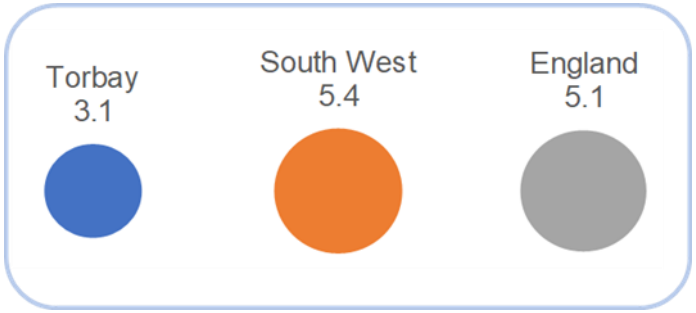
Greenhouse gas emissions

The planet is warming, linked by scientific evidence to human induced greenhouse gas emissions. Consequences of climate change include rising sea levels and increased likelihood of severe weather events such as storms, heatwaves, drought and wildfires. It is agreed that avoiding global warming of over 1.5ºC above pre-industrial levels would prevent the worst effects of climate change but temperatures have already risen by over 1ºC. High global emissions mean the world is on track to warming well in excess of 2ºC (Climate Change Committee, 2022). The UK has set a target of net zero emissions by 2050 and Torbay is working towards becoming carbon neutral by 2030.

The greenhouse gases in Fig 113 are carbon dioxide, methane and nitrous oxide. Torbay's emissions are less than the South West and England in 2020, all 3 areas have reduced compared to the previous 5 years. 2020 emissions were impacted by the COVID-19 pandemic restrictions.

Fig 113: Greenhouse gas emissions – tonnes of CO_2e per capita (per person), 2020

Source: Department for Business, Energy and Industrial Strategy (BEIS)

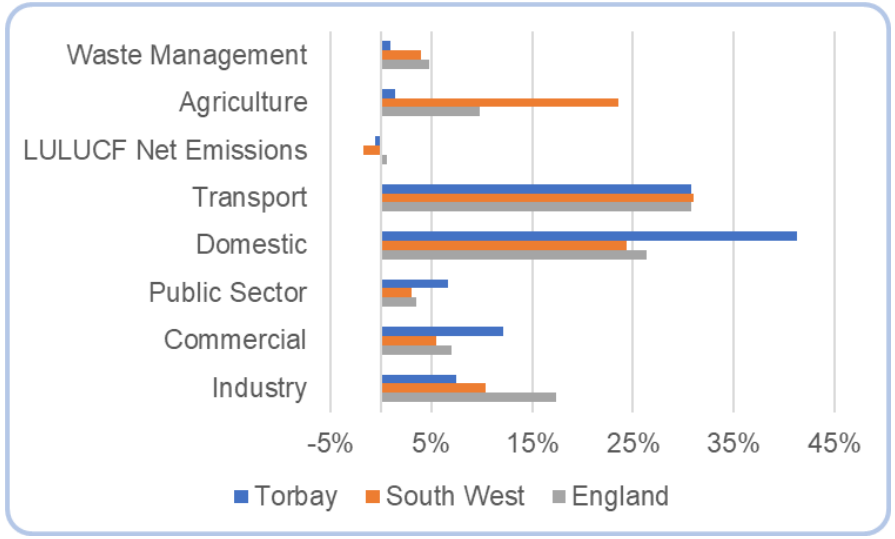


Please note: Figures cannot be compared to the UK Greenhouse Gas Inventory due to minor methodological differences and exclusions

Fig 114 splits the 2020 emissions into sectors. Most of Torbay's emissions come from the domestic sector (energy consumption in and around the home) at 41% and transport at 31% of emissions. Compared to the South West and England, Torbay has a far higher proportion of emissions that are domestic, with the commercial (12%) and public (7%) sectors also proportionally higher. Industry (7%), waste management (1%), and agriculture (1%) are proportionally lower than the South West and England. Land use, land use change and forestry (LULUCF) are net emissions at -1% in Torbay.

Fig 114: Percentage of greenhouse gas emissions allocated to each sector, 2020

Source: Department for Business, Energy and Industrial Strategy (BEIS)



Please note: Figures cannot be compared to the UK Greenhouse Gas Inventory due to minor methodological differences and exclusions.

Greenhouse gas emissions have only been measured from 2018–2020 for some emission sources but total CO_2 figures are available from 2005 onwards and shown in Fig 115 below. This shows a

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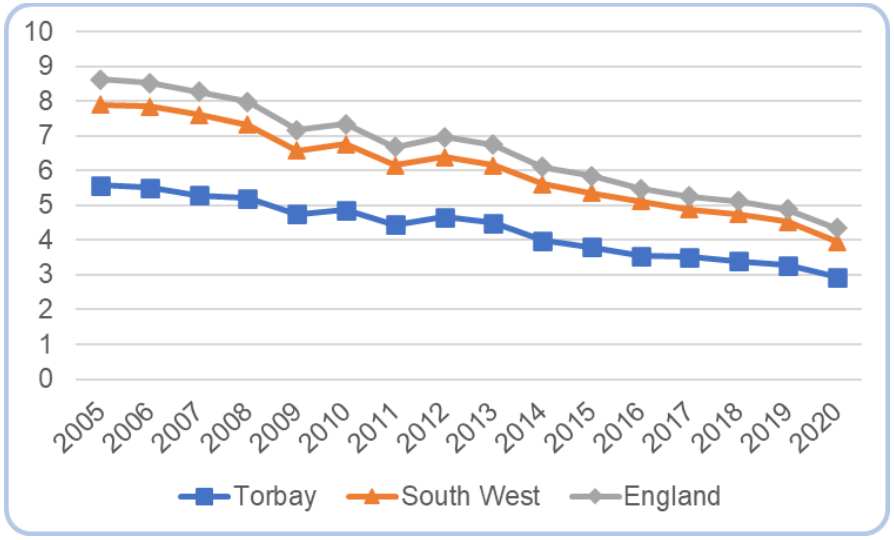
reducing trend in CO_2 emissions since 2005 with Torbay having lower emissions throughout, reduced to 2.9 tCO_2e in 2020 (4.3 in England).

Fig 115: Carbon dioxide emissions – tonnes of CO_2e per capita (per person)
Source: Department for Business, Energy and Industrial Strategy (BEIS)

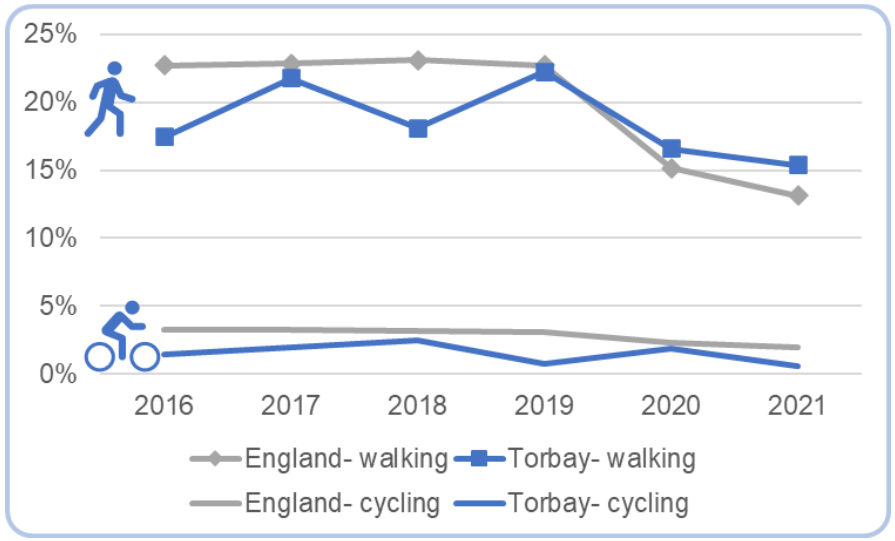


Please note: Figures cannot be compared to the UK Greenhouse Gas Inventory due to minor methodological differences and exclusions.

Walking and cycling

Walking and cycling are good for physical and mental health and the climate. Fig 116 shows that the percentage of Torbay residents walking for travel fluctuated but decreased to 15.4% in 2021, higher than England (13.1%). For cycling Torbay is lower at 0.6% of residents in 2021 compared to 2.0% in England. Figures will have been impacted from 2020 during COVID-19 restrictions.

Fig 116: Percentage of residents walking and cycling for travel at least 3 times a week, age 16+
Source: Department for Transport (Active Lives Survey – Sport England)



Transport

The second largest emitter of greenhouse gases in Torbay (and the highest in England) is transport (Fig 114).

The annual average daily flow of motor vehicles is the number estimated to pass a given point. In Torbay, numbers stayed broadly level in the last few years with a steep drop in 2020 before rising in 2021 but to a figure still much below previous levels- 3,173 vehicles in Torbay. (Department for Transport)

Using public transport rather than a motor vehicle where possible reduces emissions. The number of passenger journeys on local buses per head of population dropped steeply in 2020/21 before rising to 37.3 in 2021/22. This is still much lower than previous years (Department for Transport).

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Torbay is lower than England for both motor vehicle and local bus usage figures. From 2020, figures will have been impacted by COVID-19 restrictions, guidance and public concern.

Housing

Energy inefficient housing contributes to climate change, fuel poverty and poor health linked to cold and damp homes. Good quality housing benefits health, income, wellbeing and reduces emissions.

Energy Performance Certificates (EPCs) are required when buildings are constructed, sold or let and measure their energy efficiency. Ratings range from A (best) to G (worst). Up to 2022, 35.2% of EPCs for dwellings in Torbay were in the higher bands of A-C (Fig 117) which is 50th from the bottom out of 331 Local Authority districts. As would be expected, older properties are far less energy efficient than newer properties- 17.0% of pre 1929 properties had EPCs at Band C or above compared to 99.5% of those built from 2012 onwards.

Fig 117: Percentage of housing with Energy Performance Certificates at Band C or above, 10 years to 2022 - Torbay

Source: Department for Levelling Up, Housing and Communities, ONS

Type of dwelling with EPC	% at Band C or above
All dwellings	**35.2%**
Existing dwellings	29.4%
New dwellings	98.3%
Detached	24.2%
Semi-detached	28.6%
Terraced	33.0%
Flats/maisonettes	46.2%

Environmental impact scores are given when buildings are assessed for EPCs. This demonstrates the building's impact on the environment in terms of estimated CO_2 emissions. A higher rating means the building has less impact on the environment- A is best and G is worst. In Torbay in 2022, existing dwellings had a median score equivalent to a D band and new dwellings had a median score equivalent to a B band. Overall Torbay's dwellings had a median score which put them in band D.

Renewable electricity

The use of renewable energy sources contributes to reducing greenhouse gas emissions. At the end of 2021, Torbay's main renewable installation type was photovoltaics (solar) which is the case for the UK as a whole. Torbay had 2,204 photovoltaic installations and 2 onshore wind installations at this point. In the UK, onshore wind followed by photovoltaics provided the most installed capacity at the end of 2021, and offshore wind followed by onshore wind and then plant biomass generated the most renewable electricity during 2021. (BEIS)

The following databases are updated quarterly and track projects from inception, through planning, construction, operation and decommissioning:

- The Renewable Energy Planning Database - UK renewable electricity projects and electricity storage projects
- The Heat Networks Planning Database - UK communal and district heat networks

Trees and woodland

Trees absorb CO_2 so are a tool against climate change. Part of the UK's strategy to reach net zero by 2050 is to increase tree planting rates to at least 30,000 hectares of trees a year across the UK from 2025 onwards.

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Trees absorb air pollution so can prevent ill health. Some other benefits include providing shade against excess heat, helping to reduce flooding, and providing habitat for wildlife. Spending time in nature and greenspaces can improve health and wellbeing, mood and quality of life.

Woodland covers an estimated 9.13% of Torbay (2019) and 10% of England (2021). (Forest Research, ONS). This uses the National Forest Inventory which covers woodland of 0.5 hectares and above.

Torbay's second urban forest study, 2022, surveyed Torbay's trees (of over 7.5cm trunk diameter at breast height and over 3 metres tall). It estimated 18.2% of Torbay as tree canopy cover compared to 11.8% in the previous survey despite a reduction in the number of trees (Fig 118). It is estimated that the ecosystem services provided by the trees of carbon storage, pollution removal and avoided run-off has increased while carbon sequestration (the annual removal of carbon dioxide from the air by plants) has decreased.

Fig 118: Figures from Torbay's urban forest surveys, 2010 and 2022
Source: Torbay's urban forest: Assessing urban forest effects and values, survey 2, Treeconomics, using the i-Tree Eco model

Measure	2010	2022
Number of trees (estimate)	692,000	459,000
Tree canopy cover	11.8%	18.2%
Shrub cover	6.4%	10.8%
Carbon storage	154,000 tonnes	172,000 tonnes
Annual carbon sequestration	5,680 tonnes	4,910 tonnes
Annual pollution removal	57 tonnes	67 tonnes
Annual avoided runoff	158,000m³	195,000m³

Please note: tree canopy cover and shrub cover can overlap in some areas

Further information relating to Torbay on topics in this section can be found in:

Torbay climate pack, Met Office, 2022

Torbay's urban forest: assessing urban forest effects and values 2, Vaughan-Johncey C. Treeconomics et al, 2022

Torbay Council website: Open spaces and trees, Waste management, Climate change, Transport, Cycling and walking, Energy efficiency, Flooding and extreme weather

Further information at a national level can be found in:

Improving access to greenspace: 2020 review, Public Health England

Climate and health: applying All Our Health, OHID, 2022

Websites of the Climate Change Committee and United Nations-Climate change

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Sexual and Reproductive Health

Overview

- The all new sexually transmitted infection diagnosis rate, testing rates and the percentage of testing positivity are lower in Torbay than England. May indicate low levels of infections or other issues such as lack of testing of at risk groups.

  Source: Fingertips – Sexual and Reproductive Health Profiles

- The Torbay proportion of 15-24 year olds screened for chlamydia has been significantly higher than England (better) for 7 years.

  Source: Fingertips – Sexual and Reproductive Health Profiles

- Torbay's HIV new diagnosis rates fluctuate as numbers are very low. The most recent year (2021) has the lowest rate in the 11 years shown.

  Source: Fingertips – Sexual and Reproductive Health Profiles

- The provision of long acting reversible contraception (LARC) in Torbay has been higher than England for the 8 years shown.

  Source: Fingertips – Sexual and Reproductive Health Profiles

- Under 18 conception rates are on a decreasing trend and although still higher than the England figure they are statistically similar in the two most recent years.

  Source: Fingertips – Sexual and Reproductive Health Profiles

- Torbay has significantly higher rates of abortion than England.

  Source: Department of Health & Social Care abortion statistics, Fingertips – Sexual and Reproductive Health Profiles, ONS mid-year population estimates

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This section gives an overall picture of what sexual and reproductive health looks like in Torbay, focussing in on sexually transmitted infections, chlamydia, human papillomavirus, human immunodeficiency virus (HIV), LARC, abortions and under 18 conceptions.

Further local information on sexual and reproductive health can be found in the Torbay sexual and reproductive health needs assessment, December 2022, and the Summary profile of local authority sexual health, Torbay, UK Health Security Agency, February 2023

Sexually transmitted infections (STIs)

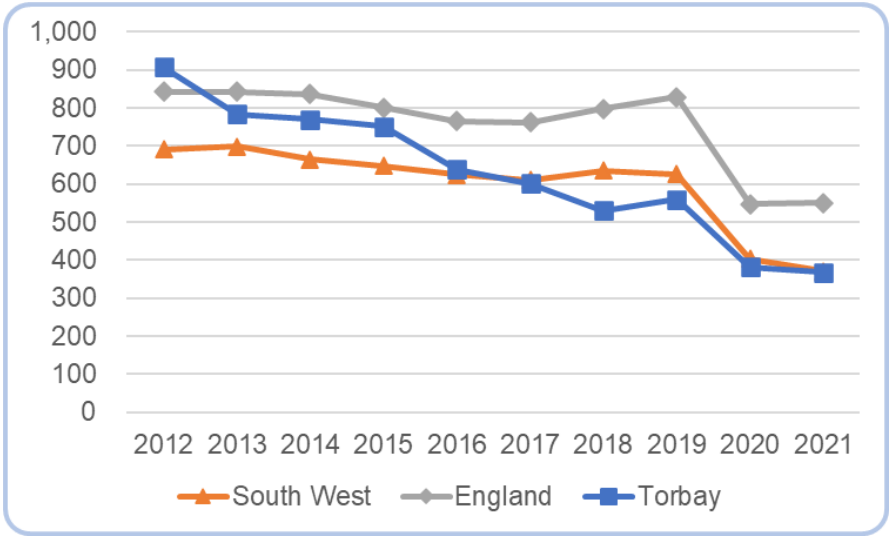
STIs can have serious longer-term consequences such as ectopic pregnancy and infertility. Therefore, early detection and treatment is important.

The delivery of local sexual health services was reconfigured in 2020 in response to and across the duration of the COVID-19 pandemic responses. This included the use of clinician initiated STI home testing and screening kits. Responses to COVID-19 will be reflected in 2020 and 2021 figures.

Fig 119 shows the diagnoses rate of STIs among people accessing sexual health services. The rate is on a decreasing trend and has been significantly below England for the last 9 years at 369 per 100,000 population in 2021 (551 in England).

Fig 119: All new STI diagnosis rate, all ages, per 100,000

Source: Fingertips - Sexual and Reproductive Health Profiles



Diagnosis rates of new STIs (excluding chlamydia in those aged under 25- the age group targeted by the National Chlamydia Screening Programme) is also on a decreasing trend and significantly lower than England. Low diagnosis rates mean a lack of identified infections but can also indicate other issues. Therefore, diagnosis rates should be looked at in conjunction with testing rates and testing positivity rates (Figs 120 and 121).

Fig 120 encompasses tests for syphilis, HIV, gonorrhoea and chlamydia (excluding chlamydia in under 25 year olds) among people accessing sexual health services. The indicator measures the total number of people tested for one or more of these infections at a new attendance. The rate has increased in 2021 to 3,195.6 per 100,000 (3,422.4 in England) after a drop in 2020- the COVID-19 pandemic will have affected the figures. Torbay has had significantly lower testing rates than England for the 10 years shown but 2021 is the highest figure in that period.

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Fig 120: STI testing rate (excluding chlamydia aged under 25), all ages, per 100,000 population aged 15 to 64
Source: Fingertips - Sexual and Reproductive Health Profiles

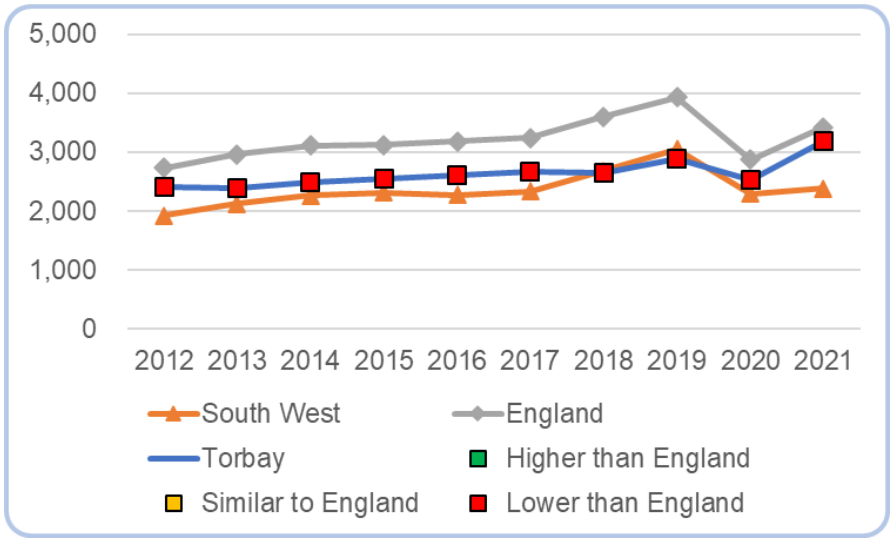

Fig 121: Percentage of STI testing positivity (excluding chlamydia aged under 25)
Source: Fingertips - Sexual and Reproductive Health Profiles

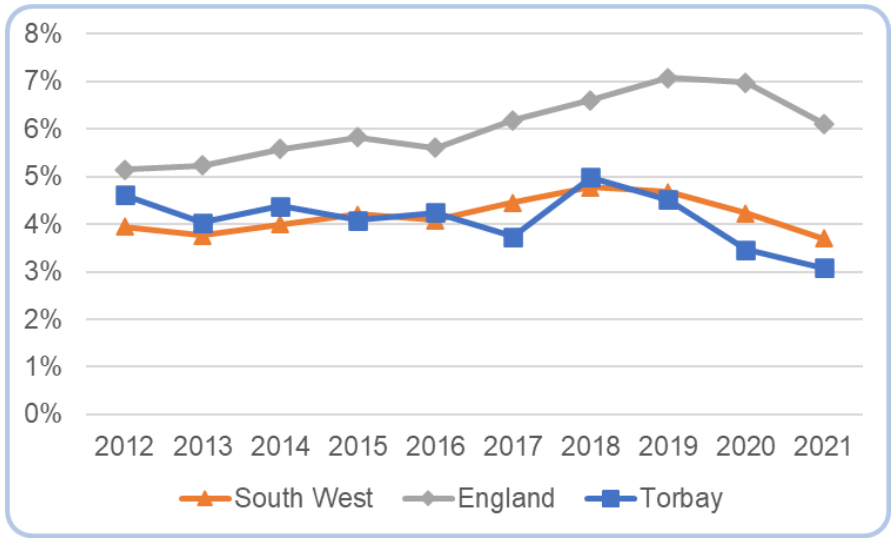

Fig 121 (as is the case in Fig 120) includes diagnoses of syphilis, HIV, gonorrhoea and chlamydia (excluding chlamydia in under 25 year olds) among those accessing sexual health services as a percentage of people tested for one or more of these infections at a new attendance. These are the standard tests recommended for people attending for a new episode of STI related care if indicated by sexual history (OHID Fingertips, Public Health profiles).

Torbay's STI percentage of testing positivity has been significantly lower than England for the last 9 years. It has been decreasing for the last few years and is almost half the England figure at 3.1% in 2021 (6.1% in England). A lower positivity rate could indicate low levels of STIs, or it could suggest that those most likely to have infections- the most at risk groups- are not being tested.

Chlamydia

Chlamydia causes avoidable sexual and reproductive ill health and in England is the most commonly diagnosed bacterial STI with rates higher in young adults than in other age groups (OHID Fingertips, Public Health Profiles). This section encompasses young people who have attended sexual health services and community-based settings.

The proportion of 15-24 year olds screened for chlamydia (asymptomatic screens and symptomatic tests) measures tests rather than people, as a percentage of the population. The Torbay percentage is significantly higher than England (better) and after a drop in 2020 has increased in 2021 (Fig 122). It remains higher than the South West and England at 19.5% (14.8% in England). The COVID-19 pandemic will have affected the figures in 2020 and 2021.

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Fig 122: Chlamydia- proportion of 15 to 24 year olds screened
Source: Fingertips - Sexual and Reproductive Health Profiles

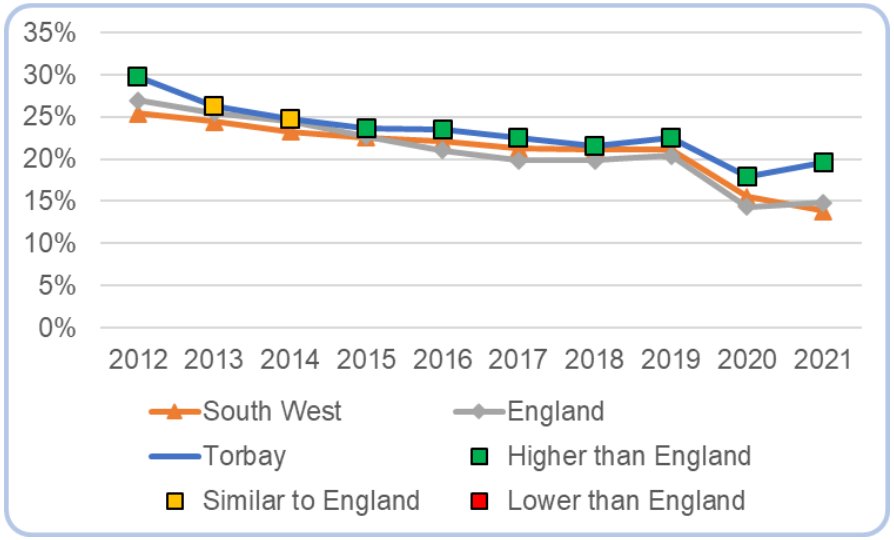
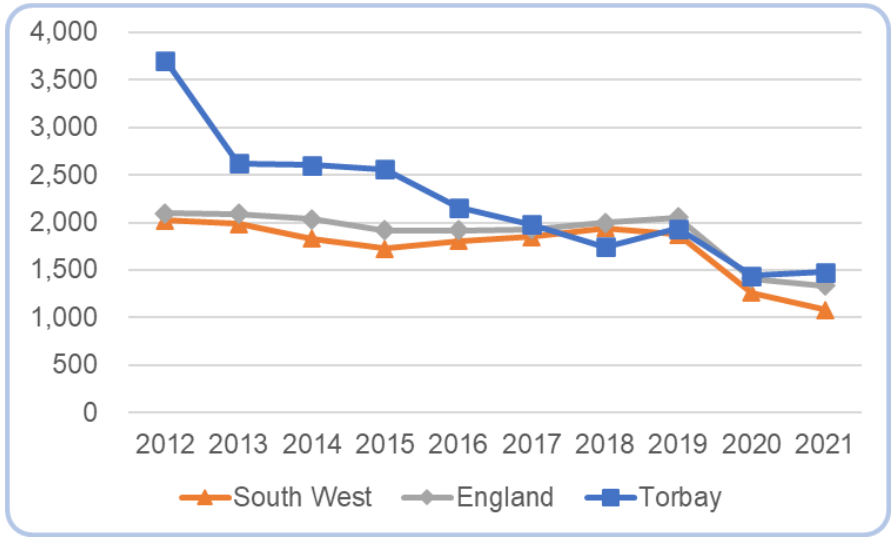


Fig 123: Chlamydia detection rate, aged 15 to 24, per 100,000
Source: Fingertips - Sexual and Reproductive Health Profiles



The chlamydia detection rate (Fig 123) is a measure of control activity (i.e. screening) in the population, not morbidity. A higher detection rate indicates higher levels of control activity. The detection rate has reduced in Torbay over the years although 2020 and 2021 will have been affected by the COVID-19 pandemic. The rate is higher than the South West and England in 2021 at 1,475 per 100,000 compared to 1,334 in England. Females have a higher detection rate than males, as is the case in England.

Human Papillomavirus (HPV)

HPV is usually asymptomatic and for most people does not cause problems. Some types of HPV, however, can cause cancers including cervical, vulval and anal cancer. (NHS- HPV).

A two-dose immunisation programme is offered to 12–14 year-olds, initially for females but extended to males from 2019. Due to the COVID-19 pandemic there were impacts on coverage in the 2019/20 and 2020/21 academic years across England. These years saw decreases in the percentage of 13-14 year old girls receiving two doses of the HPV vaccine (Fig 124) in Torbay, the South West and England. All areas are below the goal of 90% vaccination- Torbay achieved 61.6% in 2020/21 (England- 60.6% and South West- 46.4%). From September 2019 boys were offered the HPV vaccine. The first dose was received by 64.5% of 12-13 year old boys in 2020/21 which was an increase on 49.0% the year before. Torbay is below the England figure in both years (Fig 125).

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Fig 124: Percentage receiving the HPV vaccine for two doses, females aged 13 to 14 years
Source: Fingertips

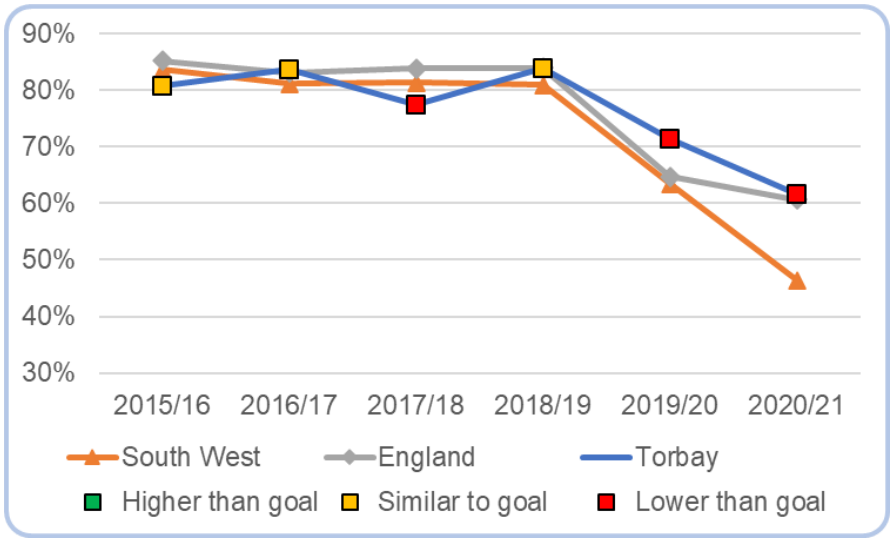
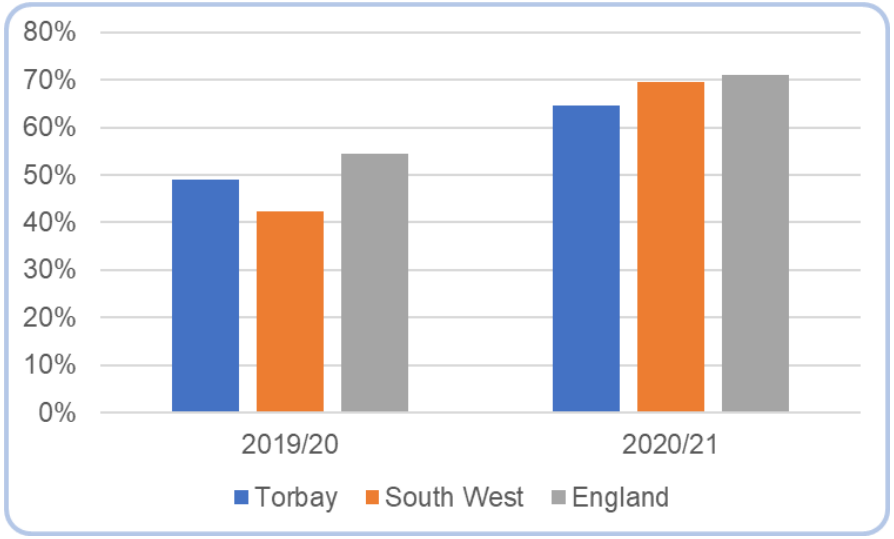


Fig 125: Percentage receiving the HPV vaccine for one dose, males aged 12 to 13 years
Source: Fingertips



Human Immunodeficiency Virus (HIV)

The reconfiguration of sexual health services during the COVID-19 pandemic will have affected 2020 and 2021 data relating to HIV.

High prevalence of HIV is defined as a rate of between 2 and 5 per 1,000 population aged 15-59 years and extremely high prevalence is defined as a rate of 5 or more. Increased life expectancy and some reduction in transmission will cause a continued rise in this prevalence especially in areas where testing and diagnosis rates are high and the undiagnosed population is kept to a low level. Therefore, lower diagnosed HIV prevalence rates are not necessarily better than higher rates. They need to be interpreted alongside other information, particularly late HIV diagnosis and rates of undiagnosed infection. (OHID Fingertips, Sexual & Reproductive Health profiles)

Torbay's diagnosed prevalence rate of those aged 15-59 has slightly reduced in 2021 to 2.00 per 1,000 which is lower than England (2.34) but higher than the South West (Fig 126). This equates to 136 people. There are 184 Torbay residents of all ages living with diagnosed HIV which equals 1.35 per 1,000 of the aged 15+ population.

Reducing late diagnoses of HIV reduces morbidity and mortality. By excluding those previously diagnosed outside of the UK, Fig 127 measures the extent that UK HIV testing is identifying late stage infections. Percentages fluctuate as numbers are low- Torbay in 2019-21 equates to 4 people lately diagnosed which is 57.1% of new diagnoses made in the UK of Torbay residents (England is 43.4%). The goal is that less than 25% of new diagnoses in the UK are late.

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Fig 126: HIV diagnosed prevalence rate, aged 15 to 59, per 1,000
Source: Fingertips - Sexual and Reproductive Health Profiles

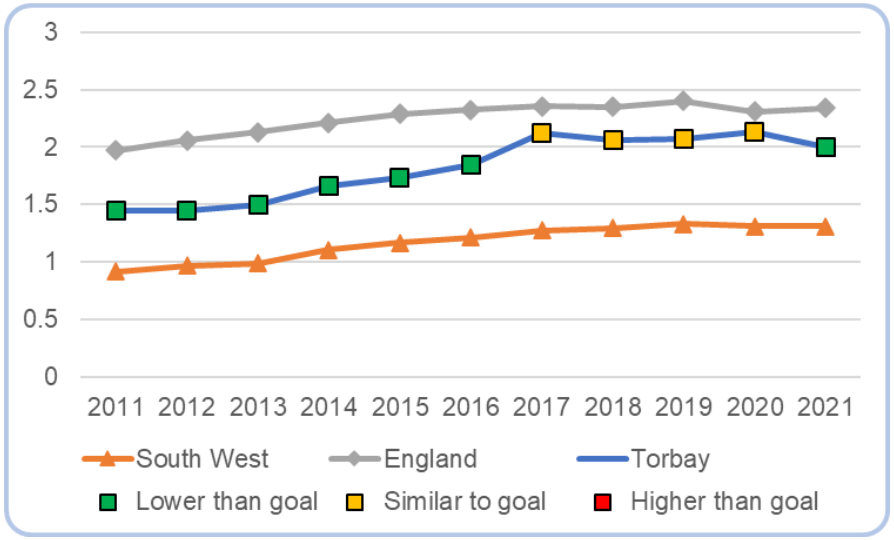


Fig 127: Percentage of late HIV diagnoses in people first diagnosed with HIV in the UK, aged 15+
Source: Fingertips - Sexual and Reproductive Health Profiles

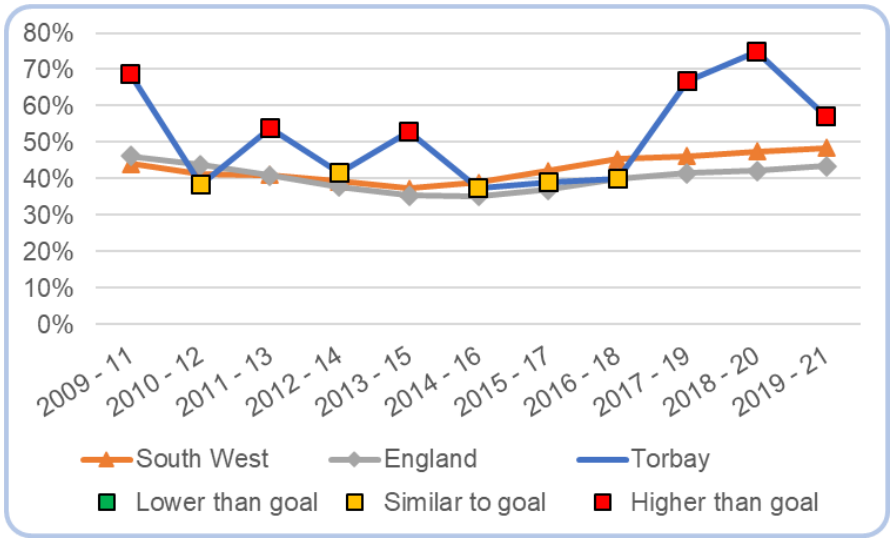
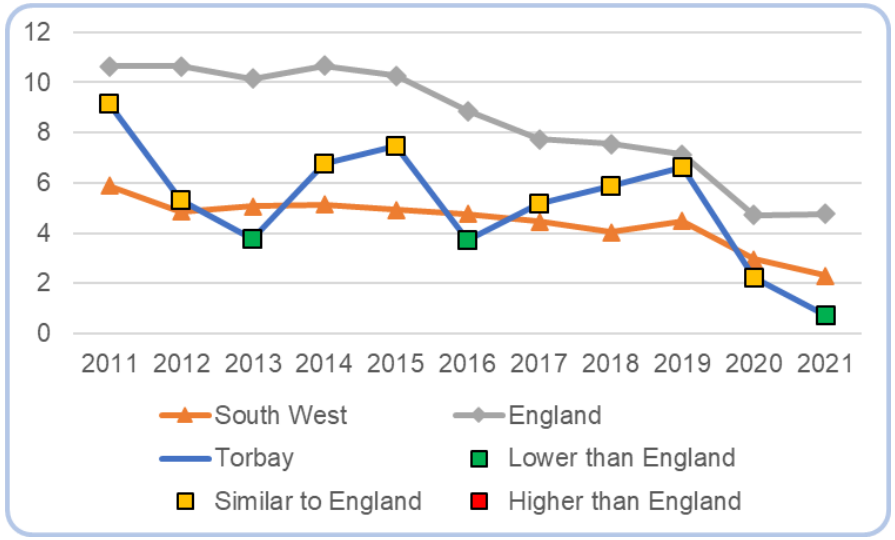


Fig 128 includes all diagnoses of HIV made in the UK, including those who were previously diagnosed abroad. Diagnoses have fluctuated as numbers are very low. The count for Torbay is 9 in 2019 and below 5 in both 2020 and 2021. The lowest rate in the 11 years shown is in 2021 at 0.7 per 100,000, significantly lower than England which is 4.8. If only those first diagnosed in the UK are included then the Torbay rate reduces further in 2019 and 2020 and remains the same in 2021.

Fig 128: New HIV diagnoses rate, all ages, per 100,000
Source: Fingertips - Sexual and Reproductive Health Profiles



HIV testing is offered to eligible attendees of specialist sexual health services and Fig 129 shows the percentage who accepted a test. In Torbay there were sharp drops in percentages for 2020 and 2021 but Torbay has been higher than England in the last 3 years shown. Data in 2020 and 2021 is likely to have been affected by the COVID-19 pandemic. In 2021 Torbay's percentage is 46.7% compared to 45.8% in England. Splitting this into groups- amongst gay, bisexual

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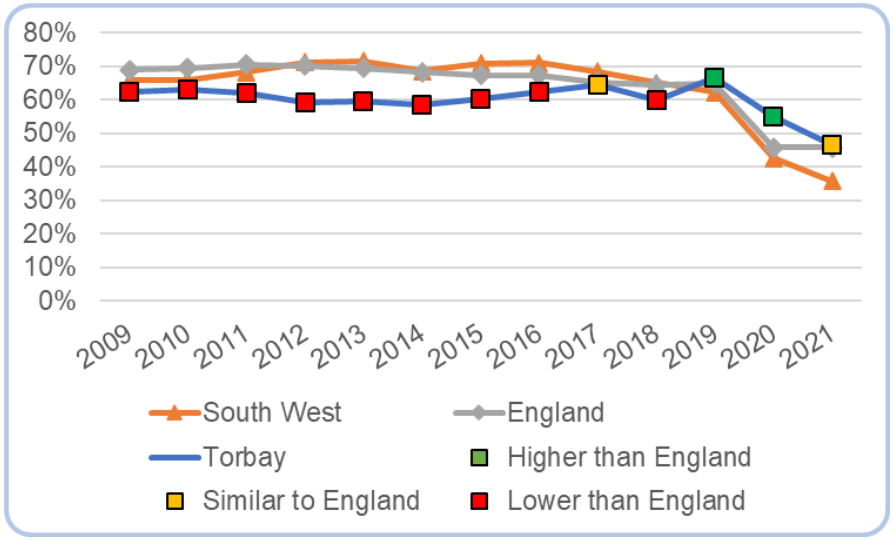
and other men who have sex with men 84.3% were tested in 2021, as well as 40.3% of women and 61.6% of men.

Fig 129: Percentage of HIV testing coverage, all ages
Source: Fingertips - Sexual and Reproductive Health Profiles

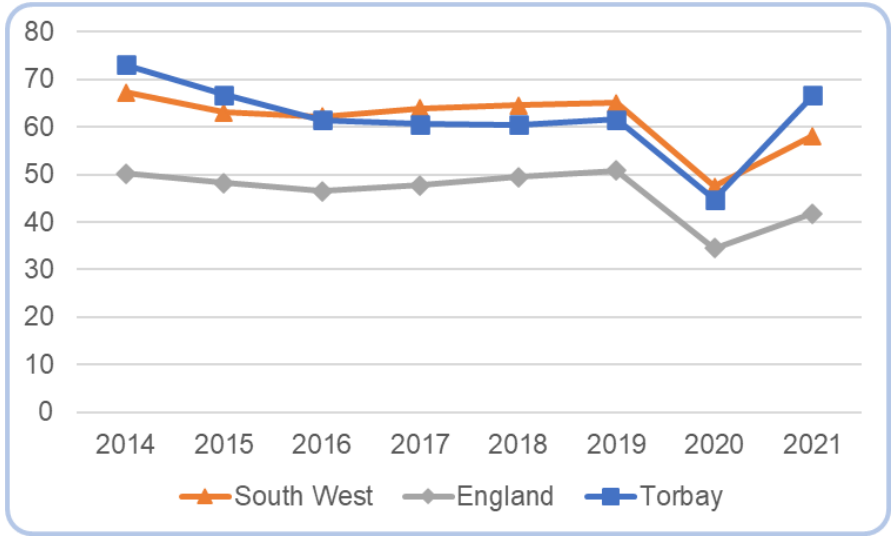


Contraception

Long-acting reversible contraception (LARC) methods do not rely on daily compliance and include injections, implants, the intrauterine device and the intrauterine system. A higher level of LARC provision is used as a proxy measure for wider access to the range of contraceptive methods available. Rates of prescribing of LARC excluding injections (this is prescribing by GPs and Sexual and Reproductive Health (SRH) services) in Torbay (Fig 130) is significantly higher than England in all the years shown. The rate has increased considerably in 2021 to 66.7 per 1,000 compared to 41.8 in England. From April 2020 during the COVID-19 pandemic there was less provision of LARC in England which will have impacted the figures.

In Torbay, the rate of GP prescribed LARC (excluding injections) has been decreasing for 7 years and has been significantly below the England average for 3 years at 13.3 per 1,000 in 2021 in Torbay. On the other hand, the rate of SRH services prescribed LARC (excluding injections) has been increasing, except for the expected drop in 2020, and has been significantly above the England average for 7 years at 53.2 per 1,000 in 2021 in Torbay. This shows the location of LARC provision moving away from local GP settings and more into specialist settings in Torbay.

Fig 130: Rate of total prescribed LARC (excluding injections), all ages, per 1,000 female population aged 15 to 44
Source: Fingertips - Sexual and Reproductive Health Profiles



Under 18s conceptions

Inequality in health and education is a cause and consequence of teenage pregnancy for young parents and their children, and children of teenage mothers are more likely to live in poverty (UKHSA, 2023).

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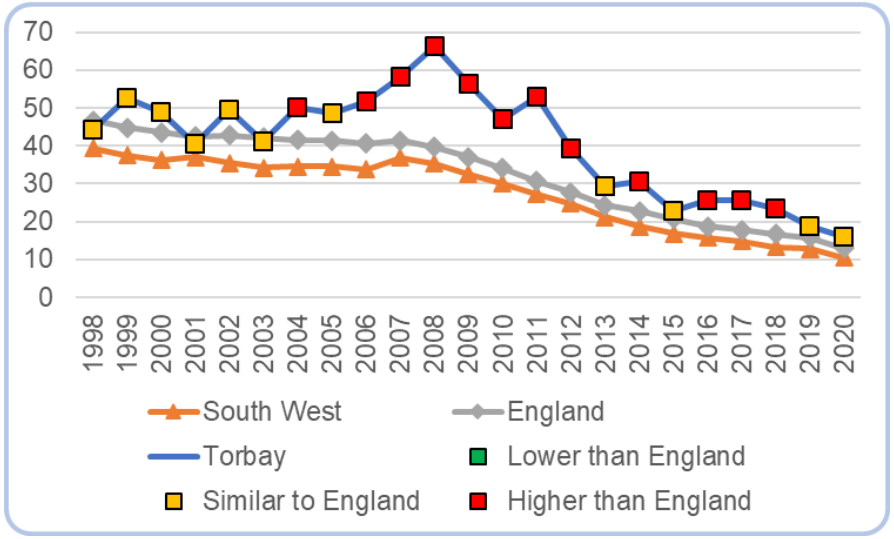
Under 18s conception rates (Fig 131) include pregnancies that result in one or more live or still births or a legal abortion. The national trend is of a falling teenage pregnancy rate and Torbay has followed this trend since the peak in 2008. Rates are still higher than England but statistically similar in 2019 and 2020 at 15.9 per 1,000 in 2020 compared to 13.0 in England. The majority of under 18s conceptions are in 16 and 17 year olds- for example- under 16s represented 3 of the 32 under 18s conceptions in 2020.

Fig 131: Under 18s conception rate per 1,000 female population aged 15 to 17

Source: Fingertips - Sexual and Reproductive Health Profiles



Abortions

Torbay has consistently had significantly higher rates of abortion than England for at least 10 years (Fig 132). In Torbay the abortion rate is 21.7 per 1,000 in 2021 compared to 18.5 in England.

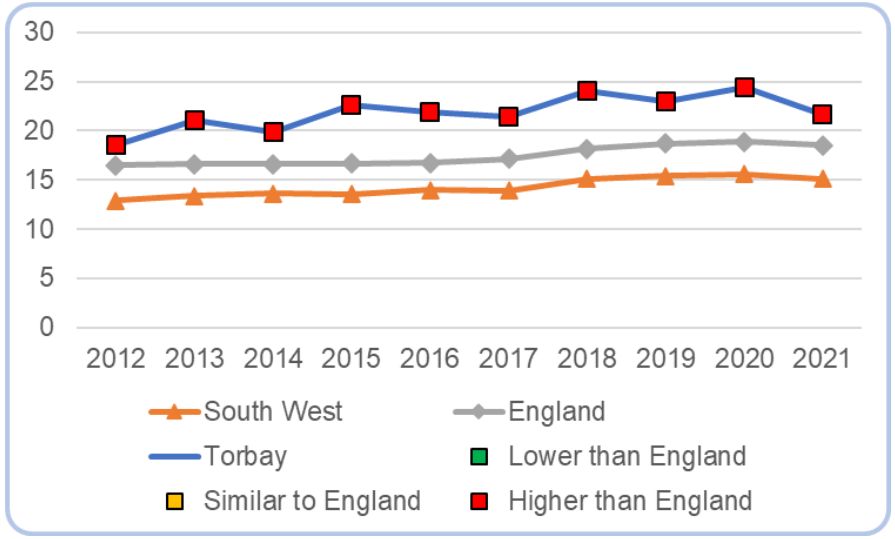
Abortion rates (along with conception rates) in under 18s are decreasing nationally and Torbay follows this trend although in the last 5 years under 18s abortion numbers in Torbay have remained broadly constant.

The proportion of abortions in those aged under 25 that were repeat abortions has also dropped in Torbay from 33.5% in 2020 to 26.8% in 2021. This is lower than the England figure in 2021 which is 29.7%. In previous years repeat abortions in under 25s were higher in Torbay than England. However, the change in Torbay between 2020 and 2021 is not statistically significant and neither is the difference between Torbay and England in 2021.

Abortion rates are much higher in England's most deprived areas than in the least deprived areas and there is a general increase as deprivation increases.

Fig 132: Abortion rate, all ages, per 1,000 female population aged 15 to 44

Source: Department of Health & Social Care abortion statistics, Fingertips - Sexual and Reproductive Health Profiles, ONS mid-year population estimates



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England or target (Latest Year)	Direction of travel compared to previous period
All new STI diagnosis rate (2021)	Rate per 100,000	369	391	371	551	Not relevant	↓
STI testing rate (exc chlamydia under 25) (2021)	Rate per 100,000	3196	2249	2388	3422	🔴	↑
Chlamydia screening coverage - 15 to 24 (2021)	%	19.5%	13.6%	13.8%	14.8%	🟢	↑
2 doses HPV coverage - Females aged 13 to 14 (2020/21)	%	61.6%	71.9%	46.4%	60.6%	🔴	↓
HIV diagnosed prevalence - 15 to 59 (2021)	Rate per 1,000	2.0	1.5	1.3	2.3	🟢	↓
HIV testing coverage (2021)	%	46.7%	40.9%	35.9%	45.8%	🟡	↓
Prescribed LARC (excluding injections) (2021)	Rate per 1,000	66.7	41.6	58.1	41.8	Not relevant	↑
Under 18s conception rate (2020)	Rate per 1,000	15.9	15.9	10.5	13.0	🟡	↓
Abortion rate (2021)	Rate per 1,000	21.7	19.6	15.1	18.5	🔴	↓

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Substance Misuse and Dependency

Overview

- Prevalence of smoking has fallen over the last decade.
  Source: Fingertips
- Tobacco use has fallen significantly among children over the last 15 years.
  Source: Smoking, Drinking and Drug Use Among Young People in England (SDD) survey
- Torbay has consistently had higher hospital admission rates than England or South West in relation to alcohol.
  Source: Fingertips, Hospital Episode Statistics
- Torbay has had a higher percentage of people successfully complete structured alcohol treatment over the last decade than England or South West.
  Source: Fingertips
- Torbay has a higher percentage of estimated opiate and/or crack cocaine users in treatment than England or South West.
  Source: National Drug Treatment Monitoring System
- At the end of the last decade there has been a significant rise in the number of drug misuse deaths in Torbay.
  Source: Fingertips

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Smoking, Alcohol and Drugs are covered within this section, whether this is prevalence, the numbers of people admitted to hospital due to these factors, mortality and levels of dependency and treatment within the community.

Tobacco

Smoking tobacco is the leading cause of preventable illness and premature deaths in the UK (Public Health England). It is also one of the most important drivers of health inequalities. Most related deaths are from lung cancer, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Smoking also increases the risk of developing other conditions including some cancers. The negative impact of passive smoking and smoking in pregnancy is well recognised.

The prevalence of adult smokers in Torbay according to the Annual Population Survey was 15.4% for 2021 which is a little higher but broadly in line with the South West and England, rates have declined significantly since 2012 although they have flattened over the last 5 years (Fig 133). Rates are higher for adult males at 17.9% when compared to adult females at 12.9%, this difference is broadly reflected across the South West and England.

There are also significant differences within Torbay around smoking prevalence dependent on the broad socio-economic group you are in. Those who have never worked, are long-term unemployed or work in routine and manual occupations generally have higher smoking rates although these rates have fallen over the last decade. Those in groups classified as Intermediate or Managerial and Professional are less likely to smoke but their rates of smoking have fallen by a smaller proportion over the last decade (Fig 134).

Fig 133: Smoking Prevalence in adults
Source: Fingertips

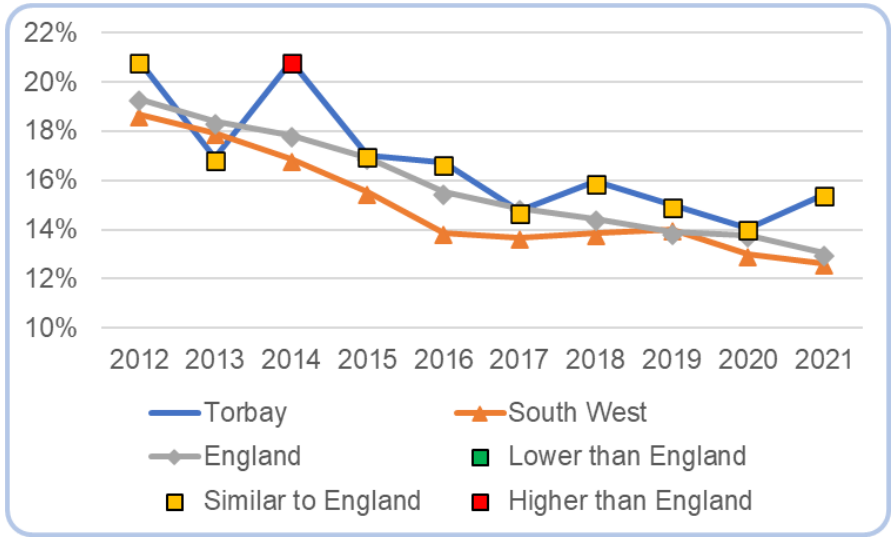
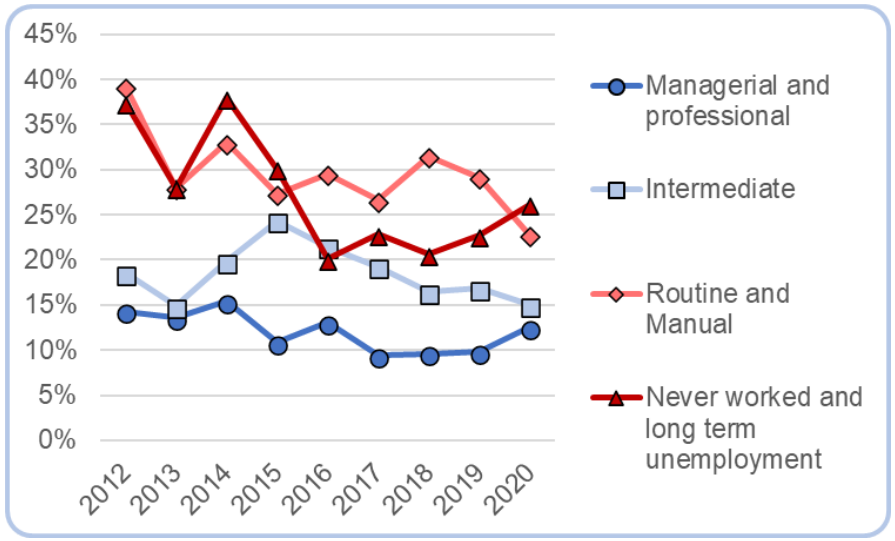


Fig 134: Smoking Prevalence in adults by socio-economic group (Torbay)
Source: Fingertips



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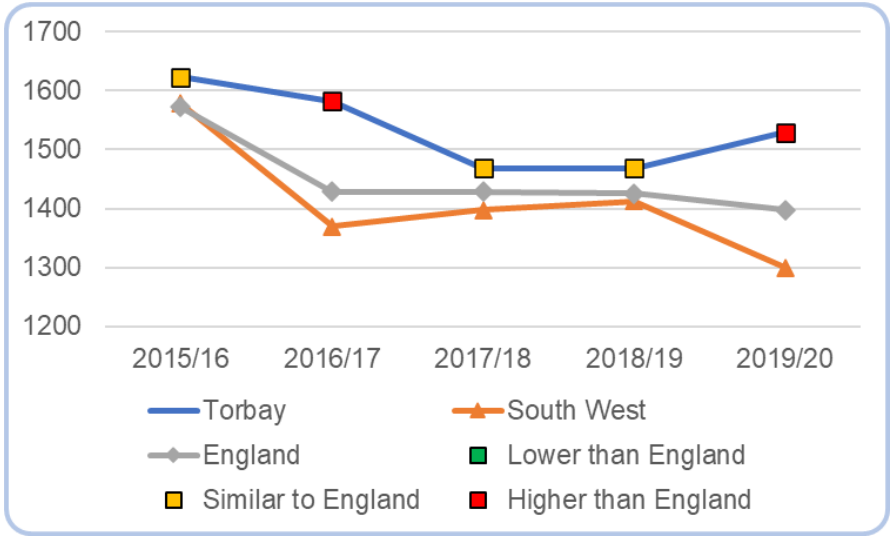
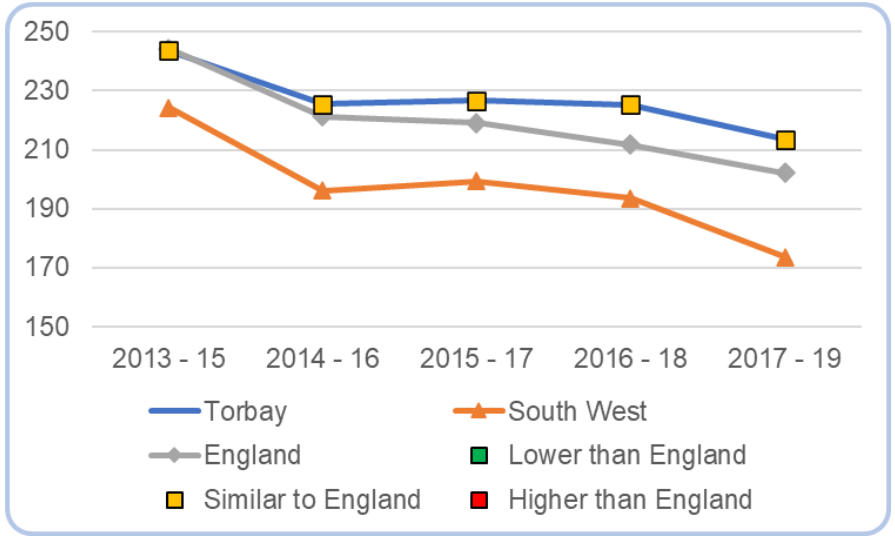
Smoking attributable admissions to hospital (adjusted to take account of differing areas age profile) for Torbay have consistently been higher than the South West and England. For the latest data available which is 2019/20 they were significantly higher (Fig 135). Across England, rates of smoking attributable admissions are twice as high in the 10% most deprived areas of England when compared to the 10% least deprived.

Fig 135: Rate of smoking attributable hospital admissions per 100,000 (Age-standardised)
Source: Fingertips



Smoking attributable mortality (adjusted to take account of differing areas age profile) for Torbay has been broadly in line with England but significantly above the South West, rates have been falling over the last decade (Fig 136). As with smoking attributable hospital admissions, there is a very significant difference across England depending on the deprivation level of the area that you live in. Smoking attributable mortality rates are more than twice as high in the 10% most deprived areas of England compared to the 10% least deprived.

Fig 136: Rate of smoking attributable mortality per 100,000 (Age-standardised)
Source: Fingertips



Attempting to stop smoking tobacco can be very difficult and there are a number of Stop Smoking services to help people quit. Some people who have quit smoking will have this status validated by having a test for the level of carbon monoxide (CO) in their bloodstream 4 weeks after quitting. Torbay has a lower rate of CO validated quitters than England. Rates of CO validated quitters as a rate of all estimated smokers have fallen across Torbay, South West and England over the last decade (Fig 137). This trend is also reflected in the number of self-reported quitters who were not CO validated. The falling rate of smokers quitting is likely to be related to the smaller number of people who smoke, services may now be concentrated on those who have found it more difficult to quit.

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Fig 137: Rate of smokers who have successfully quit at 4 weeks, CO validated per 100,000 smokers (16+)
Source: Fingertips

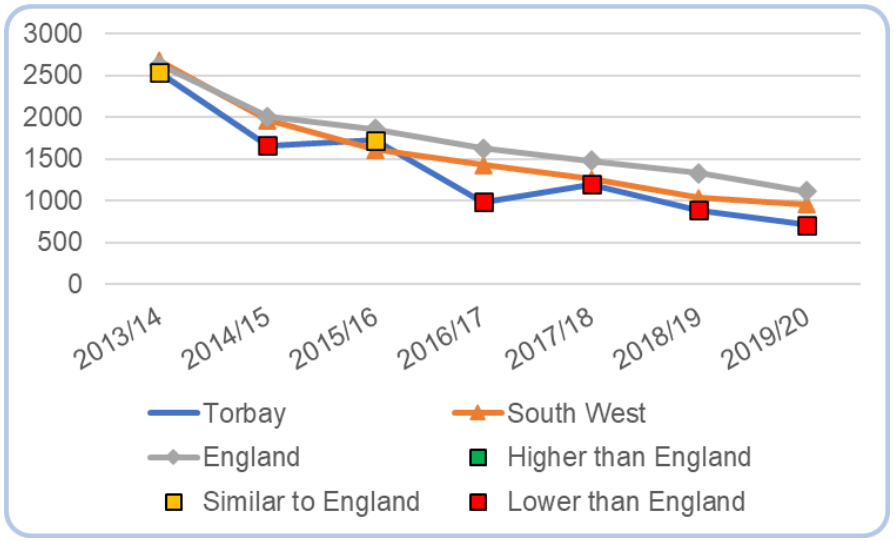
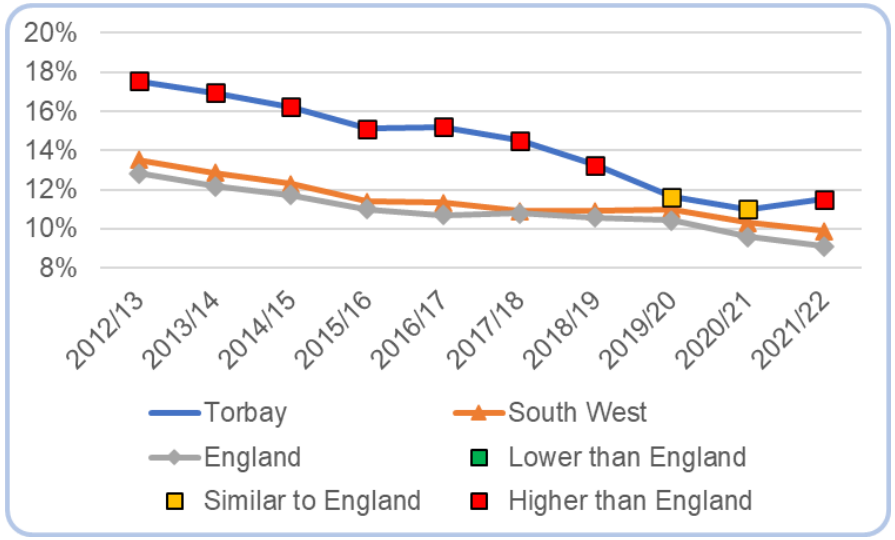


Fig 138: Percentage of women smoking at time of delivery
Source: Fingertips



Smoking during pregnancy has significant well known detrimental effects for the growth of the baby and health of the mother. The percentage of women smoking at the time of delivery has fallen significantly over the last decade in Torbay from 17.5% in 2012/13 to 11.5% in 2021/22. For 2021/22, the Torbay rate increased slightly from the previous year and was significantly higher than England after 2 years of being broadly in line, however the gap is much smaller than the previous decade (Fig 138). Across England, mothers who live in the most deprived areas are almost twice as likely to smoke at the time of delivery than those who live in least deprived areas.

The Smoking, Drinking and Drug Use Among Young People in England (SDD) survey asked a sample of 15 year olds in England if they are regular or occasional tobacco smokers. For 2021 across England, 3.3% said that they were regular smokers which compares to 21% when the survey was undertaken in 2004, those who occasionally smoke have fallen in the same period from 9% to 5.5%. In the 2021 survey, regular smoking was broadly similar amongst 15 year old boys and girls, occasional smoking was more prevalent amongst 15 year old girls.

An e-cigarette is a device that allows you to inhale nicotine in a vapour rather than smoke and are sometimes used to help manage nicotine cravings without tobacco. There is some initial evidence that taken together with face-to-face support it could be a more effective way than other nicotine replacement products to quit smoking (Using e-cigarettes to stop smoking - NHS (www.nhs.uk). The long-term effects of e-cigarettes are not known.

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The Opinions and Lifestyle Survey conducted by the Office for National Statistics for 2021 indicates that 4.9% of people aged 16 and over are a daily user of e-cigarettes (Men – 6.4%, Women – 3.5%), the largest daily user age group is 25 to 34 with 7.6% (Men 10.2%, Women 5.0%). Just over half of all cigarette smokers have used an e-cigarette at least once, ex-smokers are more likely to be daily users of e-cigarettes than cigarette smokers. Just 0.8% of people who have never smoked are daily users of e-cigarettes.

Alcohol

Alcohol misuse increases the risk of serious medical conditions such as cirrhosis of the liver, heart disease, various cancers, strokes and depression. It can lead to family breakdown, domestic abuse and financial problems. If can often stem from poor mental health. The health and social consequences affect not only the individual but those around them and the wider community.

An alcohol-specific condition is when the primary diagnosis or any of the secondary diagnoses is wholly attributable to alcohol. Torbay has consistently had higher level of admissions to hospital in relation to alcohol-specific conditions than the South West & England (Fig 139). Rates for males in Torbay are approximately double the rate for females. Across England, those who live in the most deprived areas are almost twice as likely to be admitted to hospital for an alcohol-specific condition than those who live in the least deprived areas. Torbay also has a much higher rate of admissions for alcohol-specific conditions amongst its under 18 population with rates currently double the England average, although rates have fallen over the last few years. Amongst the under 18 population in Torbay, admission rates are over twice as high for females when compared to males, although overall numbers are small with 29 admissions for females and 13 for males over the 3 year period 2019/20 – 2021/22 (Fig 140).

Fig 139: Rate of admission episodes for alcohol-specific conditions per 100,000 (Age Standardised)

Source: Fingertips, Hospital Episode Statistics for 2021/22

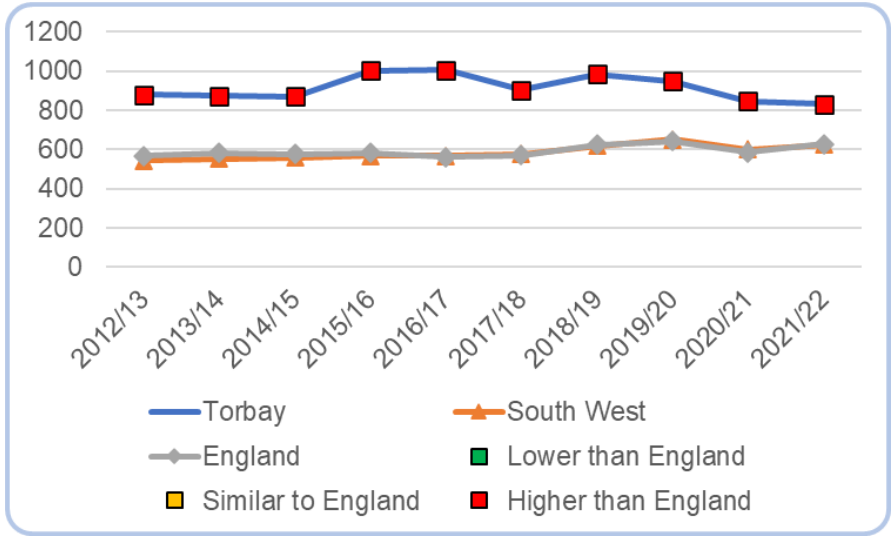
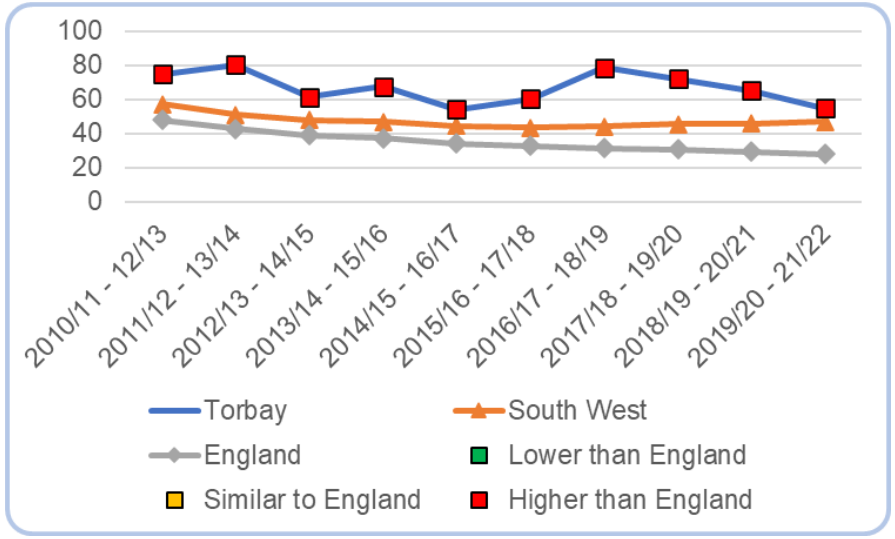


Fig 140: Rate of admission episodes for alcohol-specific conditions for Under 18s per 100,000

Source: Fingertips, Hospital Episode Statistics for 2021/22



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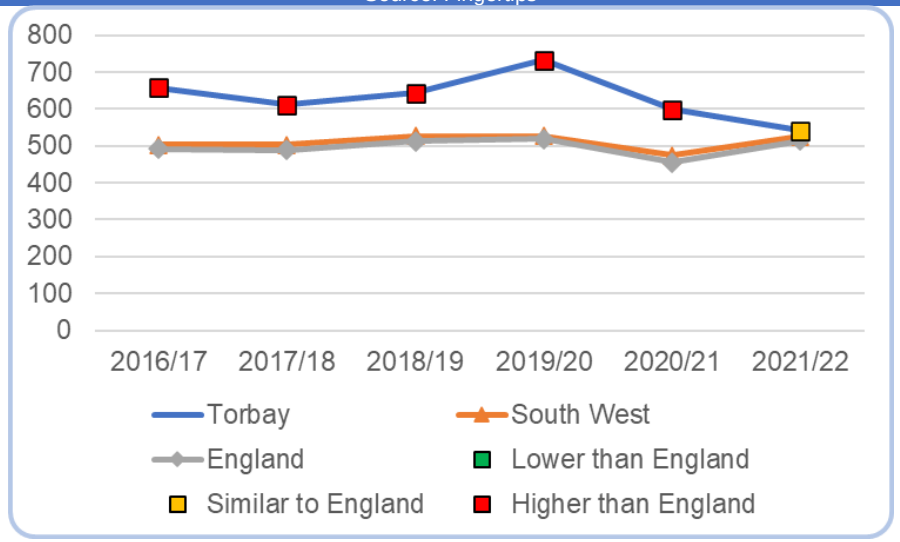
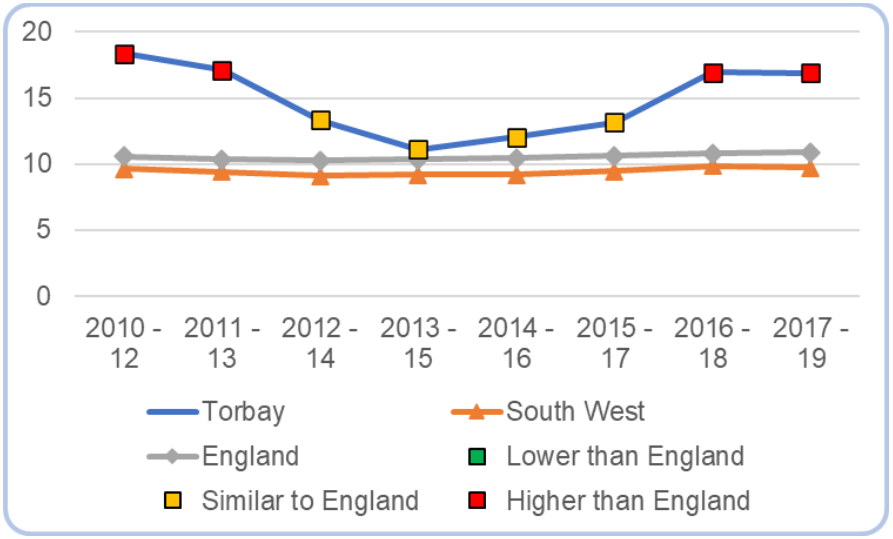
Torbay has historically had a significantly higher rate of alcohol-related admissions to hospital (Fig 141), for 2021/22, the number of alcohol-related admissions was broadly in line with England and the South West for the first time since the current method of calculation was used in 2016/17. The fall in the Torbay rate for 2021/22 when compared to the previous year is almost entirely within the female population. Rates are significantly higher in males when compared to females, for 2021/22 they are more than double female rates. The definition used here is that the primary diagnosis is an alcohol-attributable condition or a secondary diagnosis is an alcohol-attributable external cause code..

Fig 141: Rate of admission episodes for alcohol-related conditions (Narrow) per 100,000 (Age Standardised)
Source: Fingertips



Alcohol-specific mortality in Torbay has increased in the latter part of the last decade to be significantly higher than England for the last couple of 3 year periods shown (Fig 142). Local data for 2018 - 2020 and 2019 – 2021 shows a small increase from 2017 - 2019 when there were 73 deaths to 83 deaths in each of 2018 - 2020 and 2019 – 2021. Torbay also has a significantly higher level of under 75 mortality from alcoholic liver disease than the South West and England.

Fig 142: Rate of alcohol-specific mortality per 100,000 (Age Standardised)
Source: Fingertips



Over the period 2010 to 2020, Torbay had a higher proportion of alcohol users that left structured treatment free of alcohol dependence who do not then re-present to treatment within 6 months than the South West and England (Fig 143). Over the period, this equates to 1,905 successful treatments.

The University of Sheffield made estimates in 2018/19 that there were approximately 1,590 adults in Torbay with alcohol dependency. It should be noted that this was an estimate with lower and higher bounds of 1,280 adults and 2,038 adults, rates of those with alcohol dependency were estimated as slightly higher than the South West and England.

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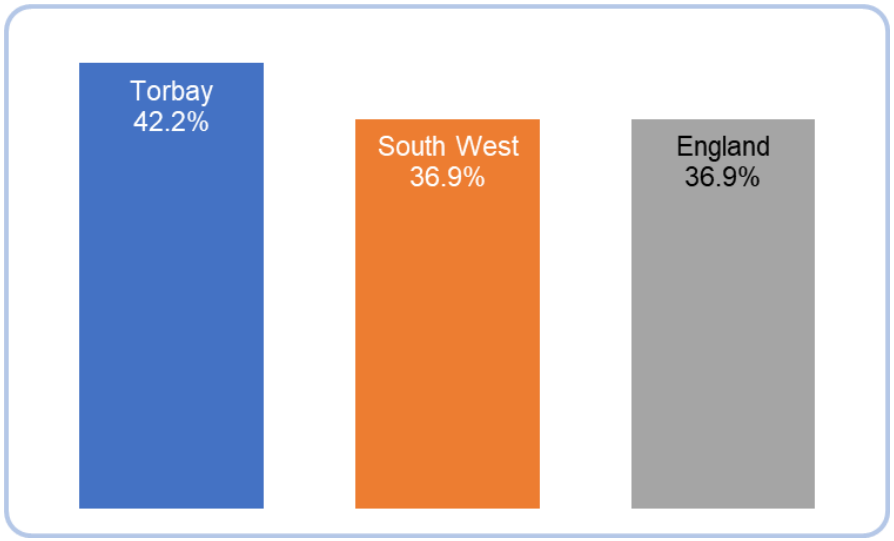
The estimated number of adults with alcohol dependency has been used as the basis to estimate the proportion of dependent drinkers who are not in treatment. Using treatment information from the National Drug Treatment Monitoring System it has been estimated that for 2020/21, significantly more dependent drinkers are in treatment in Torbay (33%) when compared to England (18%).

Fig 143: Percentage of successful structured alcohol treatment – 2010 to 2020
Source: Fingertips



Drugs

Opiates are a wide range of drugs that contain amongst others; Heroin, Morphine, Codeine, Opium and Fentanyl. Rates of successful treatment for opiate users are relatively low when compared to alcohol and non-opiate drugs. Rates of successful treatment (leaving drug free and do not re-present within 6 months) have fallen in Torbay, South West and England over the last decade (Fig 144). Torbay has remained broadly in line with England but 2020 saw a significant fall across many areas, possibly due to COVID-19 and its disturbance of drug treatment regimes.

Successful treatment for non-opiates is significantly higher than opiates and Torbay remains broadly in line with the South West and England, since 2018 successful treatments rates have been approximately 1 in 3 (Fig 145).

During 2020/21, the estimated proportion of opiates and/or crack cocaine users not in treatment was much lower in Torbay (34%) than the South West (47%) and England (52%) (Fig 146). This is based on data held by the National Drug Treatment Monitoring System and estimates of opiate or crack cocaine users produced by Liverpool John Moores University.

Fig 144: Percentage of successful structured drug treatment – Opiate user
Source: Fingertips

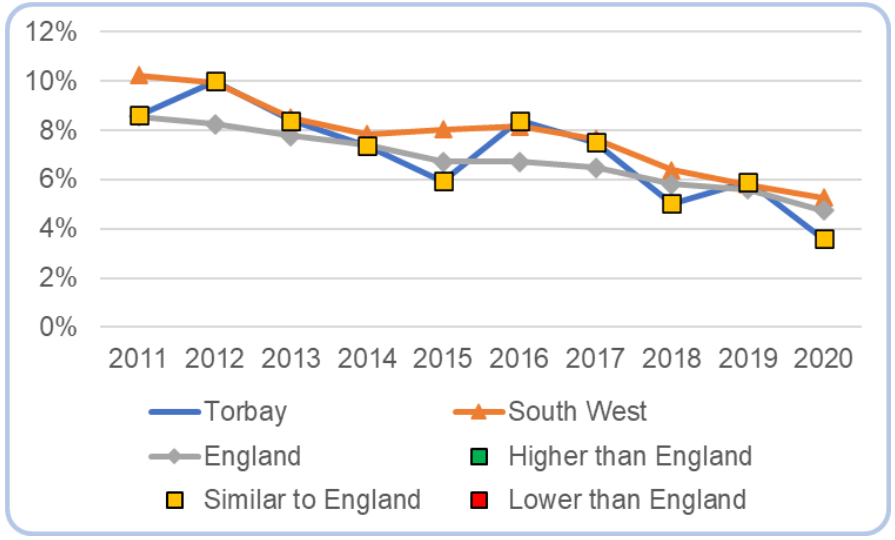


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Fig 145: Percentage of successful structured drug treatment – Non opiate user
Source: Fingertips

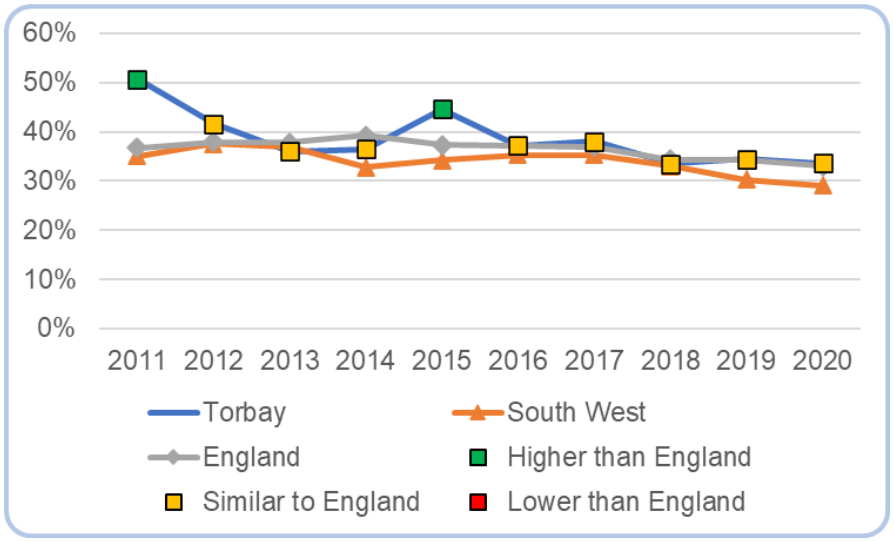
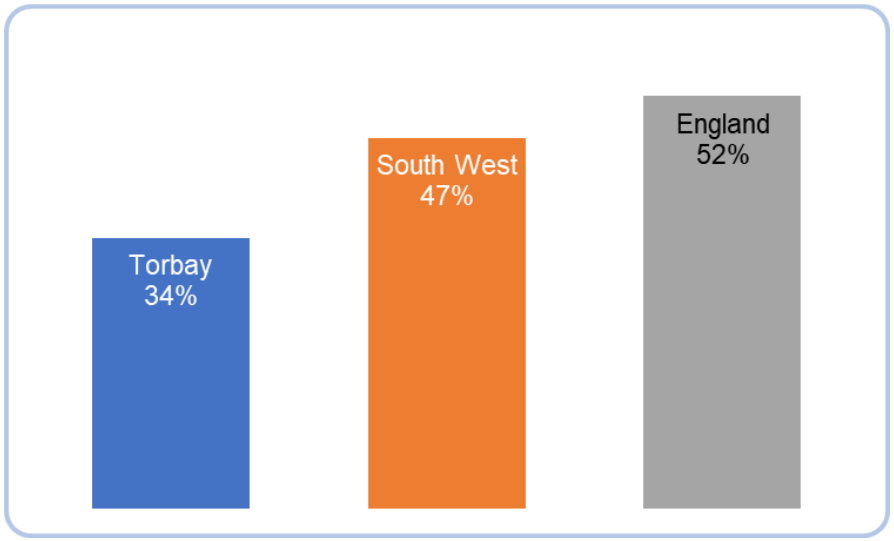
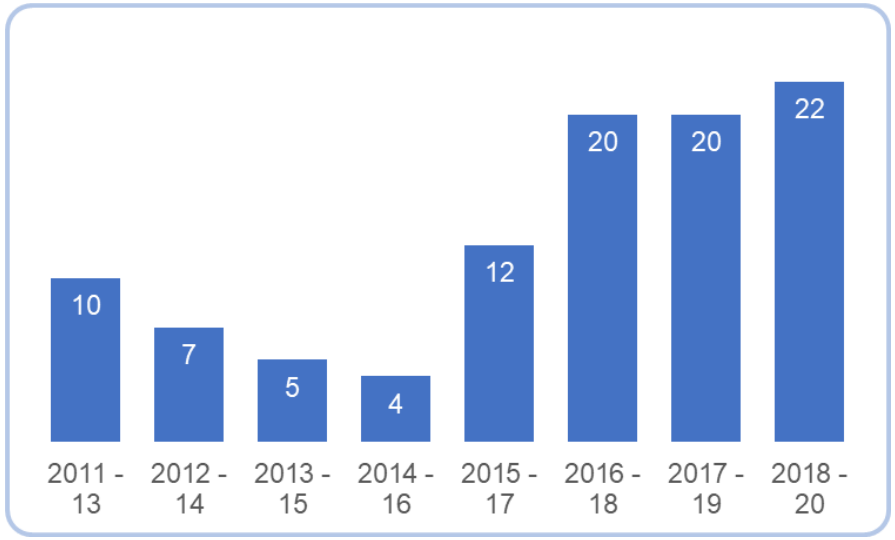


Fig 146: Estimated percentage of opiate and/or crack cocaine users not in treatment (2020/21)
Source: Fingertips



Drug misuse is a significant cause of premature mortality in the UK, particularly amongst those under 50 years. The rate of deaths from drug misuse in Torbay is broadly in line with England, Torbay has seen a rise in recorded deaths from drug misuse since the middle of the last decade with 22 deaths for 2018 to 2020 (Fig 147). Of the 34 deaths between 2015 and 2020, 23 were male and 11 were female.

Fig 147: Number of deaths from drug misuse - Torbay
Source: Fingertips



Documents you may find useful are listed below:-

NHS England » NHS Long Term Plan will help problem drinkers and smokers

The Smokefree 2030 ambition for England - House of Commons Library (parliament.uk)

From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

Smoke-free generation: tobacco control plan for England - GOV.UK (www.gov.uk)

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Smoking Prevalence (APS) (2021)	%	15.4%	12.8%	12.6%	13.0%	🟡	↑
Smoking attributable hospital admissions (2019/20)	DSR per 100,000	1529	1596	1300	1398	🔴	↑
Smoking attributable mortality (2017 - 19)	DSR per 100,000	214	223	174	202	🟡	↓
Mothers smoking at time of delivery (2021/22)	%	11.5%	10.8%	9.9%	9.1%	🔴	↑
Alcohol admissions for Under 18s (Specific) (2019/20 - 21/22)	Rate per 100,000	55	43	47	28	🔴	↓
Alcohol related admissions (Narrow) (2021/22)	DSR per 100,000	542	614	525	515	🟡	↓
Alcohol specific mortality (2017 - 19)	DSR per 100,000	16.9	13.8	9.7	10.9	🔴	↓
Successful drug treatment - Opiates (2020)	%	3.6%	3.7%	5.3%	4.7%	🟡	↓
Successful drug treatment - Non Opiates (2020)	%	33.6%	33.3%	29.1%	33.0%	🟡	↓

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Crime, Domestic Abuse and Anti-Social Behaviour

Overview

- 11,323 crimes and 3,480 anti-social behaviour incidents in Torbay reported to police during 2021/22.
  Source: Torbay Community Safety Partnership
- Rates of reported violent crime are higher in Torbay than England although the gap is narrowing.
  Source: Fingertips
- Levels of reported acquisitive crime in Torbay such as burglary, theft and shoplifting have fallen over the last 5 years.
  Source: Torbay Community Safety Partnership
- In line with national trends, far fewer children are entering the youth justice system.
  Source: Fingertips
- National Crime Survey data indicates that 29.3% of women and 14.1% of men have experienced domestic abuse at some time since the age of 16.
  Source: Crime Survey for England and Wales

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Crime, Domestic Abuse and Anti-Social Behaviour (ASB) can have significant effects on the individuals involved, and the families and communities around them. When we talk about the police data surrounding these issues, we are talking about reported levels, for instance it is acknowledged that domestic abuse and wider sexual crime is very significantly underreported to authorities, and this will lead us to use national survey data as well as reported figures to gather a better idea of prevalence.

Crime and Anti-Social Behaviour

The number of reported crimes in Torbay is slightly lower than 5 years ago (Fig 148), there has been a significant reduction in reported levels of acquisitive crime, that is crimes such as burglary, robbery, theft, shoplifting and vehicle crime. Of these sub-sections, vehicle crime and robbery buck this trend.

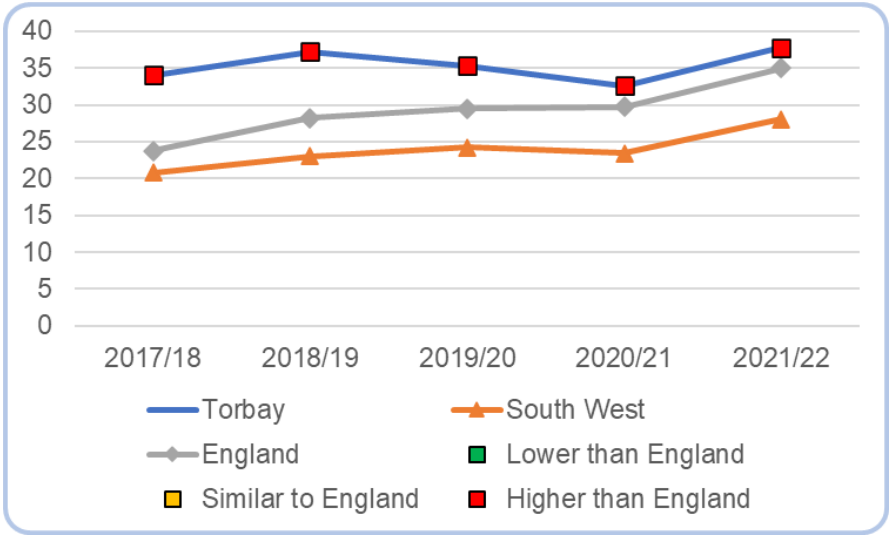
Fig 148: Crime and Anti-Social Behaviour (ASB) numbers reported to police - Torbay
Source: Torbay Community Safety Partnership

	2017/18	2018/19	2019/20	2020/21	2021/22
All Crime	11,816	12,241	11,319	10,470	11,323
All ASB	4,699	4,210	3,714	4,600	3,480
Sexual offences	440	442	431	364	430
Drug Offences	440	487	505	573	470
Acquisitive Crime	3,508	3,386	2,931	2,500	2,450

Violence is frequently used within a recorded crime, counts of violent crime from the Community Safety Partnership over the period in question had a change in methodology which doesn't allow for meaningful comparison over the 5 year period, however there are some nationally provided data sets that show Torbay's comparative level. Across England, reported violent and sexual offences are significantly more likely to occur in the most deprived areas than the least deprived areas.

Torbay has a significantly higher level of reported crimes classified as violence against the person when compared to England (Fig 149), sexual offences are counted separately.

Fig 149: Rate of Violence Offences per 1,000
Source: Fingertips



In respect of reported sexual offences, Torbay's rate is broadly in line with England and slightly above the South West (Fig 150), reported numbers fell significantly during 2020/21 in which there were multiple lockdowns due to the COVID-19 pandemic which left people more

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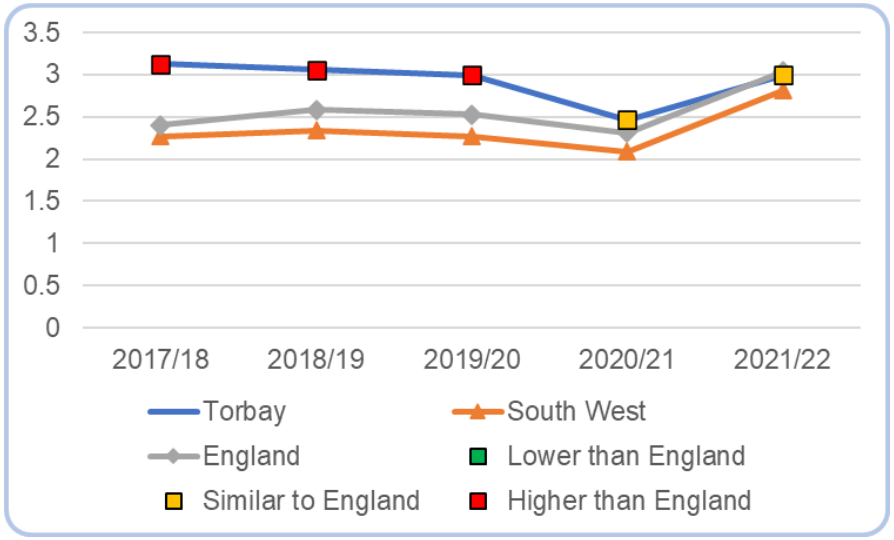
isolated from others in society. This may have led to a fall in the chance and available support to report these offences.

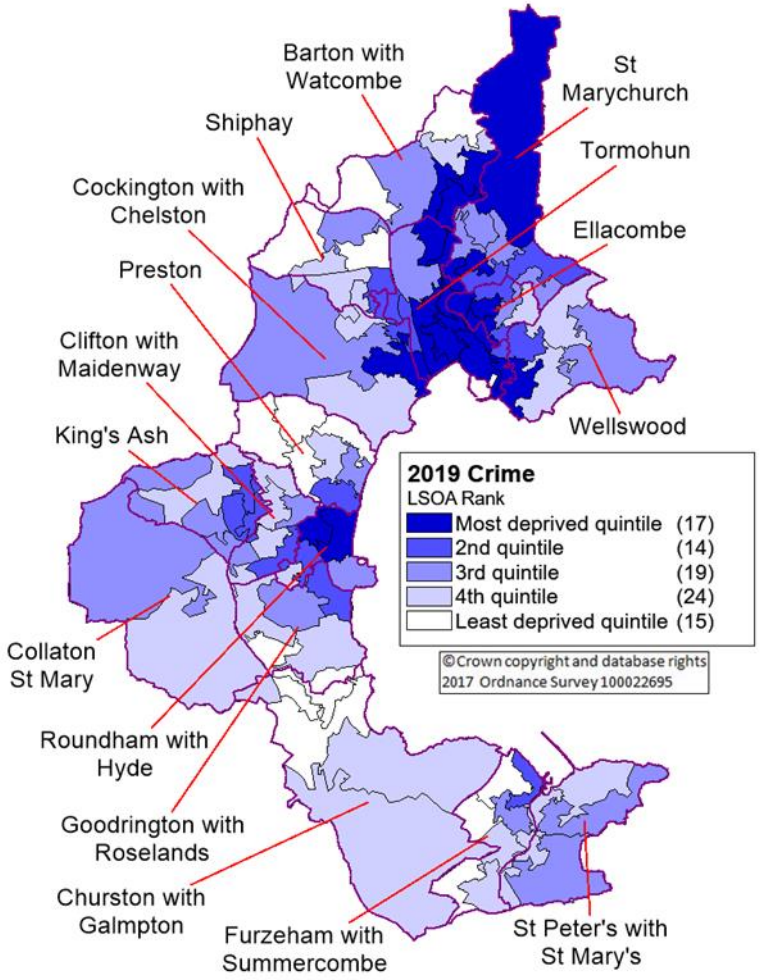
Fig 150: Rate of Sexual Offences per 1,000
Source: Fingertips



The Index of Multiple Deprivation produces a Crime Deprivation rating for small areas to give a guide to how areas are affected by crime. Although the data that it is based on relates to information gleaned in the last decade it is still a useful indicator of where levels of crime are likely to have the most impact.

The Crime sub-domain relates to the rate of violence, burglary, theft and criminal damage. The most Crime deprived areas indicated by dark blue relate to Torquay and central Paignton (Fig 151). Town centres will have higher levels of recorded crime due to the concentration of licensed premises. The areas in dark blue were ranked amongst the 20% most deprived in relation to Crime in England.

Fig 151: Rank of Crime Deprivation
Source: English Indices of Deprivation 2019



Those within the Youth Justice system are known to be amongst the most vulnerable in society. The number of 10 to 17 year olds in Torbay entering the Youth Justice system has fallen from 105 in 2013/14 to 34 in 2020/21. This is in line with reductions across

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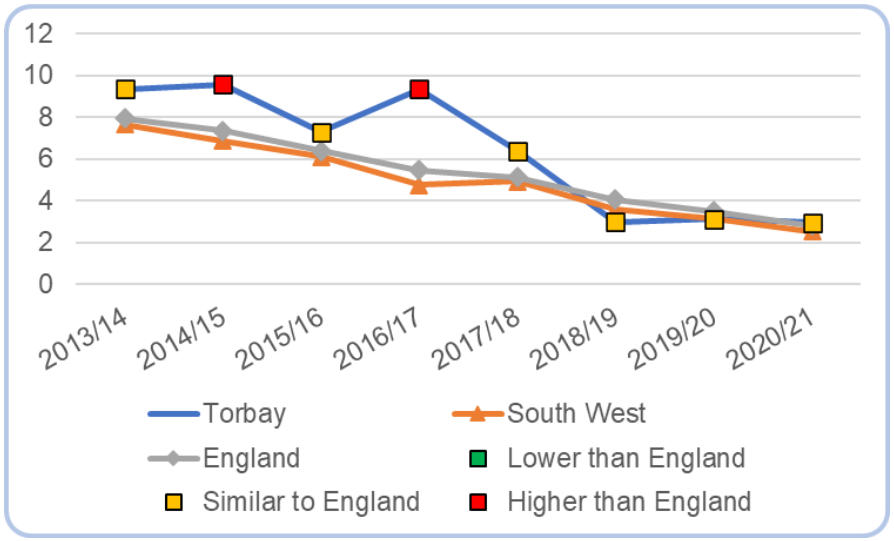
England in the numbers of children entering the Youth Justice system (Fig 152). A House of Commons committee report from November 2020 on 'How has the youth justice population changed' attributes these falls to the success of schemes that divert children and young people from court, such as formal youth cautions, youth conditional cautions and the informal community resolution.

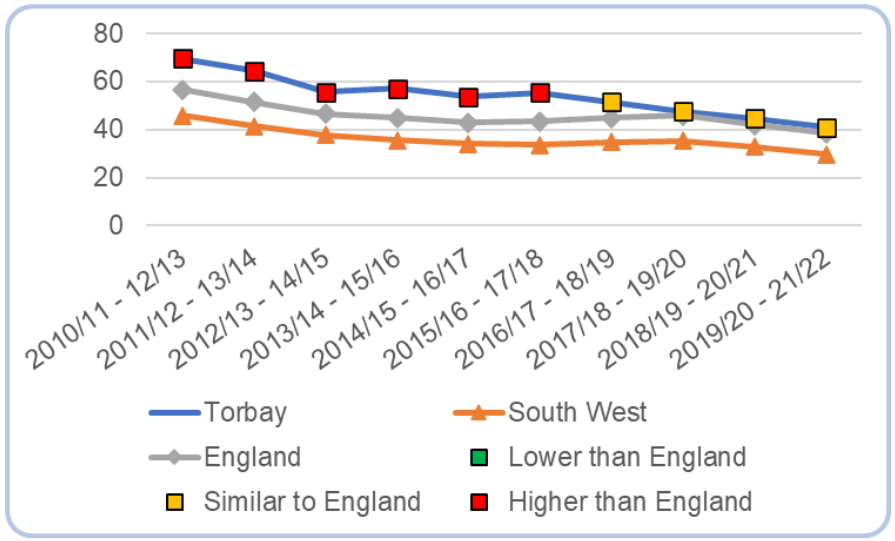
Over the same period, a similar pattern of falling rates locally and across England can be seen in relation to the number of first time offenders (of any age), these are offenders recorded as having received their first conviction, caution or youth caution.

Fig 152: Rate of children (10 to 17 yrs) entering the youth justice system per 1,000
Source: Fingertips



Hospital admissions for violence which includes sexual violence have gradually fallen over the last 10 years in Torbay and have been broadly in line with England rates over the last 4 time periods. However, rates remain significantly higher than the South West average (Fig 153). The rates have been adjusted to take account of differing geographies' age structures.

Fig 153: Rate of hospital admissions for violence (including sexual violence) per 100,000 (Age Standardised)
Source: Fingertips, 2021/22 – Hospital Episode Statistics



Domestic Abuse

The United Nations defines domestic abuse as 'a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviours that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound someone'.

Levels of domestic abuse are known to be under recognised and under reported. Levels of reported domestic abuse recorded in police figures for Torbay have remained relatively static over the last 5 years, for 2021/22 the reported figures were 3,494 (Fig 154).

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Fig 154: Domestic Abuse numbers recorded by police - Torbay
Source: Torbay Community Safety Partnership

	2017/18	2018/19	2019/20	2020/21	2021/22
Domestic Abuse	3,533	3,712	3,645	3,507	3,494

The Crime Survey for England and Wales asks people aged 16 and over about a number of subjects related to crime, this includes domestic abuse and stalking.

For the year ended March 2022, participants were asked if they had been subjected to any domestic abuse since the age of 16, this would include partner or family non-physical abuse, threats, force, sexual assault or stalking, 21.9% of people stated that they had been victims of this once or more since the age of 16 (Fig…). Rates were more than twice as high for women as men (29.3% for women, 14.1% for men). If these figures were applied directly to Torbay's 2021 population, approximately 17,800 women and 8,000 men aged 16 and over will have been subjected to domestic abuse at some point since the age of 16.

The survey found that it was more likely that people would have experienced abuse when they were aged 16 and over from partners rather than family, again it was much more likely that women would experience this abuse (Fig 155). More than 1 in 12 (8.7%) women were subject to a sexual assault (including attempts) by a partner, 1% of males had been subjected to a sexual assault (including attempts) by a partner.

There were also figures relating to being subjected to stalking since the age of 16. Almost a quarter of women (23.3%) had experienced this, as had 9.5% of men. 9.7% of women had been stalked by a partner.

Fig 155: Domestic Abuse Prevalence among adults aged 16 and over since the age of 16 (Year to March 2022) - England
Source: Crime Survey for England and Wales

	Female	Male	All
Any domestic abuse	29.3%	14.1%	21.9%
Any partner abuse	25.2%	9.9%	17.7%
Any family abuse	12.3%	6.4%	9.5%

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Weight, Exercise and Diet

Overview

- Over 1 in 4 Reception and 1 in 3 Year 6 pupils in Torbay are either overweight or obese.
  Source: Fingertips
- More than 6 in 10 Torbay adults are either overweight or obese.
  Source: Fingertips
- 50% of Torbay residents walk for 10 consecutive minutes or more, at least 3 times a week, this is more than the England average.
  Source: Department for Transport
- More than 7 in 10 children are physically active or fairly active, just under 7 in 10 adults are physically active.
  Source: Fingertips
- Torbay has higher rates of hospital admissions for eating disorders than England.
  Source: Hospital Episode Statistics
- The gap in healthy life expectancy between the most and least deprived areas in England was 18.8 years for females and 18.2 years for males.
  Source: Fingertips

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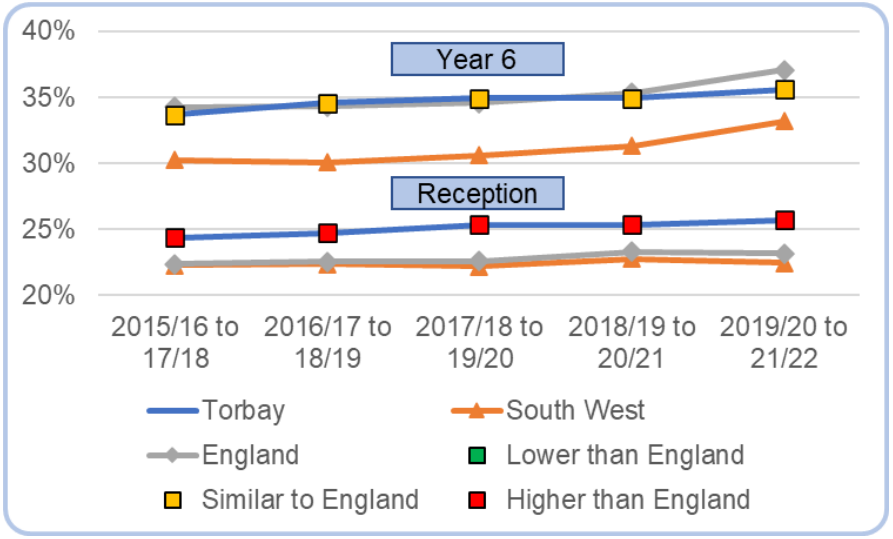
In adults, those with a physically active lifestyle have a 20% to 35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Studies tracking child obesity into adulthood have found that the probability of overweight or obese children becoming overweight or obese adults increases with age, it has also been noted that attitudes towards sport and physical activity are often shaped by experiences in childhood. Diet is also a very important aspect of health, Dr Alison Tedstone who was the chief nutritionist at Public Health England states that a healthy balanced diet is the foundation to good health, eating 5 a day and reducing our intake of calories, sugar and saturated fat is what many of us need to do to reduce the risk of long-term health problems.

Weight

The National Child Measurement Programme aims to measure the height and weight of Reception (aged 4 to 5) and Year 6 (aged 10 to 11) children at English schools.

The prevalence of overweight (including obese) Reception aged children in Torbay was approximately 1 in 4 (25.7%). Torbay has consistently had higher levels than the South West and England (Fig 156). For Year 6 children in Torbay, approximately 1 in 3 (35.6%) children were overweight or obese, this rate has been consistent with levels across England but above South West levels (Fig 156). Overweight (including obese) rates among Year 6 children have risen slightly faster than Reception aged children. Across England, rates of overweight (including obese) children are significantly higher in more deprived areas. For 2021/22, rates of overweight (including obese) children in the most deprived decile in England were 26.9% and 46.0% for Reception and Year 6 children respectively as opposed to 16.9% and 26.3% in the least deprived decile.

Fig 156: Percentage of overweight (including obese) children
Source: Fingertips



Sport England undertakes an annual 'Active Lives Survey' for those aged 18 and over which asks for height and weight to calculate their BMI.

Looking at the 6 year period from 2015/16 to 2020/21, Torbay has a similar rate of adults classified as overweight when compared to the South West and England at 61.7% (Fig 157). When you look at England figures, the percentage of those who are classified as overweight increases with age until you reach those who are 85 years and older (Fig 158). Across the last 6 years, males are 10 to 13 percentage points more likely to be classified as overweight when compared to females, for 2020/21, 69% of males and 58% of females were classified as overweight across England.

Those who live in more deprived areas are more likely to be classified as overweight when compared to those in the least deprived areas, for 2020/21 across England, 72% of those in the

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most deprived decile in England were classified as overweight compared to 58% in the least deprived decile.

Fig 157: Percentage of adults classified as overweight or obese (2015/16 to 2020/21)
Source: Fingertips

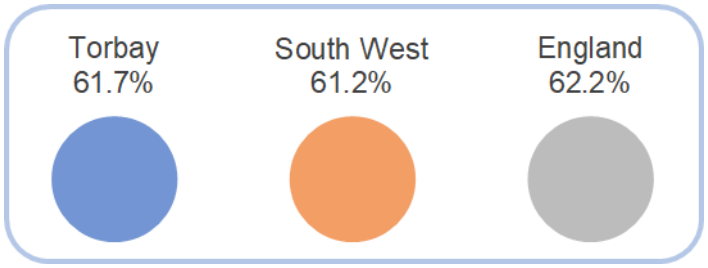
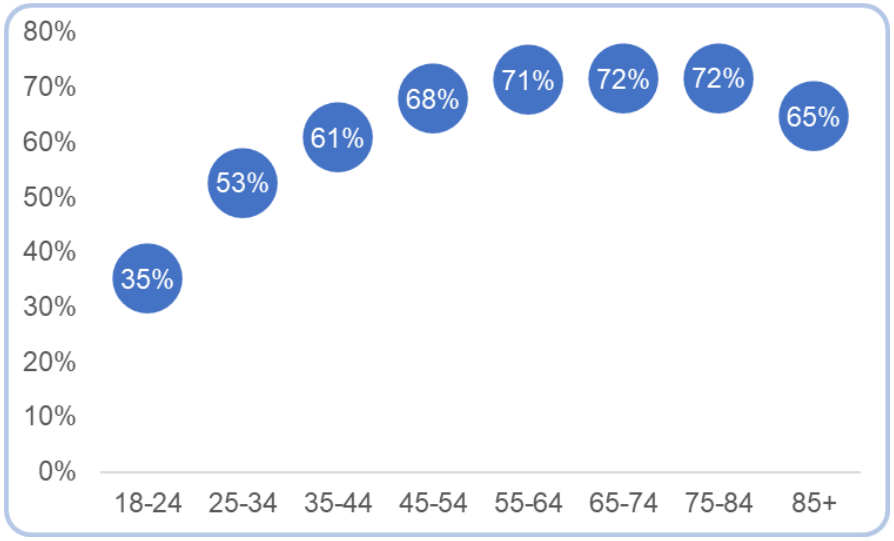


Fig 158: Percentage of adults classified as overweight or obese by age band - England (2015/16 to 2020/21)
Source: Fingertips

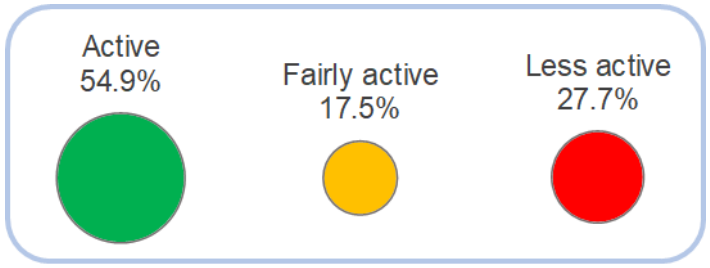


Exercise

The Active Lives Children's Survey asks a number of questions around children's level of activity.

One of the questions relates to the daily level of sport and physical activity undertaken by children aged 5 to 16 over the last week. Children can be active (an average of 60+ minutes per day), fairly active (30 to 59 minutes) or less active (less than 30 minutes). Torbay respondents show just over 1 in 2 as active and just over 1 in 4 as less active during 2021/22 (Fig 159). These figures are higher than England but there is a significant amount of volatility from year to year at a local level.

Fig 159: Percentage of children aged 5 to 16 by level of physical activity – Torbay (2021/22)
Source: Fingertips



Data from the 'Active Lives Survey' undertaken by Sport England asks questions about a person's level of physical activity over the previous 28 days. 68% of Torbay respondents over the last 6 years said that they were physically active (150 minutes of moderate intensity physical activity per week over the last 28 days), this is broadly in line with England and the South West (Fig 160). The data was weighted to take account of differing population structures in different local authorities.

Levels of those who responded as being physically active were higher across England in the least deprived areas when compared to the most deprived areas (Fig 161).

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Fig 160: Percentage of adults classified as physically active (2015/16 to 2020/21)
Source: Fingertips

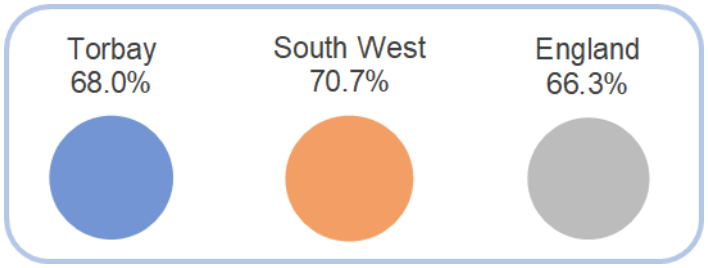
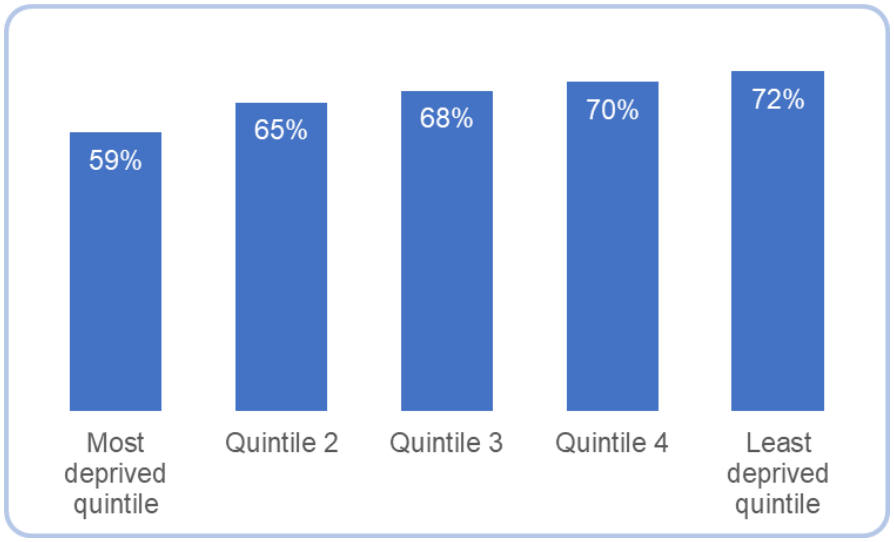


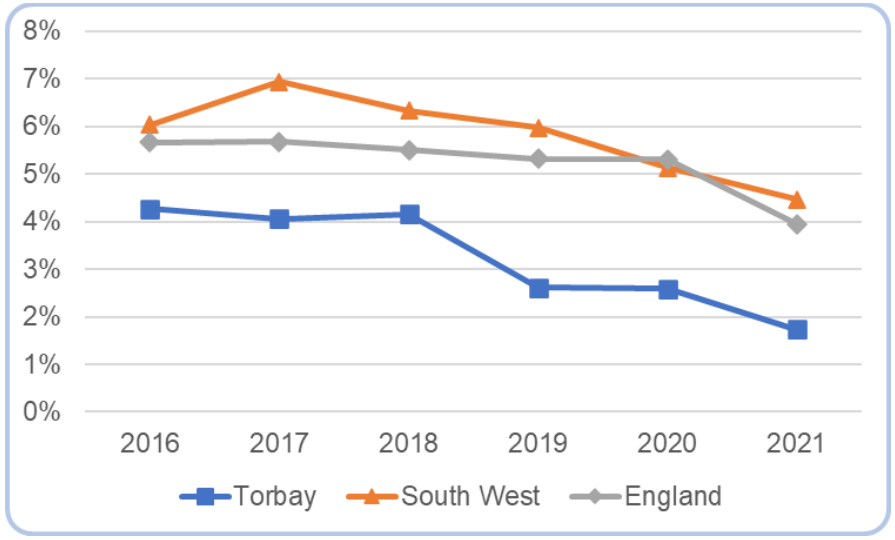
Fig 161: Percentage of adults classified as physically active by deprivation quintile - England (2015/16 to 2020/21)
Source: Fingertips



Data from the National Travel Survey and Active Lives Survey is brought together by the Department for Transport to calculate rates of cycling and walking among the population.

Rates of cycling amongst adults in Torbay have been consistently lower than rates in the South West and England. When asked if they cycled at least 3 times a week for any purpose, rates in Torbay have been consistently lower over the last 6 years (Fig 162). Torbay residents are more likely to cycle for leisure rather than for travel.

Fig 162: Percentage of adults who cycle at least 3 times a week for any purpose
Source: Department for Transport Table CW302



Rates of walking for at least 3 times a week (walk that is at least 10 continuous minutes) amongst adults in Torbay have consistently been higher than England and slightly higher than the South West, the rate in Torbay in 2021 was almost 50% (Fig 163). Residents were more than twice as likely to walk at least 3 times a week for leisure than they were for travel.

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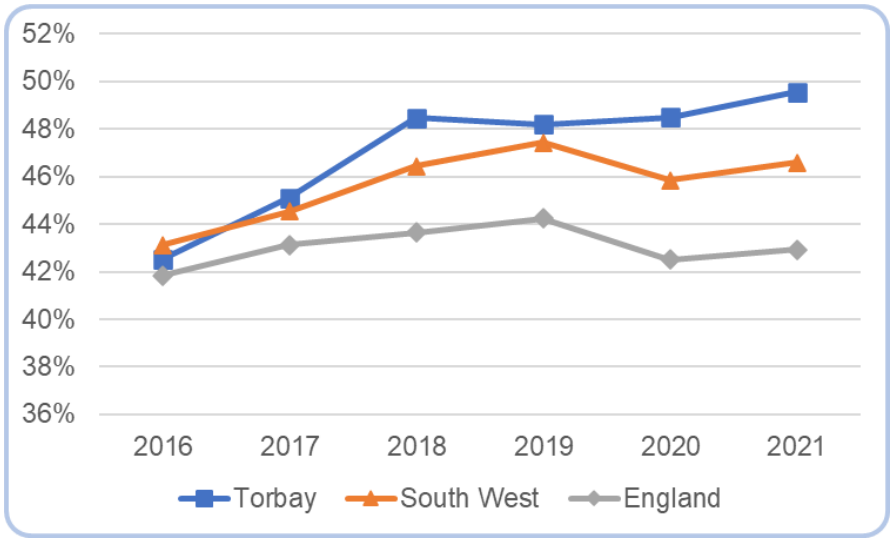
Fig 163: Percentage of adults who walk at least 3 times a week for any purpose
Source: Department for Transport Table CW303



Diet

The proportion of those adults eating 5 portions of fruit and vegetables on a 'usual day' as reported by the Active Lives Survey is 59.9%, this is significantly higher than England but broadly in line with the South West (Fig 164). Across England, there are significant differences between the most and least deprived areas, for 2019/20, 46% of those in the most deprived decile in England had their '5-a-day' compared to 63% of those in the least deprived decile.

Dietary issues are often talked about in terms of being overweight or obese. However, people also suffer from anorexia, bulimia, and other eating disorders. In the most severe cases people may be admitted to hospital, although the number of hospital admissions where the primary diagnosis is an eating disorder are small. Torbay has consistently had a significantly higher rate of admissions than England over the last 6 years and the rate is on an upward trend (Fig 165). Across England, 91.5% of admissions relate to females, 65.7% of admissions across England relate to females under 18 years. For the 6 years, 2016/17 to 2021/22, 2 out of every 3 admissions of Torbay residents where the primary diagnosis related to an eating disorder were females under the age of 18, this equates to 82 admissions.

Fig 164: Percentage of adults eating 5 portions of fruit and vegetables on a 'usual day' (2015/16 to 2019/20)
Source: Fingertips

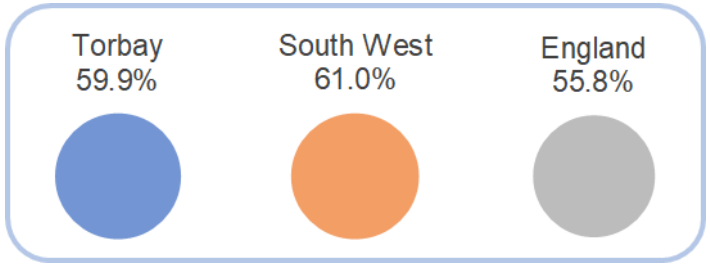
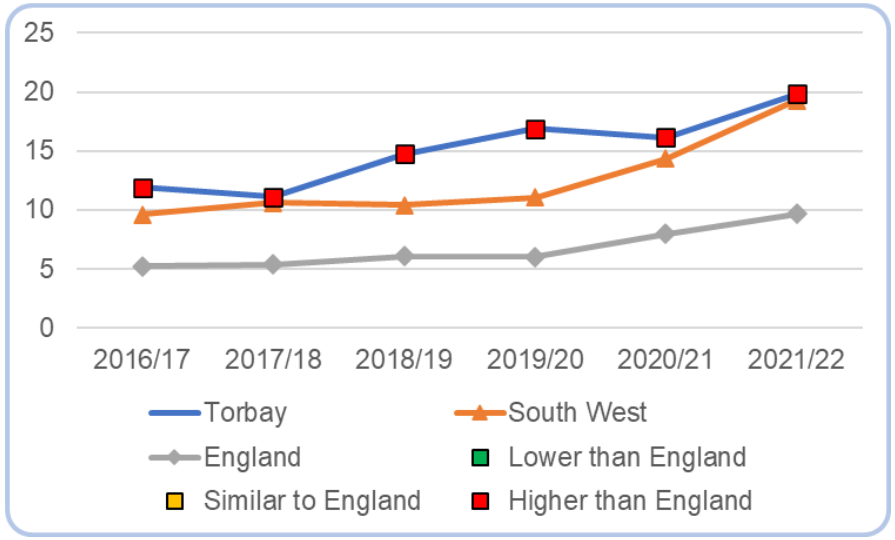


Fig 165: Rate of hospital admissions due to primary diagnosis of an eating disorder, per 100,000
Source: Hospital Episode Statistics



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Those in more deprived areas are more likely to lack the options to eat more healthily whether this is through poor access to supermarkets with fresh fruit and vegetables or lack of money to enable themselves to eat well. Food insecurity has been heightened firstly through COVID-19 and more lately through the Cost of Living crisis. Torbay Food Alliance Torbay Food Alliance | Food Banks in Torquay, Paignton and Brixham is a partnership of community organisations, working together to support people who are struggling to afford food. Since this organisation came together in March 2020, they have provided over a million meals for people in Torbay.

Healthy life expectancy and mortality

The consequences of obesity, poor diet and lack of exercise contribute to increasing the chances of a poorer level of health and increased levels of mortality.

Data for Healthy life expectancy is based on self-reported good health from the Annual Population Survey and deaths, it is weighted to take into consideration the population structure of different areas. Healthy life expectancy at birth for females in Torbay has been on a downward trend over the last decade from 64.4 years in 2010-2012 to 61.9 years in 2018-2020. Over the last decade, rates have been consistently below England and South West averages (Fig 166).

Healthy life expectancy at birth for males was at 64.1 years in 2010-2012 and stands at 63.8 years for 2018-2020, it has been broadly in line with the England average but below the South West (Fig 167).

Fig 166: Healthy life expectancy at birth - Females
Source: Fingertips

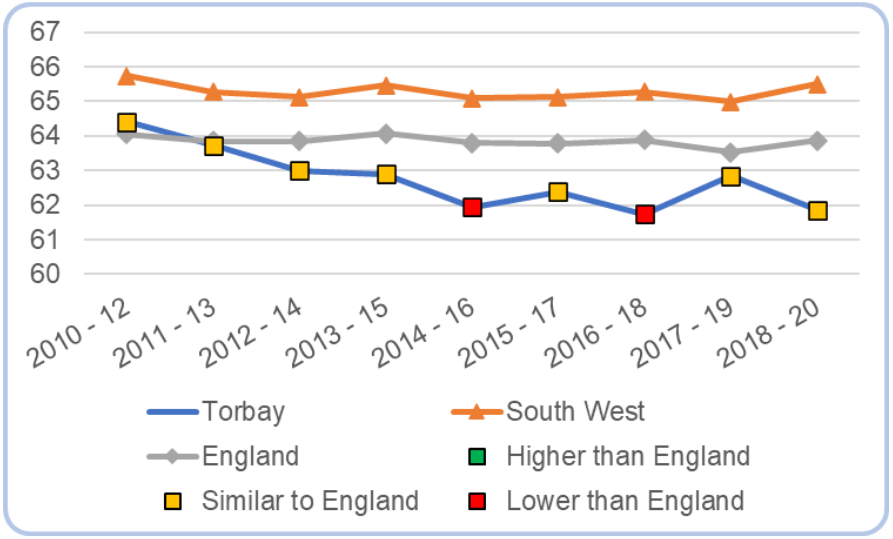
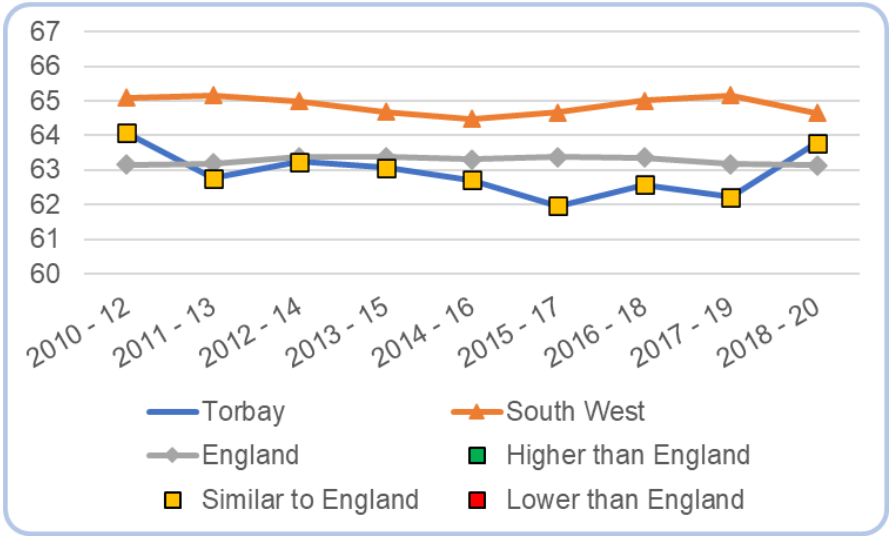


Fig 167: Healthy life expectancy at birth - Males
Source: Fingertips



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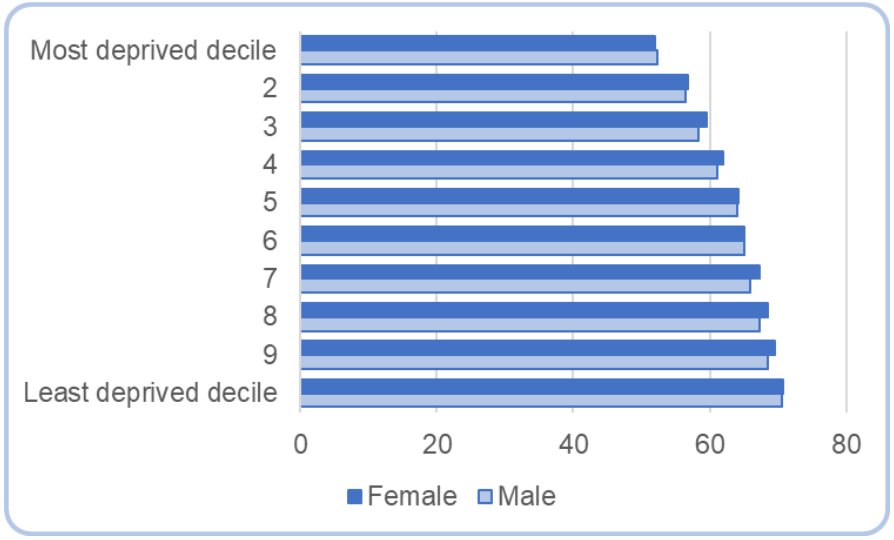
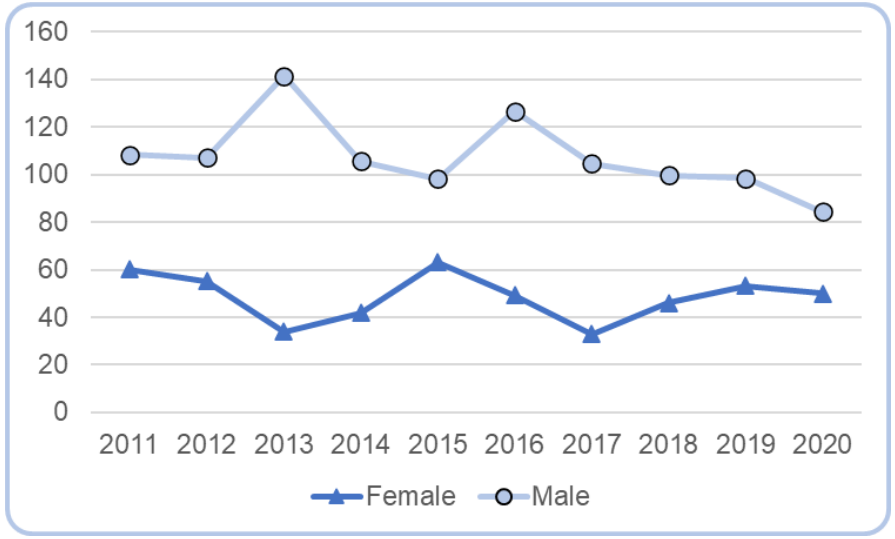
Across England, there are very large differences between those who live in the most deprived and least deprived areas. For the period 2018-2020, the gap between those who live in the most and least deprived deciles was 18.8 years for females and 18.2 years for males. Healthy life expectancy in the most deprived areas was 51.9 and 52.3 years respectively for females and males, in the least deprived areas it was 70.5 and 70.7 years respectively (Fig 168).

Fig 168: Healthy life expectancy at birth by deprivation decile – England (2018 – 20)
Source: Fingertips



Mortality rates from cardiovascular diseases includes heart disease and strokes, risks are heightened by high levels of cholesterol, lack of exercise, obesity and hypertension as well as smoking, a family history of cardiovascular disease and your ethnicity. Rates for Torbay are broadly in line with England but there are very substantial differences between females and males over the last decade (Fig 169). Males in Torbay and across England are much more likely than females to die before the age of 75 from a cardiovascular disease.

Fig 169: Under 75 mortality rate from all cardiovascular diseases – Torbay
Source: Fingertips



For further investigation, you may find the following links useful:-

Active Lives | Children And Young People Activity Data (sportengland.org)

Active Lives | Sport England

Torbay Food Alliance | Food Banks in Torquay, Paignton and Brixham

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Overweight (inc obese) children - Reception (2019/20 - 21/22)	%	26%	24%	22%	23%	🔴	↑
Overweight (inc obese) children - Year 6 (2019/20 - 21/22)	%	36%	37%	33%	37%	🟡	↑
Physically active children (2021/22)	%	55%	51%	49%	47%	🟢	↑
Physically active adults (2015/16 - 20/21)	%	68%	65%	71%	66%	🟡	↓
Adults eating their '5-a-day' (2019/20)	%	62%	54%	60%	55%	🟢	↑
Hospital admissions for eating disorders (2021/22)	Rate per 100,000	19.8	10.5	19.3	9.7	🔴	↑
Healthy life expectancy - Female (2018 - 20)	Years	61.9	61.9	65.5	63.9	🟡	↓
Healthy life expectancy - Male (2018 - 20)	Years	63.8	61.8	64.7	63.1	🟡	↑

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Oral Health

Overview

- In Torbay, 49% of children were not seen by an NHS dentist in the last year (up to June 2022) and 59% of adults were not seen in the last 2 years. This is significantly lower (better) than England.

  Source: NHS Dental Statistics – NHS Digital

- Torbay has higher levels of dental decay in 3 and 5 year olds than the South West and England.

  Source: Fingertips, from National Epidemiology Programme surveys

- The rate of hospital tooth extractions for dental caries in those aged 0-19 is significantly higher in Torbay for at least the last six years (2016/17 – 2021/22).

  Source: Hospital Episode Statistics, ONS mid-year population estimates

- Rates of hospital tooth extractions for dental caries are higher in more deprived areas.

  Source: Hospital Episode Statistics, ONS mid-year population estimates, Index of Multiple Deprivation 2019

- Oral cancer registrations and mortality are at higher levels in Torbay. As in England, mortalities of males are double that of females.

  Source: Fingertips

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Torbay's oral health is generally worse than in England as a whole with poorer oral health found in areas of deprivation. Inequalities in oral health are a significant problem in England (PHE, 2021) despite good progress being made in the last few decades. Poor oral health is an issue that is almost completely preventable. A diet with high levels of sugar, the consumption of alcohol and use of tobacco are causes of oral health problems which are also risk factors for poor general health and serious disease.

Further information on Torbay's oral health can be found in the Torbay Oral Health Needs Assessment, November 2022. Oral health inequalities at a national level is explored in Inequalities in oral health in England - GOV.UK (www.gov.uk), Public Health England, March 2021

People not seen by an NHS dentist

COVID-19 restrictions on dentists will have reduced the number of patients seen from March 2020 for the period of the restrictions.

Torbay has significantly lower (better) levels of children not seen by an NHS dentist compared with the South West and England. 49% of children were not seen by an NHS dentist in the last year (up to June 2022) which is on an improving trend (Fig 170).

59% of adults were not seen by an NHS dentist in the last two years (Fig 171). This had been an increasing (worsening) figure but as of June 2022 it started to decrease. Torbay is significantly better than the South West and England.

Fig 170: Percentage of children, aged 0-17, not seen by an NHS dentist in the last year

Source: NHS Dental Statistics – NHS Digital

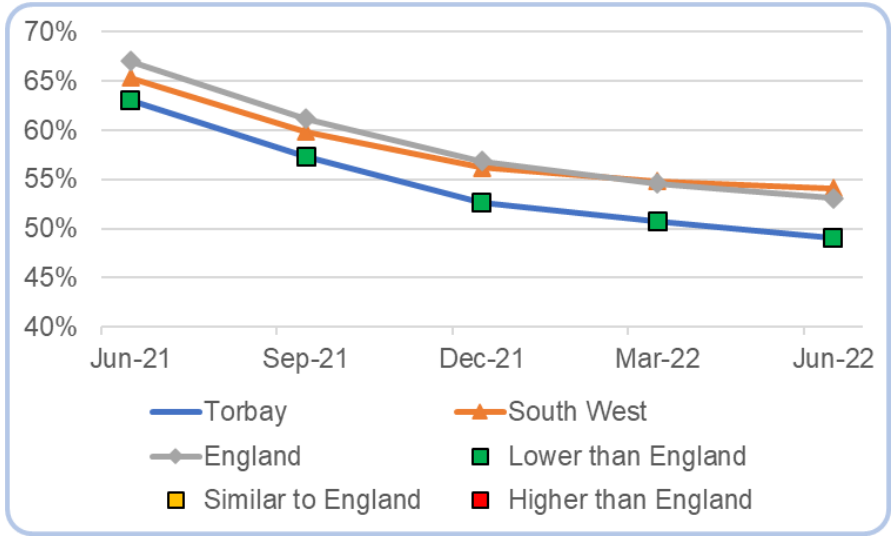
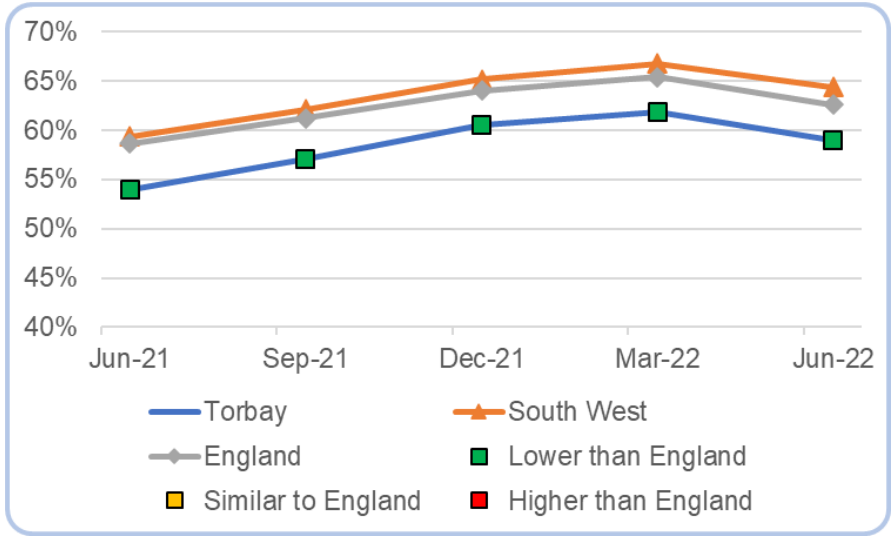


Fig 171: Percentage of adults, aged 18+, not seen by an NHS dentist in the last 2 years

Source: NHS Dental Statistics – NHS Digital



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Tooth decay in children aged 3 and 5 years

Poor oral health can impact a child's learning and development. It can cause pain and infection and impact upon speaking, eating, playing, sleeping, socialising and overall quality of life.

Torbay has higher levels of tooth decay in five year olds although statistically similar to England in 2018/19 (Fig 172). In this year 28% have visible dental decay (23% in England). It should be noted that surveys were not carried out equal years apart. Torbay (Fig 173) had an average of 1.05 decayed, missing or filled teeth per five year old child examined (0.80 in England). This was higher than but statistically similar to England in 2018/19.

Tooth decay is also at higher levels in Torbay's three year olds with an average of 0.56 decayed, missing or filled teeth compared to 0.31 in England in 2019/20 (Fig 174). It should be noted that there are a lot of Local Authorities missing from this survey of three year olds in 2019/20 due to COVID-19 restrictions.

Fig 172: Percentage of 5 year olds with visually obvious dental decay

Source: Public Health Profiles, OHID, from National Epidemiology Programme surveys

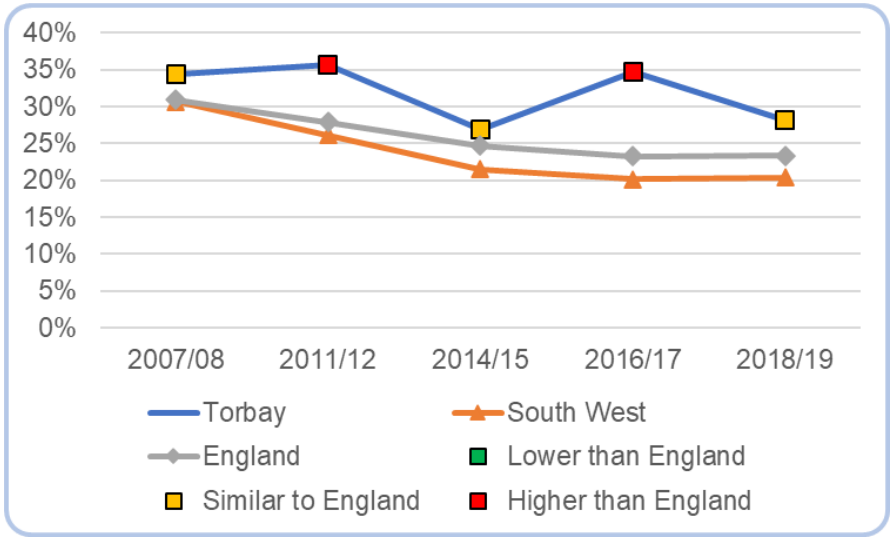


Fig 173: Average number of decayed, missing or filled teeth in 5 year olds

Source: Public Health Profiles, OHID, from National Epidemiology Programme surveys

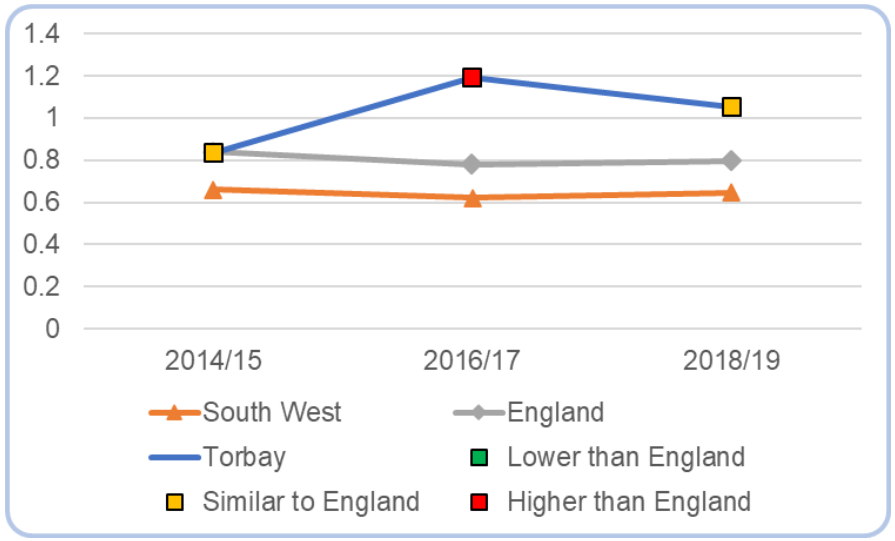
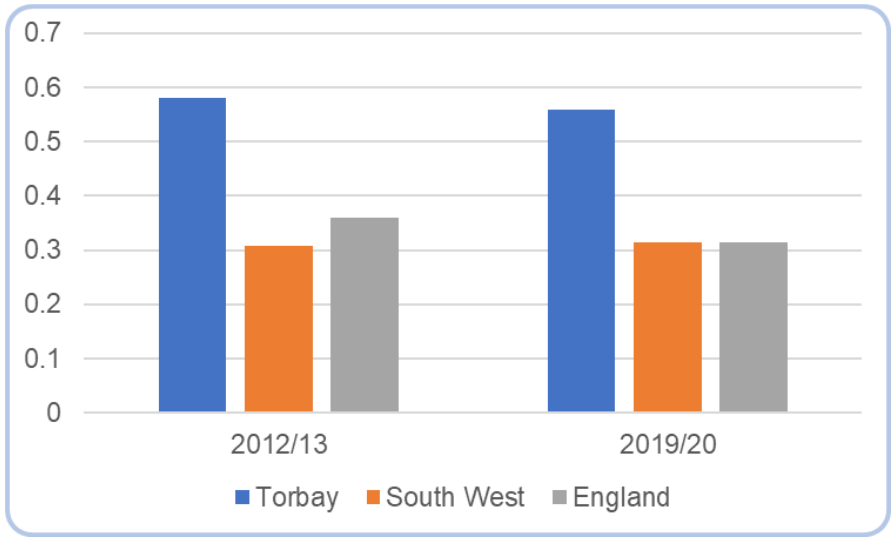


Fig 174: Average decayed, missing or filled teeth in 3 year olds

Source: Public Health Profiles, OHID, from National Epidemiology Programme surveys



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Hospital tooth extractions due to dental caries

Torbay has significantly higher rates of hospital tooth extractions due to dental caries for 0-19 year olds than the South West and England for the six years shown (Fig 175).

There are higher levels of hospital admissions for dental caries in 0-19 year olds in more deprived areas with the most deprived area having significantly higher rates of admissions than the other areas (Fig 176).

Fig 175: Rate of hospital tooth extractions due to dental caries, aged 0-19, per 100,000

Source: Hospital Episode Statistics, ONS mid-year population estimates

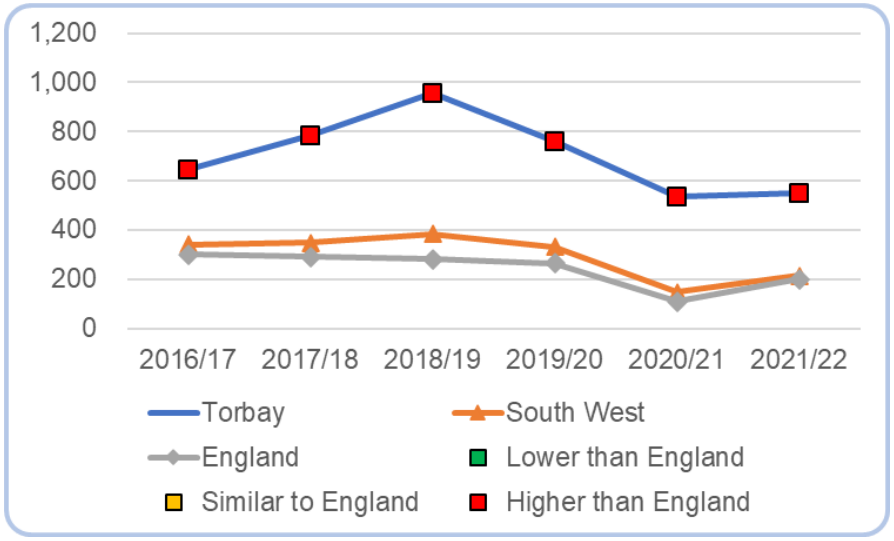
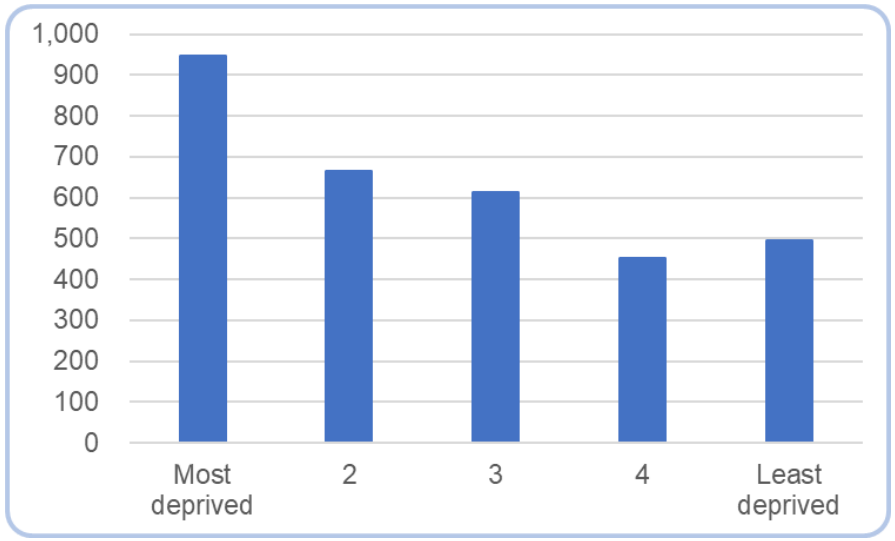


Fig 176: Torbay rates of hospital tooth extractions due to dental caries, aged 0-19, per 100,000, 2016/17–21/22, by deprivation

Source: Hospital Episode Statistics, ONS mid-year population estimates, Index of Multiple Deprivation 2019



Rates of hospital tooth extractions due to caries for adults decreased in 2020/21 and 2021/22 compared to previous years (Fig 177) and are similar to England levels at 86.7 per 100,000 in 2021/22 (77.2 in England). COVID-19 restrictions are likely to have had an impact.

As seen in 0-19 year olds, the more deprived areas of Torbay have the highest prevalence of hospital dental extractions for caries and the most deprived quintile is significantly higher than the rest (Fig 178).

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Fig 177: Rate of hospital tooth extractions due to dental caries, aged 18+, per 100,000
Source: Hospital Episode Statistics, ONS mid-year population estimates

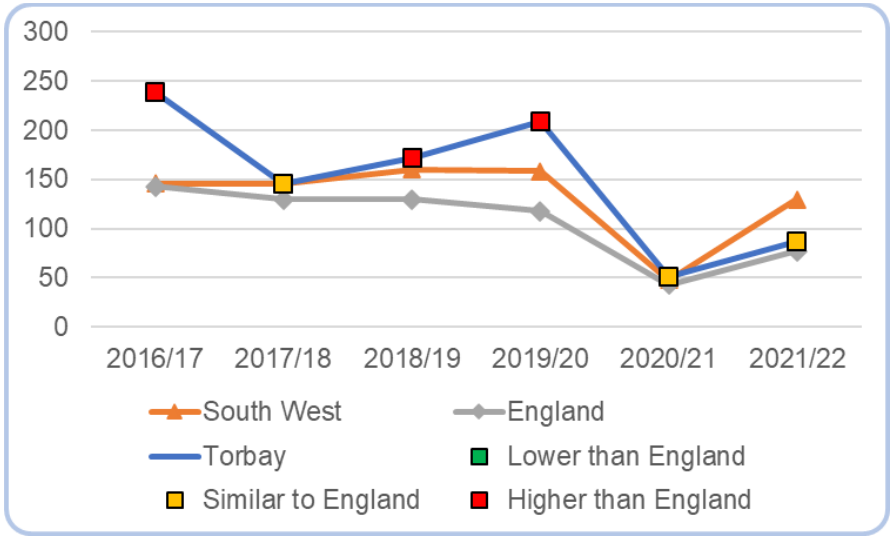
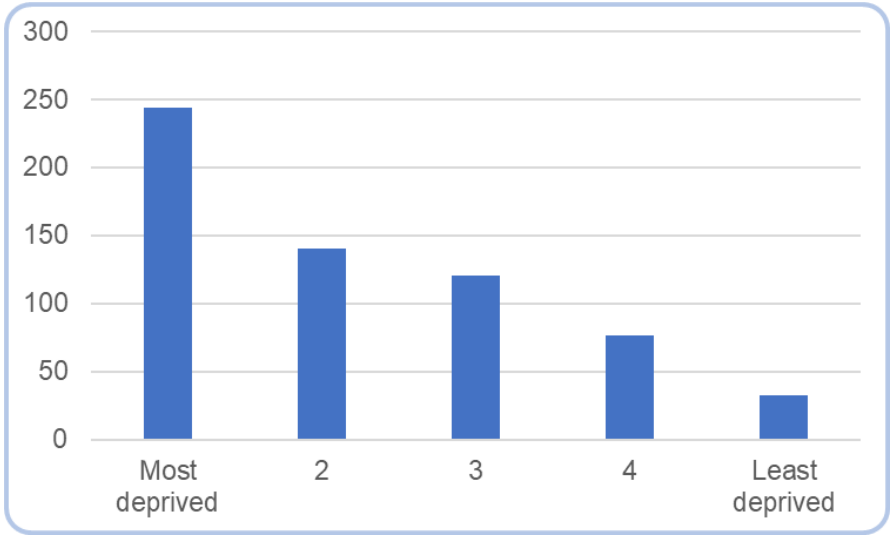


Fig 178: Torbay rates of hospital tooth extractions due to dental caries, aged 18+, per 100,000, 2016/17–21/22, by deprivation
Source: Hospital Episode Statistics, ONS mid-year pop estimates, Index of Multiple Deprivation 2019



Tooth extraction claims by NHS dentists

Tooth extractions by NHS dentists data includes all extractions, not just for dental caries. COVID-19 restrictions on dentists will have reduced the figures from March 2020 for the period of the restrictions.

Torbay rates (Fig 179) for 0-17 year olds are significantly lower than England in 2021/22 (3,418 per 100,000 compared to 3,667 in England).

For adults the rates in Fig 180 are significantly higher than England in all three years. In 2021/22 the Torbay rate is 4,963 per 100,000 compared to 4,057 in England.

Fig 179: Rate of tooth extraction claims for NHS dentistry, aged 0-17, per 100,000
Source: NHS Dental Statistics – NHS Digital, ONS mid-year population estimates

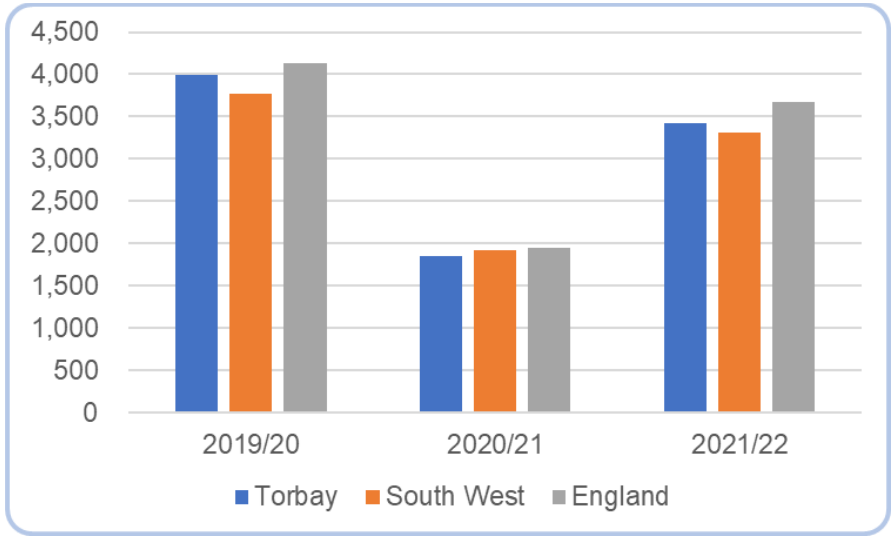


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Fig 180: Rate of tooth extraction claims for NHS dentistry, aged 18+, per 100,000
Source: NHS Dental Statistics – NHS Digital, ONS mid-year population estimates

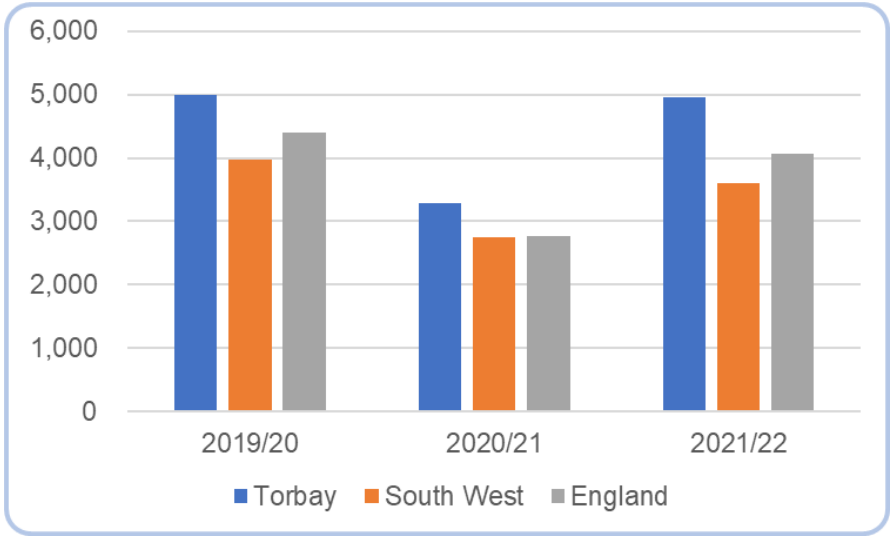
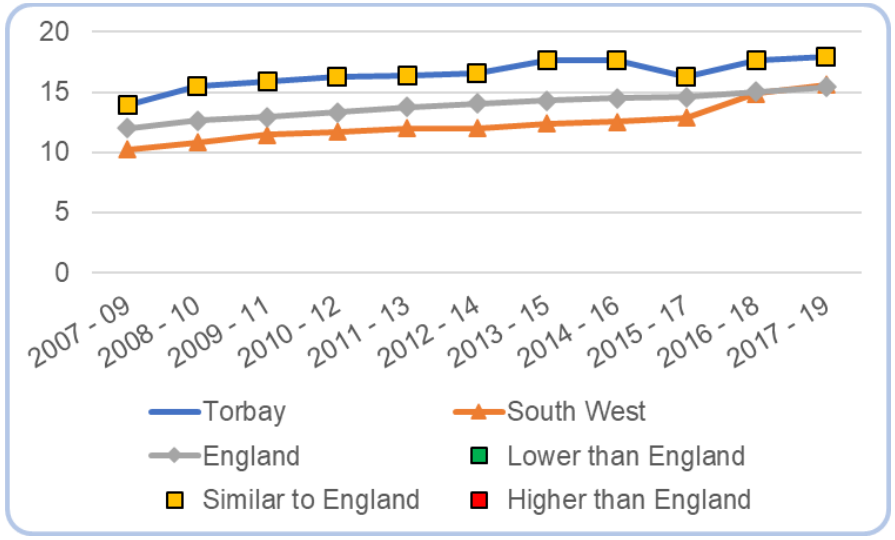


Fig 181: Rate of oral cancer registrations, all ages, per 100,000 (Age Standardised)
Source: Fingertips



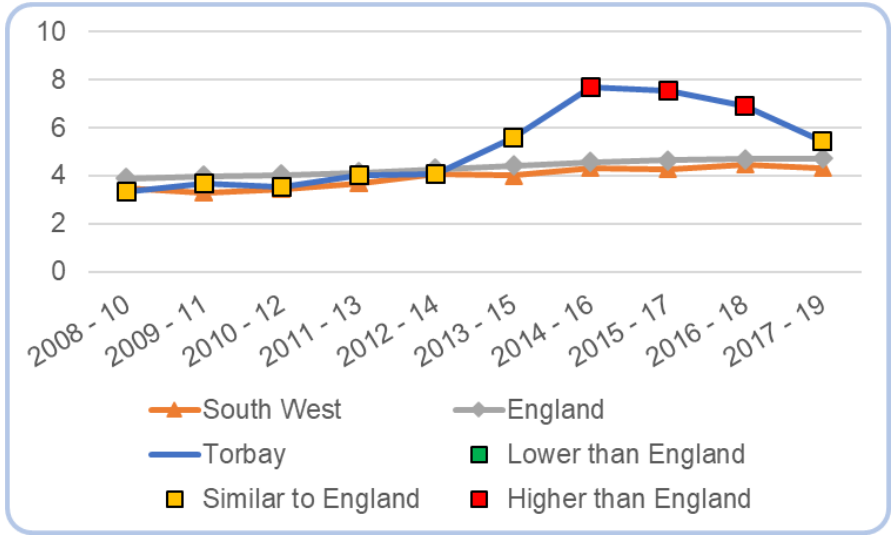
Oral Cancer

Oral cancer encompasses cancers of the lip, oral cavity, and pharynx. Tobacco and alcohol are the main causes of this type of cancer and it is more common in men than in women.

Torbay's rate of registrations of oral cancer has been higher but not statistically significantly different to England figures for the 11 periods shown (Fig 181), in 2017-19 Torbay has 17.9 registrations per 100,000 (15.4 in England). This does not include secondary cancers.

Mortality rates (Fig 182) have been significantly higher than England for three periods before reducing in 2017-19 to 5.4 per 100,000. These figures do not include secondary cancers or recurrences. Male mortality has remained double that of females as is the case in England- in 2017-19 the number of Torbay deaths from oral cancer numbered 18 males and 9 females.

Fig 182: Mortality rate from oral cancer, all ages, per 100,000 (Age Standardised)
Source: Fingertips



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Children not seen by NHS dentist in last year (June 2022)	%	49%	53%	54%	53%	🟢	↓
Adults not seen by NHS dentist in last 2 years (June 2022)	%	59%	58%	64%	63%	🟢	↓
5 year olds with visually obvious tooth decay (2018/19)	%	28%	23%	20%	23%	🟡	↓
Hospital tooth extractions due to dental caries, aged 0 to 19 (2021/22)	Rate per 100,000	551	249	213	199	🔴	↑
Hospital tooth extractions due to dental caries, aged 18+ (2021/22)	Rate per 100,000	87	79	130	77	🟡	↑
Tooth extraction claims (NHS), aged 0 to 17 (2021/22)	Rate per 100,000	3,418	3,951	3,314	3,667	🟢	↑
Tooth extraction claims (NHS), aged 18+ (2021/22)	Rate per 100,000	4,963	5,058	3,607	4,057	🔴	↑
Oral cancer registrations (2017 - 19)	DSR per 100,000	17.9	Cannot calculate	15.6	15.4	🟡	↑
Mortality from oral cancer (2017 - 19)	DSR per 100,000	5.4	Cannot calculate	4.3	4.7	🟡	↓

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Mental Health

Overview

- Torbay has higher percentages of school pupils with social, emotional and mental health needs than the England average.
  Source: Fingertips
- Prevalence of depression and of mental illness (schizophrenia, bipolar affective disorder and other psychoses) of Torbay GP patients is higher than England.
  Source: Fingertips
- Rates of Torbay Adult Social Care clients with mental health as a primary support reason who are receiving long term support are significantly higher than England for both 18-64 year olds and those aged 65+.
  Source: Adult Social Care Activity & Finance Report
- Hospital admissions for self-harm remain significantly higher in Torbay. However, the overall rate of emergency admissions for all ages is on a reducing trend.
  Source: Fingertips
- Premature mortality of adults with severe mental illness is higher than in England.
  Source: Fingertips
- Torbay suicide rates have been significantly higher than in England for the last 6 periods (up to 2019-21), they are gradually reducing from the peak in 2016-18.
  Source: Fingertips

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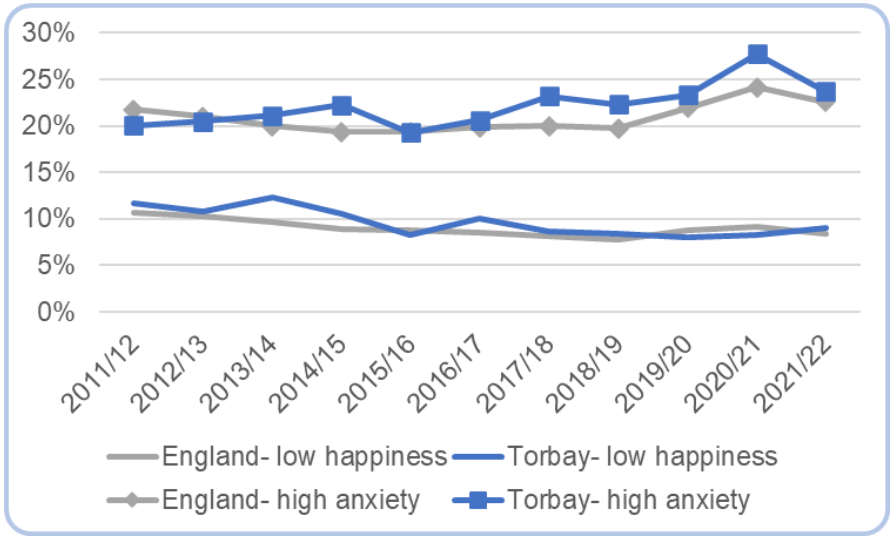
Wellbeing

In Torbay, the Annual Population Survey shows that 9% of people reported low happiness in 2021/22 (8.4% in England) (Fig 183). The Torbay figure has been between 8% and 9% for the last 5 years. The percentage reporting high anxiety peaked in 2020/21 in Torbay- COVID-19 very likely contributed to increasing anxiety levels- before dropping to 23.7% in 2021/22. Apart from 2020/21 Torbay has seen quite a level percentage of high anxiety from 2017/18 onwards.

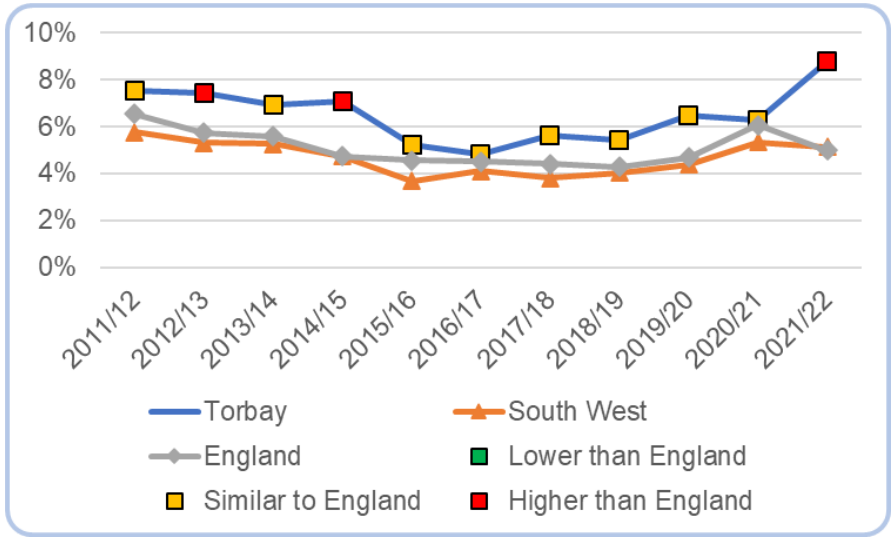
Fig 183: Percentage of people with low happiness and high anxiety scores, aged 16+
Source: Fingertips



The percentage of people in Torbay reporting low satisfaction has increased to 8.8% in 2021/22 which is the highest percentage in the 11 years shown (Fig 184).

In England, out of all age groups, low satisfaction is reported the most during the last 5 year period (up to 2021/22) in people aged 45-64 years.

Fig 184: Percentage of people with low satisfaction scores, aged 16+
Source: Fingertips



Children and young people

It is well known that a child's learning and development is affected by their mental health and wellbeing. Poor mental health in childhood can impact into adulthood and untreated mental health problems as a child can severely impact people throughout their lives.

Fig 185 shows the percentage of school children who have Special Educational Needs (SEN) with a primary need of social, emotional and mental health. Torbay is significantly higher than England throughout but has decreased and then levelled out over the last few years. Torbay is higher than England for both primary and secondary pupils with these needs.

Torbay is significantly higher than England in the percentage of both boys and girls with these needs in 2020/21 and 2021/22 (the 2 years reported by OHID). More than double the number of boys than girls identified with these needs in Torbay, the South West and England.

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Fig 185: Percentage of school pupils with social, emotional and mental health needs

Source: Fingertips

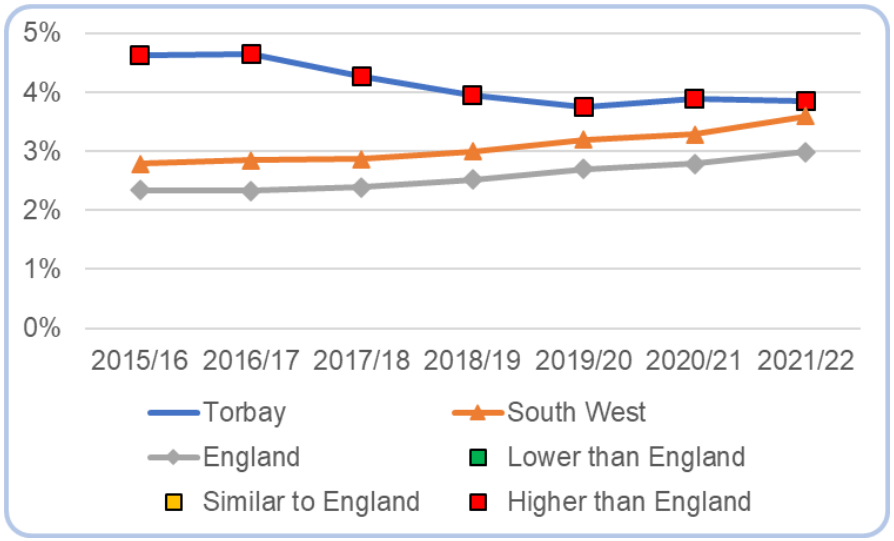
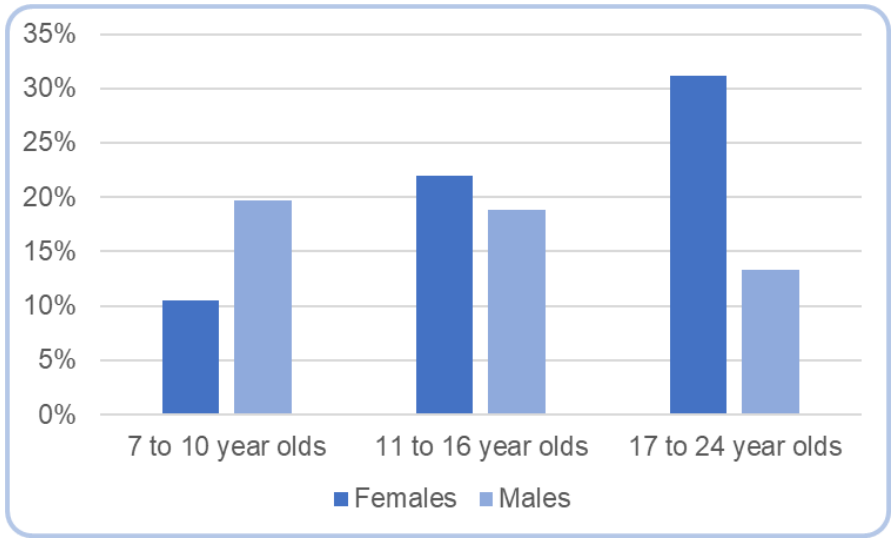


Fig 186: Percentage of children/young people with a probable mental disorder, England, 2022

Source: NHS Digital: Mental Health of Children and Young People in England, 2022, using the Strengths and Difficulties Questionnaire



The 2022 survey of the mental health of children and young people in England is the wave 3 follow up of a cohort of children and young people from 2017. Surveys took place in 2017, 2020, 2021 and 2022 with findings weighted to represent the English population of children and young people. Surveys were completed by parents and/or the children/young people depending on their age.

Rates of children aged 7-16 years with a probable mental disorder rose from 12.1% in 2017 to 16.7% in 2020 and stayed pretty stable after that at 17.8% in 2021 and 18.0% in 2022.

Looking at 7-24 year olds in 2022 (Fig 186), differences can be seen between age and sex. 19.7% of boys aged 7-10 have a probable mental disorder compared to 10.5% of girls- boys are significantly higher. Conversely, far more young women aged 17-24 than young men of this age have a probable mental disorder- 31.2% of young women and 13.3% of young men.

Mental health on GP registers

The prevalence of depression is the percentage of adult patients recorded on GP registers with a diagnosis of depression, allocated to the local authority of the practice. In Torbay, depression is on an increasing trend as in the South West and England (Fig 187). Torbay has been significantly higher than England from 2015/16 and in the 2nd highest quintile in England from 2016/17. In 2021/22 for Torbay the prevalence has levelled out.

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Fig 187: Percentage of depression on GP registers, aged 18+
Source: Fingertips

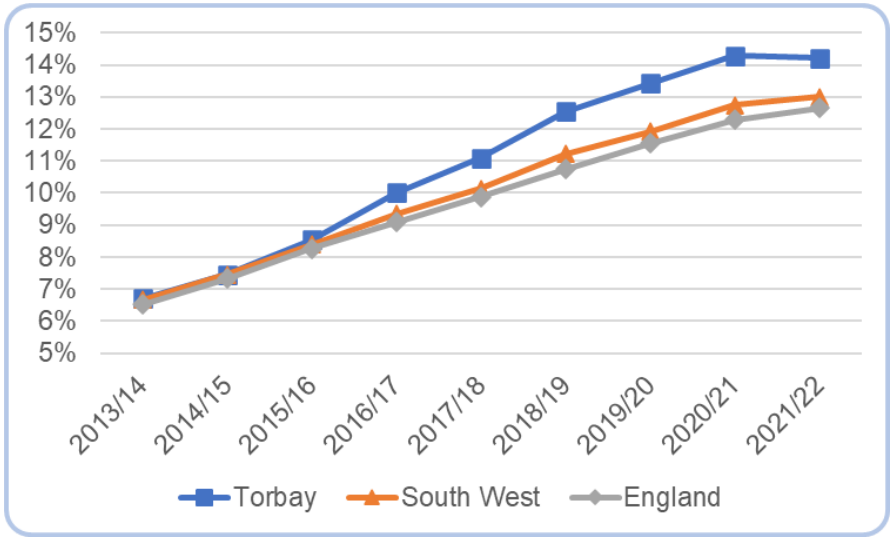
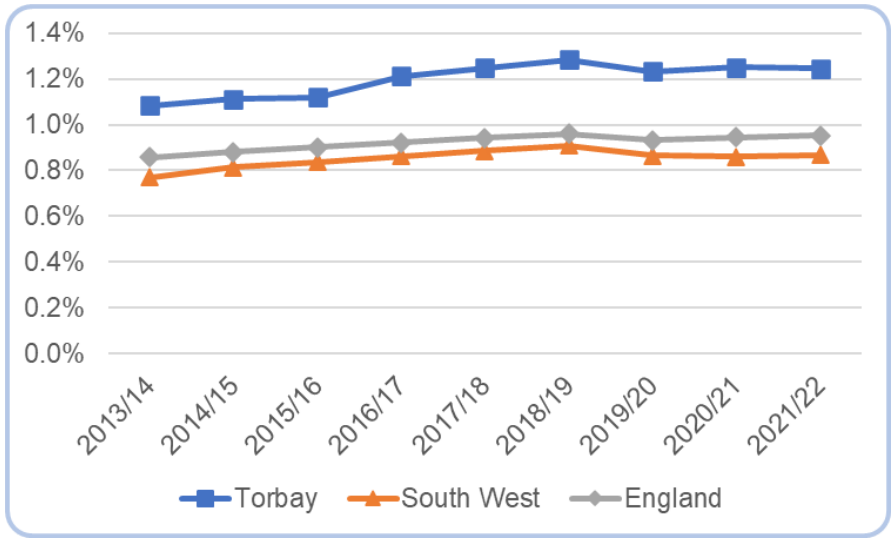


Fig 188: Percentage of schizophrenia, bipolar affective disorder and other psychoses on GP registers
Source: Fingertips



The percentage of patients on GP registers with schizophrenia, bipolar affective disorder and other psychoses is significantly higher in Torbay than the South West and England for the 9 years shown and Torbay is in the highest quintile in England (Fig 188). In 2021/22 the percentage is 1.25% of patients compared to 0.95% in England and Torbay has remained quite level for several years.

In England prevalence levels are generally much higher in more deprived areas than in less deprived areas.

Adult Social Care

Adult Social Care provides the help some people need to live as well as possible with illness or disability. Examples include help with washing, dressing, getting to work and being part of the community. Fig 189 shows clients aged 18-64 years who receive long term support and have a primary support reason of mental health. Torbay has significantly higher rates of 18-64 year olds than the South West and England for all the years shown. There are 318.4 per 100,000 receiving support during the year in Torbay compared to 138.3 in the South West and 152.1 in England in 2021/22. Torbay is on an increasing trend whereas England is decreasing.

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Fig 189: Rate of 18 to 64 year olds with a primary support reason of mental health receiving long term support from Adult Social Care during the year, per 100,000

Source: Source: Adult Social Care Activity & Finance Report

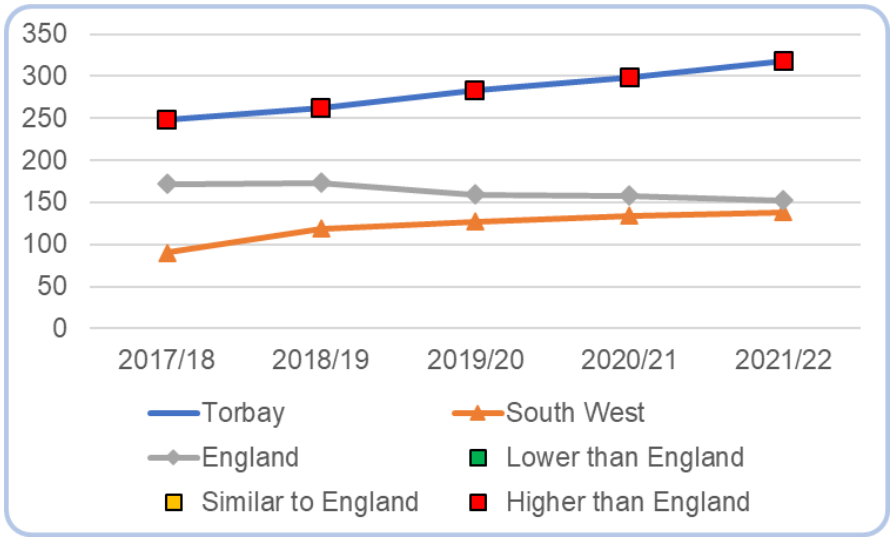
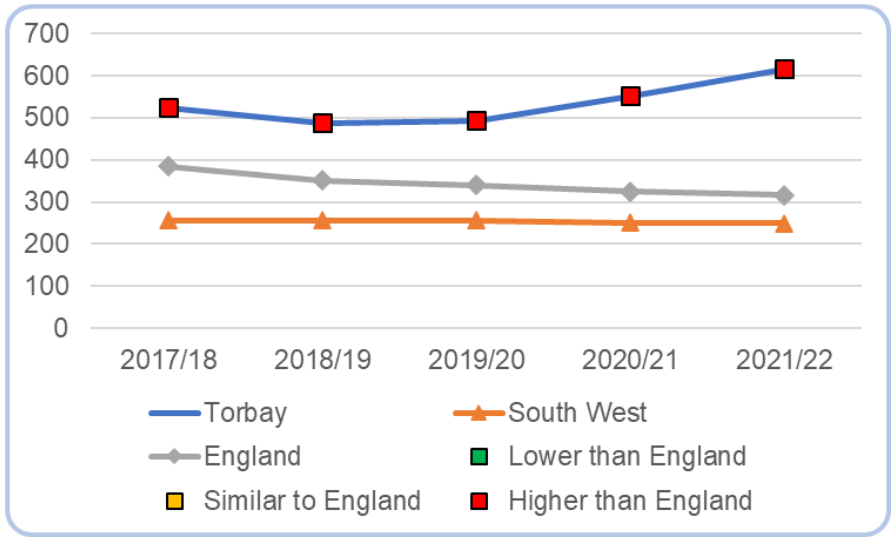


Fig 190: Rate of people aged 65+ with a primary support reason of mental health receiving long term support from Adult Social Care during the year, per 100,000

Source: Source: Adult Social Care Activity & Finance Report



As with 18-64 year olds, Torbay has significantly higher rates of people aged 65+ receiving long term support services who have a primary support reason of mental health (Fig 190). The rate has risen over the last few years while England is on a decreasing trend. Torbay has a rate of 616.2 per 100,000 receiving support during the year (250.0 in the South West and 316.2 in England).

Housing

Fig 191 below measures the percentage of adults aged 18-69 in contact with secondary mental health services who are living independently, with or without support. This means living in accommodation where they have security of tenure or appropriate stability of residence in the medium to long term or they are part of a household where the head holds security of tenure/residence. This definition does not include a hospital or care home. In Torbay in 2021/22, 18% are classed as living independently, with or without support, which is lower than the South West and England.

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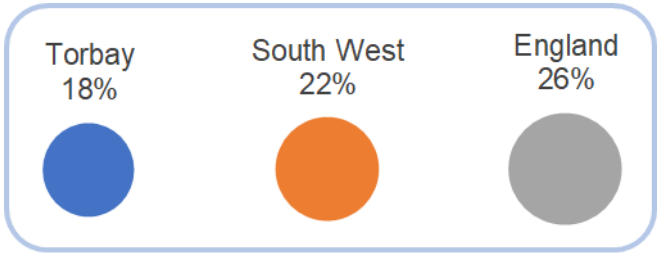
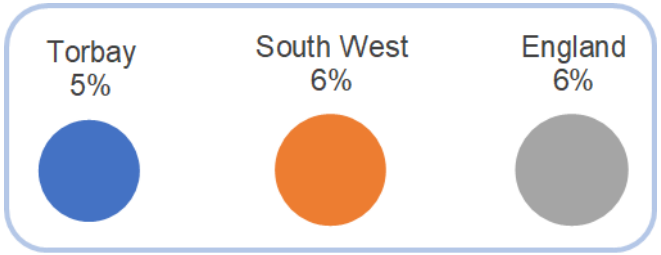
Fig 191: Percentage of adults in contact with secondary mental health services living independently, with or without support, aged 18 to 69 years, 2021/22
Source: Source: Adult Social Care Outcomes Framework, indicator 1H, (Mental Health Services Data Set)



Employment

The percentage of people in paid employment, out of adults aged 18-69 years who are in contact with secondary mental health services, is 5% in Torbay and 6% in both the South West and England in 2021/22 (Fig 192).

Fig 192: Percentage of adults in contact with secondary mental health services in paid employment, aged 18 to 69 years, 2021/22
Source: Source: Adult Social Care Outcomes Framework, indicator 1F, (Mental Health Services Data Set)



Self-harm

Self-harm in this section is defined as intentional self-injury or self-poisoning. Hospital admissions for self-harm are used as a proxy of the prevalence of severe self-harm and are only the tip of the iceberg in terms of self-harm taking place. The data is for admissions not individuals so will be influenced by people who are admitted more than once, sometimes several or many times.

Hospital admissions for self-harm are more prevalent in younger people. For 10-24 year olds (Fig 193) Torbay has fluctuated over the years but has remained far higher than England for at least the last 6 years. There are large differences between females and males, across England rates are consistently between 3 to 4 times higher for females than males. In Torbay, the number of admissions for females is almost 4 times higher than males over the 5 year period 2017/18 to 2021/22.

Fig 193: Rate of hospital admissions as a result of self-harm, aged 10 to 24, per 100,000 (Age standardised)
Source: Fingertips

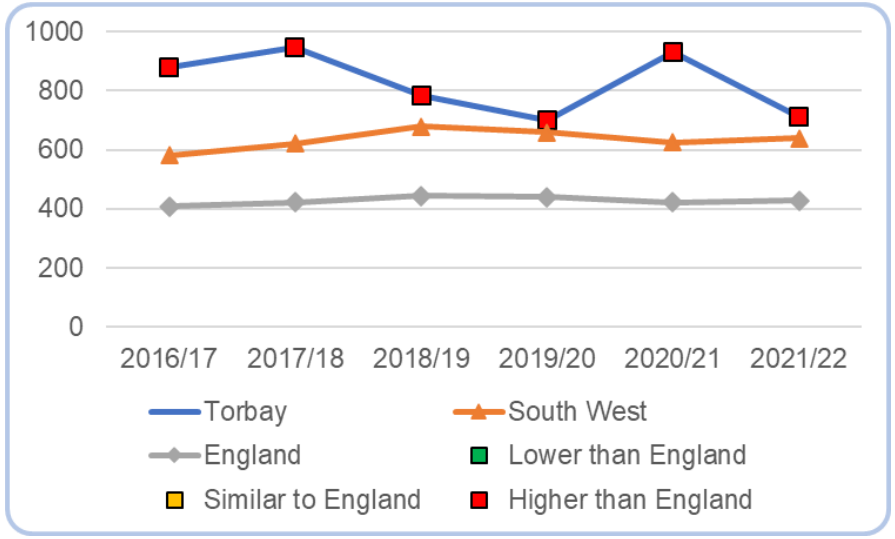


Fig 194 shows emergency hospital admissions for self-harm for all ages (approximately 99% of self-harm admissions are emergencies). Torbay is on a generally reducing trend over the 6 years shown but remains significantly higher than England throughout. In 2021/22, female rates are twice as high as for males in Torbay, the South

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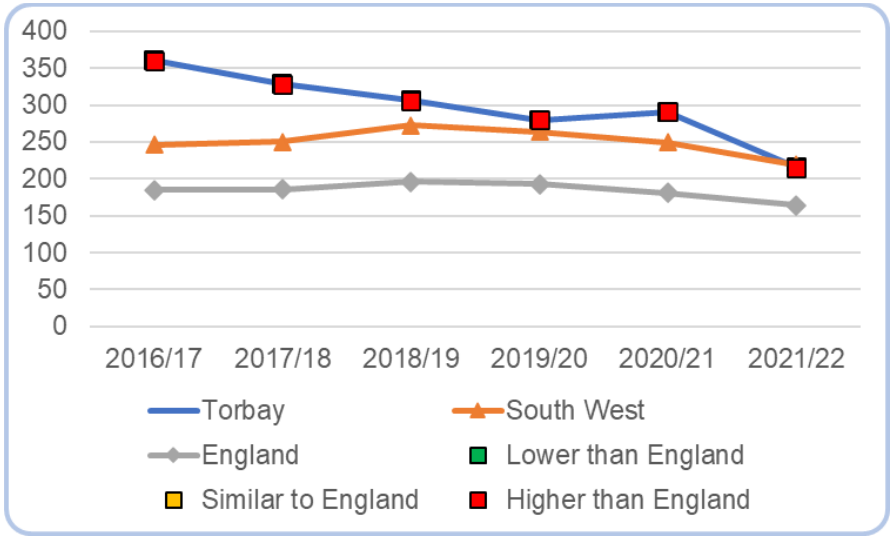
West and England, and Torbay rates for both females and males are significantly higher than the England figures. Over the years, female rates of self-harm admissions are much higher than for males.

Fig 194: Rate of emergency hospital admissions as a result of self-harm, all ages, per 100,000 (Age standardised)
Source: Fingertips

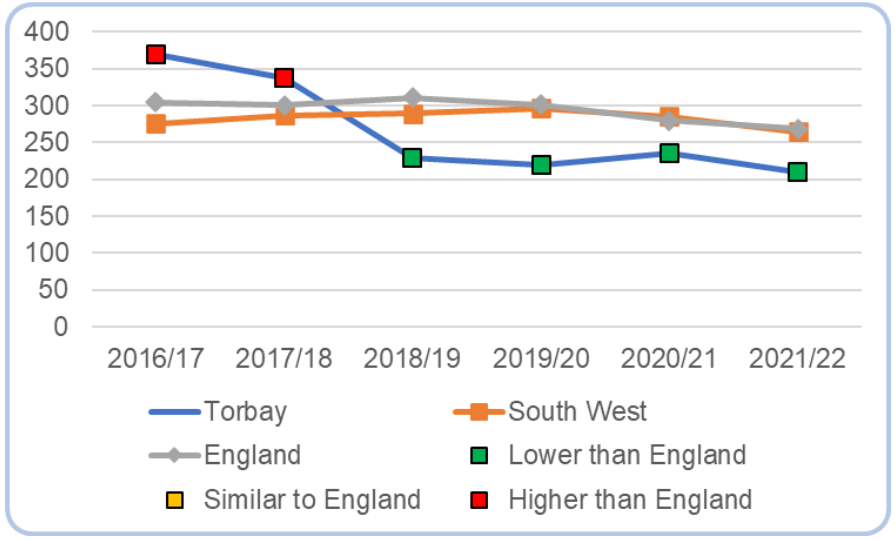


Mental health hospital admissions

Rates of hospital admissions for mental health disorders have been lower than the South West and England for 4 years (Fig 195). Torbay's lowest rate is in the most recent year, 2021/22, at 210.2 per 100,000 (268.5 in England).

These do not include admissions for self-harm. For the 6 years of Torbay's admissions combined, almost half are made up of 'Delirium, not induced by alcohol and other psychoactive substances' and 'Mental and behavioural disorders due to use of alcohol'.

Fig 195: Rate of hospital admissions for mental health conditions, all ages, per 100,000 (Age standardised)
Source: Hospital Episode Statistics



Premature mortality

Torbay has significantly higher rates of premature mortality in people with severe mental illness than the South West and England for the 4 periods shown. Torbay has a rate of 117.6 per 100,000 in 2018-20 compared to 103.6 in England (Fig 196). Rates are higher for men than for women.

This encompasses adults (aged 18-74 years) who have had a referral to secondary mental health services in the 5 years before they died. Access to services will therefore affect rates- areas where few access these services will have lower rates of premature mortality and areas where many access these services will have higher rates.

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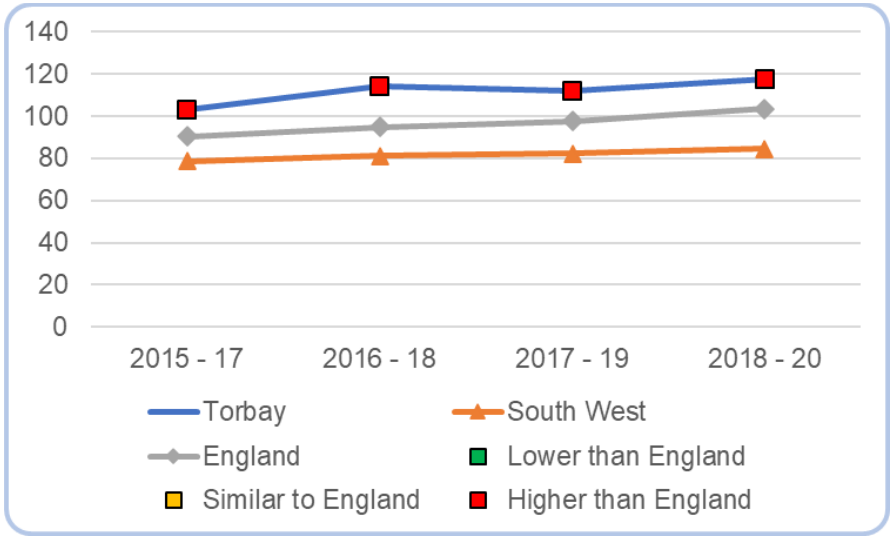
In England there is a stark difference when it comes to deprivation with rates becoming much higher as the level of deprivation increases.

Fig 196: Rate of premature mortality in adults with severe mental illness, aged 18 to 74, per 100,000 (Age standardised)
Source: Fingertips

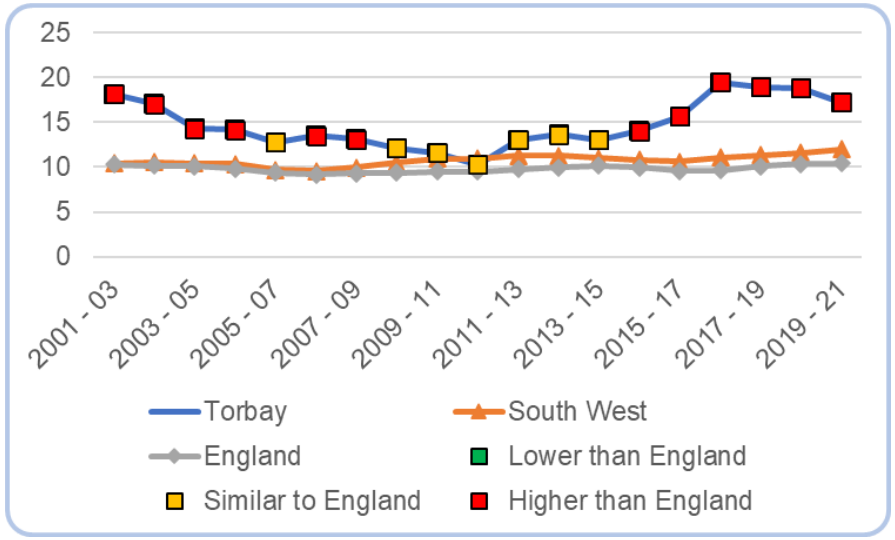


Suicide

Torbay's mortality rate from suicide (and injury of undetermined intent) remains significantly higher than England as it has for the last 6 periods. There were 17.2 suicides per 100,000 in 2019-21 (10.4 in England). This compares to 18.8 in the previous period so a slight reduction. Figures have been very gradually reducing for the last 3 periods since their peak in 2016-18 (Fig 197).

Male rates are far higher than for females in Torbay as in England. In 2019-21 (3 years combined) there were 58 suicides of Torbay residents- 42 males and 16 females.

Fig 197: Suicide rate per 100,000 (Age standardised)
Source: Fingertips



Documents that provide further information on mental health include the Torbay Suicide and Self-harm Prevention Plan 2022-2023, and at a national level- Wellbeing and mental health: Applying All Our Health, OHID, 2022

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Pupils with Social, Emotional & Mental Health Needs (2021/22)	%	3.8%	3.5%	3.6%	3.0%	🔴	↓
People with low satisfaction scores (2021/22)	%	8.8%	6.0%	5.1%	5.0%	🔴	↑
Depression Prevalence (2021/22)	%	14.2%	14.9%	13.0%	12.7%	🔴	↓
Primary support reason of mental health receiving long-term care, aged 18 to 64 (2021/22)	Rate per 100,000	318	170	138	152	🔴	↑
Primary support reason of mental health receiving long-term care, aged 65+ (2021/22)	Rate per 100,000	616	399	250	316	🔴	↑
Hospital admissions as a result of self-harm, aged 10 to 24 (2021/22)	DSR per 100,000	711	503	640	427	🔴	↓
Hospital admissions for mental health conditions (2021/22)	DSR per 100,000	210	314	265	268	🟢	↓
Premature mortality in adults with severe mental illness (2018 - 20)	DSR per 100,000	118	119	85	104	🔴	↑
Suicide rate (2019-21)	DSR per 100,000	17.2	12.0	12.0	10.4	🔴	↓

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Older People

Overview

- 65 and over population has risen in Torbay by 21% (just over 6,300 people) between the 2011 and 2021 Census.

  Source: Census

- 65 and over share of Torbay population projected to rise from 27% in 2021 to 34% by 2043.

  Source: NOMIS

- Healthy life expectancy of 11 years for the 65 and over population in Torbay is in line with England.

  Source: Fingertips

- Level of pension credit claimants higher in Torbay than England.

  Source: Stat-Xplore

- Hospital admissions for falls in those aged 65 and over are generally lower than England.

  Source: Fingertips, Hospital Episode Statistics

- Those aged 65 and over receiving long-term support through permanent admission to residential homes rose significantly during 2021/22.

  Source: Adult Social Care Activity & Finance Report

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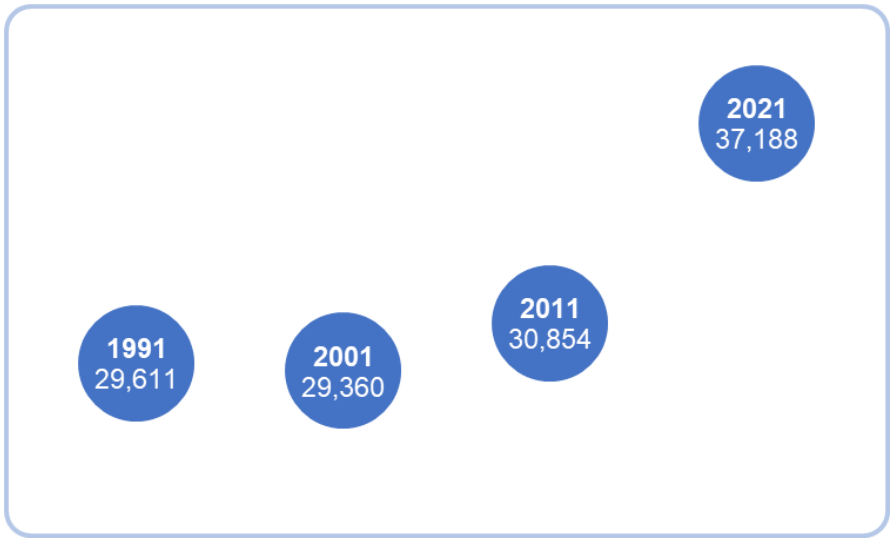
Population

The 2021 Census confirmed that an increasing number of Torbay's population are aged 65 and over. 37,188 Torbay residents were aged 65 and over which equates to 26.7% of the population, this is a significant rise from the 2011 Census figure of 30,854 which equated to 23.6% of the population (Fig 198).

Fig 198: Torbay Census population aged 65 and over
Source: Census



The 65 and older population was not evenly spread across Torbay. The proportion of those aged 65 and over was more than twice as high in wards such as Wellswood and Churston with Galmpton when compared to King's Ash and Ellacombe (Fig 199).

Torbay's population is currently projected to rise from 139,322 in the 2021 Census to 153,088 by 2043. It should be noted that projections are likely to be updated over the next year in light of the 2021 Census. The proportion of those aged 65 and over is expected to rise from 27% in the 2021 Census to 34% by 2043 (Fig 200).

Fig 199: Torbay Census population aged 65 and over by ward (2021)
Source: Census 2021

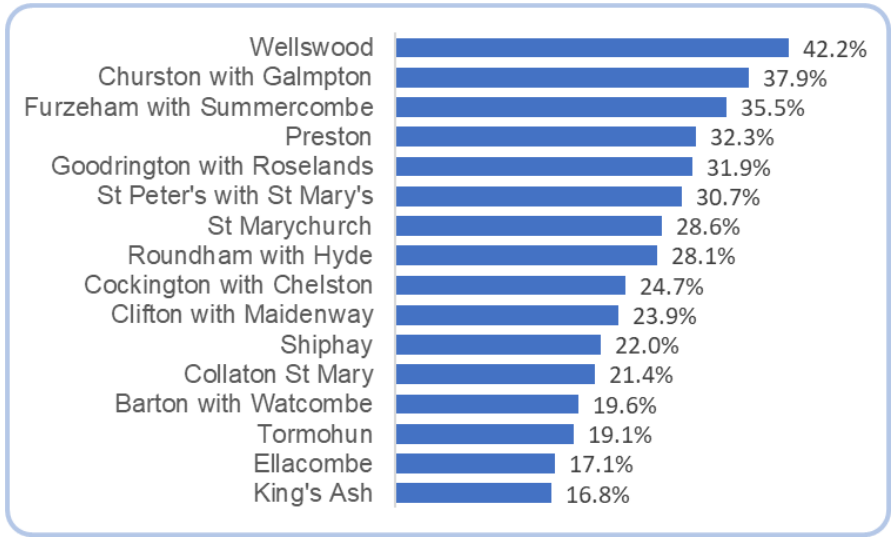
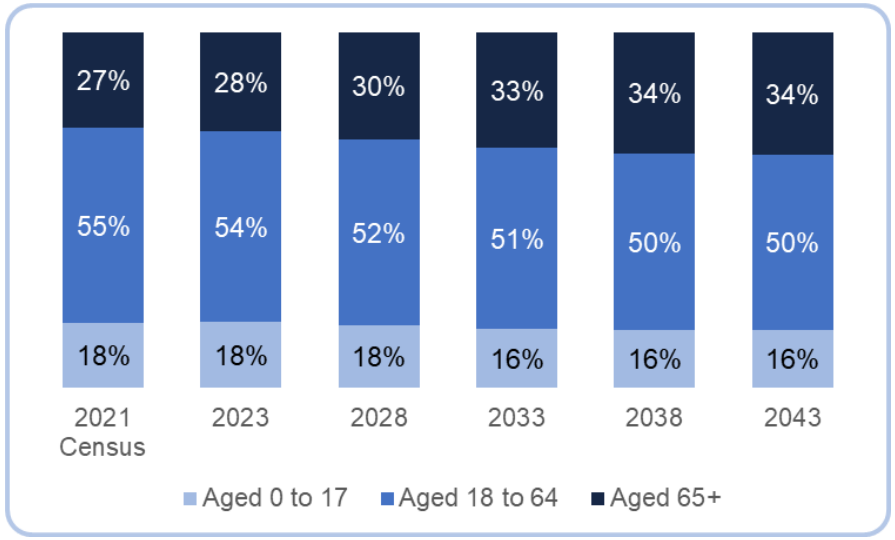


Fig 200: Population projections – Torbay
Source: NOMIS



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Life expectancy

Life expectancy and healthy life expectancy are important measures of mortality and ill health showing the trends in different sections of the community. Whilst life expectancy is an important measure, there is also the amount of someone's life that they spend in a healthy condition and the importance of that to their wellbeing. Significant advances in medicine may keep someone alive for longer but the quality of life enjoyed may be relatively poor.

Life expectancy at 65 has been broadly in line with England among females in Torbay whose life expectancy has consistently been 21 years at age 65 (Fig 201), for males it is broadly in line with England but for the latest period it was significantly higher than England at 19 years life expectancy at age 65 (Fig 202). Those aged 65 and over in the most deprived areas of Torbay have life expectancies of approximately 2 to 3 years less than those who live in the least deprived areas, it should be noted that people in residential care may reside in areas that are very different in relation to deprivation than their lives before entering care.

Healthy life expectancy shows the years that a person can expect to live in good health. For females and males in Torbay over the last decade this has averaged 11 more years of good health at age 65. Data is provided by levels of deprivation across England, there are very substantial differences between those living in the most deprived areas when compared to the least deprived. Those in the least deprived areas can expect to have a healthy life expectancy at age 65 double that of the most deprived (Fig 203).

Fig 201: Life expectancy at age 65 – Female

Source: Fingertips

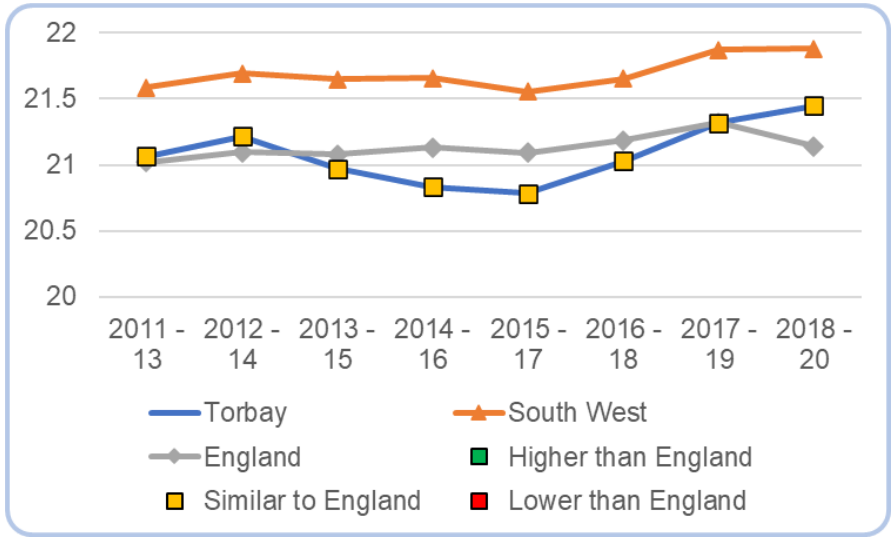

Fig 202: Life expectancy at age 65 – Male

Source: Fingertips

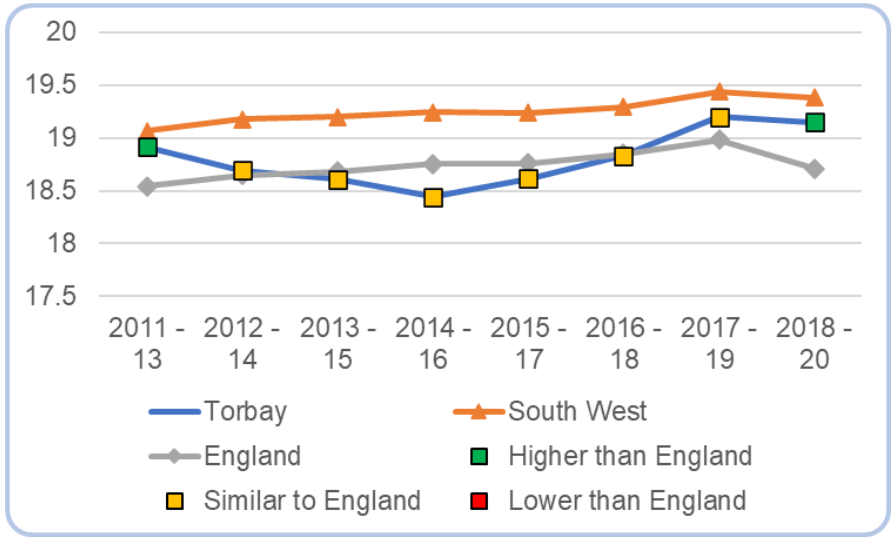

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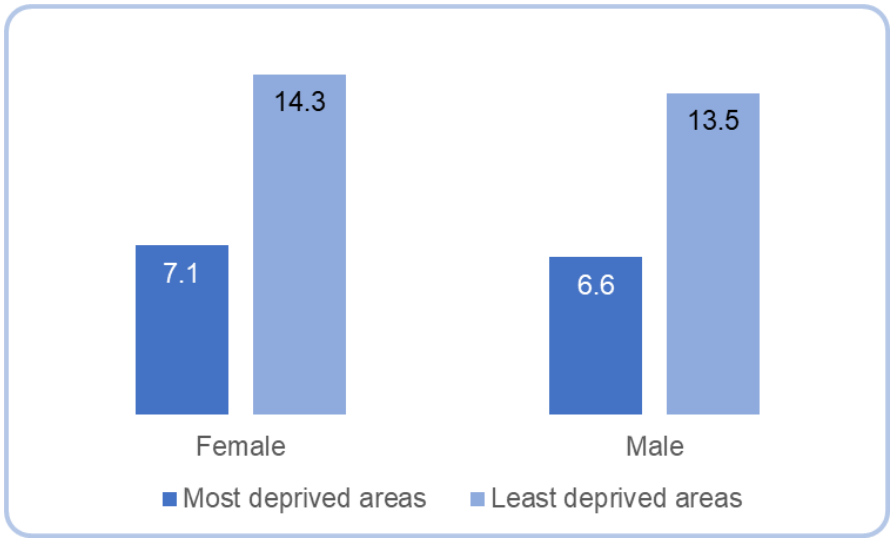
Fig 203: Healthy life expectancy at age 65 by most and least deprived areas – England
Source: Fingertips



Wellbeing and social contact

The Active Lives Survey asks a number of questions to adults around issues such as life satisfaction, happiness, finding things worthwhile, anxiety and loneliness (Fig 204). They were then asked to give a score of out 10 related to these issues. Those aged 65 to 84 scored better than all other ages across all 5 sectors although it should be noted that along with other age groups, average scores given have fallen over the 3 survey periods used (September to November 2019, September to November 2020, September to November 2021). For those aged 85 and over, the sample size was smaller but life satisfaction, happiness and finding things worthwhile scored poorly. Anxiety scored well and loneliness was lower than among young people. As a comparison, figures for those aged 16 to 44 are also given (Fig 205).

Fig 204: Active Lives Survey score for those aged 65 and over (September to November 2021) - England
Source: Active Lives Survey

	65 to 74	75 to 84	85+
How satisfied are you with life nowadays	7.38	7.45	6.83
How happy did you feel yesterday	7.46	7.61	6.88
To what extent are the things you do in your life worthwhile	7.60	7.70	7.10
How anxious did you feel yesterday (Low score is good)	2.77	2.75	2.97
Are you lonely often or always	2.73%	3.19%	6.82%

Fig 205: Active Lives Survey score for those aged 16 to 44 (September to November 2021) - England
Source: Active Lives Survey

	16 to 24	25 to 34	35 to 44
How satisfied are you with life nowadays	6.65	6.66	6.86
How happy did you feel yesterday	6.50	6.69	6.76
To what extent are the things you do in your life worthwhile	6.62	6.80	6.94
How anxious did you feel yesterday (Low score is good)	4.45	4.30	3.84
Are you lonely often or always	10.96%	9.12%	6.83%

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For 2021/22, the number of carers supported by Torbay Council during the year was 1,430, this was the highest number in the last 5 years. 2021/22 was the first time since 2018/19 that carers reported whether they had as much social contact as they would like in the Adult Social Care Activity & Finance Report. For Torbay, 33% of carers aged 65 and over stated that they had as much social contact as they would like which was broadly in line with the last survey in 2018/19, but this has fallen considerably nationwide since 2014/15. Rates were higher than the England rate of 29% and South West rate of 26% in 2021/22 (Fig 206). Please note that for 2014/15, calculations were not available to show whether Torbay was in line with England.

Adult Social Care users aged 65 and over were also asked if they had as much social contact as they would like. For Torbay, 35% said Yes, this was significantly down on figures in 2018/19 and 2019/20 when rates 47% and 52% respectively. Rates were broadly in line with England and the South West (Fig 207). Very few authorities collected figures for the 2020/21 return so that year has been removed from the graph.

Fig 206: Percentage of adult social care carers aged 65 and over who have as much social contact as they would like
Source: Adult Social Care Activity & Finance Report

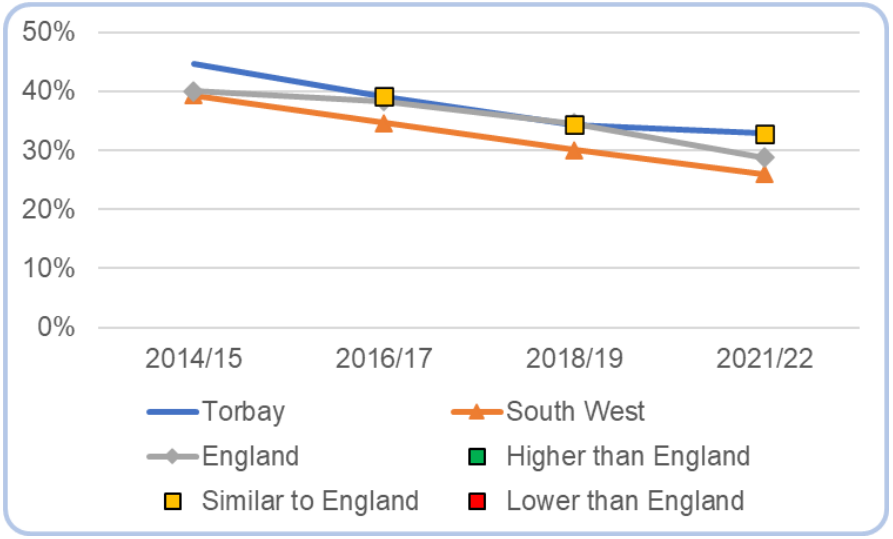
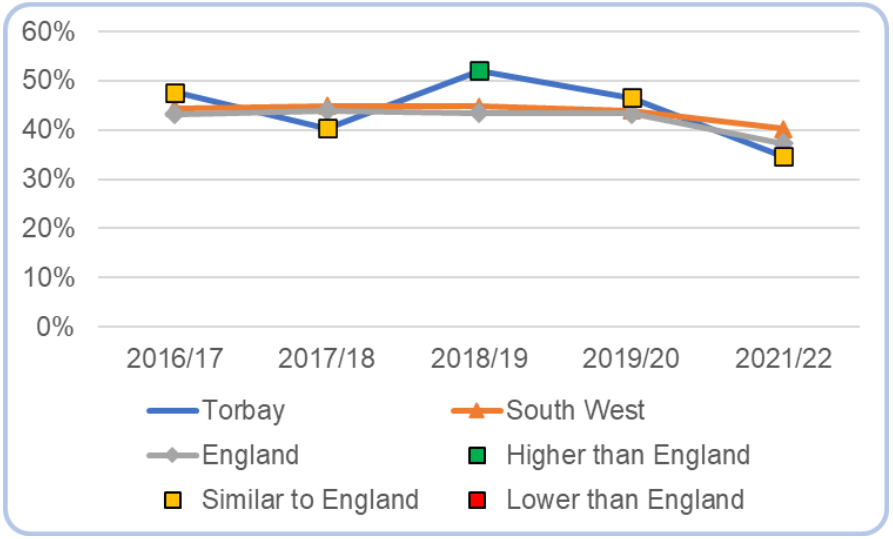


Fig 207: Percentage of adult social care users aged 65 and over who have as much social contact as they would like (No data for 2020/21)
Source: Adult Social Care Activity & Finance Report



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Pension Credit

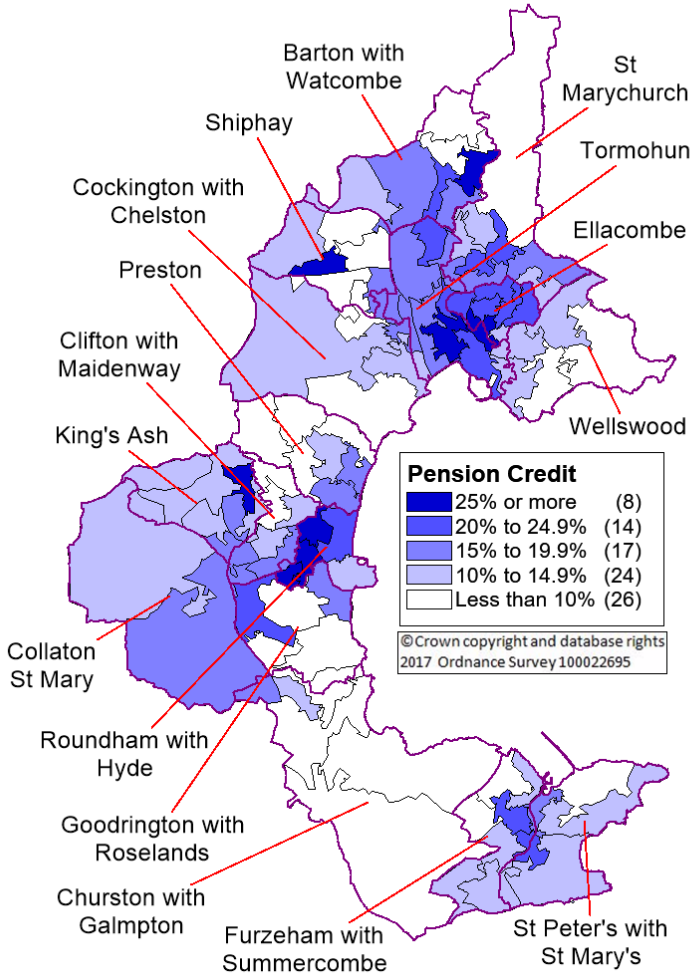
Pension Credit is there to help with living costs if you are over the State Pension age and on a low income. The level of pension credit claimants has been significantly higher in Torbay than England and the South West. The proportion of the 65+ population claiming pension credit in May 2022 was 13% in Torbay compared to 11% in England and 9% across the South West. It is thought that a significant number of pensioners who are eligible for pension credit have not claimed it. The highest percentage rates of pensioners receiving pension credit are in central Torquay and Paignton (Fig 208).

Homelessness

Homelessness can affect people of any age as their circumstances change. During 2021/22, 63 households where the main applicant was aged 65 or over were owed a homelessness prevention duty (threatened with homelessness within 56 days) or a homelessness relief duty (because they were already homeless) in Torbay. This equated to 5.8% of claims and was significantly higher than the England average of 3.6% although it should be noted that Torbay has a significantly higher population of people aged 65 and over. This was a rise from 44 households in 2019/20. Since 2018/19 rates have been consistently higher across the South West when compared to England.

Fig 208: Percentage of those aged 65 and over in receipt of pension credit (August 2021 to May 2022)

Source: Stat-Xplore



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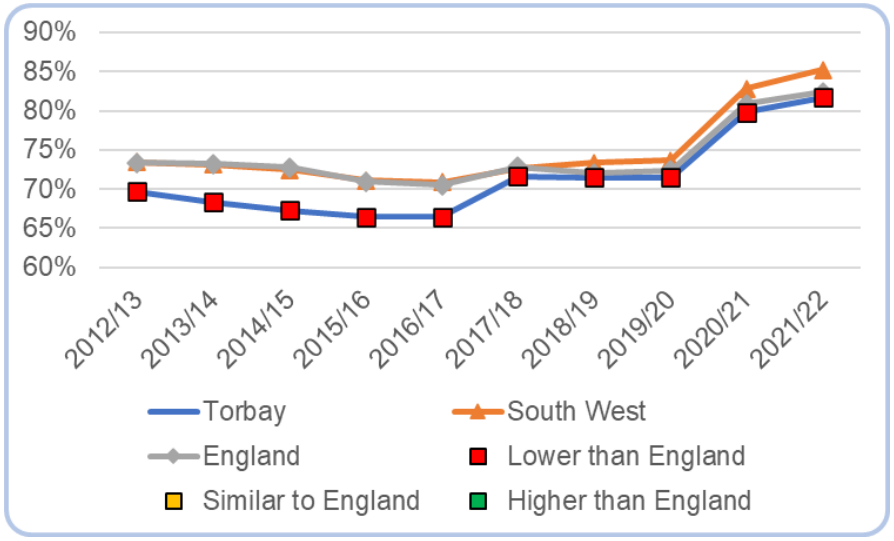
Health and Care

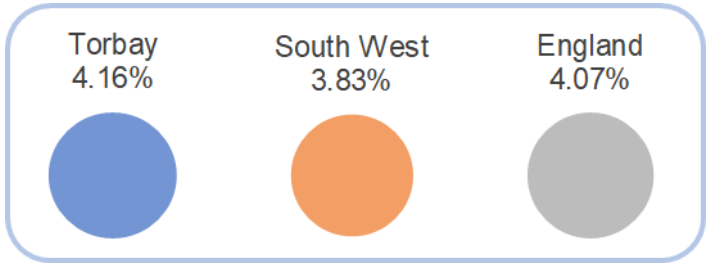
Flu vaccination rates amongst those aged 65 and over have consistently been lower than the South West and England although the gap has closed considerably in recent years, the latest period had a gap of less than 1% between Torbay and England (Fig 209). The World Health Organisation (WHO) target is 75% coverage although the national ambition for 2021 to 2022 was to reach 85% coverage. For the last 2 years, the WHO target was reached but not the 85% national ambition.

Fig 209: Percentage of those aged 65 and over who have received a flu vaccination
Source: Fingertips



Dementia rates for those aged 65 and over are recorded by GP practices, prevalence rates within Torbay are largely in line with national and regional rates at approximately 4% (Fig 210). It should be noted that these are cases where dementia has been diagnosed, the figure of 4% will be an underestimate. As the population ages, these numbers are likely to rise from the current level of 1,553 (December 2021) requiring an increase in the scale of services needed to provide treatment and support.

Fig 210: Recorded prevalence of Dementia for those aged 65 and over (December 2021)
Source: NHS Digital Recorded Dementia Diagnoses



Falls are the largest cause of emergency hospital admissions for older people, it is estimated that about 30% of people older than 65 and 50% of people older than 80 fall at least once a year (Falls in older people: assessing risk and prevention – NICE, 2013). Within Torbay, emergency hospital admissions due to falls for those aged 65 and over have been significantly lower than England in 3 of the last 4 years (Fig 211). These rates are age standardised to allow areas with significantly different age profiles to be compared. Further information on falls can be found at falls-2021.pdf (southdevonandtorbay.info)

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Fig 211: Emergency hospital admissions due to falls in people aged 65 and over, per 100,000 (Age Standardised)
Source: Fingertips, Hospital Episode Statistics for 2021/22

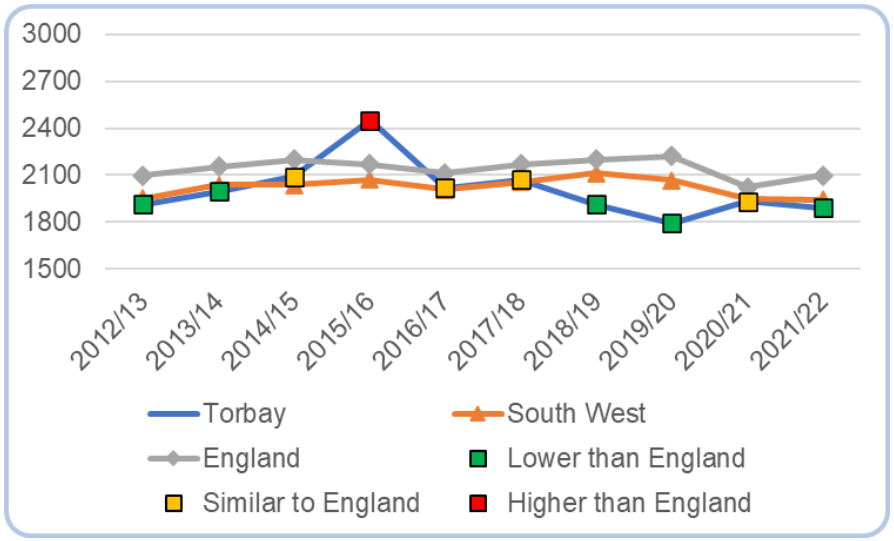
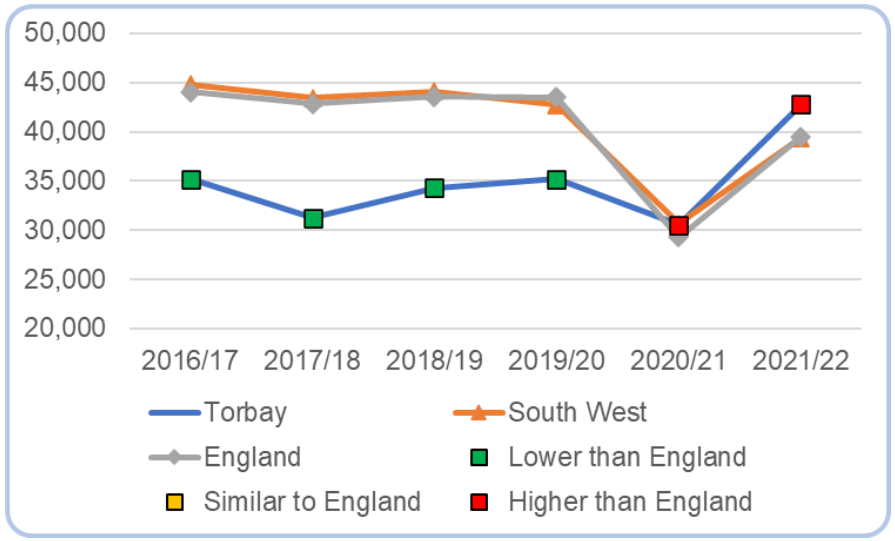


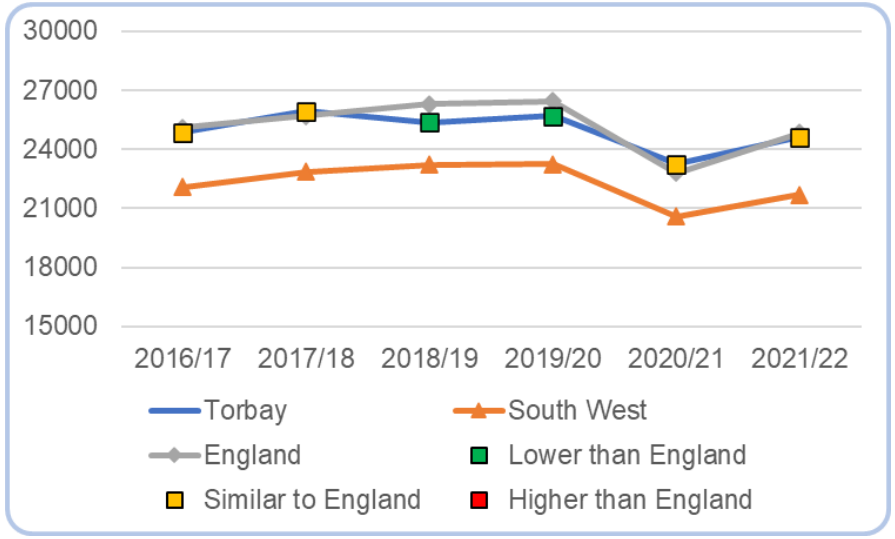
Fig 212: Planned admissions to hospital for those aged 65 and over, per 100,000 (Age Standardised)
Source: Hospital Episode Statistics



For planned admissions amongst those aged 65 and over, Torbay has consistently been significantly lower than the England average until the last 2 years when planned admission numbers have been affected by the COVID-19 pandemic (Fig 212).

For unplanned admissions amongst those aged 65 and over, Torbay's rate has fallen over the last 2 years as have the South West and England (Fig 213). Rates tend to be broadly in line with England but above the South West. These rates are age standardised to allow areas with significantly different age profiles to be compared.

Fig 213: Unplanned admissions to hospital for those aged 65 and over, per 100,000 (Age Standardised)
Source: Hospital Episode Statistics



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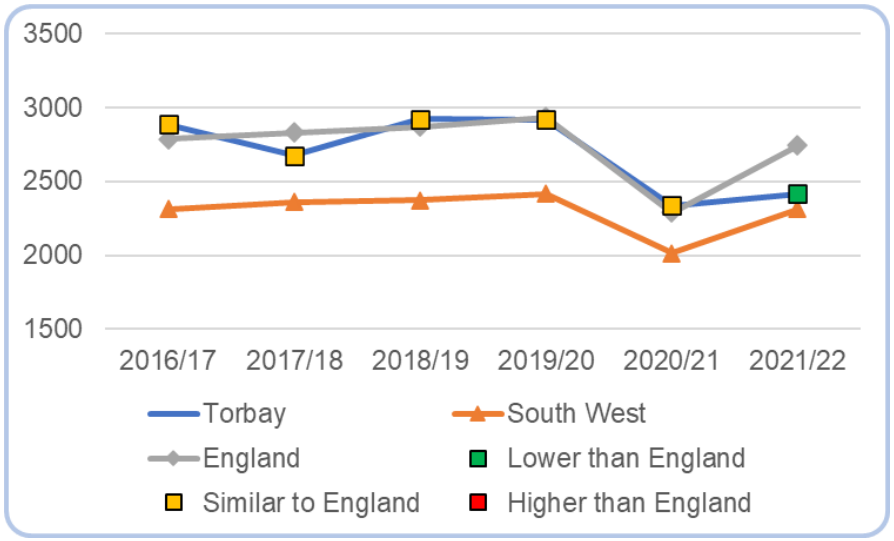
Ambulatory care sensitive (ACS) conditions are conditions where hospital admissions may be prevented by interventions in primary care. Common types of ACS conditions are Influenza, Diabetes complications, COPD and Asthma.

The rate of admissions for ACS conditions for those aged 65 and over were broadly in line with England until 2021/22 but above the South West. For 2021/22, rates were significantly below England and broadly in line with the South West (Fig 214). As with all hospital admissions, COVID-19 could have led to short-term deviations from long-term trends so a one-off deviation should be treated with caution. These rates are age standardised to allow areas with significantly different age profiles to be compared.

Fig 214: Emergency hospital admissions for ACS conditions for those aged 65 and over, per 100,000 (Age Standardised)
Source: Hospital Episode Statistics



Rates of long-term support for those funded by Torbay Adult Social Care are broadly similar for those aged 65+ when compared to the England average over the last 5 years (Fig 215). Rates are significantly higher than the South West. Within this, there are significant variations from England in some areas, those aged 65+ with a primary support reason of Learning Disability and Mental Health had much higher rates in Torbay whilst those with a primary support reason of Memory & Cognition had significantly lower rates than England.

For rates of long-term support being met by permanent admission to residential and care homes for those aged 65 and over, Torbay had broadly lower rates than England until 2021/22 (Fig 216). For 2021/22, 287 older people were permanently admitted, this is more than 100 above the average of the previous 4 years.

Fig 215: Rate of long-term support for those aged 65+, per 100,000
Source: Adult Social Care Activity & Finance Report

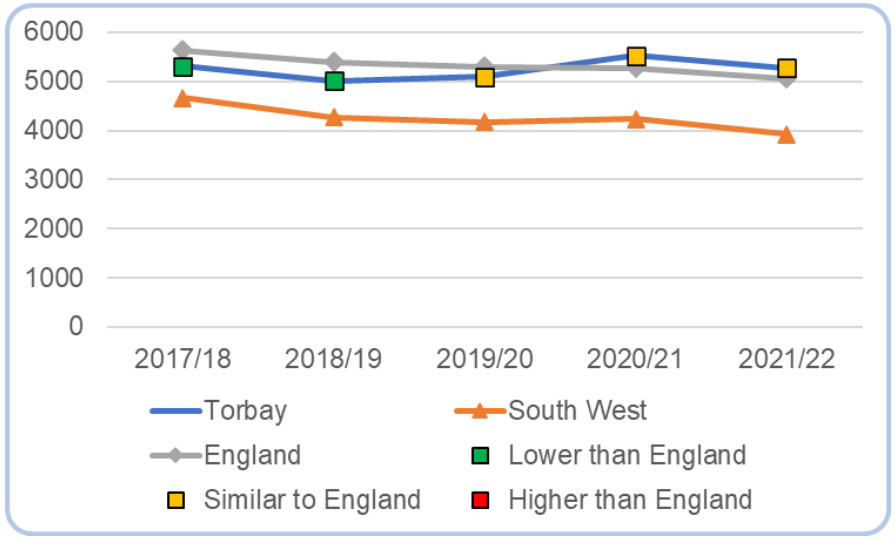


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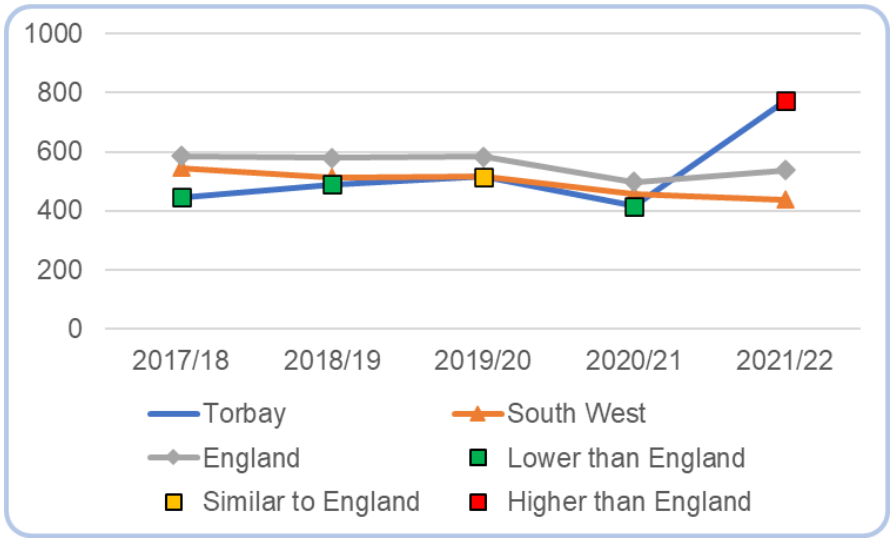
Fig 216: Rate of long-term support met by permanent admission to residential & nursing care homes aged 65+, per 100,000
Source: Adult Social Care Activity & Finance Report



Whilst this section brought together key information around Torbay's 65 and over population, information that is also relevant to older people is contained within the majority of sections within the JSNA.

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Life expectancy at age 65 - Female (2018 - 20)	Years	21.5	20.7	21.9	21.1	🟡	↑
Life expectancy at age 65 - Male (2018 - 20)	Years	19.2	18.4	19.4	18.7	🟢	↓
Healthy life expectancy at age 65 - Female (2018 - 20)	Years	11.4	11.0	12.5	11.3	🟡	↓
Healthy life expectancy at age 65 - Male (2018 - 20)	Years	10.9	10.4	11.6	10.5	🟡	↓
Pension Credit claimants (May 2022)	%	13.0%	11.7%	8.8%	11.1%	🔴	↓
Flu vaccination coverage - 65+ (2021/22)	%	81.7%	83.0%	85.3%	82.3%	🔴	↑
Prevalence of Dementia - 65+ (Dec 2021)	%	4.2%	4.1%	3.8%	4.1%	🟡	↑
Emergency admissions due to falls - 65+ (2021/22)	DSR per 100,000	1891	2287	1943	2100	🟢	↓
Long term support - 65+ (2021/22)	Rate per 100,000	5278	5562	3917	5054	🟡	↓

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Unpaid Carers

Overview

- The 2021 Census showed just over 14,900 unpaid carers in Torbay, this equates to 1 in 9 of the population aged over 5 years old. Of these carers, 5,185 provided 50 hours or more of unpaid care.

  Source: Census 2021

- Rates of unpaid care are higher in Torbay than England across all age groups in the census. 13.5% of females are unpaid carers, 9.0% of males are unpaid carers.

  Source: Census 2021

- Almost 1 in 6 (15.9%) people classified as disabled under the Equality Act are unpaid carers according to the census.

  Source: Census 2021

- Adult carers known to local social services were most likely to look after people with a physical disability, long-standing illness or problems connected to ageing.

  Source: Personal Social Services Survey of Adult Carers, 2021/22

- Almost 1 in 2 (46%) adult carers known to local social services care for 100 hours or more per week.

  Source: Personal Social Services Survey of Adult Carers, 2021/22

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An unpaid carer provides help to someone, usually an adult relative or friend, as part of their normal daily life. The 2021 Census asked if someone gave any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age, people were asked to exclude anything related to paid employment.

Carers need support and the Care Act 2014 recognises unpaid (mainly) adult carers in law in the same way as those they care for. This relates to rights to a carers assessment of support needs, support planning, and access to information and advice to enable choice about the support they need.

Census 2021 – Unpaid carers

According to the 2021 Census, Torbay had just over 14,900 unpaid carers which results in Torbay having a significantly higher proportion of its residents as unpaid carers when compared to the South West and England (Fig 217). The difference is significant even allowing for Torbay's older population profile. This shows that 1 in 9 Torbay residents over the age of 5 years undertake some unpaid care in relation to long-term physical or mental health conditions or illnesses, or problems related to old age. Torbay also has a significantly higher proportion of its residents who provide 50 hours or more of unpaid care per week (3.9% in Torbay against 2.6% for England). This equates to 5,185 carers which is just over a third of the unpaid carer population.

There are significant differences in the percentage of different age groups who are unpaid carers with almost 2 out of 3 unpaid carers being aged 50 and over (Fig 218). However, the percentage of Torbay's population who are unpaid carers is significantly higher than England across all age groups with gaps being particularly pronounced amongst age groups under the age of 50 (Fig 219).

Fig 217: Percentage of unpaid carers, aged 5 and over
Source: Census 2021

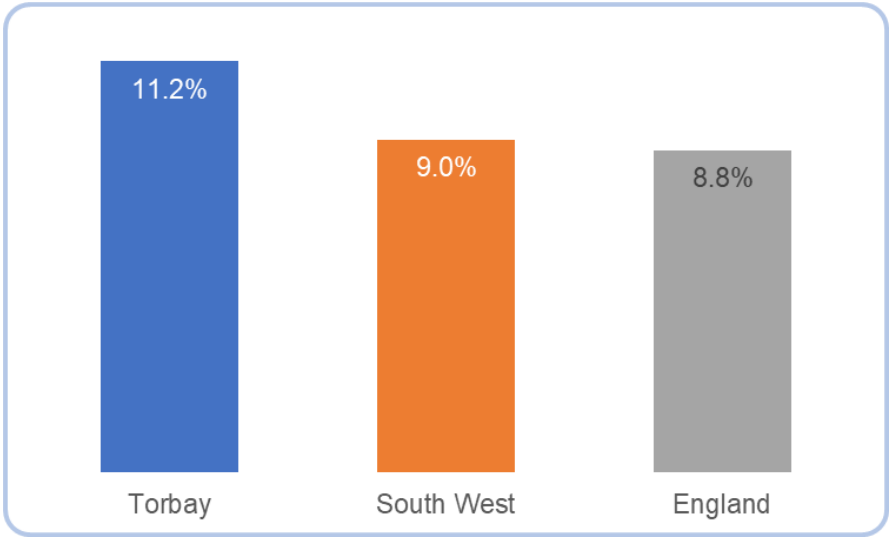

Fig 218: Unpaid carers by age group - Torbay
Source: Census 2021

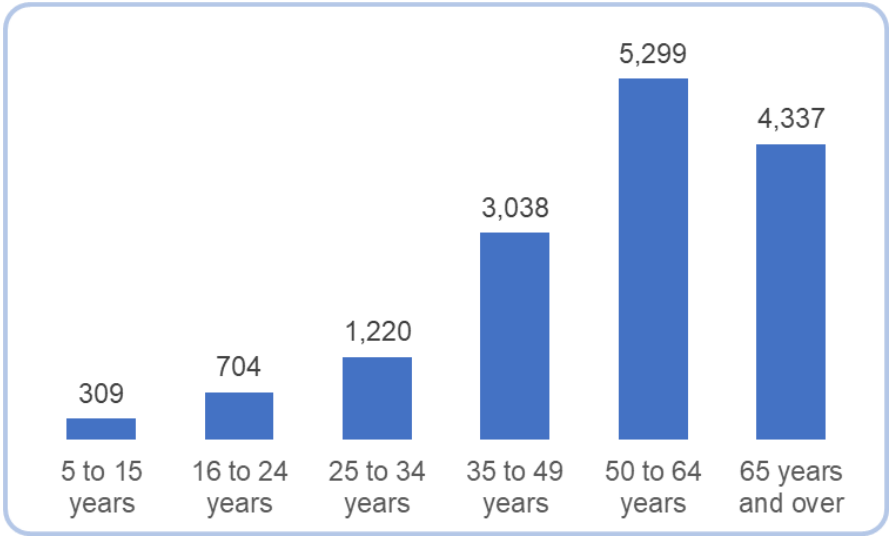

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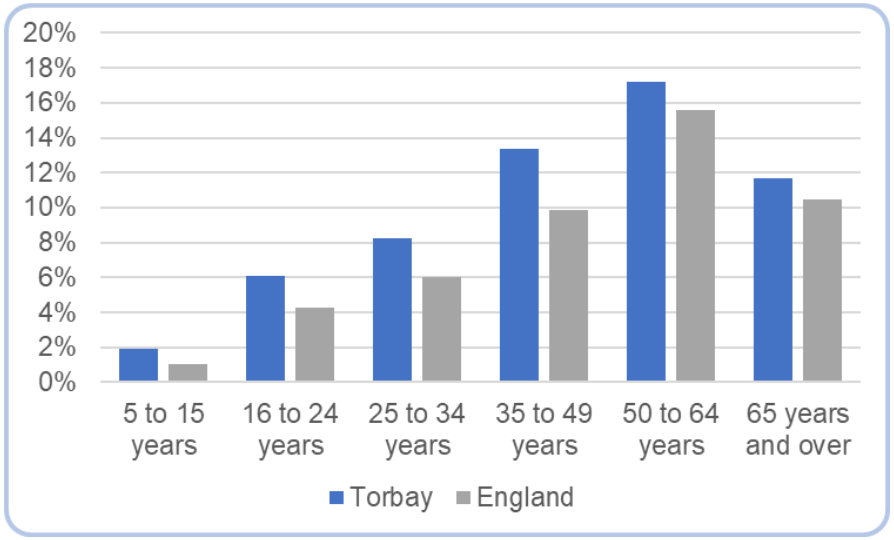
Fig 219: Percentage of unpaid carers by age group
Source: Census 2021

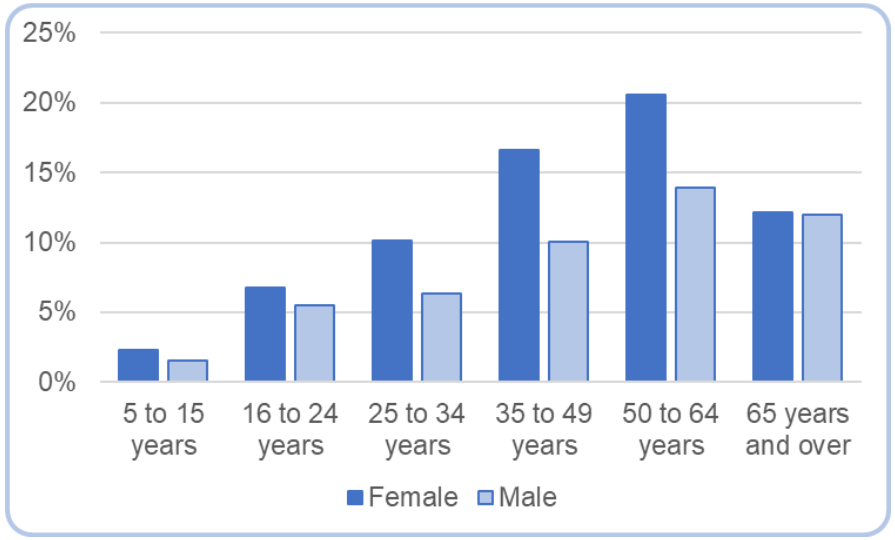


Unpaid carers are significantly more likely to be female with 13.0% of usually resident females providing unpaid care in Torbay, for males the rate is 9.5% (Fig 220). The difference is most significant in the 35 to 49 year age group where 1 in 6 females and 1 in 10 males undertake some unpaid care in relation to long-term physical or mental health conditions or illnesses, or problems related to old age (Fig 221). Just over 1 in 5 females aged between 50 and 64 years undertake some unpaid care.

Fig 220: Percentage of unpaid carers, by sex - Torbay
Source: Census 2021

	19 hours or less	20 to 49 hours	50 hours or more	Total
Female	5.7%	2.8%	4.6%	**13.0%**
Male	4.2%	2.1%	3.3%	**9.5%**

Fig 221: Percentage of unpaid carers, by age group, by sex - Torbay
Source: Census 2021



There are significant differences between areas of Torbay in relation to the number of usually resident unpaid carers. For instance, rates are lowest in the Torquay town centre area (Fig 222).

Data is also available by geographical areas known as output areas, these are very small geographical areas which contain approximately 300 people. This gives a very detailed breakdown of the particular geographical areas of Torbay, it should be noted that because of the small population numbers involved, this data can be volatile (Fig 223).

There are higher concentrations of unpaid carers in wards such as King's Ash and Furzeham with Summercombe (Fig 224).

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Fig 222: Percentage of unpaid carers, by area
Source: Census 2021

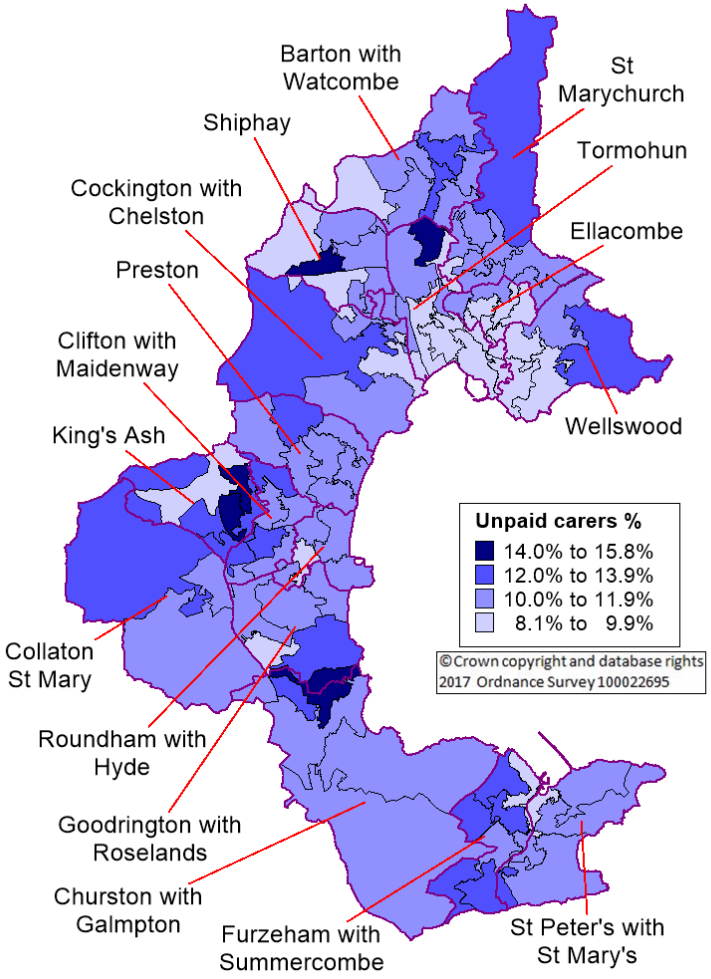

Fig 223: Percentage of unpaid carers, by output area
Source: Census 2021

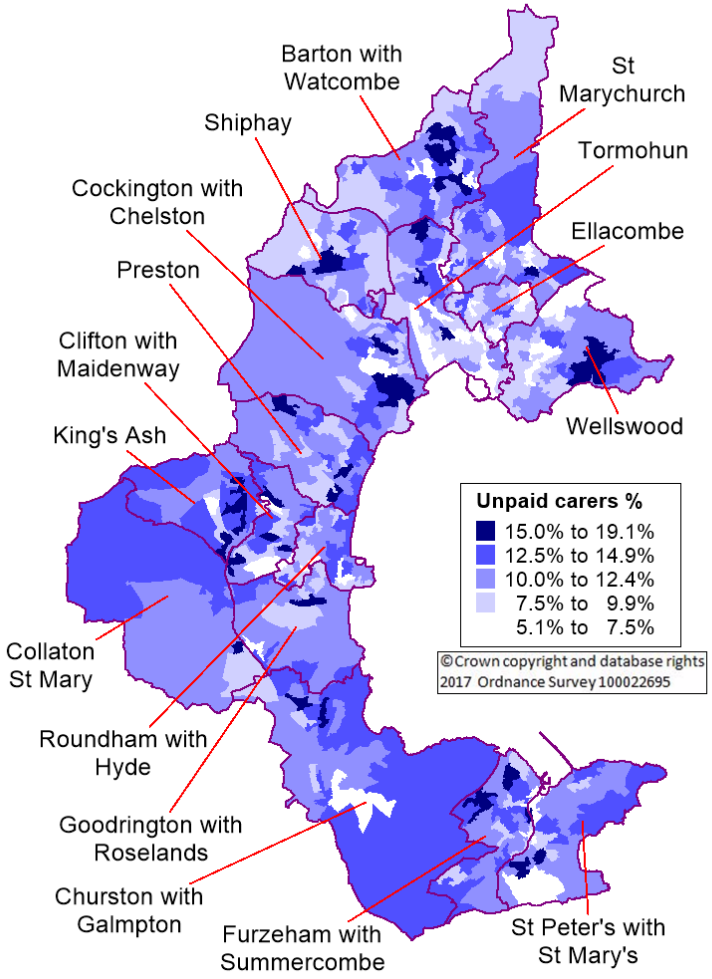

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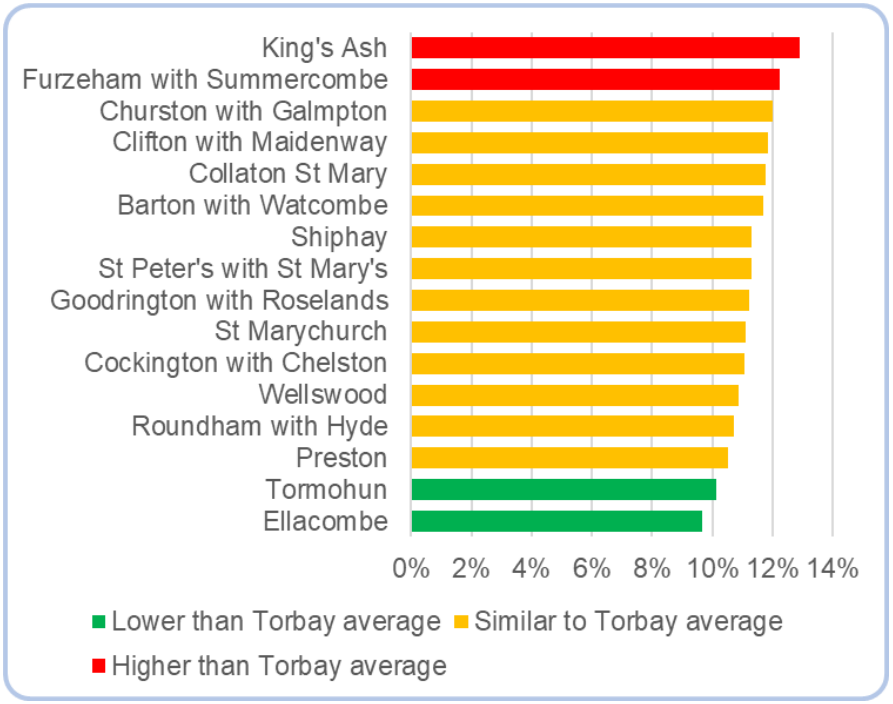
Fig 224: Percentage of unpaid carers, by ward
Source: Census 2021



Across younger age groups in Torbay it is more likely that someone will be undertaking unpaid care if they live in a more deprived area (Fig 225). This link is not observable in age groups over 50 years in Torbay.

For the 2021 Census, Torbay residents were asked if they had any physical or mental health conditions or illnesses which have lasted or are expected to last 12 months or more. If they answered yes, there was a further question 'Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?'. This definition, where people answer yes to both questions is in line with the disability definition in the Equality Act 2010.

Whilst most carers are not disabled under the Equality Act 2010, those who are disabled in line with the Equality Act 2010 are significantly more likely to be unpaid carers than those who are not disabled (Fig 226). This is the case across all age groups.

Fig 225: Percentage of unpaid carers, aged 5 to 34 years - Torbay
Source: Census 2021

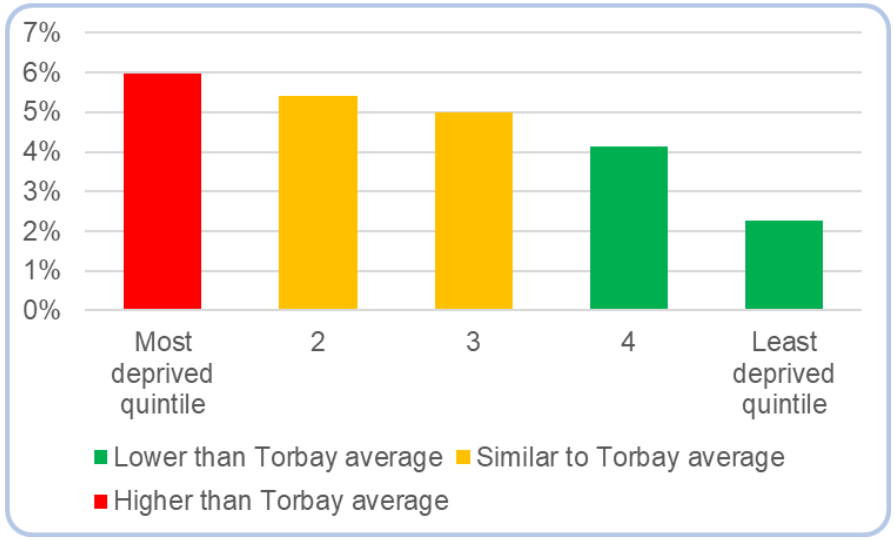
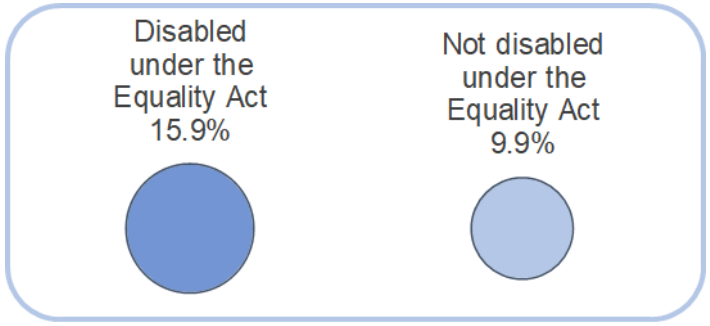


Fig 226: Percentage of unpaid carers, by disability status - Torbay
Source: Census 2021



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Personal Social Services Survey of Adult Carers, 2021/22

The survey of adult carers known to local social services takes place every other year (this pattern was broken by COVID-19) and is conducted by local authorities with adult social services responsibility. The survey seeks the opinions of carers aged 18 or over, caring for a person aged 18 or over, on a number of topics that are considered to be indicative of a balanced life alongside their unpaid caring role Personal Social Services Survey of Adult Carers in England, 2021-22 - NDRS (digital.nhs.uk) .

355 carers responded to the 2021/22 survey in Torbay, of these almost 2 out of 3 provided unpaid care to someone aged 65 or over, the person they cared for was most likely to have a physical disability followed by a long-standing illness and problems connected to ageing (Fig 227), multiple care needs for the same person could be selected. In relation to dementia, the Torbay rate of 29.8% was noticeably lower than the South West rate of 40.7%. Almost 5 out of 6 carers (82.4%) stated that the person they cared for lived with them compared to just 1 in 6 who said they lived somewhere else (Fig 228).

Of those carers who received support or services from Torbay social services in the previous 12 months, rates of satisfaction with the support and services received by themselves and the person they cared for were 74.8% during 2021/22 with dissatisfaction rates at 10.4% (Fig 229). These rates are broadly in line with 2016/17 and 2018/19. By comparison, rates of satisfaction across England for 2021/22 were 66.4% and rates of dissatisfaction were 16.4%.

Fig 227: Care Needs of person cared for – Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22

Care Need	Percentage
A physical disability	50.0%
Long-standing illness	42.1%
Problems connected to ageing	37.1%
Sight or hearing loss	32.0%
Dementia	29.8%
A mental health problem	22.8%
A learning disability or difficulty	18.8%
Terminal illness	5.3%
Alcohol or drug dependency	2.0%

Fig 228: Where does the person you care for usually live? – Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22

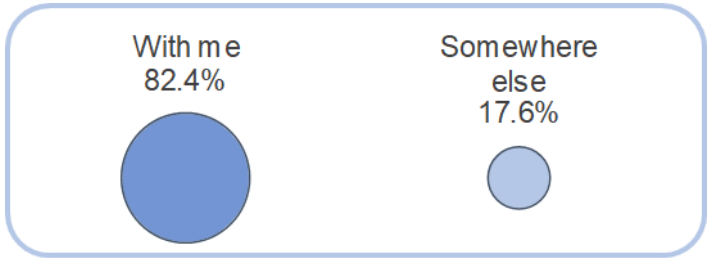

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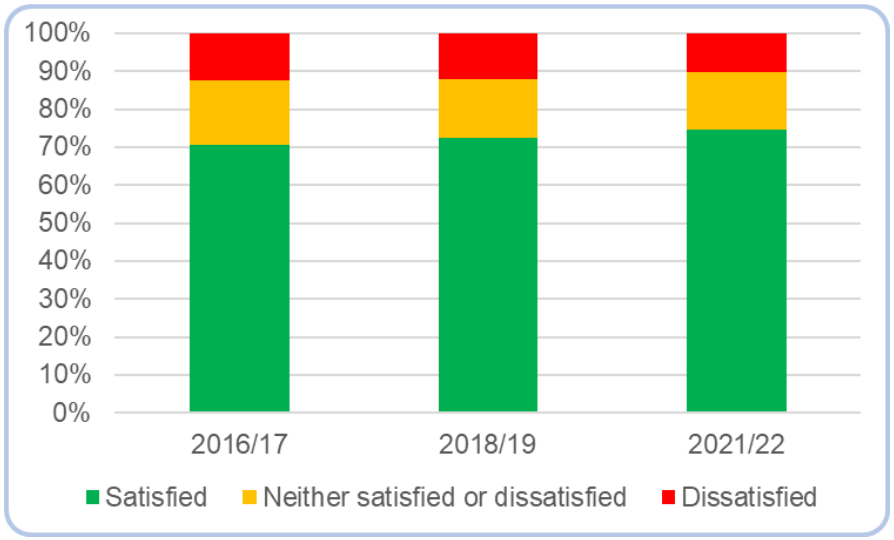
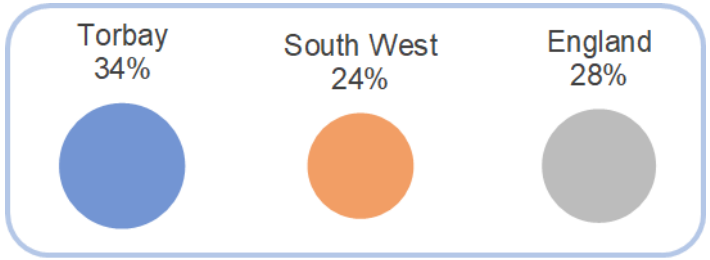
Fig 229: Levels of satisfaction with support and services carer and person cared for received from social services in last 12 months - Torbay
Source: Personal Social Services Survey of Adult Carers, 2021/22



For the period 2021/22, approximately 1 in 6 Torbay adult social carers (17.0%) state that they are able to spend their time doing things that they value or enjoy, a similar number (17.8%) state they don't do anything that they value or enjoy with their time. Most carers (65.2%) state that they do some of the things they value or enjoy but not enough. These numbers are broadly in line with the England average. Similar sentiments were expressed when asked about how much control carers had over their life.

For Torbay, 34% of adult social carers stated that they had as much social contact as they would like, which was broadly in line with the last survey in 2018/19. Rates were significantly higher than England and the South West (Fig 230). 17.6% of Torbay carers stated that they had little social contact and were socially isolated which was broadly in line with the previous survey, this is a little lower than England and the South West.

Fig 230: Percentage of adult social carers who have as much social contact as they would like – Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22



For the period 2021/22, 1 in 4 (24.6%) of Torbay adult social carers feel that they do not have enough encouragement and support. This has risen from 2016/17 when the percentage was 17.3%.

Carers were also asked if their health had been affected by their caring role, a majority of carers replied that at least 1 of the following 4 effects were felt: feeling tired, disturbed sleep, general feeling of stress and feeling depressed (Fig 231). Just 6% of respondents said that their health had not been affected by their caring role.

For the period 2021/22, adult social carers were asked if caring had caused them any financial difficulties in the previous 12 months, approximately 45% said that it caused some or a lot of financial difficulties (Fig 232). These figures are broadly in line with the 2018/19 survey, the South West and England.

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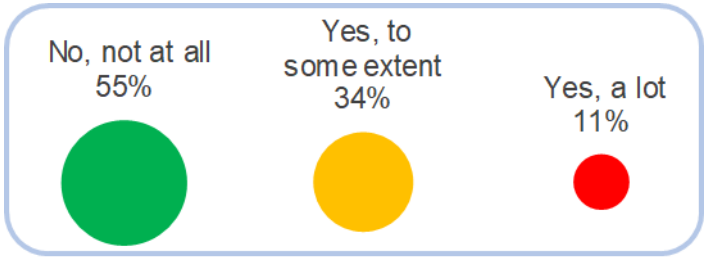
Fig 231: Percentage of adult social carers whose health had been affected by caring role in the ways listed - Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22

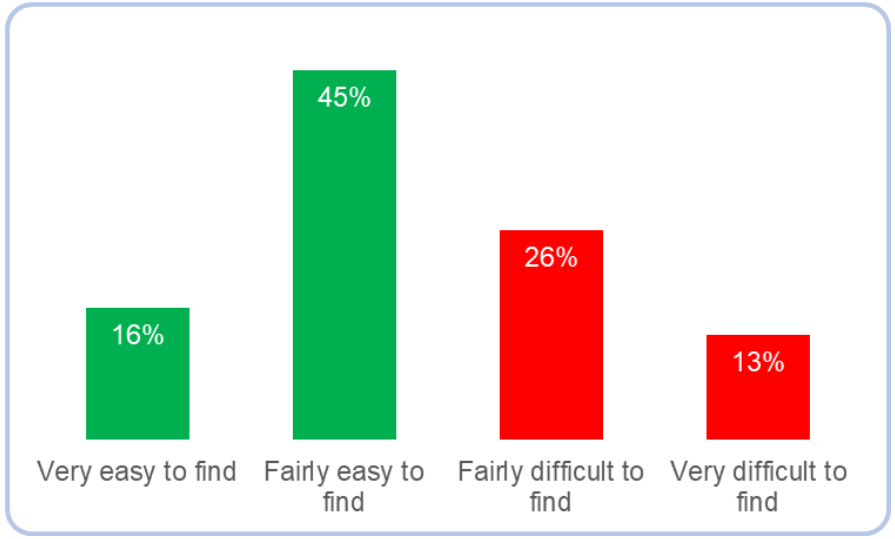
Health affected	Percentage
Feeling tired	83.9%
Disturbed sleep	70.3%
General feeling of stress	66.0%
Feeling depressed	51.0%
Short tempered/irritable	48.2%
Physical strain (eg back)	41.1%
Made an existing condition worse	24.4%
Developed my own health conditions	23.8%
Had to see own GP	20.4%
Loss of appetite	15.3%

Fig 232: Percentage of adult social carers, has caring caused you any financial difficulties in the last 12 months - Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22



Being able to access information and advice about support, services and benefits quickly and easily helps not only with practical outcomes but can also help to reduce levels of stress and anxiety around someone's caring duties. Of those Torbay adult social carers in 2021/22 who attempted to access this information and advice in the previous 12 months, more than 1 in 3 (39%) found this fairly or very difficult which is similar to South West and England rates (Fig 233). This is much higher than the 2016/17 figure of 26% for Torbay. Once accessed, 88% of information or advice was very or quite helpful. 3 in 10 Torbay carers did not attempt to access information or advice in the previous 12 months.

Fig 233: Percentage of adult social carers who have found it easy or difficult to find information and advice - Torbay (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22



Adult social carers were asked if they have been involved or consulted as much as they would want to be, in discussions about the support or services provided to the person they care for. For Torbay during 2021/22, approximately 1 in 8 (12.7%) were not aware

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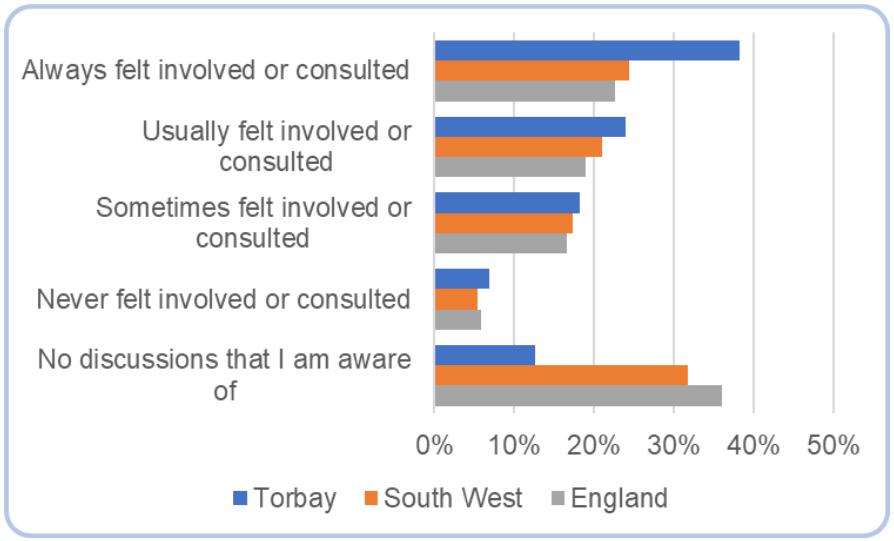
of any discussions in the last 12 months, this was a significantly lower rate than both England (36.1%) and the South West (31.8%) and significantly lower than previous results for Torbay, a further 6.9% said they never felt involved or consulted. Approximately 4 in 5 (80.4%) of carers always, usually or sometimes felt involved (Fig 234).

Fig 234: Percentage of adult social carers who feel involved or consulted (2021/22)
Source: Personal Social Services Survey of Adult Carers, 2021/22



59% of Torbay adult social carers are retired with a further 19% not in paid work. 1 in 4 were in paid full-time or part-time employment. 46% state that they spend 100 hours or more a week looking after or helping the person that they care for, this was significantly more than the England average of 36%.

Reports and further information around the Personal Social Services Survey of Adult Carers (PSSSAC) can be found at Personal Social Services Survey of Adult Carers in England, 2021-22 - NDRS (digital.nhs.uk)

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Census - Unpaid carers aged 5 and above (2021)	%	11.2%	9.9%	9.0%	8.8%	🔴	Not comparable
Census - Unpaid carers for 50 hours or more (2021)	%	3.9%	3.1%	2.7%	2.6%	🔴	Not comparable
Census - Disabled under the equality act who are also unpaid carers (2021)	%	15.9%	14.3%	14.1%	13.8%	🔴	Not comparable
PSSSAC - Satisfied with support and services from adult social services (2021/22)	%	75%	68%	66%	66%	🟢	↑
PSSSAC - Carers who have as much social contact as they like (2021/22)	%	34%	30%	24%	28%	🟢	↑
PSSSAC - Caring has caused financial difficulties in the last 12 months (2021/22)	%	45%	37%	43%	43%	🟡	↓
PSSSAC - Carers who have found it easy to find information and advice (2021/22)	%	61%	60%	62%	58%	🟡	↓
PSSSAC - Caring for 100 hours or more per week (2021/22)	%	46%	38%	42%	36%	🔴	↓

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Preventable Mortality

Overview

- Rate of deaths from causes considered preventable in the under 75 age group are higher in Torbay than England and the South West.

  Source: Fingertips

- Rate of deaths from causes considered preventable in the under 75 age group are much higher in the more deprived areas of Torbay when compared to less deprived areas of Torbay.

  Source: Primary Care Mortality Database

- Most common cause of death in Torbay that was considered preventable in the under 75 age group was Cancer, accounting for over 1 in 3 preventable deaths.

  Source: Fingertips

- Most common cause of death in Torbay that was considered preventable in the under 50 age group was Liver Disease, in particular alcoholic liver disease.

  Source: Primary Care Mortality Database

- Rate of preventable deaths among under 75 age group is much higher among males when compared to females in Torbay.

  Source: Fingertips

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The Office for Health Improvement and Disparities defines preventable mortality as relating to deaths that are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause could mainly be avoided through effective public health and primary prevention interventions. The deaths are limited to those who died before they reached the age of 75.

Preventable deaths - All causes

Preventable deaths among those aged under 75 have been significantly higher than England and South West over the latest 3 year periods available (Fig 235). Looking at local data for 2018 – 20 and 2019 – 21, rates in Torbay have remained broadly similar to 2017 - 19 Rates rose significantly in both female (Fig 236) and male (Fig 237) populations but local data shows that rates for 2018 – 20 and 2019 – 21 have remained broadly similar for females and males to 2017 - 19. The level of preventable deaths among males under 75 is close to double the rate among females under 75.

Within Torbay, over the period 2017 – 19, 5 out of 6 preventable deaths related to either cancer, cardiovascular disease, liver disease or respiratory disease. 43% of deaths amongst those aged 75 and under in Torbay, for the last 5 time periods, were considered preventable, this is in line with England.

Looking at local Torbay data for 2017 to 2021, there is significant variation between differing areas of Torbay. Those living in the most deprived areas of Torbay are significantly more likely to die of preventable causes under the age of 75 when compared to the Torbay average. Those who live in the less deprived parts of Torbay are significantly less likely to die of preventable causes before the age of 75 when compared to the Torbay average (Fig 238).

Fig 235: Under 75 mortality rate from causes considered preventable, per 100,000 (Age Standardised)
Source: Fingertips

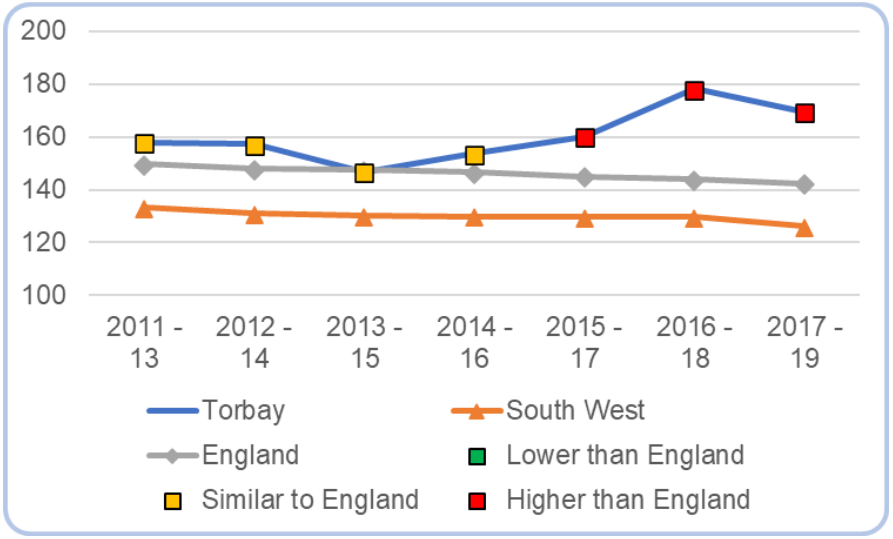

Fig 236: Under 75 mortality rate from causes considered preventable, per 100,000 (Age Standardised) - Female
Source: Fingertips

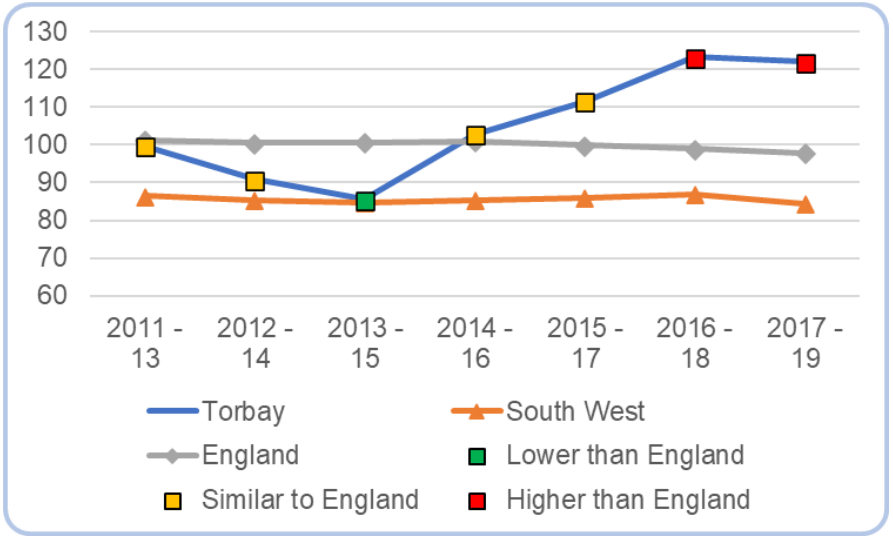

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Fig 237: Under 75 mortality rate from causes considered preventable, per 100,000 (Age Standardised) - Male
Source: Fingertips

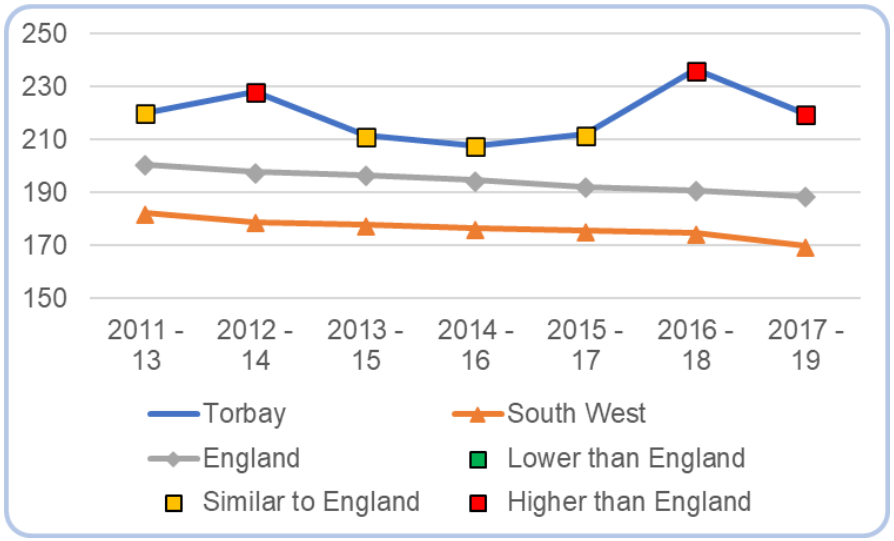
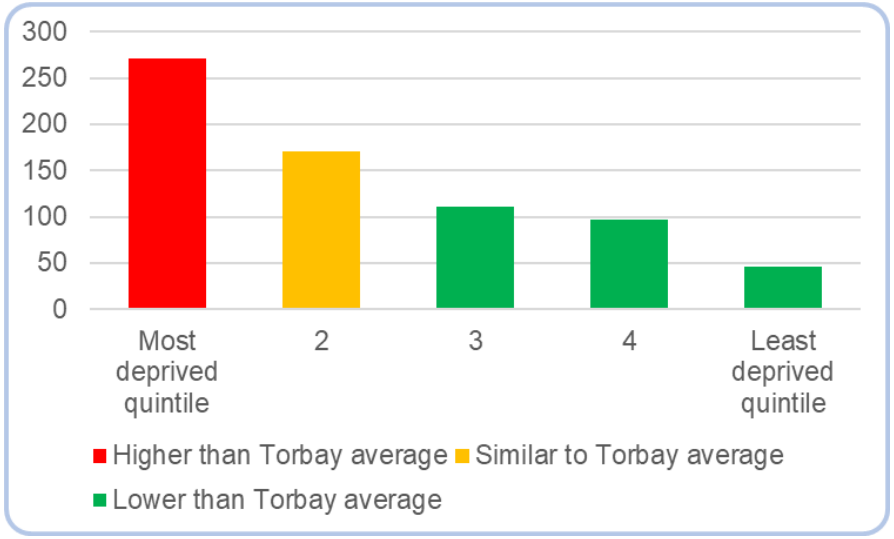


Fig 238: Under 75 mortality rate from causes considered preventable, per 100,000 (Age Standardised) – Torbay (2017–2021)
Source: Primary Care Mortality Database



Preventable deaths - Cancer

Over the period 2017 – 19, more than 1 in 3 (36.8%) of preventable deaths had an underlying cause of Cancer. Rates in Torbay have remained steady over the last decade, in line with England but above the South West (Fig 239). Males have been approximately 75% more likely than females to have a preventable cancer death in Torbay, for 2019 – 21 local data indicates a closing of that gap.

Over the 5 year period 2017 to 2021, those who live in the most deprived areas of Torbay are significantly more likely than the Torbay average to die prematurely from Cancer that was considered preventable (Fig 240). 44% of cancer deaths amongst those aged 75 and under in Torbay, for the last 5 time periods, were considered preventable, this is broadly in line with England. Just over 50% of the preventable cancer deaths in Torbay during 2017 to 2021 had an underlying cause of lung cancer.

Fig 239: Under 75 mortality rate with underlying cause of cancer that was considered preventable, per 100,000 (Age Standardised)
Source: Fingertips

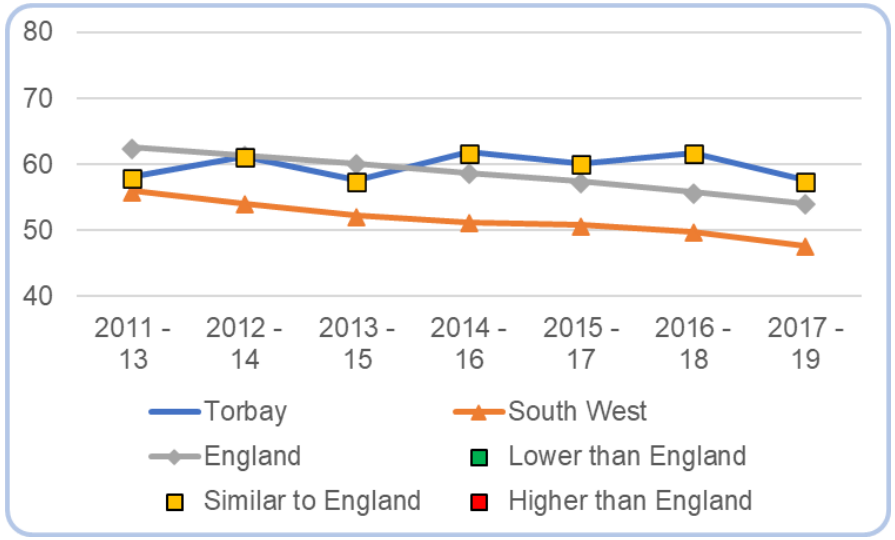


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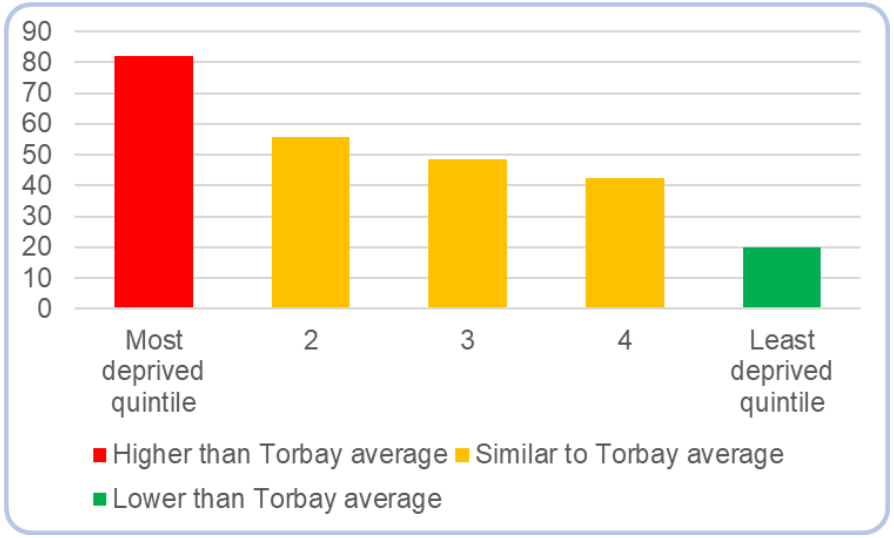
Fig 240: Under 75 mortality rate with underlying cause of cancer that was considered preventable, per 100,000 (Age Standardised) – Torbay (2017 – 2021)
Source: Primary Care Mortality Database



Preventable deaths – Cardiovascular disease

After Cancer, the next largest area of preventable deaths during 2017 - 19 in Torbay belonged to cardiovascular disease which accounted for just over 1 in 6 (17.6%) preventable deaths amongst those aged under 75. Over the last decade, rates have been broadly in line with England but higher than the South West (Fig 241). Rates among males are more than double the rates among females, both female and male rates are broadly in line with England. There are a number of known risk factors that increase the chance of suffering from cardiovascular disease including high blood pressure, smoking, high cholesterol, diabetes, physical inactivity, excess weight, ethnicity and family history.

In line with other areas of preventable death, rates are significantly higher than the Torbay average in the most deprived areas (Fig 242).

Rates in the least deprived area are in line with the Torbay average because of the relatively small size of that population. 41% of cardiovascular disease deaths amongst those aged 75 and under in Torbay, for the last 5 time periods, were considered preventable, this is broadly in line with England. Almost 7 out of 10 of the preventable cardiovascular deaths in Torbay during 2017 to 2021 had an underlying cause of coronary (ischaemic) heart disease.

Fig 241: Under 75 mortality rate with underlying cause of cardiovascular disease that was considered preventable, per 100,000 (Age Standardised)
Source: Fingertips

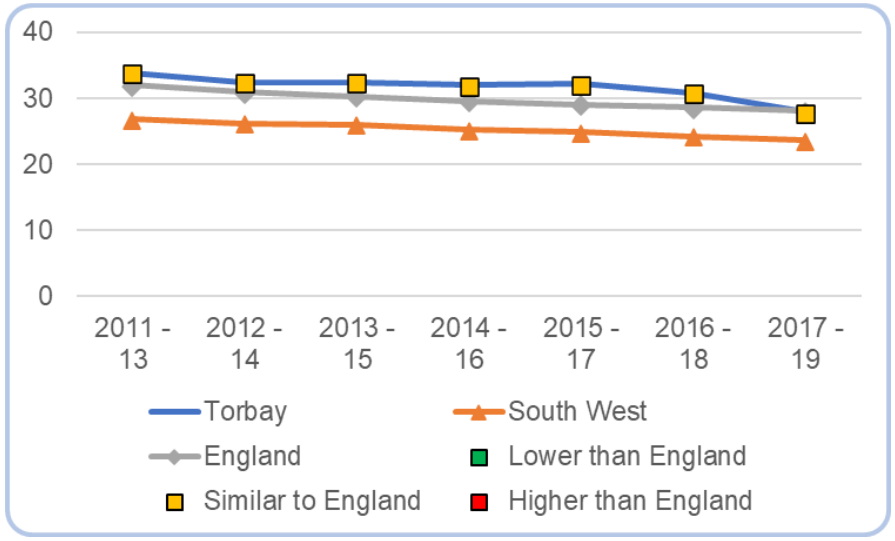


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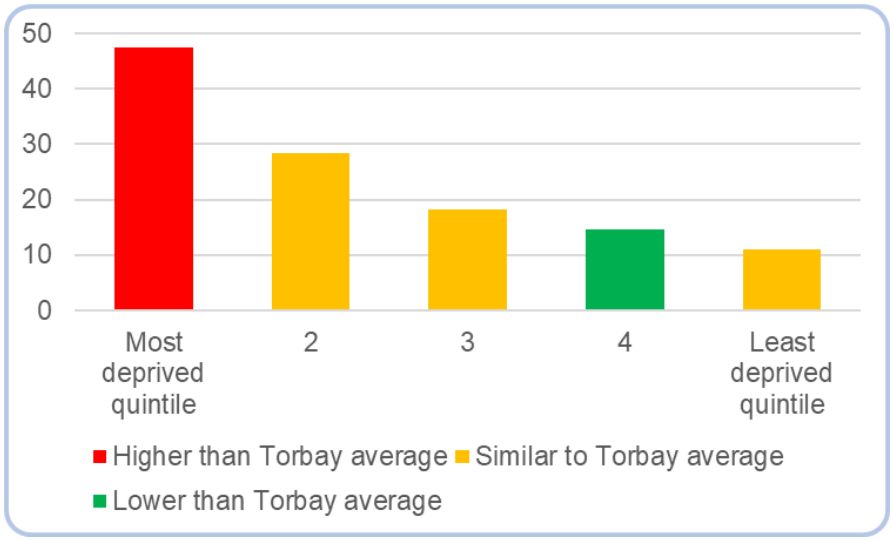
Fig 242: Under 75 mortality rate with underlying cause of cardiovascular disease that was considered preventable, per 100,000 (Age Standardised) – Torbay (2017 – 2021)
Source: Primary Care Mortality Database



Preventable deaths – Liver disease

During 2017 – 19, over 1 in 7 (15%) preventable deaths for those aged under 75 had an underlying cause of liver disease. Rates have increased significantly since the middle of the last decade (Fig 243), local data indicates a small fall during 2019 – 21 but rates remain much higher than the middle of the last decade. Rates among males are higher than females although the difference has narrowed, both female and male rates are significantly higher than England and the South West.

In line with other areas of preventable death, rates are significantly higher than the Torbay average in the most deprived areas (Fig 244). Rates in the least deprived area are in line with the Torbay average because of the relatively small size of that population. More than 9 in 10 liver disease deaths amongst those aged 75 and under in Torbay, for the last 5 time periods, were considered preventable, this is broadly in line with England. Liver disease is significantly influenced by alcohol consumption and obesity which are both amenable to public health interventions.

For the period 2017 – 21 in Torbay, almost 2 out of 3 preventable liver disease deaths had an underlying cause of alcoholic liver disease, the majority of the rest were due to an underlying cause of liver cancer. If just looking at those under 50 years of age, alcoholic liver disease accounted for more preventable deaths in Torbay than either cancer, cardiovascular disease or respiratory disease individually.

Fig 243: Under 75 mortality rate with underlying cause of liver disease that was considered preventable, per 100,000 (Age Standardised)
Source: Fingertips

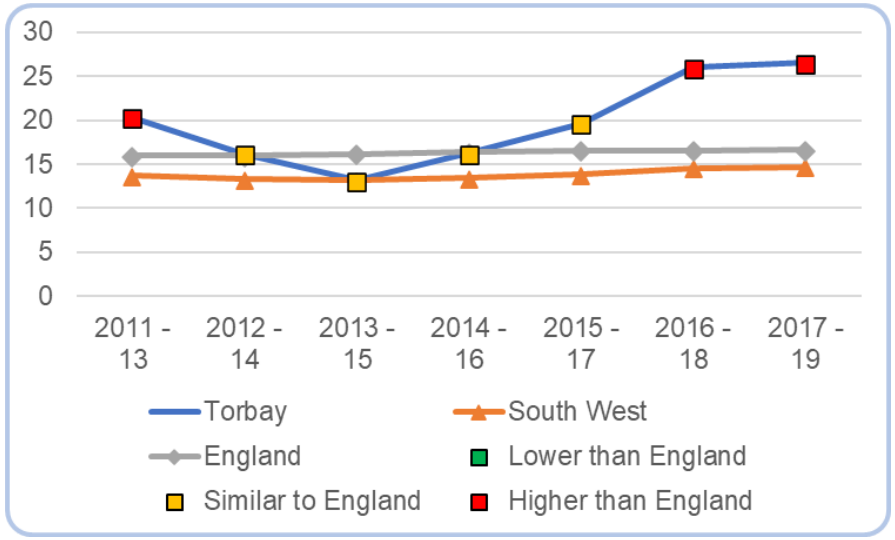


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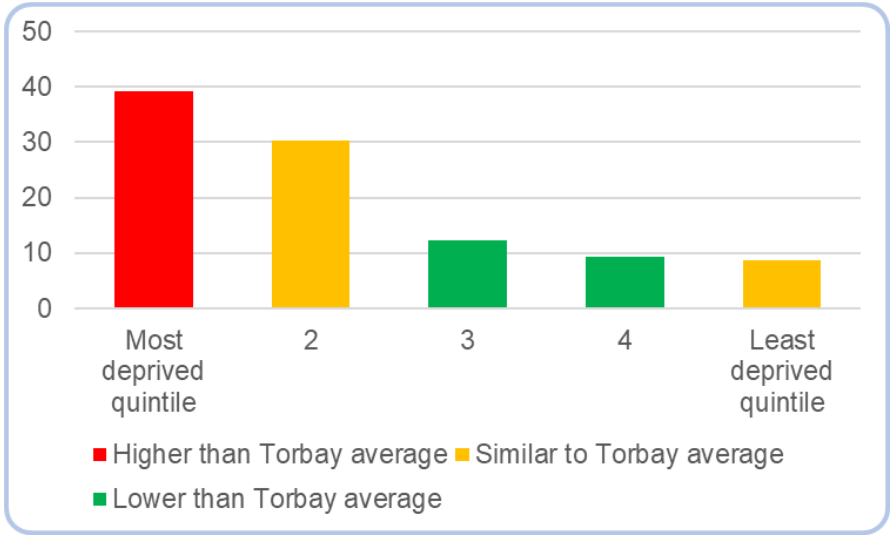
Fig 244: Under 75 mortality rate with underlying cause of liver disease that was considered preventable, per 100,000 (Age Standardised) – Torbay (2017 – 2021)
Source: Primary Care Mortality Database



Preventable deaths – Respiratory disease

During 2017 – 19, 1 in 7 (14%) preventable deaths for those aged under 75 had an underlying cause of respiratory disease. Rates have been broadly smooth over the last decade (Fig 245), local data up to 2019 - 21 indicates a continuation of this broadly flat trend. Rates among males are higher than females although the difference has narrowed, both female and male rates are broadly in line with England and higher than the South West.

Rates are significantly higher than the Torbay average in the most deprived areas (Fig 246). 55% of respiratory disease deaths amongst those aged 75 and under in Torbay, for the last 5 time periods, were considered preventable, this is slightly less than England. Chronic obstructive pulmonary disease (COPD) which is a major respiratory disease is significantly influenced by smoking. 5 out of 6 preventable respiratory disease deaths in Torbay during 2017 -21 had an underlying cause of COPD.

Fig 245: Under 75 mortality rate with underlying cause of respiratory disease that was considered preventable, per 100,000 (Age Standardised)
Source: Fingertips

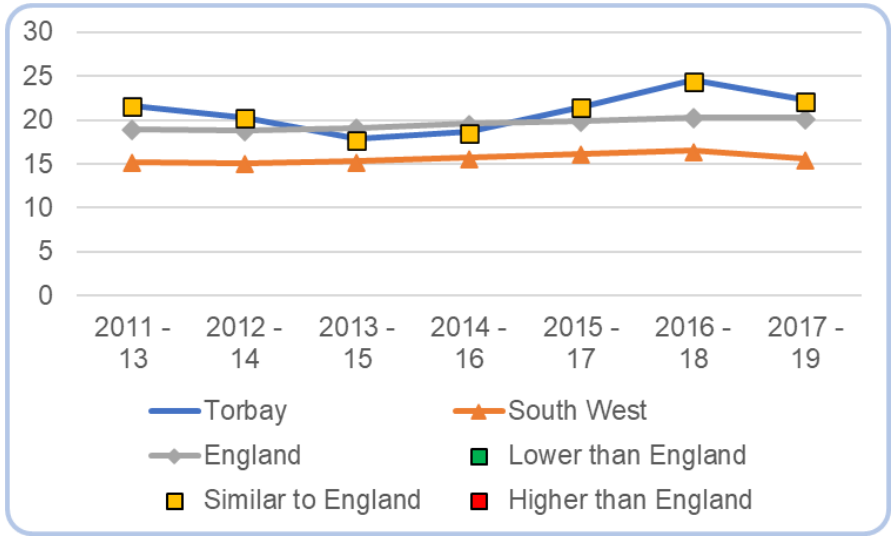


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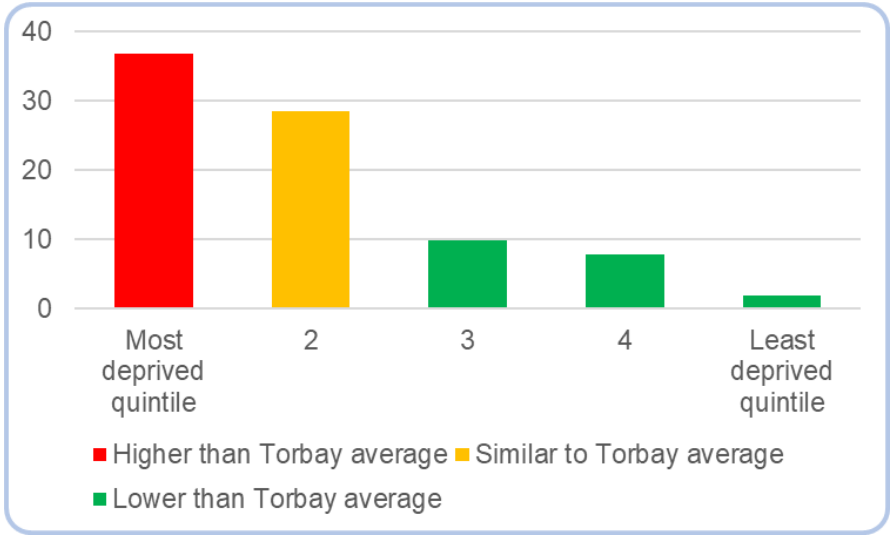
Fig 246: Under 75 mortality rate with underlying cause of respiratory disease that was considered preventable, per 100,000 (Age Standardised) – Torbay (2017 – 2021)
Source: Primary Care Mortality Database



Preventable deaths – Other causes

Looking at Torbay data for 2017 to 2021 in relation to those under 75 years, 8 out of 10 deaths that were considered preventable related to cancer, cardiovascular disease, liver disease and respiratory disease. Of deaths outside of those 4 areas, over 60% related either to suicide or potential suicide (classified as intentional self-harm or undetermined intent), or accidental poisoning due to drugs and medications. Torbay has had a suicide rate that is significantly higher than England since the middle of the last decade.

Premature deaths

Premature deaths relate to all deaths of those aged 75 and under, regardless of whether they are considered preventable. A 2 page profile giving detailed information on premature deaths can be found at Premature Death in Torbay (southdevonandtorbay.info)

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Preventable mortality - All causes (2017 - 19)	DSR per 100,000	169	162	126	142	🔴	↓
Preventable mortality - All causes (Female) (2017 - 19)	DSR per 100,000	122	116	84	98	🔴	↓
Preventable mortality - All causes (Male) (2017 - 19)	DSR per 100,000	220	211	170	189	🔴	↓
Preventable mortality - Cancer (2017 - 19)	DSR per 100,000	58	60	48	54	🟡	↓
Preventable mortality - Cardiovascular disease (2017 - 19)	DSR per 100,000	28	30	24	28	🟡	↓
Preventable mortality - Liver disease (2017 - 19)	DSR per 100,000	27	20	15	17	🔴	↑
Preventable mortality - Respiratory disease (2017 - 19)	DSR per 100,000	22	24	16	20	🟡	↓

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Eye Health

Overview

- Torbay is estimated to have a higher rate than England of people living with sight loss that has a significant impact on their daily lives.

  Source: Royal National Institute of Blind People, Sight Loss Data Tool version 5.2

- The rate of Torbay's new sight loss certifications has been significantly higher than the England average for the last 7 years (2014/15 to 2020/21).

  Source: Fingertips

- Age-related macular degeneration and glaucoma (certifications for these conditions) are at higher levels in Torbay than England in 2020/21.

  Source: Fingertips

- The rate per 100,000 of those aged 75+ registered as sight impaired or severely sight impaired in Torbay in March 2020 is lower than England. The register has fewer people in the younger age groups but rates per 100,000 are higher than England.

  Source: Fingertips, NHS Digital, ONS mid-year population estimates

- In March 2020 significantly higher percentages of people who are registered as sight impaired or severely sight impaired in Torbay have additional disabilities.

  Source: NHS Digital

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Eye conditions and sight loss can have a severe impact on people's lives, causing problems and difficulties within daily life and increasing the risk of falls. It can lead to mental health issues such as depression. Prevention of sight loss as much as is possible reduces need for social care and helps people maintain their independence. The take up of routine sight tests can detect eye problems early and enable intervention to prevent sight loss.

Living with sight loss

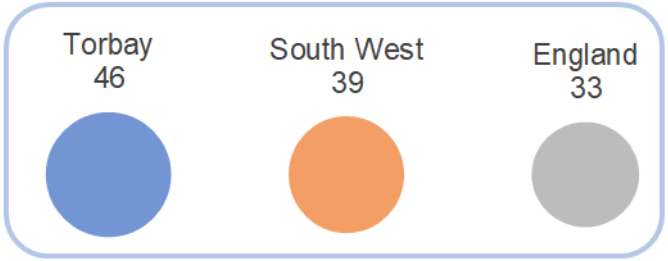
It is estimated by the RNIB that over 2 million people in the UK live with sight loss in 2022 that has a significant impact on their daily lives. The RNIB list the main causes of sight loss in descending order as uncorrected refracted error, age-related macular degeneration, cataracts, glaucoma and diabetic eye disease.

The estimate for Torbay is 6,340 people or 46 per 1,000 population in 2022 living with sight loss (Fig 247). This is significantly higher than the England rate. Age is a major factor in the prevalence of sight loss and Torbay has an ageing population. This estimate is based on age and gender but there will be other factors not included.

Included in the sight loss estimate are people registered blind or partially sighted and people whose sight is better than the level qualifying for registration but it still significantly affects them (for example, not being able to drive). It includes those who are having treatment or waiting for it (such as eye injections or surgery that could improve their sight) and those whose sight loss could be improved if they were wearing correctly prescribed glasses or contact lenses.

Fig 247: Estimated rate of people living with sight loss, per 1,000 (2022)

Source: Royal National Institute of Blind People (RNIB), Sight Loss Data Tool version 5.2



Sight loss certifications

A Certificate of Vision Impairment (CVI) is completed by an ophthalmologist for people assessed to be sight impaired (previously 'partially sighted') or severely sight impaired (previously 'blind'). This is voluntary and leads, if the patient wishes, to registration with the local authority which can help them to access services and a range of benefits.

In Torbay in 2020/21 there was a rate of 77.8 new CVIs per 100,000 (106 CVIs) which is significantly higher than the England average (Fig 248). The numbers of CVIs will have been impacted by the COVID-19 pandemic in the year 2020/21. Torbay has been higher for the 11 years shown and significantly higher for the most recent 7 years of data.

Certification is voluntary so the need is most likely greater than the rates of CVIs show. In some areas completion of the examinations required to assess for certification may be incentivised which will lead to higher rates. Lower levels of certification can mean that fewer people with the need are completing CVIs rather than that needs are low.

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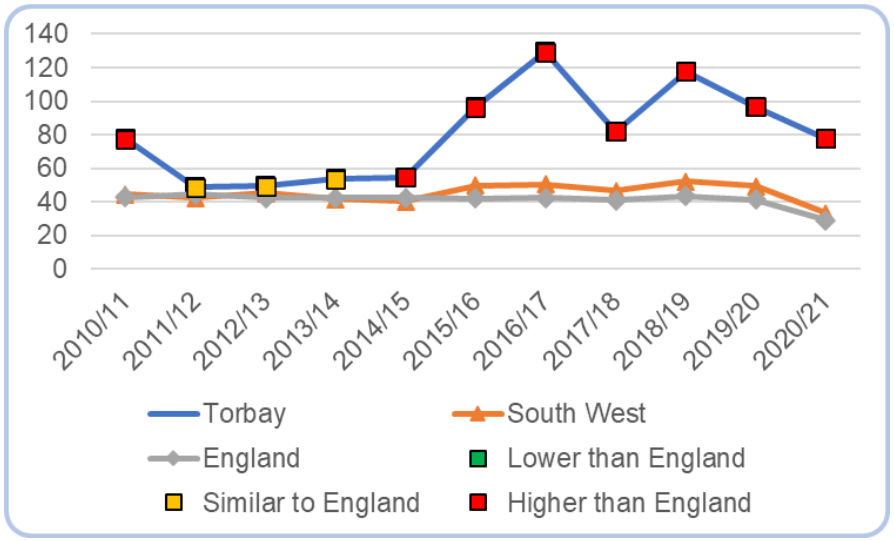
Fig 248: Rate of new sight loss certifications (Certificates of Vision Impairment), per 100,000
Source: Fingertips



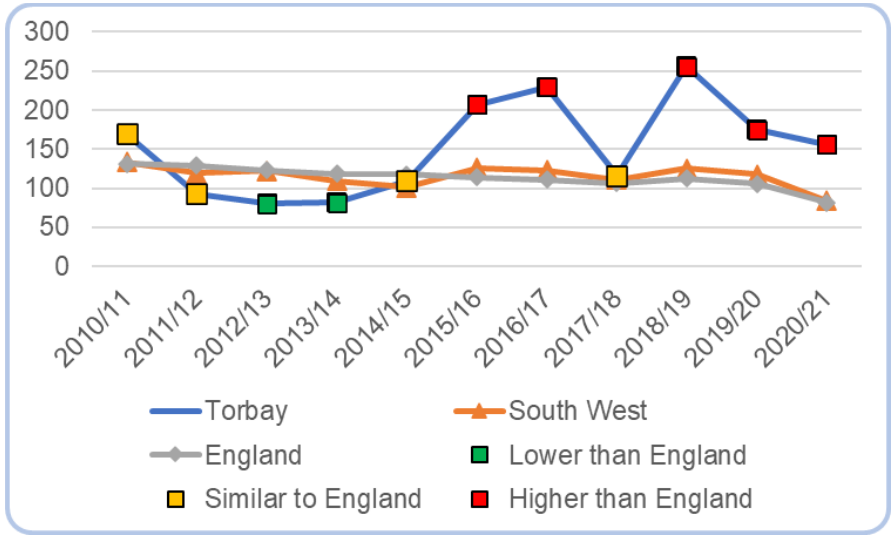
Age-related macular degeneration (AMD)

AMD normally first affects people when they are aged in their 50s and 60s. It affects the middle part of vision and can impact everyday activities. Dry AMD is common and worsens gradually- usually over several years. Wet AMD is less common and can worsen quickly- sometimes within days or weeks. (NHS)

The exact cause of AMD is not known. The condition has been linked to the following health and lifestyle issues- smoking, being overweight, high blood pressure and a family history of the condition. (NHS)

Fig 249 measures the rate of new CVIs for AMD for people aged 65 and over. Low numbers mean that Torbay rates fluctuate over the years. In 2020/21 there were 58 new CVIs for AMD, a rate of 156.2 per 100,000 (82.0 in England). This has been significantly higher than England for the most recent 3 years. The COVID-19 pandemic is likely to have impacted 2020/21 figures. As CVIs are voluntary then true numbers could be higher.

Fig 249: Age-related macular degeneration (AMD) – rates of new Certificates of Vision Impairment (CVIs), aged 65+, per 100,000
Source: Fingertips



Glaucoma

Glaucoma is an eye condition where the optic nerve becomes damaged which can lead to vision loss if not treated early and can eventually result in blindness if untreated. It is usually asymptomatic to begin with and is often only identified during a routine eye test. Risk for developing glaucoma increases with age (NHS)

Torbay's rates of new CVIs for glaucoma fluctuates over the years due to low numbers- there were 23 new CVIs in 2020/21. Torbay is significantly higher than England in 2020/21 at 28.1 new CVIs per 100,000 compared to 9.2 in England (Fig 250). These have glaucoma as the main cause or where no main cause then a

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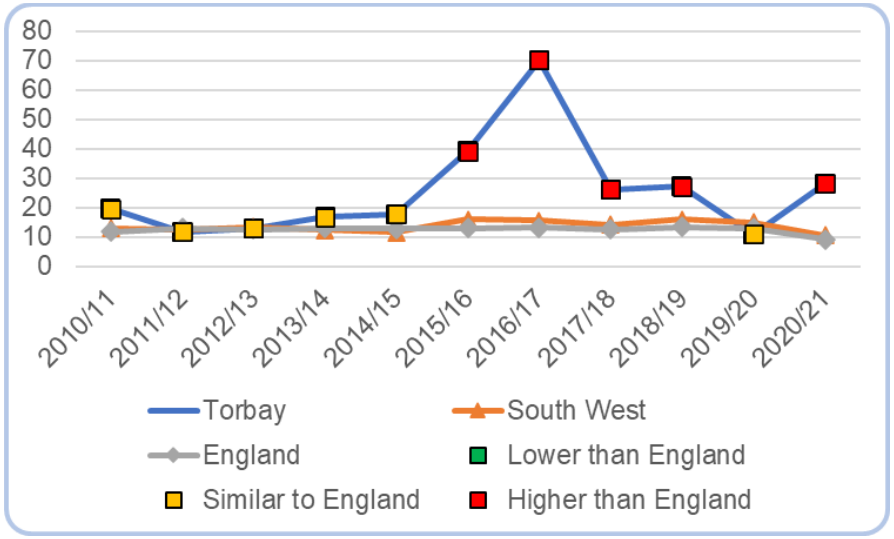
contributory cause. COVID-19 is likely to have impacted the figures in 2020/21 and as CVIs are voluntary the true rates of glaucoma could be higher.

Fig 250: Glaucoma – rates of new Certificates of Vision Impairment (CVIs), aged 40+, per 100,000
Source: Fingertips



Diabetic eye disease

Eye problems caused by diabetes are called diabetic retinopathy and if not found early could lead to sight loss. Diabetic eye screening is offered annually to those with diabetes aged 12 and over. (NHS)

An indicator measures the rate of new Certifications of Vision Impairment (CVIs) for diabetic eye disease. In Torbay the most recent year, 2020/21, has rates suppressed as numbers are too low. The previous 4 years (2016/17 – 2019/20) range from 5 to 9 certifications during the year. England rates are also very low and Torbay is significantly higher than England in 2019/20 with 7.6 per 100,000 (2.9 in England).

As has been previously stated, CVIs are voluntary so actual rates could be higher, and the COVID-19 pandemic is likely to have affected the figures in 2020/21.

Sight loss registration with the local authority

Local authorities (LAs) keep a register of sight impaired (previously 'partially sighted') and severely sight impaired (previously 'blind') people. Registration is offered when a Certificate of Vision Impairment (CVI) has been completed by an ophthalmologist who has assessed the person as meeting the sight loss criteria for the register. If the patient consents then they are added to the register and this can help them to access services and a range of benefits.

The numbers registered in each LA are collated and published every 3 years with the most recent figures being for 2019/20. As registration is voluntary it cannot be seen as the definitive number of sight impaired and severely sight impaired people. The figures rely on the register being kept up to date, deceased people being removed for example. The definition of sight loss that has a significant impact on daily life (Fig 251) used by the RNIB includes a lower threshold than the register so more people fit into that definition.

Fig 251 shows that at the end of March 2020 in Torbay there were 480 people registered as blind/severely sight impaired with 55 joining the register in 2019/20. There were 465 registered as partial sight/sight impaired with 105 joining in 2019/20. Most of those who joined the register were aged 75 and over, making up around 3 quarters of those joining.

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Fig 251: People registered with the local authority as blind/severely sight impaired or partial sight/sight impaired, Torbay (End of March 2020)

Source: NHS Digital

	Blind/severely sight impaired	Partial sight/sight impaired
On the register at end of March 2020	480	465
Joined the register during 2019/20	55	105

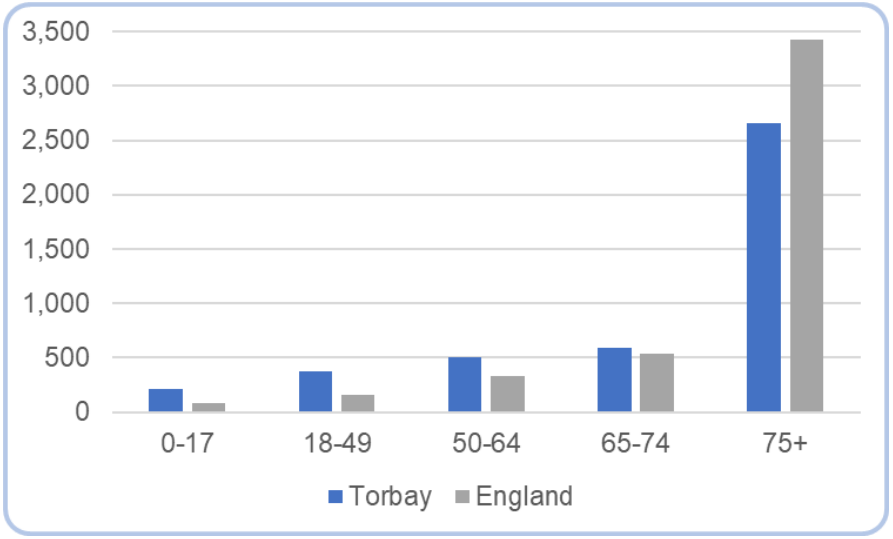
Numbers rounded to the nearest 5

Three years earlier, at the end of March 2017, there were slightly fewer people registered- 465 blind/severely sight impaired and 440 partial sight/sight impaired. In 2016/17 the numbers joining the register were the same as 2019/20 for blind/severely sight impaired people and 10 fewer partial sight/sight impaired people joining. (Numbers are rounded to the nearest 5).

Torbay's rates per 100,000 of younger age groups registered (aged up to 64 years) are significantly higher than England (Fig 252), while rates of 65-74 year olds are statistically similar to England, and the rate of those aged 75 and over is significantly lower than England. Just under half of the people on the register in March 2020 were aged 75+ with lower numbers in the younger age groups. However, the rates per 100,000 of those in the younger age groups are higher compared to England.

Fig 252: Age groups registered as blind/severely sight impaired or partial sight/sight impaired, rate per 100,000 (End of March 2020)

Source: NHS Digital, ONS mid-year population estimates



Figures for 0-4 years suppressed due to low numbers

As shown above (Fig 252), the rate of people aged 75 and over who were registered at the end of 2019/20 is lower than the England average. Fig 253 below shows that Torbay has consistently had significantly lower rates than England of people registered aged 75+, with a rate of 2,657 per 100,000 at the end of 2019/20 compared to 3,429 in England. Rates are on a decreasing trend as is the case in England. Please note that the data is shown at 3 yearly intervals as it is collated and published by NHS Digital every 3 years.

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Fig 253: Rate of people aged 75+ registered as blind/severely sight impaired or partial sight/sight impaired, per 100,000
Source: Fingertips

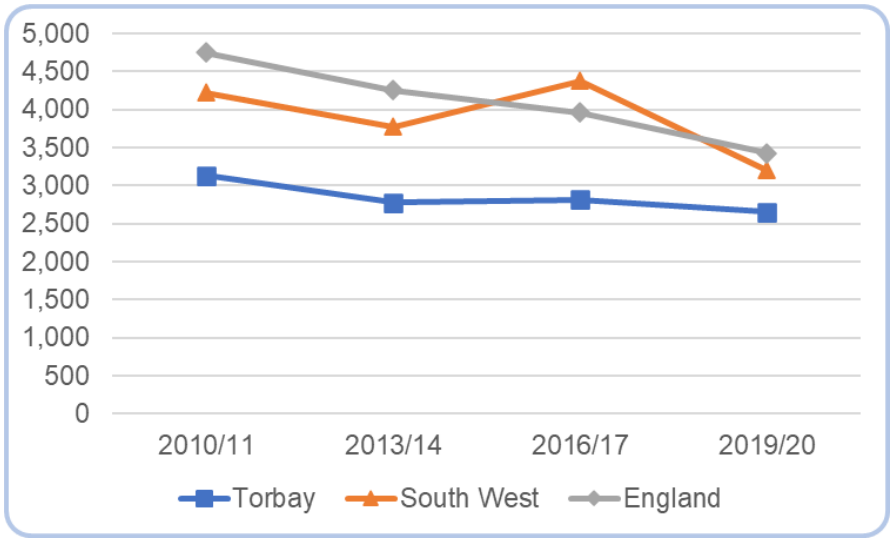
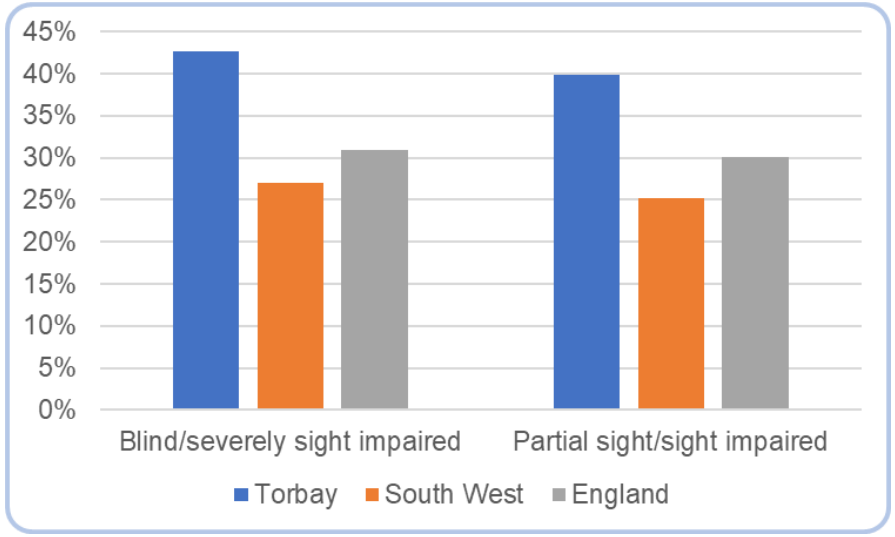


Fig 254: Percentage of people registered as blind/severely sight impaired or partial sight/sight impaired who have additional disabilities (End of March 2020)
Source: NHS Digital



The register records additional disabilities consisting of the following in 2019/20: deaf with speech, deaf without speech, hard of hearing, physical disabilities, mental health problems and learning disabilities. This relies on disability data being well recorded. The percentage recorded with additional disabilities in Torbay is 43% of blind/severely sight impaired people and 40% of partial sight/sight impaired people. This is significantly higher than the South West and England for both (Fig 254).

Further local and national information on eye health can be found in the RNIB sight loss data tool. The RNIB website provides information and support. The NHS website has information about eye conditions and sight loss.

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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Estimated rate of people living with sight loss (2022)	Rate per 1,000	46	37	39	33	🔴	No comparison
Rate of new Certificate of Vision Impairment (2020/21)	Rate per 100,000	78	33	33	29	🔴	↓
Rate of new Certificate of Vision Impairment - Age-related macular degeneration (Aged 65+) (2020/21)	Rate per 100,000	156	84	84	82	🔴	↓
Rate of new Certificate of Vision Impairment - Glaucoma (Aged 40+) (2020/21)	Rate per 100,000	28	9	11	9	🔴	↑
Rate of people aged 75+ registered as blind/severely sight impaired or partial sight/sight impaired (2019/20)	Rate per 100,000	2657	3266	3200	3429	🟢	↓
People registered as blind/severely sight impaired or partial sight/sight impaired who have additional disabilities (2019/20)	%	41%	34%	26%	31%	🔴	↑

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Diabetes and Heart Disease

Overview

- 7.8% of Torbay GP patients aged 17 and over have recorded diabetes. 9,679 patients have recorded diabetes, 92% of these cases relate to Type 2 diabetes.
  Source: Fingertips, National Diabetes Audit
- Rates of emergency hospital admissions and under 75 deaths from coronary heart disease are much higher in the most deprived areas of Torbay when compared to the least deprived.
  Source: Hospital Episode Statistics, Primary Care Mortality Database
- 18% of Torbay GP patients are known to have hypertension, many people do not realise that they have this condition so this will be a significant understatement.
  Source: Fingertips
- Smoking prevalence has fallen over the last decade. It remains significantly higher among the long-term unemployed population or those who work in routine or manual occupations.
  Source: Fingertips
- Just over 6 in 10 adults are overweight or obese in Torbay.
  Source: Fingertips

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Diabetes

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high as your body is unable to break down glucose into energy. Over a period of time these high glucose levels can seriously damage your heart, eyes, feet and kidneys. There are two main types of diabetes, for Type 1 diabetes there are no lifestyle changes that you can make to lower your risk. For Type 2 diabetes which accounts for around 90% of cases in the UK, you can help reduce your risk by controlling your weight, exercising regularly, stopping smoking, limiting alcohol and eating a balanced healthy diet.

Diabetes prevalence as recorded by the Quality Outcomes Framework has shown the prevalence of diabetes recorded by GP practices to be significantly higher than national and regional rates. For 2021/22, 7.8% of those aged 17 and over on Torbay GP Practice lists were recorded as having Diabetes as opposed to 7.3% across England (Fig 255). Since 2011/12, numbers for Torbay have increased from 7,327 in 2011/12 to 9,679 for 2021/22 (Fig 256).

The National Diabetes Audit (NDA) is a major clinical audit undertaken by NHS Digital in partnership with Diabetes UK. For Torbay in 2021/22, this showed that 8% of registrations related to Type 1 diabetes, the remaining 92% related to Type 2 diabetes.

For Type 2 diabetes registrations in Torbay for 2021/22, 57% were for males and 43% for females. 42% related to those aged 65 to 79 and 37% for those aged 40 to 64 (Fig 257).

Fig 255: Diabetes Prevalence (17+) - Torbay
Source: Fingertips

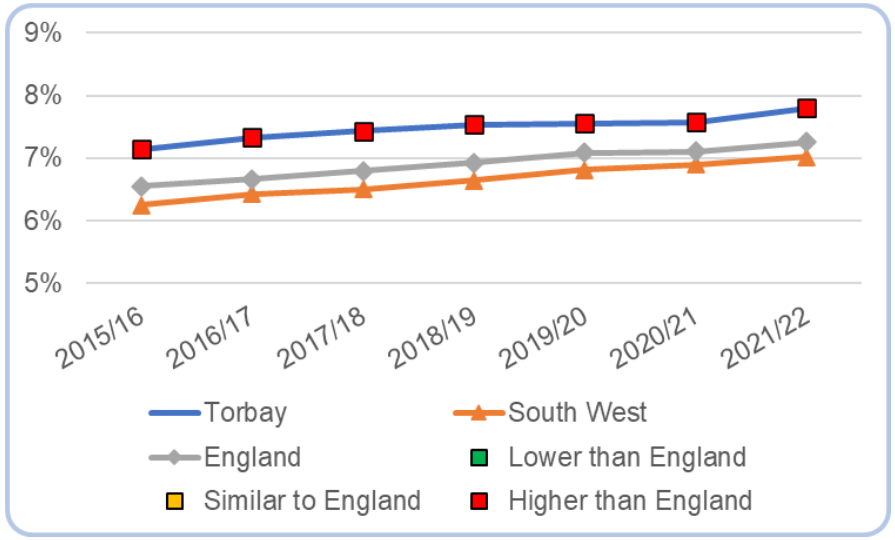

Fig 256: Number of patients recorded as having Diabetes (17+) - Torbay
Source: Fingertips

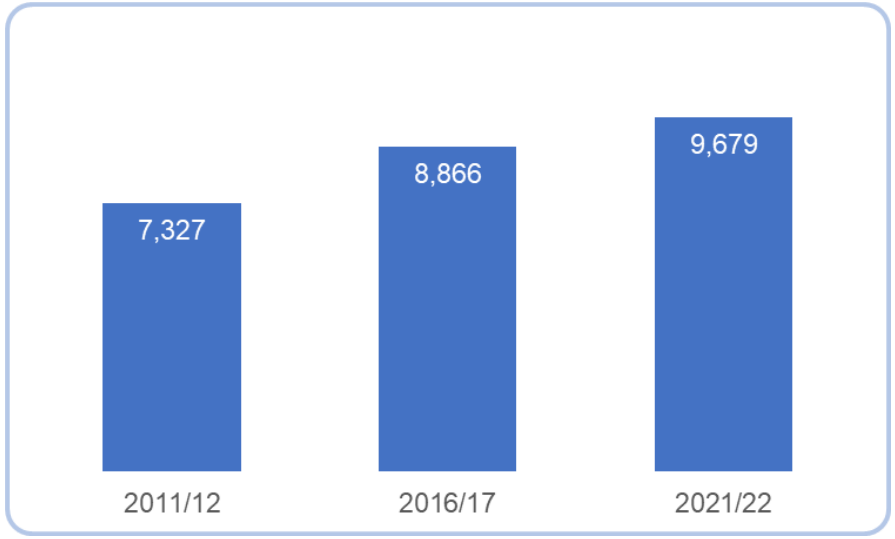

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Fig 257: Number of patients with Type 2 diabetes by age group – Torbay (2021/22)
Source: National Diabetes Audit

	Type 2 registrations
Aged under 40	235
Aged 40 to 64	3,205
Aged 65 to 79	3,700
Aged 80 and over	1,600

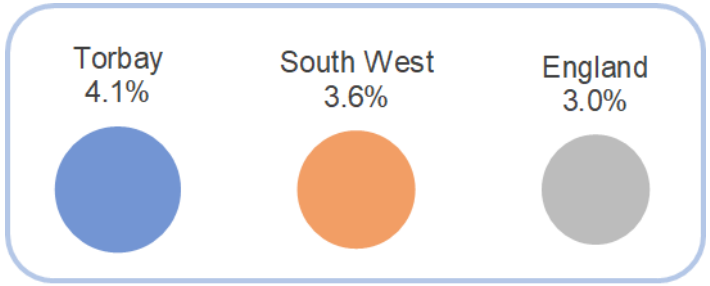
The Royal National Institute of Blind People (RNIB) offer a sight loss data tool that provides data at a local level at Sight Loss Data Tool | RNIB , the data tool can be downloaded at the bottom of the webpage link above which gives some information around rates of Diabetic eye screening and Diabetic eye disease.

There is further information around diabetes at National Diabetes Audit - NHS Digital and Context | Diabetic foot problems: prevention and management | Guidance | NICE

Heart Disease

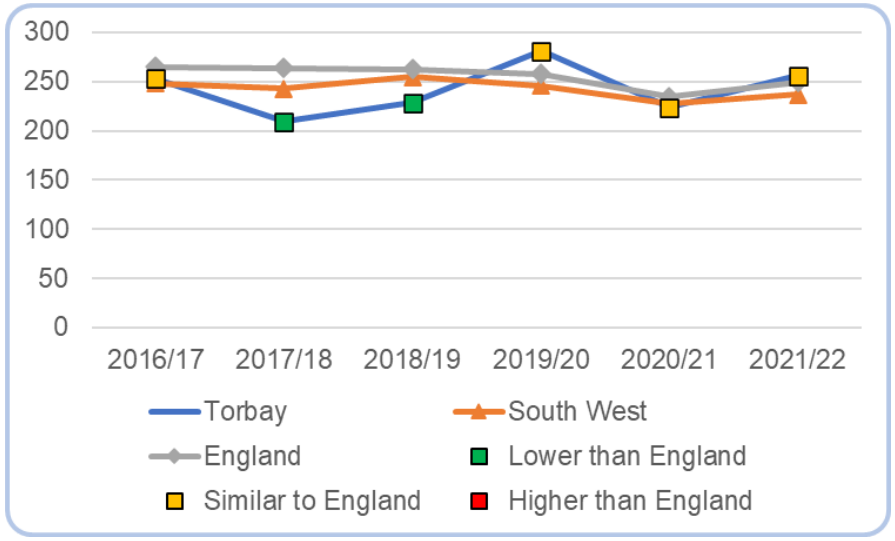
Heart Disease is a cardiovascular disease such as heart failure or coronary heart disease. Coronary heart disease is the single most common cause of premature death in the UK (OHID – Fingertips). Coronary heart disease prevalence as recorded by the Quality Outcomes Framework has shown the prevalence recorded by GP practices to be significantly higher than national and regional rates. For 2021/22, 4.1% of patients on Torbay GP Practice lists were recorded as having coronary heart disease as opposed to 3.0% across England (Fig 258). These rates have been broadly flat over the last decade.

Fig 258: Coronary Heart Disease Prevalence (2021/22)
Source: Fingertips



Allowing for age, Torbay's rate of emergency admissions for coronary heart disease is broadly in line with England and the South West, it has been steady over the last 6 years (Fig 259).

Fig 259: Rate of emergency hospital admissions for coronary heart disease per 100,000 (Age Standardised)
Source: Hospital Episode Statistics



Within Torbay, rate of admissions are significantly higher among the most deprived areas of Torbay when compared to the Torbay average (Fig 260). Rates of emergency admissions are highest

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amongst those aged in their 70s (Fig 261). Almost twice as many emergency admissions related to males (1,648 admissions) when compared to females (853 admissions) over the 6 year period 2016/17 to 2021/22.

Over the last 10 years, those aged under 75 who live in the most deprived areas of Torbay have a significantly higher mortality rate from coronary heart disease than those who live in the less deprived areas of Torbay. Those in the most deprived quintile are more than twice as likely to die from coronary heart disease before the age of 75 than those in the middle quintile of deprivation (Fig 262). Overall, there were 123 female and 444 male deaths over the 10 year period 2012-2021 of Torbay residents under the age of 75 from coronary heart disease.

Fig 260: Rate of emergency hospital admissions for coronary heart disease per 100,000 (Age Standardised) by deprivation quintile – Torbay (2016/17 to 2021/22)

Source: Hospital Episode Statistics

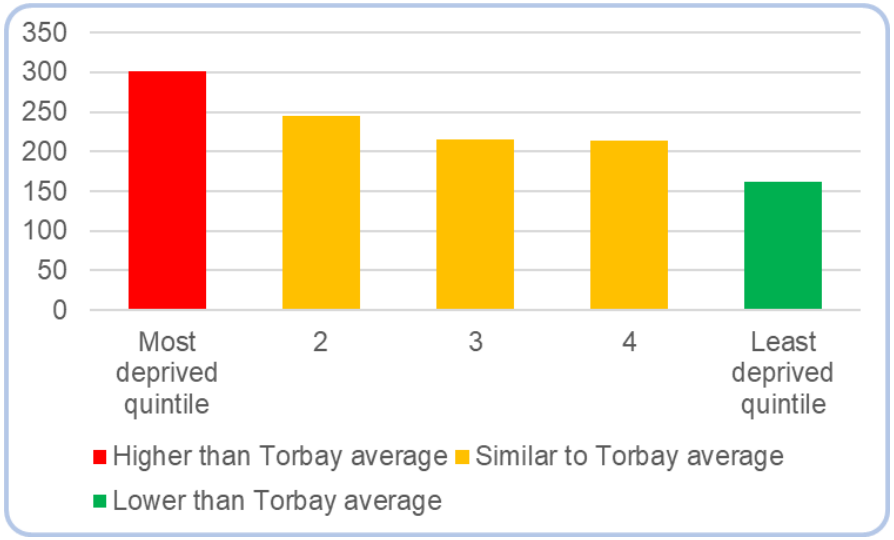

Fig 261: Rate of emergency hospital admissions for coronary heart disease per 100,000 (Age Standardised) by age group – Torbay (2016/17 to 2021/22)

Source: Hospital Episode Statistics

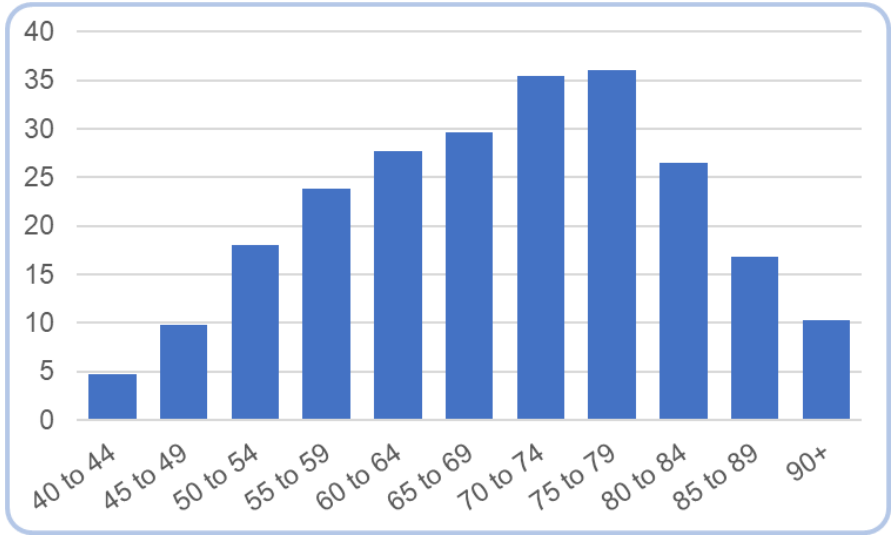

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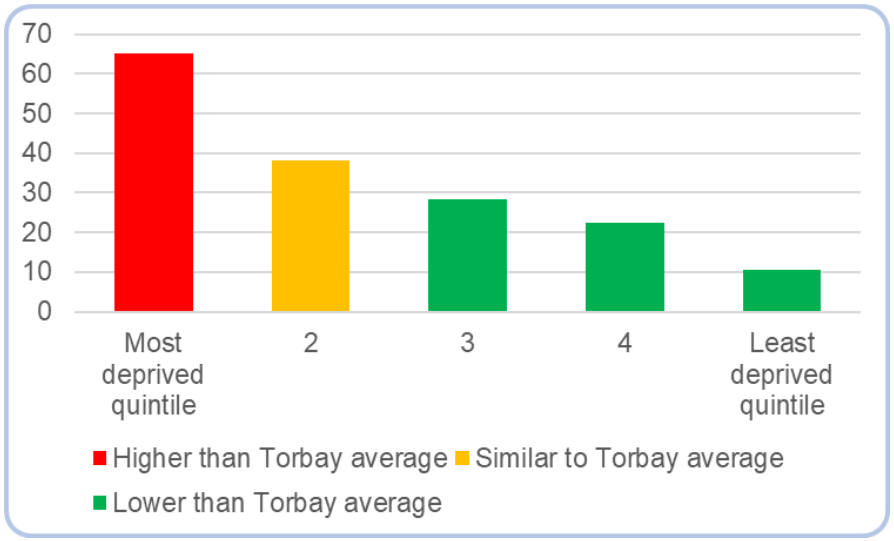
Fig 262: Rate of under 75 mortality for coronary heart disease per 100,000 (Age Standardised) – Torbay (2012 to 2021)
Source: Primary Care Mortality Database



Hypertension which is commonly known as high blood pressure increases your risk of having a heart attack, it is a condition that many people do not realise that they have and as such the prevalence rates recorded by GPs will be significant underestimates.

Hypertension prevalence as recorded by the Quality Outcomes Framework has shown the prevalence of hypertension recorded by GP practices to be significantly higher than national and regional rates. For 2021/22, 18.0% of patients on Torbay GP Practice lists were recorded as having hypertension as opposed to 14.0% across England (Fig 263).

Heart failure causes a substantial impairment of the quality of life and is very costly for the NHS to treat, second only to stroke (OHID – Fingertips), it is a long-term condition that tends to get gradually worse over time, but symptoms can often be controlled for many years.

Heart failure prevalence as recorded by the Quality Outcomes Framework has shown the prevalence of heart failure recorded by GP practices to be higher than national and in line with regional rates. For 2021/22, 1.2% of patients on Torbay GP Practice lists were recorded as having heart failure as opposed to 1.0% across England (Fig 264). It should be noted that Torbay's GP patient population is older than England so it would be expected that heart failure prevalence would be higher.

Fig 263: Hypertension Prevalence – Torbay
Source: Fingertips

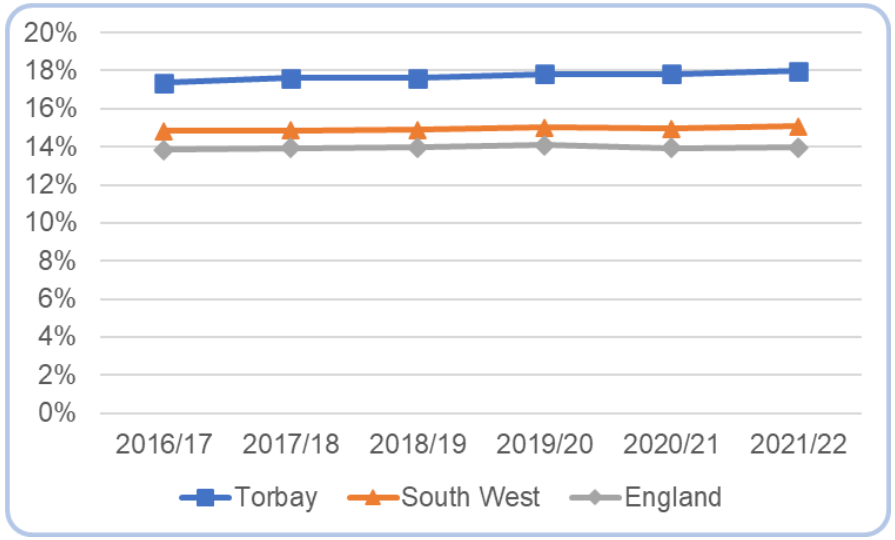


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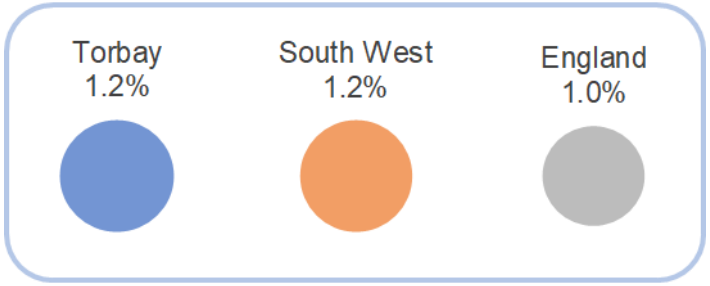
Fig 264: Heart Failure Prevalence (2021/22)
Source: Quality Outcomes Framework



Actionable Risk factors

Both Type 2 Diabetes and Heart Disease have a number of common actionable risk factors to lower your chance of suffering either. For both, you can help reduce your risk by controlling your weight, exercising regularly, stopping smoking and eating a balanced healthy diet.

The prevalence of adult smokers in Torbay according to the Annual Population Survey was 15.4% for 2021 which is a little higher but broadly in line with the South West and England, rates have declined significantly since 2012 although they have flattened over the last 5 years (Fig 265). Rates are higher for adult males at 17.9% when compared to adult females at 12.9%, this difference is broadly reflected across the South West and England.

There are also significant differences within Torbay around smoking prevalence dependent on the broad socio-economic group you are in. Those who have never worked, are long-term unemployed or work in routine and manual occupations generally have higher smoking rates although these rates have fallen over the last decade. Those in groups classified as Intermediate or Managerial and Professional are less likely to smoke but their rates of smoking have fallen by a smaller proportion over the last decade (Fig 266).

Fig 265: Smoking Prevalence in adults
Source: Fingertips

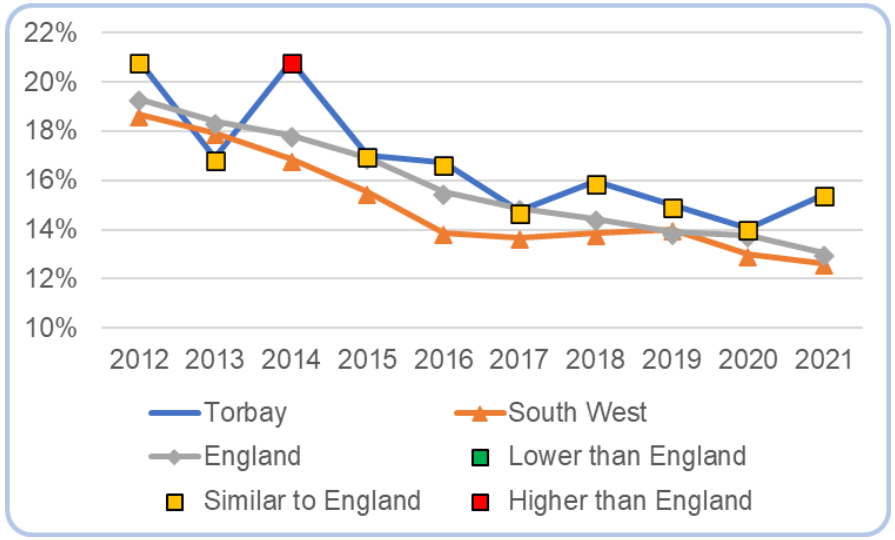
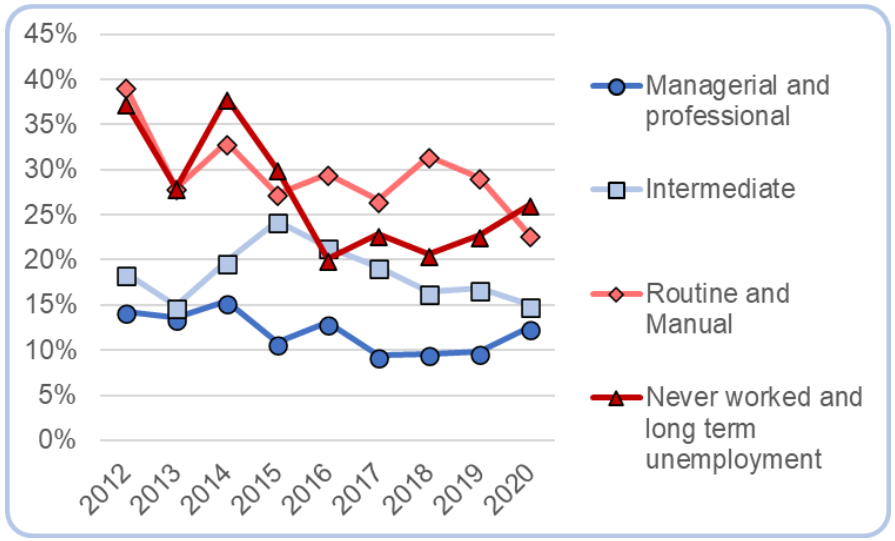


Fig 266: Smoking Prevalence in adults by socio-economic group (Torbay)
Source: Fingertips



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Sport England undertakes an annual 'Active Lives Survey' for those aged 18 and over which asks for height and weight to calculate their BMI.

Looking at the 6 year period from 2015/16 to 2020/21, Torbay has a similar rate of adults classified as overweight when compared to the South West and England at 61.7% (Fig 267). When you look at England figures, the percentage of those who are classified as overweight increases with age until you reach those who are 85 years and older (Fig 268). Across the last 6 years, males are 10 to 13 percentage points more likely to be classified as overweight when compared to females, for 2020/21, 69% of males and 58% of females were classified as overweight across England.

Those who live in more deprived areas are more likely to be classified as overweight when compared to those in the least deprived areas, for 2020/21 across England, 72% of those in the most deprived decile in England were classified as overweight compared to 58% in the least deprived decile. A lack of access to items such as fresh fruit and vegetables combined with highly processed food which is often a much cheaper option and significantly more calorific exacerbate this deprivation link.

Fig 267: Percentage of adults classified as overweight or obese (2015/16 to 2020/21)
Source: Fingertips

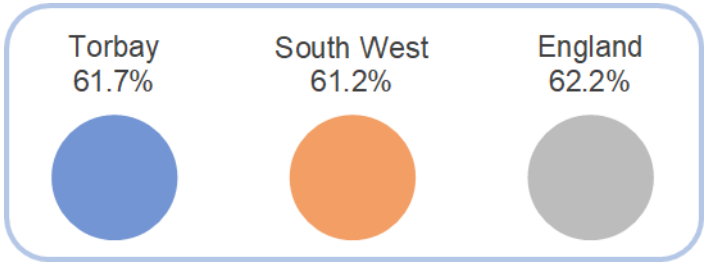
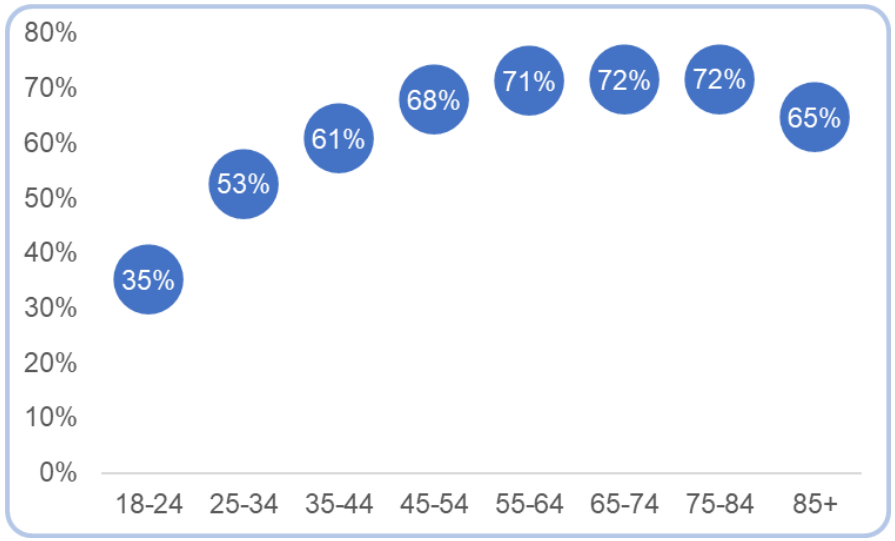


Fig 268: Percentage of adults classified as overweight or obese by age band - England (2015/16 to 2020/21)
Source: Fingertips



Data from the 'Active Lives Survey' undertaken by Sport England asks questions about a person's level of physical activity over the previous 28 days. 68% of Torbay respondents over the last 6 years said that they were physically active (150 minutes of moderate intensity physical activity per week over the last 28 days), this is broadly in line with England and the South West (Fig 269). The data was weighted to take account of differing population structures in different local authorities.

Levels of those who responded as being physically active were higher across England in the least deprived areas when compared to the most deprived areas (Fig 270).

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Fig 269: Percentage of adults classified as physically active (2015/16 to 2020/21)
Source: Fingertips

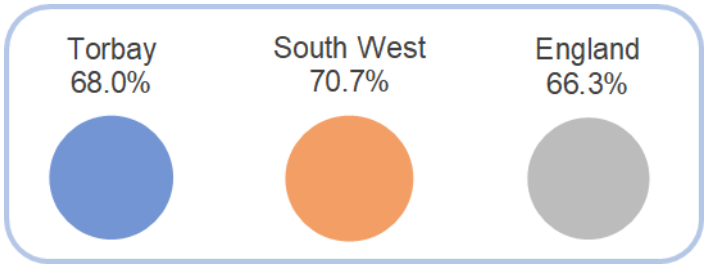
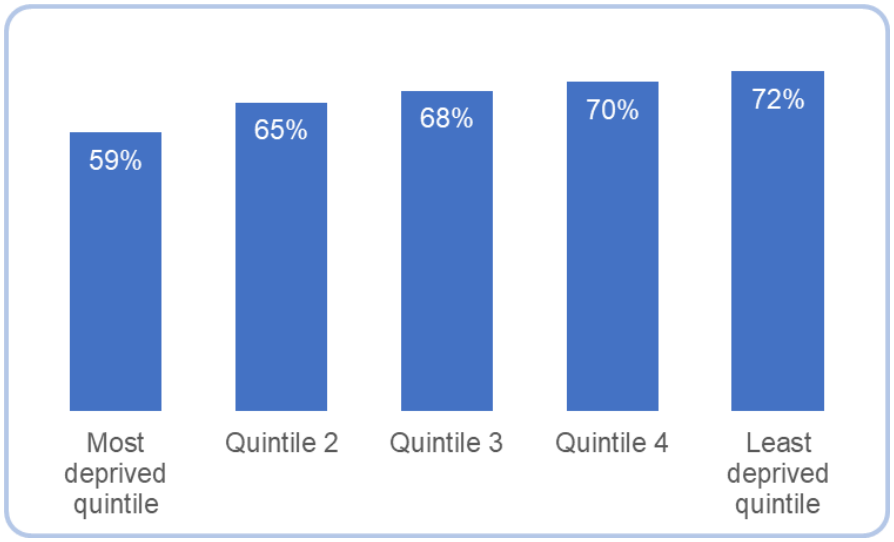


Fig 270: Percentage of adults classified as physically active by deprivation quintile - England (2015/16 to 2020/21)
Source: Fingertips



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Indicator	Measure	Torbay	Comparator Group	South West	England	RAG compared to England (Latest Year)	Direction of travel compared to previous period
Diabetes Prevalence (17+) (2021/22)	%	7.8%	7.7%	7.0%	7.3%	🔴	↑
Coronary Heart Disease Prevalence (2021/22)	%	4.1%	3.8%	3.6%	3.0%	🔴	↓
Emergency hospital admissions for coronary heart disease (2021/22)	DSR per 100,000	256	285	237	249	🟡	↑
Heart Failure Prevalence (2021/22)	%	1.2%	1.3%	1.2%	1.0%	🔴	↑
Hypertension Prevalence (2021/22)	%	18.0%	15.8%	15.1%	14.0%	🔴	↑
Smoking Prevalence (2021)	%	15.4%	12.8%	12.6%	13.0%	🟡	↑
Adults classified as overweight or obese (2015/16 to 2020/21)	%	61.7%	65.1%	61.2%	62.2%	🟡	↓
Adults classified as physically active (2015/16 to 2020/21)	%	68.0%	65.3%	70.7%	66.3%	🟡	↓

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Appendix

The following shows the sources of data for the RAG rated summary pages at the end of many of the chapters. There was not sufficient room to quote sources on those pages.

Demographics (Page 19)

Average Age: Census 2021
Dependency Ratio: Census 2021 – *Ratio of those aged 0 to 14 years and 65+ years divided by those aged 15 to 64*
Day to day activities limited: Census 2021
Gender identity not the same as sex registered at birth: Census 2021
BAME Population: Census 2021
Have a religion or belief: Census 2021
Gay or Lesbian, Bisexual or other sexual orientations: Census 2021
Life expectancy at birth (Female and Male): Fingertips
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Hospital admissions for mental health conditions: Hospital Episode Statistics
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Written and compiled by the Torbay Council Public Health Knowledge and Intelligence Team

For further information, please contact the Torbay Knowledge and Intelligence Team at statistics@torbay.gov.uk

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TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Torbay Drug and Alcohol Partnership (TDAP)
Wards Affected:	All
To:	Health & Wellbeing Board **On:** 22nd June 2023
Contact:	Mark Richards, Public Health Specialist
Email:	mark.richards@torbay.gov.uk

1. Purpose

1.1 To present the new Drug and Alcohol Partnership for Torbay

2. Recommendation

2.1 Members are asked to note the new partnership, its aims and objectives and the underlying national 10 year drug strategy 'From Harm to Hope.'

3. Supporting Information

3.1 The National Drugs Strategy

In 2021, the UK Government published its 10-year drugs strategy, From Harm to Hope. This followed on from Dame Carol Black's Independent Review of Drugs. The release of the strategy coincided with a period of escalating drug-related deaths in the UK surpassing the rates of many other countries.

'Drug related harm' is a term commonly used in the Strategy – it encompasses the negative health and social impacts associated with illicit drug use and the involvement of drug markets. The Strategy acknowledges that current approaches have not effectively reduced these harms. Various health and social issues including socio-economic deprivation, mental and physical health problems, stigma, trauma and homelessness may both pre-dispose and be exacerbated by drug dependence.

The Strategy is to be delivered through three 'pillars' or priority areas that focuses on both adults and young people.

3.1.2 1.Breaking drugs supply chains: reducing drug availability by targeting supply chains, including international, wholesale and retail providers with a particular focus on county lines drug dealing (when drugs are transported from cities to other areas and sold via a mobile phone 'line.'

2.Delivering a world class treatment and recovery system. Rebuilding and re-investing in treatment services, promoting integration of drug treatment, health and criminal justice services. Also, improving employment and accommodation opportunities.

3.Achieving a generational shift in the demand for drugs. Reducing demand by applying 'tougher and more meaningful consequences' to deter use, delivering education programmes in schools and supporting at risk families.

3.1.3. Delivery mechanism: each local authority is required to create a strategic Combating Drugs Partnership (CDP) to oversee delivery against the three pillars plus 15 supporting Commitments. Delivery will be monitored through a National Outcomes Framework and supporting metrics (see Appendix). Every CDP should comprise all relevant agencies and have senior leadership - usually through the local authority.

- Each CDP is required to undertake a local *Drug and Alcohol Needs Assessment* – outlining Torbay's position against the national metrics and identifying potential early areas of delivery (see Appendix).
- Each CDP is then required to design and deliver an *Action Plan* that includes all local groups with current and intended delivery against the 3 pillars and 15 commitments, as well as recognising and actioning improvement required and gaps in the system.

Though 'light touch', governance and oversight are provided at national level by the Joint Combating Drugs Unit (JCDU), with every CDP required to submit update reports on a regular basis.

3.1.4 Outcomes and Metrics (example only, full set available in the National Combating Drugs Outcomes Framework Pg 6&7)

1. Strategic

- *Outcome*: Reduce drug related crime
- *Headline Metric*: Number of neighbourhood crimes, domestic burglary, vehicle offences and theft from the person
- *Supporting Metric*: Proven re-offending within 12 months

2. Intermediate

- *Outcome:* Increase engagement in treatment
- *Headline Metric:* Continuity of care – engagement in community based structured treatment within three weeks of leaving prison (adults)
- *Supporting Metric:* Number of individuals in treatment in prisons and secure settings

3.2 Torbay Drug & Alcohol Partnership (TDAP)

Alongside other CDPs in the region, Torbay took the early step of including alcohol in local delivery and planning. This step has been encouraged by JCDU due to the integral nature of drugs and alcohol including dual use and the harms outlined in 3.1.

Achievements to date:

- TDAP *Terms of Reference* agreed.
- Partnership meetings held since Sept 2022
- Torbay *Joint Needs Assessment* completed (see Appendix). This then informs the *Delivery Plan* currently in development: mapping current and intended delivery by Torbay multi agency groups against the pillars, commitments and metrics.

3.2.1 Examples of work included within the Delivery Plan:

Priority 1: *Breaking the Drug Supply Chains.*

- D&C Police campaign to raise awareness of the signs of exploitation in adults and young people due to County Lines recruitment.
- Enhanced prison search capability. HMP Exeter has an airport style metal detection system and x-ray baggage scanners.

Priority 2: *Deliver a World Class Treatment and Recovery System.*

- A virtual multi-disciplinary team now meets every quarter to discuss care experienced adults who have complex multiple needs and are either homeless or at risk of homelessness.
- Drug and Alcohol Service service now doing prison in-reach work to enable release planning.
- Social Prescriber based in Probation supporting those with substance misuse issues transitioning into the community and meeting their wider health needs.

Priority 3: *Achieve a Generational Shift in the Demand for Drugs*

- Substance Misuse Outreach Worker to deliver place and education based support, increasing numbers in treatment and strengthen referral pathways.
- Workforce development and training in dual diagnosis (substance misuse/mental health).

4. Relationship to Joint Strategic Needs Assessment

4.1 Utilises the same data sources for drug and alcohol as incorporated in the TDAP Drug and Alcohol Joint Needs Assessment.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 TDAP focus on the life course and multiple workstreams supports numerous Priority Areas 1-4 of the strategy.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 No implications at this point.

Appendices

Outcomes Framework & Supporting Metrics

Torbay Drug and Alcohol Joint Needs Assessment (including pillar/Priority Areas and Commitments).

TDAP JNA FINAL JAN23.pdf

Background Papers

National Drugs Strategy 'From Harm to Hope'

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Devon Smokefree Alliance Strategy (2023-2028)
Wards Affected:	All wards
To:	Health & Wellbeing Board **On:** 22nd June 2023
Contact:	Claire Tatton, Public Health Practitioner, Mark Richards, Public Health Specialist
Email:	Claire.tatton@torbay.gov.uk Mark.richards@torbay.gov.uk

1. Purpose

To present the Devon Smokefree Alliance Strategy 2023-28.

2. Recommendation

Members are asked to note the new strategy and priority areas.

3. Supporting Information

Smoking in Torbay

Despite a continuing decline in the prevalence of smoking over recent years, smoking remains the leading cause of illness and premature mortality in the UK. Additionally, smoking is one of the largest contributors to health inequalities with some of the highest incidence rates and harm concentrated to disadvantaged groups and communities.

In Torbay, prevalence of adult smokers (18+) is 15.4% which is higher than the England value. Smoking at time of delivery and smoking attributable hospital admissions are both significantly higher than the England values and smoking in manual and routine occupations is similar to the England value. The proportion of 15 year olds who are regular smokers is around 5% (2018 data) with 84% of 11 – 15-year olds reporting they have never smoked.

Devon Smokefree Alliance

The Devon Smokefree Alliance is a partnership across Public Health teams, the NHS, Trading Standards, Environmental Health, children's centres, schools, youth settings, fire services, police, housing, Community Safety Partnerships, and the voluntary sector. The Alliance is committed to reducing the prevalence of smoking in Devon and is a member of the Smokefree Action Coalition.

The Alliance strategy and plans are based on the national Tobacco Control Plan for England and are informed by local need through the Joint Strategic Needs Assessments.

Progress under the last strategy (2018-2023)

A summary of progress made under the priority areas of the previous strategy is provided below:

Protect children and young people from tobacco and encourage smokefree pregnancies.

- The Treating Tobacco Dependence maternity pathway (delivered by Torbay and South Devon NHS Foundation Trust) launched in June 2022 and has supported 39 pregnant women to stop smoking to date.
- Torbay Council Public Health and Health Visitors in Torbay contributed to a regional sector level improvement group tasked with creating a set of recommendations to help achieve smokefree homes via the health visiting and midwifery pathways. In Torbay, the 0-19 service has benchmarked provision against the recommendations. An action plan has been created and changes to practice will be embedded by September 2023 to achieve minimum requirements of the recommendations.
- Joint working across the stop smoking services, Community and Leisure Teams, Public Health, and primary schools to develop Smokefree Play Parks – the main aspect being new pupil designed signage for the park entrances. The design is currently being finalised and signs will be produced over the summer.
- Ongoing work by Trading Standards conducting underage sale test purchases and handling complaints of underage sales both in relation to cigarettes and vapes.
- Partners across the Alliance collated and circulated information and guidance for Schools utilising content from Action on Smoking and Health (ASH) with a covering letter from the Director of Public Health.
- Working with Public Health colleagues across the region, and the Office for Health Improvement and Disparities, created a position statement on vaping from the Association of Directors of Public Health Southwest. This is currently being finalised.

Reduce health inequalities caused by smoking and support vulnerable groups to be Smokefree.

- Development of the mental health Treating Tobacco Dependence pathway across Devon through Devon Partnership Trust.
- Stoptober events were held in Job Centres in Torbay to offer support to those not in employment. Joint working with Job Centres and other organisations is being built upon by the recommissioned Torbay Healthy Behaviours Service (Your Health Torbay) both in relation to future Stoptober events and routine service delivery.

- Ongoing work by Trading Standards to reduce illegal and illicit tobacco and vapes including seizing over 600 illegal vapes in Torbay.
- Delivered a vape pilot to residents of Leonard Stocks Centre during the COVID-19 lockdown period to reduce tobacco use and sharing of tobacco products. Three clients quit using tobacco and switched to vaping and one client reduced their tobacco consumption by only smoking occasionally. 11 clients signed up to receive further support from the Healthy Lifestyles Team.
- Worked with colleagues in Plymouth to apply for funding from the National Institute for Health Research (NIHR) to pilot and evaluate a vape programme to support homeless people and those in drug and alcohol services to stop smoking. Application has passed first stage and outcome of stage two awaited.

Create and support Smokefree organisations, particularly NHS organisations.

- Development of the NHS Long Term plan Treating Tobacco Dependence programmes across acute hospitals in Devon and Devon Partnership NHS Trust.
- Provided evidence-based and up to date information about e-cigarettes to support the update of organisational smokefree policies.
- Reviewed the Devon Formulary to standardise availability and use of medication and nicotine replacement therapy products across the ICB footprint.

Priorities and areas for action for 2023-2028

A summary of the priorities and areas for action are provided below. To view the full strategy, please see Appendix.

Protect children and young people from the harms of tobacco and de-normalise tobacco use to help prevent uptake.

Areas for action include supporting smokefree pregnancies and smokefree homes, monitoring vape use in young people, working with schools to ensure young people understand the risks of vaping and enforcement of underage sales of vapes.

Reduce health inequalities caused by smoking.

Areas for action include prioritising smoking cessation support to those in vulnerable groups through partnership working across sectors, Public Health commissioned services and Treating Tobacco Dependence programme delivery.

Ensure cross-sector, strategic collaboration around tobacco control, and support the development of a smokefree culture within key organisations.

Areas for action include connecting organisations across the integrated care system to ensure continued prioritisation, advocacy, collaboration, and action and to embed smokefree policies and stop smoking support in key organisations, particularly health and social care systems.

4. Relationship to Joint Strategic Needs Assessment

The priorities of the Smokefree Alliance strategy have been informed by the Joint Strategic Needs Assessment regarding smoking rates in the local population and the identification of groups at greatest risk.

5. Relationship to Joint Health and Wellbeing Strategy

The priorities of the Smokefree Alliance Strategy will support Priority 2 - a good start to life and the overarching themes of environmental sustainability and health inequalities.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

No implications at this point.

Appendices

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n%20Alliance%20Stra

Background Papers:
The following documents/files were used to compile this report:

Smoking and tobacco: applying All Our Health - GOV.UK (www.gov.uk)

Local Tobacco Control Profiles - Data - OHID (phe.org.uk)

TORBAY Joint Strategic Needs Assessment 2022/23 (southdevonandtorbay.info)

Smokefree Devon Alliance Strategy 2018-23 - Smokefree Alliance Devon

Strategy 2023-2028

Accompanying Document:
Smokefree Devon Alliance Strategy Supporting Information [due for publication end June]

Foreword

The Smokefree Devon Alliance has been providing a co-ordinated, multi-agency approach to tobacco control since 2010. In that time, we have seen a fantastic amount of collaborative working to reduce the harm caused by tobacco in Devon and a significant reduction in adult smoking prevalence. However, tobacco dependence is still the biggest cause of preventable illness and death, and high rates persist in some of our more vulnerable populations, making it a significant driver of health inequalities. We must therefore continue to focus on this important area. The Alliance will maintain and grow our strong pan-Devon partnership and provide strategic direction in all strands of tobacco control, so that we can reduce the harm caused to communities and strive for a smokefree future.

Steve Brown

Co-Chair of the Smokefree Devon Alliance
Director of Public Health, Communities and Prosperity
Devon County Council

Tobacco use is the single biggest cause of preventable death and illness. As a Smokefree Alliance we come together to demonstrate our recognition of the detrimental impact tobacco is having on people in Devon and Torbay, and to work strategically to reduce this impact. Creating a smokefree future would not only significantly lower the pressure on our hospitals and wider health care system, but it would support a greater quality of life for many local people. By working together, I know we can continue to make a difference to this very important area of work.

Joanne Watson

Co-Chair of the Smokefree Devon Alliance
Health and Care Strategy Director, Director of Infection Control and Prevention, Consultant in Acute Medicine
Torbay and South Devon NHS Trust

Introduction

Welcome to the strategy for the Smokefree Devon Alliance, which is a partnership of organisations committed to reducing the harm caused by tobacco in Devon.

We have chosen to set out the key elements of our strategy here, so it is easy to read, accessible and adaptable.

The formation of this strategy was based on extensive research into local data and insight, as well as exploration and collaboration between the multi-agency partners of the alliance. To view some of this background information, please see the *Supporting Information* document [publication due end June 2023].

Vision

Our vision is to create a Smokefree generation in Devon where people are protected from the harms caused by tobacco and second-hand smoke.

This ambition is achievable if we all work together. Tobacco impacts on all aspects of society, but the impact falls more heavily on our most vulnerable groups (ASH, 2023). We need to reduce these unjust inequalities caused by tobacco.

No single approach to tackling smoking will be successful; concerted, sustained, and co-ordinated action on a number of issues by a wide range of stakeholders, agencies and individuals is required.

This strategy sets out the aims and objectives of the Smokefree Devon Alliance for the next five years.

Aim

The aim of this strategy is to improve the health of Devon's population by reducing the prevalence of smoking and exposure to second-hand smoke, in doing so reduce health inequalities and smoking related illnesses and deaths.

Priorities

To achieve our aim, we have decided to focus on the following strategic priorities:

Priority 1:

Protect children and young people from the harms of tobacco and de-normalise tobacco use to help prevent uptake

Areas for action:

- Support smoke free pregnancies in line with NG209
- Ensure good quality antenatal support around smoking cessation and smokefree homes
- Raise awareness of the harms of secondhand smoke to children and young people and promote smokefree environments
- Ensure effective communication, regulation and enforcement of smokefree legislation, including the prevention of underage tobacco sales and adherence to vape regulations
- Monitor vape use in young people, respond to local intelligence and promote vape education in schools
- Uplift mass media campaigns
- Co-ordinate approaches across Devon and Torbay to tobacco and related products in schools, ensuring schools have access to tobacco education resources and example smokefree policies
- Ensure professionals routinely refer children and young people who smoke for support to quit which is age appropriate
- Support and protect children in care by working in partnership to ensure effective smokefree policies and support routes

Priority 2:

Reduce health inequalities caused by smoking, by supporting high quality evidence-based interventions, with a focus on achieving equity and fairness.

Smoking is the single most important driver of health inequalities (ASH, 2023). As smoking is so detrimental to health, any success in reducing prevalence amongst disadvantaged populations has an impact on reducing health inequalities.

Areas for action:

- Ensure stop smoking services and pharmacotherapy are available and accessible to all

- Prioritise vulnerable groups in which smoking prevalence is high, or where the impact of tobacco use is particularly detrimental. We will respond to local data and insight, but will include those:
    - living with mental health conditions
    - currently pregnant or recently had a baby (including their families)
    - working in routine and manual occupations
    - living in areas of high deprivation
    - at risk of or experiencing drugs and/or alcohol misuse
    - living in social housing, vulnerably housed or experiencing homelessness
    - in the criminal justice system

- Develop and strengthen cross-organisational pathways to increase the opportunities for vulnerable groups to access stop smoking support, including within the Voluntary, Community, Social Enterprise (VCSE) sectors

- Support delivery of the Treating Tobacco Dependence programme within NHS Trusts in Devon, Torbay and Plymouth, ensuring focus on actions which reduce health inequalities

Priority 3:

Ensure cross-sector, strategic collaboration around tobacco control, and support the development of a smokefree culture within key organisations

Areas for action:

- Connect organisations across the Integrated Care System on the topic of tobacco control, to ensure continued prioritisation and to provide a forum for debate, advocacy, collaboration and action
- Embed smokefree policies and stop smoking support in key organisations, particularly health and social care systems
- Support the Treating Tobacco Dependence steering group, ensuring good communication across the system and encouraging consideration of the wider culture within organisations which can support delivery
- Support organisations to consider the role of vaping in their smokefree policies, drawing on scientific evidence
- Continue to participate in CLeaR, an evidence-based improvement model to promote excellence in tobacco control

Objectives

By 2028, the Smokefree Devon Alliance hopes to have achieved the following objectives:

1. There is sustained reduction in smoking prevalence compared to the baseline data in the indicators listed below:

	Most recent figure at time of writing (April 2023)			Indicator Last Updated
	Devon	Torbay	Plymouth	
Smoking Status at Time of Delivery	11.6%	11.5%	11.5%	2021/22
Smoking prevalence in adults with a long-term mental health condition (18+) - current smokers (GPPS)	24.7%	33.3%	28.3%	2020/21
Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	23.7%	22.7%	28.6%	2020

Statistically signifcantly better compared to England | Statistically similar compared to England | Statistically signifcantly worse compared to England

Source: Tobacco Control Profiles (OHID, 2023)

2. There is good collaborative working across the Integrated Care System which enables a joined-up approach to smoking cessation, consistency, and equity in delivery. The Smokefree Devon Alliance, the Integrated Care Board, Local Maternity and Neo-Natal Services (LMNS), Public Health, community stop smoking services and secondary care are all connected and participating in discussions in partnership, and reporting structures are in place and working effectively.

3. The Smokefree Devon Alliance has prioritised supporting smoking cessation services to reach and support people with mental health conditions and pregnant women and people to quit each year across Devon and Torbay. This information is regularly collected and monitored, to allow measurement of progress towards this objective and for services to regularly evolve and improve.

4. The sale and supply of illegal tobacco in Devon is disrupted. Activity is measured by the quantity of illegal tobacco products (including vapes) seized by Trading Standards, the number of enforcement measures taken against suppliers and ultimately by a reduction of complaints. Also by the number of “cease and desist” letters sent to illegal tobacco sellers.

5. Data on smoking and vaping prevalence amongst children and young people in Devon and Torbay is routinely collected, enabling the actions of the Smokefree Devon Alliance to be informed by intelligence.

Strategy Implementation: Action Plan

Smokefree Devon Alliance members have outlined their actions towards this strategy in the action plan, to ensure effective delivery. Members are expected to directly update progress next to their relevant actions. The plan will be regularly reviewed at meetings.

Reporting Our Progress

An annual update summary report will be provided to Devon and Torbay Health and Wellbeing Boards.
This report will be created for the Summer meeting of the health and wellbeing boards. It will also be disseminated to other key stakeholders.

Please see the supporting document *Smokefree Devon Alliance Background Information* for more information on the Alliance's governance structure.

The reporting timeline and log can be found here.

Principles

a) This is a shared vision to which we are all committed.
b) We will work together, be brave and innovative, and utilise the power of collective action and leadership.
c) We will draw on the best available evidence, insight, and intelligence. We will share good practice and listen to residents, communities, service users, and service deliverers.

Links to key reports and information

Speech from Neil O'Brien MP on Achieving a Smokefree 2030
Tobacco Control Plan for England
Devon Joint Health and Wellbeing Strategy
Devon Joint Strategic Needs Assessment (JSNA)
Torbay Joint Health and Wellbeing Strategy
Torbay Joint Strategic Needs Assessment (JSNA)
NICE Guidance 209 - Tobacco: preventing uptake, promoting quitting and treating dependence
The Khan review: making smoking obsolete

References

ASH, 2023. *Tackling Inequalities.* Available from: https://ash.org.uk/health-inequalities/tackling-inequalities [Accessed 11 April 2023].

OHID, 2023. *Local Tobacco Control Profiles.* Available from: https://fingertips.phe.org.uk/profile/tobacco-control [Accessed 11 April 2023].

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title: Devon Integrated Care System Joint Forward Plan

Wards Affected: All

To: Health and Wellbeing Board **On:** 22 June 2023

Contact: Lincoln Sargeant, Director of Public Health
Telephone:
Email: Lincoln.Sargeant@torbay.gov.uk

1. Purpose

The purpose of this report is to present for information the agreed One Devon Joint Forward Plan.

2 Background

Integrated Care Systems are required to produce an Integrated Care Strategy setting out the challenges faced by the local system and the strategic goals that will address these. A Joint Forward Plan is then developed detailing the implementation programmes that will deliver these goals.

Members received at the March meeting a draft of the One Devon Integrated Care Strategy and commented on the content. Health and Wellbeing Board chairs in Devon were also invited to input into the Strategy and the developing Joint Forward Plan at Buckfast on 23 March 2023.

The final Joint Forward Plan was approved by NHS Devon on 7 June 2023 and is being shared with Health and Wellbeing Board members for information.

3. Recommendation

Members are asked to note the content of the Joint Forward Plan.

4. Supporting Information

The Joint Forward Plan is a system wide plan which broadly describes the services And systems which will meet the needs of the whole population as set out in the Integrated Care Strategy. It reflects an intention to work in collaboration and partnership to deliver our system ambitions, but it is important to acknowledge that statutory duties remain with individual organisations.

The Joint Forward Plan sets out the plans in place across the local NHS and wider Devon System and the key milestones for delivery over the next five years. It brings together the strategies and plans that are in place or in development across the system, in individual organisations, in collaboratives and in system programmes, into a single over-arching Plan and aligns these to the strategic goals set out within the Integrated Care Strategy.

The Joint Forward Plan does not cover everything that partners are doing across the system. It include priorities in areas of wider social and economic importance, such as housing and employment, as their impact on health and wellbeing is significant and these are areas requiring collaborative working.

Page 4 of the document includes the response of the three Health and Wellbeing Boards in Devon to the draft Strategy and Joint Forward Plan, confirming they and their officers had been engaged in the process of development and relevant local authority health and wellbeing priorities were incorporated.

The nine key delivery programmes in the Plan are below.

There are also ten ‘enabling programmes’ which include population heath, system development, workforce, sustainability, research, finance, digital, estates, equality and communications and engagement.

Progress towards delivery of the strategic goals will be overseen by the Integrated Care System Executive and will report to the One Devon Partnership. Progress will also be monitored more locally through the South Local Care Partnership (LCP). Torbay Council has membership on both the One Devon Partnership and the LCP.

Publication of the Plan makes the start of an ongoing new relationship with system partners and communities, which will see both the Strategy and the Joint Forward Plan refreshed on an annual basis.

4. Relationship to Joint Strategic Needs Assessment

4.1 Priorities of all JSNAs in Devon are reflected in the strategy and Joint Forward Plan.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 Priorities reflect areas of priority within the Torbay Joint Health and Wellbeing Strategy and it will be important to ensure consistency in implementation.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 Future iterations of the Joint Health and Wellbeing Strategy will take account of the Integrated Care Strategy priority areas.

Appendices

1 The Joint Forward Plan is appended.

One Devon

Devon 5 Year Joint Forward Plan

Final

7 June 2023

#OneDevon

Contents

Signatures to be added

Foreword

We are excited to publish this, the first Devon 5 Year Joint Forward Plan (JFP), which signals a different way of working within the Devon system, for the first time bringing together plans from across different sectors within health and care in response to the One Devon Integrated Care Strategy. Local Authorities and the NHS have agreed that they will work together and be held jointly responsible for delivering the plan.

The Strategy set out the key challenges for the Devon health and care system and a set of strategic goals aimed at tackling these challenges over the next 5 years. Over recent months, system partners have been working to ensure that they take account of the Strategy in their planning, in a way that ensures alignment between health and other sectors. The Devon Joint Forward Plan brings together the strategies and plans that are in place/in development across our system, in individual organisations, in collaboratives and in system programmes, into a single over-arching Plan and has aligned these to the strategic goals set out within the Integrated Care Strategy.

In parallel, NHS partners have been developing an operational plan for 2023/24 and a recovery plan that will see both NHS Devon and partner NHS trusts move out of segment 4 of the NHS Oversight Framework by June 2024 and Local Authority partners have been planning to manage their own significant operational and financial pressures. Development of the JFP therefore recognises this context and the need to ensure that our system recovery is prioritised in the early years of the Plan and that we earn the autonomy we need to deliver transformational change. The detailed actions and milestones set out within the JFP have been aligned to recovery plans where relevant and deliverability continues to be tested, to ensure that our objectives, though ambitious, are ultimately realistic and achievable.

The JFP does not cover everything that we are doing across our system – it includes priorities in areas of wider social and economic importance, such as housing and employment, as we know that their impact on health and wellbeing is significant and these are areas where we need to develop our collaborative working.

SIGNATURE

Sarah Wollaston

SIGNATURE

Jane Milligan

Health and Wellbeing Board Opinions

There has been ongoing engagement with the three Devon Health & Wellbeing Boards throughout development of the Joint Forward Plan. Each of the Boards has submitted a formal opinion on the extent to which the JFP reflects their Health & Wellbeing Strategy, which is reproduced below. Two of the three local authorities have been through a local election process in May 2023 and engagement will continue with the reformed HWBs, as part of our ongoing work to refresh the Joint Forward Plan.

Torbay Council

By consensus [Health & Wellbeing Board] Members resolved that:

1. the draft Joint Forward Plan takes proper account of the Joint Local Health and Wellbeing Strategy;
2. the minutes of the Board meeting on the 9 March 2023 will constitute the response in writing of the Health and Well Being Board and its opinion in respect of (1).

This opinion has been confirmed as unchanged in relation to the final published JFP.

Plymouth City Council

Plymouth's HWB has been engaged throughout the process of development of the JFP and has been consulted, with the opportunity to raise questions and highlight potential omissions.

The Plymouth HWB endorses the Plan and is assured that it takes account of the current health and wellbeing strategy for Plymouth. The focus on inequalities in access and in outcomes is welcomed, and we look forward to seeing the shift in resources required to deliver on this aim.

Devon County Council

The Devon Health and Wellbeing Board has been engaged throughout the process of development of the JFP and has been consulted on each formal draft, raising questions and highlighting potential omissions.

The DCC HWB is happy to endorse the Plan and is assured that it takes account of the current health and wellbeing strategy for Devon.

Executive Summary

The Devon Joint Forward Plan

In line with national requirements, the Integrated Care System (ICS) in Devon (One Devon) produced an Integrated Care Strategy in December 2022, setting out the 12 key challenges that Devon faces and identifying a set of strategic goals that will help to address the challenges, aligned to the ***four core purposes of ICSs.***

The One Devon Partnership asked system partners to work together to make the JFP a true shared response to the Devon Integrated Care Strategy, as encouraged in the national Guidance. This JFP therefore reflects the work that is happening across the wider Devon system, in the health and care sectors and beyond, and demonstrates how this work aligns with the strategic goals in the Strategy and how it will deliver the required improvements in health and wellbeing.

Several **golden threads** run through all of the delivery and enabling programmes, including prevention (focusing on the five main causes of death and disability), population health, improved outcomes, personalisation and empowerment of individuals, inclusion, quality and safety of care and continuous learning and improvement.

It is important to acknowledge that the three local authorities in Devon are under significant financial pressure. Furthermore, NHS Devon and all three NHS acute provider trusts in Devon have been assessed as being in segment 4 of the NHS Oversight Framework. This means that we are subject to enhanced direct oversight by NHS England and additional reporting requirements and financial controls. The JFP therefore reflects the requirement to focus on system recovery and exiting segment 4 of the NHS Oversight Framework as priority in years 1-3 of the Plan, as well as setting out how the system will work together in a different way, to deliver transformational change and improve the health and wellbeing of the population creating a sustainable health and care system in Devon.

The Joint Forward Plan is a system wide plan which broadly describes the services we have in place and will develop to meet the needs of our whole population as set out in the Integrated Care Strategy. It reflects an intention to work in collaboration and partnership to deliver our system ambitions, but it is important to acknowledge that statutory duties remain with individual organisations. There are some specific statutory duties that the ICB needs to deliver as part of its statutory function, that must be met through the JFP, and these duties are incorporated throughout the plan.

Development of the Integrated Care Strategy and Joint Forward Plan has involved significant engagement and involvement activities, including analysis of extensive public feedback about health and care (collected from system partners across One Devon) between 2018 to 2022 and regular engagement with Joint Overview and Scrutiny Committees, Health & Wellbeing Boards and wider system partners through working groups and facilitated feedback events.

Delivering a Sustainable System

The JFP sets out the plans in place across the local NHS and wider Devon System and the key milestones for delivery over the next five years, but, additionally, there is an immediate requirement to stabilise the financial position and recover activity, to improve operational performance, access and quality of care. In order to achieve both of these, we need to transform the way we work together across our system – creating new ways of working was identified as a key determinant of successful delivery of the Devon Plan.

We plan to deliver the significant strategic work required to enable the successful delivery of our 5-Year Integrated Care Strategy, focusing on creating an environment for success, including:

- strengthening collaborative and integrated working through cultural change and adoption of the guiding principles resulting from the Case for Change
- adopting a Value-based Approach
- setting out a roadmap for ICS development
- embedding our agreed Devon Operating Model
- delivering financial and operational recovery

Collectively, this work responds to the significant scale of change required to achieve our vision and ambitions and establishes a sustainable way to deliver the health and care needed by the people of Devon.

Guiding principles:

- **Provide a personalised approach to health and care:** 'joined-up' packages based on individual need
- **Support our workforce:** to ensure people are able to do their best work
- **Ensure shared Decision-making:** consistently applied across all services
- **Use high value interventions:** consistently and earlier in pathways and stop providing health and care that does not add value and may be causing harm
- **Reduce our environmental impact**
- **Tackle unwarranted variation in practices, outcomes and inequality**
- **Manage risk across the system:** ensuring that decisions made in one place do not increase the risk in another and addressing challenges from a whole population perspective
- **Spread improvement and innovation**
- **Develop a 'Culture of Stewardship'**

One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money. We have set ourselves an ambitious target: ***By 2025 we will have adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.***

The model outlines how Devon will make the best use of our new collaborative structures including the One Devon Partnership (ICP), NHS Devon (ICB), provider collaboratives, local care partnerships and neighbourhoods. Adoption of the model will be completed over the next 18-24 months involving all system partners in embedding new ways of working to drive increased value to the people of Devon.

One Devon

Getting the System in balance

Financial balance is to be achieved through a focused system recovery programme focused on operational, system, clinical and intra-organisation transformation

What needs to be achieved

3 year financial plan linked to activity, workforce, performance:

- **23/24 reported position no worse than £42.3m deficit**
- **24/25 c.£30m deficit through use of non-recurrent means**
- **25/26 breakeven exit run rate position**

How we will achieve this

- Used the Drivers of the Deficit analysis as the baseline for planning and CIP expectations aligned to model hospital, GIRFT and regional benchmarks
- Stretched CIPs from 1.3% recurrent cost out to 4.5% (with system schemes in support)
- Accelerating the delivery of system-wide shared schemes
- Whole system clinically-led and planned transformation – acute through to community/primary care
- Intra-organisation wide schemes and redesign

1 **Operational improvement cost out – to 4.5%**

2 **System wide schemes – targeting c.£60m reduced run rate by Q4 23/24**

3 **Intra-organisation working and redesign**

4 **System Performance Improvement**

Activity & Performance

1. The activity required is challenging given the historic position and will require a clear Devon-wide clinical plan and new ways of working
2. Delivering on the performance position – or improving it further – will require different ways of thinking about capital, estates, digital etc (eg: a cold elective site, single PTL, sub-specialty centres, etc) as stated.

Workforce

Workforce will achieve a net -2% workforce change against the current establishment.

Delivery Principles – we will find solutions that follow these principles:

- Seek solutions that work for the system.
- No organisation will knowingly create an adverse impact on another or the system.
- Standardise practice and services where it makes sense to do so.
- Focus on cost reduction, cost containment and productivity improvements.
- Recognise that participation will be required at system, locality, neighbourhood, and organisational level on the priority areas.
- Ensure equitable distribution of funding and outcomes by locality.
- Not make new investments that lead to a deterioration in the underlying position.
- Consider financial decisions alongside quality, safety and any impact on patient experience of care.
- Share risks and benefits across the system and ensure they are fully understood by all parties.

Local Authority recovery

Our three local authorities also face significant financial and operational pressures and each has a transformation programme in place that will:

- support increased independence, choice, and control for communities;
- support timely and good quality discharge from hospital;
- support the local economy, improve job prospects and housing opportunities for local people;
- champion opportunities and improve services and outcomes for children and young people;
- support care market sustainability;
- address the impacts of the rising cost of living for those hardest hit;
- improve value for money, through cost improvement plans.

Devon's Joint Forward Plan

There are 9 key delivery programmes and 10 enabling programmes that make up the Devon JFP:

The delivery plan summarises the ambitions and the key high level objectives for each of the 9 delivery programmes and 10 enabling programmes, with additional detailed milestones and year 1 and 2 work programmes included in Appendix C and Appendix D.

Some of the key objectives for each programme are set out in the next slides.

High Level Summary of Key Objectives

Primary & Community Care
- Deliver an integrated, collaborative model of care
- Develop a proactive, preventative & personalised approach, supporting people in their own homes
- Develop sustainable, high quality general practice
- Ensure a sufficient, sustainable care market

Suicide Prevention
- Reduce the rate of suicides towards or below the national average
- Develop & deliver local partnership action plans informed by insight, data & need, & aligned to the national & local evidence base & policy

Health Protection
- Reduce health care associated infections
- Improve update of school-age immunisation
- Improve vaccine coverage, particularly measles, mumps and rubella (MMR) & in priority groups
- Improve uptake of cervical & breast screening

Employment
- Reduce number of 16-18 year old and care experienced NEETs
- Reduce number of individuals with disability/mental health need unemployed
- Support more people including unpaid carers into employment

Community Development & Learning
- Place local communities at the heart of decision-making
- Agree collective community goals
- Support community development workforce
- Integrate community partnerships into LCP infrastructure

Mental Health,
- Improve population mental health and wellbeing
- Improve outcomes and experiences of people with mental illness
- Develop a sustainable, support community offer

Learning Disability & Neurodiversity
- Deliver annual health checks & action plans for people on GP learning disability registers
- Improve autism diagnostic pathways
- Reduce reliance on locked & secure inpatient care

Children & Young People
- Provide services for children who need urgent treatment & hospital care as close to home as possible
- Deliver safe and personalised maternity care
- Proactively address health inequalities
- Develop family hubs & early help models
- Prioritise SEND and embed reforms.

Acute Services Sustainability
- Deliver high quality, safe, sustainable and affordable services as locally as possible.
- Stabilise care in the short term through increasing productivity and capacity
- Sustain care in the medium term making the best use of resources
- Transform care in the longer term working as one joined up system.

Housing
- Improve poor quality housing
- Improve identification and recognition of need for specialist housing, accommodation for older people and affordable housing
- Reduce number of people who are homeless

High Level Summary of Key Objectives

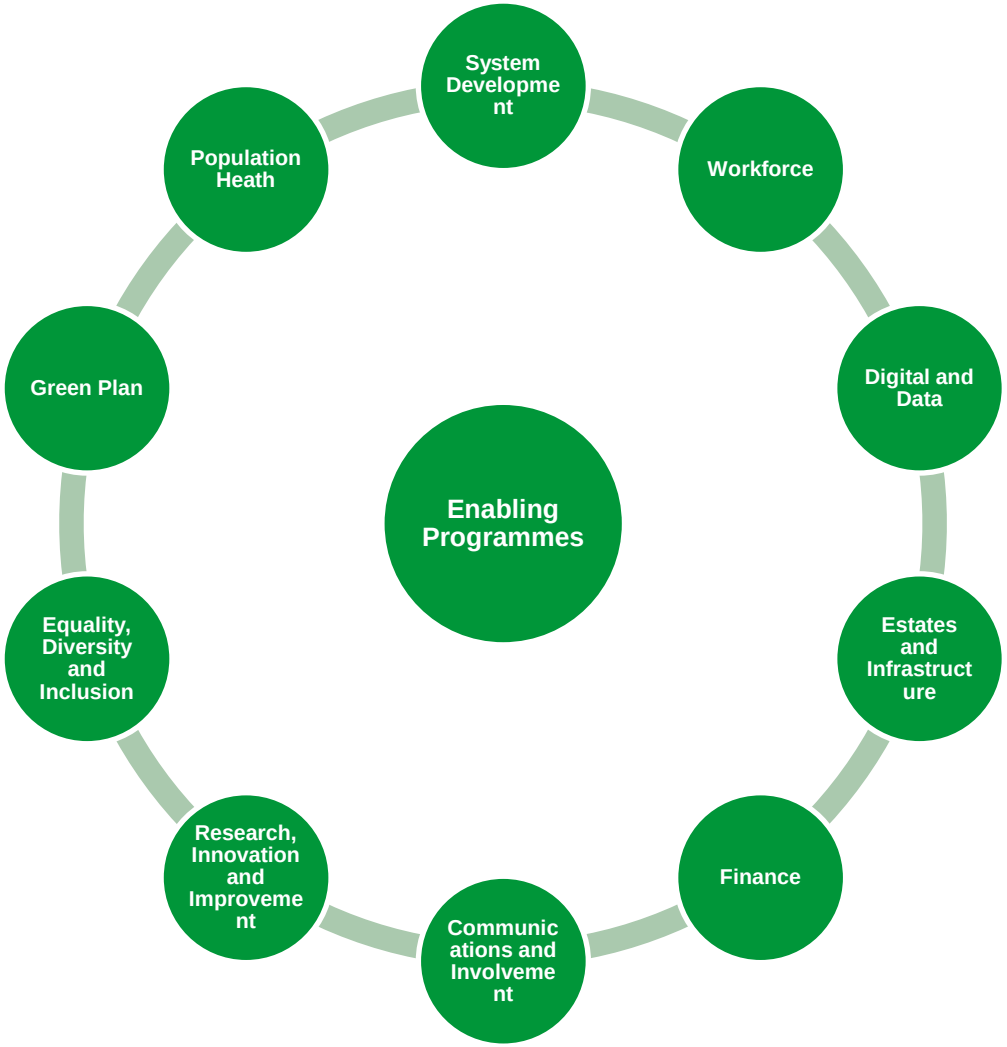
Population Health
- Deliver Core20PLUS5
- Implement co-ordinated prevention plans in priority areas with a focus on inequalities
- Develop as Anchor organisations
- Empower LCPs and collaboratives to make decisions with populations based on evidence

Digital & Data
- Empower people to use digital technology and by developing digital access to information and services
- Implement Electronic Patient Record
- Develop the Devon & Cornwall Care Record
- Develop a unified & standardised infrastructure
- Develop Business Intelligence/Population Health Management architecture & reporting

Equality, Diversity & Inclusion
- Improve innovation, performance and efficiency through a diverse workforce
- Ensure Devon's health and care services are inclusive and accessible to everyone

Research, Innovation & Improvement
- Build & strengthen networks
- Promote research & increase patient sign-up
- Ensure plans underpinned by robust evidence
- Develop capacity & capability

Estates & Infrastructure
- Support development of primary care, mental health, community and acute hospital estate
- Develop a road map for reaching Net Carbon Zero
- Work collaboratively to maximise opportunities.



System Development
- Develop a shared purpose through trust & collaboration
- Embed a 'learn by doing' approach
- Achieve thriving ICS status

Workforce
- Deliver solutions that enable to attraction, recruitment and retention of talent
- Identify new roles and ways of working and training provision
- Develop ASC career pathways

Green Plan
- Support staff to make greener journeys to work
- Deliver paper free ICB
- Increase the number of products & services bought locally

Communications & Involvement
- Support a system approach to communications & involvement
- Support programmes to work with diverse & vulnerable communities
- Ensure use of best practice principles and practice when involving people
- Build meaningful relationships with OSCs

Finance & Procurement
- Achieve recurrent balanced financial position
- Develop a financial framework that supports collaborative working
- Movement of funds into prevention.
- Commitment to shared services where appropriate
- Deliver maximum value & best quality service through collective procurement & supply chain excellence

Future plans - delivering the JFP and further development

Delivering the JFP

The JFP will be delivered through the system architecture, including Primary Care Networks, Local Care Partnerships and Provider collaboratives.

The high level delivery plan (Appendices C and D) details the actions we will take in the short and longer term and our outcomes framework will be used to monitor progress towards the strategic goals.

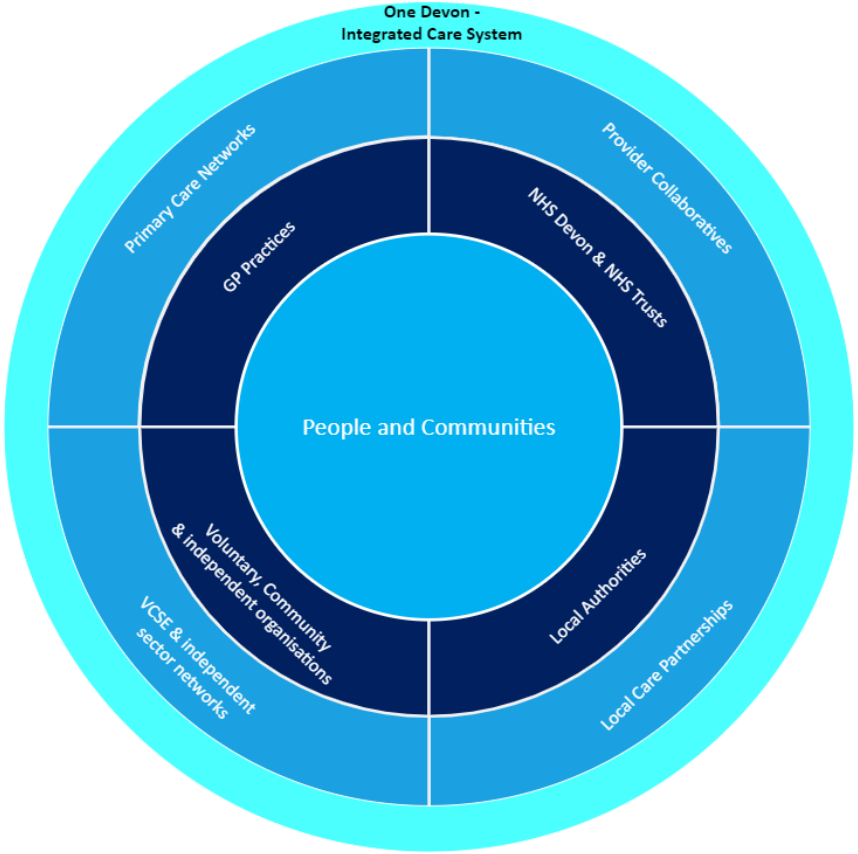
Assurance:

- The System Recovery Board will drive delivery of the recovery plan;
- Delivery of work programme milestones will be monitored through system programme infrastructure;
- Progress towards delivery of ICS strategic goals will be overseen by the ICS Executive and will report to the One Devon Partnership;
- Use of ICS maturity framework.

There are a number of key risks to delivery of the Joint Forward Plan, including:

- A potential lack of synergy between the JFP and the system recovery plan (mitigation is set out below);
- Insufficient capacity to deliver transformational change whilst focusing on recovery;
- Clinical, operational and financial pressures impact decision making, involvement and engagement, co-design and delivery of the ISD programme;
- The impending ICB reorganisation.

Work is underway within the system to review the alignment between the years 1 and 2 objectives within the JFP and the system recovery priorities and to agree any sequencing of the JFP actions that will be needed to support recovery and ensure that the longer term transformational priorities within the JFP are deliverable alongside the recovery plan.



Future Development

Publication of the JFP is not the end of a process, but the start of an ongoing new relationship with system partners and our communities, which will see both the Strategy and the JFP refreshed on an annual basis.

Over the coming weeks we will work together to put a framework in place that will support:

- Co-production of future iterations of the ICS and JFP with system partners, staff, patients and the public
- Further alignment with Local Care Partnership and Provider Collaborative objectives and with Local Authority social care plans
- Collaborative working on broader footprints, where appropriate

Additionally, there will be targeted engagement with communities around specific delivery programmes.

Introduction

What is the 5 Year Joint Forward Plan?

National Context

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and partner trusts to prepare a Joint Forward Plan (JFP) before the start of each financial year. For this, the first year, the final publication date is 30 June 2023.

Systems have 'significant flexibility' to determine the scope of the JFP and how it is developed and structured. The minimum requirement is that the JFP should describe **how the ICB and partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs**, including delivery of universal NHS commitments (as described in the annual NHS priorities and operational planning guidance and NHS Long Term Plan), addressing the four core purposes of ICSs (detailed here) and meeting legal requirements.

However, national guidance encourages systems to use the JFP to develop a ***shared delivery plan*** for the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies (JLHWSs) that is supported by the whole system, including Local Authorities and Voluntary, Community and Social Enterprise (VCSE) partners.

The key principles of the JFP are:

1. Fully aligned with the wider system partnership's ambitions;
2. Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments;
3. Delivery focused, including specific objectives, trajectories and milestones as appropriate.

Guidance also sets out some key legislative requirements and other expected content for the JFP. Appendix A sets out these requirements and a summary of how they are addressed within this Plan.

ICS Core Aims

Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience and access

Enhance productivity and value for money

Help the NHS support broader social and economic development

One Devon

One Devon's Integrated Care Strategy

The Devon Joint Forward Plan is the whole system response to the One Devon Integrated Care Strategy. The Strategy set out 12 Challenges:

1. An ageing and growing population with increasing long term conditions, co-morbidity and frailty
2. Climate change
3. Complex patterns of urban, rural and coastal deprivation
4. Housing quality and affordability
5. Economic resilience
6. Access to services, including socio-economic & cultural barriers
7. Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas
8. Varied education, training and employment opportunities, workforce availability and wellbeing
9. Unpaid care and associated health outcomes
10. Changing patterns of infectious diseases
11. Poor mental health and wellbeing, social isolation, and loneliness
12. Pressures on health and care services (especially unplanned care)

In response to the 12 Challenges and through ongoing engagement with stakeholders across the Devon System, the Integrated Care Strategy sets out the strategic goals developed to meet the assessed needs of the population, focusing on the *four core purposes of ICSs* and supporting the vision of the ICS: ***Equal chances for everyone in Devon to lead long, happy and healthy lives***

There is one over-arching strategic goal: **One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money** *(by 2025 we will have: adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status)*

The remaining strategic goals are set out below, grouped according to the ICS core aims.

Improving Outcomes in population health and healthcare

Every suicide will be regarded as preventable and we will work together as a system to make suicide safer communities across Devon and reduce suicide deaths across all ages.

The suicide rate for all areas of Devon will see a consistent downward trajectory and by 2028 the suicide rate in each local authority area will be in line with or below the England average

Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death and disability - dietary risks, tobacco, high blood pressure, high fasting plasma glucose and high BMI.

By 2028 reduce the Disability Adjusted Life Years (DALYs) lost for the top 5 modifiable risk factors and measure under 75 mortality and healthy life expectancy

We will have a safe and sustainable health and care system.

By 2025 we will: deliver all our quality, safety and performance targets within an agreed financial envelope

Children and young people (CYP) will have improved mental health and well-being

By 2024/25 we will have: at least 15,500 CYP aged (0-18) accessing NHS-funded services, 100% coverage of 24/7 crisis and urgent care response for CYP and 95% of children and young people with an eating disorder able to access eating disorder services within 1 week for urgent needs and 4 weeks for routine needs

People (including unpaid carers) in Devon will have the support, skills, knowledge and information they need to be confidently involved as equal partners in all aspects of their health and care.

By 2028 we will: extend personalised care through social prescribing and shared decision making and increased health literacy

People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.

By 2028 reduce the Disability Adjusted Life Years (DALYs) lost for the top five causes

Tackling inequalities in outcomes, experience and access

People in Devon will have access to the information and services they need, in a way that works for them, so everyone can be equally healthy and well.

By 2028 we will increase the number of people who can access and use digital technology

Everyone in Devon will be offered protection from preventable diseases and infections.

By 2028 we will have:

- *childhood vaccines - vaccine coverage of 95% of 2 doses of MMR by the time the child is 5, vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, 90% uptake of school-aged immunisation*
- *Covid and flu vaccinations - 100% offer to eligible cohorts each season; vaccine uptake in line with or exceeding national/regional/comparator benchmarking;*
- *reduced the number of healthcare acquired infections by 25%*
- *reduced antibiotic prescribing by 15% from our year 1 baseline*
- *uptake of cervical screening increased to 80%*

Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place

By 2028 we will have: increased the number of people dying in their preferred place by 25%

The most vulnerable people in Devon will have accessible, suitable, warm and dry housing

By 2028 we will have:

- *decreased the % of households that experience fuel poverty by 2%,*
- *reduced the number of admissions following an accidental fall by 20%*
- *reduced the number of households in temporary accommodation by 10%*
- *reduced the number of families placed in temporary B&B accommodation for more than 6 weeks to 0*
- *increased the % of people sleeping rough who get an offer of accommodation to 100%*
- *increased in the number of households successfully prevented from becoming homeless by 30%*
- *ensured that LPAs are fully aware of the need for key worker housing and have addressed this need in their plans*

In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience.

By 2026 Devon's workforces will be supported, empowered and skilled to deliver fully inclusive services for everyone, and Devon will be a welcoming and inclusive place to live and work where diversity is valued and celebrated;
by 2027 Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)
Reduced health inequalities for diverse populations

Enhancing productivity and value for money

People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency.

By 2026 patients will report significantly improved experience when navigating services across Devon.

We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.

By 2028 we will have: a unified approach to procuring goods, services and systems across sectors and pooled budget arrangements

People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care.

By 2028 we will have: provided a unified and standardised Digital Infrastructure

We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.

By 2028 we will have: vacancies amongst the lowest in England in the health and social care sector

One Devon

Helping the NHS support broader social and economic development

People in Devon will be provided with greater support to access and stay in employment and develop their careers.

By 2028 we will have: reduced the gap between those with a physical or mental long term condition (aged 16-64) and those who are in receipt of long term support for a learning disability (aged 18-69) and the overall employment rate by 5% and decreased the number of 16-17 year olds not in education, employment or training (NEET) to achieve or be under the national average.

Children in Devon will be able to make good future progress through school and life.

By 2027 we will have: increased the number of children achieving a good level of development at Early Years Foundation Stage as a % of all children by 3%

Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably

By 2028 we will have: directed our collective buying power to invest in and build for the longer term in local communities and businesses

We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change and supports healthier living (including promoting physical activity and active travel).

By 2028 we will: be on-track to successfully deliver agreed targets for all Local Authorities in Devon being carbon neutral by 2030 and the NHS being carbon neutral by 2040

Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people

By 2024: Local Care Partnerships will have co-produced with local communities and community groups in their area, a plan to empower and support groups to be more resilient.

One Devon

Developing our Joint Forward Plan

The Devon Joint Forward Plan

In line with national requirements, the ICS in Devon (One Devon) produced an Integrated Care Strategy in December 2022, setting out the 12 key challenges that Devon faces and identifying a set of strategic goals that will help to address the challenges, aligned to the ***four core purposes of ICSs.***

The One Devon Partnership asked system partners to work together to make the JFP a true shared response to the Devon Integrated Care Strategy, as encouraged in the national Guidance. This JFP therefore reflects the work that is happening across the wider Devon system, in the health and care sectors and beyond, and demonstrates how this work aligns with the strategic goals in the Strategy and how it will deliver the required improvements in health and wellbeing.

The **golden threads** that run through all of the delivery and enabling programmes:

- Prevention (focusing on the five main causes of death and disability)
- Population health
- Improved outcomes
- Personalisation and empowerment of individuals
- Inclusion – with a particular focus on inequalities, including in relation to neurodiversity, people with multiple complex needs, people with care experience, our armed forces population and those who have experienced trauma (including veterans), all of whom can struggle to access services.
- Quality and safety of care
- Continuous learning and improvement

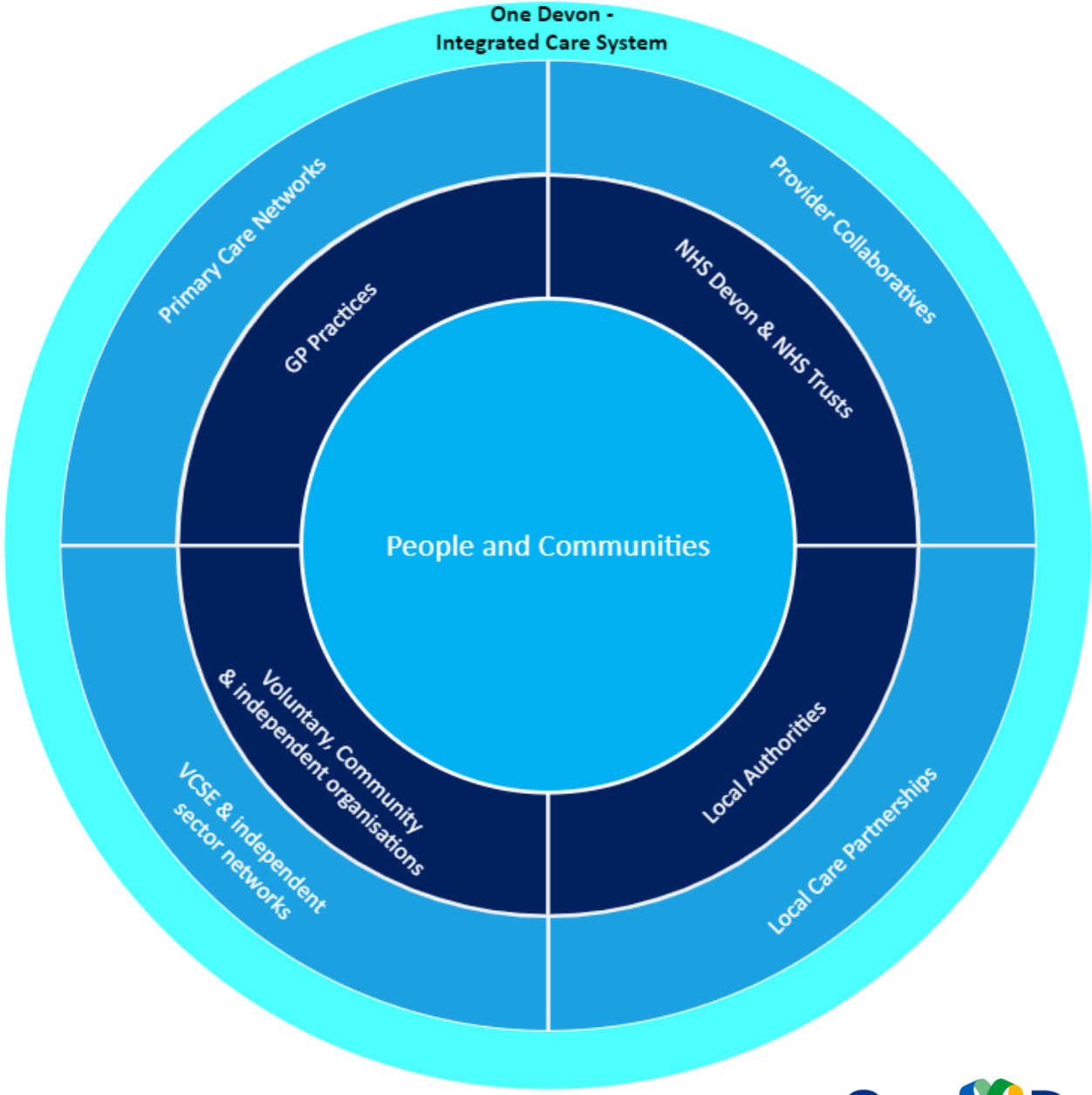
It is important to acknowledge that the three local authorities in Devon are under significant financial pressure. Furthermore, NHS Devon and all three NHS acute provider trusts in Devon have been assessed as being in segment 4 of the NHS Oversight Framework. This means that we are subject to enhanced direct oversight by NHS England and additional reporting requirements and financial controls.

The JFP therefore reflects the requirement to focus on system recovery and exiting segment 4 of the NHS Oversight Framework as priority in years 1-3 of the Plan as well as setting out how the system will work together in a different way, to deliver transformational change and improve the health and wellbeing of the population creating a sustainable health and care system in Devon.

The Devon System

Devon is a complex system, in which work is taking place on delivering elements of the Plan in different geographical and functional arrangements, including:

- Two unitary authorities (Plymouth City Council and Torbay Council)
- One county council (Devon), with 8 district councils,
- 121 GP practices, in 31 Primary Care Networks
- Devon Partnership Trust (DPT) and Livewell South West (LWSW) provide mental health services
- Four acute hospitals - North Devon District Hospital and the Royal Devon and Exeter Hospital, both managed by the Royal Devon University Healthcare NHS Foundation Trust (RDUH), Torbay and South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP)
- One ambulance trust - South West Ambulance Service Foundation Trust (SWASFT)
- Dental Surgeries, Optometrists and Community Pharmacies
- A care market consisting of independent and charitable/voluntary sector providers
- Many local voluntary sector partners across our neighbourhoods



Implementation of the Joint Forward Plan will see One Devon delivering joined-up, preventative and person-centred care for the whole population of Devon across the course of their life

Years 1 & 2 - 2023 & 2024

Recovery of services enabling residents to have access to services and care they need, at the right time, and in the right place.

Years 3 & 4 - 2025 & 2026

Individuals have an active role in their own health and know what is needed to stay healthy as possible. This is supported by a proactive, interconnected set of services, which are informed by monitoring of population health needs at neighbourhood-level.

Years 5 + - 2027 & 2028

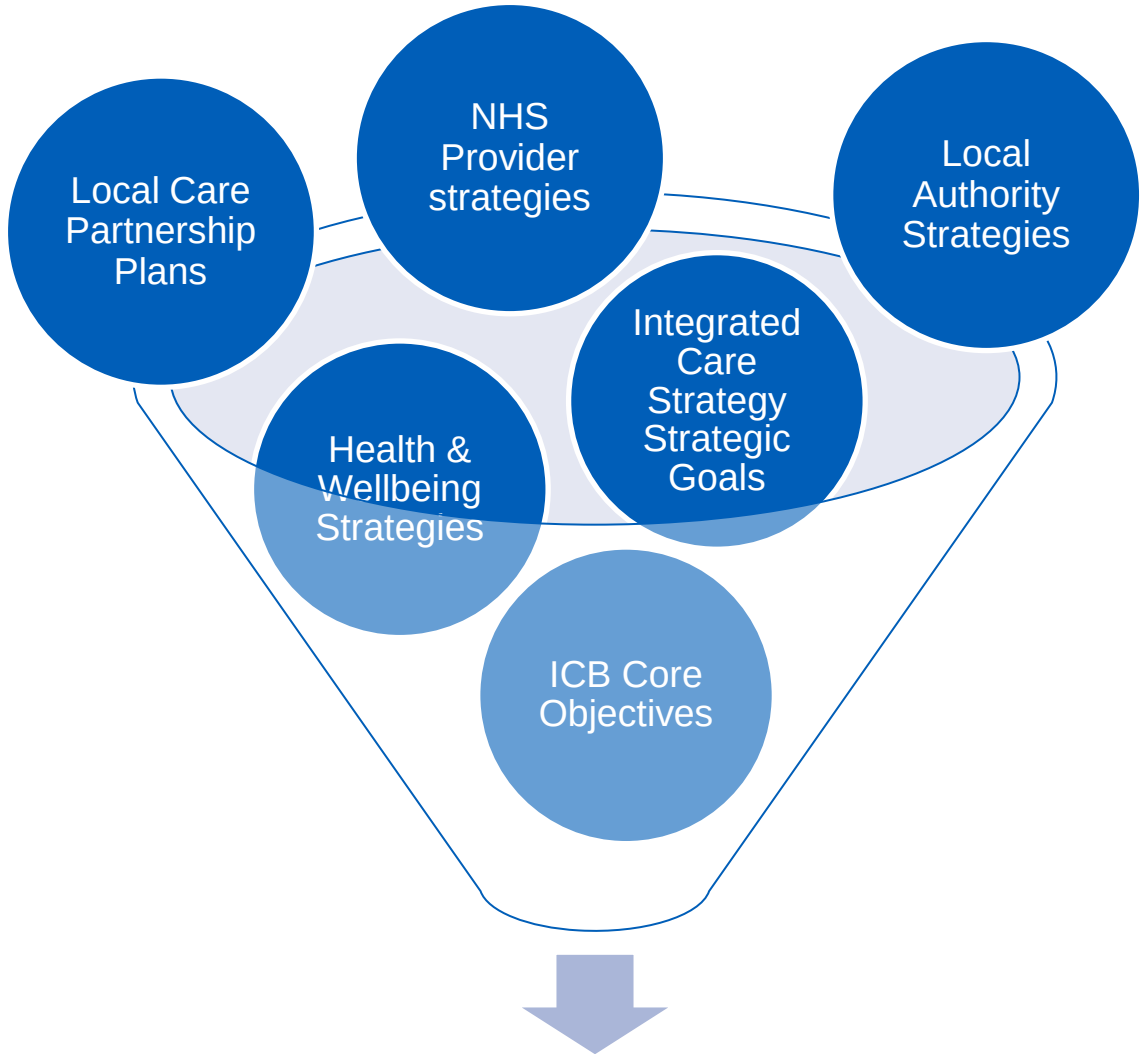
The Devon population have equal chances for everyone to lead long, happy lives

Inputs into the Joint Forward Plan

The JFP brings together many strategies and plans that already exist or are in development across the system, including, but not limited to:

- NHS Devon's strategic objectives
- Local authority strategies (eg: adult social care strategies)
- Local Care Partnership (LCP) objectives
- Provider trust strategies
- Provider collaborative priorities
- AHP strategy
- NHS Oversight Framework Segment 4 exit plan

and will demonstrate how these plans align with and deliver the One Devon Partnership strategic goals, as set out in the Integrated Care Strategy.



Involving people, partners and communities

Development of the Integrated Care Strategy and Joint Forward Plan has involved the following examples of engagement and involvement activities:

- Analysis of extensive public feedback about health and care (collected from system partners across One Devon) between 2018 to 2022 informed the development of both the Integrated Care Strategy and the Joint Forward Plan (JFP)
- The One Devon strategic goals were tested through a Joint Overview and Scrutiny Committee Masterclass (elected representatives of local communities) in October 2022.
- H&W Boards have been engaged directly throughout the process of developing the Strategy and JFP, including at a specific engagement event in March 2023 to review the JFP content.
- A further Joint Overview and Scrutiny Committee (OSC) Masterclass on the JFP in April 2023.
- VCSE and Health Watch representatives involved in system partner feedback events.

Additionally, meaningful engagement on specific areas of work is planned moving forward (e.g. Peninsula Acute Sustainability Programme).

- Over 35 separate engagement projects analysed from across health and care in Devon over 5 years
- OSC fed back that you can't argue with the goals, but they are most interested in what it means on the ground

Statutory Duties

The Joint Forward Plan is a system wide plan which broadly describes the services we have in place and will develop to meet the needs of our whole population as set out in the Integrated Care Strategy.

It reflects an intention to work in collaboration and partnership to deliver our system ambitions, but it is important to acknowledge that statutory duties remain with individual organisations.

There are some specific statutory duties that the ICB needs to deliver as part of its statutory function (listed below) that must be met through the JFP. These duties are incorporated throughout the plan and Appendix A provides more detail in relation to these.

Statutory requirements of the JPF

- Describe health services the ICB proposes to arrange to meet needs
- Duty to promote integration
- Duty to have regard to wider effect of decisions
- Financial duties
- Duty to improve quality of services
- Duty to reduce inequalities
- Duty to promote involvement of each patient
- Duty to involve the public in decisions about services
- Duty to enable patient choice
- Duty to obtain appropriate advice
- Duty to promote innovation
- Duty to facilitate and promote research and use its evidence
- Duty to promote education and training
- Duty as to regard to climate change
- Addressing the particular needs of children and young people
- Addressing the particular needs of victims of abuse
- Implement the joint health and wellbeing strategies

Devon's Joint Forward Plan

There are 9 key delivery programmes and 10 enabling programmes that make up the Devon JFP:

Delivering a sustainable health and care system in Devon

One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money

Delivering a Sustainable System

The detailed later sections of the JFP set out the plans in place across the local NHS and wider Devon System and the key milestones for delivery over the next five years. Additionally, there is an immediate requirement to stabilise the financial position and recover activity, to improve operational performance, access and quality of care. In order to achieve both of these, we need to transform the way we work together across our system – creating new ways of working was identified as a key determinant of successful delivery of the Devon Plan.

This section of the Plan outlines how we plan to deliver the significant strategic work to enable the successful delivery of our 5-Year Integrated Care Strategy, focusing on creating an environment for success, including:

- strengthening collaborative and integrated working through cultural change and adoption of the guiding principles resulting from the Case for Change
- adopting a Value-based Approach
- setting out a roadmap for ICS development
- embedding our agreed Devon Operating Model
- delivering financial and operational recovery.

Collectively, this work responds to the significant scale of change required to achieve our vision and ambitions and establishes a sustainable way to deliver the health and care needed by the people of Devon.

A case study demonstrates the collaborative work going on in Devon to support victims of domestic abuse, survivors, commissioners and service providers.

This section also sets out the key financial and performance headlines from our System 2023/24 Operational Plan and how we will ensure that we work collectively to achieve recovery. The actions to achieve recovery are captured in years 1-2 of the detailed delivery plans.

Strengthening collaborative and integrated working is the way we will make a real difference to our population
Case Study – system working making a difference

Tackling Domestic Violence and Sexual Abuse

Across Devon thousands of people each year experience domestic abuse or sexual violence. Abuse is associated with a wide range of both immediate and long-term health conditions and primary care colleagues are often the first professionals to have contact with those affected. Victims of abuse have told us they felt like they were in a revolving door of services, that didn't help them get to the heart of the problem.

John experienced sexual abuse as a young boy. He ended up on long mental health waiting lists, then in psychiatric hospital he became a dependent drinker and retired early from work on health grounds. It wasn't until he was asked 'what had happened to him' that he was able to start to understand the abuse he had suffered and begin to heal, care for himself and live well.

The Interpersonal Trauma Response Service was launched in March 2023 to support Primary Care teams in connecting victims and survivors of abuse to specialist support. Speaking at the launch, the Domestic Abuse Commissioner for England and Wales, Nicole Jacobs, called the service ground-breaking and praised the strength of relationships in Devon that helped build ambitious, innovative and adaptive partnerships to address domestic abuse and sexual violence.

The service provides training and support to primary care staff to understand and see the links between abuse, trauma and the presenting health issues. It helps build the confidence to ask questions that get behind the symptoms and provides a named person to help connect patients to a network of good help.

"You can't grow roses in concrete"

The service has grown from a collaboration stretching back over 6 years with victims and survivors, commissioners and service providers. The collaboration began by commissioners spending time with victims of abuse and listening to the stories of their lives. Sitting in their kitchens and living rooms, people described missed opportunities to intervene early, the life long, often debilitating, impact of abuse and trauma and service encounters that don't join up, are hard to navigate and can feel rushed and unfinished.

The collaboration that grew from this work enabled Devon to be one of 8 National Domestic Abuse and Health Pathfinder sites, improving our recognition and response to domestic abuse, in primary care, mental health and hospital settings. Devon, with colleagues in Cornwall, is the first Sexual Violence NHSEI Pathfinder site in the country. This work is helping us explore improved support for victims of sexual violence who have complex trauma.

The lessons from this "ground-breaking" work are;

- we need to listen deeply to people, seeing citizens as partners in addressing their own issues and making visible where our services aren't adding value.
- We need to develop a learning capability where our staff at all levels reflect on effectiveness and adapt to changing circumstances.
- we need to create 'healthy systems', working across traditional service and organisational boundaries in recognition that the complex challenges we face require us to be working collectively and collaboratively.

One Devon

Setting the Change Agenda

The way we do things together in Devon

A narrative which sets out what Devon currently does well and identifies what changes need to be made in order to deliver improved health and care services to the people of Devon.

Guiding principles:

- **Provide a personalised approach to health and care:** 'joined-up' packages based on individual need
- **Support our workforce:** to ensure people are able to do their best work
- **Ensure shared Decision-making:** consistently applied across all services
- **Use high value interventions:** consistently and earlier in pathways and stop providing health and care that does not add value and may be causing harm
- **Reduce our environmental impact**
- **Tackle unwarranted variation in practices, outcomes and inequality**
- **Manage risk across the system:** ensuring that decisions made in one place do not increase the risk in another and addressing challenges from a whole population perspective
- **Spread improvement and innovation**
- **Develop a 'Culture of Stewardship'**

The narrative was co-developed with Clinical and Professional Leadership groups across health and care and reviewed and agreed by senior leadership teams and Boards across One Devon.

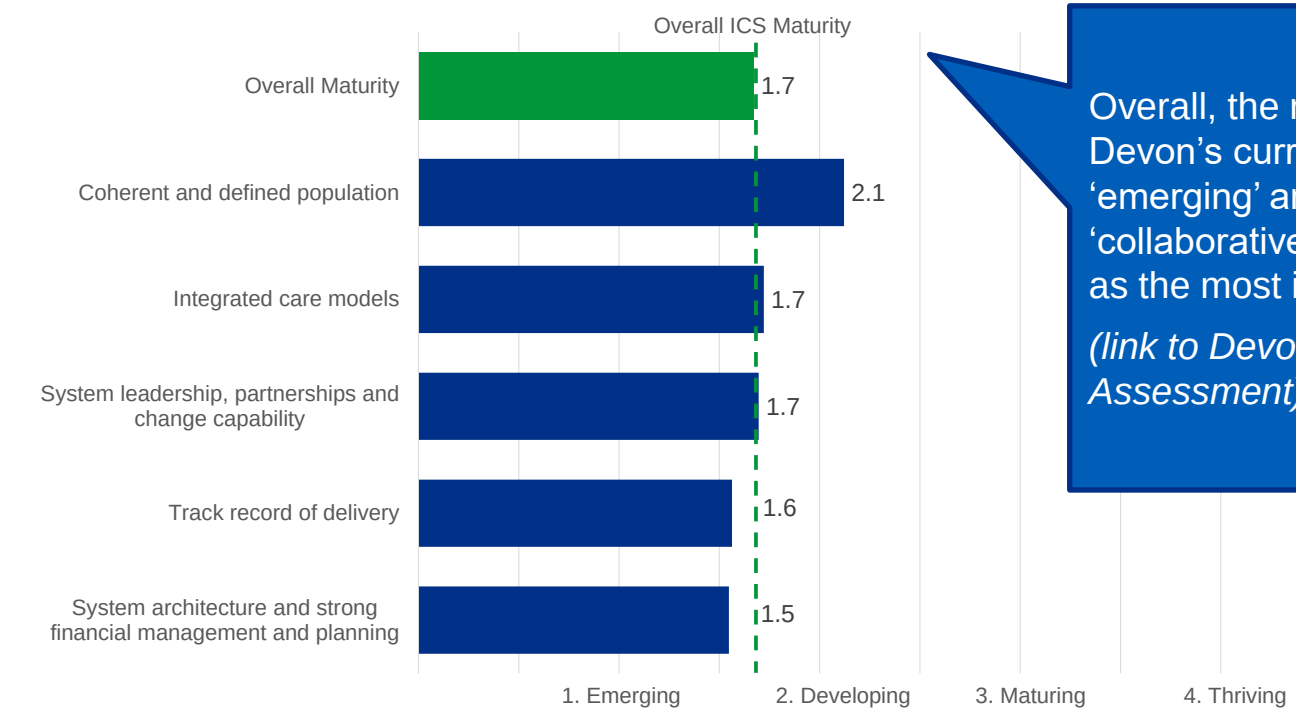
As a result of this collaborative work, system partners have broadly agreed a set of guiding principles. These will inform the Devon change agenda and guide the priorities and approach we undertake to deliver improved care and services.

Strengthening System Working

Developing One Devon

To provide One Devon with a shared understanding of our current system way of working, two diagnostic activities were undertaken in the Spring of 2022. The first, utilising a national ICS Maturity Self-assessment Tool, helped to identify One Devon's current ICS Maturity, mapped against five key domains, and the improvements required to enable us to become a 'thriving ICS'. The assessment will be repeated in 2023 to evaluate One Devon's progress.

Maturity by Domain



Overall, the results placed Devon's current ICS maturity as 'emerging' and 'developing with 'collaborative working' recurring as the most important theme.

(link to Devon ICS Maturity Assessment)

Written feedback by theme, ranked by occurrence:

1. Collaborative Working
2. Clear and Defined Goals
3. Shared Vision and Understanding
4. Performance Variation
5. Implementation
6. Organisational Boundaries
7. Tacking Inequalities
8. Accountability
9. Leadership
10. Governance
11. Culture of Change

Strengthening system working

Developing One Devon

The second diagnostic activity completed was supported by partners at the Southwest Academic Health and Science Network (SWAHSN) and focused on building a shared understanding of One Devon's current ways of working and opportunities to strengthen a collaborative and integrated approach.

The results were triangulated with output from the ICS Maturity Assessment and other sources and demonstrated consistent development themes and opportunities. The learning informed the scope and focus of the Integrated System Development Programme and provided reassurance regarding the approach.

5 opportunity areas to strengthen system working identified:

- Learn by doing
- Prioritise and implement
- Shared purpose
- Trust and collaboration
- System focus

The need to improve system working was identified as a key determinant to One Devon successfully delivering the Devon Plan.

Our ambition is outlined in the following overarching goal:

One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.

By 2025 we will have: adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.

Development of One Devon is one of the key enablers supporting the ICS to achieve its ambition.

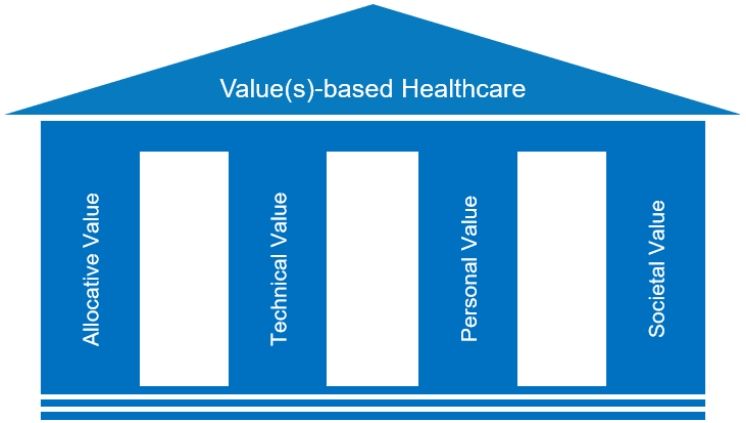
Our Overarching Philosophy

Adopting a Value-Based Approach

Devon's change agenda supports the principles outlined in 'The way we do things together in Devon' narrative to be realised. The principles are consistent with integrated working and were heavily influenced by the adoption of a value-based approach, which provides a strong framework to support delivery of Devon's strategic ambitions.

The value-based approach is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person. Strong clinical and professional support exists for the implementation of this approach in Devon and this is further supported by evidence of its effectiveness elsewhere (link to VBA lit review).

The adoption of a value-based approach in Devon will not be a distinct enabler plan, instead it is a philosophy to support the achievement of existing and future priorities and will be the lens through which we maximise value to the population of Devon by transforming services.



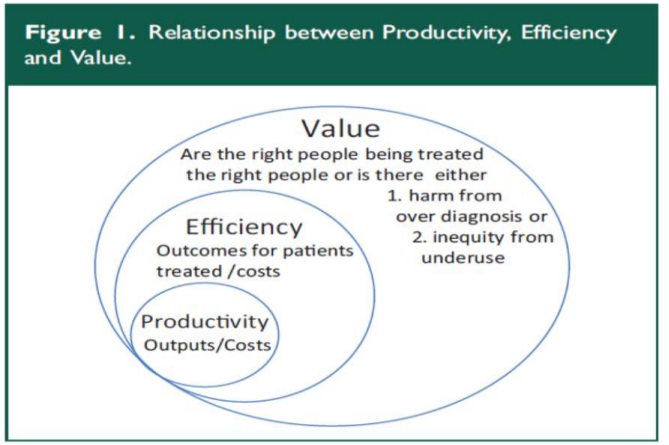
ALLOCATIVE VALUE: Equitable distribution of resources across all patient groups.

TECHNICAL VALUE: Achievement of best possible outcomes with available resources.

PERSONAL VALUE: Appropriate care to achieve patients' personal goals.

SOsocietal VALUE: Contribution of healthcare to social participation and connectedness.

This comprehensive meaning of 'value' offers a wider perspective than the interpretation of 'value' as purely monetary in the context of cost-effectiveness.



Defining Value-based Healthcare in the NHS: CEBM report

Creating an environment for Sustainable Improvement

One Devon Development Roadmap

One Devon is committed to becoming a **thriving Integrated Care System**. As a result of the diagnostic activities outlined in the Case for Change, we established a baseline from which to improve.

In response, an overarching ICS Development Roadmap was developed, including the implementation of a single operating model, to support us to achieve our commitment.

The diagnostic activities will be repeated in 2023 to evaluate progress to this end.

Creating an environment for Sustainable Improvement

Adoption of the One Devon Operating Model

Our emerging new operating model

- Our values and behaviours
- Governance arrangements, performance reporting and assurance
- Roles, responsibilities and functions of system parts
- Vision for our One Devon architecture
- Development journey for new operating mode

One Devon

One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.

By 2025 we will have adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.

The model outlines how Devon will make the best use of our new collaborative structures including the One Devon Partnership (ICP), NHS Devon (ICB), provider collaboratives, local care partnerships and neighbourhoods.

Adoption of the model will be completed over the next 18-24 months involving all system partners in embedding new ways of working to drive increased value to the people of Devon.

One Devon

Getting the System in balance

Financial balance is to be achieved through a focused system recovery programme focussed on operational, system, clinical and intra-organisation transformation

What needs to be achieved

3 year financial plan linked to activity, workforce, performance:

- **23/24 reported position no worse than £42.3m deficit**
- **24/25 c.£30m deficit through use of non-recurrent means**
- **25/26 breakeven exit run rate position**

How we will achieve this

- Used the Drivers of the Deficit analysis as the baseline for planning and CIP expectations aligned to model hospital, GIRFT and regional benchmarks
- Stretched CIPs from 1.3% recurrent cost out to 4.5% (with system schemes in support)
- Accelerating the delivery of system-wide shared schemes
- Whole system clinically-led and planned transformation – acute through to community/primary care
- Intra-organisation wide schemes and redesign

1 Operational improvement cost out – to 4.5%

Moving Trust CIP plans in line with national expectations of 4.5% cost out through an initial focus on grip and control measures introduced by summer

2 System wide schemes – targeting c.£60m reduced run rate by Q4 23/24

Stretching the delivery of strategic schemes to be delivered across the system. This includes Shared corporate services, Peoples services, Clinical support services, Enhanced primary and community services, Outpatient transformation, Estates, New Models of Care, Procurement, Digital, CHC, Allocative Efficiency

3 Intra-organisation working and redesign

Looking to intra-organisation opportunities in areas such as:

1. Single system pathways (Shared PTL, integrated pathway management etc.)
2. Single system ways of working i.e., redesign of group models, single EPR solutions across Devon and Cornwall and workforce planning.

4 System Performance Improvement

Developing a system-wide integrated improvement plans at pace through two streams of work, prioritised across UEC and Elective. Initially beginning with key system issues (e.g. frailty) and broadening out to support care pathway demands (e.g. through a surgical strategy):

1. Integrated collaborative community and social care services – working through in sequence frailty, long term conditions, urgent care; and
2. Networked acute care – through networked urgent care, elective, fragile services, virtual

Activity & Performance

1. The activity required is challenging given the historic position and will require a clear Devon-wide clinical plan and new ways of working

2. Delivering on the performance position – or improving it further – will require different ways of thinking about capital, estates, digital etc (e.g. a cold elective site, single PTL, sub-specialty centres etc) as stated.

Workforce

Workforce will achieve a net -2% workforce change against the current establishment.

Metric	2023/24 M12 (Planned)
65+ Week waits	2,956
78+ Week waits	0
104+ Week waits	0
A&E 4 Hours	72%
Cancer Faster Diagnostic	76%
System Financial Plan	(£42.3m)
Workforce	-2%

Working differently - establishing a System Recovery Function

The system recovery function will pull together key capabilities from across the system to deliver at pace and with effective

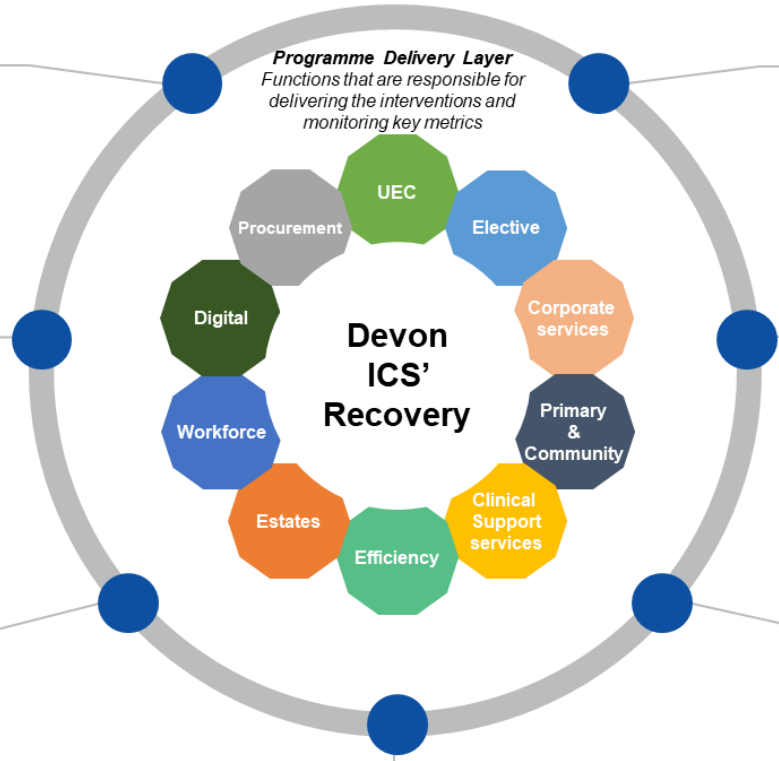
Summary

The System Recovery Programme is a critical component of our recovery plan, as it will enable Devon to work more effectively and collaboratively to build the infrastructure and capabilities needed to drive the recovery. Through this programme, all teams across the patch will be empowered to work differently, delivering innovative and coordinated solutions to the challenges we face.

Clinical, operational and finance teams will play a key role in this recovery effort, and further integration and support for cross-organisational planning and efficiency delivery will be critical to our success. By leveraging the expertise and resources of our teams, we can identify areas for improvement and drive coordinated efforts to achieve our goals. We remain committed to working collaboratively with stakeholders across the system to ensure that the System Recovery Programme is effective and sustainable in the long term.

System Recovery Programme

Function which manages the overall recovery for the system, supporting leadership and delivery functions alike to maintain momentum



Assurance
Assure benefits are being realised (e.g. costs taken out, performance metrics being achieved) and highlight instances of variations against plan.

Business and Management Info
Establish a single version of the truth through consistent data and reporting of system performance and finances.

Monitoring and escalation
Monitor progress, risks and issues, escalating quickly those that need the action, attention or decision of system leadership.

Prioritisation
Inject pace into the recovery by prioritising schemes based on benefits value, timeframes to realise benefits and capacity to deliver. Therefore creating a better-balanced recovery programme. This will be an ongoing activity to introduce new interventions and avoid distractions / diluting resources

Delivery planning
Build and manage the system's recovery roadmap driving the delivery of interventions which sit on the critical path. This capability will manage the process of changes to the recovery roadmap.

Governance and rapid decision making
Clear and focused accountability through the system governance forums: overseeing the recovery plan and ensuring the right decisions and information are shared in a timely manner to move forward at pace.

Change Management
Proactive, frequent communication of changes and rationale to stakeholders, to ensure people are brought along on the recovery journey.

The Recovery Programme is committed to exiting segment 4 measures of the NHS Oversight Framework in Quarter 1 of the financial year 2024/25

Segment 4 exit criteria

Theme	Criteria
Leadership	• Demonstrate collaborative decision-making in delivering all the SRP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system
Strategy	• Delivery of Phase 1 of the Acute Services Sustainability Programme.
UEC	• Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.
	• Achieve the defined expectations of the National Taskforce.
Elective recovery	• Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement
Finance	• Develop and deliver a short-term financial plan (2023/24) that is signed off regionally and nationally
	• Develop an outline longer-term financial plan that shows non-recurrent balance in 2024/25, and recurrent balance for 2025/26, that has Board agreement from all Devon organisations
	• Develop and agree a Capital Plan that is clearly aligned to system strategic priorities

Estimated Segment 4 Exit Date : Q1 2024/25

Underpinning each Exit criteria is a set of agreed metrics and trajectories which form the basis of the system RSP oversight and performance management arrangements

Delivery Principles – we will find solutions that follow these principles:

- Seek solutions that work for the system.
- No organisation will knowingly create an adverse impact on another or the system.
- Standardise practice and services where it makes sense to do so.
- Focus on cost reduction, cost containment and productivity improvements
- Recognise that participation will be required at system, locality, neighbourhood, and organisational level on the priority areas.
- Ensure equitable distribution of funding and outcomes by locality.
- Not make new investments that lead to a deterioration in the underlying position
- Consider financial decisions alongside quality, safety and any impact on patient experience of care.
- Share risks and benefits across the system and ensure they are fully understood by all parties.

Getting the System in Balance - Local Authority Recovery

Torbay Council

Through our integrated partnerships with people, the NHS, the VSCE and other partners, Torbay aims to strengthen care and support so that people's choices are maximised and they are enabled to live a fulfilling life in their own community.

Torbay Council and Torbay and South Devon NHS Foundation Trust are integrated partners delivering Adult Social Care in Torbay. This is a strong partnership, but we recognise the need for system-wide transformation and sustainability, underpinned by the values of our Adult Social Care Strategy and the Devon 5-year Joint Forward Plan.

Through measurable benefits the three-year Adult Social Care Joint Transformation & Sustainability Plan will deliver:

- Increased independence, choice, and control for our community through our strategic shaping and oversight of Torbay's market with a key focus on building independence through Support for Living and partnership with the VSCE.
- Timely and good quality discharge from hospital – with a focus on returning people home with good quality reablement and intermediate care support that helps them to regain and maintain their independence.
- A focus on shared information through use of technology, and easy access to Adult Social Care
- Better value for money through our cost improvement plans.

Getting the System in Balance - Local Authority Recovery

Devon County Council

Our overriding focus is to meet the needs of the young, old and most vulnerable across Devon and we will work closely with our One Devon partners to support and develop the local health and care system, to help support the local economy, improve job prospects and housing opportunities for local people, respond to climate change, champion opportunities and improve services and outcomes for children and young people, support care market sustainability, and address the impacts of the rising cost of living for those hardest hit.

The Authority needs to make significant savings in order to set a balanced budget for 2023/24. To respond to this challenge, a cross-organisational programme of transformation has identified £47.5 million of savings and new income for 2023/24 within service budgets.

Delivery of the transformation programme will not be easy, but the level of commitment from teams, working together as one organisation, and the level of assurance that has been involved in the budget-setting process, mean that the 2023/24 budget is as robust as possible and will deliver best value for the people of Devon.

Getting the System in Balance - Local Authority Recovery

Plymouth City Council

Plymouth City Council faces significant financial risks, given the continuing forecast shortfall, uncertainty about resourcing from central government, the wider economic environment and the Council's comparatively low levels of financial reserves. Savings plans totalling £25.8m have been developed across the Authority for 2023/24, with further work ongoing around future years. The Council is experiencing significant pressures post Covid with increasing acuity of need and cost pressures within both Children's and Adult Social Care.

A recovery and transformation programme is in place for Adult Social Care which focuses on a number of key areas:

- Improving access to advice, information and support to neighbourhoods, through a network of health and wellbeing hubs, our community capacity builders and community assist offer
- Early intervention and reablement to provide enabling support for our most vulnerable and their unpaid carers
- Focussed review and reassessment programme led by Livewell Southwest
- Development of new model of care for working age adults, including targeted work on transition pathways and specialist housing provision in the City
- Remodelling of our homecare market to deliver a neighbourhood model, reducing travel across the City, supporting our Net Zero Carbon agenda
- Reshaping of our existing Care Home market to increase specialist dementia capacity
- Supporting providers of health and care to recruit, develop and retain a workforce for the future through our Health and Skills Partnership.

Our Delivery Plan

The next sections of the Plan summarise the ambitions and the key high level objectives for each of the 9 delivery programmes and 10 enabling programmes, with additional detailed milestones and year 1 and 2 work programmes included in Appendix C and Appendix D.

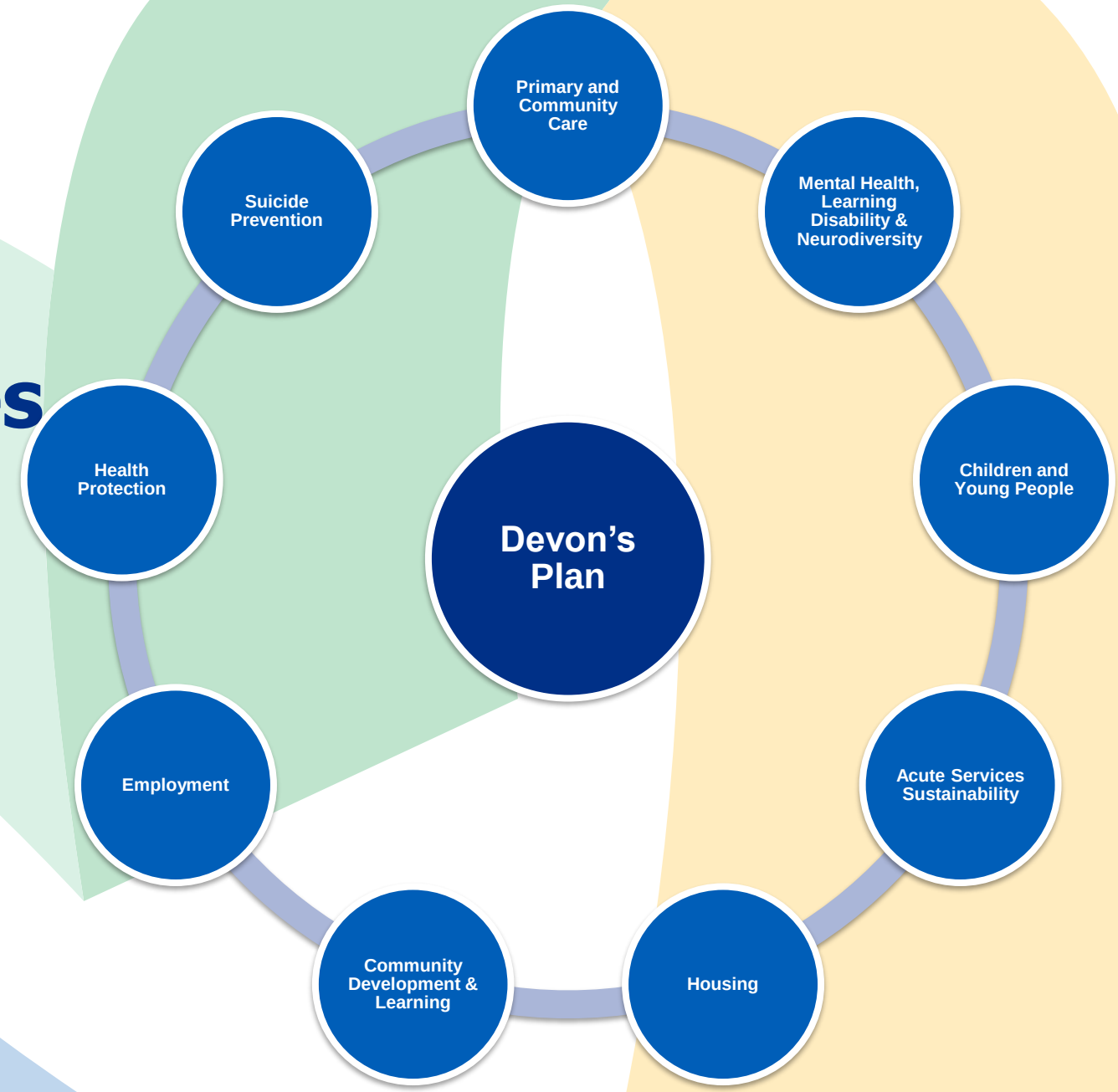
Those programmes that have been working on key transformation priorities linked to the Devon Long Term Plan have reviewed and updated these to ensure alignment to the One Devon strategic goals.

There are several golden threads that run through all of the delivery programmes, including:

- Prevention (focusing on the five main causes of death and disability)
- Population health
- Improved outcomes
- Personalisation and empowerment of individuals
- Inclusion – with a particular focus on inequalities, including in relation to neurodiversity, people with multiple complex needs, people with care experience, our armed forces population and those who have experienced trauma (including veterans), all of whom can struggle to access services.
- Quality and safety of care
- Continuous learning and improvement

Delivery Programmes

[Detailed milestones in Appendix C]



Vision and Ambition

Mental Health

Work together with partners and experts by profession and experience, to improve population mental health and wellbeing and improve outcomes and experiences of people with mental illness across Devon. We will do this by providing the right, safety staffed, affordable and sustainable care and support that is compassionate, trauma informed and co-produced

Pledges – Mental Health

Game-changer: To reduce health inequalities and improve health outcomes for people with mental ill health through action and learning. Mental health, learning disabilities and neurodiversity are everybody's business and this will be increasingly reflected through integrated care; support, care, and treatment will be person-centred so that people get the right support when they need it.

Best Care: Over time in Devon 'predisposing' factors of mental illness will not predict mental illness, they will predict proactive support which avoids mental illness where possible. All ages, groups and communities of people get the help they need to ensure all have an equal chance of enjoying resilient emotional wellbeing and mental health across their lives.

Strategy and policy: We will fully achieve the commitments set out in the NHS Long Term Plan for people with mental health problems and learning disabilities. All people with mental illness will be cared for in Devon at home, or as close to home as possible, through a sustainable, supportive community offer which reduces variation at a locality level. People who experience serious mental illness will have their physical health needs met with a view they live a life as long as the average person in Devon without mental illness

Co-Production Co-production is front and centre in designing, leading and making change – we will:

- Work in partnership with experts by experience and profession, wider community experts and including VCSE and the independent sector
- Empower people and families to work with us as partners in making sure people get the best care and support possible
- Change aims to innovate, transform and build on best practice

Housing, Employment and Education: People with serious mental illness and learning disability, including those with co-existent drug and alcohol problems, will have improved access to safe, adequate housing, employment and education options.

Year 1- 5 Objectives

Mental Health

Smart Objectives
People in the perinatal period and their families will be able to ‘get help’ early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible. More women, children and families get help early in development of need (prevention).
Children and young people have access to timely mental health care and support.
Devon will sustainably eliminate inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.
People with serious mental illness will have a complete physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.
People experiencing mental health crisis will be able to get the help they need as early as possible.
Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness.
People will have a timely dementia diagnosis and planned onward care and support.

Vision and Ambition

Learning Disability and Autism

Population Working – LDAP Strategic Approach

Strategy - as a system we reviewed up to 30 different national strategic documents, Acts and legislation that were associated with the system provision of health and social care for Learning Disabilities and Autistic People (LDAP). As a system we agreed that for our approach to have value and commitment to the people we serve, we would reduce those strategies to a number of measurable described and defined pledges. Those pledges will be co-owned through an integrated governed system - mobilised, monitored and overseen in the Learning Disability and Autism Partnership.

Pledges – Learning Disability and Autism Partnership

The Golden Thread: To reduce health inequalities and improve health outcomes for people with a learning disability and autistic people delivered through actions and learning. Golden thread of reasonable adjustments to access all services across Devon
Health Inequalities, Reasonable Adjustments, STOMP, LeDer Service Improvement programme, CTR Safe and Wellbeing reviews

Housing Accommodation and Inpatient reprovision: We need to deliver a new model of service for people with learning disabilities and autism, including those with the most complex needs, that is housing-based and shares five common principles of providing the best living environment; having a clear common pathway for delivery; ensuring better life outcomes and making best use of financial resources to create sustainable housing and services over the long-term.

Autism: Our vision is that autistic people get the support and opportunities they need to lead full and happy lives. As partners, we will work to improve services, reduce waiting lists, support the removal of barriers for autistic people of all ages and their families/carers, through improving training and awareness, provision of meaningful support, assessment and diagnosis, early identification and reducing the reliance on inpatient care through community services.

Co-production: To empower people and families to work with us as partners in making sure people get the best care and support possible.
We want to find more ways to bring this to life in the work of the innovations we support.
Meeting those hard to reach communities, hearing more, balanced views (“you said and we are doing”).
Experts by experience, VCSE

Employment: Increasing more of our adult working age community into employment

Benefits from a system approach: Collaborative working, joint ownership, shared outcomes and examples of good practice, innovation and shared risk, Clinical Input to workstreams.

Year 1- 5 Objectives

Learning Disabilities and Autism

Smart Objectives
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.
Reduce reliance on Mental Health locked and secure inpatient care, while improving the quality of Mental Health inpatient care, so that by March 2028 (in line with national target) no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an Mental Health inpatient unit
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times by March 2028.
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.

Vision and Ambition

Primary and Community Care

Primary and Community Care integration is a cornerstone of the Devon Long Term Plan, and our vision is to deliver an integrated model of care to support all people at home (includes prevention, anticipatory care, whole life course and best practice pathways).

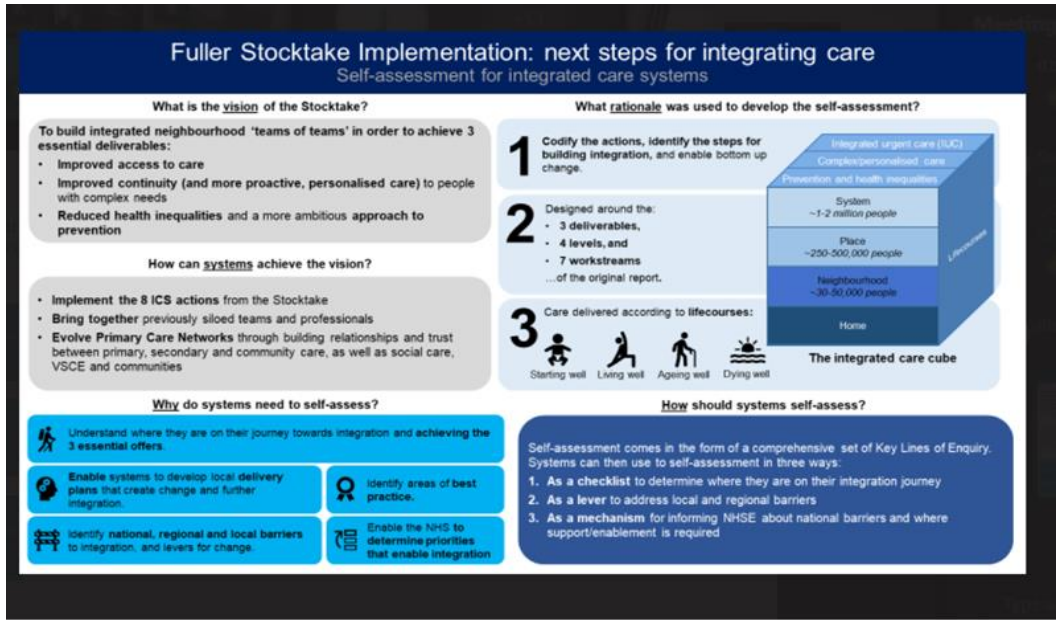
The integrated model of care described in the Devon GP strategic framework (2022) evidences alignment with the output of the national Fuller Stocktake which focuses on the development of integrated multi-disciplinary neighbourhood teams at place. Community care covers community health and social care services, voluntary sector and community organisations.

The Devon Community First strategic framework (2022) also describes the aims of building community capacity at a neighbourhood level, focusing on proactive, reliable, resilient, safe and sustainable community services.

Building on these two local strategic frameworks and with the delegation of additional primary care services (dentistry, pharmacy and optometry), Devon ICS now wants to set an ambitious target to have a fully functioning and effective **integrated model of care**, which takes a more preventative approach to delivering personalised care and addressing health inequalities within each of its five Local Care Partnership areas.

Our **integrated model of care** will be underpinned by a personalised, strength-based social care offer focused on keeping people connected and supported in their own communities

This integrated health and care offer will ensure that we meet people's needs in a way that matters to them and that supports them to stay living safely at home in their community, retaining their independence for as long as possible, living the life they want to lead.



Year 1- 5 Objectives

Primary and Community Care

Smart Objectives
Collaborative working We will have a Primary and Community Care Collaborative which functions Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes
Integrated Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community, cross organisational multi-disciplinary team to jointly deliver services
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, by 2028
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention
Avoiding Admissions Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step-up and step-down pathways via remote management, in conjunction with the local community team and specialist teams/services
Access to Information We will have a shared overview of Voluntary and Community organisations across Devon via the consistent use of the Joy App by Social Prescribers and across 100% of PCNs by 2024, which enables access by all staff
Personalised Care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)
Sustainable General Practice We will have sustainable and high quality general practice which operates within local and national Strategic Frameworks, and which has agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market • *Quality* • *Price (funding)* • *Information, advice and signposting*
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes

Vision and Ambition

Children and Young People Care Model

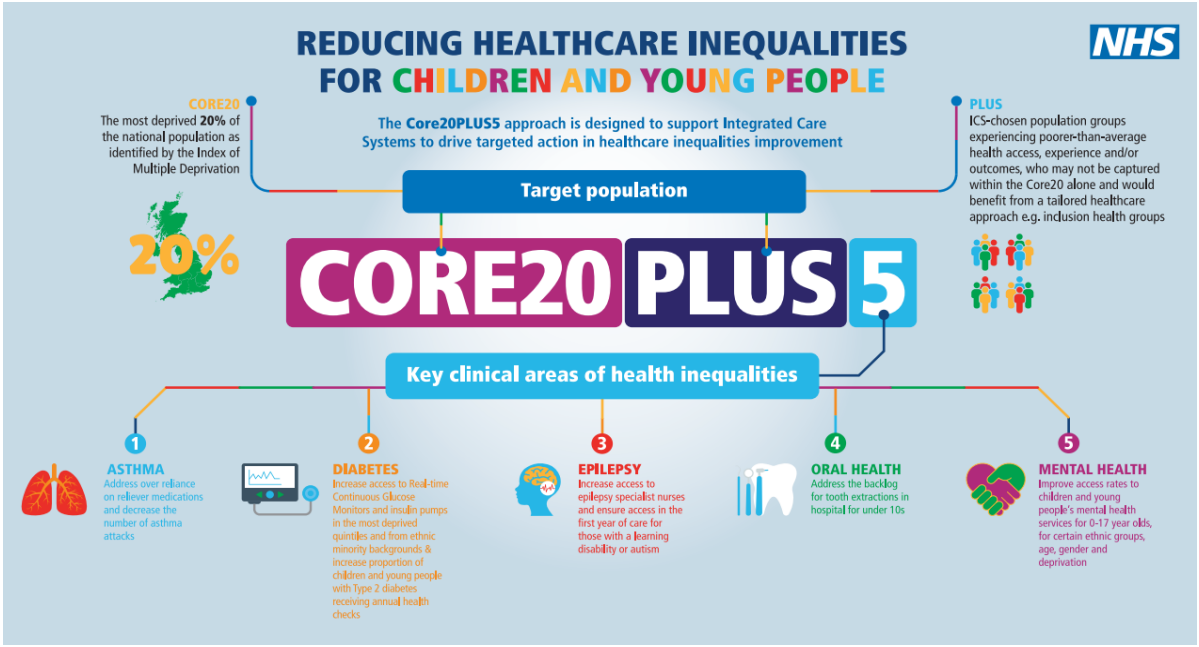
Our vision is to create an Integrated System and Care Model for Children and Young People (CYP) that supports all aspects of their health (including mental health) and wellbeing, for children and their families so that they can make good future progress through school and life. We will achieve this by working effectively in an integrated way within and across health, care and education, sharing information and knowledge and taking a strengths based approach.

Using our collective resources, we will create sustainable services and settings where children can learn and achieve their potential in life. We will ensure safe birth and optimise the first 1000 days of a child's life and enable the early identification of issues for children. We will meet the requirements of the Core20PLUS5 by proactively addressing health inequalities, working collaboratively with communities and the voluntary sector to shift to a child and family driven approach, ensuring that safeguarding is a golden thread. Transition for young people into adulthood and achieving independence will be focus for every relevant pathway. The needs of CYP with Special Education Needs and Disabilities (SEND) are a specific focus for our health, care and education system, so that we can respond effectively to the weaknesses identified through inspection and the challenges experienced by our children and families.

Our approach will be informed by joint use of high quality data and information and by listening to our communities to truly understand the needs of children and young people and their families, women and birthing people.

Our focus areas of work which span from birth, through transition to young adult are covered within SEND improvement programmes across all three Local Authorities and Local Authority led early help programmes and three NHS driven transformation programmes:

- **Services for children who need urgent treatment and hospital care** are delivered as close as possible to home and waiting times are steadily improved.
- **Children and families with neurodiverse, emotional and communication** needs are supported across health, care and education, preventing crisis and enabling them to live their best life.
- **Maternity care** is safe and offers a personalised experience to women, birthing people and their families.



Year 1- 5 Objectives

Children and Young People Care Model

Smart Objectives
Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.
Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.
Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.
By 2028, we will have proactively addressed **health inequalities**. The Core20PLUS5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.
Commissioned arrangements will be in place across Devon by 2028 to ensure that the health needs of **socially vulnerable children** are identified and met.
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.

Vision and Ambition

Acute Services Sustainability

The Covid pandemic has impacted on urgent and elective services across the UK and here in Devon - waiting times for patients needing urgent care, planned appointments and procedures have increased dramatically, impacting on our ability to deliver timely hospital services to the people of Devon.

We will work together across our local NHS organisations to deliver **high quality, safe, sustainable and affordable services** as locally as possible improving patient outcomes and experience. We will ensure that addressing health inequalities are a focus of all our work and that the whole population of Devon is able to access the care they need.

We will make sure people access the right service at first time through **effective navigation** around the care system; people with a care need should be seen by **the right professional, in the right setting, at the right time**.

In the short term to stabilise care by:	In the medium term to sustain care by:	In the longer term transform care by:
▪ Addressing the most challenged services ▪ Increasing productivity and maximising capacity ▪ Adopting and embedding best practice	▪ Delivering high quality clinical outcomes for the whole population ▪ Consistently meeting agreed performance targets ▪ Making best collective use of scarce workforce resources ▪ Ensuring best value within available financial resources ▪ Transforming pathways of care - strengthening continuous improvement	▪ Improving equity of access for all ▪ Adapting to changing population need ▪ Working as one joined-up system of services without organizational barriers ▪ Adopting new and innovative models of care ▪ Being a pace-setter in the use of digital and technical solutions ▪ Preparing for significant medical innovations eg: genomics ▪ Ensuring that location is never a barrier to accessing services

One Devon

Year 1- 5 Objectives

Acute Services Sustainability Programme - Peninsula Acute Sustainability

Smart Objectives
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)
Trust Boards, Peninsula leadership & NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement (January 2024)
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement (February/March 2024
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)

Year 1- 5 Objectives

Acute Services Sustainability - Planned Care

Smart Objectives
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.

Year 1- 5 Objectives

Acute Services Sustainability - Diagnostics

Smart Objectives
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)

Year 1- 5 Objectives

Acute Services Sustainability – Cancer

Smart Objectives
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs
Sustainability of Oncology Services
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

Year 1- 5 Objectives

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.
Improve **A&E waiting times** so that no less than 72% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 – this will be achieved through a reduction in bed occupancy, avoiding inpatient admission where possible and reducing length of stay
Improve **category 2 ambulance response times** to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 - this will be achieved through improvements in the “clinical hub” (emergency operation centre” including clinical navigation and validation, and additional ambulance response capacity
Acute bed occupancy will decrease to 94-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.

Vision and Ambition

Housing

The overall vision for housing is that people across Devon have access to a decent, safe, secure and affordable home, which is suited to their needs, promotes health and is located in a community where they want to live. The elements that contribute to this include:

1. Poor quality housing is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups (1). The impacts are wide ranging and broad; with direct relevance to healthcare, homes which are cold/damp/mouldy increase the risk of exacerbations of many illness (respiratory, cardiovascular) and of falls, leading to increased hospital attendances and admissions; and at the other end of the scale, in terms of giving children the best start in life, issues from asthma, spread of infectious diseases, and inability to concentrate on homework can have life -long impacts.
2. Specialist housing - increased range of specialist housing such as accessible wheelchair accommodation and supported accommodation to meet the needs of the most vulnerable, including people with dementia.
3. Enabling older people to promote, secure and sustain their independence in a home appropriate to their needs, including through the provision of housing across all tenures in sustainable locations and through the provision of Disabled Facilities Adaptations. This will include increased provision for retirement accommodation, extra care and residential care housing.
4. The provision of good quality affordable housing for rent or buy in the areas where people want and need to live, giving specific consideration to the need to attract and retain key health and care workers.
5. The prevention of homelessness; noting that this is far wider than simply provision of housing.

Although elements 2-4 fall within the remit of local planning authorities (LPAs) to deliver, the recommendation is for health and care partners within the ICS to engage more proactively with LPAs via planning consultations and other relevant forums, to ensure that the needs of people with complex health conditions and disabilities, such as those with mental health disorders, learning disabilities and/or autism, are reflected in housing supply.

For element 1 **poor quality housing**, the ambition for this, as indicated by the overall target, is significant since it requires some 11,000 homes across Devon to be lifted out of fuel poverty to achieve the reduction of 2 percentage points.
As well as new energy efficient homes, there are three key approaches to tackling this:

- Supporting people to improve the energy efficiency of their own homes
- Working to improve the standard, quality and management of private sector housing
- Supporting people in supplier switching, fuel debt relief and in financial management

Resources are likely to be a constraint around this, especially since funding tends to be relatively short term (e.g. Housing Support Fund). However there is much that can be done. NICE guidance QS117 [2] sets out a number of quality standards to assist with reducing these risks and this should be implemented across Devon. This centres around; identification of vulnerable people in cold homes; single point of contact for support; asking people if they live in a warm home; identifying cold homes on admission; supporting warmer homes as part of discharge planning.

Year 1- 5 Objectives

Housing

Smart Objectives
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE
Systematically identify vulnerable groups with chronic conditions and signpost for support
Identifying poor quality housing on admission/discharge planning and referring for support
For the projected need for specialist housing, accommodation to meet the needs of older people and affordable housing to be recognised in Local Plans across Devon to support housing delivery
Reduce the number of people who are homeless in particular: • No family should be in B&B accommodation over 6 weeks • 10% reduction in number of households in temporary accommodation • 30% increase in the number of households successfully prevented from becoming homeless • 100% of people who sleeps rough should be offered accommodation

Vision and Ambition

Employment

Employment is a crucial element of individual wellbeing, health and social mobility, and partners within Devon fully recognise its role as part of our wider efforts in supporting individuals to thrive, young people to advance, support services to better manage demand, and provide the health and social care system with the future workforce it needs.

At the highest level, national and international evidence suggests that individuals within employment benefit from both improved mental and physical health and wellbeing overall, with the Health Foundation highlighting that the occurrence of new mental health diagnosis amongst those in work were roughly 15% lower then amongst those outside the workplace in 2021, and that those who outside of work were also 16% more likely to have poorer health outcomes overall. Wider academic work also suggest strong links between reduced life expectancy, poorer health and mental outcomes, and reduced life satisfaction overall and prolonged experience of unemployment. This is particularly acute for younger people, where unemployment may leave a scarring impact in terms of progression, confidence, education and personal resilience (Prince's Trust, 2021).

Traditionally, Devon has performed relatively well around such issues, with economic activity rates and NEET performance amongst the best within the South West (roughly 1-2% better on average than the rest of the region). However, significant gaps existing within the area's performance, with unemployment amongst younger people roughly 1% higher then those over 25, amongst those with a disability roughly 7 to 8 times the average of the rest of the population, and for those who have experienced care roughly 10 times the County. Significant differences also existing between places within the County, with unemployment in Torbay roughly twice that in South Hams on average, levels of youth Unemployment / NEET roughly 60% higher in Plymouth than Exeter, and average wage levels for those in work in Torridge approximately £150 less per week then those in East Devon.

As such, this strategy seeks to focus upon ensuring that every resident of Devon are provided with the support they need to access and stay in employment, secure a good job they value and develop their careers. This seeks to ensure that no individual regardless of background faces a barrier to employment if they wish to work. In particular, One Devon partners seek to ensure that individuals from more vulnerable backgrounds and with more prominent barriers to employment and progression in the workplace are supported to achieve and grow. Partners are also keen to fully harness the potential of the health and social care sector as an employment destination and leverage related opportunities to support those more vulnerable. This includes a specific focus upon:

- **Younger people**, particularly those from a more complex background who may experience additional barriers into the transition into adulthood, and maybe Not in Employment, Education or Training (NEET) or at risk of being NEET as a result. This would include a specific focus on those who are care experienced and those with an SEND need.
- **Individuals who have a disability, face a mental health challenge or have another health barrier to employment**
- **Individuals with a barrier to work or progression from within our most vulnerable communities**, particularly those within the bottom 20% most deprived nationally.
- **Groups identified as being more likely to face other barriers to employment**, including older people already outside of the labour market and single adults with children

To support these target groups, partners within Devon will work together across the health and social care system to support individuals into related employment opportunities, through:

- Working together, alongside key partners such as Jobcentre Plus/DWP, to codesign and deliver relevant wraparound support for individuals to allow them to access employment. This will include exploring tailored support offers for those with a health or mental health condition, working with health and social care employers to identify opportunities for more vulnerable / complex staff, and working with workforce development colleagues to ensure that pathways are tailored to accommodate individuals regardless of circumstance.
- Working with employers across the sector and beyond to support them to employ individuals who may have move complex needs / barriers to work, for example through providing support for workplace mentors or working with skills and learning colleagues around the creation of structured traineeships and apprenticeships to offer additional routes into employment
- Come together as partners and employers to work upon and explore topics of shared interest and opportunities, for example through agreeing a single forum through which to explore employment opportunities for those with a mental health need.
- Work with wider partners on issues which support broader access to employment, including relevant housing provision, careers education, functional skills, speech and language provision, and transport
- Engage with wider place based initiatives, which seek to focus upon more specific challenges facing communities around employment, from skills uptake in our urban centres, to the challenge of connectivity in our deep rural and costal communities.

Year 1- 5 Objectives

Employment

Smart Objectives
Seek to reduce level of 16-18 year olds Not in Education Employment and Training (‘NEET’) in Devon by 1% by 2027
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027
Unpaid carers will be supported to remain in or re-enter employment
Build on resources developed across the local authorities to support more people into employment

Vision and Ambition

Suicide Prevention

Suicide is a traumatic event; the impact is felt not only by immediate family and friends, but by people in workplaces, communities and wider society. It is estimated that every suicide costs the economy £1.67 million. This estimate includes direct costs - involvement of the emergency services, healthcare and wider wellbeing support and interventions and investigations carried out by the police and coroner. There are additional indirect costs attributed, which include the lost opportunity to contribute productively to the economy, including paid work, voluntary activities and looking after children or parents. Arguably though, the most fundamental impact of all is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value. It is these intangible costs that make-up approximately 70% of the total costs of suicide.

Suicide can often be the end of a complex history of risk factors and stressing events, and the risk for suicide reflects wider inequalities in social and economic circumstances. Suicide is preventable; however, the prevention approach must address the complexity of the issue. There are many effective ways in which individuals, communities and services can help to prevent suicide and this strategic statement is intended to recognise the contributions that can be made across all sectors of society.

The *'Cross-Government Suicide Prevention Strategy'* published in 2012 and subsequently updated in 2015, 2017 and 2019 sets out the Government's priorities for addressing suicide and self-harm. [A new strategy is expected in 2023]. The NHS Long Term Plan aims to transform mental health and care services to ensure more people can access the treatment and support they need in a timely manner and in particular commits to enabling easier access to care when anyone is having a mental health crisis. This sets out the NHS ambition and confirms that reducing all suicides remains an NHS priority.

The ambition for suicide prevention is to deliver a consistent downward trajectory in the suicide rate for all areas of Devon, Plymouth and Torbay and for all people living in these areas. Our system aspires to make Devon, Plymouth and Torbay places that support people in times of personal crisis and builds individual and community resilience to improve lives.

Devon-wide partners will recognise the important contribution they can make and take a whole-community approach, recognising the contributions that can be made across all sectors of society. The approach will cover two tiers of action:

- **Level 1 Universal Interventions:** to build resilience and promote wellbeing at all ages for residents of Devon, Plymouth and Torbay.
- **Level 2 Targeted and vulnerable population groups:** targeted prevention of mental ill-health and early intervention for people at risk of mental health problems

One Devon

Year 1- 5 Objectives

Suicide Prevention

Smart Objectives
The Local Suicide Prevention Groups to each have a published annual action plan based on the national strategy which sets local delivery priorities for the year
Our local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average

Vision and Ambition

Health Protection

The 2020 Covid pandemic has highlighted the importance of protecting our population from preventable diseases, hazards and infections. This is set within the context of new and emerging threats, including antimicrobial resistance and climate change. Diseases disproportionately impact on our most vulnerable communities. We also know that some communities in Devon are least likely to access preventative services, including immunisations and screening, and yet are more likely to experience the severe consequences of diseases and infections.

To protect the Devon population, we must ensure therefore ensure that we:

- work with our system partners through strong governance and partnership arrangements to deliver our health protection responsibilities to ensure that the health of the public is protected, particularly within the context of new and emerging threats. As we move to delegated commissioning of immunisation services, including outbreak vaccinations, there will be greater emphasis on system leadership by the NHS and Devon's Local Authorities working with the UK Health Security Agency (UKHSA), presenting further opportunity to address health inequalities at the local level;
- deliver the UK 5-Year Action Plan for Antimicrobial Resistance (2019-2024) which was suspended during the Covid pandemic – this has a strong focus on infection prevention and control and our aim is to work collaboratively across the system and organisational boundaries with all providers to drive forward further reductions in healthcare associated infection across the whole system
- strengthen our surveillance, intelligence and insight to ensure that we focus on protecting our most vulnerable communities in Devon;
- embed the learning from the Covid pandemic and delivery of the Covid vaccination programme in Devon, which has highlighted the need for frontline health protection services, strong commissioning pathways, greater emphasis on community infection prevention and control, and accessible/innovative service delivery (e.g. outreach vaccinations);
- fulfil our responsibilities as a Category 1 responder, through taking a lead role in assessing risks, putting in place emergency and business continuity plans, warning and informing, embedding learning, and setting the direction of EPRR (Emergency Preparedness, Resilience and Response) strategy and priorities.
- Work with system partners, including VCSE and lived experience partners, to support the improvement of uptake of routine immunisations and screening in general and with a focus on Devon's priority populations (Core20PLUS5) for adults and children and young people; with a focus on measles, mumps and rubella (MMR), preschool booster, Core20PLUS5 key areas (early diagnosis), cancer screening in particular cervical screening uptake; and alignment with Devon's approach to the Women's Strategy and Devon's cancer priorities and workplans.

Year 1- 5 Objectives

Health Protection

Smart Objectives
Reduce occurrences of healthcare associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA) and community onset community associated (COCA) occurrences of HCAIs
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection
Providers must demonstrate a 100% offer to eligible cohorts for influenza and Covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for children and young people (CYP) and adults
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (Core20PLUS5) for CYP
Vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, with particular focus on Devon's priority populations (Core20PLUS5) for CYP
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-Covid levels, with secondary aim to achieve year on year improvement in uptake working towards the 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (Core20PLUS5) for Adults
Work closely with NHS England commissioner to support the delivery of the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (Core20PLUS5) for Adults
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon

Vision and Ambition

Communities that are strong, resilient, inclusive and connected, where people support one another in an environment that promotes health and wellbeing

Community Learning & Development

The collective power of community to improve health and wellbeing

Positive health outcomes can be achieved by addressing factors that create and protect health and wellbeing at community level. Community life, social connections, supporting access to services, creating and maintaining a health-promoting physical, economic and social environment and having a voice in local decisions are all factors that contribute to health and wellbeing. These community determinants can help buffer against disease and influence healthy lifestyle behaviours. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. Participatory approaches can directly address marginalisation and powerlessness that underpin inequities and can be more effective than professional-led services in reducing inequalities.

How communities can be supported to improve the health and wellbeing of their residents

The people that understand communities best are the people that live and work in them. Place-based working, recognises that each community is unique in terms of what it has to offer, its own particular challenges and the various factors at play that contribute to these challenges. People with the knowledge and experience of living and working in the community need to be involved in the decision-making that affects it. Not only will this prove to be more effective than a one-size-fits-all approach, but by making best use of each community's 'wellbeing assets' and the energy and enthusiasm of members of the community, it makes best use of limited resources.

Community assets include the skills and knowledge of citizens; local groups and voluntary sector organisations, including faith-based organisations, clubs and charities; local businesses; and public sector agencies, including local policing teams, schools, GP practices, nursing teams and local councils. Other assets include buildings, websites and local communication platforms. Action plans can be created by community partnerships to address needs with existing assets, identifying the gaps and exploring how they can be filled.

The purpose of community learning and development

Community development enables people to work collectively to:

- Identify their own needs and actions
- Take collective action using their strengths and resources
- Develop their confidence, skills and knowledge (including formal and informal methods of learning working particularly with under-heard and excluded groups to allow participation in the decisions and processes that shape their lives).
- Challenge unequal power relationships
- Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

There are five key values that underpin community development practice: social justice and equality, anti-discrimination, community empowerment, collective action, working and learning together

Community Development and its relationship to Health Inequalities and Population Health

Communities are in variable states of energy and organisation and communities in disadvantaged areas may need more support than others - Commissioning Community Development for Health. The plan includes the use of the One Devon Dataset and other sources of data such as the JSNA to help identify which communities face the most disadvantage and should be prioritised for this investment.

One Devon and its Community Development objectives

The role of One Devon is not to 'do' community development but to help create the conditions that foster and strengthen community action. The SMART objectives on the following pages will help create those conditions.

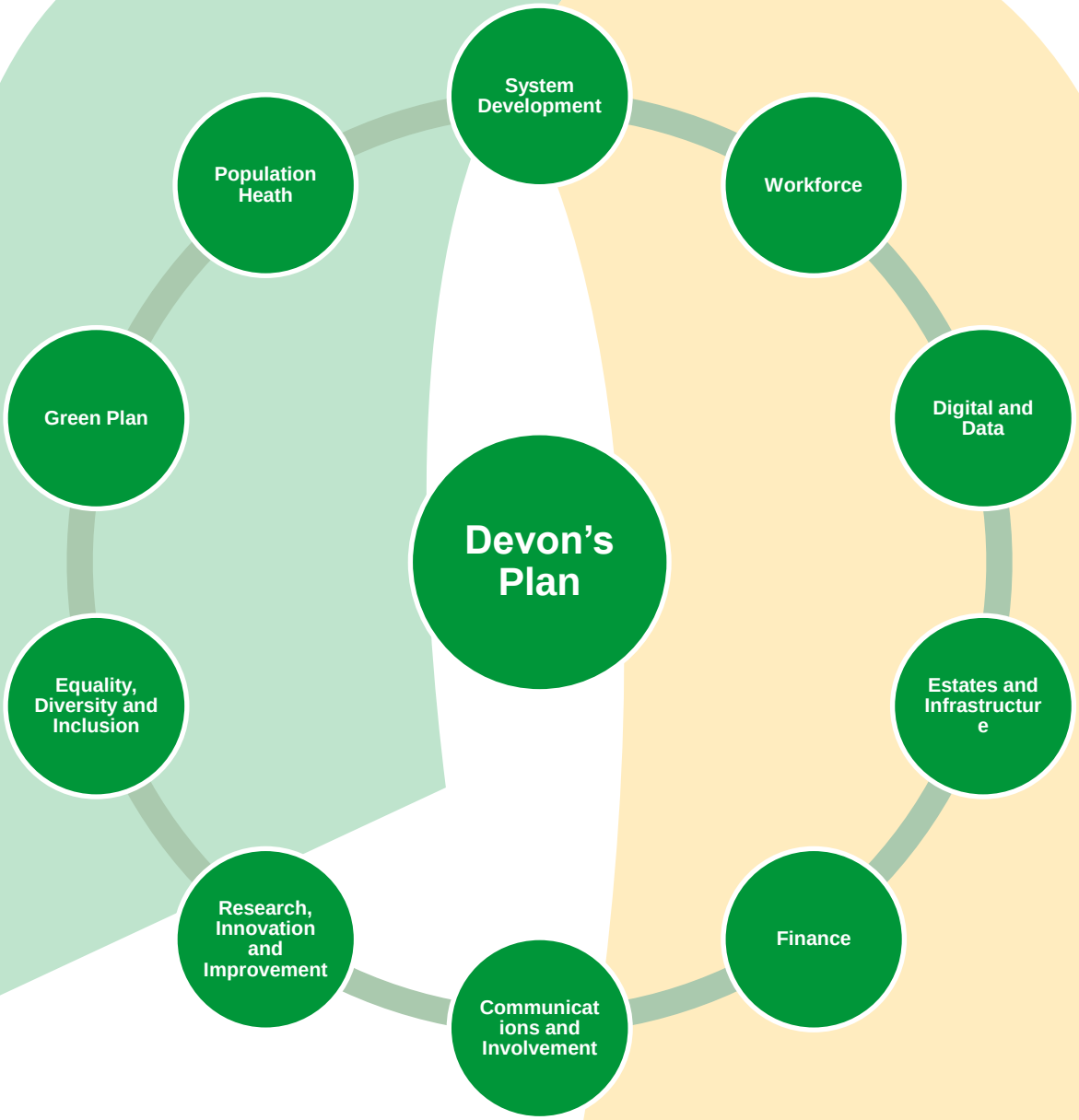
Year 1- 5 Objectives

Community Development and Learning

Smart Objectives
By 2028 local communities, and particularly disadvantaged groups, will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – ‘no decision about me without me’
By 2028 local communities will work in partnership to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.
By 2028 a Community Development workforce will be supported, equipped and trained to agreed standards, code of ethics and values-based practice
By 2028 Local Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are an equal partner both at system and local level

Enabling Programmes

[Detailed milestones in Appendix D]



Vision and Ambition

System Development

The Integrated System Development Programme aims to strengthen integrated and collaborative working in One Devon, to enable partners to implement innovative ways to collectively tackle our shared challenges improving the access to effective health and care for people in Devon.

System Partners will collectively own the delivery of the Programme, actively involving communities and people with lived experience, and will adopt five core principles to underpin all of our work together.

An innovative approach to reset the way we work together and apply learning will fundamentally change mindsets and improve the outcomes and experience for people across Devon. As a result the Programme will primarily support the overarching strategic goal outlined in the 5-Year Integrated Care Strategy:

'One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.

By 2026/7 we will have: adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.

Opportunity Area	Description
LEARN BY DOING	Real change will come from undertaking real work together and acting upon the learning we generate. One Devon will be able to continually develop if we embed a culture of learning and improvement.
PRIORITISE & IMPLEMENT	Implementing a small number of priority projects and programmes will create the conditions for us to deliver real change together on the journey towards achieving One Devon's vision.
SHARED PURPOSE	Defining and articulating (continuously) why we are doing what we are doing, and what we hope to achieve from it, will support One Devon to collectively realise a common purpose.
TRUST & COLLABORATION	Increasing levels of trust and collaboration between us will be vital to creating the conditions for progress towards One Devon's vision.
SYSTEM FOCUS	Movement towards One Devon's vision will be enabled by the extent to which we seek to understand, listen to, and take into consideration each other's needs and constraints.

Year 1- 5 Objectives

System Development

Smart Objectives
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards

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Vision and Ambition

Research, Innovation and Improvement

In order to establish new ways of working across the Devon ICS we need a more robust and dynamic approach to research and innovation. The purpose of the Research and Innovation Programme is to ensure that system partners work together to address the three common barriers identified in a review carried out in December 2021 on accessing, deploying and embedding research, innovation and improvement:

- Absence of system level process for accessing, deploying and embedding research, innovation and improvement
- Absence of the right system level capacities and capabilities within the system's organisations to make best use of research, innovation and improvement
- Absence of a systematic approach to learning

One Devon will provide its workforce with the framework, tools and support to innovate in its broadest sense. To be successful, we will develop the right **research and innovation architecture**, to deliver all our strategic goals, building an **evidence base and innovation pipeline** which directly responds to known health and care needs and the Devon Case for Change. We will **build the capacity and capability** of teams and organisations so that we achieve widespread adoption of high value innovations aligned with ICS priorities, utilising **systematic research and improvement approaches** to support rapid implementation. In doing this, we will drive spread and adoption of what works, achieve optimal use of resources and best outcomes for the people of Devon.

Specifically, the ICS is working with the South West Academic and Science Network (SWAHSN) to implement a Peninsula Research and Innovation Strategy. This will draw in core partners who represent major research and innovation assets in the region (AHSN, ARC, CRN, HEIs and Cornwall and Somerset ICSs), and will develop a new framework which will maximise the alignment of health needs with existing research and innovation expertise and networks. Funding has recently been agreed for joint role to lead the development of this new framework.

The ICS will maximise impact from research, innovation and improvement by clearly signalling its strategic ambitions and priorities to partners, to grow and focus the innovation pipeline, to achieve better alignment with system transformation programmes. The coordination of research and innovation partners and assets in the region around clear priorities will enable One Devon to leverage in additional funding from Government and other funding streams, supporting economic growth. It will also facilitate the sharing of learning with other systems regionally and nationally.

Year 1- 5 Objectives

Research, Innovation and Improvement (RII)

Smart Objectives
Build and strengthen networks at local, system, region and national level by March 2024
Promote research and increase patient sign-up with demonstrable increase by end 2026
Ensure all system workplans are underpinned by robust evidence of research and innovation
Develop capacity and capability by having a ICB RII Team by April 2024
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles by end March 2025

Vision and Ambition

Population Health

As the Integrated Care System develops there will be an increasing focus on improving the health of the population, shifting the allocation of resources from treatment to **prevention, increasing access to services and reducing health inequalities**. This will require changes throughout all parts of the system and, in particular, in the way that the ICB carries out its roles as both a commissioner and a system convener and facilitator. These changes will be embedded in the ICS development programme and all aspects of this plan, but will aim to ensure that the **impact on population health is considered in every decision made** and workplan delivered and that we move to a longer term focus.

In order to achieve these changes a programme of work will co-ordinate activities at both LCP and system level. This programme will be led by the Population Health Team (incorporating the existing HI and Prevention team and PHM workstream) and will aim to facilitate and support work throughout the system as well as delivery of specific interventions.

The overarching aim will be to ensure that there is a **focus on population health throughout the system**, that everyone has the skills, tools and knowledge to deliver change and that good practice (underpinned by robust evidence) is shared and implemented as quickly and efficiently as possible.

One Devon

Year 1 - 5 Objectives

Population Health

SMART objective
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations on an ongoing basis
Ensure delivery of Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement
Implement co-ordinated prevention plans in priority areas including CVD, diabetes and respiratory
Develop the ICB and NHS partners as Anchor Organisations by March 2026
Support the implementation of new ways of working focused on population health by April 2025

Vision and Ambition

Communications and Involvement

Vision

Through inclusive, meaningful, involvement, we will work in partnership with Devon's people and communities so that health and care services meet the needs of our population. We will champion involvement through a culture of ongoing conversations and collaboration, so that we act on what we hear and continue to build trusted relationships with a shared purpose.

Involvement principles

Our approach to involving people and communities is based on six values (aligned to the 10 principles outlined in the NHS Constitution)

Collaborative with a shared vision with our partners

- Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as two of our key partners
- Work in partnership with staff, people and communities when addressing system priorities and reconfiguring services
- Learn from what works and build on the assets of all partners in the Integrated care system (ICS) – networks, relationships and activity in the local care partnerships (LCPs).

Start with what we already know

- Use community development approaches that empower people and communities and build on existing relationships.

Act with humility and genuine enquiry

- Understand our community's needs, experiences, ideas and aspirations for health and care, using involvement to find out if change is working and is making a difference.

Be fully inclusive in our approaches to all our communities

- Build relationships based on trust, especially with those affected by health inequalities.
- Provide information that is clear and accessible for all our communities. Meet the needs of our people and communities by having various ways they can engage with health and care services.

Be responsive, act quickly on what we have heard, and tell people how we have acted on feedback

- The voices of people and communities need to be central in the decision making throughout the ICS.
- Involve people and communities at every stage when developing plans and feedback to people how their involvement has influenced decisions.

Year 1 - 5 Objectives

Communications and Involvement

The communications and involvement mechanisms that will support delivery of the JFP include:
Support the use of the new ICS involvement platform ‘Let’s Talk’ and citizens’ panel that programmes can utilise to support online involvement activities across the system
Develop an involvement identity that can be can be used across the One Devon Partnership to help raise the profile and awareness of involvement activity across Devon.
Develop a system approach to communications and involvement, working with professionals from all system partners to support consistent communications, involvement, collaboration, sharing of best practice, and co-production.
Work with partner organisations such as Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector, to deliver engagement on our behalf and to provide insights and connection to local populations
Support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
Provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Co-ordinate and support JFP leads to involve our 3 local overview and scrutiny committees addressing our statutory requirements under the Health and Social Care Act 2012, and also ensure we continue to build pro-active and meaningful relationships with all three Overview and Scrutiny Committees (OSC) in Devon, Plymouth and Torbay both individually and jointly as appropriate.

Vision and Ambition

Equality and Diversity

Vision:

Devon will be a great place to work where staff will feel valued and have a strong sense of belonging. We will champion diversity as our route to innovation and improved performance.

We will support work to tackle health inequalities by working hand in hand with local populations and our partners to understand barriers to care so that we can design services that have the needs of everyone at their core.

Core aims:

Nationally, there is growing evidence that equality and diversity improve efficiency and performance. Diversity of thought paves the way for innovation and therefore offers the opportunity to help tackle Devon's challenges, making it a better place to live and work for everyone.

Devon is a significantly challenged health and care system, with some of the longest waiting lists in the country, a significant deficit of £49.5 million (across the system) and significant workforce challenges.

Two core aims underpin the equality and diversity programme:

1. **Improve innovation, performance and efficiency through a diverse workforce**
2. **Ensure Devon's health and care services are inclusive and accessible to everyone**

Year 1 - 5 Objectives

Equality and Diversity

Equality and diversity ensures that services meet people's needs, give value for money and are fair and accessible to everyone. It means people are treated as equals, get the dignity and respect they deserve, and differences are celebrated.

Improve innovation, performance and efficiency through a diverse workforce

- Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)
- Develop and retain a diverse workforce, building a culture where our people feel valued, heard and able to be their best selves at work.
- Ensure staff recruited via the International Recruitment Hub, are well supported in their roles and deliver a campaign that celebrates our diverse workforce, tackles racism and builds cohesion in the community.
- Continue to build and support the Devon-wide ethnic equality staff network, ensuring it has meaningful input into system priorities, including develop a Devon-wide anti-racism charter that the One Devon Partnership sign up to.
- Consider race equality as part of all commissioning strategies.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance
- Support staff to feel safe, including listening and providing support to staff and managers.
- Improve data on equalities and ethnicity, including in the independent provider market.
- Include a clause in our social care contracts with acceptable standards that are monitored.

Ensure Devon's health and care services are inclusive and accessible to everyone

- Through a rolling EDI calendar, celebrate diversity and raise awareness of discrimination, empowering our workforce to be more inclusive, and demonstrating our commitment to EDI to our local populations.
- Work in partnership with the voluntary sector to understand needs and support people from diverse and vulnerable populations to have better access to health and care service.
- Support, empower and equip patient facing staff to take an inclusive approach to the accessibility and delivery of services
- Improve representation in health and care engagement forums.

Vision and Ambition

Workforce

We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.

At System level we will;

- Deliver solutions that enable the attraction, recruitment and retention of talent across our health and care providers, reducing duplication and streamlining processes.
- Use our Devon 2035 workforce vision to inform strategic workforce planning which will identify new roles and ways of working, informing our talent supply pipelines with national, regional and local training & education providers.
- Embed the One Devon Workforce Strategy Themes and Principles into workforce planning and service transformation and delivery

System working

We work collaboratively to enable our workforce to move flexibly across sectors and create new roles to meet the needs of the population and services.

Stability

We stabilise the workforce by supporting new and diverse career pathways for our current and future workforce.

Learning & Education

We commit to investing in the workforce through enrichment of development opportunities ensuring that quality and safety is at forefront.

Digital

We utilise digital technology to support innovation and transformation to our workforce and across all services we deliver.

Sustainable

We commit to achieving a skilled workforce built on a system that is financially sustainable.

Year 1- 5 Objectives

Workforce

Smart Objectives
Strategic workforce planning embedded at System level
System level attraction solutions in place that source new talent and position Devon System as an employer of choice.
Development of new roles and new ways of working embedded across Devon ICS
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future

Vision and Ambition

Digital

"Invest in a digital Devon: people will only tell their story once, first contact will be digital where appropriate and more advice and help will be available online. We want to make the most of advances in digital technology to help people stay well, prevent ill health, and provide care."

Digital technology will enable data to be available anywhere at any time for those health and care professionals needing to work in new ways. This means we can move to new models of care, with more online interactions with citizens and patients, while maintaining an understanding that digital should not be the only way to access services. This progressive approach will support a move to a new digital first paradigm of care being "a service you receive", rather than a place you go to. Irrespective of health and care setting, when the citizen needs the support from Devon health and care organisations, data will be available for the workforce to make informed decisions; the safe handling of personal data is a key responsibility. By following this digital approach more of our physical capacity is expected to be used on the predicted activity growth across services. To achieve the digital vision, the ICS Devon Digital Strategy presents five priorities to enable clinical and non-clinical transformation from both the workforce and citizen perspective. These **five digital priorities** will provide 'future proofed' digital solutions; recognising that care models continue to change:

1. **Digital Citizen**: Empower citizens to take ownership of their wellbeing and care, through digital technology and contact across the system. Digital will offer new ways of delivering care to help citizens manage their care at home.
2. **Shared Electronic Patient Record (EPR) & Operational Systems**: The convergence to common digital solutions that meets the information sharing and workflow needs of the various organisations across the ICS.
3. **Devon and Cornwall Care Record (DCCR)**: the DCCR will allow information to be available across care settings and coordination of care through specific functionality such as read/write for key flags and care plans.
4. **Business Intelligence & Population Health Management**: A cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will necessitate linked data, accessible by a shared analytical resource that can work on cross-system priorities.
5. **Unified and Standardised Infrastructure**: Levelling-up and consolidation of infrastructure, to support future enterprise scale digital systems such as Shared Electronic Patient Records (EPRs), digital technologies for citizens and also agile and frictionless cross-site working and support experience for the workforce.

An ICS digital inclusion group has formed with membership from Voluntary Community and Social Enterprise, Local Authority, health providers and the ICB. This group considers access to health and care services from the citizens perspective and to consider citizen access to health and care services irrespective of their personal digital circumstances. Digital inclusion is the prime responsibility of those involved in service transformation and design.

Staff will be supported to confidently use digital technology in their roles. When new technology is introduced, training will be provided as part of any implementation or transformation programme. For existing technologies, new starters will be supported through the normal organizational induction process and for existing staff, through in-role training where required.

Over the coming years the use of Artificial Intelligence, Machine Learning and Robotic Process Automation will become more prevalent. These technologies provide an opportunity to support staff through undertaking tasks so that they can spend more face-to-face time with patients, spend less time on repetitive tasks and concentrate their knowledge and experience on high value work whether this be in the clinical or non-clinical setting.

Year 1- 5 Objectives

Digital

Smart Objectives
Number of eligible citizens connected to the NHS App increased to support national target of 75% of people registered by 2024
Future use of ORCHA (App assurance product to support citizen self-care and social prescribing) determined by the end of the current funding in March 2024.
Develop a commissioned offer for digital solutions and technology enabled care and support, including awareness raising and increasing diversity of prescribers (social care)
Standardisation of GP practice websites achieved within 2025.
Achieve planned Virtual Ward bed targets by April 2024 across TSDFT, UHP and RDUH
Electronic Patient Records implemented in TSDFT, UHP and DPT by the end of 2025
80% of care homes to have a Digital Social Care Record by March 2024
Consider use of the Disabled Facilities Grant for technology solutions, including investigation of handyperson schemes focusing on ‘low-tech’ as well as ‘high-tech’ solutions.
Peninsula Picture Archiving and Communication System (PACS) solution for the clinical network procured and implemented by 2025
Peninsula Laboratory Information Management System (LIMS) solution for the clinical network procured and implemented by 2025
Re-procurement of GP Electronic Patient Record (EPR) clinical system by March 2024
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028
Develop Population Health Management (PHM) architecture and reporting
Develop an ICS data platform and associated reporting, linked to EPR implementation and national developments including the Federated Data Platform
Work collaboratively with regional ICS teams to develop the regional secure data environment to support future research
Unified and Standardised Infrastructure provided by 2028

Vision and Ambition

Finance and Procurement

Finance

Vision

A financial framework that supports **integrated and collaborative working arrangements**, through the Devon Operating Model, that will **deliver better experience and outcomes for the people of Devon and greater value for money**.

Ambitions

- Recurrent balanced financial position by 2025/26.
- A financial framework that:
  - supports collaborative working
  - reflects the Devon Operating Model and delegation of budgets to LCPs and provider collaboratives.
  - promotes innovative funding models and pooled budget arrangements.
- Movement of funds into prevention.
- A commitment to shared services, doing things once for Devon or the wider Peninsula where it makes sense to do so.

Procurement

Vision

We will enhance every patient experience through delivering **maximum value and the best quality service through our collective procurement and supply chain excellence**.

Ambitions

- **Patients**: The healthcare services they need are delivered on time and of the best quality.
- **Clinicians**: They are equipped with the goods and services they need to deliver world-class care.
- **Taxpayer**: The NHS is achieving value for every pound spent and delivering government priorities such as sustainability, NetZero and eradicating modern slavery.
- **Suppliers**: The NHS is easier to do business with, with opportunities to develop more innovative solutions to meet NHS and government challenges.

One Devon

Year 1- 5 Objectives

Finance

Smart Objectives
Year 1 - development of improved collaborative working, intra system financial framework, contracting and risk sharing protocols
Year 1 – agreement of functions where a shared service arrangement should be pursued helping to inform the organisational restructure within reduced Running Cost Allowance
Year 1 – development of Long term Financial Plan, trajectory to recover and sustainable financial balance over a 3-5 year scenario range
Year 1 – development of system wide interpretation of the Drivers of the Deficit to underpin future recovery
Year 1 – delivery of 23/4 recovery and Cost Improvement Programmes both organisational, strategic collaborative, and structural
Year 1 – consolidate delegated of commissioning functions for extended primary care
Year 2 – commence pivot of funding upstream towards prevention and health inequalities
Year 2 – take on formal delegation of Specialised Commissioning functions
Year 2 – corporate ICB right sized for RCA (Running Cost Allowance) allocations, emerging maturity of LCP's
Year 2 – estates strategy finalised to underpin prioritised system wide capital allocations
Year 3-5 – continued recovery to sustainable financial balance by system and by organisation

Year 1- 5 Objectives

Procurement

Smart Objectives
Improved Resilience - Covid-19 taught us that working together is essential to mitigate risk.
Reduced total Cost - The ICS represents a publicised and policy driven way of driving ‘at scale’ procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and minimise unwarranted variation
Greater Value - The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients
Better Supplier Management - Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories
Optimised Workforce - The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access to more diverse roles and opportunities across the system
Improved Capability and enabling Great Careers - Working together frees up capacity to give us time to develop and leverage specific skills and expertise

Vision and Ambition

Strategic Estates and Facilities

1. To redevelop the **acute hospital estate** through the funds available via the New Hospital Programme
2. To develop the **community services and mental health estate** to ensure it remains relevant, fit for purpose and located within the right places with an ambition to provide more specialist services outside of the traditional hospital setting
3. To enable and support the **development of the primary care estate** through PCN strategies and supporting GPs to integrate primary care with community service developments
4. To develop a road map for estates and facilities activity to reach **Net Carbon Zero by 2040**
5. To undertake **strategic procurement** of estates and facilities contracts to leverage buying power for providers on behalf of the ICS
6. To work in collaboration with the public sector in Devon to ensure **One Public Estate** opportunities are maximised
7. For estates and facilities expertise to **work in collaboration** across the ICS to ensure efficiency, skill sets and joint delivery programmes remain optimal

One Devon

Year 1- 5 Smart Objectives

Strategic Estates and Facilities

Year 1	Year 2
Undertake strategic review of the ICS-wide health estate	Categorise all of the estate into ‘core, flex and tail’ and agree strategies for each site or development opportunity
Develop an investment plan and a 5 year capital prioritisation pipeline	Prioritise funding allocations whilst taking advantage of national funding review outcomes and TIF funding
Develop a cross-matrix team that can support the delivery of estates and facilities at an ICS-wide level	Integrate provider service departments where possible to create resilience, efficiencies and succession planning
Deliver a public facing ICS Estates Strategy	Commence delivery of the implementation plans that shall support each area of the Estates Strategy

Vision and Ambition

Green Plan

The ICS supports the co-ordination of carbon reduction across the system through the actions to reach net-zero outlined in the **Devon Greener NHS plans** and the **Devon Carbon Plan**.

The ICS also recognises the need to identify the key risks to our system from climate change and to develop a plan to adapt to and mitigate these risks**.** Addressing the climate and ecological emergency is an opportunity to create a fairer, healthier, more resilient and more prosperous society.

Actions like encouraging everyone to be more active by walking and cycling, reducing our reliance on paper and purchasing our products and services more locally will all help to improve public health, support our budget and reduce pressures on the NHS and social care.

Year 1- 5 Objectives

Green Plan

Smart Objectives
More Devon ICB staff will make greener journeys to work.
Devon ICB will be a paper free organisation by 2028.
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners.

Delivering the Joint Forward Plan and Future Development

Delivering the plan in 23/24
Governance
Outcomes Framework
Risks to delivery
Future refresh of the JFP

Delivering the JFP

Delivery

The JFP will be delivered through system architecture that includes:

- Primary care networks and collaboratives
- Local care partnerships
- Networks
- Provider collaboratives
- System level transformation programme boards

Assurance

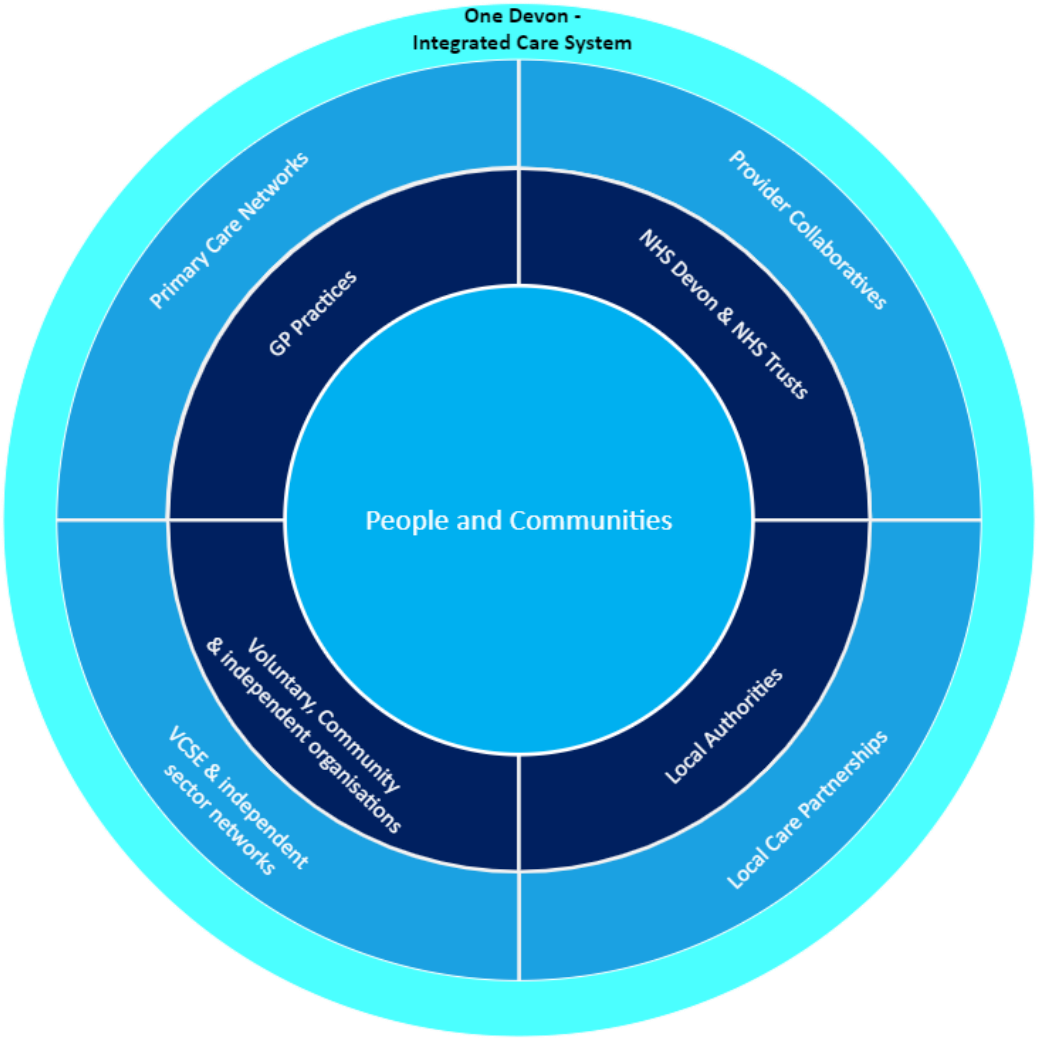
- Outcomes framework will be used to monitor progress towards the strategic goals
- The System Recovery Board will drive delivery of the recovery plan
- Delivery of work programme milestones will be monitored through system programme infrastructure
- Progress towards delivery of ICS strategic goals will be overseen by the ICS Executive and will report to the One Devon Partnership
- System development will be measured through the ICS maturity framework

Engagement

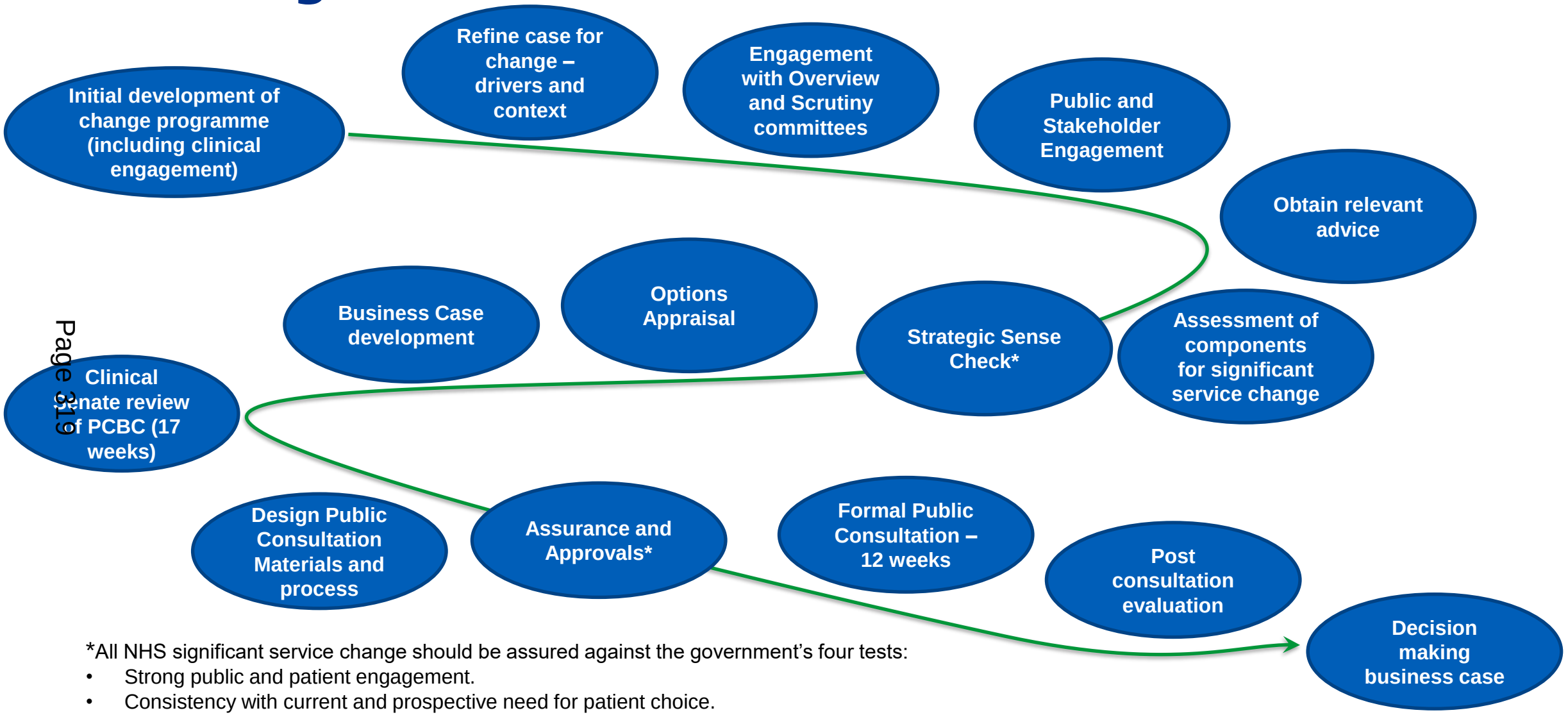
- Targeted engagement by programmes with people and communities

Annual refresh

- On-going work with system partners and programme leads to refresh each year



Delivering Transformation



*All NHS significant service change should be assured against the government's four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear, clinical evidence base.
- Support for proposals from clinical commissioners

Accountability

Our Vision	**One Devon Partnership**	**Equal chances for everyone in Devon to lead long, happy and healthy lives**			
Our Aims	**One Devon Partnership** **NHS Devon**	**Improving Outcomes in population health and healthcare**	**Tackling inequalities in outcomes, experience and access**	**Enhancing productivity and value for money**	**Helping the NHS support broader social and economic development**
Our Strategic Goals	**One Devon Partnership** **ICS Executive**	**Every suicide will be regarded as preventable and we will work together as a system to make suicide safer communities across Devon and reduce suicide deaths across all ages**	**People in Devon will have access to the information and services they need, in a way that works for them, so everyone can be equally healthy and well.**	**People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency.**	**People in Devon will be provided with greater support to access and stay in employment and develop their careers.**
		We will have a safe and sustainable health and care system.	**Everyone in Devon will be offered protection from preventable diseases and infections.**	**People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care.**	**Children and young people will be able to make good future progress through school and life.**
		People (including unpaid carers) in Devon will have the support, skills, knowledge and information they need to be confidently involved as equal partners in all aspects of their health and care.	**Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place**	**We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.**	**We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change, supports healthier living (including promoting physical activity and active travel).**
		Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death early and disability	**The most vulnerable people in Devon will have accessible, suitable, warm and dry housing**	**We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.**	**Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people**
		Children and young people (CYP) will have improved mental health and well-being	**In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience.**		**Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably**
		People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.			
Delivery Programmes	**NHS Devon/ Local Authorities/ Programme Boards**	**Mental health, learning disability and neurodiversity**	**Women and Children**	**Acute Services Sustainability**	**Primary and Community Care**
		Housing	**Community Development and Learning**	**Employment**	**Health Protection**
		Suicide Prevention			
Enabling Programmes		**System Development**	**Workforce**	**Digital & Data**	**Estates and Infra-structure**
		Finance & Procurement	**Communications & Involvement**	**Research, Innovation & Improvement**	**Equality, Diversity & Inclusion**
		Green Plan	**Population Health**		

ICS Outcomes Framework

Framework available via interactive dashboard with ‘drill down’ ability to highlight inequalities and drive local action

Breakdowns at three ICS ‘tiers’ (system, LCP and PCN), two local authority ‘tiers’, and inequalities (socio-economic, geographic, personal characteristics, clinical factors)

Alignment with other frameworks (NHS, PH, ASCOF, HWB)

Some narrative (qualitative) measures

Ongoing co-design process with strategic commissioning partnership to ensure fitness for purpose

Flexibility in terms of addition of new indicators

First set of data to be produced in June 2023.

Indicators

- Admissions Following Accidental Fall
- Deaths in usual place of residence
- Total Carbon Emissions (kt CO2)
- NHS and LA Attributable Carbon Emissions (kt CO2)
- Deaths attributable to air pollution
- Index of Multiple Deprivation
- Access to Community Facilities
- Rough sleepers per 1,000 households
- Average house price to FT salary ratio
- Households in temp accommodation
- Supply of key worker housing
- Fuel poverty
- One Devon Cost of Living Index
- Community/Business investment
- Experience of navigating services
- Waiting Times
- Support from local organisations to manage own condition
- Digital exclusion risk index (DERI)
- Unified Digital Infrastructure

- Healthy Life Expectancy at birth
- Gap in Healthy Life Expectancy at birth
- Under 75 mortality rate from preventable causes (persons <75yrs)
- Global Burden of Disease: Top 10 Causes (DALYs) and Top 10 Modifiable Risk Factors (DALYs)
- Children achieving a good level of development at the end of Reception
- 16-17 year olds not in education, employment or training (NEET)
- Employment of people with mental illness or learning disability
- Workforce diversity (employment profile vs Devon by EDI characteristics)
- Uptake/Coverage of Local Authority Carer Support Services
- Unpaid Carers Quality of Life
- Carers Social Connectedness
- MMR vaccine uptake (5 years old)
- Flu vaccine uptake (at risk individuals)

- Covid-19 vaccination rates
- Children and young people accessing mental health services
- Coverage of 24/7 crisis MH support
- Suicide Rate
- Social Prescribing Uptake Rates
- Access to CYP eating disorders services
- Avoidable admissions for ambulatory care-sensitive conditions
- Patient Activation Measures
- Access to dentists / pharmacy / optometry / primary care
- Vacancy Rate for ICS Organisations
- Financial Sustainability
- Unified Approach to Procurement and Commissioning
- Community Empowerment/Volunteering

One Devon

Challenges/risks to delivery

There are a number of key risks to delivery of the Joint Forward Plan, including:

- A potential lack of synergy between the JFP and the system recovery plan (mitigation for this is set out below);
- Insufficient capacity to deliver transformational change whilst focusing on recovery;
- Clinical, operational and financial pressures impact decision making, involvement and engagement, co-design and delivery of the ISD programme;
- The impending ICB reorganisation;

Work is underway within the system to review the alignment between the years 1 and 2 objectives within the JFP and the system recovery priorities and to agree any sequencing of the JFP actions that will be needed to support recovery and ensure that the longer term transformational priorities within the JFP are deliverable alongside the recovery plan.

The ICS Development Roadmap integrates the contributions of all 9 Delivery Work Plans and those of the 10 Enablers towards delivering the overarching strategic goal. Programme leads will meet twice a year to review progress against the Roadmap, adopt a 'learn by doing' approach and adapt plans as needed. To support this approach, One Devon will undertake a full ICS Maturity Assessment once a year and a 'light touch' Assessment at the 6 month point in between. The outputs from these assessments will by used by the system-wide work plan leads and will inform any changes to delivery work plans.

Future Development of JFP

This Plan has been developed at pace in response to the One Devon Integrated Care Strategy and in line with national timeframes. It is important to acknowledge that publication of the JFP is not the end of a process, but is the start of an ongoing new relationship with system partners and our communities, which will see both the Strategy and the JFP refreshed on an annual basis.

Over the coming weeks we will work together to put a framework in place that will support:

- Co-production of future iterations of the ICS and JFP with system partners, staff, patients and the public
- Further alignment with Local Care Partnership and Provider Collaborative objectives and with Local Authority social care plans
- Collaborative working on broader footprints, where appropriate

and that draws on feedback from NHS trust boards and other partners during the approval process.

Additionally, there will be targeted engagement with communities around specific delivery programmes, including as part of our significant service change process, set out on slide 93.

APPENDICES

APPENDIX A
Universal NHS commitments Statutory Duties

National NHS objectives 2023/24

Area	Objective
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

ICB Core Functions and Statutory Duties

Our NHS Statutory Duties	How we will meet our duties
Describe health services the ICB proposes to arrange to meet needs	This Joint Forward Plan broadly describes the health services we have in place, and will arrange, to meet the needs of our population as set out in the Integrated Care Strategy. Each year we also produce an Operating Plan that provides more detail about the planned performance of services; the Operating Plan detail is included in Appendices C and D
Duty to promote integration	The Joint Forward Plan is an integrated system-wide plan that encompasses a wide range of programmes that will contribute to improving the health and wellbeing of people living and working in Devon. Each programme describes how system partners are working together to deliver joined up services.
Duty to have regard to wider effect of decisions	The Joint Forward Plan is a system-wide plan to meet the aims and strategic goals set out in the Integrated Care Strategy. The strategy is overseen by the One Devon Partnership which will have the remit to ensure the full consequences of any decisions made are understood
Financial duties	The national financial framework sets requires a collective responsibility to not consume more than the agreed share of NHS resources. Slides 37- 42 outline how we plan to achieve System Balance.
Duty to improve quality of services	Everybody has the right to feel safe and have confidence in the services provided across Devon. We are committed to securing continuous improvement and will ensure that our services are of appropriate quality and that we have robust mechanisms in place to intervene where quality and safety standards are not being met or are at risk. We have developed robust metrics to measure the impact of the plan through our Outcomes Framework and have a Performance and Quality reporting function in place. This is support the achievement of the strategic goals to have 'a safe and sustainable health and care system.
Duty to reduce inequalities	One of our system aims is 'Tackling inequalities in outcomes, experience and access' and 2 of our strategic goals focus on the top five risk factors and causes of death and disability. A third strategic goals explicitly states that we want 'everyone to have an equal opportunity to be healthy and well'. To achieve this the delivery programmes outline how they will contribute to reduce inequalities, particularly in relation to Core20PLUS5 and, in line with the 2022 Armed Forces Bill, with regard to serving military personnel, reservists, veterans and their families. To support this work, the Population Health enabler programme has been developed.
Duty to promote involvement of each patient	We are committed to promoting personalised care across all the services we deliver across our organisations. Our approach outlined in the strategic goal 'People in Devon will be support to stay well at home, through preventative, proactive and personalised care'. Specifically, the Primary and Community Care programme describes how it will use the comprehensive model of personalised care to deliver this ambition.
Duty to involve the public in decisions about services	Our Working with People and Communities strategy sets out our principles for involving local people. The Communications and Engagement enabling programme outlines how we will support delivery leads to ensure people and communities are involved in a meaningful way.
Duty to enable patient choice	We support patient choice in our commissioning plans in a number of ways. These include expanding the use of personal budgets through our personalised care commissioning and the use of the Devon Referral Support Service (DRSS), which supports patient choice at the point of referral into secondary care.

ICB Core Functions and Statutory Duties

Our NHS Statutory Duties	How we will meet our duties
Duty to obtain appropriate advice	We ensure that we obtain appropriate advice throughout the development of plans. This includes from: clinicians (both local and through regional networks), NHSE (regional and national), the South West Clinical Senate and legal advice. Obtaining advice is particularly important to us in our delivery of transformation as outlined on slide 93.
Duty to promote innovation	We work closely with the South West Academic Health Science Network to ensure we are cognisant of innovation and best practice. The Research and Innovation enabling programme has been developed to ensure all delivery programmes are supported in the delivery of this duty.
Duty to facilitate and promote research and use its evidence	We work closely with the South West Academic Health Science Network to ensure we are cognisant of research and best practice and that we promote research within Devon. The Research and Innovation enabling programme has been developed to ensure all delivery programmes are supported in the delivery of this duty.
Duty to promote education and training	Our Joint Forward Plan has three strategic goals related to education and training including – school readiness, supporting people to access and stay in employment and ensuring we have people with the right skills within our system. The Children and Young people delivery programme focuses on this whilst the employment and workforce enabling programmes outline how they will support these ambitions.
Duty as to regard to climate change etc	Our Green Plan enabling programme outlines our clear commitment to successfully deliver targets for all local authorities to be carbon neutral by 2030 and the NHS by 2040.
Addressing the particular needs of children and young people	Our plan includes two specific strategic goals on children and young people and the children and young people delivery programme outlines the wide programme of work.
Addressing the particular needs of victims of abuse	Serious violence has a devastating impact on lives of victims and families, instils fear within communities and is extremely costly to society. NHS Devon has a domestic abuse and sexual violence (DASV) strategy that outlines actions to improve the health response to victims and perpetrators who are staff or patients in Devon. Over the last two years much has been achieved (eg: a network of DASV champions, robust DASV policies, commissioning of an Interpersonal Trauma Primary Care service, due to commence in April 2023). Locally, compliance with the Duty with be monitored through the Safeguarding and Vulnerable People Steering Group, which will report quarterly to the Quality and Performance Committee and updates regarding Duty activity will be included in safeguarding reports to the System Quality & Performance Group. The case study on slide 30 shows how the ICS is working collaboratively to progress this important agenda.
Implement any joint local health and wellbeing strategy	There are three Health and Wellbeing Boards in Devon and we have worked closely with all three to ensure that their priorities are reflected in this plan.

APPENDIX B
Metrics and Baselines

Improving Outcomes in population health and healthcare

Strategic Goal	Metric	Baseline
Every suicide will be regarded as preventable and we will work together as system to make suicide safer communities across Devon and reduce suicide deaths across all ages	*The suicide rate for all areas of Devon will see a consistent downward trajectory and by 2028 the suicide rate in each local authority area will be in line with or below the England average*	Rate per 100,000 persons 2019-21: • England 10.4 • Devon CC 12.5 • Plymouth CC 10.7 • Torbay C 17.2
Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death early and disability - - Dietary risks, Tobacco, High blood pressure, High fasting plasma glucose and High BMI	*By 2028 reduce the DALY (Disability adjusted life years) lost for the top 5 modifiable risk factors, and measure under 75 mortality and healthy life expectancy*	Current healthy life expectancy variance by LA is: • Torbay Female: 23.2 years, Male: 14.5 years, • Plymouth F: 20.6 and M: 14.8 • Devon F: 15.9 and M: 14.1. Under 75 mortality rate from preventable causes by LA: 2016-20, • Devon 4,948, • Plymouth 1,885, • Torbay 1,229. Standardised rates (England = 100) are Plymouth 112.1, Torbay 111.8 and Devon 78.9.
We will have a safe and sustainable health and care system.	*By 2025 we will: deliver all our quality, safety and performance targets within an agreed financial envelope*	
People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.	*By 2028 reduce the DALY (Disability adjusted life years) lost for the top 5 causes*	Preventable admissions: Ambulatory Care Sensitive (ACS) conditions 23,604 in 2021/22, 95% is a reduction of 22,424
People (including unpaid carers) in Devon will have the support, skills, knowledge and information they need to be confidently involved as equal partners in all aspects of their health and care.	*By 2028 we will: extend personalised care through social prescribing and shared decision making and increased health literacy*	
Children and young people we have improved mental health and well-being	*By 2024/25 we will have: at least 15,500 CYP aged (0-18) accessing NHS-funded services, 100% coverage of 24/7 crisis and urgent care response for CYP and 95% of children and young people with an eating disorder able to access eating disorder services within 1 week for urgent needs and 4 weeks for routine needs*	

Tackling inequalities in outcomes, experience and access

Strategic Goal	Metric	Baseline
People in Devon will have access to the information and services they need, in a way that works for them, so everyone can be equally healthy and well.	*By 2028 we will increase the number of people who can access and use digital technology*	
The most vulnerable people in Devon will have accessible, suitable, warm and dry housing	*By 2028 we will have:* • *decreased the % of households that experience fuel poverty by 2%,* • *reduced the number of admissions following an accidental fall by 20%* • *reduced the number of households in temporary accommodation by 10%* • *reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0* • *Increased the % of people sleeping rough who get an offer of accommodation to 100%* • *increased in the number of households successfully prevented from becoming homeless by 30%* • *ensured that LPAs are fully aware of the need for key worker housing and have addressed this need in their plans*	2020 figures for % of households with fuel poverty: Plymouth 13.9%, Torbay 12.4% and Devon 11.8% (although range within DCC of 13.3% Exeter to 10.6% East Devon). SW position is 11.4% and national 13.2%. From previous LTP work there are around 6k falls-related admissions each year in Devon.
Everyone in Devon will be offered protection from preventable diseases and infections.	*By 2028 we will have:* *- Childhood vaccines - vaccine coverage of 95% of 2 doses of MMR by the time the child is 5, vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, 90% uptake of school-aged immunisation* *- Covid and flu vaccinations - 100% offer to eligible cohorts each season; vaccine uptake in line with or exceeding national/regional/comparator benchmarking;* *- reduced the number of healthcare acquired infections by 25%* *- reduced antibiotic prescribing by 15% from our year 1 baseline* *- Uptake of cervical screening increased to 80%*	
Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place	*By 2028 we will have: increased the number of people dying in their preferred place by 25%*	2019/20 baseline is 8,650 people died in an unwanted place of death across the ICS
In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience.	*By 2026 Devon's workforces will be supported, empowered and skilled to deliver fully inclusive services for everyone, and Devon will be a welcoming and inclusive place to live and work where diversity is valued and celebrated;* *by 2027 Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)* *Reduced health inequalities for diverse populations*	

Enhancing **productivity** and value for money

Strategic Goal	Metric	Baseline
People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency	*By 2026 patients will report significantly improved experience when navigating services across Devon.*	
We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.	*By 2028 we will have: a unified approach to procuring goods, services and systems across sectors and pooled budget arrangements*	
People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care.	*By 2028 we will have: provided a unified and standardised Digital Infrastructure*	
We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.	*By 2028 we will have: vacancies amongst the lowest in England in the health and social care sector*	Vacancy rates: varies depending on organisation and work group. Overall for Devon ASC 6.8%, NHS 7.2%. We already benchmark well versus the England average (9.7% for the NHS) and SW position.

Helping the NHS support broader social and economic development

Strategic Goal	Metric	Baseline
People in Devon will be provided with greater support to access and stay in employment and develop their careers	*By 2028 we will have: reduced the gap between those with a physical or mental long term condition (aged 16-64) and those who are in receipt of long term support for a learning disability (aged 18-69) and the overall employment rate by 5% and decreased the number of 16-17 year olds not in education, employment or training (NEET) to achieve or be under the national average.*	End 2020 NEET (16-17 yrs old) was Devon 514, Plymouth 225 and Torbay 111. End 2020 NEET (16-17 yrs old). Employment: 2 indicators: 1. Gap in the employment rate between those with a physical or mental long term condition (aged 16-64) and the overall employment rate: 21/22: Plymouth 9.9, Devon 9.7, Torbay 11.3 (SE region 9.7 average, England 9.9 average) 2. Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 69) and the overall employment rate: 20/21: Plymouth 71.6, Devon 72.3, Torbay 67.7 (SE region 72.4 average, England 70.0 average)
We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change, supports healthier living (including promoting physical activity and active travel).	*By 2028 we will: be on-track to successfully deliver agreed targets for all Local Authorities in Devon being carbon neutral by 2030 and the NHS being carbon neutral by 2040*	
Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people	*By 2024: Local Care Partnerships will have co-produced with local communities and community groups in their area, a plan to empower and support groups to be more resilient.*	
Children and young people in Devon will be able to make good future progress through school and life.	*By 2027 we will have: increased the number of children achieving a good level of development at Early Years Foundation Stage as a % of all children by 3%*	The 2019 position for % achieving a good level of development (not measured since) was Devon: 72.7%, Torbay 70.8% and Plymouth 68.3%. The SW average is 72.0% and nationally 71.8%.
Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably	*By 2028 we will have; directed our collective buying power to invest in and build for the longer term in local communities and businesses*	

APPENDIX C
Delivery Programme Milestones

Year 1- 5 Objectives and Milestones

Mental Health – Perinatal and Early Years

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
People in the perinatal period and their families will be able to 'get help' early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible More women, children and families get help early in development of need (prevention).	At least 1,115 women and birthing people/ year will access perinatal mental health support Develop plans to ensure that: • Referrals are accepted from pre-conception to 24 months postnatally. • Partners can access mental health assessment including signposting or referral as needed. • Increase the range of psychological therapies available. Establish working relationships with NHSE and/ or the South West Provider Collaborative to design a whole system perinatal clinical pathway	Implement plans to ensure that: • Referrals are accepted from pre-conception to 24 months postnatally. • Partners can access mental health assessment including signposting or referral as needed. • Increase the range of psychological therapies available. Service review of access, experience and outcomes in perinatal mental health completed. The review and data evidences increased access to support within four weeks of referral on 23/24 baseline figures. Review of commissioning arrangements for service delivery	Implement actions and recommendations from the Service Review Review effectiveness of current arrangements and implement any amendments re new policy and guidance Review of commissioning arrangements for service delivery

One Devon

Year 1- 5 Objectives and Milestones – Mental Health

Mental Health – Children and Young People's Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
Children and young people have access to timely mental health care and support	At least 15,754 children and young people will access mental health assessment. Working in partnership with the Children's board the ICS will develop a 3-5 year plan to continue growing access to mental health support, care and treatment for children and young people, using a THRIVE based approach. By 2027/28 95% of schools in Devon will have access to Mental Health in Schools services Devon will evaluate the current Mental Health Support Teams in Schools (MHST) model in partnership with Local Authorities and Education Partners and offer, in the context of the evidence based and needs of children and young people in Devon. Implement agreed action plans to embed any amendments to meet new policy and guidance for years 2-3	Implement plan to grow access to NHS funded mental health support care and treatment for children and young people across Devon. By the end of 2025, 60% of children and young people with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, care and treatment Review effectiveness of current arrangements Subject to national intentions and requirements, we will co-produce (with experts by experience and experts by profession) and implement an approach which iterates the national MHST model, based on the needs of the population and the evidence base	Review effectiveness of current arrangements and implement any amendments re new policy and guidance Review of commissioning arrangements for service delivery to plan that by 2028, 80% or more of children and young people with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, care and treatment 95% of schools in Devon will be able to access support to develop a whole school to mental health and wellbeing which is compassionate, trauma and shame informed.

One Devon

Year 1- 5 Objectives and Milestones

Mental Health – Adult Mental Health

Smart Objectives	Milestones-Year 1	Milestones- Year 2-3	Milestones-Year 4-5
Devon will sustainably eliminate inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.	In line with the NHS 23/24 Planning guidance, develop a 3-year plan to localise and transform mental health, in-patient services Review of commissioning arrangements for service delivery completed ICS will establish a comprehensive understanding of housing, employment and educational needs to inform strategic development plans for Devon and these plans will include options to meet the needs of people with complex mental health needs including those with drug and alcohol dependency.	Average Length of Stay will be 28 days for non-specialist acute adults inpatients, and 45 days for older adults with appropriate oversight of staffing levels. Delivery of alternative crisis care options is effective including crisis cafés, crisis houses, community mental health offers non urgent crisis support Devon can provide the right level of resource for people who require psychiatric intensive care services	Delayed Transfer of Care will be 2% (rolling average), people requiring admission will be proactively supported to maintain community relationships through joined up therapeutic care (from primary and community care and inpatient settings), home tenancies or ownership and employment. By the end of 2027/28 all acute psychiatric inpatient care will be delivered in area unless there is an exceptional clinical need.

Year 1- 5 Objectives and Milestones

Mental Health – Adult Mental Health

Smart Objectives	Milestones-Year 1	Milestones- Year 2-3	Milestones-Year 4-5
People with serious mental illness will have a complete physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.	Local Care Partnerships will ensure that 60% of people with serious mental illness have a complete physical health check in the last 12 months. Local Care Partnerships and the MHLDN Provider Collaborative will work together to ensure that people with serious mental illness who take antipsychotic medications have access to regular health checks to manage the associated risks.	Local Care Partnerships will aim to ensure that 75% of people with severe mental illness have their annual physical health check and that this leads to co-development of meaningful health action plan and access to follow up care as needed. Local Care Partnerships will focus enabling smoking cessation and access to diabetes clinics to help manage the health of people with severe mental illness.	Local Care Partnerships will ensure that 75% of people with severe mental illness have their annual physical health check and have a co-developed and meaningful health action plan and access to follow up care as needed. Joined up mental health and physical health care provision is available in local community hubs, GP practices, diagnostic clinics and urgent treatment centres.

Year 1- 5 Objectives and Milestones

Mental Health - Adult Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
People experiencing mental health crisis will be able to get the help they need as early as possible	Develop and implement community alternatives to admission which respond to the needs of high intensity users and are aligned to home treatment and community mental health services within Primary Care Networks. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year one	Call abandonment rate of under 5% through delivery of First Response telephony service for Devon aligned to 111/999 with oversight of staffing levels and staff training and development. The system will produce a shared risk care pathway for high intensity/frequent and MH crisis led attendances across the services from Primary to Acute. Develop and implement NPA actions to further improve crisis support to people in mental distress	By the end of 2027/28 all people in Devon will have safe and equitable access to crisis and urgent mental health provision outside of emergency departments. This offer will be integrated and co-ordinated with local services, primary care, specialist mental health, and community services (VCSE/Statutory).

One Devon

Year 1- 5 Objectives and Milestones

Mental Health - Adult Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.	At least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24 Increased access to NHS Talking Therapies will mean that at least 32,476 people access psychological therapies in 2023/24. At least 75% of people will be seen within 6 weeks and 95% of people will be seen within 18 weeks. More than 50% of people will achieve clinical recovery Mental Health services will operate a “no wrong door” approach Improve the use of data to influence commissioning and planning decisions Develop a commissioning 3- year plan to address the mental health needs of 16 – 25 year olds, without a psychosis Ensure effective, timely and consistent early intervention in psychosis services are commissioned	Implement the 3- year plan to set out how the emotional health, wellbeing and mental health needs of young adults, aged 16-25, are to be met Clinical and satisfaction outcomes for MH community services improves 5% from 2023 baseline	95% of adults and older adults with ‘routine’ mental health needs will wait less than 4 weeks to access NHS funded mental health support, including specialist services and specialist psychological intervention. Young people aged 16-25 will be able to access and receive integrated care, support and treatment across health and education that is personalised and aligned to their emotional health, wellbeing and health needs. By the end of each year clinical and satisfaction outcomes will improve by 5% year on year from 2023 baseline By the end of 2027/28 % of adults and older adults will wait 4 weeks or less to access specialist mental health services including psychological interventions.

One Devon

Year 1- 5 Objectives and Milestones

Mental Health - Mental Health for All

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness	Work to influence partners to ensure that housing planning includes options for people with severe mental illness, learning disabilities and/or neurodiversity and rough sleepers supporting market development of extra care and supported housing. MHLDN Provider Collaborative will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. MHLDN Provider Collaborative will develops a system wide assertive outreach plan for people with significant rehabilitation and complex emotional needs. Formal evaluation to inform future commissioning intentions across Health and Social to increase capability of supported living market. Individual Placement Support will achieve supporting 1,196 people with mental illness into work .	A comprehensive rough sleepers plan to be developed jointly with Local Care Partnerships, to include access to care and treatment. Review commissioning arrangements for supported living market for MHLDN. Build extra care and supported housing options into ICS housing planning programmes to reduce any need to place people out of area Implementation of future commissioning intentions across Health and Social Care of the Test of Change Pilot (for LDA) to increase capacity and capability of supported living market. IPS will achieve a 10% increase on the access target for 23/24 (1,316).	90% of people admitted to a psychiatric inpatient wards are discharged to safe, appropriate housing with the right care and support package without delay. All people with complex and very severe presentations have focussed assertive rehabilitation to prevent the need for out of area placements. Promote and influence system plans to become Disability Confident registered employers.

Year 1- 5 Objectives and Milestones

Mental Health - Older Adults

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
People will have a timely dementia diagnosis and planned onward care and support.	Devon will attain 63% of the required national standard of 66% dementia diagnosis rate A formal commissioning review of memory assessment provision will be completed to align capacity to demand alongside outlining any gaps in ability to meet demand Development of a system-wide Dementia plan to support people with dementia. Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care Review of commissioning arrangements for service delivery for 24/.25 operating planning	Memory Assessment Service review actions are implemented to ensure ability to meet 66% DDR Implementation of a system-wide Dementia plan to support people with dementia. Review of commissioning arrangements for service delivery to inform future planning Carers needs are reviewed with actions to ensure effective support put in place	People who need a dementia diagnoses can get that diagnosis within 8 weeks of referral Older persons services are aligned across frailty and dementia care pathways and people receive the best care when needed Carers needs are fully supported to support people with dementia to remain at home as long as is safe and the right outcome for the family Joined up mental health and physical health care provision is available in local community hubs, GP practices, diagnostic clinics and urgent treatment centres.

Year 1 and 2 (operational plan detail)

Mental Health - Perinatal and Early Years

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

People in the perinatal period and their families will be able to 'get help' early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible
 	
More women, children and families get help early in development of need (prevention).
	At least 1,115 women and birthing people/ year will access perinatal mental health support
	
	Develop plans to ensure that:
	• Referrals are accepted from pre-conception to 24 months postnatally.
	• Partners can access mental health assessment including signposting or referral as needed.
	• Increase the range of psychological therapies available.
	
	Establish working relationships with NHSE and/ or the South West Provider Collaborative to design a whole system perinatal clinical pathway
		• Recruit to new service community posts aligned to mental health investment standard budgets
		• New staffing to support ability to meet demand and meet national trajectories
		• Develop plans to ensure that:
		  • Referrals are accepted from pre-conception to 24 months postnatal
		  • Partners can access mental health assessment including signposting or referral as needed.
		  • Increase the range of psychological therapies available.
		
		• With support from the SW Provider Collaborative and Children's Board to establish a programme of work to design a whole system perinatal clinical pathway which brings together existing provision and is integrated and co-ordinated with specialist support, education, and support.
			Women, with mental illness, receive the postnatal care they need pre and post birth
			
			Opportunity to build perinatal mental health care into wider system response to improve overall health and wellbeing of mothers
			
			Children born to women with mental illness have improved early years outcomes
			
			Families and partners receive better mental health support, advice and guidance leading to general overall improved outcomes

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Year 1 and 2 (operational plan detail)

Mental Health – Children and Young People's Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Children and young people have access to timely mental health care and support	At least 15,754 children and young people will access mental health assessment. Working in partnership with the Children's board the ICS will develop a 3-5 year plan to continue growing access to mental health support, care and treatment for children and young people, using a THRIVE based approach. By 2027/28 95% of schools in Devon will have access to Mental Health in Schools services Devon will evaluate the current Mental Health Support Teams in Schools (MHST) model in partnership with Local Authorities and Education Partners and offer, in the context of the evidence based and needs of children and young people in Devon. Implement agreed action plans to embed any amendments to meet new policy and guidance for years 2-3	• Working with the Devon wide Children's Board to support the Integrated Care System to develop a 3 to 5 year plan to increase access to CYP mental health, care and treatment • To roll out Mental Health in Schools programmes to those schools with allocated funding in year 1 • To support Children's services complete formal evaluation of the MH in Schools programme in year 1 with a view to commission in year 2 for 95% of Devon schools to be able to access a minimum standard of MH in Schools • To agree plans to embed any amendments to MH in Schools to meet new policy and guidance for years 2-3 • Improving support offered to CYP cohorts through transition towards adulthood delivered through joined up policy and decision making via the Children's board and the Collaborative arrangements • Review effectiveness of current arrangements for transitions across CYP and adult MH pathways through co-production of care pathways taking into account data, feedback and outcomes leading to revision of commissioned services to more effectively meet needs	Children and Young people get mental health intervention at the earliest opportunity Prevention of increasing likelihood of long term mental illness is at the forefront of school response to mental health and wellbeing response Joined up CYP and broader adult MH response to meet the needs of young people with a mental illness

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Devon will sustainably eliminate inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.	In line with the NHS 23/24 Planning guidance, develop a 3-year plan to localise and transform mental health, in-patient services Review of commissioning arrangements for service delivery completed ICS will establish a comprehensive understanding of housing, employment and educational needs to inform strategic development plans for Devon and these plans will include options to meet the needs of people with complex mental health needs including those with drug and alcohol dependency.	• Set out a 3-year plan to localise and transform mental health, in-patient services • Mental Health providers will ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, will ensure this is for the shortest time possible • Support the ICS to complete a comprehensive review of housing, employment and educational needs to inform strategic development plans for Devon to meet the needs of people with complex mental health needs including those with drug and alcohol dependency • Review of community provision and pathways across health and social care • The IPP team to complete due diligence with NHS Devon to potentially move Older Persons and Learning Disability out of area beds to the IPP team. Impact to ensure effective review and oversight of all adult MH specialist out of area placements with a view to an overall reduction in OOA and ability to reinvest in supported housing in Devon for people with serious mental health needs	People with serous mental illness will be cared for close to home when they need a hospital admission People will be provided with a range of alternatives to hospital care when in mental distress When admission is needed it will be timely and of high quality minimising the need for long term admission Opportunities to reinvest any reduction in costs by brining people back to Devon

One Devon

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
People with serious mental illness will have a complete physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.	Local Care Partnerships will ensure that 60% of people with serious mental illness have a complete physical health check in the last 12 months. Local Care Partnerships and the MHLDN Provider Collaborative will work together to ensure that people with serious mental illness who take antipsychotic medications have access to regular health checks to manage the associated risks.	• Through the Collaborative support Local Care Partnerships to focus enabling services such as smoking cessation and access to diabetes clinics to direct support to people with severe mental illness • Deliver the revised system model for prescribing anti-psychotic drugs and monitoring physical health in people with severe mental illness (SMI) • Support LCPs to ensure people with SMI have access to an annual GP led physical health check leading to a meaningful care plan to meet their physical health needs • Review options to share data effectively across MH providers and primary care to reduce duplication of effort and increase use of resource • Support ICS to consider mental health in the development of physical health policy	People with serious mental illness get the right physical health care that is planned effectively to support improved health outcomes Joined up health care planning across GPs and specialist mental health services is effective and positive for people with an SMI Data evidences improvement in meeting national standards

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
People experiencing mental health crisis will be able to get the help they need as early as possible	Develop and implement community alternatives to admission which respond to the needs of high intensity users and are aligned to home treatment and community mental health services within Primary Care Networks. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year one	Develop and implement community alternatives to admission which respond to the needs of high intensity users and are aligned to home treatment and community mental health services within Primary Care Networks. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year on including implementation of the revised MH Act	People in mental distress get the right care through the right person and/or service to reduce escalation of need 111 is able to effectively support people in mental distress reducing need for people accessing A&E departments The Police and Mental Health services work in partnership to effectively meet the needs of people who are in a mental health crisis Delivery of the new MH Act is successful

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.	At least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24
	
	Increased access to NHS Talking Therapies will mean that at least 32,476 people access psychological therapies in 2023/24. At least 75% of people will be seen within 6 weeks and 95% of people will be seen within 18 weeks. More than 50% of people will achieve clinical recovery
	
	Mental Health services will operate a “no wrong door” approach
	
	Improve the use of data to influence commissioning and planning decisions
	
	Develop a commissioning 3- year plan to address the mental health needs of 16 – 25 year olds, without a psychosis
	
	Ensure effective, timely and consistent early intervention in psychosis services are commissioned
		• Deliver the Community Mental Health transformation programme by end of 24/25
		• Recruit fully to key roles funded in 23/24 to further enhance MH community care
		• Develop a commissioning 3 - year plan to address the mental health needs of 16 – 25 year olds, without a psychosis
		• Commission a consistent Devon Early Intervention Psychosis service (tailored to local need where indicated)
		• NHS Talking Therapies will:
		  • Monitor uptake of digital offer and work with provider to support promotion of offer.
		  • Continue to increase the presence of specific workforce in wider teams to promote referral to NHS Talking Therapies and monitor impact.
		  • Continue to enhance existing close working relationships with primary care mental health teams and NHS Talking Therapies to promote access to IAPT, working to understand and respond to barriers to referral and ensure the breadth of offer is understood. Monitor impact on referral patterns.
		  • Ensure optimal use of trainees clinical capacity to support increased service access
			People access MH care quickly and are supported by multi agency teams ensuring need is met by the most appropriate service
			
			MH community services have increased staffing across the providers with an improved ability to meet demand

Year 1 and 2 (operational plan detail)

Mental Health – Mental Health for All

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness	Work to influence partners to ensure that housing planning includes options for people with severe mental illness, learning disabilities and/or neurodiversity and rough sleepers supporting market development of extra care and supported housing. MHLDN Provider Collaborative will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. MHLDN Provider Collaborative will develops a system wide assertive outreach plan for people with significant rehabilitation and complex emotional needs. Formal evaluation to inform future commissioning intentions across Health and Social to increase capability of supported living market. Individual Placement Support will achieve supporting 1,196 people with mental illness into work	• Support the ICS to develop housing plans for people with severe mental illness, learning disabilities and/or neurodiversity and rough sleepers supporting market development of extra care and supported housing. • Support the ICS to develop a 3 year plan to support a reduction in the number of people who are rough sleepers who have severe mental illness, learning disability and/or neurodiversity • MHLDN Provider Collaborative will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. • Develop and deliver system a defined and costed plan for enhanced support for people with significant mental health rehabilitation and complex emotional needs. • Complete an evaluation of need re: people with SMI to inform future commissioning intentions across Health and Social to increase capability of supported living market. • Talkworks (NHS talking Therapies) to develop and recruit to new employment support roles (two year DWP funding) • Talkworks and VSCE contracted services for supporting people with mental illness will achieve supporting 1,196 people with mental illness into work	People with SMI get the right housing and housing support to maintain their wellbeing and reduce likelihood of relapse in their mental state People are supported to remain in work and/or employers are supported to understand the needs of people with SMI working in their organisations Devon has an improved housing offer to meet the needs of people with SMI and dual diagnosis of dependency

Year 1 and 2 (operational plan detail)

Mental Health – Older Adults

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

People will have a timely dementia diagnosis and planned onward care and support.	Devon will attain 63% of the required national standard of 66% dementia diagnosis rate
	
	A formal commissioning review of memory assessment provision will be completed to align capacity to demand alongside outlining any gaps in ability to meet demand
	
	Development of a system-wide Dementia plan to support people with dementia.
	
	Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care
	
	Review of commissioning arrangements for service delivery for 24/.25 operating planning
		• A formal commissioning review of Devon memory assessment provision will be completed to consider capacity needed to meet demand alongside outlining any gaps in ability to meet demand. The review will identify patterns in wait times, referrals and diagnosis rates. Outputs to feed into 24/25 operational planning and revised service specification
		• The ICS will develop a 5 year dementia plan that develops a partnership system approach for dementia, based on shared goals and ambitions with broad sign up
		• In year 2 implement the partnership approach
		• Supported by Local Care Partnerships:
		  • Promote and support the Dear GP support tool for care homes
		  • Direct engagement with target GP practices to support improved diagnosis rates
		• Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care
		• Review of commissioning arrangements for service delivery for 24/.25 operating planning
			People with possible dementia receive a timely diagnosis that is supported by a personal plan for onward support
			
			Devon has a defined dementia strategy that provides a whole system integrated approach

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Ensure a minimum (in line with NHSE National target) 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.	75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 Improve the accuracy and increase size of GP Learning Disability registers Work alongside NHSE set the AHC trajectories from March 2024 Roll out of CYP letter to GP through SEND pathways Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities Improve live data reporting	The Learning Disability and Autism team will ensure 75% of people over the age of 14 GP learning disability registers receive an annual health check and health action plan and will work alongside NHSE set the AHC trajectories from March 2024 Continue to improve the accuracy and increase size of GP Learning Disability registers Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities	The Learning Disability and Autism team will ensure 75% of people over the age of 14 GP learning disability registers receive an annual health check and health action plan and will work alongside NHSE set the AHC trajectories from March 2024 Continue to improve the accuracy and increase size of GP Learning Disability registers Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Reduce reliance on Mental Health locked and secure inpatient care, while improving the quality of Mental Health inpatient care, so that by March 2024 (in line with national target) no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an Mental Health inpatient unit	Work alongside NHSE to establish programme of work moving forward and set the trajectories from March 2024 Implement the changes to the DSR/C(E)TR policy and guidance January 2023 in collaboration with system partners, to identify those at risk of admission and to ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, to ensure this is for the shortest time possible Implement actions from the Mental Health, Learning Disability and Autism quality transformation programme Review of Learning Disabilities and Autism commissioning pathway Development of business cases to improve pathways To establish a comprehensive understanding of housing needs to inform strategic housing development plans for children and adults with a learning disability and Autistic people Formal evaluation to inform future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market	Commissioning responsibilities of extended provision of inpatient facility for Learning Disabilities and autistic people bringing people closer to home Review effectiveness of current arrangements and implement any amendments to new DSR/C(E)TR policy and guidance Implement actions from the Mental Health, Learning Disability and Autism quality transformation programme Development of business cases to improve pathways Review of formal evaluation and implementation of future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market *To support the development of a range of available housing options for people with complex needs, including appropriate social housing and home ownership, along with the skilled support needed to successfully support tenure*	Commissioning responsibilities of extended provision of inpatient facility for Learning Disabilities and autistic people bringing people closer to home Review effectiveness of current arrangements and implement any amendments to new DSR/C(E)TR policy and guidance Implement actions from the Mental Health, Learning Disability and Autism quality transformation programme Development of Community Pathway Review of commissioning arrangements for the supported living market

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times by March 2028.	• Monitor the delivery of the Oliver McGowan training to health and social care workforce • Alignment of priorities to NHSE Autism mandate (to be released Jan/Feb 23) • Working with provider's to cleanse the national autism data set • Analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Review of Autism pathway across Devon and development of business cases to make pathway improvements • Develop initiatives to improve autism diagnostic assessment pathways and reduce waiting lists • Develop and implement workplan to improve support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	• Monitor the delivery and impact of the Oliver McGowan training to the 62,000 health and social care workforce • Continued analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Commissioning of revised pathway to improve autism diagnostic and reduce waiting lists • Continued implementation of workplan to improve support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	• Monitor the impact of the Oliver McGowan training to the 62,000 health and social care workforce • Analysis of national and local autism data across health and social care • Evaluation of Autism pathway to make recommendations to improve current pathway
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.	Engage in the south west regional clinical model developments of extended scope into community pathway.	The Learning Disability and Autism team will work alongside system workforce leads and providers to develop and implement a workforce plan and commissioning structure in line with operational planning guidance.	Continued implementation of workforce plan

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.	• Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics • Fortnightly AHC drop-in sessions for LD champions to provide support and guidance • Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake. • Improve live data reporting, by considering national exemplar and linking with BI to seek solution, a high number of data reporting has been explored with other areas however the lack of an information sharing agreement stops this progressing. • Ensure Adult Social Care workforce understands the rights of the individual for inclusion on the GP register • Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities • Raise awareness and promote annual health checks for 14-17year olds by regular meetings with children's services, schools, parents, carers and primary care to agree and co-produce a sustained promotional campaign to improve awareness and promote the uptake of AHC. Work underway with the PCN chairs to develop promotional video and/or leaflets with bid monies from NHSE • Develop final report and next steps of ' A letter to my GP' pilot targeted at special schools to encourage young people to write a letter introducing themselves to their GP to establish better relationships and increase uptake of AHC for this group. . • Roll out of CYP letter to GP through SEND pathways • Promote training to GP practice staff to increase awareness and confidence in delivering AHC to CYP Improve data reporting and frequency for CYP, Promotional videos to be finalised and shared across organisations and LD champions	Annual health checks can identify undetected health conditions early and reduce inequalities improving life expectancy of people with a learning disability Improved data reporting Improved understanding of the importance of an annual health check through training and webinars Promotion of the benefits of an annual health check Increase in reasonable adjustments

One Devon

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	**Timely Discharge** • Monitored ICB Commissioned inpatient beds against a '12-point discharge plan' to ensure discharges are timely and effective **Admission Avoidance** • Implement the changes to the DSR/C(E)TR policy and guidance January 2023 in collaboration with system partners, to identify those at risk of admission and to ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, to ensure this is for the shortest time possible • Review of community provision and pathways across health and social care • Further development of the STOMP and STAMP programme **Repositioning inpatient beds closer to home** NHSE South West region has secured £40 million of capital funding to reposition inpatients beds closer to home, shared between the North and South of the region. Devon ICB is lead commissioner for the South group of ICB's (Cornwall, Isles of Scilly, Dorset and Somerset). Experts by experience have been commissioned to co-produce the environmental plans and clinical model which is currently in development together with financial and workforce modelling. **Community pathways** Review of Learning Disability and autism commissioning pathways. **Developing the provider market** To complete the formal evaluation to inform future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market **Housing** • To establish a comprehensive understanding of housing needs to inform strategic housing development plans with partners and monitor progress, through developing clear, trackable and accessible needs data for people needing housing, including children, those coming back into the local system AND those at risk of leaving the local system. • To support the development of a range of available housing options for people with complex needs, including appropriate social housing and home ownership, along with the skilled support needed to successfully support tenure. Including the development of clear pathways and processes to support people with complex needs to access each of these housing options as appropriate. This will include all stakeholders having the relevant information and expertise to facilitate these pathways. • To work in partnership to provide the best possible housing environment for people with learning disabilities and autism, using standardised eligibility and assessment tools; good design principles; comprehensive a shared understanding of current best practice • For people with complex needs and their circles of support to be fully included in the planning and delivery of their housing needs, and for people with complex needs to live healthier, happier and more socially inclusive lives by having homes of their own • To ensure that our overall housing model is sustainable and affordable in the long-term, reducing reliance on wholly debt-funded development by making the best use of available public funds, personal investment and use of land-assets within the public estate	People with a learning disability and/or autism will be supported to lead more independent lives in the communities of their choice. Reduction in out of area hospital admissions through greater support closer to home Increased reasonable adjusted housing and accommodation options for people with complex needs Reduction in health inequalities

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.	• Improving awareness, general understanding and acceptance of autism within society through monitoring the delivery of the Oliver McGowan training to the 62,000 health and social care workforce • Alignment of priorities to NHSE Autism mandate (to be released Jan/Feb 23) • Working with provider's to cleanse the national autism data set • Analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Building the right support in the community through reviewing pathways and supporting people in hospital or inpatient care through the reprovision of inpatient beds • Develop initiatives to improve autism diagnostic assessment pathways and reduce waiting lists • Enabling early identification of neurodiversity to provide support during early years of childhood including improving access to education for neurodiverse children and young people and support positive transitions into adulthood • Improving support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	Reduction in health inequalities through improved awareness and general understanding of Autism Improved support for autistic people Reduction in waiting list Improved access to data which will inform future commissioning intentions Reasonable adjustments for autistic people
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.	• Receive the national workforce data collection from NHSE to develop baseline on current local resource • Assurance Audit of current commissioning arrangements • Continued engagement and collaboration with the community pathway clinical modelling developments on the extended scope for the inpatient developments for the south west region. • Undertake a gap analysis from current challenges in our commissioning structure • Work in collaboration with current providers to review deliver and develop commissioning intentions going forward • Explore how investment can be utilised to commission a seven-day specialist multidisciplinary service and crisis care where appropriate • The Learning Disability and Autism team will work alongside system workforce leads and providers to develop a workforce plan and commissioning structure in line with operational planning guidance.	Reduction in the current commissioning gaps to ensure the right support is accessed for the right people at the right time. Enhance accessibility into community services 7 days a week (where appropriate) Needs led approach rather then diagnostic led

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Collaborative working We will have a Primary and Community Care Collaborative which functions Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes	**March 2024** Developed functional GP Provider Collaborative Plan to establish Community Collaborative signed off by system Understand relationship with LCPs and interface with other Provider Collaboratives	**March 2025/26** GP Provider Collaborative recognised as high functioning Community Collaborative established and recognised as functional Collective forum for Primary and Community Care established and working in the context of LCPs and other Provider Collaboratives Integrated model of care co-designed and produced	**March 2028** Primary and Community Collaborative integrated and embedded within the Devon operating model, and recognised as high functioning Integrated model of care implemented in each of the five Local Care Partnership areas

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Integrated Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community, cross organisational multi-disciplinary team to jointly deliver services.	**March 2024** • Implement remote clinical support (Immedicare) to a further 60 care homes across Devon • Reduce Community Services waiting lists	**March 2025/26** • 100% PCNs and Community MDTs with defined integrated approach – cross organisational MDTs that include community health, social care and VCSE input • Evaluation of care home clinical support	**March 2028** • Digital maturity which enables sharing of all relevant information in a timely way across different organisation systems • Roll out of care home clinical support dependant on evaluation of service and model
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, by 2028	• Embed 111 and 999 referral pathways to UCR - 20% target for UCR referrals from 111/999 • Establish self-referral pathways across Devon • Increase 2 hour response target to 70%	• Increase 2 hour response target to 80% • Increase range and targets for services as set out as Intermediate Care nationally • Understand viable model for Devon to implement a single coordination centre	• Increase 2 hour response target to 90% • Digital maturity which enables coordinated activity across out of hospital services in Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention	**March 2024** • Implement CVD prevention plan, and those for Diabetes, Hypertension, Respiratory and other Long Term Conditions	**March 2025/26** • Identification of at risk population groups – for CVD and other Long Term Conditions, measurable increase against baseline	**March 2028** • Continued increase in number of people supported at home and through use of digital and remote monitoring services • Increase proportion of identified people treated optimally to target, utilising medical and behavioural interventions
Avoiding admissions Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services	**March 2024** • 224 virtual ward beds will be available across the system • 80% utilisation based on 7 day length of stay • Develop capacity to include admission avoidance use of virtual wards • Digital inclusion addressed via VCSE input to each virtual ward	**March 2025/26** • System evaluation of virtual ward services • Increase breadth of clinical pathways using virtual wards • Deliver programme for Remote Monitoring which support patients in Primary Care to manage their Long Term Conditions	**March 2028** • Virtual ward pathways embedded across Devon for admission avoidance and discharge for all suitable conditions • Remote Monitoring in place consistently across Devon which supports patients with one or more Long Term Conditions

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Access to Information We will have a shared overview of Voluntary and Community organisations across Devon via the consistent use of the Joy App by Social Prescribers and across 100% of PCNs by 2024, which enables access by all staff	**March 2024** • 100% of PCNs using Joy App • 100% of VCSE based Social Prescribers using JOY App • Explore expansion to 'Waiting Well' offer for patients	**March 2025/26** • Evaluation of JOY App completed and informed future provision • Continued use of JOY App or alternative as outcome of evaluation which is focussed on ease of access for staff and patients	**March 2028** Continued use of JOY App (or alternative) across 100% of PCNs with expansion across; • Mental Health • Community Connectors • Children's services
Personalised care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)	**March 2024** • 70% target for death in preferred place of care • Each LCP will have plans to support Ageing Well in their population, aligned to the Devon Healthy Ageing Handbook	**March 2025/26** • 80% target for death in preferred place of care • Through use of PHM each LCP will target severe & moderately frail patients proactively to ensure personalised & preventative care planning	**March 2028** • 90% target for death in preferred place of care • Frailty patients and those living with Dementia experience personalised care in all out of hospital services

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Sustainable General Practice We will have sustainable and high quality general practice which operates within local and national Strategic Frameworks, and which has agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change.	• Quality and Outcome Framework achievement <90% • PCN Directed Enhanced Services delivery to 100% population • 100% operating within funding envelope • Operating plan appointment targets achieved • Funded plan in place to support development of ICS based scalable models	• Year 1 achievements maintained • Operating plan appointment targets achieved • Scalable development programme in place and supporting sustainability requests • Scoping of opportunity to manage 'back office' functions across PCNs complete	• Year 1-3 achievements maintained • Operating plan appointment targets achieved • Scalable models in place and proactively engaged by contractors seeking sustainability support • Model to support cross PCN management of 'back office' functions in place
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market - *quality* - *Price (funding)* - *Information, advice and signposting*	• Each LA completes their Market Sustainability Plans as required by the Market Sustainability and Improvement Fund • Market oversight compliant as per the CQC Assurance Framework • Review discharge model to ensure the market can support hospital flow	• Complex Care alternative models of care developed • Year 2 of market sustainability plans delivered	

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes	• Tender for new Supported Living contract for Devon (first specification and pricing structure introduced) to improve choice, control and quality of tenancies through the separation of housing and support. • Make better use of Extra Care schemes across Devon. • Work with District/City Councils to ensure that local plans include supported housing in communities for people we support. • Make better use of Shared Lives schemes across Devon, particularly for young people age 16+. • Set out with the independent provider market the strategic objectives that we are working to achieve in Devon, including quality provision, sustainability and the training/skills required	• Work with independent providers to develop different models of Supported Living, including individual units in a hub and spoke model within communities. • Develop Extra Care schemes for people with dementia and for people with Learning Disabilities. • Increase supply of Shared Lives placements across Devon. • Continue work with District/City Councils to ensure that local plans include housing for people we support.	

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Collaborative working We will have a Primary and Community Care Collaborative which functions Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes	**March 2024** Developed functional GP Provider Collaborative Plan to establish Community Collaborative signed off by system	• Devon Collaborative Board development sessions will support and inform the development of the GP Provider Collaborative • Assess the current position and the maturity of the GP Provider Collaborative against a recognised framework/process • Initiate and explore scope and remit of a Community Care Provider Collaborative, in the context of Local Care Partnerships • Adopt the Devon operating model for the Provider Collaborative and establish timeline for development and integration to form single function • Explore ways in which broader Primary Care – Pharmacy, Optometry and Dentistry will be incorporated	1. Primary Care Provider Collaborative will be able to represent the primary care voice and input in a more equitable way within the system 2. The Provider Collaborative will be able to contribute to decision making regarding service improvement and funding which will lead to improved patient access and more resilient services
Integrated Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community, cross organisational multi-disciplinary team to jointly deliver services.	**March 2024** • Implement remote clinical support (Immedicare) to a further 60 care homes across Devon • Reduce Community Services waiting lists	• Identify service lines with highest number of people waiting across adults & children services • Implement a system wide community list reduction steering group to provide system leadership and oversight of delivery • Support providers to set trajectories for reduction. • Monitor performance against set trajectories • Set out clinical validation methods with providers learning from the ERF work • Implement the 2-day Reablement standard	1. Targeted work with key services likely to achieve highest level of reduction - 10% reduction in Community Services waiting list by 2024 - LTC 2. People waiting for community services are supported to minimise adverse impacts or harm

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, by 2028	**March 2024** • Embed 111 and 999 referral pathways to UCR - 20% target for UCR referrals from 111/999 • Establish self-referral pathways across Devon • Increase 2 hour response target to 70%	• Improve data quality through CSDS reporting • Identify paramedic roles within UCR services that can support an increased 'pull' of patients from SWAST • Review current referral triage processes to identify any delay in meeting 2 hour standard • Implement self-referral pathway to UCR across Devon	1. Increased referrals from 111/999 services and reduction in ED attendances and admissions 2. Optimise time between referral to initial assessment – improved patient experience
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention	**March 2024** • Implement CVD prevention plan, and those for Diabetes, Hypertension, Respiratory and other Long Term Conditions	• Implementation of Population Health Management across all areas where PCNs have signed up • Joint multi-disciplinary training sessions which develop the local model and offer • Delivery of long term condition plans for specific conditions across the ICB and Public Health teams	1. Population health management enables delivery to local population needs, addressing areas of health inequality 2. Improved management of long term conditions which leads to reduced unplanned care

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Preventative Care Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services	**March 2024** • 224 virtual ward beds will be available across the system • 80% utilisation based on 7 day length of stay • Develop capacity to include admission avoidance use of virtual wards • Digital inclusion addressed via VCSE input to each virtual ward	• Develop a shared pathway approach across virtual ward provision • Increase clinical pathways utilising virtual wards • Increase capability for admission avoidance provision - develop direct referral mechanism from UCR services, SWASFT, out of hours and care homes (via Immedicare)	1. Increase admission avoidance and increase hospital discharge ability 2. More people will experience supported care at home
Preventative Care Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services	**March 2024** • 224 virtual ward beds will be available across the system • 80% utilisation based on 7 day length of stay • Develop capacity to include admission avoidance use of virtual wards • Digital inclusion addressed via VCSE input to each virtual ward	• Develop a shared pathway approach across virtual ward provision • Increase clinical pathways utilising virtual wards • Increase capability for admission avoidance provision - develop direct referral mechanism from UCR services, SWASFT, out of hours and care homes (via Immedicare)	1. Increase admission avoidance and increase hospital discharge ability 2. More people will experience supported care at home
Access to Information We will have a shared overview of Voluntary and Community organisations across Devon via the consistent use of the Joy App by Social Prescribers and across 100% of PCNs by 2024, which enables access by all staff	**March 2024** • 100% of PCNs using Joy App • 100% of VCSE based Social Prescribers using JOY App • Explore expansion to 'Waiting Well' offer for patients	• Ensure 75% of PCN's currently using Joy App are embedded in practice • Ensure 75% of VCSE based Social Prescribers are currently using Joy App • Negotiate with the remaining 25% of each to be onboarded by March 2024 • Deliver bespoke training sessions on how to use the Joy App for the remaining 25% • Link the Waiting Well programme led by Living Options Devon to the Joy App Marketplace	1. The number of people receiving Social Prescription and the impact of this is known and understood 2. An up to date Market place of community assets is maintained 3. Social Prescribers in PCN's and the VCSE are better supported

Duplicate

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Personalised care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)	**March 2024** • 70% target for death in preferred place of care • Each LCP will have plans to support Ageing Well in their population, aligned to the Devon Healthy Ageing Handbook	• Personal health budget process already in place and has been extended to personalised discharge budgets to support those leaving hospital • End of Life commissioning review recommendations to be progressed • Each locality area developing a healthy ageing board or equivalent to oversee local delivery of the health ageing handbook • Population health management will inform local focus on their most vulnerable groups	1. Reduced unplanned care for those vulnerable groups who have a personalised approach 2. Improved patient and family experience for those experiencing personalised care 3. Increased numbers of people dying in their chosen place
Sustainable General Practice We will have Sustainable and high quality general practice operating within local and national Strategic Frameworks, with agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change.	• Quality and Outcome Framework achievement <90% • PCN Directed Enhanced Services delivery to 100% population • 100% operating within funding envelope • Operating plan appointment targets achieved • Funded plan in place to support development of ICS based scalable models	• Increase GP workforce through flexible offers option, broadening contractor models, direct recruitment programme • Increase Additional Roles Reimbursement Scheme (ARRS) workforce through optimal use of ARRS staff and upper decile ARRS staff churn performance, delivered through ARSS focussed retention programme • Increase upskilling of existing staff via Devon Training Hub delivered training and development programmes	1. Upper decile ICS total GP team appts 2. +5% pre-pandemic total GP team appts 3. Exceed same day GP response target (35%) 4. Exceed within 2 weeks of request target (85%)

Year 1 and 2 (operational plan detail)

Primary and Community Care Integration

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market - *quality* - *Price (funding)* - *Information, advice and signposting*	• Each LA completes their Market Sustainability Plans as required by the Market Sustainability and Improvement Fund • Market oversight compliant as per the CQC Assurance Framework • Review discharge model to ensure the market can support hospital flow	• To be developed	1. High quality social care provision available across Devon supported by a diverse range of resilient independent and voluntary sector providers
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes	• Tender for new Supported Living contract for Devon (first specification and pricing structure introduced) to improve choice, control and quality of tenancies through the separation of housing and support. • Make better use of Extra Care schemes across Devon. • Work with District/City Councils to ensure that local plans include supported housing in communities for people we support. • Make better use of Shared Lives schemes across Devon, particularly for young people age 16+. • Set out with the independent provider market the strategic objectives that we are working to achieve in Devon, including quality provision, sustainability and the training/skills required	• To be developed	1. More people supported to live independently in their own homes

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.	Systems dashboard in place to monitor performance against elective recovery targets (eliminated >65 week waiters). Validation and risk stratification processes identified in line with new national guidance and implement once validated locally and regionally and plan to evaluate in place. Aligned with the National CYP Urgent and Emergency Care (UEC) objectives and the Paediatric Peninsula Acute Sustainability programme develop plans for a standardised Same Day Emergency Care (SDEC) and Short stay paediatric/Children's assessment units (PAU/CAU) model. Regional SiC ODN leading this programme of work in line with national guidelines. Confirm that UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.	Monitor performance against elective recovery targets to ensure that >52 week waiters are eliminated. Develop the Paediatric Outreach and Ambulatory model of care that integrates paediatrics with primary and community services supporting CYP at home and in their community. Ensure pathways and out of hospital services for a standardised SDEC/PAU models are in place *(not inc. CYP MH).* Ensure a clear and equitable offer for UTC and Navigation for CYP. Potential public consultation depending on level of change required in each Trust.	Paediatric Outreach and Ambulatory model of care delivered. Standardised SDEC/PAU model with networked out of hours solution delivered.

One Devon

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Holistic integrated neurodevelopmental assessment pathway:** • Co-produce a the new pathway. • Produce options appraisal and recommendations for the new pathway. • Transition to new pathway to commence at end of year 1. **Early access keyworker pilot:** • Recruit additional keyworkers working across the ICP for a 12 month test of change. • Develop and maintain a directory of services. **Speech and Language Communication Needs (SLCN):** • Establish a shared system wide understanding of current level of SLCN, provision and gaps. • Better understand the connections between SLCN and Social Emotional Mental Health (SEMH), Adverse Childhood Experience (ACE). trauma, offending and employability.	**Holistic integrated neurodevelopmental assessment pathway:** • Develop a digital Neurodiversity offer. • Establish a network of workforce and public facing training systems. • Framework rolled out for evaluation and co-production by the children and families. **Early access keyworker pilot:** • Establish a neurodiversity Club for CYP and their families. • Develop and implement an accessible integrated local offer, without the need for a diagnostic assessment. • Undertake an evaluation of Keyworkers as part of the neurodiversity & SLCN pathway. **Speech and Language Communication Needs (SLCN):** • Implement Communities of Practices that link with Family Hubs and Best start in Life. • Establish a network of workforce training systems which support differential diagnosis and professional development. • Develop a robust transdisciplinary offer of support for CYPS with SLCN/SEMH.	**Holistic integrated neurodevelopmental assessment pathway:** • Full transition to new pathway embedded in practice. **Early access keyworker pilot:** • Develop a toolkit which can be used in place of a diagnosis. • Establish alignment of peer support workers working in partnership with other services. **Speech and Language Communication Needs (SLCN):** • Implement model of delivery and pathways which address the inequalities and inequities experienced by CYP and their families accessing SLCN across the ICP.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones -Year 1	Milestones- Year 2-3	Milestones -Year 4-5
Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.	**By June 2023:** Produce a local Maternity system plan aligned to the national **Maternity Single Delivery Plan** that delivers: Personalised Care and Choice: • Review existing and embed new personalised care and support plans for pregnancy, birth and postnatally • Ensure transition is seamless between services and sectors Improved equity and outcomes: • Improve access to antenatal education • Embed specialist smoking cessation pathways • Deliver Pelvic Health Services Enhanced Quality and Safety: • Full implementation of Ockenden Interim and final recommendations • Implement Perinatal Quality Surveillance model at Trust & System level • Full compliance with Saving Babies Lives Care Bundles version 2 • Align escalation policies with appropriate ICB oversight • Implement preterm birth pathways in all Trusts. Improve maternal mental health and emotional wellbeing offer: • Deliver bereavement support for perinatal death • Devon wide perinatal mental health collaborative established • Review maternity estate so that choice of place of birth is available • Develop an enhanced Digital Maternity Information Systems (MIS) • Improved joint working and alignment of vision • Improve community outreach and co-production	Personalised Care and Choice: • Consistent, evidence based information Equity and improved outcomes: • Referral to the national diabetes prevention programme • A postnatal contraception offer • Improved uptake of vaccination in pregnancy • System wide infant feeding strategy • Full implementation of enhanced continuity of carer (some services) • Full implementation of the Neonatal Critical Care Review Enhanced Quality and Safety: • Implement East Kent Report recommendations • Devon Dashboard operational • 50% reduction in stillbirth, neonatal death, maternal death and intrapartum brain injury • Sharing learning from complaints and incidents • Full participation in South West Maternal Medicine Network • Implement Saving Babies Lives Care Bundles V3 Maternal mental health and emotional wellbeing offer: • System wide Maternal Mental Health offer including VCSE Enabled by: • Community outreach and engagement • Enhanced support for Maternity Voices Partnerships	**By 2027:** • Implement Maternity & Neonatal Equity & Equality Plans through Interventions & Clinical pathways for vulnerable & protected groups, and improve the universal care offer. • Choice will be offered to women and birthing people of three places of birth. • Establish routine reporting of Maternity & Neonatal Quality & Safety reporting to Trust and ICB Boards. • Intelligence will be triangulated from data sources, complaints, incidents and user experience to monitor interdependencies and impacts. • Implement the recommendations of the Ockenden Nottingham Report (Anticipated 2025).
Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.	By the end of Q3 2023-2024: • Co-produce a 5 year LMNS Workforce Strategy • Produce a plan to address workforce objectives outlined in key maternity and neonatal documentation • Produce a reliable baseline of Devon maternity & neonatal workforce profiles • Redesignation of Maternity Support Workers to band 3's with appropriate training and supervision plans in place (national mandate). • Core Competency Framework will be implemented across all Trusts	• Develop a trust and system succession plan, to support system staff to develop themselves and securing high quality leadership for the future • Ensure job plans for obstetricians will include time for improving shared clinical governance	• Implement, in line with Devon LMNS Equity and Equality Plans, race equality for staff through the recommendations of the Workforce Race Equality Standard (WRES) in maternity and neonatal settings.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
By 2028, we will have proactively addressed **health inequalities**. The Core20PLUS5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.	Complete stocktake with each of the key areas and populations in Devon. Baseline Core20PLUS5 dashboard developed, via Devon Intelligence Functions Group, linking with regional team as appropriate. Develop network of stakeholders and pathways for the identified priority groups: 1. Children and families in the 20% most deprived areas and areas of rural and coastal deprivation 2. Children and young people in care, 3. Neurodiverse children 4. Young carers Develop clear work programmes for the key clinical areas: • Asthma • Diabetes • Epilepsy • Oral Health • (Mental Health – delivered by mental health workstream) • (Healthy Weight)	Established pathways within the relevant clinical areas, including the priority groups. Deliver the priority service development improvement plans for the key clinical areas, with consideration of four priority groups.	Monitor and evaluate against Core20PLUS5 approach – universal and targeted.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Commissioned arrangements will be in place across Devon by 2028 to ensure that the health needs of **socially vulnerable children** are identified and met.	Establish the conditions for working together across health, care and education to enable joint commissioning. Deliver a system dashboard that will provide robust health data. Complete a stocktake of current level of provision and gaps for the health of care-experienced young adults.	Complete a 12month test of change for the Care Leaver Nursing service based on evidence for the Care Leaver pilot. Each local area to have a graduated pathway of support for children, young people, young adults, carers and the wider support network. Increase Children in care services to 21 years.	Robust monitoring in place for improvement and strengthened joint commissioning approaches moving towards integrated commissioning for the local areas. For all areas of health to be part of the care leavers covenant. Increase children in care services to 25 years.
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.	**Torbay:** Funded Family Hub model in place. **Plymouth:** Submission of bid and development of roll-out plan completed (if successful). **Devon:** Established Best Start in Life Programme Strategic Priorities with the aim to bring together 0-5 services.	**Torbay:** Delivery of comprehensive Family Hubs model, with effective communications to ensure that parents and carers are aware of the services and support available. **Plymouth:** TBC dependent on bid. **Devon:** Established delivery of the Best Start in Life Programme.	

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.	Create the conditions for service improvement and joint commissioning across the local areas (health, care and education), supported by co-production mechanisms. Agree integrated SEND strategies for each local area. Deliver new code of practice and work with Local Authorities subject to the new inspection framework. Deliver a system dashboard that includes robust health data.	Clear local offer established for each local area, including a graduated pathway of support to CYP and families. Define the outcomes framework that demonstrate improvements.	Robust monitoring in place for improvement and continued strengthening of joint commissioning approaches moving towards integrated commissioning for the local areas.

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.	**Year 1:**
	• Systems dashboard in place to monitor performance against elective recovery targets (eliminated >65 week waiters).
	• Validation and risk stratification processes identified in line with new national guidance and implement once validated locally and regionally and plan to evaluate in place.
	• Aligned with the National CYP UEC objectives and the Paediatric Peninsula Acute Sustainability programme develop plans for a standardised SDEC and Short stay paediatric/Children's assessment units (PAU/CAU) model.
	• Regional SiC ODN leading this programme of work in line with national guidelines.
	• Confirm that UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.
	
	Year 2:
	• Monitor performance against elective recovery targets to ensure that >52 week waiters are eliminated.
	• Develop the Paediatric Outreach and Ambulatory model of care that integrates paediatrics with primary and community services supporting CYP at home and in their community.
	• Ensure pathways and out of hospital services for a standardised SDEC/PAU models are in place *(not inc. CYP MH).*
	• Ensure a clear and equitable offer for UTC and Navigation for CYP.
	• Potential public consultation depending on level of change required in each Trust.
		Urgent treatment and hospital care:
		• Establish assurance processes with Trust providers via the Paediatric steering group (mobilised in 22/23) with regional and national CYPER support.
		• Regularly monitor performance via system dashboard and report position to Planned Care Team in line with governance processes.
		• Work with trusts to identify CYP waiters and those at highest risk or risk of harm, scoping options for mutual aid and ensuring there is timely access to assessment and interventions.
		• Review current pathways for non-clinical validation for adults and scope and develop a clinical and non-clinical validation process for CYP and evaluation to support effectiveness of validation and risk stratification..
		• Work collaboratively with UEC to scope the process of a standardised SDEC and Short stay paediatric/Children's assessment units (PAU/CAU) model to support development of plans.
		
		Surgery in Children (SiC):
		• Dependent on national guidelines:
		  • Support Trusts to develop robust theatre lists booking and scheduling practice to enable adoption of HVLC principles.
		  • Develop plans to take forward (draft) minimum CYP elective recovery expectations and set up processes to support and monitor Trusts to meet targets.
		• Develop a clinical validation process for CYP.
		• Confirm if UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.
		• Develop assurance processes and support Trusts to recovery at pace in line with expected target of Q2 2023/24.
		• Scope the level of public consultant required, depending on level of change in each Trust.
			• Reduction in waiting lists, with a focus of eliminating >65 by April 2024 and >52 week waits by April 2025.
			
			• Reduce outpatient follow-ups (OPFU) in line with national ambition of 25% against 2019/20 by March 2024.
			
			• Reduction in agency or locum costs (key deliverable for PASP – to be quantified).
			
			• Part of the all age target, to ensure 85% theatre utilisation for all elective procedures from April 2023 onwards.
			
			• Reduction in zero LOS for CYP with common childhood illness (to be quantified).

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Holistic integrated neurodevelopmental assessment pathway:** **Year 1:** • Co-produce a the new pathway. • Produce options appraisal and recommendations for the new pathway. • Transition to new pathway to commence at end of year 1. **Year 2:** • Develop a digital Neurodiversity offer. • Establish a network of workforce and public facing training systems. • Framework rolled out for evaluation and co-production by the children and families.	**Holistic integrated neurodevelopmental assessment pathway:** **Year 1:** • Monthly workstream meetings agreed, Senior Leads nominated as Chairs and stakeholders invited. • Analysis of service and workforce data to identify and address gaps. • Expert Lived experience reference group to be established and nominations to be invited. • Hold 2 face to face events for Communication and coproduction with parents including national autistic society. • Draft and pilot common paperwork 'request for assessment' that will support a referrer to make a decision to refer for an assessment or not. • Agree on process which includes: Who can refer; who can complete an assessment; Single front door/ point of access; Decision making tool / triage process for referrals received; age related guidelines. • Workstream groups to agree timeline for testing and implementation. Test and adapt as necessary. • Prepare the options for a consistent referral and assessment paperwork. **Year 2:** • Undertake research and evaluate existing websites and apps; compile summary; ask young people and their families for their views. • Workstream group to review changes made to assessment pathway, amend, confirm and roll out consistent across ICP. • Compile a list of training that is available free of charge as well as those charged at a universal and specialist level. Take advice as to what is most effective and relevant for the Devon system and advertise and promote. • Agree with each provider the data to be collected and centrally analysed. Gaps identified and noted.	Improved access to support at universal and targeted level resulting in a shift in culture and a reduction in the drive of families seeking a diagnosis as a means to get support will result in the following impacts: • Waiting list for a neurodivergent diagnosis will have reduced to within NHS standard time frames (18 weeks) by 2025. • Requests for EHCPS will have decreased to bring Torbay, Devon and Plymouth in line with the national average. • We know that the baseline experience satisfaction for families who have neurodivergent is low and through the keyworker scheme we will see an incremental increase for parents / carers and CYP for the support they receive. • The number of children and young people on multiple waiting lists is reduced (target to be determined). • We are hoping to undertaken and economic evaluation of this benefits of this piece of work.
	Early access keyworker pilot: **Year 1:** • Recruit additional keyworkers working across the ICP for a 12 month test of change. • Develop and maintain a directory of services. **Year2:** • Establish a neurodiversity Club for CYP and their families. • Develop and implement an accessible integrated local offer, without the need for a diagnostic assessment. • Undertake an evaluation of Keyworkers as part of the neurodiversity & SLCN pathway.	**Early access keyworker pilot:** **Year 1:** • Develop job plans and person specifications for new keyworker roles. • Recruit additional keyworkers to work across the ICP. • Develop SoPs for the new keyworker service aligned with locality early help systems. • Gather key information on what services are available at a local level and provide this to the Joy.app and local offer directories of service. • Collate and promote resources that can be used by families. **Year 2:** • Key workers with families draft what an early identification and training offer looks like • Consider digital technologies that promotes and provides local information that can support families information and advice • Complete the 2 new outcome star as part of evaluation • Develop business case for continuation and further roll out of key workers.	

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Speech and Language Communication Needs (SLCN)** **Year 1:** • Establish a shared system wide understanding of current level of SLCN, provision and gaps. • Better understand the connections between SLCN and Social Emotional Mental Health (SEMH), Adverse Childhood Experience (ACE). trauma, offending and employability. **Year 2:** • Implement Communities of Practices that link with Family Hubs and Best start in Life. • Establish a network of workforce training systems which support differential diagnosis and professional development. • Develop a robust transdisciplinary offer of support for CYPS with SLCN/SEMH.	**Speech and Language Communication Needs (SLCN):** **Year 1:** • Each provider to input their data – workforce, service referral and activity on to the Balanced System. Including their service offer. • Central analysis of data provided identifying strengths and gaps, making recommendations to decision makers for addressing inequity of access. • Communication and coproduction with parents to be planned • Specialist SLCN/SEMH to attend team meetings within education, care and health raising awareness and offering training at both a universal and targeted level. **Year 2:** • Attend Family Hub strategic planning group • Develop job plans and person specifications for SLT roles in Family Hubs • Recruit additional SLTs working across the ICP. • Develop SoPs for the SLTs aligned with Family Hubs • Prepare costings for investment required in SLCN workforce. • Submit and present to senior executives for decision making • Recruit to additional SLCN posts across the ICP • Compile a database of training that is available (free of charge as well as charged). • Promote training on offer via organisation staff websites. • Update staff appraisal paperwork to identify and record what training completed for SLCN/SEMH	There is a clear integrated model of provision across health, social care, education, voluntary and third sector, in partnership with young people and their families, ensuring needs are identified and met effectively, which will have the following impact: • Greater confidence and capacity to support SLCN needs within the universal workforce (to be tested trough workforce survey). • Waiting list for a SLCN intervention will have reduced (95% CYP seen within the constitutional standard) to within NHS standard time frames (18 weeks) by 2025. • % of CYP requiring SEN support is moving towards national average rate per population for SLCN. • % of CYP requiring EHCP is moving towards national average rate per population for SLCN.

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.	**By June 2023:** Produce a local Maternity system plan aligned to the national **Maternity Single Delivery Plan** that delivers:
	Personalised Care and Choice:
	• Review existing and embed new personalised care and support plans for pregnancy, birth and postnatally
	• Ensure transition is seamless between services and sectors
	Improved equity and outcomes:
	• Improve access to antenatal education
	• Embed specialist smoking cessation pathways
	• Deliver Pelvic Health Services
	Enhanced Quality and Safety:
	• Full implementation of Ockenden Interim and final recommendations
	• Implement Perinatal Quality Surveillance model at Trust & System level
	• Full compliance with Saving Babies Lives Care Bundles version 2
	• Align escalation policies with appropriate ICB oversight
	• Implement preterm birth pathways in all Trusts.
	Improve maternal mental health and emotional wellbeing offer:
	• Deliver bereavement support for perinatal death
	• Devon wide perinatal mental health collaborative established
	• Review maternity estate so that choice of place of birth is available
	• Develop an enhanced Digital Maternity Information Systems (MIS)
	• Improved joint working and alignment of vision
	• Improve community outreach and co-production
	Year 2:
	Personalised Care and Choice:
	• Consistent, evidence based information
	Equity and improved outcomes:
	• Referral to the national diabetes prevention programme
	• A postnatal contraception offer
	• Improved uptake of vaccination in pregnancy
	• System wide infant feeding strategy
	• Full implementation of enhanced continuity of carer (some services)
	• Full implementation of the Neonatal Critical Care Review
	Enhanced Quality and Safety:
	• Implement East Kent Report recommendations
	• Devon Dashboard operational
	• 50% reduction in stillbirth, neonatal death, maternal death and intrapartum brain injury
	• Sharing learning from complaints and incidents
	• Full participation in South West Maternal Medicine Network
	• Implement Saving Babies Lives Care Bundles V3
	Maternal mental health and emotional wellbeing offer:
	• System wide Maternal Mental Health offer including VCSE
	Enabled by:
	• Community outreach and engagement
		• Review contents SDP, anticipated March 23rd 2023. Significant changes to programme deliverables not anticipated
		• Align current plans and timescales to national strategic requirements of the SDP.
		• Develop Serious Incidents thematic analysis review tool
		• Literature review of best practise guidance and evidence
		• Map the existing antenatal education offer to make best use of 'collaborative advantage'- Production of a cohesive antenatal education offer from a range of sources.
		• Service user review- what is required from our services
		• Production of antenatal service specification, demonstrating alignment of resources
		• Monitor implementation in Trusts via LMNS Safety and Governance & LMNS Board
		• Share learning & devise shared system wide clinical governance
		• Take appropriate LMNS/ICB actions as outlined in Ockenden Interim
		• Monitor Trust implementation of Saving Babies Lives Care Bundles version 2
		• Liaise with South West regional Maternity Transformation Programme (MTP) to ensure compliance
		• Share learning & clinical governance across the system
		• Implement preterm birth pathways in line with Saving Babies Lives Care Bundles version 2.
		• Ensure specialist bereavement midwives in post, who have undertaken specialist bereavement training
		• Availability of perinatal bereavement rooms and facilities
		• Links to funeral directors, national charities and local support groups will be in place
		• Review estate utilisation and future service provision models
		• Develop estates utilisation plan aligned to strategic vision for maternity service delivery, including alignment with Family Hubs (MTP: Community Hubs)
		• Fully implemented maternity information systems, to include electronic patient held record (ePHR)
		• Scope and plan to enhance maternity digital provision, with an aim of digital maturity aligned to ICS roadmap
		• Implement data sharing agreements to enable system wide data visualisation and sharing
		• Map community assets available that address inequalities within the community
		• Identify community support 'deserts' and plan service delivery to fill these gaps
		• Identification of community champions and support interventions for signposting (aligned to Best Start in Life)
		• An LMNS financial plan prioritising community outreach and coproduction
			CQC survey indicated areas for improvement:
			• There will be a 1 point increase in the post natal experience scores by 2024.
			• There will be a 0.1 point increase in experience of antenatal check-ups by March 2024.
			• There will be a 0.2 point increase in labour and birth experience by March 2024.
			
			For all maternity services to have full Baby Friendly Initiative (BFI) accreditation by 2025.
			
			Improved Outcomes
			• A 50% reduction by 2025 in:
			  • Stillbirth
			  • Neonatal Death
			  • Maternal Death
			  • Intrapartum Brain Injury
			• Reduction in preterm births from 8% to 6% (Nationally)
			• Increased breast milk at first feed to 78% by March 2024 (in line with regional value).
			• Increased breastfeeding at 6-8 weeks to 55% by March 2024 (in line with regional value).
			• Smoking at time of Delivery will be at 6% or less by 2024.

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.	**By the end of Q3 2023-2024:**
	• Co-produce a 5 year LMNS Workforce Strategy
	• Produce a plan to address workforce objectives outlined in key maternity and neonatal documentation
	• Produce a reliable baseline of Devon maternity & neonatal workforce profiles
	• Redesignation of Maternity Support Workers to band 3's with appropriate training and supervision plans in place (national mandate).
	• Core Competency Framework will be implemented across all Trusts
	
	Year 2:
	• Develop a trust and system succession plan, to support system staff to develop themselves and securing high quality leadership for the future
	• Ensure job plans for obstetricians will include time for improving shared clinical governance
		• Review extensive national guidance on improving workforce recruitment, retention & wellbeing.
		• Produce a plan to address national strategic guidance on improving maternity & neonatal workforce recruitment, retention and wellbeing.
		• Engage with Higher education Institutions (HEIs) to plan future workforce needs.
		• Plan to implement the recommendations of the workforce race equality standard.
		• Prepare to co-produce a long term maternity and neonatal workforce strategy.
		• Develop the system maternity leadership and oversight.
		• Enhance maternity & neonatal leadership and oversight for safety and improving outcomes, including at Trust executive level.
		• Implement the relevant actions regarding workforce and leadership from the Ockenden reports.
		• Implement recommendations in regard to training and development, with focus on the following areas:
		  • MDT training
		  • Respecting diversity, including cultural competence training
		  • Implementation of the A-EQUIP model
		  • Provision of broad career pathways
		  • Ensuring that maternity training funding is ring fenced
		• Implement learning from SCORE culture surveys.
		• Take an active leadership role in supporting a culture of shared learning, openness and transparency, especially in regard to incidents and complaint.
		• Detailed analysis of the maternity & neonatal workforce.
		• Review of existing literature from HEE, NHSE etc such as workforce planning guidance, and safe staffing levels as outlined in the Ockenden report.
		• Ensure that Maternity Support Workers are designated as band 3 and there is an Maternity Support Workers competency framework in place to upskill this staff group.
		• Ensure that MSW's are coded accurately on ESR, utilising the new national MSW codes.
		• Oversight of core competency framework implementation in Trusts via LMNS Board core-competency-framework.pdf (england.nhs.uk).
		• Sharing learning & resources across the system.
			Increase the establishment (in post) vacancy & decrease sickness absence rates for Obstetricians, Neonatologists, Midwives, Maternity Support Workers and Neonatal Nurses (this should be in line with individual unit recommendations from BirthRate+ & Ockenden) - target to be confirmed once review has been undertaken to determine the accurate baseline.
			
			NHS staff survey questions on staff experience & morale (target to be confirmed once review has been undertaken to determine the baseline).
			
			Every newly registered midwife to have a preceptorship programme by 2025.

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
By 2028, we will have proactively addressed **health inequalities**. The Core20PLUS5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.	**Year 1:** • Complete stocktake with each of the key areas and populations in Devon. • Baseline Core20PLUS5 dashboard developed, via Devon Intelligence Functions Group, linking with regional team as appropriate. • Develop network of stakeholders and pathways for the identified priority groups: 1. Children and families in the 20% most deprived areas and areas of rural and coastal deprivation 2. Children and young people in care, 3. Neurodiverse children 4. Young carers • Develop clear work programmes for the key clinical areas: • Asthma • Diabetes • Epilepsy • Oral Health • (Mental Health – delivered by mental health workstream) • (Healthy Weight) **Year 2:** • Established pathways within the relevant clinical areas, including the priority groups. • Deliver the priority service development improvement plans for the key clinical areas, with consideration of four priority groups.	**Year 1:** • Planning, monitoring and evaluation with a focus on health inequality groups. • Use data from national asthma dashboard (including deprivation data) and risk stratification tool to target support to PCNs and practises with children at high and very high risk. • Produce targeted communications with schools in most deprived areas. • Build relationships with SW CYP epilepsy team to support alignment of regional and national guidance and to local priorities, with consideration of priority groups. **Year 2:** • Deliver the priority service development improvement plans for asthma, diabetes and epilepsy with consideration of four priority groups. • Promote and share learning from eclipse tool to improve number of practises using the data.	**Asthma:** • To have a year on year reduction in emergency attendance and unplanned admissions due to asthma in secondary care. • 55% of GP practices within Devon have prescribed over 6.7 SABA inhalers within a year. Initial aim in the first 2 years is for 80% of GP practices to be prescribing 6.7 or less SABA inhalers per year for CYP. • To have jointly reviewed with primary care 90% of CYP identified as "Very High Risk" on eclipse in Devon by July 2024. • To have a remote review and recommendation with primary care - 80% of CYP identified on eclipse as "High Risk" and prescribed 3 or more SABA inhalers within a year by July 2024. **Diabetes:** • Identify Trusts with greatest disparity in uptake of rtCGM and insulin pumps based on deprivation and ethnicity. • Support Trusts where disparity has been identified to increase access to rtCGM and insulin pumps. • Increase proportion of CYP with Type 2 diabetes receiving NICE recommended care processes (all six health checks: HbA1C, Blood Pressure, BMI, Urinary Albumin, Foot exam & Thyroid). • Ensure CYP in Devon have equitable access to diabetes care and a reduction in variation across the three NHS Trusts, evidenced by a range of outcome measures in the National Paediatric Diabetes Audit (NPDA).

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.	**Year 1:** **Torbay:** Funded Family Hub model in place. **Plymouth:** Submission of bid and development of roll-out plan completed (if successful). **Devon:** Established Best Start in Life Programme Strategic Priorities with the aim to bring together 0-5 services. **Year 2:** **Torbay:** Delivery of comprehensive Family Hubs model, with effective communications to ensure that parents and carers are aware of the services and support available. **Plymouth:** TBC dependent on bid **Devon:** Established delivery of the Best Start in Life Programme.	• Enhanced intervention led early years offer. • Work with Local Authorities to develop Family Hub and Early Help models across Devon ICS to support children's development and readiness for school. • Use family hubs as a spring board to bridge the gap between services. • Work within an integrated care partnership footprint to understand how to work across boundaries – health, social care, housing, public health etc. • Develop an evidence-based enhanced service offer for the early years.	

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.	**Year 1:** • Create the conditions for service improvement and joint commissioning across the local areas (health, care and education), supported by co-production mechanisms. • Agree integrated SEND strategies for each local area. • Deliver new code of practice and work with Local Authorities subject to the new inspection framework. • Deliver a system dashboard that includes robust health data. **Year 2:** • Clear local offer established for each local area, including a graduated pathway of support to CYP and families. • Define the outcomes framework that demonstrate improvements.	• Develop a strong local area governance to ensure there are defined structure roles and responsibilities, lines of accountability and commitment of resources to deliver and support the rapid delivery of the areas of significant weakness identified in the Ofsted and CQC inspections. • Map education, health, and care provision across the Local Area, identifying and addressing gaps in relation to meeting needs of children and young people with SEND, through an improved graduated approach, and clearly communicate this. • Develop effective methods of co-production to ensure that children, young people, parents, and carers' lived experiences and expertise is valued and embedded within all layers of work. • Review and redefine the joint commissioning strategy co-producing priorities based on a good understanding of local need and local spend. • Continue to ensure that resources are deployed to the best possible effect to achieve good outcomes for children and young people and make best use of public funds. • Have a workforce development plan that establishes a skilled, sustainable, supported, and sufficient workforce across the Local Area to deliver services to children and young people with SEND. • Develop a system dashboard that includes robust health data. • Develop methods to ensure there is robust commissioning for a smooth transition for CYP with SEND and who are well prepared for the next stage of their education, employment or training and their adult lives. • Develop a set of Value-based behaviours for communication. • Identify the local offers for each local area to support embedding these across the system for CYP and families.	Health input into EHCPs is provided within the statutory timeframe of 6 weeks – target 95% by 2024. There will be a reduction in the requests for EHCPs (due to appropriate help and support being received early). Individual targets for each Local Authority being set by the SEND programmes and will be confirmed. Parents report through Parent / Carer surveys that co-production is embedded within SEND improvement programmes. The percentage of children and young people absence from school with EHC Plans to reduce by 2025 to less than 10%. The percentage of new EHC Plans that meet the quality standard in the Quality Assurance framework greater than 70% by 2025.

Year 1- 5 Objectives and Milestones (1/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)	Paediatric, medical and surgical assessment workshops x 9 complete (May 2023) Targeted engagement with patients, the public, ICS partners, Overview and Scrutiny Committees, workforce & voluntary sector complete (June 2023) Options for redesign of paediatric, medical and surgical assessment generated (July 2023)	Finished in year 1	Finished in year 1
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)	Financial framework in support of the Peninsula Acute Sustainability Programme in place (July 2023)	Framework finished in year 1 Financial monitoring	Framework finished in year 1 Financial monitoring
Trust Boards, Peninsula leadership & NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement but not public consultation • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)	Expert advice: legal, Consultation Institute and other stakeholders advice given (September 2023) Recommendations endorsed by the leadership within Devon & Cornwall ICS (September 2023) Recommendations endorsed by NHSE South West (September 2023)	Finished in year 1	Finished in year 1

Year 1- 5 Objectives and Milestones (2/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement but not public consultation (January 2024)	Roadmap produced for Programme A (October 2023) Implementation plans in support of Programme A (January 2024)	Additional implementation plans in support of Programme A Commencement of implementation of Programme A, from April 2024 (or sooner for some fragile services)	
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement but not public consultation (February/March 2024)	Targeted involvement and engagement with stakeholders complete (ie with workforce, clinicians, partners, public etc) (to March 2024)	Finished in year 1	

Year 1- 5 Objectives and Milestones (3/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)	• NHSE SW Stage 1: Strategic Sense Check & Assurance – approval to procced to NHSE South West Clinical Senate with proposed service changes (October/November 2023) • Options appraisal and impact assessment starts (October 2023) • NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline)	• Options appraisal and impact assessment ends (January 2024) • (…continued) NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline) • NHSE SW Stage 2: Assurance and recommendations to NHSE National Team (Programme B service changes only) (June 2024) • Pre-Consultation Business Case (Programme B - PCBC) approved for public consultation – (June 2024) • NHSE assurance to proceed to public consultation (June 2024) • Public consultation on significant service change - Programme B (July to September 2024) • Consultation feedback report (November 2024) • Decision making business case ready (November 2024) • Decision-making business case approved (December 2024)	

Year 1- 5 Objectives and Milestones (4/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)	The following, initial, fragile services will be sustainable: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC) A tranche 2 list of priority fragile services which will be stabilised (Date TBC)	N/A – subsumed within the Peninsula Acute Sustainability Programme	N/A – subsumed within the Peninsula Acute Sustainability Programme

Year 1 and 2 (operational plan detail) – (1/2)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)	Paediatric, medical and surgical assessment workshops x 9 complete (May 2023) Targeted engagement with patients, the public, ICS partners, Overview and Scrutiny Committees, workforce & voluntary sector complete (June 2023) Options for redesign of paediatric, medical and surgical assessment generated (July 2023)	Undertake 9 workshops: • 3 x paediatric assessment • 3 x medical assessment • 3 x surgical assessment Develop a set of high-level scenarios and recommendations for the Peninsula Acute Provider Collaborative and Trust Boards Subject to leadership feedback, undertake engagement with internal and external stakeholders	Peninsula-wide view on reconfiguration of paediatric, medical and surgical assessment
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)	Financial framework in support of the Peninsula Acute Sustainability Programme in place (July 2023)	Devon ICS and Cornwall ICS Directors of finance oversee the development of a Peninsula Acute Sustainability Programme financial framework	Ensures that proposed changes are financial viable
Trust Board, Peninsula leadership& NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement but not public consultation • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)	Expert advice: legal, Consultation Institute and other stakeholders advice given (September 2023) Recommendations endorsed by the leadership within Devon & Cornwall ICS (September 2023) Recommendations endorsed by NHSE South West (September 2023)	• Triage the emerging service change programme • Apply the significant service change test to create two programmes • Undertake targeted internal and external engagement • Invite independent review of the programmes: check and challenge • Put in place a team to undertake options appraisal in support of change programmes A & B • Undertake options analysis and appraisal • Undertake EQIA • Seek legal advice • Engage with Peninsula leadership. • Engage with NHSE South West leadership	Clarity on services which can be reconfigured starting in 2023 and those which will be subject to a significant service change – public consultation process

Year 1 and 2 (operational plan detail) – (2/3)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement but not public consultation (January 2024)	Roadmap produced for Programme A (October 2023) Implementation plans in support of Programme A (January 2024)	Design the roadmap for programme A Start designing tranche 1 implementation plans within programme A	Clarity regarding the level of change which will start to have impact from 2024
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement but not public consultation (February/March 2024)	Targeted involvement and engagement with stakeholders complete (ie with workforce, clinicians, partners, public etc) (March 2024)	Undertake targeted internal and external engagement	An understanding of the view, opinions and impact of service change on public, patients and other stakeholder
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)	• NHSE SW Stage 1: Strategic Sense Check & Assurance – approval to procced to NHSE South West Clinical Senate with proposed service changes (October/November 2023) • Options appraisal and impact assessment starts (October 2023) • NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline) • NHSE SW Stage 2 Assurance checkpoint (June 2024) • NHSE assurance to proceed to public consultation • Consolation material are ready (June 2024 • Pre-consultation business case ready for consultation June2024 • Public consultation (July to September 2024) • Public consultation report available (November 2024 • Decision Making Business Case (DMBC) available (November 2024) • Decision Making Business Case (DMBC) approved (December 2024)	• Ensure that Devon and Cornwall have met NHSE's 5 key tests for significant service change have been met • Coordinate stakeholders and prepare the materials so that the NHSE South West Clinical Senate have the information they require to undertake their review • We will work with NHSE South West Clinical Senate on it's 17-20 week review of our pre-consultation business case • Build on existing Devon ICS and Cornwall ICS case for change to create tailored case for change for PCBC • Coordinate stakeholders and prepare the materials so that the NHSE South West and NHSE National Team have transparency on the benefits and risks associated with significant service change programme A • Secure letter of assurance from NHS England confirming that Devon ICS & Cornwall ICS can proceed with public consultation • Work with stakeholders to prepare the material for the 3-month public consultation • Support the communications teams with the evaluation of the public consultation feedback and write up and subsequent engagement • Depending on the outcome of the public engagement – prepare for the Decision Making Business Case	An approved programme of significant change endorsed by: • Devon & Cornwall leadership • NHSE South West leadership • Public and patients

Year 1 and 2 (operational plan detail) – (3/3)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)	The following, initial, fragile services will be sustainable: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC) A tranche 2 list of priority fragile services which will be stabilised (Date TBC)	• Define the objective and leadership group with a mandate and accountability to develop a clinical and operational solution (i.e. which CMO/MD & Network Leadership?) • Establish a Task and Finish Group to lead work to stabilise priority fragile services • Develop a clear evidence base for change (i.e. what exactly is wrong with the service?) Assess against national and local exemplars of best practice (i.e. what does good, and excellence look like?) Develop immediate proposals for stabilisation of service (secure PASP Board signoff to stabilisation implementation plan and start to make changes) Develop proposals for sustainability phase (i.e. having fixed the short-term what is required for the medium term) Develop proposals for transformation phase (i.e. full alignment with the PASP transformational change programme to determine what needs to take place to transform the clinical model to remove fragility)	Avoidance of service breakdown. Improved equity of access for patients. Improved use of resources across the Peninsula

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Planned Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Implementation of Devon wide theatre utilisation standard operating procedure as part of the System Theatre Transformation programme • Implementation of the One Devon Pilot in Orthopaedics, Spinal and Ophthalmology • Maintain agreed protected elective beds in each Trusts • Implementation of GIRFT/Model Hospital/HVLC best practice • Maximisation of capacity in new system and provider assets, accelerators and TIF schemes • Continue to develop and embed Clinical Referral Guidelines (CRGs), commissioned pathways and policies; • Embed C2C referral protocols as per the Good Practice guide. • Increase use of Specialist Advice to support an increase of referrals being diverted away from secondary care; • Develop a 2023/24 Optimising Referral Primary Care Local Enhanced Service (LES) to improve quality of Advice and Guidance (A&G) referrals and sharing of learning from A&G returns within primary care teams; • monitor against EBI List 1 and work to implement EBI 2 and 3.	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Embedding and further roll out of 2023 projects	

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Planned Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. Opportunities exist in 24/25 and beyond with biosimilar ustekinumab, pegfilgrastim, aflibercept, omalizumab and denosumab anticipated to come to market as well as generic pitolisant, romiplostim, eltrombopag and certolizumab

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Planned Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Implementation of Devon wide theatre utilisation standard operating procedure as part of the System Theatre Transformation programme • Implementation of the One Devon Pilot in Orthopaedics, Spinal and Ophthalmology • Maintain agreed protected elective beds in each Trusts • Implementation of GIRFT/Model Hospital/HVLC best practice • Maximisation of capacity in new system and provider assets, accelerators and TIF schemes • Continue to develop and embed Clinical Referral Guidelines (CRGs), commissioned pathways and policies; • Embed C2C referral protocols as per the Good Practice guide. • Increase use of Specialist Advice to support an increase of referrals being diverted away from secondary care; • Develop a 2023/24 Optimising Referral Primary Care Local Enhanced Service (LES) to improve quality of Advice and Guidance (A&G) referrals and sharing of learning from A&G returns within primary care teams; • monitor against EBI List 1 and work to implement EBI 2 and 3.	Through a robust outpatient transformation programme working with Trust outpatient management and clinical leads. This will be delivered through focussed actions plans delivered through the System Theatre Transformation Programme, the One Devon Pilot and the Surgical Pathway Innovation Group This will be delivered through a robust demand management programme	By March 2024, the Devon System will reduce the number of patients waiting over 65 weeks for elective care to 2,956 by the end of March 2024. The Devon System specific activity target of 103% of 19/20 activity in 2023/24 achieve 85% Day Case and 85% theatre utilisation. Outpatient transformation will deliver a 25% reduction of outpatient follow ups and increased first outpatient appointments through increased productivity. We will eliminate the number of patients waiting over two years for treatment in Devon by December 2023

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Planned Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	This will be delivered through work led by the ICB Secondary Care Medicines Optimisation Team	Reduced spend on prescribing in Secondary care

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Diagnostics

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation	Business cases approved Funding received Builders contracted Staff recruited Equipment ordered Buildings completed and service commissioned	Service accreditation achieved	
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth	ICB – Board paper to SET April 23 describing the options for expanding capacity. Strategic approval of a preferred option by ICB and Trust boards completed by August 23.	Business case completed Business case approved Building/service partner commissioned Staff recruited Equipment ordered Facilities commissioned	Accreditation maintained Programme completed and services commissioned.

Year 1- 5 Objectives and Milestones

Acute Services Sustainability – Diagnostics

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25	Business case completed Business case approved	Funding received Engagement of building partner. Estates plan & design process complete Target operating model developed.	Building completed. Commencement of service delivery.
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24	GP Direct access of chest, abdomen, and pelvis CT scans, brain MRI and abdomen and pelvis ultrasound. Pathways effective and consistent	Further extend GP Direct access in line with national programmes	Evaluate patient experience and outcome impact and operational benefits
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24	Aligned SMART objectives set for clinical networks	Performance managed and objectives reviewed	Performance managed and objectives reviewed
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling	Training capacity increased Endoscopy Admin competency framework rolled out	Staff passporting supported Clinical and screening endoscopist capacities met	Upskilling for engagement with innovations embedded
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)	Continue engagement in relevant pilots and networks to establish adoption strategy	Planning and initial implantation for at least two significant innovations Rolling development of adoption strategy	Impact evaluations Mature adoption capability

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Diagnostics

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation	Continue to attend project delivery meetings with Trusts. Continue to link with NHSE regional team to support delivery.	Delivery of two additional rooms and training capacity by December 2023 (Torbay and Plymouth) Delivery of a further two additional rooms (Tiverton) and training capacity by September 2024 Resolution of capacity and accreditation shortfalls Sustained clearance of backlogs and performance issues for better patient experience and outcomes Securing of delivery premium Delivery of a further two additional rooms (Barnstaple) as part of new hospital development c.2026/27
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth	ICB – Board paper to SET March 23 describing the options for expanding capacity. Strategic approval of a preferred option by ICB and Trust boards completed by August 23.	An agreed long term strategic plan for the delivery of capacity with a supporting programme delivery plan

Year 1 and 2 (operational plan detail)

Acute Services Sustainability – Diagnostics

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25	Continue to co ordinate and oversee the activity between the provider trust and NHSE until the project moves into the delivery phase. Once in delivery phase to move to having oversight of the Trust project on behalf of the ICB.	Achievement of the requirements of the national strategy to increase diagnostic capacity .
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24	Facilitate, and establish the monitoring of, GP Direct access for chest, abdomen, and pelvis CT scans, brain MRI and abdomen and pelvis ultrasound. Ensure pathway readiness and consistency	More beneficial to patients who have vague symptoms so they get the right test quicker. This will increase a faster diagnosis within the 62 day pathway. Best use of GP and diagnostic resources.
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24	Continue engagement with key networks to ensure their commitment to productive, aligned SMART objectives. Extend engagement where necessary for key objectives	More rapid and impactful realisation of service improvements through aligned clinical leadership and engagement across teams
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling	Continue coordination with SW Endoscopy Training Academy. Assure alignment and harnessing of wider workforce strategies and opportunities	Upskilled teams (clinicians, nurses and support staff) Increased portability of staff Improved specialist recruitment and retention Demand growth met and staff shortages avoided
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)	Continue engagement with key programmes and pilots. Focus on exploring the potential and implications of game changing innovations (e.g. GRAIL Trial and other genomic innovations, Artificial Intelligence)	Improved patient experience and outcomes, and maximised productivity, through the full exploitation of game changing innovations and policy changes

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Cancer

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24	Deliver BPTP milestones in suspected prostate, lower gastrointestinal, skin and breast cancer pathways.	Roll out BPTP across all suspected cancer pathways	Sustain BPTP milestones and exceed achievement of 75% target across each tumour group
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs	Maximise the use of IS capacity and continue to prioritise cancer pathways to reduce backlogs. Delivery of prioritised action plans for most challenged pathways		
Sustainability of Oncology Services	Development of Oncology Workforce Strategy	Development of service redesign to be agreed year 1	Sustainability of services, including workforce through workforce planning, establishing pipelines and delivery of education through Cancer Academy
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Prepare for increasing use of screening programmes and pilots to reduce late-stage diagnosis (eg.targeted lung checks, GRAIL trial, liver surveillance, widened Bowel cancer screening), including preparing for the management of consequential demand and impacts on wider providers (e.g. diagnostics, mental health, primary care) from 2023/24 Establish non-specific symptoms pathways across each provider	Implementation of GRAIL pilot Expansion of TLHC programme across Devon Evaluation of NSS pathways to inform commissioning intentions for 24/25	

Year 1 and 2 (operational plan detail)

Acute Services Sustainability – Cancer

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24	The ICB will work with systems and providers to develop and implement action plans to improve cancer waiting times performance with a focus on achieving the faster diagnosis standard and reducing the delays to diagnosis.	Improved patient experience and outcomes through the delivery of proven best practice pathways
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs	Minimum of weekly reviews at trust level are in place to ensure there is focus on reducing the cancer waiting list backlogs and improve performance against the 62 day referral to treatment target.	Improved patient experience and outcomes through the avoidance of harms arising from delayed diagnosis or treatment
Sustainability of Oncology Services	SRO in post to support programme Working group established to agree actions and lead delivery within each provider. Working with Peninsula Cancer Alliance and specialist commissioning to support delivery of agreed service developments	Increased service resilience and consistency Improved patient experience and outcomes through reduced delays and variation in care
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Prepare for increasing use of screening programmes and pilots to reduce late stage diagnosis (e.g. targeted lung checks, GRAIL trial, liver surveillance, widened Bowel cancer screening), including preparing for the management of consequential demand and impacts on wider providers (e.g. diagnostics, mental health, primary care) from 2023/24 Establish Non-specific symptoms pathways in each provider	Improved patient experience and outcomes through much earlier diagnosis and treatment of cancers including some with vague symptoms

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.	New Integrated Urgent Care Service (IUCS) consolidation complete and year 1 service development and improvement plan delivered Implementation of SW 999 transformation plan priorities for acute pathways (SDEC pathways) and community services (UCR and mental health) across all localities Increase in referrals to urgent community response and same day emergency care from 111/999 Enhanced clinical validation in 111 and 999 in place, including ITK link between SWASFT and IUCS CAS	IUCS service development and improvement plan year 2 priorities delivered and year 3 and 4 plan agreed Full access to SDEC services for ambulance services as “trusted assessors” Increasing range of options available to those using 111 Online, reducing pressure on call answering Digital referral from 111 and 999 to UCR starts	Digital referral enabled to UCR fully implemented All urgent and crisis services accept referrals from 111 and 999 and adopt the full national DOS templates to maximise referrals and alternatives to ED/999
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.	Five year CUC workforce plan in place UTC development plan	Implementation of workforce plan begins Remote consultation option in all UTCs Implementation of UTC development plan begins	Completion of workforce plan and all benefits realised UTC development plan complete, including primary care minor injury offer to release capacity in UTCs
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.	Consistent medical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service Frailty and paediatric services at each hospital	Consistent medical and surgical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service and NHS 111 Frailty service available for 70 hours per week at each hospital – accessible to ambulance service and 111	Paediatric services available 7 days a week and accessible to ambulance service and 111

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Improve **A&E performance** at all hospitals – the ICB meets the 72% seen in 4-hours target.	ICB achievement of national performance standard for A&E waiting by the end of the financial year (31st March 2024)		
Improve **ambulance response times** across all call categories, with particular emphasis on category 2 – SWASFT meet the recovery plan target of mean response time of 30 minutes.	SWASFT category 2 mean response time of 30 minutes achieved by end of the financial year (31st March 2024)		
Acute bed occupancy will decrease to 92-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.	Achieving 96% bed occupancy by end of the financial year (31st March 2024)		

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Urgent and Emergency Care

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.	• New Integrated Urgent Care Service (IUCS) consolidation complete and year 1 service development and improvement plan delivered • Implementation of SW 999 transformation plan priorities for acute pathways (SDEC pathways) and community services (UCR and mental health) across all localities • Increase in referrals to urgent community response and same day emergency care from 111/999 • Enhanced clinical validation in 111 and 999 in place, including ITK link between SWASFT and IUCS CAS	• We have seen a significant improvement in call answering performance in 111 as a result and an increase in clinical assessment service (CAS) resources. • Our priorities for next year are to grow the workforce across the service by better matching health advisor capacity to demand to improve call answering performance further and strengthening the clinical workforce out of hours to increase capacity and time to treatment. Additionally, we will be looking to embed digital development and dedicated end of life care out of hours.	Better outcomes for patients calling 111, and getting patients to the right place, first time.
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.	• Five year CUC workforce plan in place • UTC development plan	• Partnership and system working to support standardisation of the UTCs across Devon. An ICB programme board will sit at the heart of this workstream to ensure this is delivered. • On-site UTC and GP streaming – support the contracting of these workstreams to ensure they are delivered efficiently and effectively.	Equity of community urgent care offer across Devon
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.	• Consistent medical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service • Frailty and paediatric services at each hospital	A more consistent model will be in place by enabling more robust and visible pathways for any referring service. • Development of an ED based SDEC environment. • Development of paediatric SDEC services and palliative care support in ED. Further pathway development and frailty/paediatric SDEC will enable admission avoidance for patients being assessed for inclusion onto the VW without attending an acute site, which will release capacity within acute “front door” departments such as ED/SDEC/AMU. In addition, the opportunities of closer links with community pathways such as UCR 2hr response, falls teams, EHCH, 111 and 999 will continue to be explored to maximise the potential for acute admission avoidance.	Reduction in avoidable admissions and support our most vulnerable residents across Devon

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Urgent and Emergency Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Improve **A&E performance** at all hospitals – the ICB meets the 72% seen in 4-hours target.	ICB achievement of national performance standard for A&E waiting by the end of the financial year (31st March 2024)	UEC recovery plan includes detailed actions to reduce acute bed occupancy down to 86-92% at sites, to improve flow and ED waiting times. Actions include admission avoidance schemes, use of virtual ward and intermediate care beds.	Improved patient experience, reduced ED crowding, performance standard achieved
Improve **ambulance response times** across all call categories, with particular emphasis on category 2 – SWASFT meet the recovery plan target of mean response time of 30 minutes.	SWASFT category 2 mean response time of 30 minutes achieved by end of the financial year (31st March 2024)	UEC recovery plan (ambulance) includes detailed actions to enhance clinical input in the 999 hub and increase response capacity across the south west. Actions include recruitment of clinicians to hubs for navigation and validation of category 2 cases, and increase in response capacity including make ready hubs, additional staff and third party resources.	Improved patient experience, quality and safety improvement, performance standard achieved
Acute bed occupancy will decrease to 94-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.	Achieving 96% bed occupancy by end of the financial year (31st March 2024)	The system is committed to increasing acute bed capacity and reducing bed occupancy through supressing growth in non-elective admissions to c2.5%, increasing bed capacity through escalation and community bed capacity and decreasing rates of no criteria to reside. Developments in same day emergency care will contribute to reductions in average length of stay. Block booking of P2 and P1 capacity will be important to ensure available support is in place to meet the NCTR target and to support in particular 92% G&A bed occupancy. Support from the VCSE will be a key priority for the next financial year in supporting pathway 0 and pathway 1 flow.	Improved patient flow through each acute site and more capacity for patients who need care the most

Year 1- 5 Objectives and Milestones

Housing

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE;	Map out the ways in which people in different areas can access support for; • grants for insulation • Support in energy efficiency • Financial aid and advice • Housing Standards • Advocacy and support to address poor living conditions To provide guide on how to support patients tackle fuel poverty. Identify areas of insufficient resource and work strategically to improve EPC rating. Establish baseline.	Updated based on new government advice and schemes Consider any gaps determined through the previous work and develop resources **By end of yr 2: Devon foot print covered with fit for purpose referral mechanisms**	Continuous improvement based on feedback from those we wish to refer and those being referred.
Systematically identify vulnerable groups with chronic conditions and signpost for support;	Define 'vulnerable groups' and set up referral mechanisms to pilot; at least 1 through hospital OP, at least 1 through Pharmacy (via medications) per LCP / LA area **Cohort size established** **Pilot in place**	Learning from the pilot scheme, widen range of conditions to **cover 50%** of those identified as vulnerable due to health issues Develop PHM processes to identify at-risk groups and pilot communications channels	Expand to **cover 100%** of those with relevant health issues Expand to other vulnerable groups where there is no known current existing health issue. - use of face to face and/or PHM approaches
Identifying poor quality housing or lack of secure housing on admission/discharge planning and referring for support	Map out what is currently done and spread good practice. Identify the gaps and work with hospitals to set up pathways as pilots. Needs analysis of support and resource requirements. **Baseline established**	Learning from pilot and widen implementation to embed appropriate housing and health assessments to enable early identification of poor quality housing and those at risk of homelessness	Implement pathways in full for a defined vulnerable population
For the projected need for specialist housing, accommodation to meet the needs of older people, and affordable housing, to be recognised in Local Plans across Devon to support housing delivery	Housing needs assessments completed for high priority groups, such as people with complex LD and/or autism returning from out of area placements Engagement with planning leads/fora to a) provide assurance that this work is in hand b) offer support if needed on the assumptions and modelling to form the projections if appropriate.	Housing needs assessments completed for relevant population cohorts, such as people with mental health disorders, dementia and complex needs By the end of year 2, ICS/ One Devon will have a shared understanding of the different needs and the different delivery plans across the whole of Devon, for these elements of housing	
Reduce the number of people who are homeless in particular; • reduced the number of households in temporary accommodation by 10% • reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0 • Increased the % of people sleeping rough who get an offer of accommodation to 100% • increased in the number of households successfully prevented from becoming homeless by 30%	**Devon wide collation of baseline, plans and delivery timelines** Identification of any factors or gaps where a wider system approach may support the achievement of the deliverables. Every person rough sleeping should be offered accommodation. Assessment should be undertaken to reason and barriers on why this may not be preventing street homelessness to improve pathways and support solutions.	No households with children in B&B accommodation over 6 week (end of 2024) There is complexity around rough sleeping and if the target is not met then there still should be assurances that a safe and warm place to sleep was offered and that the root cause for refusal is then used to develop a better offer in the future Reduction in people housed under homelessness duties of 10% pa	Maintenance of the targets around rough sleeping and families in B&B accommodation Reduction in people housed under homelessness duties of 10% pa

Year 1 and 2 (operational plan detail)

Housing

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE;	Map out the ways in which people in different areas can access support for; • grants for insulation • Support in energy efficiency • Financial aid and advice • Housing Standards • Advocacy and support to address poor living conditions To provide guide on how to support patients tackle fuel poverty. Identify areas of insufficient resource and work strategically to improve EPC rating. Establish baseline.	• Set up working group with representation across La areas • Collate LA web pages / information on support and share • Consider where there are gaps and seek to fill through learning from local areas • Learn from best practice across areas • Identify baseline of number of people seeking support ad their referral routes (eg social prescribing, self referral) Need to consider liking in with other existing housing networks such as Environmental Health Housing. Also at LA or other level. Happy to provide some more detail, but need elevating a bit. Also need to think potentially big regional EPC funding program.	Clear referral processes Baseline of number referred and receiving support
Systematically identify vulnerable groups with chronic conditions and signpost for support;	Define 'vulnerable groups' and set up referral mechanisms to pilot; at least 1 through hospital OP, at least 1 through Pharmacy (via medications) per LCP / LA area **Cohort size established** **Pilot in place**	• Consideration of evidence base to determine most sensitive conditions to cold / poor quality homes • Identify the different cohorts who could be eligible for support (explore use of PHM, fuel • Engage with Pharmacy via LPC – consider leaflets distribution as part of meds reviews or dispensed meds • Engage with hospital consultants around the key conditions (eg respiratory) and identify routes for the signposting (leaflet, face to face, posters, emails, texts….)	Reduce readmissions / admissions for those most likely to suffer exacerbations
Identifying poor quality housing or lack of secure housing on admission/discharge planning and referring for support	Map out what is currently done and spread good practice. Identify the gaps and work with hospitals to set up pathways as pilots Needs analysis of support and resource requirements.	• Seek advice from colleagues on discharge practices where it relates to homes • Consideration of approaches – learn from best practice, identify gaps and opportunities. • Link into the referral processes	Reduce readmissions / admissions for those most likely to suffer exacerbations
For the projected need for specialist housing, accommodation to meet the needs of older people, and affordable housing, to be recognised in Local Plans across Devon to support housing delivery	Housing needs assessments completed for high priority groups, such as people with complex LD and/or autism returning from out of area placements Engagement with planning leads/fora to a) provide assurance that this work is in hand b) offer support if needed on the assumptions and modelling to form the projections if appropriate.	• Link to LA leads to identify the plans that are in place • Consider whether there may be advantages to working together around assumptions and projections for the modelling of need	Longer term provision of relevant forms of housing
Reduce the number of people who are homeless in particular; • *reduced the number of households in temporary accommodation by 10%* • *reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0* • *Increased the % of people sleeping rough who get an offer of accommodation to 100%* • *increased in the number of households successfully prevented from becoming homeless by 30%*	**Devon wide collation of baseline, plans and delivery timelines** Identification of any factors or gaps where a wider system approach may support the achievement of the deliverables. Every person rough sleeping should be offered accommodation. Assessment should be undertaken to reason and barriers on why this may not be preventing street homelessness to improve pathways and support solutions.	• Engage with LA leads • Develop / utilise forum to ensure different elements of the system are connected (if not already) • Work with them to understand gaps especially where factors such as domestic abuse, mental health, trauma, substance misuse, primary care are relevant factors and ensure that the connections are made between the commissioners of the different services – if not already	Reductions in homelessness / prevention

Year 1- 5 Objectives and Milestones

Employment

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Seek to reduce level of 16-18 year olds Not in Education Employment and Training ('NEET') in Devon by 1% by 2027	Reduction in NEET performance when compared to national average of 0.25%	Reduction in NEET performance when compared to national average of 0.5%	Reduction in NEET performance when compared to national average of 1%
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 0.5% when compared with the national average.	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 2% when compared with the national average.	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 4% when compared with the national average.
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027	Reduction in number of young people who are care experienced who are considered NEET reduced by 4% when compared with the national average.	Reduction in number of young people who are care experienced who are considered NEET reduced by 8% when compared with the national average.	Reduction in number of young people who are care experienced who are considered NEET reduced by 16% when compared with the national average.
Unpaid carers will be supported to remain in or re-enter employment	Resources developed to support unpaid carers to remain in or re-enter employment.	Unpaid carers able to access additional support to remain in or re-enter employment.	Increase in the number of unpaid carers able to remain in and re-enter employment.
Build on resources developed across local authorities to support more people into employment.	Resources and services enhanced and developed to support people into employment.	People able to easily access resources to support them into employment.	Increase in the number of people being supported to find and retain employment.

Year 1 and 2 (operational plan detail)

Employment

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Seek to reduce overall levels of NEET performance amongst 16-19 year olds within the Devon area by 1% by 2027	Reduction in NEET performance when compared to national average of 0.25%	Coordination of ongoing NEET prevention activity with JCP / DWP as well as County, District and health related NEET provision. Coordination of in school NEET prevention and wider support products (Transitions, Focus 5, etc) through aligned NEET partnership.	Reduction in NEET Levels, reduced economic scarring and wider socio-economic benefits from individual impacts.
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 0.5% when compared with the national average.	Alignment of targeted support for individuals with a disability or other health barrier to employment through local programme approach, including Devon's Employment Hub and the Plymouth Employment Hub. Coordination alongside core national programme's such as Restart and JCP/ DWP's national disability and mental health related support products. Creation of a single Mental Health Employment Forum. Alignment of approach with wider workstreams around workforce development, careers and education, housing and transport.	Reduction in overall level of unemployment amongst those with a disability, mental health need or wider health related barrier to employment, reduced service demand and improved economic/well being outcomes from economically active individuals
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027	Reduction in number of young people who are care experienced who are considered NEET reduced by 4% when compared with the national average.	Coordination of ongoing NEET prevention activity with JCP / DWP as well as County, District and health related NEET provision. Coordination of in school NEET prevention and wider support products (Transitions, Focus 5, etc) through aligned NEET partnership. Specific alignment of local authority CIC, Care Leaver and wider care experience support services through Care Leaver protocol with DWP / JCP	Reduction in NEET Levels amongst Care experienced in Devon, reduced economic scarring and wider socio-economic benefits from individual impacts.

Year 1 and 2 (operational plan detail)

Employment

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Unpaid carers will be supported to remain in or re-enter employment	Resources developed to support unpaid carers to remain in or re-enter employment.	Plan in development	More unpaid carers remaining in and re-entering employment.
Build on resources developed across the local authorities to support more people into employment.	Resources and services enhanced and developed to support people into employment.	Plan in development	More people being supported to find and retain employment.

Year 1- 5 Objectives and Milestones

Suicide Prevention

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
The Local Suicide Prevention Groups to each have a published annual action plan based on the national strategy which sets local delivery priorities for the year	Action plans published and delivered	Action plans published and delivered	Action plans published and delivered
Our local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards	Board reports presented	Board reports presented	Board reports presented
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups	Annual action plans deliver targeted training provision relevant to local need	Annual action plans deliver targeted training provision relevant to local need	Annual action plans deliver targeted training provision relevant to local need
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average	The rate in each local authority area is stable	The rate in each local authority area is on a downward trajectory and is in line with or below the England average	The rate in each local authority area is on a downward trajectory and is in line with or below the England average

Year 1 and 2 (operational plan detail)

Suicide Prevention

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
The Local Suicide Prevention Groups to each have a published annual action plan based on the national strategy which sets local delivery priorities for the year	Action plans published and delivered	Action plans agreed in multi-agency suicide prevention groups and delivered by members with annual report at end of each financial year monitoring progress.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be in line with or below the England average
Our local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards	Reports presented to Boards	Chair of Suicide Prevention Group (Public Health Lead) ensures annual report produced and presented at Health and Wellbeing Board at start of following financial year.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be in line with or below the England average

Year 1 and 2 (operational plan detail)

Suicide Prevention

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups	Annual action plans deliver targeted training provision relevant to local need	Chair of Suicide Prevention Group (Public Health Lead) ensures action plan contains targeted training delivery as agreed by group members and monitors delivery throughout the year at the regular group meetings. Collaboration with other 2 groups in the ICB to join up where same training needs identified	System awareness of suicide and suicide prevention continues to grow as relevant training provided. Aiming for number?
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average	The rate in each local authority area is stable	ONS data on rolling 3 year suicide rate (Persons) for each local authority area available annually and Public Health leads will produce an annual report with the rates for each area and ICB level and compare them to the England average rate.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be in line with or below the England average

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Reduce occurrences of healthcare associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA)) *and* community onset community associated (COCA) occurrences of HCAIs	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10%	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% from Year 1	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 25% or more across a 5 year period
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection Antimicrobial stewardship: Start smart - then focus - GOV.UK (www.gov.uk) Course: TARGET antibiotics toolkit hub (rcgp.org.uk) Antibiotic stewardship tools, audits and other resources: Audit toolkits (rcgp.org.uk)	All prescribers signed up to Start Smart Then Focus principles and this requirement to be included within commissioning contracts. Peninsula wide antimicrobial resistance (AMR) group and action plan to be launched. Establish baseline for antibiotic prescribing.	All secondary care providers ensuring prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. To have reduced antibiotic prescribing by 5% from year 1 baseline.	To have reduced antibiotic prescribing by 15% from year 1 baseline.

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Providers must demonstrate a 100% offer to eligible cohorts for influenza and Covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for children and young people (CYP) and adults	• System wide governance structures in place to oversee planning, delivery and increasing uptake of each programme including emphasis on increasing access and addressing health inequalities. An Equality and Health Inequalities Impact Assessment will be completed ahead of each programme launch. • 100% offer to eligible cohorts each season • Vaccine uptake in line with or exceeding national/regional/comparator benchmarking • Vaccine confidence training offer developed • Programme evaluation in place to capture and embed learning • Inclusion and Prevention checklist rolled out with reasonable adjustments in place as standard, in partnership with VCSE/NHS Devon Equality Diversity and Inclusion (EDI)	• As in Year 1 but learning embedded from previous seasons • Year on year improvement in uptake amongst priority cohorts • Delivery of vaccine confidence training	• As in Year 1 but learning embedded from previous seasons • Year on year improvement in uptake amongst priority cohorts • Vaccine confidence training embedded across the system

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for children and young people (CYP)	• Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	• Year 1 activity delivered • Action plan implemented	• Vaccine coverage 95%
Vaccine coverage of 95% of 4-in-1 preschool booster by the time the child is 5, with particular focus on Devon's priority populations CORE20PLUS for CYP	• Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	• Year 1 activity delivered • Action plan implemented	• Vaccine coverage 95%
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-Covid levels, with secondary aim to achieve year on year improvement in uptake working towards the 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP	• New provider/contract in place • Working closely with NHS England commissioners, support the development of a Devon-wide SAIs strategy to increase uptake. This work will be led by NHS England Integrated Public Health Commissioning Team as the commissioner of the SAI provider. The multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead) will play a key role in developing and delivering community focused interventions that support the work undertaken by the SAI provider. Interventions/activities to increase uptake will be agreed as part of this group.	• Year 1 activity delivered • Action plan implemented	• Vaccine uptake – improvement compared to previous year

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Reduce the decline in cervical screening coverage and stabilise uptake Implement NHSE-funded Learning Disability Primary Care Liaison Nurse to focus on cervical screening	Maintain/stabilise uptake Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Improvement in uptake compared to previous year
Work closely with NHS England commissioner to support the delivery of the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (CORE20PLUS) for Adults	National guidance awaited – detailed milestones for overall uptake trajectories and specific groups of focus to be determined and confirmed with NHS England Integrated Public Health Commissioning Team. Campaign delivered. Make progress to achieve national standard	Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Locally agreed targets are achieved	Locally agreed targets are achieved
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon.	Audit tool completed and reviewed	Gaps addressed	Pathways in place

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Reduce occurrences of Health care associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA)) *and* community onset community associated (COCA) occurrences of HCAIs	By Year 1, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10% By Year 2, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% from Year 1.	• Early sampling to promote early switch to the most suitable antibiotic – broad to narrow spectrum • Reducing use of broad spectrum antimicrobials generally – use of targeted antimicrobials • Discharging patients as soon as fit for discharge from hospitals – longer in hospital likelihood of development of HCAI • Discourage use of repeat prescriptions for antimicrobials unless indicated • Use of the Devon Community Infection Management Service (CIMS) teams to support primary care • Effective IPC practices	Reduce antibiotic use in primary care through early identification and treatment of bacterial infections.
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection	By Year 1, all prescribers signed up to Start Smart Then Focus principles and this requirement to be included within commissioning contracts. Peninsula wide antimicrobial resistance (AMR) group and action plan to be launched. Establish baseline for antibiotic prescribing. By Year 2, all secondary care providers ensuring prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. To have reduced antibiotic prescribing by 5% from year 1 baseline.	• Early sampling to allow early switch to the most suitable antibiotic – broad to narrow spectrum. • Reducing use of broad spectrum antimicrobials generally – use of targeted antimicrobials. • Individual prescribing benchmarked against local and national antimicrobial prescribing rates and trends • Local and national antimicrobial resistance rates and trends are monitored and reported • Support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.	Reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Providers must demonstrate a 100% offer to eligible cohorts for influenza and Covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for CYP and adults	System wide governance structures in place to oversee planning, delivery and increasing uptake of each programme including emphasis on increasing access and addressing health inequalities. An Equality and Health Inequalities Impact Assessment will be completed ahead of each programme launch. 100% offer to eligible cohorts each season Vaccine uptake in line with or exceeding national/regional/comparator benchmarking Vaccine confidence training offer developed Programme evaluation in place to capture learning with learning embedded from previous seasons Year on year improvement in uptake amongst priority cohorts Delivery of vaccine confidence training	System wide multi-agency governance and reporting structure in place to oversee planning and delivery of both programmes utilising existing structures already established within the ICS for delivery of flu and Covid vaccination programmes. Dedicated Health Inequalities Cell (led by Public Health) and NHS Outreach Programme in place to focus on increasing access and addressing health inequalities in uptake of both programmes. EHIAs completed as part of programme planning. All vaccination sites to have completed inclusion and prevention checklist with reasonable adjustments in place. Vaccine confidence lead in place and training offer developed and piloted in Devon working with the NHS England Regional Screening and Immunisation Team. Comms strategy developed. Regular monitoring of performance and uptake in place to inform action.	Delivery of other services such as physical health checks alongside vaccination when reaching vulnerable/seldom heard cohorts. Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action.
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP	Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	MMR strategy led via multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead). Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP	Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	Preschool booster strategy led via multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead). Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-Covid levels, with secondary aim to achieve 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP	New provider/contract in place Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	New provider/contract in place alongside performance monitoring. Working closely with NHS England commissioners, support the development of a Devon-wide SAIs strategy to increase uptake. This work will be led by NHS England Integrated Public Health Commissioning Team as the commissioner of the SAIS provider. The multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead) will play a key role in developing and delivering community focused interventions that support the work undertaken by the SAI provider. Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Reduce the decline in cervical screening coverage and stabilise uptake. Maintain/stabilise uptake Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Implement NHSE-funded Learning Disability Primary Care Liaison Nurse to focus on cervical screening	Multi-agency Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and those living in the 20% most deprived neighbourhoods	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Support NHS England to deliver the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (CORE20PLUS) for Adults	Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Campaign delivered. Make progress to achieve national standard	Multi-agency Maximising Screening Uptake Group established with clear action plan in place. Comms strategy in place.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon.	Audit tool completed and reviewed		

Year 1- 5 Objectives and Milestones

Community Learning & Development

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
By 2028 Local communities will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – 'no decision about me without me'	By 2024: One Devon will have create a strategic framework as an ICS approach to building health capacity in communities with communities This will include a 'toolkit' to support each community in a way that meets their needs. This will also include a commitment and strategic intent to enable LCPs to work with communities with funding at place. By 2024: we'll have a mapped out existing networks, forums and community activities so that we can build on these assets and support where gaps are evident (NHS Statutory Guidance)	By 2025: Local Care Partnerships will have co-produced a plan with local communities, including particularly disadvantaged groups, to empower and support groups to be more resilient (One-Devon-5-year-integrated-care-strategy) By 2025: Local Care Partnerships will have sequenced their support offer to communities based on level of deprivation and need By 2025: the role of communities and health will be fully recognised and local plans to invest in this as one of the four pillars of population health will have been created. (King's Fund)	By 2028: we will have directed our collective buying power to invest in and build for the longer term in local communities and businesses (One-Devon-5-year-integrated-care-strategy) By 2028: we will have supported the development of place-based partnerships that involve a wide range of partners to act on the full range of factors that influence health and wellbeing By 2028 communities will have a sense of purpose, hope, mastery and control over their own lives and immediate environment. (Health Creation Alliance, 2022) .

Year 1- 5 Objectives and Milestones

Community Learning & Development

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
By 2028 Local communities will be able to work collectively to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.	By 2024: Health creation practices will be supported across all communities	By 2025: the vital role of communities in tackling the wider determinants of health will be recognised and their contribution supported. (King's Fund)	By 2028 community partnerships will realise their potential and create actions across all levels of their influence to reduce the impact of inequality
By 2028 a Community Development workforce will be supported, equipped and trained to agreed standards, code of ethics and values-based practice	By 2024: Support workforce to develop the skills, values and processes required for effective and appropriate community development so they may best harness 'the family of community-centred approaches' to empower communities to work collectively (PHE)	By 2025: Community-identified training needs for the VCSE and community groups/partners will be supported by One Devon to support health creation practices e.g. MECC and Mental Health 1st Aid	By 2028 we will have created a learning culture that challenges, examine and reflect on our community development practice, providing accountability, reassurance and protection (Community Learning and Development Standards Council, 2023)
By 2028 Local Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are an equal partner both at system and local level	By 2024: The anchor institutions across Devon will have a collective understanding of their opportunities to support communities By 2024: One Devon will work with communities and anchor institutions to map infrastructure and identify gaps, opportunities and issues	By 2025: the ICS Estates Strategy will include a strategic intent to work with local communities to support infrastructure By 2025: a joint commissioning strategy across NHS and Local Authorities will provide Health & Wellbeing Hubs led by the VCSE and community	By 2028: Community Hubs will be embedded in communities that have identified for themselves a need for them and will support the VCSE and community groups to maximise the health and wellbeing of their local citizens
By 2028 local communities, and particularly disadvantaged groups, will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – 'no decision about me without me'	Milestones to be developed.	Milestones to be developed.	Milestones to be developed.

Year 1 (operational plan detail)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 Local communities will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – 'no decision about me without me'	By 2024: One Devon will have created a strategic framework as an ICS approach to building health capacity in communities with communities This will include a 'toolkit' to support each community in a way that meets their needs. This will also include a commitment and strategic intent to enable LCPs to work with communities with funding at place. By 2024: we'll have a mapped out existing networks, forums and community activities so that we can build on these assets and support where gaps are evident (NHS Statutory Guidance)	• Devon system task and finish group formed to agree role description and network for the leads to work with one another on shared resources • One Devon provides steer and support to enable Anchor Institutions to support local communities with skills and assets • LCPs identify role within their LCP who will be the lead for community development • LCP leads tasked with engagement in their LCP area to establish working principles and benefits • Agree survey, structured interviews, focus group. Community Learning & Development Network Group compiles locality findings into single document highlighting variation	Empowered communities working in partnership with each other and LCPs to support their own health, wellbeing and resilience and reduce health inequalities. Clear understanding across the system of the principles of community development and the benefits. Devon ICS to be asked to support evaluation of whether those benefits are being realised Clear understanding of gaps and focus of support and funding

Year 1 (operational plan detail)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 Local communities will be able to work collectively to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.	By 2024: Health creation practices will be supported across all communities By 2024: the vital role of communities in tackling the wider determinants of health will be recognised and their contribution supported. (King's Fund) By 2024: One Devon will seek opportunities to ensure community learning and development is at the core of certain posts such as strategic system leadership, social prescribers and community connectors	• System working group leads on stocktake led by each locality that identifies where community development infrastructure exists • questionnaire sent out through locality networks and through local knowledge of LCP lead. • building on what is already there but primarily working through existing voluntary sector and community groups to fill gaps Communities will be supported to (Community Development standards): • Identify their own needs and actions • Take collective action using their strengths and resources • Develop their confidence, skills and knowledge • Challenge unequal power relationships • Promote social justice, equality and inclusion	Increased citizen/community agency - to facilitate and create the conditions for community led-action. Community development infrastructure in place

Year 1 (operational plan detail)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 Local Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are an equal partner both at system and local level	By 2024: The anchor institutions across Devon will have a collective understanding of their opportunities to support communities By 2024: One Devon will work with communities and anchor institutions to map infrastructure and identify gaps, opportunities and issues	• ICB Estates decisions include community opportunities when reviewing use of estates • Devon system task and finish group formed with estates lead across the ICS to work with LCP leads and community developers to map existing assets and gaps	Community groups benefit from use of skills and resources of anchor institutions Infrastructure as a key enabler to community success is considered strategically
By 2028 a Community Development workforce will be supported, equipped and trained to agreed standards, code of ethics and values-based practice	Support workforce to develop the skills, values and processes required for effective and appropriate community development so they may best harness 'the family of community-centred approaches' to empower communities to work collectively (PHE)	• Include in same survey and through existing knowledge of community development roles • LCP lead will compile list of LCP CD resources / CPD opportunities and discuss how resources could be pooled to achieve shared organisational aims • Set up CPD training calendar with partners that deliver community development National occupat-ional standards (NOS) training • Identified wider CPD opportunities with local/regional providers	Best use of limited resource, shared engagement and development opportunities

APPENDIX D
Enabling programme Milestones

#OneDevon

Year 1- 5 Objectives & Milestones

System Development

Smart Objectives	Milestones - Year 1 Achieving 'Developing' ICS Maturity Assessment standards	Milestones - Year 2-3 Achieving 'Maturing' ICS Maturity Assessment standards	Milestones - Year 4-5 Achieving 'Thriving' ICS Maturity Assessment standards
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards	• Common purpose starting to be built with collective ownership across all parts of the system emerging	• Clear shared vision and objectives across all parts of the system including VCSE, primary care, local authorities and NHS partners, with consistent progress seen	• A strong public narrative how integrated working is benefiting them and demonstrable impact on outcomes
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards	• All system leaders signed up to working together with ability to carry out decisions that are made	• Collaborative and inclusive system leadership and governance developing, with effective ongoing involvement of voluntary and community partners, service users etc.	• Strong collaborative and inclusive system leadership established, with a focus on building relationships
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards	• A developing culture of learning and sharing with system leaders solving problems together and drawing on experience of others	• Dedicated capacity and supporting infrastructure being developed to enable change at system, place and neighbourhood levels	• Leaders across the system skilled at identifying and scaling innovation, with a strong focus on outcomes and population health
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards delivering national priorities and operational plan improvement plans (including exiting NHS Oversight Framework segment 4) • Plans to increase involvement of all system partners in system-wide change	• Evidence of strong delivery towards national priorities and delivery of national guidance (including exiting NHS Oversight framework segment 4) • Effective involvement of all system partners in decision making at system, place and neighbourhood levels	• Track record of delivery of priorities with resources focused on priorities and system control total being achieved
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards understanding of organisational and system issues, and alignment across the system	• Robust approach in place to support challenged organisations and address systemic issues	▪ System partners and leaders join forces to tackle challenges together as they emerge, including when under pressure

Year 1 and 2 (operational plan detail)

System Development

SMART objective Year 1 & 2	Milestones – by end of Year 2, Devon will fully achieve 'developing' and moving towards 'maturing' ICS Maturity Assessment standards	How are you going to achieve – actions you are going to take	Impact
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards	• Common purpose starting to be built with collective ownership across all parts of the system emerging • Clear shared vision and objectives across all parts of the system including VCSE, primary care, local authorities and NHS partners, with consistent progress seen	• 5-Year Integrated Care Strategy and Joint Forward Plan co-produced • Adoption of Devon Operating Model commenced • VBA 'tests of change' completed • Adoption of Devon Operating Model completed • Spread of VBA adoption continued (pending Year 1 evaluation) • Implementation of a System Development Communication & Engagement Plan	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards	• All system leaders signed up to working together with ability to carry out decisions that are made • Collaborative and inclusive system leadership and governance developing, with effective ongoing involvement of voluntary and community partners, service users etc. • One Devon's Clinical and Professional Leadership Framework fully implemented	• Phase I of senior system leadership development completed • Phase II cascade of system leadership development commenced • Change Leader Event series commenced (continues annually) • Devon approach to leadership development confirmed • Common leadership standards consistently applied across Devon from appointment to exit employee lifecycle • Implementation of a system partner involvement plan – increased involvement of service users, carers and the public	• Year 1 – move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Year 2 - Achievement of Leadership NHS Oversight Framework segment 4 exit criteria
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards	• A developing culture of learning and sharing with system leaders solving problems together and drawing on experience of others • Dedicated capacity and supporting infrastructure being developed to enable change at system, place and neighbourhood levels	• UEC Navigation improvement test of change completed • Improvement approach documented and replication plan approved • Devon capability in outward mindsets training established • System diagnostic/ ICS Maturity evaluation completed (Repeat Years 3 & 5) • Spread of Improvement approach to other Devon priorities commenced • Capability within system partners to adopt Improvement approach established	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Contributing to achievement of UEC NHS Oversight Framework segment 4 exit criteria

Year 1 and 2 (operational plan detail)

System Development

SMART objective Year 1 & 2	Milestones – by end of Year 2, Devon will fully achieve 'developing' and moving towards 'maturing' ICS Maturity Assessment standards	How are you going to achieve – actions you are going to take	Impact
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards	• Evidence of strong progress towards delivering national priorities and operational plan improvement plans (including exiting NHS Oversight Framework segment 4) • Plans to increase involvement of all system partners in system-wide change • Effective involvement of all system partners in decision making at system, place and neighbourhood levels	• Targeted interventions to drive focus on priorities completed • Strategic change approach designed and established • Evaluation of delivery of priorities to inform continuous improvement • Learning from others and rapid adoption of best practice underway	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Contributing to achievement of NHS Oversight Framework segment 4 exit criteria
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards understanding of organisational and system issues, and alignment across the system • Robust approach in place to support challenged organisations and address systemic issues	• Assessment of adoption of a value-based approach completed • Local Care Partnership and Provider Collaborative development commenced • Devon Discovery series commenced • Spread of adoption of a value-based approach commenced • Maturity of Local Care Partnerships and Provider Collaboratives improved	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment

Year 1- 5 Objectives and Milestones

Research, Innovation and Improvement

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Build and strengthen networks at local, system, region and national level by March 2024	Map of stakeholders, strengths, assets and barriers	Networks in place across system and Peninsula	
Promote research and increase patient sign-up with demonstrable increase by end 2026	Agreements in place with providers to promote Research and Innovation	Commissioners recognise importance of research and incorporate into all contracts	
Ensure all system workplans are underpinned by robust evidence of research and innovation	All sections of Joint Forward Plan include Research and Innovation	All sections of Joint Forward Plan include Research and Innovation	All sections of Joint Forward Plan include Research and Innovation
Develop capacity and capability by having a ICB RII Team by April 2024	Recruit to Joint Appointment with the AHSN	Fully established Research and Innovation Support Team with Medical Directorate Training and Development Programme	
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles by end March 2025	Implementation of Regional Innovation Strategy	Implementation of Regional Innovation Strategy	Implementation of Regional Innovation Strategy Devon recognised as a system with strengths in this area

Year 1 and 2 (operational plan detail)

Research, Innovation and Improvement

SMART objective	Milestone – Year 1	How are you going to achieve – actions you are going to take	Impact
Build and strengthen networks at local, system, region and national level by March 2024	Map of stakeholders, strengths, assets and barriers	Establish RII network with COIS and provide ongoing support. Strengthen system networks and provide a point of co-ordination	There is routine evaluation, shared learning and roll-out of good practice
Promote research and increase patient sign-up with demonstrable increase by end 2026	Agreements in place with providers to promote Research and Innovation	Work with research organisations to understand what support is required and how to build this into commissioning arrangements	Organisations undertaking research are supported in their work and frameworks are in place to share learning.
Ensure all system workplans are underpinned by robust evidence of research and innovation	All sections of Joint Forward Plan include Research and Innovation	Work with all sections leads to ensure that delivery of the Integrated Care Strategy is underpinned by research and innovation	Research and Innovation is a key consideration in the development and delivery of plans and not seen as a separate activity. This will be demonstrated in planning documents
Develop capacity and capability by having a ICB RII Team by April 2024	Recruit to Joint Appointment with the AHSN	Agree Job description. Undertake recruitment. Induction and integration with posts in NHS Cornwall and Isles of Scilly (CIOS) and Somerset. Ensure support available within the ICB for this role	Increased capacity to support RII
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles by end March 2026	Implementation of Regional Innovation Strategy	Complete Peninsula-wide prioritisation process. Work with system partners to map capacity within agreed missions and facilitate additional work in these areas	There will be increased activity in the areas targeted by the Regional Innovation Strategy

Year 1- 5 Objectives and Milestones

Population Health

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations on an ongoing basis	By April 24 each LCP and Collaboratives will have a plan which clearly sets out how it will improve population health and reduce inequalities Rollout PHM supported by One Devon dataset	By April 24 there will be a resource and information package available to support local work	LCPs and Provider collaboratives able to demonstrate reductions in outcomes
Ensure delivery of Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement	Delivery of targets in line with national reporting requirements	Demonstrable reduction in inequalities in access and experience	
Implement co-ordinated prevention plans in priority areas including CVD, diabetes and respiratory	Co-ordinated programmes of work delivering on national targets with a particular focus on CVD, Respiratory and Diabetes	High Impact Interventions in place in line with national major conditions strategy	
Develop the ICB and NHS partners as Anchor Organisations by March 2026	By April 24 all NHS organisations in Devon are able to demonstrate how they are supporting social and economic development	Demonstrable changes in social and economic development resulting from work of Anchor Organisations	
Support the implementation of new ways of working focused on population health by April 2025	By April 25 people-led change will be demonstrable throughout the ICS	Trauma-informed approach across all ICS services	

Year 1 and 2 (operational plan detail)

Population Health

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations on an ongoing basis	By April 24 each LCP and Collaboratives will have a plan which clearly sets out how it will improve population health and reduce inequalities Rollout PHM supported by One Devon dataset	Provide advice, guidance and information to LCPs Work with Locality PHM co-ordinators to implement PHM Work with VCSE to ensure contribution to plans	Local delivery of change resulting in measurable improved outcomes
Ensure delivery of Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement	Delivery of targets in line with national reporting requirements	Provide support to 5 priority areas Establish monitoring of progress	Achievement of national targets
Implement co-ordinated prevention plans in priority areas including CVD, diabetes and respiratory	Co-ordinated programmes of work delivering on national targets	Map priority prevention workstreams Agree resources/budget in line with requirements (including support for clinical leads) Develop mechanisms for co-ordination and networking Ensure links to other workstreams	Improved outcomes and achievement of national targets
Develop the ICB and NHS partners as Anchor Organisations by March 2026	By April 24 all NHS organisations in Devon are able to demonstrate how they are supporting social and economic development	Implementation of programme of work lead by Steering Group	All NHS organisations contributing to social and economic development
Support the implementation of new ways of working focused on population health by April 2025	By April 25 People led change will be demonstrable throughout the ICS	Continue to support existing programmes of work and facilitate shared learning	Demonstrable changes in the way we approach commissioning for improved population health outcomes.

Year 1 - 5 objectives

Communications and Involvement

The communications and involvement mechanisms that will support delivery of the JFP include:
Support the use of the new ICS involvement platform ‘Let’s Talk’ the and citizens’ panel that programmes can utilise to support online involvement activities across the system
Develop an involvement identity that can be can be used across the One Devon Partnership to help raise the profile and awareness of involvement activity across Devon.
Develop a system approach to communications and involvement, working with professionals from all system partners to support consistent communications, involvement, collaboration, sharing of best practice, and co-production.
Work with partner organisations such as Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector, to deliver engagement on our behalf and to provide insights and connection to local populations
Support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
Provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Co-ordinate and support JFP leads to involve our 3 local overview and scrutiny committees addressing our statutory requirements under the Health and Social Care Act 2012, and also ensure we continue to build pro-active and meaningful relationships with all three Overview and Scrutiny Committees (OSC) in Devon, Plymouth and Torbay both individually and jointly as appropriate.

Year 1 - 5 objectives

Equality and Diversity

Equality and diversity ensures that services meet people's needs, give value for money and are fair and accessible to everyone. It means people are treated as equals, get the dignity and respect they deserve, and differences are celebrated.

Improve innovation, performance and efficiency through a diverse workforce

- Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)
- Develop and retain a diverse workforce, building a culture where our people feel valued, heard and able to be their best selves at work.
- Ensure staff recruited via the International Recruitment Hub, are well supported in their roles and deliver a campaign that celebrates our diverse workforce, tackles racism and builds cohesion in the community.
- Continue to build and support the Devon-wide ethnic equality staff network, ensuring it has meaningful input into system priorities, including develop a Devon-wide anti-racism charter that the One Devon Partnership sign up to.
- Consider race equality as part of all commissioning strategies.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance
- Support staff to feel safe, including listening and providing support to staff and managers.
- Improve data on equalities and ethnicity, including in the independent provider market.
- Include a clause in our social care contracts with acceptable standards that are monitored.

Ensure Devon's health and care services are inclusive and accessible to everyone

- Through a rolling EDI calendar, celebrate diversity and raise awareness of discrimination, empowering our workforce to be more inclusive, and demonstrating our commitment to EDI to our local populations.
- Work in partnership with the voluntary sector to understand needs and support people from diverse and vulnerable populations to have better access to health and care service.
- Support, empower and equip patient facing staff to take an inclusive approach to the accessibility and delivery of services

One Devon

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Strategic workforce planning embedded at System level	• Detailed 5 year workforce plan in place for NHS providers. • Initial development of 'first cut' of Primary & Social Care workforce plan. • Build and launch of One Devon Strategic Workforce Planning tool for Acute and MH providers.	• Detailed 5 year workforce plan for Health, Primary & Social Care workforce. • Further development of One Devon Strategic Workforce Planning tool to roll out to Primary and Social Care workforce.	• 5 year workforce plan further developed with detailed data from VCSE sector included. • Further development of One Devon Strategic Workforce Planning tool to roll out to VCSE and other sectors.
System level attraction solutions in place that source new talent and position Devon System as an employer of choice.	• Development of a set of attraction strategy principles and a system recruitment event planner for 23-24 • Introduction of a Career Hub in schools to support youth engagement (work experience and career pathways) • Online Devon/SW attraction and careers page (one landing page to support recruitment, careers, apprenticeships, work experience, events etc) • System approach to simplifying recruitment and removing barriers to recruitment	• Multi-year System attraction strategy and event planning in place and securing new talent into Devon. • Development of a Devon talent pool to have a readily available pool of resources to fulfil requirements. • One Devon employer brand fully developed and utilised across all System partners to support recruitment of high calibre talent into Devon.	• One Devon recognised as employer of choice. • Talent pipelines developed for key roles across System partners.

One Devon

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Development of new roles and new ways of working embedded across Devon ICS	• New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	• Opportunities to develop new skills, knowledge and experience that support the needs of the population/community. • Our workforce will be built to meet the needs of the local population and embrace new roles built around skills, knowledge, experience and behaviours. • Staff have access to System-wide development opportunities for their personal and professional growth.	• Skill diversity of new workforce models & ways of working across One Devon recognised as adding significant value and fully embedded into service redesign across all System partners.
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future	• New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	• Opportunities to develop new skills, knowledge and experience that support the needs of the population/community. • Our workforce will be built to meet the needs of the local population and embrace new roles built around skills, knowledge, experience and behaviours. • Staff have access to System-wide development opportunities for their personal and professional growth.	• Skill diversity of new workforce models & ways of working across One Devon recognised as adding significant value and fully embedded into service redesign across all System partners.

Year 1 and 2 (operational plan detail)

Workforce

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Strategic workforce planning embedded at System level	• Detailed 5 year workforce plan in place for NHS providers (Yr1) and Primary & Social Care (Yr2) • Build and launch of One Devon Strategic Workforce Planning tool for Acute and MH providers.	• Roll-out of strategic workforce planning self-assessment tool across all sectors of the System to inform workforce plan numbers. • Development of Devon strategic workforce planning tool and methodology to standardise process and embed best practise across Devon partners. • Ongoing engagement with whole System stakeholders to inform Primary & Social Care workforce plan.	Strategic workforce plan informing supply and demand and skill mix.
System level attraction solutions that source new talent and position Devon System as an employer of choice.	• Development of a set of attraction strategy principles and a system recruitment event planner for 23-24 • Introduction of a Career Hub in schools to support youth engagement (work experience and career pathways) • Online Devon/SW attraction and careers page (one landing page to support recruitment, careers, apprenticeships, work experience, events etc) • System approach to simplifying recruitment and removing barriers to recruitment	Multiple workstreams in place under Attraction, Retention & Workforce Solutions Pillar focusing on; • Development of Devon employer brand and roll out of collaborative working across attraction and recruitment activity. • Enabling mobility of workforce across System providers. • Improving retention of staff across Devon • Reducing reliance on agency staff and embedding collaborative Bank models.	Reduced turnover – target <5% (tba) Reduced vacancy levels - target tba. Reduced agency spend – target <1% of pay bill Workforce growth lower than activity growth in each of the next 5 years
Development of new roles and new ways of working embedded across Devon ICS	• New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	Multiple workstreams in place under Workforce Strategy and Learning & Education Pillars focusing on System level working to create new roles, increase the skill-diversity of our workforce (ie making greater use of our unregistered workforce).	Unregistered workforce delivering more H&C services. New supply pipelines identified through creation of new roles.

Year 1 and 2 (operational plan detail)

Workforce

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future	New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	Multiple workstreams in place under Attraction, Retention & Workforce Solutions Pillar, Workforce Strategy and Learning & Education Pillars focusing on; • Development of Devon employer brand and roll out of collaborative working across attraction and recruitment activity. • Enabling mobility of workforce across System providers. • Improving retention of staff across Devon • Reducing reliance on agency staff and embedding collaborative Bank models. • System level working to create new roles, increase the skill-diversity of our workforce (ie making greater use of our unregistered workforce).	Reduced turnover – target (tba) Reduced vacancy levels -target (tba)

Year 1- 5 Objectives and Milestones

Digital – Digital Citizen

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Number of eligible citizens connected to the NHS App increased to support national target of 75% of people registered by 2024.		National target of 75% of people registered for the NHS App by 2024	
Future use of ORCHA (App assurance product to support citizen self-care and social prescribing) determined by the end of the current funding in March 2024.	Business case developed to determine re-procurement		
Standardisation of GP practice websites achieved within 2025.	Develop and implement prototype website template for pilot practices	Standardisation of GP practice websites implemented upon successful prototyping and piloting.	
Achieve planned Virtual Ward bed targets by April 2024 across the TSDFT, UHP and RDUH		Virtual Ward beds planned by April 2024 South - Torbay and South Devon – 57 VW beds West - University Hospital Plymouth – 100 VW beds North and East - Royal Devon University Hospital – 100 VW beds	
Develop a commissioned offer for digital solutions and technology enabled care and support, including awareness raising and increasing diversity of prescribers (social care)	To be populated by social care		
Consider use of the Disabled Facilities Grant for technology solutions, including investigation of handyperson schemes focusing on 'low-tech' as well as 'high-tech' solutions	Complete feasibility work to understand the opportunity to use DFG to support tech and digital solutions	Implement plan to utilise DFG to increase the availability of technology solutions that support people to remain in, or return to, their own homes	

Year 1- 5 Objectives and Milestones

Digital – Shared EPR and Operational Systems

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
EPRs implemented in TSDFT and UHP and DPT by 2025	OBC and FBC completed TSDFT, UHP and DPT	EPR implemented in TSDFT, UHP and DPT	
80% of care homes to have a Digital Social Care Record by March 2024	Digital social care records procured and implemented		
Peninsula Picture Archiving and Communication System (PACS) solution for the clinical network procured and implemented by 2025	PACS solution procured	PACS implementation complete	
Peninsula Laboratory Information Management System (LIMS) solution for the clinical network procured and implemented by 2025	LIMS solution procured	LIMS implementation complete	
Re-procurement of GP Electronic Patient Record (EPR) clinical system by March 2024	Re-procurement of GP EPR system completed		

Year 1- 5 Objectives and Milestones

Digital – Devon and Cornwall Care Record

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028	▪ RDUH connected ▪ TSDFT connected ▪ Hospices sharing/providing information ▪ 95% of Devon GP practices connected ▪ Commence connection of Care Homes ▪ DCC connected ▪ Plymouth City Council Connected ▪ Torbay Council Connected	▪ Care Home connections continued	▪ Care Homes connected
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028	▪ Treatment Escalation Plan developed within DCCR and ready for implementation ▪ Commence expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Business Case completed for future investment and continuing development of additional functionality (e.g. care plans) of the Devon and Cornwall Care Record including citizen access	▪ Continued expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Continued development of additional functionality	▪ Citizen access provided to the Devon and Cornwall Care Record

Year 1- 5 Objectives and Milestones

Digital: Population Health Management

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Develop PHM architecture and reporting	Support the resumption of the PHM programme with PCN-level data packs. Fully embed the One Devon Dataset use request process.	Add additional data flows into the One Devon Dataset (SWAST, 111, housing) and develop further population segmentation approaches	
Develop an ICS data platform and associated reporting, linked to EPR implementation and national developments including the Federated Data Platform	Develop the infrastructure to support a consistent platform for collating and sharing key data within the ICS	Onboard organisations in-line with EPR implementation timelines	
Work collaboratively with regional ICS teams to develop the regional secure data environment to support future research	Support the development of regional SDE plans	Implement the initial regional SDE	

Year 1- 5 Objectives and Milestones

Digital – Standardised and Unified Infrastructure

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Unified and Standardised Infrastructure provided by 2028	▪ Common end user device specification agreed ▪ Mobile telephony savings delivered through each organisation ▪ Business case completed for Data centre and cloud	▪ Data centre rationalisation subjected to business case approval ▪ Mobile telephony savings delivered through each organisation	▪ Data centre rationalisation subjected to business case approval ▪ Mobile telephony savings delivered through each organisation

Year 1 and 2 (operational plan detail)

Digital

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028	▪ RDUH connected ▪ TSDFT connected ▪ Hospices providing information ▪ 95% of Devon GP practices connected ▪ Commence and continue connection of Care Homes ▪ DCC connected ▪ Plymouth City Council Connected ▪ Torbay Council Connected	▪ All core organisations connected as provider and consumers of information in the Devon and Cornwall Care Record. People in Devon will only have to tell their story once, with all clinical and care staff having access to the information they need when they need it, through a shared digital system across health and care.
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028	▪ Treatment Escalation Plan developed within DCCR and ready for implementation ▪ Commence expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Business Case completed for future investment and continuing development of additional functionality (e.g. care plans) of the Devon and Cornwall Care Record including citizen access ▪ Continued expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Continued development of additional functionality	▪ Additional functionality of the Devon and Cornwall Care Record demonstrated through the development of the electronic Treatment Escalation Plan. ▪ People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care. ▪ The commitment to further developing and investing in the Devon and Cornwall Care Record is determined.

Year 1- 5 Objectives and Milestones

Procurement

Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
• development of improved collaborative working, intra system financial framework, contracting and risk sharing protocols	• commence pivot of funding upstream towards prevention and health inequalities	▪ continued recovery to sustainable financial balance by system and by organisation
• agreement of functions where a shared service arrangement should be pursued helping to inform the organisational restructure within reduced Running Cost Allowance	• take on formal delegation of Specialised Commissioning functions	
• development of Long term Financial Plan, trajectory to recover and sustainable financial balance over a 3-5 year scenario range	• corporate ICB right sized for RCA (Running Cost Allowance) allocations, emerging maturity of LCP's	
• development of system wide interpretation of the Drivers of the Deficit to underpin future recovery	• estates strategy finalised to underpin prioritised system wide capital allocations	
• delivery of 23/4 recovery and Cost Improvement Programmes both organisational, strategic collaborative, and structural		
• consolidate delegated of commissioning functions for extended primary care		

The Procurement milestones will be determined through the development and approval of a Business Case, which will be submitted to NHS Devon CFO and the Trust CFOs by the end of June.

Year 1

Procurement

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Improved Resilience	Please note that the milestones will be determined through the development and approval of a Business Case, which will be submitted to NHS Devon CFO and the Trust CFOs by the end of June. *How* we will achieve the objectives is outlined to the right, and will inform a 1-3 year programme	*We will do this through working across the ICS and with NHS Supply Chain and strategic partners to provide greater protection from supply failures, price increases and quality defects*	
Reduced total Cost		*We will do this through expanding the category-led approach, by analysing our expenditure, seeking new areas of influence, tactical benchmarking, and re-assessing opportunities to standardise products and services and enhance clinical outcomes*	
Greater Value		*We will do this by developing and promoting value-based procurement methodologies, re-assessing our stakeholder needs, and through evidence-based outcomes, such as those identified through the GIRFT programme*	
Better Supplier Management		*We will do this by adopting a consolidated, once-only approach towards Supplier Relationship Management (SRM), acting a single ICS commercial voice*	
Optimised Workforce		*We will do this by developing an Organisational Model which drives efficiency, harmonises our skills and experience, and eliminates duplication*	
Optimised Workforce		*We will do this by ensuring that enhanced efficiency provides the capacity and the means to support all staff in achieving their aspirations, and to inspire excellence. We will celebrate success, and design an organisation model which enables clear career pathways at local, regional and national level*	

Year 1- 5 Smart Objectives and milestones

Strategic Estates and Facilities

Year 1	Year 2
Undertake strategic review of the ICS-wide health estate	Categorise all of the estate into ‘core, flex and tail’ and agree strategies for each site or development opportunity
Develop an investment plan and a 5 year capital prioritisation pipeline	Prioritise funding allocations whilst taking advantage of national funding review outcomes and TIF funding
Develop a cross-matrix team that can support the delivery of estates and facilities at an ICS-wide level	Integrate provider service departments where possible to create resilience, efficiencies and succession planning
Deliver a public facing ICS Estates Strategy	Commence delivery of the implementation plans that shall support each area of the Estates Strategy

Year 1 (operational plan detail)

Strategic Estates and Facilities

Year 1 objective	How are you going to achieve?
Deliver a public facing ICS estates strategy by December 2023	Consultants have been commissioned to support this NHSE mandated requirement and joint provider workshops are being facilitated to agree process and approach
Complete an investment and capital prioritisation plan for the next 5 years	Consultants have been commissioned to support this NHSE mandated requirement and joint provider workshops are being facilitated to agree process and approach
Eradicate empty accommodation across the NHS Property Services estate	Undertake sufficient engagement with key stakeholders to agree exit plans and obtain Executive Board agreement to hand back the properties to NHS PS for a disposal
Facilitate the development of the Devon NHP Programme	Establish and create ICB governance surrounding NHP sign offs and delivery to ensure relevant workstreams are in agreement with provider plans
Facilitate the development of the PCN estates strategies	Establish protocols surrounding phase three of the PCN toolkit work to ensure each PCN plan is being developed within the patients best interests and within the ICB's affordability envelope

Year 1- 5 Objectives and Milestones

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5	Strategic Goal
More Devon ICB staff will make greener journeys to work.	10% increase in the number of staff making greener journeys to work	20% increase in the number of staff making greener journeys to work	40% increase in the number of staff making greener journeys to work	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities
Devon ICB will be a paper free organisation by 2028.	20% reduction in the use of paper across the ICB	40% reduction in the use of paper	Devon ICB is a paper free organisation.	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners.	Increase of 10% more products and services bought locally	Increase of 20% more products and services bought locally	Increase of 50% more products and services bought locally	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities

Year 1 and 2 (operational plan detail)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
More Devon ICB staff will make greener journeys to work.	10% increase in the number of staff making greener journeys to work	Complete review of electric car charging points at ICB venues by March 24	Create a baseline for future improvement
		Explore the potential for subsidised public transport usage for staff by working with ICB HR teams to establish the current offer to staff	More staff are encouraged to reduce their reliance on petrol and diesel cars
		Further promote our EV Car buying scheme	
		Further promote NHS Devon's Cycle to Work scheme	
Devon ICB will be a paper free organisation by 2028	20% reduction in the use of paper across the ICB	Provide communications to staff on the cost of using paper	The reliance on paper is reduced
		Reduce the numbers of printers being made available across the ICB	
		Promote Ecosia as the preferred Internet Browser	
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners	Increase of 10% more products and services bought locally	Work with procurement colleagues to further develop the Social Value weightings on contract awards to include "buy local"	More things are bought locally to reduce our carbon footprint

One Devon

APPENDIX E
Glossary

Glossary (A-C)

Abbreviation	Meaning
A&E	Accident and Emergency
A&G	Advice and Guidance
ABCD	Asset-based-community-development
ACE	Adverse Childhood Experience
ACS	Ambulatory Care Sensitive
A-EQUIP model	Advocating and Educating for Quality Improvement
AHC	Annual Health Checks
AHSN	Academic Health Science Network
AMR	Antimicrobial resistance
ARC	Applied Research Collaboration
ARRS	Additional Roles Reimbursement Scheme
ASC	Adult Social Care
B&B	Bed and Breakfast
BFI	Baby Friendly Initiative
BMI	Body Mass Index
BPTP	Best Practice Timed Pathway
C.diff	Clostridium difficile
C2C	Clinician to Clinician
CAS	Clinical Assessment Service
CEO	Chief Finance Officer
CHC	Continuing Healthcare
CIC	Community Interest Company
CIOS	NHS Cornwall and Isles of Scilly
CIP	Cost Improvement Programme
CLD	Community learning and development
CMO	Chief Medical officer
COCA	Community onset community associated
Core20PLUS5	The most deprived 20% of the national population PLUS the 5 ICS chosen population groups experiencing poorer than average health access, experience and/or outcomes that may not be captured in the core 20.
CPD	Continued Professional Development
CQC	Care Quality Commission
CRGs	Clinical Referral Guidelines
CRN	Clinical Research Network
CSDS	Community Services Data Set
CT	Computerised tomography
CTR	Care and Treatment review
CUC	Community Urgent Care
CVD	Cardiovascular disease
CYP	Children and Young People

Glossary (D-I)

Abbreviation	Meaning
DASV	Domestic abuse and sexual violence
DCCR	Devon and Cornwall Care Record
DDR	Dementia Diagnosis Rate
DMBC	Decision Making Business Case
DNA	Did Not Attend
DOS	Directory of Services
DPT	Devon Partnership Trust
DSR/C(E)TR Policy	Dynamic Support Register (DSR) and Care (Education) and Treatment Review C(E)TR policy
DWP	Department for Work and Pensions
EBI	Evidence Based Interventions
Ecosia	Search engine that uses the advertising revenue from searches to plant trees
ED	Emergency Department
EDI	Equality, diversity and inclusion
EHCP	Education, health and care plan
EHCS	Emergency Healthcare Plan
EPC	Energy Performance Certificate
ePHR	Electronic Patient Held Record
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EQIA	Equality and Quality Impact Assessment
ERF	Elective Recovery Fund
G&A	General and Acute
GIRFT	Getting it right first time national programme, designed to improve the treatment and care of patients through in-depth review of services
GRAIL	Healthcare company focused on saving lives and improving health by pioneering new technologies for early cancer detection
HbA1C	Haemoglobin A1c (HbA1c) test measures the amount of blood sugar (glucose) attached to your haemoglobin
HCAI	Healthcare associated infections
HEE	Health Education England
HEI	Higher Education Institution
HI	Health Inequalities
HR	Human Resources
HVLC	High Volume Low Complexity
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board (NHS Devon)
ICS	Integrated Care System (One Devon Partnership)
Immedicare	Telemedicine service providing 24/7 NHS video-enabled clinical support for care homes nationally
IPS	Individual Placement Support
IUCS	Integrated Urgent Care Service

Glossary (J-N)

Abbreviation	Meaning
JCP	Job Centre Plus
JFP	Joint Forward Plan
JLHWS	Joint Local Health and Wellbeing Strategy
JOY app	Real-time directory and case management tool that enables GPs and other health and social care professionals to easily refer into local services, helping to create a more joined-up system for service users.
JSNA	Joint Strategic needs Assessment
L&D	Learning and Development
LA	Local Authority
LCP	Local Care Partnership
LD	Learning Disability
LDA	Learning Disability and Autism
LDAP	Learning Disabilities and Autistic People
LeDer	Learning from Lives and Deaths (People with a Learning Disability and Autistic People)
LES	Local Enhanced Services
LGBTQ+	Lesbian, gay, bisexual, transgender, queer (sometimes questioning) plus other identities included under the LGBTQ+ umbrella
LIMS	Laboratory Information Management System
LMNS	Local maternity and neonatal system
LOS	Length of Stay
LPA	Local Planning Authorities
LTC	Long term condition
LTP	Long Term Plan
MD	Medical Director
MDT	Multi-disciplinary team
MECC	Making every contact count
MH	Mental Health
MHLDN	Mental Health, Learning Disability and Neurodiversity
MHST	Mental Health Support Teams in Schools model
MIS	Maternity Information System
MMR	Measles, mumps, and rubella
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MSW	Maternity Support Worker
NCTR	No criteria to reside
NEET	Not in employment, education, or training
NHP	New Hospitals Programme
NHSE	NHS England
NHSEI	NHS England & Improvement
NICE	National Institute for Health and Care Excellence
NOS	National Occupational Standards
NPA	National Partnership Agreement

Glossary (N-S)

Abbreviation	Meaning
NPDA	National Paediatric Diabetes Audit
NSS	Non-site specific
Ofsted	Office for Standards in Education, Children's Services and Skills
ONS	Office for National Statistics
OP	Outpatient
OPFU	Outpatient Follow Up
ORCHA	Organisation for the Review of Care and Health Apps
OSC	Overview and Scrutiny Committee
PACS	Picture Archiving and Communication System
PASP	Peninsular Acute Sustainability Programme
PAU/CAU	Paediatric/Children's assessment unit
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
PHE	Public Health England
PHM	Population Health Management
PIFU	Patient Initiated Follow-Up
PS	Property Service
PTL	Patient tracking list
RDUH	Royal Devon University Healthcare Foundation Trust
RI	Research, improvement and innovation
rtCGM	Real time continuous glucose monitoring
RTT	Referral to Treatment
SABA inhalers	Short-acting beta agonists
SAI	School-aged immunisation
SCORE Culture surveys	Anonymous, online tool that can be used to gain insight into a team's safety culture to help the team identify strengths and weaknesses and start to drive genuine improvement
SDEC	Same Day Emergency Care
SEMH	Social Emotional Mental Health
SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities
SET	Senior Executive Team
SIAG	System Improvement Assurance Group
SIC ODN	Surgery in Children Operational Delivery Network
SLCN	Speech and Language Communication Needs
SLT	Speech and Language Therapist
SMART objectives	Specific; Measurable; Achievable; Realist; Timebound

Glossary (S-Z)

Abbreviation	Meaning
SOP	Standard Operating Procedure
SRM	Supplier Relationship Management
SRP	System Recovery Programme
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stopping overmedication of people with a learning disability, autism or both
SW	Southwest
SWAHSN	Southwest Academic Health Science Network
SWAST	South Western Ambulance Service NHS Foundation Trust
THRIVE	The THRIVE Framework for system change is an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and their families.
TIF	Tech Innovation Framework
TLHC	Targeted Lung Health Check Programme
TSDFT	Torbay and South Devon NHS Foundation Trust
UCR	Urgent Community Response
UDA	Unit of Dental Activity
UEC	Urgent and Emergency Care
UHP	University Hospital Plymouth NHS Trust
UKHSA	UK Health Security Agency
VBA	Value Based Approach
VCSE	Voluntary, Community and Social Enterprise
VW	Virtual Ward
WRES	Workforce Race Equality Standard

One Devon