One Devon
Joint Forward Plan

Draft v3
30 March 2023

#OneDevon

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Executive Summary

To be added

Chapter 1 – Executive Summary

TO BE ADDED

Introduction

What is the 5 Year Joint Forward Plan?

National Context

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and partner trusts to prepare a Joint Forward Plan (JFP) before the start of each financial year. For this, the first year, the final publication date is 30 June 2023.

Systems have 'significant flexibility' to determine the scope of the JFP and how it is developed and structured. The minimum requirement is that the JFP should describe **how the ICB and partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs**, including delivery of universal NHS commitments (as described in the annual NHS priorities and operational planning guidance and NHS Long Term Plan), addressing the four core purposes of ICSs and meeting legal requirements.

However, national guidance encourages systems to use the JFP to develop a ***shared delivery plan*** for the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies (JLHWSs) that is supported by the whole system, including Local Authorities and Voluntary, Community and Social Enterprise (VCSE) partners.

The key principles of the JFP are:

1. Fully aligned with the wider system partnership's ambitions;
2. Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments;
3. Delivery focused, including specific objectives, trajectories and milestones as appropriate.

Appendix A (to be completed) sets out the current position of the Devon system against the universal NHS commitments and the projection for the end of years 1 and 2, based on the work programme set out in this JFP.

Guidance also sets out some key legislative requirements and other expected content for the JFP. Appendix A also sets out these requirements and a summary of how they are addressed within this Plan.

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One Devon's Interim Integrated Care Strategy

The Devon Joint Forward Plan is the whole system response to the One Devon Interim Integrated Care Strategy. The Strategy set out 12 Challenges:

1. An ageing and growing population with increasing long term conditions, co-morbidity and frailty
2. Climate change
3. Complex patterns of urban, rural and coastal deprivation
4. Housing quality and affordability
5. Economic resilience
6. Access to services, including socio-economic & cultural barriers
7. Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas
8. Varied education, training and employment opportunities, workforce availability and wellbeing
9. Unpaid care and associated health outcomes
10. Changing patterns of infectious diseases
11. Poor mental health and wellbeing, social isolation, and loneliness
12. Pressures on health and care services (especially unplanned care)

In response to the 12 Challenges and through ongoing engagement with stakeholders across the Devon System, the Interim Integrated Care Strategy sets out the strategic goals developed to meet the assessed needs of the population, focusing on the *four core purposes of ICSs* and supporting the vision of the ICS: ***Equal chances for everyone in Devon to lead long, happy and healthy lives***

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

The remaining strategic goals are set out on the next 4 slides, grouped according to the ICS core aims.

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Improving Outcomes in population health and healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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Tackling inequalities in outcomes, experience and access

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

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

Everyone in Devon will be offered protection from preventable infections.

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

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

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

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

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

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

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

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Enhancing productivity and value for money

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

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

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

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

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

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

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

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

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Helping the NHS support broader social and economic development

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

By 2028 we will have:

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

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

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

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

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

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

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

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

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

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Developing our Joint Forward Plan

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The Devon Joint Forward Plan

In line with national requirements, the ICS in Devon (One Devon) produced an Interim Integrated Care Strategy in December 2022, setting out the 12 key challenges that Devon faces and identifying a set of strategic goals that will help to address the challenges, aligned to the ***four core purposes of ICSs.***

The One Devon Partnership asked system partners to work together to make the JFP a true shared response to the Devon Interim Integrated Care Strategy, as encouraged in the national Guidance. This JFP therefore reflects the work that is happening across the wider Devon system, in the health and care sectors and beyond, and demonstrates how this work aligns with the strategic goals in the Strategy and how it will deliver the required improvements in health and wellbeing.

Prevention, improved outcomes, personalisation, quality and safety of care sit at the heart of this Plan and provide a golden thread through all of the delivery and enabling programmes.

It is important to acknowledge that the three local authorities in Devon are under significant financial pressure. Furthermore, NHS Devon and all three NHS acute provider trusts in Devon have been assessed as being in segment 4 of the NHS System Oversight Framework (SOF). This means that we are subject to enhanced direct oversight by NHS England and additional reporting requirements and financial controls. The JFP therefore reflects the requirement to focus on system recovery and exiting SOF4 as priority in years 1-3 of the Plan.

This JFP will also set out how the system will work together in a different way, to deliver transformational change and improve the health and wellbeing of the population creating a sustainable health and care system in Devon.

ICS Core Aims

Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience and access

Enhance productivity and value for money

Help the NHS support broader social and economic development

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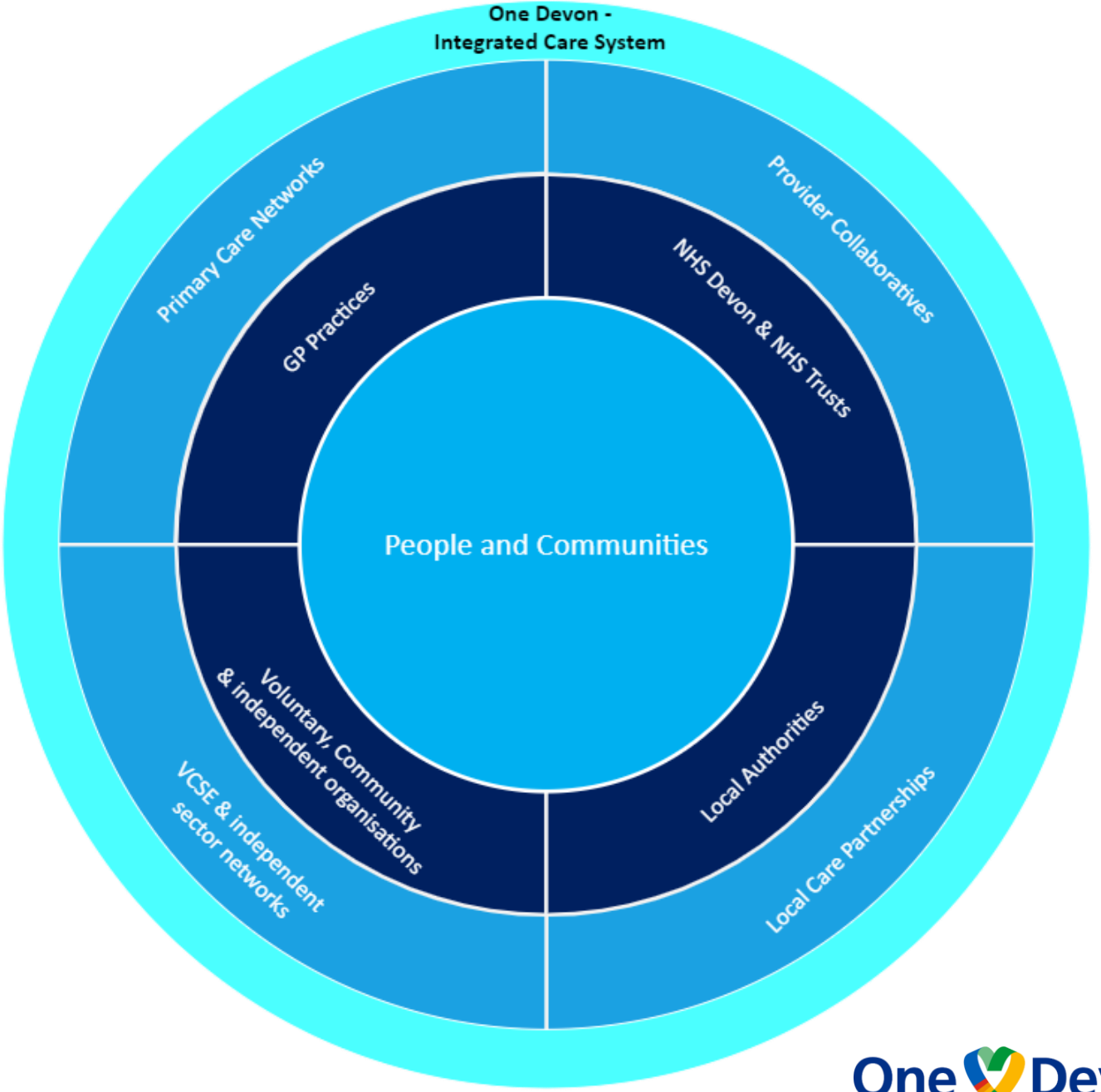
The Devon System

Devon is a complex system, in which work is taking place on delivering elements of the Plan in different geographical and functional arrangements, including:

- 3 local authorities
- 4 NHS trusts
- 5 local care partnerships
- 31 primary care networks

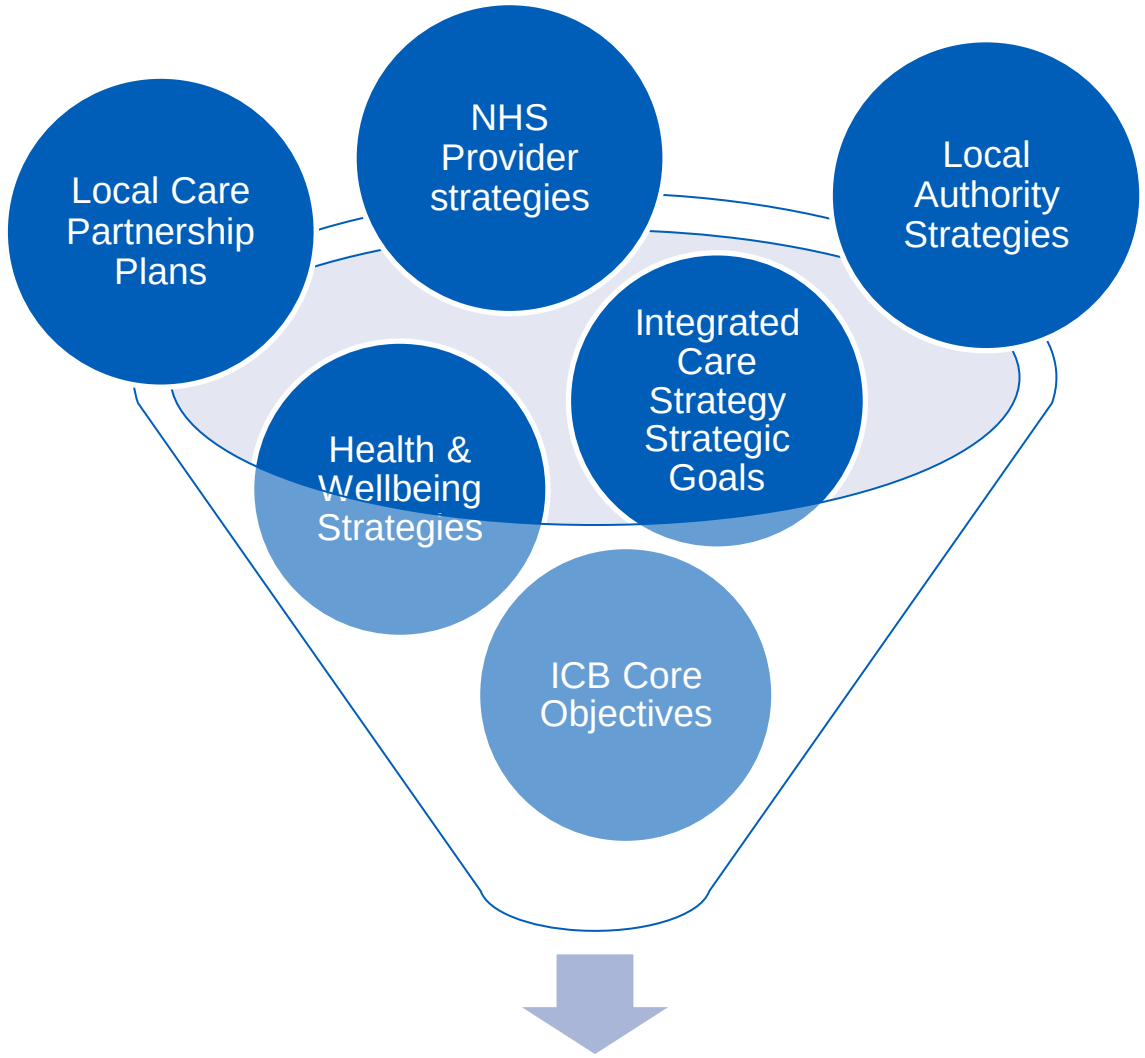


Inputs into the Joint Forward Plan

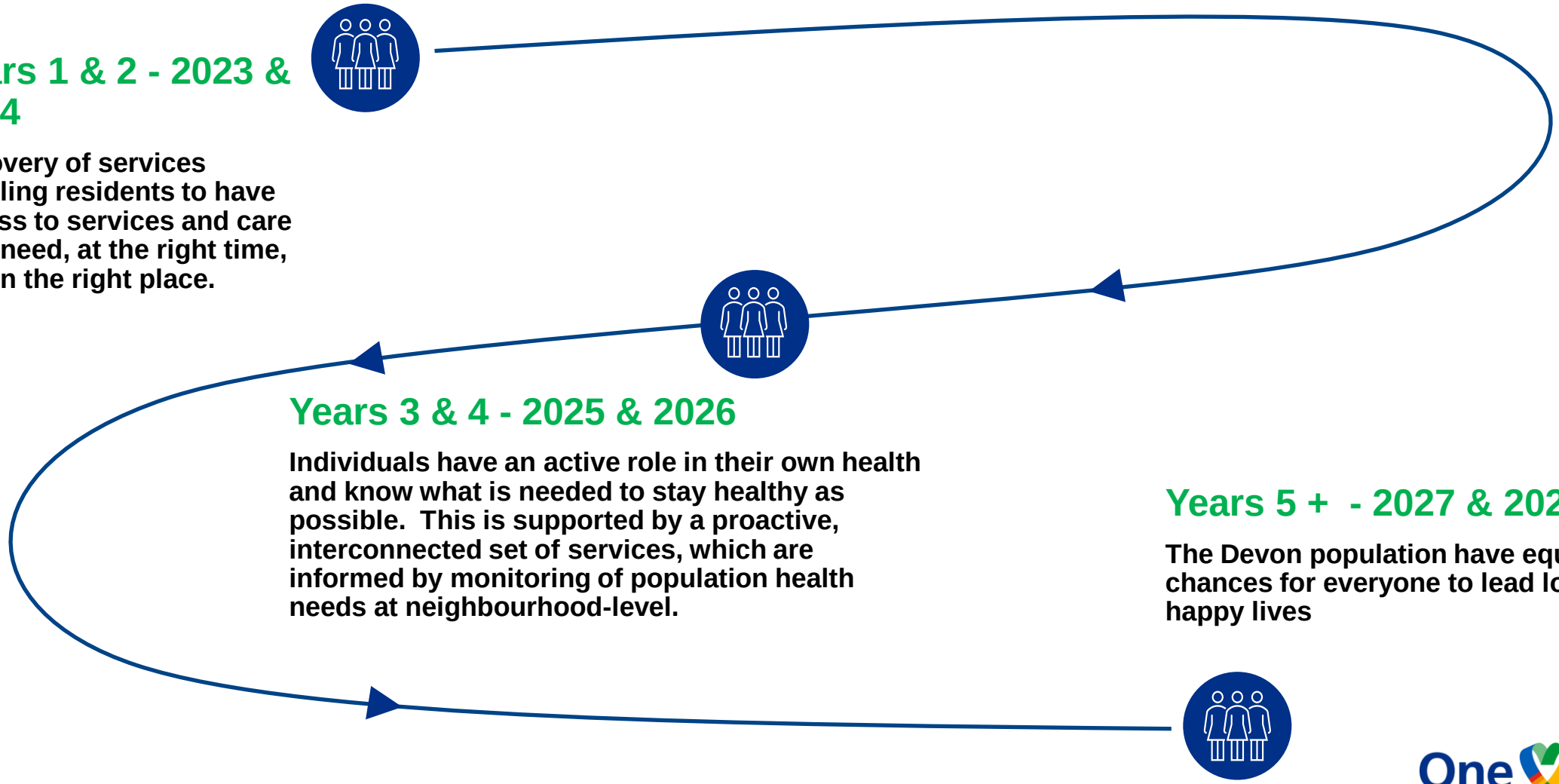
The JFP brings together many strategies and plans that already exist or are in development across the system, including, but not limited to:

- NHS Devon's strategic objectives (see appendix A)
- Local authority strategies (eg: adult social care strategies)
- Local Care Partnership (LCP) objectives
- Provider trust strategies
- Provider collaborative priorities
- SOF4 exit plan

and will demonstrate how these plans align with and deliver the One Devon Partnership strategic goals, as set out in the Interim Integrated Care Strategy.



Implementation of the Joint Forward Plan will see One Devon delivering joined-up, preventative and person-centred care for the whole population of Devon across the course of their life



Years 1 & 2 - 2023 & 2024

Recovery of services enabling residents to have access to services and care they need, at the right time, and in the right place.

Years 3 & 4 - 2025 & 2026

Individuals have an active role in their own health and know what is needed to stay healthy as possible. This is supported by a proactive, interconnected set of services, which are informed by monitoring of population health needs at neighbourhood-level.

Years 5 + - 2027 & 2028

The Devon population have equal chances for everyone to lead long, happy lives

Involving people, partners and communities

Development of the Integrated Care Strategy and Joint Forward Plan has involved the following engagement and involvement activities:

- Analysis of extensive public feedback about health and care (collected from system partners across One Devon) between 2018 to 2022 informed the development of both the Integrated Care Strategy and the Joint Forward Plan (JFP)
- The One Devon strategic goals were tested through a Joint Overview and Scrutiny Committee Masterclass (elected representatives of local communities) in October 2022.
- H&W Boards have been engaged directly throughout the process of developing the Strategy and JFP, through a specific engagement event in March 2022 to review the JFP content.
- A further Joint Overview and Scrutiny Committee (OSC) Masterclass on the JFP in April 2023.
- VCSE and Health Watch representatives involved in system partner feedback events: further system partner engagement planned at a local level in May.

Additionally, meaningful engagement on specific areas of work is planned moving forward (e.g. Peninsula Acute Sustainability Programme).

- Over 35 separate engagement projects analysed from across health and care in Devon over 5 years
- OSC fed back that you can't argue with the goals, but they are most interested in what it means on the ground

Devon's Joint Forward Plan

There are 9 key delivery programmes and 10 enabling programmes that make up the Devon JFP:

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Delivering a sustainable health and care system in Devon

One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money

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Strengthening collaborative and integrated working is the way we will make a real difference to our population
Case Study – system working making a difference

Tackling Domestic Violence and Sexual Abuse

Across Devon thousands of people each year experience domestic abuse or sexual violence. Abuse is associated with a wide range of both immediate and long-term health conditions and primary care colleagues are often the first professionals to have contact with those affected. Victims of abuse have told us they felt like they were in a revolving door of services, that didn't help them get to the heart of the problem.

John experienced sexual abuse as a young boy. He ended up on long mental health waiting lists, then in psychiatric hospital he became a dependent drinker and retired early from work on health grounds. It wasn't until he was asked 'what had happened to him' that he was able to start to understand the abuse he had suffered and begin to heal, care for himself and live well.

The Interpersonal Trauma Response Service was launched in March 2023 to support Primary Care teams in connecting victims and survivors of abuse to specialist support. Speaking at the launch, the Domestic Abuse Commissioner for England and Wales, Nicole Jacobs, called the service ground-breaking and praised the strength of relationships in Devon that helped build ambitious, innovative and adaptive partnerships to address domestic abuse and sexual violence.

The service provides training and support to primary care staff to understand and see the links between abuse, trauma and the presenting health issues. It helps build the confidence to ask questions that get behind the symptoms and provides a named person to help connect patients to a network of good help.

"You can't grow roses in concrete"

The service has grown from a collaboration stretching back over 6 years with victims and survivors, commissioners and service providers. The collaboration began by commissioners spending time with victims of abuse and listening to the stories of their lives. Sitting in their kitchens and living rooms, people described missed opportunities to intervene early, the life long, often debilitating, impact of abuse and trauma and service encounters that don't join up, are hard to navigate and can feel rushed and unfinished.

The collaboration that grew from this work enabled Devon to be one of 8 National Domestic Abuse and Health Pathfinder sites, improving our recognition and response to domestic abuse, in primary care, mental health and hospital settings. Devon, with colleagues in Cornwall, is the first Sexual Violence NHSEI Pathfinder site in the country. This work is helping us explore improved support for victims of sexual violence who have complex trauma.

The lessons from this "ground-breaking" work are;

- we need to listen deeply to people, seeing citizens as partners in addressing their own issues and making visible where our services aren't adding value.
- We need to develop a learning capability where our staff at all levels reflect on effectiveness and adapt to changing circumstances.
- we need to create 'healthy systems', working across traditional service and organisational boundaries in recognition that the complex challenges we face require us to be working collectively and collaboratively.

Delivering a Sustainable System

The detailed later sections of the JFP set out the plans in place across the local NHS and wider Devon System and the key milestones for delivery over the next five years. However, in order to achieve this, we need to transform the way we work together across our system. Additionally, there is an immediate requirement to stabilise the financial position and recover activity, to improve operational performance, access and quality of care.

This section of the Plan outlines how we plan to deliver the significant strategic work to enable the successful delivery of our 5-Year Integrated Care Strategy, focusing on creating an environment for success, including:

- strengthening collaborative and integrated working through cultural change and adoption of the guiding principles resulting from the Case for Change
- adopting a Value-based Approach
- setting out a roadmap for ICS development
- embedding our agreed Devon Operating Model
- delivering financial and operational recovery.

Collectively, this work responds to the significant scale of change required to achieve our vision and ambitions and establishes a sustainable way to deliver the health and care needed by the people of Devon.

This section also sets out the key financial and performance headlines from our System 2023/24 Operational Plan and how we will ensure that we work collectively to achieve recovery. This is captured in years 1-2 of the detailed delivery plans.

Finally, this section addresses some of the statutory requirements that need to be addressed by the JFP, including a case study that demonstrates the collaborative work going on in Devon to support victims of domestic abuse, survivors, commissioners and service providers.

Setting the Change Agenda

The way we do things together in Devon

A narrative which sets out what Devon currently does well and identifies what changes need to be made in order to deliver improved health and care services to the people of Devon.

Guiding principles:

- **Provide a personalised approach to health and care:** 'joined-up' packages based on individual need
- **Support our workforce:** to ensure people are able to do their best work
- **Ensure shared Decision-making:** consistently applied across all services
- **Use high value interventions:** consistently and earlier in pathways and stop providing health and care that does not add value and may be causing harm
- **Reduce our environmental impact**
- **Tackle unwarranted variation in practices, outcomes and inequality**
- **Manage risk across the system:** ensuring that decisions made in one place do not increase the risk in another and addressing challenges from a whole population perspective
- **Spread improvement and innovation**
- **Develop a 'Culture of Stewardship'**

The narrative was co-developed with Clinical and Professional Leadership groups across health and care and reviewed and agreed by senior leadership teams and Boards across One Devon.

As a result of this collaborative work, system partners have broadly agreed a set of guiding principles. These will inform the Devon change agenda and guide the priorities and approach we undertake to deliver improved care and services.

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Our Overarching Philosophy

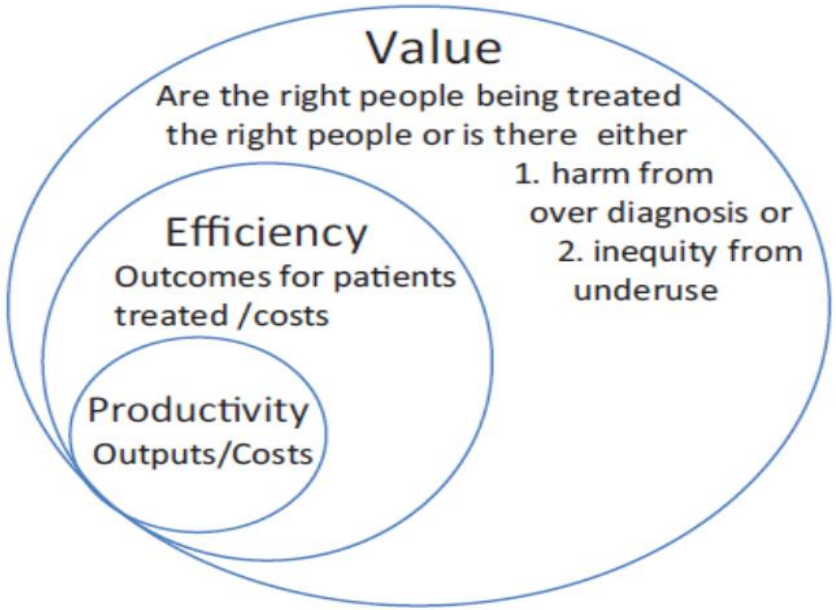
Adopting a Value-Based Approach

Devon's change agenda supports the principles outlined in 'The way we do things together in Devon' narrative to be realised. The principles are consistent with integrated working and were heavily influenced by the adoption of a value-based approach, which provides a strong framework to support delivery of Devon's strategic ambitions.

The value-based approach is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person. Strong clinical and professional support exists for the implementation of this approach in Devon and this is further supported by evidence of its effectiveness elsewhere (link to VBA lit review).

The adoption of a value-based approach in Devon will not be a distinct enabler plan, instead it is a philosophy to support the achievement of existing and future priorities and will be the lens through which we maximise value to the population of Devon by transforming services. As a next step, Devon will produce a Value-based Approach Full Business Case exploring various options of Adoption *(link to VBA report).*

Figure 1. Relationship between Productivity, Efficiency and Value.



Creating an environment for Sustainable Improvement

One Devon Development Roadmap

One Devon is committed to becoming a **thriving Integrated Care System**. As a result of the diagnostic activities outlined in the Case for Change, we established a baseline from which to improve.

In response, an overarching ICS Development Roadmap was developed, including the implementation of a single operating model, to support us to achieve our commitment.

The diagnostic activities will be repeated in 2023 to evaluate progress to this end.

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Creating an environment for Sustainable Improvement

Adoption of the One Devon Operating Model

Our emerging new operating model

- Our values and behaviours
- Governance arrangements, performance reporting and assurance
- Roles, responsibilities and functions of system parts
- Vision for our One Devon architecture
- Development journey for new operating mode

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One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.

By 2025 we will have adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.

The model outlines how Devon will make the best use of our new collaborative structures including the One Devon Partnership (ICP), NHS Devon (ICB), provider collaboratives, local care partnerships and neighbourhoods.

Adoption of the model will be completed over the next 18-24 months involving all system partners in embedding new ways of working to drive increased value to the people of Devon.

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Getting the System in balance

Financial balance is to be achieved through a focused system recovery programme focussed on operational, system, clinical and intra-organisation transformation

What needs to be achieved

3 year financial plan linked to activity, workforce, performance:

- **23/24 reported position no worse than £49.5m deficit**
- **24/25 c.£30m deficit through use of non-recurrent means**
- **25/26 breakeven exit run rate position**

How we will achieve this

- Using the 'Drivers of the Deficit' analysis as the baseline for planning and Cost Improvement Programme (CIP) expectations, aligned to model hospital, GIRFT* and regional benchmarks
- Stretching CIPs from 1.3% recurrent cost out to 4.5% (with system schemes in support)
- Accelerating the delivery of system-wide shared schemes
- Whole system clinically-led and planned transformation – acute through to community/primary care
- Intra-organisation wide schemes and redesign

1 Operational improvement cost out – to 4.5%

Moving Trust CIP plans in line with national expectations of 4.5% cost out through an initial focus on grip and control measures introduced by summer

2 System wide schemes – targeting c.£60m reduced run rate by Q4 23/24

Stretching the delivery of strategic schemes to be delivered across the system. This includes Shared corporate services, Peoples services, Clinical support services, Enhanced primary and community services, Outpatient transformation, Estates, New Models of Care, Procurement, Digital, CHC, Allocative Efficiency

3 Intra-organisation working and redesign

Looking to intra-organisation opportunities in areas such as:

1. Single system pathways (Shared PTL, integrated pathway management etc.)
2. Single system ways of working i.e., redesign of group models, single EPR solutions across Devon and Cornwall and workforce planning.

4 System-wide clinical plan

Developing a system-wide clinical plan and clinically-led transformation at pace through two streams of work, prioritised to begin with key system issues (e.g. frailty) and broadening out to support care pathway demands (e.g. through a surgical strategy):

1. Integrated collaborative community and social care services – working through in sequence frailty, long term conditions, urgent care; and
2. Networked acute care – through networked urgent care, elective, fragile services, virtual

Activity & Performance

1. The activity required is challenging given the historic position and will require a clear Devon-wide clinical plan and new ways of working
2. Delivering on the performance position – or improving it further – will require different ways of thinking about capital, estates, digital etc (e.g. a cold elective site, single PTL, sub-specialty centres etc) as stated.
3. Although the performance position is improving, there would still be 4,219 patients waiting over 65 weeks for care and this requires further focus.

Performance between the start and end of 2023/24

The latest planning submission includes a system wide improvement of RTT performance for long waiters driven by decreases in waits across all Trusts.

- **Overall waiting list to increase by +8.6k (5%)**
- **52 week increase: +14%**
- **65 week decrease: -21%**
- **78 week decrease: -19%**

Significant ERF stretch has been applied to support elective performance improvements

Workforce

A revised net -2% workforce change has been described against the current establishment.

Metric	2023/24 M12 (Planned)
65+ Week waits	4,219
78+ Week waits	964
104+ Week waits	0
A&E 4 Hours	71.9%
Cancer 62+ Day waits	488
System Financial Plan	(£49.5)
Workforce	-2%

*** GIRFT – Getting It Right First Time national programme designed to improve the treatment and care of patients through in-depth review of services**

Working differently - establishing a System Recovery Function

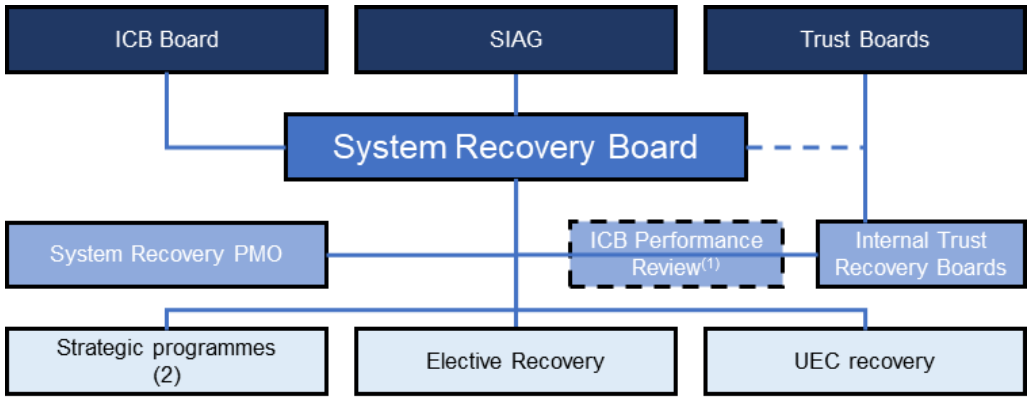
The system recovery function will pull together key capabilities from across the system to deliver at pace and with effective

The System Recovery Programme is a critical component of our recovery plan, as it will enable Devon to work more effectively and collaboratively to build the infrastructure and capabilities needed to drive the recovery. Through this programme, all teams across the patch will be empowered to work differently, delivering innovative and coordinated solutions to the challenges we face.

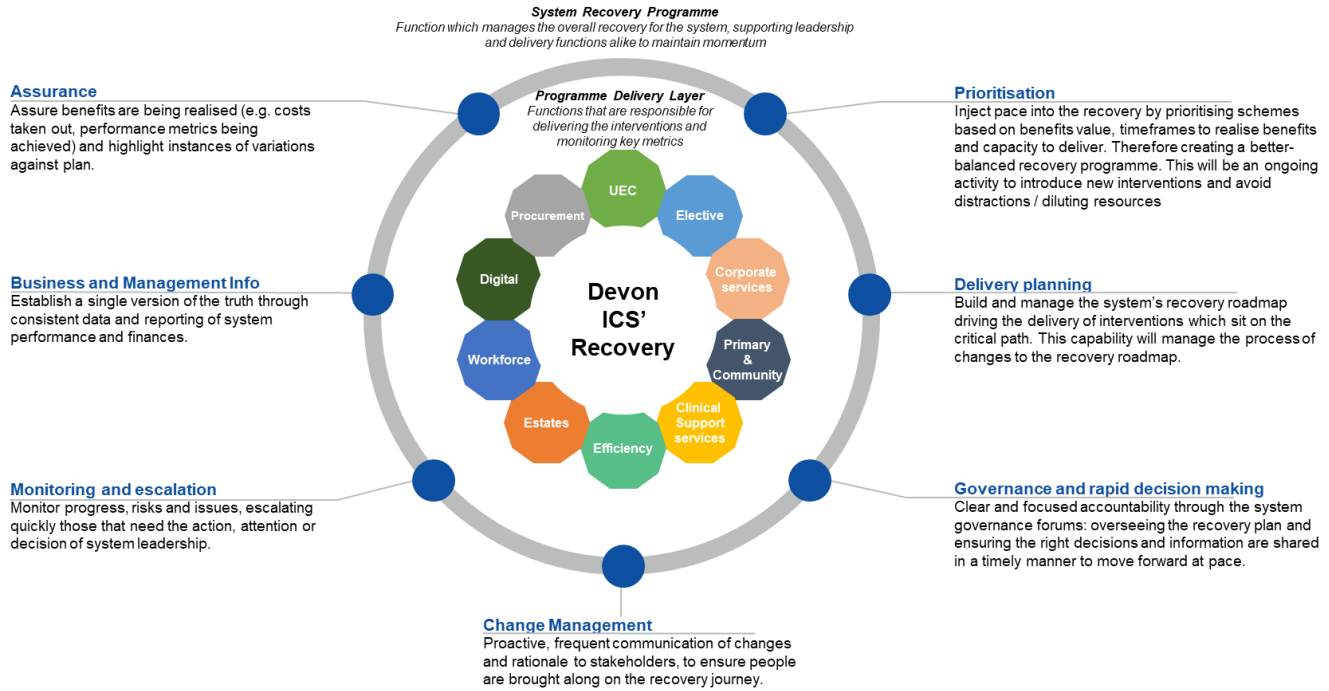
Clinical, operational and finance teams will play a key role in this recovery effort, and further integration and support for cross-organisational planning and efficiency delivery will be critical to our success. By leveraging the expertise and resources of our teams, we can identify areas for improvement and drive coordinated efforts to achieve our goals. We remain committed to working collaboratively with stakeholders across the system to ensure that the System Recovery Programme is effective and sustainable in the long term.

Establishing a system recovery function and programme delivery structure

A comprehensive, integrated recovery programme is required to drive delivery across the system, and we will leverage existing governance mechanisms where possible to achieve this. The diagrams below highlight the delivery structure and tasks the function will perform.



(1) ICB Performance Review may be performed by system recovery function
(2) Strategic programmes are being worked up and will be agreed shortly



The Recovery Programme is committed to exiting SOF4 measures in Q1 FY24/25

SOF4 exit criteria

Theme	Criteria
Leadership	• Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system
Strategy	• Delivery of Phase 1 of the Acute Services Sustainability Programme.
UEC	• Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.
	• Achieve the defined expectations of the National Taskforce.
Elective recovery	• Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement
Finance	• Develop and deliver a short-term financial plan (2023/24) that is signed off regionally and nationally
	• Develop an outline longer-term financial plan that shows non-recurrent balance in 2024/25, and recurrent balance for 2025/26, that has Board agreement from all Devon organisations
	• Develop and agree a Capital Plan that is clearly aligned to system strategic priorities

Estimated Segment 4 Exit Date : Q1 2024/25

Underpinning each Exit criteria is a set of agreed metrics and trajectories which form the basis of the system RSP oversight and performance management arrangements

Delivery Principles – we will find solutions that follow these principles:

- Seek solutions that work for the system.
- No organisation will knowingly create an adverse impact on another or the system.
- Standardise practice and services where it makes sense to do so.
- Focus on cost reduction, cost containment and productivity improvements
- Recognise that participation will be required at system, locality, neighbourhood, and organisational level on the priority areas.
- Ensure equitable distribution of funding and outcomes by locality.
- Not make new investments that lead to a deterioration in the underlying position
- Consider financial decisions alongside quality, safety and any impact on patient experience of care.
- Share risks and benefits across the system and ensure they are fully understood by all parties.

Delivery Programmes

Detailed milestones in appendix

Our priorities

The next sections of the Plan summarise the ambitions and the key high level objectives for each of the 9 delivery programmes and 10 enabling programmes, with additional detailed work programmes included in Appendix C and Appendix D.

Those programmes that have been working on key transformation priorities linked to the Devon Long Term Plan have reviewed and updated these to ensure alignment to the One Devon strategic goals.

There are several golden threads that run through all of the delivery programmes, including:

- population health
- prevention
- inclusion
- personalised care and empowerment of individuals

During April and May the system will undertake a review of the entire programme and will agree any sequencing of objectives required to reflect the focus on recovery in the early years.

There are some important statutory requirements that need to be addressed within the JFP that do not sit within the remit of the key programmes. These are set out overleaf.

Statutory Requirements

Duty to patient choice

ADD – how the ICB will ensure patient choice is considered when developing and implementing commissioning plans

Duty to obtain appropriate advice

ADD – ICB strategy for seeking expert advice, including through formal governance arrangements and broader engagement.

Serious Violence Duty

Serious violence has a devastating impact on lives of victims and families, instils fear within communities and is extremely costly to society. The Police, Crime, Sentencing and Courts Act 2022 sets out that from 31 January 2023 ICBs will be under a duty to undertake a strategic needs assessment and produce a plan to prevent and reduce 'serious violence', with partners such as Local Authorities and the police. The definition of 'serious violence' now includes domestic abuse and sexual offences. Guidance on the Serious Violence Duty was published by the Home Office on 16 December 2022 -Serious Violence Duty - GOV.UK (www.gov.uk).

NHS Devon has a domestic abuse and sexual violence (DASV) strategy that outlines actions to improve the health response to victims and perpetrators who are staff or patients in Devon. Over the last two years much has been achieved (eg: a network of DASV champions, robust DASV policies, commissioning of an Interpersonal Trauma Primary Care service, due to commence in April 2023). The Duty requires the specified authorities to work together to:

- identify an appropriate local partnership and lead partner. This will be the Community Safety Partnerships that exist within Torbay, Plymouth, and Devon. A lead partner has yet to be identified.
- identify the kinds of serious violence that occur in the area (through a strategic needs assessment to be completed by September 2023),
- identify the causes of that violence (so far as it is possible to do so), and
- to prepare and implement a strategy for preventing and reducing serious violence in the area.

Providers, although not named as specified authorities, also have a role to play in the provision of data, contributing to the strategic needs assessment and the implementation of any interventions. Compliance against the Duty will be measured through nationally and locally agreed measures, such as reduction in hospital admissions for assaults with a knife or sharp object and reduction in homicides. Locally, compliance with the Duty with be monitored through the Safeguarding and Vulnerable People Steering Group, which will report quarterly to the Quality and Performance Committee and updates regarding Duty activity will be included in safeguarding reports to the System Quality & Performance Group.

The case study on p20 shows how the ICS is working collaboratively to progress this important agenda.

Vision and ambition

Mental Health

Work collaboratively, with partners and experts by profession and experience, to improve population mental health and wellbeing and improve outcomes and experiences of people with mental health problems, learning disabilities and/ or neurodiversity across Devon. We will do this by providing the right, safely staffed, affordable and sustainable services that are compassionate, trauma informed and co-produced by empowered experts of experience and profession.

We will fully achieve the commitments set out in the NHS Long Term Plan for people with mental health problems and learning disabilities.

Mental health, learning disabilities and neurodiversity are everybody's business and will be increasingly reflected through **integrated** care offers across all organisations and partners; support, care, and treatment will be person-centred across all services and organisations so that people get the support they need when they need it.

Over time in Devon 'predisposing' factors of mental illness will not predict mental illness, they will predict proactive support which avoids mental illness where possible. Parents, families, children and young people will get the help they need to ensure that all infants, children and young people have an equal chance of enjoying resilient emotional wellbeing and mental health in their lives.

All people with mental illness, learning disability and/ or neurodiversity will be cared for in Devon at home, or as close to home as possible, through a sustainable, supportive community offer which reduces variation at a locality level.

People who experience serious mental illness and/or learning disability will have their physical health needs met with a view they live a life as long as the average person in Devon without mental illness. All people with serious mental illness and learning disability, including those with co-existent drug and alcohol problems, will have improved access to safe, adequate housing, employment and education options.

Year 1- 5 Objectives

Mental Health

Smart Objectives
1.) People in the perinatal period (pre-conception- 24 months postnatally) and their families will be able to 'get help' early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible. In 2023/24 at least 1,115 women and birthing people will access specialist perinatal mental health support.
2.) By 2027/28 an agreed model for supporting infants and children in the early years (0-5's) parents and families mental health will be responding to the needs of families across Devon.
3.) In 2023/24 at least 15,754 children and young people will access NHS funded mental health support, care and in Devon.
4.) By 2027/28, we will increase access to CYP MH services, such that at least 70% of children and young people with mental health problems have access to NHS funded mental health support, care and treatment.
5.) Subject to national requirements, by 2027/28, 95% of children and young people referred with 'routine' mental health needs will wait less than 4 weeks to access NHS funded and non-NHS funded mental health support, care and treatment.
6.) By 2027/28, 95% of schools in Devon will be offered support to develop a whole school approach to mental health and wellbeing which is compassionate, trauma and shame informed.
7.) By 2025/26 Devon will have sustainably eliminated inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.
8a.) By 2023/24 60% of people with serious mental illness will have a complete physical health check in the last 12 months. 8b.) By 2026/27 75% of people with serious mental illness will have a complete physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.
9.) By 2027/28 people experiencing mental health crisis will be able to get the help they need at home or in the local community. a.) We will respond to mental distress as early as possible: by the end of 2023/24 the call abandonment rate in the FRS telephony service will be less than 5% b.) We will reduce the level of preventable attendance at emergency departments: by the end of 2027/28 the number of preventable attendances at emergency departments by people experiencing mental health crisis (without physical health indications) will be reduced by 30% (subject to data availability from DGH providers).

Year 1- 5 Objectives

Mental Health

Smart Objectives
10) By the end of 2027/28 the transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities. a.) In 2023/24 at least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24. b.) By the end of 2024/25 at least 32,476 people access psychological therapies in 2023/24. c.) By the end of each year clinical and satisfaction outcomes will improve by 5% year on year from 2023 baseline (or as otherwise aligned to the national CQUIN for CMH Outcomes). d.) By the end of 2027/28 95% of adults and older adults will wait 4 weeks or less to access specialist mental health services including psychological interventions.
11a.) From 2023/24 onwards 95% of children and young people who are referred to eating disorder services will get help with 4 weeks if they have 'routine' needs and within 1 week if they have 'urgent' needs. 11b) By the end of 2025/26 95% of people of all ages who are referred to eating disorder services will get help with 4 weeks if they have 'routine' needs and within 1 week if they have 'urgent' needs.
12a.) By the end of 2027/28 the % of people of xxx aged 18-69 who are in employment will increase to the national average (9.1% from 6.5%) 12b.)By the end of 2027/28 the % of the population who are in receipt of long term support for a learning disability that are in paid employment (aged 18-64) will increase by x% 12a.)By the end of 2027/28 the % of adults with a learning disability who live in stable and appropriate accommodation in Devon will increase by x% 12d.)By the end of 2027/28 the % of adults in contact with secondary mental health services who live in stable and appropriate accommodation in Devon will increase by x%

Vision and ambition

Learning Disability and Autism

Population Working – LDAP Strategic Approach
Strategy - as a system we reviewed up to 30 different national strategic documents, Acts and Legislation that were associated to the system provision of health and social care for Learning Disabilities and Autistic People.
As a system we agreed that our approach to have value and commitment to the people we serve we would reduce those strategies to a number of measurable described and defined pledges. Those pledges will be co owned an integrated governed system, mobilised monitored and overseen in the Learning Disability and Autism Partnership.

Pledges – Learning Disability and Autism Partnership

The Golden Thread: To reduce health inequalities and improve health outcomes for people with a learning disability and autistic people delivered through actions and learning. Golden thread of reasonable adjustments to access all services across Devon
Health Inequalities, Reasonable Adjustments, STOMP, LeDer Service Improvement programme, CTR Safe and Wellbeing reviews

Housing Accommodation and Inpatient reprovision: We need to deliver a new model of service for people with learning disabilities and autism, including those with the most complex needs, that is housing-based and shares five common principles of providing the best living environment; having a clear common pathway for delivery; ensuring better life outcomes and making best use of financial resources to create sustainable housing and services over the long-term.

Autism: Our vision is that autistic people get the support and opportunities they need to lead full and happy lives. As partners, we will work to improve services, reduce waiting lists, support the removal of barriers for autistic people of all ages and their families/carers, through improving training and awareness, provision of meaningful support, assessment and diagnosis, early identification and reducing the reliance on inpatient care through community services.

Co-production: To empower people and families to work with us as partners in making sure people get the best care and support possible.
We want to find more ways to bring this to life in the work of the innovations we support.
Meeting those hard to reach communities, hearing more, balanced Views, you said and we are doing
Experts by experience, VCSE

Employment: Increasing more of our adult working age community into employment

Benefits from a system approach: Collaborative working, joint ownerships, shared outcomes and examples of good practice, innovation and shared risk, Clinical Input to workstreams.

Year 1- 5 Objectives

Learning Disabilities and Autism

Smart Objectives
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.
Reduce reliance on Mental Health locked and secure inpatient care, while improving the quality of Mental Health inpatient care, so that by March 2028 (in line with national target) no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an Mental Health inpatient unit
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times by March 2028.
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.

Vision and ambition

Primary and Community Care

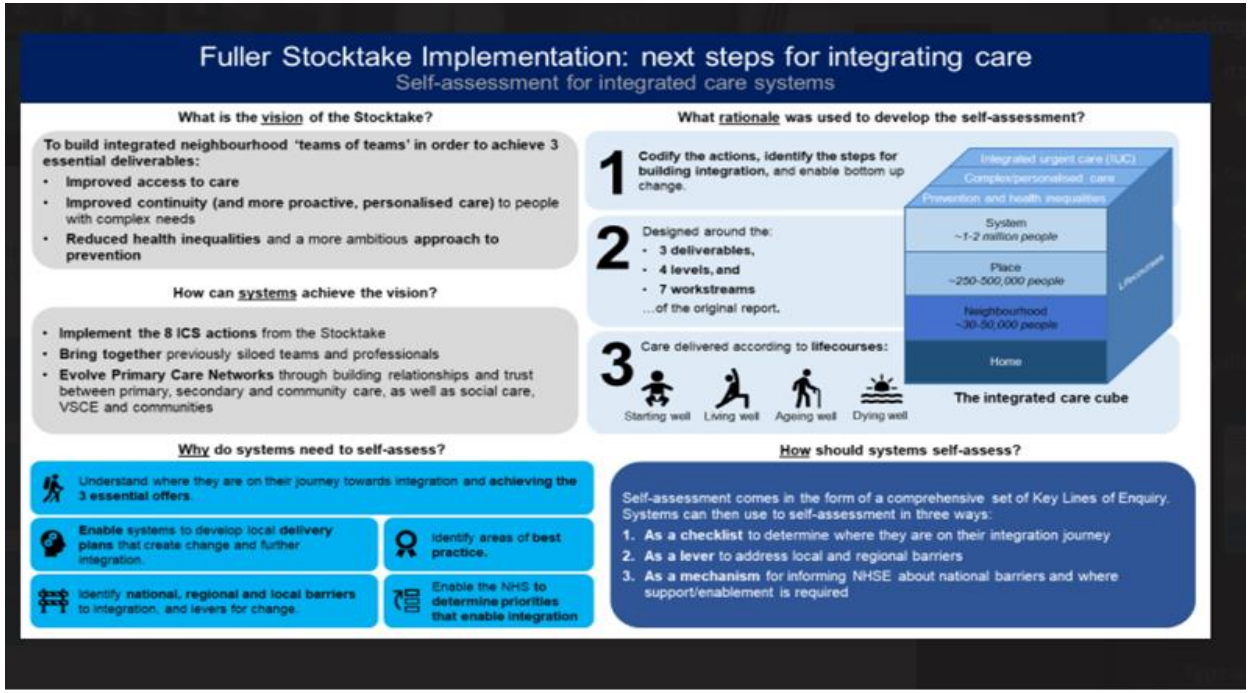
Primary and Community Care integration is a cornerstone of the Devon Long Term Plan, and our vision is to deliver an integrated model of care to support all people at home (includes prevention, anticipatory care, whole life course, and best practice pathways).

The integrated model of care described in the Devon GP strategic framework (2022) evidences alignment with the output of the Fuller Stocktake which focusses on the development of integrated multi-disciplinary neighbourhood teams at place. Community care covers community health and social care services and voluntary sector and community organisations.

At a local level the Devon Community First strategic framework (2022) also described the aims of building community capacity at a neighbourhood level, focussing on proactive, reliable, resilient, safe and sustainable community services.

Building on these two local strategic frameworks and with the delegation of additional primary care services (dentistry, pharmacy and optometry), Devon ICS now wants to set an ambitious target to have a fully functioning and effective **integrated model of care**, which takes a more preventative approach to delivering personalised care and addressing health inequalities within each of it's five Local Care Partnerships.

This will ensure that we meet people's needs in a way that matters to them, and that supports them to stay living safely at home in their community, retaining their independence for as long as possible, living the life they want to lead.



Year 1- 5 Objectives

Primary and Community Care

Smart Objectives
Collaborative working By 2028 we will have a Primary and Community Care Collaborative which functions across Devon. This will enable further integration across Social Care, Mental Health and VCSE organisations by designing a model which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes
Preventative Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community multi-disciplinary team to jointly deliver services, including Urgent Community Response, which meets the 2-hour response target to avoid hospital admissions for 90% of referrals, by 2028
Proactive Care We will be able to identify the people that are most likely to benefit from an integrated proactive approach, with a focus on prevention and early intervention
Preventative Care Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services
Access to Information We will have a shared overview of Voluntary and Community organisations across Devon via the consistent use of the Joy App by Social Prescribers and across 100% of PCNs by 2024
Sustainable General Practice We will have General Practices across Devon working in ways that reflects the focus placed on sustainability within both our local and national Strategic Frameworks, with agreed standards at GP Practice and PCN level by 2028
Objective regarding Pharmacy, Optometry and Dentistry to be developed
Objective relating to Social Care (including Independent market) to be developed

Vision and ambition

Children and Young People Care Model

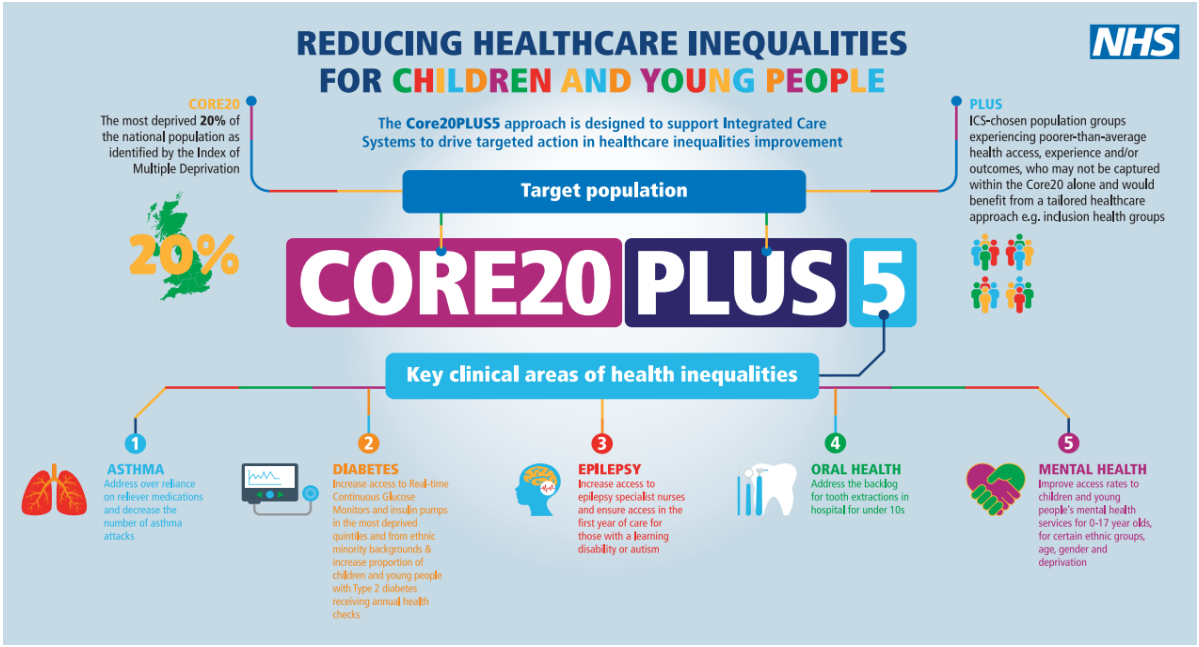
Our vision is to create an Integrated System and Care Model for Children and Young People (CYP) that supports all aspects of their health (including mental health) and wellbeing, for children and their families so that they can make good future progress through school and life. We will achieve this by working effectively in an integrated way within and across health, care and education, sharing information and knowledge and taking a strengths based approach.

Using our collective resources, we will create sustainable services and settings where children can learn and achieve their potential in life. We will ensure safe birth and optimise the first 1000 days of a child's life and enable the early identification of issues for children. We will meet the requirements of the Core20PLUS5 by proactively addressing health inequalities, working collaboratively with communities and the voluntary sector to shift to a child and family driven approach, ensuring that safeguarding is a golden thread. Transition for young people into adulthood and achieving independence will be focus for every relevant pathway. The needs of CYP with Special Education Needs and Disabilities (SEND) are a specific focus for our health, care and education system, so that we can respond effectively to the weaknesses identified through inspection and the challenges experienced by our children and families.

Our approach will be informed by joint use of high quality data and information and by listening to our communities to truly understand the needs of children and young people and their families, women and birthing people.

Our focus areas of work which span from birth, through transition to young adult are covered within SEND improvement programmes across all three Local Authorities and Local Authority led early help programmes and three NHS driven transformation programmes:

- Services for children who need urgent treatment and hospital care are delivered as close as possible to home and waiting times are steadily improved.
- Children and families with neurodiverse, emotional and communication needs are supported across health, care and education, preventing crisis and enabling them to live their best life.
- Maternity care is safe and offers a personalised experience to women, birthing people and their families.



Year 1- 5 Objectives

Children and Young People Care Model

Smart Objectives
Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.
Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.
Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.
By 2028, we will have proactively addressed **health inequalities**. The Core20Plus5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.
Commissioned arrangements will be in place across Devon by 2028 to ensure that the health needs of **socially vulnerable children** are identified and met.
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.

Vision and ambition

Acute Services Sustainability

The Covid pandemic has impacted on urgent and elective services across the UK and here in Devon - waiting times for patients needing urgent care, planned appointments and procedures have increased dramatically, impacting on our ability to deliver timely hospital services to the people of Devon.

We will work together across our local NHS organisations to deliver high quality, safe, sustainable and affordable services as locally as possible improving patient outcomes and experience. We will ensure that addressing health inequalities are a focus of all our work and that the whole population of Devon is able to access the care they need.

We will make sure people access the right service at first time through **effective navigation** around the care system; people with a care need should be seen by the right professional, in the right setting, at the right time.

In the short term to stabilise care by:	In the medium term to sustain care by:	In the longer term transform care by:
▪ Addressing the most challenged services ▪ Increasing productivity and maximising capacity ▪ Adopting and embedding best practice	▪ Delivering high quality clinical outcomes for the whole population ▪ Consistently meeting agreed performance targets ▪ Making best collective use of scarce workforce resources ▪ Ensuring best value within available financial resources ▪ Transforming pathways of care - strengthening continuous improvement	▪ Improving equity of access for all ▪ Adapting to changing population need ▪ Working as one joined-up system of services without organizational barriers ▪ Adopting new and innovative models of care ▪ Being a pace-setter in the use of digital and technical solutions ▪ Preparing for significant medical innovations e.g genomics ▪ Ensuring that location is never a barrier to accessing services

Year 1- 5 Objectives

Acute Services Sustainability Programme - Peninsula Acute Sustainability

Smart Objectives
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)
Trust Boards, Peninsula leadership & NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement but not public consultation • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement but not public consultation (January 2024)
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement but not public consultation (February/March 2024
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)

Year 1- 5 Objectives

Acute Services Sustainability - Planned Care

Smart Objectives
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.

Year 1- 5 Objectives

Acute Services Sustainability - Diagnostics

Smart Objectives
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)

One Devon

Year 1- 5 Objectives

Acute Services Sustainability – Cancer

Smart Objectives
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs
Sustainability of Oncology Services
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

Year 1- 5 Objectives

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.
Improve **A&E waiting times** so that no less than 72% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 – this will be achieved through a reduction in bed occupancy, avoiding inpatient admission where possible and reducing length of stay
Improve **category 2 ambulance response times** to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 - this will be achieved through improvements in the “clinical hub” (emergency operation centre” including clinical navigation and validation, and additional ambulance response capacity
Acute bed occupancy will decrease to 94-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.

Vision and ambition

Housing

The overall vision for housing is that people across Devon have access to a decent, safe, secure and affordable home, which is suited to their needs, promotes health and is located in a community where they want to live. The elements that contribute to this include:

1. Poor quality housing is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups (1). The impacts are wide ranging and broad; with direct relevance to healthcare, homes which are cold/damp/mouldy increase the risk of exacerbations of many illness (respiratory, cardiovascular) and of falls, leading to increased hospital attendances and admissions; and at the other end of the scale, in terms of giving children the best start in life, issues from asthma, spread of infectious diseases, and inability to concentrate on homework can have life -long impacts.
2. Specialist housing - increased range of specialist housing such as accessible wheelchair accommodation and supported accommodation to meet the needs of the most vulnerable, including people with dementia.
3. Enabling older people to promote, secure and sustain their independence in a home appropriate to their needs, including through the provision of housing across all tenures in sustainable locations and through the provision of Disabled Facilities Adaptations. This will include increased provision for retirement accommodation, extra care and residential care housing.
4. The provision of good quality affordable housing for rent or buy in the areas where people want and need to live, giving specific consideration to the need to attract and retain key health and care workers.
5. The prevention of homelessness; noting that this is far wider than simply provision of housing.

Although elements 2 -4 fall within the remit of local planning authorities (LPAs) to deliver, the recommendation is for health and care partners within the ICS to engage more proactively with LPAs via planning consultations and other relevant forums, to ensure that the needs of people with complex health conditions and disabilities, such as those with mental health disorders, learning disabilities and/or autism, are reflected in housing supply.

For element 1 **poor quality housing**, the ambition for this, as indicated by the overall target, is significant since it requires some 11,000 homes across Devon to be lifted out of fuel poverty to achieve the reduction of 2 percentage points.
As well as new energy efficient homes, there are three key approaches to tackling this;

- Supporting people to improve the energy efficiency of their own homes
- Working to improve the standard, quality and management of private sector housing
- Supporting people in supplier switching, fuel debt relief and in financial management

Resources are likely to be a constraint around this, especially since funding tends to be relatively short term (e.g. Housing Support Fund). However there is much that can be done. NICE guidance QS117 [2] sets out a number of quality standards to assist with reducing these risks and this should be implemented across Devon. This centres around; identification of vulnerable people in cold homes; single point of contact for support; asking people if they live in a warm home; identifying cold homes on admission; supporting warmer homes as part of discharge planning.

Year 1- 5 Objectives

Housing

Smart Objectives
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE
Systematically identify vulnerable groups with chronic conditions and signpost for support
Identifying poor quality housing on admission/discharge planning and referring for support
For the projected need for specialist housing, accommodation to meet the needs of older people and affordable housing to be understood across Devon, and to be taken account within the relevant Local Plans across the footprint, with associated delivery plans
Reduce the number of people who are homeless in particular: • No family should be in B&B accommodation over 6 weeks (would need to be agreed collectively with LA, 5 is the government guide) • 10% reduction in number of households in temporary accommodation (remember this will be against a backdrop of increasing demand) • X% increase in the number of households successfully prevented from becoming homeless (use 22/23 benchmark data) • 100% of people who sleeps rough should be offered accommodation

Vision and Ambition

Employment

Employment is a crucial element of individual wellbeing, health and social mobility, and partners within Devon fully recognise its role as part of our wider efforts in supporting individuals to thrive, young people to advance, support services to better manage demand, and provide the health and social care system with the future workforce it needs.

At the highest level, national and international evidence suggests that individuals within employment benefit from both improved mental and physical health and wellbeing overall, with the Health Foundation highlighting that the occurrence of new mental health diagnosis amongst those in work were roughly 15% lower then amongst those outside the workplace in 2021, and that those who outside of work were also 16% more likely to have poorer health outcomes overall. Wider academic work also suggest strong links between reduced life expectancy, poorer health and mental outcomes, and reduced life satisfaction overall and prolonged experience of unemployment. This is particularly acute for younger people, where unemployment may leave a scarring impact in terms of progression, confidence, education and personal resilience (Prince's Trust, 2021).

Traditionally, Devon has performed relatively well around such issues, with economic activity rates and NEET performance amongst the best within the South West (roughly 1-2% better on average than the rest of the region). However, significant gaps existing within the area's performance, with unemployment amongst younger people roughly 1% higher then those over 25, amongst those with a disability roughly 7 to 8 times the average of the rest of the population, and for those who have experienced care roughly 10 times the County. Significant differences also existing between places within the County, with unemployment in Torbay roughly twice that in South Hams on average, levels of youth Unemployment / NEET roughly 60% higher in Plymouth than Exeter, and average wage levels for those in work in Torridge approximately £150 less per week then those in East Devon.

As such, this strategy seeks to focus upon ensuring that every resident of Devon are provided with the support they need to access and stay in employment, secure a good job they value and develop their careers. This seeks to ensure that no individual regardless of background faces a barrier to employment if they wish to work. In particular, One Devon partners seek to ensure that individuals from more vulnerable backgrounds and with more prominent barriers to employment and progression in the workplace are supported to achieve and grow. Partners are also keen to fully harness the potential of the health and social care sector as an employment destination and leverage related opportunities to support those more vulnerable. This includes a specific focus upon:

- Younger people, particularly those from a more complex background who may experience additional barriers into the transition into adulthood, and maybe Not in Employment, Education or Training (NEET) or at risk of being NEET as a result. This would include a specific focus on those who are care experienced and those with an SEND need.
- Individuals who have a disability, face a mental health challenge or have another health barrier to employment
- Individuals with a barrier to work or progression from within our most vulnerable communities, particularly those within the bottom 20% most deprived nationally.
- Groups identified as being more likely to face other barriers to employment, including older people already outside of the labour market and single adults with children

To support these target groups, partners within Devon will work together across the health and social care system to support individuals into related employment opportunities, through:

- Working together, alongside key partners such as Jobcentre Plus/DWP, to codesign and deliver relevant wraparound support for individuals to allow them to access employment. This will include exploring tailored support offers for those with a health or mental health condition, working with health and social care employers to identify opportunities for more vulnerable / complex staff, and working with workforce development colleagues to ensure that pathways are tailored to accommodate individuals regardless of circumstance.
- Working with employers across the sector and beyond to support them to employ individuals who may have move complex needs / barriers to work, for example through providing support for workplace mentors or working with skills and learning colleagues around the creation of structured traineeships and apprenticeships to offer additional routes into employment
- Come together as partners and employers to work upon and explore topics of shared interest and opportunities, for example through agreeing a single forum through which to explore employment opportunities for those with a mental health need.
- Work with wider partners on issues which support broader access to employment, including relevant housing provision, careers education, functional skills, speech and language provision, and transport
- Engage with wider place based initiatives, which seek to focus upon more specific challenges facing communities around employment, from skills uptake in our urban centres, to the challenge of connectivity in our deep rural and costal communities.

Year 1- 5 Objectives

Employment

Smart Objectives
Seek to reduce level of 16-18 year olds Not in Education Employment and Training (‘NEET’) in Devon by 1% by 2027
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027

Vision and ambition

Suicide Prevention

Suicide is a traumatic event; the impact is felt not only by immediate family and friends, but by people in workplaces, communities and wider society. It is estimated that every suicide costs the economy £1.67 million. This estimate includes direct costs which are; involvement of the emergency services, healthcare and wider wellbeing support and interventions and investigations carried out by the police and coroner. There are additional indirect costs attributed which include the lost opportunity to contribute productively to the economy, including paid work, voluntary activities and looking after children or parents. Arguably though, the most fundamental impact of all is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value. It is these intangible costs that make-up approximately 70% of the total costs of suicide.

Suicide can often be the end of a complex history of risk factors and stressing events, and the risk for suicide reflects wider inequalities in social and economic circumstances. Suicide is preventable; however, the prevention approach must address the complexity of the issue. There are many effective ways in which individuals, communities and services can help to prevent suicide and this strategic statement is intended to recognise the contributions that can be made across all sectors of society.

The *'Cross-Government Suicide Prevention Strategy'* published in 2012 and subsequently updated in 2015, 2017 and 2019 sets out the Government's priorities for addressing suicide and self-harm. [A new strategy is expected in 2023]. The NHS Long Term Plan aims to transform mental health and care services to ensure more people can access the treatment and support they need in a timely manner and in particular commits to enabling easier access to care when anyone is having a mental health crisis. This sets out the NHS ambition and confirms that reducing all suicides remains an NHS priority.

Year 1- 5 Objectives

Suicide Prevention

Smart Objectives
The Local Suicide Prevention Groups each have a published annual action plan which sets delivery for the year
Local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards
Local Suicide Prevention Groups to prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention
Public Health Teams monitor suicide rates and produce an annual report that monitors the rate in each area and at ICB level and compares it to the England average rate

Vision and ambition

Health Protection

The 2020 covid pandemic has highlighted the importance of protecting our population from preventable diseases, hazards and infections. This is set within the context of new and emerging threats, including antimicrobial resistance and climate change. Diseases disproportionately impact on our most vulnerable communities. We also know that some communities in Devon are least likely to access preventative services, including immunisations and screening, and yet are more likely to experience the severe consequences of diseases and infections.

To protect the Devon population, we must ensure therefore ensure that we:

- work with our system partners through strong governance and partnership arrangements to deliver our health protection responsibilities to ensure that the health of the public is protected, particularly within the context of new and emerging threats. As we move to delegated commissioning of immunisation services, including outbreak vaccinations, there will be greater emphasis on system leadership by the NHS and Devon's Local Authorities, presenting further opportunity to address health inequalities at the local level;
- deliver the UK 5-Year Action Plan for Antimicrobial Resistance (2019-2024) which was suspended during the COVID Pandemic – this has a strong focus on infection prevention and control and our aim is to work collaboratively across the system and organisational boundaries with all providers to drive forward further reductions in healthcare associated infection across the whole system
- strengthen our surveillance, intelligence and insight to ensure that we focus on protecting our most vulnerable communities in Devon;
- embed the learning from the covid pandemic and delivery of the covid vaccination programme in Devon, which has highlighted the need for frontline health protection services, strong commissioning pathways, greater emphasis on community infection prevention and control, and accessible/innovative service delivery (e.g. outreach vaccinations);
- fulfil our responsibilities as a Category 1 responder through taking a lead role in assessing risks, putting in place emergency and business continuity plans, warning and informing, embedding learning, and setting the direction of EPRR (Emergency Preparedness, Resilience and Response) strategy and priorities.
- Work with system partners including VCSE and lived experience partners to support the improvement of uptake of routine immunisations and screening in general and with a focus on Devon's priority populations (CORE20PLUS) for adults and children and young people; with a focus on MMR, preschool booster, CORE20PLUS 5 key areas (early diagnosis), cancer screening in particular cervical screening uptake; and alignment with Devon's approach to the Women's Strategy and Devon's cancer priorities and workplans

Year 1- 5 Objectives

Health Protection

Smart Objectives
Reduce occurrences of HCAIs (C.diff, MRSA, gram negative organisms) in primary care using the Start Smart Then Focus principles
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection
Providers must demonstrate a 100% offer to eligible cohorts for influenza and covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for CYP and adults
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP
Vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS for CYP
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-covid levels, with secondary aim to achieve year on year improvement in uptake working towards the 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults
Consistently achieve the national colposcopy screening to diagnostic test screening standard with focus on Devon's priority populations (CORE20PLUS) for Adults
Improve access and uptake for those specifically with an LD or with SMI to bowel screening to achieve the same uptake as the general population
Work closely with NHS England commissioner to support the delivery of the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (CORE20PLUS) for Adults
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon

Vision and ambition

Community Learning & Development

When community stakeholders work together for the benefit of the community they live or work in, the collective power of community can be transformational. There are examples of this working well in places across Devon. Building trust, creating shared understanding and learning and developing together will create the optimal conditions for collaborative work between One Devon and all communities within Devon. One Devon believes in the strength **of increasing the health capacity in communities**, and community learning and development is the tool to achieve that goal.

The role of One Devon is not to 'do' community development in Devon, but to help create the conditions that foster and strengthen community action – catalysing and building on **community capacity** to take action together. These conditions include providing the right investment and supporting with the evidence-based frameworks and tools available. The One Devon plan includes providing support to communities to use a variety of evidence-based approaches such as **asset-based-community-development** (ABCD), health creation practices, experience-based co-design and community learning and development (CLD). Different or blended approaches can work well according to individual circumstances and a range of tools will be provided to spread the use of such evidence-based practices. It also acknowledges the need to invest in community 'infrastructure' building - the building blocks that enable community partnerships to engage, organise and develop including Community Development roles and skills development such as those that support citizens to take collaborative leadership roles in public-sector decision-making settings.

Communities are in variable states of energy and organisation and communities in disadvantaged areas may need more support than others - Commissioning Community Development for Health. The plan includes the use of the One Devon Dataset and other sources of data such as the JSNA to help identify which communities face the most disadvantage and should be prioritised for this investment. **Community partnerships will be supported to identify their own needs and priorities** based on local knowledge, local targeted engagement (particularly of those who have been previously under-heard) and localised public health data. One Devon will work with communities to tackle gaps, understanding that different groups will need differing levels and offers of support.

Communities have a wide range of **"health assets"** that include the skills and knowledge of citizens, local groups and voluntary sector organisations including faith-based organisations, clubs and charities, local businesses, and public sector agencies including local policing teams, schools, GP practices, nursing teams and local councils. Other assets include buildings, websites and local communication platforms . Action plans can be created by community partnerships to address needs with existing assets, identifying the gaps and exploring how they can be filled.

Local Care Partnerships will **support and empower Community Partnerships** in the same way that they are supported by Devon Partnerships such as the Integrated Care Partnership and vice versa. This nested model aims to bring an equilibrium to the power dynamic, shifting more power and influence to the level that can have the most effect on health. Communities will be **involved in co-design from the start.**

A common evaluation framework will be developed that enables **communities to choose the measures of success** based on what matters to them and to learn and build on what works. It will also include evaluation over ways of working to establish whether they increase such things as control, connection and confidence – all of which can be evidenced to improve wellbeing. The evaluation framework will additionally provide the basis for ongoing investment in community and citizen-led action.

The Plan is in line with NICE guidelines & principles of good practice and fulfils the statuary guidance. However, it will be verified from the experience of community development work over the past decade in Devon and it is intended to be a living document that will continue be **co-developed in partnership with community stakeholders.**

Year 1- 5 Objectives

Community Learning & Development

Smart Objectives
By 2028 local communities will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – ‘no decision about me without me’
By 2028 local communities will be able to work collectively to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.
By 2028 a Community Development workforce will be supported, empowered and skilled to deliver fully inclusive services for everyone equipped, trained to agreed standards and following a Code of ethics and values-based practice
By 2028 One Devon will fully embrace its role in working alongside the communities of Devon as an equal partner both at system and local level

Enabling Programmes

Detailed milestones in appendix

Vision and ambition

System Development

The Integrated System Development Programme aims to strengthen integrated and collaborative working in One Devon, to enable partners to implement innovative ways to collectively tackle our shared challenges improving the access to effective health and care for people in Devon.

System Partners will collectively own the delivery of the Programme, actively involving communities and people with lived experience, and will adopt five core principles to underpin all of our work together.

An innovative approach to reset the way we work together and apply learning will fundamentally change mindsets and improve the outcomes and experience for people across Devon. As a result the Programme will primarily support the overarching strategic goal outlined in the 5-Year Integrated Care Strategy:

'One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money.

By 2026/7 we will have: adopted a single operating model to support the delivery of health and care across Devon and will have achieved thriving ICS status.

Opportunity Area	Description
LEARN BY DOING	Real change will come from undertaking real work together and acting upon the learning we generate. One Devon will be able to continually develop if we embed a culture of learning and improvement.
PRIORITISE & IMPLEMENT	Implementing a small number of priority projects and programmes will create the conditions for us to deliver real change together on the journey towards achieving One Devon's vision.
SHARED PURPOSE	Defining and articulating (continuously) why we are doing what we are doing, and what we hope to achieve from it, will support One Devon to collectively realise a common purpose.
TRUST & COLLABORATION	Increasing levels of trust and collaboration between us will be vital to creating the conditions for progress towards One Devon's vision.
SYSTEM FOCUS	Movement towards One Devon's vision will be enabled by the extent to which we seek to understand, listen to, and take into consideration each other's needs and constraints.

Year 1- 5 Objectives & Milestones

System Development

Smart Objectives
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards

Vision and ambition

Research and Innovation

In order to establish new ways of working across the Devon ICS we need a more robust and dynamic approach to research and innovation. The purpose of the Research and Innovation Programme is to ensure that system partners work together to address the three common barriers identified in a review carried out in December 2021 on accessing, deploying and embedding research, innovation and improvement:

- *Absence of system level process for accessing, deploying and embedding research, innovation and improvement*
- *Absence of the right system level capacities and capabilities within the system's organisations to make best use of research, innovation and improvement*
- *Absence of a systematic approach to learning*

One Devon will provide its workforce with the framework, tools and support to innovate in its broadest sense. To be successful, we will develop the right research and innovation architecture, to deliver all our strategic goals, building an evidence base and innovation pipeline which directly responds to known health and care needs and the Devon Case for Change. We will build the capacity and capability of teams and organisations so that we achieve widespread adoption of high value innovations aligned with ICS priorities, utilising systematic research and improvement approaches to support rapid implementation. In doing this, we will drive spread and adoption of what works, achieve optimal use of resources and best outcomes for the people of Devon.

Specifically, the ICS is working with the South West Academic and Science Network (SWAHSN to implement a Regional Innovation Strategy. This will draw in Core Partners who represent major Research and Innovation Assets in the region (AHSN, ARC, CRN, HEIs), and will develop a new framework which will maximise the alignment of health needs with existing research and innovation expertise and networks, Funding has recently been agreed for joint role to lead the development of this new framework.

The ICS will maximise impact from research, innovation and improvement by clearly signalling its strategic ambitions and priorities to partners, to grow and focus the innovation pipeline, to achieve better alignment with system transformation programmes. The coordination of research and innovation partners and assets in the region around clear priorities will enable One Devon to leverage in additional funding from Government and other funding streams, supporting economic growth. It will also facilitate the sharing of learning with other systems regionally and nationally.

Year 1- 5 Objectives and Milestones

Research and Innovation

Smart Objectives
Build and strengthen networks at local, system, region and national level
Promote research and increase patient sign-up
Ensure all system workplans are underpinned by robust evidence of research and innovation
Develop capacity and capability.
Develop underpinning structure and governance mechanisms

Vision and ambition

Population Health

As the Integrated Care System develops there will be an increasing focus on improving the health of the population, shifting the allocation of resources from treatment to prevention, increasing access to services and reducing health inequalities. This will require changes throughout all parts of the system and, in particular, in the way that the ICB carries out its roles as both a commissioner and a system convener and facilitator. These changes will be embedded in the ICS development programme and all aspects of this plan but will aim to ensure that the impact on population health is considered in every decision made and workplan delivered and that we move to a longer term focus

In order to achieve these changes a programme of work will co-ordinate activities at both LCP and system level. This programme will be led by the Population Health Team (incorporating the existing HI and Prevention team and PHM workstream) and will aim to facilitate and support work throughout the system as well as delivery of specific interventions. The overarching aim will be to ensure that there is a focus on population health throughout the system, that everyone has the skills, tools and knowledge to deliver change and that good practice (underpinned by robust evidence) is shared and implemented as quickly and efficiently as possible.

Year 1 - 5 objectives

Population Health

SMART objective
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations
Ensure delivery of Core20+5 deliverables (including adult and CYP)
Implement co-ordinated prevention plans in priority areas
Develop the ICB and NHS partners as Anchor Organisations
Support the implementation of new ways of working focused on population health

Vision and ambition

Engagement and Involvement

Vision

Through inclusive, meaningful, involvement, we will work in partnership with Devon's people and communities so that health and care services meet the needs of our population. We will champion involvement through a culture of ongoing conversations and collaboration, so that we act on what we hear and continue to build trusted relationships with a shared purpose.

Involvement principles

Our approach to involving people and communities is based on six values. There are also 10 principles outlined in the NHS Constitution that we must adopt. The table below outlines how principles align.

Collaborative with a shared vision with our partners

- Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as two of our key partners
- Work in partnership with people and communities when addressing system priorities and reconfiguring services
- Learn from what works and build on the assets of all partners in the Integrated care system (ICS) – networks, relationships and activity in the local care partnerships (LCPs).

Start with what we already know

- Use community development approaches that empower people and communities and build on existing relationships.

Act with humility and genuine enquiry

- Understand our community's needs, experiences, ideas and aspirations for health and care, using involvement to find out if change is working and is making a difference.

Be fully inclusive in our approaches to all our communities

- Build relationships based on trust, especially with those affected by health inequalities.
- Provide information that is clear and accessible for all our communities. Meet the needs of our people and communities by having various ways they can engage with health and care services.

Be responsive, act quickly on what we have heard, and tell people how we have acted on feedback

- The voices of people and communities need to be central in the decision making throughout the ICS.
- Involve people and communities at every stage when developing plans and feedback to people how their involvement has influenced decisions.

Year 1 - 5 objectives

Communications and Involvement

The communications and involvement mechanisms that will support delivery of the JFP include:
The new ICS involvement platform ‘Let’s Talk’ the and citizens’ panel that programmes can utilise to support online involvement activities across the system
Partnerships with involvement professionals from all system partners that can support collaboration, sharing of best practice, and co-production of involvement
Partnerships with Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector that will can offer insights and connection to local populations
Learning from the vaccination outreach programme will support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
We will provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Develop an involvement identity that can be can be used across the One Devon Partnership to help raise the profile and awareness of involvement activity across Devon.

Vision and ambition

Equality and Diversity

Vision:

Devon will be a great place to work where staff will feel valued and have a strong sense of belonging. We will champion diversity as our route to innovation and improved performance.

We will support work to tackle health inequalities by working hand in hand with local populations and our partners to understand barriers to care so that we can design services that have the needs of everyone at their core.

Core aims:

Nationally, there is growing evidence that equality and diversity improve efficiency and performance. Diversity of thought paves the way for innovation and therefore offers the opportunity to help tackle Devon's challenges, making it a better place to live and work for everyone.

Devon is a significantly challenged health and care system, with some of the longest waiting lists in the country, a significant deficit of £49.5 million (across the system) and significant workforce challenges.

Two core aims underpin the equality and diversity programme:

1. Improve performance and efficiency through a diverse workforce
2. Ensure Devon's health and care services are inclusive and accessible to everyone

Year 1 - 5 objectives

Equality and Diversity

Equality and diversity ensures that services meet people's needs, give value for money and are fair and accessible to everyone. It means people are treated as equals, get the dignity and respect they deserve, and differences are celebrated.

Improving innovation and value for money

- New perspectives and different ideas that come from a diverse workforce support innovation (The Kings Fund)
- Diversity results in better decision making and therefore improves financial performance (McKinsey)
- Efficient services that better meet peoples' needs and keep people in good health can reduce the need for costly and prolonged care further down the line.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance

Improving workforce recruitment and retention

An inclusive working environment, that encourages everyone to bring their own ideas forward helps employees feel valued, appreciated and encouraged

- Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)
- Develop and retain a diverse workforce, building a culture where our people feel valued, heard and able to be their best selves at work.
- Ensure staff recruited via the International Recruitment Hub, are well supported in their roles and deliver a campaign that celebrates our diverse workforce, tackles racism and builds cohesion in the community.
- Continue to build and support the Devon-wide ethnic equality staff network, ensuring it has meaningful input into system priorities, including develop a Devon-wide anti-racism charter that the One Devon Partnership sign up to.

Delivering better care

When staff feel valued with a sense of belonging, they are likely to provide better care to patients

- Through a rolling EDI calendar, celebrate diversity and raise awareness of discrimination, empowering our workforce to be more inclusive, and demonstrating our commitment to EDI to our local populations.

Improving health outcomes and reducing health inequalities

Equality and diversity help us overcome barriers to care so we can design services that meet the needs of everyone. Inclusive services provide better outcomes and experience and therefore help to tackle health inequalities

- Take learning from the Covid-19 outreach vaccination programme and work with partner organisations to support people from diverse and vulnerable populations have better access to health and care service, focusing particularly for those with visual and hearing impairments, people with learning disabilities and those for whom English is a second language.

Vision and ambition

Workforce

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

At System level we will;

- deliver solutions that enables the attraction, recruitment and retention of talent across our health and care providers, reducing duplication and streamlining processes.
- Use our Devon 2035 workforce vision to inform strategic workforce planning which will identify new roles and ways of working, informing our talent supply pipelines with national, regional and local training & education providers.
- Embed the One Devon Workforce Strategy Themes and Principles into workforce planning and service transformation and delivery

System working

We work collaboratively to enable our workforce to move flexibly across sectors and create new roles to meet the needs of the population and services.

Stability

We stabilise the workforce by supporting new and diverse career pathways for our current and future workforce.

Learning & Education

We commit to investing in the workforce through enrichment of development opportunities ensuring that quality and safety is at forefront.

Digital

We utilise digital technology to support innovation and transformation to our workforce and across all services we deliver.

Sustainable

We commit to achieving a skilled workforce built on a system that is financially sustainable.

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives
Strategic workforce planning embedded at System level
System level attraction solutions that source new talent and position Devon System as an employer of choice.
Development of new roles and new ways of working embedded across Devon ICS

Vision and ambition

Digital

"Invest in a digital Devon: people will only tell their story once, first contact will be digital where appropriate and more advice and help will be available online. We want to make the most of advances in digital technology to help people stay well, prevent ill health, and provide care."

Digital technology will enable data to be available anywhere at any time for those health and care professionals needing to work in new ways. This means we can move to new models of care, with more online interactions with citizens and patients, while maintaining an understanding that digital should not be the only way to access services. This progressive approach will support a move to a new digital first paradigm of care being "a service you receive", rather than a place you go to. Irrespective of health and care setting, when the citizen needs the support from Devon health and care organisations, data will be available for the workforce to make informed decisions; the safe handling of personal data is a key responsibility. By following this digital approach more of our physical capacity is expected to be used on the predicted activity growth across services. To achieve the digital vision, the ICS Devon Digital Strategy presents five priorities to enable clinical and non-clinical transformation from both the workforce and citizen perspective. These **five digital priorities** will provide 'future proofed' digital solutions; recognising that care models continue to change:

1. **Digital Citizen**: Empower citizens to take ownership of their wellbeing and care, through digital technology and contact across the system. Digital will offer new ways of delivering care to help citizens manage their care at home.
2. **Shared Electronic Patient Record (EPR) & Operational Systems**: The convergence to common digital solutions that meets the information sharing and workflow needs of the various organisations across the ICS.
3. **Devon and Cornwall Care Record (DCCR)**: the DCCR will allow information to be available across care settings and coordination of care through specific functionality such as read/write for key flags and care plans.
4. **Business Intelligence & Population Health Management**: A cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will necessitate linked data, accessible by a shared analytical resource that can work on cross-system priorities.
5. **Unified and Standardised Infrastructure**: Levelling-up and consolidation of infrastructure, to support future enterprise scale digital systems such as Shared Electronic Patient Records (EPRs), digital technologies for citizens and also agile and frictionless cross-site working and support experience for the workforce.

An ICS digital inclusion group has formed with membership from Voluntary Community and Social Enterprise, Local Authority, health providers and the ICB. This group considers access to health and care services from the citizens perspective and to consider citizen access to health and care services irrespective of their personal digital circumstances. Digital inclusion is the prime responsibility of those involved in service transformation and design.

Staff will be supported to confidently use digital technology in their roles. When new technology is introduced, training will be provided as part of any implementation or transformation programme. For existing technologies, new starters will be supported through the normal organizational induction process and for existing staff, through in-role training where required.

Over the coming years the use of Artificial Intelligence, Machine Learning and Robotic Process Automation will become more prevalent. These technologies provide an opportunity to support staff through undertaking tasks so that they can spend more face-to-face time with patients, spend less time on repetitive tasks and concentrate their knowledge and experience on high value work whether this be in the clinical or non-clinical setting

Year 1- 5 Objectives

Digital

Smart Objectives
Number of eligible citizens connected to the NHS App increased to support national target of 75% of people registered by 2024
Future use of ORCHA (App assurance product to support citizen self-care and social prescribing) determined by the end of the current funding in March 2024.
Standardisation of GP practice websites achieved within 2025.
Achieve planned Virtual Ward bed targets by April 2024 across TSDFT, UHP and RDUH
Electronic Patient Records implemented in TSDFT, UHP and DPT by the end of 2025
80% of care homes to have a Digital Social Care Record by March 2024
Peninsula Picture Archiving and Communication System (PACS) solution for the clinical network procured and implemented by 2025
Peninsula Laboratory Information Management System (LIMS) solution for the clinical network procured and implemented by 2025
Re-procurement of GP Electronic Patient Record (EPR) clinical system by March 2024
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028
Develop Population Health Management (PHM) architecture and reporting
Develop an ICS data platform and associated reporting, linked to EPR implementation and national developments including the Federated Data Platform
Work collaboratively with regional ICS teams to develop the regional secure data environment to support future research
Unified and Standardised Infrastructure provided by 2028

Vision and ambition

Procurement

Vision

We will enhance every patient experience through delivering maximum value and the best quality service through our collective procurement and supply chain excellence.

Ambitions

- **Patients**: The healthcare services they need are delivered on time and of the best quality.
- **Clinicians**: They are equipped with the goods and services they need to deliver world-class care.
- **Taxpayer**: The NHS is achieving value for every pound spent and delivering government priorities such as sustainability, NetZero and eradicating modern slavery.
- **Suppliers**: The NHS is easier to do business with, with opportunities to develop more innovative solutions to meet NHS and government challenges.

Year 1- 5 Objectives

Procurement

Smart Objectives
Improved Resilience - Covid-19 taught us that working together is essential to mitigate risk.
Reduced total Cost - The ICS represents a publicised and policy driven way of driving ‘at scale’ procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and minimise unwarranted variation
Greater Value - The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients
Better Supplier Management - Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories
Optimised Workforce - The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access to more diverse roles and opportunities across the system
Improved Capability and enabling Great Careers - Working together frees up capacity to give us time to develop and leverage specific skills and expertise

Vision and ambition

Strategic Estates and Facilities

1. To redevelop the acute hospital estate through the funds available via the New Hospital Programme
2. To develop the community services and mental health estate to ensure it remains relevant, fit for purpose and located within the right places with an ambition to provide more specialist services outside of the traditional hospital setting
3. To enable and support the development of the primary care estate through PCN strategies and supporting GPs to integrate primary care with community service developments
4. To develop a road map for estates and facilities activity to reach Net Carbon Zero by 2040
5. To undertake strategic procurement of estates and facilities contracts to leverage buying power for providers on behalf of the ICS
6. To work in collaboration with the public sector in Devon to ensure One Public Estate opportunities are maximised
7. For estates and facilities expertise to work in collaboration across the ICS to ensure efficiency, skill sets and joint delivery programmes remain optimal

One Devon

Year 1- 5 Smart Objectives and milestones

Strategic Estates and Facilities

Year 1	Year 2
Undertake strategic review of the ICS-wide health estate	Categorise all of the estate into ‘core, flex and tail’ and agree strategies for each site or development opportunity
Develop an investment plan and a 5 year capital prioritisation pipeline	Prioritise funding allocations whilst taking advantage of national funding review outcomes and TIF funding
Develop a cross-matrix team that can support the delivery of estates and facilities at an ICS-wide level	Integrate provider service departments where possible to create resilience, efficiencies and succession planning
Deliver a public facing ICS Estates Strategy	Commence delivery of the implementation plans that shall support each area of the Estates Strategy

Vision and ambition

Green Plan

The ICS supports the co-ordination of carbon reduction across the system through the actions to reach net-zero outlined in the Devon Greener NHS plans and the Devon Carbon Plan.

The ICS also recognises the need to identify the key risks to our system from climate change and to develop a plan to adapt to and mitigate these risks. Addressing the climate and ecological emergency is an opportunity to create a fairer, healthier, more resilient and more prosperous society.

Encouraging everyone to be more active by walking and cycling; improving air quality through the electrification of vehicles; insulating homes and work places, and eating more sustainable and balanced diets will all improve public health and reduce pressures on the NHS and social care

One Devon

Year 1- 5 Objectives

Green Plan

Smart Objectives
Develop a sustainability training programme for all ICS staff.
Review induction training for new starters to include how we are meeting the green agenda and overview of the ICS Green Plan.
Encourage staff to provide suggestions and ideas on how sustainability can be improved in all areas across the organisations
Work across the system to ensure all care is delivered with carbon reduction principles as a key consideration e.g., reducing the amount of unnecessary visits to hospital as part of a package of care.
Promote and encourage the use of Ecosia (a company that plants trees based on the number of times the search engine is used) as the search engine used by ICS staff.
Explore the provision of electric car charging points at all venues that host ICS staff.
Explore the potential for subsidised public transport usage for staff
Review recycling facilities across estates and work with clients to increase options to recycle
Purchase or generate 100% electricity from renewable energy sources.
Ensure the system plan is aligned with deliverables in the Estates Delivery Plan. Including replacing lights with LED, removal of coal and oil boilers, renewable energy generation.
Explore alternative greener energy suppliers for our sites.
Consider the use of solar energy on all existing and new sites.
Create an internal campaign to increase awareness amongst primary care clinicians about prescribing ‘greener medication’.

Year 1- 5 Objectives

Green Plan

Smart Objectives
Develop systemwide plans for clinically appropriate prescribing of lower carbon inhalers, in line with the commitment of a 50% reduction by 2028 and a 6% reduction in 2021/22 on a 2019/20 baseline. (IIF)
Develop systemwide approaches to optimise use of medical gases, including reducing nitrous oxide waste.
Create a campaign to inform patients on how the correct use of medicines can contribute to carbon reduction.
Identify and report all single use plastics across ICS sites and replace with recyclable, low carbon alternatives where possible.
All providers within the ICS should only be purchasing 100% recycled paper and be reducing paper usage.
Take action to address single use plastics, and specifically eliminate unnecessary catering plastics.
Develop a Green Impact Assessment Checklist for all new policies and procurement.
Review and adapt menus to offer healthier lower carbon options for patients, staff and visitors.
Where possible, buy locally sourced products promoting the concept of the Devon Pound.
Update risk registers across partners to include climate related risks including floods and heatwaves and identify key adaptation actions to mitigate the predicted impacts on the ICS of climate change. Ensure the delivery of these adaptation actions are undertaken.

Delivering the Joint Forward Plan and Future Development

Health and Wellbeing Board Opinions
Delivering the plan in 23/24
Governance
Outcomes Framework
Risks to delivery
Future refresh of the JFP

#OneDevon

To be added

Health and Wellbeing Board Opinion

Delivering the JFP

The JFP will be delivered through system architecture described earlier, that includes:

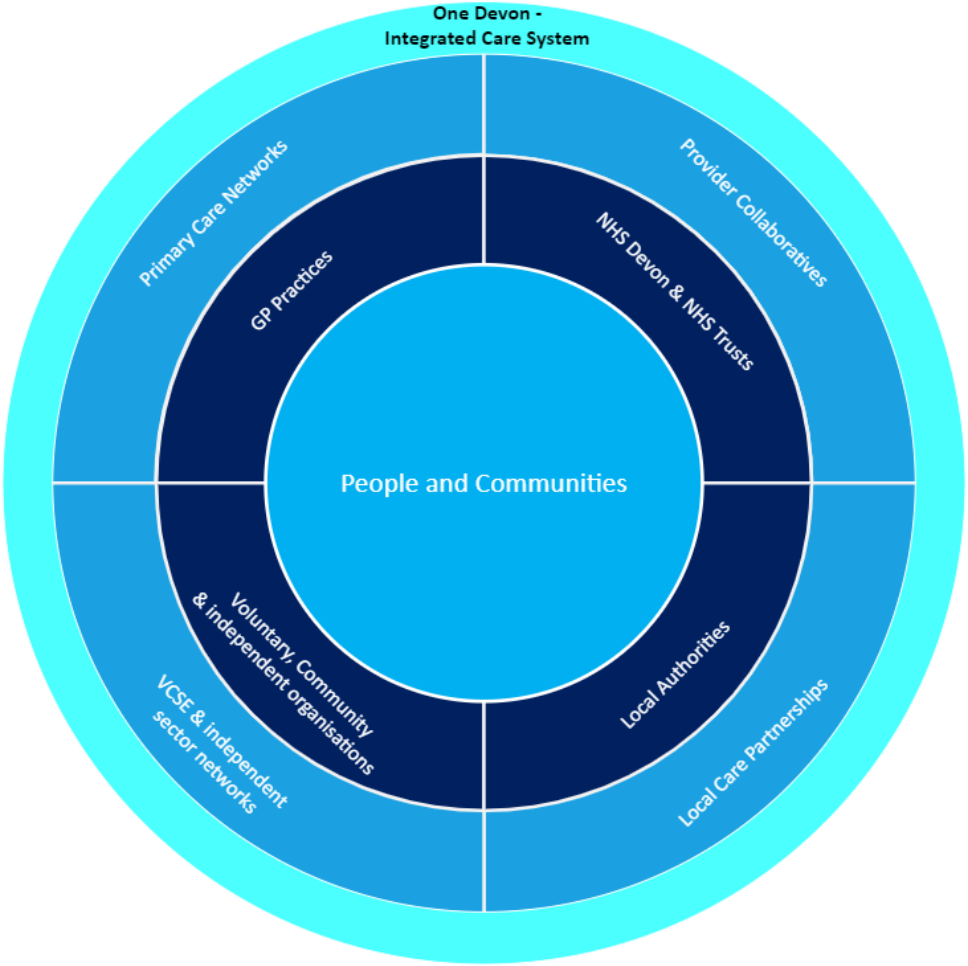
- Primary care networks and collaboratives
- Local care partnerships
- Networks
- Provider collaboratives
- System level transformation programme boards

The high level delivery plan (Appendices C and D) details the actions we will take in the short and longer term.

The outcomes framework will be used to monitor progress towards the strategic goals.

Assurance:

- The System Recovery Board will drive delivery of the recovery plan
- Delivery of work programme milestones will be monitored through system programme infrastructure
- Progress towards delivery of ICS strategic goals will be overseen by the Devon Executive Strategy & Transformation Group and will report to the One Devon Partnership
- Use of ICS maturity framework



into appendix?

Objectives of LCPs

Whilst much of the delivery of the JFP will sit with local teams, there are also some areas of focus within Joint Local Health & Wellbeing Strategies that are not reflected in the systemwide work programmes, but which sit within agreed LCP priorities.

The broad scope of services where LCPs are best placed to lead service improvement have been identified as follows:

Prevention and Health Inequalities

Champion health and well-being as a real priority, placing a much greater emphasis on prevention and levelling up health outcomes.

Community Care	Urgent Care Pathways	Acute Pathways	Mental Health	Children's Services
Majority of services where there is **integration with Primary and Community Services, Adult Social Care and Public Health** (e.g. long term condition management)	LCPs have key role in bringing local system partners together to improve Urgent Care Pathways and performance as this requires a **coordinated local response**	LCPs involved in providing more **care out of hospital and in the community**. This includes service improvement of pathways into, and out of hospital (Diagnostic Services, Therapies and Outpatients). Examples include admission avoidance, frequent attenders etc.	LCPs should work with the MHLDN Provider Collaborative to develop and implement **model for CMHF** and also coordinate LTC management **for Dementia** patients – linking with Care in the Community	LCPs should be involved in developing **a collaboration for Children's Services** with support from the ICB. This will be led by DCSs in local authorities, building on the Devon C&FHP. Specific objectives will be set for this programme of work

One Devon

To be added

Outcomes Framework – TO BE COMPLETED

To be added

Governance – TO BE COMPLETED

To be added

Challenges/risks to delivery – TO BE COMPLETED

To be added

Future Development of JFP – TO BE COMPLETED

Refresh processes during 23/24:

- Co-production with patients/public

APPENDICES

APPENDIX A
Universal NHS commitments and legislative requirements

National NHS objectives 2023/24

Area	Objective
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

5 Year Joint Forward Plan – key requirements

Legislative requirements:

- Describing the health services for which the ICB proposes to make arrangements
- Duty to promote integration
- Duty to have regard to wider effect of decisions
- Financial duties
- Implementing any JLHWSs
- Duty to improve quality of services
- Duty to reduce inequalities
- Duty to promote involvement of each patient
- Duty to involve the public
- Duty to patient choice
- Duty to obtain appropriate advice
- Duty to promote innovation
- Duty in respect of research
- Duty to promote education and training
- Duty as to climate change, etc
- Addressing the particular needs of children and young persons
- Addressing the particular needs of victims of abuse

Other recommended content:

- Workforce
- Performance
- Digital/data
- Estates
- Procurement/supply chain
- Population health management
- System development
- Supporting wider social and economic development

ICB Core Functions and Statutory Duties

JFP Legislative Requirements	Comments
Describe health services the ICB proposes to arrange to meet needs	
Duty to improve quality of services	
Duty to reduce inequalities	
Duty to promote involvement of each patient	
Duty to enable patient choice	
Duty to obtain appropriate advice	
Duty to promote innovation	
Duty to facilitate and promote research and use its evidence	
Duty to promote education and training	
Duty to promote integration	
Duty to have regard to wider effect of decisions	
Duty as to regard to climate change etc	
ICB involve the public in decisions about services	
Addressing the particular needs of children and young people	
Addressing the particular needs of victims of abuse	
Implement any joint local health and wellbeing strategy	
Financial duties	

NHS Devon's strategic objectives

To be updated – move to appendix?

Improve population health

- Work in partnership with community and 'anchor' organisations (such as education and police) to address the social determinants of health (1)
- Reduce health inequalities through public health and mental health support (2)
- Enable a greater shift from treatment to prevention (3)

Improve services and reduce unwarranted variation

- Deliver safe and effective urgent and emergency care services that better meet people's needs (4)
- Reduce the number of people waiting for elective care – with a specific short term focus on 104-week waits (5)
- Improve the capacity of primary care – with particular attention to challenged areas, such as Plymou (6)
- Improve the quality of mental health services – particularly for Special Educational Needs and Disabilities services (7)
- Support and treat more people in their own homes and communities to help them live healthily and independently (8)

Make more efficient use of our resources

- Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan (9)
- Develop a workforce strategy to ensure resilience of key services (10)
- Maximise the use of digital technology and data so it is evidence based and outcome focused (11)
- Minimise our negative impact on the environment and ensure services are green/sustainable (12)

Develop our culture and how we operate

- Develop and embed a new culture for the 'One Devon' system and create stronger relationships built on integration and trust (13)
- Develop a system operating model, so we are clear on system decision-making, local care partnership accountability, and development of a more locally-based, citizen-led approach to planning and delivering services (14)

Enablers to delivery

(i) Digital; (ii) Workforce; (iii) Estates; (iv) Good governance; and (v) Communications and engagement

APPENDIX B
Metrics and Baselines

Improving Outcomes in population health and healthcare

Strategic Goal	Metric	Baseline
Every suicide should be regarded as preventable and we will save lives by adopting a zero suicide approach in Devon, transforming system wide suicide prevention and care.	*By 2024 each LCP will have a suicide prevention plan*.	144 suicides in the latest year (2021)
Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death early and disability	*By 2028 we will have: decreased the gap in healthy life expectancy between the least deprived and most deprived parts of our population by 25% and decreased the under 75 mortality rate from causes considered preventable by 25%*	Current healthy life expectancy variance by LA is: Torbay Female: 23.2 years, Male: 14.5 years, Plymouth F: 20.6 and M: 14.8 and Devon F: 15.9 and M: 14.1. Under 75 mortality rate from preventable causes: 2016-20, Devon 4,948, Plymouth 1,885, Torbay 1,229. Standardised rates (England = 100) are Plymouth 112.1, Torbay 111.8 and Devon 78.9.
We will have a safe and sustainable health and care system.	*By 2025 we will: deliver all our quality, safety and performance targets within an agreed financial envelope*	
People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.	*By 2025 we will: reduce the level of preventable admissions by 95%*	Preventable admissions: Ambulatory Care Sensitive (ACS) conditions 23,604 in 2021/22, 95% is a reduction of 22,424
People (including unpaid carers) in Devon will have the support, skills, knowledge and information they need to be confidently involved as equal partners in all aspects of their health and care.	*By 2028 we will: extend personalised care through social prescribing and shared decision making and increased health literacy*	
Children and young people we have improved mental health and well-being	*By 2024/25 we will have: at least 15,500 CYP aged (0-18) accessing NHS-funded services, 100% coverage of 24/7 crisis and urgent care response for CYP and 95% of children and young people with an eating disorder able to access eating disorder services within 1 week for urgent needs and 4 weeks for routine needs*	

Tackling inequalities in outcomes, experience and access

Strategic Goal	Metric	Baseline
People in Devon will have access to the information and services they need, in a way that works for them, so everyone can be equally healthy and well.	*By 2028 we will increase the number of people who can access and use digital technology and and improved access to dentists, pharmacy, optometry, primary care*	
The most vulnerable people in Devon will have accessible, suitable, warm and dry housing	*By 2028 we will have: decreased the % of households that experience fuel poverty by 2%, reduced the number of admissions following an accidental fall by 20%*	2020 figures for % of households with fuel poverty: Plymouth 13.9%, Torbay 12.4% and Devon 11.8% (although range within DCC of 13.3% Exeter to 10.6% East Devon). SW position is 11.4% and national 13.2%. From previous LTP work there are around 6k falls-related admissions each year in Devon.
Everyone in Devon will be offered protection from preventable infections.	*By 2028 we will have: increased the numbers of children immunised as part of the school immunisation programmes by 10%, increasing the uptake of those eligible for Covid and Flu vaccines by 10% and reduced the number of healthcare acquired infections by 10%.*	
Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place	*By 2028 we will have: increased the number of people dying in their preferred place by 25% and those who want it will have advanced care planning in place.*	2019/20 baseline is 8,650 people died in an unwanted place of death across the ICS
In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience.	*By 2026 Devon's workforces will be supported, empowered and skilled to deliver fully inclusive services for everyone, and Devon will be a welcoming and inclusive place to live and work where diversity is valued and celebrated*; *by 2027 Devon's workforce will be representative of local populations; and by 2028 our estates, information and services will be fully inclusive of the needs of all our populations*	

One Devon

Enhancing productivity and value for money

Strategic Goal	Metric	Baseline
People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency	*By 2026 patients will report significantly improved experience when navigating services across Devon.*	
We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.	*By 2028 we will have: a unified approach to procuring goods, services and systems across sectors and pooled budget arrangements*	
People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care.	*By 2028 we will have: provided a unified and standardised Digital Infrastructure*	
We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.	*By 2028 we will have: vacancies amongst the lowest in England in the health and social care sector*	Vacancy rates: varies depending on organisation and work group. Overall for Devon ASC 6.8%, NHS 7.2%. We already benchmark well versus the England average (9.7% for the NHS) and SW position.

One Devon

Helping the NHS support broader social and economic development

Strategic Goal	Metric	Baseline	Challenge
People in Devon will be provided with greater support to access and stay in employment and develop their careers	*By 2028 we will have: reduced the gap between those with a physical or mental long term condition (aged 16-64) and those who are in receipt of long term support for a learning disability (aged 18-69) and the overall employment rate by 5% and decreased the number of 16-17 year olds not in education, employment or training (NEET) by 25%.*	End 2020 NEET (16-17 yrs old) was Devon 514, Plymouth 225 and Torbay 111. NEnd 2020 NEET (16-17 yrs old). Employment: 2 indicators: 1. Gap in the employment rate between those with a physical or mental long term condition (aged 16-64) and the overall employment rate: 21/22: Plymouth 9.9, Devon 9.7, Torbay 11.3 (SE region 9.7 average, England 9.9 average) 2. Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 69) and the overall employment rate: 20/21: Plymouth 71.6, Devon 72.3, Torbay 67.7 (SE region 72.4 average, England 70.0 average)	3, 5, 8, 11
We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change, supports healthier living (including promoting physical activity and active travel).	*By 2028 we will: be on-track to successfully deliver agreed targets for all Local Authorities in Devon being carbon neutral by 2030 and the NHS being carbon neutral by 2040*		2
Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people	*By 2024: Local Care Partnerships will have co-produced with local communities and community groups in their area, a plan to empower and support groups to be more resilient.*		11
Children and young people in Devon will be able to make good future progress through school and life.	*By 2027 we will have: increased the number of children achieving a good level of development at Early Years Foundation Stage as a % of all children by 3%*	The 2019 position for % achieving a good level of development (not measured since) was Devon: 72.7%, Torbay 70.8% and Plymouth 68.3%. The SW average is 72.0% and nationally 71.8%.	3, 8
Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably	*By 2028 we will have; directed our collective buying power to invest in and build for the longer term in local communities and businesses*		2, 3, 5

APPENDIX C
Delivery Programme Milestones

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
1.) People in the perinatal period (pre-conception- 24 months postnatally) and their families will be able to 'get help' early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible. In 2023/24 at least 1,115 women and birthing people will access specialist perinatal mental health support. This SMART objective aligns to wider LMNS single operating plan.	At least 1,115 women and birthing people/ year will access perinatal mental health support Develop plans to ensure that: - Referrals are accepted from pre-conception to 24 months postnatally. - Partners can access mental health assessment including signposting or referral as needed. - Increase the range of psychological therapies available. Establish working relationships with NHSE and/ or the South West Provider Collaborative which influence how perinatal provision across the whole pathway is rebalanced. Complete review of wait time profiles across perinatal mental health offer.	Implement plans to ensure that: - Referrals are accepted from pre-conception to 24 months postnatally. - Partners can access mental health assessment including signposting or referral as needed. - Increase the range of psychological therapies available. 95% of people who require perinatal and/ or maternal mental health services are able to access support within four weeks of referral. Complete a review of access, experience and outcomes in perinatal mental health pathways across Devon, including assessment of the response to health inequalities and risk factors for mental illness in a family. Prepare a 2-year plan to respond to the review, setting out how parents and families with increased likelihood of mental illness will be offered help proactively.	Implement the 2-year plan to ensure that 95% of parents and families with **features** which strongly correlated with future mental health problems in children and young people will be offered help proactively and early in the development of a need and earlier in the perinatal period. We will work to enable rebalancing of provision across the range of needs so that more women get help early in development of need.

One Devon

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
2.) By 2027/28 an agreed model for supporting infants and children in the early years (0-5's) parents and families mental health will be responding to the needs of families across Devon.	Develop a 3- year plan to implement a model infant, parent and family mental health which brings together existing provision and is integrated and co-ordinated with specialist support, education, and support. This plan will interface with the maternal and perinatal pathways and will align to the implementation of Family Hubs.	All infants and children in the early years with their parents and families, will be able to access support and intervention in relation to their emotional and language and communication development needs. This support will be aligned to a whole family approach.	The Health and Social Care workforce who come into regular contact with infants can identify signs of infant mental distress and access support to respond to their concerns

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5	Strategic Goal
3.) In 2023/24 at least 15,754 children and young people will access NHS funded mental health support, care and in Devon. 4.) By 2027/28, we will increase access to CYP MH services, such that at least 70% of children and young people with mental health problems have access to NHS funded mental health support, care and treatment. 5.) Subject, to national requirements, by 2027/28, 95% of children and young people referred with 'routine' mental health needs will wait less than 4 weeks to access NHS funded and non-NHS funded mental health support, care and treatment.	At least 15,754 children and young people will access mental health. Working in partnership health, education and social care leads will develop a 3-year plan to continue growing access to mental health support, care and treatment for children and young people, using a THRIVE based approach. Review wait times across provision; review equity of access, outcomes and experience and unwarranted variation across Devon. Develop a 2-year plan to address inequities and unwarranted variation.	Implement plan to grow access to NHS funded mental health support care and treatment for children and young people across Devon. Implement plan to address inequities and unwarranted variation in provision across Devon. 80% of children and young people with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, care and treatment (including sub-speciality provision i.e. Eating Disorder Services).	At least 70% of children and young people with mental health problems have access to NHS funded mental health support, care and treatment. Monitor impact of plans to address inequalities and unwarranted variation in provision across Devon. 95% of children and young people referred with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, care and treatment (including sub-speciality provision i.e. Eating Disorder Services).	Children and young people in Devon will be able to make good future progress through school and life. Children and young people we have improved mental health and well-being In partnership with Devon's diverse people and communities, Equality, Diversity and Inclusion will be everyone's responsibility so that diverse populations have equity in outcomes, access and experience. We will have a safe and sustainable health and care system. People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care. People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency. Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death early and disability.
6.) By 2027/28, 95% of schools in Devon will be offered support to develop a whole school approach to mental health and wellbeing which is compassionate, trauma and shame informed.	Devon will evaluate the current Mental Health Support Teams in Schools (MHST) model in partnership with Local Authorities and Education Partners and offer, in the context of the evidence based and needs of children and young people in Devon. Implement agreed action plans with each Local Authority to embed new SEND reforms and address deficits identified through the Torbay and Devon Local Area Inspection's. Refer to CYP Care Model for alignment.	Subject to national intentions and requirements, we will co-produce (with experts by experience and experts by profession) and implement an approach which iterates the national MHST model, based on the needs of the population and the evidence base.	95% of schools in Devon will be able to access support to develop a whole school to mental health and wellbeing which is compassionate, trauma and shame informed.	

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones-Year 1	Milestones- Year 2-3	Milestones-Year 4-5
7a.) By 2025/26 Devon will have sustainably eliminated inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.	In line with the NHS 23/24 Planning guidance, develop a 3-year plan to localise and realign mental health, in-patient services by March 2024.	Average Length of Stay will be 21 days for non-specialist acute adults inpatients and 45 days for older adults (needs clinical clarification) through all inpatient settings providing enhanced therapeutic interventions with appropriate oversight of staffing levels. Devon will have sustainably eliminated inappropriate out of area bed use for people who need hospital admission for acute mental ill health.	Delayed Transfer of Care will be 2% (rolling average), people requiring admission will be proactively supported to maintain community relationships through joined up therapeutic care (from primary and community care and inpatient settings), home tenancies or ownership and employment (links to objective 12d). By the end of 2027/28 all acute psychiatric inpatient care will be delivered in area unless there is an exceptional clinical need.
8a.) By 2023/24 60% of people with serious mental illness will have a complete physical health check in the last 12 months. 8b.) By 2026/27 75% of people with serious mental illness will have a complete physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.	Local Care Partnerships will ensure that 60% of people with serious mental illness have a complete physical health check in the last 12 months. Local Care Partnerships and the MHLDN Provider Collaborative will work together to ensure that people with serious mental illness who take antipsychotic medications have access to regular health checks to manage the associated risks.	Local Care Partnerships will aim to ensure that 75% of people with severe mental illness have their annual physical health check and that this leads to co-development of meaningful health action plan and access to follow up care as needed. Local Care Partnerships will focus enabling smoking cessation and access to diabetes clinics to help manage the health of people with severe mental illness.	Local Care Partnerships will ensure that 75% of people with severe mental illness have their annual physical health check and have a co-developed and meaningful health action plan and access to follow up care as needed. Joined up mental health and physical health care provision is available in local community hubs, GP practices, diagnostic clinics and urgent treatment centres.

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
9.) By 2027/28 people experiencing mental health crisis will be able to get the help they need at home or in the local community. a.) We will respond to mental distress as early as possible: by the end of 2023/24 the call abandonment rate in the FRS telephony service will be less than 5% b.) We will reduce the level of preventable attendance at emergency departments: by the end of 2027/28 the number of preventable attendances at emergency departments by people experiencing mental health crisis (without physical health indications) will be reduced by 30% (subject to data availability from DGH providers).	Local Care Partnerships deliver High Intensity Users services with partners. Develop and implement community alternatives to admission which respond to the needs of high intensity users and are aligned to home treatment and community mental health services within Primary Care Networks.	Call abandonment rate of under 5% through delivery of a single First Response telephony service for Devon aligned to 111/999 with oversight of staffing levels and staff training and development. Reduce preventable admissions to acute hospitals by 10% (subject to data availability from District General Hospitals – DGH)	Reduce preventable admissions by 30%. (subject to data availability from District General Hospitals – DGH). By the end of 2027/28 all people in Devon will have safe and equitable access to crisis and urgent mental health provision outside of emergency departments. This offer will be integrated and co-ordinated with local services, primary care, specialist mental health, and community services (VCSE/Statutory).

One Devon

Year 1- 5 Objectives and Milestones

Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
10) By the end of 2027/28 the transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities. a.) In 2023/24 at least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24. b.) By the end of 2024/25 at least 32,476 people access psychological therapies in 2023/24. c.) By the end of each year clinical and satisfaction outcomes will improve by 5% year on year from 2023 baseline (or as otherwise aligned to the national CQUIN for CMH Outcomes). d.) By the end of 2027/28 95% of adults and older adults will wait 4 weeks or less to access specialist mental health services including psychological interventions.	Increased access to Community Mental Health Services, at least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24. Clinical and satisfaction outcomes improve 5% year on year from 2023 baseline (this will be aligned to the national CQUIN for CMH Outcomes). Develop a 3- year plan to ensure that the emotional health, wellbeing and mental health needs of young people, aged 16-25, are integrated across health and education. The plan will establish a locality multi-agency integrated model delivering a 'stepped care' approach with a no discharge in/ referral out approach, where every professional with the locality understands what their role is for the individual joining up primary, secondary and VCSEI resources in the most appropriate way for young people.	Increased access to NHS Talking Therapies will mean that at least 32,476 people access psychological therapies in 2023/24. At least 75% of people will be seen within 6 weeks and 95% of people will be seen within 18 weeks. More than 50% of people will achieve clinical recovery. Implement the 3- year plan to ensure that the emotional health, wellbeing and mental health needs of young adults, aged 16-25, are integrated across health and education provision.	95% of adults and older adults with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, including specialist services and specialist psychological intervention. Young people aged 16-25 will be able to access a rand receive integrated care, support and treatment across health and education that is personalised and aligned to their emotional health, wellbeing and health needs.

One Devon

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
1.) People in the perinatal period and their families will be able to 'get help' early in the development of a mental health need in an accessible setting which avoids further mental illness and harm when possible. This SMART objectives aligns to wider LMNS single operating plan.	At least 1,115 women/ year will access perinatal mental health support Referrals are accepted from pre-conception to 24 months postnatally Partners can access mental health assessment including signposting or referral as needed Increasing the range of psychological therapies available. Establish working relationships with NHSE and/ or the South West Provider Collaborative which influence how perinatal provision across the whole pathway is rebalanced.		

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
2.) We will deliver a co-ordinated range of responses to help infants and children in the early years (0-5), parents and families develop strong foundations for mental health and wellbeing.	Develop a 3- year plan to implement a model infant, parent and family mental health which brings together existing provision and is integrated and co-ordinated with specialist support, education, and support. This plan will interface with the maternal and perinatal pathways and will align to the implementation of Family Hubs.		
3.) At least 70% of children and young people with mental health problems have access to NHS funded mental health support, care and treatment.	Finalise a 3-year plan to continue to grow access to mental health support, care and treatment for children and young people in Devon. At least 15,754 children and young people will access mental health services in Devon.		

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
4.) 95% of children and young people referred with 'routine' mental health needs will wait less than 4 weeks to access NHS funded mental health support, care and treatment (including sub-speciality provision i.e. Eating Disorder Services).	Review equity of access, outcomes and experience and unwarranted variation in NHS funded provision across Devon. Develop a 2-year plan to address inequities and unwarranted variation.		
5.) Children and young people will experience a 'no wrong door' approach so that whoever they, or their families choose to speak to about their mental health, they will support them or help them access appropriate support.	Implement agreed action plans aligned to each Local Authorities to embed new SEND reforms and address the deficits identified through the Torbay and Devon Local Area Inspection's. Please refer to the CYP Care Model for alignment.		
6.) 95% of schools in Devon will have established a whole school approach to mental health and wellbeing which is compassionate, trauma and shame informed.	Devon will evaluate the current MHST model and offer in the context of the evidence based and needs of children and young people across Devon.		

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
7.) By 2027/28 sustainably eliminate inappropriate out of area bed use for people who need hospital admission for acute mental ill health	In line with the NHS 23/24 Planning guidance, develop a 3-year plan to localise and realign mental health, in-patient services by March 2024.	There are three broad action areas in year 1 which are associated with progressing this SMART objective to sustainably eliminate inappropriate out of area bed use for people who need hospital admission. They are: **A) Maintain progress towards eliminating all inappropriate adult/ older adult acute out of area inpatient stays by:** - maintaining existing arrangements with independent sector providers -delivering work as part of the wider quality programme to ensure that any potential for unplanned loss of acute inpatient care is mitigated by ensuring resilient resourcing and maintaining high quality provision **B) Reducing the average length of stay for adults and older adults by:** - review the data in relation to average length of stay across Devon broken down by geography, needs and other factors correlated with length of stay - identifying key trends and short term actions for in year completion - identify unwarranted variation and variance from best practice to inform 3- year plan **C. Develop a 3- year plan to localist and realign mental health in-patient services by March 2024. This will involve:** - in Q1 and Q2- undertaking a system wide review of the provision available against the needs of the population, best practice and benchmarking information to understand the optimal offer and the gap between the optimal and current position - in Q3 use the reviews undertaken in Q1 and Q2 to develop the 3- year plan - in Q4 finalise and sign off the 3- year plan to localise and realign mental health inpatient services	The number of adults and older adults who receive inpatient care out of area will continue to reduce overall. Devon's 'share' of the national inappropriate out of area placements will be less than our population share. Inpatient provision will be appropriately staffed and offer high quality support, care and treatment. The average length of stay will be understood and in key outlier areas will begin to reduce. There is will a clear system plan, aligned to the MHLDN Joint Forward Plan to localise and realign mental health inpatient care by March 2024.

One Devon

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
8) By 2025/26 95% of people with serious mental illness will have an annual physical health check which leads on to each person having a meaningful action plan and access to follow up care as needed.	Local Care Partnerships will ensure 60% people on the SMI register will have their annual physical health check.		

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
9.) By 2028 people experiencing mental health crisis will be able to get the help they need at home or as close to home as possible in the local community. We will respond to mental distress as early as possible, reducing the level of preventable attendance at emergency departments of people with of people experiencing mental health crisis by x (a present data held in acutes regarding MH attendance at ED).	Call abandonment rate of under 5% through delivery of a single First Response telephony service for Devon aligned to 111/999 with oversight of staffing levels and staff training and development. Local Care Partnerships develop a joined up suicide prevention strategy. Local Care Partnerships deliver High Intensity Users services with partners	There are three broad action areas in year 1 which are associated with progressing this SMART objective to respond more effectively to needs of people experiencing mental health crisis. They are: **A.) All people in Devon will have safe, resilient, prompt and equitable access to crisis and urgent mental health provision.** - plan and implement a single first response telephony system across Devon aligned to 111/999 and with capacity to support oversight of staffing levels, staff training and development. - the telephony system will support improvements in data and informatics ensuring consistent information across Devon and enabling action to ensure that abandonment rates are consistently below 5%. **B.) More people will get crisis and urgent mental health support which meets their needs in the home or local community.** -Ensuring resilience of the home based mental health crisis response- ensure resilient delivery of crisis response home treatment teams for adults and older adults across Devon ensuring compliance with best practice and sustainable staffing -Improving the community based mental health crisis response- informed by the 2022/23 crisis alternatives provision review, undertake planned procurement of community crisis alternatives and mobilise new arrangements. **C.) When people with urgent or crisis mental health needs contact emergency services / emergency departments and wider primary and community care provision they will get the help, they need.** - Support ongoing review and improvement of police and ambulance services responses to support people experiencing mental health crisis to ensure high quality, sustainable provision is available - The needs of people experiencing mental health crisis will be considered by all partners to ensure that there is parity of esteem. This includes Local Care Partnerships developing a joined up suicide prevention strategy and delivering High Intensity Users services with partners	The First Response Service will be more resilient with greater scope for onward development including moving towards Option 2 111 access. Improvements to address call abandonment rates over 5% will be delivered. Home and community based responses for adults and older adults experiencing mental health crisis will be more sustainable and better able to respond to the needs of people in Devon. Together these actions will help ensure that there is an appropriate response earlier in the development of mental health crisis and avoid harm associated and leading to a reduction in the number of people who presentably access emergency services and/or attend emergency departments in mental health crisis.

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
10.) By the end of 2027/28 the transformation of adult community mental health provision will be complete, integrating care locally with the right partners across local providers with increased activity of 5% year on year.	Increased access to Community Mental Health Services, at least 19,668 people will access Adult and Older Adult Community Mental Health Services in 2023/24.		
	Increased access to NHS Talking Therapies will mean that at least 32,476 people access psychological therapies in 2023/24. At least 75% of people will be seen within 6 weeks and 95% of people will be seen within 18 weeks. More than 50% of people with achieve clinical recovery.		
	Clinical and satisfaction outcomes improve 5% year on year from 2023 baseline (this will be aligned to the national CQUIN for CMH Outcomes)		

Year 1 and 2 (operational plan detail)

Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
12.) To provide safe, affordable housing with options for employment and/or education for people living with a serious and/or enduring mental illness and learning disability/ autism.	A comprehensive rough sleepers strategy developed jointly, led by Local Care Partnerships, to include access to care and treatment. Housing planning includes options for people with severe mental illness, learning disabilities and/or neurodiversity and rough sleepers supporting market development of extra care and supported housing. MHLDN Provider Collaborative develops a system wide assertive outreach strategy for people with significant rehabilitation needs. Formal evaluation to inform future commissioning intentions across Health and Social Care of the Test of Change Pilot (for LDA) to increase capacity and capability of supported living market. IPS will achieve an access target of 1196 people.	There are three broad areas of work which will be initiated in Year 1 to support delivery of this SMART objective to help more people with mental health problems, learning disabilities and/or neurodiversity to live in safe affordable housing and access education and employment opportunities. These include: **A.) Developing a 3- year plan to support rough sleepers in Devon in Year 1 will include:** - bringing together information about the current needs and offers to support people who are rough sleepers, particularly those with severe mental illness, learning disability and/or neurodiversity - identifying unwarranted variation and opportunities to improve and strengthen the support offer - developing a 3- year plan to support a reduction in the number of people who are rough sleepers who have severe mental illness, learning disability and/or neurodiversity **B.) Working with housing planners and developing the development of housing supply and the support living market by:** - establish a comprehensive understanding of housing needs to inform strategic housing development plans with partners and monitor progress, through developing clear, trackable and accessible needs data for people needing housing, including children, those coming back into the local system AND those at risk of leaving the local system -support the development of a range of available housing options for people with complex needs, including appropriate social housing and home ownership, along with the skilled support needed to successfully support tenure. Including the development of clear pathways and processes to support people with complex needs to access each of these housing options as appropriate. This will include all stakeholders having the relevant information and expertise to facilitate these pathways. - work in partnership to provide the best possible housing environment for people with learning disabilities and autism, using standardised eligibility and assessment tools; good design principles; comprehensive a shared understanding of current best practice - completing the formal evaluation of the 'test of change pilot' for LDA to increase capacity and capability of the supported living market - develop commissioning intentions based on the evaluation of the 'test of change pilot' - developing a 3- year plan to support people with significant rehabilitation needs through system wide assertive outreach strategy for rehabilitation - people with complex needs and their circles of support to be fully included in the planning and delivery of their housing needs, and for people with complex needs to live healthier, happier and more socially inclusive lives by having homes of their own - ensure that our overall housing model is sustainable and affordable in the long-term, reducing reliance on wholly debt-funded development by making the best use of available public funds, personal investment and use of land-assets within the public estate **C.) Increasing access to employment for people with severe mental illness, learning disability and/ or neurodiversity by:** - expanding the Individual Placement Service offer so that more people (1,196 in total) with severe mental illness get help to access and retain employment - Develop plans to enable ICS Devon to lead by example in the employment of people with severe mental illness, learning disabilities and/or neurodiversity	There will be a 3- year plan in Devon support rough sleepers Working in partnership we will begin work to ensure that people with severe mental illness, learning disabilities and/or neurodiversity have access to housing options and supported living options which respond to their needs. There will be a 3- year plan supporting ongoing collaboration which includes key areas of focus including support people with rehabilitation needs and complex needs. Access to employment will be improved for people with severe mental illness, learning disabilities and/or neurodiversity; ICS Devon partners will lead by example, working to ensure good practice in relation to employing people with severe mental illness, learning disabilities and neurodiversity.

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Ensure a minimum (in line with NHSE National target) 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2028 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.	75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 Improve the accuracy and increase size of GP Learning Disability registers Work alongside NHSE set the AHC trajectories from March 2024 Roll out of CYP letter to GP through SEND pathways Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities Improve live data reporting	The Learning Disability and Autism team will ensure 75% of people over the age of 14 GP learning disability registers receive an annual health check and health action plan and will work alongside NHSE set the AHC trajectories from March 2024 Continue to improve the accuracy and increase size of GP Learning Disability registers Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities	The Learning Disability and Autism team will ensure 75% of people over the age of 14 GP learning disability registers receive an annual health check and health action plan and will work alongside NHSE set the AHC trajectories from March 2024 Continue to improve the accuracy and increase size of GP Learning Disability registers Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics Fortnightly AHC drop-in sessions for LD champions to provide support and guidance Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Reduce reliance on Mental Health locked and secure inpatient care, while improving the quality of Mental Health inpatient care, so that by March 2028 (in line with national target) no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an Mental Health inpatient unit	Work alongside NHSE to establish programme of work moving forward and set the trajectories from March 2024 Implement the changes to the DSR/C(E)TR policy and guidance January 2023 in collaboration with system partners, to identify those at risk of admission and to ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, to ensure this is for the shortest time possible Implement actions from the Mental Health, Learning Disability an d Autism quality transformation programme Review of Learning Disabilities and Autism commissioning pathway Development of business cases to improve pathways To establish a comprehensive understanding of housing needs to inform strategic housing development plans for children and adults with a learning disability and Autistic people Formal evaluation to inform future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market	Commissioning responsibilities of extended provision of inpatient facility for Learning Disabilities and autistic people bringing people closer to home Review effectiveness of current arrangements and implement any amendments to new DSR/C(E)TR policy and guidance Implement actions from the Mental Health, Learning Disability and Autism quality transformation programme Development of business cases to improve pathways Review of formal evaluation and implementation of future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market *To support the development of a range of available housing options for people with complex needs, including appropriate social housing and home ownership, along with the skilled support needed to successfully support tenure*	Commissioning responsibilities of extended provision of inpatient facility for Learning Disabilities and autistic people bringing people closer to home Review effectiveness of current arrangements and implement any amendments to new DSR/C(E)TR policy and guidance Implement actions from the Mental Health, Learning Disability and Autism quality transformation programme Development of Community Pathway Review of commissioning arrangements for the supported living market

Year 1- 5 Objectives and Milestones

Learning Disabilities and Autism

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times by March 2028.	• Monitor the delivery of the Oliver McGowan training to health and social care workforce • Alignment of priorities to NHSE Autism mandate (to be released Jan/Feb 23) • Working with provider's to cleanse the national autism data set • Analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Review of Autism pathway across Devon and development of business cases to make pathway improvements • Develop initiatives to improve autism diagnostic assessment pathways and reduce waiting lists • Develop and implement workplan to improve support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	• Monitor the delivery and impact of the Oliver McGowan training to the 62,000 health and social care workforce • Continued analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Commissioning of revised pathway to improve autism diagnostic and reduce waiting lists • Continued implementation of workplan to improve support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	• Monitor the impact of the Oliver McGowan training to the 62,000 health and social care workforce • Analysis of national and local autism data across health and social care • Evaluation of Autism pathway to make recommendations to improve current pathway
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.	Engage in the south west regional clinical model developments of extended scope into community pathway.	The Learning Disability and Autism team will work alongside system workforce leads and providers to develop and implement a workforce plan and commissioning structure in line with operational planning guidance.	Continued implementation of workforce plan

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 as well as continue to improve the accuracy and increase size of GP Learning Disability registers.	• Quarterly Learning Disability webinars to health care professionals and Learning Disability Champions with specific focus on AHC's and other relevant topics • Fortnightly AHC drop-in sessions for LD champions to provide support and guidance • Monthly monitoring of AHC uptake with a targeted approach to offer support to GP practices with a lower uptake. • Improve live data reporting, by considering national exemplar and linking with BI to seek solution, a high number of data reporting has been explored with other areas however the lack of an information sharing agreement stops this progressing. • Ensure Adult Social Care workforce understands the rights of the individual for inclusion on the GP register • Promote the benefits of AHC's through staff/GP newsletters and encourage GPs to complete the AHC's around the person's birthday to increase uptake and size of GP learning disabilities • Raise awareness and promote annual health checks for 14-17year olds by regular meetings with children's services, schools, parent carer chairs and primary care to agree and coproduce a sustained promotional campaign to improve awareness and promote the uptake of AHC. Work underway with the PCF chairs to develop promotional video and/or leaflets with bid monies from NHSE • Develop final report and next steps of ' A letter to my GP' pilot targeted at special schools to encourage young people to write a letter introducing themselves to their GP to establish better relationships and increase uptake of AHC for this group. . • Roll out of CYP letter to GP through SEND pathways • Promote training to GP practice staff to increase awareness and confidence in delivering AHC to CYP Improve data reporting and frequency for CYP, Promotional videos to be finalised and shared across organisations and LD champions	Annual health checks can identify undetected health conditions early and reduce inequalities improving life expectancy of people with a learning disability Improved data reporting Improved understanding of the importance of an annual health check through training and webinars Promotion of the benefits of an annual health check Increase in reasonable adjustments

One Devon

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	**Timely Discharge** • Monitored ICB Commissioned inpatient beds against a '12-point discharge plan' to ensure discharges are timely and effective **Admission Avoidance** • Implement the changes to the DSR/C(E)TR policy and guidance January 2023 in collaboration with system partners, to identify those at risk of admission and to ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, to ensure this is for the shortest time possible • Review of community provision and pathways across health and social care • Further development of the STOMP and STAMP programme **Repositioning inpatient beds closer to home** NHSE South West region has secured £40 million of capital funding to reposition inpatients beds closer to home, shared between the North and South of the region. Devon ICB is lead commissioner for the South group of ICB's (Cornwall, Isles of Scilly, Dorset and Somerset). Experts by experience have been commissioned to co-produce the environmental plans and clinical model which is currently in development together with financial and workforce modelling. **Community pathways** Review of Learning Disability and autism commissioning pathways. **Developing the provider market** To complete the formal evaluation to inform future commissioning intentions across Health and Social Care of the Test of Change Pilot that seeks to increase capacity and capability of the supported living market **Housing** • To establish a comprehensive understanding of housing needs to inform strategic housing development plans with partners and monitor progress, through developing clear, trackable and accessible needs data for people needing housing, including children, those coming back into the local system AND those at risk of leaving the local system. • To support the development of a range of available housing options for people with complex needs, including appropriate social housing and home ownership, along with the skilled support needed to successfully support tenure. Including the development of clear pathways and processes to support people with complex needs to access each of these housing options as appropriate. This will include all stakeholders having the relevant information and expertise to facilitate these pathways. • To work in partnership to provide the best possible housing environment for people with learning disabilities and autism, using standardised eligibility and assessment tools; good design principles; comprehensive a shared understanding of current best practice • For people with complex needs and their circles of support to be fully included in the planning and delivery of their housing needs, and for people with complex needs to live healthier, happier and more socially inclusive lives by having homes of their own • To ensure that our overall housing model is sustainable and affordable in the long-term, reducing reliance on wholly debt-funded development by making the best use of available public funds, personal investment and use of land-assets within the public estate	People with a learning disability and/or autism will be supported to lead more independent lives in the communities of their choice. Reduction in out of area hospital admissions through greater support closer to home Increased reasonable adjusted housing and accommodation options for people with complex needs Reduction in health inequalities

Year 1 and 2 (operational plan detail)

Learning Disabilities and Autism

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.	• Improving awareness, general understanding and acceptance of autism within society through monitoring the delivery of the Oliver McGowan training to the 62,000 health and social care workforce • Alignment of priorities to NHSE Autism mandate (to be released Jan/Feb 23) • Working with provider's to cleanse the national autism data set • Analysis of national and local data to identify gaps and workforce requirements to support the delivery of the programme • Building the right support in the community through reviewing pathways and supporting people in hospital or inpatient care through the reprovision of inpatient beds • Develop initiatives to improve autism diagnostic assessment pathways and reduce waiting lists • Enabling early identification of neurodiversity to provide support during early years of childhood including improving access to education for neurodiverse children and young people and support positive transitions into adulthood • Improving support offered to autistic young people through transition towards adulthood delivered through the Children and Young Person Gamechanger	Reduction in health inequalities through improved awareness and general understanding of Autism Improved support for autistic people Reduction in waiting list Improved access to data which will inform future commissioning intentions Reasonable adjustments for autistic people
Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.	• Receive the national workforce data collection from NHSE to develop baseline on current local resource • Assurance Audit of current commissioning arrangements • Continued engagement and collaboration with the community pathway clinical modelling developments on the extended scope for the inpatient developments for the south west region. • Undertake a gaps analysis from current challenges in our commissioning structure • Work in collaboration with current providers to review deliver and develop commissioning intentions going forward • Explore how investment can be utilised to commission a seven-day specialist multidisciplinary service and crisis care where appropriate • The Learning Disability and Autism team will work alongside system workforce leads and providers to develop a workforce plan and commissioning structure in line with operational planning guidance.	Reduction in the current commissioning gaps to ensure the right support is accessed for the right people at the right time. Enhance accessibility into community services 7 days a week (where appropriate) Needs led approach rather then diagnostic led

One Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care Integration

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Collaborative working We will have a Primary and Community Care Collaborative which functions across Devon by 2028. This will enable further integration across Social Care, Mental Health and VCSE organisations by designing a model which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes	**March 2024** Developed functional GP Provider Collaborative Plan to establish Community Collaborative signed off by system	**March 2025/26** GP Provider Collaborative recognised as high functioning Community Collaborative established and recognised as functional Collective forum for Primary and Community Care established Integrated model of care co-designed and produced	**March 2028** Primary and Community Collaborative integrated and recognised as high functioning Integrated model of care implemented in each of the five Local Care Partnership areas

Year 1- 5 Objectives and Milestones

Primary and Community Care Integration

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Preventative Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community, cross organisational multi-disciplinary team to jointly deliver services, including Urgent Community Response, which meets the 2-hour response target to avoid hospital admissions for 90% of referrals, by 2028	**March 2024** Embed 111 and 999 referral pathways to UCR - 20% target for UCR referrals from 111/999 Establish self-referral pathways across Devon Increase 2 hour response target to 70% Implement remote clinical support (Immedicare) to a further 60 care homes across Devon	**March 2025/26** 100% PCNs and Community MDTs with defined integrated approach – cross organisational MDTs that include community health, social care and VCSE input Increase 2 hour response target to 80% Evaluation of care home clinical support	**March 2028** Increase 2 hour response target to 90% Digital maturity which enables sharing of all relevant information in a timely way across different organisation systems Roll out of care home clinical support dependant on evaluation of service and model

One Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care Integration

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Proactive Care We will be able to identify the people that are most likely to benefit from an integrated proactive approach, with a focus on prevention and early intervention	**March 2024** Implement CVD prevention plan, and those for Diabetes, Hypertension and other Long Term Conditions	**March 2025/26** Reduced emergency admission for people with Ambulatory Care Sensitive conditions Identification of at risk population groups – for CVD and other Long Term Conditions, measurable increase against baseline	**March 2028** Continued increase in number of people supported at home and through use of digital and remote monitoring services Increase proportion of identified people treated optimally to target, utilising medical and behavioural interventions
Preventative Care Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services	**March 2024** 224 virtual ward beds will be available across the system 80% utilisation based on 7 day length of stay Develop capacity to include admission avoidance use of virtual wards Digital inclusion addressed via VCSE input to each virtual ward	**March 2025/26** System evaluation of virtual ward services Increase breadth of clinical pathways using virtual wards Establish programme for Remote Monitoring which support patients in Primary Care to manage their Long Term Conditions	**March 2028** Virtual ward pathways embedded across Devon for admission avoidance and discharge for all suitable conditions Remote Monitoring in place consistently across Devon which supports patients with one or more Long Term Conditions

Year 1- 5 Objectives and Milestones

Primary and Community Care Integration

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Access to Information We will have a shared overview of Voluntary and Community organisations across Devon via the consistent use of the Joy App by Social Prescribers and across 100% of PCNs by 2024, which enables access by all staff	**March 2024** 100% of PCNs using Joy App 100% of VCSE based Social Prescribers using JOY App Explore expansion to 'Waiting Well' offer for patients	**March 2025/26** Evaluation of JOY App completed and informed future provision Continued use of JOY App or alternative as outcome of evaluation which is focussed on ease of access for staff and patients	**March 2028** Continued use of JOY App (or alternative) across 100% of PCNs with expansion across; • Mental Health • Community Connectors • Children's services
Proactive Care The comprehensive model for personalised care will be utilised across every integrated team and advanced care planning will be used to ensure that 90% of patients are able to die in their preferred place of care by 2028	**March 2024** 70% target for death in preferred place of care Each LCP will have plans to support Ageing Well in their population, aligned to the Devon Healthy Ageing Handbook	**March 2025/26** 80% target for death in preferred place of care Through use of PHM each LCP will target severe & moderately frail patients proactively to ensure personalised & preventative care planning	**March 2028** 90% target for death in preferred place of care

One Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care Integration

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Sustainable General Practice We will have General Practices across Devon working in ways that reflects the focus placed on sustainability within both our local and national Strategic Frameworks, with agreed standards at GP Practice and PCN level by 2028	Quality and Outcome Framework achievement <90% PCN Directed Enhanced Services delivery to 100% population 100% operating within funding envelope Operating plan appointment targets achieved Funded plan in place to support development of ICS based scalable models	Year 1 achievements maintained Operating plan appointment targets achieved Scalable development programme in place and supporting sustainability requests Scoping of opportunity to manage 'back office' functions across PCNs complete	Year 1-3 achievements maintained Operating plan appointment targets achieved Scalable models in place and proactively engaged by contractors seeking sustainability support Model to support cross PCN management of 'back office' functions in place
Objective regarding Pharmacy, Optometry and Dentistry to be developed			
Objective relating to Social Care (including Independent market) to be developed			

Year 1 and 2 (operational plan detail)

Primary and Community Care Integration

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Preventative Care Each Primary Care Network (PCN) will have an integrated approach to working with their local community multi-disciplinary team to jointly deliver services, including Urgent Community Response, which meets the 2-hour response target to avoid hospital admissions for 90% of referrals, by 2028	**March 2024** Embed 111 and 999 referral pathways to UCR - 20% target for UCR referrals from 111/999 Establish self-referral pathways across Devon Increase 2 hour response target to 70% Implement remote clinical support (Immedicare) to a further 60 care homes across Devon	• Improve data quality through CSDS reporting • Identify paramedic roles within UCR services that can support an increased 'pull' of patients from SWAST • Review current referral triage processes to identify any delay in meeting 2 hour standard • Implement self-referral pathway to UCR across Devon	1. Increased referrals from 111/999 services and reduction in ED attendances and admissions 2. Optimise time between referral to initial assessment – improved patient experience
10% reduction in Community Services waiting list by 2024		• Identify service lines with highest number of people waiting across adults & children services • Implement a system wide community list reduction steering group to provide system leadership and oversight of delivery • Support providers to set trajectories for reduction. • Monitor performance against set trajectories • Set out clinical validation methods with providers learning from the ERF work • Implement the 2-day Reablement standard	1. Targeted work with key services likely to achieve highest level of reduction 2. People waiting for community services are supported to minimise adverse impacts or harm

Year 1 and 2 (operational plan detail)

Primary and Community Care Integration

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Sustainable General Practice We will have General Practices across Devon working in ways that reflects the focus placed on sustainability within both our local and national Strategic Frameworks, with agreed standards at GP Practice and PCN level by 2028	Quality and Outcome Framework achievement <90% PCN Directed Enhanced Services delivery to 100% population 100% operating within funding envelope Operating plan appointment targets achieved Funded plan in place to support development of ICS based scalable models	• Increase GP workforce through flexible offers option, broadening contractor models, direct recruitment programme • Increase Additional Roles Reimbursement Scheme (ARRS) workforce through optimal use of ARRS staff and upper decile ARRS staff churn performance, delivered through ARSS focussed retention programme • Increase upskilling of existing staff via Devon Training Hub delivered training and development programmes	1. Upper decile ICS total GP team appts 2. +5% pre-pandemic total GP team appts 3. Exceed same day GP response target (35%) 4. Exceed within 2 weeks of request target (85%)
Preventative Care Further development of Virtual Ward capacity will be delivered by each of our Acute Trusts, working with all local partners and out-reaching to deliver both step up and step down pathways via remote management, in conjunction with the local community team and specialist teams/services	**March 2024** 224 virtual ward beds will be available across the system 80% utilisation based on 7 day length of stay Develop capacity to include admission avoidance use of virtual wards Digital inclusion addressed via VCSE input to each virtual ward	• Develop a shared pathway approach across virtual ward provision • Increase clinical pathways utilising virtual wards • Increase capability for admission avoidance provision - develop direct referral mechanism from UCR services, SWASFT, out of hours and care homes (via Immedicare)	1. Virtual wards will be available as an integral part of more clinical pathways to support admission avoidance and increase hospital discharge ability 2. More people will experience supported care at home

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.	Systems dashboard in place to monitor performance against elective recovery targets (eliminated >65 week waiters). Validation and risk stratification processes identified in line with new national guidance and implement once validated locally and regionally and plan to evaluate in place. Aligned with the National CYP Urgent and Emergency Care (UEC) objectives and the Paediatric Peninsula Acute Sustainability programme develop plans for a standardised Same Day Emergency Care (SDEC) and Short stay paediatric/Children's assessment units (PAU/CAU) model. Regional SiC ODN leading this programme of work in line with national guidelines. Confirm that UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.	Monitor performance against elective recovery targets to ensure that >52 week waiters are eliminated. Develop the Paediatric Outreach and Ambulatory model of care that integrates paediatrics with primary and community services supporting CYP at home and in their community. Ensure pathways and out of hospital services for a standardised SDEC/PAU models are in place *(not inc. CYP MH).* Ensure a clear and equitable offer for UTC and Navigation for CYP. Potential public consultation depending on level of change required in each Trust.	Paediatric Outreach and Ambulatory model of care delivered. Standardised SDEC/PAU model with networked out of hours solution delivered.

One Devon

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Holistic integrated neurodevelopmental assessment pathway:** • Co-produce a the new pathway. • Produce options appraisal and recommendations for the new pathway. • Transition to new pathway to commence at end of year 1. **Early access keyworker pilot:** • Recruit additional keyworkers working across the ICP for a 12 month test of change. • Develop and maintain a directory of services. **Speech and Language Communication Needs (SLCN):** • Establish a shared system wide understanding of current level of SLCN, provision and gaps. • Better understand the connections between SLCN and Social Emotional Mental Health (SEMH), Adverse Childhood Experience (ACE). trauma, offending and employability.	**Holistic integrated neurodevelopmental assessment pathway:** • Develop a digital Neurodiversity offer. • Establish a network of workforce and public facing training systems. • Framework rolled out for evaluation and co-production by the children and families. **Early access keyworker pilot:** • Establish a neurodiversity Club for CYP and their families. • Develop and implement an accessible integrated local offer, without the need for a diagnostic assessment. • Undertake an evaluation of Keyworkers as part of the neurodiversity & SLCN pathway. **Speech and Language Communication Needs (SLCN):** • Implement Communities of Practices that link with Family Hubs and Best start in Life. • Establish a network of workforce training systems which support differential diagnosis and professional development. • Develop a robust transdisciplinary offer of support for CYPS with SLCN/SEMH.	**Holistic integrated neurodevelopmental assessment pathway:** • Full transition to new pathway embedded in practice. **Early access keyworker pilot:** • Develop a toolkit which can be used in place of a diagnosis. • Establish alignment of peer support workers working in partnership with other services. **Speech and Language Communication Needs (SLCN):** • Implement model of delivery and pathways which address the inequalities and inequities experienced by CYP and their families accessing SLCN across the ICP.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones -Year 1	Milestones- Year 2-3	Milestones -Year 4-5
Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.	**By June 2023:** Produce a local Maternity system plan aligned to the national **Maternity Single Delivery Plan** that delivers: Personalised Care and Choice: • Review existing and embed new personalised care and support plans for pregnancy, birth and postnatally • Ensure transition is seamless between services and sectors Improved equity and outcomes: • Improve access to antenatal education • Embed specialist smoking cessation pathways • Deliver Pelvic Health Services Enhanced Quality and Safety: • Full implementation of Ockenden Interim and final recommendations • Implement Perinatal Quality Surveillance model at Trust & System level • Full compliance with Saving Babies Lives Care Bundles version 2 • Align escalation policies with appropriate ICB oversight • Implement preterm birth pathways in all Trusts. Improve maternal mental health and emotional wellbeing offer: • Deliver bereavement support for perinatal death • Devon wide perinatal mental health collaborative established • Review maternity estate so that choice of place of birth is available • Develop an enhanced Digital Maternity Information Systems (MIS) • Improved joint working and alignment of vision • Improve community outreach and co-production	Personalised Care and Choice: • Consistent, evidence based information Equity and improved outcomes: • Referral to the national diabetes prevention programme • A postnatal contraception offer • Improved uptake of vaccination in pregnancy • System wide infant feeding strategy • Full implementation of enhanced continuity of carer (some services) • Full implementation of the Neonatal Critical Care Review Enhanced Quality and Safety: • Implement East Kent Report recommendations • Devon Dashboard operational • 50% reduction in stillbirth, neonatal death, maternal death and intrapartum brain injury • Sharing learning from complaints and incidents • Full participation in South West Maternal Medicine Network • Implement Saving Babies Lives Care Bundles V3 Maternal mental health and emotional wellbeing offer: • System wide Maternal Mental Health offer including VCSE Enabled by: • Community outreach and engagement • Enhanced support for Maternity Voices Partnerships	**By 2027:** • Implement Maternity & Neonatal Equity & Equality Plans through Interventions & Clinical pathways for vulnerable & protected groups, and improve the universal care offer. • Choice will be offered to women and birthing people of three places of birth. • Establish routine reporting of Maternity & Neonatal Quality & Safety reporting to Trust and ICB Boards. • Intelligence will be triangulated from data sources, complaints, incidents and user experience to monitor interdependencies and impacts. • Implement the recommendations of the Ockenden Nottingham Report (Anticipated 2025).
Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.	By the end of Q3 2023-2024: • Co-produce a 5 year LMNS Workforce Strategy • Produce a plan to address workforce objectives outlined in key maternity and neonatal documentation • Produce a reliable baseline of Devon maternity & neonatal workforce profiles • Redesignation of Maternity Support Workers to band 3's with appropriate training and supervision plans in place (national mandate). • Core Competency Framework will be implemented across all Trusts	• Develop a trust and system succession plan, to support system staff to develop themselves and securing high quality leadership for the future • Ensure job plans for obstetricians will include time for improving shared clinical governance	• Implement, in line with Devon LMNS Equity and Equality Plans, race equality for staff through the recommendations of the Workforce Race Equality Standard (WRES) in maternity and neonatal settings.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
By 2028, we will have proactively addressed **health inequalities**. The Core20Plus5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.	Complete stocktake with each of the key areas and populations in Devon. Baseline CORE20+5 dashboard developed, via Devon Intelligence Functions Group, linking with regional team as appropriate. Develop network of stakeholders and pathways for the identified priority groups: 1. Children and families in the 20% most deprived areas and areas of rural and coastal deprivation 2. Children and young people in care, 3. Neurodiverse children 4. Young carers Develop clear work programmes for the key clinical areas: • Asthma • Diabetes • Epilepsy • Oral Health • (Mental Health – delivered by mental health workstream) • (Healthy Weight)	Established pathways within the relevant clinical areas, including the priority groups. Deliver the priority service development improvement plans for the key clinical areas, with consideration of four priority groups.	Monitor and evaluate against Core20PLUS5 approach – universal and targeted.

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Commissioned arrangements will be in place across Devon by 2028 to ensure that the health needs of **socially vulnerable children** are identified and met.	Establish the conditions for working together across health, care and education to enable joint commissioning. Deliver a system dashboard that will provide robust health data. Complete a stocktake of current level of provision and gaps for the health of care-experienced young adults.	Complete a 12month test of change for the Care Leaver Nursing service based on evidence for the Care Leaver pilot. Each local area to have a graduated pathway of support for children, young people, young adults, carers and the wider support network. Increase Children in care services to 21 years.	Robust monitoring in place for improvement and strengthened joint commissioning approaches moving towards integrated commissioning for the local areas. For all areas of health to be part of the care leavers covenant. Increase children in care services to 25 years.
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.	**Torbay:** Funded Family Hub model in place. **Plymouth:** Submission of bid and development of roll-out plan completed (if successful). **Devon:** Established Best Start in Life Programme Strategic Priorities with the aim to bring together 0-5 services.	**Torbay:** Delivery of comprehensive Family Hubs model, with effective communications to ensure that parents and carers are aware of the services and support available. **Plymouth:** TBC dependent on bid. **Devon:** Established delivery of the Best Start in Life Programme.	

One Devon

Year 1- 5 Objectives and Milestones

Children and Young People Care Model

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.	Create the conditions for service improvement and joint commissioning across the local areas (health, care and education), supported by co-production mechanisms. Agree integrated SEND strategies for each local area. Deliver new code of practice and work with Local Authorities subject to the new inspection framework. Deliver a system dashboard that includes robust health data.	Clear local offer established for each local area, including a graduated pathway of support to CYP and families. Define the outcomes framework that demonstrate improvements.	Robust monitoring in place for improvement and continued strengthening of joint commissioning approaches moving towards integrated commissioning for the local areas.

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Services for children who need **urgent treatment and hospital care** will be delivered as close as possible to home and waiting times for paediatrics, specialist care and surgery will steadily improved across the next five years.	**Year 1:**
	• Systems dashboard in place to monitor performance against elective recovery targets (eliminated >65 week waiters).
	• Validation and risk stratification processes identified in line with new national guidance and implement once validated locally and regionally and plan to evaluate in place.
	• Aligned with the National CYP UEC objectives and the Paediatric Peninsula Acute Sustainability programme develop plans for a standardised SDEC and Short stay paediatric/Children's assessment units (PAU/CAU) model.
	• Regional SiC ODN leading this programme of work in line with national guidelines.
	• Confirm that UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.
	
	Year 2:
	• Monitor performance against elective recovery targets to ensure that >52 week waiters are eliminated.
	• Develop the Paediatric Outreach and Ambulatory model of care that integrates paediatrics with primary and community services supporting CYP at home and in their community.
	• Ensure pathways and out of hospital services for a standardised SDEC/PAU models are in place *(not inc. CYP MH).*
	• Ensure a clear and equitable offer for UTC and Navigation for CYP.
	• Potential public consultation depending on level of change required in each Trust.
		Urgent treatment and hospital care:
		• Establish assurance processes with Trust providers via the Paediatric steering group (mobilised in 22/23) with regional and national CYPER support.
		• Regularly monitor performance via system dashboard and report position to Planned Care Team in line with governance processes.
		• Work with trusts to identify CYP waiters and those at highest risk or risk of harm, scoping options for mutual aid and ensuring there is timely access to assessment and interventions.
		• Review current pathways for non-clinical validation for adults and scope and develop a clinical and non-clinical validation process for CYP and evaluation to support effectiveness of validation and risk stratification..
		• Work collaboratively with UEC to scope the process of a standardised SDEC and Short stay paediatric/Children's assessment units (PAU/CAU) model to support development of plans.
		
		Surgery in Children (SiC):
		• Dependent on national guidelines:
		  • Support Trusts to develop robust theatre lists booking and scheduling practice to enable adoption of HVLC principles.
		  • Develop plans to take forward (draft) minimum CYP elective recovery expectations and set up processes to support and monitor Trusts to meet targets.
		• Develop a clinical validation process for CYP.
		• Confirm if UHP can be formalised as a CYP surgical hub and additional theatre capacity as system resource.
		• Develop assurance processes and support Trusts to recovery at pace in line with expected target of Q2 2023/24.
		• Scope the level of public consultant required, depending on level of change in each Trust.
			• Improved access to data to inform future commissioning intentions.
			• Reduction in health inequalities through improved awareness and general understanding.
			• Improved experiences for CYP and their families and ensuring they feel supported whilst they are waiting.
			• Timely access to assessment and treatments, prioritisation of highest risk or those at risk of harm and potential impairment or disability.
			• Improved performance in line with National standards for RTT and national expectations:
			  • Reduction in waiting lists, with a focus to eliminating >65 and >52 week waits.
			  • Reducing ED attendances and emergency admissions.
			  • Reduction in zero LOS for CYP with common childhood illness.
			  • Reduction of outpatient follow-ups (OPFU) in line with national ambition to support reducing the OPFU.
			• Improved support for CYP and their parents/carers.
			• Reduction in agency or locum costs.
			• Improving access and the journey for parents/carers & CYP who need advice or access.
			• Improved trauma pathways.
			• Robust and standardised theatre procedures and maximisation in day case rates.
			• Increased efficiency.
			• Reduction in zero LOS for CYP with common childhood illness.

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Holistic integrated neurodevelopmental assessment pathway:** **Year 1:** • Co-produce a the new pathway. • Produce options appraisal and recommendations for the new pathway. • Transition to new pathway to commence at end of year 1. **Year 2:** • Develop a digital Neurodiversity offer. • Establish a network of workforce and public facing training systems. • Framework rolled out for evaluation and co-production by the children and families.	**Holistic integrated neurodevelopmental assessment pathway:** **Year 1:** • Monthly workstream meetings agreed, Senior Leads nominated as Chairs and stakeholders invited. • Analysis of service and workforce data to identify and address gaps. • Expert Lived experience reference group to be established and nominations to be invited. • Hold 2 face to face events for Communication and coproduction with parents including national autistic society. • Draft and pilot common paperwork 'request for assessment' that will support a referrer to make a decision to refer for an assessment or not. • Agree on process which includes: Who can refer; who can complete an assessment; Single front door/ point of access; Decision making tool / triage process for referrals received; age related guidelines. • Workstream groups to agree timeline for testing and implementation. Test and adapt as necessary. • Prepare the options for a consistent referral and assessment paperwork. **Year 2:** • Undertake research and evaluate existing websites and apps; compile summary; ask young people and their families for their views. • Workstream group to review changes made to assessment pathway, amend, confirm and roll out consistent across ICP. • Compile a list of training that is available free of charge as well as those charged at a universal and specialist level. Take advice as to what is most effective and relevant for the Devon system and advertise and promote. • Agree with each provider the data to be collected and centrally analysed. Gaps identified and noted.	Improved access to support at universal and targeted level resulting in a shift in culture and a reduction in the drive of families seeking a diagnosis as a means to get support. Need for diagnostic assessment is less urgent, as needs met earlier. Requests for EHCPS will also have decreased. Children and Young people no longer on multiple waiting lists for single assessments within one or across multiple organisations Increase in the number of families accessing and positive experience of receiving support from services. Improved awareness amongst families and practitioners of support available with greater clarity provided to families and referrers. Increased training offer for the workforce across health care and education. Reduce the inequalities and inequities experienced by CYP and their families accessing SLCN across the ICP.
	Early access keyworker pilot: **Year 1:** • Recruit additional keyworkers working across the ICP for a 12 month test of change. • Develop and maintain a directory of services. **Year2:** • Establish a neurodiversity Club for CYP and their families. • Develop and implement an accessible integrated local offer, without the need for a diagnostic assessment. • Undertake an evaluation of Keyworkers as part of the neurodiversity & SLCN pathway.	**Early access keyworker pilot:** **Year 1:** • Develop job plans and person specifications for new keyworker roles. • Recruit additional keyworkers to work across the ICP. • Develop SoPs for the new keyworker service aligned with locality early help systems. • Gather key information on what services are available at a local level and provide this to the Joy.app and local offer directories of service. • Collate and promote resources that can be used by families. **Year 2:** • Key workers with families draft what an early identification and training offer looks like • Consider digital technologies that promotes and provides local information that can support families information and advice • Complete the 2 new outcome star as part of evaluation • Develop business case for continuation and further roll out of key workers.	

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Children and families with **neurodiverse, emotional and communication needs** will be supported across health, care and education, preventing crisis and enabling them to live their best life.	**Speech and Language Communication Needs (SLCN)** **Year 1:** • Establish a shared system wide understanding of current level of SLCN, provision and gaps. • Better understand the connections between SLCN and Social Emotional Mental Health (SEMH), Adverse Childhood Experience (ACE). trauma, offending and employability. **Year 2:** • Implement Communities of Practices that link with Family Hubs and Best start in Life. • Establish a network of workforce training systems which support differential diagnosis and professional development. • Develop a robust transdisciplinary offer of support for CYPS with SLCN/SEMH.	**Speech and Language Communication Needs (SLCN):** **Year 1:** • Each provider to input their data – workforce, service referral and activity on to the Balanced System. Including their service offer. • Central analysis of data provided identifying strengths and gaps, making recommendations to decision makers for addressing inequity of access. • Communication and coproduction with parents to be planned • Specialist SLCN/SEMH to attend team meetings within education, care and health raising awareness and offering training at both a universal and targeted level. **Year 2:** • Attend Family Hub strategic planning group • Develop job plans and person specifications for SLT roles in Family Hubs • Recruit additional SLTs working across the ICP. • Develop SoPs for the SLTs aligned with Family Hubs • Prepare costings for investment required in SLCN workforce. • Submit and present to senior executives for decision making • Recruit to additional SLCN posts across the ICP • Compile a database of training that is available (free of charge as well as charged). • Promote training on offer via organisation staff websites. • Update staff appraisal paperwork to identify and record what training completed for SLCN/SEMH	There is effective ongoing shared understanding through robust analysis to inform current and future priorities within service developments and to inform and influence joint commissioning priorities. There is a clear integrated model of provision across health, social care, education, voluntary and third sector, in partnership with young people and their families, ensuring needs are identified and met effectively. Improved awareness amongst families and practitioners of support available. Increased training offer for the workforce across health care and education. Reduce the inequalities and inequities experienced by CYP and their families accessing SLCN across the ICP. The connections between SLCN and SEMH, ACEs. trauma, offending and employability will be better understood so that it can be met through a MDT approach. Reduce the inequalities and inequities experienced by CYP and their families accessing SLCN across the ICP.

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Maternity care will be safe and offer a personalised experience to women, birthing people and their families. Key safety targets to be achieved by 2025.	**By June 2023:** Produce a local Maternity system plan aligned to the national **Maternity Single Delivery Plan** that delivers:
	Personalised Care and Choice:
	• Review existing and embed new personalised care and support plans for pregnancy, birth and postnatally
	• Ensure transition is seamless between services and sectors
	Improved equity and outcomes:
	• Improve access to antenatal education
	• Embed specialist smoking cessation pathways
	• Deliver Pelvic Health Services
	Enhanced Quality and Safety:
	• Full implementation of Ockenden Interim and final recommendations
	• Implement Perinatal Quality Surveillance model at Trust & System level
	• Full compliance with Saving Babies Lives Care Bundles version 2
	• Align escalation policies with appropriate ICB oversight
	• Implement preterm birth pathways in all Trusts.
	Improve maternal mental health and emotional wellbeing offer:
	• Deliver bereavement support for perinatal death
	• Devon wide perinatal mental health collaborative established
	
	• Review maternity estate so that choice of place of birth is available
	• Develop an enhanced Digital Maternity Information Systems (MIS)
	• Improved joint working and alignment of vision
	• Improve community outreach and co-production
	Year 2:
	Personalised Care and Choice:
	• Consistent, evidence based information
	Equity and improved outcomes:
	• Referral to the national diabetes prevention programme
	• A postnatal contraception offer
	• Improved uptake of vaccination in pregnancy
	• System wide infant feeding strategy
	• Full implementation of enhanced continuity of carer (some services)
	• Full implementation of the Neonatal Critical Care Review
	Enhanced Quality and Safety:
	• Implement East Kent Report recommendations
	• Devon Dashboard operational
	• 50% reduction in stillbirth, neonatal death, maternal death and intrapartum brain injury
	• Sharing learning from complaints and incidents
	• Full participation in South West Maternal Medicine Network
	• Implement Saving Babies Lives Care Bundles V3
	Maternal mental health and emotional wellbeing offer:
		• Review contents SDP, anticipated March 23rd 2023. Significant changes to programme deliverables not anticipated
		• Align current plans and timescales to national strategic requirements of the SDP.
		• Develop Serious Incidents thematic analysis review tool
		• Literature review of best practise guidance and evidence
		• Map the existing antenatal education offer to make best use of 'collaborative advantage'- Production of a cohesive antenatal education offer from a range of sources.
		• Service user review- what is required from our services
		• Production of antenatal service specification, demonstrating alignment of resources
		• Monitor implementation in Trusts via LMNS Safety and Governance & LMNS Board
		• Share learning & devise shared system wide clinical governance
		• Take appropriate LMNS/ICB actions as outlined in Ockenden Interim
		• Monitor Trust implementation of Saving Babies Lives Care Bundles version 2
		• Liaise with South West regional Maternity Transformation Programme (MTP) to ensure compliance
		• Share learning & clinical governance across the system
		• Implement preterm birth pathways in line with Saving Babies Lives Care Bundles version 2.
		• Ensure specialist bereavement midwives in post, who have undertaken specialist bereavement training
		• Availability of perinatal bereavement rooms and facilities
		• Links to funeral directors, national charities and local support groups will be in place
		• Review estate utilisation and future service provision models
		• Develop estates utilisation plan aligned to strategic vision for maternity service delivery, including alignment with Family Hubs (MTP: Community Hubs)
		• Fully implemented maternity information systems, to include electronic patient held record (ePHR)
		• Scope and plan to enhance maternity digital provision, with an aim of digital maturity aligned to ICS roadmap
		• Implement data sharing agreements to enable system wide data visualisation and sharing
		• Map community assets available that address inequalities within the community
		• Identify community support 'deserts' and plan service delivery to fill these gaps
		• Identification of community champions and support interventions for signposting (aligned to Best Start in Life)
		• An LMNS financial plan prioritising community outreach and coproduction
		• A review of experiences and outcomes for vulnerable and protected groups
			Improved Governance
			• Trust boards, LMNS & ICB have improved oversight of maternity & neonatal services
			• System wide learning from incidents & complaints is shared
			• Improved quality & assurance
			• Trusts feel supported
			• Reduced duplication
			Improved Experience
			• Users feel supported
			• Informed choice & consent
			• Improved access to services
			• Improved postnatal ward experience
			• Awareness of community resource
			• Reduced need to repeat history
			• Consistent information across organisations
			• Users feel listened to & involved in care decisions
			Improved Outcomes
			• Improved Perinatal Mental Health
			• Reduced readmissions for first time parents Clear pathways of care, enabling access to the right care at the right time from the right professional
			• A 50% reduction in:
			  • Stillbirth
			  • Neonatal Death
			  • Maternal Death
			  • Intrapartum Brain Injury
			• Reduction in preterm births from 8% to 6% (Nationally)
			• Increased breastfeeding rates
			• Improved stability of family unit
			• Reduction in looked after children
			• Reduced pelvic floor injury
			Reduced Impact of inequalities
			• Care planning appropriate to individual circumstances
			Improved collaboration
			• All professionals have access to the same information (where relevant)
			Financial associated with above improved outcomes
			Disbenefits
			• Short term increased workload to align system interfaces & interdependencies
			• Requirement for clinical time to engage in transformation

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact

Through a 5 year maternity and neonatal strategy, we will fund, plan and deliver a safe, inclusive, well trained and sustainable maternity & neonatal workforce for now and the future, which supports a reduction in turnover and vacancies.	**By the end of Q3 2023-2024:**
	• Co-produce a 5 year LMNS Workforce Strategy
	• Produce a plan to address workforce objectives outlined in key maternity and neonatal documentation
	• Produce a reliable baseline of Devon maternity & neonatal workforce profiles
	• Redesignation of Maternity Support Workers to band 3's with appropriate training and supervision plans in place (national mandate).
	• Core Competency Framework will be implemented across all Trusts
	
	Year 2:
	• Develop a trust and system succession plan, to support system staff to develop themselves and securing high quality leadership for the future
	• Ensure job plans for obstetricians will include time for improving shared clinical governance
		• Review extensive national guidance on improving workforce recruitment, retention & wellbeing.
		• Produce a plan to address national strategic guidance on improving maternity & neonatal workforce recruitment, retention and wellbeing.
		• Engage with Higher education Institutions (HEIs) to plan future workforce needs.
		• Plan to implement the recommendations of the workforce race equality standard.
		• Prepare to co-produce a long term maternity and neonatal workforce strategy.
		• Develop the system maternity leadership and oversight.
		• Enhance maternity & neonatal leadership and oversight for safety and improving outcomes, including at Trust executive level.
		• Implement the relevant actions regarding workforce and leadership from the Ockenden reports.
		• Implement recommendations in regard to training and development, with focus on the following areas:
		  • MDT training
		  • Respecting diversity, including cultural competence training
		  • Implementation of the A-EQUIP model
		  • Provision of broad career pathways
		  • Ensuring that maternity training funding is ring fenced
		• Implement learning from SCORE culture surveys.
		• Take an active leadership role in supporting a culture of shared learning, openness and transparency, especially in regard to incidents and complaint.
		• Detailed analysis of the maternity & neonatal workforce.
		• Review of existing literature from HEE, NHSE etc such as workforce planning guidance, and safe staffing levels as outlined in the Ockenden report.
		• Ensure that Maternity Support Workers are designated as band 3 and there is an Maternity Support Workers competency framework in place to upskill this staff group.
		• Ensure that MSW's are coded accurately on ESR, utilising the new national MSW codes.
		• Oversight of core competency framework implementation in Trusts via LMNS Board core-competency-framework.pdf (england.nhs.uk).
		• Sharing learning & resources across the system.
			Accurate information about maternity & neonatal staffing enabling forward planning
			Securing the pipeline of future maternity & neonatal workforce
			Improving workforce recruitment- improved fill rates against establishment
			Improving workforce retention
			Improving workforce wellbeing & satisfaction
			Improving succession planning for future maternity & neonatal leadership
			Consistent workforce practises across the system such as training & education
			Safe staffing is enabled
			Improved quality & safety
			Improved efficiency of services

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
By 2028, we will have proactively addressed **health inequalities**. The Core20Plus5 approach will be part of core business for all children and young people's pathways, ensuring that the priority populations and clinical areas are a key focus.	**Year 1:** • Complete stocktake with each of the key areas and populations in Devon. • Baseline CORE20PLUS5 dashboard developed, via Devon Intelligence Functions Group, linking with regional team as appropriate. • Develop network of stakeholders and pathways for the identified priority groups: 1. Children and families in the 20% most deprived areas and areas of rural and coastal deprivation 2. Children and young people in care, 3. Neurodiverse children 4. Young carers • Develop clear work programmes for the key clinical areas: • Asthma • Diabetes • Epilepsy • Oral Health • (Mental Health – delivered by mental health workstream) • (Healthy Weight) **Year 2:** • Established pathways within the relevant clinical areas, including the priority groups. • Deliver the priority service development improvement plans for the key clinical areas, with consideration of four priority groups.	• Planning, monitoring and evaluation with a focus on health inequality groups.	• Increased collaborative working to reduce health inequalities across the system to improve outcomes for CYP across the life course. • Increased aware of health inequalities across the system, with a focus within the 5 key clinical areas. • Increased data intelligence to enable a tailored healthcare approach. • CYP and their families will experience seamless transition between services and will be able to access specialist services when they need them • Services will be designed around the needs of CYP. • CYP will have a strong voice in their care. • Young people will transition seamlessly into adults health services were appropriate.

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
Family Hub and Early Help models are developed across Devon ICS by 2026, working with Local Authorities to support children's development and readiness for school.	**Year 1:** **Torbay:** Funded Family Hub model in place. **Plymouth:** Submission of bid and development of roll-out plan completed (if successful). **Devon:** Established Best Start in Life Programme Strategic Priorities with the aim to bring together 0-5 services. **Year 2:** **Torbay:** Delivery of comprehensive Family Hubs model, with effective communications to ensure that parents and carers are aware of the services and support available. **Plymouth:** TBC dependent on bid **Devon:** Established delivery of the Best Start in Life Programme.	• Enhanced intervention led early years offer. • Work with Local Authorities to develop Family Hub and Early Help models across Devon ICS to support children's development and readiness for school. • Use family hubs as a spring board to bridge the gap between services. • Work within an integrated care partnership footprint to understand how to work across boundaries – health, social care, housing, public health etc. • Develop an evidence-based enhanced service offer for the early years.	• Reduce unplanned hospital admissions • Improve health literacy • Ensure families are receiving employment support • Measure improvement via activity and process measures • Reduce infant mortality • Reduce tooth decay • Improve wellbeing and reduce need for more specialist care

One Devon

Year 1 and 2 (operational plan detail)

Children and Young People Care Model

SMART objective	Milestones	How are you going to achieve – actions you are going to take	Impact
The **Special Education Needs and Disabilities (SEND)** of children and families will be prioritised across Devon. New SEND reforms will be embedded across the three Local Authorities and to address the weaknesses identified through the Torbay and Devon Local Area Inspection's within the mandated timeframes for each local area.	**Year 1:** • Create the conditions for service improvement and joint commissioning across the local areas (health, care and education), supported by co-production mechanisms. • Agree integrated SEND strategies for each local area. • Deliver new code of practice and work with Local Authorities subject to the new inspection framework. • Deliver a system dashboard that includes robust health data. **Year 2:** • Clear local offer established for each local area, including a graduated pathway of support to CYP and families. • Define the outcomes framework that demonstrate improvements.	• Develop a strong local area governance to ensure there are defined structure roles and responsibilities, lines of accountability and commitment of resources to deliver and support the rapid delivery of the areas of significant weakness identified in the Ofsted and CQC inspections. • Map education, health, and care provision across the Local Area, identifying and addressing gaps in relation to meeting needs of children and young people with SEND, through an improved graduated approach, and clearly communicate this. • Develop effective methods of co-production to ensure that children, young people, parents, and carers' lived experiences and expertise is valued and embedded within all layers of work. • Review and redefine the joint commissioning strategy co-producing priorities based on a good understanding of local need and local spend. • Continue to ensure that resources are deployed to the best possible effect to achieve good outcomes for children and young people and make best use of public funds. • Have a workforce development plan that establishes a skilled, sustainable, supported, and sufficient workforce across the Local Area to deliver services to children and young people with SEND. • Develop a system dashboard that includes robust health data. • Develop methods to ensure there is robust commissioning for a smooth transition for CYP with SEND and who are well prepared for the next stage of their education, employment or training and their adult lives. • Develop a set of Value-based behaviours for communication. • Identify the local offers for each local area to support embedding these across the system for CYP and families.	Coherent action has led to improvement in the lives of children and young people with SEND and their families, so they have positive lived experiences at home and in their community. Increased support for CYP with SEND from birth to 25, through a graduated approach across education, health, and social care, resulting in better outcomes for children and young people in their local schools. Using public funds appropriately will ensure effective resources are used to achieve good outcomes for CYP. Children, young people, parents, and carers' lived experiences are embedded within all layers of work to ensure effective co-production. All children and young people with SEND are in appropriate educational placements receiving at least a good quality of education, with health and social care support as needed, to achieve their potential. Children and young people with SEND are well prepared for the next stage of their education, employment or training and their adult lives, supported by robust commissioning for a smooth transition. There is a skilled, sustainable, and sufficient workforce across the Local Area to deliver services to children and young people with SEND.

Year 1- 5 Objectives and Milestones (1/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)	Paediatric, medical and surgical assessment workshops x 9 complete (May 2023) Targeted engagement with patients, the public, ICS partners, Overview and Scrutiny Committees, workforce & voluntary sector complete (June 2023) Options for redesign of paediatric, medical and surgical assessment generated (July 2023)	Finished in year 1	Finished in year 1
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)	Financial framework in support of the Peninsula Acute Sustainability Programme in place (July 2023)	Framework finished in year 1 Financial monitoring	Framework finished in year 1 Financial monitoring
Trust Boards, Peninsula leadership & NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement but not public consultation • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)	Expert advice: legal, Consultation Institute and other stakeholders advice given (September 2023) Recommendations endorsed by the leadership within Devon & Cornwall ICS (September 2023) Recommendations endorsed by NHSE South West (September 2023)	Finished in year 1	Finished in year 1

Year 1- 5 Objectives and Milestones (2/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement but not public consultation (January 2024)	Roadmap produced for Programme A (October 2023) Implementation plans in support of Programme A (January 2024)	Additional implementation plans in support of Programme A Commencement of implementation of Programme A, from April 2024 (or sooner for some fragile services)	
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement but not public consultation (February/March 2024)	Targeted involvement and engagement with stakeholders complete (ie with workforce, clinicians, partners, public etc) (to March 2024)	Finished in year 1	

Year 1- 5 Objectives and Milestones (3/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)	• NHSE SW Stage 1: Strategic Sense Check & Assurance – approval to procced to NHSE South West Clinical Senate with proposed service changes (October/November 2023) • Options appraisal and impact assessment starts (October 2023) • NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline)	• Options appraisal and impact assessment ends (January 2024) • (…continued) NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline) • NHSE SW Stage 2: Assurance and recommendations to NHSE National Team (Programme B service changes only) (June 2024) • Pre-Consultation Business Case (Programme B - PCBC) approved for public consultation – (June 2024) • NHSE assurance to proceed to public consultation (June 2024) • Public consultation on significant service change - Programme B (July to September 2024) • Consultation feedback report (November 2024) • Decision making business case ready (November 2024) • Decision-making business case approved (December 2024)	

Year 1- 5 Objectives and Milestones (4/4)

Acute Services Sustainability - PASP

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)	The following, initial, fragile services will be sustainable: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC) A tranche 2 list of priority fragile services which will be stabilised (Date TBC)	N/A – subsumed within the Peninsula Acute Sustainability Programme	N/A – subsumed within the Peninsula Acute Sustainability Programme

Year 1 and 2 (operational plan detail) – (1/2)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will have identified an initial set of Peninsula Acute Sustainability Programme sustainability recommendations (July 2023)	Paediatric, medical and surgical assessment workshops x 9 complete (May 2023) Targeted engagement with patients, the public, ICS partners, Overview and Scrutiny Committees, workforce & voluntary sector complete (June 2023) Options for redesign of paediatric, medical and surgical assessment generated (July 2023)	Undertake 9 workshops: • 3 x paediatric assessment • 3 x medical assessment • 3 x surgical assessment Develop a set of high-level scenarios and recommendations for the Peninsula Acute Provider Collaborative and Trust Boards Subject to leadership feedback, undertake engagement with internal and external stakeholders	Peninsula-wide view on reconfiguration of paediatric, medical and surgical assessment
There will be a financial framework in support of the Peninsula Acute Sustainability Programme which sits within the context of both Devon and Cornwall's overarching ICS financial frameworks (July 2023)	Financial framework in support of the Peninsula Acute Sustainability Programme in place (July 2023)	Devon ICS and Cornwall ICS Directors of finance oversee the development of a Peninsula Acute Sustainability Programme financial framework	Ensures that proposed changes are financial viable
Trust Board, Peninsula leadership& NHSE South West signoff clinical models, acute sustainability options and proposed service changes, resulting in: • An agreed Programme A: a service change programme which requires engagement but not public consultation • An agreed Programme B:a service change programme which requires engagement and public consultation (September 2023)	Expert advice: legal, Consultation Institute and other stakeholders advice given (September 2023) Recommendations endorsed by the leadership within Devon & Cornwall ICS (September 2023) Recommendations endorsed by NHSE South West (September 2023)	• Triage the emerging service change programme • Apply the significant service change test to create two programmes • Undertake targeted internal and external engagement • Invite independent review of the programmes: check and challenge • Put in place a team to undertake options appraisal in support of change programmes A & B • Undertake options analysis and appraisal • Undertake EQIA • Seek legal advice • Engage with Peninsula leadership. • Engage with NHSE South West leadership	Clarity on services which can be reconfigured starting in 2023 and those which will be subject to a significant service change – public consultation process

Year 1 and 2 (operational plan detail) – (2/3)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will document the road-map and implementation plans for **Programme A**: a service change programme which requires engagement but not public consultation (January 2024)	Roadmap produced for Programme A (October 2023) Implementation plans in support of Programme A (January 2024)	Design the roadmap for programme A Start designing tranche 1 implementation plans within programme A	Clarity regarding the level of change which will start to have impact from 2024
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement but not public consultation (February/March 2024)	Targeted involvement and engagement with stakeholders complete (ie with workforce, clinicians, partners, public etc) (March 2024)	Undertake targeted internal and external engagement	An understanding of the view, opinions and impact of service change on public, patients and other stakeholder
We will complete the significant service change process for the agreed projects and programmes within **Programme B**: the service change programme which requires engagement and public consultation (to December 2024)	• NHSE SW Stage 1: Strategic Sense Check & Assurance – approval to procced to NHSE South West Clinical Senate with proposed service changes (October/November 2023) • Options appraisal and impact assessment starts (October 2023) • NHSE SW Clinical Senate Review of significant service changes in group B January to May 2024 (17 to 20 weeks – mandatory, fixed NHSE timeline) • NHSE SW Stage 2 Assurance checkpoint (June 2024) • NHSE assurance to proceed to public consultation • Consolation material are ready (June 2024 • Pre-consultation business case ready for consultation June2024 • Public consultation (July to September 2024) • Public consultation report available (November 2024 • Decision Making Business Case (DMBC) available (November 2024) • Decision Making Business Case (DMBC) approved (December 2024)	• Ensure that Devon and Cornwall have met NHSE's 5 key tests for significant service change have been met • Coordinate stakeholders and prepare the materials so that the NHSE South West Clinical Senate have the information they require to undertake their review • We will work with NHSE South West Clinical Senate on it's 17-20 week review of our pre-consultation business case • Build on existing Devon ICS and Cornwall ICS case for change to create tailored case for change for PCBC • Coordinate stakeholders and prepare the materials so that the NHSE South West and NHSE National Team have transparency on the benefits and risks associated with significant service change programme A • Secure letter of assurance from NHS England confirming that Devon ICS & Cornwall ICS can proceed with public consultation • Work with stakeholders to prepare the material for the 3-month public consultation • Support the communications teams with the evaluation of the public consultation feedback and write up and subsequent engagement • Depending on the outcome of the public engagement – prepare for the Decision Making Business Case	An approved programme of significant change endorsed by: • Devon & Cornwall leadership • NHSE South West leadership • Public and patients

Year 1 and 2 (operational plan detail) – (3/3)

Acute Services Sustainability - PASP

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will stabilise fragile services, starting with 5 priority services: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC)	The following, initial, fragile services will be sustainable: Urology, Interventional Radiology, Stroke, Microbiology and Oncology (Date TBC) A tranche 2 list of priority fragile services which will be stabilised (Date TBC)	• Define the objective and leadership group with a mandate and accountability to develop a clinical and operational solution (i.e. which CMO/MD & Network Leadership?) • Establish a Task and Finish Group to lead work to stabilise priority fragile services • Develop a clear evidence base for change (i.e. what exactly is wrong with the service?) Assess against national and local exemplars of best practice (i.e. what does good, and excellence look like?) Develop immediate proposals for stabilisation of service (secure PASP Board signoff to stabilisation implementation plan and start to make changes) Develop proposals for sustainability phase (i.e. having fixed the short-term what is required for the medium term) Develop proposals for transformation phase (i.e. full alignment with the PASP transformational change programme to determine what needs to take place to transform the clinical model to remove fragility)	Avoidance of service breakdown. Improved equity of access for patients. Improved use of resources across the Peninsula

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Planned Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Implementation of Devon wide theatre utilisation standard operating procedure as part of the System Theatre Transformation programme • Implementation of the One Devon Pilot in Orthopaedics, Spinal and Ophthalmology • Maintain agreed protected elective beds in each Trusts • Implementation of GIRFT/Model Hospital/HVLC best practice • Maximisation of capacity in new system and provider assets, accelerators and TIF schemes • Continue to develop and embed Clinical Referral Guidelines (CRGs), commissioned pathways and policies; • Embed C2C referral protocols as per the Good Practice guide. • Increase use of Specialist Advice to support an increase of referrals being diverted away from secondary care; • Develop a 2023/24 Optimising Referral Primary Care Local Enhanced Service (LES) to improve quality of Advice and Guidance (A&G) referrals and sharing of learning from A&G returns within primary care teams; • monitor against EBI List 1 and work to implement EBI 2 and 3.	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Embedding and further roll out of 2023 projects	

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Planned Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. Opportunities exist in 24/25 and beyond with biosimilar ustekinumab, pegfilgrastim, aflibercept, omalizumab and denosumab anticipated to come to market as well as generic pitolisant, romiplostim, eltrombopag and certolizumab

One Devon

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Planned Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will reduce the number of long waiting patients for elective care with a plan to return to waits of less than 18 weeks in the next five years. This will be achieved by increasing productivity and maximising elective capacity in Devon and implementation of the national and local best practice including GIRFT and model hospital	• Key focus on scheduling 'Super Clinics' for the specialties with the highest non-admitted waits: • Reduction in DNAs as a result of embedding the key actions specified in the priority specialties. • Remote Consultations to be used routinely (where appropriate) for the identified specialties • Patient Initiated Follow-Up (PIFU) implemented in the priority specialties. Every PIFU pathway to meet minimum quality standards.) • Specialist Advice: • Job planned in priority specialties • Ensure specialist advice is embedded • Implementation of One stop clinics/HOT clinics wherever appropriate • Validation – Regular clinical review of waiting lists embedded to ensure patients are on the right pathway and still need to be seen • Stopping unrequired follow-ups via discharge by default or structured follow up: • Secondary Care triage of referrals embedded in the priority specialties • Implementation of Devon wide theatre utilisation standard operating procedure as part of the System Theatre Transformation programme • Implementation of the One Devon Pilot in Orthopaedics, Spinal and Ophthalmology • Maintain agreed protected elective beds in each Trusts • Implementation of GIRFT/Model Hospital/HVLC best practice • Maximisation of capacity in new system and provider assets, accelerators and TIF schemes • Continue to develop and embed Clinical Referral Guidelines (CRGs), commissioned pathways and policies; • Embed C2C referral protocols as per the Good Practice guide. • Increase use of Specialist Advice to support an increase of referrals being diverted away from secondary care; • Develop a 2023/24 Optimising Referral Primary Care Local Enhanced Service (LES) to improve quality of Advice and Guidance (A&G) referrals and sharing of learning from A&G returns within primary care teams; • monitor against EBI List 1 and work to implement EBI 2 and 3.	Through a robust outpatient transformation programme working with Trust outpatient management and clinical leads. This will be delivered through focussed actions plans delivered through the System Theatre Transformation Programme, the One Devon Pilot and the Surgical Pathway Innovation Group This will be delivered through a robust demand management programme	By March 2024, the Devon System will reduce the number of patients waiting over 65 weeks for elective care to 4,219 by the end of March 2024. The Devon System specific activity target of 103% of 19/20 activity in 2023/24 achieve 85% Day Case and 85% theatre utilisation. Outpatient transformation will deliver a 25% reduction of outpatient follow ups and increased first outpatient appointments through increased productivity. We will eliminate the number of patients waiting over two years for treatment in Devon by December 2023

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Planned Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
We will standardise high-cost medicines use in secondary care to improve patient outcomes while rationalising costs within 5 years.	Horizon scanning will continue looking towards new advances in therapy as well as potential savings opportunities from patent expiries and introduction of biosimilar medicines. We will continue exemplary collaborative work with providers to optimise biosimilar uptake as seen with adalimumab and more recently with ranibizumab. The savings opportunities in 23/24 are minimal due to products being low volume usage (tocilizumab, botulinum toxin and bevacizumab),	This will be delivered through work led by the ICB Secondary Care Medicines Optimisation Team	Reduced spend on prescribing in Secondary care

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Diagnostics

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation	Business cases approved Funding received Builders contracted Staff recruited Equipment ordered Buildings completed and service commissioned	Service accreditation achieved	
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth	ICB – Board paper to SET April 23 describing the options for expanding capacity. Strategic approval of a preferred option by ICB and Trust boards completed by August 23.	Business case completed Business case approved Building/service partner commissioned Staff recruited Equipment ordered Facilities commissioned	Accreditation maintained Programme completed and services commissioned.

Year 1- 5 Objectives and Milestones

Acute Services Sustainability – Diagnostics

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25	Business case completed Business case approved	Funding received Engagement of building partner. Estates plan & design process complete Target operating model developed.	Building completed. Commencement of service delivery.
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24	GP Direct access of chest, abdomen, and pelvis CT scans, brain MRI and abdomen and pelvis ultrasound. Pathways effective and consistent	Further extend GP Direct access in line with national programmes	Evaluate patient experience and outcome impact and operational benefits
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24	Aligned SMART objectives set for clinical networks	Performance managed and objectives reviewed	Performance managed and objectives reviewed
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling	Training capacity increased Endoscopy Admin competency framework rolled out	Staff passporting supported Clinical and screening endoscopist capacities met	Upskilling for engagement with innovations embedded
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)	Continue engagement in relevant pilots and networks to establish adoption strategy	Planning and initial implantation for at least two significant innovations Rolling development of adoption strategy	Impact evaluations Mature adoption capability

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Diagnostics

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Complete endoscopy room extensions and facility improvements in Torbay, Plymouth and Exeter in 2023/24, and in Barnstaple in 2026/27, to underpin ICS recovery, meet demand growth and ensure service accreditation	Continue to attend project delivery meetings with Trusts. Continue to link with NHSE regional team to support delivery.	Delivery of two additional rooms and training capacity by December 2023 (Torbay and Plymouth) Delivery of a further two additional rooms (Tiverton) and training capacity by September 2024 Resolution of capacity and accreditation shortfalls Sustained clearance of backlogs and performance issues for better patient experience and outcomes Securing of delivery premium Delivery of a further two additional rooms (Barnstaple) as part of new hospital development c.2026/27
Develop a strategy for the provision of further endoscopy capacity in 2025/26-2033/34 to achieve parity with national levels of access and meet future long-term demand growth	ICB – Board paper to SET March 23 describing the options for expanding capacity. Strategic approval of a preferred option by ICB and Trust boards completed by August 23.	An agreed long term strategic plan for the delivery of capacity with a supporting programme delivery plan

on

Year 1 and 2 (operational plan detail)

Acute Services Sustainability – Diagnostics

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Establish community diagnostic centres in Torbay in 2023/24 and in Plymouth by 2024/25	Continue to co ordinate and oversee the activity between the provider trust and NHSE until the project moves into the delivery phase. Once in delivery phase to move to having oversight of the Trust project on behalf of the ICB.	Achievement of the requirements of the national strategy to increase diagnostic capacity .
Extend the use of GP direct access to improve diagnostic turnaround times and patient experience from 2023/24	Facilitate, and establish the monitoring of, GP Direct access for chest, abdomen, and pelvis CT scans, brain MRI and abdomen and pelvis ultrasound. Ensure pathway readiness and consistency	More beneficial to patients who have vague symptoms so they get the right test quicker. This will increase a faster diagnosis within the 62 day pathway. Best use of GP and diagnostic resources.
Ensure all relevant clinical networks contribute significantly to service productivity and quality improvement from 2023/24	Continue engagement with key networks to ensure their commitment to productive, aligned SMART objectives. Extend engagement where necessary for key objectives	More rapid and impactful realisation of service improvements through aligned clinical leadership and engagement across teams
Increase virtual training academy scope and scale in 2023/24-2025/26 to support recruitment and clinical, nursing and support staff upskilling	Continue coordination with SW Endoscopy Training Academy. Assure alignment and harnessing of wider workforce strategies and opportunities	Upskilled teams (clinicians, nurses and support staff) Increased portability of staff Improved specialist recruitment and retention Demand growth met and staff shortages avoided
Plan for significant service transformations in 2025/26-2033/34 triggered by technological innovations (e.g. Artificial Intelligence, genomic testing) and policy decisions (e.g. widened screening criteria)	Continue engagement with key programmes and pilots. Focus on exploring the potential and implications of game changing innovations (e.g. GRAIL Trial and other genomic innovations, Artificial Intelligence)	Improved patient experience and outcomes, and maximised productivity, through the full exploitation of game changing innovations and policy changes

One Devon

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Cancer

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24	Deliver BPTP milestones in suspected prostate, lower gastrointestinal, skin and breast cancer pathways.	Roll out BPTP across all suspected cancer pathways	Sustain BPTP milestones and exceed achievement of 75% target across each tumour group
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs	Maximise the use of IS capacity and continue to prioritise cancer pathways to reduce backlogs. Delivery of prioritised action plans for most challenged pathways		
Sustainability of Oncology Services	Development of Oncology Workforce Strategy	Development of service redesign to be agreed year 1	Sustainability of services, including workforce through workforce planning, establishing pipelines and delivery of education through Cancer Academy
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Prepare for increasing use of screening programmes and pilots to reduce late-stage diagnosis (eg.targeted lung checks, GRAIL trial, liver surveillance, widened Bowel cancer screening), including preparing for the man agement of consequential demand and impacts on wider providers (e.g. diagnostics, mental health, primary care) from 2023/24 Establish non-specific symptoms pathways across each provider	Implementation of GRAIL pilot Expansion of TLHC programme across Devon Evaluation of NSS pathways to inform commissioning intentions for 24/25	

Year 1 and 2 (operational plan detail)

Acute Services Sustainability – Cancer

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Achieve Faster Diagnosis Standards by implementing best practice timed pathways in 2023/24	The ICB will work with systems and providers to develop and implement action plans to improve cancer waiting times performance with a focus on achieving the faster diagnosis standard and reducing the delays to diagnosis.	Improved patient experience and outcomes through the delivery of proven best practice pathways
Achieve 62-day referral to treatment targets in 2023/24 including clearance of all cancer backlogs	Minimum of weekly reviews at trust level are in place to ensure there is focus on reducing the cancer waiting list backlogs and improve performance against the 62 day referral to treatment target.	Improved patient experience and outcomes through the avoidance of harms arising from delayed diagnosis or treatment
Sustainability of Oncology Services	SRO in post to support programme Working group established to agree actions and lead delivery within each provider. Working with Peninsula Cancer Alliance and specialist commissioning to support delivery of agreed service developments	Increased service resilience and consistency Improved patient experience and outcomes through reduced delays and variation in care
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Prepare for increasing use of screening programmes and pilots to reduce late stage diagnosis (e.g. targeted lung checks, GRAIL trial, liver surveillance, widened Bowel cancer screening), including preparing for the management of consequential demand and impacts on wider providers (e.g. diagnostics, mental health, primary care) from 2023/24 Establish Non-specific symptoms pathways in each provider	Improved patient experience and outcomes through much earlier diagnosis and treatment of cancers including some with vague symptoms

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.	New Integrated Urgent Care Service (IUCS) consolidation complete and year 1 service development and improvement plan delivered Implementation of SW 999 transformation plan priorities for acute pathways (SDEC pathways) and community services (UCR and mental health) across all localities Increase in referrals to urgent community response and same day emergency care from 111/999 Enhanced clinical validation in 111 and 999 in place, including ITK link between SWASFT and IUCS CAS	IUCS service development and improvement plan year 2 priorities delivered and year 3 and 4 plan agreed Full access to SDEC services for ambulance services as “trusted assessors” Increasing range of options available to those using 111 Online, reducing pressure on call answering Digital referral from 111 and 999 to UCR starts	Digital referral enabled to UCR fully implemented All urgent and crisis services accept referrals from 111 and 999 and adopt the full national DOS templates to maximise referrals and alternatives to ED/999
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.	Five year CUC workforce plan in place UTC development plan	Implementation of workforce plan begins Remote consultation option in all UTCs Implementation of UTC development plan begins	Completion of workforce plan and all benefits realised UTC development plan complete, including primary care minor injury offer to release capacity in UTCs
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.	Consistent medical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service Frailty and paediatric services at each hospital	Consistent medical and surgical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service and NHS 111 Frailty service available for 70 hours per week at each hospital – accessible to ambulance service and 111	Paediatric services available 7 days a week and accessible to ambulance service and 111

Year 1- 5 Objectives and Milestones

Acute Services Sustainability - Urgent and Emergency Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Improve **A&E performance** at all hospitals – the ICB meets the 72% seen in 4-hours target.	ICB achievement of national performance standard for A&E waiting by the end of the financial year (31st March 2024)		
Improve **ambulance response times** across all call categories, with particular emphasis on category 2 – SWASFT meet the recovery plan target of mean response time of 30 minutes.	SWASFT category 2 mean response time of 30 minutes achieved by end of the financial year (31st March 2024)		
Acute bed occupancy will decrease to 94-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.			

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Urgent and Emergency Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Improve **effective navigation** around the urgent care system by increasing the range of services available for 111 and 999 to refer to and increasing clinical input into 111 and 999.	New Integrated Urgent Care Service (IUCS) consolidation complete and year 1 service development and improvement plan delivered Implementation of SW 999 transformation plan priorities for acute pathways (SDEC pathways) and community services (UCR and mental health) across all localities Increase in referrals to urgent community response and same day emergency care from 111/999 Enhanced clinical validation in 111 and 999 in place, including ITK link between SWASFT and IUCS CAS		
Enhance the role of **community urgent care** to manage demand for urgent care through Urgent Treatment Centre primary care minor injuries services development.	Five year CUC workforce plan in place UTC development plan		
Increase number of patients seen in **same day emergency care** by extending the range of services across Devon for medical, surgical, frailty and paediatrics.	Consistent medical SDEC 12 hours/day, 7 days a week across Devon – accessible to ambulance service Frailty and paediatric services at each hospital		

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Urgent and Emergency Care

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Improve **A&E performance** at all hospitals – the ICB meets the 72% seen in 4-hours target.	ICB achievement of national performance standard for A&E waiting by the end of the financial year (31st March 2024)	UEC recovery plan includes detailed actions to reduce acute bed occupancy down to 86-92% at sites, to improve flow and ED waiting times. Actions include admission avoidance schemes, use of virtual ward and intermediate care beds.	Improved patient experience, reduced ED crowding, performance standard achieved
Improve **ambulance response times** across all call categories, with particular emphasis on category 2 – SWASFT meet the recovery plan target of mean response time of 30 minutes.	SWASFT category 2 mean response time of 30 minutes achieved by end of the financial year (31st March 2024)	UEC recovery plan (ambulance) includes detailed actions to enhance clinical input in the 999 hub and increase response capacity across the south west. Actions include recruitment of clinicians to hubs for navigation and validation of category 2 cases, and increase in response capacity including make ready hubs, additional staff and third party resources.	Improved patient experience, quality and safety improvement, performance standard achieved
Acute bed occupancy will decrease to 94-96% by 2024 through reducing the number of patients within a General or Acute bed who do not meet the criteria to reside (NCTR) to no more than 5% and reducing length of stay.			

Year 1- 5 Objectives and Milestones

Housing

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE;	Map out the ways in which people in different areas can access support for; • grants for insulation • Support in energy efficiency • Financial aid and advice • Housing Standards • Advocacy and support to address poor living conditions To provide guide on how to support patients tackle fuel poverty. Identify areas of insufficient resource and work strategically to improve EPC rating. Establish baseline.	Updated based on new government advice and schemes Consider any gaps determined through the previous work and develop resources **By end of yr 2: Devon foot print covered with fit for purpose referral mechanisms**	Continuous improvement based on feedback from those we wish to refer and those being referred.
Systematically identify vulnerable groups with chronic conditions and signpost for support;	Define 'vulnerable groups' and set up referral mechanisms to pilot; at least 1 through hospital OP, at least 1 through Pharmacy (via medications) per LCP / LA area **Cohort size established** **Pilot in place**	Learning from the pilot scheme, widen range of conditions to **cover 50%** of those identified as vulnerable due to health issues Develop PHM processes to identify at-risk groups and pilot communications channels	Expand to **cover 100%** of those with relevant health issues Expand to other vulnerable where there is no known current existing health issue. - use of face to face and/or PHM approaches
Identifying poor quality housing or lack of secure housing on admission/discharge planning and referring for support	Map out what is currently done and spread good practice. Identify the gaps and work with hospitals to set up pathways as pilots. Needs analysis of support and resource requirements. **Baseline established**	Learning from pilot and widen implementation to embed appropriate housing and health assessments to enable early identification of poor quality housing and those at risk of homelessness *Further details tbc*	Implement pathways in full for a defined vulnerable population *Further details tbc*
For the projected need for **specialist housing, accommodation to meet the needs of older people and affordable housing** to be understood across Devon, and to be taken account within the relevant Local Plans across the footprint, with associated delivery plans	Housing needs assessments completed for high priority groups, such as people with complex LD and/or autism returning from out of area placements Engagement with planning leads/fora to a) provide assurance that this work is in hand b) offer support if needed on the assumptions and modelling to form the projections if appropriate.	Housing needs assessments completed for relevant population cohorts, such as people with mental health disorders, dementia and complex needs By the end of year 2, ICS/ One Devon will have a shared understanding of the different needs and the different delivery plans across the whole of Devon, for these elements of housing	
Reduce the number of people who are homeless in particular; • No family should be in B&B accommodation over 6 weeks. (would need to be agreed collectively with LA,, 5 is the government guide) • 10% reduction in number of households in temporary accommodation (remember this will be against a backdrop of increasing demand) • X% increase in the number of households successfully prevented from becoming homeless. (use 22/23 benchmark data • 100% of people who sleeps rough should be offered accommodation	**Devon wide collation of baseline, plans and delivery timelines** Identification of any factors or gaps where a wider system approach may support the achievement of the deliverables. Every person rough sleeping should be offered accommodation. Assessment should be undertaken to reason and barriers on why this may not be preventing street homelessness to improve pathways and support solutions.	No households with children in B&B accommodation over 6 week (end of 2024) There is complexity around rough sleeping and if the target is not met then there still should be assurances that a safe and warm place to sleep was offered and that the root cause for refusal is then used to develop a better offer in the future Reduction in people housed under homelessness duties of 10% pa	Maintenance of the targets around rough sleeping and families in B&B accommodation Reduction in people housed under homelessness duties of 10% pa

Year 1 and 2 (operational plan detail)

Housing

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Ensure a simple route for referral to support with issues around poor quality housing for those where health is a concern across all areas, which accepts referrals from a range of health, social and VCSE;	Map out the ways in which people in different areas can access support for; • grants for insulation • Support in energy efficiency • Financial aid and advice • Housing Standards • Advocacy and support to address poor living conditions To provide guide on how to support patients tackle fuel poverty. Identify areas of insufficient resource and work strategically to improve EPC rating. Establish baseline.	• Set up working group with representation across La areas • Collate LA web pages / information on support and share • Consider where there are gaps and seek to fill through learning from local areas • Learn from best practice across areas • Identify baseline of number of people seeking support ad their referral routes (eg social prescribing, self referral) Need to consider liking in with other existing housing networks such as Environmental Health Housing. Also at LA or other level. Happy to provide some more detail, but need elevating a bit. Also need to think potentially big regional EPC funding program.	Clear referral processes Baseline of number referred and receiving support
Systematically identify vulnerable groups with chronic conditions and signpost for support;	Define 'vulnerable groups' and set up referral mechanisms to pilot; at least 1 through hospital OP, at least 1 through Pharmacy (via medications) per LCP / LA area **Cohort size established** **Pilot in place**	• Consideration of evidence base to determine most sensitive conditions to cold / poor quality homes • Identify the different cohorts who could be eligible for support (explore use of PHM, fuel • Engage with Pharmacy via LPC – consider leaflets distribution as part of meds reviews or dispensed meds • Engage with hospital consultants around the key conditions (eg respiratory) and identify routes for the signposting (leaflet, face to face, posters, emails, texts….)	Reduce readmissions / admissions for those most likely to suffer exacerbations
Identifying poor quality housing or lack of secure housing on admission/discharge planning and referring for support	Map out what is currently done and spread good practice. Identify the gaps and work with hospitals to set up pathways as pilots Needs analysis of support and resource requirements.	• Seek advice from colleagues on discharge practices where it relates to homes • Consideration of approaches – learn from best practice, identify gaps and opportunities. • Link into the referral processes	Reduce readmissions / admissions for those most likely to suffer exacerbations
For the projected need for **specialist housing, accommodation to meet the needs of older people and affordable housing** to be understood across Devon, and to be taken account within the relevant Local Plans across the footprint, with associated delivery plans	Housing needs assessments completed for high priority groups, such as people with complex LD and/or autism returning from out of area placements Engagement with planning leads/fora to a) provide assurance that this work is in hand b) offer support if needed on the assumptions and modelling to form the projections if appropriate.	• Link to LA leads to identify the plans that are in place • Consider whether there may be advantages to working together around assumptions and projections for the modelling of need	Longer term provision of relevant forms of housing
Reduce the number of people who are homeless in particular; • No family should be in B&B accommodation over 6 weeks. (would need to be agreed collectively with LA,, 5 is the government guide) • 10% reduction in number of households in temporary accommodation (remember this will be against a backdrop of increasing demand) • X% increase in the number of households successfully prevented from becoming homeless. (use 22/23 benchmark data • 100% of people who sleeps rough should be offered accommodation	**Devon wide collation of baseline, plans and delivery timelines** Identification of any factors or gaps where a wider system approach may support the achievement of the deliverables. Every person rough sleeping should be offered accommodation. Assessment should be undertaken to reason and barriers on why this may not be preventing street homelessness to improve pathways and support solutions.	• Engage with LA leads • Develop / utilise forum to ensure different elements of the system are connected (if not already) • Work with them to understand gaps especially where factors such as domestic abuse, mental health, trauma, substance misuse, primary care are relevant factors and ensure that the connections are made between the commissioners of the different services – if not already	Reductions in homelessness / prevention

Year 1- 5 Objectives and Milestones

Employment

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Seek to reduce level of 16-18 year olds Not in Education Employment and Training ('NEET') in Devon by 1% by 2027	Reduction in NEET performance when compared to national average of 0.25%	Reduction in NEET performance when compared to national average of 0.5%	Reduction in NEET performance when compared to national average of 1%
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 0.5% when compared with the national average.	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 2% when compared with the national average.	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 4% when compared with the national average.
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027	Reduction in number of young people who are care experienced who are considered NEET reduced by 4% when compared with the national average.	Reduction in number of young people who are care experienced who are considered NEET reduced by 8% when compared with the national average.	Reduction in number of young people who are care experienced who are considered NEET reduced by 16% when compared with the national average.

One Devon

Year 1 and 2 (operational plan detail)

Employment

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Seek to reduce overall levels of NEET performance amongst 16-19 year olds within the Devon area by 1% by 2027	Reduction in NEET performance when compared to national average of 0.25%	Coordination of ongoing NEET prevention activity with JCP / DWP as well as County, District and health related NEET provision. Coordination of in school NEET prevention and wider support products (Transitions, Focus 5, etc) through aligned NEET partnership.	Reduction in NEET Levels, reduced economic scarring and wider socio-economic benefits from individual impacts.
Reduction in number of individuals with a disability or mental health need who are unemployed compared to the national average by 4% by 2027	Reduction in number of individuals with a disability or mental health need who are unemployed reduced by 0.5% when compared with the national average.	Alignment of targeted support for individuals with a disability or other health barrier to employment through local programme approach, including Devon's Employment Hub and the Plymouth Employment Hub. Coordination alongside core national programme's such as Restart and JCP/ DWP's national disability and mental health related support products. Creation of a single Mental Health Employment Forum. Alignment of approach with wider workstreams around workforce development, careers and education, housing and transport.	Reduction in overall level of unemployment amongst those with a disability, mental health need or wider health related barrier to employment, reduced service demand and improved economic / well bien outcomes form economically active individuals
Reduction in the number of care experienced young people who are considered NEET within Devon by 2027	Reduction in number of young people who are care experienced who are considered NEET reduced by 4% when compared with the national average.	Coordination of ongoing NEET prevention activity with JCP / DWP as well as County, District and health related NEET provision. Coordination of in school NEET prevention and wider support products (Transitions, Focus 5, etc) through aligned NEET partnership. Specific alignment of local authority CIC, Care Leaver and wider care experience support services through Care Leaver protocol with DWP / JCP	Reduction in NEET Levels amongst Care experienced in Devon, reduced economic scarring and wider socio-economic benefits form individual impacts.

Year 1- 5 Objectives and Milestones

Suicide Prevention

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
The Local Suicide Prevention Groups to each have a published annual action plan which sets delivery for the year	Action plans published and delivered	Action plans published and delivered	Action plans published and delivered
Local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards	Board reports presented	Board reports presented	Board reports presented
Local Suicide Prevention Groups to prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention	Annual action plans deliver targeted training provision relevant to local need	Annual action plans deliver targeted training provision relevant to local need	Annual action plans deliver targeted training provision relevant to local need
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average	The rate in each local authority area is stable	The rate in each local authority area is on a downward trajectory and is in line with or below the England average	The rate in each local authority area is on a downward trajectory and is in line with or below the England average

Year 1 and 2 (operational plan detail)

Suicide Prevention

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
The Local Suicide Prevention Groups to each have a published annual action plan which sets delivery for the year	Action plans published and delivered	Action plans agreed in multi-agency suicide prevention groups and delivered by members with annual report at end of each financial year monitoring progress.	Ensures multi-agency approach to suicide prevention and focuses groups to deliver interventions together
Local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards	Reports presented to Boards	Chair of Suicide Prevention Group (Public Health Lead) ensures annual report produced and presented at Health and Wellbeing Board at start of following financial year.	Health and Wellbeing Board sighted on delivery of action plans and able to seek assurance on delivery and outcomes

One Devon

Year 1 and 2 (operational plan detail)

Suicide Prevention

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Local Suicide Prevention Groups to prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention	Annual action plans deliver targeted training provision relevant to local need	Chair of Suicide Prevention Group (Public Health Lead) ensures action plan contains targeted training delivery as agreed by group members and monitors delivery throughout the year at the regular group meetings. Collaboration with other 2 groups in the ICB to join up where same training needs identified	System awareness of suicide and suicide prevention continues to grow as relevant training provided
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average	The rate in each local authority area is stable	ONS data on rolling 3 year suicide rate (Persons) for each local authority area available annually and Public Health leads will produce an annual report with the rates for each area and ICB level and compare them to the England average rate.	System visibility of current annual position with regards to suicide rates. Stability at this stage with full effect of pandemic and cost of living crisis still to be felt is deemed appropriate

Year 1 and 2 (operational plan detail)

Suicide Prevention

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Local Suicide Prevention Groups to prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention	Annual action plans deliver targeted training provision relevant to local need	Chair of Suicide Prevention Group (Public Health Lead) ensures action plan contains targeted training delivery as agreed by group members and monitors delivery throughout the year at the regular group meetings. Collaboration with other 2 groups in the ICB to join up where same training needs identified	System awareness of suicide and suicide prevention continues to grow as relevant training provided
Public Health Teams monitor suicide rates and produce an annual report that monitors the rate in each area and at ICB level and compares it to the England average rate	The rate in each local authority area is stable	ONS annual update data on suicide rate (Persons) for each local authority area available annually and Public Health leads will produce an annual report with the rates for each area and ICB level and compare them to the England average rate.	System visibility of current annual position with regards to suicide rates. Stability at this stage with full effect of pandemic and cost of living crisis still to be felt is deemed appropriate

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Reduce occurrences of HCAIs (C.diff, MRSA, gram negative organisms) in primary care using the Start Smart Then Focus principles	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10% in primary care	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% in primary care from Year 1	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 25% or more across a 5 year period in primary care
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection Antimicrobial stewardship: Start smart - then focus - GOV.UK (www.gov.uk) Course: TARGET antibiotics toolkit hub (rcgp.org.uk) Antibiotic stewardship tools, audits and other resources: Audit toolkits (rcgp.org.uk)	All prescribers signed up to Start Smart Then Focus principles and this requirement to be included within commissioning contracts. Peninsula wide antimicrobial resistance (AMR) group and action plan to be launched. Establish baseline for antibiotic prescribing.	All secondary care providers ensuring prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. To have reduced antibiotic prescribing by 5% from year 1 baseline.	To have reduced antibiotic prescribing by 15% from year 1 baseline.

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Providers must demonstrate a 100% offer to eligible cohorts for influenza and covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for CYP and adults	• System wide governance structures in place to oversee planning, delivery and increasing uptake of each programme including emphasis on increasing access and addressing health inequalities. An Equality and Health Inequalities Impact Assessment will be completed ahead of each programme launch. • 100% offer to eligible cohorts each season • Vaccine uptake in line with or exceeding national/regional/comparator benchmarking • Vaccine confidence training offer developed • Programme evaluation in place to capture and embed learning • Inclusion and Prevention checklist rolled out with reasonable adjustments in place as standard, in partnership with VCSE/NHS Devon EDI	• As in Year 1 but learning embedded from previous seasons • Year on year improvement in uptake amongst priority cohorts • Delivery of vaccine confidence training	• As in Year 1 but learning embedded from previous seasons • Year on year improvement in uptake amongst priority cohorts • Vaccine confidence training embedded across the system

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP	• Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	• Year 1 activity delivered • Action plan implemented	• Vaccine coverage 95%
Vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS for CYP	• Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	• Year 1 activity delivered • Action plan implemented	• Vaccine coverage 95%
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-covid levels, with secondary aim to achieve year on year improvement in uptake working towards the 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP	• New provider/contract in place • Working closely with NHS England commissioners, support the development of a Devon-wide SAIs strategy to increase uptake. This work will be led by NHS England Integrated Public Health Commissioning Team as the commissioner of the SAI provider. The multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead) will play a key role in developing and delivering community focused interventions that support the work undertaken by the SAI provider. Interventions/activities to increase uptake will be agreed as part of this group.	• Year 1 activity delivered • Action plan implemented	• Vaccine uptake – improvement compared to previous year

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Reduce the decline in cervical screening coverage and stabilise uptake Implement NHSE-funded Learning Disability Primary Care Liaison Nurse to focus on cervical screening [SU HARVEY TO CONFIRM]	Maintain/stabilise uptake Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Improvement in uptake compared to previous year
Consistently achieve the national colposcopy screening to diagnostic test screening standard with focus on Devon's priority populations (CORE20PLUS) for Adults	Achieve national standard	Achieve national standard	Achieve national standard
Improve access and uptake for those specifically with an LD or with SMI to bowel screening to achieve the same uptake as the general population	Population Health Management approach embedded Inclusion and Prevention checklist rolled out with reasonable adjustments in place as standard, in partnership with VCSE/NHS Devon EDI NICE guidance implemented	Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults and CYP	Same uptake achieved as general population

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Consistently achieve the national colonoscopy screening to diagnostic test screening standard with focus on Devon's priority populations (CORE20PLUS) for Adults	Achieve national standard	Achieve national standard	Achieve national standard
Work closely with NHS England commissioner to support the delivery of the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (CORE20PLUS) for Adults	National guidance awaited – detailed milestones for overall uptake trajectories and specific groups of focus to be determined and confirmed with NHS England Integrated Public Health Commissioning Team. Campaign delivered. Make progress to achieve national standard	Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Locally agreed targets are achieved	Locally agreed targets are achieved
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon.	Audit tool completed and reviewed	Gaps addressed	Pathways in place

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Reduce occurrences of HCAIs (C.diff, MRSA, gram negative organisms) in primary care using the Start Smart Then Focus principles	By Year 1, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10% in primary care. By Year 2, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% in primary care from Year 1.	• Early sampling to promote early switch to the most suitable antibiotic – broad to narrow spectrum • Reducing use of broad spectrum antimicrobials generally – use of targeted antimicrobials • Discharging patients as soon as fit for discharge from hospitals – longer in hospital likelihood of development of HCAI • Discourage use of repeat prescriptions for antimicrobials unless indicated • Use of the Devon Community Infection Management Service (CIMS) teams to support primary care • Effective IPC practices	Reduce antibiotic use in primary care through early identification and treatment of bacterial infections.
Ensure effective antimicrobial use in line with NICE guidance and the Start Smart Then Focus principles to optimise outcomes, reduce the risk of adverse events and to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection	By Year 1, all prescribers signed up to Start Smart Then Focus principles and this requirement to be included within commissioning contracts. Peninsula wide antimicrobial resistance (AMR) group and action plan to be launched. Establish baseline for antibiotic prescribing. By Year 2, all secondary care providers ensuring prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. To have reduced antibiotic prescribing by 5% from year 1 baseline.	• Early sampling to allow early switch to the most suitable antibiotic – broad to narrow spectrum. • Reducing use of broad spectrum antimicrobials generally – use of targeted antimicrobials. • Individual prescribing benchmarked against local and national antimicrobial prescribing rates and trends • Local and national antimicrobial resistance rates and trends are monitored and reported • Support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.	Reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Providers must demonstrate a 100% offer to eligible cohorts for influenza and covid vaccination programmes, and to achieve at least the uptake levels of the previous seasons for each eligible cohort, and ideally exceed them where applicable - with particular focus on Devon's priority populations (CORE20PLUS) for CYP and adults	System wide governance structures in place to oversee planning, delivery and increasing uptake of each programme including emphasis on increasing access and addressing health inequalities. An Equality and Health Inequalities Impact Assessment will be completed ahead of each programme launch. 100% offer to eligible cohorts each season Vaccine uptake in line with or exceeding national/regional/comparator benchmarking Vaccine confidence training offer developed Programme evaluation in place to capture learning with learning embedded from previous seasons Year on year improvement in uptake amongst priority cohorts Delivery of vaccine confidence training	System wide multi-agency governance and reporting structure in place to oversee planning and delivery of both programmes utilising existing structures already established within the ICS for delivery of flu and covid vaccination programmes. Dedicated Health Inequalities Cell (led by Public Health) and NHS Outreach Programme in place to focus on increasing access and addressing health inequalities in uptake of both programmes. EHIAs completed as part of programme planning. All vaccination sites to have completed inclusion and prevention checklist with reasonable adjustments in place. Vaccine confidence lead in place and training offer developed and piloted in Devon working with the NHS England Regional Screening and Immunisation Team. Comms strategy developed. Regular monitoring of performance and uptake in place to inform action.	Delivery of other services such as physical health checks alongside vaccination when reaching vulnerable/seldom heard cohorts. Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action.
Vaccine coverage of 95% of two doses of MMR by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP	Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	MMR strategy led via multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead). Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, with particular focus on Devon's priority populations (CORE20PLUS) for CYP	Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	Preschool booster strategy led via multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead). Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Achieve recovery of School-aged Immunisation (SAI) uptake to pre-covid levels, with secondary aim to achieve 90% target as stated in national service specification with particular focus on Devon's priority populations (CORE20PLUS) for CYP	New provider/contract in place Multi-agency Devon Maximising Immunisation Uptake Group established with clear action plan in place	New provider/contract in place alongside performance monitoring. Working closely with NHS England commissioners, support the development of a Devon-wide SAIs strategy to increase uptake. This work will be led by NHS England Integrated Public Health Commissioning Team as the commissioner of the SAIS provider. The multi-agency Devon Maximising Immunisation Uptake Group (co-chaired by NHS England Screening and Immunisation Team and LA Public Health, Health Protection lead) will play a key role in developing and delivering community focused interventions that support the work undertaken by the SAI provider. Interventions/activities to increase uptake will be agreed as part of this group.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Halt the decline in cervical screening coverage and then to improve uptake year on year towards a goal of 80%, with focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults	Reduce the decline in cervical screening coverage and stabilise uptake. Maintain/stabilise uptake Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Implement NHSE-funded Learning Disability Primary Care Liaison Nurse to focus on cervical screening	Multi-agency Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and those living in the 20% most deprived neighbourhoods	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Consistently achieve the national colposcopy screening to diagnostic test screening standard with focus on Devon's priority populations (CORE20PLUS) for Adults			Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Improve access and uptake for those specifically with an LD or with SMI to bowel screening to achieve the same uptake as the general population	Population Health Management approach embedded Inclusion and prevention checklist rolled out in partnership with VCSE/NHS Devon EDI with reasonable adjustments in place as standard. NICE guidance implemented. Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults and Children and Young people	Multi-agency Maximising Screening Uptake Group established with clear action plan in place, with focus on LD and SMI cohorts. Inclusion and prevention checklist rolled out in partnership with VCSE/NHS Devon EDI with reasonable adjustments in place as standard. NICE guidance implemented. Comms strategy in place.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action

Year 1 and 2 (operational plan detail)

Health Protection

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Consistently achieve the national colonoscopy screening to diagnostic test screening standard with focus on Devon's priority populations (CORE20PLUS) for Adults Note: reference to uptake and MSUGs removed as this is is work led by ICB on diagnostics capacity	Achieve national standard	Will need some text here from the diagnostics team please	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Support NHS England to deliver the upcoming national campaign to increase breast screening uptake and reduce inequalities coverage (NHS England and provider led) with focus on Devon's priority populations (CORE20PLUS) for Adults	Maximising Screening Uptake Group established with clear action plan in place, which includes focus on first invitation and Devon's priority populations (CORE20PLUS) for Adults Campaign delivered. Make progress to achieve national standard	Multi-agency Maximising Screening Uptake Group established with clear action plan in place. Comms strategy in place.	Comms impact monitored. Evaluation of plans undertaken. Regular monitoring of performance and uptake in place to inform action
Addressed the commissioning and delivery gaps identified in the 2022 South West Gap Analysis Action Plan Tool for Health Protection Frontline Services to ensure that Devon has pathways in place for key pathogens and capabilities and can respond effectively to health protection related incidents and emergencies across different communities in Devon.	Audit tool completed and reviewed		

Year 1- 5 Objectives and Milestones (2/2)

Community Learning & Development

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
By 2028 Local communities will be able to work collectively to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.	By 2024: Health creation practices will be supported across all communities	By 2025: the vital role of communities in tackling the wider determinants of health will be recognised and their contribution supported. (King's Fund)	By 2028 community partnerships will realise their potential and create actions across all levels of their influence to reduce the impact of inequality
By 2028 a Community Development workforce will be supported, empowered and skilled to deliver fully inclusive services for everyone equipped, trained to agreed standards and following a Code of ethics and values-based practice	By 2024: Support workforce to develop the skills, values and processes required for effective and appropriate community development so they may best harness 'the family of community-centred approaches' to empower communities to work collectively (PHE)	By 2025: Community-identified training needs for the VCSE and community groups/partners will be supported by One Devon to support health creation practices e.g. MECC and Mental Health 1st Aid	By 2028 we will have created a learning culture that challenges, examine and reflect on our community development practice, providing accountability, reassurance and protection (Community Learning and Development Standards Council, 2023)
By 2028 One Devon will fully embrace its role in working alongside the communities of Devon as an equal partner both at system and local level	By 2024: The anchor institutions across Devon will have a collective understanding of their opportunities to support communities By 2024: One Devon will work with communities and anchor institutions to map infrastructure and identify gaps, opportunities and issues	By 2025: the ICS Estates Strategy will include a strategic intent to work with local communities to support infrastructure By 2025: a joint commissioning strategy across NHS and Local Authorities will provide Health & Wellbeing Hubs led by the VCSE and community	By 2028: Community Hubs will be embedded in communities that have identified for themselves a need for them and will support the VCSE and community groups to maximise the health and wellbeing of their local citizens

Year 1 (operational plan detail) (1/2)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 Local communities will be empowered by placing them at the heart of decision making through inclusive and participatory processes and have an active role in decision-making and governance – 'no decision about me without me'	By 2024: One Devon will have create a strategic framework as an ICS approach to building health capacity in communities with communities This will include a 'toolkit' to support each community in a way that meets their needs. This will also include a commitment and strategic intent to enable LCPs to work with communities with funding at place. By 2024: we'll have a mapped out existing networks, forums and community activities so that we can build on these assets and support where gaps are evident (NHS Statutory Guidance)	• Devon system task and finish group formed to agree role description and network for the leads to work with one another on shared resources • One Devon provides steer and support to enable Anchor Institutions to support local communities with skills and assets • LCPs identify role within their LCP who will be the lead for community development • LCP leads tasked with engagement in their LCP area to establish working principles and benefits • Agree survey, structured interviews, focus group. Community Learning & Development Network Group compiles locality findings into single document highlighting variation	Empowered communities working in partnership with each other and LCPs to support their own health, wellbeing and resilience and reduce health inequalities. Clear understanding across the system of the principles of community development and the benefits. Devon ICS to be asked to support evaluation of whether those benefits are being realised Clear understanding of gaps and focus of support and funding

One Devon

Year 1 (operational plan detail) (2/2)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 Local communities will be able to work collectively to bring about positive social change by identifying their collective goals, engaging in learning and taking action to bring about change for their communities.	By 2024: Health creation practices will be supported across all communities By 2024: the vital role of communities in tackling the wider determinants of health will be recognised and their contribution supported. (King's Fund) By 2024: One Devon will seek opportunities to ensure community learning and development is at the core of certain posts such as strategic system leadership, social prescribers and community connectors	• System working group leads on stocktake led by each locality that identifies where community development infrastructure exists • questionnaire sent out through locality networks and through local knowledge of LCP lead. • building on what is already there but primarily working through existing voluntary sector and community groups to fill gaps Communities will be supported to (Community Development standards): • Identify their own needs and actions • Take collective action using their strengths and resources • Develop their confidence, skills and knowledge • Challenge unequal power relationships • Promote social justice, equality and inclusion	Increased citizen/community agency - to facilitate and create the conditions for community led-action. Community development infrastructure in place
By 2028 One Devon will fully embrace its role in working alongside the communities of Devon as an equal partner both at system and local level	By 2024: The anchor institutions across Devon will have a collective understanding of their opportunities to support communities By 2024: One Devon will work with communities and anchor institutions to map infrastructure and identify gaps, opportunities and issues	• ICB Estates decisions include community opportunities when reviewing use of estates • Devon system task and finish group formed with estates lead across the ICS to work with LCP leads and community developers to map existing assets and gaps	Community groups benefit from use of skills and resources of anchor institutions Infrastructure as a key enabler to community success is considered strategically

Year 1 (operational plan detail) (2/2)

Community Learning & Development

SMART objective Year 1 & 2	Milestones (Year 1 and 2)	How are you going to achieve – actions you are going to take	Impact
By 2028 a Community Development workforce will be supported, empowered and skilled to deliver fully inclusive services for everyone equipped, trained to agreed standards and following a Code of ethics and values-based practice	• Support workforce to develop the skills, values and processes required for effective and appropriate community development so they may best harness 'the family of community-centred approaches' to empower communities to work collectively (PHE)	• Include in same survey and through existing knowledge of community development roles • LCP lead will compile list of LCP CD resources / CPD opportunities and discuss how resources could be pooled to achieve shared organisational aims • Set up CPD training calendar with partners that deliver community development National occupational standards (NOS) training • Identified wider CPD opportunities with local/regional providers	Best use of limited resource, shared engagement and development opportunities

APPENDIX D
Enabling programme Milestones

Year 1- 5 Objectives & Milestones

System Development

Smart Objectives	Milestones - Year 1 Achieving 'Developing' ICS Maturity Assessment standards	Milestones - Year 2-3 Achieving 'Maturing' ICS Maturity Assessment standards	Milestones - Year 4-5 Achieving 'Thriving' ICS Maturity Assessment standards
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards	• Common purpose starting to be built with collective ownership across all parts of the system emerging	• Clear shared vision and objectives across all parts of the system including VCSE, primary care, local authorities and NHS partners, with consistent progress seen	• A strong public narrative how integrated working is benefiting them and demonstrable impact on outcomes
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards	• All system leaders signed up to working together with ability to carry out decisions that are made	• Collaborative and inclusive system leadership and governance developing, with effective ongoing involvement of voluntary and community partners, service users etc.	• Strong collaborative and inclusive system leadership established, with a focus on building relationships
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards	• A developing culture of learning and sharing with system leaders solving problems together and drawing on experience of others	• Dedicated capacity and supporting infrastructure being developed to enable change at system, place and neighbourhood levels	• Leaders across the system skilled at identifying and scaling innovation, with a strong focus on outcomes and population health
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards delivering national priorities and operational plan improvement plans (including exiting SOF4) • Plans to increase involvement of all system partners in system-wide change	• Evidence of strong delivery towards national priorities and delivery of national guidance (including exiting SOF4) • Effective involvement of all system partners in decision making at system, place and neighbourhood levels	• Track record of delivery of priorities with resources focused on priorities and system control total being achieved
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards understanding of organisational and system issues, and alignment across the system	• Robust approach in place to support challenged organisations and address systemic issues	▪ System partners and leaders join forces to tackle challenges together as they emerge, including when under pressure

Year 1 and 2 (operational plan detail)

System Development

SMART objective Year 1 & 2	Milestones – by end of Year 2, Devon will fully achieve 'developing' and moving towards 'maturing' ICS Maturity Assessment standards	How are you going to achieve – actions you are going to take	Impact
By 2024/5 a strong **shared purpose** across system partners, Local Care Partnerships and Provider Collaboratives will support delivery of our Devon Plan achieving thriving ICS Maturity Assessment standards	• Common purpose starting to be built with collective ownership across all parts of the system emerging • Clear shared vision and objectives across all parts of the system including VCSE, primary care, local authorities and NHS partners, with consistent progress seen	• 5-Year Integrated Care Strategy and Joint Forward Plan co-produced • Adoption of Devon Operating Model commenced • VBA 'tests of change' completed • Adoption of Devon Operating Model completed • Spread of VBA adoption continued (pending Year 1 evaluation) • Implementation of a System Development Communication & Engagement Plan	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment
By 2026/7 levels of **trust and collaboration** between system partners, Local Care Partnerships and Provider Collaboratives will have increased achieving thriving ICS Maturity Assessment standards	• All system leaders signed up to working together with ability to carry out decisions that are made • Collaborative and inclusive system leadership and governance developing, with effective ongoing involvement of voluntary and community partners, service users etc. • One Devon's Clinical and Professional Leadership Framework fully implemented	• Phase I of senior system leadership development completed • Phase II cascade of system leadership development commenced • Change Leader Event series commenced (continues annually) • Devon approach to leadership development confirmed • Common leadership standards consistently applied across Devon from appointment to exit employee lifecycle • Implementation of a system partner involvement plan – increased involvement of service users, carers and the public	• Year 1 – move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Year 2 - Achievement of Leadership SOF4 exit criteria
By 2026/7 a **'learn by doing'** approach will be embedded within our culture of improvement achieving thriving ICS Maturity Assessment standards	• A developing culture of learning and sharing with system leaders solving problems together and drawing on experience of others • Dedicated capacity and supporting infrastructure being developed to enable change at system, place and neighbourhood levels	• UEC Navigation improvement test of change completed • Improvement approach documented and replication plan approved • Devon capability in outward mindsets training established • System diagnostic/ ICS Maturity evaluation completed (Repeat Years 3 & 5) • Spread of Improvement approach to other Devon priorities commenced • Capability within system partners to adopt Improvement approach established	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Contributing to achievement of UEC SOF4 exit criteria

Year 1 and 2 (operational plan detail)

System Development

SMART objective Year 1 & 2	Milestones – by end of Year 2, Devon will fully achieve 'developing' and moving towards 'maturing' ICS Maturity Assessment standards	How are you going to achieve – actions you are going to take	Impact
By 2024/5 system partners, Local Care Partnerships and Provider Collaboratives will be consistently **implementing priorities** achieving thriving ICS Maturity Assessment standards	• Evidence of strong progress towards delivering national priorities and operational plan improvement plans (including exiting SOF4) • Plans to increase involvement of all system partners in system-wide change • Effective involvement of all system partners in decision making at system, place and neighbourhood levels	• Targeted interventions to drive focus on priorities completed • Strategic change approach designed and established • Evaluation of delivery of priorities to inform continuous improvement • Learning from others and rapid adoption of best practice underway	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment • Contributing to achievement of SOF4 exit criteria
By 2025/6 a unified **system focus** will be demonstrated by all system partners, Local Care Partnerships and Provider Collaboratives achieving thriving ICS Maturity Assessment standards	• Evidence of progress towards understanding of organisational and system issues, and alignment across the system • Robust approach in place to support challenged organisations and address systemic issues	• Assessment of adoption of a value-based approach completed • Local Care Partnership and Provider Collaborative development commenced • Devon Discovery series commenced • Spread of adoption of a value-based approach commenced • Maturity of Local Care Partnerships and Provider Collaboratives improved	• Year 1 - move from **'emerging'** to delivering the **'developing'** measures of the ICS Maturity Assessment • Year 2 - partial achievement of the **'maturing'** measures of the ICS Maturity Assessment

One Devon

Year 1- 5 Objectives and Milestones

Research and Innovation

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Build and strengthen networks at local, system, region and national level	Map of stakeholders, strengths, assets and barriers	Networks in place across system and Peninsula	
Promote research and increase patient sign-up	Agreements in place with providers to promote Research and Innovation	Commissioners recognise importance of research and incorporate into all contracts	
Ensure all system workplans are underpinned by robust evidence of research and innovation	All sections of Joint Forward Plan include Research and Innovation	All sections of Joint Forward Plan include Research and Innovation	All sections of Joint Forward Plan include Research and Innovation
Develop capacity and capability.	Recruit to Joint Appointment with the AHSN	Fully established Research and Innovation Support Team with Medical Directorate Training and Development Programme	
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles.	Implementation of Regional Innovation Strategy	Implementation of Regional Innovation Strategy	Implementation of Regional Innovation Strategy Devon recognised as a system with strengths in this area

One Devon

Year 1 and 2 (operational plan detail)

Research and Innovation

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Joint Appointment with SWAHSN	Agree Job description. Undertake recruitment. Induction and integration with posts in CIOS and Somerset. Ensure support available within the ICB for this role	Increased capacity to support RII
Implementation of Regional Innovation Strategy	Complete Peninsula-wide prioritisation process. Work with system partners to map capacity within agreed missions and facilitate additional work in these areas	Promotion of RII in targeted areas focused on system priorities.
Develop system and wider networks	Establish RII network with COIS and provide ongoing support. Strengthen system networks and provide a point of co-ordination	Evaluation, shared learning and roll-out of good practice
Increased support for organisations which undertake research include NHS providers	Work with research organisations to understand what support is required and how to build this into commissioning arrangements	Organisations undertaking research are supported in their work and frameworks are in place to share learning.
Ensure all system workplans are underpinned by robust evidence of research and innovation	Work with all sections leads to ensure that delivery of the Integrated Care Strategy is underpinned by research and innovation	Research and Innovation is a key consideration in the development and delivery of plans and not seen as a separate activity.

Year 1- 5 Objectives and Milestones

Population Health

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations	By April 24 each LCP and Collaboratives will have a plan which clearly sets out how it will improve population health and reduce inequalities Rollout PHM supported by One Devon dataset	By April 24 there will be a resource and information package available to support local work	LCPs and Provider collaboratives able to demonstrate reductions in outcomes
Ensure delivery of Core20+5 deliverables (including adult and CYP)	Delivery of targets in line with national reporting requirements	Demonstrable reduction in inequalities in access and experience	
Implement co-ordinated prevention plans in priority areas	Co-ordinated programmes of work delivering on national targets with a particular focus on CVD and Diabetes	High Impact Interventions in place in line with national major conditions strategy	
Develop the ICB and NHS partners as Anchor Organisations	By April 24 all NHS organisations in Devon are able to demonstrate how they are supporting social and economic development	Demonstrable changes in social and economic development resulting from work of Anchor Organisations	
Support the implementation of new ways of working focused on population health	By April 25 People led change will be demonstrable throughout the ICS	Trauma-informed approach across all ICS services	

Year 1 and 2 (operational plan detail)

Population Health

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Our LCPs and provider collaboratives will have the support and evidence base they need to deliver change at local level and will be empowered to make decisions with their populations	By April 24 each LCP and Collaboratives will have a plan which clearly sets out how it will improve population health and reduce inequalities Rollout PHM supported by One Devon dataset	Provide advice, guidance and information to LCPs Work with Locality PHM co-ordinators to implement PHM Work with VCSE to ensure contribution to plans	Local delivery of change resulting in improved outcomes
Ensure delivery of Core20+5 deliverables (including CYP)	Delivery of targets in line with national reporting requirements	Provide support to 5 priority areas Establish monitoring of progress	Achievement of national targets
Implement co-ordinated prevention plans in priority areas	Co-ordinated programmes of work delivering on national targets	Map priority prevention workstreams Agree resources/budget in line with requirements (including support for clinical leads) Develop mechanisms for co-ordination and networking Ensure links to other workstreams	Improved outcomes and achievement of national targets
Develop the ICB and NHS partners as Anchor Organisations	By April 24 all NHS organisations in Devon are able to demonstrate how they are supporting social and economic development	Implementation of programme of work lead by Steering Group	All NHS organisations contributing to social and economic development
Support the implementation of new ways of working focused on population health	By April 25 People led change will be demonstrable throughout the ICS	Continue to support existing programmes of work and facilitate shared learning	New approaches will be embedded to support sustainable approach

Year 1 - 5 objectives

Communications and Involvement

The communications and involvement mechanisms that will support delivery of the JFP include:
The new ICS involvement platform ‘Let’s Talk’ the and citizens’ panel that programmes can utilise to support online involvement activities across the system
Partnerships with involvement professionals from all system partners that can support collaboration, sharing of best practice, and co-production of involvement
Partnerships with Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector that will can offer insights and connection to local populations
Learning from the vaccination outreach programme will support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
We will provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Develop an involvement identity that can be can be used across the One Devon Partnership to help raise the profile and awareness of involvement activity across Devon.

Year 1 - 5 objectives

Communications and Involvement

There are five key enablers to the delivery of our objectives:
Partnership working with provider involvement colleagues Working together with provider organisations and local authorities will ensure we are more than the sum of our parts. Working together we will be more resilient, share expertise, resources and insights and can influence real service improvements for people and communities in Devon.
Devon's Citizen's Panel Is fully representative of the Devon population is a powerful channel for One Devon. It enables us to test ideas, approaches and themes on priorities and programmes with a group of 1,700 Devon residents.
Devon's online Involvement platform Based on the success of the citizen's panel, NHS Devon is investing in a new online community and stakeholder involvement platform that will allow us to increase our community participation further and better understand the feedback we receive. The platform will mean we can build an online involvement community, enhancing our ability to have two-way conversations with people and communities even more than we already do.
Devon, Plymouth and Torbay Overview and Scrutiny Committees Involving our elected members in Devon is fundamental to our approach to involvement and inclusion. Not only does it address our statutory requirements under the Health and Social Care Act 2012, but also ensures we continue to build pro-active and meaningful relationships with all three Overview and Scrutiny Committees (OSC) in Devon, Plymouth and Torbay.
Partnership working with Healthwatch and the VCSE

Year 1 - 5 objectives

Equality and Diversity

Equality and diversity ensures that services meet people's needs, give value for money and are fair and accessible to everyone. It means people are treated as equals, get the dignity and respect they deserve, and differences are celebrated.

Improving innovation and value for money

- New perspectives and different ideas that come from a diverse workforce support innovation (The Kings Fund)
- Diversity results in better decision making and therefore improves financial performance (McKinsey)
- Efficient services that better meet peoples' needs and keep people in good health can reduce the need for costly and prolonged care further down the line.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance

Improving workforce recruitment and retention

An inclusive working environment, that encourages everyone to bring their own ideas forward helps employees feel valued, appreciated and encouraged

- Recruit a more diverse workforce that is reflective of Devon's local population with an initial focus on race and ethnicity (8%) LGBTQ+ (3%) and people with a disability (20%)
- Develop and retain a diverse workforce, building a culture where our people feel valued, heard and able to be their best selves at work.
- Ensure staff recruited via the International Recruitment Hub, are well supported in their roles and deliver a campaign that celebrates our diverse workforce, tackles racism and builds cohesion in the community.
- Continue to build and support the Devon-wide ethnic equality staff network, ensuring it has meaningful input into system priorities, including develop a Devon-wide anti-racism charter that the One Devon Partnership sign up to.

Delivering better care

When staff feel valued with a sense of belonging, they are likely to provide better care to patients

- Through a rolling EDI calendar, celebrate diversity and raise awareness of discrimination, empowering our workforce to be more inclusive, and demonstrating our commitment to EDI to our local populations.

Improving health outcomes and reducing health inequalities

Equality and diversity help us overcome barriers to care so we can design services that meet the needs of everyone. Inclusive services provide better outcomes and experience and therefore help to tackle health inequalities

- Take learning from the Covid-19 outreach vaccination programme and work with partner organisations to support people from diverse and vulnerable populations have better access to health and care service, focusing particularly for those with visual and hearing impairments, people with learning disabilities and those for whom English is a second language.

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Strategic workforce planning embedded at System level	5 year workforce plan in place for NHS providers and informative detail from Primary & Social Care	5 year workforce plan further developed with detailed primary and social care data included.	5 year workforce plan further developed with detailed data from VCSE sector included
System level attraction solutions that source new talent and position Devon System as an employer of choice.	System-wide approach to job and career fairs in place and securing new recruits. Devon 'employer brand' fully developed and used in all recruitment activity.	Development of a Devon talent pool to have a readily available pool of resources to fulfil requirements.	
Development of new roles and new ways of working embedded across Devon ICS	New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	Further development of new roles and ways of working, informing service redesign across H&C pathways. L&D and career pathway plans for new roles fully developed and in delivery	

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
System working - we work collaboratively to enable our workforce to move flexibly across sectors and create new roles to meet the needs of the population and services			
Stability - we stabilise the workforce by supporting new and diverse career pathways for our current and future workforce			
Learning & Education - we commit to investing in the workforce through enrichment of development opportunities ensuring that quality and safety is at the forefront			

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Digital - we utilise digital technology to support innovation and transformation to our workforce and across all services we deliver			
Sustainable - we commit to achieving a skilled workforce built on a system that is financially sustainable			

Year 1 and 2 (operational plan detail)

Workforce

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Strategic workforce planning embedded at System level	5 year workforce plan in place for NHS providers and informative detail from Primary & Social Care	• Roll-out of strategic workforce planning self-assessment tool across to inform workforce plan numbers. • Development of Devon strategic workforce planning tool and methodology to standardise process and embed best practise across Devon partners	Strategic workforce plan informing supply and demand and skill mix.
System level attraction solutions that source new talent and position Devon System as an employer of choice.	System-wide approach to job and career fairs in place and securing new recruits. Devon 'employer brand' fully developed and used in all recruitment activity.	Multiple workstreams in place under Workforce Capacity Pillar focusing on; • Development of Devon employer brand and roll out of collaborative working across attraction and recruitment activity. • Enabling mobility of workforce across System providers. • Improving retention of staff across Devon • Reducing reliance on agency staff and embedding collaborative Bank models.	Reduced turnover – target <5% (tba) Reduced vacancy levels - target tba. Reduced agency spend – target <2.9% of paybill
Development of new roles and new ways of working embedded across Devon ICS	New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	Multiple workstreams in place under Workforce Strategy and Learning & Education Pillars focusing on System level working to create new roles, increase the skill-diversity of our workforce (ie making greater use of our unregistered workforce).	Unregistered workforce delivering more H&C services. New supply pipelines identified through creation of new roles.

Year 1 and 2 (operational plan detail)

Workforce

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
System working - we work collaboratively to enable our workforce to move flexibly across sectors and create new roles to meet the needs of the population and services			
Stability - we stabilise the workforce by supporting new and diverse career pathways for our current and future workforce			
Learning & Education - we commit to investing in the workforce through enrichment of development opportunities ensuring that quality and safety is at the forefront			

Year 1 and 2 (operational plan detail)

Workforce

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Digital - we utilise digital technology to support innovation and transformation to our workforce and across all services we deliver			
Sustainable - we commit to achieving a skilled workforce built on a system that is financially sustainable			

Year 1- 5 Objectives

Digital

Smart Objectives
Number of eligible citizens connected to the NHS App increased to support national target of 75% of people registered by 2024
Future use of ORCHA (App assurance product to support citizen self-care and social prescribing) determined by the end of the current funding in March 2024.
Standardisation of GP practice websites achieved within 2025.
Achieve planned Virtual Ward bed targets by April 2024 across the TSDFT, UHP and RDUH
EPRs implemented in TSDFT and UHP by 2025
Peninsula PACS solution for the clinical network procured and implemented by 2025
Peninsula LIMS solution for the clinical network procured and implemented by 2025
Re-procurement of GP EPR clinical system by March 2024
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028
Develop PHM architecture and reporting
Develop an ICS data platform and associated reporting, linked to EPR implementation and national developments including the Federated Data Platform
Work collaboratively with regional ICS teams to develop the regional secure data environment to support future research
Unified and Standardised Infrastructure provided by 2028

Year 1- 5 Objectives and Milestones

Digital – Digital Citizen

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Number of eligible citizens connected to the NHS App increased to support national target of 75% of people registered by 2024.		National target of 75% of people registered for the NHS App by 2024	
Future use of ORCHA (App assurance product to support citizen self-care and social prescribing) determined by the end of the current funding in March 2024.	Business case developed to determine re-procurement		
Standardisation of GP practice websites achieved within 2025.	Develop and implement prototype website template for pilot practices	Standardisation of GP practice websites implemented upon successful prototyping and piloting.	
Achieve planned Virtual Ward bed targets by April 2024 across the TSDFT, UHP and RDUH		Virtual Ward beds planned by April 2024 South - Torbay and South Devon – 57 VW beds West - University Hospital Plymouth – 100 VW beds North and East - Royal Devon University Hospital – 100 VW beds	

Year 1- 5 Objectives and Milestones

Digital – Shared EPR and Operational Systems

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
EPRs implemented in TSDFT and UHP and DPT by 2025	OBC and FBC completed TSDFT, UHP and DPT	EPR implemented in TSDFT, UHP and DPT	
80% of care homes to have a Digital Social Care Record by March 2024	Digital social care records procured and implemented		
Peninsula Picture Archiving and Communication System (PACS) solution for the clinical network procured and implemented by 2025	PACS solution procured	PACS implementation complete	
Peninsula Laboratory Information Management System (LIMS) solution for the clinical network procured and implemented by 2025	LIMS solution procured	LIMS implementation complete	
Re-procurement of GP Electronic Patient Record (EPR) clinical system by March 2024	Re-procurement of GP EPR system completed		

Year 1- 5 Objectives and Milestones

Digital – Devon and Cornwall Care Record

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028	▪ RDUH connected ▪ TSDFT connected ▪ Hospices sharing/providing information ▪ 95% of Devon GP practices connected ▪ Commence connection of Care Homes ▪ DCC connected ▪ Plymouth City Council Connected ▪ Torbay Council Connected	▪ Care Home connections continued	▪ Care Homes connected
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028	▪ Treatment Escalation Plan developed within DCCR and ready for implementation ▪ Commence expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Business Case completed for future investment and continuing development of additional functionality (e.g. care plans) of the Devon and Cornwall Care Record including citizen access	▪ Continued expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Continued development of additional functionality	▪ Citizen access provided to the Devon and Cornwall Care Record

Year 1- 5 Objectives and Milestones

Digital: Population Health Management

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Develop PHM architecture and reporting	Support the resumption of the PHM programme with PCN-level data packs. Fully embed the One Devon Dataset use request process.	Add additional data flows into the One Devon Dataset (SWAST, 111, housing) and develop further population segmentation approaches	
Develop an ICS data platform and associated reporting, linked to EPR implementation and national developments including the Federated Data Platform	Develop the infrastructure to support a consistent platform for collating and sharing key data within the ICS	Onboard organisations in-line with EPR implementation timelines	
Work collaboratively with regional ICS teams to develop the regional secure data environment to support future research	Support the development of regional SDE plans	Implement the initial regional SDE	

Year 1- 5 Objectives and Milestones

Digital – Standardised and Unified Infrastructure

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Unified and Standardised Infrastructure provided by 2028	▪ Common end user device specification agreed ▪ Mobile telephony savings delivered through each organisation ▪ Business case completed for Data centre and cloud	▪ Data centre rationalisation subjected to business case approval ▪ Mobile telephony savings delivered through each organisation	▪ Data centre rationalisation subjected to business case approval ▪ Mobile telephony savings delivered through each organisation

Year 1 and 2 (operational plan detail)

Digital

SMART objective Year 1 & 2	How are you going to achieve – actions you are going to take	Impact
Remaining core health and care organisations connected to the Devon and Cornwall Care Record by 2028	▪ RDUH connected ▪ TSDFT connected ▪ Hospices providing information ▪ 95% of Devon GP practices connected ▪ Commence and continue connection of Care Homes ▪ DCC connected ▪ Plymouth City Council Connected ▪ Torbay Council Connected	▪ All core organisations connected as provider and consumers of information in the Devon and Cornwall Care Record. People in Devon will only have to tell their story once, with all clinical and care staff having access to the information they need when they need it, through a shared digital system across health and care.
Additional functionality of the Devon and Cornwall Care Record scoped and implemented by 2028	▪ Treatment Escalation Plan developed within DCCR and ready for implementation ▪ Commence expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Business Case completed for future investment and continuing development of additional functionality (e.g. care plans) of the Devon and Cornwall Care Record including citizen access ▪ Continued expansion of connection to the Devon and Cornwall Care Record across different care settings ▪ Continued development of additional functionality	▪ Additional functionality of the Devon and Cornwall Care Record demonstrated through the development of the electronic Treatment Escalation Plan. ▪ People in Devon will only have to tell their story once and clinicians will have access to the information they need when they need it, through a shared digital system across health and care. ▪ The commitment to further developing and investing in the Devon and Cornwall Care Record is determined.

One Devon

Year 1- 5 Objectives and Milestones* see note

Procurement

Smart Objectives (from previous slide)	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Improved Resilience			
Reduced total Cost			
Greater Value			
Better Supplier Management			
Optimised Workforce			
Optimised Workforce			

*** Please note that the milestones will be determined through the development and approval of a Business Case, which will be submitted to NHS Devon CFO and the Trust CFOs by the end of June.**

Year 1

Procurement

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Improved Resilience	Please note that the milestones will be determined through the development and approval of a Business Case, which will be submitted to NHS Devon CFO and the Trust CFOs by the end of June. *How* we will achieve the objectives is outlined to the right, and will inform a 1-3 year programme	*We will do this through working across the ICS and with NHS Supply Chain and strategic partners to provide greater protection from supply failures, price increases and quality defects*	
Reduced total Cost		*We will do this through expanding the category-led approach, by analysing our PO and AP expenditure, seeking new areas of influence, tactical benchmarking, and re-assessing opportunities to standardise products and services and enhance clinical outcomes*	
Greater Value		*We will do this by developing and promoting value-based procurement methodologies, re-assessing our stakeholder needs, and through evidence-based outcomes, such as those identified through the GIRFT programme*	
Better Supplier Management		*We will do this by adopting a consolidated, once-only approach towards Supplier Relationship Management (SRM), acting a single ICS commercial voice*	
Optimised Workforce		*We will do this by developing an Organisational Model which drives efficiency, harmonises our skills and experience, and eliminates duplication*	
Optimised Workforce		*We will do this by ensuring that enhanced efficiency provides the capacity and the means to support all staff in achieving their aspirations, and to inspire excellence. We will celebrate success, and design an organisation model which enables clear career pathways at local, regional and national level*	

Year 1- 5 Smart Objectives and milestones

Strategic Estates and Facilities

Year 1	Year 2	Year 3	Year 4	Year 5
Undertake strategic review of the ICS-wide health estate	Categorise all of the estate into ‘core, flex and tail’ and agree strategies for each site or development opportunity			
Develop an investment plan and a 5 year capital prioritisation pipeline	Prioritise funding allocations whilst taking advantage of national funding review outcomes and TIF funding			
Develop a cross-matrix team that can support the delivery of estates and facilities at an ICS-wide level	Integrate provider service departments where possible to create resilience, efficiencies and succession planning			
Deliver a public facing ICS Estates Strategy	Commence delivery of the implementation plans that shall support each area of the Estates Strategy			

Year 1 (operational plan detail)

Strategic Estates and Facilities

Year 1 objective	How are you going to achieve?
Deliver a public facing ICS estates strategy by December 2023	Consultants have been commissioned to support this NHSE mandated requirement and joint provider workshops are being facilitated to agree process and approach
Complete an investment and capital prioritisation plan for the next 5 years	Consultants have been commissioned to support this NHSE mandated requirement and joint provider workshops are being facilitated to agree process and approach
Eradicate empty accommodation across the NHS Property Services estate	Undertake sufficient engagement with key stakeholders to agree exit plans and obtain Executive Board agreement to hand back the properties to NHS PS for a disposal
Facilitate the development of the Devon NHP Programme	Establish and create ICB governance surrounding NHP sign offs and delivery to ensure relevant workstreams are in agreement with provider plans
Facilitate the development of the PCN estates strategies	Establish protocols surrounding phase three of the PCN toolkit work to ensure each PCN plan is being developed within the patients best interests and within the ICB's affordability envelope

Year 1- 5 Objectives and Milestones (1)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Develop a sustainability training programme for all ICS staff.	All staff to be offered training by March 2024	All staff received annual training	All staff received annual training
Review induction training for new starters to include how we are meeting the green agenda and overview of the ICS Green Plan.	All new staff to be informed of the Green Plan on induction by March 2024.	All new staff to be informed of the Green Plan on induction.	All new staff to be informed of the Green Plan on induction.
Encourage staff to provide suggestions and ideas on how sustainability can be improved in all areas across the organisations .	Staff suggestion scheme in place by March 2024	Staff suggestion scheme in place by March 2024	Staff suggestion scheme in place by March 2024

Year 1- 5 Objectives and Milestones (2)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Work across the system to ensure all care is delivered with carbon reduction principles as a key consideration e.g., reducing the amount of unnecessary visits to hospital as part of a package of care.	All staff to be offered training by March 2024	All staff received annual training	All staff received annual training
Promote and encourage the use of Ecosia as the search engine used by ICS staff.	Promote alternative option to all staff by April 23	All staff are aware of the option	All staff are aware of the option

Year 1- 5 Objectives and Milestones (3)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Explore the provision of electric car charging points at all venues that host ICS staff.	Complete review of electric car charging points at all venues by March 24	Act on the findings of the review	Act on the findings of the review
Explore the potential for subsidised public transport usage for staff	Work with HR teams across the ICS to establish current offer to staff and develop a ICS wide coordinated plan by March 24	TBC	TBC
Review recycling facilities across estates and work with clients to increase options to recycle.	Complete review by March 24	Act on the recommendations of the review	Act on the recommendations of the review
Purchase or generate 100% electricity from renewable energy sources.	Explore the possibility and financial feasibility of this approach by March 24	TBC	TBC

One Devon

Year 1- 5 Objectives and Milestones (4)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Ensure the system plan is aligned with deliverables in the Estates Delivery Plan. Including replacing lights with LED, removal of coal and oil boilers, renewable energy generation.	Link the Green Plan to the Estates Delivery Plan by April 23	Plans are linked	Plans are linked
Explore alternative greener energy suppliers for our sites.	Explore the possibility and financial feasibility of this approach by March 24	TBC	TBC
Consider the use of solar energy on all existing and new sites.	Explore the possibility and financial feasibility of this approach by March 24		
Create an internal campaign to increase awareness amongst primary care clinicians about prescribing ‘greener medication’.	Work with the Green Primary Care Clinical Lead to create the campaign by June 23	Maintain the campaign	Maintain the campaign

Year 1- 5 Objectives and Milestones (5)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Develop systemwide plans for clinically appropriate prescribing of lower carbon inhalers, in line with the commitment of a 50% reduction by 2028 based on a 2019/20 baseline. (IIF)	Work with Primary Care to develop a Plan by March 24	Plan fully embedded	Plan fully embedded
Develop systemwide approaches to optimise use of medical gases, including reducing nitrous oxide waste.	Work with acute trust Green leads to develop plan by March 24	Plan fully embedded	Plan fully embedded
Create a campaign to inform patients on how the correct use of medicines can contribute to carbon reduction.	Campaign produced by March 24	Revisit and repeat campaign	Revisit and repeat campaign
Identify and report all single use plastics across ICS sites and replace with recyclable, low carbon alternatives where possible.	Complete audit of single use plastics by March 24	Review single use plastic audit and report on progress	Review single use plastic audit and report on progress

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Year 1- 5 Objectives and Milestones (6)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
All providers within the ICS will only be purchasing 100% recycled paper and be reducing paper usage.	Provide guidance to providers by March 24	Review and distribute the amended guidance	Review and distribute the amended guidance
Take action to address single use plastics, and specifically eliminate unnecessary catering plastics.	Provide guidance to providers by March 24	Review and distribute the amended guidance	Review and distribute the amended guidance
Develop a Green Impact Assessment Checklist for all new policies and procurement.	Checklist produced by June 23	Review use of the checklist	Review use of the checklist
Review and adapt menus to offer healthier lower carbon options for patients, staff and visitors.	Work with partners/providers to assess the financial feasibility of this approach by March 24	TBC	TBC
Where possible, buy locally sourced products promoting the concept of the Devon Pound.	Work with procurement colleagues to further develop the Social Value weightings on contract awards to include “buy local”	More contracts are awarded to local organisations where possible	More contracts are awarded to local organisations where possible

Year 1- 5 Objectives and Milestones (7)

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Update risk registers across partners to include climate related risks including floods and heatwaves and identify key adaptation actions to mitigate the predicted impacts on the ICS of climate change. Ensure the delivery of these adaptation actions are undertaken.	Update risk registers by March 24	Maintain risk registers to include climate change considerations	Maintain risk registers to include climate change considerations

Year 1 and 2 (operational plan detail) (1)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Develop a sustainability training programme for all ICS staff.	All staff to be offered training by March 2024	Work with Devon Training Hub and NHSE Greener Team to develop an on-line training offer	All staff are aware of the ICS Green Plan and their contribution to it
Review induction training for new starters to include how we are meeting the green agenda and overview of the ICS green plan.	All new staff to be informed of the Green Plan on induction by March 2024.	Work with HR/OD colleagues to include Green awareness in our new staff Induction Packs	
Encourage staff to provide suggestions and ideas on how sustainability can be improved in all areas across the organisations.	Staff Suggestion Scheme in place by March 2024	Work with HR/OD to develop a Green Champion Group to support the Staff Suggestion Scheme	
Work across the system to ensure all care is delivered with carbon reduction principles as a key consideration e.g., reducing the amount of unnecessary visits to hospital as part of a package of care.	All staff to be offered training by March 2024	Work with Devon Training Hub and NHSE Greener Team to develop an on-line training offer	

Year 1 and 2 (operational plan detail) (2)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Promote and encourage the use of Ecosia as the search engine used by ICS staff.	Promote alternative option to all staff by April 23	Promote the opportunity on Staff Webinar and in the Staff Bulletin	More staff will use Ecosia as their search engine
Explore the provision of electric car charging points at all venues that host ICS staff.	Complete review of electric car charging points at all venues by March 24	Work with Estates and Sustainability Leads to complete the review with a view to increasing the provision of electric car charging points	More staff are encouraged to reduce their reliance on petrol and diesel cars
Explore the potential for subsidised public transport usage for staff	Work with HR teams across the ICS to establish current offer to staff and develop a ICS wide coordinated plan by March 24	Work with HR teams across the ICS to develop a ICS wide coordinated approach	
Review recycling facilities across estates and work with clients to increase options to recycle.	Complete review by March 24	Work with Green Champions to review the recycling facilities on their sites and use this information to complete a review with recommendations on how to increase recycling	Recycling is increased across the ICS

Year 1 and 2 (operational plan detail) (3)

Green Plan

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Purchase or generate 100% electricity from renewable energy sources.	Explore the possibility and financial feasibility of this approach by March 24	Work with Estates and Sustainability Leads to review our current position and establish whether there is potential to change providers or explore renewable options	The ICS uses electricity from renewable sources where possible
Ensure the system plan is aligned with deliverables in the Estates Delivery Plan. Including replacing lights with LED, removal of coal and oil boilers, renewable energy generation.	Link the Green Plan to the Estates Delivery Plan by April 23	Work with the Strategic Estates Lead to link the strategic plans.	There is a consistent and coordinated approach to the Green Agenda.
Explore alternative greener energy suppliers for our sites.	Explore the possibility and financial feasibility of this approach by March 24	Work with Estates and Sustainability Leads to review our current position and establish whether there is potential to change providers or explore renewable options	The ICS uses electricity from renewable sources where possible

Year 1 and 2 (operational plan detail) (4)

Green Plan

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Consider the use of solar energy on all existing and new sites.	Explore the possibility and financial feasibility of this approach by March 24	Work with Estates and Sustainability Leads to review our current position and establish whether there is potential to change providers or explore renewable options	The ICS uses electricity from renewable sources where possible
Create an internal campaign to increase awareness amongst primary care clinicians about prescribing 'greener medication'.	Work with the Green Primary Care Clinical Lead to create the campaign by June 23	Work with the Green Primary Care Clinical Lead and Comms/Engagement to create the campaign	Increase awareness of the Green Plan to Primary Care colleagues
Develop systemwide plans for clinically appropriate prescribing of lower carbon inhalers, in line with the commitment of a 50% reduction by 2028 based on the 2019/20 baseline. (IIF)	Work with Primary Care to develop a Plan by March 24	Work with the Green Primary Care Clinical Lead along with front line clinicians to develop the plan and produce guidance for colleagues	Increase the number of low carbon inhalers prescribed by Primary Care

Year 1 and 2 (operational plan detail) (5)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
Develop systemwide approaches to optimise use of medical gases, including reducing nitrous oxide waste.	Work with Acute Trust Green/Sustainability leads to develop plan by March 24	Work with Acute Trust Green/Sustainability leads along with front line clinicians to develop the plan and produce guidance for colleagues	Reduce nitrous oxide waste
Create a campaign to inform patients on how the correct use of medicines can contribute to carbon reduction.	Campaign produced by March 24	Work with HR/OD to develop a campaign to be used on Social Media	Patients contribute to NHS carbon reduction targets
Identify and report all single use plastics across ICS sites and replace with recyclable, low carbon alternatives where possible.	Complete audit of single use plastics by March 24	Work with Green Champions to report and review the use of single use plastics on their sites and use this information to complete a review with recommendations on how to reduce this where possible	Reduction of single use plastics

Year 1 and 2 (operational plan detail) (6)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
All providers within the ICS will only be purchasing 100% recycled paper and be reducing paper usage.	Provide guidance to providers by March 24	Work with Comms colleagues to develop guidance for providers.	100% recycled paper is increased and paper usage is reduced
Take action to address single use plastics, and specifically eliminate unnecessary catering plastics.	Provide guidance to providers by March 24	Work with Green Champions to report and review the use of single use plastics on their sites and use this information to complete a review with recommendations on how to reduce this where possible Work with Comms colleagues to develop guidance for providers.	Reduction of single use plastics
Develop a Green Impact Assessment Checklist for all new policies and procurement.	Checklist produced by June 23	Work with procurement colleagues to design and embed the Checklist	Green Impact is considered for new polices and procurement

Year 1 and 2 (operational plan detail) (7)

Green Plan

SMART objective	Milestone	How are you going to achieve – actions you are going to take	Impact
Review and adapt menus to offer healthier lower carbon options for patients, staff and visitors.	Work with partners/providers to assess the financial feasibility of this approach by March 24	Work with partners and providers to establish their current position and decide on a consistent approach to food provision for patients	Healthier lower carbon options available for patients across the ICS
Where possible, buy locally sourced products promoting the concept of the Devon Pound.	Work with procurement colleagues to further develop the Social Value weightings on contract awards to include “buy local”	Work with procurement colleagues to review and revise the current Social Value weightings applied to the Green Agenda	More things are bought locally to reduce our carbon footprint
Update risk registers across partners to include climate related risks including floods and heatwaves and identify key adaptation actions to mitigate the predicted impacts on the ICS of climate change. Ensure the delivery of these adaptation actions are undertaken.	Update risk registers by March 24	Work with Governance to include climate related risks in risk registers	Climate related risks are acknowledged and addressed.