onenortherndevon

Partners' report

AUGUST UPDATE

Person-centred

Place-based

System Co-ordination



2022

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CONTENTS //

AUGUST 2022

PROGRAMME UPDATES

PERSON

1. The Flow Approach
2. High Flow
3. Secondary Care Flow
4. Primary Care Flow
5. Community Mental Health Flow
6. Community Flow

PLACE

1. One Ilfracombe
2. One Atlantic
3. One Barnstaple
4. Torrington 100
5. Live Well in Braunton
6. One South Molton
7. Holsworthy District Community Forum

SYSTEM

Reducing health inequalities

1. Developing North Devon's health inequalities strategy
2. Core 20 Plus Connector pilot
3. Tackling fuel poverty together
4. Anticipating the cost of living crisis (pre-project development)

Improving wellbeing

1. Healthy Ageing North Devon (HAND) - FAME project
2. Promoting healthy weight and physical activity
3. Active Travel
4. Wellbeing at Work
5. Serious Mental Illness & Physical Activity
6. Nature on Prescription
7. Tackling loneliness with transport

ONE NORTHERN DEVON PARTNERSHIP

1. About us
2. Why needed
3. Our Vision
4. Our Strategy and themes

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 6 clients are supported by High Flow.
1 client is supported High Flow Step-Down.

02 KEY ACHIEVEMENTS

- Client 12 presented at the Health Inequalities event and sat on recruitment panel additional High Flow Caseworker (Lottery funded)
- Lottery funding application successful for additional case worker
- Client 16 - safety/domestic abuse concerns but TAP working well, now in Encompass Supported Women's Accommodation having previously been living on the streets.

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Prioritising safeguarding and support of Client 16 to help her remain in her new accommodation
- Supporting the other Flows & new staff building the wider Flow Team
- Employ new High Flow Caseworker from Lottery funds & Peer Mentor
- Increase awareness of TAP process internally and externally

04 BARRIERS, LEARNING, SUPPORT REQUIRED

- Co-production work - involve case worker in communication to support client in case they are triggered.

HIGH FLOW

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AUGUST 2022

INPUTS

High Flow Caseworker
High Flow Project Co-ordinator

£48,000 per year

OUTPUTS

APRIL 2022 - JULY 2022

Team Around the Person meetings x 8
Connections/Referrals to community services x 3
Connections/Referrals to statutory services x 4
General Money Advice/banking x 17
Food Parcel Given x 17
Form Filling x 6
Housing Advice Provided x 3
Welfare benefits advice x 1
Support to find alternative housing x 2
Support to attend medical appts x 36
Support to contact/attend counselling x 6
Support to manage tenancy/licence x 4
Support to develop self care skills x 10
Support to dependent/co-dependent x 17
Improved Devon Home Choice Banding x 1
Safety Plan completed x 7
Support to meet aspirations x 16
Support to improve employment prospects x 0
Supported training/volunteering x 1
Signposted to external agencies x 5
Support to attend dentist/opticians x 11
Support with recovery journey x 27
Supported into Accommodation x 3
IT support incl. virtual meetings & emails x 7
Client involved in co-production work x 7
Safeguarding meeting conducted x 1

OUTCOMES

APR 2022 - JULY 2022

Financial Gain Other x 1
Alternative Housing Secured x 3
Bailiff action prevented x 0
Supported to remain in property x 3
Debt managed x 0
Eviction averted/homelessness prevented x 1
External Health Assessment conducted x 6
Financial gain/charitable payment x 8
Home Care/aids/adaptations obtained x 0
Improved living conditions x 9
Improved engmnt w/Health Services x 13
Improved Family Relationships x 3
Improved social skills/relationships x 5
Improved financial status x 0
Improved life skills x 8
Improved meaningful activities x 18
Improved motivation x 26
Improved personal hygiene x 2
Improved physical health x 4
Increased Independence x 14
Appropriately engaging with GP x 2
Successful court action x 1
Moved into employment x 0
Client took own action to address issue x 17
Community activity achieved x 3
Client/dependent supported to live safely x 8
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.

SECONDARY CARE FLOW //

AUGUST 2022



'Flow' launched into secondary care in May 2022, with a Flow Co-ordinator based at North Devon District Hospital, as an embedded member within their pain team. The pain team were confident that this role would complement the work of their team who already work in ways that are holistic, are about what matters to the individual and that recognises the causal factors of pain can often be driven by factors that can't be managed purely clinically.

01 NUMBERS SUPPORTED

Currently 7 clients are supported by Secondary Care Flow

02 KEY ACHIEVEMENTS

- Flow Co-ordinator now well embedded in the Pain Team at NDDH and attends their MDT every Wednesday
- Successful application made to Bideford Bridge Trust on behalf of complex client for decluttering - £900

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

- 6 month review plCarold with pain team lead

04 BARRIERS, LEARNING, SUPPORT REQUIRED

- Secondary Care Flow Co-ordinator has 15 hours per week and is finding that she is nearing capacity
- Pharmacy issues are causing problems especially for the elderly who are not able to do prescriptions online. This is particularly bad in Braunton.

SECONDARY CARE FLOW //

AUGUST 2022

INPUTS

High Flow Caseworker
High Flow Project Co-ordinator

£48,000 per year

OUTPUTS

MAY 2022 - JULY 2022

Team Around the Person meetings x 1
Connections/Referrals to community services x 2
Connections/Referrals to statutory services x 5
General Money Advice/banking x 0
Form Filling x 3
Housing Advice Provided x 0
Welfare benefits advice x 0
Support to find alternative housing x 0
Support to attend medical appts x 1
Support to contact/attend counselling x 1
Support to manage tenancy/licence x 0
Support to develop self care skills x 2
Support to dependent/co-dependent x 1
Support to meet aspirations x 9
Support to improve employment prospects x 0
Supported training/volunteering x 1
Signposted to external agencies x 8
Support to attend dentist/opticians x 0
Supported into accommodation x 0
IT support incl. virtual meetings & emails x 0
Client involved in co-production work x 0
Safeguarding meeting conducted x 1

OUTCOMES

MAY 2022 - JULY 2022

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

>>> EXIT STRATEGY

Funding is secured from the NDDH Pain Team substantively for 15 hours per week

SECONDARY CARE FLOW // CASE STUDY AUG 2022



I really appreciate your help and know you are the sort of person who will try to help me

- Carol, late 50s

Carol has multiple long term health conditions and looks after her husband, who has terminal cancer, and her elderly father. She was feeling exhausted with coordinating all of the appointments for herself, her father and her husband.

What mattered to Carol

The Pain Team Lead Professional has known Carol for a few years, within the Pain Service. He had the 'What Matters to me" conversation with Carol, then referred her to the Flow Coordinator, to support with her home and social life which was what mattered the most to Carol.

Initial telephone contact with Carol identified that circumstances at home were problematic. Carol reported she was being supported by NDADA and was awaiting another Social Worker to make contact. Carol said she felt extremely alone and unsupported. She was tearful at times and said she really wanted to change things to support her health and wellbeing.

Initially it was unclear whether Carol required the Team around the Person (TAP) or purely support with making adjustments within her home life.

During the Flow assessment it was identified that the thing which matters the most to Carol, was to obtain a professional de-clutterer for her house. Carol's home situation is a further health risk, in terms of trip risk and fire hazard. It also means that Carol sleeps on the floor.

Carol reported she feels let down by the system with many services promising support but never seeing it through. She reports feeling suicidal on several occasions, which she has reported to her GP and Pain Clinician. Carol self-discharged from the Mental Health Team, though is still seeing a Clinical Psychologist.

What has happened?

Carol receives PIP and a small work-based pension but is not yet of state pensionable age, so finances are very tight. The Flow Co-ordinator researched decluttering services but found them to come in at a high daily rate (£180 per day). Carol reported that she could not afford the service. The Flow Co-ordinator therefore applied for funding via the Bridge Trust on Carol's behalf and this was successful.

It's still early days but the Flow Co-ordinator hopes that having a de-cluttered house will be a good foundation to work on other things that matter to Carol.

COMMUNITY MENTAL HEALTH FLOW // AUGUST 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.

Outputs and outcomes for the previous years can be found here

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

CURRENT SITUATION

This work is currently paused as the Community Mental Health Flow Co-ordinator has moved out of the area and MIND in Somerset have been unable to recruit to the post so far.

VCSE partners are reporting that recruitment is currently challenging. OND partners are asked if they have any thoughts on how to overcome these issues which appear to be part of a national issue of employment exceeding demand.

PRIMARY CARE FLOW //

AUGUST 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.

PROJECT STAGE

- Prototype 1 completed with 3 patients and 3 GPs
- Prototype 2 initiated with further patient, further 2 patients/GPs being recruited
- Pilot across 4 x PCNs started in April 2022
- 5 open cases

01

Outputs and outcomes for the previous years can be found here

02

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

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.

04

KEY PRIORITIES FOR THE NEXT 2 MONTHS

Lack of referrals into the project from GPs, other routes being considered. Oliver Hassall attending Coast & Country PCN meetings to explain process.

PRIMARY CARE FLOW //

AUGUST 2022

INPUTS

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

£20,000 per year



OUTPUTS

APRIL 2022 - JULY 2022

Patients referred into service x 3
Primary care professionals referring x 3
Cases concluded successfully x 1
Flow debrief meetings x 2
Signposting to external organisation x 1
Support to contact and attend counselling appointments x 1
Support working towards goals and aspirations x 1
Support with recovery journey x 1
Team Around the Person Meeting Conducted x 3
Referral to MASH/NDADA x 1

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



OUTCOMES

APRIL 2022 - JULY 2022

External health assessment conducted x 1

>>> 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.

COMMUNITY FLOW

// AUGUST 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

42 people have been referred into Community Flow since April 2022,
40 of which were RDUH referrals, 1 DPT and 1 Community Healthcare
3 referrals were declined
4 volunteer home visits, 1 volunteer phonecall
10 volunteers fully inducted

02

KEY ACHIEVEMENTS

- Volunteer audit now carried out, 10 volunteers fully up to date
- 9 volunteers agreed to be on whatsapp group for communications
- Secured additional funding for Community Flow Co-ordinators and Tier 2 unregulated care provision

03

KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Increase referrals from hospital
- Increase 3rd party volunteer capacity
- Recruit 2 additional Community Flow Co-ordinators
- Recruit unregulated care provider co-ordinators
- Volunteer face-to-face event

04

BARRIERS, LEARNING, SUPPORT REQUIRED

Lack of geographical spread of volunteers (Ilfracombe, Woolacombe, Lynton & Lynmouth in particular & no 3rd party provider found by TTVS).

COMMUNITY FLOW // JUNE 2022

INPUTS

1.1 FTE Community Flow Manager

1.1 FTE Community Flow Coordinator

Outputs

Total referrals: 42
Total referrals declined: 3 (inappropriate)

Total volunteer visits: 4
Total volunteer hours spent on visits: 4 hours 35 mins
Total volunteer phone calls: 1
Total volunteer hours spent on calls: 10 mins

Total CF Coordinator phone calls to patient: 55
Total CF Coordinator hours spent phone calls to patient: 24 hours 30 mins

Total CF Coordinator ward visits to patient: 25
Total CF Coordinator hours spent ward visits to patient: 14 hours 5 mins

Total CF Coordinator home visits: 2
Total CF Coordinator hours spent home visits: 4 hours

Volunteers currently active: 10
7 TTVS volunteers
3 RDUHT volunteers

Withdrawn volunteers: 13 (due to volunteer audit by CFM)
4 TTVS
9 RDUHT

CAP meetings: 7
What matters to me conversations: 7

Community Connections:

- Community groups/activities (addressing loneliness) x5
- Money Advice Services x2
- Community Developer x9
- Social Prescriber x2

Onward Referrals:

- Community Nursing Team x1
- Housing Services x1
- Social Services Adult Team x2
- Form Filling x1
- Housing Advice x1
- Welfare benefits advice x1
- Support to dependent/co-dependent x1
- Signposted to external organisation x10
- Client involved in coproduction work x3

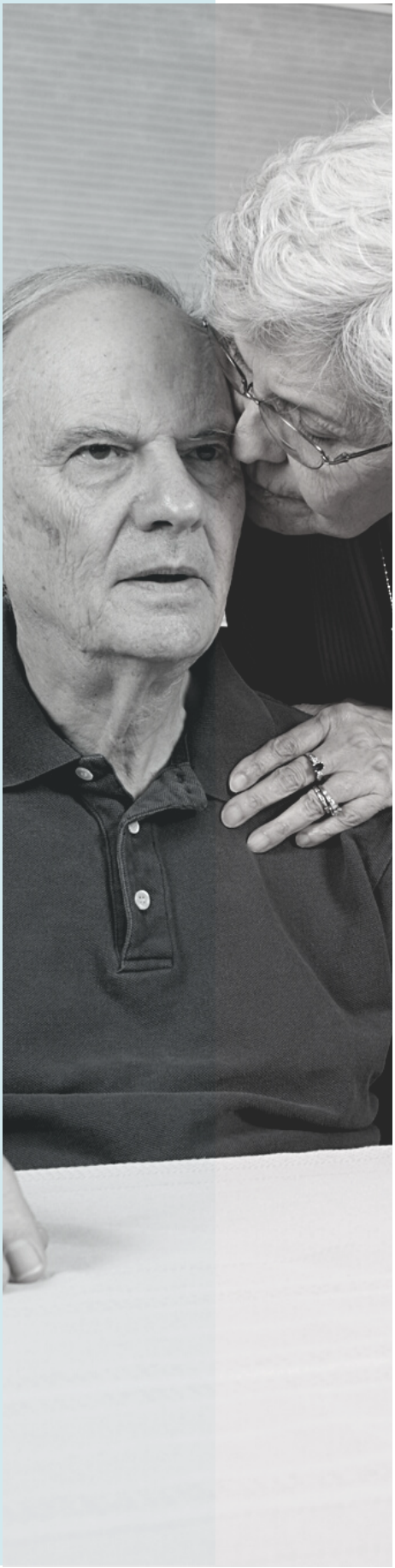
Outcomes

- Financial gain – other x2
- Support to remain in property x1
- Debt Managed x1
- External health assessment conducted x2
- Home care/aids/adaptations obtained x1
- Improved engagement w/health services x2
- Improved meaningful activities x1
- Improved motivation x1
- Moved into training/volunteering x2
- Appropriately engaging with GP x5
- Client/dependent supported to live safely x4
- Client took own action to address an issue x1

>>> EXIT STRATEGY

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

COMMUNITY FLOW **CASE STUDY** // AUGUST 2022



Alfred was referred to Community Flow by the Discharge Co-ordinator in NDDH. Alfred has dementia and lives with his wife, who is also his main carer. Although Alfred lacked capacity to consent to our support, his wife who has LPOA for his health was able to say that she thinks he would benefit from our involvement and so the Community Flow Co-ordinator - Tom - agreed to meet her and Alfred at their home after he had been discharged from hospital.

Tom made a follow up call to the family to check that Alfred had settled home after discharge. He also asked if they would allow him to contact the Community Developer and Social Prescriber for their area – which they agreed to so he requested information on local resources (community groups, events etc) and also referred Alfred to the Alzheimer's society with his wife's permission.

The couple had also been referred by the ward to Devon Carers so by this point there were quite a few agencies involved and Tom spent time with Alfred and his wife explaining what each one does and how they can help. He also gave them a list of local community groups given by the Community Developer and Social Prescriber. He discussed all of them with Alfred and his wife and highlighted the ones that they liked the sound of. Tom anticipates that Alfred may need extra support to access these things due to his dementia. He has completed a "this is me" profile which the Alzheimer's society developed to record the important information a person with dementia wants to share with other people such as their interests, medical information and conversation starters for people to use in unfamiliar settings. This will be helpful for Alfred if he is to attend any groups.

The next steps are to call ahead to these groups to tell Alfred's story so that the family do not have to always repeat it – Tom will share the information anonymously at first and then let the family know to get in touch if it sounds as though they will be able to welcome Alfred to their group. Alfred's wife highlighted several other needs such as "respite" which Tom highlighted to Devon Carers and also information about supporting a loved one with dementia which he requested from the Alzheimer's society. Tom says his role has been mostly to "join the dots" for Alfred and connect the various sources of support and help him and his wife to make sense of it.

one ilfracombe
our future, our choice

Chair: Cllr Rod Donovan
Community Developer: Charmain Lovett

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



OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Kailo: Collaborative research	Connected the Kailo Project (University of Exeter funded research project) in with the Academy, churches and Junior Schools	One Ilfracombe are now a 'key partner' in linking Kailo to local organisations	Dartington Service Design Lab Exeter.University
Welcome to Exmoor trips	Created video Evaluation of Welcome to Exmoor trips for Active Devon funded trips, once-weekly for 8 weeks. weekly trips. Supported by a volunteer from ITC volunteers and Ilfracombe Community Transport	Hugely improved the health, happiness and confidence,' life-changing', by connecting people with others in nature. See Video evaluation	Ilfracombe Community Transport Exmoor National Park Active Devon
Community Forum (Living Well)	Agendas, minutes and presentations. We're having a break for August but have plCarold in presentations for September	Sent comprehensive updates to partners post meeting	Over 35 cross-sector partners
Combe Christmas (Lights ceremony and weekend event)	Writing follow up report on capacity to deliver CC through Ilfracombe Town Council.		Ilfracombe Town Council

Local support

The Ilfracombe Centre	Supporting them to acquire funding for a defibrillator. Connected with local family that have been raining funds and Tyrell League of friends
Ilfracombe Link centre	Regular meetings with DCC and DPT over the ongoing and future use of the Link Centres CD Attended Co-production training through DCC

Wider partnership work

Tackling Loneliness Through Transport	Co-produced ideas with OND for how we could create/support transport-based projects in Ilfracombe. Also trying to secure further DfT funding for local projects.
High Flow: National Lottery Partnership	Meeting with Partnership to co-design the CD approach to supporting residents with multiple, complex needs. CD attending working group meetings / future trainings

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.

OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

Chair: Dr Ruth Tapsall
Community Developer: Lara Eley



PROJECT	OUTPUTS	OUTCOMES	PARTNERS

NEW COMMUNITY DEVELOPER RECRUITED - STARTS SEPTEMBER 5TH 2022

Chair: Louise Flagg
Community Developer: Ella McCann



One Barnstaple priorities

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

AOUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Community Engagement:It's a New Day – Recruitment, Wellbeing and Advice Fair." 13.07.2022	Supported Griffiths Construction Company to find venue (pannier Market) and connect with organisations	"How many meaningful interactions / contacts did you make during your time at the event? 6 x exhibitors reported 1 – 5 1 x exhibitor reported 5 – 10 1 x exhibitor reported 15-20 1 x exhibitor reported 30 - 35 See Devon Live news report	Griffiths Construction Company
Community Engagement: Camerados Living Room pop-up @Re-Connect and Create Fest 17.07.2022	Organised The Shambles for a pop up living room. Created a leaflet to recruit volunteers. Ordered Camerados box and funding from BTC via NDVS for room hire.	Evaluation taking place – conversations with Camerados HQ about ongoing Camerados events with scope to make some changes and potentially support other local areas	Camerados Re-Connect and Create Fest
12-Week PCN taster sessions	Confirmation of underspend for use on further sessions in the autumn 2022 Gathering feedback to improve next run of sessions	Impact report for Pilot 12 Week Activity and Leisure Taster Programme (Submitted to Active Devon July 2022) Future collaboration with One Atlantic / sharing of learning	Barnstaple Alliance PCN Active Devon B. Town Council 17 delivery partners
Wellbeing Cafe Community Connecting and Development (PCN CD)	Setup informal, low-key drop-in sessions at the Shambles (front of the Pannier Market) Signposting / helping to navigate services / speaking to agencies on person's behalf / prioritise actions	Wider determinant and personal support 1:1 See August 2022 project report	Barnstaple Alliance PCN Active Devon B. Town Council 17 delivery partners
'Groop' Virtual Hub (priority 8) A Community management platform	Posted to Groop 'Young people needed for Health Inequalities interviews' > Mark (OneSmallStep) shared details of Youth service in Barnstaple and Youth worker in Bideford	Young people interviewed for OND video	One Small Step

Local support

x3 local organisations	Discussing potential socially prescribed art/sculpture programmes/sessions (need transport). offering peer support and signposting to organisation al support (governance/procedures etc). Exploring scope for activity sessions, mindfulness and experience sessions. Linked to recruitment event.

TORRINGTON 100
One Great Community

Chair: Carolmarie Shillito
Community Developer: Michelle Harding

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.



OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
T100 website	Moving the T100 website content to a page hosted on TTV website	Partnered with TTVS to improve communication and engagement with the local and wider community	TTVS
World Alzheimer's day film @The Plough	Discussed provision with the Plough Arts Centre. Sourcing funding to cover the £200 for the film	To support people suffering with memory loss and their family / friends / carers	T100 Dementia Friendly Communication working Group The Plough Arts Centre
Young Carers performance and celebration event Part of Carers' Art and Resource Events (CARE	Event with performance by young carers to an audience of over 40 older carers/cared for, their siblings and families, readings by older carers and carers plus jubilee feast and display of all artwork mounted and displayed.	Young carers from Torridge and West Devon and 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.	T100 Dementia Friendly Communication working Group The Plough Arts Centre
Community Fayre 2022:	Exploring potential partners	A Wellbeing and Community event to help residents and community groups reconnect post Covid	TTVS T100

Local Support

Peters Marland Parish Council	Help with funding for church roof
Bickford Centre	Met to discuss possible funding
Memory Cafe	Looking at funding options and ways we can engage with people from outlying rural villages who struggle with transport

HOLSWORTHY & DISTRICT COMMUNITY FORUM

Chair: Geoff Cusick
Community Developer: Alyce Barber



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

OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Action plan and priorities	Carried out initial discovery conversations with several established community groups focusing on key priorities. Steering group has been formed to look at survey results, JSNA & previous survey with the aim of update list of priorities / areas of focus based on recent results	Support HDCF to develop an asset/priority based Action plan Assets will help all partners including Social Prescribers	HDCF Live West Dart Academy
Children & Young Peoples asset database	Researched available assets online and met with local groups	Created a Children & Young Peoples asset database inc cross border provision	HDCF
Volunteer Database	TTVS Database for volunteers continues to be developed Additional recruitment at HDCF Coffee Morning event	New Volunteers recruited to help with Community Fridge	HDCF TTVS
Database of services and organisations	Originally created by CD & SPs in 2000. SP recently shared current database and jointly keeps update by engaging with groups to use and update when ready	Country & Coast PCN General Public once released This will be shared with TTVS & OND	Country & Coast PCN
ROC – Community Engagement event (October 2022)	Met with the organiser (ROC) and funder (Methodist Church) This is part of a 12-month Community Engagement programme	Partner with ROC / Methodist Church to support and deepen community engagement efforts - avoiding replication	ROC Methodist Church Holsworthy College
Community Fridge Tackling Food waste	Planning permission has been submitted (seeking temporary location)	Recruited volunteers	Foodbank, Trussell Trust, Live Well North Devon, Men's Shed

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.

OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE



PROJECT	OUTPUTS	OUTCOMES	PARTNERS

AWAITING FUNDING DECISON BEFORE RECRUITING COMMUNITY DEVELOPER

In Development

- The Braunton Men's shed has received a Heritage lottery award for £10,000 which will mean they can start work on their premises
- Involved with further evaluation of chill swim
- Working with Coastal PCN, specifically Cean medical centre, to pilot social prescribing for military families at Chivenor.
- Keen to reinvigorate our Companion walking scheme and are in discussions with the Countryside centre about future collaborative projects.
- Social Prescriber will be supporting 'OND Community Flow' work in Braunton

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

OUTCOMES FOR PREVIOUS MONTHS/YEARS CAN BE FOUND HERE

PROJECT	OUTPUTS	OUTCOMES	PARTNERS
Community Asset Mapping	Updating community provision Excel	Shared working document on google drive between CD/OSM network.	OSM PCN/SP
Funding	Met with TTVS to discuss funding available to OSM	Funding proposal submitted for arts/theatre youth projects.	TTVS
Engagement: OND Health Equity	Completed OND HI survey and Connected 'Research my Way' to three groups: Dementia Support, Sunshine Circle and Hidden Illnesses SM	Local groups will have a voice in OND health Equity strategy 3 young people signposted to support with filming	OND OSM Research Your Way
Youth Club	Evening youth club starting at South Molton Pannier Market including skate ramps.	Starting mid August 2022 on a weekly basis.	SMTC YMCA OSM
Youth Club	Evening youth club starting at South Molton Pannier Market including skate ramps.	Starting mid August 2022 on a weekly basis.	SMTC YMCA OSM
South Molton Community News	Community News might be closing due to lack of volunteers, OSM could pick this up and develop	In discussion with SMTC/CN	SMTC YMCA OSM

Local Support

Equine Echoes	Signposted to social prescriber for new referrals.
Kailo	Introduced to OSM groups and exhibited at 'It's a New Day'
NDVS	Supported them with ideas for their next Volunteer and Management Forum
OND	Supported them with ideas for their next Volunteer and Management Forum

OC SYSTEMS INDEX

// AUGUST 2022

OND SUPPORT REQUIRED

Priority	Strategic / Operational	Issues and Barriers	System support or Resources Required	Escalation to	Status
HIGH	Operational	OC's require functioning website / database with central OND database	Additional developer time (Neil Ingram)	Andrea Beacham / James Lander	Open
MEDIUM	Operational	A platform for Flow CAP communications to keep all case notes / files together	Secure, cross-sector platform to discuss CAP's	Simon Rapsey	Open
/	Operational	CDs do not understand the types of flow, referral pathways, team members	Completed - A Flow overview / diagram has been completed	Nicola Topham / James Lander	Closed
MEDIUM	Strategic	OCs requested a mental Health oversight / coordination	Agenda point for future OC group meeting / DMHA CD to coordinate Northern MH updates	James Lander	Open
HIGH	Strategic	OCs highlighted the importance to discuss how OND / OCs could help mitigate the effects of the rising costs of living	All partners to submit ideas / available resources to support	James Lander	Open
MEDIUM	Strategic / Operational	Supporting statutory partner community engagement - demand increasing	Database to easily share details / Shared engagement platform	OND Board	open
HIGH	Operational	Prioritising workplan / meetings to attend	Employer, OC Chair, CD and OND to agree	James Lander	open

HEALTHY AGEING IN NORTHERN DEVON

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

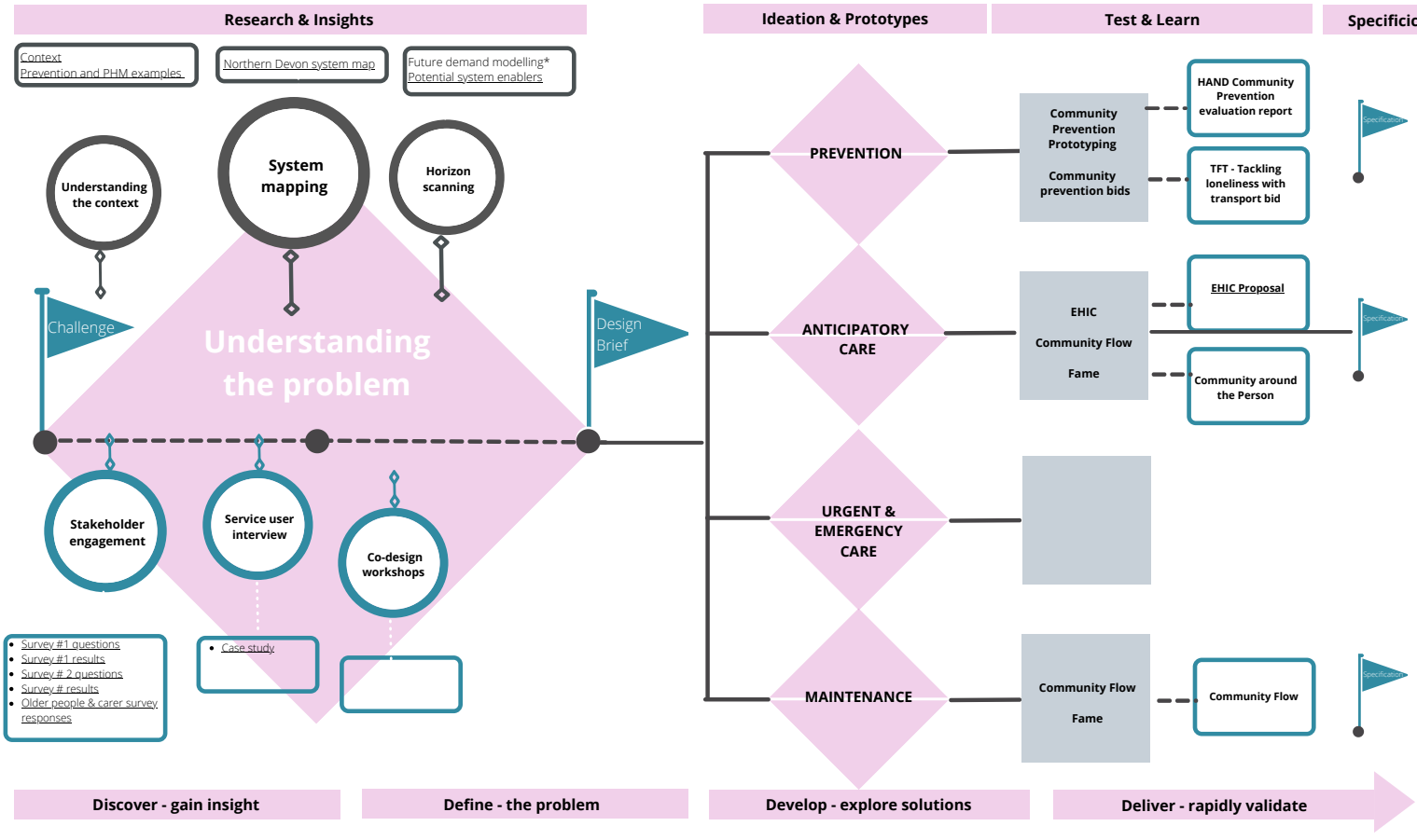
HEALTHY AGEING IN NORTHERN DEVON

PROGRESS SO FAR - AUGUST 2022

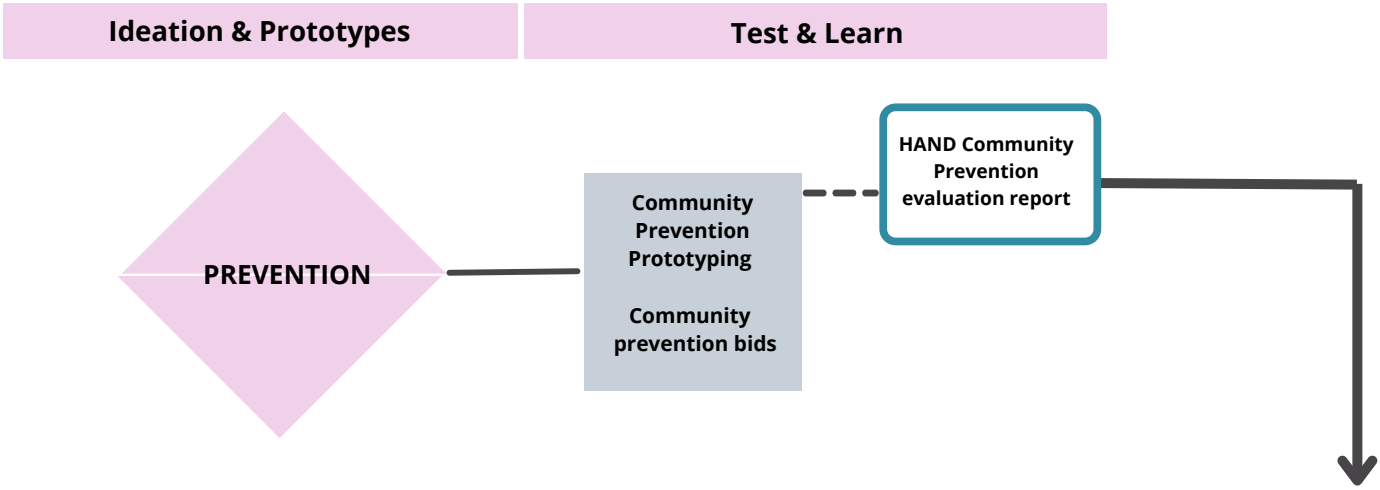
We are using system design methodology in order to co-design a more joined up offer of care and support to older people in Northern Devon aimed at reducing the likelihood of becoming frail, of preventing escalation of frailty following injury or illness and improving ability to regain independence and quality of life to the extent possible should frailty occur.

Following two whole-system workshops, which gathered broad insights across the whole ageing well pathway, it was agreed that work would be split into the following domains:

- Prevention
- Anticipatory care
- Urgent & emergency care
- Maintenance



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

Live Longer Better

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. DPT's Community Mental Health Framework Local Implementation team, care home managers, staff, residents and carers and VSCE groups in the locality are being targeted as key populations to educate. Active Devon will host a Live Longer Better conference in September. LIVE LONGER BETTER DEVON - ONLINE CONFERENCE - Active Devon

Connecting You (Tackling Loneliness with Transport)

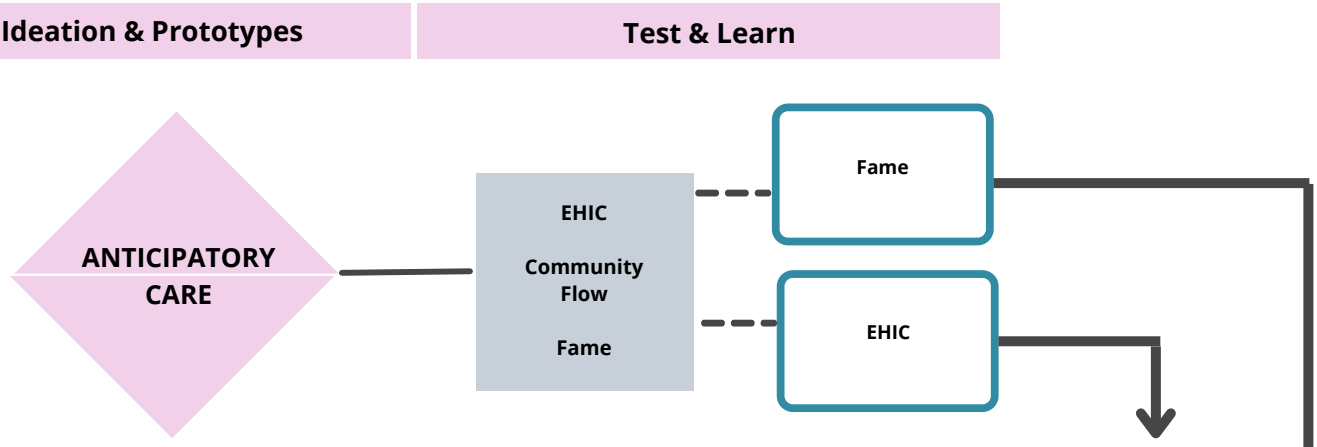
£50,000 has been awarded to One Northern Devon from DCC to deliver projects across Northern Devon.

Agreed programme:

- Nature on Prescription, building a social prescription by offering links to nature including Active Walks, and activities, ensuring transport is included in the prescription for communities of North Devon and Torridge
- Tarka Line Creatives, engaging harder to reach beneficiaries with wellbeing through creative activities using the Tarka rail line.

Key Partners: One Ilfracombe, Tarka Line Creatives, Devon and Cornwall Rail Partnership, Devon County Council

Progress in Anticipatory Care theme





Enhanced Health in Care Homes

The EHCH Reconditioning Initiative is aimed at increasing activity in care home residents to reduce deconditioning. Care Homes receive regular visits from our Activity Facilitator who engages with residents, family members and staff. The Activity Facilitator gives guidance on basic personalised exercises for residents and supports family and staff to assist. The Activity Facilitator also signposts to relevant activities in the community and online and makes links with voluntary and other organisations that may benefit residents. He also educates staff, patients and families on the importance of staying active. Care Homes can also apply for funding to purchase equipment and access programmes/ opportunities that meet the needs of the Care Home and residents. A Project Co-ordinator supports the care homes to apply for the funding, collects data for outcome measures and supports the Activity Facilitator. We also provide free online training to care home staff on activity in older adults and encourage engagement with the "Live Longer Better" approach. The project also involves training and support for care home teams working within local Primary Care Networks to help prioritise activity and address deconditioning in care home residents.

Project Leads: Dr Fiona Duncan, Caroline Sanford.
Project Co-ordinator: Liv Sanford
Activity Facilitator: Andrew Jeffery

Summary of progress Aug 2022:
Co-ordinator and Activity Facilitator recruited and in place.
Baseline activity surveys complete
Funding granted to some Care Homes, others being supported in bids
Online training resources shared with Care Home managers/staff.
Regular engagement with Care Home managers.

FAME (The Falls Management and Exercise programme)

£84,000 has been granted from Devon ICS falls prevention fund to:

- Identify and train 4 L4 Postural Stability Instructors
- Run seven FAME 24-week programmes across Northern Devon – (one in each One Community)
- Facilitate improved mobility along with social interaction for participants
- Work to ensure sustainable relationships and activities continue beyond the programme
- Leave a legacy of PSIs able to deliver FAME in Northern Devon.

Progress so far:

- Active Devon/ Vista Wellbeing have agreed to provide co-ordination of the project.
- Two L4 PSIs already qualified in N. Devon
- Two candidates identified for PSI training
- PSI course scheduled for November

Next Steps:

- Recruit further two candidates for PSI training
- Work with PCNs, Community Health Teams to identify participants
- Identify venues

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

'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 November 22 and April 23.

This module sits within the Personalised care Programme for Devon Training Hub. The team of facilitators from DPT, Active Devon, Barnstaple Alliance PCN and a local CIC have been invited to present their training model at the NHS England SW Physical health in SMI Community of Practice in the autumn.

The Enhanced Health in Care Homes 'Reconditioning Initiative' has 12 local Care homes signed up and an activity co-ordinator is in post. This role involves going into Care homes to support them develop activity programmes and support resident move more. They will also be engaging with PCN social prescribers and community connectors to effectively sign post to local community activities.

Active Hospital
Royal Devon University Healthcare (North) is incorporating an 'Active Hospital' approach to its tertiary complex hernia service that will increase promotion and support to be more active for patient's on the waiting list.

ADDRESSING FUEL POVERTY

// AUGUST 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:

Lead organisation: 361 Energy

Input into the report from: North Devon Council

Summary of outcomes from 361 Energy including projects such as:

- The North Devon Fuel Poverty Crisis Intervention Program,
- Local Energy Advice Partnership
- North Devon Council project
- Redress Warmer Homes project.

The summer months are generally quieter months for 361 Energy because people are on holiday and are not thinking so much about their energy bills. This year is slightly different because the cost of energy is in the news most of the time and at the forefront of people's minds. Our priority now is to refer as many people as possible to grant schemes that will fund home insulation, new heating systems and solar panels etc before the winter. This is because these measures should reduce the amount of energy households need to buy in order to keep their homes warm.

We are finding more and more people with complex debt issues and we are in discussions with the local CAB team to find funding to help people bridge the income gap as the cost of living rises.

North Devon Fuel Poverty Crisis Intervention project with PCNs

Energy 361 has completed 100 visits/ calls. The referral route for all PCNs is now open after a short pause on the processing. Many of the people who qualify for this project also qualify for the Sustainable Warmth Fund, so we hope to get some good outcomes for people when it comes to improving the energy efficiency of their home.

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

ADDRESSING FUEL POVERTY

// AUGUST 2022



Summary of outcomes from 361 Energy advice visits June / July 2022

		361 Energy advice
Clients seen		135
Potential annual savings made by installing small energy efficiency measures		£ 5,125
Potential annual savings made if all behaviour change suggestions are implemented. Includes defrosting freezer, boiling only water that's needed, switching off lights, washing clothes at cooler temp, turning thermostat down by 1degree etc.		£61,355
Financial assistance	Includes debt write-offs, benefits referral, WHD/PHD, Water tariffs, top-ups	£49,616
ECO / heating systems	(value of successful grants)	£3,695.00
Other help	Includes council tax help, loan access, white goods,	£570
Gifted/ loaned items for warmth	(radiators, dehumidifiers, throws, curtains)	10
Onward referrals	Financial	18
	Crisis support	10
	Health, safety & wellbeing	27
	Safeguarding	-
	Housing needs (incl adaptations)	3
	ECO measures	25
	Sustainable Warmth Fund	39
	Added to PSR	51
Retrofit opportunities identified		
		-
	Total benefit (financial only) to clients	£120,361
	Average per client seen	£891.56

ADDRESSING FUEL POVERTY

// AUGUST 2022



Sustainable Warmth Fund

We continue to refer household to the sustainable warmth fund, A fund that is open until 31st March 2023. In June & July we referred another 39 households (60 in total since May) from across North Devon and Torridge.
Work is due to commence on the first houses this month.

Green Homes Grant Local Authority Delivery 2 (GHG LADS2)

The eligibility criteria for the SWF is a household income of £30,000 or less and an EPC of E, F or G. We had quite a few properties that had an EPC of D who still needed help to improve their home but wouldn't qualify for the SWF. During July we were made aware that EON and City Energy had been given an extension for another fund that helps with energy efficiency improvements (GHG LADS 2)), and they were accepting applications for more houses. We referred 25 households with an EPC rating of D to this fund. The deadline for installations is September 2022 so we'll hear about the success of these referrals over the next month. However, we've heard from many of the home owners to say they've been contacted by City Energy and the surveys and recommendations have already been completed.

Report from North Devon Council

NDC have approved 21 ECO flexibility declarations for measures including cavity wall insulation & loft insulation.
NDC provided 2 Warm Up Grants which will fund new boilers. 361 Energy have also funded the installation of a boiler for one customer and the repairs of a further three boilers/ immersion heaters.
The table shows snapshot data as at 9th August for installations both completed and pending for both North Devon and Torridge council areas:

Council area	Applications	Household type	Installations completed	Measures	Installations Pending
TDC	167	7 social / 4 private / 156 owner occupiers	12	11xSolar PV, 1xAir Source Heat Pump	19
NDC	365	8 private / 357 owner occupiers	85	68xSolar PV, 6x loft insulation, 2xInternal Wall Insulation, 2xAir Souce Heat Pump, 7x ventilation	66



02 KEY PRIORITIES FOR NEXT QUARTER

- The key priority is addressing the looming cost of living crisis. At the moment it feels like everybody is totally under resourced to meeting the tidal wave of debt and requests for help that is coming.
-

03 SUPPORT REQUESTED FROM OND BOARD/PARTNERS

- 1.361 Energy have been contacted by someone who manages a lot of woodland across North Devon. They would like to set up a supply chain to offer free logs to people in need this winter. 361 Energy can identify the people who are in need, we need to find organisations that can help with the logistics of getting the logs from the site where they are being dried to the people who need them.
- 2.Filling up an oil or LPG tank is going to be a struggle for a lot of people this winter. Prices have doubled in the last few months (a full 1200l tank of oil has reached £1200). Often people must pay in one lump sum for the oil rather than spreading the cost over several months. A 0% interest loan of up to £1000 is available to people in Torridge but there is not a lot of help out there that will help people who can't access the loan. If people can't top up their tanks, they won't have access to heat or hot water.

ACTIVE TRAVEL

// AUGUST 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 PlCarolr
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

OND's Active Travel Group are engaging with Highways Development and Planning teams from DCC, NDC and TDC to support maximum community co-design in the developing Local Cycling and Walking Implementation Plan (LCWIP) and the Joint Local Plan; 'People and Place'. Key areas such as fast food outlet/ easy access to fresh food in new housing developments and reduced speed limits to promote safer '20 mins neighbourhoods'.

NATURE ON PRESCRIPTION



Unsplash/Getty Images/Pratik Bhide For The Swaddle

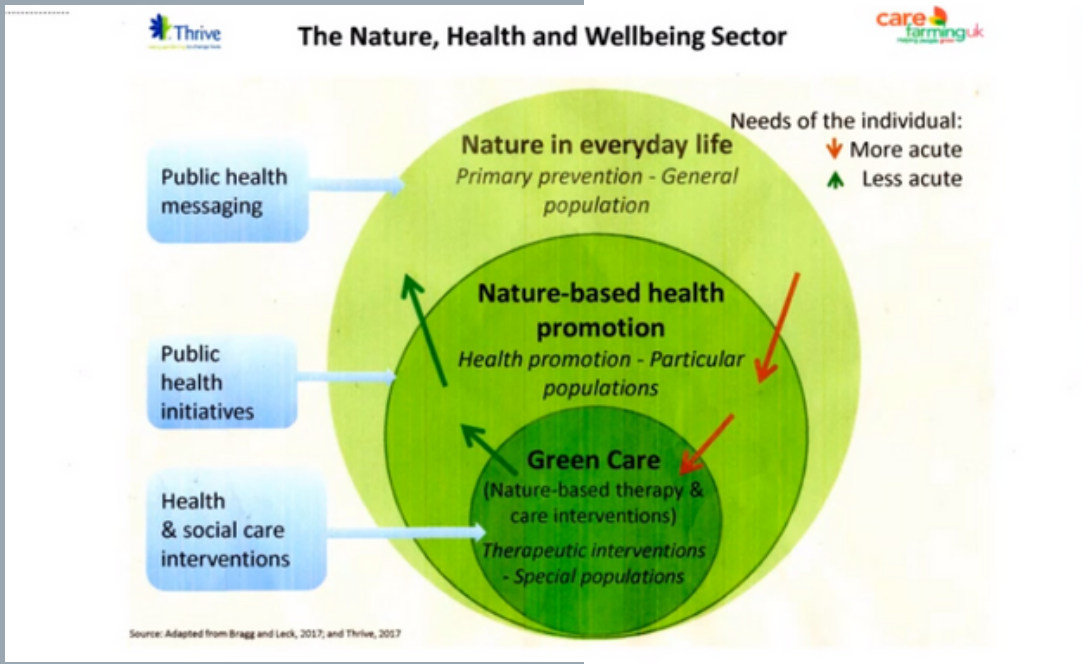
Spending time in nature, particularly around water, offers huge health and wellbeing benefits to individuals but also has a role in helping the environment and reducing pressures on public spending that are caused by the knock-on effects of stress, depression and anxiety.

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 provider for this work.



Nature on Prescription Pilot

The original Nature on Prescription pilot has now ended.

Key Headlines:

• 81 participants accessed 4 activities:

- Chill Swim benefiting people experiencing anxiety & depression
- Straw Patch benefiting people experiencing loneliness
- Park Yoga benefiting people experiencing anxiety & depression
- Exmoor Bus Trips benefiting people experiencing loneliness and lack of physical activity

the projects

• Nature on prescription toolkit has been created to support other organisations deliver these types of programmes

• The Nature on Prescription legacy will continue within the Connecting You programme



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

OND's Workplace Wellbeing programme, in partnership with South West Business Council, supports local SMEs launched with a webinar on 30th May. Two more webinars are filling fast in September and October with recruitment to the network ongoing at local jobs fairs and through partner support. All businesses are 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 and links to anchor institutions wellbeing / employee assistance programmes. A wellbeing champion network is being developed with an initial event planned for November 2022.

Latest report can be found here

SUPPORTING PEOPLE WHO ARE MOST AT RISK OF POOR HEALTH

// AUGUST 2022

There are certain groups of people who tend to have worse health and a lower life expectancy than the general population. They are often socially excluded and experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma.

Termed by the NHS as 'inclusion health groups', it includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

This contributes considerably to increasing health inequalities.

Poor access to health & care services is a result of multiple barriers, related both to the individual and services:

(taken from PHE Inclusion Health Guidance May 2021)



System barrier

difficulty understanding and navigating the system

Fear

Fear of punitive action after accessing services

Language barrier

not speaking the language or be able to read or write

Barriers for profesionals

Professionals not feeling able to support people with socially complex problems. They may feel they don't have the resources to appropriately support them.

Poor past experience

past experience of being turned away from services or being badly treated

ICSs are asked to consider approaches to improve support for people in these groups including:

- Joined up action to mitigate universal policies which can disproportionately affect marginalised groups
- Building trust with people and communities; communicating in a way that allows people to understand and use information to make decisions about their own health and ultimately respect their choice.
- Personalised, trauma informed, strengths-based care that treats people with humanity and compassion.
- Working with people with lived experience and local partners, particularly (VCSE) sector to evaluate and improve how people are supported – taking services to people where necessary.
- Promoting the message that everyone is welcome in General Practice and, if necessary, challenging system and professional barriers within health services to ensure people access the services they need. Key resources include the GP registration campaign, Safe Surgeries Toolkit and the PCN planning tool.

There are a number of projects currently working to address some of these barriers:

- Homeless GP outreach service
- High Flow - support for people with complex needs
- Trauma-informed practice (how you can have an impact)
- Community support hubs - outreach
- Pathways Homelessness Needs Assessment
- Outpatients DNA project
- Core 20 Plus 5 Connector pilot

Updates on each of these are found on the following pages

SUPPORTING PEOPLE WHO ARE MOST AT RISK OF POOR HEALTH

PROJECT UPDATES
AUGUST 2022

pathway
Healthcare for homeless people

The Pathways Homelessness Needs Assessment

The Pathways Homelessness Needs Assessment (to inform hospital discharge pathway) continues in data collection phase with support from the locality, ensuring a broad range of stakeholder input. NB learning from the Community Flow project should be considered alongside these findings once published.

The Pathways Assessment will be accompanied by a broader light touch inclusion health needs assessment (being undertaken by Public Health) to understand the needs and gaps in support in Northern Devon for those most marginalised groups of society including those who are homeless.

A Homelessness Stakeholder online meeting and Refugee, Asylum Seeker and Resettlement Stakeholder meeting, both planned for 31st August will inform the corporate needs assessment. The vision and aim of the work is to inform and coordinate systemwide commissioning decisions from 2023 onwards, where a number of short term funding (Contain Outbreak Management Fund, COMF etc) will come to an end and substantive health contracts are due to be reviewed.

This work will also be replicated in the other localities with a view to inform place based decisions alongside opportunities for system-wide commissioning.

Lead for Norhern Locality - Charlotte Pavitt, DCC Public Health

HOMELESS GP OUTREACH

// AUGUST 2022



Homelessness describe a wide range of circumstances where people have no secure home. This includes rough sleepers, sofa surfers,temporarily housed residents (eg in hostels, night shelters, pods, bed and breakfast) and those in supported accommodation.

Your environment is one of the key factors shaping your health and being homeless is one of the harshest and most challenging environments



Health & social inequalities

Childhood trauma
Poverty
Socially excluded
Poor health outcomes
Illiteracy
50 times more likely to have Hep C
34 times more likely to have TB
12 times more likely to have Epilepsy
6 times more likely to have heart disease
9 times more likely to commit suicide
Excess mortality ratio of 7.9 in males and 11.9 in females
Average age at death 45 for males and 43 for females
Trimorbidity- more likely to experience physical, mental health and addiction problems at the same time

HOMELESS GP OUTREACH

// AUGUST 2022



Barriers to accessing primary healthcare

•Fear
•Stigma
•Feeling judged
•Restrictive requirements eg proof of address, proof of benefits, new patient questionnaires
•Lack of knowledge and awareness
•Chaotic lifestyle

Scale of the problem in Northern Devon

•100 Rough sleepers/Vulnerably housed
•200 Hidden Homeless
•2,300 presentations per year to DCC for homeless related issues
•144 ED attendances per year

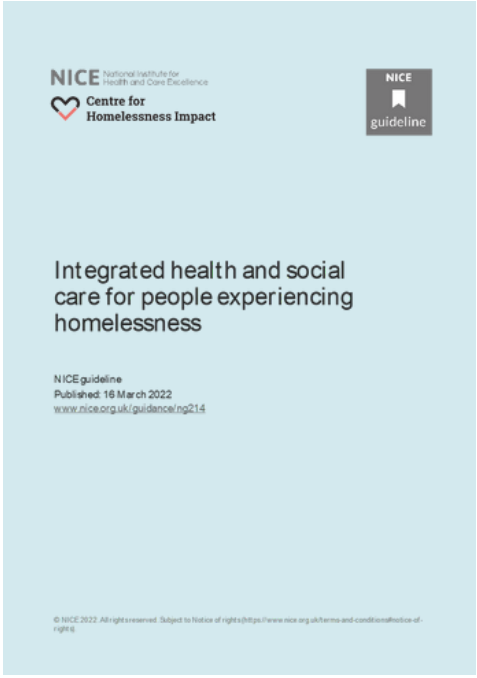
NO COMMISSIONED HEALTH CARE SERVICE

1.1 Recognise that MORE EFFORT and TARGETED APPROACHES are often needed to ensure that health and social care for people experiencing homelessness is available and accessible, and provided to the same standards and quality as the general population

1.1.5 Recognise the importance of LONGER CONTACT TIMES in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness

1.1.3 Promote engagement by providing services that are PERSON CENTRED, EMPATHETIC AND NON-JUDGEMENTAL, aiming to reduce health inequalities and be inclusive and pay attention to the diverse experiences of people using the service

1.5.13 Take Health and Social Care Services to people experiencing homelessness by providing multidisciplinary outreach care in NON-TRADITIONAL SETTINGS, such as on the street, hostels or day centres.


NICE National Institute for Health and Care Excellence
Centre for Homelessness Impact
NICE guideline

Integrated health and social care for people experiencing homelessness

NICE guideline
Published: 16 March 2022
www.nice.org.uk/guidance/ng214

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Summary of primary care homeless services across Devon:

Service Detail	Service		
Locality	Torquay	Western	Eastern
Provider	Chilcote Surgery	Adelaide Street Surgery	Clock Tower Surgery
Location & Base	Leonard Stocks Centre on Factory Row, Torquay town centre	Shekinah Centre – Bath Street, George House, and a smaller service within the Probation service in Plymouth city centre	Clock Tower Surgery, New North Road, Exeter city centre
Population covered	Those who are termed "homelessness", that is those in the position of having no secure home which may include rough sleepers, hostel and shelter residents, and placed B&B residents.	Outreach Primary Medical Services for homeless people and individuals attending probation services who are not able to access mainstream general practice.	People in Exeter who are: - (a)Homeless with no fixed abode (b)Vulnerable housed or "sofa surfing" (c)An asylum seeker who is vulnerably housed (d)Within the "travelling community" residing within the Haldon Hill area **Includes both adults and children*
Period of contract	1 April 2017 – 30 June 2020	1 April 2017- 31 March 2022	1 September 2012 – 28 February 2022
Summary of service provided *(taken from service spec)*	- 3 x 2-hour GP sessions and 1 x 4-hour nurse session - The development and production of an up-to-date register of patients - Liaison with local statutory services and other services working with the homelessness - Promotion of health services - Flexible registration procedures - Flexible appointment systems - The provision of training to appropriate practice staff - Provision for appropriate and regular screening assessments - The use of relevant guidelines on the prescription of drugs if medication has street value or potential toxicity - Provision of a health promotion and harm minimisation programme - Appropriate referral to mental health and drug and alcohol services - Specialist assessment of the physical and mental health of homeless people when registering.	-3.5 half-day GP sessions per week and 1 nurse half-day session per week for patient consultations in the specified venues (with a leeway of 18 GP half-day sessions and 6 nurse half-day sessions per year not being provided) - Provide a pre-bookable and drop-in service which is publicised to prospective service users -Service users can see the GP of their choice at either venue or at the main practice sites -Patient needs are monitored and regularly reviewed to adjust support and facilitate discharge to main stream GP practice appropriately To monitor: - - number of sessions provided - number of patients registered - patient contact with the service - progress in patients moving into mainstream general practice - A&E usage - patient satisfaction (annually) - registration and eligibility criteria.	- Minimum of 38 hours per week (with a mix of morning and afternoon drop in and appointment slots) - Provide the service in an accessible and non-challenging location - Work with an integrated team to provide health and social care specialised services - Provide opportunistic screening and immunisation for infectious diseases and conditions prevalent in this high risk patient group (e.g. Hep B, Hep C and TB) - Reduce the level of A&E attendances and emergency admissions by this patient group through multiagency case monitoring of heavy users - Work to reduce the average duration of these admissions through establishing weekly multiagency discharge planning meetings for these patients. - Work closely with commissioners and providers to support people with complex mental health problems in order to reduce emergency admissions in to mental health secondary care services - Work closely with all the other key professionals and agencies in supporting this client group - Provide innovative services that identifies and responds to future needs through flexible, co-ordinated working with commissioners and other providers within the available resources.

HOMELESS GP OUTREACH

// AUGUST 2022

North Devon service

As part of the joint working initiative of One Northern Devon and One Barnstaple a piece of work was undertaken in 2020 to look at what the population of Barnstaple felt were priorities for the town and surrounding areas. HOMELESSNESS was identified as one of their priorities and One Barnstaple set up a partnership working group between Primary Care, North Devon Council, Freedom Communities and the Encompass Southwest charity to focus on this area

2021 Enhanced Rough Sleeper Outreach Team –addition of Louise Scantlebury (Community Matron) and Sam Brown (Registered Mental Health Nurse) and Jayne Head (Together Drug and Alcohol Worker)

2021 GP Weekly outreach clinic- Dr Nigel Moody, Dr Lucy Dallimore, Dr Clare Hollister

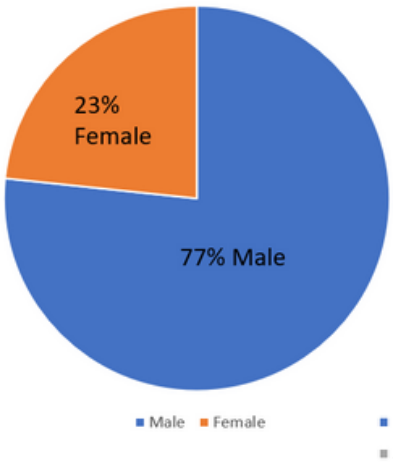
Freedom Centre GP Clinic

•Started March 2021
•Thursday 9-1pm
•Prebookable and drop in appointments offered
•Acute on the day problems
•30min comprehensive homeless assessments –mental and physical health assessment, drug and alcohol assessment, smoking, BP, weight, health promotion, BBV screening
•Work closely with Freedom Outreach staff to support patients
•Open communication with Registered GP-Task sent to GP if patient seen in outreach clinic

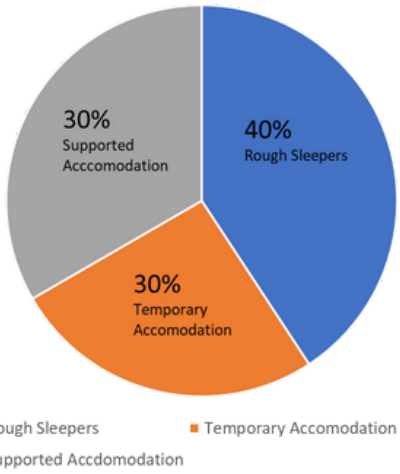
Audit one year on …

•54 patients seen
•Average age 42yrs
•140 GP appointments 48 DNA's
•14 patients helped to register with BA practice
•17 referrals
•3 admissions
•14 Routine Blood tests performed
•13 patients screened for BBV. 1 case Hep C detected.
•20 flu vaccinations, 18 covid vaccinations

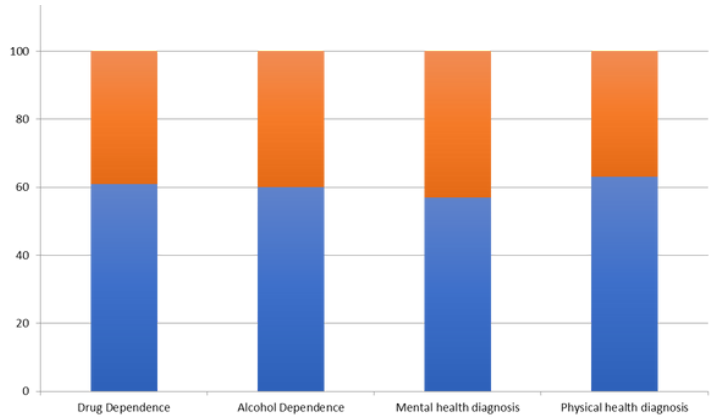
Gender



Housing/rough sleepers



Co-morbidities



Developing the service

•Cervical Screening- 92% of women seen in our service were overdue cervical smear. Aim to improve and increase uptake, focusing on overcoming barriers such as accessibility, fear (high rate of sexual violence), lack of education and awareness re importance of screening
•Focusing on improving Chronic Disease Management- 100% of patients seen had positive smoking history. High rates undiagnosed and untreated COPD/Asthma.

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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.



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TOGETHER WE'RE BETTER

PERSON CENTRED • PLACE FOCUSSED • SYSTEM COORDINATION






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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

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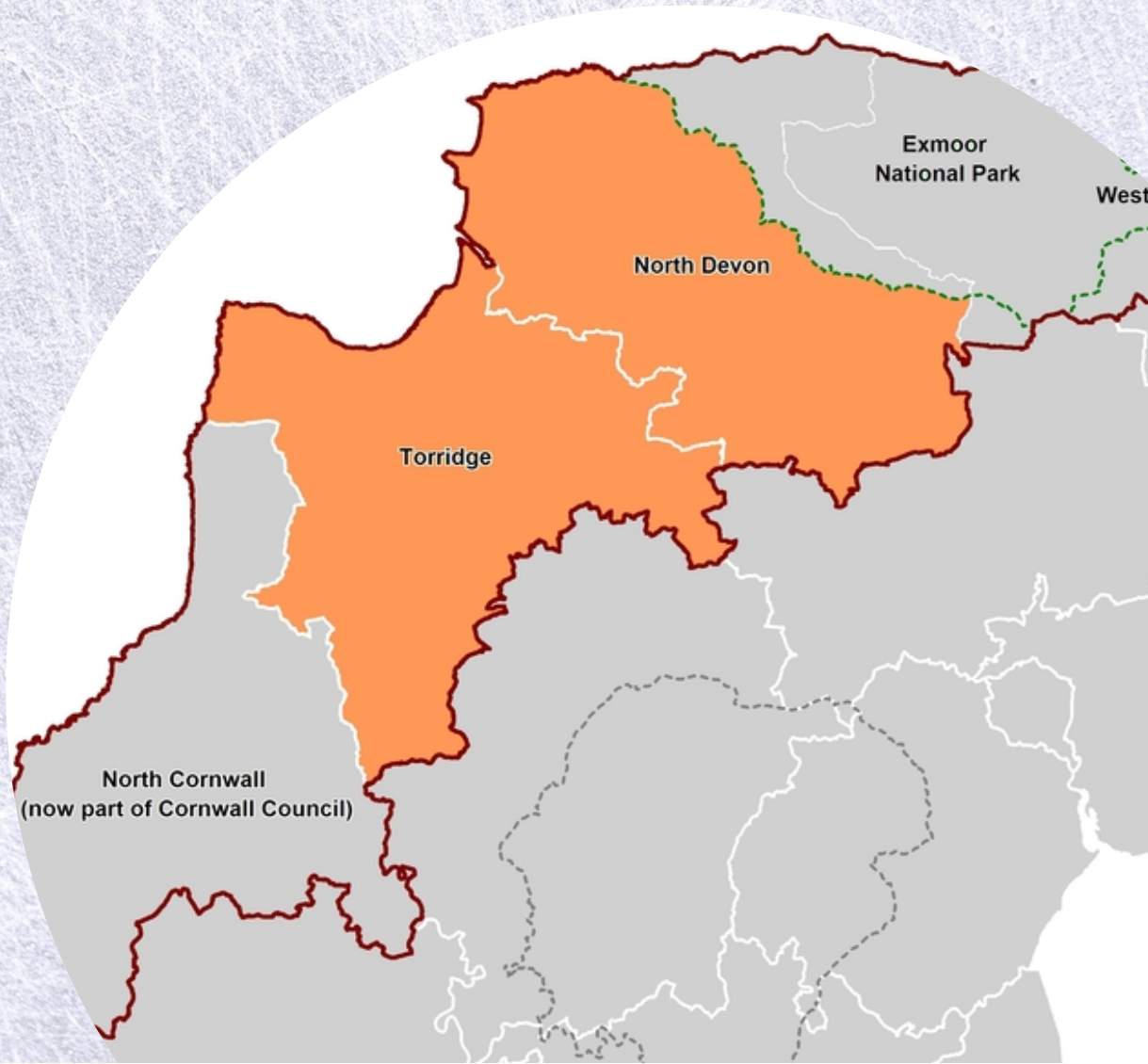
Our vision

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



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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:

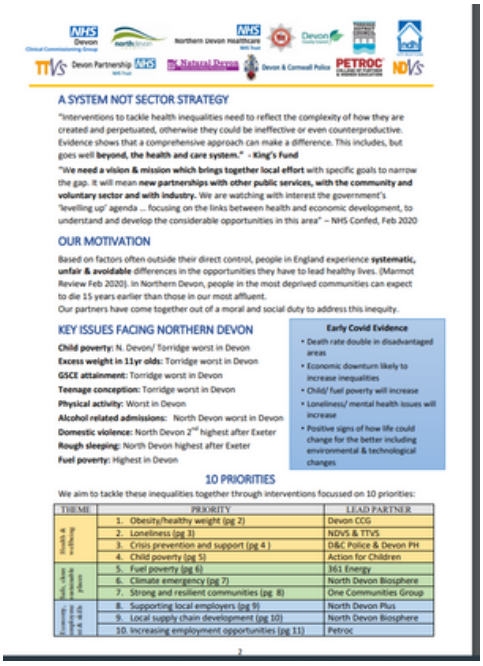
Empowering communities

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
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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

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The 3 Pillars

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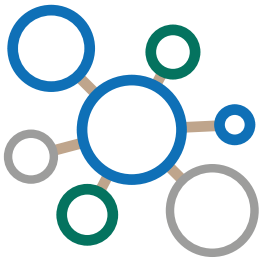

SYSTEM

Organisational support for system co-ordination