TORBAY COUNCIL

Wednesday, 26 November 2025

Meeting of the Health and Wellbeing Board

Thursday, 4 December 2025
2.00 pm
The Banking Hall, Town Hall, Castle Circus, Torquay

Members of the Board

Karen Barry, NHS Devon Integrated Care Board
Peter Collins, NHS Devon
Pat Harris, Healthwatch Torbay
Tara Harris, Divisional Director of Community and Customer Services
Roy Linden, Devon and Cornwall Police
Nancy Meehan, Director Children's Services
Paul Northcott, Adult Safeguarding Board
Paul Phillips, Department for Work and Pensions
Lincoln Sargeant, Director of Public Health
Tanny Stobart, Imagine This Partnership (Representing the Voluntary Children and Young People Sector)
Simon Tapley, Torbay and South Devon NHS Foundation Trust
Pat Teague, Ageing Well Assembly
Councillor Bye
Councillor David Thomas
Councillor Tranter

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 5 - 8)

To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 25 September 2025.

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. Torbay Joint Health & Wellbeing Strategy 2026 – consultation draft (Pages 9 - 20)

To consider the consultation draft of the Joint Health and Wellbeing Strategy 2026-30.

6. Director of Public Health Annual Report 2025 on Ageing (Pages 21 - 30)

To note the Public Health Annual Report 2025 on Ageing.

7. NHS Health and Care Strategy 2026 - 2031 (Pages 31 - 104)

To consider the NHS Health and Care Strategy 2026 - 2031

8. **Autism Strategy 2025 - 2028** (Pages 105 - 120)
To note the report on the above.

9. **Peninsula Health Protection Annual Report 2024/25** (Pages 121 - 218)
To consider the Devon, Cornwall and Isle of Scilly Health Protection Committee Annual Assurance Report 2024/25.

10. **Torbay Better Care Fund - quarterly monitoring report** (To Follow)

11. **2026 Health and Wellbeing Board work programme** (Pages 219 - 222)
To note the Health and Wellbeing Board work programme 2026.

12. **Any other business**
CQC report

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Minutes of the Health and Wellbeing Board

25 September 2025

-: Present :-

Councillor Nick Bye, Tara Harris, Lincoln Sargeant, Pat Teague and Councillor David Thomas (Chair)

(Also in attendance: Nancy Meehan joined the meeting virtually)

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8. Apologies

Apologies were received from Pat Harris, Healthwatch who was represented by Kevin Dixon and Paul Phillips, Department for Work and Pensions who was represented by Stuart Evans.

9. Minutes

The Minutes of the Health and Wellbeing Board held on 19 June 2025 were confirmed as a correct record and signed by the Chair.

10. Declaration of interest

No interests were declared.

11. NHS 10 year plan & Neighbourhood health - what do these mean for Health and Wellbeing Board partners?

The Board received an update from the Senior Locality Manager (South & West), NHS Devon that a local engagement programme was launched in July to support the Government's 10-Year Health Plan, focusing on three key shifts: hospital to community, analogue to digital, and sickness to prevention. Over 3,400 pieces of feedback were received via surveys, workshops, and face-to-face activities.

Key themes included strong public support for a free NHS, concerns over staffing, access to services, and long waiting times. Satisfaction with the management of the NHS was low, and funding was seen as a priority.

Respondents had expressed mistrust of AI and called for more integrated care. In South Devon and Torbay, 545 responses received highlighted issues such as GP access, hospital delays, and A&E pressures.

The strategy includes integrated neighbourhood health teams and standardised community services.

The Health and Care Strategy was due for sign-off by the ICB Board on 16 October, with next steps involving Local Care Partnership conversations and testing new approaches in Torbay over the next 1 – 2 years.

12. Joint Health and Wellbeing Strategy 2026-30

The Board received an update on the draft Torbay Health & Wellbeing Strategy 2026–30, which sets a strategic platform to promote integration across council departments and allied sectors.

The Strategy outlines a neighbourhood health approach and identifies priority areas for Years 1–2, focusing on children and young people, working-age adults, and older adults.

Key interventions include a programme of activities to support physical, mental and social wellbeing for children and young people; the Connect to Work scheme to help adults return to employment; and age-friendly initiatives addressing housing, transport and health for older residents.

Members expressed support for the Strategy's principles and its targeted, co-designed delivery programmes aimed at reducing inequalities and improving health outcomes across the Bay.

Resolved by consensus:

That the draft Joint Health and Wellbeing Strategy be endorsed.

13. Torbay Better Care Fund 2024 - 25 - Quarter 1 sign off

The Board received an update on the Torbay Better Care Fund (BCF) 2024 – 2025 confirming that Torbay remains on track to meet its key targets.

Emergency admissions for patients aged 65plus were being closely monitored under revised metrics, with performance currently aligned to planned trajectories. Discharge metrics show strong outcomes, with 91%–94% of patients discharged on their Discharge Ready Date (DRD), exceeding the 89.3% target.

The average delay for those not discharged on DRD remains below the 4-day target. Residential admissions were being tracked against an annual target, with Quarter 1 figures indicating progress is on course. Data collection methods had changed, and reporting now focuses on high-level summaries.

Financially, Quarter 1 expenditure stands at £6.78 million, representing 22% of the total BCF allocation.

Resolved by consensus:

That the Torbay Better Care Fund 2025 – 26 Quarter 1 report be approved.

14. Torbay Children's Safeguarding Partnership Annual Report

Penny Smith, former chair of the Children's Safeguarding Partnership, presented the Torbay Children's Safeguarding Partnership Annual Report and provided the Board with an update.

The report was produced in line with statutory requirements and the revised Working Together to Safeguard Children 2023 guidance and outlined the partnership's governance structure, independent scrutiny arrangements, and financial contributions.

The report reflected the activity completed during the Chair's tenure and highlighted ongoing discussions around equitable funding. Members noted the report's alignment with national guidance and its relevance to future planning.

Resolved by consensus:

That the Health and Wellbeing Board note and endorse the Torbay Safeguarding Children's Partnership Annual report 2024 – 2025.

Chair

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TORBAY COUNCIL

Meeting: Health and Wellbeing Board **Date:** 8/12/25

Wards affected: All

Report Title: Torbay Joint Health and Wellbeing Strategy: consultation draft

When does the decision need to be implemented? For information

Cabinet Member Contact Details: Hayley Tranter, Cabinet member for Adult and Community Services, Public Health and Inequalities, hayley.tranter@torbay.gov.uk

Director Contact Details: Lincoln Sargeant, Director of Public Health, lincoln.sargeant@torbay.gov.uk

Authors: Julia Chisnell, Consultant in Public Health julia.chisnell@torbay.gov.uk

1. Purpose of Report

1.1 This paper encloses the consultation draft of the Joint Health and Wellbeing Strategy 2026-30.

2. Reason for Proposal and its benefits

2.1 The programmes of work described in the Strategy will help us to deliver our vision of a healthy, happy and prosperous Torbay by helping to promote the health and wellbeing of our population.

2.2 Members received and agreed a draft of the Strategy at the September meeting of the Health and Wellbeing Board. Only very minor changes have been made since that date.

2.3 The draft Strategy will be launched for public consultation following agreement by Cabinet 16 December 2025.

3. Recommendation(s) / Proposed Decision

3.1.1 Members are asked to note the consultation draft.

1 Background

Local authorities and NHS have a joint duty to produce, through the Health and Wellbeing Board: (1) a Joint Strategic Needs Assessment (JSNA) and (2) a Joint Health & Wellbeing Strategy.

The Strategy should:

- address the needs & inequalities identified in the JSNA
- set out key strategic priorities for action & outcomes members will jointly achieve
- inform local commissioning
- promote integration between health & care, as well as other Local Authority functions such as housing, transport, economy, and environment.

The main requirement is to involve all Health and Wellbeing Board partners in development & delivery. There is no prescribed timing, content, format or lifespan.

Our current Strategy runs from 2022-26. Torbay – in parallel with Devon – is developing a new Strategy to run from 2026.

2 Key considerations

Some key considerations in the preparation of the 2026 Strategy:

- This is a time of particular organisational change, with the clustering of Integrated Care Boards and the prospect of Local Government Reorganisation. Any Strategy needs to be flexible in adapting to future local structures.

- Learning from the 2022-26 Strategy suggests it is desirable to allow for a refresh of detailed action plans annually or biannually, within the four year framework.

- The Government's 10 Year Plan for the NHS contains implications for local authorities. Alongside specific programme commitments, the plan proposes the creation of a 'Neighbourhood Health Service'. Local Authorities are partners in the development of neighbourhood health plans, under the leadership of Health and Wellbeing Boards.

3 Allied strategies and stakeholders

In addition to the 10 Year Plan, there are local strategies and stakeholders with a particular relevance to the development of our Health and Wellbeing Strategy, including among others:

- The new Devon Health and Care Strategy

- Torbay Corporate Plan, Economic Strategy, Housing and Homelessness Strategies, Regeneration plans, and strategic plans relating to Children's and Adults Social Care.

- The Torbay Story and Place Leadership Board.

4 Our approach

In the light of (2) and (3), our approach in development the 2026 Strategy therefore follows some key principles:

- Engaging Health and Wellbeing Board members as a minimum
- Working in close partnership with Devon County Council and Plymouth City Council in terms of Strategy development and timescales
- Working closely with Integrated Care Board (ICB) colleagues and taking account of the developing ICB Health and Care Strategy
- Engaging with the Place Leadership Board, Local Care Partnership and Economy colleagues to enable shared priorities and some consistency of approach
- A focus on neighbourhood health and wellbeing.

5 Timetable

The development timetable for this year's report is below. This includes formal and informal engagement with Council and partner forums to allow opportunities for key constituencies to input into the report.

Activity	Timeline
Scoping discussions with partners	March – June 2025
Develop outline content	Sept – Oct 2025
Finalise draft Strategy	Oct – Nov 2025
Public consultation	Dec 25 – Jan 26
Approve & publish Strategy (full Council)	May 2026

6 Outline of content & themes for the 2026-30 Strategy

The Strategy is designed to influence the implementation of health and wellbeing improvement programmes through the following routes:

1 Highlighting the needs in our population that all of us developing strategies, or commissioning services, need to respond to.

2 Summarising the areas of activity required to address our population needs, in the ways people have said they want to see.

3 Identifying the principles and priority areas which will inform delivery of the Strategy over the next four years.

4 Developing an annual delivery programme of three programmes each year which will be sponsored by the Board.

The **key challenges** in the Strategy are taken from the recently published 2025/26 Joint Strategic Needs Assessment TORBAY JOINT STRATEGIC NEEDS ASSESSMENT 2025/26.

Feedback from the recent **engagement** on the NHS 10 Year Plan has informed the Strategy.

The **vision** of the Strategy is around *healthy neighbourhoods*, with a focus on delivering *prevention in place*.

Draft **priority delivery programmes** for the first year, developed and agreed with Health and Wellbeing Board members, are:

- *Healthy spaces - children and young people*
    - Tackling the issues of low physical activity, poor diet, home or school insecurity, education underachievement, and unreadiness for work.
    - Focusing on the work relating to the 'play' domain begun under the auspices of Child Friendly Torbay.
    - Led by community groups in partnership with the local authority and other stakeholders.
    - Involving a programme of activities to build physical, mental and social health and wellbeing.

- *Healthy work - working age adults*
    - Tackling the issues of unemployment through physical or mental ill health, NEETs, and disparities in opportunity for care experienced young people and carers
    - Focusing on Connect to Work with wrap around support from NHS and VCSE partners
    - Building confidence, employment opportunities, mentoring, practical, health, and social support.

- *Healthy ageing - older adults*
    - Tackling disparities in frailty onset, ill-heath, and dependence on social care, isolation, housing insecurity
    - Age Friendly actions around housing, transport and health

- Led by VCSE, with local authority and other partners

7. Financial Opportunities and Implications

7.1 None identified

8. Legal Implications

8.1 None identified

9. Engagement and Consultation

9.1 The draft Strategy has been developed with input from stakeholders including Health and Wellbeing Board and Torbay Place Board members, Council teams, commissioners, Local Care Partnership representatives, Voluntary and Community sector colleagues. It incorporates feedback from recent public engagement in relation to the NHS 10 Year Plan including the plan for neighbourhood health.

9.2 This paper requests approval to proceed to public consultation.

10. Procurement Implications

10.1 None identified

11. Protecting our naturally inspiring Bay and tackling Climate Change

11.1 Promoting health and wellbeing includes enhanced use of our natural green and blue spaces through active travel, physical activity, healthy spaces, and connecting with nature.

11.2 Climate change is an identified risk to health through increased infections, population displacement, excess heat and cold, and mental distress. Actions to mitigate the impact are included in our recommendations around health protection and health promotion.

12. Associated Risks

12.1 No specific risks are identified. The Strategy is built on tacking the needs and risks to population health highlighted in the Joint Strategic Needs Assessment.

13. Equality Impact Assessment

Protected characteristics under the Equality Act and groups with increased vulnerability	Data and insight	Equality considerations (including any adverse impacts)	Mitigation activities	Responsible department and timeframe for implementing mitigation activities
Age	18 per cent of Torbay residents are under 18 years old. 55 per cent of Torbay residents are aged between 18 to 64 years old. 27 per cent of Torbay residents are aged 65 and older.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. Different age-groups have different health risks; these are highlighted for priority activity. Year 1-2 priority 1 focuses on mental, physical and social wellbeing of children and young people. Priority 3 focuses on Age Friendly actions around housing, transport and health.	Not applicable	Not applicable
Carers	At the time of the 2021 census there were 14,900 unpaid carers in Torbay. 5,185 of these provided 50 hours or more of care.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. Carers are highlighted as a priority for support.	Not applicable	Not applicable

Disability	In the 2021 Census, 23.8% of Torbay residents answered that their day-to-day activities were limited a little or a lot by a physical or mental health condition or illness.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. People with physical and mental ill-health and disabilities are highlighted for activity.	Not applicable	Not applicable
Gender reassignment	In the 2021 Census, 0.4% of Torbay's community answered that their gender identity was not the same as their sex registered at birth. This proportion is similar to the Southwest and is lower than England.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision.	Not applicable	Not applicable
Marriage and civil partnership	Of those Torbay residents aged 16 and over at the time of 2021 Census, 44.2% of people were married or in a registered civil partnership.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision.	Not applicable	Not applicable
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.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision.	Not applicable	Not applicable
Race	In the 2021 Census, 96.1% of Torbay residents described their ethnicity as white. This is a higher proportion than the South	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our	Not applicable	Not applicable

	West and England. Black, Asian and minority ethnic individuals are more likely to live in areas of Torbay classified as being amongst the 20% most deprived areas in England.	population. No adverse impacts are anticipated from this decision. The Strategy contains guidance for commissioners and those developing strategies which includes analysis of differential provision, access and outcomes when planning services, to ensure inequalities are addressed.		
Religion and belief	64.8% of Torbay residents who stated that they have a religion in the 2021 census.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. The Strategy contains guidance for commissioners and those developing strategies which includes analysis of differential provision, access and outcomes when planning services, to ensure inequalities are addressed.	Not applicable	Not applicable
Sex	51.3% of Torbay's population are female and 48.7% are male	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. The Strategy contains guidance for commissioners and those developing strategies which includes analysis of differential provision, access and outcomes when planning services, to ensure inequalities are addressed.	Not applicable	Not applicable

Sexual orientation	In the 2021 Census, 3.4% of those in Torbay aged over 16 identified their sexuality as either Lesbian, Gay, Bisexual or, used another term to describe their sexual orientation.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision. The Strategy contains guidance for commissioners and those developing strategies which includes analysis of differential provision, access and outcomes when planning services, to ensure inequalities are addressed.	Not applicable	Not applicable
Armed Forces Community	In 2021, 3.8% of residents in England reported that they had previously served in the UK armed forces. In Torbay, 5.9 per cent of the population have previously served in the UK armed forces.	The Torbay Joint Health and Wellbeing Strategy aims to promote and improve the health and wellbeing across the whole of our population. No adverse impacts are anticipated from this decision.	Not applicable	Not applicable
Additional considerations				
Socio-economic impacts (Including impacts on child poverty and deprivation)		People in more challenged socio-economic circumstances are at greater risk of poor health and wellbeing and are therefore highlighted for priority activity.	Not applicable	Not applicable
Public Health impacts (Including impacts on the general health of the population of Torbay)		All programmes are designed to improve population health.	All programmes are designed to improve population health.	Not applicable
Human Rights impacts		Services and providers will remain cognisant of human rights, including the right to life,	Not applicable	Not applicable

		health, privacy, education and prohibition of discrimination.		
Child Friendly	Torbay Council is a Child Friendly Council and all staff and Councillors are Corporate Parents and have a responsibility towards cared for and care experienced children and young people.	Highlighted as a priority activity.	Not applicable	Not applicable

14. Cumulative Council Impact

14.1 The Strategy takes account of priorities and activities across People and Place teams, including economic strategy, adult and children's social care, education and housing.

14.2 All teams are expected to take note of the needs and priorities highlighted in the Strategy when developing strategy or commissioning services.

15. Cumulative Community Impacts

15.1 All of these programmes involve close partnership working across the Integrated Care System, including voluntary, community and social enterprise (VCSE) sector, and all are intended to promote and improve health across the whole of our population.

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TORBAY COUNCIL

Meeting: Health and Wellbeing Board **Date:** 8/12/25

Wards affected: All

Report Title: Torbay Director of Public Health Annual Public Health Report

When does the decision need to be implemented? For information

Cabinet Member Contact Details: Hayley Tranter, Cabinet member for Adult and Community Services, Public Health and Inequalities, hayley.tranter@torbay.gov.uk

Director Contact Details: Lincoln Sargeant, Director of Public Health, lincoln.sargeant@torbay.gov.uk

Authors: Lincoln Sargeant, Director of Public Health lincoln.sargeant@torbay.gov.uk; Julia Chisnell, Consultant in Public Health julia.chisnell@torbay.gov.uk

1. Purpose of Report

1.1 This paper provides an outline of content and recommendations of the 2025/26 public health annual report describes plans for implementation.

2. Reason for Proposal and its benefits

2.1 The annual report responds to a major challenge to every individual in the population – how to age healthily – and puts forward recommendations to promote healthy ageing for individuals and environments across Torbay.

3. Recommendation(s) / Proposed Decision

3.1.1 Members are asked to note the report and invited to engage in conversations and activities to promote healthy ageing in Torbay.

1 Background

The public health annual report is a statutory function of the Director Public Health. It gives us an opportunity to shine a spotlight on an important issue for our local population. It also gives us an opportunity to make recommendations where we want to see action, either for ourselves as a council, or for partners agencies. Recent reports include physical activity, the Covid pandemic, mental health, cardiovascular disease, and in 2024, women's health.

The report is for anyone interested in the topic or with a relevant role. However the recommendations are usually directed at policy makers and implementers, commissioners and providers - ie Council teams and members, NHS partners and VCSE - and therefore these are the key audience. Wider groups, such as business and education, are a potential audience, depending on the topic. There are also messages for our communities and citizens.

An important challenge for us is to ensure the report is accessible as possible for any reader whatever their background. This has been a key consideration in the development of this report.

Our 2025 Report is on ageing – specifically Healthy Ageing – which is a significant challenge for us within the dramatic demographic context of a substantially ageing population. The nature of the challenge was set out clearly in the Chief Medical Officers *Annual Report for England 2023: Health in an Ageing Society*, available here: Report The population is projected to be substantially higher in rural and coastal areas. There are also significant inequalities in relation to ageing, with people in lower socio-economic groups ageing faster, and living more years in ill-health. All these factors are relevant for Torbay.

The Torbay Joint Strategic Needs Assessment gives a picture of the latest local picture, and trends. A few key points:

- The population 65+ rose by 15% between 2013-2023
- This upward trend is projected to continue, with 34% of the population expected to be aged 65 and over by 2043
- The healthy life expectancy for someone currently 65 years old is 11-12 years – in line with England. This represents around *half* of our remaining lives spent in health (53% for women and 57% for men, women on average living longer).
- The level of pension credit claimants is higher than England
- The rate of those aged 65 and over permanently admitted to residential care homes or receiving long term support at home, is higher than England
- Rates of unpaid carers are higher than England across all age groups and their health and wellbeing is poorer than other groups in the population.

Development of the Report

The report has been developed in collaboration with the following:

- Colleagues across Torbay Council
- Torbay Citizens' Assembly (key partners)
- Torbay Learning Disability Ambassadors
- Active Devon
- Torbay Age UK
- Torbay & South Devon NHS Foundation Trust
- Torbay Communities
- Healthwatch Torbay
- Engaging Communities South West
- Members of the Torbay and South Devon Local Care Partnership

Partners have been particularly involved in providing insight and creative input into the report, in the form of workshop sessions, videos and interviews. They have also shared a large sample of the enthusiastic, innovative work within the Bay to promote and encourage healthy ageing, which we have referred to in the Report.

Summary of content & recommendation areas

Three products have been produced this year:

- Technical report containing evidence and discussion of key subject areas
- Webpages on the Partnerships website (main resource)
- Short easy read summary being developed in collaboration with Torbay Learning Disability Ambassadors.

A summary of the website content is below.

Chapter	**Themes & content**
Definitions	• Chronological, biological and environmental ageing; social perceptions • Ageing & frailty – the fitness gap • Domains of healthy ageing
How does it feel to grow old in Torbay?	• Quotes and video footage collated by Torbay Citizens Assembly
How long will I live?	• Data, lifespan, healthspan, disparities in life expectancy
Aspects of ageing: issues and opportunities	• Loneliness and isolation • Work, volunteering and caring • Housing • Transport • Social attitudes

	• Digital connection
What we are doing	• Active lives / Live Longer better • Healthy Ageing Partnership • Age Friendly Torbay

Recommendations are informed by evidence of best practice, and citizen and partner views on areas where they would like to see action.

Recommendation area	**Audience**		
	For the Local Authority	**For partners**	**For citizens**
1. Promote interventions that increase **community connectedness** & belonging			
2. Promote access to **work and volunteering** opportunities			
3. Promote support for **carers**			
4. Implement ***Age Friendly Torbay,*** with a focus on the domains of **Housing, Transport** and **Health** in year 1			
5. Recognise and value the contribution of older adults to all aspects of society Promote **age friendly language**, policies and cultures			
6. Promote digital inclusion by engaging older adults when introducing new systems, supporting digital skills training, and ensuring alternative routes for people with no digital access			
7. Promote physical, mental, social and cognitive health through Torbay healthy ageing programmes			
8. Promote **enabling health and care** through the South Devon and Torbay Health Ageing			

Partnership in collaboration with Torbay Citizens' Assembly			

Publication and promotion

The report is due to be available from 12 December following a launch event at the Torbay Citizens' Assembly meeting. Different aspects of the content, and the recommendations, will be promoted with stakeholders across the Bay.

Implementation

A more detailed implementation plan, with outcome measures, will be developed and shared following publication of the Report. Many of the actions are already in train.

A formal progress report on implementation will be included in the annual report for 2026/27. Updates on implementation will be shared with the stakeholders during the year.

7. Financial Opportunities and Implications

7.1 None identified

8. Legal Implications

8.1 None identified

9. Engagement and Consultation

9.1 The annual report has been developed in partnership with a range of partners identified in the acknowledgements section of the report.

10. Procurement Implications

10.1 None identified

11. Protecting our naturally inspiring Bay and tackling Climate Change

11.1 Promoting health and wellbeing includes enhanced use of our natural green and blue spaces through active travel, physical activity, healthy spaces, and connecting with nature.

11.2 Climate change is an identified risk to older adults and activities to promote healthy ageing will increase resilience to these changes.

12. Associated Risks

12.1 No specific risks are identified.

13. Equality Impact Assessment

Protected characteristics under the Equality Act and groups with increased vulnerability	Data and insight	Equality considerations (including any adverse impacts)	Mitigation activities	Responsible department and timeframe for implementing mitigation activities
Age	18 per cent of Torbay residents are under 18 years old. 55 per cent of Torbay residents are aged between 18 to 64 years old. 27 per cent of Torbay residents are aged 65 and older.	The annual report focuses on the health and wellbeing of older adults but also promotes healthy activities throughout the lifecourse.	Not applicable	Not applicable
Carers	At the time of the 2021 census there were 14,900 unpaid carers in Torbay. 5,185 of these provided 50 hours or more of care.	The annual report highlights the importance of carer health and wellbeing.	Not applicable	Not applicable
Disability	In the 2021 Census, 23.8% of Torbay residents answered that their day-to-day activities were limited a little or a lot by a physical or mental health condition or illness.	The annual report promotes healthy ageing including prevention and management of long term health conditions.	Not applicable	Not applicable

Gender reassignment	In the 2021 Census, 0.4% of Torbay's community answered that their gender identity was not the same as their sex registered at birth. This proportion is similar to the Southwest and is lower than England.	No differential impact identified.	Not applicable	Not applicable
Marriage and civil partnership	Of those Torbay residents aged 16 and over at the time of 2021 Census, 44.2% of people were married or in a registered civil partnership.	No differential impact identified.	Not applicable	Not applicable
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.	No differential impact identified.	Not applicable	Not applicable
Race	In the 2021 Census, 96.1% of Torbay residents described their ethnicity as white. This is a higher proportion than the South West and England. Black, Asian and minority ethnic individuals are more likely to live in areas of Torbay classified as being amongst the 20% most deprived areas in England.	No differential impact identified.	Not applicable	Not applicable

Religion and belief	64.8% of Torbay residents who stated that they have a religion in the 2021 census.	No differential impact identified.	Not applicable	Not applicable
Sex	51.3% of Torbay's population are female and 48.7% are male	No differential impact identified.	Not applicable	Not applicable
Sexual orientation	In the 2021 Census, 3.4% of those in Torbay aged over 16 identified their sexuality as either Lesbian, Gay, Bisexual or, used another term to describe their sexual orientation.	No differential impact identified.	Not applicable	Not applicable
Armed Forces Community	In 2021, 3.8% of residents in England reported that they had previously served in the UK armed forces. In Torbay, 5.9 per cent of the population have previously served in the UK armed forces.	No differential impact identified.	Not applicable	Not applicable
Additional considerations				
Socio-economic impacts (Including impacts on child poverty and deprivation)		People in more challenged socio-economic circumstances are at greater risk of poor health and wellbeing and are therefore an important target group for the recommendations of the report.	Not applicable	Not applicable
Public Health impacts (Including impacts on the general health of the population of Torbay)		All programmes are designed to improve population health.	All programmes are designed to improve population health.	Not applicable
Human Rights impacts		Services and providers will remain cognisant of human rights, including the right to life,	Not applicable	Not applicable

		health, privacy, education and prohibition of discrimination.		
Child Friendly	Torbay Council is a Child Friendly Council and all staff and Councillors are Corporate Parents and have a responsibility towards cared for and care experienced children and young people.	Inter-generational activities, and all age-friendly programmes, are promoted through the annual report.	Not applicable	Not applicable

14. Cumulative Council Impact

14.1 The Strategy takes account of priorities and activities across People and Place teams, including economic strategy, adult and children's social care, education and housing.

14.2 All teams are expected to take note of the needs and priorities highlighted in the Strategy when developing strategy or commissioning services.

15. Cumulative Community Impacts

15.1 All of these programmes involve close partnership working across the Integrated Care System, including voluntary, community and social enterprise (VCSE) sector, and all are intended to promote and improve health across the whole of our population.

TORBAY COUNCIL

Devon Health and Care Strategy

Toby Hewlett, Director of Strategic Programmes and Planning, NHS Devon

1. Purpose of Report

1.1. To brief Torbay Health and Wellbeing Board members on the newly launched Devon Health and Care Strategy.

1.2. The Devon Health and Care Strategy has been submitted as a separate paper for review.

2. Reason for Proposal and its benefits

2.1. The strategy reflects a shared vision to transform the way health and care services are delivered across the county, ensuring that every individual receives the right care, at the right time, in the right place.

2.2. It is shaped by the priorities set out in the NHS 10 Year Health Plan: Fit for the Future, which sets a bold and clear roadmap for the future of healthcare across England over the next decade.

2.3. The NHS Plan challenges us to build a sustainable, person-centred health and care system that improves outcomes, reduces inequalities, and supports people to live healthier lives.

2.4. The Devon-wide strategy aligns fully with these national ambitions and goes further by placing a strong emphasis on collaboration across health, social care, voluntary, and community sectors.

2.5. This strategy sets out clear priorities to improve prevention and early intervention, integrate services more effectively, and support people to manage their own health and wellbeing.

2.6. Importantly, this strategy embodies our commitment to ‘place-based’ care, recognising the unique needs of communities across Devon—from urban centres to rural areas.

3. Appendices

Appendix 1: The Devon Health and Care Strategy has been submitted separately

4. Background Documents

4.1. The Devon Health and Care Strategy has been designed with the insights gained from the Devon 10 Year Plan engagement programme at the core.

Supporting Information

5. Introduction

5.1. NHS Devon's Health and Care Strategy sets out a bold and necessary transformation to ensure the long-term financial sustainability of our health and care system. With a projected financial gap of £781 million by 2030/31 if we do nothing, the strategy recognises that maintaining current models of care is no longer viable.

5.2. Instead, we are committing to a fundamental shift in how services are commissioned, delivered, and measured—anchored in value, outcomes, and efficiency.

5.3. Central to this transformation is the adoption of a new three-tier model of delivery—Neighbourhoods, Place, and Specialist Settings—designed to integrate care around local populations and reduce reliance on acute services.

5.4. Neighbourhoods will become the default delivery point for non-specialist activity, supported by multidisciplinary teams and commissioned through lead provider frameworks. This approach enables proactive, personalised care and supports the strategic shift from treatment to prevention.

5.5. To deliver this model within a constrained financial envelope, NHS Devon is implementing a set of strategic commissioning intentions aligned with the Model ICB blueprint. These include a rigorous focus on productivity—both organisational and system-wide—using tools such as the Model Hospital and mutual aid arrangements.

5.6. To stimulate transformation, growth funding will be directed into a Neighbourhood Development Fund, supporting schemes that reduce acute activity and improve community-based care.

5.7. This strategy is not only a financial imperative—it is a commitment to delivering equitable, but high-quality care also that meets the needs of Devon's population now and into the future.

5.8. Through disciplined commissioning, innovative contracting, and systemwide collaboration, NHS Devon will build a health and care system that is both resilient and sustainable.

6. Options under consideration

6.1. N/A

7. Financial Opportunities and Implications

7.1. N/A

8. Legal Implications

8.1. N/A

9. Engagement and Consultation

9.1. The Devon Health and Care Strategy has been designed with the insights gained from the Devon 10 Year Plan engagement programme at the core.

9.2. Ten targeted design workshops, each aligned to a chapter of the strategy, involving stakeholders from across the system—health, care, voluntary sector, and community representatives.

9.3. Interactive and iterative engagement, where stakeholders tested ideas, refined options, and helped identify barriers and enablers to change through the Design Steering Group and engagement with localities.

9.4. Over 125 individuals participated in one or more of the strategic workshops held to inform the development of this health and care strategy.

10. Procurement Implications

10.1. N/A

11. Protecting our naturally inspiring Bay and tackling Climate Change

11.1. N/A

12. Associated Risks

12.1. N/A

13. Equality Impact Assessment

The Council has a public sector duty under the Equality Act 2010 to have 'due regard' to advancing equality of opportunity between those persons who share a relevant protected characteristic and persons who do not share it. The Act also seeks to eliminate discrimination, harassment and victimisation. It is important that you carefully and thoroughly consider the different potential impacts that the decision being taken may have on people who share protected characteristics.

It is not enough to state that a proposal will affect everyone equally. There should be thorough consideration as to whether particular groups or individuals are more likely to be affected than others by the proposals and decision. Please complete the table below. If you consider there to be no positive or negative impacts state 'there is no differential impact'.

Protected characteristics under the Equality Act and groups with increased vulnerability	**Data and insight**	**Equality considerations (including any adverse impacts)**	**Mitigation activities**	**Responsible department and timeframe for implementing mitigation activities**
Age	18 per cent of Torbay residents are under 18 years old. 55 per cent of Torbay residents are aged between 18 to 64 years old. 27 per cent of Torbay residents are aged 65 and older.			

Carers	At the time of the 2021 census there were 14,900 unpaid carers in Torbay. 5,185 of these provided 50 hours or more of care.			
Disability	In the 2021 Census, 23.8% of Torbay residents answered that their day-to-day activities were limited a little or a lot by a physical or mental health condition or illness.			
Gender reassignment	In the 2021 Census, 0.4% of Torbay's community answered that their gender identity was not the same as their sex registered at birth. This proportion is similar to the Southwest and is lower than England.			
Marriage and civil partnership	Of those Torbay residents aged 16 and over at the time of 2021 Census, 44.2% of people were married or in a registered civil partnership.			
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.			
Race	In the 2021 Census, 96.1% of Torbay residents described their ethnicity as white. This is a higher proportion than the South West and England. Black, Asian and minority ethnic individuals are more likely to live in areas of Torbay classified as being amongst the 20% most deprived areas in England.			
Religion and belief	64.8% of Torbay residents who stated that they have a religion in the 2021 census.			
Sex	51.3% of Torbay's population are female and 48.7% are male			
Sexual orientation	In the 2021 Census, 3.4% of those in Torbay aged over 16 identified their sexuality as			

	either Lesbian, Gay, Bisexual or, used another term to describe their sexual orientation.			
Armed Forces Community	In 2021, 3.8% of residents in England reported that they had previously served in the UK armed forces. In Torbay, 5.9 per cent of the population have previously served in the UK armed forces.			
Additional considerations				
Socio-economic impacts (Including impacts on child poverty and deprivation)				
Public Health impacts (Including impacts on the general health of the population of Torbay)				
Human Rights impacts				
Child Friendly	Torbay Council is a Child Friendly Council, and all staff and Councillors are Corporate Parents and have a			

	responsibility towards cared for and care experienced children and young people.			

14. Cumulative Council Impact

(proposed changes elsewhere in the Council which might worsen the impacts identified above)

Are any cumulative impacts of the proposal/s identified across your service area affecting other departments or potential impact from other service areas? Please explain what these might be (you may need to revisit this section once proposals have been further defined)

Please write 'None' if not applicable

14.1.

15. Cumulative Community Impacts

(proposed changes within the wider community (including the public sector) which might worsen the impacts identified above). Are any cumulative impacts identified across your service area from proposals in other public services or partner organisations? Please explain what these might be (you may need to revisit this section once proposals have been further defined)

Please write 'None' if not applicable

15.1.

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NHS Devon

Health and Care Strategy

2026/2031

Shaping NHS services to improve the health of our communities and residents in Devon

Contents

Foreword

I am honoured to introduce our new, ambitious Health and Care Strategy for Devon. This strategy reflects our shared vision to transform the way health and care services are delivered across the county, ensuring that every individual receives the right care, at the right time, in the right place.

It is shaped by the priorities set out in the NHS 10 Year Health Plan: Fit for the Future, which sets a bold and clear roadmap for the future of healthcare across England over the next decade.

The NHS Plan challenges us to build a sustainable, person-centred health and care system that improves outcomes, reduces inequalities, and supports people to live healthier lives.

Our Devon-wide strategy aligns fully with these national ambitions and goes further by placing a strong emphasis on collaboration across health, social care, voluntary, and community sectors.

We know that the challenges facing Devon's population are complex. From an ageing population to rising demand for mental health services, and the ongoing need to tackle health inequalities, we must work smarter and more innovatively.

This strategy sets out clear priorities to improve prevention and early intervention, integrate services more effectively, and support people to manage their own health and wellbeing.

By focusing on personalised care, digital innovation, and workforce development, we aim to create a resilient and responsive system that delivers high-quality care close to home. As we set out our vision for the future of health and care, we remain firmly committed to delivering services that are not only high-quality and person-centred, but also financially sustainable. This strategy reflects our dedication to making responsible choices that ensure long-term value, resilience, and equity across our system. By rooting our new model of delivery, we aim to safeguard resources while continuing to meet the evolving needs of our communities.

Importantly, this strategy embodies our commitment to 'place-based' care, recognising the unique needs of communities across Devon—from urban centres to rural areas.

We are determined to break down traditional barriers between health and social care, working together in partnership with local authorities, voluntary organisations, and, crucially, the people we serve.

This is a pivotal moment for health and social care in Devon and together we will build a healthier, more connected Devon.

I look forward to working with all our partners and communities as we embark on this vital journey.

Libby Ryan-Davies
Chief Strategic Commissioning & Planning Officer

Personas

The Devon personas have been developed to bring to life the experiences of people across our communities, helping us to understand the impact of health and care services on real lives.

Personas are not statistical profiles, but carefully constructed stories that reflect the complex needs, circumstances, and aspirations of different groups in our population.

By grounding planning and engagement in these lived perspectives, we can design services that respond to what matters most to people, rather than to systems alone.

The use of AI has enabled these personas to be expanded and enriched, drawing on a wide range of local and national data, strategic priorities such as the NHS 10-Year Plan, and insights from local engagement.

This approach ensures that each personas remain dynamic, evidence-based, and sensitive to emerging challenges and opportunities.

By using personas, decision-makers can more clearly see how changes in policy or service delivery might be experienced by different people.

They provide a powerful way to test ideas, explore unintended consequences, and identify opportunities for prevention, integration, and innovation.

Most importantly, they help to ensure that patient and public insights are not only heard but actively shape the design of future health and care services in Devon. Some examples of how we can apply the personas with application of the model are described on the next page.

Margaret Plum, 84, Mid Devon

Margaret's healthcare can be fragmented, hospital-focused and she has several conditions including mild dementia, hypertension, osteoarthritis, mobility issues, and she is at risk of falls. She is heavily reliant on carers and rural transport, and experiences loneliness.

Under the NHS Devon strategy her experience shifts significantly. Care is delivered closer to home through **neighbourhood health hubs** and regular **frailty checks**, reducing the need for hospital travel.

Prevention becomes central: dementia-friendly programmes, falls-prevention groups, and personalised exercise support improve her independence.

Technology plays a supportive role, with a simple **wearable fall detector** linked to an appropriate responder, ensuring quick response and reassurance.

Social prescribing connects her to befriending groups and accessible transport, tackling loneliness and isolation. A **shared care record** prevents repetition and coordinates her support across services.

For Margaret, delivering the NHS Devon strategy means fewer crises, stronger community connections, and a system designed around prevention, independence, and dignity in later life.

Riley Rivers, 9, Exeter

Riley lives with his mum. He has epilepsy and is waiting for an attention deficit hyperactivity disorder (ADHD) assessment. At present, most of his care is hospital-based. His epilepsy requires multiple appointments, and he faces a lot of challenges with behaviour and stigma at school.

Under the NHS Devon strategy, Riley's experience becomes more joined-up and community-centred. His epilepsy reviews take place in his **neighbourhood community hub**, with results shared across health and care providers.

The NHS and schools work closer together to help manage his conditions, reducing stigma and improving his experiences at school.

Early intervention is prioritised: school-based mental health teams help Riley manage behaviour and anxiety before crises escalate, and his ADHD assessment is completed more quickly.

Technology, such as a **wearable seizure monitor**, provides reassurance and reduces unnecessary hospital visits.

Through **social prescribing**, Riley joins inclusive after-school activities, while his mum accesses peer and financial support.

His care shifts from fragmented hospital journeys to **integrated, preventative, community-focused support**, helping him thrive as a child.

Executive Summary

NHS Devon's Health and Care Strategy sets out a bold and necessary transformation to ensure the long-term financial sustainability of our health and care system. With a projected financial gap of £781 million by 2030/31 if we do nothing, the strategy recognises that maintaining current models of care is no longer viable.

Instead, we are committing to a fundamental shift in how services are commissioned, delivered, and measured—anchored in value, outcomes, and efficiency.

Central to this transformation is the adoption of a new three-tier model of delivery—Neighbourhoods, Place, and Specialist Settings—designed to integrate care around local populations and reduce reliance on acute services.

Neighbourhoods will become the default delivery point for non-specialist activity, supported by multidisciplinary teams and commissioned through lead provider frameworks. This approach enables proactive, personalised care and supports the strategic shift from treatment to prevention.

To deliver this model within a constrained financial envelope, NHS Devon is implementing a set of strategic commissioning intentions aligned with the Model ICB blueprint. These include a rigorous focus on productivity—both organisational and system-wide—using tools such as the Model Hospital and mutual aid arrangements.

Providers will be expected to harmonise quality and performance standards at the lowest sustainable cost and deliver a minimum 3% cost improvement programme (CIP) beyond baseline efficiencies.

Contracting protocols are also evolving to reflect this strategic direction. NHS Devon will move towards commissioning for outcomes rather than activity, with clear expectations and key performance indicators (KPIs) embedded in contract negotiation meetings commencing October 2025.

These meetings will ensure alignment between provider plans and the ICB's five-year commissioning roadmap, enabling a more accountable and transparent planning process.

To stimulate transformation, growth funding will be directed into a Neighbourhood Development Fund, supporting schemes that reduce acute activity and improve community-based care. Specialties such as dermatology, urology, orthopaedics, and cardiology will be commissioned through lead provider arrangements, with further transformation planned in urgent care, community hospitals, and midwifery-led units.

This strategy is not only a financial imperative—it is a commitment to delivering equitable, but high-quality care also that meets the needs of Devon's population now and into the future.

Through disciplined commissioning, innovative contracting, and system-wide collaboration, NHS Devon will build a health and care system that is both resilient and sustainable.

Introduction

NHS Devon Integrated Care Board (ICB), responsible for planning, funding, and overseeing services across the county, is leading a bold and necessary transformation. Our communities face rising demand, an ageing population with increasingly complex needs, entrenched health inequalities, and persistent financial pressures—all intensified by the ongoing recovery from the Covid-19 pandemic.

Despite the dedication of staff across NHS and care services, the system is under sustained strain. People in Devon continue to experience long waits for elective treatment, there is pressure on urgent and emergency care, and delays in accessing assessments, diagnosis, treatment and community-based support across a spectrum of services.

Services can feel fragmented and difficult to navigate, with care often arriving only at crisis point. Outcomes and access vary significantly depending on geography and circumstance, and the financial position across the system remains fragile, limiting the ability to invest in new models of care.

The current system is not designed to meet the modern, diverse needs of Devon's communities—whether that's rural and coastal populations with limited access, children and young people needing earlier mental health support, or older adults living with multiple long-term conditions who require more joined-up, personalised care.

Strategic and financial context

NHS Devon's core funding encompasses all commissioned services, including acute, mental health, and community care. Almost 80% of running costs are attributed to staffing, with the remainder covering estates and other non-pay expenses.

Despite receiving £163 million above its needs-based population allocation, the system remains financially fragile, requiring £54 million in deficit support to break even in 2025/26.

This financial imbalance limits the capacity to invest in innovation, respond to rising demand, and deliver sustainable improvements. However, the strategic redistribution of resources across Devon's four localities is beginning to correct historical inequities, bringing planned expenditure closer to fair share allocations and aligning with the principles of the Model ICB Blueprint.

Our population of around 1.3 million is ageing rapidly, with 24% aged 65 or older, well above the national average, and growth among those aged 75+ accelerating.

This demographic shift, combined with geographic and social inequalities, creates stark contrasts in health outcomes, with up to a 20-year difference in healthy life expectancy across the county.

Rising demand across all service areas, especially the delays in accessing assessments, diagnosis, treatment and community-based support is compounded by workforce shortages**,** fragmented care pathways, and infrastructure risks.

The system's IT and estates vary significantly in quality, with some facilities in urgent need of repair, posing risks to continuity and safety.

Nationally, policy frameworks such as the NHS Long Term Plan and the Fuller Stocktake have laid the foundation for the expectations for the NHS to deliver.

They call for a fundamental reconfiguration of services dissolving the long-standing divides between primary, community, and secondary care, and enabling more joined-up, person-centred approaches.

At the heart of this transformation is the emerging Neighbourhood model, a nationally endorsed delivery vehicle for integrated care.

This model envisions care being designed and delivered at a local level, tailored to the specific needs of neighbourhood populations, typically serving 30,000 to 50,000 people. It brings together general practice, community services, mental health, social care, the voluntary sector, and increasingly, public health and housing working as a single team around the individual.

The Neighbourhood model is not simply a structural change, it represents a paradigm shift in how care is conceptualised and delivered. It is the mechanism through which the three strategic shifts outlined by government are being operationalised.

This Strategy should be seen alongside the NHS Devon Strategic Commissioning Intentions and full Medium Term Financial Plan

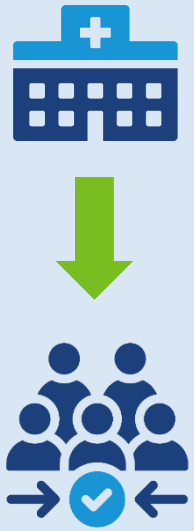
Our health and care strategy describes our future model and how we align services to deliver optimal outcomes for our population.

Our strategic commissioning intentions will describe how we will allocate resource to deliver the future service model within allocation.

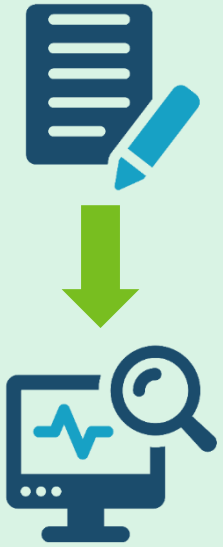
Our medium-term financial plan will describe the financial model the strategy will need to be delivered within and impact of commissioning intentions.

The three shifts

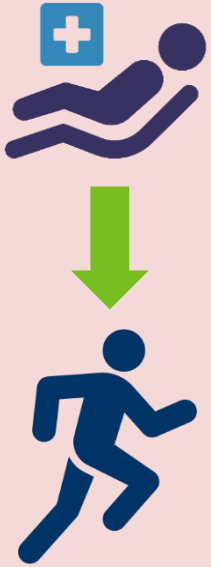
From hospitals to community and primary care: shifting the centre of gravity of the NHS closer to people's homes.



From analogue to digital: embedding digital tools to support access, coordination, and self-management.



From treatment to prevention: focusing on early intervention, population health, and reducing health inequalities.



This national direction is underpinned by growing evidence that locally integrated, neighbourhood-based care delivers better outcomes, improves patient and staff experience, and reduces unwarranted variation. It also enables more effective use of resources by aligning services around population need rather than organisational boundaries.

As Integrated Care Boards (ICBs), we are expected to lead the implementation of this model ensuring that neighbourhood teams are empowered, resourced, and supported to deliver care that is proactive, personalised, and equitable.

Our vision

“We imagine a Devon where everyone can live well—on their own terms, in communities that value equity, sustainability, and belonging.

This means recognising the rich complexity of people’s lives, identities, and experiences, and the many factors that shape health and wellbeing beyond traditional services.

By nurturing a culture of curiosity, care, and shared responsibility, we will work across boundaries to challenge injustice, reimagine support, and act boldly together.

Rooted in trust, lived experience, and community strengths, we are committed to lasting change—so that everyone, especially those historically underserved, can thrive now and for generations to come.”

A targeted strategic approach

In response, NHS Devon's strategic long-term approach will mark a seismic shift toward place-based, outcome-led delivery though a new model of care that is based around Neighbourhood Delivery.

This transformation is guided by the principles of the NHS 10-Year Plan and the NHS Medium Term Planning, which emphasizes earned autonomy, reduced duplication, and a relentless focus on productivity and value. We aim to fully embrace the greater financial flexibility, with fewer national priorities and more local discretion to tailor services to community needs.

Devon's strategy embraces this opportunity, aligning its financial planning, workforce development, digital innovation, and care redesign with the overarching goal of improving population health, reducing inequalities, and delivering consistently high-quality care.

This strategy is not just about recovery, it is about building a sustainable future and builds on existing work across the Integrated Care System, including the Joint Forward Plan, the Integrated Care Strategy, and local authority and provider plans.

It draws on national guidance such as the NHS 10-Year Plan and the Model ICB Blueprint, which advocate for earned autonomy, reduced duplication, and a sharper focus on productivity and value.

By aligning local priorities with national expectations, Devon is embracing the opportunity to tailor services to community needs, supported by greater financial flexibility and system-wide collaboration.

Structured around new model of delivery, the strategy sets out high-level commissioning intentions that reflect a shared ambition across all services directly commissioned by the ICB.

It aims to stabilise the system in the short term, while enabling long-term transformation through redesigned care pathways, digital innovation, a stronger focus on prevention and population health, and better use of workforce and estate resources.

Operating within a defined financial envelope, the strategy supports a shift from reactive and siloed approaches to proactive, preventative, and integrated models of care placing people at the centre and ensuring that care follows the individual, not the other way around.

Achieving this vision will require a phased, pathway-led, and coordinated effort, underpinned by strong leadership and alignment across the system.

The strategy is anchored by four core principles:

- sustainability, through financial, operational and environmental resilience
- quality and value, by delivering effective care that maximises impact
- person-centred care, designed around what matters to individuals and communities, and an
- accessibility, ensuring equitable access regardless of location, background, or circumstance.

By looking outward to national models and inward to local insights, Devon's strategy sets a clear direction for transformation—one that is grounded in collaboration, shaped by evidence, and focused on delivering better outcomes for all.

Our system

Progress has been made to improve services and outcomes, NHS Devon faces a range of long-term challenges that demand a major shift in how care is planned, delivered, and experienced.

Rising demand, an ageing population, increasing health inequalities, and financial and workforce pressures mean that continuing with our current models of care is not sustainable.

The NHS in Devon must remain attentive to the evolving national policy landscape, including changes to organisational structures and system footprints, while also recognising and responding to the expectations of our population.

Our population want to experience services that are easier to navigate, more joined-up, and more responsive to their individual needs. They wish to be supported to maintain their health, live independently for longer, and access care as close to home as possible.

Our population

Devon is undergoing a significant demographic transformation. Over the past decade, the population has grown by 9.7%. However, this growth is not evenly distributed across age groups. While the number of young people aged 0–19 has increased by less than 1%, the population aged 75–84 has surged by over 40%. This disproportionate growth in older age groups is reshaping the landscape of public service demand, particularly in health and social care.

Two primary factors are driving this shift. First, the legacy of the post-World War II baby boom continues to influence population structure. The birth rate in 1947 was approximately 50% higher than in 1937, and those born during this peak will turn 78 in 2025. This cohort is now entering the age range associated with higher health and care needs.

Second, Devon experiences consistent inward migration, particularly among individuals aged 35–70, drawn by the region's quality of life, environment, and retirement appeal.

This migration pattern results in a lower proportion of residents under the age of 53, except for a temporary spike in the 19–22 age group due to the presence of two major universities. Beyond age 53, Devon has a significantly older population profile compared to national averages.

Looking ahead, official projections indicate that Devon's population will continue to grow at a steady rate of approximately 0.7% per year, adding around 68,000 people over the next decade. Crucially, this growth will be concentrated among those aged 65 and over.

The baby boom generation will begin to enter the 85+ age bracket, while their children transition into later life, contributing to a substantial increase in the 65–74 age group. This demographic shift will have profound implications for the design, delivery, and sustainability of health and care services across the county.

Strategic implications for health and care services

As the population ages, we anticipate a corresponding rise in mortality rates and an increase in the intensity of health and care service usage. It is well established that the final years of life are associated with disproportionately high service demand. Previous estimates suggest that approximately one-third of a person's lifetime care costs are incurred in the last two years of life.

This underscores the urgency of strategic planning and resource allocation to ensure that services remain responsive, resilient, and financially sustainable.

To support this planning, the Devon System Demand Model has been developed. This model provides a comprehensive framework for understanding and forecasting service pressures, built around three interrelated components: health needs, demand, and supply.

- **Health Needs** are measured using Disability Adjusted Life Years (DALYs), a metric that captures both the prevalence and severity of illness, as well as premature mortality. Health needs increase significantly with age — a person aged 90 or older typically has health needs eight times greater than someone in their twenties.
- **Demand reflects the actual utilisation of health services** and the system's capacity to respond. It is shaped by population behaviour, accessibility of services, and system responsiveness.
- **Supply encompasses** the full spectrum of resources required to meet demand, including workforce, hospital beds, medications, equipment, and infrastructure.

Together, these components enable a strategic understanding of how demographic trends will impact service delivery and provide a foundation for evidence-based decision-making.

Changing patterns of health need

Analysis of DALYs over time reveals that health needs in Devon remained broadly stable between 2000 and 2015. However, since then, the system has entered a phase of accelerated growth in health needs, closely linked to the increasing number of people aged 75 and over. While demographic change is a key driver, other factors — including technological advances, evolving clinical practices, and non-demographic growth — also contribute to rising demand.

Conditions most affected by ageing show the highest annual growth rates. These include:

- respiratory infections (+3.4%)
- dementia (+3.3%)
- falls (+2.8%)
- diabetes (+2.7%), and
- stroke (+2.4%).

Additionally, in line with national statistics around 2.16% of the Devon population, approximately 26,000 people, are known to have a learning disability, with 8,000 registered in primary care. Since COVID-19, referrals for autism and ADHD support have quadrupled, driven by increased public awareness and demand. This surge has placed exceptional pressure on health services, highlighting a critical gap in capacity and access for neurodivergent populations.

Addressing deprivation and health inequality

Devon's demographic challenges are further compounded by persistent health inequalities and pockets of deprivation. Urban centres such as Plymouth, Torbay, and Ilfracombe experience the highest levels of deprivation, with additional hotspots in Exeter and Barnstaple.

Notably, Plymouth has more residents in the lowest deprivation quintile than the rest of Devon combined. Rural and coastal areas, particularly in North and West Devon, also face significant deprivation, driven by low wages, limited employment opportunities, and a high cost of living. These socioeconomic factors have a direct impact on health outcomes and service utilisation. Neurodivergent individuals, particularly autistic people, face significantly poorer health outcomes and higher risks of early mortality.

Analysis of acute hospital spending reveals clear variation by deprivation level, with differences evident across both urgent and planned care services. Addressing these inequalities is essential to delivering equitable care and ensuring that all communities across Devon benefit from strategic investment and service transformation. This will require a coordinated approach across health, social care, housing, and economic development sectors.

Protected characteristics

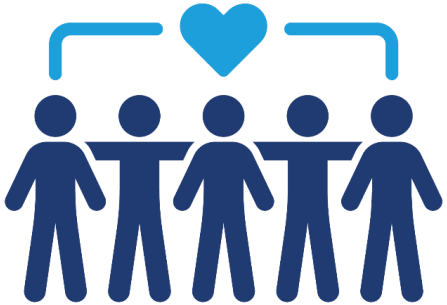
People with protected characteristics whether related to race, religion, sexuality, gender, or other aspects of identity often face distinct health needs and systemic barriers that result in poorer outcomes.

Tackling these disparities is a core commitment of NHS Devon and a fundamental principle of integrated care. All NHS-commissioned services will be expected to embed equity principles into their design and delivery. These include:

- **Proportionality**: Resources and interventions should be targeted according to need, recognising that some groups require more support to achieve equitable outcomes.
- **Accessibility**: Services must be physically, culturally, and linguistically accessible to all, removing barriers to entry and engagement.
- **Participation**: Communities must be actively involved in shaping the services they use, ensuring lived experience informs decision-making.
- **Transparency**: Data on outcomes must be collected, analysed, and shared to monitor progress and hold the system accountable.
- **Sustainability**: Equity efforts must be embedded into long-term planning, not treated as short-term initiatives.

Commissioned outcomes will be measured at Neighbourhood level, where care is delivered closest to communities, and monitored at Place, where strategic oversight ensures consistency and accountability.

To support this, NHS Devon has developed a nationally pioneering set of AI-generated personas realistic, data-driven profiles that reflect the lived experiences, demographics, and health conditions of diverse communities across Devon.



These personas are used to inform impact assessments, public engagement, and service design, helping to embed equity into every stage of planning and delivery.

By incorporating these personas into strategy development, service redesign, and Equality and Quality Impact Assessments (EQIAs), the system can better understand and respond to the needs of underrepresented groups. They will also be used iteratively in design workshops and decision-making processes to test service accessibility and equity.

Inclusion of health groups such as people experiencing homelessness face some of the most severe health inequalities. These individuals often experience multiple, compounding risk factors including stigma, poverty, trauma, and discrimination, leading to significantly poorer health outcomes and reduced life expectancy.

This strategy places equity, inclusion, and lived experience at the heart of system transformation. By embedding these principles into commissioning, service design, and workforce development, NHS Devon will build a health and care system that works for everyone, especially those who have historically been underserved.

Financial sustainability

In line with the Model ICB Blueprint, ICBs are now positioned as strategic commissioners, responsible for leading system-wide reform and optimising resource allocation. The Medium-Term Financial Plan (MTFP) plays a foundational role in this shift, supporting the development of leaner operating models and enabling ICBs to live within their means while delivering improved outcomes. It is a critical strategic tool for the ICB, designed to bridge the gap between long-term ambitions and short-term operational delivery.

Its core purpose is to provide a shared financial framework across system partners, enabling coordinated planning over a five-year horizon. This approach supports the delivery of the NHS 10-Year Plan by translating strategic goals into actionable financial trajectories, identifying the resources required to meet population health needs, and ensuring systems remain financially sustainable and together with our new contracting model, it will help rebalance system relationships.

It must be triangulated with workforce, activity, and quality plans, and co-produced with system partners to reflect shared priorities. This ensures that financial planning is not conducted in isolation but is embedded within broader strategic and operational frameworks.

The new operational planning guidance reinforces this alignment by setting out a focused set of national priorities, including improving access to timely care, increasing productivity, and addressing health inequalities.

Medium-term financial plan (MTFP) model in Devon

A Devon five-year Medium Term Financial Plan (MTFP) is being developed which fully aligns with the Health and Care Strategy. It will show how the financial challenge will be met across Devon as it drives towards achieving financial sustainability and sets the guard rails from within which the Devon Health and Care Strategy will be delivered.

The MTFP will set out investment strategies that allocate resources over time that are aligned with population needs. These investments will be focused on 'left shift' supported by equity analysis that will help ensure that resources are allocated towards improving equitable access, delivering care in the most appropriate setting and reducing health inequalities. They will be driven by data and population insights, with a strong focus on prevention, equity, and outcomes.

Current position

The Devon system is financially challenged and is both overspending and overfunded. This results in debt repayments being required annually to repay deficits and allocation reductions known as convergence being made to bring Devon back within the tolerance of the target needs-based population allocation. This, together with an underlying deficit in excess of £200m, leads to a challenging road to recovery.

	26/27 £m	27/28 £m	27/29 £m	29/30 £m	30/31 £m
Opening Underlying Posiion	-204.0	-305.4	-417.6	-536.1	-649.1
Convergence	-24.2	-24.7	-25.3	-15.3	-15.7
Allocation Growth	107.8	109.3	111.8	114.6	117.8
Demand Increases	-25.9	-29.9	-30.2	-29.0	-27.0
Inflation	-145.8	-153.0	-160.6	-168.7	-177.2
Minimum Uplift	-13.4	-13.8	-14.2	-14.6	-15.1
Exit ULP	-305.4	-417.6	-536.1	-649.1	-766.2
Debt Repayment	-14.2	-14.5	-14.8	-15.2	-15.6
	-319.7	**-432.1**	**-550.9**	**-664.3**	**-781.8**
ICB baseline	3,222.0	3,295.2	3,370.0	3,457.7	3,533.3
Savings required	-9.9%	-13.1%	-16.3%	-19.2%	-22.1%

Equity

Based on national funding formula, NHS Devon has reviewed its spend against programme area and locality to establish where inequity sits in funding of our services, this also identifies how our total overspend (or Distance from Target) is split.

Overall this shows an under-resourcing of Prescribing and Primary care whilst we spend £112m more than expected on community care, £66m more than expected on our Acute care and £30m more than expected on Mental Health.

The analysis also shows variation between locality with only one locality (Northern) showing as requiring a total spend below that which would be expected.

There should be a note of caution in interpreting these numbers as given current lack of Electronic Patient Records in Torbay and South Devon Hospital and University Hospital Plymouth there is a gap in current activity coded which will have implications for Devon's allocation of

resource based on the National Formula.

Devon providers will need to address coding issues to ensure the system receives its fair share of resources. In the meantime the equity analysis will be used as a directional tool alongside other benchmarking data to inform local allocation of resource as part of our commissioning plan and full MTFP.

Core ICB Funding						
25/26 plan expenditure	Eastern £m	Northern £m	Plymouth £m	Sth Devon & Torbay £m	Western £m	
G&A and maternity	557.8	235.3	437.4	534.6	68.4	1
Community	133.0	49.6	93.9	121.2	16.5	
MH	113.5	43.2	83.9	91.1	11.5	
Prescribing	74.6	34.2	58.9	63.7	10.2	
Primary Care	14.2	5.9	11.3	10.9	1.7	
Total	**893.2**	**368.2**	**685.4**	**821.6**	**108.3**	**2**
25/26 expected expenditure						
G&A and maternity	568.6	251.1	412.5	470.3	65.0	1
Community	97.1	43.4	66.4	84.5	11.4	
MH	96.9	42.0	81.6	83.1	9.8	
Prescribing	77.3	33.8	59.0	65.9	9.5	
Primary Care	15.4	6.2	10.7	11.9	1.7	
Total	**855.3**	**376.4**	**630.1**	**715.7**	**97.3**	**2**
25/26 inequity						
G&A and maternity	-10.8	-15.7	24.9	64.3	3.4	
Community	36.0	6.1	27.5	36.8	5.2	
MH	16.7	1.2	2.3	8.1	1.7	
Prescribing	-2.7	0.4	0.0	-2.3	0.8	
Primary Care	-1.2	-0.2	0.6	-1.0	0.0	
Total	**37.9**	**-8.2**	**55.3**	**105.9**	**11.0**	

Future delivery

To deliver the medium-term financial plan (MTFP), financial sustainability and return on investment discipline will be at the core of our financial framework, underpinned by advanced population health management, value-based healthcare and a neighbourhood-first approach.

We will develop insights into cost behaviour and value achieved from commissioning services to inform healthcare planning and the better allocation of resources over time.

Productivity improvements will be required to achieve financial sustainability and free up funding for investment and service transformation.

Services will be reviewed to ascertain whether they can be stopped, shifted into a different service model or environment, or completely transformed but without the need for large capital investments, which will be limited. This will be supported by maximising digital transformation to reduce cost and improve productivity.

As the population ages, particularly with a sharp rise in those aged 65 and over, the burden of disease intensifies, leading to greater and more complex service demand. At the same time, the capacity to meet this demand through workforce, infrastructure, and clinical resources is limited, creating a mismatch that directly impacts financial sustainability.

We need to respond to the underlying inequity of spend on our population. The overall spend per person varies by 7.5% (£54 per person) from the lowest spend in the most deprived quintile to affluent quintile.

The highest spend in the 2nd most Urgent care spend per person is higher in more deprived areas, but planned care spend is higher in the more affluent areas. In the most deprived areas, urgent care makes up 47.5% of the total acute hospital tariff spend per person, but this reduced to 39.5% for the most affluent. Most of the higher urgent care tariff per person in the deprived communities is linked to higher type 1 ED attendances that are nearly double the rate seen in the most affluent areas (£53 compared to £28)

How the strategy was developed

The journey so far

We embarked on a journey to develop and deliver a comprehensive, inclusive, and future-focused strategy that ensures safe, effective, and sustainable health care for all people in Devon. This is aligned to national NHS direction and policy framework of focusing on population health, prevention, recovery of core NHS services, improving access, and reducing health inequalities though a lifecycle. It includes:

- Whole-population focus
- Care across the continuum
- Responding to system pressure and sustainability

The development of Devon's Health and Care Strategy has been guided by a structured Discover–Design–Deliver methodology. This approach ensures that transformation is not only evidence-based and strategically sound, but also inclusive and co-produced with the people who use and deliver services across the system.

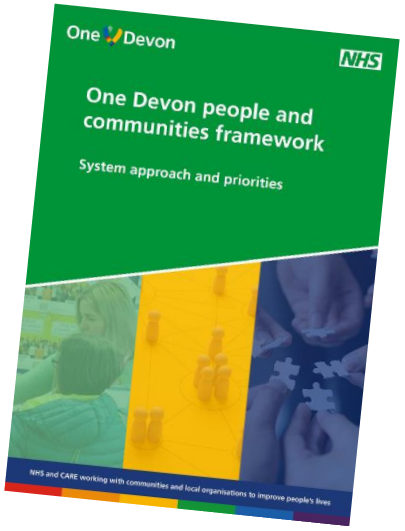
Discover phase: Building a shared understanding

The Discover phase focused on developing a rich understanding of the current health and care landscape in Devon, completed through:

- Reviewing existing intelligence through the system's insights library, which collates data on population health, service performance, and inequalities.
- Drawing on the 10-Year Plan engagement, which involved over 3,400 participants across Devon. This provided a robust evidence base, particularly around the three strategic shifts:
  - From hospitals to community and primary care
  - From treatment to prevention
  - From analogue to digital services

As part of the 10 Year Plan engagement, a committed cohort of over 200 individuals expressed interest in ongoing involvement were identified. This presents a valuable opportunity to establish a citizens' panel or bespoke reference groups to support continued co-design and accountability.

The One Devon People and Communities Framework demonstrates how we will work together across the One Devon System to widen engagement opportunities to the whole Devon population.



The Framework ensures that the voices of those who experience health inequalities, or those who live in rural, coastal or remote communities, have an equal chance to be heard and influence decision making.

The Devon 10 Year Plan Engagement programme proves the effectiveness of this approach. This was recognised by regional colleagues as a leading example.

To support the Framework, NHS Devon has developed a service change process. This has been agreed by leaders from across Devon to provide a consistent approach to managing service change.

Key findings from the Discover phase

The Discover phase has provided a rich understanding of the current position of the Devon Integrated Care System (ICS). Drawing on population data, system analysis, and extensive stakeholder engagement, we have identified the key pressures, opportunities, and priorities that ultimately shaped the development of NHS Devon's Health and Care Strategy.

While many of the findings may not be unexpected, they offer a clear and compelling evidence base from which the strategy can confidently move forward. They validate long-standing concerns, reinforce national policy direction, and highlight the areas where transformation is most urgently needed.

Demographic and population insights

Devon's population is undergoing significant demographic change, marked by an ageing population and increasing diversity in health and care needs. Older age groups are growing rapidly, driving demand for more complex and long-term care, including end-of-life support. Alongside this, there is a sharp rise in neurodiversity-related needs, particularly autism and ADHD, and Learning Disabilities with more individuals seeking diagnosis and support than ever before. This surge reflects growing public awareness and changing expectations around access to timely, personalised care.

Cultural attitudes and population expectations are also evolving, with people increasingly seeking proactive, inclusive, and responsive health services that reflect their lived experiences and identities. These shifts present a major challenge for the health and care system, which must adapt to meet rising demand, reduce inequalities, and deliver care that is both person-centred and culturally competent.

System pressures and infrastructure challenges

Devon is operating within a significantly challenged financial environment, having ended 2024/25 with a substantial deficit despite receiving support funding, and facing a much larger underlying financial gap that signals the need for strategic reform. Our unique geography adds further complexity, with remote rural and coastal communities facing persistent accessibility barriers.

Although deprivation levels are relatively low overall, health outcomes vary widely, with stark differences in healthy life expectancy across the county.

Infrastructure across IT and estates is inconsistent, with some facilities in good condition and others in urgent need of repair—posing risks to business continuity, safety, and service quality.

These pressures reflect a system that must evolve to meet growing and changing population needs, while ensuring resilience, equity, and sustainability.

Stakeholder engagement insights

Stakeholder engagement has been central to the Discover phase, ensuring that the strategy is shaped by the voices of our communities and professionals.

To support the Government's 10-Year Health Plan, NHS Devon led a comprehensive engagement programme involving staff, patients, the public, and partners across Devon.

Over 3,400 participants contributed to Devon's 10-Year Health Plan engagement, providing a robust evidence base for strategic development.

Described nationally as 'the biggest conversation about the future of the NHS since its inception,' this programme aimed to capture local voices on the three big shifts shaping healthcare.

NHS Devon tailored this engagement locally, ensuring the views of Devon's diverse communities informed both local priorities and the national plan.

Co-designed with Healthwatch Devon, Plymouth, and Torbay, and supported by the Devon Engagement Partnership (DEP), the programme aligned its questions with the national framework to maintain consistency.

The objectives were to:

- Reach the right people, in the right places, at the right time—especially those in Core20PLUS5 groups and seldom heard communities.
- Encourage ongoing public involvement in NHS transformation.
- Drive participation in the national 10 Year Plan survey.
- Maintain clarity and creativity in engagement to minimise confusion.
- Collaborate with neighbouring ICBs in Cornwall and Somerset.

The success of this approach relied on strong partnerships and using trusted networks across Devon to maximise reach and impact.

Three main engagement tools were used:

- An online survey for workforce and public (hosted on the One Devon website)
- A locally adapted “Workshop in a Box”
- Engagement postcards distributed at events

While survey and workshop questions mirrored the national programme, workshop content was adapted to resonate with Devon’s communities, making conversations meaningful and relevant. Though the survey was primarily online, phone responses were facilitated by Healthwatch and promoted in all communications.

Engagement postcards were also distributed at local events. NHS Devon’s communications and engagement team led the programme, supported by providers, local authorities, South Western Ambulance Service NHS Foundation Trust (SWASFT), Healthwatch, voluntary sector organisations, and other key partners. A communications toolkit helped partners promote the programme as trusted community voices.

Five engagement days across Devon raised awareness, encouraged survey completion, hosted workshops, and supported postcard responses—with strong backing from Healthwatch, voluntary sector groups, and provider colleagues.

To reach those most affected by health inequalities, NHS Devon invested in the voluntary, community and social enterprise (VCSE) sector through a small grants scheme. This enabled community organisations to hold targeted workshops, including:

- Yes Brixham (Homelessness)
- Adventure Therapy (Young People)
- Headway Devon (Learning Disability/Acquired Brain Injury)
- Age Concern (Carers and Older People)
- Hikmat Devon (Ethnically Diverse Communities)
- Citizens Advice (People with Physical Disabilities)
- Devon Communities Together (Coastal Communities)

Devon’s approach was recognised regionally as a model of best practice, with many other South West ICBs adopting similar methods.

Our thorough approach generated strong participation and broad representation:

- Over 3,400 individual feedback responses
- 2,353 survey completions
- 50 workshops (10% of all national workshops) with 358 attendees
- Over 700 written postcards completed
- More than 220 people signed up for ongoing engagement

Key themes

- Strong support for the NHS being free at the point of access
- The NHS workforce is seen as the system's most valuable but vulnerable asset
- Appreciation for the wide range of services and their personal impact
- Urgent need to improve access to primary care, mental health, A&E, and elective services
- Generally positive experiences when accessing care, despite low satisfaction with overall NHS management (reflecting national trends)
- Need for adequate NHS funding
- A call for better integration and communication between services
- Emphasis on prevention, diagnostics, and earlier intervention to reduce illness
- Desire for greater investment in frontline services and a reduction in management costs
- Recognition of technology's potential to improve efficiency and care coordination, balanced by concerns over AI, data privacy, and digital exclusion

Learning from local, national, international examples

Since its inception, the NHS has undergone numerous system-wide reorganisations in response to changing demographics, cultural shifts, advances in medical science, and the need for financial sustainability.

It continues to evolve to deliver care that is more personalised, effective, preventative, and sustainable—an imperative in today's complex healthcare environment and emerging policy landscape. In this section, we highlight examples of innovative and effective approaches to managing patients with complex needs and multiple long-term conditions.

These case studies illustrate how Primary Care, Community Services, and Acute Settings are working collaboratively to improve outcomes for our populations.

Local examples of good practice

Integrated care and health inequalities (including primary care)

Delivery of one-off hospital discharge Personal Health Budgets (PHB) as part of discharge planning have now been embedded with a centralised support model to simplify payment processes and minimise impact and workload forward-based staff. Leads in the local system are working with the Southwest Integrated Personalised Care Team to support to embed training offers centred on the 'what matters to you' conversation as part of the discharge planning process.

One Northern Devon' is a partnership of the NHS, social care, local housing authorities, police, fire service, local businesses and voluntary and community groups working together to reduce inequalities and improve health and well-being. The partnership has devised the 'Flow programme' to bring teams together to work in a more integrated way to support people with complex needs. Focussing on what matters to the person – which frequently relates to housing, finances and debt, it utilises a 'Team around the Person' and 'Community around the Person' approach. As well as the positive impact this has on people's lives, it has also been shown to reduce demand on the system. 'High Flow' focusses on the most frequent users of A&E and other emergency services and has resulted in a 60% reduction in A&E visits from these service users alongside reductions for SWAST, Police and Devon Partnership Trust. In one year, for 6 service users, this demand reduction equated to: £103,831.92.

Plymouth City Council has created the Creative Solutions Forum (CSF) to meet the needs of people who do not fit into standard care settings. Practitioners, managers and commissioners across public health, adult social care and mental health work together to provide integrated and bespoke offers for people and support workers. Staff report better risk management, less anxiety over high-risk cases and huge improvements in inter-service relationships, trust and co-operation. Around 70% of cases are resolved in one visit and almost all cases in 3 visits. Bespoke approaches have begun to replace standardised care, there are fewer inter-service hand-offs, better understanding of risk and inter-service co-operation has become the default, rather than the exception. Most importantly, culture right across the system has changed.

PCNs in Devon are also planning to deliver anticipatory care and personalised care more systematically and will be working to expand focus on CVD diagnosis and prevention to reduce demand on other community and hospital services.

National examples of good practice

Tackling Fuel Poverty in Cheshire and Merseyside: A Population Health Management Approach

Rising energy costs and wider cost-of-living pressures have driven more households into fuel poverty, which is strongly linked to worsening health outcomes. Cold homes increase the risk of respiratory and cardiovascular disease, poor mental health, and unintentional injury. The Institute of Health Equity estimates thousands of unplanned hospitalisations are directly associated with cold homes, while NICE suggests that preventative measures could avoid up to 28,000 deaths each year.

To address these risks, Cheshire and Merseyside Integrated Care Board (ICB), supported by NHS England's Innovation for Healthcare Inequalities Programme (InHIP), has adopted a population health management (PHM) approach. This involves using data to identify, engage, and support those most at risk, particularly people with respiratory illness living in fuel poverty.

Working with NHS, voluntary and community sector (VCS), and local authority partners, the ICB has launched several "trailblazer" projects across the integrated care system (ICS). These multidisciplinary initiatives use targeted interventions to improve health outcomes and reduce the wider impact of fuel poverty.

The trailblazers aim to:

- Rapidly identify and engage high-risk patients
- Reduce the number of exacerbations experienced
- Improve adherence and effectiveness of inhaler therapies
- Enable quicker eligibility checks for patients suitable for remote monitoring pathways
- Reduce fuel poverty debt by signposting sources of financial support

In the longer term, these interventions are expected to ease pressure on local health services by reducing GP visits, A&E attendances, unplanned admissions, and emergency calls linked to respiratory conditions aggravated by cold homes.

Bromley by Bow

The Bromley by Bow Centre, once described by former health minister Lord Mawhinney as “one of the most impressive displays of social entrepreneurship anywhere in Europe,” has grown from a small East End initiative into an internationally recognised charity. Based in Tower Hamlets, one of England’s most deprived areas—with nearly 40% of children in low-income households and a 10-year life expectancy gap between rich and poor men—the centre was founded in the 1980s by a local priest, his congregation, and volunteers to address deep social inequalities. Initially, it offered childcare, adult learning, welfare advice, a café, and community space.

By the 1990s, it was clear that conventional health and social care models were failing local residents. In response, the charity established its own GP practice, joined in 1997 by Dr Sam Everington and Dr Julia Davis, pioneering a model of care centred on the social determinants of health. Remarkably, this was the first British GP practice owned by patients and rented to the NHS. It later evolved into the Bromley by Bow Health Partnership, now employing 110 staff and serving more than 28,000 patients across three practices, including a walk-in clinic for 500 unregistered patients weekly.

The centre combines primary care with community services and research, empowering patients to engage actively in their health. Located in Bob’s Park, its design embraces green space and creativity, with projects like therapeutic horticulture for adults with disabilities and public art to foster community pride. Services extend beyond health into housing, welfare, employment, and money management, reflecting its philosophy of “health by stealth.” This holistic approach not only addresses immediate needs but also supports education, employment, and local enterprise development, contributing to the regeneration of East London.

A cornerstone of its work is “social prescribing,” enabling GPs to refer patients to non-clinical, in-house experts tackling root causes of poor health, from debt to isolation. This frees doctors to focus on clinical care while addressing wider health inequalities. Evidence of impact is strong: in 2014, Tower Hamlets ranked highest nationally for cholesterol and blood pressure control in patients with diabetes and heart disease.

The Bromley by Bow Centre demonstrates how integrated, community-led health and social services can transform lives and reduce inequalities at scale.

End of life care service for people with dementia living in care homes in Walsall

NHS Walsall Clinical Commissioning Group commissioned Dementia Support Workers (DSWs) to provide evidence-based advice, development sessions, and practical support to care home staff. Their aim is to promote best practice in dementia and end of life care, working closely with staff, residents, and families to identify improvements that enhance outcomes and quality of life.

This initiative was developed in collaboration with Pathways 4 Life (Accord Group and Age UK Walsall) and St Giles Walsall Hospice, responding to the pressing need for better dementia care, particularly at end of life. Many people with dementia continue to die in acute hospitals rather than in their care home, despite a preference to remain in familiar surroundings.

Two community-based DSWs work across Walsall, promoting person-centred care while fostering strong joint working with hospice teams, nursing case managers, ambulance staff, occupational therapists, voluntary organisations, and community groups.

Their engagement begins with observation studies in care homes, assessing person-centred practice, communication, and use of assistive technology. They deliver development sessions to build staff skills and create improvement plans with managers using **Care Fit for VIPS**. Recommendations often include better signage, orientation aids, and opportunities for socialisation and meaningful activity.

DSWs also support adoption of the **Namaste Care approach**, delivering tailored sessions to improve staff communication, understanding, and role modelling. Signs of pain or depression are escalated to GPs. The guiding principles of the service are to:

- make sure people with dementia are always at the centre of everything
- maximise partnership working
- utilise an evidence-based practice approach
- empower and engage volunteers, staff and families to maximise contribution
- Early evaluation has found the service has:
- decreased unnecessary hospital admissions
- increased resident engagement in activities
- improved staff confidence and skills
- strengthened links between Health and Social Care
- enhanced continuity of care through better communication

- improved staff understanding of what constitutes an emergency
- introduced more effective and efficient documentation
- This integrated, evidence-based model is helping to transform dementia and end of life care across Walsall.

International examples of good practice

How GRAND Mental Health reduced psychiatric inpatient hospitalisations by 93%

The organisation GRAND Mental Health is a Certified Community Behavioural Health Clinic (CCBHC) that offers behavioural health services in addition to support with diet, physical health, housing, and employment. The organization operates facilities in thirteen Oklahoma counties, including three crisis centres.

To reduce inpatient hospitalisations and create lower levels of care for people experiencing behavioural health crises, GRAND Mental Health created dedicated 24/7 crisis stabilisation services and extended virtual care access points into the community. The model changed the way crisis care in the region works.
With GRAND's new crisis care strategy, police can quickly and easily connect people with clinicians at the urgent recovery centre to assess patient need. Patients can also communicate directly with clinicians when in crisis or if they need support.

The result Compared to the baseline year of 2015, the model has shown the following results for GRAND's adult clients:

- Reduced inpatient hospitalizations at any Oklahoma psychiatric hospital by 93.1% (from 959 in 2015 to 66 in 2021)
- Reduced inpatient hospitalizations at Wagoner Hospital by 100% (from 841 in 2015 to 0 in 2021)
- Reduced inpatient bed days at Wagoner Hospital by 100% (from 1,115 in 2015 to 0 in 2021)
- Saved state and federal government $62 million dollars (from 2016-2021)
- Increased number of adult clients served by 163.5% (from 4,326 in 2015 to 11,401 in 2021)

When GRAND started the model, they were a fee-for-service (FFS) community mental health organization. Under FFS, GRAND was able to recoup the money spent from their general revenue budget by reducing the rate of no-show appointments. While GRAND eventually transitioned to a Certified Community Behavioural Health Clinic (CCBHC) business model, leadership believe this approach would have continued to bring a positive return on investment under FFS.

Buurtzorg: revolutionising home care in the Netherlands

Home care in the Netherlands supports the chronically ill, people with dementia, and those needing end-of-life care. It includes both medical services, such as wound care and injections, and personal support, such as bathing and help with daily living. By the mid-2000s, however, Dutch home

care faced serious challenges: declining quality, rising costs, lack of continuity, and a disillusioned nursing workforce.
Frustrated by this situation, nurse Jos de Blok left his job to found Buurtzorg ("neighbourhood care"), a radical alternative centred on patient needs and frontline autonomy. Rejecting centralised management, Buurtzorg empowered small nursing teams to integrate families and neighbourhood resources into holistic care solutions. This approach aimed to simplify the system, deliver higher quality care at lower cost, and improve job satisfaction among nurses.

- Buurtzorg's model consists of three key components:
- Self-governing teams of 10–12 nurses providing both medical and supportive home care
- An IT system to reduce administration and allow teams to self-monitor performance
- Regional coaches offering advice and promoting best practice without performance targets

Each neighbourhood-level team covers around 10,000 people and 40 patients. Nurses act as "health coaches", coordinating care with GPs, involving families, and mobilising community support. Objectives include:

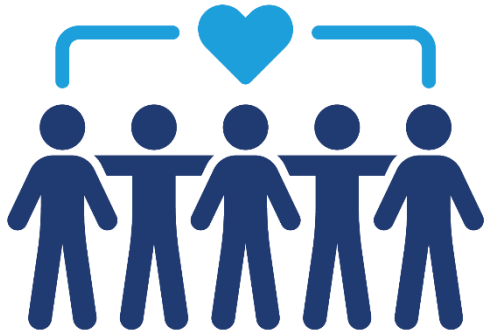
- Creating a financially sustainable, holistic model of care
- Boosting nurse satisfaction through autonomy
- Maintaining or restoring patients' independence
- Training patients and families in self-care
- Building neighbourhood networks of support

The outcomes have been notable:

- Patient satisfaction scores are 30% above the national average;
- between 2008–2013 the average rating was 9.1/10
- Patients stay in care for 5.5 months on average versus 7.5 months elsewhere, with 50% receiving care for less than three months – suggesting greater independence
- However, Buurtzorg patients are admitted to nursing homes at a younger age compared to others

By 2018, Buurtzorg had 10,000 nurses in 900 independent teams, caring for 70,000 patients annually. At its peak, 60% of Dutch community nurses worked for Buurtzorg, influencing national elderly care policy and inspiring competitors to adopt self-steering models.

While overall savings are debated, it is estimated that nationwide adoption of Buurtzorg could save the Dutch economy €2 billion annually. Its impact on patient satisfaction, independence, and nurse morale has been profound, offering a globally recognised model of sustainable, community-based care.



Design Phase: Co-creating the future

Building on the insights gathered, the Design phase focused on collaboratively shaping the strategy's content, priorities, and delivery models.

Key activities included:

- Ten targeted design workshops, each aligned to a chapter of the strategy, involving stakeholders from across the system—health, care, voluntary sector, and community representatives.
- Interactive and iterative engagement, where stakeholders tested ideas, refined options, and helped identify barriers and enablers to change through the Design Steering Group and engagement with localities.
- Validation of emerging models, ensuring that proposed solutions are grounded in lived experience and operational reality.

Over 125 individuals participated in one or more of the strategic workshops held to inform the development of this health and care strategy. These workshops were aligned with the following thematic chapters:

- Population health and prevention interventions
- Neighbourhood health services and primary care
- Community services and the bridging neighbourhood system
- Secondary and tertiary care
- Implementation via enabling plans

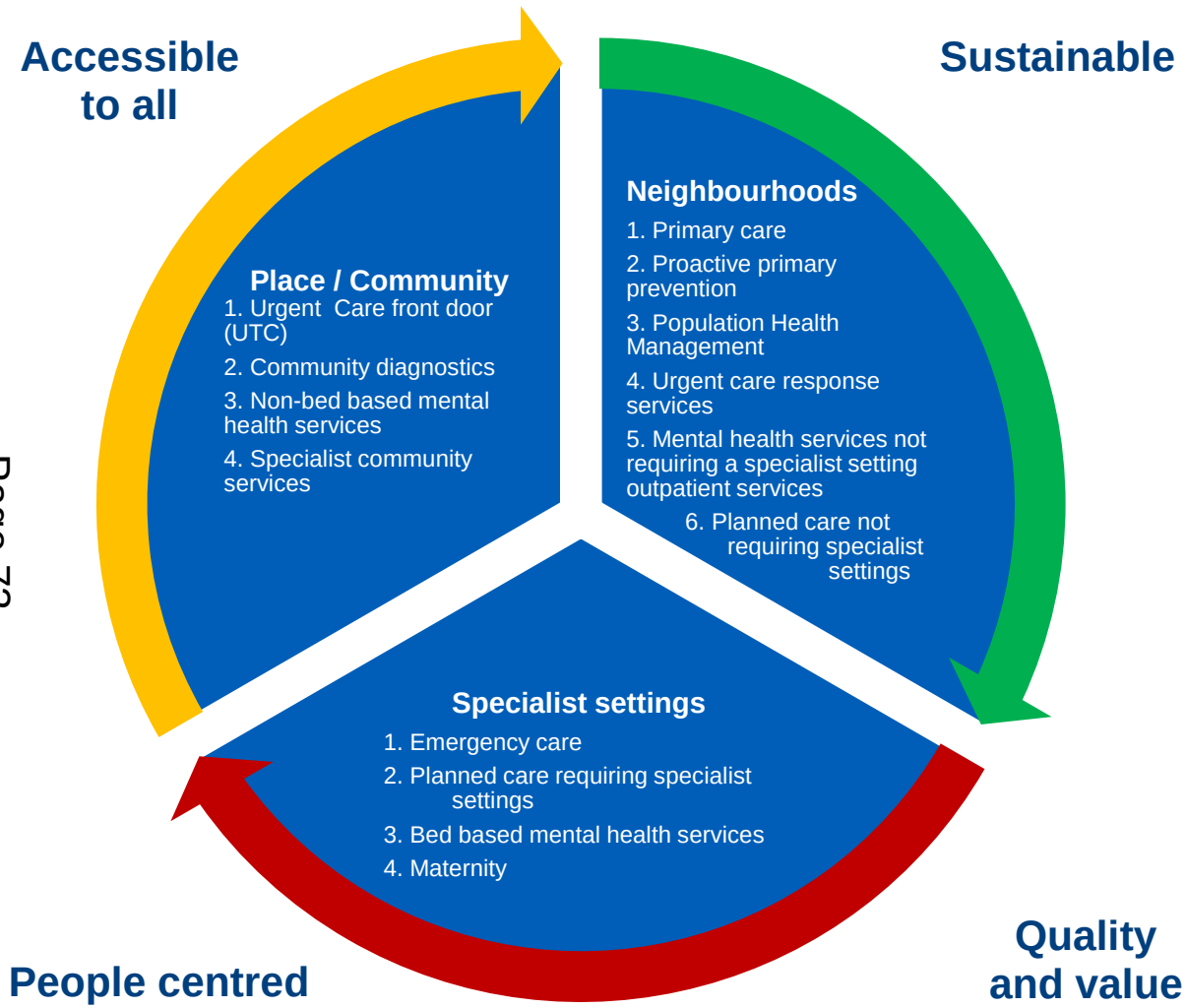
The workshops generated valuable insights and outputs. The initial round focused on assessing the current state, envisioning the future state, identifying system-wide gaps, and defining the necessary "bridges" to transition from the current to the desired future state. The second round of workshops built upon this foundation, using the identified bridges to shape detailed workplans, define intended outcomes, and establish measurable metrics. These contributions are reflected throughout this strategy document and will continue to inform future planning, development, and commissioning activity.

Design principles

Four core design principles serve as strategic guardrails for the development and implementation of our system-wide strategy. These principles have been rigorously tested and refined through extensive engagement during the Design phase. They underpin the delivery model and shape the anticipated impact of the transformational changes required to improve outcomes, enhance equity, and ensure sustainability across the Devon system.

Sustainable	Quality and value	People-centred	Accessible to all
• Sustainability means being able to live within our means and being conscious of the health system we leave to future generations. • Be deliverable within the financial resources available to us, eliminating the reliance on deficit support or funding above the fair shares allowance • Develop services that can be delivered using current estate • Deliverable with the projected available workforce • Support a shift from treatment to prevention to increase healthy life expectancy • Reduce the environmental impact of healthcare services • Deliver nationally and regionally agreed performance standards	• Quality and value means ensuring that we are balancing maximising the outcomes we get from our investment with delivering what is right. • Consider how it maximises outcomes: patient experience, financial, and patient and population health outcomes • Be honest about what cannot be delivered or where difficult decisions on resource allocation need to be made • Be considerate of its impact on all parts of our population, with clear impact assessments to help us understand any unintended consequences • Deliver on nationally and regionally agreed quality standards	• People-centred means being considerate of all the people impacted by our decisions. • Involve patients and the wider public in the design of their services • Involve patients and the wider public in the design of their services • Build services that cater for the needs of people and not the service • Enable the health workforce to deliver, and invest in them to retain and develop skills within the system • Involve partners from other organisations wherever there is an impact on them	• Accessible to all means ensuring ease of access to services and clear navigation through the health system. • Have clear access points that are understood by our population and partner organisations • Ensure a consistency of approach and service regardless of the access point to receive healthcare services • Minimise the number of handovers between organisations, and where they occur ensure that the patient journey is not affected by them • Navigate people to the right service for their needs as quickly as possible • Commission services which reduce health inequalities especially for the most disadvantaged groups

Our model of care



- **Neighbourhood** – Supporting integrated, community-based care tailored to local populations, with a strong focus on prevention, early intervention, and personalised support. This is community-based care across a population of between 30,000–50,000 people. Delivery is led by Integrated Neighbourhood Teams (INTs) that use combined resources to deliver joint outcomes. Outcomes are commissioned from a lead provider who will collaborate with other health services (including primary care), social care and VCSE organisations to deliver contracts.

- **Place** – Enabling coordination across services within localities, ensuring that care is joined-up across primary, community, mental health, social care, and voluntary sector partners.

- **Specialist settings** – Providing strategic oversight, specialist services, and infrastructure to support consistency, equity, and sustainability across Devon.

Building on this foundation, we have collaboratively developed a care Model for Devon that is tailored to our local context, responsive to population health needs, and aligned with our collective ambitions.

This model outlines a coherent framework for organising and delivering care across three integrated levels, ensuring consistency, coordination, and community relevance, though: care that cannot be delivered in non-specialist settings and high-volume interventions that can benefit from economies of scale. Services should be commissioned to deliver national best practice to maximise cost and quality outcomes.

This layered approach will enable a shift toward more integrated, proactive, and person-centred care, ensuring that services are designed around people, not organisations, and that care follows the individual across settings and life stages.

The emerging model is not a fixed blueprint, it is a living framework for ongoing collaboration, innovation, and refinement. It will continue to evolve through engagement, testing, and learning, utilising the voices of our communities and the expertise of our workforce.

This approach ensures that Devon's health and care system remains responsive, resilient, and aligned to the needs of today's population and future generations.

Applying a population health management methodology – treatment to prevention

Our Delivery Model is dependent on the application of a Population Health Methodology for all service delivery. Population Health Management (PHM) is how we work collaboratively to understand and improve the health of people and communities, using joined-up data and intelligence. It goes beyond data analysis to include community engagement, clinical and financial input, evidence-based planning, and ongoing evaluation.

PHM enables us to identify and reduce health inequalities through proactive and preventative care, targeting resources where they will have the greatest impact. Techniques such as segmentation, risk stratification, and impact modelling help identify local 'at risk' cohorts, allowing us to design tailored interventions that prevent ill-health, improve care for those with long-term conditions, and reduce unwarranted variation in outcomes.

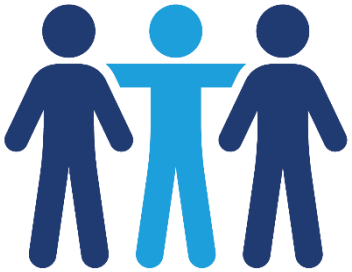
This approach is central to delivering more equitable, effective, and sustainable health and care services across Devon and will be central to transformation.

Devon's population is aging faster than the national average, leading to a rise in long-term conditions and increasing demand on secondary and urgent care services. Without a shift toward prevention and early intervention, the system will face growing pressure and financial strain.

A population health approach enables us to respond proactively supporting people to live healthier for longer and reducing the number of years lived in poor health.
This approach is especially critical in areas of deprivation, where life expectancy is shorter and poor health begins earlier. It also helps address the significant variation in healthy life expectancy and service demand across Devon.

Aligned with national PHM principles—including those set out in the NHS Long Term Plan, Core20PLUS5, and the ICB Model Blueprint, we are focusing on:

- **Reducing health inequalities** by targeting early intervention and prevention in communities with the greatest need.
- **Improving outcomes** through personalised care, healthy lifestyle promotion, and support for self-management.
- **Enhancing cost-efficiency** by reducing reliance on reactive, high-cost services through earlier, community-based support.
- **Increasing quality of life** by helping people maintain independence and wellbeing throughout their lives.
- **Supporting sustainability** by easing the burden of chronic disease and enabling better resource allocation.



This population health approach is embedded within our success measures framework, which tracks progress through a combination of quantitative indicators (e.g. waiting times, admission rates, workforce data), qualitative feedback (e.g. lived experience, staff and community engagement), and independent evaluation.

These measures will evolve as the strategy is implemented, ensuring we remain responsive to emerging needs.

Population health management in Devon

Using a learning cycle, Population Health Management (PHM) in Devon will enable us to work collaboratively across health, care, and community systems to better understand and improve the health of our population. By integrating joined-up data and intelligence, PHM helps us identify patterns in service use—highlighting where care is sub-optimal, where people are not accessing services in a timely way, and where there may be overuse or underuse. This insight

supports more effective service planning and resource allocation. This continuous cycle of learning ensures that PHM remains dynamic, responsive, and embedded in our wider strategy to create a healthier, fairer, and more sustainable Devon. A PHM methodology will help us in:

- **Identify patterns** – who is accessing services, where is care sub-optimal, who isn't accessing services in a timely manner
- **Risk stratify**, segment population, identify high risk cohorts and plan specific interventions, services and pathways
- **Shift from hospital to community** with earlier interventions and prevention
- **Population health** – role of wider determinants (e.g. through social prescribing) instead of, or as well as, healthcare

Digital transformation – analogue to digital

Digital transformation will be a central driver of change across Devon's Health and Care Strategy Delivery Model, and it is aligned to the ambitions set out in the national 10-Year Health Plan. We will harness digital innovation to respond to rising demand, an aging population, and increasing financial pressures delivering care that is more proactive, efficient, and resilient.

Through the implementation of integrated care records, virtual consultations, remote monitoring, and data-driven planning, we will reshape how services are delivered and accessed.

Our strategy commits to embedding digital solutions at scale, investing in infrastructure, building digital capability across the workforce, and ensuring inclusive access for all communities.

System-wide data-sharing	Standardised and Unified Infrastructure	Shared EPR and Operational Systems	Person centred care	Harnessing new technology
1. Shared patient data to support health and care across settings (NHS, care and community partners) 2. A quality-led approach to IG to resolve data-sharing barriers 3. Systems that enable a real-time linked data set 4. Optimisation of local instance of the Federated Data Platform 5. Dynamic System-wide Demand Management and Forecasting Capabilities	1. 'Staff Passport Technology' for cross-border team working and movement 2. Cyber secure infrastructure 3. Standardise and rationalise technology 4. Maximise economies of scale through converged contracts 5. Digital Collaborative Corporate Service 6. Single data architecture and consistent data management processes	1. Optimised single electronic patient record (EPR) across Devon acute hospital settings 2. Devon and Cornwall Care Record (DCCR) 3. A connected Devon and Cornwall Laboratory Information Management System 4. Medication optimisation capabilities 5. Automated end-to-end Pathway management for visibility and alerts 6. Converge systems to support corporate functions	1. NHS App 2. Single Patient Record to enable joined up care and patient engagement / activation 3. Personalised care plan 4. Digital inclusion strategy 5. Enabling easy navigation for patients, carers, teams 6. Safe adoption of virtual therapists, triage and remote monitoring in mental health 7. Neighbourhood health technology offers for wearables	1. AI to improve productivity and decision making through AI-enabled and AI-delivered health care 2. Wearables technology to support neighbourhood health and care 3. Surgical efficiency via Robotics 4. Digital decision-making based on patient outcomes and value to person and System

In a system under pressure, digital transformation will be a core part of how we deliver sustainable, high-quality care now and into the future. The following are principles of the digital innovation for Devon:

Quality in all we do

We will put quality at the heart of achieving best value in health and care. Delivering safe, effective, and person-centred services ensures that required outcomes are achieved and resources are used in the most impactful way. Our understanding of quality is shaped both by the voices of our population—who tell us what matters most to them in their care—and by the expertise of our clinicians, who bring evidence, professional standards, and frontline insight.

This partnership between clinical leadership and lived experience gives us a rounded view of what high-quality care truly means. By listening to patients and staff, and by embedding clinical judgement into our decision-making, we can design and deliver services that are responsive, viable, and represent the best value for our communities.

By building trusted relationships with clinical care and professional leaders we are able to create a unified approach to quality that is intelligence driven, clinical informed that drives innovation and transformation. We will use global best practice knowledge that can be adapted and adopted to drive high value commissioning and delivery.

We will lead a culture of continuous improvement, clinical excellence and evidence-based practice by using total quality management methodology and use of the national quality board frameworks.

With quality as our guiding principle, this strategy commits us to building a system that delivers:

- **Safe care** – risks are anticipated, and harm is minimised through strong clinical governance and leadership.
- **Effective care** – good outcomes are consistently achieved, informed by clinical evidence, clinical leadership, innovation, and research.
- **Positive patient experience** – people feel respected, listened to, and supported
- **High value** – resources are used responsibly to deliver the greatest possible benefit for patients, customers, communities, and taxpayers.

Neighbourhood health service and primary care - hospital to community

What is a neighbourhood?

Neighbourhoods are geographic areas with populations of 30-50,000 and are a way of working in which self-defined and often hyper-local, and statutory services, work together to improve the health and wellbeing of their population.

Neighbourhood working involves statutory and non-statutory stakeholders bringing their assets, capability, capacity and experience to a common goal.

Devon has not yet fully defined its Neighbourhoods, though work to do so is underway. Our Place arrangements in Devon, the five Locality Care Partnership's (LCPs), are being supported to define neighbourhood boundaries to ensure full coverage across the county. Within a Neighbourhood, Integrated Neighbourhood Teams (INTs) will be established to deliver health and care outcomes. Establishing our Neighbourhood footprints is essential, but we anticipate that our initial configuration will need to evolve over time. In some areas initial alignment with Devon's 31 Primary Care Networks (PCNs) will enable the development of services given their essential role as the clinical backbone of INTs, however it is essential that Neighbourhood footprints should be determined by local needs, local community demographics, and the existing assets in each area.

Aligning with PCN boundaries is a starting point, but INTs may need to work across them to provide effective, person-centred care. There are several essential foundations that our LCPs will take forward in order to establish our Neighbourhoods and foster a collaborative approach to successfully deliver our ambitions.

These include, ensuring the right representation and engagement with local stakeholders, strengthening the voice of the citizen, applying PHM methodology and risk stratification to understand local need, developing a clear local vision, and supporting system leadership development that will enable collaboration between partners to enable delivery.

Integrated Neighbourhood Teams (INTs)

Our Integrated Neighbourhood Teams (INTs) will become the primary interface for our population with health care services. Bringing together health, social care and VCSE partners, taking a multidisciplinary team approach using shared patient-level data, INTs will identify people at greatest risk, proactively reviewing and supporting interventions to keep them healthy.

Neighbourhood working is not just about the location of services but improving the population's health. Our neighbourhood teams will operate at the scale that makes the most sense for their populations.

Where it works most effectively, they will respond quickly to emerging needs, mobilise resources, and build strong, trusted relationships within their communities. Citizens and communities should be at the centre of

these teams, as active partners in the design and ongoing delivery of services.

Once established, INTs will be formally commissioned, via a lead provider, to deliver a wider range of physical and mental health services.

The commissioning arrangements will move away from paying for activity within these services, to paying for outcomes, allowing flexible use of resource to deliver the right interventions for the Neighbourhood population.

INTs will be encouraged to commit resource to reflect need, delivering more for those that have greatest need, rather than relying on delivering a standard, universal offer to all.

We will develop a risk stratification tool that can be used by the INTs to identify and understand local population need.

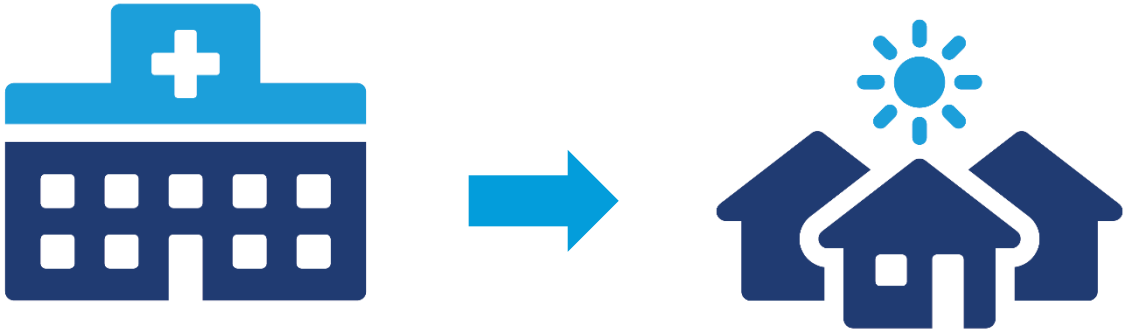
Applying a PHM approach, the INTs will initially focus on developing multidisciplinary team approaches to support the identification and supportive interventions for individuals with multiple long-term conditions in line with the national Neighbourhood guidance, making reasonable adjustments for individuals as required.

Through our Place arrangements, commissioning relationships will be further strengthened with local authority partners to align commissioning plans and give a clear steer on agreed outcomes to INTs. The commissioning approach will be permissive enough to allow INTs to use resources collectively, regardless of source. This will remain in place for as long as the INT is delivering commissioned outcomes.

INTs will also be supported to build relationships with private enterprise in order to develop income streams and outside investment that can be reinvested into health and social care services.

INTs will establish a physical hub for services to be co-located. While this may be within current NHS estate, where possible this should be within the heart of the neighbourhood, and consideration will be given to how partners collectively use their resource to support INTs.

INTs will be asked to take an all-age approach and will need to consider how to plan services around different groups, for example: services for children being delivered outside of school hours.



Moving activity from hospital to neighbourhood

Wherever services do not need to be delivered within a specialist setting, there will be consideration given to transferring to Neighbourhoods for delivery.

Primary care

Primary care will be central to the delivery of INTs. General practice and Primary Care Networks (PCNs) will expand to improve access for patients via telephone and digital means, in addition to face-to-face access. Patients can expect to receive clinically appropriate inputs from a variety of clinical and non-clinical staff delivered in an appropriate timeframe,

dependant on their needs. There will be greater promotion of self-management and use of community assets within their Neighbourhood.

INTs will continue to focus on improving the dental offer to our population, particularly for those with urgent needs, those requiring stabilisation of their oral health, and with a strong focus on prevention and ensuring lifelong good dental health.

Community pharmacy will further expand its service offer, often localising delivery for patients and supporting partner providers. Recognising pharmacy is not immune from delivery pressures, we will seek to commission a broader range of services on a longer timeframe, giving providers the confidence to grow their businesses and extend their offer.

Ophthalmic services will be required to ensure excluded groups are able to access the care and services they need. Initially this will be by ensuring that those within Special Educational Settings (SEND) have a robust and comprehensive offer, and where that is not readily accessed, work with SEND providers to identify and remove access barriers.

A problem-based approach to innovation will be established, using technology to help improve primary care. By understanding the challenges and through use of case studies, we will explore the best options to address these challenges at scale, which we know will include enabling safe, appropriate, and timely information exchange between system partners.

Urgent care response and virtual wards

INTs will be expected to develop a service that responds rapidly to those with an urgent care need (all age, physical or mental health) to support them to remain within the Neighbourhood, rather than need admission into a specialist setting. This should include ‘hospital at home’, which will replace the current virtual ward model.

Supporting discharge

INTs will be expected to deliver models to support early discharge from specialist settings. They will work with specialist providers to identify patients where support plans can be enacted to complete non-specialist treatment within a neighbourhood setting.

Outpatient services

INTs will deliver follow-up care to those that have had interventions in specialist settings.

This will be proportionate to the need of the individual and follow-up activity will be stopped where it is adding little to no clinical value.

Women's health

INTs will deliver integrated reproductive, preventative, and early-intervention services where these services do not require specialist settings. The aim is to improve women's health outcomes, reduce health inequalities, and prevent escalation to specialist gynaecological interventions wherever possible.

Mental health, learning disabilities, and neurodiversity

INTs will remove barriers between mental and physical health at a neighbourhood level, delivering primary prevention to their population based on totality of health need. INTs will work collaboratively to develop local support networks and peer-to-peer offers that will support those with mental health needs to avoid crisis. Support for patients and families

When individuals are escalated to more specialist services, either community or bed–based, neighbourhood teams will remain the primary care navigators for that patient, working with specialist services to revert to neighbourhood wherever possible, including for patients that have a Learning Disability and or neurodiversity.

Children and young people

INTs will deliver universal and preventative services that are embedded within the environments where children live, learn, and grow.

Neighbourhood delivery for children and young people will include strong alignment with schools, early years settings, and local authority locality structures. This integrated approach ensures that services are coordinated, equitable, and responsive to the diverse needs of children and families. It also enables early identification of health and developmental concerns, allowing for timely intervention and support.

The children's clinical workforce is highly specialised and often lacks the critical mass required for hyper-local delivery. As a result, while services must be accessible and community-based, they also need to be delivered at a scale that ensures quality and sustainability.

How will this feel different for our patients

- Those with greater need will be prioritised and interventions will be in place to keep people with long term conditions healthy.
- People will be able to have multiple needs met at once rather than making separate appointments with different agencies
- People will be able to access health services as part of their day-to-day routine instead of travelling to NHS settings
- People will only need to give their information once and not repeat this when using other local services
- People will need to access Hospital settings less and receive more care closer to their home
- When people have an urgent care crisis they will be supported to stay at home and have their needs met locally instead of travelling to other settings
- People with greatest need will receive a more "fair share" of available funding, increased outside investment in NHS services will mean more services available for all
- When services are not delivering for people the ICB will be able to intervene using contractual levers to support improvement

This necessitates close collaboration with services such as primary care, hospital-based care, and community health teams. The strategy adopts a whole-age approach, recognising the need for seamless transitions from childhood to adulthood—particularly for children and young people with special educational needs and disabilities (SEND), who may access services from birth up to the age of twenty-five.

At the heart of neighbourhood-level children and young people delivery is a commitment to prevention and health promotion. Health visitors and early years practitioners play a critical role in supporting families during the first 1,001 days (from conception to age two) laying the foundation for lifelong health and development.
School nurses will work in partnership with education settings to deliver immunisations, sexual health advice, and mental health screening. GPs will provide accessible care with strong links to paediatric expertise and multidisciplinary teams.

Community-based parenting programmes and peer support networks further strengthen protective

factors within families, promoting resilience and wellbeing. Digital tools are increasingly used to enhance early identification and access to support, offering families timely advice and resources through an online platform.

Place and Community

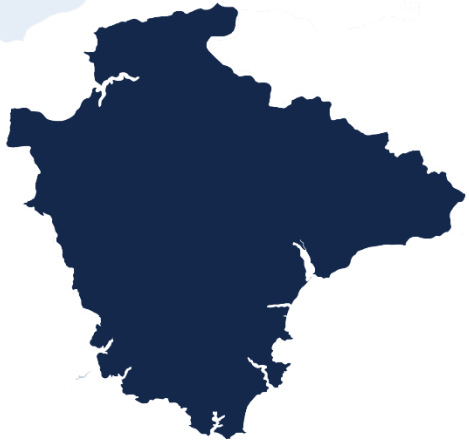
In the integrated care landscape, the concepts of Place and Community are central to delivering health and care services that are both strategically coordinated and locally responsive. These two dimensions operate across multiple neighbourhoods, each contributing uniquely to the design and delivery of care.

Place refers to a defined geographical footprint typically serving populations between 250,000 and 500,000 within which health and care organisations collaborate to plan, commission, and deliver services.

Place-based partnerships will align with Locality Care Partnerships (LCPs), and provide the infrastructure and governance needed to support neighbourhood development and delivery. They aim to enable coordination across neighbourhoods, particularly where services benefit from economies of scale, such as treatment centres, diagnostics, and workforce planning.

Place also plays a critical role in resource management, including estates, digital infrastructure, and innovation funding. Acting as the operational layer for Devon ICS, they will be pivotal in ensuring that neighbourhood teams are supported with the tools, investment, and strategic oversight required to deliver integrated care effectively.

Place is the structure that will support Neighbourhood development and delivery and sits across a geographical footprint that aligns with LCPs. Some services will be delivered across this footprint where there is benefit of economies of scale for this to be done across multiple neighbourhoods.



Community is defined not by geography, but by shared identity, experience or need, or protected

characteristics. Communities may be demographic (such as children and young people, older adults), clinical (such as people with mental health needs or neurodiversity), or experiential (such as carers, veterans, or LGBTQ+ individuals).

While communities often reside within a place, their boundaries are shaped by social connection and lived experience, rather than administrative borders.

Community-based approaches are essential for addressing health inequalities and ensuring that services are culturally competent, trauma-informed, and co-produced. By listening to and working with communities, the system can design care that reflects lived experience and builds trust.

Community is less structural, based around our people and their shared characteristics. While this may be around people who live in a similar geographical place, this will primarily be groups with similar demographic features or clinical needs.

Together, Place, Community and Neighbourhoods form a tri-level model that enables the health and care system to be both strategically coherent and locally responsive. This integrated approach ensures that services are designed around people, not organisations—delivering better outcomes, reducing inequalities, and building stronger relationships between services and the populations they serve.

How will we work at Place?

Locality Care Partnerships (LCPs) will serve as the primary delivery mechanism for neighbourhood-level health and care transformation.

Embedded within the broader framework of Integrated Care Systems (ICSs), LCPs are designed to bring together NHS organisations, local authorities, voluntary and community sector partners, and other stakeholders to co-design and deliver services that reflect the unique needs of local populations.

With support from NHS Devon, each LCP will be tasked with identifying and establishing core priorities at the neighbourhood level. These priorities will be informed by population health data, local intelligence, and community engagement.

Where appropriate, LCPs will collaborate across neighbourhoods to deliver services at scale—particularly in areas where specialist expertise, economies of scale, or infrastructure investment are required to ensure sustainability and equity of access.

To support this, a place-based estate register will be maintained, cataloguing available assets for neighbourhood use. This aligns with national ambitions to repurpose underutilised NHS estate and maximise value for money.

The 10-Year Health Plan highlights the need for neighbourhood teams to have access to appropriate facilities, technology, and working environments to deliver integrated care effectively. Strategic capital investment will be essential to modernise infrastructure and support the development of neighbourhood health centres.

Urgent care services will be coordinated through a dual-level approach. While urgent care response – such as community-based crisis teams and same-day access – will be delivered locally within neighbourhoods, the urgent care "front door", including Urgent Treatment Centres (UTCs) and walk-in hubs, will be strategically managed at the place level.

This ensures consistency, efficiency, and equitable access across the county, in line with NHS England's neighbourhood health guidelines. Innovation will be a cornerstone of neighbourhood transformation. Each place will hold Innovation Funds to support the piloting of new services, technologies, and models of care. These funds will be accessible through neighbourhood-led bids and will be governed by a clear framework of desired outcomes, including health equity, service integration, and sustainability.

Where pilot projects require longer-term evaluation or development, multi-year funding arrangements will be considered to ensure continuity and impact. National guidance encourages the use of innovation funding to support projects that are co-produced with communities, digitally enabled, and aligned with broader NHS priorities such as the Net Zero Carbon Plan and population health improvement.

Additionally, any national or regional pilot programmes with allocated resources will be channelled through these local innovation funds to ensure alignment with local strategies and continuity of funding. This approach reflects a broader shift in NHS policy from centralised service delivery to place-based, community-led transformation.

By empowering LCPs to lead at the neighbourhood level, supported by strategic coordination at place, we can build a health and care system that is agile, inclusive, and responsive to the needs of the people it serves.

Delivering for our communities

Mental health, learning disabilities, and neurodiversity

Mental health services across Devon will undergo a strategic shift—from a predominantly bed-based model to one that prioritises prevention, early intervention, and recovery. This transformation aligns with NHS England's national direction to move care from hospitals into communities, reduce reliance on inpatient beds, and embed mental health within broader integrated care systems.

At Place level, NHS Devon will commission a comprehensive suite of recovery and aftercare services designed to support individuals transitioning out of acute care.

These services will be co-produced with service users and community partners, ensuring they are responsive, trauma-informed, and focused on long-term wellbeing. The goal is to reduce readmissions, promote independence, and enable people to live well in their communities.
Mental health will be fully integrated into Neighbourhood services, alongside physical health, as part of a whole-person approach.

This includes both proactive prevention and urgent care response, ensuring that mental health needs are addressed in the same way as physical health—timely, locally, and holistically.

Clear and consistent access points to mental health services will be established across the county. These will be designed to reduce fragmentation, improve navigation, and ensure equitable access regardless of location or background.

Secondary prevention at Place-based delivery will also focus on secondary prevention, targeting early detection and timely intervention:

- Mental Health Support Teams (MHSTs) in schools will continue to expand, offering evidence-based interventions for mild-to-moderate mental health issues, supporting whole-school approaches, and linking education settings with specialist services. These teams are a cornerstone of the NHS Long Term Plan's ambition to improve access for children and young people.

- Annual health checks and physical health checks for people with Severe Mental Illness (SMI) will be commissioned and monitored at Place. These checks are vital for identifying preventable conditions early and addressing the significant health inequalities faced by people with SMI, whose life expectancy is 15–20 years shorter than the general population. Checks will include cardiovascular disease risk assessments, metabolic screening, and lifestyle support, with follow-up interventions embedded into personalised care plans.

Children and young people

At the community level, services are designed to support children and families through targeted, multi-agency coordination. This tier of delivery sits across multiple neighbourhoods and is aligned with local authority-defined localities and school clusters, enabling a joined-up approach to meeting complex needs.

Delivery at Place will focus on commissioning and sustaining integrated services that bring together education, social care, community health, and voluntary sector partners. These services are essential for children and young people who require more than universal support, including those with Special Educational Needs and Disabilities (SEND), mental health needs, and neurodiversity.

Multi-disciplinary teams comprising early help practitioners, school nurses, social workers, educational psychologists, therapists, and community nurses will work collaboratively to provide coordinated care. These teams will operate within locality-based structures to ensure consistency, reduce duplication, and improve access to support.

Community-level services will include:

- Targeted support for children with additional needs, including SEND and neurodevelopmental conditions.
- Community-based mental health and therapy services, designed to be accessible and responsive.
- Integrated locality teams, offering wraparound support for families through coordinated case management.
- School-based mental health interventions, including drop-in clinics and early access to psychological support.
- Data-sharing protocols to identify and support children at risk, such as those with poor attendance, safeguarding concerns, or emerging health issues.
- Partnerships with youth services and voluntary organisations, ensuring holistic development and continuity of care.

Services will be commissioned and monitored at Place, ensuring strategic alignment, equitable access, and consistent standards across Devon. The aim is to reduce escalation to statutory services, improve school attendance and mental wellbeing, and ensure early identification of issues.

By embedding targeted support within communities and aligning it with local systems, NHS Devon will reduce health inequalities and ensure that every child and family has access to the right help, at the right time, in the right setting.

Maternity

NHS Devon will commission perinatal services that reduce health inequalities, provide care within communities, manage social and medical complexity, and improve outcomes for the most vulnerable. Services designed to be holistic, accessible, and person-centred and recognise the profound impact of social determinants on maternal and infant health and work to address systemic barriers that disproportionately affect marginalised populations.

At their core, these services will be community-based and culturally responsive, ensuring care is delivered in local settings that are familiar and trusted by those who use them.

By co-locating services within community hubs, outreach centres, or via home visits, care will become more accessible to underserved groups, including ethnic minorities, refugees, young parents, and those experiencing poverty, trauma, or unstable housing.

To manage social and medical complexity, multidisciplinary teams; including midwives, obstetricians, mental health professionals, social workers, and community health advocates will collaborate seamlessly. These teams will identify and respond to multiple needs early, offering personalised care plans that integrate clinical treatment with social support, safeguarding, and mental health interventions.

Importantly, these services will adopt a data-driven approach to monitor disparities and evaluate outcomes, ensuring that interventions are tailored and targeted. Community voices, especially those with lived experience, will be embedded into service design and delivery, ensuring care is not only for communities, but with them.

Through these approaches, perinatal services will work to close the gap in health outcomes, improve maternal and infant wellbeing, and provide dignified, respectful care that empowers all families, especially those facing the greatest challenge.

How will this feel different for our patients

- People will receive the same level of service regardless of which urgent care centre they attend
- People with mental health needs will be supported to remain in their community instead of in inpatient services
- People will be able to access innovative services earlier without risk that funding gets pulled based on the annual funding cycle
- Children will be supported to maintain social and educational requirements alongside delivery of interventions for health needs

Care within specialist settings

Specialist settings deliver interventions that cannot be provided in the community. This includes physical and mental health hospitals delivering acute care such as:

- University Hospital Plymouth
- Royal Devon and Exeter Hospital
- North Devon District Hospital
- Torbay Hospital
- Mental health facilities provide a range of care from single-sex mental health hospitals, acute care and medium – low secure services:
  - Wonford House (Exeter)
  - Torbay Mental Health Unit (Torquay)
  - Glenbourne (Plymouth)
  - Langdon Hospital (Dawlish)
  - Lee Mill
  - Franklyn Hospital (Exeter)
  - The Moorings
  - Plymbridge House

Delivering care within specialist settings

Care within specialist settings is high costs and requires scarce clinical resource. Distribution of this resource too widely can risk reducing quality of care through unsustainable and inefficient services. Devon will embed not only the new model of delivery but also enable the shift from acute to community. Options for consolidating some services onto fewer sites where it is safe and makes sense to do so will also be considered.

The level of specialisation of staff within acute settings can lead to a false assumption of greater skill and that specialist centres are a better place to receive care.

In most cases, better outcomes can be achieved within Neighbourhoods. However, for those that need specialised resource and especially bedded care (for physical or mental health needs), the only place this can be delivered is within one of our acute hospitals and other bedded settings.

To establish what activity needs to be delivered within a specialist setting, a value-based commissioning review of all specialities will need to be undertaken to establish:

- Activity that can stop
- Activity that can be transferred to Neighbourhoods
- Activity for which there needs to be a transformed model

How will this feel different for our patients

- Stays in hospital will be shorter and more services will be provided closer to home.
- People may need to travel further to access services if they are delivered on fewer sites. The quality of the service will increase as specialist resource is consolidated, and people will wait less time for an intervention.
- Those who have an emergency care need will have this addressed sooner.
- People will experience a seamless handover between organisations
- People will be seen by the right service and professional for their need, irrespective of the hospital site that they are at

Making it happen

To deliver NHS Devon's Health and Care Strategy, we will establish a coordinated and outcome-driven delivery framework that aligns system leadership, operational planning, and local implementation.

The initial priority will be to embed the new model of delivery, with a particular focus on the development and mobilisation of Neighbourhood teams as the core delivery vehicle for integrated, person-centred care.

This will be supported by a robust success framework, which defines clear outcomes across strategic priorities such as improved population health, reduced inequalities, enhanced access and experience, and financial sustainability.

These outcomes will be tracked through a transparent performance dashboard, enabling continuous learning, accountability, and system-wide alignment.

Delivery will be enabled by a suite of supporting plans including organisational structure, culture, teams and partners, empowering patients and citizens, digital transformation, estates, finance, and ongoing engagement ensuring the system has the capacity, capability, and infrastructure to implement change.

We will adopt a life-course approach to service design, ensuring that care is responsive to the needs of people at every stage of life.

Governance will be streamlined to support agile decision-making, with neighbourhood teams, place-based partnerships, and system-level boards working in alignment.

Success measures framework

Devon's Health and Care Strategy will deliver meaningful and lasting change, and this change needs to be monitored through a clear set of outcomes and measures.

These will help us understand whether we are improving health and wellbeing, reducing inequalities, and building a more integrated, sustainable system. Aligned with the Model ICB Blueprint, NHS Devon will act as a system convenor, architect, and steward moving from transactional oversight to transformational, strategic leadership. This approach will guide the future development of healthcare services to meet the needs of our residents, which will be reflected in our commissioning intentions paving the way for the 'left shift' is service delivery and in how we allocate resources and measure success.

The success measures framework has been developed collaboratively through extensive engagement during the Design phase, ensuring it reflects the priorities, insights, and aspirations of all stakeholders involved.

This framework outlines the key outcomes we aim to achieve and the metrics by which progress will be measured. It serves not only as a tool for accountability, but also as a guide for continuous improvement, helping us to track impact, celebrate successes, and identify areas for further development.

Working with our partners, we will use Population Health Management approaches to establish a life-cycle delivery approach

Take a Neighbourhood-first approach
- Ensure an equal voice for decision, design and delivery for the voluntary sector, local authority and community partners in line with the shift '**From Hospital to Community'**
- Develop an inclusive approach to digitally enabled care to make sure it can expand neighbourhood capacity and enhance local capabilities
- Use patient access and demand insights to better plan specialist care across neighbourhood, place and secondary/tertiary for optimal outcomes

Embed a focus on equity and prevention
- Reduce inequity to narrow gaps in health outcomes between the most and least advantaged communities
- Improve access to care for underserved groups, including rural, coastal, and deprived populations
- Increase uptake of preventative services in areas of greatest need and focused on local disease profiles to shift 'From Sickness to Prevention'

Improve health and wellbeing outcomes
- Provide accessible and equitable universal services including vaccination and screening programmes
- Enable and evidence joined-up working across health, care and voluntary sectors to deliver 'whole person' care

Ensure financial and operational sustainability

Ensure Financial and Operational Sustainability
- Deliver care within the system's financial envelope
- Reduce unwarranted variation and duplication of services
- Improve productivity and value for money across the system
- Rebalance financials based on need and equity

Support workforce resilience and a shared culture

Support Workforce Resilience and a Shared Culture
- Take a deliberate and robust approach to shifting our culture, reducing organisational barriers, and placing patients at the heart of delivery
- Improve recruitment, retention, and staff wellbeing
- Expand roles and training to support new models of care
- Double down on collective leadership, collaboration, and organisational culture development

Innovate for digital and infrastructure transformation

Innovate for Digital and Infrastructure Transformation
- Increase use of digital tools to support access, self-management, and

Co-design and co-deliver accessible, joined care
- Increased delivery of care through a neighbourhood and place-based model to enable the shift 'From Hospital to Community'
- Drive up consistent use of personalised care plans and shared decision-making in line with national goals
- Improved navigation and continuity of care across services

Strong, consistent leadership
- Clearly define compassionate working and leadership/management process
- Develop a shared purpose that can underpin all planning, delivery and evaluation approaches
- Shift from transactional management to transformational leadership in line with the three shifts of the 10 Year Plan

A culture of collective responsibility
- Establish a positive culture; behaving, communicating, acting collaboratively for our communities
- Build a system-wide joint workforce plan to build the right competences within a health and social care setting
- Commit to a real 'no blame' transparent culture with 'bridge' relationships dedicated to fostering collaboration

Ensure quality across everything we do
- Embed a transparent and consistent impact assessment process in decision-making across and between system partners
- Support the most vulnerable in our populations with a robust system-wide safeguarding approach
- Define quantitative and qualitative outcomes and measures at the start of all service (re)design to enable honest evaluation

Embrace a value-based care approach
- Define and account for value through multiple lenses including person-centred and population health outcomes, financial balance, responsible resource and estate planning
- Develop an evidence-based framework that commits to changing or stopping investment when anticipated value is not realised

Clear governance and accountability
- Develop relationships built on strong foundations of trust to support the shift 'From Hospital to Community'
- Ensure clarity on where decisions are made, by whom, and how
- Establish risk management approaches to recognise and reward

Tracking progress and delivering outcomes

We have developed desired outcomes and associated metrics that form the foundation for how we monitor and evaluate progress throughout the lifecycle of the Strategy in line with our success framework. It not only identifies the key outcomes we aim to achieve but also sets out the metrics that will help us assess whether we are on track and delivering meaningful change.

Crucially, it enables us to monitor the impact of our new model of care delivery, ensuring that the changes we expect—across population health, service quality, equity, and system sustainability—are being realised.

To ensure these measures are both actionable and reflective of system-wide impact, we will adopt a balanced approach that includes:

- **Quantitative indicators** – such as waiting times, admission rates, and workforce data to provide a clear and objective view of system performance.
- **Qualitative feedback** – including lived experience, staff insights, and community engagement – to capture the human impact and ensure our work reflects what matters most to people.
- **Regular reporting** – to system partners, stakeholders, and the public, supporting transparency, shared accountability, and continuous dialogue.
- **Independent evaluation** – to validate outcomes, assess the effectiveness of our interventions, and inform ongoing learning and improvement.

These metrics are dynamic and will evolve as the Strategy is implemented, enabling us to remain responsive to emerging needs, challenges, and opportunities.

By embedding this monitoring framework into our governance and delivery structures, we are committing to a culture of openness, learning, and accountability—ensuring that our collective efforts lead to a healthier, fairer Devon for all.

This approach complements, rather than replaces, the system's ongoing responsibilities to meet national and local requirements under business-as-usual operations.

Alongside the transformative ambitions of the Strategy, providers are expected to continue delivering all mandated operating plan targets and pursue internal improvement programmes as part of their core functions. They should:

- Meet the requirements set out in the national operating planning guidance
- Meet the requirements set out in the national elective reform plan
- Meet the requirements set out in the national Urgent and Emergency Care plan
- Deliver within the context of the national 10 Year Health Plan
- Deliver within the context of the national neighbourhood health plan

Domain: Accessible to all

High level-outcomes	Metric
• **Take a Neighbourhood-first approach** • **Embed a focus on equity and prevention** • **Improve health and wellbeing outcomes**	• Access and navigation • % urgent care demand met same day • Digital triage success rate • Access equity for Core20PLUS5+ populations • Social prescribing uptake • Caseload coverage • Anticipatory care plan completion • Personalised Care Plan completion • Elective waiting times (referral to treatment (RTT) compliance) • A&E 4-hour target performance • Referral to treatment (RTT) metrics • Length of stay (LoS) • Bed occupancy rates

Domain: Sustainable

High Level-Outcomes	Metric
• **Ensure financial and operational sustainability** • **Support workforce resilience and a shared culture** • **Innovate for digital and infrastructure transformation**	• % of GP practices connected to Shared Care Record (SCR) • Digital maturity index scores • % of staff using integrated digital systems (e.g. Devon and Cornwall Care Record (DCCR) • Data sharing compliance (GDPR readiness) • Use of AI and advanced analytics in care pathways • Utilisation rate of estate (clinical and non-clinical) • % of estate meeting functional suitability standards • Carbon footprint and energy efficiency of estate • Staff survey results (engagement, morale, safety culture) • Sickness absence rates • Vacancy rates and turnover • Workforce equality metrics (e.g. WRES, WDES) • Training uptake and continued professional development (CPD) participation • Governance maturity assessments • Annual ICB statutory assessment results • Financial performance (surplus/deficit)

Domain: Quality and value

High level-outcomes	Metric
• **Ensure quality across everything we do** • **Embrace a value-based care approach** • **Develop clear governance and accountability processes**	• Cross-sector multidisciplinary team (MDT) participation • Rotational staff roles established • Referral response times across sector • % of contracts with outcome-based commissioning • % of pooled budgets across system partners

Domain: People-centred

Level-Outcomes	Metric
• **Co-design and co-deliver accessible, joined care** • **Enable a strong, consistent leadership** • **Create a culture of collective responsibility**	• Home discharge rate from recovery pathways • Readmission within 30 days • Friends and Family Test (FFT) scores • Patient experience survey results • Complaints and compliments data • Carer-reported experience measures • Patient Activation Measure (PAM) scores • Smoking prevalence, obesity rates, alcohol-related admissions • Vaccination coverage (e.g. flu, COVID-19) • Screening uptake (e.g. cervical, bowel, breast) • % of budget allocated to prevention • Population health management (PHM) indicators • Avoidable mortality rates • Health-related quality of life for people with long-term conditions • Emergency readmission rates within 30 days • Patient-reported outcome measures (PROMs) • Life expectancy at birth and at 75 • Early cancer diagnosis rates Hospital Standardised Mortality Ratio (HSMR

Enabling plans

Empowering patients and citizens

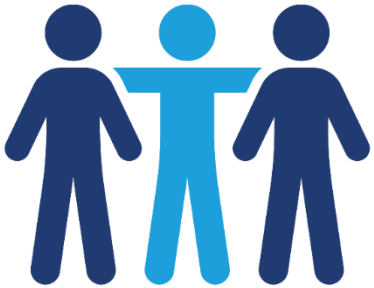
Through a focus on citizen and patient engagement, we will co-develop a community contract that clearly outlines mutual roles and responsibilities, fostering shared ownership of health outcomes.

A new Engagement Framework will be launched to strengthen how we listen, involve, and respond to our communities, supported by enhanced training for staff in patient communication and engagement.

We will also audit and improve our communication methods to ensure they are inclusive, accessible, and effective. In parallel, our Neighbourhood Shift approach will see the creation of a ‘Patient Partnership’ plan to guide the transition of services into community settings, ensuring that changes are co-designed and responsive to local needs.

A dedicated workforce transition plan will support staff through these changes, enabling a smooth and sustainable shift in how care is delivered.

- **Co-develop a Community Contract** Engage citizens and patients in structured dialogue to define mutual roles, responsibilities, and expectations around health and care.
- **Launch a new Engagement Framework** Establish clear principles, processes, and tools for listening, involving, and responding to community voices across all service areas.
- **Develop a ‘Patient Partnership’ Plan** Co-design service transition plans with communities to ensure local relevance, responsiveness, and sustainability.
- **Implement a Workforce Transition Plan** Support staff through the shift to community-based care with tailored guidance, role clarity, and change management support.



Culture, teams and partners

Creating a thriving, collaborative culture across our health and care system is essential to delivering meaningful change.

Under the workforce planning strand, we will develop a system-wide, skills-based workforce plan with a five-year horizon, ensuring we have the right capabilities in place to meet future needs.

We will also reignite the Staff Passport initiative to enable greater cross-site mobility and flexibility, supporting integrated working.

Through a comprehensive review of organisational development (OD) and training, we will establish Strategic Education Groups to provide governance and oversight to create a unified training and leadership development plan that reflects shared priorities.

A collective training purchasing strategy will help maximise value and consistency across the system. At the leadership level, we will strengthen alignment and collaboration through the development of a Committee in Common across statutory and partner boards to deliver joint executive training with a focus on compassionate leadership, ensuring our leaders are equipped to guide transformation with empathy and purpose.

- **Develop a system-wide, skills-based workforce plan** Create a five-year roadmap that aligns workforce capabilities with future service needs across the health and care system.
- **Reignite the Staff Passport initiative**
- **Establish multi-agency agreements to enable this plan**
- **Create a Unified Training & Leadership Development Plan** Design a shared curriculum that reflects system-wide priorities and supports consistent professional growth.
- **Deliver Joint Executive Training in Compassionate Leadership** Equip senior leaders with the skills to lead transformation with empathy, purpose, and system-wide perspective.

Enabling functions

Digital and data

Harnessing the power of digital innovation and data intelligence is vital to transforming health and care delivery across our system.

We will enhance the Devon and Cornwall Shared Care Record (DCCR) to support outcomes-based planning and enable clustering across the Peninsula, laying the groundwork for a single Shared Care Record that facilitates seamless, person-centred care.

A unified Information Governance (IG) approach will be developed, including a sign-up strategy for GP practices and a shared policy and leadership structure across Devon and Cornwall, ensuring trust, transparency, and compliance.

Crucially, we will capture the patient voice to guide how data and digital tools are integrated into care.

Through the development of a Common Technical Infrastructure (CTI), we will enable cross-border working and interoperability across the Peninsula.

Our approach to Artificial Intelligence (AI) will prioritise staff engagement, training, and early evaluation of return on investment.

Finally, we will co-develop Digital Inclusion plans with VCSEs, local authorities, and ICS partners to address barriers to access and ensure that no one is left behind in the digital transformation.

- **System wide data sharing** Patient information will be shared with those who need access from different health, care and VCSE settings using a unified platform.
- **A unified Information Governance (IG) approach** will be developed, including a sign-up strategy for GP practices and a shared policy and leadership structure across Devon and Cornwall.
- **Standardised and unified infrastructure** Development of a single data management and reporting architecture by the system-wide business intelligence (BI) shared service.
- **Shared EPR and operational systems** The implementation of a single Electronic Patient Record (EPR) across all Devon acute hospitals and the Devon and Cornwall Care Record (DCCR) will continue to be the shared care record for sharing patient information across health and care settings.

Organisational structure

A coherent and agile organisational structure is essential to delivering integrated, neighbourhood-focused care.

We will begin with a comprehensive pan-system review of structures across NHS organisations and partners to identify opportunities for alignment, simplification, and improved collaboration.

Using business intelligence (BI) and Population Health Management (PHM) insights, we will support the strategic Neighbourhood 'Left Shift', enabling services to move closer to communities and better reflect local needs. This will be shaped in partnership with VCSE and community experts to define tailored neighbourhood offers.

To support understanding and engagement, a targeted Change Communications plan will be developed to clearly explain structural changes and their benefits to staff, partners, and the public.

Finally, we will establish a Whole System Planning approach, including a system-wide structure and training plan underpinned by co-designed metrics, ensuring that transformation is measurable, inclusive, and sustainable.

- **Leverage BI and PHM Insights to guide service shift** Use data-driven intelligence to support the strategic 'Left Shift' of services into community settings, tailored to local population needs.
- **Workforce plan.**
- **Incorporate a detailed system workforce plan** that support neighbourhood and place development.
- **Co-design metrics to measure transformation** Develop inclusive, meaningful indicators to track progress, impact, and sustainability of structural changes

Estate and infrastructure

Modernising our estate and infrastructure is key to enabling care that is accessible, integrated, and future ready.

In community services, we will design place-based estate models that reflect local needs and support virtual care through mapped digital infrastructure. Asset consolidation will continue to ensure efficient use of resources, while a hub-and-spoke model will be developed around 5–6 strategically located community hubs to anchor neighbourhood care.

For primary care, we will review estate quality and develop a Primary Care Network (PCN) estate plan, alongside exploring new funding models and NHS ownership options to secure long-term sustainability.

Within acute services, we will maintain a steady-state approach to existing estate, while planning for service consolidation.

Future ward design—including virtual wards—will be co-led by digital and data teams to ensure alignment with technological capabilities.

A dedicated funding plan will be developed to support the reduction of outpatient activity, enabling a shift toward more proactive and community-based care.

- Design place-based estate models
- These models will inform the development and infrastructure to deliver services at place and in the most appropriate setting
- Map digital infrastructure for virtual estates planning
- Develop hub and spoke model
- Continue asset consolidation

Funding model

Transforming how we fund, and resource care is critical to enabling a shift from reactive to proactive, community-based services.

We will plan for a strategic resource shift from acute to community settings, addressing key challenges such as capital versus revenue funding to ensure financial sustainability.

We will develop delegated budgets for Integrated Neighbourhood Teams, empowering local decision-making and fostering accountability.

A comprehensive contract review will extend contract durations and embed outcomes-based commissioning, aligning incentives with population health goals.

In parallel, we will undertake a strategic commissioning review to assess statutory funding flows and evaluate the role of block contracts in supporting system-wide priorities.

We will create a Population Health Management (PHM)-informed funding

model for preventative care, ensuring that investment is targeted where it can have the greatest long-term impact on health and wellbeing.

The next phase of this work will focus on collaboration with relevant teams and stakeholders across the system to co-develop and implement each of the six enabling plans.

This will ensure that the plans are fully aligned with our overarching health and care strategy, grounded in operational realities, and shaped by the expertise and insight of those delivering and receiving care.

Through inclusive engagement, clear governance, and phased delivery, we will translate strategic intent into meaningful, system-wide change.
We will design a fair and equitable funding model that is:

- Fair
- Based on outcomes
- Provides equity
- Incorporates deprivation and protected characteristics
- Aligned to contractual models

Looking forward

As NHS Devon moves into the delivery phase of this strategy, we reaffirm our commitment to working in genuine partnership with our communities, providers, and system partners.

This is not just a principle it is a foundational approach embedded in our People and Communities Framework, which sets out a system-wide ambition to ensure that every voice, especially those from marginalised and Core20PLUS5 communities, is heard and influences decision-making.

Through the Devon Engagement Partnership (DEP), we will continue to nurture inclusive, coordinated, and transparent relationships. The DEP provides the governance and assurance that our system is meaningfully listening to and working with people and communities.

Engagement will be continuous, visible, and aligned to the four aims of the Integrated Care System—improving outcomes, tackling inequalities, enhancing value, and supporting broader social and economic development.

In parallel, we are implementing a renewed contract management framework, as outlined in our contract management approach blueprint. This framework introduces a structured, risk-based model for oversight and collaboration with NHS providers.

Key features include:

- Monthly contract review meetings (CRMs) chaired by senior ICB executives, providing a formal platform to monitor performance, quality, finance, and risk.
- Joint technical working groups (JTWGs) that underpin CRMs with detailed analysis of activity, referrals, waiting times, and financial impacts.
- A delivery management report (DMR) and Power BI dashboards to ensure a single version of the truth across the system.
- Clear governance and escalation routes to ensure accountability and alignment with strategic commissioning intentions.

This approach is designed to be proportionate, transparent, and focused on continuous improvement. It supports the development of commissioning intentions, service transformation, and financial sustainability, while ensuring that patient safety and experience remain central to all discussions.

Evaluation and learning will be embedded at every stage. We will use structured reporting, action tracking, and feedback loops to assess impact, adapt our approach, and ensure that our strategy remains responsive to the needs of our population. This includes formal reporting into NHS Devon's governance structures and assurance committees, and alignment with national planning and oversight frameworks.

Together, through inclusive engagement, robust contract oversight, and a culture of learning, we will deliver a strategy that is ambitious, accountable, and rooted in the lived experiences of the people we serve.

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TORBAY AUTISM STRATEGY 2025 – 2028

Introduction

We are dedicated to enhancing the lives of Autistic individuals in Torbay. To achieve this, we've teamed up with members of the Autism Partnership Board to develop a meaningful strategy that outlines clear goals. The Board has chosen to align the Torbay Strategy with the National strategy for autistic children, young people, and adults for the period of 2021 to 2026. In addition to these discussions, we sought input from the community through surveys and consultation sessions that engaged carers and professionals in support services.

Our vision is to create a community in Torbay that is both understanding and inclusive. We are collaborating with the Torbay Autism Ambassadors to identify ways to dismantle existing barriers while highlighting the valuable contributions of autistic individuals. This strategy complements and supports various other initiatives across the Integrated Care systems, including the Adult Social Care Strategy and the Thriving Communities framework, where individuals can prosper.

About Autism

Autism is a lifelong, developmental condition that affects how people communicate and relate to other people, and how they experience the world around them. It is estimated that one in one hundred people in the UK are autistic. People's strengths and challenges vary widely and how they experience the world and people around them can be quite different. It is important to treat each person individually and remember if you have met one autistic person, you have met one autistic person. While autism is not a learning disability, around 4 in 10 autistic people have a learning disability. Additionally, some individuals diagnosed with autism may also experience comorbid conditions such as ADHD, gastrointestinal conditions, mental health conditions such as OCD, depression and anxiety (list not exhaustive).

It is predicted that 451,698 adults (18+) in England have Autism Spectrum Condition (ASC), and this figure is predicted to rise to 488,185 by 2040.

As per the 2021 census, Torbay has a population of approximately 139,322. Data from POPPI and PANSI predicts that there are approximately 1,134 people in Torbay with ASC, however we are aware that official figures are difficult to establish as some people with ASC may not recognise themselves as being Autistic or come in to contact with adult social care services. There are many reasons for this, such as autistic people developing their own coping strategies to overcome day to day difficulties, misdiagnosis due to overlapping mental health problems and/or long waiting times for a diagnosis.

Myths and facts

Although over 700,000 people in the UK are autistic (more than 1 in 100 people), false and often negative perceptions about the condition are commonplace.

This lack of understanding can make it difficult for people on the autism spectrum to have their condition recognised and to access the support they need. Misconceptions can lead to some autistic people feeling isolated and alone. In extreme cases, it can also lead to abuse and bullying.

- ★ Autism affects more than 1 in 100 people – **fact**. Over 700,000 people in UK are autistic, which means that 2.8m people have a relative on the autism spectrum.
- ★ People tend to 'grow out' of autism in adulthood – **myth**. It is a lifelong condition – autistic children become autistic adults.
- ★ Autism affects both boys and girls – **fact**. There is a popular misconception that autism is simply a male condition. This is false.
- ★ Some autistic people do not speak – **fact**. Some autistic people are non-verbal and communicate through other means. However, autism is a spectrum condition, so everyone's autism is different.
- ★ Autism is a mental health problem – **myth**. Autism is a developmental disability. It is a difference in how your brain works. Autistic people can have good mental health, or experience mental health problems, just like anyone else.
- ★ All autistic people are geniuses – **myth**. Just under half of all people with an autism diagnosis also have a learning disability. Others have an IQ in the average to above average range. 'Savant' abilities like extraordinary memory are rare.
- ★ Everyone is a bit autistic – **myth**. While everyone might recognise some autistic traits or behaviours in people they know, to be diagnosed with autism, a person must consistently display behaviours across all the different areas of the condition. Just having a fondness for routines, a good memory or being shy does not make a person 'a bit autistic'.
- ★ Autism is a learning disability – **myth.** A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life. Some autistic people also have a learning disability, but some do not.

Torbay Autism Partnership Board

TORBAY AUTISM AMBASSADORS

Torbay's Autism Partnership Board was launched in November 2022 and members meet four times a year. Membership of the Board comprises of eight Autistic Ambassadors, two Family Carer Representatives, Torbay Council, Torbay & South Devon NHS Foundation Trust, adult social care providers, Devon & Cornwall Police and representatives from the voluntary sector. The role of the Board is to participate in, and influence decisions concerning the development of new services, review of existing services, policies and strategies and driving equality and justice for Autistic people in Torbay. More information about the Torbay Autism Partnership Board can be found here.

Torbay's Autism Ambassadors have played a pivotal role in the development of the Torbay Autism Strategy. From setting the key priorities, providing feedback based on their own experiences with those priority areas, collaborating in engagement exercises, and ultimately giving the strategy the final sign-off. An action plan will be developed as a mechanism to deliver the key priorities from this strategy, and will be monitored by, and held accountable to the Autism Partnership Board.

National Strategy

Following the Think Autism Strategy (DHSC, 2014) published in 2014, The Department of Health and Social Care issued 'Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy' (DHSC, 2015). The guidance states that there must be meaningful local autism partnership arrangements, which set a clear direction for improving services, and that the views, wishes, feeling and beliefs of people with autism and their carers should be listened to carefully, through a variety of methods such as autism partnership boards, consultation events or online consultation forms.

The 2009 Autism Act states that the Secretary of State must publish and keep under review a National Autism Strategy. In 2021, DHSC, the Department of Education and NHSE, published the National Strategy for Autistic Children, Young People and Adults (DHSE, 2021-2026). The purpose of the Strategy is to improve the lives of autistic people and their families and carers in England and to support them to lead fulfilling and happy lives. Following an initial meeting with Torbay's Autism Ambassadors, they agreed that the priorities of the national strategy were relevant and reflective of the issues that autistic people in Torbay are facing, and that they should be mirrored for the Torbay Autism Strategy. The key national priority areas of the National Strategy are:

- Improving understanding and acceptance of autism within society
- Improving autistic people's access to education, and supporting positive transitions into adulthood
- Supporting more autistic people into employment
- Tackling health and care inequalities for autistic people
- Building the right support in the community and supporting people in inpatient care
- Improving support within the criminal and youth justice systems

Local strategies are fundamental to setting out a clear vision and plan of how we want to support our local communities, whilst ensuring that resources are allocated effectively and gaps are addressed. Co-producing the strategy allows the community to have their say on issues important to them and the areas they feel need to be addressed. Co-production allows individuals to have their voice heard and encourage a collegiate approach to the formation of strategies.

Special Educational Needs and Disabilities (SEND)

The Torbay SEND Strategy and Torbay Adults Autism Strategy address different needs at various life stages. The SEND Strategy focuses on children, young people, and their families, while the Adults Autism Strategy addresses issues faced by Autistic Adults (18+). Despite these differences, Adult Social Care and Children's Services will work together to ensure a smooth transition from childhood to adulthood, providing continuous support and resources.

The Torbay SEND strategy sets out a vision and direction of travel for children and young people 0 – 25 years, with Special Educational Needs and Disabilities (SEND) in Torbay. It is intended to cover the 'local area' of Torbay and can only be achieved through effective partnership between children, young people, parent and carers and our local system; the local authority, Integrated Care System (ICS) (health), public health, NHS England for specialist services, early years settings, schools, further education provisions and the voluntary and community sector.

A Shared Vision

- The shared vision for the SEND strategy was produced with representatives from across the local area. The shared vision is:
  - **SEND is everybody's business** - embedding the vision and values into the practice of everyone who works with children and families from 0-25 years.
  - **Identify and respond to needs early** - in ways that value lived experience and expertise, offering personalised care and support.
  - **Deliver in the right place at the right time** - always asking 'so what difference are we making in the life of this child or young person?'

The vision for the SEND strategy will be delivered through five priority areas:

- **Priority 1:** SEND is everyone's business - embedding our values through education, health and social care, changing culture and reforming our workforce.
- **Priority 2:** Identify and act on children's needs at the earliest opportunity, through valuing lived experience and expertise.
- **Priority 3:** Understand the needs of our children, young people and families and make sure joint commissioning supports service delivery and we make best use of all resources
- **Priority 4:** Make sure that all early years providers and mainstream educational settings support an inclusive approach to education
- **Priority 5:** Improve transition planning for young people moving into adulthood.

- To achieve this vision, young people, parents, carers, professionals and services across the local area have agreed to adopt a set of principles that have been set out in a partnership pledge. We know that the success of our strategy depends on cultural change. The commitments that we expect everyone to adopt and sign up to have been defined by our children and young people.

The full Torbay SEND Strategy 2023 – 2030 can be found here

Torbay Local Offer

The law says that every local authority must have a SEND Local Offer that provides information for and about services, processes and resources to support children and young people up to the age of 25 with special educational needs and disabilities (SEND), their parents or carers and the practitioners who support them - all in one place. Knowing what is out there gives you more choice and control over what support is right for you or your child.

The Torbay SEND Local Offer is part of the Family Hubs Torbay. Family Hubs are a new way of bringing together all the support a family may need and provides a welcoming space and a 'front door' for families from pregnancy through to young people turning 19 (or 25 if they experience SEND).

Visit the Torbay SEND Local Offer

Co-Production and Public Consultation

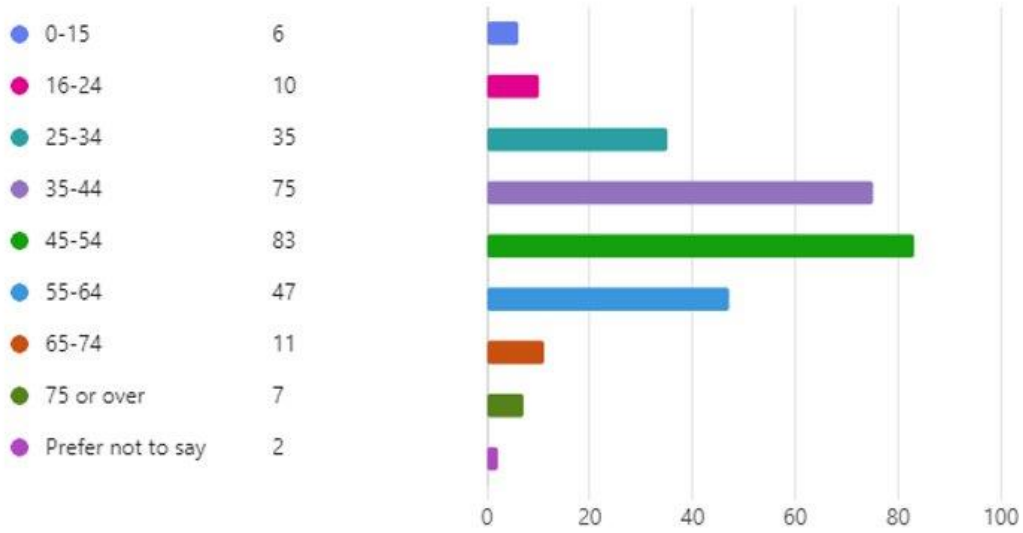
Our Torbay Autism Ambassadors have played an important part in the co-production of this strategy and will continue to monitor it throughout its lifespan to ensure that progress is being made.

In November 2024, a public online consultation was held in Torbay to collect valuable feedback on the strategy priorities while gaining insights into the experiences of local residents. This initiative was promptly followed by a working lunch with the Autism Ambassadors, facilitating a collaborative dialogue on autism-related issues. The analysis of the consultation responses identified key themes across each priority area, emphasising a need for enhanced autism awareness and understanding throughout the community. In April 2025, a subsequent strategy engagement session was organised for professionals who directly support autistic individuals or work in relevant organisations. This session aimed to strengthen connections among practitioners and to ensure that the collective knowledge and insights gained from both the public consultation and ongoing discussions are effectively integrated into the strategic initiatives, ultimately fostering a more inclusive environment for autistic individuals in Torbay.

Consultation Responses

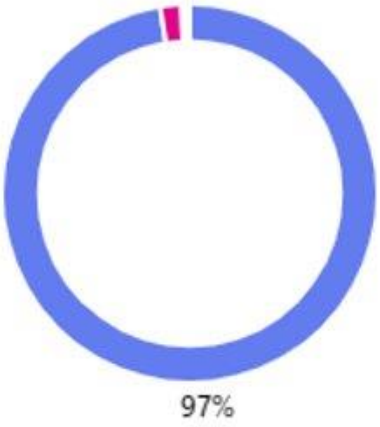
What is your sex?

Which of the following age group applies to you?



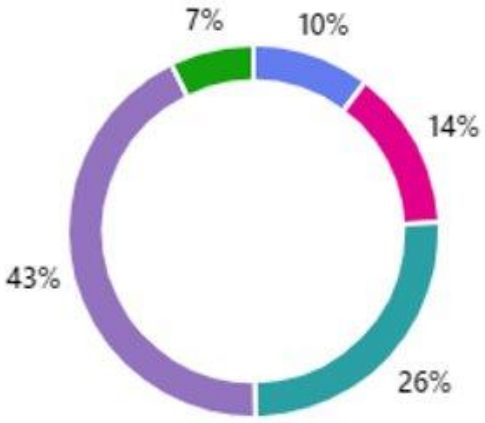
Which of the following best describes your ethnic background?

White	268
Mixed ethnic background	5
Asian or Asian British	1
Black or Black British	0
Other	1



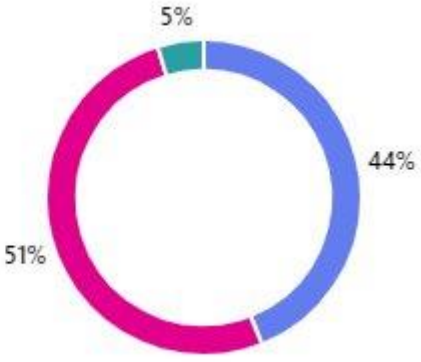
Do you identify as:

A diagnosed autistic person	38
An undiagnosed autistic person	52
A carer	95
The family member of an autistic person	159
Other	27

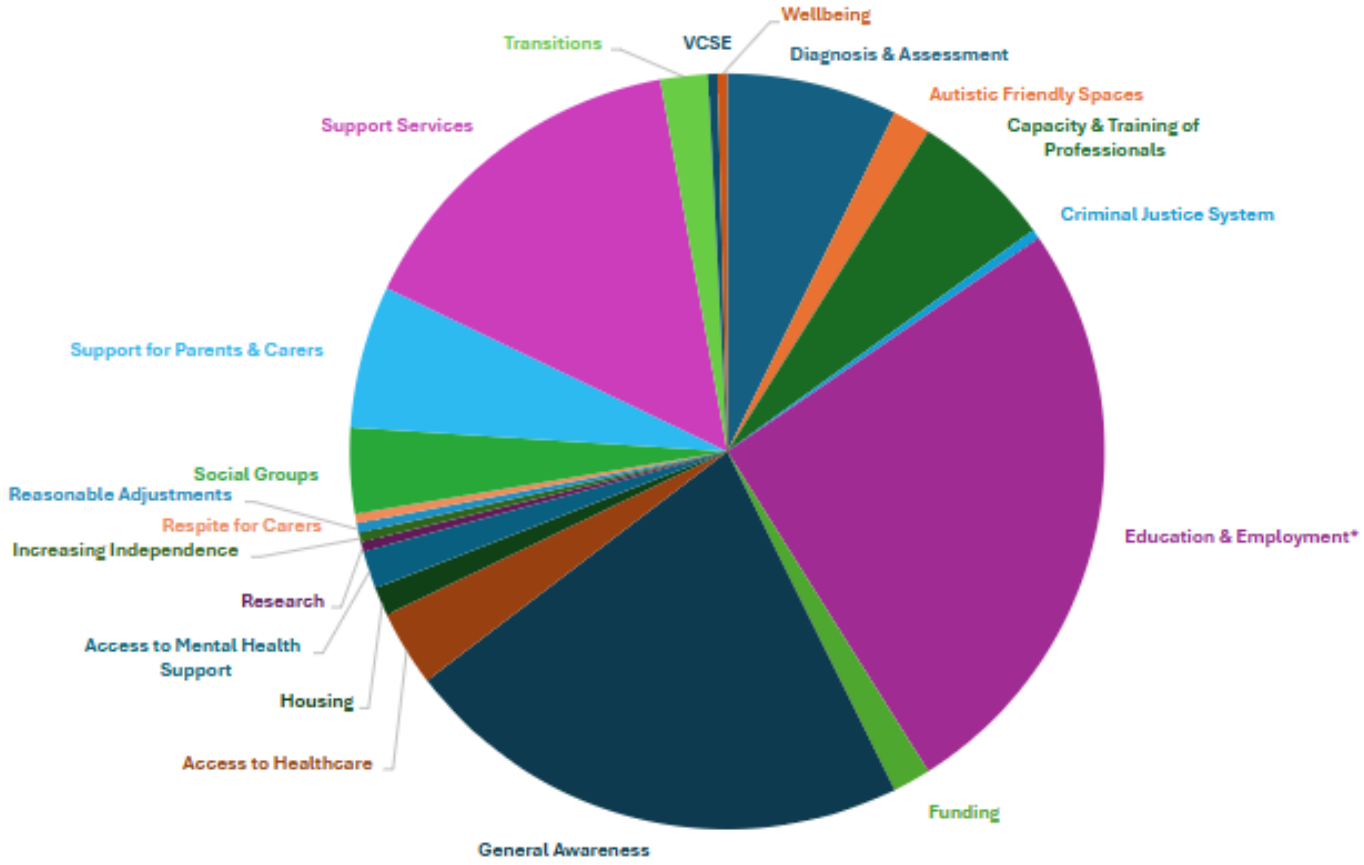


Do you consider yourself, or the autistic person you are related to or care for, to have a learning disability?

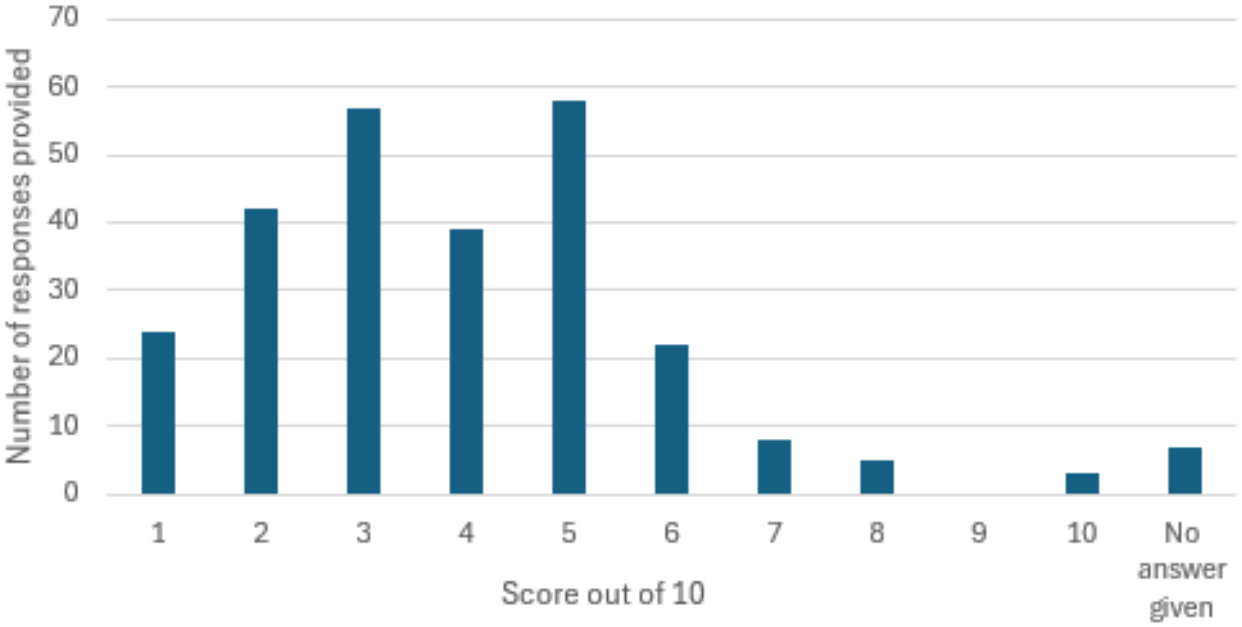
Yes	121
No	141
N/A	13



What do you think are the most important issues facing autistic people in Torbay today?



Out of 10, how would you rank Torbay residents' understanding of autism?



Based on the responses provided, the median score out of 10 is 2.8.

Our Key Priorities

Priority: Improving understanding and acceptance of autism within society

What we know

Our consultation revealed that although there is some awareness of autism in Torbay, there is still a significant opportunity to deepen understanding and promote better knowledge within both the community and local services.

Many individuals reported that both the general public and professionals often lack a proper understanding of autism. This includes misconceptions about autistic behaviours and needs. There are numerous accounts of people facing judgmental stares, rude comments, and even verbal abuse when autistic behaviours are displayed in public. Some have been accused of bad parenting or told that autism isn't a real condition, whilst also hearing the common misconception of "everyone is a bit autistic". Families often feel judged or stigmatised due to behaviours associated with autism, leading to social withdrawal and reluctance to seek help.

However, some positive experiences are noted, particularly with organisations and individuals who are understanding and accommodating. Examples include certain schools, community members who offer assistance during difficult moments, and local attractions and organisations.

'I've heard various people say, "we're all on the spectrum". That one I hate as it really undermines and devalues the real struggles of autistic people.'

'My experience has been varied - some people have an understanding of the condition and respond well. Others are judgemental and don't understand.'

Our goals are to:

- Enhance the public's understanding of Autism and its diverse impacts on individuals.
- Work towards improving pre-conceived ideas about autism and addressing myths and misinformation.
- Promote the importance of making reasonable adjustments for everyone affected wherever possible.
- Raise awareness with the autistic community about what makes reasonable adjustments, reasonable.
- Improve access to community spaces that are friendly and accommodating for Autistic individuals.
- Ensure that relevant professionals receive Oliver McGowan training pertinent to their roles.
- Raise awareness about various communication methods that support individuals with Autism.
- Engage with local businesses and retailers to explore how we can work together to promote understanding.

Priority: Tackling health and care inequalities for autistic people

What we know

The findings from our consultations reveal a spectrum of experiences within the healthcare system, ranging from commendable to concerning. Positive feedback highlights instances where healthcare staff demonstrated knowledge, made necessary adjustments such as providing quiet rooms and modifying communication styles, and actively involving parents or caregivers when appropriate. However, some respondents indicated that the healthcare system has not been able to make essential accommodations for autistic individuals. Common issues include unsuitable physical environments, characterised by crowded waiting areas and overwhelming sensory inputs, as well as prolonged waiting periods and uncertainty regarding appointment schedules. Moreover, barriers to accessing healthcare services are prevalent. Many individuals report difficulties in navigating appointment systems, including complex online forms and inconsistent interactions over the phone. Additionally, our consultations identified a lack of adequate mental health support specifically tailored to the needs of autistic individuals, coupled with confusion surrounding the process of obtaining appropriate services.

These findings underscore the need for enhanced training, increased awareness, and the implementation of strategies among healthcare professionals in Torbay who engage with autistic individuals. The nature of these professional interactions has a significant impact on the well-being of autistic individuals and their families, thus illustrating the importance of addressing both positive and negative experiences within healthcare settings.

'Access to quiet areas is very limited. Some healthcare workers are not up to date on autism training'

Our goals are to:

- Continue to support the roll out of the Oliver McGowan Training
- Support the roll out of the Reasonable Adjustment Digital Flag
- Raise awareness of reasonable adjustment in healthcare settings.
- Raise awareness of the challenges with Communication during appointments and how to support people effectively.
- Advocate for the use of easy-read appointment letters where required.
- Continue to promote the principles within the Triangle of Care initiative (a partnership between professionals, the person being cared for and the Carer). - The Triangle of Care explained
- Increase awareness of the Torbay health passport.
- Improved information and advice on how to access appropriate mental health support for autistic individuals.
- Raise awareness about co-morbidities, and how Autism links with other health issues
- Maintain knowledge and awareness of our local LeDer (Learning from lives and deaths – People with a learning disability and autistic people) Review findings and learning.

Priority: Supporting more autistic people into employment

What we know

Contributing meaningfully through work, enjoying one's job, and feeling a sense of worth are important. However, the latest official statistics show that only around 3 in 10 working age autistic disabled people are in employment, compared with around 5 in 10 for all disabled people and 8 in 10 for non-disabled people (DWP, 2024).

Autistic people face the largest pay gap of all disability groups, receiving a third less than non-disabled people on average. Autistic graduates are twice as likely to be unemployed after 15 months as non-disabled graduates, with only 36% finding full time work in this period. Autistic graduates are most likely to be overqualified for the job they have, most likely to be on zero-hours contracts, and least likely to be in a permanent role (DWP, 2024).

Our consultation findings highlight the importance of understanding and accommodating employers or managers. Individuals reported experiences of employers lacking understanding of autism and mental health, instances of bullying and discrimination, isolation from colleagues and feelings of overwhelm and burnout.

Supportive workplaces that acknowledge disabilities and make reasonable adjustments contribute significantly to positive experiences. Workplaces that have a good understanding of autism and other disabilities create a more inclusive environment; this includes colleagues who are knowledgeable and show good attitudes toward neurodiversity.

Torbay currently funds

'My work life is managed well by a supportive family and colleagues who understand my needs'

'My daughter is missing out in huge elements of her education and is unlikely to gain any qualifications. She is concerned that this will be a major barrier to employment and independence in the future.'

Our goals are to:

- Strengthen partnerships with employers in Torbay to foster collaboration.
- Encourage local businesses to participate in autism-related events and training to enhance their expertise.
- Support and encourage more employers to offer work experience and work trials.
- Support and champion autistic friendly employers and businesses
- Cultivate connections with Disability Employment Advisors.
- Collaborate with local job centres to raise awareness and understanding of autism among staff working with autistic individuals.
- Raise awareness of reasonable adjustments to employers and promote toolkits and resources that can assist with implementing them.
- Promote information and resources available for employers, unemployed autistic people and autistic employees.
- Explore, support and raise awareness of local employment and skills support programmes, including those aimed at building self-esteem and confidence.

Priority: Building the right support in the community and supporting people in inpatient care

What we know

The consultation revealed several gaps in support for autistic individuals, such as peer support among autistic people and practical assistance when individuals require help navigating systems and accessing mainstream services.

To address these issues, it is important to create environments where autistic people feel secure and accepted. This includes developing autism-friendly public spaces and community hubs. Additionally, organizing social activities and groups can help reduce isolation and promote engagement within the community. Improved access to information, guidance, and signposting is essential to ensure that autistic individuals can readily discover the support available to them.

In July 2025, The Brook Inpatient Unit at Langdon Hospital, Dawlish opened. The Brook unit is a 10-bed acute admission unit for those with a mental health condition and learning disability and/or who are autistic. The Torbay Autism Partnership Board have been kept informed of progress of the build and given the opportunity to visit the unit prior to opening.

"There is a lack of support and groups for autistic adults - support is not just needed for autistic children. Autistic children become autistic adults and still need support."

Our goals are to:

- Enhance the accuracy of information and data collection, so that commissioners can analyse local trends and make well-informed commissioning decisions for the autistic community in Torbay.
- Bridge the social support/peer support gap for autistic adults, ensuring they receive the assistance they need.
- Improve accessibility to information, advice and signposting to support services for autistic individuals and their family carers in Torbay.
- Explore the potential for creating an accessible hub where autistic individuals can connect within their local communities. This hub could serve as a supportive space for socializing, participating in activities, obtaining practical assistance, accessing peer support, and finding valuable information and advice.
- Develop and maintain links between the Torbay Autism Partnership Board and local inpatient units and their outreach services.
- Continue to maintain links with Adult Autism and ADHD Service (DAANA) and Devon Adult Autism Intervention Team.

Priority: Improving support within the criminal and youth justice systems

What we know

People with Autism are heavily represented in both the prison and probation population and amongst victims of crime. Our consultation results provided a varied response when it came to interactions with the police. Some individuals report positive experiences, highlighting police support during crises such as suicidal incidents, however others recount negative experiences, noting a lack of understanding and inappropriate handling of situations involving autistic individuals.

There is a recurring concern that police and justice system staff are not adequately trained to recognize and interact with neurodiverse individuals, and that misinterpretation of behaviours associated with autism often leads to unjust treatment or escalation of situations.

"The Police were brilliant during a suicidal incident."

"Local police lack understanding of autism and additional needs"

Our goals are to:

- Emphasise the necessity for specialised training for all criminal and justice system personnel on neurodiversity.
- Advocate for collaborative approaches that involve families and professionals to support affected individuals better.
- Ensure there is consistent representation from Devon & Cornwall Police and Probation services to the Torbay Autism Partnership Board.
- Work with Devon & Cornwall Police and Probation services to raise awareness within the organisations and collaborate on new and existing ideas and initiatives.

Priority: Improving autistic peoples access to education and support positive transitions into adulthood

What we know

Many respondents to our consultation noted the knock-on effect of the lack of support during early education and a lack of adequate support and preparation from professionals in preparing autistic people for adulthood. Services and guidance that should assist with transitions are often absent or insufficient and feedback indicated that ineffective communication between parents, carers and professionals such as educators, social workers, and healthcare providers can hamper the development of effective transition plans.

Autistic individuals and their families often feel ignored or invisible within the system, leading to worries about their future and what will become of them without proper support.

Of the 1716 Education Health and Care Plans (EHCP) maintained by Torbay (up to 31st May 2025), 535 children and young people are identified as having an autism as their primary need. Torbay Adult Social Care and Torbay Children's Services will work together to ensure a smooth transition from childhood to adulthood, providing continuous support and resources.

"There is inadequate support for higher education and autistic adults trying to access education"

"My daughter was failed by mainstream schools and there are no appropriate specialist provisions. They are unlikely to be able to gain any qualifications due to lack of professional expertise and the appropriate schools and provisions. My daughter's mental health is also deteriorating due to this failure"

Our goals are to:

- Continue to maintain links between children's services and adult social services to promote smooth transitions into adulthood.
- Explore and promote local skills programmes.
- Effective multi-agency early identification and pathways for support ensure that early and timely help addresses needs well.
- Transition plans will focus on opportunities, experience and skill development to build confidence, self advocacy and informed choice
- Ensure there is support available for those who do not meet the threshold of holding an EHCP or have a diagnosis.

Help and Support signposting

Our Autism Partnership Board is highlighting the services available to autistic adults and their carers in Torbay. You can find out more information here.

Are you are experiencing mental health distress? Or maybe you are worried about someone else's emotional state. There are many organisations that can help and support you. Find out who to contact and what help is available on the Devon Partnership Trust website

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TORBAY COUNCIL

Meeting: Health and Wellbeing Board **Date:** 4 December 2025

Wards affected: All

Report Title: Devon, Cornwall, and Isles of Scilly Health Protection Committee Annual Assurance Report 2024/25

When does the decision need to be implemented? Report for information

Cabinet Member Contact Details: Hayley Tranter, Cabinet Member Adult & Community Services, Public Health & Inequalities Hayley.Tranter@torbay.gov.uk

Director Contact Details: Lincoln Sargeant, Director of Public Health Lincoln.Sargeant@torbay.gov.uk

Authors: Mandy Guy, Public Health Specialist Mandy.Guy@torbay.gov.uk; Julia Chisnell, Consultant in Public Health Julia.Chisnell@torbay.gov.uk

1. Purpose of Report

1.1 The purpose of this report is to share with members the Devon, Cornwall, and Isles of Scilly Health Protection Committee Annual Assurance Report 2024/25.

2. Reason for Proposal and its benefits

2.1 The Devon, Plymouth, Torbay and Cornwall & Isles of Scilly Health Protection Committee prepare an annual assurance report for the constituent Health and Wellbeing Boards, detailing progress against statutory duties and strategic priorities during the previous year.

2.2 The report describes how partners, including Torbay Public Health, work together to protect our population from infectious disease and environmental hazards.

3. Recommendation(s) / Proposed Decision

3.1 Members are asked to note the content of the annual assurance report.

Appendices

Appendix 1: The annual assurance report of the Devon, Cornwall and Isles of Scilly Health Protection Committee Annual Assurance Report 2024/25

Supporting Information

1. Introduction

1.1 Torbay, Devon, Plymouth, and Cornwall & Isles of Scilly Local Authority Public Health teams are partners in the Devon and Cornwall Health Protection Committee which provides assurance that health protection functions are being effectively discharged across the Peninsula.

1.2 The Committee prepares an annual assurance report for the constituent Health and Wellbeing Boards, detailing progress against statutory duties and strategic priorities during the previous year.

1.3 The report considers the key domains of Health Protection:

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

1.4 The report sets out for each of these domains:

- Assurance arrangements
- Performance and activity during 2024/25
- Actions taken against health protection priorities identified for 2024/25
- Priorities for 2025/26.

1.5 There is a delay between the reporting period and the preparation of the report due to the timetable for publication of annual performance data. The Torbay Public Health team drafted the report this year, with contributions from local authority, NHS and regional colleagues.

2. Key points from the report including highlights for Torbay

2.1 The wider system responded to a range of infectious disease outbreaks or particular high levels of disease during the year including acute respiratory infections, sexually transmitted

infections, avian flu and pertussis (whooping cough). Torbay also continued to work with other partners on measles and high consequence infectious disease preparedness although no cases were recorded locally.

2.2 In May 2024 Torbay and Devon Public Health and Environmental Health teams, along with UK Health Security Agency, responded to a major outbreak of Cryptosporidiosis that affected Torbay and South Hams. A boil water notice was issued by South West Water and was in place for eight weeks. The recovery phase continued after the boil water notice was lifted and the investigation into the incident is still ongoing in 2025. The outbreak involved many Council departments working together, and the voluntary sector in Torbay were invaluable in supporting vulnerable communities during the outbreak.

Avian flu was confirmed in Torbay as well as many other areas in the peninsula and outbreaks of Avian Flu continue to remain a problem in birds. Advice, signage and arrangements for the collection of dead birds remains in place in Torbay.

2.3 The Public Health team worked with partners to maintain and strengthen resilience planning, infection prevention and control arrangements, and antimicrobial resistance across local settings. The Torbay AMR (antimicrobial resistance) group promotes local initiatives across settings, focusing on education, business and the care sector. The work with education providers included awareness, education sessions, hand-washing training and resource packs for early years. This work led to Torbay Public Health team being nominated for a national award and we were a finalist in the category

2.4 Campaigns during the year included heat health, measles, vaccination, tick awareness, TB and winter preparedness. Torbay Public Health was involved with the production of podcasts and training materials on TB and vaccinations.

2.5 Areas where local screening or immunisation coverage is comparatively low had – and continue to have – special focus:

- Screening: Many of the screening programmes remain above the national England average, although breast screening performance in Torbay was below the required standard. This has now stabilised after a fall over the previous three years. However, the regional screening and immunisation team has been working with providers both to increase overall breast screening uptake and to the use health equity tools to identify actions to target groups where uptake is lower.

- Vaccination: There was a focus on childhood and school based vaccines including MMR and HPV, and a programme of activity to improve uptake of Winter vaccines including flu, Covid and shingles. Torbay Public Health are members of the Maximising Immunisation Uptake Group which works on reducing inequalities in vaccination uptake. Additional funding from Vaccination Innovation Funding enabled some Torbay GP surgeries to undertake a vaccine data cleanse, with a focus on

MMR. Work to increase vaccine uptake in all target groups remains a priority for us in the current year, and a range of actions are in place.

2.6 Public Health have been working closely with partners on the challenges of climate change on health, with work including mitigation measures, adaption and best practice.

2.7 Priorities identified for 2025/26 follow the same key themes:

- Tackling the climate emergency
- Infection prevention and management and anti-microbial resistance
- Improving vaccination coverage
- Pandemic preparedness
- Inclusion health and addressing inequalities.

3. Financial Implications

3.1 None.

4. Legal Implications

4.1 None.

5. Engagement and Consultation

5.1 Key stakeholders have contributed to the assurance report and are listed in section 10 of the report.

6. Procurement Implications

None.

7. Protecting our naturally inspiring Bay and tackling Climate Change

7.1 Climate and Environment remain one of the priorities for the Committee. Health protection is critically affected by climate change and the frequency and intensity of environmental health threats such as flooding and heatwaves, which heightens the risk of infectious diseases and vector transmission. Chapter eight of the report focuses on Climate and Environment (see pages 51-52), and the climate emergency remains one of the priorities for the Health Protection Committee.

8. Associated Risks

8.1 No risks associated with the assurance report. Pandemic is an identified risk on individual organisational risk registers and all have mitigations and preparatory activities in place.

9. Equality Impact Assessment

Protected characteristics under the Equality Act and groups with increased vulnerability	**Data and insight**	**Equality considerations (including any adverse impacts)**	**Mitigation activities**	**Responsible department and timeframe for implementing mitigation activities**
Age	18 per cent of Torbay residents are under 18 years old. 55 per cent of Torbay residents are aged between 18 to 64 years old. 27 per cent of Torbay residents are aged 65 and older.	The Protection Assurance Report covers the arrangements in place to protect and improve the health of the population. It covers all ages but focuses on those more vulnerable to certain health risks or hazards.	Not applicable	Not applicable
Carers	At the time of the 2021 census there were 14,900 unpaid carers in Torbay. 5,185 of these provided 50 hours or more of care.	No differential impact although carers are prioritised for certain programmes eg flu and covid vaccination.	Not applicable	Not applicable
Disability	In the 2021 Census, 23.8% of Torbay residents answered that their day-to-day	No differential impact although those vulnerable through health conditions are prioritised for certain	Not applicable	Not applicable

	activities were limited a little or a lot by a physical or mental health condition or illness.	programmes eg vaccination.		
Gender reassignment	In the 2021 Census, 0.4% of Torbay's community answered that their gender identity was not the same as their sex registered at birth. This proportion is similar to the Southwest and is lower than England.	No differential impact	Not applicable	Not applicable
Marriage and civil partnership	Of those Torbay residents aged 16 and over at the time of 2021 Census, 44.2% of people were married or in a registered civil partnership.	No differential impact	Not applicable	Not applicable
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	No differential impact although pregnant women and infants are prioritised for certain programmes eg vaccination.	Not applicable	Not applicable

	notable fall in the numbers of live births since the middle of the last decade across all geographical areas.			
Race	In the 2021 Census, 96.1% of Torbay residents described their ethnicity as white. This is a higher proportion than the South West and England. Black, Asian and minority ethnic individuals are more likely to live in areas of Torbay classified as being amongst the 20% most deprived areas in England.	No differential impact	Not applicable	Not applicable
Religion and belief	64.8% of Torbay residents who stated that they have a religion in the 2021 census.	No differential impact	Not applicable	Not applicable
Sex	51.3% of Torbay's population are female and 48.7% are male	No differential impact	Not applicable	Not applicable
Sexual orientation	In the 2021 Census, 3.4% of those in Torbay aged over 16 identified their sexuality as	No differential impact	Not applicable	Not applicable

	either Lesbian, Gay, Bisexual or, used another term to describe their sexual orientation.			
Armed Forces Community	In 2021, 3.8% of residents in England reported that they had previously served in the UK armed forces. In Torbay, 5.9 per cent of the population have previously served in the UK armed forces.	No differential impact	Not applicable	Not applicable
Socio-economic impacts (Including impacts on child poverty and deprivation)		No differential impact	Not applicable	Not applicable
Public Health impacts (Including impacts on the general health of the population of Torbay)		No differential impact	Not applicable	Not applicable
Human Rights impacts		No differential impact	Not applicable	Not applicable
Child Friendly	Torbay Council is a Child Friendly Council, and all staff and Councillors are Corporate Parents and have a responsibility towards cared for and care experienced	No differential impact	Not applicable	Not applicable

	children and young people.			

10. Cumulative Council Impact

10.1 The health protection agenda should have positive impacts on the work of the Education and Adult Social Care sectors through infection prevention and disease control.

11. Cumulative Community Impacts

11.1 None.

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Devon, Cornwall, and Isles of Scilly Health Protection Committee

Annual Assurance Report

2024/25

Published November 2025

for the Health and Wellbeing Boards of Devon County Council, Torbay Council, Plymouth City Council, Cornwall Council, and the Council of Isles of Scilly

Contents

Acronyms and definitions

AMR	Antimicrobial resistance
APHA	Animal and Plant Health Agency
ARIs	Acute Respiratory Infections
Care OBRA	Care Outbreak Risk Assessment
CHIS	Childhood Health Information Service
Core20PLUS5	Approach to inform action to reduce healthcare inequalities
The Committee	DCIoS Health Protection Committee
CIoS	Geographical area of Cornwall and Isles of Scilly
COMF	Contain outbreak management funding
CSMS	Cervical Screening Management System
DEFRA	Department for Environment, Food and Rural Affairs
DTaP-IPV	Diphtheria, tetanus, pertussis, and polio (immunisation)
E. coli	Escherichia Coli
EPRR	Emergency Planning, Resilience and Response
FIT 80	Faecal Immunochemical Test
GAS	Group A streptococcal
GBMSM	Gay, bisexual and other men who have sex with men
HEAT	Health Equity Assessment Tool
HES	Hospital Eye Services
HPAG	Health Protection Advisory Group
HMO	House of Multiple Occupancy
HPV	Human papillomavirus
ICB	Integrated Care Board
ICS	Integrated Care System
IMT	Incident Management Team
IPC	Infection Prevention and Control
JCVI	Joint Committee on Vaccination and Immunisation
JESIP	Joint Emergency Service Interoperability Programme
JFP	Joint Forward Plan
KPIs	Key Performance Indicators
LRF	Local resilience forum

LHRP	Local Health Resilience Partnership
MIUG	Maximising Immunisation Uptake Group
MECC	Make Every Contact Count
MRES	Measles and Rubella Elimination Strategy
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for health and Care Excellence
OCT	Optical Coherence Tomography OR Outbreak Control Team
PHE	Public Health England
RDUH	Royal Devon University Hospital
SQAS	Screening Quality Assurance Service
TOR	Terms of Reference
UKHSA	United Kingdom Health Security Agency
VaST	NHS England Vaccination and Screening Team
VCSE	Voluntary Community and Social Enterprise

1. ABOUT THIS REPORT

This report provides a summary of the assurance functions of the Devon, Cornwall, and Isles of Scilly Health Protection Committee (the Committee) for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council, and the Council of the Isles of Scilly, and reviews performance for the period from 1 April 2024 to 31 March 2025.

The report considers the following key domains of health protection:

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

The report sets out:

- Assurance arrangements/structures
- Performance and activity during 2024/25
- Actions taken against health protection priorities identified for 2024/25
- Priorities for 2025/26

2. ASSURANCE ARRANGEMENTS

2.1 ASSURANCE ROLE

Local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their populations. The Committee is mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, and Cornwall Council and the Council of the Isles of Scilly to provide assurance that adequate arrangements are in place for the prevention, surveillance, planning, and response required to protect the public's health.

2.2 MEETINGS

The Committee met quarterly and action notes, an action log, screening and immunisation and infection prevention control (IPC) reports were circulated. Terms of Reference (TOR) were updated during this year and a summary of these with affiliated groups listed is included in Appendix 1. A summary of organisational roles in relation to delivery, surveillance and assurance is included in Appendix 2.

2.3 REPORTING

The Committee's Annual Assurance Report for 2023/24 was published in January 2025 and circulated to committee members for local authority health protection leads to submit to their respective Health & Wellbeing boards.

2.4 LOCAL HEALTH PROTECTION STRUCTURES

Local health protection structures include:

- Devon System Health Protection touchpoint meets regularly for the three Devon local authority health protection leads, Devon Integrated Care Board (ICB) IPC lead, the NHS England Vaccination and Screening Team (VaST), United Kingdom Health Security Agency (UKHSA) locality leads, Environmental Health and Emergency Planning.

- Cornwall and Isles of Scilly link with relevant stakeholders strategically via a quarterly Cornwall Health Protection Board.

In addition, other locally determined structures and groups support delivery and monitoring of health protection activity at local authority level, including the Torbay Health Protection Forum and the Plymouth Health Protection Board

2.5 SYSTEM DEVELOPMENTS FOLLOWING THE HEALTH AND CARE ACT

The Health and Care Act 2022 formally established the Integrated Care System structure of Integrated Care Boards and Integrated Care Partnerships and a requirement to publish integrated care strategies.

2.5.1 Devon System

The Devon Integrated Care System (ICS) published a five year integrated care strategy in December 2022. The accompanying Joint Forward Plan (JFP) was issued in June 2023 (updated in January 2025) describing how the strategy for health and care would be put into practice and how strategic goals would be achieved.

2.5.2 Cornwall and Isles of Scilly System

The 10-year Cornwall and Isles of Scilly ICS Strategy was bought together in the second half of 2022 and the first version was published in March 2023 with the Cornwall and Isles of Scilly 5-year JFP.

Links to the online strategies and plans for both Devon and Cornwall & Isles of Scilly are available in Appendix 3.

2.6 HEALTH PROTECTION COMMITTEE PRIORITIES 2024/25

The Health Protection committee consider the system assurance priorities as part of the annual assurance process and provides these within the annual report. The 2024/25 annual

priorities remain the same. This report describes evidence of progress against these priority areas.

1. **Climate Emergency**

   Work closely with partners to address the climate emergency and develop plans in relation to flooding, heatwave, cold weather, and other climate related mitigations or emergencies, with an emphasis on the impact on vulnerable groups.

2. **Infection Prevention and Management**

   Take action to strengthen infection prevention arrangements and tackle anti-microbial resistance:

   - promote health protective behaviours
   - strengthen infection prevention systems within health and care and wider settings
   - reduce healthcare associated infections
   - tackle antimicrobial resistance
   - implement the regional Infection Prevention and Management Strategy at local level

3. **Vaccinations**

   Work via the Maximising Immunisation Uptake Groups on shared objectives, to protect our population against outbreaks, by implementing targeted local actions.

4. **Pandemic Preparedness**

   Develop and strengthen all hazards planning and pandemic preparedness, promote resilience, and build on learning from the Covid Inquiry as findings are shared.

5. **Continuous Improvement in Health Protection**

   Work towards continuous improvement in health protection. Implement the Sector Led Improvement, and Gap Analysis Action Plans and audit performance against the What Does Good Look Like in health protection tool, sharing best practice and embedding learning from experience.

6. Inclusion & Inequalities

Protect the health of people experiencing greater inequalities in health or access.

Implement the Inclusion Health Agenda through health protection systems.

7. Work to support local strategic plans

See links to plans in Appendix 3.

3. PREVENTION AND CONTROL OF INFECTIOUS DISEASE

3.1 SURVEILLANCE ARRANGEMENTS

UKHSA provide a quarterly verbal update to the Committee covering epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level. These updates are delivered and recorded in meeting notes.

Stakeholder notifications of all incidents and outbreaks are sent to the relevant local authority public health teams, including relevant information and any requests for local action.

UKHSA produce monthly locality surveillance data packs which are shared with each of the four Local Authorities. Local shared arrangements in Devon enable the sharing of these to yield intelligence across the ICB area.

UKHSA Field Epidemiological Service produces a fortnightly bulletin providing surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus for the UKHSA South West region.

Following review of current networks within the South West and Devon, the Health Protection Advisory Group was discontinued. UKHSA have established a quarterly Regional Environmental Health Network for UKHSA and environmental health teams to engage and share learning. The SW Zoonoses Liaison Group continues to meet every 6 months and held a regional face-to-face event in March 2024.

3.2 RESPONSE

UKHSA South West Health Protection Team provide the specialist response to infectious disease and hazard related situations across Devon and Cornwall and Isles of Scilly, supported by local, regional, and national expertise. The team has responded to multiple outbreaks in a variety of settings including but not limited to care homes, educational settings, asylum seeker settings and custodial institutions. A summary table of situations is available in Appendix 4.

3.3 SPECIFIC INFECTIONS

3.3.1 Acute Respiratory Infections - Covid-19 and Influenza

The epidemiology of acute respiratory infections during 2024-25 winter season was dominated by influenza with very few COVID-19 outbreaks being seen across the South West.

In England, the influenza season started in the second half of November 2024 with rising influenza A(H1N1)pdm09 activity that peaked just before the start of the new year (2025) and declined after; influenza B activity started in January, leading to a slow decline of overall influenza activity

Overall influenza activity in England during the 2024 to 2025 season was higher than in the 2023 to 2024 season. Compared to the 2022 to 2023 season the peak was similar in both intensity as well as timing, but the 2024 to 2025 season had a slower overall decline due to the late influenza B activity[1] Despite overall activity being higher, mortality estimates in the 2024 to 2025 season were lower than in the 2022 to 2023 season.

The COVID-19 vaccination programmes were delivered in spring then alongside influenza vaccination in autumn 2024/25, with increased alignment of cohorts and co-administration.

As part of the business-as-usual approach, UKHSA's outbreak risk assessment (care OBRA) for adult social care settings has streamlined the reporting of outbreak information by care providers to the UKHSA Health Protection Team since its launch in August 2023.

Details on work to maximise COVID19 and influenza vaccine uptake can be found in section 5.

3.3.2 Pertussis

Pertussis activity in England surged dramatically in 2024, marking the largest outbreak since 2012. 14,894 laboratory-confirmed cases were reported in 2024, compared with just 856 cases in 2023, representing a 1,600% increase. This resurgence followed several years of

[1] Influenza in the UK, annual epidemiological report: winter 2024 to 2025 - GOV.UK

historically low incidence during and immediately after the COVID-19 pandemic, when social restrictions suppressed transmission.

The outbreak peaked in May 2024, with over 3,000 cases nationally in that month alone, before declining gradually through the second half of the year. Despite this reduction, case numbers remained elevated compared to pre-pandemic years until late autumn. By December 2024, monthly totals had fallen to levels similar to those seen before the pandemic, though still higher than typical non-peak years.

Pertussis affected all age groups and regions, but the majority of cases occurred in older individuals: 58.7% were aged 15 years or older, while 18.2% were in children aged 10–14 years and 11.1% in those aged 5–9 years. Infants under three months - too young for full vaccination - remained at highest risk for severe outcomes, with 433 cases and 11 infant deaths reported in 2024. Most of these deaths occurred in babies whose mothers had not received antenatal vaccination.

The sharp rise in cases coincided with declining vaccine uptake, particularly among pregnant women, where coverage fell to 58.9% in March 2024, down from a peak of 72.6% in 2017. This reduction in maternal immunisation likely contributed to increased vulnerability among newborns. However, there are signs that this trend is reversing, as annual coverage in England increased to 65.6% in 2024/25.

By early 2025, incidence had dropped substantially. Between January and March 2025, 335 confirmed cases were reported - monthly totals similar to those seen in low, non-peak years. No infant deaths were recorded in this period, though sporadic cases continue to occur, underscoring the need for sustained vigilance and vaccination efforts.

Pertussis remains a cyclical disease, with peaks every 3–5 years. The 2024 outbreak exceeded the scale of the 2012 epidemic and highlights the combined impact of waning immunity, reduced vaccine uptake, and post-pandemic shifts in population susceptibility. Strengthening antenatal and childhood vaccination coverage is critical to preventing future outbreaks and protecting vulnerable infants.

3.3.3 Measles

In 2024/2025 there were outbreaks of measles nationally, particularly in under-vaccinated communities. In the SW there were a large number of cases around the Bristol area, but limited transmission elsewhere in the region. There remains an ongoing risk of imported cases into the SW from either international travel or travel from elsewhere in the UK. In Devon and Cornwall, the system responded with increased communication and engagement to increase MMR uptake in low uptake communities. Although MMR uptake in the SW is higher than average, promotion of MMR vaccination remains key. System preparedness to manage suspected/confirmed cases and provision of post-exposure-prophylaxis is also a key resilience measure.

3.3.4 Avian Influenza

UKHSA works with the Animal and Plant Health Agency (APHA), the Department for Environment, Food and Rural Affairs (Defra) and the public health agencies of the 4 nations to monitor the risk to human health of avian influenza (influenza A H5N1) in England. However, viruses evolve all the time and UKHSA continues to closely monitor the situation for any evidence of changing risk to the public, including through the surveillance of people who have come into contact with infected poultry. Testing for diagnostic and surveillance purposes requires health professionals to swab symptomatic individuals for those who have been exposed to a probable or confirmed bird case of avian influenza. [2,3]

A swabbing pathway in Cornwall and Isles of Scilly is in place, however Devon's lack of a swabbing pathway was recorded as a risk on the Devon ICB Risk Register during 2023-24. In 2024-5 work has been ongoing to address this. South and West Devon now have an agreement in place and progress is being made towards addressing the remaining gap (North & East, or the RDUH footprint). The risk will remain on the risk register until a pathway is in place in all localities.

Antiviral prescribing pathways are in place in Cornwall and Isles of Scilly and Devon.

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[2] Investigation into the risk to human health of avian influenza (influenza A H5N1) in England: technical briefing 5 - GOV.UK (www.gov.uk)

[3] UKHSA update on avian influenza - GOV.UK (www.gov.uk)

3.3.5 Vector Borne Disease

Globally, ticks are one of the most significant disease vectors. A vector is a living organism, such as ticks or mosquitoes, that can transmit infections between animal or human hosts.

Ticks can pick up pathogens while feeding on an infected animal host and subsequently transmit them to hosts they may feed on. In the UK, the most important tick species to human health is Ixodes ricinus (sheep or deer tick). This species can be found feeding on humans and is a vector of Lyme disease and other tick-borne infections.

The Fingertips tool was updated to include Lyme Disease in March 2022. The South West historically has seen a high incidence of this tick borne infection when compared to England and this remains the case. The rates of acute Lyme disease by local authority are likely to be an underestimate of the true incidence of acute Lyme disease in England as cases of Lyme disease are not statutorily notifiable by medical practitioners and cases may be diagnosed clinically and treated without laboratory diagnostics being performed as per NICE guidelines. Additionally, cases diagnosed at local NHS or private laboratories but not sent to the Rare and Imported Pathogens Laboratory (RIPL) for confirmation are not included in this dataset.

National UKHSA social media campaigns continue to be supported by local communications for being "tick aware".

3.3.6 Sexually Transmitted Diseases

In 2024, England recorded 364,750 new STI diagnoses, an 8.8% decrease from 2023, despite stable testing volumes. Chlamydia remained the most common infection (168,889 cases), though diagnoses fell by 13%, particularly among young women. Gonorrhoea declined by 15.9% to 71,802 cases, but antimicrobial resistance is an escalating concern, with ceftriaxone-resistant strains increasing in 2025. Infectious syphilis rose to 9,535 cases - the highest since 1948 - reflecting ongoing transmission among GBMSM (gay, bisexual and other men who have sex with men) and rising rates in heterosexual populations. Genital herpes saw a modest increase, while genital warts continued to decline, aided by HPV vaccination. Persistent health inequalities remain, with higher sexually transmitted infection rates in some

ethnic minority groups. These patterns underscore the need for sustained prevention, targeted interventions for high-risk groups, and vigilance against emerging drug resistance.

In the South West, sexual health services continue to work closely with local authority public health commissioners, supported by UKHSA, to understand trends and put targeted interventions in place.

3.4 NOTABLE LOCAL OUTBREAKS AND INCIDENTS

3.4.1 Avian Flu

Outbreaks of Avian Flu were supported in Devon, Torbay and Cornwall. These involve wide engagement from partners including Trading Standards, Beaches and Harbours, DEFRA, Environmental Health, Communications, and Waste Management Services.

3.4.2 Cryptosporidiosis

Torbay and Devon Public Health and Environmental Health Teams, along with UKHSA responded to a major water borne cryptosporidium outbreak in May 2024. A boil water notice was issued by South West Water for eight weeks in the affected areas of Torbay and South Hams. There was a large voluntary sector led response on the ground to support vulnerable communities. The investigation into this incident is still ongoing in 2025.

Cornwall Council Public Health and Environmental Health team supported UKHSA and APHA with a recurring cryptosporidiosis outbreak associated with an open farm. This was a particularly complex outbreak and highlighted a number of challenges in managing outbreaks associated with open farms.

3.4.3 Other Outbreaks

UKHSA continued to work closely with the local authority public health and environmental health teams and ICB to manage a range of outbreaks and incidents. Examples include invasive group A streptococcus in people who inject drugs and healthcare settings and TB in

various settings. The teams also support scabies outbreaks in closed settings. Scabies is not a notifiable disease, however it can be challenging and complex to manage and prevent spread.

Devon Public Health team supported 10 scabies outbreaks in 2024/5 - mostly in older adult social care settings, where recognition and treatment and be particularly challenging for residents with complex needs and care staff living in shared accommodation or with families.

In Torbay health protection teams followed up two suspected scabies outbreaks within the homeless community.

In Cornwall, two care homes were supported with scabies outbreaks and a third home was able to diagnose and contain a single case. There was also an outbreak in a college.

3.5 INFECTION MANAGEMENT AND OUTBREAK PREVENTION

Both Devon and Cornwall and Isles of Scilly ICBs have community infection management services in place to support health and care settings with IPC practice, queries and response to communicable disease risk and management.

A review of the Devon service in 2024/5 confirmed it was performing well and providing value for the funding provided. In Cornwall the dedicated service for primary care and care homes continues to be hosted by the ICB.

A range of IPC resources and guidance are provided, hosted and shared in a variety of ways, including through training, liaison with provider networks; hosting on various electronic platforms and via communications such as newsletters.

Strategic multi-agency groups are in place within both ICB areas that ensure a joined-up system approach to IPC challenges.

Public Health teams support the provision of health protection communications, with regular public facing communication promoting good hygiene practices, infection prevention and control advice and vaccine uptake. Information is shared to the public via Resident Newsletters; (printed and social media updates), and guidance and health protection messaging and resources are shared with Schools, Early Years, SEND settings, Nurseries and

Registered Childcare providers via the relevant local platforms, newsletters, bulletins and other communication routes.

IPC support for non-health and care settings continues to be recorded as a risk on the NHS Devon and Cornwall ICB Risk Registers and is escalated at regional level. System response relies on case-by-case responses and flex of ICB IPC teams rather than a systematic offer.

In Cornwall local monitoring and surveillance of gastrointestinal infection cases and other communicable diseases bolsters UKHSA regional work.

3.6 PUBLIC HEALTH ADVICE, COMMUNICATIONS AND ENGAGEMENT

UKHSA delivered multiple educational and awareness raising events on health protection including infection prevention webinars for schools and early years settings and the regional South West Health Protection Conference, SW Zoonoses Conference and TB awareness day. UKHSA, Torbay TB services and Devon County Council developed podcasts regarding tuberculosis aimed at care workers for the 'who cares?' podcast series.

Devon filmed a short lived-experience video to support Lyme disease awareness/tick bite prevention communications (video hosted on YouTube) and has worked broadly in 2024-5 with National Parks and many other stakeholders to publicise risk and prevention measures.

UKHSA facilitates the networking of partners via the Migrant Health Network, Environmental Health Officer Network, Early Years and Educational Settings Network, and South West Care Settings Health Protection Network and the overarching South West Health Protection Network. A new South West Public Health Climate Change Network/Community of Practice was established in January 2024 to support public health leads in sharing best practice in their work on climate change.

All local authorities contributed to an infection, prevention and management strategy development day and attended vaccination practice development, seasonal debriefs and vaccination strategy workshops.

Local Authorities continued work locally to uplift of national/regional/local UKHSA communications around a wide range of campaigns or issues including for example: Lyme

disease / tick awareness, heat health, measles, antimicrobial resistance prevention/awareness, vaccination and winter preparedness.

Torbay and Devon local authority public health teams with UKHSA and Torbay Hospital TB lead nurse developed also training material and podcasts around TB for care sector and other key audiences.

Local Authority public heath teams and UKHSA supported medical student education across the Peninsula in the delivery of lectures, workshops and special study units relating to Health Protection.

Local Authorities also engaged staff in learning and training in relation to the climate emergency and carbon literacy.

Cornwall Council health protection team delivered a wide variety of health protection communications and campaigns across digital platforms to support:

- Seasonal vaccinations and routine immunisations, low uptake and health inequalities,
- Resources for health inclusion groups, pregnancy vaccinations
- Reactive communications during an outbreak associated with a farm setting
- Cancer sign and symptoms awareness, and screening
- Festival health and wellbeing
- Seasonal health and wellbeing and cold/heat health alert
- Guidance and resources for adult social care
- AMR awareness week
- TB awareness.

The Devon and CIoS ICBs, Local Authorities, vaccination teams the South West Vaccination and Screening Team, and communication colleagues have coordinated significant communications and engagement to support immunisation and screening uptake across the peninsular. This is demonstrated in more detail in the relevant sections below.

All agencies participated in the Covid Inquiry in response to the initial modules. All learning will be fed back into practice to inform future response.

3.7 WORK WITH SPECIFIC SETTINGS AND POPULATIONS

3.7.1 Supporting Migrant Health and Resettlement

As in the past few years, Health Protection remained a key element of the multi-agency approach to supporting asylum seekers and refugees arriving at temporary accommodation in Devon, Torbay, and Cornwall.

One large family contingency hotel accommodating asylum seekers remains open in Devon. Housing has been stood up in areas of Devon and Cornwall for refugees arriving from Afghanistan via the Afghan Resettlement Programme, as well as other dispersed accommodation for asylum seekers in accommodation within private rentals, family homes and HMOs.

All arrivals in Devon and Cornwall have been supported and/or encouraged to register with NHS General Practitioners (GPs) and NHS Devon continue to work with primary care supporting the hotel and provide funding to enable enhanced health checks for all patients registered. Support from the Devon ICB outreach vaccination team is still provided to support vaccine confidence as well as delivery and uptake of vaccinations to move people in line with the UK vaccination schedule. Cornwall Council refugee and asylum seeker outreach team provides support to refugees arriving from Afghanistan via the Afghan Resettlement programme. The CFT TB team is supporting primary care to consider TB when in consultation with patients. Supported development of translation services crib sheet for GP receptions.

UKHSA has supported settings and primary care with case management of infections as required and DCC have helped with providing messaging around the importance of infection prevention and management to staff, settings and residents.

NHS Devon used funding provided to support people resettled in Devon from Afghanistan to provide screening for Latent Tuberculosis Infection in line with the NHS migrant health guide, with the hospital trusts working in partnership together to enable this to be achieved.

All local authorities, NHS and voluntary partners continued to offer support for health, care, education and wider needs.

Plymouth and Cornwall Councils have a Resettlement Service, which work with partners to meet the wider needs of refugees and support new arrivals.

3.7.2 Health for Homeless

Cornwall Council Public Health team commissions the 'Health for Homeless' service to deliver outreach primary care services to homeless and rough sleepers across Cornwall, including seasonal vaccinations and immunisations and blood borne virus screening. The service works to deliver specialist clinics with PCNs for registered homeless patients, as well as outreach in community settings and temporary accommodation for homeless and rough sleepers who are not registered, partnering with the Cornwall Council library van to deliver in rural locations without appropriate facilities.

Torbay, Devon and Plymouth local authority public health teams also work closely with homeless settings and outreach to promote and support health protection behaviours and to prevent and respond to outbreaks, where possible aligning health protection with opportunities for wider health promotion.

4 SCREENING PROGRAMMES

4.1 Background

Population screening programmes make a significant impact on early diagnosis thus contributing the reduction in deaths and ill-health. There are six programmes: bowel, breast and cervical cancer screening programmes, and three non-cancer screening programmes comprised of antenatal and newborn screening (six programmes), abdominal aortic aneurysm and diabetic eye screening programmes.

Assurance of performance and improvement in performance or programme delivery is delivered through a number of mechanisms:

1. Programme changes and development e.g. national programme changes; new technologies
2. Strategic developments e.g. Cervical cancer eliminations strategy
3. Partnership working e.g. Maximising Immunisation Uptake Group (MIUG) partnerships; Endoscopy transformation plan; Devon and Cornwall Health protection meetings
4. Regional developments e.g. Learning disability screening practitioners; peri-natal vaccination coordinators
5. Performance is monitored monthly via NHSE VaST Performance, Quality and Delivery meetings, regional reports, dashboards and escalation protocols, audits and incidents review, meetings held jointly with Screening Quality Assurance Service (SQAS)
6. Provider performance monitoring

    - Quarterly programme boards are held with each of the providers that are commissioned to provide the screening programmes (or components of the screening e.g. labs). Programme KPIs, QA visit recommendations incidents, risks, audits, best practice and inequalities are all reviewed at each programme board.
    - Contract meetings with each provider take place quarterly
    - Screening incidents are notified to SQAS and VaST for review of incidents, cases and response and any additional assurances / responses are made and

followed up with VaST and providers agreeing improvement plans to address and monitor where necessary.

- SQAS visits: Each autumn the SQAS review the information about each screening service and identify which service should be prioritised for a SQAS visit (full / targeted) or a targeted desktop review in the following NHS year. Visits are made to review the service and identify best practice areas for further development and any support required.

4.2 Summary, by exception, of activity during 2024/25

BOWEL

Coverage:

The programme performed well across the Peninsula, achieving coverage above the England rate, similar to the South West and above the target of 70%.

Programme changes:

Age extension: The 50-52 year age extension was completed by all providers in Devon and Cornwall during 2024/25.

Faecal Immunochemical Test (FIT 80): In anticipation of a bowel FIT 80 roll out, regional planning began in 2024 via the Endoscopy Networks to develop the workforce, estates and equipment planning required. FIT 80 is estimated to increase the number of colonoscopies required by about a third and requires additional endoscopy capacity and associated laboratory support to enable this. This was assisted by the adoption of resect and discard training allowing the endoscopists to resect certain polyps without the need for pathology sampling. Over the course of 2024-25 all three providers in Devon and Cornwall made good progress with this planning and were expected to be able to join the national roll-out waves as they came online.

A new inequalities standard was introduced from April 2025.

Service developments:

No services in the Peninsula received a QA visit. A targeted review with one provider was undertaken focused on pathology turnaround times.

Inequalities:

Health promotion work was ongoing across providers, including use of HEAT tool with all providers. The Torbay and South Devon bowel cancer screening programme appointed a health promotion specialist. There was ongoing work in the local prison and consideration of how to engage people who were on probation and how to best engage with rural communities.

Royal Cornwall Healthcare Trust undertook work with locally known groups, for example fishermen and homeless communities and were working on a pathway for homeless patients after a positive FIT test.

Programme awareness was promoted via radio stations, local community organisations, and through stands at community hospitals.

BREAST

Coverage Published data at the end of 2024 showed that the coverage was above the 70% efficiency standard for Devon, Plymouth, and CIOS. Torbay was just below this at 67.3% but stabilised after a fall over the previous 3 years.

Programme changes

Providers in the South West were using open invites which meant women often took longer to book an appointment, meaning the screening episode could not be closed prior to 6 months after eligibility, which is the cut-off of calculation of coverage rates. Following a national review of the models, a decision was made to move all providers to a timed invite model, as this was assessed as being more effective for driving uptake. South West VaST worked with providers to make this transition and the use of times invites was introduced at the beginning of 2025/26.

Service Developments:

A serious national incident affecting very high-risk breast referrals was declared in February 2024. Women who received radiotherapy for Hodgkin Lymphoma when under the age of 35 have an increased risk of breast cancer and should be offered annual screening. A national audit identified that historically some women had not been referred. Whilst not a breast screening incident, local screening programmes were asked to offer all affected women the appropriate screening tests and then ensure an offer of annual screening. Numbers affected in Devon and Cornwall were relatively small and all providers responded quickly to complete screening and follow-up of any screen-positive women. This was completed by August 2024.

A new permanent city centre static screening site in Plymouth at Merchant House opened in February 2024.

A new mobile unit was delivered for North & East Devon for commencement in April 2025, which will open with extended hours.

Two providers received a QA visit in 2024/25.

Inequalities:

A regional breast inequalities workshop was held in December 2025

All providers undertook range of health promotion activities. They regularly attended events and work in partnership with local providers, community spaces and VSCE community to reach underserved populations to raise the profile of the importance of breast screening, participated in media interviews and supported events such as Breast Fest and other initiatives to improve access.

CERVICAL

Coverage:

Coverage for both 25–49 and 50–64 age groups had declined over recent years but was relatively static during this period. The South West continued to perform strongly relative to the national position:

- Highest coverage nationally for the 25–49 cohort
- Second highest coverage for the 50–64 cohort

To address persistent inequalities, targeted interventions continued:

- Support for GP practices with lowest uptake using coverage dashboards
- Insights surveys to primary care to understand operational barriers
- Development of tailored toolkits, including: a learning disability support pack for sample takers and a mental health training module for cervical screening staff.

Colposcopy Performance:

NHS England VaST continued to work closely with providers and ICBs to manage sustained pressure on colposcopy services. The increase in referrals driven by primary HPV screening and symptomatic GP referrals persisted. High-risk referrals were prioritised, but routine referrals within 6 weeks continued to breach intermittently. All providers maintained action plans, and performance was monitored monthly via regional dashboards and escalation protocols.

Programme Changes:

Cervical Screening Management System:

The new NHS Cervical Screening Management System (CSMS) successfully went live on 24 June 2024, replacing the legacy Open Exeter system. CSMS streamlines call/recall processes and integrates with the NHS App, which began delivering screening invites and reminders digitally from May 2025. All providers completed mandatory training and updated standard operating procedures to reflect the transition.

Screening Interval Changes:

Following UK National Screening Committee recommendations, routine screening intervals for individuals aged 25–49 who tested HPV negative were expected to change from 3-yearly to 5-yearly from July 2025. This aligns England with Scotland and Wales and reflects robust evidence that 5-year intervals are equally safe. Those testing positive for HPV or with a history of abnormal results will continue to be invited more frequently.

Cervical Cancer Elimination Strategy:

In March 2025, NHS England published its Cervical Cancer Elimination Plan outlining the ambition to eliminate cervical cancer by 2040, in line with WHO's target of fewer than 4 cases per 100,000. The South West was actively supporting development of this strategy, with a current incidence rate of 9.8 per 100,000, slightly above the national average of 9.4.

Development of a Regional Cervical Cancer Elimination Strategy began, following a face-to-face stakeholder event held on 19 November 2024. The regional strategy was scheduled to launch in June 2025, aligning with national priorities and embedding equity, access, and innovation at its core.

The South West's five year regional goals included:

- *Achieving ≥90% HPV vaccination coverage for boys and girls*
- *Increasing cervical screening uptake to ≥70% in the 25–49 cohort*
- *Ensuring ≥90% of individuals diagnosed with cervical disease receive treatment*

Local initiatives continued to focus on:

- Strengthening colposcopy pathways and treatment standards
- Addressing barriers to access through community engagement and data driven targeting
- Leveraging CSMS and NHS App integration to improve uptake
- Maintaining a strong HPV vaccination programme. This continued to show significant impact. A 2024 BMJ study confirmed an 83.9% reduction in cervical cancer incidence among vaccinated cohorts. Coverage for adolescents in the South West region remained among the highest nationally, with Year 10 female coverage at 77.9% (23-24 academic year)

Inequalities:

Following a successful pilot in Devon, talks were underway with providers and Cancer Alliances to expand drop-in cervical screening clinics across the region. These clinics offer flexible, appointment-free access for eligible individuals who may face barriers to attending traditional GP-based appointments.

A new drop-in clinic launched at Royal Cornwall Hospital Trust (RCHT) in December 2024, offering screening to eligible individuals aged 24.5–64, including those overdue or not registered with a GP.
Standard Operating Procedures and evaluation frameworks were in place to ensure quality and inform future rollout.

ANTENATAL / NEONATAL

ANNB screening comprises of 6 discrete programmes, each with their own standards.

Coverage:

Coverage of the antenatal and newborn screening programme remained very high, as these are an integral part of routine maternity care and postnatal care.

Performance

All services were mostly meeting all requirements against national key performance indicators (KPIs) and standards. All services met achievable or acceptable for coverage of the six programmes. Main breaches related to certain aspects of the newborn blood spot screening programme and the need for repeat sampling which continued to be a challenge due to multiple factors. A regional deep dive of the repeat blood spot standard (NB2) was completed and findings shared, including highlighting best practice and agreeing next steps. Service pressures and capacity were experienced with screening teams and ultrasound capacity, and providers worked hard to ensure that screening programmes were prioritised. One provider completed a Quality Assurance antenatal pathway review in Q1 2024/25 and one hearing screening programme had a Quality Assurance visit during the reporting period.

The national hearing screening programme community model threshold standard for review of any baby moved from five weeks to four weeks in 2024/25, so that all services met or were required to meet this standard. Standards for the newborn and infant physical examination were revised.

Inequalities:

Maternity providers completed late-booking audits.

One provider moved to conduct the hearing screen prior to discharge, wherever possible, for those babies who fall into groups who may find it harder to access community-based screening once discharged including for example: travelling families, vulnerable families, and those in contact with child protection and safeguarding services.

DIABETIC EYE SCREENING

Uptake: Both Cornwall and Devon providers performed well in terms of uptake both being above the achievable target 85%. (Q1 and Q2 2024/25)

Performance:

Performance against the other national KPIs and standards was good. Meeting the acceptable level of 80% for timely attendances at appointment in the Hospital Eye Services (HES) continued to be a challenge and was closely monitored. All cases were being triaged and most urgent prioritised. Significant delays due to capacity issues were seen with one service for routine appointments, and VaST worked with the providers and the ICB to address these.

Programme changes:

Extension of intervals from one to two years for all low risk patients commenced in October 2023 and were completed.

All providers implemented Optical Coherence Tomography (OCT) into their digital surveillance pathway for patients who are seen at intervals of less than one year (higher risk surveillance patients). OCT can definitively identify those patients requiring referral to ophthalmology services and those that can continue in the digital surveillance pathway that might otherwise have needed referral when OCT was not available.

Service Developments:

One provider received a QA review focussed on specific elements within the slit lamp biomicroscopy (SLB) surveillance pathway, to support a planned move of this element from ophthalmology services to the diabetic eye screening service. A planned programme was in place to move patients across to this service as they became due for their surveillance SLB check, bringing the service into line with other programmes.

Due to the specialist equipment needed for the implementation of OCT, Devon consolidated their digital surveillance services onto four sites in alignment to each of the four acute Trusts areas which patients would have previously attended for ophthalmology services. Cornwall had four fixed sites and one mobile unit to support access. Further work will be undertaken by VaST in 2025-26 to review access distances.

Inequalities:
Screening providers and VaST used the HEAT tool to identify and plan inequalities activities over the year and include for example, considering different and more accessible clinic sites, work within the prisons in Devon, and "Did Not Attend" audit to understand barriers to attendance.

ADOMINAL AORTIC ANEURYSM

Coverage: 2023/24 data published March 2025.

Initial screen coverage (S04) continues to be high, and all three programmes providing AAA screening to Devon and Cornwall populations had performance above the achievable target of ≥ 85% for 2023/24 and all were in the top five programmes across England.

Annual surveillance screen coverage within 6 weeks of due date (S05): All three programmes achieved the acceptable target (≥85%) and the Peninsula (PEN) programme was in the top ten of providers.

Quarterly surveillance screen coverage within 4 weeks of due date (S06):
The PEN (peninsula) and South Devon & Exeter programmes were above the achievable target (≥95%) and in the top ten of providers.

Service quality: The main challenge in the programme both nationally and regionally continued to be the high proportion of patients having to wait for longer than 8 weeks for surgery due to ongoing pressures within surgery and intensive care services. The South Devon and Exeter programme achieved the achievable threshold (second highest programme in country) and the other two programmes whilst below the acceptable target exceeded the England performance and were also in the top 10 of programmes. All breaches longer than 12 weeks were robustly tracked. The VaST worked closely with the screening services and the regional Vascular Surgery Network to closely track these patients, monitor reasons for delay and ensure surgery was carried out at the earliest opportunity.

Inequalities: The three providers for Devon and Cornwall population exceeded the achievable level of service users (who live in a LSOA classed as decile 1-3) who were conclusively tested and are all ranked in the top 5 providers across England. All providers completed the PHE Health Equity Assessment Tool (HEAT) tool and had action plans to further improve uptake and reduce inequalities. They worked in partnership to highlight services to specific groups of service users, for example farmers, veterans, and prisoners.

In Cornwall the AAA programme delivered outreach work to reduce inequalities in uptake, including working with fishermen, farmers, people with a learning disability and people with autism, and through engagement with food banks.

5 IMMUNISATION PROGRAMMES

5.1 Background

Immunisations are one of the most significant public health developments in the prevention of infectious disease. The routine vaccine schedule in the UK is available here along with

vaccine acronyms used in this section.[4] In addition to the routine immunisation programmes, the COVID-19 vaccination programme has continued to be delivered in line with the Joint Committee on Vaccination and Immunisation (JCVI) guidance.

5.2 Summary, by exception, of activity during 2024/25

PRE SCHOOL IMMUNISATIONS
Routine: All local authorities performed above the England average across the range of childhood immunisations. In Devon and Cornwall, the priority remained the uptake of the MMR dose 1 and 2 and DTaP-IPV preschool booster vaccines in 5-year-olds. Devon and Plymouth and Torbay had MMR 1 (at 5 years) coverage above 95% and Cornwall are well above 90%. Devon and Plymouth and Torbay had coverage of the primary course (at 5 years) above 95% with Cornwall within 0.1% of achieving this. For MMR 2 coverage Devon and Plymouth were above 90%. Torbay and Cornwall had coverage less than 90% for both MMR dose 2 and all four LA are now just below 90% for the preschool booster DTaP-IPV at 5 years. For the Hib/ MenC booster (at 5 years), Devon is at 95% and the other three LA areas are above 90%. **Maximising Immunisation Uptake:** Work continued aiming to increase MMR and child immunisations uptake and reduce inequalities through the Devon and Cornwall Maximising Immunisation Vaccination Groups, (MIUG), and the ICB Vaccination Teams. These all used the evidence-based regional MMR action plan produced by NHSE VAST team. In Devon, Vaccination Innovation Funding (VIF) was also used to enable GP practices to undertake local work for their registered patients. Additional workstreams via the Devon and Cornwall MUIGs included: 1. MMR17-30 project undertaken in Feb/Mar 2024. 2. Further phases of vaccination data cleanse (Primary Care) with MMR as a priority

[4] Routine childhood immunisation schedule - GOV.UK (www.gov.uk)

3. Establishing GP practice immunisations leads networks in both Cornwall and Devon
4. Inclusion of social care support data in CHIS childhood immunisations dashboard to support liaison and project work with local CIC teams.

The South West Commissioning Support Unit were commissioned to provide additional support to a number of targeted practices with lowest immunisation uptake across the region.

Upcoming changes:

There was preparation for the 2025/26 childhood immunisation schedule changes and the anticipated change from January 2026, where children would be offered a combined vaccine for measles, mumps, rubella and varicella (chickenpox).

SCHOOL AGED IMMUNISATIONS

To Note: Data for 2024/25 not published at the time of writing

Coverage (2023/24 data):

Year 9 Td/IPV and MenACWY uptake was below South West and England for all four local authority areas. By year 10 the gap had narrowed.

HPV uptake in year 8 for both females and males was significantly lower than both England and South West[5] averages. Cornwall had HPV female coverage in year 10 above both England and South West values, compared with all three Devon LA areas which were below. For HPV male coverage in Year 10, Cornwall was marginally below both England and South West values whilst all three Devon LA areas were further below with 5-7% differences.

Service developments:

A new provider (Kernow Health) was commissioned for Devon commencing August 2023, meaning that both Devon and Cornwall have the same provider. The mobilisation of this new service created additional challenges for delivery in that first year with some impact being seen on the existing Cornwall provision for 2023/24.

[5] But not for Isles of Scilly

During 2024/25 NHSE VaST team and the provider worked to develop and implement operational delivery plans with a strong focus on activities to increase uptake including reviewing operational processes to support easier consent; increased school and parent engagement; providing additional community clinics; targeting lower uptake areas / schools earlier in the programme to provide opportunity for additional catch-up work and school revisits. Improvements were seen in uptake for the 2024/25 academic year.

The core offer of the service was expanded to include an offer of MMR catch up alongside the routine school age immunisations. This check mainly identified that MMR had been previously given and afforded an opportunity to update records. A small number of MMR were also given (~30).

Using funding available via the access and inequalities fund from NHSE VaST, the University of Exeter and the Schools Aged Immunisation service co-developed a project to increase awareness of vaccine preventable diseases and improve access to vaccinations in Gypsy Roma Traveller communities across Devon and Cornwall (commenced Feb 2025).

Work to understand how the EDUCATE[6] tool might be best utilised was ongoing, with a survey undertaken in Cornwall schools and one school in Torbay piloting this.

VACCINATIONS IN PREGNANCY

Maternity Programme (to protect infants)

The NHSE VaST supported a perinatal pathway work programme which is the key vehicle to deliver ongoing improvements to access and acceptability of the vaccination programme to maximise uptake.

To support efforts to maximise all vaccines in pregnancy (including seasonal flu) and the targeted newborn BCG vaccination programme, regional funding was made available in

[6] The HPV Educate resource was developed by researchers at the University of Bristol and the London School of Hygiene and Tropical Medicine (LSHTM) using co-production methods and an iterative approach with teenagers and key informants. It consists of a lesson plan which has been refined following consultation, and associated resources including activities and further information for teachers. University of Bristol: EDUCATE

2024/25 to develop a peri-natal immunisation lead role and support improvements in uptake and service delivery to all vaccines in the perinatal pathway across the South West. All the maternity providers in Devon and Cornwall now have their leads in place. The leads will support developments to improve uptake and vaccine timeliness including enhanced reporting, development of action plans and coming together as a regional network coordinated by the VaST team to share learning and best practice.

RSV: RSV was added to the vaccines in pregnancy schedule from 1 Sept 2024. This vaccine would be routinely offered from 28 weeks (although RSV circulates seasonally, the vaccine is given once all year round). As part of the mobilisation, initial vaccinations were given later in pregnancy in time for the 2024-25 winter RSV season. The South West was the second highest performing region for RSV.

Pertussis: Both Devon and Cornwall ICBs performed above the optimal performance target of 60%. GP Practices are required to participate in a national vaccination and immunisation campaign each year, as a requirement of the GP contract. Due to the number of cases of pertussis increasing and the recent infant deaths, the 2024/25 national campaign focussed on the pertussis vaccination programme for pregnant women. The campaign ran from Tuesday 1 October 2024 to Monday 31 March 2025. Due to the full coverage of offer of pertussis in maternity care in place in the South West, the system was in a good position from a maternity offer perspective. The NHSE VaST developed and shared advice with primary care to support best practice opportunistic delivery, signposting and reducing risk of confusion. Local systems amplified communication messages for example, Cornwall undertook a MUIG project: Maternal Pertussis Comms & Engagement Campaign. Over 1.5 million impressions were delivered across the various channels, resources were supplied to antenatal clinic areas and engagement continued via Cornwall's first baby show https://cornishstuff.com/portreath/cornwalls-first-ever-baby-show-promises-essential-resources-for-parents/

OLDER PEOPLE IMMUNISATIONS

Coverage:

As of 31 July 2025 the RSV vaccine coverage for older adults in the catch-up cohorts, in the South West was 67.3%, which was second region in the country (England 63.4%). Unpublished local performance monitoring data indicates that both Cornwall and Devon have coverage above England and in keeping with the South West. RSV vaccine coverage report in older adults for catch-up cohorts in England: July 2025 - GOV.UK

Programme delivery:

PPV: Adults over 65 years are eligible for routine single dose vaccination. As age increases so does coverage as this is a measure of total population uptake and increasing age offers more time for the vaccine to be given after turning 65 years. Coverage in the Peninsula LA areas exceeded the optimal performance for coverage (75%) for the 75+ year group and exceeded the efficiency standard (65%) for the 65+years group emphasising the importance of continuing to offer these vaccinations in older years and also of the need to do more work to improve the timeliness of the vaccination closer to the age of first eligibility in order to gain more protection from the vaccine for these groups. Coverage for the Peninsula LA areas, South West and England values lay within 2.5% range of each other (75+year group) and 2.3% range of each other (65+year group).

Shingles: The 'Shingrix for All' immunisation programme began on 1 September 2023. The programme offers 2 doses of the Shingrix vaccine to all immunocompetent individuals turning 65 and 70 and severely immunosuppressed individuals turning 50 and over. As this is a two dose regime at 6-12 months apart there is limited data available for 2024-25 as those that became eligible in this period would not necessarily have reached the date of their second vaccine.

Programme changes:

The RSV vaccination programme for older adults was launched in England on 1 September 2024 as a single-dose vaccine for adults turning 75 years old on or after the programme start date. A catch-up programme for those aged over 75 at programme start, until they are

80 years of age, was also in place. Those turning 80 during the first year of the programme were also eligible until 31 August 2025 (subsequently extended).

Upcoming changes:

Teams were planning for upcoming changes including:

Shingles: The eligibility for severely immunosuppressed group was lowered from 50 years to 18 years commencing September 2025

Men B / Mpox: Opportunistic immunisation to be delivered by sexual health services for GBMSM population from September 2025

RSV: JCVI have recommended that RSV eligible cohort be extended to include everyone over 75 years no matter what age (therefore extending use beyond the current 79 years to include all adults over 80 years) and for all residents in care homes. Ministerial decision will be required, and timescales are not confirmed.

SEASONAL IMMUNISATIONS (FLU AND COVID19 IMMUNISATIONS)

Autumn 2024/25 (COVID19 and influenza)

The Seasonal Influenza season in 2024-2025 ran from September 2024 until end of March 2025. Cohorts included people aged 65+, all Care Home residents and staff, housebound patients, Health and Social Care Workers and Clinically Extremely Vulnerable groups as identified by the Green Book.

Performance is shown in the tables below.

With the exception of Torbay 65 year and over, and children aged 2-3 years cohorts, all areas exceeded the national figures for flu immunisations across the groups.

All areas exceeded the national figures across all the age groups for COVID19 (except the Torbay 75-79 cohort).

Both the Devon and Cornwall and Isles of Scilly ICBs delivered vaccinations through Primary Care Networks, Community Pharmacies, Large Vaccination Centres and a wide range of outreach activities.

Both Devon and Cornwall ICBs monitor delivery and vaccine delivery oversight through vaccinations operational delivery group and oversight groups. All ICBs were asked to submit plans in line with national and regional guidance.

Seasonal influenza immunisation uptake for season in 2024-25

	Aged 65 and over	Under 65 (at risk)	2 year olds	3 year olds	Primary school aged
Cornwall & IOS ICB	76.6%	41.2%	46.1%	45.0%	55.3%
Devon	79.5%	46.9%	53.8%	56.0%	65.7%
Plymouth	77.7%	41.9%	45.1%	46.1%	60%
Torbay	74.3%	42.5%	39.4%	42.0%	56.2%
South West	79.4%	45.8%	49.7	50.8	62.8%
England	74.9%	40%	41.7%	43.5%	54.5%

Source: seasonal-flu-vaccine-uptake-in-GP-patients-2024-2025-data.ods

COVID19 immunisation uptake for Autumn 2024-25

Covid 19 Jan 29 2025)	65-69 years	70-74 years	75-79 year	80+years
Kernow (Cornwall and Isles of Scilly)	57.2%	67.0%	72.6%	75.7%
Devon	60.8%	69.5%	74.2%	77.8%
Plymouth	52.9%	61.4%	67.8%	71.8%
Torbay	49.4%	58.6%	63.7%	68.2%
South West	59.6%	68.6%	73.9%	77.0%
England	47.8%	58.0%	65.0%	67.6%

The flu in pregnancy uptake data is challenging due to difficulties in being able to identify denominator figures and recording issues and are likely to be under-estimates. Data is shown in the appendices but should be viewed with caution. All the maternity providers in Devon and Cornwall now have their peri-natal immunisation leads in place who support improvements in uptake and service delivery to all vaccines in the perinatal pathway.

Spring 2025 (COVID19)

Cohorts included people aged 75+, all Older Adult Care Home residents and staff, housebound patients, and patients that were immunosuppressed as identified by the Green Book.

Inequalities continued to be a strong focus of both programmes with outreach into areas of deprivation and/ or low uptake and in locations Devon and Plymouth and Torbay have, such as food banks; community centres; soup runs; complex lives settings; and bespoke clinics for specific groups such as carers. Providing added value of these contacts continued to be a priority, with other needs identified and addressed as part of the Making Every Contact Count agenda and created an opportunity for wider support.

6. HEALTH CARE ASSOCIATED INFECTIONS AND ANTIMICROBIAL RESISTANCE

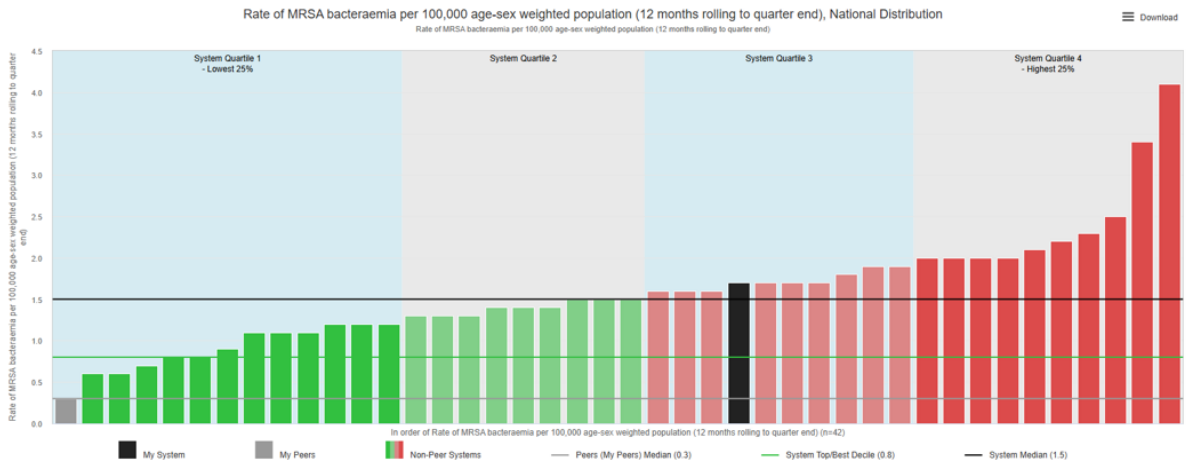
6.1 KEY PERFORMANCE

The following information summarises the key performance position and developments for health care associated infections, antimicrobial resistance work and key challenges over 2024/25 across the geography of Devon and Cornwall and Isles of Scilly (CIoS).

The shared data charts are courtesy of Model Health System NHS Digital. Figures are presented as rates per 100,000 population and are age-sex weighted. The numerator is sourced from the UKHSA healthcare-associated infection (HCAI) data capture system, and the denominator is a 12-month average GP registered population. The calculated rates are 12 months rolling to quarter end. Cornwall is displayed in black and Devon in grey.

Cases and rates for key organisms 2024/25

Methicillin Resistant Staphylococcus Aureus (MRSA)



NHS Cornwall ICB:

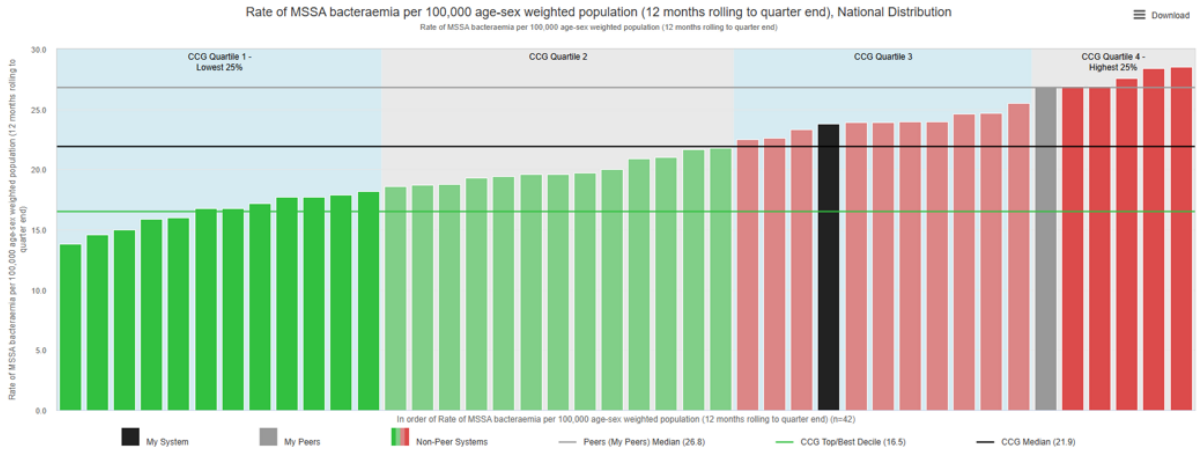
There were a total of 2 cases of MRSA blood stream infections (BSI) in Cornwall from 1st April 2024 to 31st March 2025, this is a 12-month rolling rate (age/sex standardised) of 0.3 per 100,000 and places Cornwall in the lowest quartile nationally.

NHS Devon ICB:

There were a total of 26 cases of MRSA blood stream infections (BSI) in Devon from 1st

April 2024 to 31st March 2025, at the end of quarter 4 this is a 12-month rolling rate of 1.7 per 100,000 and places Devon in the mid-high quartile nationally.

Methicillin Sensitive Staphylococcus Aureus (MSSA)



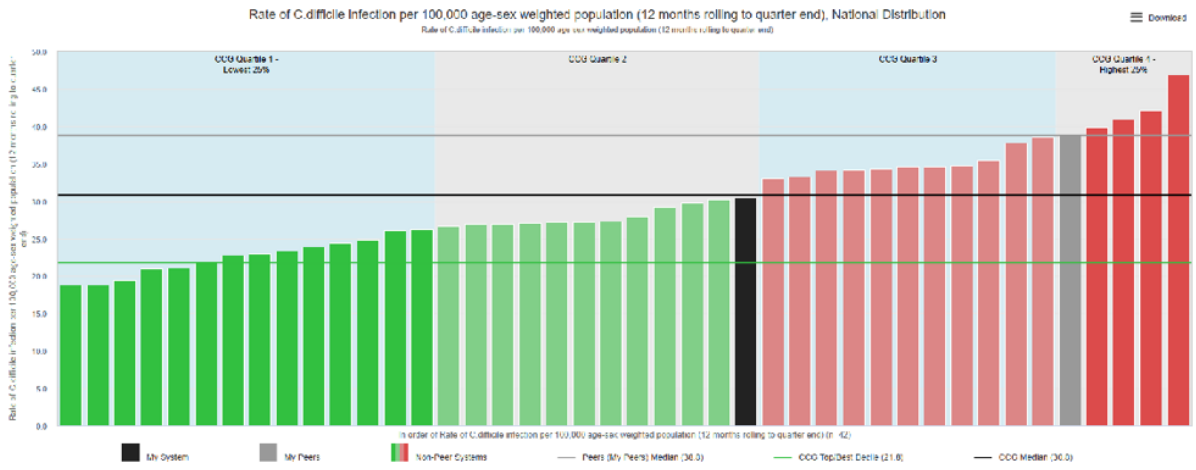
NHS Cornwall ICB:

There were a total of 161 cases of MSSA blood stream infections (BSI) in Cornwall from 1st April 2024 to 31st March 2025, this is a 12-month rolling rate (age/sex standardised) of 21.9 per 100,000, placing Cornwall in the mid-high quartile nationally

NHS Devon ICB:

There were a total of 385 cases of MSSA blood stream infections (BSI) in Devon from 1st April 2024 to 31st November 2025, at the end of quarter 4 this is a 12-month rolling rate of 25.0 per 100,000, placing Devon in the mid-high quartile nationally.

Clostridioides difficile (C. difficile)



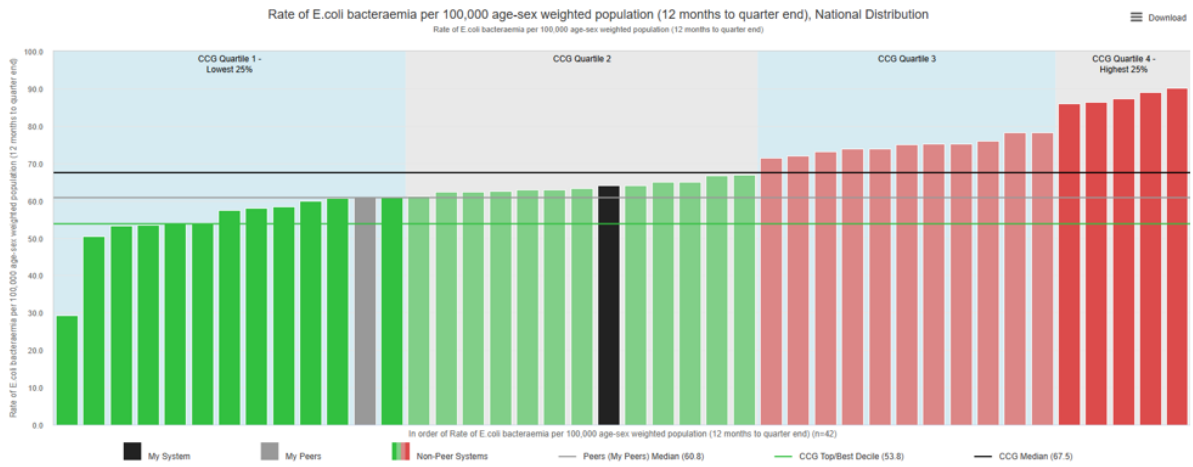
NHS Cornwall ICB:

There were a total of 301 cases of *C. difficile* blood stream infections (BSI) in Cornwall from 1st April 2024 to 31st March 2025, this is a 12-month rolling rate (age/sex standardised) of 38.8 per 100,000, placing Cornwall in the highest quartile nationally.

NHS Devon ICB:

There were a total of 497 cases of *C. difficile* blood stream infections (BSI) in Devon from 1st April 2024 to 31st March 2025, at the end of quarter 4 this is a 12-month rolling rate of 30.4 per 100,000, placing Devon in the mid-low quartile nationally.

Escherichia Coli (E. coli)



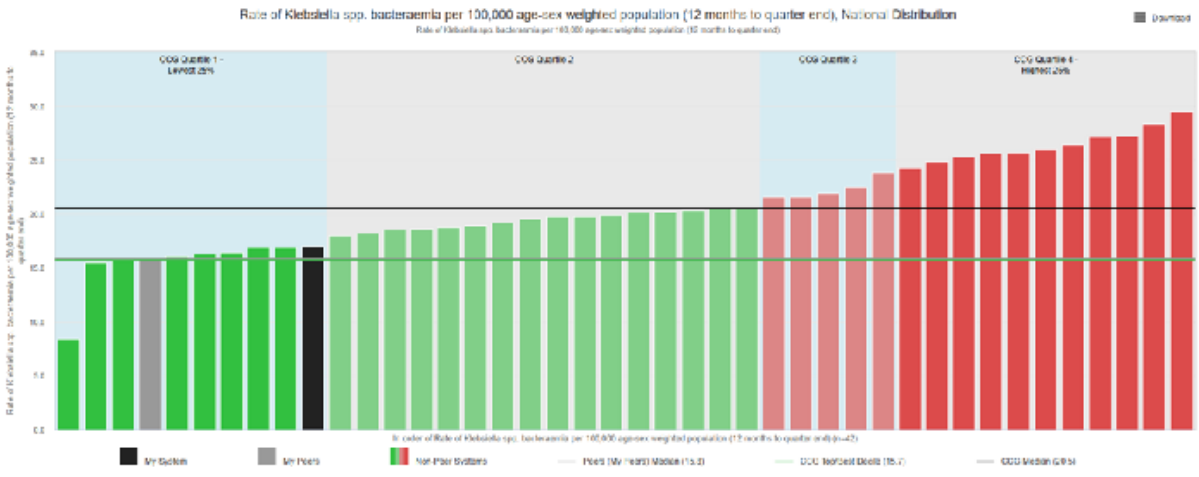
NHS Cornwall ICB:

There were a total of 484 cases of *E. coli* blood stream infections (BSI) in Cornwall from 1st April 2024 to 31st March 2025, this is a 12-month rolling rate (age/sex standardised) of 60.8 per 100,000, and places Cornwall in the lowest quartile nationally.

NHS Devon ICB:

There were a total of 1069 cases of *E. coli* blood stream infections (BSI) in Devon from 1st April 2024 to 31st March 2025, at the end of quarter 4 this is a 12-month rolling rate of 64.1 per 100,000, and places Devon in the mid-low quartile nationally.

Klebsiella



NHS Cornwall ICB:

There were a total of 124 cases of *Klebsiella* blood stream infections (BSI) in Cornwall from 1st April 2024 to 31st March 2025this is a (age/sex standardised) 12-month rolling rate of 15.8 per 100,000, placing Cornwall in the lowest quartile nationally.

NHS Devon ICB:

There were a total of 278 cases of *Klebsiella* blood stream infections (BSI) in Devon from 1st April 2024 to 31st March 2025, at the end of quarter 4 this is a 12-month rolling rate of 17.0 per 100,000, placing Devon the lowest quartile nationally.

6.2 ANTIMICROBIAL RESISTANCE (AMR) WORKING GROUPS

6.2.1 Peninsula AMR Group

The Peninsula Anti-microbial resistance group (PARG) met on a quarterly basis during 2024/2025 and through working groups structured around the main ambitions of the South West Infection Prevention and Control Strategy, including:

Prevention

This group focused on the development of a project to standardise urine sampling in primary care.

Communications and workforce

The communications group focused on two campaigns during the year, World Antimicrobial Resistance Week (November 2024) and WHO Hand Hygiene Day (May 2025). For both campaigns the working group developed sector specific communications materials which were shared with PARG members to further share with their networks, including early years and education, universities, care settings, healthcare settings, farmers, food premises and the public.

These collaborative LA efforts included both broad sharing of public-facing campaign materials alongside internal staff communications to raise awareness of tangible calls to action that can contribute to AMR prevention.

Data and digital

The data and digital group is developing a central repository hosted on NHS Futures to host and share AMR resources and collateral.

Health inequalities

This group has shared best practice across the Peninsula in addition to vaccine uptake work to reduce inequalities through the Devon and Cornwall MIUGs. Devon has delivered IPC training for staff working with health inclusion groups.

One Health

While not part of the SW IPC Strategy, One Health is central to AMR. This group has worked to embed a 'One Health' approach through all PARG workstreams.

All PARG groups have worked to progress the ambitions of the South West Infection Prevention and Control Strategy.

The PARG is made up of representatives across Devon, Cornwall and IoS systems, including primary care (both in-hours and out-of-hours), acute trusts, Academia, Infection Prevention and Control, Public Health (LAs and UKHSA), ICB medicines optimisation, pharmacy, APHA, dentists, and veterinary.

Torbay AMR group continues to promote initiatives across settings. The team was nominated for a national award for the work with schools and early years and was a finalist in the category.

6.2.2 World Antimicrobial Awareness Week 2024

As part of the World Antimicrobial Awareness Week 2024; engagement activities, information and initiatives were shared across NHS Trusts, Local Authorities, universities, and schools throughout the Peninsula. These collaborative LA efforts included both broad sharing of public-facing campaign materials alongside internal staff communications to raise awareness of tangible calls to action that can contribute to AMR prevention.

6.3 PROGRESS ON KEY HCAI & AMR CHALLENGES

Investigations into all healthcare-onset, healthcare-associated cases have been undertaken. Within Cornwall, these have identified key learning themes which include missed opportunities for face-to-face GP consultation, no documented follow up of urinary tract infections (UTI), midstream urine samples not being collected, dipping urine (a Point of Care Testing (POCT)) in patients over the age of 65, missed testing due to lack of detail on microbiology request forms, and multiple cannulation attempts. The picture in Devon was similar and also found the majority of cases were community-onset or community-associated (COCA).

MSSA work has been less well covered during the pandemic due to the many other pressures. However, both systems are placing this work within their IPC 2024-2025 work plans focusing

on non-infection specific quality improvement plans within the following themes: wound care, UTI, pneumonia, timely care, sampling, and prescribing patterns.

C. Difficile has shown an increase both regionally and nationally, to the point where a national incident has been declared. Reasons behind this rise are unclear, and additional *C. difficile* metrics are likely to be added to the data capture system to determine the cause of the rise in cases.

Within the Cornwall system a patient-held, 'Think C. diff' passport continues to be rolled out across Cornwall for all patients with a *C. difficile* infection diagnosis. The system infection control lead is representing the Devon system at a national *C. difficile* strategic level, and both Devon and Cornwall are a member of the regional *C. difficile* data collaborative. In addition, individual trusts each have *C. difficile* reduction strategies in place and results from some of these works have been shared at national level. Community onset *C. difficile* monitoring and theme/trend analysis is taking place in Devon localities but has yet to be combined across the Devon footprint- this is planned for 2025/26.

7 EMERGENCY PLANNING, RESILIENCE AND RESPONSE

7.1 DCIOS RESPONSE

Emergency Planning, Resilience and Response (EPRR) is led across the region by the NHS with the support of local authority partners as part of multi-agency partnerships; in the Peninsula this is the Devon, Cornwall and the Isles of Scilly Local Resilience Forum (LRF).

Relevant forum members responded to the following major/ critical incidents in 2024/25:

- A Major Incident was declared by the Police, in April 2024, in response to a series of contaminated drug incidents that resulted in 9 admissions to North Devon District Hospital of which two subsequently died. An issue identified was the lack of awareness of other contaminated drug incidents in the Region, which resulted in the hospitals clinicians responding in isolation. A process was subsequently agreed whereby OHID

SW will provide updates on unusual drug incidents for EDs across the Region via NHS England SW ROC.

- The May 2024 Cryptosporidium incident in areas of Torbay and South Hams placed some pressures on Primary Care in the area and was monitored by NHS Devon IPC staff but did not require a full incident response by the ICB.
- In August/ September 2024, when investigation was being undertaken into two possible unexploded ordinances in Plymouth, NHS Devon, University Hospitals Plymouth and Livewell Southwest, worked with partners to put in place a pre-prepared response, in case of any need for an evacuation of residents. This multi-agency work, whilst not activated, resulted in the development and adoption by the LRF of the Operation Luxvale Protocol, which will guide any future multi-agency response to unexploded ordinance in the DCIoS area.
- Response to adverse weather events, included several named storms during 2024/25 that resulted in power outages. Efforts focused on maintaining access to health and care services and ensuring that vulnerable patients are identified and supported throughout these incidents.
- Devon and C&IOS System Critical Incidents: Robust system responses were activated on several occasions due to various causes for example, escalating pressures upon urgent and emergency care services.
- Through multi-agency collaboration and exercise, the Isles of Scilly Reinforcement Plan has been updated by the Cornwall Council Emergency Management team. This plan ensures that resources can be activated and sent to the islands in the event of a critical or major incident.

7.2 INDUSTRIAL ACTION

Emergency planning was involved in preparing for and responding to industrial action taken by NHS staff during the year. Previous system wide industrial action plans were reviewed and updated with lessons identified from the last periods of action, working collaboratively with providers. A debriefs was held and learning identified will be embedded into the next iteration of planning assumptions.

7.3 EPRR RESPONSE ACTIVITY

7.3.1 Devon

Robust EPRR function with has been maintained:

- Early 2025 saw NHS Devon EPRR become a team as the outcome of the 2023-24 restructure recognised that the function had been under resourced. The increased resource to two full-time, trained, EPRR staff is enabling a wider range of concurrent work than was previously possible.
- The Nationally driven cuts and changes to ICBs will result in an ICB Cluster being implemented. This work will change EPRR structures going forward, however, national and regional direction on what this will entail has not yet been received.
- The ongoing 2023-24 restructure, and the announcement of a further round of cuts and further restructure, has continued the churn of on-call staff within the ICB, requiring frequent inductions of new Directors and Managers in addition to the maintenance of established on-call staffs knowledge.
- The Senior EPRR Manager also chairs the LHRP Business Management Group (BMG) and supports LRF work across capabilities such as Whole Society Resilience; Human Aspects, Evacuation & Shelter; and Vulnerable People groups.
- The delivery of the nationally mandated EPRR Assurance was completed in October 2024 with the ICB and all NHS Providers in Devon achieving Substantial or Full compliance with the Core Standards for EPRR.

7.3.2 Cornwall and Isles of Scilly

The team have continued to deliver a robust EPRR function with highlights listed below:

- Joint principles of health command training has been successfully delivered across the Peninsula, with sessions led collaboratively by the EPRR leads from both Devon and Cornwall. The local Director on Call training programme has undergone a comprehensive review, resulting in a refreshed training package. Monthly refresher sessions are now offered and have been well received, helping to ensure that our directors are equipped to provide effective system-wide leadership during incident response, in line with our Category One responsibilities.

- Delivery of the EPRR annual assurance process, supporting providers through a quarterly meeting assessment process to deliver collaborative working and support
- Provide leadership for the Local Health Resilience Partnership (LHRP), including overseeing the review and revision of the risk register and coordinating the upcoming evaluation of the associated work plan Head of EPRR is part of several national groups led by NHS England including CBRN and Pandemic preparedness.
- Development of LHRP/ LRF Pandemic Framework working in collaboration with the LRF capability lead.
- Act as Senior Responsible Officer (SRO) for Health on the LRF
- Exercise Effluvium was undertaken to outline the response to a major gas leak in a large urban community and included the impacts on the healthcare system locally.

7.4 DEVON, CORNWALL, AND ISLES OF SCILLY EXERCISES & PLANNING

Valuable lessons were taken from each of the exercises undertaken which have been built into workplans going forward.

In April 2024, a Devon system-wide Exercise, Pathalogia, was run with the support of NHS England SW Cyber Security to work through the Devon system's response to a cyber attack. Learning from the exercise is informing IT Disaster Recovery planning and how that links into the response to operational impacts.

NHS Devon, NHS Cornwall and Isles of Scilly ICB, University Hospitals Plymouth and Livewell Southwest participated in Exercise Hydropical (a part of Operation Skippered), a first of kind, multi-agency exercised response to a counter terrorism incident, in Plymouth in September 2024. The lessons from this exercise have informed national preparedness for terror incidents and bolstered local understanding of the health system's role and support for these operations.

At the request of the Health Protection Committee, Exercise Helios was undertaken in February 2025 to understand "the immediate response arrangements and long-term adaptations needed to ensure we are prepared for a protracted period of high temperatures". A debrief report with recommendations for future work has been shared with members of this committee as well as the Local Resilience Forum. The overarching findings of the exercise were that:

- There is a varying level of maturity of plans by individual agencies leading to an inability for the Local Health Resilience Partnership (LHRP) to be assured that the health of the population will be adequately protected during an extreme heat event.
- There are some multi-agency plans and frameworks that support the common consequences of an event of this nature, however there is a need to further explore the joint response arrangements and strategy for dealing with events of this nature.
- There is a need to explore the communication strategy for communicating with the public in events of this nature, to ensure that the messaging is tailored to get the most engagement from the various at risk groups. We all need to consider our ability to utilise national media outlets to support the local response.

Exercise Ultravox focused on the increasing use of synthetic opioids, highlighting the associated risks to users and the potential impact on the wider health system. The event featured valuable insights from Drug and Alcohol Implementation Coordinators and provided key networking opportunities for partners. In response, we have established systems to ensure alerts from the local drug information network are promptly shared with relevant healthcare partners, enabling timely action in the event of synthetic drug overdose incidents.

Various other exercises have taken place to test agency responses across partners to a range of scenarios.

7.5 LRF Pandemic Framework

In December 2024, the Local Health Resilience Partnership (LHRP) agreed to reframe its approach to pandemic preparedness, acknowledging that the LHRP does not hold a direct response function. Subsequently, the executive team committed to developing a pandemic framework document under the Local Resilience Forum (LRF), with input from partners across the LRF. This work has progressed well, and the draft framework is scheduled to be tested during Exercise Pegasus the national Tier One pandemic exercise beginning in September 2025.

7.6 SEVERE WEATHER PLANS

Severe weather plans are reviewed annually against any changes in guidance and assessed through the annual EPRR assurance process. We are running a capability style delivery of the LHRP workplan with a specific workgroup for this capability to ensure all plans are aligned with national guidance at operational levels.

7.7 ASSURANCE

The annual EPRR assurance was delivered in 2024 and signed off by the LHRP.

7.8 TRAINING

Training is delivered at a system and Peninsula level for principles of health command. Locally within CIOS we also deliver system level loggist training, all Directors on call have access to LRF level training such as JESIP and are encouraged to participate in any exercises.

As well as the joint PHC training referred to above, all NHS Devon on-call staff undergo internal on-call induction/ refresher training each year to maintain their awareness of the processes and systems in place for a multi-agency emergency response. Similarly, there is also a refresher programme in CIOS and on-call staff have access to LRF multi-agency training, including the Joint Emergency Services Interoperability Protocols training.

8. CLIMATE AND ENVIRONMENT

This section of the report was introduced 2022/23, seeking to continue development from the setting of work programme priority on climate in the 2021-22 Committee report.

Climate change is a growing threat, and exacerbates many existing health protection challenges, for example changing the epidemiology of infectious and vector borne diseases.[7] Nationally, UKHSA continues to prioritise research and action on climate change adaptation through the UKHSA Centre for Climate and Health Security

In the South West, UKHSA, OHID, FPH sustainability representatives and LA leads from Devon and Cornwall worked together through the South West Climate Change Public Health Leads Network, to share best practice and increase impact and influence on climate change. The network is building connections with professionals across Greener NHS and emergency planning.

In DCIOS, the Devon, Cornwall and Isles of Scilly (DCIoS) Climate Impacts Group (CIG) is the main partnership that coordinates Peninsula-wide action on climate adaptation, preparing communities and organisations for a changing climate, and improving resilience across the region, and has published a risk register and the DCIOS Climate Adaptation Strategy. Work on de-carbonisation and net zero is coordinated through the Devon Climate Emergency net zero plan and the Cornwall Climate Emergency plan.

The DCIOS Health Protection Committee and regular locality meetings have 'climate change' on the agenda as standing item as an ongoing prompt to consider the risks and opportunities for actions that have climate, health and equity co-benefits.

CIOS are working at system level on health creation models and adaptation, and mitigation plans which reduce the production of carbon by considering a wellness health model rather than the traditional sickness model. The climate change work in health is not just focused on response to climate change e.g. floods and heatwaves but the bigger picture of meeting the Net Zero targets in Green Plans through overall channel shift into health creation, healthier

[7] Climate change: health effects in the UK - GOV.UK

societies, moving care closer to communities and reducing the requirement for carbon intensive secondary care.

There are many actions already taking place across the Peninsula that are successfully reducing greenhouse gas emissions, increasing resilience and implementing the four local authorities carbon neutral / net zero plans. Please refer to local websites and plans for detail on specific actions.

https://www.cornwall.gov.uk/climateemergencydpd

https://devonclimateemergency.org.uk/devon-carbon-plan/

https://www.plymouth.gov.uk/climate-emergency-action-plan

https://www.torbay.gov.uk/council/climate-change/carbon-neutral-council-action-plan/

9. PROGRAMME PRIORITIES

The DCIOS Health Protection Committee has reviewed the work programme priorities in the formulation of this report and agreed the priorities set out below. These build on progress during the previous year.

1. Climate Emergency

Work closely with partners to address the climate emergency and develop plans in relation to flooding, heatwave, cold weather, and other climate related mitigations or emergencies, with an emphasis on the impact on vulnerable groups.

2. Infection Prevention and Management

Take action to strengthen infection prevention arrangements and tackle anti-microbial resistance:

- promote health protective behaviours
- strengthen infection prevention systems within health and care and wider settings
- reduce healthcare associated infections
- tackle antimicrobial resistance
- implement the regional Infection Prevention and Management Strategy at local level.

3. Screening and Vaccinations

Work in partnership across the system to improve uptake and reduce inequalities in screening and vaccination rates, with a focus on vulnerable populations. This work is driven forward by the Maximising Immunisation Uptake Groups in relation to vaccination and a similar approach is endorsed by the board for screening.

4. Pandemic Preparedness

Develop and strengthen planning and pandemic preparedness across the system, promote resilience, and build on learning from the Covid Inquiry, regional and national exercises as they are established.

5. Strengthen local Health Protection System, taking an all hazards approach

Collectively deliver continuous improvement in health protection. Develop the local Memorandum of Understanding and pathways taking into account service planning and response needs for specific hazards including, but not limited to HCIDs, climate change adaption and mitigation (e.g. severe weather events), emerging zoonotic risks (e.g. Avian Influenza) and Acute Respiratory Infection.

6. Inclusion & Inequalities

Protect the health of people experiencing greater inequalities in health or access. Implement the Inclusion Health Agenda through health protection systems.

7. Work to support local strategic plans

See links to plans in Appendix 3

10. AUTHORS AND CONTRIBUTORS

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With thanks to all contributors from members of the Health Protection Committee

11. Appendices

Appendix 1 Devon, Cornwall and Isles of Scilly Health Protection Committee summary terms of reference

1. Aim, Scope & Objectives

Aim

To provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

Scope

The scope of health protection to be considered by the committee will include prevention and control of infectious diseases, immunisation and screening, healthcare associated infections, non-infectious environmental hazards, and emergency planning and response (including severe weather, environmental and non-environmental hazards).

Objectives

- To provide strategic oversight of the health protection system operating across Devon, Plymouth, Torbay, Cornwall Council & the Council of the Isles of Scilly.
- To oversee the development, monitoring and review of a memorandum of understanding that outlines the roles and responsibilities of the UKHSA, Integrated Care Systems (Devon, and Cornwall & the Isles of Scilly), and upper tier/lower tier/unitary authorities in relation to health protection.
- To provide oversight of health protection intelligence reported to the committee and be appraised of risks, incidents, or areas of underperformance.
- To review and challenge the quality of health protection plans and arrangements to mitigate any risks.
- To share and escalate risks, incidents and underperformance to appropriate bodies (e.g. Health and Wellbeing Boards/Local Health Resilience Partnership, NHS England) when health protection plans and arrangements are insufficient to protect the public. The escalation route will depend on the risk or area of underperformance.
- To agree an annual programme of work to further improve local health protection arrangements as informed by the respective Health and Wellbeing Strategies for Devon, Plymouth, Torbay, Cornwall Council and the Council of the Isles of Scilly and their Director of Public Health's Annual Report and Joint Strategic Needs Assessments.
- To review and challenge arrangements for the delivery of existing and new national screening and immunisation programmes or extensions to existing programmes.

- To promote reduction in inequalities in health protection across Devon, Plymouth, Torbay, and Cornwall & the Isles of Scilly.
- To oversee and ratify a Health Protection Committee Annual Report.

2. Membership

Chair: Director of Public Health

Business Support

Members:
UKHSA Health Protection Consultants
NHS England South West Vaccinations & Screening Team
NHS Devon IPC Team
NHS Kernow ICB Director of IPC
Consultant in Public Health: Local Authority Health Protection Lead
EPRR Leads from NHS Devon ICB and NHS Kernow ICB
Co-Chair of Health Protection Advisory Group
Local Health Resilience Partnership Co-Chair
Devon Strategic Environmental Health Group Representative
Co-Chairs of Peninsula AMR Group

Minutes are also circulated to:

Chief Nursing Officer, NHS Devon ICB and NHS Kernow ICB

3. Meetings & Conduct of Business

3.1 The Chairperson of the Health Protection Committee will be either a Director of Public Health from Devon County Council, Plymouth City Council, Torbay or Cornwall Council. Directors of Public Health serving these councils will review this position annually.

3.2 For meetings to be quorate they must comprise:
- The Chairperson of the Health Protection Committee, or their deputy
- Leads or their deputies from the Local Authority Public Health (minimum of one representative from Cornwall and one from the Devon Local Authorities)
- Leads or their deputies from the Integrated Care Board
- Leads or their deputies from the UKHSA
- Leads or their deputies from the VAST

3.3 All meeting papers will be circulated at least seven days in advance of the meeting date.

3.4 The agenda (standing items listed in 3.6 below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.

3.5 Meetings will be held quarterly.

3.6 Standing agenda items will include the following:

- Health Protection Exception Reports
- Communicable Diseases, Environmental Hazards & Health Protection UKHSA Quarterly Update
- Healthcare Associated Infections Quarterly Report
- Screening and Immunisation Quarterly Performance and Risk Monitoring Report
- Peninsula Cancer Prevention Alliance: Feedback from Devon & Cornwall Meeting
- Emergency Planning update
- Annual Assurance Report
- Update on ongoing work programme priorities[8] (where not already provided)
- Joint Forward Plans
- Gap Analysis Action Plan (GAAP) Tool Implementation
- Risks
- Any Other Business

3.7 An annual report of the Committee will be forwarded to members of the Health and Wellbeing Boards for Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council & the Council of the Isles of Scilly. Also present as an annual agenda item to the Local Health Resilience Partnership.

3.8 Terms of Reference to be reviewed annually.

AFFILIATED GROUPS

In addition, several groups sit alongside the Committee with remits for:

- Infection Prevention and Control
- Antimicrobial Stewardship
- Immunisation
- Screening
- Seasonal vaccination
- Emergency planning (including Local Resilience Forums)
- Migrant and Refugee health
- Tuberculosis & Hepatitis

All oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and UKHSA and into individual partner organisations.
NHSE, UKHSA and ICBs provide quarterly performance, surveillance, and assurance reports to the Committee.
Local authority lead officers review surveillance and performance monitoring information to identify health protection risks and/or under performance prior to committee meetings.

[8] as outlined in the Annual Assurance Report

Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against any identified risks, or to improve performance. The outcomes of these discussions are formally reported to the Committee for consideration and agreement.

Appendix 2 Roles in relation to delivery, surveillance and assurance

Prevention and control of infectious disease

UKHSA local health protection teams lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents. They have responsibility for declaring a health protection incident, major or otherwise and are supported by local, regional, and national expertise.

NHS England is responsible for managing and overseeing the NHS response to any incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

Integrated Care Boards ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks.

Local authorities, through their Director of Public Health or their designate, have overall responsibility for strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by NHSE and UKHSA, supported by the local authorities and NHS. In addition, they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

UKHSA provides a quarterly report to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level. Surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus, are published during the winter months.

Screening and Immunisation

Population Screening and Immunisation programmes are commissioned by NHS England and Improvement under what is known as the Section 7A agreement. There are 20 population immunisation programmes and 11 population screening programmes. These programmes cover the whole life course from antenatal to elderly persons and, in any one year, approximately 70% of the population will become eligible for at least one immunisation programme or screening test. These programmes are a core element of prevention and early diagnosis and offer opportunities for accessing populations to improve wider health and wellbeing.

NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and new-born programmes that are part of the CCG Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner.

UK Health Security Agency is responsible for setting national screening and immunisation policy and standards through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by NHS England work alongside NHS England Public Health Commissioning colleagues as part of a wider Vaccination and Screening Team to provide accountability for the commissioning of the programmes and system leadership.

Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting NHS England in efforts to improve programme coverage and uptake.

The South West Vaccination and Screening Team provides quarterly reports to the Health Protection Committee for each of the national screening and immunisation programmes.

Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with NHS England specialists to agree mitigating activities.

Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

Locality Immunisation Group activity was suspended during the pandemic but has been re-introduced in 2022 and badged as Maximising Immunisation Uptake Groups, where all local activity to improve coverage and reduce inequalities is planned and co-ordinated working with local system partners.

Separate planning and oversight groups are in place for seasonal influenza and covid.

There are oversight groups (Programme Boards) for all screening programmes and these form part of the local assurance mechanisms to identify risks and oversee continuous quality improvement. In addition, specific project groups are convened, as necessary, to oversee significant developments in the programmes and the introduction of new programmes.

All the oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and individual partners.

Healthcare associated infections

NHS England sets out and monitors the NHS Outcomes Framework which includes Domain Five (safety): treating and caring for people in a safe environment and protecting them from avoidable harm. NHS England holds Integrated Care Boards to account for performance against indicators under this domain, which includes incidence of healthcare associated methicillin-resistant Staphylococcus aureus bacteraemia and incidence of Clostridium difficile infection.

UKHSA, through its consultants in communicable disease control, leads the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, and is responsible for declaring a health protection incident.

The ICBs role is to ensure, through contractual arrangements with provider organisations, that health care associated infection standard operating procedures are in all provider contracts and are monitored regularly. In addition, ICBs must be assured that the Infection Prevention and Control Teams covering the hospital and NHS community healthcare provided services sector are robust enough to respond appropriately to protect the local population's health, and that risks of health care associated infection have been identified, are mitigated against, and are adequately controlled.

The local authority, through the Director of Public Health or their designate, has overall responsibility for the strategic oversight of a health care associated infection incident affecting their population's health. They should ensure that an appropriate response is put in place by NHS England and UKHSA, supported by the ICB.

The Regional Infection Prevention & Control (IPC) Network is a monthly forum for all stakeholders working towards the elimination of avoidable health care associated infections. The Devon IPC group covers health and social care interventions in clinical, home, and residential care environments, identifying risks, sharing best practice and collaborating in system-wide approaches. The group is co-ordinated by NHS Devon ICB and is a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Local Authority Public Health, UKHSA, Medicines Optimisation and NHS England.
In Cornwall there is an IPC system alliance with multi-agency attendance working on a similar agenda, also reporting into the Health Protection Committee. There is cross-attendance between the Devon and Cornwall groups.

Emergency planning and response

Local resilience forum (LRF) is a multi-agency partnership made up of representatives from local public services, including the emergency services, local authorities, the NHS, the

Environment Agency, and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The geographical area the forum covers, reflects the police area of Devon, Cornwall, and the Isles of Scilly.

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, UKHSA and local authority representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

All Councils continue to engage with the Local Resilience Forum and the Local Health Resilience Partnership in undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as required.

Appendix 3 Links to Strategies and Plans

Cornwall and Isles of Scilly ICS Strategy
https://cios.icb.nhs.uk/ics/

Cornwall and Isles of Scilly Joint Forward Plan
https://docs.cios.icb.nhs.uk/DocumentsLibrary/NHSCornwallAndIslesOfScilly/Organisation/Policies/230405JFPJune2023edition.pdf

Devon ICS Strategy and **Devon Joint Forward Plan**
https://onedevon.org.uk/about-us/our-vision-and-ambitions/our-devon-plan/

Plymouth Climate Emergency Action Plan
https://www.plymouth.gov.uk/climate-emergency-action-plan-2022

Devon, Cornwall, and Isles of Scilly Climate Adaptation Strategy
https://www.climateresilient-dcios.org.uk/#:~:text=View%20Consultation%20Report-,The%20Devon%2C%20Cornwall%20and%20Isles%20of%20Scilly%20(DCIoS)%20Climate,change%20increasingly%20affects%20the%20UK.

Cornwall and Isles of Scilly ICS Strategy
https://cios.icb.nhs.uk/ics/

Cornwall and Isles of Scilly Joint Forward Plan
https://docs.cios.icb.nhs.uk/DocumentsLibrary/NHSCornwallAndIslesOfScilly/Organisation/Policies/230405JFPJune2023edition.pdf

Devon Carbon Plan
https://devonclimateemergency.org.uk/devon-carbon-plan/

Plymouth Climate Emergency Action Plan
https://www.plymouth.gov.uk/climate-emergency-action-plan-2022

Appendix 4 Counts of situations by principal contexts and infectious agents

Local Authorities: Devon, Plymouth Torbay, Cornwall and Isles of Scilly

APRIL 2024 TO 31 MARCH 2025

Counts of Respiratory Situations by Principal Contexts and Infectious Agents

	Primary context				
Infective organism	**Care Home**	**Nursery/ School**	**Other**	**N/A**	**Total**
Bordetella spp	<5	<5	<5	<5	<5
COVID-19	7	<5	<5	<5	10
Influenza A virus, Seasonal	5	<5	<5	<5	5
Influenza B virus	<5	<5	<5	<5	<5
Influenza (not specified)	66	8	<5	38	113
Parainfluenza virus	<5	<5	<5	<5	<5
Respiratory syncytial virus (RSV)	<5	<5	<5	<5	<5
(blank)	<5	<5	<5	<5	<5
Total	79	9	<5	42	133

Other context = Custodial institution, Hospice, Hospital, Household, Supported living facility, workplace

Where the numbers of incidents are small, they are denoted as <5 to protect anonymity.

Counts of Gastrointestinal Situations by Principal Context

Primary context	Number of Situations
Care Home	50
Nursery	16
School	13
Other	37
Grand Total	116

Other context = boat, custodial institution, hotel, visitor attraction, workplace

Gastrointestinal situations include: Diarrhoea and/or vomiting, Enteric Fever, Food Poisoning, Gastroenteritis, Gastrointestinal infection (GI), and Infectious bloody diarrhoea

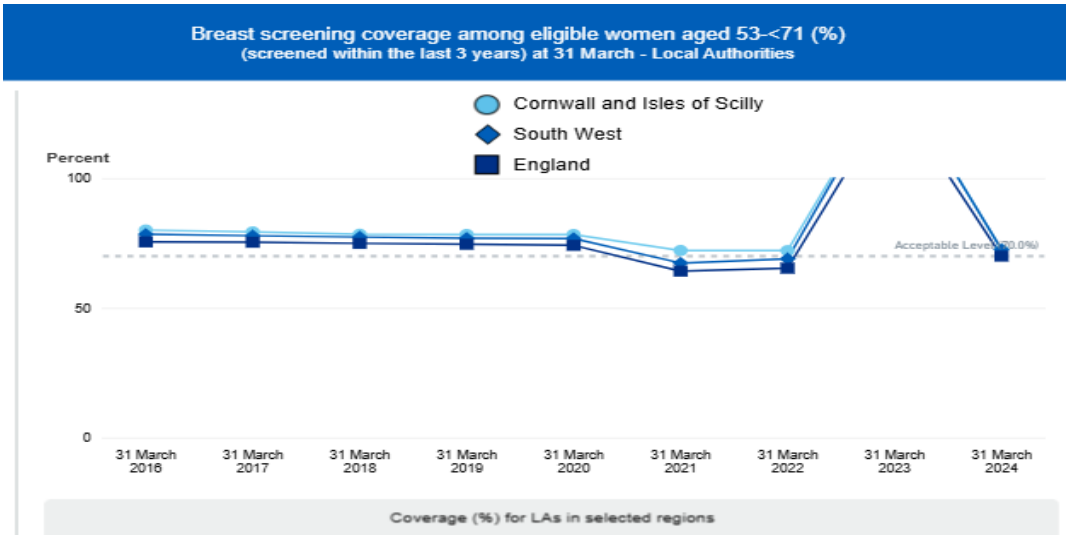
Appendix 5 Screening data 2024/25

Cancer Screening Coverage Data

Breast Screening: Coverage amongst eligible women aged 53-≤71 screened within last 3 years at 31 March (%)

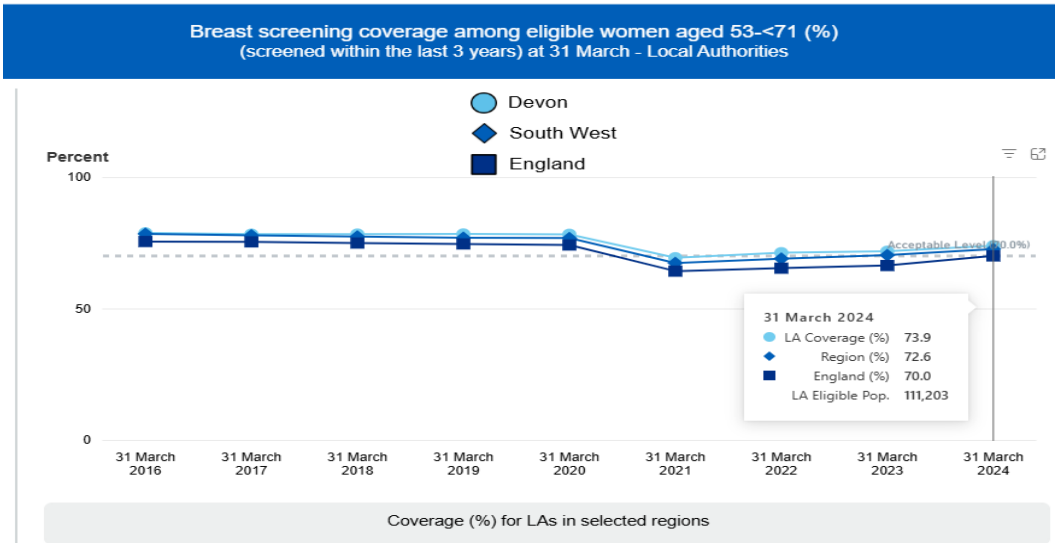
Source: NHS Digital, Timeseries from 2016 – 2024. NB all programmes were significantly impacted by COVID. Extracted August 2025 Microsoft Power BI

Cornwall & Isles of Scilly

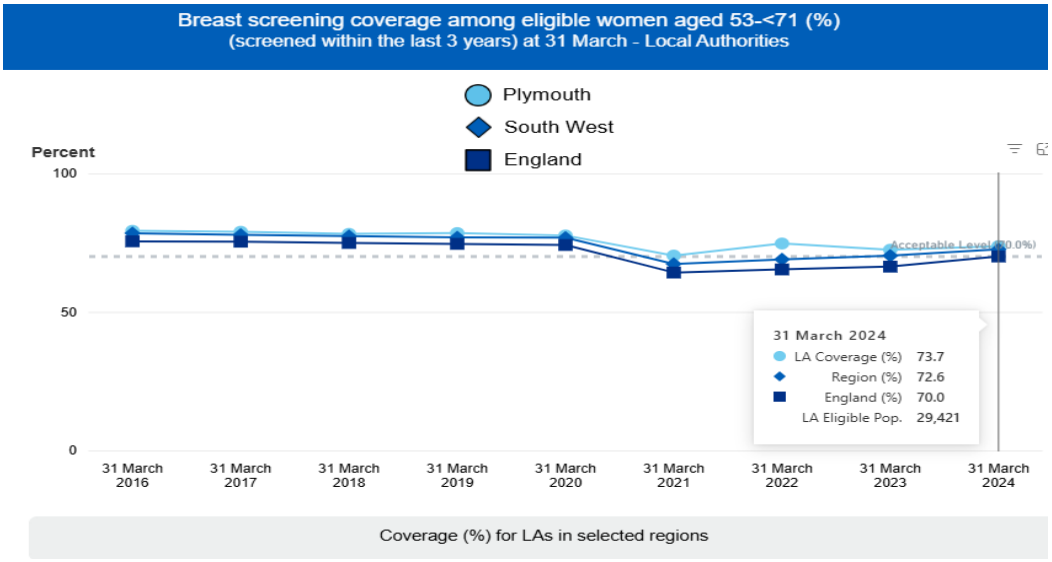


To note: there is an error in this diagram for the 31 March 2023 figures. Taken from a different data source Cancer Services - Data | Fingertips | Department of Health and Social Care, the figure for 2022/23 was 70.5% and the values for the South West and England are 70.3% and 66.4% respectively as shown in the following diagrams.

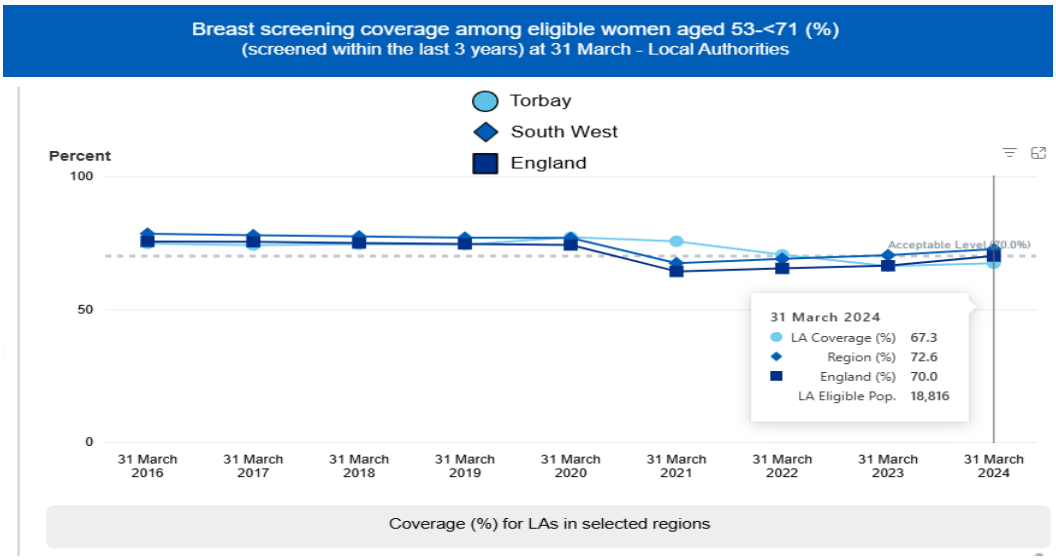
Devon



Plymouth



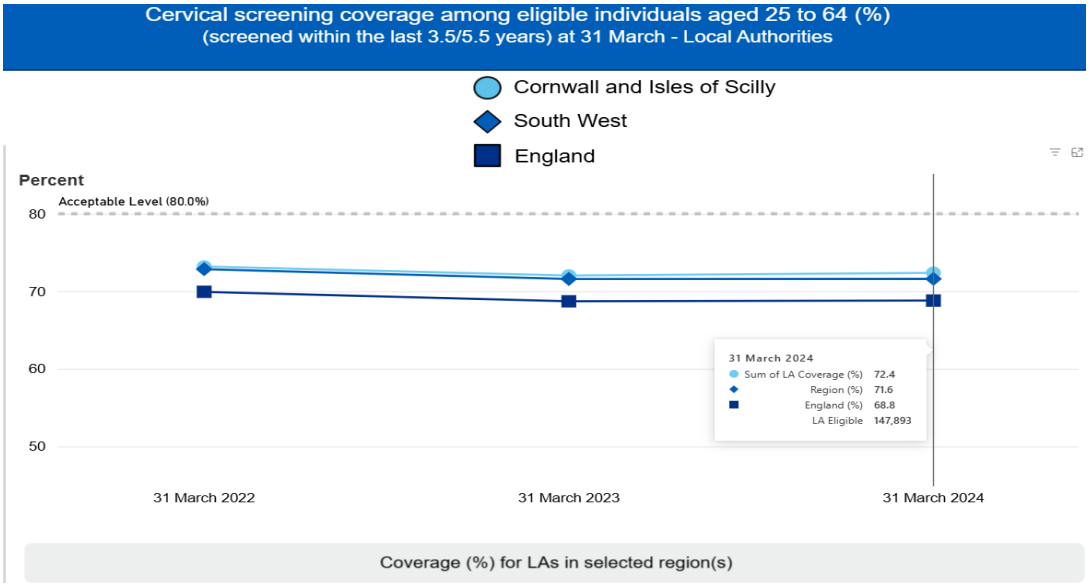
Torbay



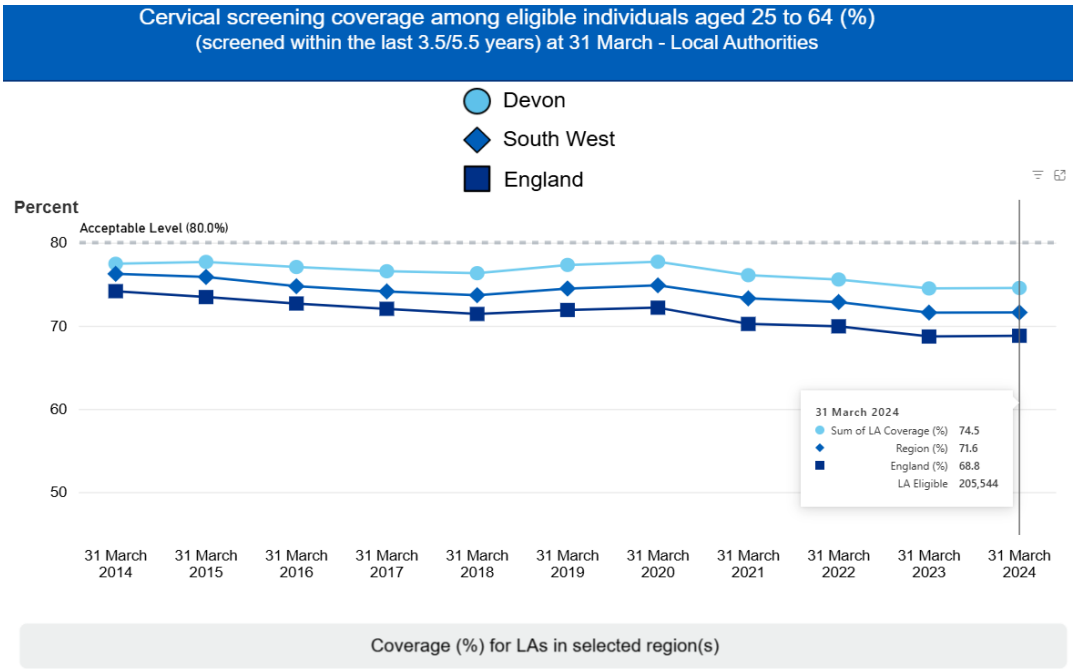
Cervical: Coverage amongst eligible individuals aged 25 to 64 screened within last 3.5/ 5.5 years at 31 March (%)

Source: NHS Digital, Timeseries from 2014– 2024 Extracted August 2025 Microsoft Power BI

Cornwall and Isles of Scilly[9]

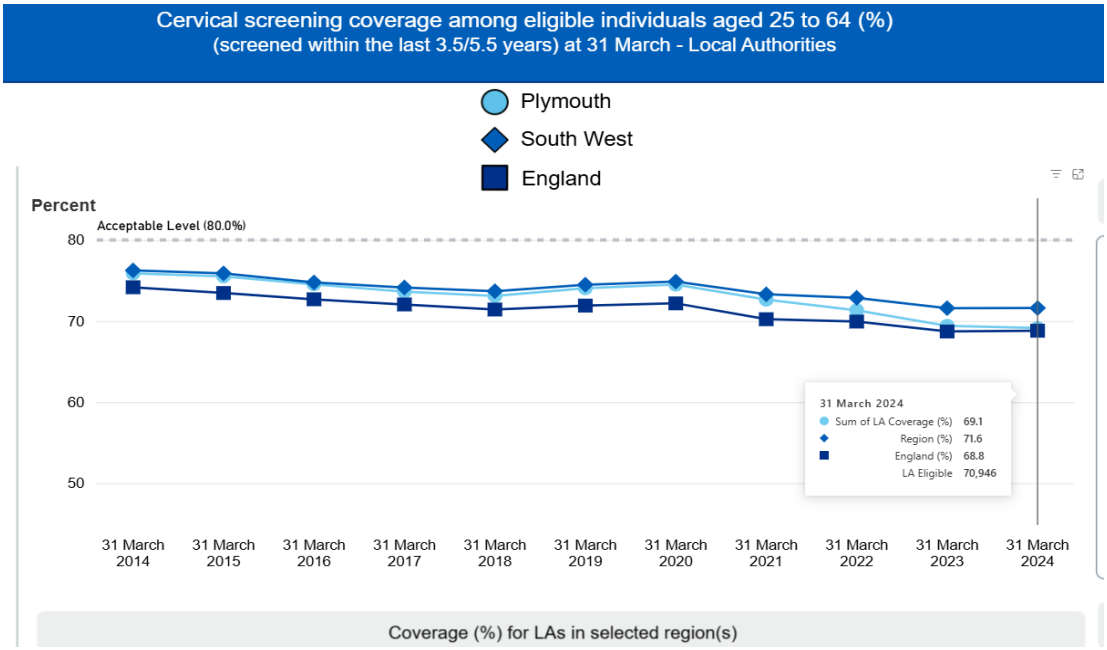


Devon

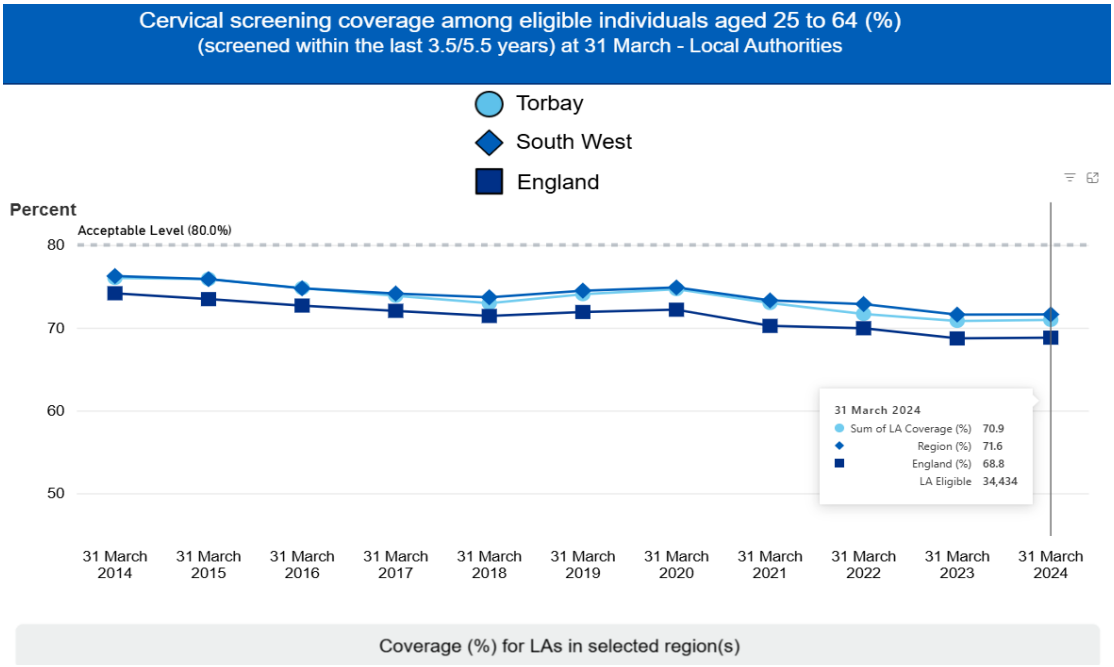


[9] Cornwall and Isles of Scilly has a break in data so that preceding data is shown separately in the NHS Digital series. Therefore most up to date time series is shown here.

Plymouth



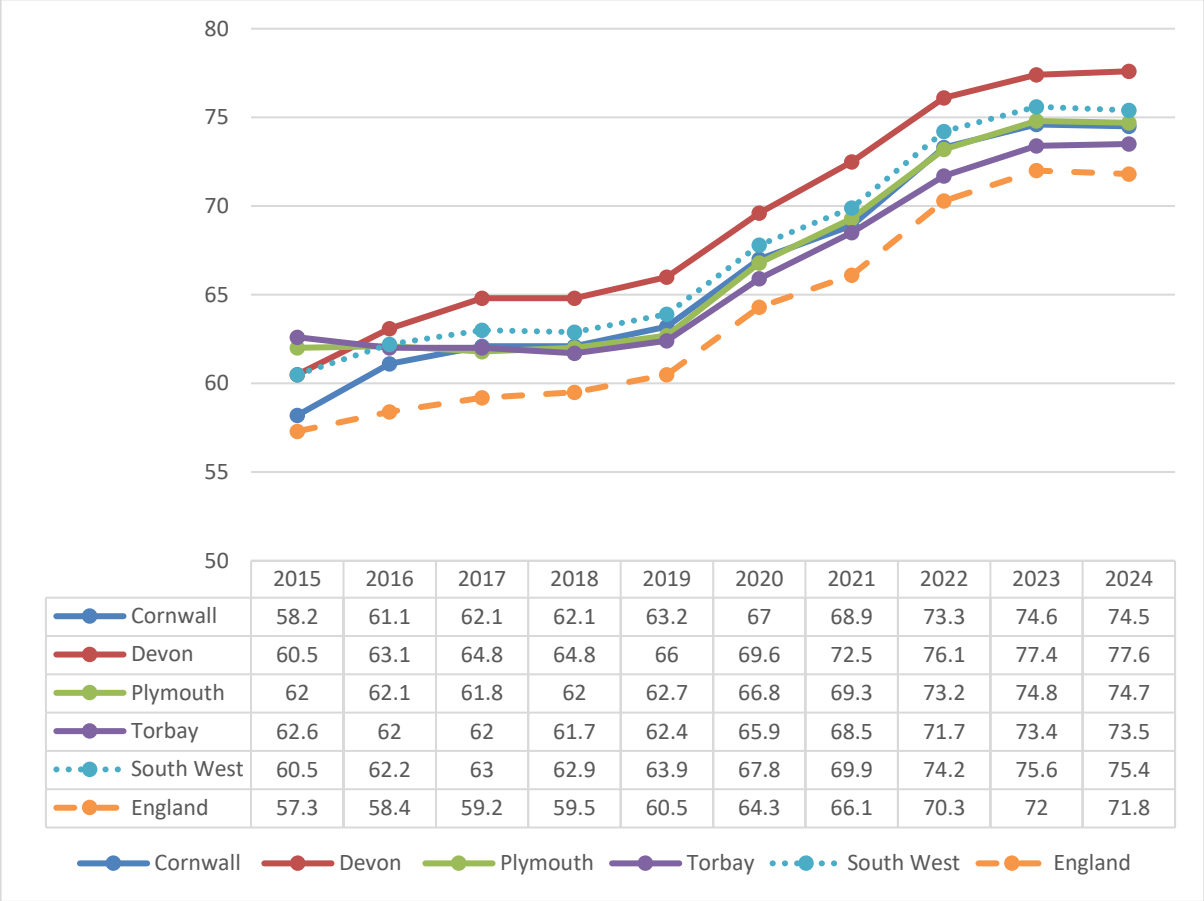
Torbay



Bowel Cancer screening coverage

Source: [Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care]

Graph x: Graph showing the proportion of eligible men and women aged 60 to 74 invited for screening who had an adequate faecal occult blood test (FOBt) screening result in the previous 30 months.



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Cornwall	58.2	61.1	62.1	62.1	63.2	67	68.9	73.3	74.6	74.5
Devon	60.5	63.1	64.8	64.8	66	69.6	72.5	76.1	77.4	77.6
Plymouth	62	62.1	61.8	62	62.7	66.8	69.3	73.2	74.8	74.7
Torbay	62.6	62	62	61.7	62.4	65.9	68.5	71.7	73.4	73.5
South West	60.5	62.2	63	62.9	63.9	67.8	69.9	74.2	75.6	75.4
England	57.3	58.4	59.2	59.5	60.5	64.3	66.1	70.3	72	71.8

Non- cancer Screening Programs

Abdominal Aortic Aneurysm screening

Screen shots from [AAA standards report 2023 to 2024 - GOV.UK]

Figure 5: coverage - percentage of eligible cohort men conclusively tested within the screening year plus 2 months, by screening provider, England, 1 April 2023 to 31 March 2024

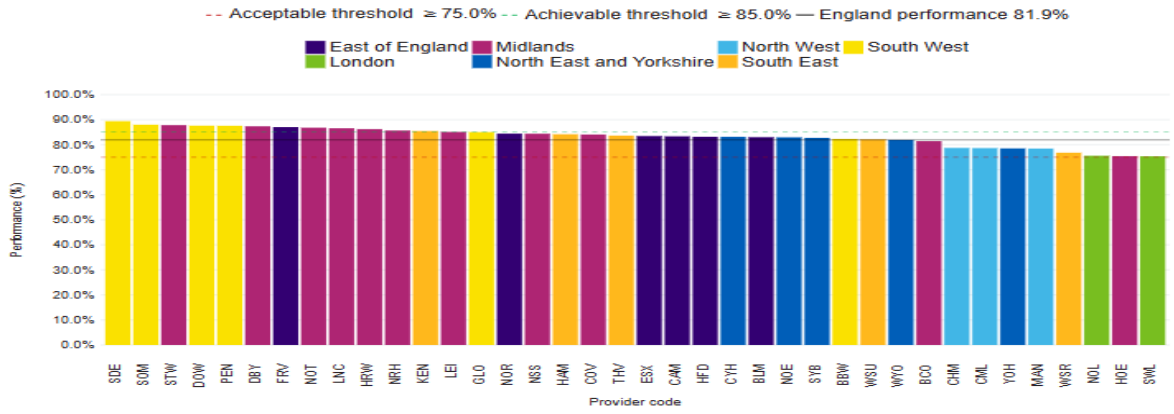


Figure 9: coverage - percentage of men in the eligible cohort who were tested and who lived in a lower super output area (LSOA) classed as decile 1 to 3 in the English indices of deprivation (IoD) 2019, by screening provider, England, 1 April 2023 to 31 March 2024

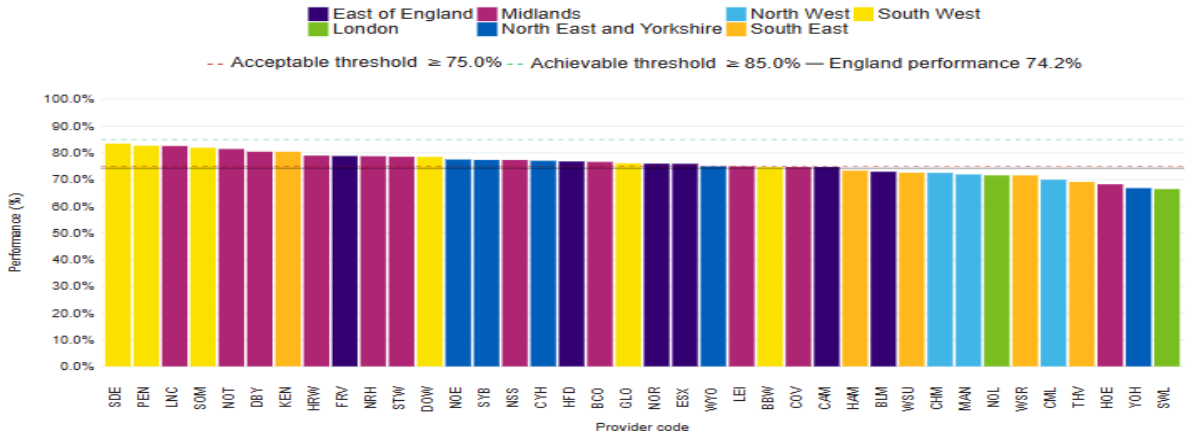
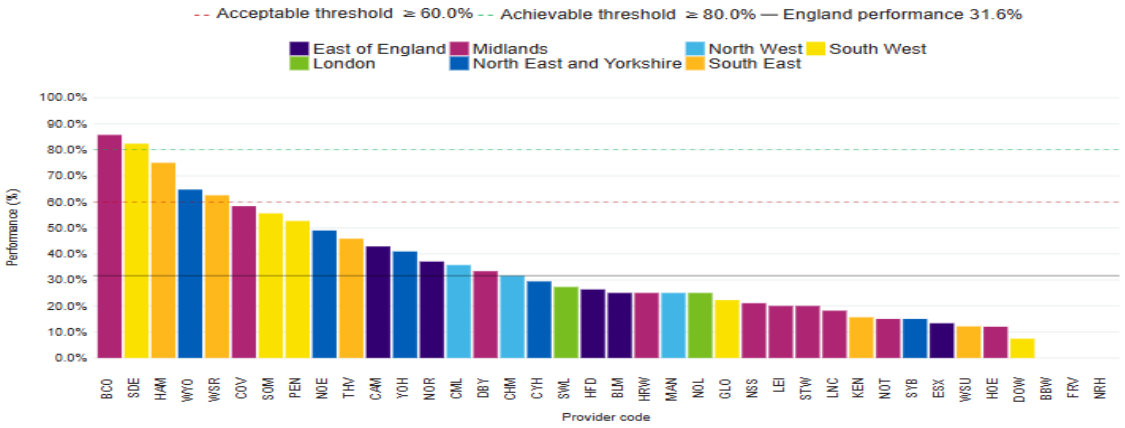


Figure 20: referral - percentage of men with aorta ≥ 5.5cm or men with an aorta ≥ 4.0cm that has grown ≥ 1cm in one year, deemed fit for intervention and not declining, operated on by a vascular specialist within 8 weeks, by screening provider, England, 1 April 2023 to 31 March 2024



Antenatal and Newborn Screening

NHS population screening programmes: KPI reports 2024 to 2025 - GOV.UK

All figures shown are percentages

Neonatal Newborn Hearing Screen	Q1	Q2	Q3	Q4
Cornwall & IOS	99.8	99.8	99.1	99.4
North Devon	98.9	98.9	98.8	99.4
Plymouth	99.7	99.5	99.7	99.7
Torquay and Teignbridge	99.6	98.3	98.6	97.3
South West	99.3	99.2	99.1	99.2
England	99.1	99.0	98.8	98.6
Acceptable level: greater than or equal to 98.0%; Achievable level: greater than or equal to 99.5%				

Newborn and Infant Physical Examination	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	96.3	95.6	97.0	95.8
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.1	99.0	98.7	98.9
Plymouth Hospitals NHS Trust (UHP)	95.8	96.1	95.4	95.2
Torbay and South Devon NHS Foundation Trust (T&SD)	99.3	98.2	99.0	97.9
South West	97.5	97.4	97.5	97.2
England	96.4	96.4	96.4	96.5
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Infectious diseases screening- Coverage HIV	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	99.9	99.8	99.7	99.9
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.6	99.7	99.7	99.5
Plymouth Hospitals NHS Trust (UHP)	99.7	99.8	99.5	99.3
Torbay and South Devon NHS Foundation Trust (T&SD)	99.6	99.1	99.8	99.2
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Infectious diseases screening- Coverage Hepatitis B	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	99.9	99.8	99.7	99.9
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.6	99.7	99.7	99.5
Plymouth Hospitals NHS Trust (UHP)	99.7	99.8	99.6	99.3
Torbay and South Devon NHS Foundation Trust (T&SD)	99.6	99.1	99.8	99.2
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Infectious diseases screening- Coverage Syphilis	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	99.9	99.8	99.7	99.9
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.6	99.7	99.7	99.5
Plymouth Hospitals NHS Trust (UHP)	99.7	99.8	99.6	99.3
Torbay and South Devon NHS Foundation Trust (T&SD)	99.6	99.1	99.8	99.2
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Infectious diseases screening- Coverage Syphilis	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	99.9	99.8	99.7	99.9
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.6	99.7	99.7	99.5
Plymouth Hospitals NHS Trust (UHP)	99.7	99.8	99.5	99.3
Torbay and South Devon NHS Foundation Trust (T&SD)	99.6	99.1	99.8	99.2
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Antenatal sickle cell and thalassaemia screening ST1 coverage	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	96.3	95.6	97.0	99.9
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.1	99.0	98.7	99.6
Plymouth Hospitals NHS Trust (UHP)	95.8	96.1	95.4	99.5
Torbay and South Devon NHS Foundation Trust (T&SD)	99.3	98.2	99.0	99.2
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Antenatal sickle cell and thalassaemia screening ST2 -timeliness of antenatal screening	Q1	Q2	Q3	Q4
Royal Cornwall Hospitals NHS Trust (RCHT)	95.5	97.6	93.8	70.1
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	88.0	76.0	72.3	65.3
Plymouth Hospitals NHS Trust (UHP)	92.3	84.0	82.7	64.3
Torbay and South Devon NHS Foundation Trust (T&SD)	57.4	57.4	53.2	79.9
Acceptable level: ≥ 50.0%; Achievable level: ≥ 75.0%				

Antenatal sickle cell and thalassaemia screening ST3 - completion of family origin questionnaire (FOQ)	Q1	Q2	Q3	Q4

Royal Cornwall Hospitals NHS Trust (RCHT)	99.9	99.8	99.7	97.8
Royal Devon University Healthcare NHS Foundation Trust (RDUH)	99.6	99.8	99.7	100.0
Plymouth Hospitals NHS Trust (UHP)	99.4	99.7	99.6	98.4
Torbay and South Devon NHS Foundation Trust (T&SD)	99.6	99.3	99.8	98.3
Acceptable level: ≥ 95.0%; Achievable level: ≥ 97.5%				

Q4_2024-25_Publication_ANNB_KPI_Data_V1.ods

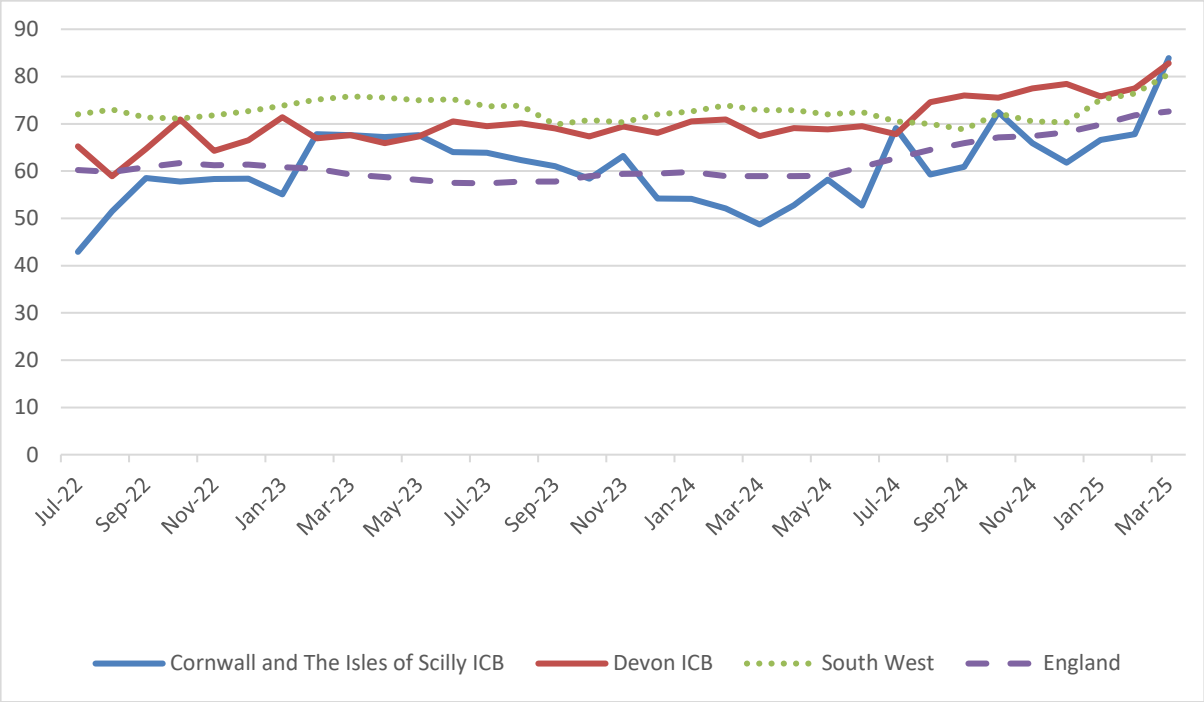
Q4 2024-25	**Newborn Blood Spot Coverage**
CIOS ICB	All Acceptable
Devon ICB	
For coverage: Acceptable level: ≥ 95.0%; Achievable level: ≥ 99.0%	

Appendix 6 Immunisations

Vaccines in Pregnancy

Pertussis coverage (%): July 2022 to March 2025

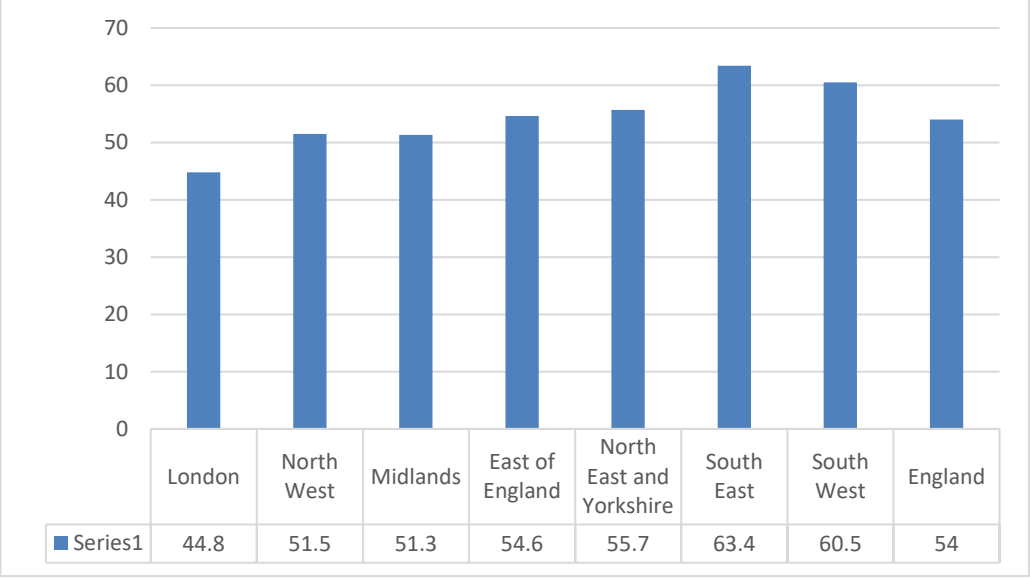
hpr0425-prenatal-prtsss-vc-data-tables.xlsx



Pertussis immunisation in pregnancy: vaccine coverage (England) - GOV.UK

RSV coverage in pregnant women measures in April 2025 (%)

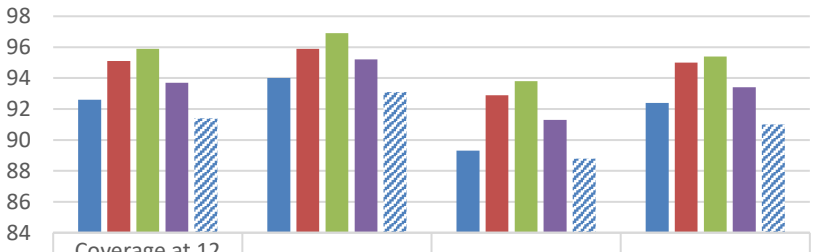
Respiratory syncytial virus (RSV) maternal vaccination coverage in England: April 2025 - GOV.UK



Childhood Immunisations

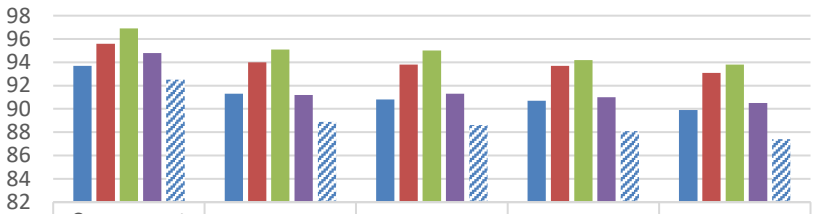
Annual 2024-25 COVER data [cover-data-tables-2024-to-2025.ods]

Coverage at 12 months



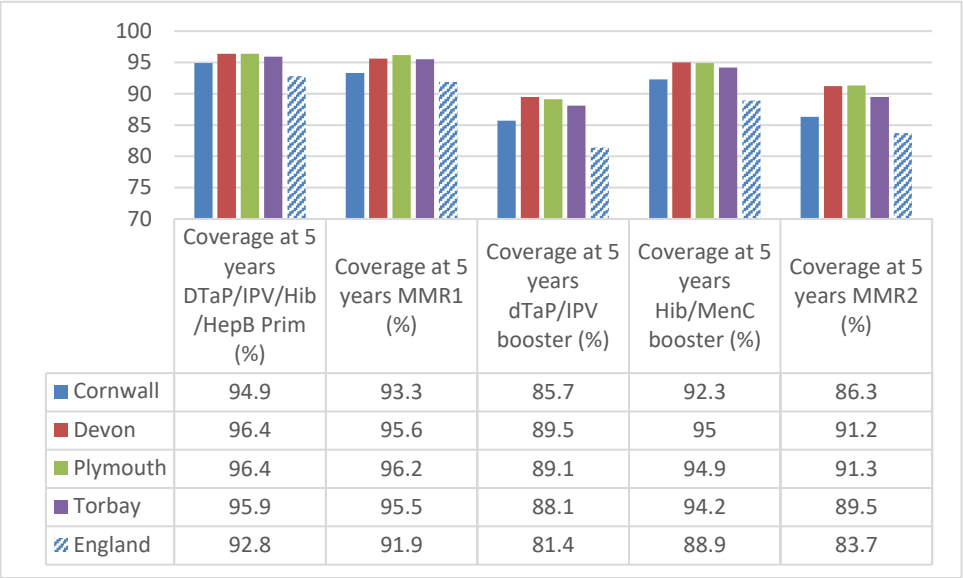
	Coverage at 12 months DTaP/IPV/Hib/HepB (%)	Coverage at 12 months PCV1 (%)	Coverage at 12 months rotavirus (%)	Coverage at 12 months MenB (%)
Cornwall	92.6	94	89.3	92.4
Devon	95.1	95.9	92.9	95
Plymouth	95.9	96.9	93.8	95.4
Torbay	93.7	95.2	91.3	93.4
England	91.4	93.1	88.8	91

Coverage at 24 months



	Coverage at 24 months DTaP/IPV/Hib/HepB Prim (%)	Coverage at 24 months MMR1 (%)	Coverage at 24 months Hib/MenC booster (%)	Coverage at 24 months PCV booster (%)	Coverage at 24 months MenB booster (%)
Cornwall	93.7	91.3	90.8	90.7	89.9
Devon	95.6	94	93.8	93.7	93.1
Plymouth	96.9	95.1	95	94.2	93.8
Torbay	94.8	91.2	91.3	91	90.5
England	92.5	88.9	88.6	88.1	87.4

Coverage at 5 years

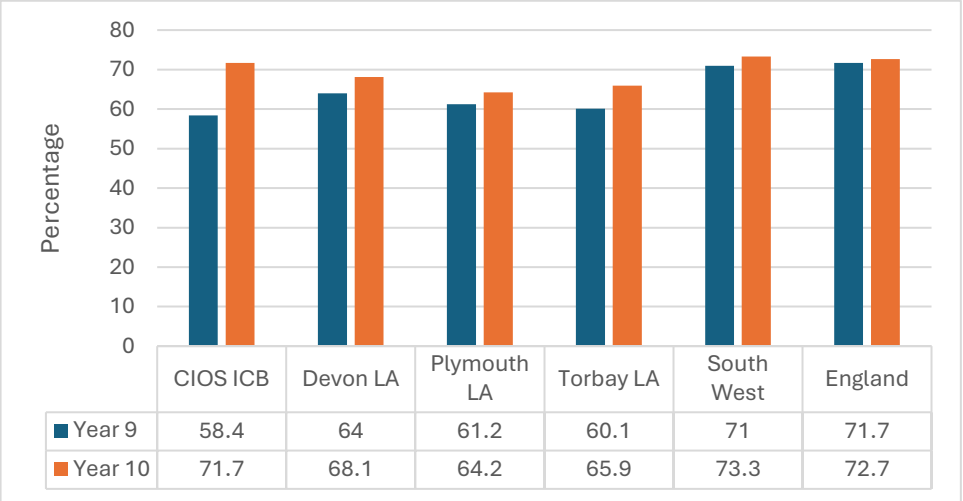


	Coverage at 5 years DTaP/IPV/Hib /HepB Prim (%)	Coverage at 5 years MMR1 (%)	Coverage at 5 years dTaP/IPV booster (%)	Coverage at 5 years Hib/MenC booster (%)	Coverage at 5 years MMR2 (%)
Cornwall	94.9	93.3	85.7	92.3	86.3
Devon	96.4	95.6	89.5	95	91.2
Plymouth	96.4	96.2	89.1	94.9	91.3
Torbay	95.9	95.5	88.1	94.2	89.5
England	92.8	91.9	81.4	88.9	83.7

School aged immunisations

Td/IPV vaccine coverage by local authority[10] September 2023 to August 2024

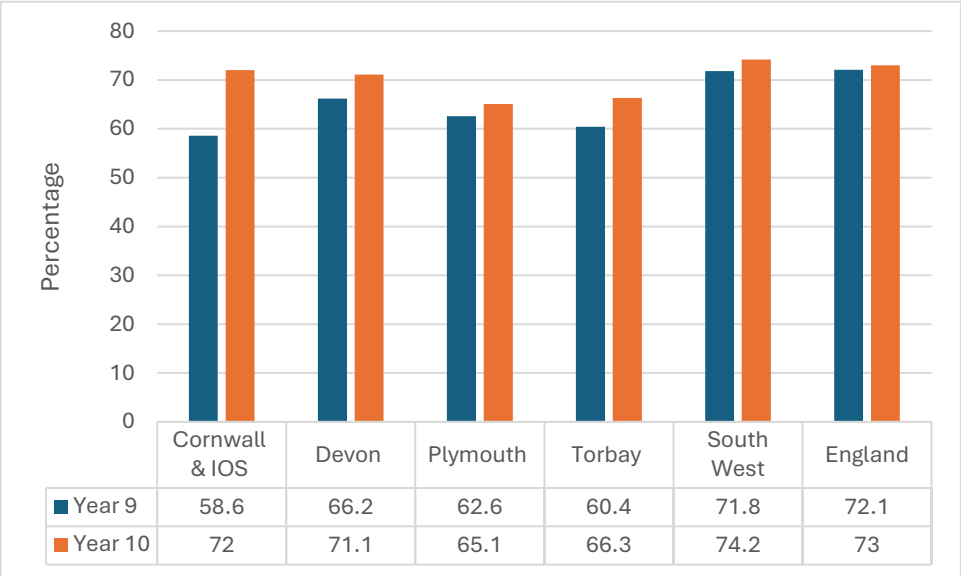
hpr0125-td-ipv-vc-data-tables_v4.xlsx



	CIOS ICB	Devon LA	Plymouth LA	Torbay LA	South West	England
Year 9	58.4	64	61.2	60.1	71	71.7
Year 10	71.7	68.1	64.2	65.9	73.3	72.7

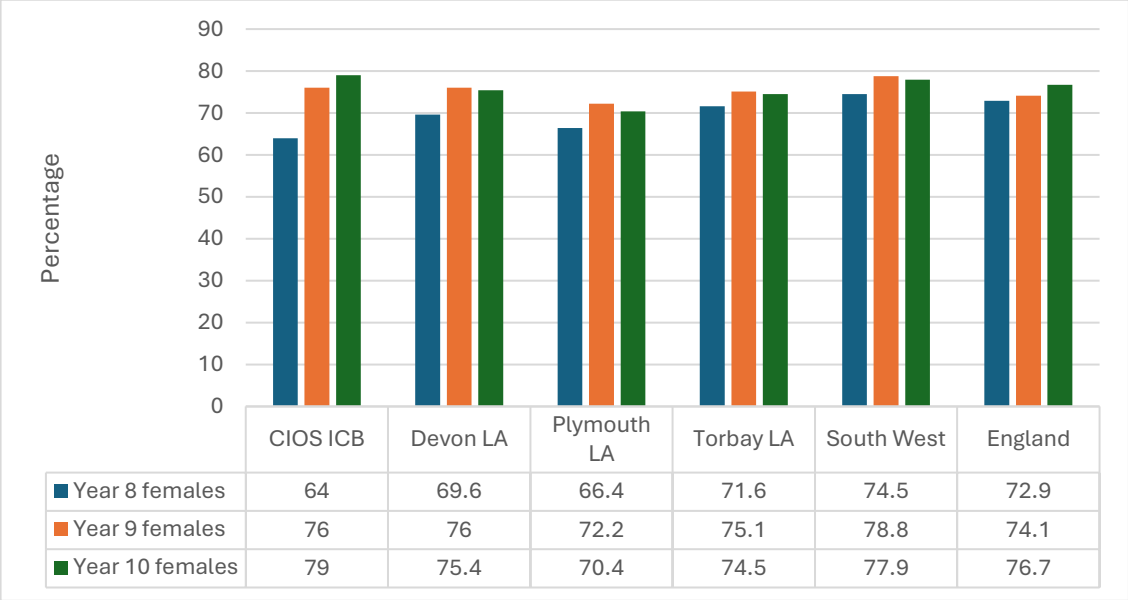
[10] Data comes from Local Authority tables for Devon, Plymouth and Torbay and for Cornwall and IOS the data is taken from the ICB table

MenACWY adolescent vaccine coverage data by local authority*,, September 2023 to August 2024 hpr0125-men-acwy-vc-data-tables_v2.xlsx



	Cornwall & IOS	Devon	Plymouth	Torbay	South West	England
Year 9	58.6	66.2	62.6	60.4	71.8	72.1
Year 10	72	71.1	65.1	66.3	74.2	73

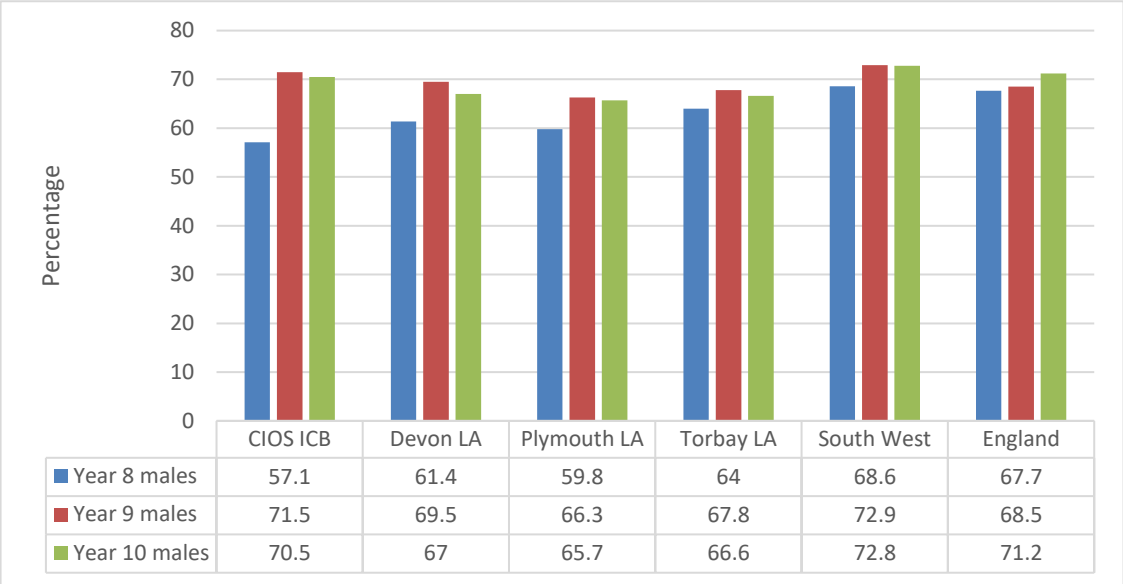
HPV vaccine coverage (female) data by local authority*, September 2023 to August 2024
HPV-data-tables-2023-to-2024.ods



	CIOS ICB	Devon LA	Plymouth LA	Torbay LA	South West	England
Year 8 females	64	69.6	66.4	71.6	74.5	72.9
Year 9 females	76	76	72.2	75.1	78.8	74.1
Year 10 females	79	75.4	70.4	74.5	77.9	76.7

HPV vaccine coverage (male) data by local authority*, September 2023 to August 2024

HPV-data-tables-2023-to-2024.ods



	CIOS ICB	Devon LA	Plymouth LA	Torbay LA	South West	England
Year 8 males	57.1	61.4	59.8	64	68.6	67.7
Year 9 males	71.5	69.5	66.3	67.8	72.9	68.5
Year 10 males	70.5	67	65.7	66.6	72.8	71.2

Adult immunisations

RSV: Number 01 September 2024 (commencement of programme) to 23 March 2025

NHS Region of GP Practice	Number of individuals who have received an RSV vaccination to date[11]
England[12]	1,796,270
East of England	231,432
London	153,720
Midlands	341,958
North East and Yorkshire	288,946
North West	207,862
South East	333,536
South West	226,359

Weekly Statistics by Region, NHS Digital cover period 01 September 2024 (commencement of programme) to 23 March 2025

The regional data combines all the cohorts and this will include some pregnant women so to give some perspective on split the national data for all cohorts is shown below

RSV cohort	Number of individuals who have received an RSV vaccination to date
England	1,796,270
Older adult catch up	1,511,438
Older adult routine	85,499
Maternity	188,729

PPV

PPV coverage 2024-25	Coverage aged 65+(%)	Coverage age 75+(%)
Cornwall & IOS	73.2	84.2
Devon	73.8	84.2
Plymouth	73.4	85.1
Torbay	71.5	86.7
South West	74.2	85.7

[11] Only records with a vaccination date between 1 September 2024 to 23 March 2025 have been included.

[12] An individual's NHS region is derived from the registered GP practice in the NHS Master Patient Index (MPI). The sum of the regions will not equal the England total. This is due to a number of individuals vaccinated in England who are registered to non-English practices or are not currently registered with a GP.

England	73.6	85.6

Efficiency standard 65%

Optimal performance level 75%

Source: hpr0825-ppv-vc-data-tables.xlsx

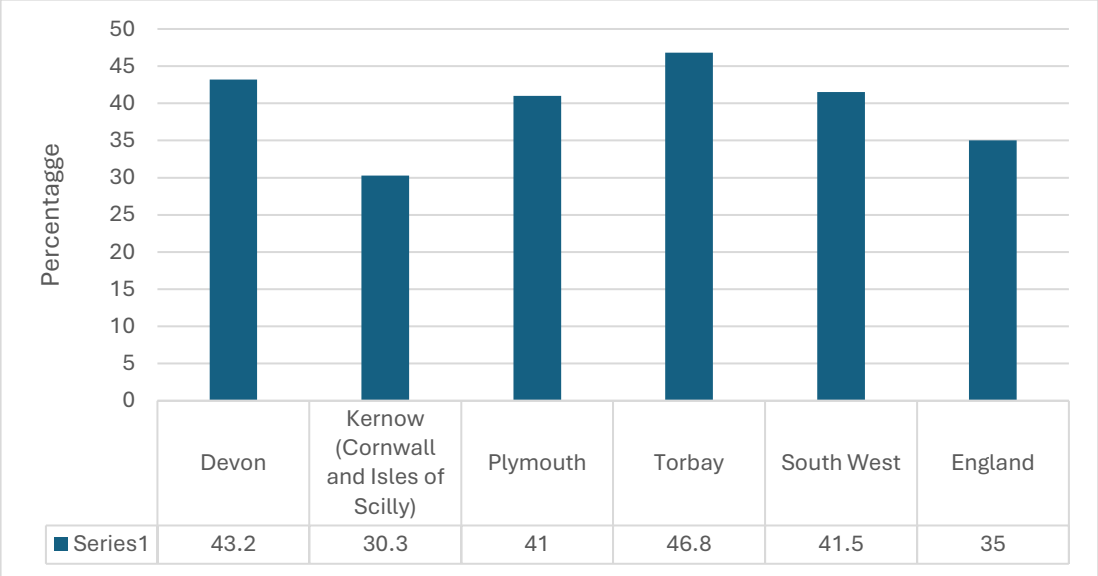
Seasonal vaccinations (2024/25)

Flu

Pregnancy

Seasonal influenza vaccine uptake in GP patients: winter season 2024 to 2025 - GOV.UK

To Note: These data include all women already pregnant or becoming pregnant (in the first, second or third trimesters) as diagnosed by a medical professional from 1 September 2024. Accurately identifying this denominator is challenging and denominators may be regarded as over-inclusive as they may include women that become eligible and then ineligible before they are vaccinated. Vaccine uptake for pregnant women is likely to be underestimated.



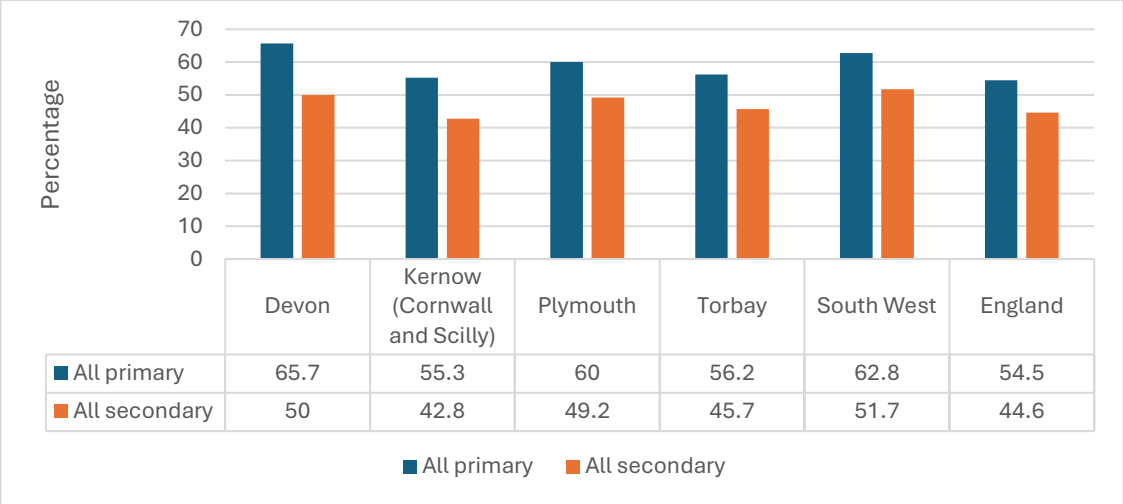
2-3 year olds

seasonal-flu-vaccine-uptake-in-GP-patients-2024-2025-data.ods

Flu vaccination 2024-25	Age 2 combined (%)	Age 3 combined (%)
Kernow (Cornwall and Isles of Scilly)	46.1	45.0
Devon	53.8	56.0
Plymouth	45.1	46.1
Torbay	39.4	42.0
South West	49.7	50.8
England	41.7	43.5

School age

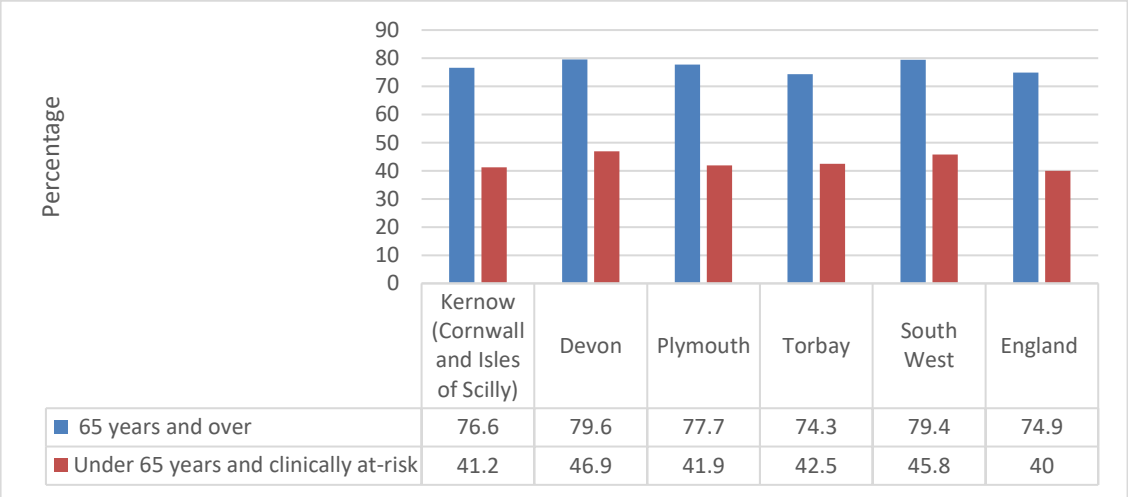
Flu uptake Primary & Secondary School (aged 4 – 16 years), data extracted from Government seasonal child influenza uptake data 2024/25[13]



	Devon	Kernow (Cornwall and Scilly)	Plymouth	Torbay	South West	England
All primary	65.7	55.3	60	56.2	62.8	54.5
All secondary	50	42.8	49.2	45.7	51.7	44.6

Adult Immunisations - Flu vaccination uptake in GP patients over 65 years, data extracted from Government seasonal influenza uptake data 2024/25

seasonal-flu-vaccine-uptake-in-GP-patients-2024-2025-data.ods



	Kernow (Cornwall and Isles of Scilly)	Devon	Plymouth	Torbay	South West	England
65 years and over	76.6	79.6	77.7	74.3	79.4	74.9
Under 65 years and clinically at-risk	41.2	46.9	41.9	42.5	45.8	40

[13] For the Kernow local authority (which comprises Cornwall and the Isles of Scilly), most children were offered the vaccine through school delivery programmes, except for the Isles of Scilly, where the programme was delivered through GPs.

Flu FHCW: Final Autumn 2024/25 Statistics by Trust, NHS Digital cover period 01 September 2024 31 March 2025 Sourced and compiled on 29/08/2025

Title:	Autumn 2024/25 Flu Vaccinations to Frontline Healthcare Workers in England by NHS Trust
Summary:	The number of individuals who are frontline healthcare workers who have had a vaccination for flu in England during the Autumn 2024/25 campaign by NHS Trust.
Period:	1 September 2024 to 31 March 2025
Source:	DPS (Data Processing Service) Direct Flow, NHS England
Basis:	England
Published:	10 July 2025
Status:	Published
Definition:	The data in this release includes all individuals identified as a frontline healthcare worker who could be matched to DPS Direct Flow vaccination data.

Organisation code[3]	Organisation name[3]	Organisation type[3]	Number of frontline healthcare workers	Number of frontline healthcare workers who have had an autumn flu vaccination	Percentage of frontline healthcare workers who have had an autumn flu vaccination
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	Trust	4,572	2,385	52.2%
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	Trust	5,534	2,252	40.7%
RH8	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	Trust	10,176	4,902	48.2%
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	Trust	3,813	1,440	37.8%
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	Trust	6,499	3,004	46.2%
RWV	DEVON PARTNERSHIP NHS TRUST	Trust	2,853	1,382	48.4%

Seasonal influenza vaccine uptake in healthcare workers: winter season 2024 to 2025 - GOV.UK

COVID 19 Autumn

COVID-19 | UKHSA data dashboard

Covid 19 Jan 29 2025)	65-69 years (%)	70-74 years (%)	75-79 years (%)	80+years (%)
Kernow (Cornwall and Isles of Scilly)	57.2	67.0	72.6	75.7
Devon	60.8	69.5	74.2	77.8
Plymouth	52.9	61.4	67.8	71.8
Torbay	49.4	58.6	63.7	68.2
South West	59.6	68.6	73.9	77.0
England	47.8	58.0	65.0	67.6

TORBAY COUNCIL

Meeting: Health and Wellbeing Board **Date:** 4 December 2025

Wards affected: All

Report Title: Health and Wellbeing Board work programme 2026

When does the decision need to be implemented? December 2025

Cabinet Member Contact Details: Hayley Tranter, Cabinet Member Adult & Community Services, Public Health & Inequalities Hayley.Tranter@torbay.gov.uk

Director Contact Details: Lincoln Sargeant, Director of Public Health Lincoln.Sargeant@torbay.gov.uk

Author: Julia Chisnell, Consultant in Public Health, Julia.Chisnell@torbay.gov.uk

1. Purpose of Report.

1.1 The purpose of this report is to share with members the draft Health and Wellbeing Board work programme and meeting schedule for 2026.

2. Reason for Proposal and its benefits

2.1 The work programme of the Health and Wellbeing Board is structured around the statutory responsibilities of the Board. For example, the Board is required to receive and endorse the Joint Strategic Needs Assessment, the Pharmaceutical Needs Assessment and the Joint Health and Wellbeing Strategy, when these are updated.

2.2 The format for the meeting schedule is slightly different this year. Items are divided into:

- Focus items for discussion
- Statutory or policy items for reporting or sign off
- Partners items requiring sign off or visibility to board members
- New policy or strategy

2.3 The draft schedule for 2026 is included at **Appendix 1**. Additional items may be added during the year.

2.4 Partners are asked to ensure any new papers requiring Health and Wellbeing Board approval are notified in advance so they can be added to the forward plan.

2.5 Development workshops (online or in person) are scheduled quarterly in between formal Board meetings. These are designed to enable a more detailed and interactive discussion of key topics. It is proposed these are structured around the Joint Health and Wellbeing Strategy 2026-30 priority areas, in the coming year.

2.6 The Health and Wellbeing Board continues to hold a risk register. Members may raise risks they wish to put forward for inclusion in the register.

3. Recommendation(s) / Proposed Decision

Members are asked to endorse the Health and Wellbeing Board Work Programme for 2026.

4. Financial Opportunities and Implications

None identified

5. Legal Implications

None identified

6. Engagement and Consultation

None

7. Procurement Implications

None identified

8. Protecting our naturally inspiring Bay and tackling Climate Change

The workplan will include papers relating to a range of issues including climate change.

9. Associated Risks

No specific risks are identified.

Appendix 1

Health and Wellbeing Board draft meeting schedule 2026

Meeting quarter	Focus items for discussion	Statutory or policy items for sign off / reporting	Partner items for sign off / visibility*	New policy / strategy**
March	Suicide plan spotlight ⇐ Joint Health & Wellbeing Strategy 2026-30 post consultation document. To agree process for monitoring progress & delivery of priorities. Torbay Housing needs assessment	Torbay / Devon annual suicide plan refresh Annual Torbay Drug & Alcohol Partnership report Torbay Better Care Fund: end of year review & annual plan for 2026/27	Torbay and South Devon NHS Foundation Trust Strategy	Design process for Integrated Neighbourhood health teams
June	Joint Strategic Needs Assessment spotlight ⇐ Joint Health & Wellbeing Strategy – spotlight topic review	Torbay Joint Strategic Needs Assessment Torbay Better Care Fund – quarterly sign off		
September	Joint Health & Wellbeing Strategy – spotlight topic review	Torbay Children's Safeguarding annual report		

Meeting quarter	Focus items for discussion	Statutory or policy items for sign off / reporting	Partner items for sign off / visibility*	New policy / strategy**
	Year round system readiness: annual planning for adverse weather events	Torbay Better Care Fund – quarterly sign off		
December	Annual Report spotlight  Joint Health & Wellbeing Strategy – spotlight topic review	Director of Public Health Annual Report Peninsula Annual Health Protection Report Health and Wellbeing Board work programme – annual forward plan Torbay and Devon Adult Safeguarding Partnership – Annual Report Torbay Better Care Fund – quarterly sign off		

* These items are likely to be requested by partners during the year depending on timetables and policy. For example the ICB Health and Care Strategy.

** Examples would be the NHS 10 Year Plan; Neighbourhood Health.