onenortherndevon

Partners' report

FEBRUARY UPDATE

Person-centred

Place-based

System Co-ordination



2022

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FEB 2022

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ONE NORTHERN DEVON PARTNERSHIP

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THE FLOW APPROACH

Our Flow Programme is our flagship approach to delivering person-centred care that aims to transform the way services support people with multiple or complex needs.

Why needed?

People most in need of support are least likely to receive it. Many describe feeling 'bounced around' services telling their story again & again. People feel distanced from the professionals that support them as they get referred to multiple services.

What is the OND 'Flow' approach?

Flow helps people get the full support they need to help them manage difficult circumstances and traumatic experiences. Rather than referring on, practitioners remain their key supporters and have 'What Matters' conversations that focus on the person's goals and strengths as well as their needs. A plan is developed together and the practitioner 'pulls in' a team with the help of a Flow Co-ordinator so that support 'flows' around them.

Key elements of Flow



Personalised support – not one-size-fits-all



Team approach, including the individual



Pulling in support – not referring on



Understanding what matters



Focussing on goals as well as needs



Co-produce a plan

FLOW PILOT	HIGH FLOW	YOUTH FLOW
The OND Flow pilot focused on service users in one town -Barnstaple	Supported the highest intensity service users across the system	Supported young people to overcome barriers to work

PRIMARY CARE FLOW	COMNITY MENTAL HEALTH FLOW	COMMUNITY FLOW	SECONDARY CARE FLOW
Supporting patients with multiple needs in primary care	Supporting people discharged from mental health wards	Supporting people to access community & voluntary support	Supporting patients with multiple needs in primary care

one northern devon HIGH FLOW

In January 2020, One Northern Devon launched 'High Flow', a personalised and holistic support programme for the 20 most intensive users of public services in Northern Devon. The High Flow programme aims to better meet the needs of these individuals and use the learning to improve the future system response.

01 NUMBERS SUPPORTED

Currently 7 clients are supported by High Flow, In total, 16 people have been accepted onto the programme, 3 didn't engage (2 due to change of circumstances), therefore 13 clients have been supported by the High Flow programme plus co-dependents.

02 KEY ACHIEVEMENTS

Funding has been secured to June 2022 and we continue to seek opportunities to develop the project in the future.

The journey client 12 has made in the time of working with the project has been remarkable and significant. At this stage she awaits therapy, however, has now scored zero for CNA after 18 months of engagement, the case will remain open to ensure that the positive changes and progress made is sustainable.

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Asking partners to contribute to the service
- Expanding High Flow to include a 'step down' service
- Agreeing the process after identifying system failures
- Confirming CCG analyst support
- Renewing the ISA

04 BARRIERS, LEARNING, SUPPORT REQUIRED

Step-down process for high flow clients who will still require support but not at a level provided by the project e.g. community / social support.

HIGH FLOW

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FEB 2022

INPUTS

High Flow Caseworker
High Flow Project Co-ordinator

£48,000 per year

OUTPUTS

JAN 2020 - JAN 2022

General Money Advice/banking x 16
Food Parcel Given x 43
Form Filling x 16
Housing Advice Provided x 24
Welfare benefits advice x 8
Support to find alternative housing x 13
Support to attend medical appts x 62
Support to contact/attend counselling x 21
Support to develop self care skills x 15
Support to manage tenancy/licence x 6
Support to dependent/co-dependent x 50
Improved Devon Home Choice Banding x 1
Contact with Care Co-ordinator x 22
Team Around the Person meetings x 104
Safety Plan completed x 4
Connections/Referrals to statutory services x 53
Connections/Referrals to community services x 18
Support to meet aspirations x 15
Signposted to external agencies x 15
Support to attend dentist/opticians x 2
Support with recovery journey x 14
IT support incl. virtual meetings & emails x 1
Client involved in co-production work x 7
Supported into Accommodation x 5

OUTCOMES

JAN 2020 - JAN 2022

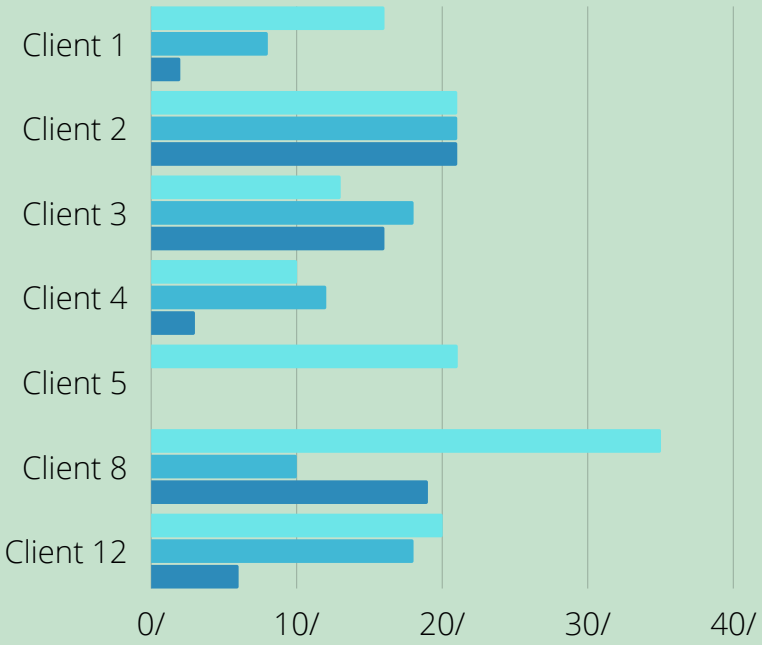
Financial Gain Other x 2
Alternative Housing Secured x 2
Bailiff action prevented x 1
Supported to remain in property x 2
Debt managed x 8
Eviction averted/homelessness prevented x 3
External Health Assessment conducted x 9
Financial gain/charitable payment x 4
Home Care/aids/adaptations obtained x 10
Improved living conditions x 11
Improved engmnt w/Health Services x 46
Improved Family Relationships x 28
Improved social skills/relationships x 3
Improved financial status x 5
Improved life skills x 4
Improved meaningful activities x 17
Improved motivation x 30
Improved personal hygiene x 4
Increased Independence x 7
Appropriately engaging with GP x 20
Successful court action x 1
Moved into employment x 2
Client to own action to address issue x 35
Community activity achieved x 2
Client/dependent supported to live safely x 6

>>> EXIT STRATEGY

Funding is now secured to March 2024 through iBCF funds. The High Flow evaluation report has been circulated to all partners to ask for contributions to a step-down service which will allow more capacity in the High Flow cohort.

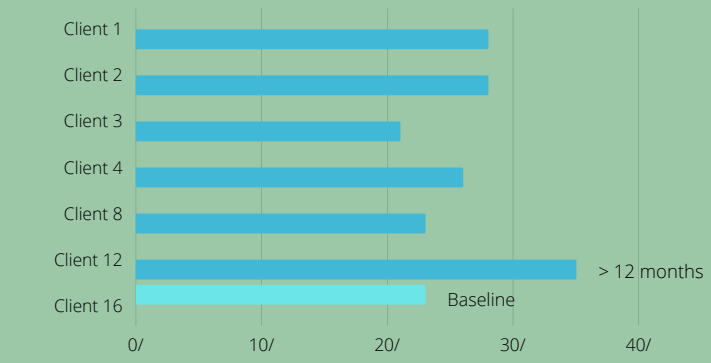
OTHER RESULTS

COMPLEX NEEDS ASSESSMENTS



There has been an average 11.5 point reduction in the complex needs of the clients on the programme. The complex needs assessment shows a high correlation with demand.

PERSONAL OUTCOME EVALUATION



1. In general, I feel I am in charge of the situation in which I live
2. I have a sense of direction and purpose in life
3. In general, I feel confident and positive about myself
4. I often feel overwhelmed by my responsibilities
5. I feel that my personal circumstances are understood by the relevant services
6. I feel supported by relevant services to meet my goals

1= STRONGLY DISAGREE, 6 = STRONGLY AGREE

Personal outcome measures were not recorded at the start of the project due to the complexity and number of questions being asked. New measures have now been agreed and are being recorded but we are unable yet to measure personal scores from the baseline position.

"We need to demonstrate to everyone – not least the critical minds of the Treasury – where improvements are taking place and how they are delivering efficiencies as well as improving health outcomes.
The good news is that much is already happening up and down the country.
Take for example the High Flow project in Northern Devon which has brought agencies together to reduce A&E demand among those with complex and multiple needs.
Matthew Taylor, Chief Executive, NHS Confederation

IMPACT ON SERVICES

Cost saving across all services when comparing pre-project demand to current demand is:

£101,487

HIGH FLOW // CASE STUDY

"How can so many bad things happen to one person? But I am so glad you are here to support me. I honestly think I would have curled up and died by now if you were not there. You do a fantastic job with a 'difficult' person [I do know me!]"

You will never know how much I appreciate what you do for me - I have been close to the edge [dying, not relapsing] several times and you have been there in the nick of time.



''Miriam' is a woman in her early 60s who has suffered multiple traumas throughout her life and experiences severe PTSD symptoms from a horrific attack whilst serving in the military. She was referred into High Flow by Devon Partnership Trust being well known to their services along with primary and secondary care.

Miriam is a recovering alcoholic - dry for 8 years but addicted to codeine which she purchases over-the-counter or online.

The TAP was initially convened in December 2021 and has involved the High Flow Caseworker, the GP, DPT Care Coordinator, DPT Housing Support and NDC Housing Officer, Together Drug and Alcohol worker.

Actions are instigated and shared out amongst the team including Miriam. These are mainly aimed at supporting the appropriate use of her medication and looking for housing as she has been served a 'notice to quit'

Miriam has been nothing short of remarkable in fully engaging in her recovery since her last admissions into hospital following a phone conversation with then HFCW where she disclosed a suicide plan. The HFCW managed an admission in a fast and supported way so she suffered as little distress as possible. Whilst on the ward she felt able to disclose, and in turn face, her addiction to over-the- counter drugs. This was a turning point for her. Since then she has been fully engaged with the drug and alcohol service who became part of the TAP. Her improved stabilization has resulted in her being able to access mental health services in such a consistent way she has now been placed on the waiting list for therapy.

During this time, Miriam had to face eviction from her home of 8 years (due to her landlady selling). This had a significant negative effect for several months. The support of the TAP was critical as the client was at continual high risk of relapse & high risk of suicide.

HF funding enabled Miriam to collect her prescribed substitute medication from drug services which she has to do in person so that it can be supervised by the pharmacist. Miriam has now moved into a social housing property for over 55's. Drug and alcohol services are now able to look at a reduction plan and she has accepted a referral to Positive People programme as she wishes to look at how she may be able to work back towards employment.

PRIMARY CARE FLOW //

FEB 2022



Primary Care Flow is testing whether the Flow model can work further upstream in a more preventative and targeted way, utilising our existing workforce to provide a more person-centred and joined-up approach. There is no dedicated support worker for patients, instead a Flow Co-ordinator supports professionals to join up support so that it flows around the individual and addresses what matters.

01 PROJECT STAGE

Prototype 1 completed with 3 patients and 3 GPs
Prototype 2 initiated with further patient, further 2 patients/GPs being recruited

02 DESCRIPTION

Lead professional has 'What Matters' conversation with patient in the context of their circumstances, relationships and past experiences. The patient identifies their goals, alongside what helps and what prevents them achieving them. A 'Team around the Person' (TAP) is formed by the Flow Co-ordinator to support the patient with their individual needs from any relevant service from all sectors including the voluntary and community sector through the 'One Communities'.

03 COHORT DESCRIPTION

Aged 20-44 AND [depression OR anxiety OR autism OR learning disability] AND obesity AND living in LSOA with lowest deprivation quintile.
Cohort was chosen as thought to have markers of current and future mental and physical health problems and significant exposure to social determinants of poor health. Younger age group selected as a 'way in' to families/households and exposure to adverse social determinants increased by COVID-19

04 RATIONALE

Increasingly patients present to primary care with mental health problems, medically unexplained symptoms, chronic pain and polypharmacy. Although attending with health presentations, factors contributing to these are often not biomedical but social and frequently underpinned by adverse life experiences. Even though their needs would be better served by other services, we have insufficient time or knowledge to link with those agencies. Patients with multiple needs bounce from one service to another - repeating their story time and again and never getting their underlying needs met. Primary Care Flow provides the tools and roles needed to deliver patient-centred care.

PRIMARY CARE FLOW //

FEB 2022

INPUTS

Flow Co-ordinator (p/t)
Lead professional time for
What Matters conversations

£20,000 per year



OUTPUTS

JAN 2021 - JAN 2022

Patients referred into service x 5
Primary care professionals referring x 4
What Matters conversations with Lead Professional x 7
Cases concluded successfully x 1
Flow debrief meetings x 7
Referrals to statutory services x 5
Connected with community developer x 4
Food Parcel Given x 1
Housing Advice Provided x 2
Support to contact and attend counselling appointments x 2
Support to Manage Tenancy/Licence x 1
Support with children x 1
Support working towards goals and aspirations x 5
Team Around the Person Meeting Conducted x 19
Support to contact or attend counselling appointments x 2
Referral to Pain Team x 2
Community around the Person interventions (in person) x 2
Community around the Person interventions (virtual) x 5
Connected to Social Prescriber x 4
Charitable support x 2
Help gaining voluntary work x 1
Referral to MASH/NDADA x 2
Support with children x 1
GP Flow Debrief meeting x 6
GP specialist referrals x 3
GP individual WMTM conversations x 7
Client Satisfaction Forms completed x 7
Patient Interviews completed x 7
Primary Care Flow Patient Leadership meetings x 4
Professionals attending trauma-informed training x 3

Project outputs:
Flow Toolkit for Primary Care devised
Primary Care Flow Pack developed, roles defined
Training for GPs for 'trauma informed' conversations



OUTCOMES

JAN 2021 - JAN 2022

Client involved in co-production work x 3
Financial Gain/Charitable payment x 2 (laptops)
Improved Family Relationships x 1
Improved meaningful activities x 5
Entered employment x 1
Improved motivation x 2
Increased independence x 1
Earlier medical diagnosis x 1
Improved child wellbeing x 1
Increased physical activity x 4
Increased physical safety x 1
Alternative housing secured x 1
Community activity achieved x 4
Client took own action to address an issue x 4
Client/dependent supported to live safely x2

4 x clients going swimming
1 x client going to the gym
1 x client attending community activity (beach clean)
1 x client supported to address damp & mould in house, become sole occupier, house-swap, debt and compensation
1 x undiagnosed long term condition identified and treated

GPs reported a significant increase in:

- understanding the circumstances affecting the health of their patient;
- knowing what is important to them;
- being able to support their patient with non-medical issues affecting their health,
- and in satisfaction with their patient consultation (6-point scaling questions)

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>>> EXIT STRATEGY

A further year's funding has been agreed with the four PCNs to pilot Primary Care Flow across Northern Devon. The pilot will aim to test both the effectiveness, efficiency and scalability of the model.

PRIMARY CARE FLOW // CASE STUDY

I'm really pleased about it (Flow), (previously) I had all sorts of different conversations with different people about me and my sons and it gets very confusing. There's not enough time when you go into the doctors.... (Flow) made me feel that I am important. Which I've never really felt – I had an abusive childhood and that's how it made me feel - Sue



I feel her life has changed. And that for me has been amazing - Sue's GP

'"Sue" is in her 50s and lives in social housing with her two adult sons. Her grandson lived in a chaotic household with his mother and Sue was concerned for his safety and wanted him to live with them. Sue's other son lived on her sofa - she wanted him to find alternate accommodation.

Sue experienced an abusive childhood. She struggles with persistent pain, has swelling in her legs and finds it difficult to get around. She has Type 2 diabetes, and memory lapses. Sue says "it how it is" and has a good sense of humour but her life is incredibly complicated and overwhelming.

Sue's GP had a 'What Matters' conversation with her to start to identify what was most important to her. The only thing that mattered was her grandson and "not to die". The Flow Coordinator noted that Sue had enjoyed swimming before lockdown as well as doing things with her grandson and this seemed a good place to start with a small Team around the Person (TAP) meeting. Sue has now had six TAPs.

Progress has been made in a number of the areas that were highlighted as important through the TAP meetings.

Sue wanted to ensure that her grandson was safe and ideally wanted him to live with Sue and her son. Through a MASH referral Sue and her son now have the grandson placed and living with them.

The team have discussed the next steps for finding alternative accommodation for her son who lives on her sofa but this continues to be difficult. Sue has a wonderful GP is looking to have a three-way conversation with Sue and her son to see if they consider Primary Care Flow for her son individually.

Sue is now a member of a swimming pool where she goes with her grandson and found this eased her pain. The Flow Coordinator has supported a referral to CDP in order to start with an OT assessment and connected her to Navigate who have now made contact so that Sue has the right benefits in place to support her grandson.

The Persistent Pain Team attended a TAP to discuss her pain and next steps. The PCN Community Connector is now helping Sue fill in forms and offer some ongoing one-to-one support.

COMMUNITY MENTAL HEALTH FLOW //

AUG 2021



The Community Mental Health Flow service bridges the gap between inpatient care and community support and facilitates more timely and effective discharges by providing enhanced support for people as they continue their recovery in the community.

01

KEY OBJECTIVES

Help clients achieve recovery goals

Support with managing benefits handling, personal budgets and finance advice

Facilitate opportunities for educational, work-related and social activities

Work alongside clinical details of treatment and support plan

Help to secure and maintain housing

02

NUMBERS SUPPORTED

10 clients referred into the service since start

4 current clients

0 clients waiting to start/consent

42 visits/sessions held with clients

7 introductory visits made to clients on ward

03

KEY ACHIEVEMENTS

Telephone calls to CCO more effective than emails

Met Sector B Team virtually

04

BARRIERS, LEARNING, SUPPORT REQUIRED

Lack of internet access to wards (Ruby now got a form)

Lack of returned feedback/evaluation forms

COMMUNITY MENTAL HEALTH FLOW // SEP 2021

INPUTS

CMHF Navigator

£46,500 per year

OUTPUTS

MAR 2021 - SEP 2021

No. of What Matters conversations held with clients: **10**
No. of face to face or virtual visits to clients**: 42**
No. of pre-visit calls to clients**: 7**
No. self-care boxes completed: **1**
No. safety plans completed: **3**
No. connections made to community services this month: **34**

- Healthy Active Lifestyle Services
- Wellbeing Services
- Mental health services
- Referrals to Community Developer
- Referrals to Money Advice Services
- Loneliness services
- Food and nutrition services
- Personal support (care) services
- Home safety checks
- Fuel poverty
- Referrals to Social Prescriber

Number of connections/onward referrals to statutory services this month: **41**

- Community mental health teams
- Community nursing team
- Personal support (social) services
- GP services
- Housing services
- Social services (adult team)

No. TAPs held x **7**
No. CAPs held x **3**
No. Client Satisfaction forms completed **x 4**

OUTCOMES

JAN 2020 -SEP 2021

	Client 1	Client 2	Client 3
Do you feel calmer with your current situation at home since engaging with the service?	3-4 ~~yes~~ it has been good and been a good distraction, however I still have lots of things to work through.	5	4
Do you feel you are managing your mental health needs in a safer way?	3-4 I feel like it has been a good distraction for me.	5	5 Strongly agree – I think I am managing them safer
Do you feel you have a clearer understanding of where future is heading?	I did know about learning direct courses, but I was never supported to do it until I enrol within the Community Mental Health Project.	4	N/a Question removed from survey
Do you feel supported with finances/debt management since the service?	I never needed this service	4	N/a
Do you have a clearer understanding of what is available for you within the community?	We are still working on my goals and aspirations, but I have since signed up to a learning direct course and sourced myself a laptop to be able to do the 'craft your way to recovery'. It's been really helpful talking to someone, and when I had a meeting with the police Ruby really supported me with this and helped with my anxiety before the interview.	5	4 Agree – it is happening in a natural way
Have we met your needs/goals and aspirations we identified in your What Matters to Me conversation?	New Question	New Question	Neither agree or disagree, I didn't have any goals and aspirations starting the course but with Ruby's support, I have found myself naturally identifying interests and being able to find a bit of space for them.
Have you felt supported from The community Mental Health Flow team?	Very, I have even sent an email of gratification to the DPT ward for linking me with Community Mental Health project and Ruby.	5	Yes, Ruby has been the only person there through the transitions for me on a social level and has come each week, has supported me to stay alive, helped me believe in life again, her chats with me have been so helpful.

NB. It is difficult to include patient outcomes such as stable housing and work as the CMHF Navigator only works with patients in the first few weeks after discharge.

>>> EXIT STRATEGY

Funding has now been secured for this role through DPT to April 2023.

COMMUNITY MENTAL HEALTH FLOW // CASE STUDY

"Thanks for the support and involvement with Sophie's recovery journey, I feel confident that she is well equipped prior to discharge."

- DPT Ward Consultant



Sophie was still on the mental health ward when she was referred to the Community Mental Health Flow Navigator. She had a personality disorder diagnosis and had previous admissions.

Sophie lives in her own home with her child, however her parents managed her finances, bills and the majority of Sophie's daily life. Sophie lacked independence, social engagement and meaningful activities that brought any form of joy to her life.

The Navigator met with Sophie on the ward and had a What Matters conversation. Sophie felt she needed support to be more independent to manage money and integrate into the community. She was also interested in horticulture.

The Navigator connected Sophie with Community Developers and did research on what was available in the community. She presented 3 horticultural options, supported with enrolments to Devon Learning online hub to access courses. The navigator made a onward referral into Wiser Money and connected Sophie with Christians against Poverty to attend a life skills course supporting her with basic life skills including money management and daily living.

Sophie and the Navigator explored community options from art classes, horse agriculture schemes, meeting groups in the community and Flourish in Nature. Sophie was keen to explore these options post discharge but didn't feel ready to make initial contact so the Navigator supported her with all IT/Telephone work.

The client was given a Package of Care, and had a date for discharge. The Navigator attended the discharge meeting and handed over all the information and findings of community connections to the client's package of care coordinator, who said they would support Sophie with enrolment going forward.

COMMUNITY FLOW

// AUG 2021



OND Community Flow aims to provide better access to community support and includes the Home from Hospital & Connecting with Communities projects. Main aims are to ensure:

1. Patients leaving hospital have practical & emotional support to settle at home & avoid unnecessary re-admission.

2. People identified by clinicians receive the non-medical support they need in order to reduce unnecessary medical interactions.

01 NUMBERS SUPPORTED

36 people have been referred into the Community Flow service to date

02 KEY ACHIEVEMENTS

Secured iBCF funding to support CD role within CAP.
Setting up a SLA with TTVS so that 3rd party delivery partners can recruit, induct, train, coordinate volunteers.
Tier 1 - now part of comprehensive discharge support plan

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

Recruiting Community Manager
Recruiting Community Flow Co-ordinator
Engagement with NDDH wards and SPOA to raise profile

04 BARRIERS, LEARNING, SUPPORT REQUIRED

Getting referrals - we need to develop better contacts within the hospital wards and SPoA. Have joined RnR huddles but most of their patients appear to have regulated care needs and the few that have mentioned Community Flow have not sent referral forms

COMMUNITY FLOW // FEB 2022

INPUTS

1.1 FTE Community Flow Manager

£51,500 per year

AIM 1 (Home from Hospital):

Objective 1: NDHT staff understand the benefits and are referring into the HfH service
KPIs:
• 130 referrals in 1st 6 months & every 6 months thereafter
• 95% of referrers would be 'likely' or 'very likely' to use the service again
• 95% of referrers would be 'likely' or 'very likely' to recommend this service to a colleague
• 85% of referrers felt more comfortable discharging the patient knowing this service was being provided

Objective 2: Patients receive a 'Settle at Home' visit from a volunteer within 24 hours of discharge
KPIs:
• 35 volunteers fully recruited, inducted and insured within 6 months
• 35 volunteers maintained on volunteer database every 6 months
• Risk assessment and SOP approved by NDHT governance and reviewed every 6 months.
• 260 patient visits in 1st 6 months & every 6 months thereafter
• 100% patient outcome logs returned to original referrer

Objective 3: Patient feels more supported the first few days after discharge from hospital
KPIs:
• 90% of patients felt more supported practically than they would have without the visit
• 90% of patients felt more supported emotionally that they would have without the visit
• 90% of needs identified matched with appropriate support where this is available

AIM 2 (Connecting with Communities):

Objective 1: NDHT, Community Health & Social Care, DPT, Primary Care, SWAST & Independent Care Sector staff understand the benefits and are referring into the Connecting with Communities service
KPIs:
• 260 referrals in first 6 months and every 6 months thereafter
• 520 patient visits in first 6 months and every 6 months thereafter
• 100% patient outcome logs returned to original referrer
• 95% of referrers were 'likely' or 'very likely' to recommend this service to a colleague

Objective 2: To create better connections to non-medical support for people within our communities
KPIs:
• 90% of patients felt their wider needs were understood
• 90% of patients felt supported to meet their wider needs
• 80% of patients felt their wider needs were met
• 90% of needs identified matched with appropriate support where this is available

Objective 3: To understand gaps in provision so that this can be passed back to the relevant One Community
KPIs:
• 100% of gaps identified passed to relevant Community Developer to consider how these could be filled
• 50% of gaps identified are being actively developed by the Community Developers

Outputs and Outcomes

To date:

Total NDHT volunteers recruited, inducted x 24

NDHT Volunteers currently active x 14

NDHT Volunteers awaiting induction x 5

NDHT Volunteers withdrawn x 5

Referrals into Settle/Support at Home service x 36

Home visits to patients x 16

Phone calls to patients x 23

'Community around the Person' interventions x 1

Volunteer checklists completed x 8

Discharge issues raised with ward x 1 (medication)

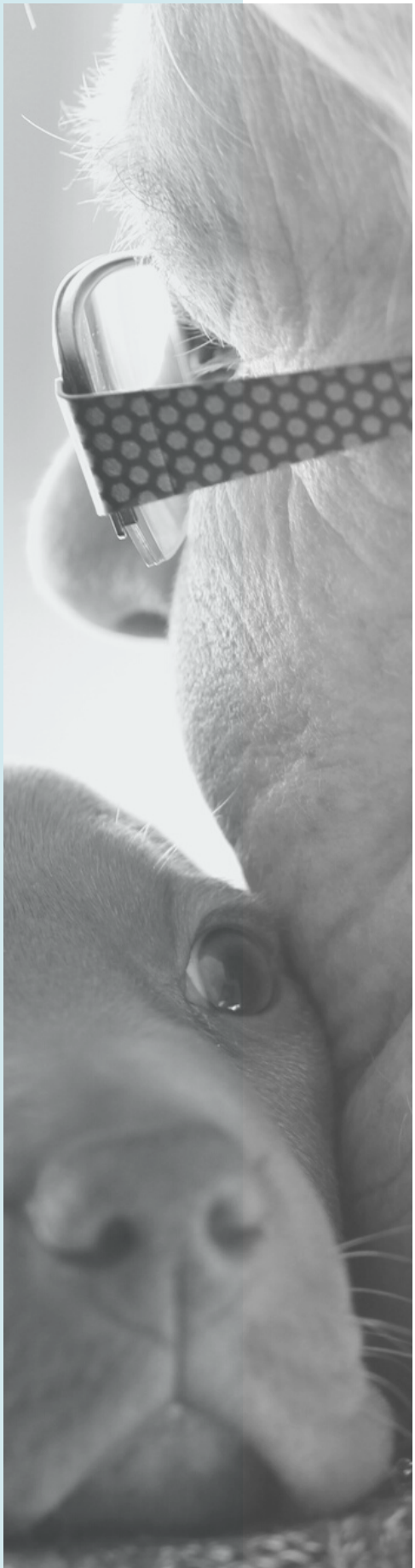
Signposting to community activities x 1

Connections made to statutory support x 3

Connections made to voluntary support x 1

>>> EXIT STRATEGY

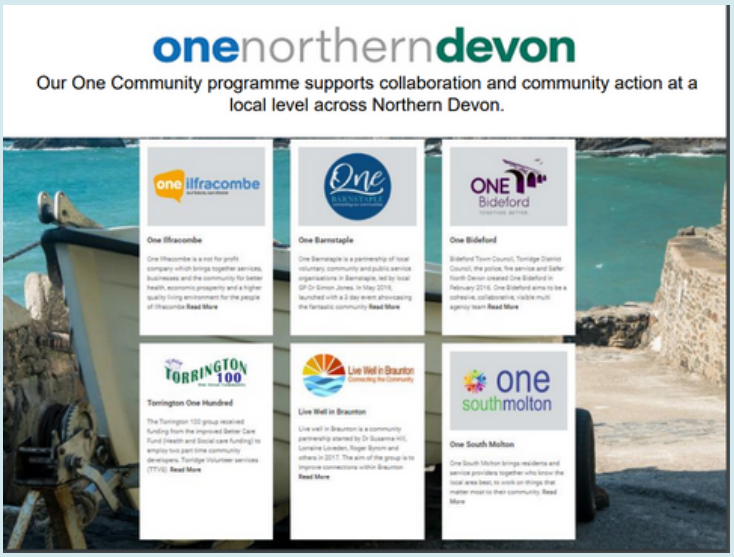
Funding is secured to August 2023 for the Home from Hospital Service from NHS Charities Together funding



Harriet is in her late 70's and was referred into the Home from Hospital service in April 2021. A Settle at Home volunteer visited her at home to help her settle back in at home. The volunteer identified that she needed help with her weekly shopping and support with housing as she wishes to move to a ground floor flat as her mobility is declining. She struggles to get up and down the large concrete stairs to and from her flat by herself. She also wanted help with her dog (who is 15) due to the struggle with the stairs.

Ongoing voluntary support from a local community group was found for Harriet, which enabled a volunteer to visit her and make sure she is ok, helping her with anything she needs, collecting her pension, shopping etc. The local volunteer group have now provided a dog walking provision for Harriet, since May 2021, and ongoing volunteer support from the Cinnamon Trust, to walk her dog every evening, was organised. The community group volunteer felt that Harriet needed further support and helped organise a chaperone with a friend and a car from a local Community Car Scheme which enabled Harriet to be chaperoned to and from her hospital appointment.

Finally, a referral was made to Care Direct who have signposted Harriet to North Devon Council Housing for ongoing support to locate her a ground floor flat. The CAP intervention consisted of ongoing email contact with the volunteer and phone contact with the patient and volunteer. The patient feedback highlighted that Harriet felt more supported practically and emotionally than she would have without the volunteer visit/call and that her wider needs were understood and supported. Not only did this service make leaving hospital and coming home easier but her but she would recommend this service to others leaving hospital and feels better able to access community and statutory support as a result of the service.

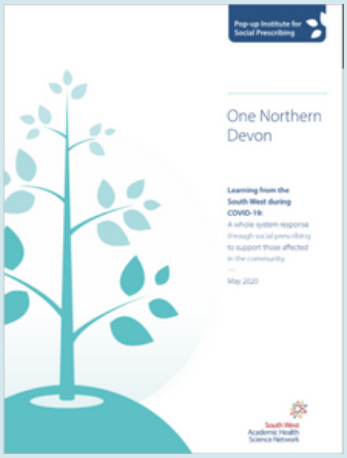


Community Developers play a vital role in the One Communities in building resilience and responding to emergencies

The One Community infrastructure and One Community Developers were a vital part of Northern Devon's Community Covid response in 2020.

The SWAHSN report on this response can be found here:

https://www.swahsn.com/wp-content/uploads/2020/06/SWAHSN-Social-Prescribing-Case-Study-7_FINAL.pdfding



01 PROGRESS IN OBTAINING INVESTMENT FOR THE COMMUNITY DEVELOPER ROLE 2022/2023

- It was reported at the December 2021 OND meeting that funding for the One Community Developer roles in our seven One Communities ends at the end of March 2022.
- An investment proposal outlining the benefits to all partners in continuing these roles was discussed.
- The cost of the provision per Community Developer is £24,413 per annum or £170,891 per annum in total for all 7 Community developers
- Since then, the following has been committed:
  - £99,000 iBCF
  - £50,000 Public Health

(to continue to fund the Community around the Person approach)

  - £10,000 North Devon Council (in principle)
  - £10,000 Torridge District Council (in principle)

And financial commitments have been obtained from the following town councils:

  - South Molton Town Council
  - Ilfracombe Town Council

The Community Developer roles are therefore safe for the next financial year. Thank you to partners for your support of this role which plays a vital part in the prevention agenda.

The outputs and outcomes described on the following pages are testament to the hard work of the Community Developers.

one ilfracombe
our future, our choice

Community priorities:

The priorities identified by One Ilfracombe following engagement with Ilfracombe residents and considering the local public health data are:

- Increasing life expectancy
- Enabling older people to remain independent longer
- Helping our young people to reach their potential
- Increased growth of local business
- More Ilfracombe residents in work
- Improving town image
- More residents feeling proud

Chair: Cllr Rod Donovan
Community Developer: Charmain Lovett



MAR 2021 - JAN 2022/2021

OUTCOMES FOR PREVIOUS YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
SEA SWIMMING TRAINING	Funding to hire a sea swimming coach to help build confidence &improve safety	Over 60 swimmers now trained in sea swimming	Chill UK, Rapparee Swimmers, Active Devon
ACTIVE ILFRACOMBE ONLINE	Created video library	Weekly live online exercise sessions	Active Devon, Sam Courton Personal Training
OUT OF THE BLUE CADETS	Over 100 students have participated over 3 years	Ilfracombe Academy & parent feedback: Improved attendance at school, better attitude, more confidence	Fire & Rescue, Police, RNLI, SWAST, Ilfracombe Academy
COMMUNITY FLOW	Home from hospital pilot & signposting	Signposted to community assets	Combe Coastal PCN, Lyn Health, Northern Devon Healthcare Trust
MEN'S SHED	Obtained funding, orders of materials, connects with other community support	20 regular members, increased confidence, improved activity level & multiple community projects	Cllr Paul Crabb, Chocolate Emporiam, District Lions, Junior School, Rugby Club, NDC, Straw Patch CIC
PARK YOGA	Organisation of free park yoga	40 people attend weekly over 5 months	Park Yoga, Community Yoga project CIC, Ilfracombe Football Club, Active Devon
ILFRACOMBE YOUTH GYM/OPENING DOORS	Funding of £2800 for equipment and running costs.	20 young people from lower income families, becoming more active and building confidence	Active Devon Studio 20 Devon & Cornwall Police
LIVING WELL MEETING	monthly meeting of people/organisations to focus on H&W of Ilfracombe residents	Organisations feel more connected. Brilliant networking opportunity. Knowledge sharing. Keeping up to date with local projects.	35+ cross-sector partners
ASSET MAPPING	Updating asset spreadsheer Online web directory	useful signposting tool for the Community Connectors and wider community	n/a
RETURN TO ACTIVITY PROJECT	15 Pilates/Qigong attendees	Supporting building people's confidence in getting back into activity post-covid	Body Aware Pilates Active Devon
SEA SWIMMING TRAINING	Secured Funding to hire a sea swimming coach Over 60 swimmers trained in sea safety	help build confidence and improve safety	Chill UK Raperee Swimmers Active Devon
OUTDOOR MENTAL HEALTH SUPPORT FOR OLDER PEOPLE	Secured £950 of Funding for North Devon Homes referrals	16 older NDH residents improving their well being	Active Devon Studio 20 Devon & Cornwall Police

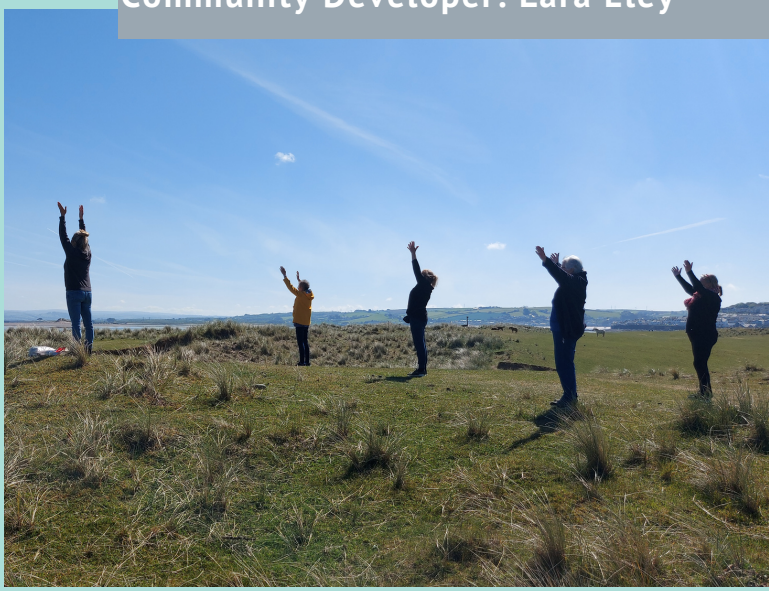
OneAtlantic

Community priorities:

The priorities identified by One Atlantic following engagement with local residents and considering the local public health data are:

- Increase the health & wellbeing of our communities in Bideford and surrounding areas
- Work closely with our local social prescribing team to identify the needs of the community and develop projects to meet these needs.
- Use our community engagement to identify projects such as mental health issues and physical activity need and work together to develop projects.

Chair: Dr Ruth Tapsall
Community Developer: Lara Eley



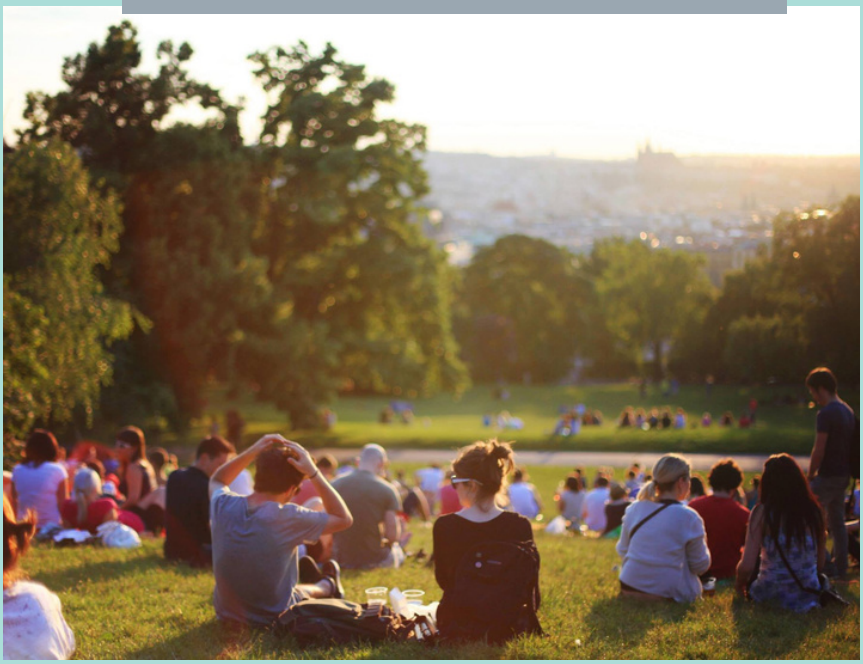
MAR 2021 - JAN 2022/2021

OUTCOMES FOR PREVIOUS YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
TTVS Velocity	recruiting 3rd sector groups/organisations for Digital training	Evaluation in June 2022	Cosmic CIC TTVS
Healthy Cooking classes	4 older adults attending a pilot 5 weeks (need identified by SP) Local GP shaped recipes	Learn Devon Evaluation available in March 2022	Social Prescribers Learn Devon
OND Healthy Ageing in Northern Devon	Healthy cooking class and the arts and wellbeing project Asset mapping	Evaluation in March 2022	OND multi-partner steering group
OND Arts & Culture, Health and Wellbeing	Participants chose artist Sourcing participants from healthcare, ongoing project man.	Evaluation in March 2022	OND multi-partner steering group
OND Mental Health Survey	35 responses in the EX39 area	results were used to develop OND Arts & Culture, Health and Wellbeing project	n/a
Mindful Walk and Yoga	5 ladies attended (100% attendance)	rated 9/10 for enjoyment, social aspect, relaxation	Bideford Yoga Active Devon (funder) TDC
Gentle Yoga Course - for older people / new to yoga	6 week online course 7 attendees	found it very beneficial for their wellbeing and loved it.	Bideford yoga Torridge Social Prescribers
Activity Vouchers	Funded 10 football vouchers for families struggling financially and 6 horse-riding for students	Youths have been able to continue to play and enjoy football improved behaviour and confidence at school	Follyfoot riding school Bideford AFC Youth Bideford College Active Devon
Asset mapping	map of provisions (beyond the food bank	see OND food report	Devon Community Foundation

One BARNSTAPLE
connecting our communities

Chair: Louise Flagg
Community Developer: Ella McCann



The priorities identified by One Barnstaple following engagement with Barnstaple residents and considering the local public health data are:

1. Funding and future planning
2. Create a local Mental Health Network
3. Create a volunteer bank
4. A connected community
5. A physical community hub
6. Media and Comms coordination
7. To become a food network
8. A virtual hub

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
12 Week PCN leisure & activity taster sessions	Programme of 12 sessions created with multiple partners - CD organised, advertised, facilitated	Participant feedback has highlighted changes in behavioural, psychological and physical health and wellbeing. Has also lead to increased membership with local community groups. See session by session report for more detailed outcome/outputs and Interim report for full details	Active Devon Queens theatre, Exmoor National Park, Devon libraries, tennis centre and more
Virtual Hub (priority 8)	DCC funded ' Groop' online platform to increase integration and collaboration Organise meetings and One Community communications	80+ Active members 58 organisations Living Options Devon have been supported to set up their own Groop for beneficiaries and volunteers	Devon County Council NDVS
OB Mental Health Network (priority 2)	Set up an interactive google map for professionals (2020), superseded by 'Adoddle' interactive map (2021) Exploring use of 'Devon-Connect' platform with NDVS	'Clarity counselling' harnessed this information to apply for for bids and approach potential partners	Learn Devon, Fern Centre, Clarity counselling, Survivors Alliance NDVS, Early Nourishment CIC, One Small Step, Co-op member pioneer, DPT, Recovery Devon
Connected Communities	Supporting research to capture reflections of experience of recruitment/retention of autistic/anxious staff		Petroc Waymakers CIC
Volunteer bank (priority 3): Covid Isolation response	Volunteer bank development and support - Draft proposal in development. Sourcing potential partners '	Recruited 'local notice board champions	Barnstaple Town Council North Devon Council NDVS

TORRINGTON 100
One Great Community

Chair: Annemarie Shillito
Community Developer: Martin Rawle

Community priorities:

The priorities identified by Torrington 100 following engagement with residents and considering the local public health data are:

- Create a forum that allows all local stakeholders to have a say in the continuing development of their community, related to wellbeing involving: Residents and the public, voluntary, community & private sectors
- Be part of the wider Devon Integrated Care System (ICS) and in particular One Northern Devon
- Build Community Capacity by delivering sustainable activities, projects and services to meet peoples' needs.



PROJECT	OUTPUTS	OUTCOMES	PARTNERS
CAMERADOS	Youth focus via a pop-up launch at the food Festival 25/3/22.	Pop-up 'living room' on 5/3/22 at the Pavilion Castle Gardens	1 Camerado volunteer Torrington Food and Craft Fair Pavilion Castle Gardens
OND Arts, Culture and Wellbeing	£500 funding secured to reach young carers - The full programme at The Plough for Carers Day (25 March 2022) is fully scoped	A co-created workshop to shape future creative sessions for carers	The Plough Arts Centre, artists, Devon Carers and a panel of individual carers
TTVS Velocity	promoting a digital development for local voluntary organisations		Cosmic TTVS
OND Healthy Ageing in Northern Devon (HAND)			
Ring and Ride service	Supported setup and posted Facebook advertising to re-established an old service for outlying villages	2 Volunteers recruited to run the service. 5 passengers on early December route	
Directory of Services	Collating local activities/services for asset mapping and public use	Online Directory 222 local services across 20 categories	n/a
OND Community Flow	3 volunteers recruited for NDHT (Home from Hospital) Supporting CAPs as a conduit for individuals wishing to Connect with their Community	CD case study example	NDHT TTVS OND
Community Fayre	Manged setup, secured funding, donations and refreshments. Promoted online, radio, newspapers	Event held 2/11/21: 321 attended - 36 organisations, 251 residents See case study See Evaluation report see Local press report	

HOLSWORTHY & DISTRICT COMMUNITY FORUM

Chair: Geoff Cusick
Community Developer: Bridget Cordory



Community priorities:

Community Engagement underway, which, alongside joint strategic needs assessment data for Holsworthy will form the aims and objectives for HCDF.

The Forum will meet as often as it needs to develop and implement local action plans based on their needs and assets.
It will assess it needs through:

- Engaging residents and businesses
- Understanding their public health needs using the Joint Strategic Needs Assessment (Devon County Council)
- Engaging local service providers

We will develop a joint action plan to meet these needs

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
TTVS Velocity Digital training	Promoting Training schedule to local voluntary/community organisations		TTVS Cosmic
OND Community Flow	3 NDHT volunteers recruited		TTVS OND NDHT
Community Engagement	Survey 2022 Online and paper survey - Results published March 2022 Coffee morning 27 attendees, 24 survey responses	To Update list of priorities / areas of focus based on recent results - supports a joint 2022/23 action plan (with TTVS)	TTVS
Walk and Talk promotional Event	3 people attended the event on 28th May 2021	Reduced social isolation (short term pilot)	Active Devon
Asset Mapping	Created database spreadsheet for TTVS	Database is used by social prescribers Coast & Country PCN	TTVS Coast & Country PCN
Energy Poverty Event	Focusing on providing help and support with cost of living issues	Event 10/4/22 13:30 - 1700	361 Energy
Community Fridge	Agreeing food waste collection and gathering local funding. Volunteer recruitment begins February 2022. Venue organised (library)	In development - Evaluation will be undertaken by steering group	Devon County Council Food waste team, Mother Elizabeth, Melissa Trudgill, Derrick Brett (Dartmoor Multi-Academy Trust) Holsworthy Town Council and Library, Tavistock Community Fridge

Live Well in Braunton
Connecting the Community

Chair: Dr Susanna Hill
Community Developer: Sophie Brookes

Community priorities:

Live Well in Braunton is a community resource helping people to live healthier and happier lives. Our aim is to make the village more connected and build social equity across the community'

We are a team of local people who are engaged with most of the voluntary and statutory organisations across Braunton. We support existing projects, help identify gaps within the community and bring people together to fill them. We also work very closely with our local GP Surgery at Caen Medical Centre providing 1 to 1 support for individuals via our social prescriber.



PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Braunton and Communities Forum	Bi-monthly meeting to review local needs and create interventions. 40 + attendees	Organisations feel more connected. Networking opportunity. Knowledge sharing. Keeping update to date with local projects	40+ local organisations
Community Flow	5 NDHT volunteers recruited (3 Active) CAP interventions - from simple signposting to longer more supported work to connect them to what matters to them To look at developing gaps in provision within the community, Promoting services to wider community	Men's Shed was setup to tackle the social isolation gap for older men (identified by social prescriber)	TTVS OND NDHT PCN Caen Medical centre
Asset mapping and directory	Live Well online and paper directory being reviewed and updated post COVID	When complete will be available: Website Socials Library Caen Medical centre	Caen Medical centre
Loneliness: Companion walking pilot	1:1 Companion walks, aim to start clients on a journey to happier more active lives in nature, with a tailored progression pathway to other groups and activities - volunteers recruited Process written Volunteer training completed Pilot underway	Improved Health and Wellbeing See case study and background information direct quotes in the case study. Final report April 2022	North Devon Coast Areas of National Outstanding Beauty Braunton Caen Rotary. LWIB Social Prescriber at Caen Medical Centre, Vista Well being
Braunton and Rural Communities Men's Shed	Braunton Parish Council signed letter of intent, for Mens Shed to use piece of land (subject to planning application) Facebook recruitment - over 100 men showed interested	Expected increase in happiness More focussed and new sense of purpose (Men's Shed Assoc.)	Braunton Parish Council Men's Shed Association
Braunton Arts project	Young people (16-24) who are struggling with their mental health, will attend creative workshops in March.		Arts Council Northern Devon Culture, Healt Wellbeing Case Study Project StudioKIND

onesouthmolton

Chair: Maria Hosegood
Community Developer: Jess Twydall



Community priorities:

The priorities identified by One South Molton following engagement with South Molton residents and considering the local public health data are:

Objectives:

To enable individuals and the South Molton Community to improve and promote their own health and well-being.

To support families and vulnerable members of the community with the effects of the pandemic, including food support

To work closely with the South Molton Social Prescriber to identify community need and develop projects and support to meet these needs

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
OSM Re-launch event	Organised Comms: Voice FM Radio Interview and posters. Gathered stallholders. Community engagement to re-evaluate local priorities	Connecting residents with local services and volunteer opportunities Matching engagement data with JSNA data to update OSM CD priorities	15 local / regional organisations
OND Healthy Ageing in Northern Devon (HAND)	Awarded £2000 for physical and mental health: feelings after pandemic, bereavements, etc. aimed at ageing people, supporting with mental and physical health. Boosting confidence, improving social isolation.	Evaluate in March 2022 Sustainability baseline and evaluation for new project has been set up to assess mental physical and social impact + development of buddy/mentor role.	Simonsbath House Outdoor Centre
Setting up a steering group	Sourced key partners Facilitate meeting	Involved in setting up One South Molton as a not for profit LTD company	
OND Community flow	1 DPT client CAP intervention and signposted to equine therapy sessions. referred 4 people to community transport scheme	Gap filling - Future partnership working with Nature on Prescription programme, to access further funding for equine therapy for other high flow clients and groups working with those in mental health recovery.	NDHT OSM One Barnstaple Equine Echoes
Kickstarter programme	Managing 1 intern for 4hrs per/week	Intern is no longer homeless: rehomed with parents in South Molton And assisting with Community Mapping for local database	Job Centre/ NDVS (funder) YMCA South Molton library South Molton Town Council
Forest bathing	6 referrals to forest bathing via social prescriber Weekly sessions established	Client feedback - less isolated, decreased anxiety, improved mental health. Referrals can now be made from CD and SP	Courage Copse Creatives
OND Arts, Culture and Wellbeing	awarded £1,000 funding for a mural project, set up working group, linked with schools and YMCA	Leading to group activities, then a self-sustaining artists' group	Beaford Arts One South Molton, Local GP Community college, Baptist Church Youth Club YMCA
Peer Support Home Visits - Arts/Wellbeing	Peer support coffee afternoons for people with live experience of mental health at YMCA.	Buddy/mentor system, people referred via community flow, CAP, social prescribers	Arts Destination South Molton YMCA Social Prescriber Community Development Worker OSM

ADDRESSING FUEL POVERTY // FEB 2022



The strength of the OND Fuel Poverty group is its cross-functional, multi-organisational approach to tackling the issue. The team includes members from OND, NDVS, NDHT, NDC, TDC, 361 Energy, North Devon Homes, Fremington Medical Centre, Barnstaple Alliance and Public Health Devon

01 PROGRESS SINCE LAST UPDATE:

- Warmer Homes Adviser, Mel Eyers joined the team at NDVS & 361 Energy in October 2021. A post funded by Energy Redress for two years.

- In the same month, the contract to deliver home energy advice to the recipients of the Disability Facilities Grant from North Devon Council was started.

- 361 Energy have implemented a new CRM system to manage the increased demand for home energy advice.

- New secure referral process implemented making it easier for partners to refer customers directly to 361 Energy .

- A pilot study has been set up between 361 Energy & Fremington Medical Centre, focussing on working together to identify and help patients most at risk of fuel poverty. This is a 3-phase project.

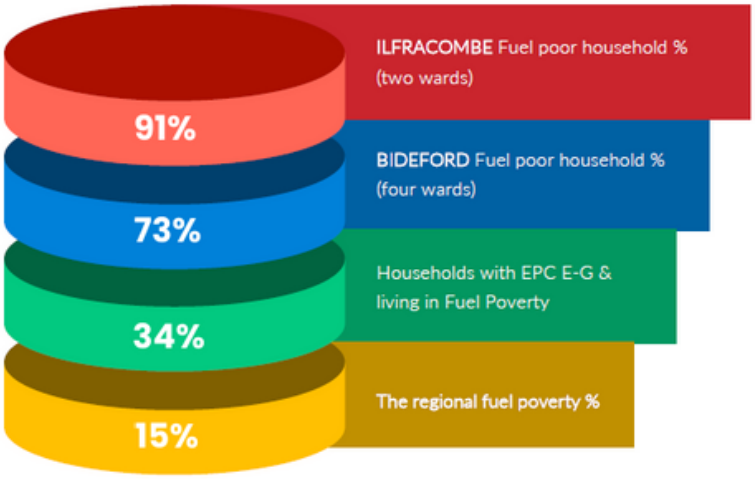
    o **Phase 1:** 361 Energy analysed the home analytics database for households within Fremington wards at risk of fuel poverty (to postcode level). The medical centre compared the list against their records. A letter was sent by the medical centre, to the patients who have health conditions that could be worsened by cold, damp homes & whose postcode was on the vulnerable to fuel poverty list. 500 letters were sent out, 15 people have responded so far. Patients were instructed to contact Fremington Medical Centre to be referred by reception staff.

    o **Phase 2**: Staff will talk to patients directly about fuel poverty and refer directly to 361 Energy (with permission). They're looking into whether they can flag the post codes (that are most at risk of fuel poverty) on their system as a reminder to medical staff to have the discussion if they suspect their patient is experiencing fuel poverty.

    o **Phase 3:** Promotion on 361 Energy service in the waiting rooms. ·

- We're currently working with the Barnstaple Alliance group as part of their mapping project with the South West Academic Health Science Network to expand the Fremington pilot study to the wider Barnstaple area.

02 LOCALITY STATS



ILFRACOMBE
91% of households in East & West Ilfracombe are in the 4th quartile of fuel poverty

BIDEFORD
73% across the house wards of Bideford are in the 4th quartile of fuel poverty

ENERGY PERFORMANCE
34% of fuel poor households also have an EPC rating of E-G

REGIONAL AVERAGE
The regional average is worse than national and masks how clustered the impact of fuel poverty is on certain communities

03 SUMMARY OF OUTCOMES FROM ENERGY ADVICE VISITS

		Scheme		
		LEAP	Redress	Disability fund
		Sept 21 – Jan 22	Oct 21– Jan 22	Oct 21 – Jan 22
		88	37	19
Estimated savings because of small measures fitted (e.g LEDs, radiator reflectors etc)		£3,292	£1,700	£515
Estimated savings because of behavioural changes		£13,049	£7,039	£1,939
Financial assistance	Includes debt write-offs, benefits referral, WHD/PHD, Water tariffs, top-ups	£19,617	£15,266	£7,896
ECO / heating systems	(value of successful grants)	£5,140	-	£8,153
Other help	Includes council tax help, loan access, white goods,	£860	£900	£450
Gifted/ loaned items for warmth	(portable radiators, dehumidifiers, throws)	2	14	-
Onward referrals	Financial	17	41	13
	Health, safety & wellbeing	5	27	4
	Safeguarding	-	1	-
	Housing needs (incl adaptations)	2	13	6
	Energy Company Obligation (ECO) measures- e.g loft insulation, cavity wall insulation.	9	11	5
	Added to the Western Power Distribution Priority Service Register	7	19	5
Retrofit opportunities identified		14	18	6
	Total benefit (financial only) to clients	£41,958	£24,905	£18,953
	Average per client seen	£477	£673	£998

04 KEY PRIORITIES FOR THE NEXT QUARTER

- Working towards getting some more successful referrals for the larger energy efficiency measures through ECO and other grant funding.
- Developing information documents to leave behind with customers following a home visit.
- Continuing to build the 361 Energy team to help support residents across northern Devon through the increasing energy crisis.
- Building stronger links with referral partners.

ADDRESSING FUEL POVERTY // OCT 2021

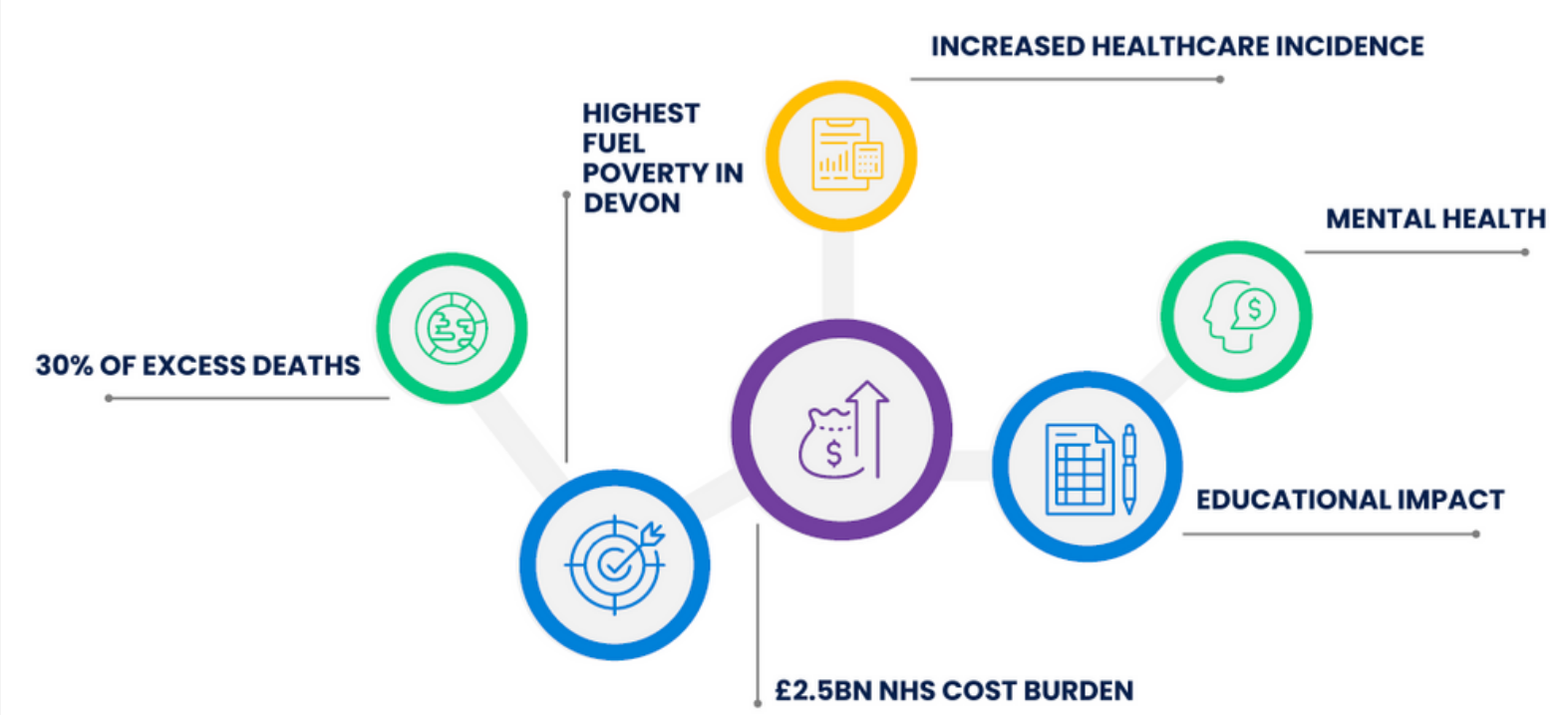
FUEL POVERTY DEFINITION

Households that have required fuel costs that are above average (the national median level) and were they to spend that amount, they would be left with a residual income below the official poverty line

ON THE GROUND MEANING

Residents need to make day-to-day decisions about heating their homes adequately OR paying rent, feed their families and other basic needs

05 FUEL POVERTY'S WIDER IMPACT



06 LOCALITY CONTRIBUTING FACTORS



INPUTS

1.5 FTE Warmer Homes Advisor
1.0 FTE Warmer Homes Co-ordinator

£133,739 Redress
£60,000 NDC
£875,000 LAD 2

OLDER PEOPLE LIVING WITH FRAILTY //

FEB 2022

CO-DESIGNING FUTURE CARE & SUPPORT

HAND

Healthy Ageing in Northern Devon



Aim:

An integrated model of care and support for older people living with frailty, designed together by the people receiving the support and those delivering it across Northern Devon

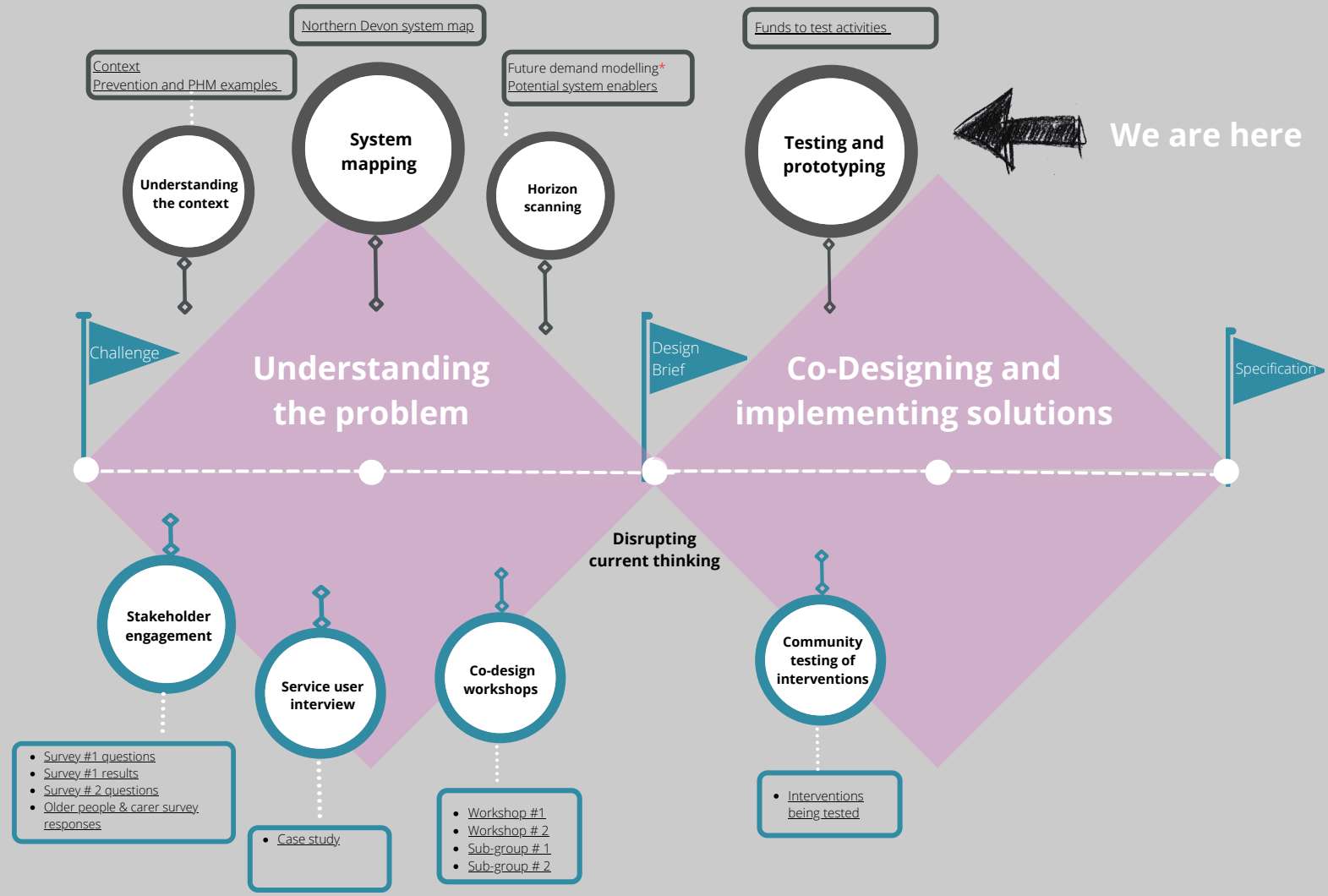
Objectives:

1. To understand what matters to older people living with frailty, their families and carers and how they would feel best supported to live healthy, independent lives
2. To understand the barriers to delivering the care and support identified
3. To understand the current provision
4. To understand future demand and risks
5. To consider what current and future enablers may be available
6. To co-design an integrated model of care

Steering Group members:

Chair: Andrea Beacham, OND Programme Manager
Lindsay Stanbury, Our Future Hospitals Operational Lead
Dr Fiona Duncan, PCN Clinical Lead for Care Homes
Dr Karen Davies, Medical Director, NDHT
Carole McCormack - Devon Senior Voice
Gordon Back, Team Manager, Older Persons Mental Health, DPT
Sue Matthews, Litchdon Patient Participation Group
Matt Hitchins, Our Future Hospitals Admin Manager
Stella Doble, Assistant Director Health & Social Care
Moses Warburton, CCG
Katherine Smith - Group Manager, NDHT
Brian Clifton - Devon Senior Voice, Patient Sector Network
Amanda Bowen - TTVS, Voluntary Sector Rep

Healthy Ageing in Northern Devon - System Service Design



We discovered 8 main themes:



Co-ordinated care



Workforce



Person-centred care



Loneliness









OLDER PEOPLE LIVING WITH FRAILTY // FEB 2022

CO-DESIGNING FUTURE CARE & SUPPORT

Testing activities in communities to tackle what matters to older people in Northern Devon

1 MAP PROVISION FOR OLDER PEOPLE

Work with the One Community Developers & Social Prescribers to create a list of what is available in local communities

PROGRESS SO FAR:

The One Community Developers have provided a list of local provision for older people.

2 IMPROVE ACCESS TO INFORMATION ABOUT CURRENT PROVISION

NEXT STEPS:

To be uploaded onto the One Community databases.
To be shared with the HAND Steering Group for agreement around how to disseminate

3 FILL GAPS IN PROVISION FOR OLDER PEOPLE

Using the results of the two surveys to identify what older people said would help them feel less isolated:

- Keeping well (prevention)
- Workforce
- Co-ordinated support
- Loneliness
- Access - services
- Access - transport
- Access - local
- Access - digital

PROGRESS SO FAR:

Successfully applied for Devon CCG Prevention Funds to work with communities to explore ways they can fill gaps identified by communities.

So far:
- Age Concern volunteers
- Dementia support
- Go North Devon
- Connecting actively with Nature
- Straw Patch eco-therapy

NEXT STEPS:

Shout-out to local businesses to see if they would like to support by offering their venue for sessions for older people

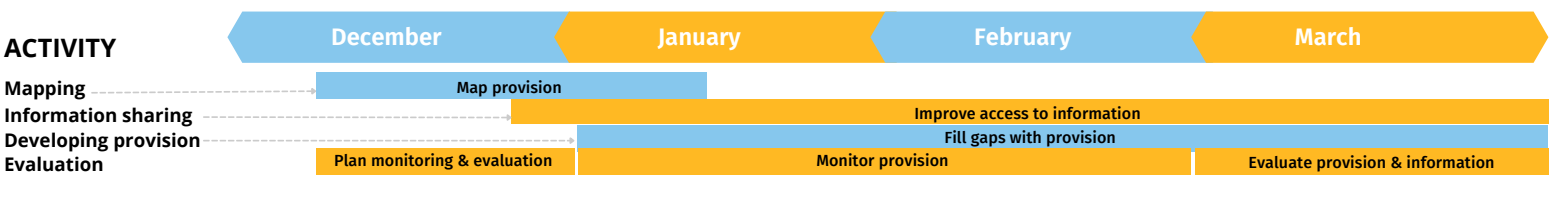
4 EVALUATE THE NEW PROVISION

For each new service provision, report on:

- What did they do? How many older people attended?
- How did they benefit? How long did they benefit for?
- Resources required for sustainability
- Testamonials/video

NEXT STEPS:

Evaluate the different tests of change and, if effective, include in the system strategy for supporting older people to age well.



HEALTHY WEIGHT & PHYSICAL ACTIVITY



Obesity is a major factor in poor health, disease and life expectancy.
This strategy will place the most vulnerable as its central focus with all work streams prioritising disadvantaged groups.

Team members:

Chair: Dr Kay Brennan, CCG Clinical Advisor
Adrian Avery, Torridge District Council
Alex Baker, Petroc
Anita Griggs, Vista Wellbeing
Victoria Barnes, Northern Devon Healthcare Trust
Claire Fox, Action for Children
Elaine O'Flaherty, Devon County Council
Gareth Dix, Active Devon
Hannah McDonald, OND
Sam Ismael, Barnstaple Alliance
Jessica Foy, Action for Children
Jane Jeyes, Devon CCG
Kirsty Hill, Devon County Council
Mark Keeley, One Small Step
Matt De'ath, Parkwood Leisure
Matthew Wright, Lex Leisure
Melanie Smith, One Small Step

We will work with partners to create healthy places

o o Maximise physical activity opportunities engaging with local leisure providers
o Work with businesses and planning authorities to support healthy eating-out options
o Improve access to places where people can grow and share healthy food
o Promote healthy places of work by supporting all OND partner organisations to sign up to the Healthy Weight Declaration

We will promote healthy lifestyles

o Create a strong Northern Devon presence for national and regional physical activity initiatives and maximise funding and resources
o Link with schools and local supply chain work to promote healthy eating at school
o Support healthy lifestyle choices in pregnancy, early years and throughout life
o Promote exercise for prevention, treatment & management of chronic disease
o Establish network of ‘healthy weight leads’ in each key organisation in Northern Devon

HEALTHY WEIGHT & PHYSICAL ACTIVITY



Progress since last report

An innovative and collaborative educational programme – 'Serious Mental Illness and Physical activity – a knowledge and skills toolkit' was delivered to health and social care professionals across the Devon ICS in January. Dr Brennan representing Devon CCG and OND, Devon Partnership Trust, Active Devon, Vista Wellbeing and an OHID 'Moving Healthcare Professional Clinical Champion', presented a 2-part module attracting 33 attendees, including those working in prison/forensic rehabilitation, social prescribing, health and wellbeing coaching, in-patient mental health rehabilitation, community mental health and community connectors. This was run within Devon Training Hub's 'Personalised Care' programme with plans to repeat the training across the system including to newly qualified GPs.

OND are working with Parkwood Leisure's regional management and sports development team as the new Barnstaple leisure centre opens in May (16.05.22). A meeting in November brought stakeholders together on site to discuss future facilities that community groups can book, which has its own toilet and hand wash facilities, with discussions ongoing within the One Communities, VSCE & NHS.

One Barnstaple are working with DCC on setting up community fridges across Devon.

BeeZee Bodies and One Small Step are offering Men only weight management programmes, with good uptake to weekly online sessions.

'Live Longer Better' which forms part of One Northern Devon's approach to Healthy Ageing in North Devon (HAND) is delivering an online learning programme aimed to educate, inspire and support older adults drop a decade in their fitness and reset how we all think and talk about ageing. Both professional and citizen focused licenses are being distributed throughout our communities, VSCE leaders and health and social care professionals. The course was developed by Sir Muir Grey, former Chief Knowledge Officer for the NHE and an 'optimal ageing' advocate and campaigner. Active Cornwall, Ageing Well Torbay and HAND are supporting and learning from each other.

The Healthy Ageing North Devon (HAND) steering group are supporting Primary Care Networks and NDHT utilise CCG funding focused on 'Enhanced Care in Care Homes' with a focus on increasing everyday movement and activity of residents plus support families and carers and promotes falls prevention education and initiatives.

ACTIVE TRAVEL

// FEB 2022



Aim:

Create a safe cycling and walking network and improve walking and cycling routes in Northern Devon by bringing all interested parties together to establish proposals to support our healthy weight and physical activity objective.

Team members:

Joint Chair: Dr Kay Brennan, CCG Clinical Advisor
Joint Chair: David Relph, OND
Carole Coombs, OND
Rob Passmore, OND
Andrea Davies, DCC Councillor
John Womersley, OND, CCG
Adrian Avery, Torridge District Council
Steve Pitcher, North Devon Cycling Campaign
Ricky Knight, Bikeabilty
Andy Bowman, ex Town Planner
Chris Fuller, Economic Regeneration Torridge DC
Peter Leaver, Barnstaple Town Councillor
Philip Hackett, Torridge Councillor
Andrew Saywell, County Councillor
Robbie Mack, North Devon Green Party

Latest update

The Active Travel forum (a sub-group of the healthy Weight and Physical Activity forum) are engaging with NDDC and TDC on their Joint Local Plan.

NDHT's 'Our Future Hospital' project management team are also being supported to review travel to, from and within hospital grounds and a Torridge District Council based survey on e-bikes and co-cars use is currently running.

OND HEALTH INEQUALITIES

FEB 2022

One Northern Devon, supported by the OND Health Inequalities Team, is updating OND's 10 year Wellbeing Strategy in the context of the Covid-19 pandemic.

To do this it is considering:

- the new NHSE/I Health Inequalities Strategy
- the Devon ICS framework for tackling health inequalities
- local statistical inequalities data
- local experiential data from citizens and service providers
- Existing evidence around causal factors & interventions that work

The following timeline is proposed:



In order to build the strategy, the sub group will be considering the following bullet points, which OND partners are asked to contribute their views on at the 22nd February 2022 meeting:

- **Latest inequalities data – where & what?**

Where are they focused geographically? What are the main inequalities in Northern Devon? Do they still correlate to the 10 priorities in OND's existing strategy or have other priorities emerged or become more significant since the pandemic?

- **What existing evidence is there of:**

1. The causal factors
2. Interventions that work

- **Engagement with people experiencing health inequalities** to get a better understanding of the factors involved and what they think could help
- **Engagement with service providers** to get a better understanding of the factors involved and what they think could help
- **Tests of change** to inform future investment proposals

OND HEALTH INEQUALITIES

On 26.10.21 The OND Partnership Board were asked four questions:

1.How do inequalities manifest themselves in the services you deliver?
2.Where are the greatest inequality issues and risks in terms of a) access to your services; and b) outcomes
3.Having heard back from partners, what areas might make the most difference to the people of Northern Devon if we worked on them together?

Feedback from the groups was noted as follows:

Housing
- The housing situation for young people is dire. Young people are being made homeless.
- Education is difficult due to housing difficulties.

Poor physical health of those with complex needs
- There have been a number of deaths due to poor health in High Flow. Should more healthcare be in place for people with complex needs.
- Poor physical health of those with severe mental illness. Access to annual physical health checks

Fuel poverty
- In OND's existing strategy & more relevant than ever

Mental ill health & substance abuse (esp. alcohol)
- Growing need, and disparities are increasing so need to shift focus to preventative measures such as licencing and availability. Also the impact on family units and impact to children.
- From a police perspective the main issue is mental health due to increase of people in crisis & lack of dedicated place of safety in North Devon.
- There is a correlation between wealth and health inequalities and there is an increased risk of mental health within primary care setting and it is forecast that issues of economic deprivation will increase.

Transport
- There is a lack of transport, preventing people from getting to support.
- Some rural parishes don't have the opportunities of larger communities, including transport.

Digital
- Lack of digital support, and skills to access, or health issues that prevent them from accessing. Lack of communication between communities.
- Although digital access is the most efficient way of delivering a service this has also digitally excluded some people.

Social connections
- Social connections provide support in the community but where they are lacking it results in delayed discharges and poorer outcomes.

Young people
- COVID is impacting the ability of young people to interact with others resulting in increased safeguarding reports and anti-social behaviour.
- Young carers don't have the same opportunities and they are not recognised across professions.

What else is needed?
- The workforce needs to be able to access other services quickly
- Shared understanding of what is meant by inequality
- Better understanding of the benefits of and access to the 'green agenda'

Actions:
Each partner to provide a case study on how inequalities have impacted their service users

OND HEALTH INEQUALITIES

Notes of the 8th October 2021 meeting of the OND Health Inequalities sub-group can be found here
Notes of the 27th January 2022 meeting of the OND Health Inequalities sub-group can be found here

Headlines identified so far

JSNA health outcomes inequalities

• Low life and healthy life expectancy and high self reported ill health/work limiting ill health and premature death correlated with deprivation
• The proportion of children in poverty across Devon as a whole is greatest in Torridge, with a strong correlation to deprivation across the board (as expected)
• Emergency admissions (for both acute illness and ACS conditions) across Devon as a whole ranks North Devon and Torridge in the top 3 for each of the three indicators (if not the top 2), again a deprivation correlation
• Mood and anxiety disorders is significantly greater in Torridge and North Devon compared to other localities (Highest in urban city/towns in sparse settings and Ilfracombe, Barnstaple, Bideford, Holsworthy top ranking towns)

Health Outcome Inequalities - Devon Health and Wellbeing

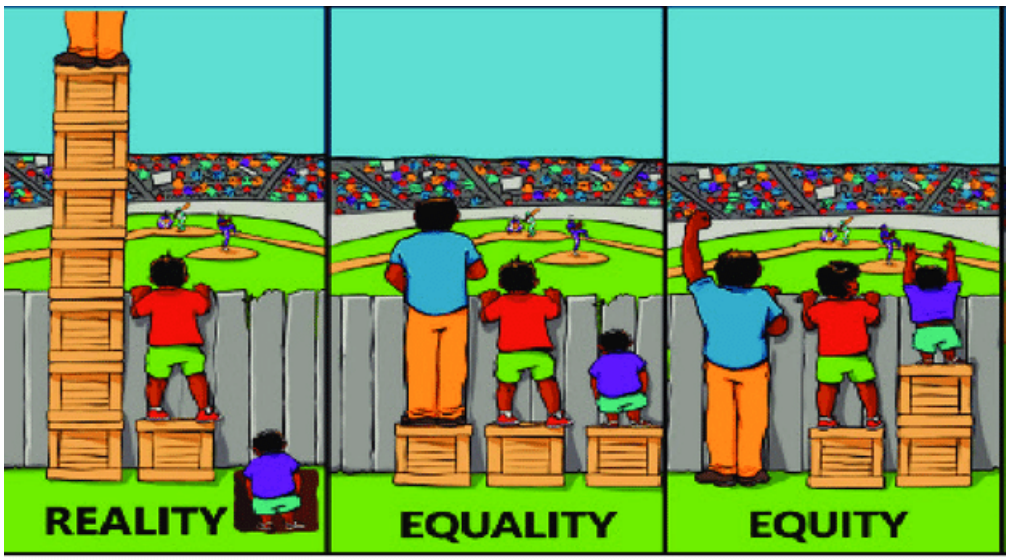
The JSNA headline tool - Devon Health & Wellbeing more broadly shows (NB data is not always timely):
• Starting well:
o Note child poverty above (15.5%, Devon 12.2%)
o GSCE attainment lower (36.2%, Devon 40.9%)
o Self harm admissions (10-24 yo) higher than Devon 4.097/100,000 vs 3017/100,000 for Devon County Council
• Living well:
o Lifestyle behaviours aligned to deprivation – 27.5% inactive, 23.5% harmful alcohol use, 15% smoking, 30,4% excessive weight (2018 figures, so pandemic is likely to have exacerbated these)
o Mental health data too dated (2011!) but national evidence has shown an increase in need due to the pandemic (and the point above suggests this would be even greater in N Devon).
• Aging well:
o No meaningful insight to draw out
• Most prevalent mosaic group in N Devon is "well off owners in rural locations enjoying the benefits of country life." To me this sounds alarm bells in that much of the data is too blunt at this level and will be masking further granular inequalities. Therefore I would suggest we go with these headlines to cross ref with the feedback but do an additional piece of analysis (supported by the Public Health Intelligence team) to further drill down to inform smaller locality inequalities - Charlotte Pavitt

PHE fingertips data Public Health Outcomes Framework - Data - PHE

For North Devon the following stands out:
• Sickness absence both short and long term stands out (which may be linked to mental health problems)
• Homelessness (households owed a duty) 2019/20 is significantly higher(N Devon is the worst in the SW)
• Emergency admissions for YP injuries (15-24yo), for intentional self harm is significantly higher (as above)
• Adult obesity & overweight is high – North Devon ranked 3rd in region – will also have a deprivation gradient
• Alcohol related admissions – top 95% in England
• Diabetes rates are top 95% (but data modelled from 2018) so treat with caution
• Dementia diagnosis rate (65y +) ranked in top 95% nationally (2021)

In summary – Mental Health resulting in self harm and sickness absence; alcohol use; obesity and inactivity; homelessness; dementia might be the key points, with all bar dementia being correlated to deprivation in terms of further inequality. More work is needed to understand inequalities at a more local/granular level.

TACKLING INEQUALITIES IN HEALTH // AUGUST 2021



Health Inequalities Team

Andrea Beacham
Dr Oliver Hassall
Dr Kay Brennan
Simon Chant
Charlotte Pavitt
Richard Blackwell
Nicola Mitchell
Lee Coulson
Jumoke Famakinwa

NHS England's priorities and planning guidance for 2021/22 for delivery through local Integrated Care Systems (ICS) includes some key priorities for reducing health inequalities:

One Northern Devon has been working on each of these for some time

- Population health management techniques will be used to aid targeted recovery strategies, promote equitable access and optimal outcomes for all groups
- Personalised care: proactive, multi-disciplinary, cross-sector support to be provided by systems to at-risk groups, those with greatest health inequalities or most complex needs, and awaiting multiple appointments. NHSEI is working with systems to develop real-time data tools and techniques to identify these patients
- Systems will develop plans for the prevention of ill-health, covering both primary and secondary prevention deliverables as outlined in the Long Term Plan, and setting out support for the expansion of smoking cessation services, improved uptake of the NHS diabetes prevention programme and CVD prevention
- Funding for Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Coordinators; and the acceleration of existing Comprehensive Model for Personalised Care requirements, including personal health budgets, social prescribing referrals and personalised care and support plans
- Implementation - working collaboratively across systems to deliver on these priorities

WORKPLACE WELLBEING

// FEBRUARY 2022



Research consistently demonstrates that organisations perform better when employees are healthy, focused and motivated. To put this in context, FTSE 100 companies that prioritise employee health and wellbeing outperform the rest of the FTSE 100 by 10%.
A company that prioritises health and wellbeing in the workplace will not only reduce absences, but also attract and retain talent, improve productivity and boost morale.

One Northern Devon is a partner in the North Devon Biosphere Community Renewal Fund programme.

£16,000 has been allocated from this fund. South West Business Council is our lead providers for this work.

Overall aim:

To reduce sickness rates and improve productivity in Northern Devon by supporting small and medium sized local businesses and organisations to improve the workplace wellbeing of their employees.

Objectives:

- To share the wellbeing resources available to the Northern Devon Anchor Institutions with smaller businesses and organisations.
- To create an Investors in Wellbeing scheme for businesses to work towards
- To create a network of Workplace Wellbeing champions who can cascade down the resources available to promote healthy lifestyles
- To increase mental health awareness amongst employers and employees

A Workplace Wellbeing programme to support local businesses is being developed with Southwest Business Council leaders and DWP using CRF funding. The evaluated and accredited scheme will engage with 20 local businesses initially to promote healthier lifestyles for the workforce, increase mental health awareness and creating a local workplace health champion network

Deliverables

Create information pack for businesses to include:
- what are the benefits to your business in investing in workplace wellbeing?
- what is the OND Workplace Wellbeing scheme?
- what will businesses receive?
    - mental health awareness training
    - webinars etc (see offer from training provider - funded)
    - anchor institution offer - see below
- what commitment do we need from businesses?

NATURE ON PRESCRIPTION

// FEBRUARY 2022



Unsplash/Getty Images/Pratik Bhide For The Swaddle

Spending time in nature, particularly around water, offers huge health and wellbeing benefits to individuals but also has a role in helping the environment and reducing pressures on public spending that are caused by the knock-on effects of stress, depression and anxiety.

One Northern Devon in conjunction with the North Devon Biosphere have been successful in receiving funding from the UK Community Renewal Fund to capitalise on the well-established benefits that having access to nature can have on a person's health.

Social Prescribing is currently delivered by Primary Care Networks across northern Devon and many are developing Wellbeing Teams that can offer health coaching and support for people's wider needs that impact on their health.

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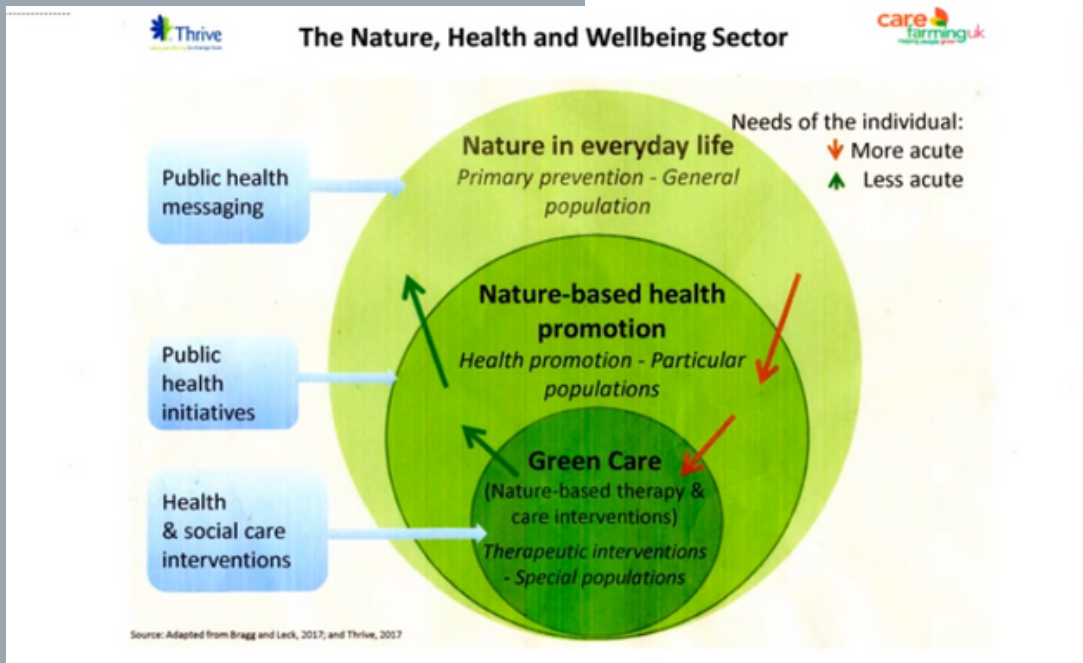


onenortherndevon

About us

One Northern Devon is a multi-sector partnership working together to improve wellbeing in North Devon & Torridge. It aims to reduce health inequalities through co-ordination of the activity of all partners involved in the wider determinants of health through an approach that is person-centred and place-focussed.

At its heart is an understanding that people need more than just good NHS services to keep well. A person's living conditions, work and social environment have a big impact on their health, even contributing to a difference in life expectancy of up to 15 years in some areas of North Devon.

If we can tackle problems like unsuitable housing, poor employment prospects and social isolation, we can help prevent the poor health that results from such factors.

In order to more effectively address issues like these, housing and environmental services, education providers, employers, community groups, fire, police and health and social care services need to work together.



onenortherndevon

TOGETHER WE'RE BETTER

PERSON CENTRED • PLACE FOCUSSED • SYSTEM COORDINATION






onenortherndevon

Why needed

Based on factors often outside their direct control, people in England experience:

- **systematic**
- **unfair**
- **avoidable**

differences in the opportunities they have to lead healthy lives.



In Northern Devon, people in the most deprived communities can expect to die 15 years earlier than those living in our most affluent ones.

Our partners have come together out of a moral and social duty to address this inequity

onenortherndevon

Our vision

Our vision is that people in Northern Devon live happy and healthy lives in safe, clean and connected communities where people are supportive of one another and aspirations are achieved through equal access to the best education & employment, whilst living in decent homes and enjoying our world-class natural environment.



Inequalities are inter-related and place-based

Child poverty: N. Devon/ Torridge worst in Devon
Excess weight in 11yr olds: Torridge worst in Devon
GSCE attainment: Torridge worst in Devon
Teenage conception: Torridge worst in Devon
Physical activity: Worst in Devon
Alcohol related admissions: North Devon worst in Devon
Domestic violence: North Devon 2nd highest after Exeter
Rough sleeping: North Devon highest after Exeter
Fuel poverty: Highest in Devon

"Disadvantages are concentrated in particular parts of the population and can be mutually reinforcing" - King's Fund

One Northern Devon's 10 Year Wellbeing Strategy to address local inequalities can be found here



onenorthern**devon**

Safe, Clean, Sustainable Places | Health & Wellbeing | Economy, Employment & Skills

10 Year Quality of Life Strategy – 2020-2030

VISION

One Northern Devon's Strategy covers a 10 year period starting in 2020, the year that saw a global pandemic transform the way we live and work. By bringing together our full range of partners in a united purpose, we can mitigate the threats and challenges brought about by the crisis and use every opportunity and advantage we have in Northern Devon to design a way of life that is fairer for all.

Our vision is that people in Northern Devon live **happy and healthy lives** in safe, clean and connected communities where people are supportive of one another and aspirations are achieved through **equal access to the best education & employment, whilst living in decent homes and enjoying our world-class natural environment**

Who are we?

One Northern Devon is a partnership of public services, businesses, voluntary & community groups

What do we do?

We **collaborate** together, influence policy & **work over the long term** to improve the quality of life, protect our shared natural environment and address local inequality

Why do we exist?

We exist because **concerted, systematic action** is needed across **multiple fronts** to address the causes of health & social inequalities. We need to work as **ONE system** to tackle complex, multifaceted factors involved

Our strength:

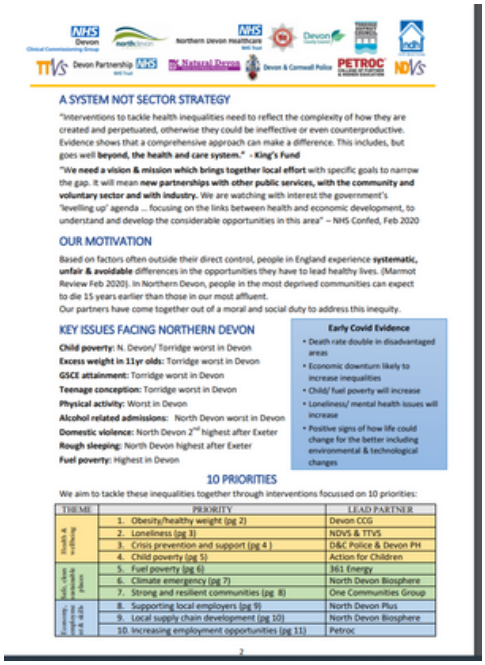
Our strength is in being able to **bring organisations and communities together** to change things for the better

Our approach:

Collaboration is key - there are things we can ogly do and problems we can only solve if we work together.

We create positive change by:

- Empowering communities
- Working together to improve services
- Challenging each other to work in a way that benefits us all
- Acting as a collective voice for Northern Devon
- Attracting new resources to Northern Devon



A SYSTEM NOT SECTOR STRATEGY

"Interventions to tackle health inequalities need to reflect the complexity of how they are created and perpetuated, otherwise they could be ineffective or even counterproductive. Evidence shows that a comprehensive approach can make a difference. This includes, but goes well **beyond, the health and care system."** - **King's Fund**

"We need a vision & mission which brings together local effort with specific goals to narrow the gap. It will mean **new partnerships with other public services, with the community and voluntary sector and with industry.** We are watching with interest the government's 'levelling up' agenda … focusing on the links between health and economic development, to understand and develop the considerable opportunities in this area" – NHS Confed, Feb 2020

OUR MOTIVATION

Based on factors often outside their direct control, people in England experience **systematic, unfair & avoidable** differences in the opportunities they have to lead healthy lives. (Marmot Review Feb 2020). In Northern Devon, people in the most deprived communities can expect to die 15 years earlier than those in our most affluent.
Our partners have come together out of a moral and social duty to address this inequity.

KEY ISSUES FACING NORTHERN DEVON

Child poverty: N. Devon/ Torridge worst in Devon
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Rough sleeping: North Devon highest after Exeter
Fuel poverty: Highest in Devon

Early Covid Evidence

- Death rate double in disadvantaged areas
- Economic downturn likely to increase inequalities
- Child/ fuel poverty will increase
- Loneliness/ mental health issues will increase
- Positive signs of how life could change for the better including environmental & technological changes

10 PRIORITIES

We aim to tackle these inequalities together through interventions focussed on 10 priorities:

THEME	PRIORITY	LEAD PARTNER
Health & wellbeing	1. Obesity/healthy weight (pg 2)	Devon CCG
	2. Loneliness (pg 3)	NDVS & TTVS
	3. Crisis prevention and support (pg 4)	D&C Police & Devon PH
	4. Child poverty (pg 5)	Action for Children
	5. Fuel poverty (pg 6)	361 Energy
Safe, clean sustainable places	6. Climate emergency (pg 7)	North Devon Biosphere
	7. Strong and resilient communities (pg 8)	One Communities Group
Economy, employment & skills	8. Supporting local employers (pg 9)	North Devon Plus
	9. Local supply chain development (pg 10)	North Devon Biosphere
	10. Increasing employment opportunities (pg 11)	Petroc

2

One Northern Devon has agreed an **approach** to working together on its strategy to address inequalities , namely, that:

- Services would work towards becoming truly **person-centred.** This would necessarily involve understanding what mattered to the service user
- Services would be commissioned and delivered in **a 'place-based'** way, taking into account the individual needs and assets available in a place and supporting system infrastructure at community level. Just as context matters on an individual level, so it matters on a community level.
- Organisations would work together and **co-ordinate** their activities so that people didn't have to try and piece them together themselves

PERSON
One-to-one support for individuals

PLACE
Whole population support to communities

SYSTEM
Organisational support for system co-ordination

About One Northern Devon

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The 3 Pillars

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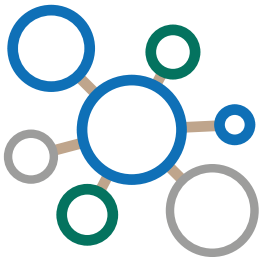
PERSON

One-to-one support for individuals



PLACE

Whole population support to communities



SYSTEM

Organisational support for system co-ordination