onenortherndevon

Partners' report

JUNE UPDATE

Person-centred

Place-based

System Co-ordination



2022

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JUNE 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.
Outputs and outcomes for the previous years can be found here

01 NUMBERS SUPPORTED

Currently 5 clients are supported by High Flow, 2 more are at the pre-consent stage, 1 client was closed.
1 client has been referred into the High Flow step-down programme

02 KEY ACHIEVEMENTS

- Step-down process for high flow clients has started who will still require support but not at a level provided by the project e.g. community / social support.
- Client 4 had her first Cataract operation
- Client 8 completed an residential detox
- Client 12 completed some more co production work

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Embed HF Step Down
- Supporting the other Flows & new staff building the wider Flow Team
- Supporting Client 8 in her rehabilitation post detox

04 BARRIERS, LEARNING, SUPPORT REQUIRED

- Wider need for practitioners to understand the TAP process
- Womens First / Mind post hosted by ESW suggested a 4 week closure for a client without an exit strategy or consultation with the TAP

HIGH FLOW

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JUNE 2022

INPUTS

High Flow Caseworker
High Flow Project Co-ordinator

£48,000 per year

OUTPUTS

APR 2022 - MAY 2022

Team Around the Person meetings x 3
Connections/Referrals to community services x 3
Connections/Referrals to statutory services x 1
General Money Advice/banking x 16
Food Parcel Given x 14
Form Filling x 4
Housing Advice Provided x 2
Welfare benefits advice x 0
Support to find alternative housing x 1
Support to attend medical appts x 17
Support to contact/attend counselling x 6
Support to manage tenancy/licence x 9
Support to develop self care skills x 8
Support to dependent/co-dependent x 6
Improved Devon Home Choice Banding x 1
Safety Plan completed x 5
Support to meet aspirations x 13
Support to improve employment prospects x 0
Supported training/volunteering x 1
Signposted to external agencies x 2
Support to attend dentist/opticians x 7
Support with recovery journey x 21
Supported into Accommodation x 1
IT support incl. virtual meetings & emails x 5
Client involved in co-production work x 2

OUTCOMES

APR 2022 - MAY 2022

Financial Gain Other x 4
Alternative Housing Secured x 2
Bailiff action prevented x 0
Supported to remain in property x 2
Debt managed x 8
Eviction averted/homelessness prevented x 1
External Health Assessment conducted x 5
Financial gain/charitable payment x 7
Home Care/aids/adaptations obtained x 0
Improved living conditions x 5
Improved engmnt w/Health Services x 13
Improved Family Relationships x 2
Improved social skills/relationships x 4
Improved financial status x 0
Improved life skills x 4
Improved meaningful activities x 7
Improved motivation x 18
Improved personal hygiene x 2
Improved physical health x 3
Increased Independence x 11
Appropriately engaging with GP x 23
Successful court action x 1
Moved into employment x 2
Client to own action to address issue x 13
Community activity achieved x 1
Client/dependent supported to live safely x 6
Case condluded successfully x 1

>>> EXIT STRATEGY

Funding is now secured to March 2024 through iBCF funds. The High Flow evaluation report was sent to all partners to ask for contributions to a step-down service to allow more capacity in the High Flow cohort. Funding has been agreed from TDC, DPT & NL.

HIGH FLOW // CASE STUDY JUNE 2022

High Flow has helped me tremendously, I have come out of my shell more and feel more confident as before would not talk to strangers… I am more able to now make better decisions for myself. Katie as a caseworker has been amazing with a great sense of humour, so friendly, kind, caring and understanding, always wanting to listen and a very good listener. So overall happy to be involved with you. So thank you very much hope we will stay in touch in the future - Angela, 48



'Angela' lives with her son in his early 20's in social housing. Angela is unable to work because of her poor mobility & has in turn been a high demand on the health service in particular, although known to other agencies as well. Carers provide personal care.

Angela struggled with her weight since childhood & led an unhealthy lifestyle with a poor diet. She suffered with depression & anxiety throughout her life.

She consented to High Flow in February 2020 after a referral by the PCN & asking for support on diet & self esteem & confidence building. However not long after engagement it became clear Angela struggled to run her home & maintain her tenancy which was in jeopardy due to the physical state & cleanliness of it property. It later transpired that she had a huge amount of current & historic debt that was unresolved. Angela struggled with social skills & day to day life. She and her son are very dependent on each other.

What mattered to Angela

Initially what mattered was to address her weight & presentation however upon the disclosure of the debts & housing situation these then became a priority. She felt she never had her own space and time to call her own.

What happened

TAPs began and included her Social Landlord so she could secure her housing situation. HF funded some 'clear out' days which led to a cleaner coming in weekly. Angela match-funded this & then took on the payments herself.

For her depression & anxiety she referred herself to Talk Works but didn't keep the session up so the HFCW referred to CLARITY. Due to the logistics of the building she was unable to continue & then went back to Talk Works. Covid hampered these sessions but she eventually completed them & said that she felt much happier & able to manage her depression & anxiety. Angela remained active in her TAPs & the Social Landlord was satisfied with how she was running the home & the tenancy was no longer in jeopardy.

Adult Social Care also attended the TAPS & her care was increased & house adaptations were offered. The HFCW attempted to support her son, referring him to Youth Flow but he felt unable to continue with the project. Wiser Money attended the TAPs. Angela found it hard to share what she needed to re finances to get the support necessary & this work came to a bit of a halt however when she felt ready again she engaged to an outcome that showed she has disposable income each month & it was budgeting she needed support with. Angela & the HFCW & the son had some very open & frank discussions about this & the relationship remained good. She expressed a wish to book a holiday & went away last Summer with her son & a friend of hers. She reported feeling much better & far more in control of her situation. She even felt able to go to the supermarket without feeling so self conscious.

As time went on her need for the HFCW reduced & conversations gravitated more around accessing community activities so it was suggested to her that she was 'Stepped Down' to concentrate on the these activities she had expressed a desire to do…having some time to call her own. The Step Down handover is now happening. The SDCW is supporting her to choose & access what she would like to do.

COMMUNITY MENTAL HEALTH FLOW //

JUNE 2022



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.

KEY OBJECTIVES

- Help clients achieve recovery goals
- Support to manage benefits, personal budgets & finance advice
- Facilitate opportunities for educational, work-related & social activities
- Work alongside clinical details of treatment and support plan
- Help to secure and maintain housing

Outputs and outcomes for the previous years can be found here

01 NUMBERS SUPPORTED

3 clients referred into the service since April 2022

0 current clients (due to case worker re-locating)

9 visits/sessions held with clients

02 KEY ACHIEVEMENTS

- WMTM conversation has been amended to be a verbal and less formal approach with less invasive questions and project relevant and specific questions
- Discharge Facilitator gave extremely positive feedback about CMHF the support it provides their service with in-patients. Access to care notes has been granted meaning less duplication within the project so clients no longer need to repeat their story which is more trauma-informed and less re- triggering. N
- Navigator is now able to hold TAPS and CAPS for porfessionals meaning the professionals around the patient are working as a collective.

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

Recruit new CMH Flow Co-ordinator

04 BARRIERS, LEARNING, SUPPORT REQUIRED

Lack of access to internet and printing on the wards continues to be a barrier

COMMUNITY MENTAL HEALTH FLOW // JUNE 2022

INPUTS

CMHF Navigator

£46,500 per year

OUTPUTS

APR 2022 - MAY 2022

No. of clients referred: 3
No. of clients closed: 3
What Matters conversations held with clients: 0
Face to face or virtual visits to clients: 9
Pre-visit calls to clients: 0
Walk & Talk sessions: 1
No. self-care boxes completed: 0
Money advice/banking/housing/welfare support: 4
Help with form filling: 0
Support to attend medical appointments: 1
Support to contact/attend counselling: 1
Support to manage tenancy/licence: 0
Support to develop self-care skills: 0
Support to dependent/co-dependent: 0
No. safety plans completed: 0
Support to meet aspirations: 2
Support to improve employment prospects: 0
Signposted to external organisation: 0
Support with recovery journey: 0
IT support incl. virtual meetings, emails etc: 0
Safeguarding meeting attended: 0
No. connections made to community services:

- Healthy Active Lifestyle Services: 0
- Community groups/activities: 0
- Mental wellbeing support groups: 0
- Referrals to Money Advice Services: 0
- Connection with Community Developer: 0
- Charities (eg dom.abuse, counselling): 1

Number of connections/onward referrals to statutory services:

- Community Mental Health teams/Care Co-ordinator: 90
- Discharge facilitator: 70
- GP services: 1
- Housing services: 3

No. TAPs held x 0, No. CAPs held x 0
Flow meetings with Lead Professional x 0
No. Client Satisfaction forms completed x 0

OUTCOMES

APR 2022 -MAY 2022

Improved meaningful activities x 1
Increased independence x 1

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 been secured for this role through DPT to April 2023.

COMMUNITY MENTAL HEALTH FLOW // CASE STUDY

'I am blown away by the Navigator's knowledge and understanding of community activities, I am grateful for all her hard work and support with my patients. I have learnt more with regards to community options in the past 3 months than I have my entire time as a discharge facilitator, her hard work and enthusiasm has blown me away - Discharge Facilitator



Maggie' had been sectioned for some time on a mental health ward but was due for discharge back to her home, where she had lived with her children who had gone to live temporarily with their father. Maggie would begin a phased return with them at a pace that suited her recovery journey. She had a diagnosis of anxiety, depression, PTSD and EUPD. She engaging with her Care Co-ordinator and continuing psychotherapy.

What mattered to Maggie

When the CMHF navigator visited Maggie, she was struggling to imagine what life in the community would be like. Maggie felt let down by services in the past and was apprehensive and anxious. She was concerned she could no longer afford her house with her daughter having left education. Maggie would have liked eventually to re-start education and had previously wanted to become a Social Worker. She had been a Personal Assistant prior to admission, enjoyed charitable work and caring for people. She had been known to be empathetic and caring. Her initial goals were simply to survive. Her follow-up goal was to shower daily. The CMHF Navigator met with Maggie weekly to build rapport whilst Maggie was in the 'staying safe' phase of her recovery.

After some weeks, Maggie expressed to the CMHF Navigator that she wanted to feel like a supportive mother again. She also said that her house was too big, and its poor condition caused her stress. She also disclosed previous domestic emotional abuse and was interested in perhaps one day going on a Pattern Changing course of some description. She said she enjoyed art, walking, and keeping fit.

The navigator compiled a list of 14 community courses, learning and activities that were of interest to Maggie and she enrolled on a course with MIND 'Managing Your Mental Health as a Parent' which she felt would be benefit her in supporting her children at home again full time. Maggie doesn't feel ready to engage with community activities but after her recent TAP meeting, she asked for the list of activities for future reference. The TAP included Maggie's Care Co-Ordinator, Social Worker, Community Developer, Personal Assistant and Housing Officer., It was clarified for Maggie, during the TAP who was now supporting her housing, as she had been very confused and overwhelmed by her housing situation. Maggie has remained at home since her discharge. She has self-harmed twice but has managed her risk independently by contacting her professional team. Although expressing the desire to 'give up' Maggie engages well with the Navigator and has been grateful for the support received.

COMMUNITY FLOW

// JUNE 2022



OND Community Flow aims to provide better access to community support and includes the Settle and Support at Home service. The programmes 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 healthcare professionals receive the non-medical support they need in order to reduce unnecessary medical interactions.

01 NUMBERS REFERRED

56 people have been referred into the Settle and Support Service

02 KEY ACHIEVEMENTS

Collaborative leadership - worked with a service user to support service improvements to the Community around the Person approach and language used in patient facing information leaflets and feedback forms.

Recruited Community Manager and Community Flow Co-ordinator now in post and co-located within North Devon District Hospital and St Georges Road (Rapid response). This will support increased communication with key staff and provide a more efficient referral pathway.

TTVS now recruiting 3rd party volunteer organisations across Northern Devon to increase the volunteer offer and geographic spread of volunteers.

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

Continue engagement with NDDH wards and STS to raise profile of service and increase referrals.

Work with other discharge services to act as a single point of contact for the VCSE sector.

Increase the volunteer provision by reaching out to third parties (led by TTVS).

Work with DCC, NDDH and the VCSE sector to explore current unregulated provision, current need and new ways of improving access to unregulated support at a place-level.

04 BARRIERS, LEARNING, SUPPORT REQUIRED

Reduced capacity within DCC Integrated Adult Social care and Hospital discharge staff has made it difficult to find out the exact extent of the need for unregulated provision. However, a DCC Integrated Adult Social care rep now sits on the steering group and will look for ways to work with the communities on the challenge.

Trust procedure has caused lengthy delays to setting up the 'Settle and Support at Home' service. Nonetheless, we now have a single point of contact within volunteering to support this.

COMMUNITY FLOW // JUNE 2022

INPUTS

1.1 FTE Community Flow Manager

1.1 FTE Community Flow Coordinator

Objective 1: RDUHT, DPT and Community Health staff understand the benefits and are referring into the 'Settle and Support' service
KPIs:
• xxx referrals in 1st 6 months & every 6 months thereafter
• xxx 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
• 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
• 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

Objective 4: 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 5: 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, for the 'Settle/Support at Home' Service:

Total RDUHT volunteers recruited, inducted
2021 /22 - 24
2022/23 - 0 (April-May 2022)

RDUHT Volunteers currently active
2021 /22 - 13
2022/23 - 13 (April-May 2022)

RDUHT Volunteers awaiting induction
2021 /22 - 5
2022/23 - 5 (April-May 2022)

RDUHT Volunteers withdrawn
2021 /22 - 6
2022/23 - 0 (April-May 2022)

Referrals into Settle/Support at Home service
2021 /22 - 44
2022/23 - 12 (April-May 2022)

Referrals declined
2021 /22 - 11
2022/23 - 2 (April-May 2022)

Home visits to patients
2021 /22 - 17
2022/23 - 3 (April-May 2022)

Phone calls to patients
2021 /22 - 25
2022/23 - 0 (April-May 2022)

Volunteer visit forms returned
2022/23 - 3 (April-May 2022)

Volunteer feedback completed x 0
Referrer feedback completed x 0
Patient feedback completed x 0

Discharge issues raised with ward
2021 /22 - 1 (medication)
2022/23 - 1 (medication)

To date, for 'Community Flow' support (April-May 2022)

'Community around the Person' interventions - 3

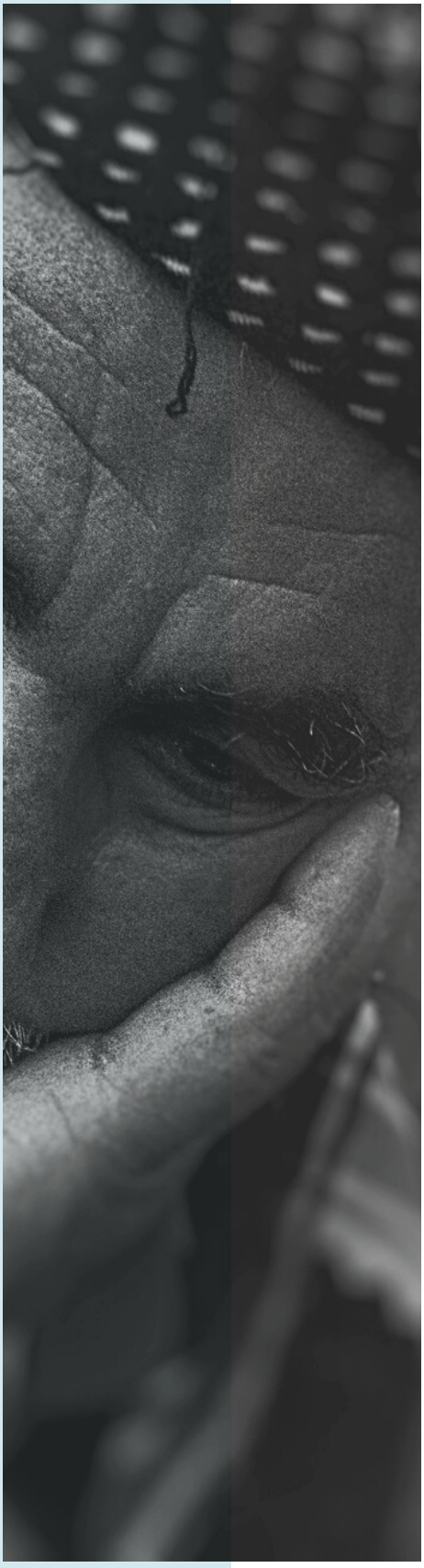
Number of Community Connections made - 1 (money advice)

Connections made to statutory support - 0

>>> EXIT STRATEGY

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

COMMUNITY FLOW // CASE STUDY



Terry was discharged from hospital after a bank holiday weekend. There were concerns that he would become isolated at home, as he had limited connections in his local community, and a risk of falling as he could be unsteady on his feet. The Community Flow Coordinator took the referral over the phone from the ward. The coordinator had been unable to reach Terry by phone and because of this concerns had instructed a volunteer to visit. A Trust volunteer was secured and arrived the day after discharge, finding that Terry could not get up to answer the door. They also noticed that Terry's home was untidy and cluttered and was informed by the patient that they had not taken his medication for diabetes.

At this point, the volunteer called the coordinator. They were still with Terry and the neighbour had also arrived as they were worried. Terry was isolated at home. His neighbours reported that he had become more reluctant to have visitors over time, this may have been due to deteriorating mental health. The coordinator advised the volunteer to ask the neighbour to call an ambulance, anticipating that it would take a while and did not want to commit the volunteer to this wait. Terry was then readmitted to hospital later that evening.

After re-admission, the coordinator visited Terry on the ward, and noticed the patient seemed confused, they explained that he had been readmitted after the volunteer had visited him and found him unwell. He said he remembered and spoke about how he was feeling.
All our involvement was fed back to the ward who referred Terry. The volunteer fed back that she was glad she had visited because Terry was unwell when she found him and was able to support around his readmission to hospital and reassure him.

On this occasion, we noticed several things that could have happened differently and could have given Terry a different outcome. These have been recorded via a safeguarding referral and have met the criteria for an inquiry due to an unsafe discharge. As the patient is now receiving further medical support and access to mental health support, it is assumed that the volunteer visit lessened patient suffering and prevented a serious medical incident.

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



APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Kailo: Collaborative research	Met Kailo team to discuss the history of Ilfracombe, One Ilfracombe, previous youth engagement and also potential partners who would want to get involved.	One Ilfracombe are now a 'key partner' in linking Kailo to local organisations and other One Communities	Dartington Service Design Lab Exeter.University
Welcome to Exmoor trips	Secured funding from Active Devon 8 weeks of weekly trips Supported by a volunteer from ITC volunteers Developed links with Ilfracombe Community Transport	Hugely improved the health, happiness and confidence, with many (including volunteer) saying that this has been 'life-changing' for them. E.g. one participant who lost her husband during Covid and hadn't left the house since, They have left the house and moved from pessimistic to laughing and joking with everyone by the last week.	Ilfracombe Community Transport Exmoor National Park Active Devon

Local groups/organisations supported

Devon & Somerset Fire & Rescue Service	Support to engage with more older, vulnerable residents in town. Connected with the Lantern Friendship Group and North Devon homes. Sallie McKay-Roper will also be presenting at the Living Well Meeting in June 2022
Ilfracombe Link centres	Met with the Commissioning managers for Adult Health & Social Care at DCC around the the use of Link Centres for community groups going forward - Introduced them to a newly formed local Arts CIC and also a lady wanting to lead a female mental health peer support group

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



APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS

CURRENTLY RECRUITING A COMMUNITY DEVELOPER

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

APRIL / MAY 2022 - OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Community Engagement Events	One Barnstaple booked to attend: ND Homes Summer Fayre 11.08.2022 Re-Connect and Create Fest 17.07.2022 - Griffiths Recruitment and Wellbeing Day 13.07.2022	To provide more awareness of what One Barnstaple is / advocate for the work and services provided by OB members. To engage with community members informally, to listen and understand current themes, interests, strengths and areas for development to inform OB priorities and ongoing action plan. The Shambles will feature a pop up living room - Created leaflet to recruit volunteers. Camerados box has arrived. Secured funding available from BTC via NDVS for room hire.	Multiple
One Barnstaple Mental Health Network (priority 2)	Mental Health Network members invited to visit Rosebank Link Centre 01.06.2022 with OB remaining part of the DCC and DMHA meetings Reducing potential resistance from VCSE membership by advocating for improved cross-project communications (currently not shared in an accessible way)	Modelling a team working and positive approach, promoting systems working by reducing hierarchical barriers and encouraging collaborative leadership. Linked OND and Devon MH Alliance to the OB MH network. .	Devon Mental Health Alliance Devon County Council One Barnstaple Mental Health Network Mind OND
Volunteer bank (priority 3) (In development)	£8000 BTC Strategic Grant awarded to OB (NDVS) Exploring Groop online Platform / Devon Connect to host administration of the Volunteer Bank / manage volunteer opportunities	In development with NDVS and Devon Connect platform	Devon Mental Health Alliance Devon County Council One Barnstaple Mental Health Network Mind OND
Internships with One Barnstaple (In development)	Initial Meetings with Petroc	Drafting Role Descriptions for Internships with One Barnstaple Core Team	Interns Petroc One Barnstaple One Barnstaple Members Community Members
Community Gardens and Green Spaces Network (In development)	3 monthly meetings - Brought together professionals and volunteers to discuss current projects and activities in the area. Being opened up to other localities.	Agreed continuation of network meetings with a view to collaborate Aim - to develop community members understanding of assets and opportunities available	Nature on Prescription North Devon Biosphere Local Community Garden projects Co-Op Group Barnstaple Rotary
Community Food Network (priority 7): Community Fridge (In development)	Building a network of people who want to be involved. Visited South Molton Community Fridge. Live West looking into a potential town centre venue for the initial site.	DCC can cover volunteer management including insurance initially whilst a suitable host is found to take on the project	DCC Waste Team Live West Co-Op Group Petroc Barnstaple Library

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.



APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
OND Arts, Culture and Wellbeing Part of **C**arers' Art and Resource Events (CARE)	£500 funding secured to reach young carers [8-23 yrs.] and the cared for C.A.R.E unpaid carers Event schedule (25 March 2022) - Supporting carers and referred to ongoing support/advice	Celebration event for all involved and families with art work displayed June 2nd 2022 at The Plough 1 Booklet distribution Proposal T100 Case study OND Culture, Health and Wellbeing evaluation	The Plough Arts Centre, Local artists Devon Carers A panel of individual carers
Create and Celebrate: Part of Carers' Art and Resource Events (CARE)	Arts and drama sessions for young and adult carers linked to ACE funds and a jubilee party event on 2 June at The Plough arts centre. 3x young carers drama workshops at The Plough focused on exploring the role of the young carer and creating a forum theatre piece that helps an audience participate and better understand the subject matter. 3x Young carers arts workshops at The Plough creating materials that support the jubilee carers party and performance.	Young carers from Torridge and West Devon contacted through the Devon Young Carers and Young Carers Connected, also their families, giving them the space to relax and enjoy being youngsters again, and express what it means to them to be a young carer and network with both other young carers and peers they may not have met before. They also took part in a survey on health inequalities and pressures on their families.	Hayley Buscombe, Devon Carers. Tracy Downs – Young Carers Connected, Zoe Stewart, Devon Young Carers, Lorraine Pearce Torrington Memory Café, Cathrine Simmonds, Bickford Centre, Knit and Natter Group – Town Hall, The Plough Arts Centre
OND Healthy Ageing in Northern Devon (HAND): **Part of Carers' Art and Resource Events (CARE)**	2x arts workshops for older carers and cared-for, including people with Dementia. 1x arts workshop@ Memory Cafe. 2x Storytelling workshops with an actor working with older people who attend the Bickford Centre, knit and Natter at the Town Hall and Memory Café.	Older carers and the people they care for were able to reconnect – many for the first time since Covid, able to get out and meet new people, express themselves and have fun, take a break from the ordinary pressures of caring and find advice on how to help themselves plus have a taste of workshops they may continue with in the future.	The Plough Arts Centre, Local artists Devon Carers A panel of individual carers

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

APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Volunteer Database	Meet with TTVS volunteer coordinator. TTVS will host a database of Holsworthy volunteers enabling access to volunteers with the relevant skill set to be matched with projects in the town & surrounding area. Members of the public who expressed interest in volunteering via H&DCF survey / past projects have been contacted	Increased TTVS volunteer database	TTVS
Database of services and organisations	Contacted community groups via social media requesting updated details. Groups will be encouraged to add themselves to Devon Connect	Country & Coast PCN have shared access for SP's General Public once released	Country & Coast PCN
Holsworthy Energy Event	Fair was attended by approx. 60 people, mainly families. HDCF wishes to repeat the event but aim at working people & older people.	South West Water and Energy 365 were able to give practical help with bills Very positive feedback from all attended. One attendee commented "I no longer felt backed into a corner"	Multiple (see report)
Community Engagement Survey 2022	Engagement with residents, local service providers and businesses Draft priorities created for review recommending Key Priorities to review. CD compared the recent survey, prior HCIG survey, JSNA and OND 10 priorities	Steering group is currently updating the list of priorities / areas of focus based on recent results, Development of a joint action plan 22/23 to meet community needs	HDCF Live West

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.



APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
OND Culture, Health & Wellbeing: Young People's Art Workshops	initial Focus morning took place 29.01.22 4 successful art workshops collaborating with local artist and art studio - StudioKind Young people (16-24) who are struggling with their mental health, attended creative workshops	Remarkable feedback – help people improve their wellbeing Decision to continue Art club which is being run by local volunteer with support from local artist	Beaford Arts OND Culture, Health and Well-Being StudioKind Arts Council
Men's Shed:Braunton and Rural Communities	35 members signed up so far Group meet regularly on Saturday mornings Formed own Committee Awaiting consent for site for Shed Plans going ahead for interior of Shed Initial scoping and meetings set up by LWIB who continue to support as the work develops.	Plans are to collaborate with Men's Shed on a variety of other Live Well in Braunton projects	Men's Shed
Companion walking group	Administrator appointed Training agreed Seeking walk leaders	Improved opportunity for walking as a group – better for health and aim to build peer support into this approach Tackling loneliness and social isolation	Local volunteers
In Developemnt	Increased Communication, Improving Opportunities for young people, Improved access to activity, Volunteering hub		

onesouthmolton

Chair: Alison Verney
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 currently being finalised.

Aims
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

APRIL / MAY 2022
OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Forum / Steering group	Monthly Forum meeting setup Alison Verney recruited as volunteer chairperson for OSM	Terms of reference/values adopted. New members recruited	Various organisations incl. NDVS, YMCA, SMTC North Devon Biosphere Positive People, ADSM
Asset Mapping	Updating community provision for South Molton Introduced OSM and HAND to Sunshine Circle.	Shared working document on google drive between CD and SP Older people mapped assets and areas for improvement in SM	OSM PCN/SP Sunshine Circle
OND Community flow	Setting up games (Rummikub) Club once a week (Fridays). Signposted couple to Nature Made coffee mornings (a OND HAND project).	Supporting CAP - increasing social interactions to tackle loneliness and improve mental wellbeing	Encompass OND OSM
Community engagement	Regular 6 weekly interview on The Voice Radio Connected 'Research my Way' to three groups for Health Inequalities survey:	Secured venue and local organisations for Recruitment and wellbeing event set for 29th June Local groups will have a voice in OND health inequalities strategy	Research Your Way (OND) Dementia Support, Sunshine Circle and Hidden Illnesses SM
Employment (Young people)	Unemployment identified as gap In provision. Links made with Petroc to offer 1-1 success coaches and mentoring to over 19s in South Molton	Drop in session taking place in June at YMCA for young people to sign up to courses/training.	Petroc College Barnstaple YMCA SM OSM
OND Arts, Culture and Wellbeing	Set up working group recruitment process of Artist in Residence at YMCA – applications/interviews	Intergenerational project, links with local schools and YMCA to support young people in arts. see OND Culture, Health and Wellbeing evaluation March 2022	Beaford Arts Local GP, Community college, Baptist Church Youth Club, YMCA Arts Destination South Molton

OLDER PEOPLE LIVING WITH FRAILTY //

JUNE 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

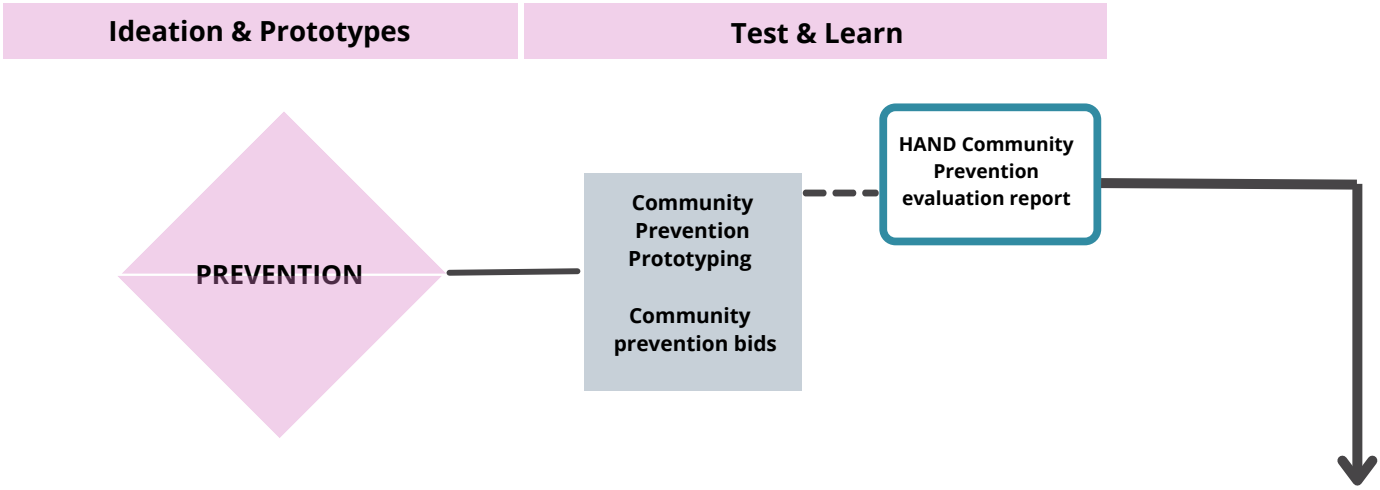
Objectives:

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

Progress in Prevention theme



We funded 9 community activities:



Straw Patch



Dementia support



Guided Walks



Go North Devon



Memory Cafe



Tai Chi



Age Concern buddies



2 x Coffee & Chats

Evaluation report on these activities can be found here

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

The Straw Patch



Investment: £1,280

Intention/activity: Having been approached by the Ilfracombe Friendship Group (formerly Ilfracombe Pensioners Club) who were interested in finding somewhere to resume activities after they had stopped due to Covid, we wanted to invite a group of 12 to the Patch for 8 weeks and offer a range of activities to help them socialise, get some gentle exercise and try some fun new activities.

Intended benefits:
Participants are able to spend time in a quiet, rural space and getting a chance to enjoy nature. Within a few weeks participants usually feel happier, confident, more active and have an increased enthusiasm to try new activities. Through accessing our countryside setting, spending some time in our allotment and petting our animals for a couple of hours a week the participants quickly remember their love for being outdoors.

HAND priorities addressed:
Keeping well (prevention)
Loneliness
Access - transport



"This is much better than popping pills any day of the week" - Person referred by GP



"Lovely to have company as I live on my own and things can get out of perspective. Loved it. Long may it last."



What happened?
9 participants took part for 13 weeks. 5 participants completed baseline and follow up evaluations.
All 5 participants who completed a follow up evaluation reported positive experiences being involved as a volunteer at the Straw Patch. All 5 said they felt more: connected to nature; physically active; experienced improved mental wellbeing and increased their social interaction. 3 out of 5 said they were undertaking more activity than before.



"I really don't want these sessions to end. We need to think of ways to keep this going"



Conclusion
This project intended to enrol 12 participants but was only able to recruit 9. This was likely due to the limited advertising to one community group.
The objective of encouraging participants to attend other groups was not met.

The participants who were able to join the 6 sessions on offer reported positive experiences.

This project needs £125 per session to cover costs of transport and support staff. Community Developer support would be needed to confirm if there is a sustainable self funding future.

Dementia support

Investment: £1,300





Intention/activity: To set up a communal garden at the Amory Centre in South Molton for people living with Dementia. To provide support to next of kin, family and people with dementia. Go into people's homes who are unable to travel to the Amory Centre to participate in a gardening project with an aim to encourage participants to come to the Amory Centre to join others in gardening classes.

Intended benefits:
Participants are able to spend time in a quiet, rural space and getting a chance to enjoy nature. Within a few weeks participants usually feel happier, confident, more active and have an increased enthusiasm to try new activities. Through accessing our countryside setting, spending some time in our allotment and petting our animals for a couple of hours a week the participants quickly remember their love for being outdoors.



Winner of Platinum Jubilee Champion Award 2022

"These awards launched by the Royal Voluntary Service in honour of Her Majesty The Queen's 70 years of service, have given us the opportunity to celebrate the remarkable contribution of all volunteers, who truly are the backbone of our country.
Congratulations to all our Platinum Champions - and my heartfelt thanks to you and to the millions of volunteers across the UK who give their time and talents so generously."
Her Royal Highness, The Duchess of Cornwall

HAND priorities addressed:
Keeping well
Workforce
Co-ordinated support
Loneliness
Access - Services



What happened:
Gardening sessions were run at the Amory Centre, once a week for 16 weeks with 23 participants who self-referred from local publicity. Based on conversations with participants the offer was expanded from gardening to other activities such as painting, crafts and cognitive activities. A home service was put on for those who couldn't attend the sessions.

Project lead created dementia awareness packs, being distributed and sold in the UK. Profits from this are being used to fund future dementia sessions and activities.

The Project Leader has won an award for her entrepreneurship, working with people living with Dementia as a result of leading this project.

Carers were able to have 2.5 hours of respite while their family member attended a session. In total the carers received 40 hours of respite.

"It's been super, I like the company. I don't go out , so its nice that you come to see me. You are always happy and you brighten up my day."



Gardening scheme to help people with dementia given boost

Gardening provides lots of opportunities for reminiscing activities using all our senses

"She had given up with all her past hobbies and interests so it was wonderful to see her beaming face when sjhe had completed making a bird box." - Relative

Conclusion:
The project was a great success and evidence showed it provided many benefits to participants and carers/families.
To continue funding this activity for another year and undertake further dementia friendly evaluations to assess whether those who may be hard to reach have been invited to participate. Also to support the expansion of the project and recruit more volunteers.

"I like painting and making the cakes. We made planters too. I like coming here, being with people, friends and gardening."

Dementia Support Case Study #1



Susan was referred to the gardening group by social services. She had found it hard to mix with others and the project leader initially went into Susan's home for some one to one sessions in the community building. After a couple of sessions Susan was able to join the weekly group. During the group sessions Susan's grandchildren were able to go swimming with their mother, enjoying some time together knowing that their nan was at gardening club. The family have been signposted to Devon Young Carers. Susan has meanwhile gained confidence, improved her hand eye coordination, manual dexterity and has become a sociable member of the group.



"I like painting and making the cakes. We made planters too. I like coming here, being with people, friends and gardening."

Dementia Support Case Study #2



I visit Christine every Tuesday and Wednesday at lunch times to assist her with meal preparation as well as to support her with activities. Christine has a carer that visits for one hour a day and apart from this does not see anyone else.

Christine told me that although she does like her own company sometimes, she does find it hard to get motivated and to feel bothered to do the activities she used to enjoy. Christine expressed interest in flower arranging, baking and gardening. During her sessions I bring nature to her inside and she has loved making flower arrangements as well as baking cakes and planting bulbs in her garden.

"Its been super, I like the company. I don't go out , so its nice that you come to see me. You are always happy and you brighten up my day."



Go North Devon

Investment: £5,000

Shopmobility gives me the independence to get out on my own without having to rely on other people



Intention/activity:
The provision of supported door to door accessible transport and/or mobility equipment for people who have problems accessing services and local facilities due to a lack of mobility, public or private transport. The free taster sessions (3 journeys for up to 2 hours each for each participant) will boost confidence, ease loneliness and promote independence.
Both services are further enhanced by the support of volunteer sighted guides/shopping escorts (subject to availability). Journeys will be a mix of essential shopping and social trips depending on the timetable and demand. Up to 3 free of charge trips per person.
Promote taster sessions in the local press, radio and via social media
Intended numbers for Ring & Ride: 20 -25 people per week (200 -250 people over a 10 week period). Intended numbers for Shopmobility: 15 people per week (150 people over a 10 week period)



Intended benefits:
Reduce the experience of loneliness in older people
Increase availability of transport to support older people accessing services, shopping and attending social events.

HAND priorities addressed:
Loneliness
Access - transport
Access - services



What happened:
Taking place over a period of 8 weeks from 31st January to 30th March, there were 14 Ring and Ride participants and 6 Shopmobility participants.

Conclusion:
There were far fewer participants (6% of the originally intended numbers) than intended despite a significant amount of money and time being spent on staff time and advertising. The service was publicised in 12 different locations including the EX33 magazine, the Golden Years article in the North Devon Gazette, the Voice radio and through the social prescribers. No referrals were received from the Social Prescribers. It is difficult to conclude the benefits to the individuals from the survey results received.

Go North Devon struggled to enrol participants as there was an anxiety about sharing transport with others. Shopmobility services were thought to have not recruited participants because of changing shopping habits with more older people shopping online.

The original timeframe was found to be too short, so the project been extended in terms of time to enable Go North Devon to enrol more participants and be re-evaluated to see if this has the potential to address and contribute to the overall HAND objectives.



"If it was not for the Ring & Ride service we would not be able to get out. The help we receive is indescribable and we would not use anything else."

Simonsbath - Guided Walks



Investment: £4,242

Intention/activity:
To provide guided walks on Exmoor for 8 weeks for two hours each week

Intended benefits:
Increase in health and well being. Combat isolation and loneliness



HAND priorities addressed:
Keeping well (prevention)
Workforce
Co-ordinated support
Access - Services
Access - Transpo
Access - Local
Access - Digital



It's good to chat, it's good both mentally and physically. Nice walks, good company, friendly guides. To be recommended. I have since joined the Wednesday wanderer Barnstaple

What happened?
There were 17 participants who joined the group. Their average age was 73. The group had 4 males and 13 females. There were 16 walks in total in Lynton & South Molton.

Feedback from participants was very positive.







"Enjoyed meeting some lovely people - will be keeping in touch with some of them. Walking in all different weathers which I wouldn't have done - discovered fresh places and walks"

"I Struggled to find local groups, as few started up again since covid. It has helped me to meet people since finding myself alone in an area I don't know well. Brilliant for me. Made new friends to hopefully meet up for future walks."

Conclusion
All objectives of the project were met.

Memory Cafe

Investment: Torrington 100 Community Developer time

Intention/activity:
The Torrington Memory Cafe was at a standstill after Lockdown. T100's Community Developer attended the first session where there were only 3 carers and the people they cared for. He spent time supporting the development of the governance and leadership, helped the group promote and market themselves until now there are 12 attending regularly and the numbers are going up. He has been able to introduce the leader to some new activities including the arts activities supported by T100. To date there has been a storytelling session with dramatist Philip Robinson and there will be another arts focused session later in March. Philip reported that his sessions have been very well received.

Intended benefits:
Support Families living with Dementia in the wider Torrington area, through social, creative and reminiscent activity, shared experience and peer support.

HAND priorities addressed:
Loneliness
Keeping well
Coordinated support



So glad we came. Mum hasn't stopped smiling since she got here.

"By visiting established elderly groups in Torrington I will work with older people to enable connection, recognition and an opportunity to be heard. Investing time in this is essential to build a relationship for trust and ideas to grow. The project will encourage social interaction and re-establishment of social links for those feeling isolated by Covid, and enable them to co-create a piece of work: an illustrated book of their real-life stories. The work itself will enable both carers and non-carers to see those cared for in a new light, to stimulate a conversation around memory loss, dementia, and the isolation these conditions create, and how we can offer more support and value people for who they are, not just who they were. Up to 35 older people directly impacted, 400 through indirect engagement."
Philip Robinson = dramatist/storyteller

What happened:
Sessions had between 16-20 older people attending. Running
every 3rd Friday in Bideford and every 1st Friday of the month
between December and May 2022



Conclusion:
The memory cafe continues and is now sustainable and no longer requires funding to keep
running





I didn't think my husband would like it today as he's never been one for groups but he recognised an old colleague from his farming days from and they've been chatting ever since. And he's talking about coming again.

Tai Chi

Investment: Torrington 100 Community Developer time



Intention/activity:
As people get older we find they worry about keeping fit and active but for most, going to the gym or an exercise class is prohibitive. Tai Chi provides the ideal opportunity to strengthen both the lower and upper body and improve flexibility. Tai Chi also promotes well-being and increased confidence by improving strength and balance and reducing stress.

Intended benefits:
Increased strength & balance
Improved confidence
Reduced loneliness



HAND priorities addressed:
Keeping Well (prevention)
Access local
Loneliness

What happened:
Classes run weekly with on average 20 people participated in each class.

"Tai Chi has helped me improve my balance and I feel more confident going out for a walk and practice my breathing techniques if I get a bit anxious"

What happened:
Classes run weekly with on average 20 people participated in each class.

Conclusion:
People said that they felt stronger and an increase in self confidence after joining the Tai Chi classes.

"Tai Chi has helped me improve my balance and I feel more confident going out for a walk and practice my breathing techniques if I get a bit anxious"

"I thoroughly enjoy my weekly class with Ian. He is so knowledgeable and patient and I leave feeling relaxed and invigorated"



Age Concern Buddies



Investment: £3,625

Intention/activity:
With additional recruited volunteers to enable and support clients to gain confidence to take advantage of social events, re-kindle friendships, and regain self confidence within themselves.

Intended benefits
For a pilot project to support 12 clients to "Go out and About" for 8 weeks for 2 hours on community transport. Also to reduce our current waiting list by providing a weekly home visitor for a further 10 clients. This service once actioned will be on going as required.



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

Mrs B was recovering from back issues but feeling isolated and not going out due to pain. Mrs B now has volunteer buddy and has attended Rainbow Club since May 22. "It was nice to have somewhere to go and have some company"

"I am enjoying supported to go out. I hope to build confidence to go out on my own eventually" Mrs W has anxiety and depression, she now receives weekly volunteer buddy who enables her to get out and about and her husband receives respite. Mrs W enjoys her trips out very much and has been visiting new places which is helping her confidence a little"

What happened
8 new clients have registered with the HAND project of Age Concern. 6 have been assigned a volunteer buddy.
4 new clients were introduced to The Rainbow Club, supported by volunteer buddy.
1 new client has a weekly home visit from buddy which includes a stroll around the block to increase clients confidence.
1 new client has a weekly shopping trip with a buddy.
Partnership working with the Ring and Ride service, Go North Devon. 8 clients given leaflets, 3 new clients signed up to receive transport.



"I lost confidence in going out after falling and breaking a leg, I felt very depressed, service stopped due to me having covid too. Mrs R has received a weekly volunteer buddy, including trips out to local gardens and a bigger trip to Rosemoor. Mrs R says "I feel I can do anything now, I never thought I'd get this far"

Conclusion:
After 9 weeks of the project being active, they have met their 12 week target. Final evaluation of service in July
Clients didn't want any further photographs and paper work struggle for older people with sight issues.
Further funding requested, particularly with transport and buddy on transport.

"This is the first time I've been out of my house in 3 years, I'll be coming again too - thank you."



Naturemade - South Molton



What happened?
10 older people attending a coffee afternoon once a fortnight.
4 coffee afternoons taken place to date, positive feedback received from older people.

Conclusion:
Intended benefits and numbers on target.

Another 6 coffee afternoons to go...

Naturemade - South Molton

"This is the first time I've been out of my house in 3 years, I'll be coming again too - thank you."

Investment - £1,000

Intention/activity:
To provide an older people's coffee afternoon for up to 10 people on a fortnightly basis, targeting those in South Molton parish who are particularly isolated and/or vulnerable and lonely. Referrals taken from Community Developer and social prescriber in South Molton.



Intended benefits
To reduce loneliness, isolation, increase companionship and feel good feeling with like minded people.

HAND priorities addressed
Keeping well (preventation)
Loneliness
Access - local

What happened?
10 older people attending a coffee afternoon once a fortnight.
4 coffee afternoons taken place to date, positive feedback received from older people.

Conclusion:
Intended benefits and numbers on target.

Another 6 coffee afternoons to go...



HEALTHY WEIGHT & PHYSICAL ACTIVITY



Progress since last report

Serious Mental Illness and Physical Activity – a knowledge and skills toolkit' will be delivered to health and social care professionals across the Devon ICS in September 22.

·**Barriers, Issues, Risks** –the learning theme and narrative of 'inactivity as a community concern' provides a convening call to align the system to make this a priority once we have an ICS. How we can we embed this learning topic and style into the system.

'**Live Longer Better'** which forms part of One Northern Devon's approach to Healthy Ageing in North Devon (HAND) continues to deliver 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. Care home managers, staff, residents and carers along with veterans are being targeted as key populations to educate.

·**Key priorities for the next quarter** – promote with health and social care professionals, VSCE groups and individual citizens across the locality. Evaluate the learning with a feedback survey.

A primary care led 'reconditioning initiative' with funding aimed to increase activity levels of residents in local older adult care is recruiting an activity facilitator and therapist. The British Geriatric Society has launched a National Falls Prevention Co-ordination Group, providing information for preventing falls and 'reconditioning' older adults by being more active post-covid. Information for providers of services for older people| British Geriatrics Society (bgs.org.uk)

Barnstaple Alliance PCN is piloting a 6-12 week programme of taster sessions supporting people connect with leisure with the aim of increasing movement, reducing isolation and loneliness and to improve health for those with long term conditions.

OND's Workplace Wellbeing programme that supports local businesses launched with a webinar on 30th May. Two more webinars will follow with recruitment to the free programme ongoing at local jobs fairs and through partnerst. All businesses will be followed on with 1:1 consultancy sessions to support development of organisational wellbeing strategies, team development sessions on themes such as body language and goal setting as well as access to a digital wellbeing library.

ADDRESSING FUEL POVERTY // APRIL 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, 4 x Primary Care Networks and Public Health Devon

01 PROGRESS SINCE LAST UPDATE:

- In financial year 21/22 361 Energy delivered 315 home energy visits & advice calls. With estimated total savings of £165,036 to those households. We started the year with a much smaller team. We've spent most of the year building up the team's capacity to deliver more energy advice. Now have 1 full and 5 part time home energy advisers and 1 trainee helping us with our onward referrals. Since the last update 120 home visits and/ or energy advice calls have been completed (Feb & March 22)
- Those households have saved an estimated combined total of £76,333 in the form of benefits received, energy savings through behaviour change and energy efficiency measures installed etc.
- A £10,000 grant from the Household Support Fund helped deliver a new boiler for 4 households. One household had been without heating and hot water for 11 months. All 4 households were unable to pay for the installation of the boilers themselves.
- £82,887 secured from the CCG Covid Expansion Fund to expand fuel poverty mapping project deliver home energy advice to 315 households. The project will see all 4 PCNs work in partnership with 361 Energy, to target people most vulnerable to health issues that are made worse by living in a cold home identified at risk through primary and secondary health care settings (see item 4)
- Curtain Bank project funded by Western Power Distribution has been set up. The Curtain Bank is a stock of donated curtains with thermal lining attached by a group of expert sewing volunteers. The curtains are available to all 361 Energy customers (and others in need) that don't currently have curtains (or whose curtains are very thin) to help reduce draughts from windows & doors.
- £130 000 allocated from DCC to TDC between November to March. £126,684 grants were distributed, 246 applications, 214 grants awarded, 89 for direct energy cost support, The household support fund mk2 is due to start 6th May however TDC have approved a small amount of additional funding (36k) to continue the current scheme until this date. Both schemes are administered by Encompass on behalf of TDC, meaning that applicants get additional debt advice and wider support included.

INPUTS

3.5 FTE Warmer Homes Advisors
1.0 FTE Warmer Homes Co-ordinator

£133,739 Redress
£60,000 NDC
£875,000 LAD 2
£82,887 CCG

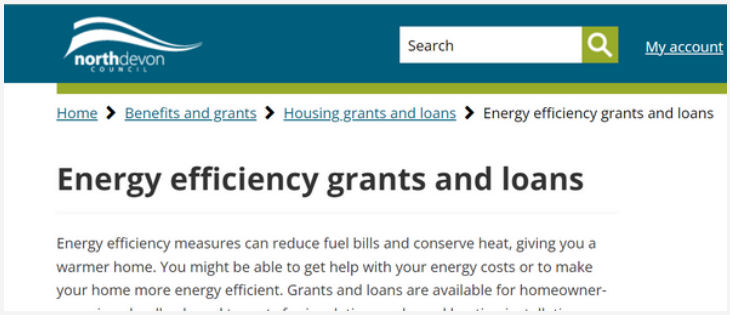
PROGRESS CONT'D

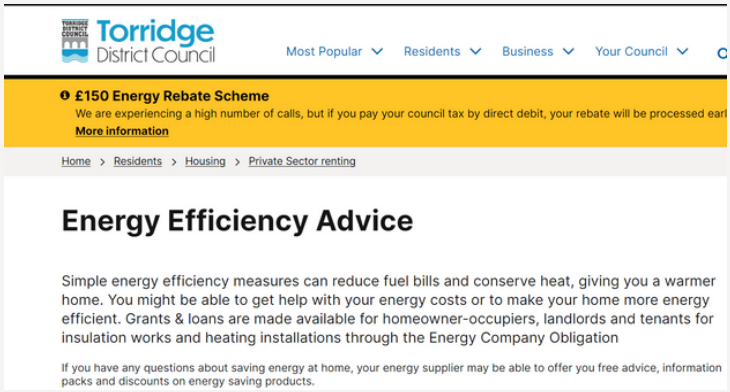


- NDC has created a webpage relating to Energy efficiency grants and loans. This will be updated for new funding opportunities (i.e Boiler Upgrade Scheme BUS), updates & links to other organisations for advice, energy efficiency grants & loans

- 2021/22 - NDC approved 192 ECO flexibility declarations for measures including cavity wall insulation, loft insulation, 1st time central heating, air source heat pumps, solar PV.

- 2021/22 – NDC provided 12 Warm Up Grants. These grants, up to £2,000 per property, provide top-up funding for energy efficiency measures where energy providers are part-funding energy efficiency measures under their Energy Company Obligation (ECO) or other government scheme.





- Green Homes Grant LA Delivery - phase 2:
  - TDC initial allocation was £634,458k
  - NDC initial allocation was £875,788k

These will be re-assessed across all local authorities taking into account demand & successful installations. Applications ended 31st March with installations to be done by end June 2022.

Table to the right shows data as at 21st April for TDC & NDC.

	Applications	Household type	Installations completed	£ installations	Installations to be completed
TDC	167	7 social / 4 private / 156 owner occupiers	2	12,469	5
NDC	365	8 private / 357 owner occupiers	8	£76,504	18

- Sustainable Warmth - brings together Green Homes Grant Local Authority Delivery scheme phase 3 & Home Upgrade Grant (HUG) phase 1. LAD3 supports low-income households heated by mains gas, HUG supports low-income households with homes off-gas grid. Consortium bid led by DCC with all Devon Local Authorities, with retrofit support service being provided by community energy groups (ECOE, 361 Energy, SDCE, TEC). Target no of properties for TDC & NDC = 58. Scheme to be launched end April.

- North Devon Homes were successful in an consortium bid (West of England Combined Authority) for Social Housing Decarbonisation Fund to provide external wall insulation, loft insulation top ups, thermal doors, upgraded heating systems (from E7 to high heat retention heaters) & some minor draught proofing measures & cylinder insulation upgrades for 38 bungalows in Witheridge & Bishops Nympton.

- NDC has commissioned 361 Energy for 3 years (£60k) to provide home energy service tailored to each customer. The service includes energy saving tips, support to help manage energy debt, guidance on using heating systems efficiently, help to access energy efficiency improvement grants (ie loft insulation) & free energy saving measures like LED lightbulbs, draught proofing & radiator reflectors per household.

02 KEY PRIORITIES FOR NEXT QUARTER

Supporting people through the 'cost of living' crisis. We're seeing a lot more people with complex debt issues because their household income is not enough to cover the rising cost of living.

Strengthening partnership working to make sure our customers can access all the financial support available to them to help keep on top of their energy bills.

Supporting as many as possible to access the Sustainable Warmth Fund, set up to raise the energy efficiency rating of low-income and low EPC rated homes ahead of predicted October price rise.

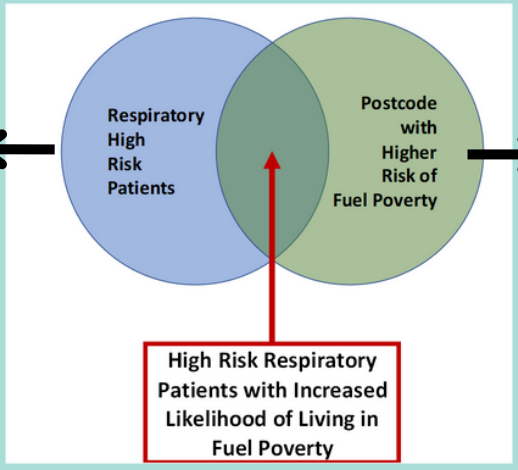
Working with the Primary Care Networks to deliver the targets set out in the Covid Expansion Fund alongside the Energy Redress project.

03 SUPPORT REQUESTED FROM OND BOARD/PARTNERS

- Financial support to help people pay for oil top ups in the North Devon council area would be helpful. There are many people who are unable to afford the cost of topping up their oil or LPG tank now. The Lendology bulk buy fuel loans are not available in North Devon (but they are in Torridge).
- Where new electric storage heaters are being installed in properties for tenants, please ensure that they are given a lesson in how to use them efficiently (many people are being left to figure it out themselves and it's costing them a fortune).
- Consider setting up a Post Covid Response Loan (as set out by Lendology) to help with back log of bill payments following COVID.
- Let us know of any potential funds that can be used for pre-payment meter top-ups or to bulk buy emergency items like electric blankets or dehumidifiers.

04 SPOTLIGHT ON RESPIRATORY & FUEL POVERTY HIGH RISK COHORT

- Asthma patients on ICS, or LABA, or LAMA, or Montelukast in last 6 months AND prednisolone issued more than 4 times in last 6 months
- COPD patients on triple therapy in the last 4 months
- COPD patients on Roflumilast last 4 months (NB: this should be zero as this is generally only prescribed in acute settings)
- From these 3 queries the patient's ID, age and postcode are extracted



361 Energy have provided a data set consist of every dwelling in the catchment area (currently North Devon but to be expanded to Torridge The dataset consists of:

- Postcode of the dwelling
- Main fuel type
- Secondary fuel type
- Standard Assessment Procedure (SAP) rating of the dwelling
- Annual energy demand estimate (kW h)

ACTIVE TRAVEL

// JUNE 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
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

Matt Collins, Team Leader for Highways Development and Transport Planning (North) from DCC has joined the AT forum and presented an overview of the Local Cycling and Walking Infrastructure Plan (LCWIP) with a review of the responses to their 2 stakeholder events being fed into their report.
·**Key priorities for the next quarter** – send a formal AT forum response letter to DCC concerning the LCWIP proposals. Continue to engage with local planners with a focus on reduction of health inequalities through improving routes and access to travelling on foot or non-motorised transport around north devon.

Support requested from OND board/partners

·Engage and support the 'Live longer better' programme of learning to support a cultural revolution in changing attitudes and our approaches to healthy ageing and longevity in North Devon
·Promotion of the OND 'Workplace Wellbeing' programme. Larger companies/partners consider supporting SMEs in their neighbourhood and lead by example by becoming being part of the network.

NATURE ON PRESCRIPTION // JUNE 2022



Unsplash/Getty Images/Pratik Bhide For The Swaddle

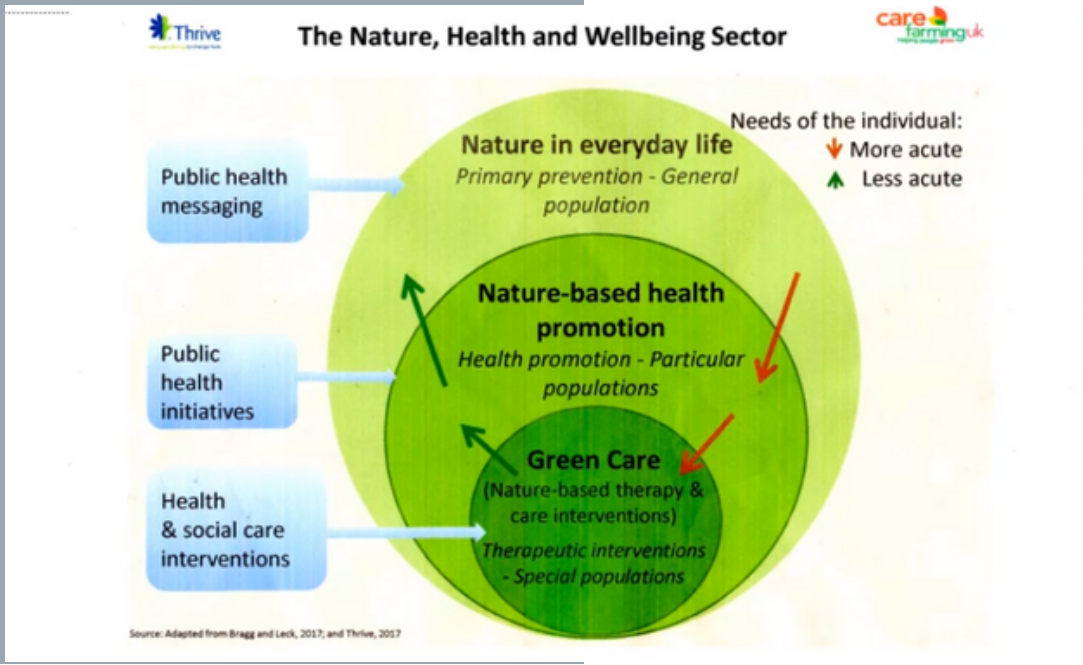
Spending time in nature, particularly around water, offers huge health and wellbeing benefits to individuals but also has a role in helping the environment and reducing pressures on public spending that are caused by the knock-on effects of stress, depression and anxiety.

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.

Nature on Prescription evaluation report can be found here

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



WORKPLACE WELLBEING

// JUNE 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.

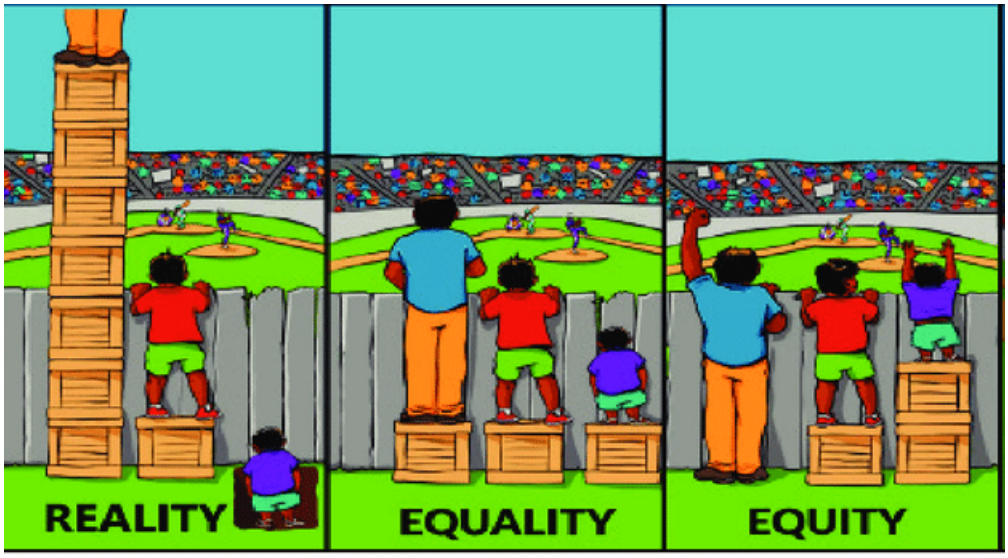
Objectives:

- 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

Latest report can be found here

TACKLING INEQUALITIES IN HEALTH // JUNE 2022



Health Inequalities Team

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

ONE NORTHERN DEVON IS HOLDING A HEALTH EQUITY STAKEHOLDER WORKSHOP ON WEDNESDAY 30TH JUNE. OBJECTIVES OF THE WORKSHOP:

- Participants' commitment to developing a strategy for reducing health inequalities in Northern Devon
- To understand how people across the system can continue to be involved in shaping and delivering it
- For everyone to be able to see their role and their potential role in reducing Health Inequalities.
- To get greater clarity over the barriers and what needs to be done to remove or mitigate them.
- Better visibility of the 'system'- what we're all doing, and where we could join up better. Whether we think our collective resources are targeted in the places that will have the most impact.
- To explore what participants could do now and how we could support you in doing that.

AGENDA

9.30-10.40

HEALTH INEQUALITIES

SETTING THE SCENE

WHAT DO WE WANT TO ACHIEVE TODAY?

WHY CO-PRODUCE?

HEALTH INEQUALITIES

INSIGHTS GATHERED SO FAR

YOUR EXPERIENCE

WHAT IS YOUR EXPERIENCE?

WHAT ARE THE DRIVERS?

WHAT ARE THE BARRIERS?

10.40 -11.15

SYSTEM THINKING

SYSTEM THINKING

SYSTEM AIM

COMPONENT PARTS

REFLECTIONS

SYSTEM MAPPING: *WHERE ARE YOU IN THE SYSTEM?

TEA BREAK*

11.30 -12.30

FOCUS AREAS

COMPLEX NEEDS

PERSPECTIVE OF A HIGH FLOW CLIENT

PERSPECTIVE OF A SUPPORT ORGANISATION

REFLECTIONS

TABLE DISCUSSION:

YOUR ROLE

COULD YOU HAVE A GREATER ROLE?

WHAT MIGHT STOP YOU?

WHO ELSE NEEDS TO BE INVOLVED?

12.30- 13.15

LUNCH BREAK*

13.15 - 14.15

FOCUS AREAS

HOUSING

PERSPECTIVE OF A LOCAL HOUSING AUTHORITY

PERSPECTIVE OF A SUPPORT ORGANISATION

REFLECTIONS

TABLE DISCUSSION:

SAME QUESTIONS

TEA BREAK*

14.30 - 16.00

GOING FOWARD

INSIGHTS FROM TODAY

WHAT WERE THE SYSTEM BARRIERS THAT WERE IDENTIFIED?

CAN ANYONE IN THE ROOM RESPOND TO THOSE BARRIERS NOW?

RESPONSES

NEXT STEPS

WHAT WERE THE TAKE-AWAY ACTIONS?

HOW DO WE CONTINUE TO LEARN FROM PEOPLE'S EXPEREINCES IN BETWEEN NOW AND NOVEMBER?

WHAT ARE THE NEXT STEPS IN CO-DEVELOPING THE STRATEGY?

*DURING ONE OF THE BREAKS, PLEASE VISIT RICHARD AND HIS KUMU BOARD IN THE SIDE ROOM. PLACE DOTS ON THE BOARD TO REPRESENT WHERE YOUR ROLE IN THE SYSTEM IS, AND THEN PLACE YOUR 'DOTS' ON THE BOARD WHERE YOU THINK IT WOULD HAVE THE MOST IMPACT ON HEALTH INEQUALITIES. RICHARD WILL EXPLAIN! WE'RE INTERESTED TO KNOW IF YOU FEEL OUR RESOURCES ARE IN THE PLACES YOU THINK WOULD HAVE THE MOST IMPACT. WE'LL LET YOU KNOW THE RESULTS AT THE END OF THE DAY.

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.



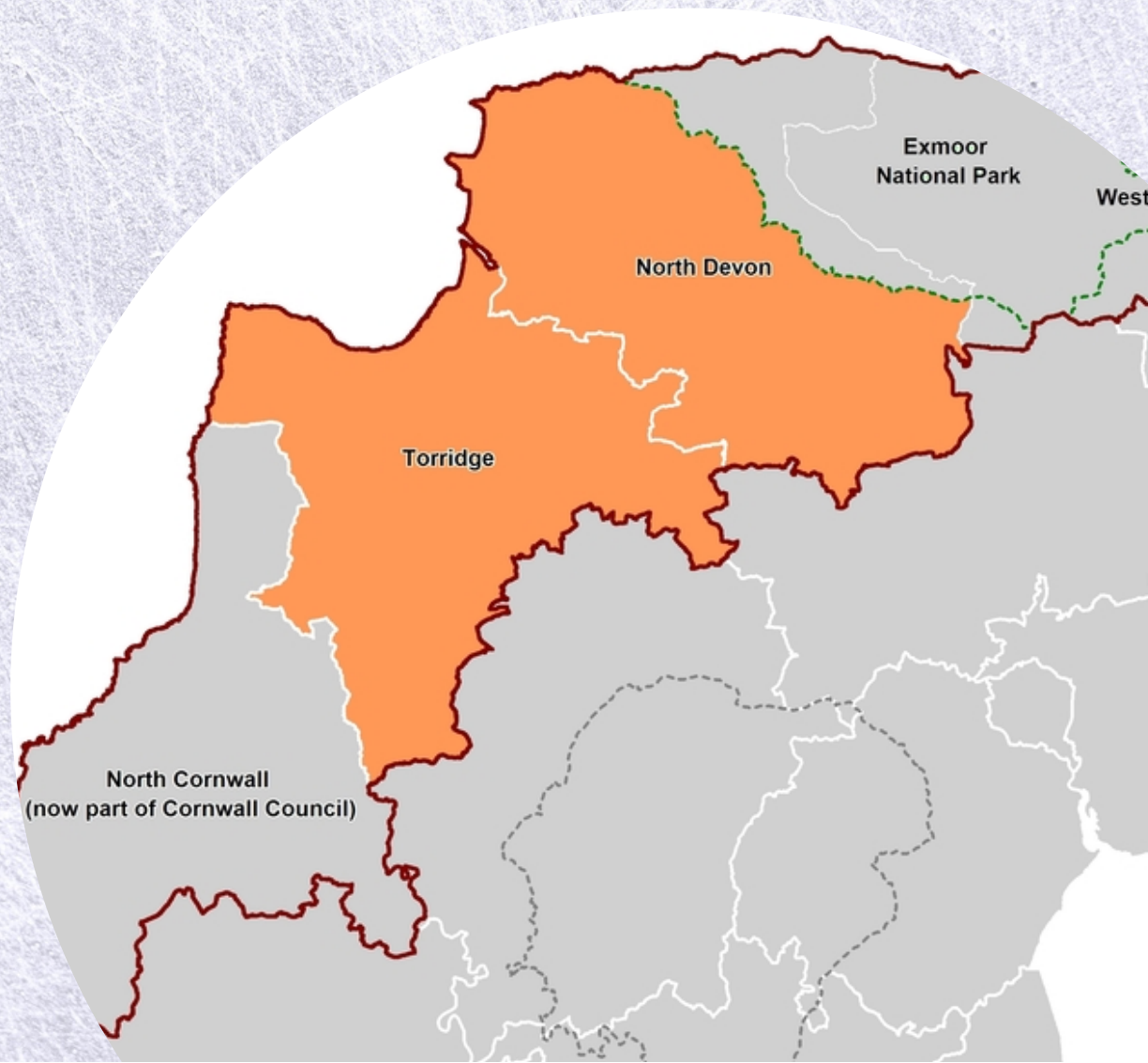
In Northern Devon, people in the most deprived communities can expect to die 15 years earlier than those living in our most affluent ones.

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 only do and problems we can only solve if we work together.

We create positive change by:

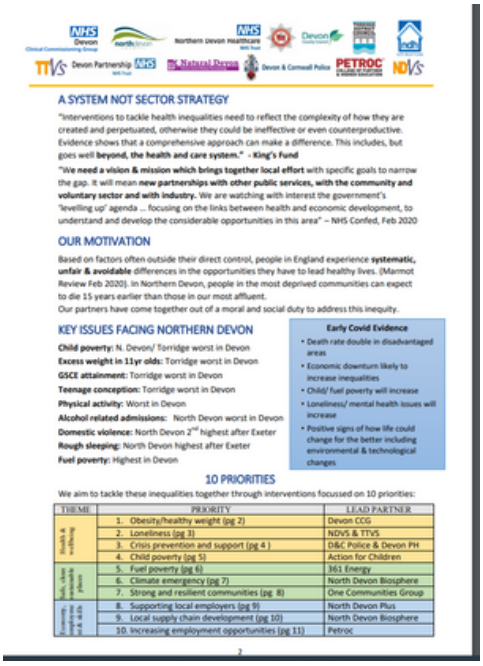
Empowering communities

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
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

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 FH
	4. Child poverty (pg 5)	Action for Children
Safe, clean sustainable places	5. Fuel poverty (pg 6)	361 Energy
	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

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

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.

The 3 Pillars

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.



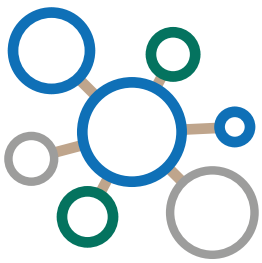
PERSON

One-to-one support for individuals



PLACE

Whole population support to communities



SYSTEM

Organisational support for system co-ordination