One Devon

Devon 5 Year Joint Forward Plan

Final (v0.5) 24 May 2023

#OneDevon

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Signatures to be added

Foreword

We are excited to publish this, the first Devon 5 Year Joint Forward Plan (JFP), which signals a different way of working within the Devon system, for the first time bringing together plans from across different sectors within health and care in response to the One Devon Integrated Care Strategy. Local Authorities and the NHS have agreed that they will work together and be held jointly responsible for delivering the plan.

The Strategy set out the key challenges for the Devon health and care system and a set of strategic goals aimed at tackling these challenges over the next 5 years. Over recent months, system partners have been working to ensure that they take account of the Strategy in their planning, in a way that ensures alignment between health and other sectors. The Devon Joint Forward Plan brings together the strategies and plans that are in place/in development across our system, in individual organisations, in collaboratives and in system programmes, into a single over-arching Plan and has aligned these to the strategic goals set out within the Integrated Care Strategy.

In parallel, NHS partners have been developing an operational plan for 2023/24 and a recovery plan that will see both NHS Devon and partner NHS trusts move out of level 4 of the NHS System Oversight Framework (SOF4) by June 2024 and Local Authority partners have been planning to manage their own significant operational and financial pressures. Development of the JFP therefore recognises this context and the need to ensure that our system recovery is prioritised in the early years of the Plan and that we earn the autonomy we need to deliver transformational change. The detailed actions and milestones set out within the JFP have been aligned to recovery plans where relevant and deliverability continues to be tested, to ensure that our objectives, though ambitious, are ultimately realistic and achievable.

The JFP does not cover everything that we are doing across our system – it includes priorities in areas of wider social and economic importance, such as housing and employment, as we know that their impact on health and wellbeing is significant and these are areas where we need to develop our collaborative working.

SIGNATURE

Sarah Wollaston

SIGNATURE

Jane Milligan

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Health and Wellbeing Board Opinions

There has been ongoing engagement with the three Devon Health & Wellbeing Boards throughout development of the Joint Forward Plan. Each of the Boards has submitted a formal opinion on the extent to which the JFP reflects their Health & Wellbeing Strategy, which is reproduced below. Two of the three local authorities have been through a local election process in May 2023 and engagement will continue with the reformed HWBs, as part of our ongoing work to refresh the Joint Forward Plan.

Torbay Council

By consensus [Health & Wellbeing Board] Members resolved that:

1. the draft Joint Forward Plan takes proper account of the Joint Local Health and Wellbeing Strategy;
2. the minutes of the Board meeting on the 9 March 2023 will constitute the response in writing of the Health and Well Being Board and its opinion in respect of (1).

This opinion has been confirmed as unchanged in relation to the final published JFP.

Plymouth City Council

Plymouth's HWB has been engaged throughout the process of development of the JFP and has been consulted, with the opportunity to raise questions and highlight potential omissions.

The Plymouth HWB endorses the Plan and is assured that it takes account of the current health and wellbeing strategy for Plymouth. The focus on inequalities in access and in outcomes is welcomed, and we look forward to seeing the shift in resources required to deliver on this aim.

Devon County Council

The Devon Health and Wellbeing Board has been engaged throughout the process of development of the JFP and has been consulted on each formal draft, raising questions and highlighting potential omissions.

The DCC HWB is happy to endorse the Plan and is assured that it takes account of the current health and wellbeing strategy for Devon.

Executive Summary

The Devon Joint Forward Plan

In line with national requirements, the Integrated Care System (ICS) in Devon (One Devon) produced an 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 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.

Several **golden threads** run through all of the delivery and enabling programmes, including prevention (focusing on the five main causes of death and disability), population health, improved outcomes, personalisation and empowerment of individuals, inclusion, quality and safety of care and continuous learning and improvement.

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 (SOF4). 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, as well as setting 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.

The Joint Forward Plan is a system wide plan which broadly describes the services we have in place and will develop to meet the needs of our whole population as set out in the Integrated Care Strategy. It reflects an intention to work in collaboration and partnership to deliver our system ambitions, but it is important to acknowledge that statutory duties remain with individual organisations. There are some specific statutory duties that the ICB needs to deliver as part of its statutory function, that must be met through the JFP, and these duties are incorporated throughout the plan.

Development of the Integrated Care Strategy and Joint Forward Plan has involved significant engagement and involvement activities, including analysis of extensive public feedback about health and care (collected from system partners across One Devon) between 2018 to 2022 and regular engagement with Joint Overview and Scrutiny Committees, Health & Wellbeing Boards and wider system partners through working groups and facilitated feedback events.

Delivering a Sustainable System

The JFP sets out the plans in place across the local NHS and wider Devon System and the key milestones for delivery over the next five years, but, additionally, there is an immediate requirement to stabilise the financial position and recover activity, to improve operational performance, access and quality of care. In order to achieve both of these, we need to transform the way we work together across our system – creating new ways of working was identified as a key determinant of successful delivery of the Devon Plan.

We plan to deliver the significant strategic work required 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.

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'**

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. We have set ourselves an ambitious target: ***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 focused 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 £42.3m deficit**
- **24/25 c.£30m deficit through use of non-recurrent means**
- **25/26 breakeven exit run rate position**

How we will achieve this

- Used the Drivers of the Deficit analysis as the baseline for planning and CIP expectations aligned to model hospital, GIRFT and regional benchmarks
- Stretched 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%	**2** System wide schemes – targeting c.£60m reduced run rate by Q4 23/24
3 Intra-organisation working and redesign	**4** System Performance Improvement

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 (eg: a cold elective site, single PTL, sub-specialty centres, etc) as stated.

Workforce

Workforce will achieve a net -2% workforce change against the current establishment.

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.

Local Authority recovery

Our three local authorities also face significant financial and operational pressures and each has a transformation programme in place that will:

- support increased independence, choice, and control for communities;
- support timely and good quality discharge from hospital;
- support the local economy, improve job prospects and housing opportunities for local people;
- champion opportunities and improve services and outcomes for children and young people;
- support care market sustainability;
- address the impacts of the rising cost of living for those hardest hit;
- improve value for money, through cost improvement plans.

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Devon's Joint Forward Plan

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

The delivery plan summarises the ambitions and the key high level objectives for each of the 9 delivery programmes and 10 enabling programmes, with additional detailed milestones and year 1 and 2 work programmes included in Appendix C and Appendix D.

Some of the key objectives for each programme are set out in the next slides.



Primary & Community Care
- Deliver an integrated, collaborative model of care
- Develop a proactive, preventative & personalised approach, supporting people in their own homes
- Develop sustainable, high quality general practice
- Ensure a sufficient, sustainable care market

Suicide Prevention
- Build resilience & promote wellbeing at all ages
- Target prevention of mental ill-health and early intervention for people at risk of mental health problems

Health Protection
- Reduce health care associated infections
- Improve update of school-age immunisation
- Improve vaccine coverage, particularly measles, mumps and rubella (MMR) & in priority groups
- Improve uptake of cervical & breast screening

Employment
- Reduce number of 16-18 year old and care experienced NEETs
- Reduce number of individuals with disability/mental health need unemployed
- Support more people including unpaid carers into employment

Community Development & Learning
- Place local communities at the heart of decision-making
- Agree collective community goals
- Support community development workforce
- Integrate community partnerships into LCP infrastructure



Mental Health,
- Improve population mental health and wellbeing
- Improve outcomes and experiences of people with mental illness
- Develop a sustainable, support community offer

Learning Disability & Neurodiversity
- Deliver annual health checks & action plans for people on GP learning disability registers
- Improve autism diagnostic pathways
- Reduce reliance on locked & secure inpatient care

Children & Young People
- Provide services for children who need urgent treatment & hospital care as close to home as possible
- Deliver safe and personalised maternity care
- Proactively address health inequalities
- Develop family hubs & early help models
- Prioritise SEND and embed reforms.

Acute Services Sustainability
- Deliver high quality, safe, sustainable and affordable services as locally as possible.
- Stabilise care in the short term through increasing productivity and capacity
- Sustain care in the medium term making the best use of resources
- Transform care in the longer term working as one joined up system.

Housing
- Improve poor quality housing
- Improve identification and recognition of need for specialist housing, accommodation for older people and affordable housing
- Reduce number of people who are homeless

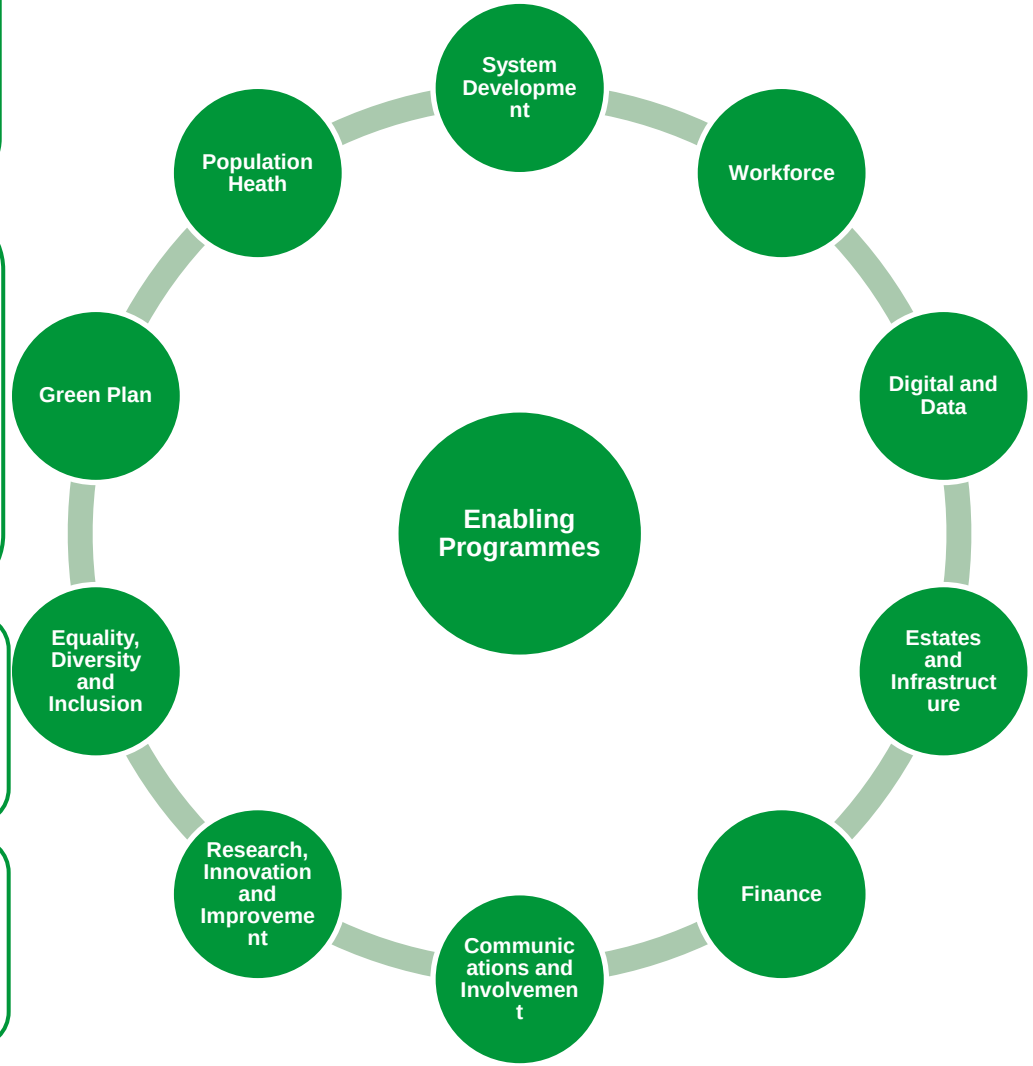
Population Health
- Deliver Core20PLUS5
- Implement co-ordinated prevention plans in priority areas with a focus on inequalities
- Develop as Anchor organisations
- Empower LCPs and collaboratives to make decisions with populations based on evidence

Digital & Data
- Empower people to use digital technology and by developing digital access to information and services
- Implement Electronic Patient Record
- Develop the Devon & Cornwall Care Record
- Develop a unified & standardised infrastructure
- Develop Business Intelligence/Population Health Management architecture & reporting

Equality, Diversity & Inclusion
- Improve innovation, performance and efficiency through a diverse workforce
- Ensure Devon's health and care services are inclusive and accessible to everyone

Research, Innovation & Improvement
- Build & strengthen networks
- Promote research & increase patient sign-up
- Ensure plans underpinned by robust evidence
- Develop capacity & capability

Estates & Infrastructure
- Support development of primary care, mental health, community and acute hospital estate
- Develop a road map for reaching Net Carbon Zero
- Work collaboratively to maximise opportunities.



System Development
- Develop a shared purpose through trust & collaboration
- Embed a 'learn by doing' approach
- Achieve thriving ICS status

Workforce
- Deliver solutions that enable to attraction, recruitment and retention of talent
- Identify new roles and ways of working and training provision
- Develop ASC career pathways

Green Plan
- Support staff to make greener journeys to work
- Deliver paper free ICB
- Increase the number of products & services bought locally

Communications & Involvement
- Support a system approach to communications & involvement
- Support programmes to work with diverse & vulnerable communities
- Ensure use of best practice principles and practice when involving people
- Build meaningful relationships with OSCs

Finance & Procurement
- Achieve recurrent balanced financial position
- Develop a financial framework that supports collaborative working
- Movement of funds into prevention.
- Commitment to shared services where appropriate
- Deliver maximum value & best quality service through collective procurement & supply chain excellence

Future plans - delivering the JFP and further development

Diagram to be re-formatted

Delivering the JFP

The JFP will be delivered through the system architecture, including Primary Care Networks, Local Care Partnerships and Provider collaboratives.

The high level delivery plan (Appendices C and D) details the actions we will take in the short and longer term and our outcomes framework will be used to monitor progress towards the strategic goals.

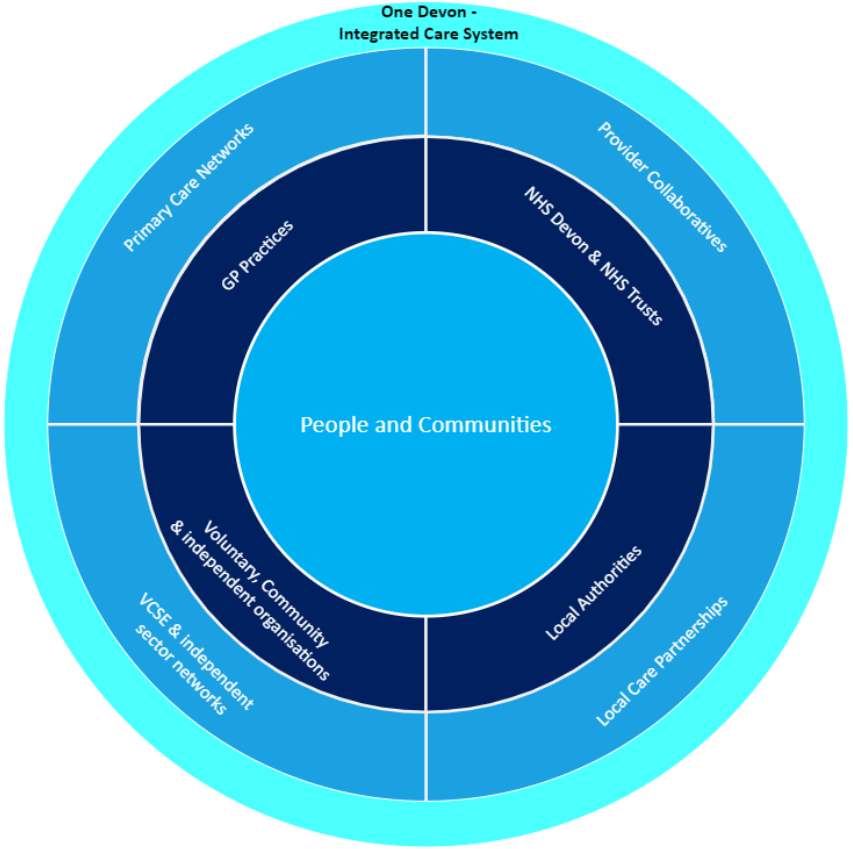
Assurance:

- 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 ICS Executive and will report to the One Devon Partnership;
- Use of ICS maturity framework.

There are a number of key risks to delivery of the Joint Forward Plan, including:

- Lack of synergy between the JFP and the system recovery plan;
- Insufficient capacity to deliver transformational change whilst focusing on recovery;
- Clinical, operational and financial pressures impact decision making, involvement and engagement, co-design and delivery of the ISD programme;
- The impending ICB reorganisation.

Work is underway within the system to review the alignment between the years 1 and 2 objectives within the JFP and the system recovery priorities and to agree any sequencing of the JFP actions that will be needed to support recovery and ensure that the longer term transformational priorities within the JFP are deliverable alongside the recovery plan.



Future Development

Publication of the JFP is not the end of a process, but the start of an ongoing new relationship with system partners and our communities, which will see both the Strategy and the JFP refreshed on an annual basis.

Over the coming weeks we will work together to put a framework in place that will support:

- Co-production of future iterations of the ICS and JFP with system partners, staff, patients and the public
- Further alignment with Local Care Partnership and Provider Collaborative objectives and with Local Authority social care plans
- Collaborative working on broader footprints, where appropriate

Additionally, there will be targeted engagement with communities around specific delivery programmes.

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 (detailed here) 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.

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

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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One Devon's Integrated Care Strategy

The Devon Joint Forward Plan is the whole system response to the One Devon 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 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 below, grouped according to the ICS core aims.

Improving Outcomes in population health and healthcare

Every suicide will be regarded as preventable and we will work together as a system to make suicide safer communities across Devon and reduce suicide deaths across all ages.

The suicide rate for all areas of Devon will see a consistent downward trajectory and by 2028 the suicide rate in each local authority area will be in line with or below the England average

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 and disability - dietary risks, tobacco, high blood pressure, high fasting plasma glucose and high BMI.

By 2028 reduce the Disability Adjusted Life Years (DALYs) lost for the top 5 modifiable risk factors and measure under 75 mortality and healthy life expectancy

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

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 (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

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 2028 reduce the Disability Adjusted Life Years (DALYs) lost for the top five causes

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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

Everyone in Devon will be offered protection from preventable diseases and infections.

By 2028 we will have:

- *childhood vaccines - vaccine coverage of 95% of 2 doses of MMR by the time the child is 5, vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, 90% uptake of school-aged immunisation*
- *Covid and flu vaccinations - 100% offer to eligible cohorts each season; vaccine uptake in line with or exceeding national/regional/comparator benchmarking;*
- *reduced the number of healthcare acquired infections by 25%*
- *reduced antibiotic prescribing by 15% from our year 1 baseline*
- *uptake of cervical screening increased to 80%*

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%

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%*
- *reduced the number of households in temporary accommodation by 10%*
- *reduced the number of families placed in temporary B&B accommodation for more than 6 weeks to 0*
- *increased the % of people sleeping rough who get an offer of accommodation to 100%*
- *increased in the number of households successfully prevented from becoming homeless by 30%*
- *ensured that LPAs are fully aware of the need for key worker housing and have addressed this need in their plans*

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 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%)
Reduced health inequalities for diverse populations

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.

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

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% and decreased the number of 16-17 year olds not in education, employment or training (NEET) to achieve or be under the national average.

Children 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%

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

We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change and 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.

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Developing our Joint Forward Plan

#OneDevon

The Devon Joint Forward Plan

In line with national requirements, the ICS in Devon (One Devon) produced an 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 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.

The **golden threads** that run through all of the delivery and enabling programmes:

- Prevention (focusing on the five main causes of death and disability)
- Population health
- Improved outcomes
- Personalisation and empowerment of individuals
- Inclusion – with a particular focus on inequalities, including in relation to neurodiversity, people with multiple complex needs, people with care experience, our armed forces population and those who have experienced trauma (including veterans), all of whom can struggle to access services.
- Quality and safety of care
- Continuous learning and improvement

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 (SOF4). 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 as well as setting 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.

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The Devon System

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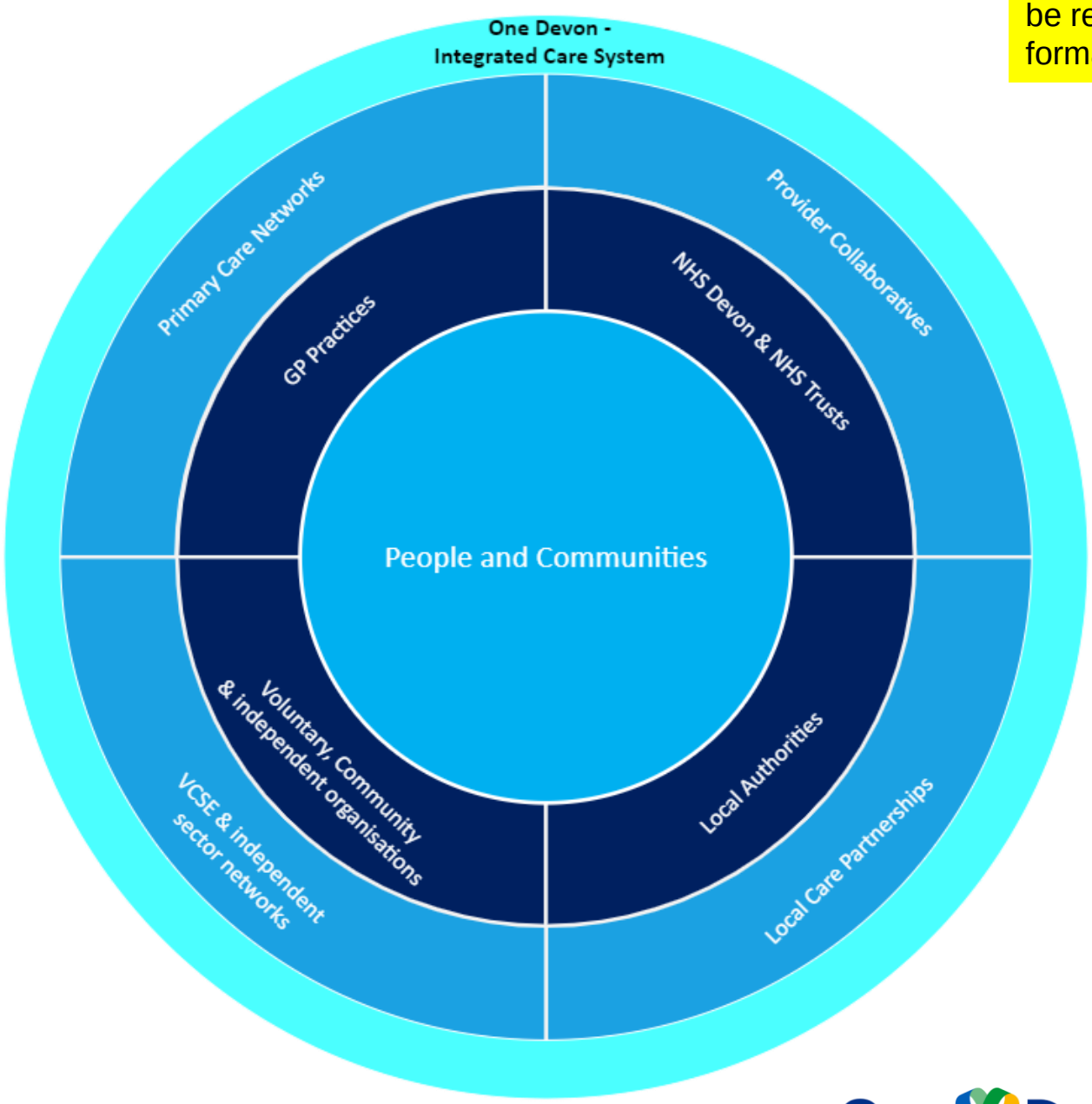
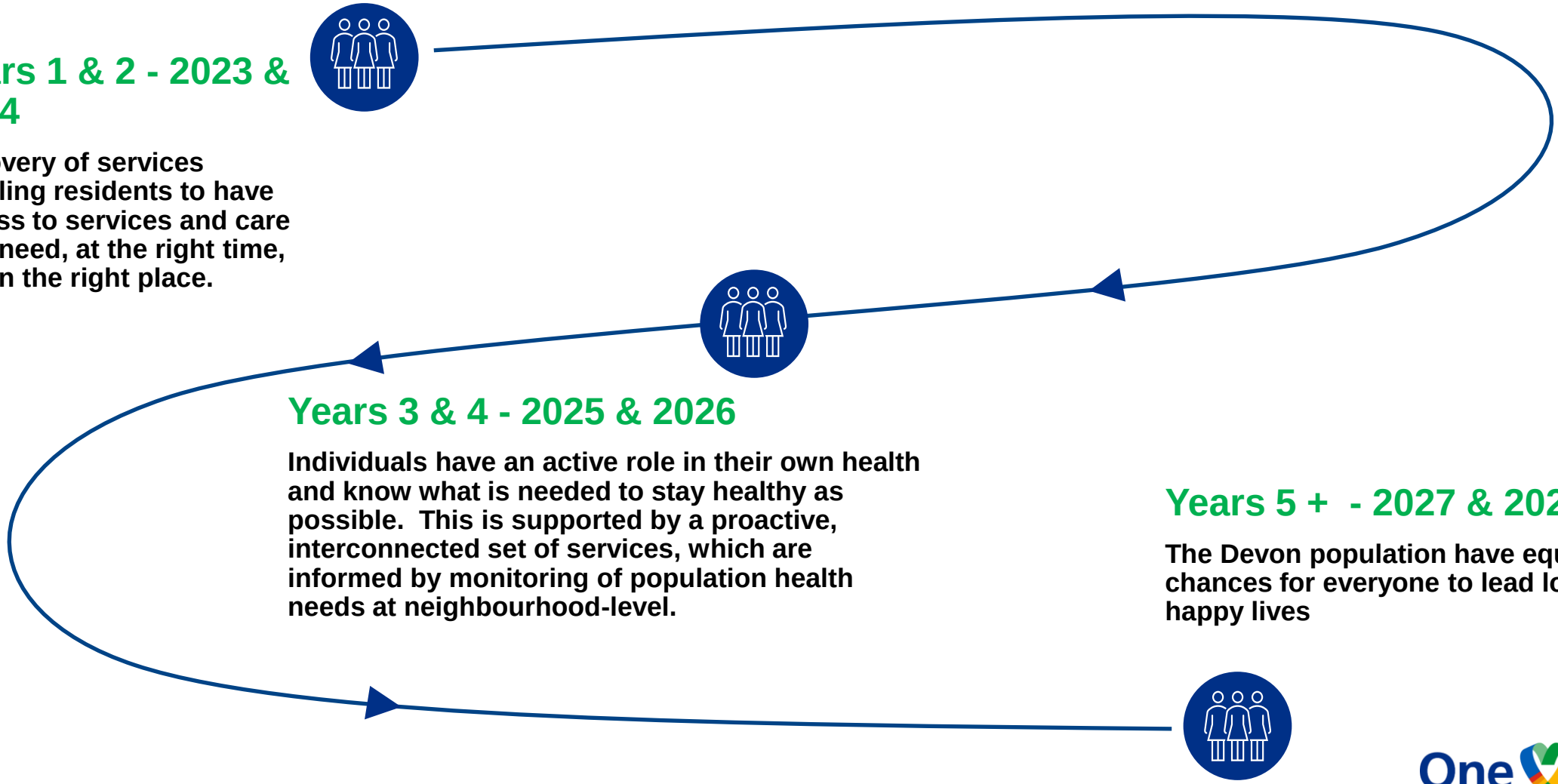
Devon is a complex system, in which work is taking place on delivering elements of the Plan in different geographical and functional arrangements, including:

- Two unitary authorities (Plymouth City Council and Torbay Council)
- One county council (Devon), with 8 district councils,
- 121 GP practices, in 31 Primary Care Networks
- Devon Partnership Trust (DPT) and Livewell South West (LWSW) provide mental health services
- Four acute hospitals - North Devon District Hospital and the Royal Devon and Exeter Hospital, both managed by the Royal Devon University Healthcare NHS Foundation Trust (RDUH), Torbay and South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP)
- One ambulance trust - South West Ambulance Service Foundation Trust (SWASFT)
- Dental Surgeries, Optometrists and Community Pharmacies
- A care market consisting of independent and charitable/voluntary sector providers
- Many local voluntary sector partners across our neighbourhoods



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

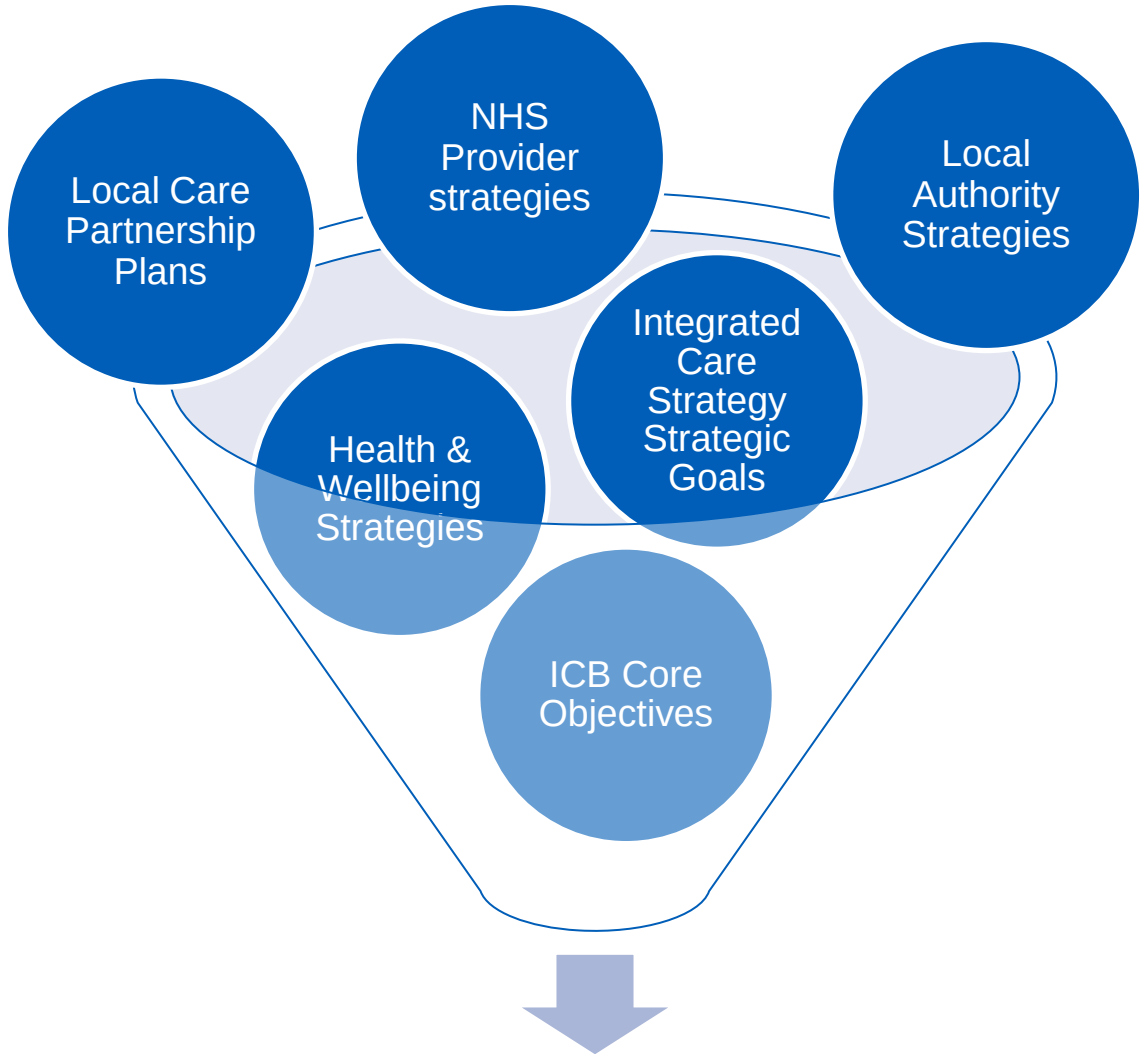
The Devon population have equal chances for everyone to lead long, happy lives

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
- Local authority strategies (eg: adult social care strategies)
- Local Care Partnership (LCP) objectives
- Provider trust strategies
- Provider collaborative priorities
- AHP strategy
- SOF4 exit plan

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



Involving people, partners and communities

Development of the Integrated Care Strategy and Joint Forward Plan has involved the following examples of 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, including at a specific engagement event in March 2023 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.

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

Statutory Duties

The Joint Forward Plan is a system wide plan which broadly describes the services we have in place and will develop to meet the needs of our whole population as set out in the Integrated Care Strategy.

It reflects an intention to work in collaboration and partnership to deliver our system ambitions, but it is important to acknowledge that statutory duties remain with individual organisations.

There are some specific statutory duties that the ICB needs to deliver as part of its statutory function (listed below) that must be met through the JFP. These duties are incorporated throughout the plan and Appendix A provides more detail in relation to these.

Statutory requirements of the JPF

- Describe health services the ICB proposes to arrange to meet needs
- Duty to promote integration
- Duty to have regard to wider effect of decisions
- Financial duties
- Duty to improve quality of services
- Duty to reduce inequalities
- Duty to promote involvement of each patient
- Duty to involve the public in decisions about services
- 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 as to regard to climate change
- Addressing the particular needs of children and young people
- Addressing the particular needs of victims of abuse
- Implement the joint health and wellbeing strategies

Devon's Joint Forward Plan

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



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

#OneDevon

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. Additionally, there is an immediate requirement to stabilise the financial position and recover activity, to improve operational performance, access and quality of care. In order to achieve both of these, we need to transform the way we work together across our system – creating new ways of working was identified as a key determinant of successful delivery of the Devon Plan.

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.

A case study demonstrates the collaborative work going on in Devon to support victims of domestic abuse, survivors, commissioners and service providers.

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. The actions to achieve recovery are captured in years 1-2 of the detailed delivery plans.

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.

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.

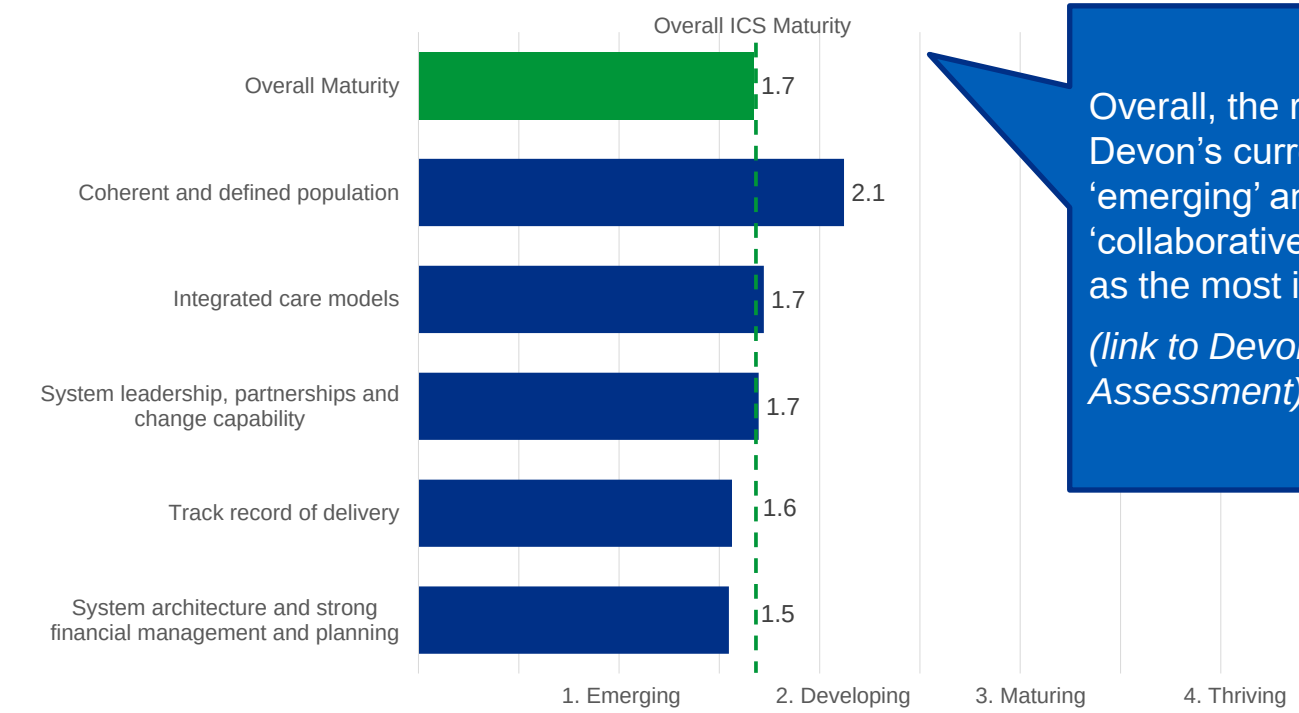
One Devon

Strengthening System Working

Developing One Devon

To provide One Devon with a shared understanding of our current system way of working, two diagnostic activities were undertaken in the Spring of 2022. The first, utilising a national ICS Maturity Self-assessment Tool, helped to identify One Devon's current ICS Maturity, mapped against five key domains, and the improvements required to enable us to become a 'thriving ICS'. The assessment will be repeated in 2023 to evaluate One Devon's progress.

Maturity by Domain



Overall, the results placed Devon's current ICS maturity as 'emerging' and 'developing with 'collaborative working' recurring as the most important theme.

(link to Devon ICS Maturity Assessment)

Written feedback by theme, ranked by occurrence:

1. Collaborative Working
2. Clear and Defined Goals
3. Shared Vision and Understanding
4. Performance Variation
5. Implementation
6. Organisational Boundaries
7. Tacking Inequalities
8. Accountability
9. Leadership
10. Governance
11. Culture of Change

Strengthening system working

Developing One Devon

The second diagnostic activity completed was supported by partners at the Southwest Academic Health and Science Network (SWAHSN) and focused on building a shared understanding of One Devon's current ways of working and opportunities to strengthen a collaborative and integrated approach.

The results were triangulated with output from the ICS Maturity Assessment and other sources and demonstrated consistent development themes and opportunities. The learning informed the scope and focus of the Integrated System Development Programme and provided reassurance regarding the approach.



5 opportunity areas to strengthen system working identified:

- Learn by doing
- Prioritise and implement
- Shared purpose
- Trust and collaboration
- System focus

The need to improve system working was identified as a key determinant to One Devon successfully delivering the Devon Plan.

Our ambition is outlined in the following overarching 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.

Development of One Devon is one of the key enablers supporting the ICS to achieve its ambition.

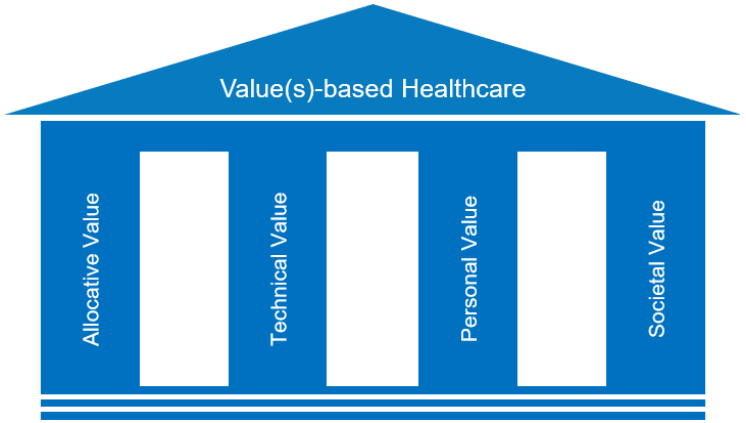
Our Overarching Philosophy

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.



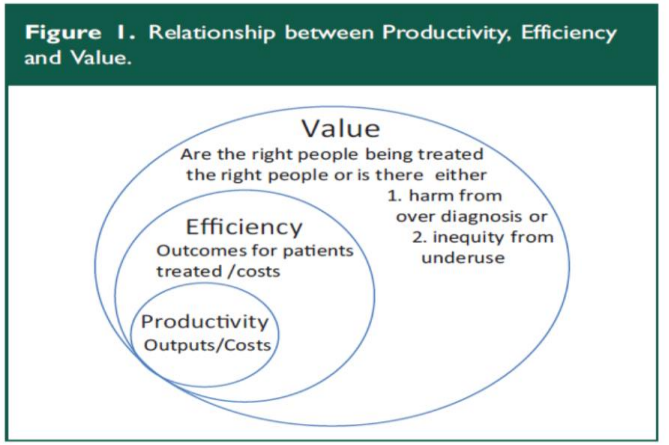
ALLOCATIVE VALUE: Equitable distribution of resources across all patient groups.

TECHNICAL VALUE: Achievement of best possible outcomes with available resources.

PERSONAL VALUE: Appropriate care to achieve patients' personal goals.

SOsocietal VALUE: Contribution of healthcare to social participation and connectedness.

This comprehensive meaning of 'value' offers a wider perspective than the interpretation of 'value' as purely monetary in the context of cost-effectiveness.



Defining Value-based Healthcare in the NHS: CEBM report

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.

One Devon

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

One 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.

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.

One Devon

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 £42.3m deficit**
- **24/25 c.£30m deficit through use of non-recurrent means**
- **25/26 breakeven exit run rate position**

How we will achieve this

- Used the Drivers of the Deficit analysis as the baseline for planning and CIP expectations aligned to model hospital, GIRFT and regional benchmarks
- Stretched 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 Performance Improvement

Developing a system-wide integrated improvement plans at pace through two streams of work, prioritised across UEC and Elective. Initially beginning 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.

Workforce

Workforce will achieve a net -2% workforce change against the current establishment.

Metric	2023/24 M12 (Planned)
65+ Week waits	2,956
78+ Week waits	0
104+ Week waits	0
A&E 4 Hours	72%
Cancer Faster Diagnostic	76%
System Financial Plan	(£42.3m)
Workforce	-2%

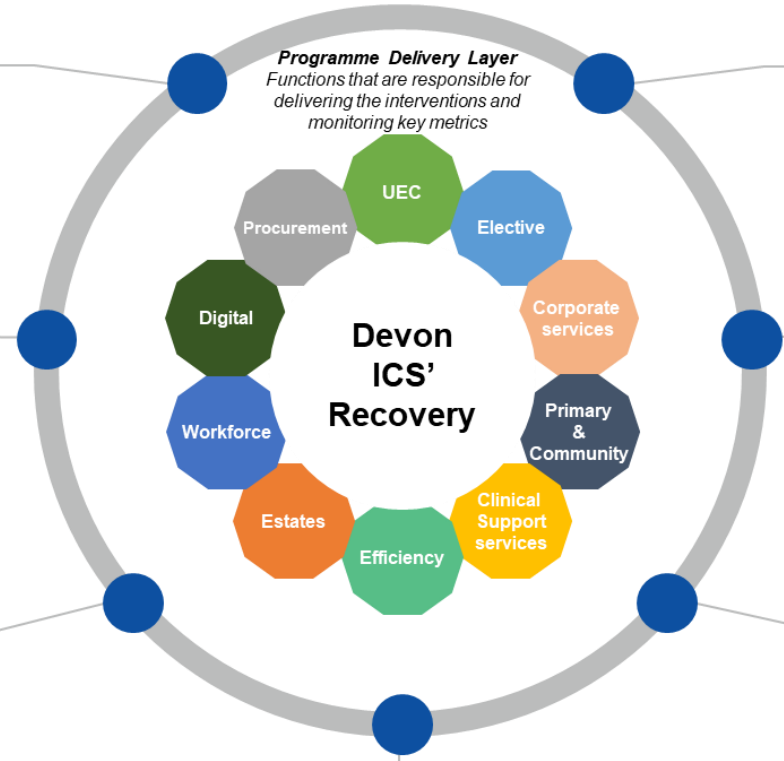
Working differently - establishing a System Recovery Function

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

Summary

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.



Assurance
Assure benefits are being realised (e.g. costs taken out, performance metrics being achieved) and highlight instances of variations against plan.

Business and Management Info
Establish a single version of the truth through consistent data and reporting of system performance and finances.

Monitoring and escalation
Monitor progress, risks and issues, escalating quickly those that need the action, attention or decision of system leadership.

Prioritisation
Inject pace into the recovery by prioritising schemes based on benefits value, timeframes to realise benefits and capacity to deliver. Therefore creating a better-balanced recovery programme. This will be an ongoing activity to introduce new interventions and avoid distractions / diluting resources

Delivery planning
Build and manage the system's recovery roadmap driving the delivery of interventions which sit on the critical path. This capability will manage the process of changes to the recovery roadmap.

Governance and rapid decision making
Clear and focused accountability through the system governance forums: overseeing the recovery plan and ensuring the right decisions and information are shared in a timely manner to move forward at pace.

Change Management
Proactive, frequent communication of changes and rationale to stakeholders, to ensure people are brought along on the recovery journey.

The Recovery Programme is committed to exiting SOF4 measures in Quarter 1 of the financial year 2024/25

SOF4 exit criteria

Theme	Criteria
Leadership	• Demonstrate collaborative decision-making in delivering all the SRP 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.

Getting the System in Balance - Local Authority Recovery

Torbay Council

Through our integrated partnerships with people, the NHS, the VSCE and other partners, Torbay aims to strengthen care and support so that people's choices are maximised and they are enabled to live a fulfilling life in their own community.

Torbay Council and Torbay and South Devon NHS Foundation Trust are integrated partners delivering Adult Social Care in Torbay. This is a strong partnership, but we recognise the need for system-wide transformation and sustainability, underpinned by the values of our Adult Social Care Strategy and the Devon 5-year Joint Forward Plan.

Through measurable benefits the three-year Adult Social Care Joint Transformation & Sustainability Plan will deliver:

- Increased independence, choice, and control for our community through our strategic shaping and oversight of Torbay's market with a key focus on building independence through Support for Living and partnership with the VSCE.
- Timely and good quality discharge from hospital – with a focus on returning people home with good quality reablement and intermediate care support that helps them to regain and maintain their independence.
- A focus on shared information through use of technology, and easy access to Adult Social Care
- Better value for money through our cost improvement plans.

Getting the System in Balance - Local Authority Recovery

Devon County Council

Our overriding focus is to meet the needs of the young, old and most vulnerable across Devon and we will work closely with our One Devon partners to support and develop the local health and care system, to help support the local economy, improve job prospects and housing opportunities for local people, respond to climate change, champion opportunities and improve services and outcomes for children and young people, support care market sustainability, and address the impacts of the rising cost of living for those hardest hit.

The Authority needs to make significant savings in order to set a balanced budget for 2023/24. To respond to this challenge, a cross-organisational programme of transformation has identified £47.5 million of savings and new income for 2023/24 within service budgets.

Delivery of the transformation programme will not be easy, but the level of commitment from teams, working together as one organisation, and the level of assurance that has been involved in the budget-setting process, mean that the 2023/24 budget is as robust as possible and will deliver best value for the people of Devon.

Furthermore, delivery of the 2023/24 budget enables us to move forward with investment in our services to drive continuous improvement and efficiency in all areas of our organisation.

The Authority has, over many years, built up its reserves to a significant level and in recent years used these reserves to protect services and enable transformation and invest to save projects. Although now at a more modest level the reserves are still at an appropriate level to safeguard financial resilience and manage risk.

One Devon

Getting the System in Balance - Local Authority Recovery

Plymouth City Council

Plymouth City Council faces significant financial risks, given the continuing forecast shortfall, uncertainty about resourcing from central government, the wider economic environment and the Council's comparatively low levels of financial reserves. Savings plans totalling £25.8m have been developed across the Authority for 2023/24, with further work ongoing around future years. The Council is experiencing significant pressures post Covid with increasing acuity of need and cost pressures within both Children's and Adult Social Care.

A recovery and transformation programme is in place for Adult Social Care which focuses on a number of key areas:

- Improving access to advice, information and support to neighbourhoods, through a network of health and wellbeing hubs, our community capacity builders and community assist offer
- Early intervention and reablement to provide enabling support for our most vulnerable and their unpaid carers
- Focussed review and reassessment programme led by Livewell Southwest
- Development of new model of care for working age adults, including targeted work on transition pathways and specialist housing provision in the City
- Remodelling of our homecare market to deliver a neighbourhood model, reducing travel across the City, supporting our Net Zero Carbon agenda
- Reshaping of our existing Care Home market to increase specialist dementia capacity
- Supporting providers of health and care to recruit, develop and retain a workforce for the future through our Health and Skills Partnership.

One Devon

Our Delivery Plan

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 milestones and year 1 and 2 work programmes included in Appendix C and Appendix D.

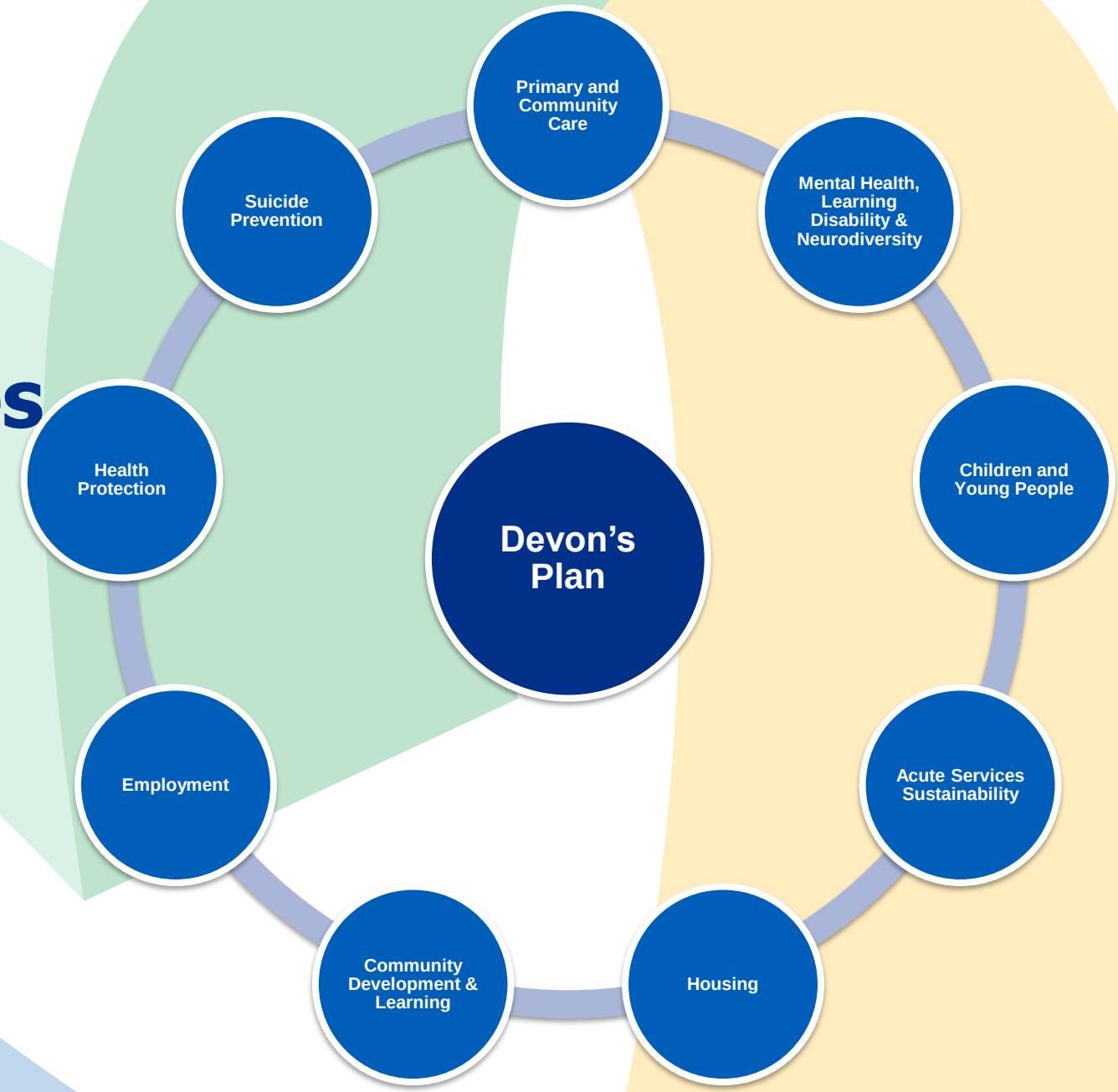
Those programmes that have been working on key transformation priorities linked to the Devon Long Term Plan have reviewed and updated these to ensure alignment to the One Devon strategic goals.

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

- Prevention (focusing on the five main causes of death and disability)
- Population health
- Improved outcomes
- Personalisation and empowerment of individuals
- Inclusion – with a particular focus on inequalities, including in relation to neurodiversity, people with multiple complex needs, people with care experience, our armed forces population and those who have experienced trauma (including veterans), all of whom can struggle to access services.
- Quality and safety of care
- Continuous learning and improvement

Delivery Programmes

[Detailed milestones in Appendix C]



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Vision and ambition

Mental Health

Work together with partners and experts by profession and experience, to improve population mental health and wellbeing and improve outcomes and experiences of people with mental illness across Devon. We will do this by providing the right, safety staffed, affordable and sustainable care and support that is compassionate, trauma informed and co-produced

Pledges – Mental Health

Game-changer: To reduce health inequalities and improve health outcomes for people with mental ill health through action and learning. Mental health, learning disabilities and neurodiversity are everybody's business and this will be increasingly reflected through integrated care; support, care, and treatment will be person-centred so that people get the right support when they need it.

Best Care: 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. All ages, groups and communities of people get the help they need to ensure all have an equal chance of enjoying resilient emotional wellbeing and mental health across their lives.

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

Co-Production Co-production is front and centre in designing, leading and making change – we will:

- Work in partnership with experts by experience and profession, wider community experts and including VCSE and the independent sector
- Empower people and families to work with us as partners in making sure people get the best care and support possible
- Change aims to innovate, transform and build on best practice

Housing, Employment and Education: 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
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. More women, children and families get help early in development of need (prevention).
Children and young people have access to timely mental health care and support.
Devon will sustainably eliminate inappropriate out of area bed use for adults who need hospital admission for acute mental ill health.
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.
People experiencing mental health crisis will be able to get the help they need as early as possible.
Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness.
People will have a timely dementia diagnosis and planned onward care and support.

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 with the system provision of health and social care for Learning Disabilities and Autistic People (LDAP). As a system we agreed that for 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 through 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 ownership, 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).

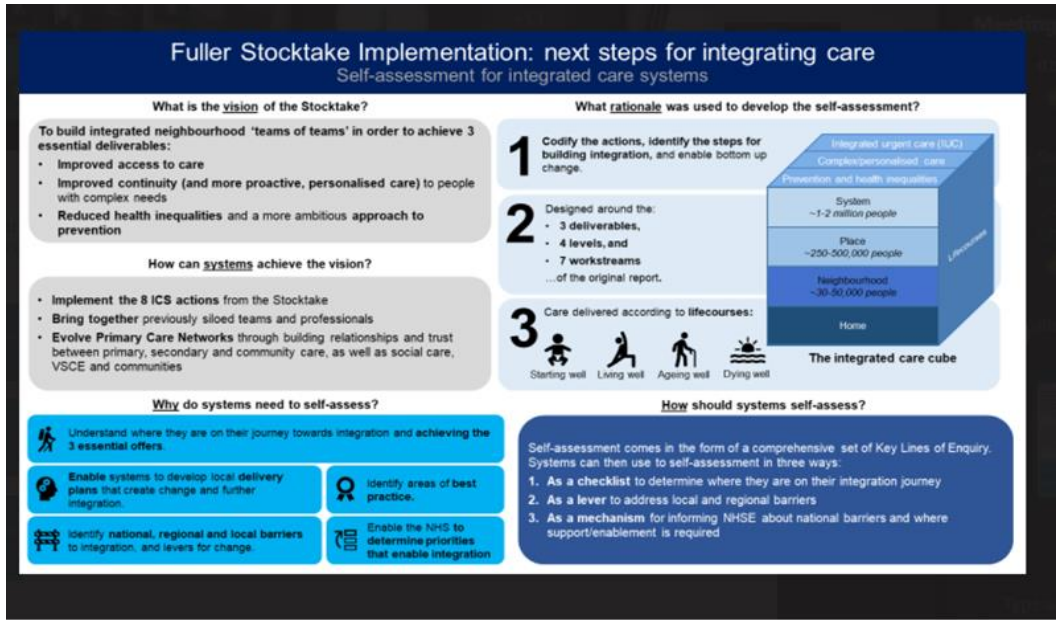
The integrated model of care described in the Devon GP strategic framework (2022) evidences alignment with the output of the national Fuller Stocktake which focuses on the development of integrated multi-disciplinary neighbourhood teams at place. Community care covers community health and social care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

The Devon Community First strategic framework (2022) also describes the aims of building community capacity at a neighbourhood level, focusing 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 its five Local Care Partnership areas.

Our **integrated model of care** will be underpinned by a personalised, strength-based social care offer focused on keeping people connected and supported in their own communities

This integrated health and care offer 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 We will have a Primary and Community Care Collaborative which functions Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, which meets population needs and addresses health inequalities via Local Care Partnerships, whilst maintaining consistent standards and outcomes
Integrated 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
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, by 2028
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention
Avoiding Admissions 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, which enables access by all staff
Personalised Care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)
Sustainable General Practice We will have sustainable and high quality general practice which operates within local and national Strategic Frameworks, and which has agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market • *Quality* • *Price (funding)* • *Information, advice and signposting*
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes

Vision and ambition

Children and Young People Care Model

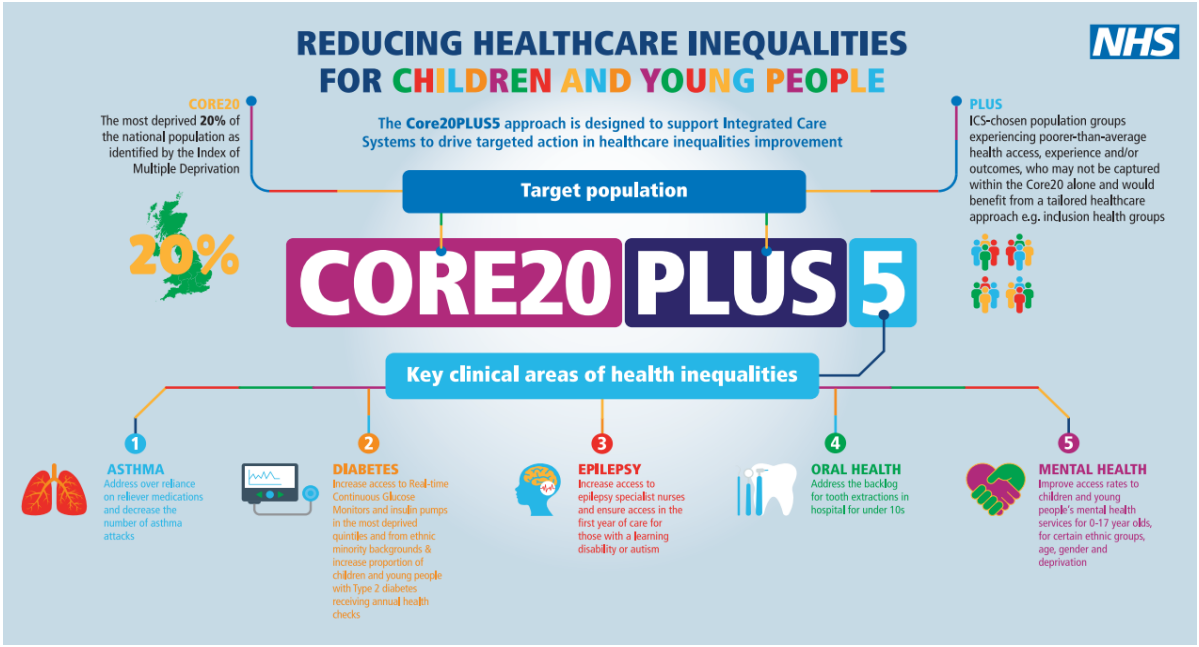
Our vision is to create an Integrated System and Care Model for Children and Young People (CYP) that supports all aspects of their health (including mental health) and wellbeing, for children and their families so that they can make good future progress through school and life. We will achieve this by 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 eg: genomics ▪ Ensuring that location is never a barrier to accessing services

One Devon

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 • 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 (January 2024)
We will undertake targeted engagement with key stakeholders on **Programme A**: a service change programme which requires engagement (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)

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 recognised in Local Plans across Devon to support housing delivery
Reduce the number of people who are homeless in particular: • No family should be in B&B accommodation over 6 weeks • 10% reduction in number of households in temporary accommodation • 30% increase in the number of households successfully prevented from becoming homeless • 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
Unpaid carers will be supported to remain in or re-enter employment
Build on resources developed across the local authorities to support more people into employment

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 - 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.

The ambition for suicide prevention is to deliver a consistent downward trajectory in the suicide rate for all areas of Devon, Plymouth and Torbay and for all people living in these areas. Our system aspires to make Devon, Plymouth and Torbay places that support people in times of personal crisis and builds individual and community resilience to improve lives.

Devon-wide partners will recognise the important contribution they can make and take a whole-community approach, recognising the contributions that can be made across all sectors of society. The approach will cover two tiers of action:

- **Level 1 Universal Interventions:** to build resilience and promote wellbeing at all ages for residents of Devon, Plymouth and Torbay.
- **Level 2 Targeted and vulnerable population groups:** targeted prevention of mental ill-health and early intervention for people at risk of mental health problems

Year 1- 5 Objectives

Suicide Prevention

Smart Objectives
The Local Suicide Prevention Groups to each have a published annual action plan based on the national strategy which sets local delivery priorities for the year
Our local Suicide Prevention Groups to report annually on their suicide rates and their annual action plan to their respective Health and Wellbeing Boards
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups
Public Health Teams to monitor suicide rates in their areas and for the whole ICB and compare it to the England average

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 working with the UK Health Security Agency (UKHSA), 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 (Core20PLUS5) for adults and children and young people; with a focus on measles, mumps and rubella (MMR), preschool booster, Core20PLUS5 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.

One Devon

Year 1- 5 Objectives

Health Protection

Smart Objectives
Reduce occurrences of healthcare associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA) and community onset community associated (COCA) occurrences of HCAIs
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 children and young people (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 (Core20PLUS5) 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 (Core20PLUS5) 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 (Core20PLUS5) for Adults
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 (Core20PLUS5) 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

Communities that are strong, resilient, inclusive and connected, where people support one another in an environment that promotes health and wellbeing

Community Learning & Development

The collective power of community to improve health and wellbeing

Positive health outcomes can be achieved by addressing factors that create and protect health and wellbeing at community level. Community life, social connections, supporting access to services, creating and maintaining a health-promoting physical, economic and social environment and having a voice in local decisions are all factors that contribute to health and wellbeing. These community determinants can help buffer against disease and influence healthy lifestyle behaviours. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. Participatory approaches can directly address marginalisation and powerlessness that underpin inequities and can be more effective than professional-led services in reducing inequalities.

How communities can be supported to improve the health and wellbeing of their residents

The people that understand communities best are the people that live and work in them. Place-based working, recognises that each community is unique in terms of what it has to offer, its own particular challenges and the various factors at play that contribute to these challenges. People with the knowledge and experience of living and working in the community need to be involved in the decision-making that affects it. Not only will this prove to be more effective than a one-size-fits-all approach, but by making best use of each community's 'wellbeing assets' and the energy and enthusiasm of members of the community, it makes best use of limited resources.

Community assets 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.

The purpose of community learning and development

Community development enables people to work collectively to:

- Identify their own needs and actions
- Take collective action using their strengths and resources
- Develop their confidence, skills and knowledge (including formal and informal methods of learning working particularly with under-heard and excluded groups to allow participation in the decisions and processes that shape their lives).
- Challenge unequal power relationships
- Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

There are five key values that underpin community development practice: social justice and equality, anti-discrimination, community empowerment, collective action, working and learning together

Community Development and its relationship to Health Inequalities and Population Health

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.

One Devon and its Community Development objectives

The role of One Devon is not to 'do' community development but to help create the conditions that foster and strengthen community action. The SMART objectives on the following pages will help create those conditions.

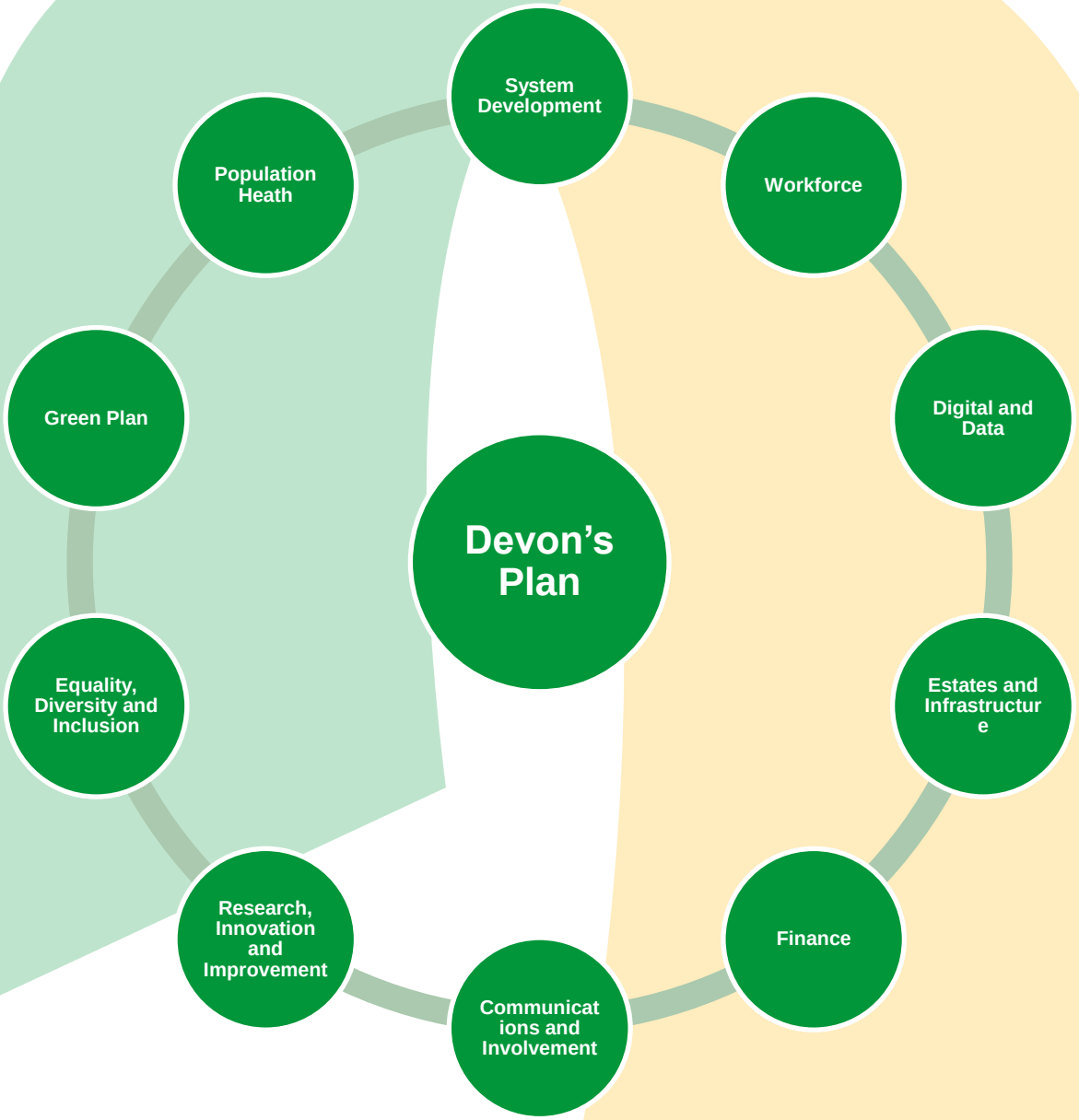
Year 1- 5 Objectives

Community Development and Learning

Smart Objectives
By 2028 local communities, and particularly disadvantaged groups, 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 work in partnership 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, equipped and trained to agreed standards, code of ethics and values-based practice
By 2028 Local Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are an equal partner both at system and local level

Enabling Programmes

[Detailed milestones in Appendix D]



#OneDevon

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, Innovation and Improvement

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 Peninsula Research and Innovation Strategy. This will draw in core partners who represent major research and innovation assets in the region (AHSN, ARC, CRN, HEIs and Cornwall and Somerset ICSs), 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, Innovation and Improvement (RII)

Smart Objectives
Build and strengthen networks at local, system, region and national level by March 2024
Promote research and increase patient sign-up with demonstrable increase by end 2026
Ensure all system workplans are underpinned by robust evidence of research and innovation
Develop capacity and capability by having a ICB RII Team by April 2024
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles by end March 2025

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.

One Devon

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 on an ongoing basis
Ensure delivery of Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement
Implement co-ordinated prevention plans in priority areas including CVD, diabetes and respiratory
Develop the ICB and NHS partners as Anchor Organisations by March 2026
Support the implementation of new ways of working focused on population health by April 2025

Vision and ambition

Communications 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 (aligned to the 10 principles outlined in the NHS Constitution)

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 staff, 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:
Support the use of the new ICS involvement platform ‘Let’s Talk’ and citizens’ panel that programmes can utilise to support online involvement activities across the system
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.
Develop a system approach to communications and involvement, working with professionals from all system partners to support consistent communications, involvement, collaboration, sharing of best practice, and co-production.
Work with partner organisations such as Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector, to deliver engagement on our behalf and to provide insights and connection to local populations
Support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
Provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Co-ordinate and support JFP leads to involve our 3 local overview and scrutiny committees addressing our statutory requirements under the Health and Social Care Act 2012, and also ensure we continue to build pro-active and meaningful relationships with all three Overview and Scrutiny Committees (OSC) in Devon, Plymouth and Torbay both individually and jointly as appropriate.

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 innovation, 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.

Improve innovation, performance and efficiency through a diverse workforce

- 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.
- Consider race equality as part of all commissioning strategies.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance
- Support staff to feel safe, including listening and providing support to staff and managers.
- Improve data on equalities and ethnicity, including in the independent provider market.
- Include a clause in our social care contracts with acceptable standards that are monitored.

Ensure Devon's health and care services are inclusive and accessible to everyone

- 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.
- Work in partnership with the voluntary sector to understand needs and support people from diverse and vulnerable populations to have better access to health and care service.
- Support, empower and equip patient facing staff to take an inclusive approach to the accessibility and delivery of services
- Improve representation in health and care engagement forums.

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 enable 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 in place 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
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future

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.
Develop a commissioned offer for digital solutions and technology enabled care and support, including awareness raising and increasing diversity of prescribers (social care)
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
Consider use of the Disabled Facilities Grant for technology solutions, including investigation of handyperson schemes focusing on ‘low-tech’ as well as ‘high-tech’ solutions.
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

Finance and Procurement

Finance

Vision

A financial framework that supports **integrated and collaborative working arrangements**, through the Devon Operating Model, that will **deliver better experience and outcomes for the people of Devon and greater value for money**.

Ambitions

- Recurrent balanced financial position by 2025/26.
- A financial framework that:
  - supports collaborative working
  - reflects the Devon Operating Model and delegation of budgets to LCPs and provider collaboratives.
  - promotes innovative funding models and pooled budget arrangements.
- Movement of funds into prevention.
- A commitment to shared services, doing things once for Devon or the wider Peninsula where it makes sense to do so.

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.

One Devon

Year 1- 5 Objectives

Finance

Smart Objectives
Year 1 - development of improved collaborative working, intra system financial framework, contracting and risk sharing protocols
Year 1 – agreement of functions where a shared service arrangement should be pursued helping to inform the organisational restructure within reduced Running Cost Allowance
Year 1 – development of Long term Financial Plan, trajectory to recover and sustainable financial balance over a 3-5 year scenario range
Year 1 – development of system wide interpretation of the Drivers of the Deficit to underpin future recovery
Year 1 – delivery of 23/4 recovery and Cost Improvement Programmes both organisational, strategic collaborative, and structural
Year 1 – consolidate delegated of commissioning functions for extended primary care
Year 2 – commence pivot of funding upstream towards prevention and health inequalities
Year 2 – take on formal delegation of Specialised Commissioning functions
Year 2 – corporate ICB right sized for RCA (Running Cost Allowance) allocations, emerging maturity of LCP's
Year 2 – estates strategy finalised to underpin prioritised system wide capital allocations
Year 3-5 – continued recovery to sustainable financial balance by system and by organisation

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.

Actions like encouraging everyone to be more active by walking and cycling, reducing our reliance on paper and purchasing our products and services more locally will all help to improve public health, support our budget and reduce pressures on the NHS and social care.

Year 1- 5 Objectives

Green Plan

Smart Objectives
More Devon ICB staff will make greener journeys to work.
Devon ICB will be a paper free organisation by 2028.
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners.

Delivering the Joint Forward Plan and Future Development

Delivering the plan in 23/24
Governance
Outcomes Framework
Risks to delivery
Future refresh of the JFP

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Diagram to be updated

Delivering the JFP

Delivery

The JFP will be delivered through system architecture that includes:

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

Assurance

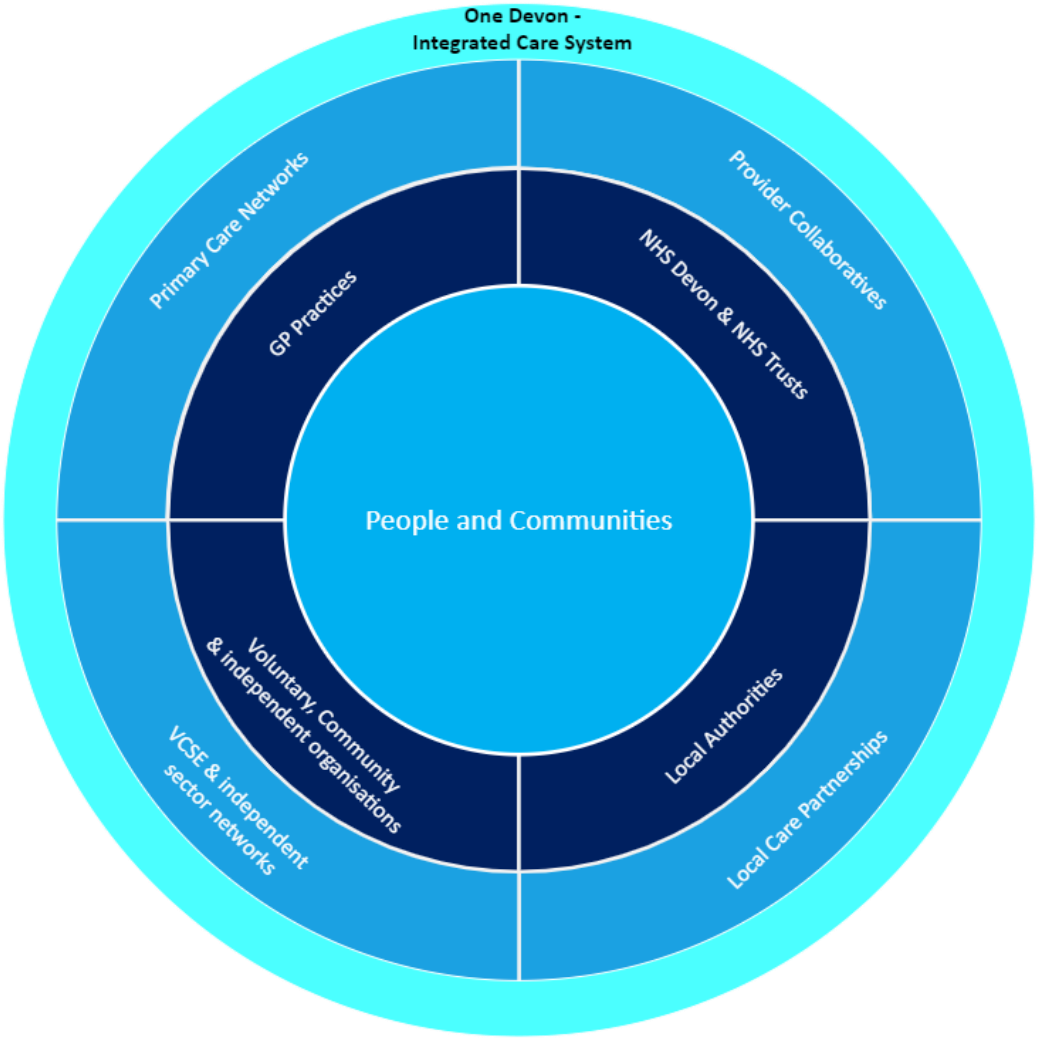
- Outcomes framework will be used to monitor progress towards the strategic goals
- The System Recovery Board will drive delivery of the recovery plan
- Delivery of work programme milestones will be monitored through system programme infrastructure
- Progress towards delivery of ICS strategic goals will be overseen by the ICS Executive and will report to the One Devon Partnership
- System development will be measured through the ICS maturity framework

Engagement

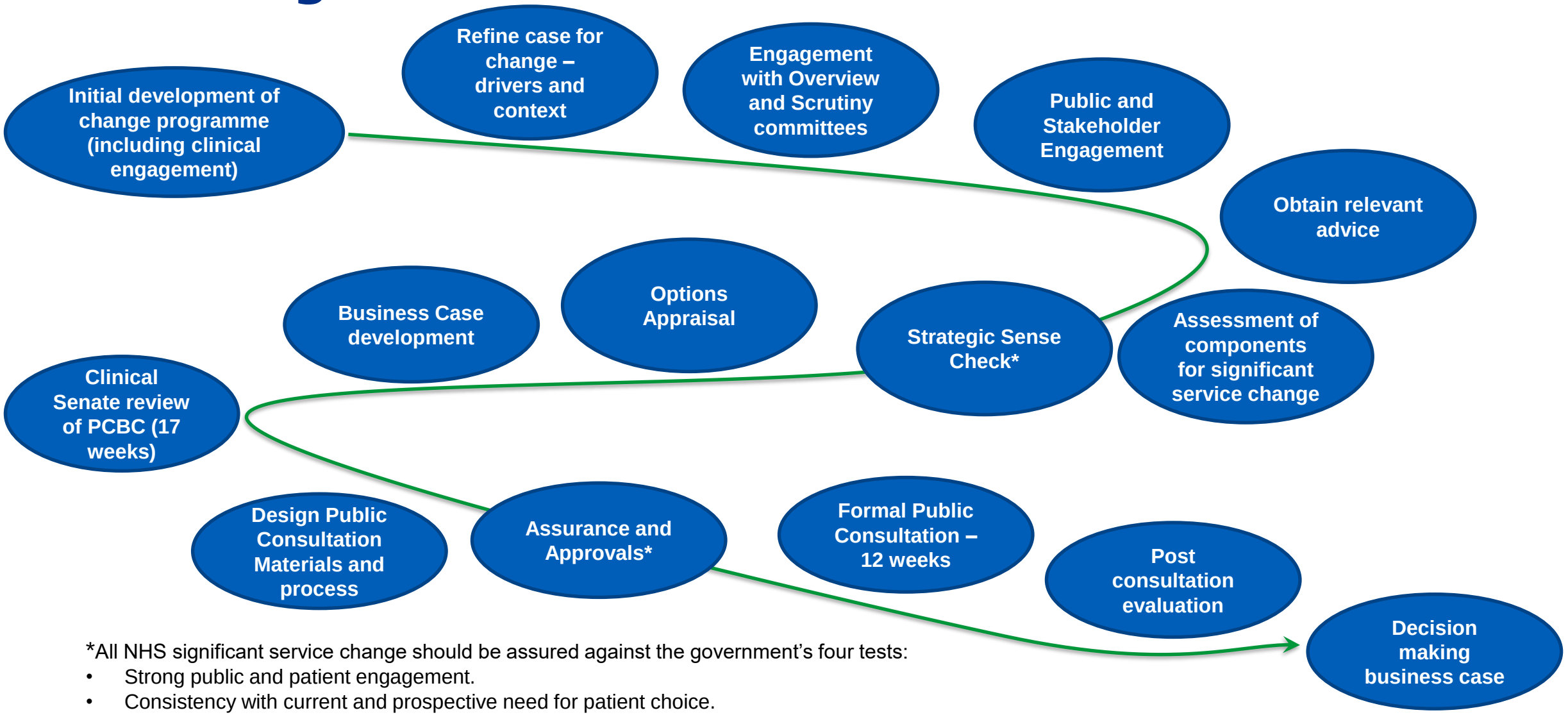
- Targeted engagement by programmes with people and communities

Annual refresh

- On-going work with system partners and programme leads to refresh each year



Delivering Transformation



*All NHS significant service change should be assured against the government's four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear, clinical evidence base.
- Support for proposals from clinical commissioners

Accountability

Our Vision	**One Devon Partnership**	**Equal chances for everyone in Devon to lead long, happy and healthy lives**			
Our Aims	**One Devon Partnership** **NHS Devon**	**Improving Outcomes in population health and healthcare**	**Tackling inequalities in outcomes, experience and access**	**Enhancing productivity and value for money**	**Helping the NHS support broader social and economic development**
Our Strategic Goals	**One Devon Partnership** **ICS Executive**	Every suicide will be regarded as preventable and we will work together as a system to make suicide safer communities across Devon and reduce suicide deaths across all ages	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.	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.	People in Devon will be provided with greater support to access and stay in employment and develop their careers.
		We will have a safe and sustainable health and care system.	Everyone in Devon will be offered protection from preventable diseases and infections.	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.	Children and young people will be able to make good future progress through school and life.
		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.	Everyone in Devon who needs end of life care will receive it and be able to die in their preferred place	We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.	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).
		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	The most vulnerable people in Devon will have accessible, suitable, warm and dry housing	We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.	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
		Children and young people (CYP) will 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.		Local and county-wide businesses, education providers and the VCSE will be supported to develop economically and sustainably
		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.			
Delivery Programmes	**NHS Devon/ Local Authorities/ Programme Boards**	**Mental health, learning disability and neurodiversity** / **Women and Children**	**Acute Services Sustainability** / **Primary and Community Care** / **Housing**	**Community Development and Learning** / **Employment**	**Health Protection** / **Suicide Prevention**
Enabling Programmes		**System Development** / **Workforce**	**Digital & Data** / **Estates and Infra-structure** / **Finance & Procurement**	**Communications & Involvement** / **Research, Innovation & Improvement**	**Equality, Diversity & Inclusion** / **Green Plan** / **Population Health**

ICS Outcomes Framework

Framework available via interactive dashboard with ‘drill down’ ability to highlight inequalities and drive local action

Breakdowns at three ICS ‘tiers’ (system, LCP and PCN), two local authority ‘tiers’, and inequalities (socio-economic, geographic, personal characteristics, clinical factors)

Alignment with other frameworks (NHS, PH, ASCOF, HWB)

Some narrative (qualitative) measures

Ongoing co-design process with strategic commissioning partnership to ensure fitness for purpose

Flexibility in terms of addition of new indicators

First set of data to be produced in June 2023.

Indicators

- Admissions Following Accidental Fall
- Deaths in usual place of residence
- Total Carbon Emissions (kt CO2)
- NHS and LA Attributable Carbon Emissions (kt CO2)
- Deaths attributable to air pollution
- Index of Multiple Deprivation
- Access to Community Facilities
- Rough sleepers per 1,000 households
- Average house price to FT salary ratio
- Households in temp accommodation
- Supply of key worker housing
- Fuel poverty
- One Devon Cost of Living Index
- Community/Business investment
- Experience of navigating services
- Waiting Times
- Support from local organisations to manage own condition
- Digital exclusion risk index (DERI)
- Unified Digital Infrastructure

- Healthy Life Expectancy at birth
- Gap in Healthy Life Expectancy at birth
- Under 75 mortality rate from preventable causes (persons <75yrs)
- Global Burden of Disease: Top 10 Causes (DALYs) and Top 10 Modifiable Risk Factors (DALYs)
- Children achieving a good level of development at the end of Reception
- 16-17 year olds not in education, employment or training (NEET)
- Employment of people with mental illness or learning disability
- Workforce diversity (employment profile vs Devon by EDI characteristics)
- Uptake/Coverage of Local Authority Carer Support Services
- Unpaid Carers Quality of Life
- Carers Social Connectedness
- MMR vaccine uptake (5 years old)
- Flu vaccine uptake (at risk individuals)

- Covid-19 vaccination rates
- Children and young people accessing mental health services
- Coverage of 24/7 crisis MH support
- Suicide Rate
- Social Prescribing Uptake Rates
- Access to CYP eating disorders services
- Avoidable admissions for ambulatory care-sensitive conditions
- Patient Activation Measures
- Access to dentists / pharmacy / optometry / primary care
- Vacancy Rate for ICS Organisations
- Financial Sustainability
- Unified Approach to Procurement and Commissioning
- Community Empowerment/Volunteering

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Challenges/risks to delivery

There are a number of key risks to delivery of the Joint Forward Plan, including:

- Lack of synergy between the JFP and the system recovery plan;
- Insufficient capacity to deliver transformational change whilst focusing on recovery;
- Clinical, operational and financial pressures impact decision making, involvement and engagement, co-design and delivery of the ISD programme;
- The impending ICB reorganisation;

Work is underway within the system to review the alignment between the years 1 and 2 objectives within the JFP and the system recovery priorities and to agree any sequencing of the JFP actions that will be needed to support recovery and ensure that the longer term transformational priorities within the JFP are deliverable alongside the recovery plan.

The ICS Development Roadmap integrates the contributions of all 9 Delivery Work Plans and those of the 10 Enablers towards delivering the overarching strategic goal. Programme leads will meet twice a year to review progress against the Roadmap, adopt a 'learn by doing' approach and adapt plans as needed. To support this approach, One Devon will undertake a full ICS Maturity Assessment once a year and a 'light touch' Assessment at the 6 month point in between. The outputs from these assessments will by used by the system-wide work plan leads and will inform any changes to delivery work plans.

Future Development of JFP

This Plan has been developed at pace in response to the One Devon Integrated Care Strategy and in line with national timeframes. It is important to acknowledge that publication of the JFP is not the end of a process, but is the start of an ongoing new relationship with system partners and our communities, which will see both the Strategy and the JFP refreshed on an annual basis.

Over the coming weeks we will work together to put a framework in place that will support:

- Co-production of future iterations of the ICS and JFP with system partners, staff, patients and the public
- Further alignment with Local Care Partnership and Provider Collaborative objectives and with Local Authority social care plans
- Collaborative working on broader footprints, where appropriate

Additionally, there will be targeted engagement with communities around specific delivery programmes, including as part of our significant service change process, set out on slide 93.

APPENDICES

APPENDIX A
Universal NHS commitments Statutory Duties

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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

ICB Core Functions and Statutory Duties

Our NHS Statutory Duties	How we will meet our duties
Describe health services the ICB proposes to arrange to meet needs	This Joint Forward Plan broadly describes the health services we have in place, and will arrange, to meet the needs of our population as set out in the Integrated Care Strategy. Each year we also produce an Operating Plan that provides more detail about the planned performance of services; the Operating Plan detail is included in Appendices C and D
Duty to promote integration	The Joint Forward Plan is an integrated system-wide plan that encompasses a wide range of programmes that will contribute to improving the health and wellbeing of people living and working in Devon. Each programme describes how system partners are working together to deliver joined up services.
Duty to have regard to wider effect of decisions	The Joint Forward Plan is a system-wide plan to meet the aims and strategic goals set out in the Integrated Care Strategy. The strategy is overseen by the One Devon Partnership which will have the remit to ensure the full consequences of any decisions made are understood
Financial duties	The national financial framework sets requires a collective responsibility to not consume more than the agreed share of NHS resources. Slides 37- 42 outline how we plan to achieve System Balance.
Duty to improve quality of services	Everybody has the right to feel safe and have confidence in the services provided across Devon. We are committed to securing continuous improvement and will ensure that our services are of appropriate quality and that we have robust mechanisms in place to intervene where quality and safety standards are not being met or are at risk. We have developed robust metrics to measure the impact of the plan through our Outcomes Framework and have a Performance and Quality reporting function in place. This is support the achievement of the strategic goals to have 'a safe and sustainable health and care system.
Duty to reduce inequalities	One of our system aims is 'Tackling inequalities in outcomes, experience and access' and 2 of our strategic goals focus on the top five risk factors and causes of death and disability. A third strategic goals explicitly states that we want 'everyone to have an equal opportunity to be healthy and well'. To achieve this the delivery programmes outline how they will contribute to reduce inequalities, particularly in relation to Core20PLUS5 and, in line with the 2022 Armed Forces Bill, with regard to serving military personnel, reservists, veterans and their families. To support this work, the Population Health enabler programme has been developed.
Duty to promote involvement of each patient	We are committed to promoting personalised care across all the services we deliver across our organisations. Our approach outlined in the strategic goal 'People in Devon will be support to stay well at home, through preventative, proactive and personalised care'. Specifically, the Primary and Community Care programme describes how it will use the comprehensive model of personalised care to deliver this ambition.
Duty to involve the public in decisions about services	Our Working with People and Communities strategy sets out our principles for involving local people. The Communications and Engagement enabling programme outlines how we will support delivery leads to ensure people and communities are involved in a meaningful way.
Duty to enable patient choice	We support patient choice in our commissioning plans in a number of ways. These include expanding the use of personal budgets through our personalised care commissioning and the use of the Devon Referral Support Service (DRSS), which supports patient choice at the point of referral into secondary care.

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ICB Core Functions and Statutory Duties

Our NHS Statutory Duties	How we will meet our duties
Duty to obtain appropriate advice	We ensure that we obtain appropriate advice throughout the development of plans. This includes from: clinicians (both local and through regional networks), NHSE (regional and national), the South West Clinical Senate and legal advice. Obtaining advice is particularly important to us in our delivery of transformation as outlined on slide 93.
Duty to promote innovation	We work closely with the South West Academic Health Science Network to ensure we are cognisant of innovation and best practice. The Research and Innovation enabling programme has been developed to ensure all delivery programmes are supported in the delivery of this duty.
Duty to facilitate and promote research and use its evidence	We work closely with the South West Academic Health Science Network to ensure we are cognisant of research and best practice and that we promote research within Devon. The Research and Innovation enabling programme has been developed to ensure all delivery programmes are supported in the delivery of this duty.
Duty to promote education and training	Our Joint Forward Plan has three strategic goals related to education and training including – school readiness, supporting people to access and stay in employment and ensuring we have people with the right skills within our system. The Children and Young people delivery programme focuses on this whilst the employment and workforce enabling programmes outline how they will support these ambitions.
Duty as to regard to climate change etc	Our Green Plan enabling programme outlines our clear commitment to successfully deliver targets for all local authorities to be carbon neutral by 2030 and the NHS by 2040.
Addressing the particular needs of children and young people	Our plan includes two specific strategic goals on children and young people and the children and young people delivery programme outlines the wide programme of work.
Addressing the particular needs of victims of abuse	Serious violence has a devastating impact on lives of victims and families, instils fear within communities and is extremely costly to society. 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). 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 slide 30 shows how the ICS is working collaboratively to progress this important agenda.
Implement any joint local health and wellbeing strategy	There are three Health and Wellbeing Boards in Devon and we have worked closely with all three to ensure that their priorities are reflected in this plan.

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APPENDIX B
Metrics and Baselines

Improving Outcomes in population health and healthcare

Strategic Goal	Metric	Baseline
Every suicide will be regarded as preventable and we will work together as system to make suicide safer communities across Devon and reduce suicide deaths across all ages	*The suicide rate for all areas of Devon will see a consistent downward trajectory and by 2028 the suicide rate in each local authority area will be in line with or below the England average*	Rate per 100,000 persons 2019-21: • England 10.4 • Devon CC 12.5 • Plymouth CC 10.7 • Torbay C 17.2
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 - - Dietary risks, Tobacco, High blood pressure, High fasting plasma glucose and High BMI	*By 2028 reduce the DALY (Disability adjusted life years) lost for the top 5 modifiable risk factors, and measure under 75 mortality and healthy life expectancy*	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 • Devon F: 15.9 and M: 14.1. Under 75 mortality rate from preventable causes by LA: 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 2028 reduce the DALY (Disability adjusted life years) lost for the top 5 causes*	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*	
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%* • *reduced the number of households in temporary accommodation by 10%* • *reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0* • *Increased the % of people sleeping rough who get an offer of accommodation to 100%* • *increased in the number of households successfully prevented from becoming homeless by 30%* • *ensured that LPAs are fully aware of the need for key worker housing and have addressed this need in their plans*	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 diseases and infections.	*By 2028 we will have:* *- Childhood vaccines - vaccine coverage of 95% of 2 doses of MMR by the time the child is 5, vaccine coverage of 95% of 4-in-1 pre-school booster by the time the child is 5, 90% uptake of school-aged immunisation* *- Covid and flu vaccinations - 100% offer to eligible cohorts each season; vaccine uptake in line with or exceeding national/regional/comparator benchmarking;* *- reduced the number of healthcare acquired infections by 25%* *- reduced antibiotic prescribing by 15% from our year 1 baseline* *- Uptake of cervical screening increased to 80%*	
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%*	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 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%)* *Reduced health inequalities for diverse populations*	

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
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) to achieve or be under the national average.*	End 2020 NEET (16-17 yrs old) was Devon 514, Plymouth 225 and Torbay 111. End 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)
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.*	
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%.
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*	

APPENDIX C
Delivery Programme Milestones

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Year 1- 5 Objectives and Milestones

Mental Health – Perinatal and Early Years

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
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 More women, children and families get help early in development of need (prevention).	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 to design a whole system perinatal clinical pathway	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. Service review of access, experience and outcomes in perinatal mental health completed. The review and data evidences increased access to support within four weeks of referral on 23/24 baseline figures. Review of commissioning arrangements for service delivery	Implement actions and recommendations from the Service Review Review effectiveness of current arrangements and implement any amendments re new policy and guidance Review of commissioning arrangements for service delivery

Year 1- 5 Objectives and Milestones – Mental Health

Mental Health – Children and Young People's Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
Children and young people have access to timely mental health care and support	At least 15,754 children and young people will access mental health assessment. Working in partnership with the Children's board the ICS will develop a 3-5 year plan to continue growing access to mental health support, care and treatment for children and young people, using a THRIVE based approach. By 2027/28 95% of schools in Devon will have access to Mental Health in Schools services 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 to embed any amendments to meet new policy and guidance for years 2-3	Implement plan to grow access to NHS funded mental health support care and treatment for children and young people across Devon. By the end of 2025, 60% 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 Review effectiveness of current arrangements 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	Review effectiveness of current arrangements and implement any amendments re new policy and guidance Review of commissioning arrangements for service delivery to plan that by 2028, 80% or more 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 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.

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Year 1- 5 Objectives and Milestones

Mental Health – Adult Mental Health

Smart Objectives	Milestones-Year 1	Milestones- Year 2-3	Milestones-Year 4-5
Devon will sustainably eliminate 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 transform mental health, in-patient services Review of commissioning arrangements for service delivery completed ICS will establish a comprehensive understanding of housing, employment and educational needs to inform strategic development plans for Devon and these plans will include options to meet the needs of people with complex mental health needs including those with drug and alcohol dependency.	Average Length of Stay will be 28 days for non-specialist acute adults inpatients, and 45 days for older adults with appropriate oversight of staffing levels. Delivery of alternative crisis care options is effective including crisis cafés, crisis houses, community mental health offers non urgent crisis support Devon can provide the right level of resource for people who require psychiatric intensive care services	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. By the end of 2027/28 all acute psychiatric inpatient care will be delivered in area unless there is an exceptional clinical need.

One Devon

Year 1- 5 Objectives and Milestones

Mental Health – Adult Mental Health

Smart Objectives	Milestones-Year 1	Milestones- Year 2-3	Milestones-Year 4-5
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 - Adult Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
People experiencing mental health crisis will be able to get the help they need as early as possible	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. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year one	Call abandonment rate of under 5% through delivery of First Response telephony service for Devon aligned to 111/999 with oversight of staffing levels and staff training and development. The system will produce a shared risk care pathway for high intensity/frequent and MH crisis led attendances across the services from Primary to Acute. Develop and implement NPA actions to further improve crisis support to people in mental distress	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 - Adult Mental Health

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones- Year 4-5
Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.	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 will achieve clinical recovery Mental Health services will operate a “no wrong door” approach Improve the use of data to influence commissioning and planning decisions Develop a commissioning 3- year plan to address the mental health needs of 16 – 25 year olds, without a psychosis Ensure effective, timely and consistent early intervention in psychosis services are commissioned	Implement the 3- year plan to set out how the emotional health, wellbeing and mental health needs of young adults, aged 16-25, are to be met Clinical and satisfaction outcomes for MH community services improves 5% from 2023 baseline	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 and receive integrated care, support and treatment across health and education that is personalised and aligned to their emotional health, wellbeing and health needs. By the end of each year clinical and satisfaction outcomes will improve by 5% year on year from 2023 baseline By the end of 2027/28 % of adults and older adults will wait 4 weeks or less to access specialist mental health services including psychological interventions.

One Devon

Year 1- 5 Objectives and Milestones

Mental Health - Mental Health for All

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness	Work to influence partners to ensure that 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 will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. MHLDN Provider Collaborative will develops a system wide assertive outreach plan for people with significant rehabilitation and complex emotional needs. Formal evaluation to inform future commissioning intentions across Health and Social to increase capability of supported living market. Individual Placement Support will achieve supporting 1,196 people with mental illness into work .	A comprehensive rough sleepers plan to be developed jointly with Local Care Partnerships, to include access to care and treatment. Review commissioning arrangements for supported living market for MHLDN. Build extra care and supported housing options into ICS housing planning programmes to reduce any need to place people out of area Implementation of 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 a 10% increase on the access target for 23/24 (1,316).	90% of people admitted to a psychiatric inpatient wards are discharged to safe, appropriate housing with the right care and support package without delay. All people with complex and very severe presentations have focussed assertive rehabilitation to prevent the need for out of area placements. Promote and influence system plans to become Disability Confident registered employers.

Year 1- 5 Objectives and Milestones

Mental Health - Older Adults

Smart Objectives	Milestones- Year 1	Milestones- Year 2-3	Milestones-Year 4-5
People will have a timely dementia diagnosis and planned onward care and support.	Devon will attain 63% of the required national standard of 66% dementia diagnosis rate A formal commissioning review of memory assessment provision will be completed to align capacity to demand alongside outlining any gaps in ability to meet demand Development of a system-wide Dementia plan to support people with dementia. Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care Review of commissioning arrangements for service delivery for 24/.25 operating planning	Memory Assessment Service review actions are implemented to ensure ability to meet 66% DDR Implementation of a system-wide Dementia plan to support people with dementia. Review of commissioning arrangements for service delivery to inform future planning Carers needs are reviewed with actions to ensure effective support put in place	People who need a dementia diagnoses can get that diagnosis within 8 weeks of referral Older persons services are aligned across frailty and dementia care pathways and people receive the best care when needed Carers needs are fully supported to support people with dementia to remain at home as long as is safe and the right outcome for the family Joined up mental health and physical health care provision is available in local community hubs, GP practices, diagnostic clinics and urgent treatment centres.

One Devon

Year 1 and 2 (operational plan detail)

Mental Health - Perinatal and Early Years

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

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
 	
More women, children and families get help early in development of need (prevention).
	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 to design a whole system perinatal clinical pathway
		• Recruit to new service community posts aligned to mental health investment standard budgets
		• New staffing to support ability to meet demand and meet national trajectories
		• Develop plans to ensure that:
		  • Referrals are accepted from pre-conception to 24 months postnatal
		  • Partners can access mental health assessment including signposting or referral as needed.
		  • Increase the range of psychological therapies available.
		
		• With support from the SW Provider Collaborative and Children's Board to establish a programme of work to design a whole system perinatal clinical pathway which brings together existing provision and is integrated and co-ordinated with specialist support, education, and support.
			Women, with mental illness, receive the postnatal care they need pre and post birth
			
			Opportunity to build perinatal mental health care into wider system response to improve overall health and wellbeing of mothers
			
			Children born to women with mental illness have improved early years outcomes
			
			Families and partners receive better mental health support, advice and guidance leading to general overall improved outcomes

Year 1 and 2 (operational plan detail)

Mental Health – Children and Young People's Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Children and young people have access to timely mental health care and support	At least 15,754 children and young people will access mental health assessment. Working in partnership with the Children's board the ICS will develop a 3-5 year plan to continue growing access to mental health support, care and treatment for children and young people, using a THRIVE based approach. By 2027/28 95% of schools in Devon will have access to Mental Health in Schools services 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 to embed any amendments to meet new policy and guidance for years 2-3	• Working with the Devon wide Children's Board to support the Integrated Care System to develop a 3 to 5 year plan to increase access to CYP mental health, care and treatment • To roll out Mental Health in Schools programmes to those schools with allocated funding in year 1 • To support Children's services complete formal evaluation of the MH in Schools programme in year 1 with a view to commission in year 2 for 95% of Devon schools to be able to access a minimum standard of MH in Schools • To agree plans to embed any amendments to MH in Schools to meet new policy and guidance for years 2-3 • Improving support offered to CYP cohorts through transition towards adulthood delivered through joined up policy and decision making via the Children's board and the Collaborative arrangements • Review effectiveness of current arrangements for transitions across CYP and adult MH pathways through co-production of care pathways taking into account data, feedback and outcomes leading to revision of commissioned services to more effectively meet needs	Children and Young people get mental health intervention at the earliest opportunity Prevention of increasing likelihood of long term mental illness is at the forefront of school response to mental health and wellbeing response Joined up CYP and broader adult MH response to meet the needs of young people with a mental illness

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Devon will sustainably eliminate 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 transform mental health, in-patient services Review of commissioning arrangements for service delivery completed ICS will establish a comprehensive understanding of housing, employment and educational needs to inform strategic development plans for Devon and these plans will include options to meet the needs of people with complex mental health needs including those with drug and alcohol dependency.	• Set out a 3-year plan to localise and transform mental health, in-patient services • Mental Health providers will ensure person-centred planning and support minimises the risk of admission to hospital, and where admission is unavoidable, will ensure this is for the shortest time possible • Support the ICS to complete a comprehensive review of housing, employment and educational needs to inform strategic development plans for Devon to meet the needs of people with complex mental health needs including those with drug and alcohol dependency • Review of community provision and pathways across health and social care • The IPP team to complete due diligence with NHS Devon to potentially move Older Persons and Learning Disability out of area beds to the IPP team. Impact to ensure effective review and oversight of all adult MH specialist out of area placements with a view to an overall reduction in OOA and ability to reinvest in supported housing in Devon for people with serious mental health needs	People with serous mental illness will be cared for close to home when they need a hospital admission People will be provided with a range of alternatives to hospital care when in mental distress When admission is needed it will be timely and of high quality minimising the need for long term admission Opportunities to reinvest any reduction in costs by brining people back to Devon

One Devon

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
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.	• Through the Collaborative support Local Care Partnerships to focus enabling services such as smoking cessation and access to diabetes clinics to direct support to people with severe mental illness • Deliver the revised system model for prescribing anti-psychotic drugs and monitoring physical health in people with severe mental illness (SMI) • Support LCPs to ensure people with SMI have access to an annual GP led physical health check leading to a meaningful care plan to meet their physical health needs • Review options to share data effectively across MH providers and primary care to reduce duplication of effort and increase use of resource • Support ICS to consider mental health in the development of physical health policy	People with serious mental illness get the right physical health care that is planned effectively to support improved health outcomes Joined up health care planning across GPs and specialist mental health services is effective and positive for people with an SMI Data evidences improvement in meeting national standards

One Devon

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
People experiencing mental health crisis will be able to get the help they need as early as possible	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. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year one	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. Deliver the 111 First Response standard for mental health Data influences commissioning and planning decisions to ensure services operate safely and effectively Plan to deliver the National Partnership (NPA) agreement with the police and partners agreeing some areas for focus in year on including implementation of the revised MH Act	People in mental distress get the right care through the right person and/or service to reduce escalation of need 111 is able to effectively support people in mental distress reducing need for people accessing A&E departments The Police and Mental Health services work in partnership to effectively meet the needs of people who are in a mental health crisis Delivery of the new MH Act is successful

Year 1 and 2 (operational plan detail)

Mental Health – Adult Mental Health

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

Transformation of adult community mental health provision will be complete, integrating care locally with the right partners across localities.	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 will achieve clinical recovery
	
	Mental Health services will operate a “no wrong door” approach
	
	Improve the use of data to influence commissioning and planning decisions
	
	Develop a commissioning 3- year plan to address the mental health needs of 16 – 25 year olds, without a psychosis
	
	Ensure effective, timely and consistent early intervention in psychosis services are commissioned
		• Deliver the Community Mental Health transformation programme by end of 24/25
		• Recruit fully to key roles funded in 23/24 to further enhance MH community care
		• Develop a commissioning 3 - year plan to address the mental health needs of 16 – 25 year olds, without a psychosis
		• Commission a consistent Devon Early Intervention Psychosis service (tailored to local need where indicated)
		• NHS Talking Therapies will:
		  • Monitor uptake of digital offer and work with provider to support promotion of offer.
		  • Continue to increase the presence of specific workforce in wider teams to promote referral to NHS Talking Therapies and monitor impact.
		  • Continue to enhance existing close working relationships with primary care mental health teams and NHS Talking Therapies to promote access to IAPT, working to understand and respond to barriers to referral and ensure the breadth of offer is understood. Monitor impact on referral patterns.
		  • Ensure optimal use of trainees clinical capacity to support increased service access
			People access MH care quickly and are supported by multi agency teams ensuring need is met by the most appropriate service
			
			MH community services have increased staffing across the providers with an improved ability to meet demand

Year 1 and 2 (operational plan detail)

Mental Health – Mental Health for All

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact
Improve life opportunities, including reducing the need to place people out of area to meet their care needs, for people with a mental illness	Work to influence partners to ensure that 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 will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. MHLDN Provider Collaborative will develops a system wide assertive outreach plan for people with significant rehabilitation and complex emotional needs. Formal evaluation to inform future commissioning intentions across Health and Social to increase capability of supported living market. Individual Placement Support will achieve supporting 1,196 people with mental illness into work	• Support the ICS to develop housing plans for people with severe mental illness, learning disabilities and/or neurodiversity and rough sleepers supporting market development of extra care and supported housing. • Support the ICS to develop 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 • MHLDN Provider Collaborative will integrate with existing housing forums in Devon to inform and influence planning approaches so that the needs of people with severe mental illness, learning disabilities and/or neurodiversity are represented. • Develop and deliver system a defined and costed plan for enhanced support for people with significant mental health rehabilitation and complex emotional needs. • Complete an evaluation of need re: people with SMI to inform future commissioning intentions across Health and Social to increase capability of supported living market. • Talkworks (NHS talking Therapies) to develop and recruit to new employment support roles (two year DWP funding) • Talkworks and VSCE contracted services for supporting people with mental illness will achieve supporting 1,196 people with mental illness into work	People with SMI get the right housing and housing support to maintain their wellbeing and reduce likelihood of relapse in their mental state People are supported to remain in work and/or employers are supported to understand the needs of people with SMI working in their organisations Devon has an improved housing offer to meet the needs of people with SMI and dual diagnosis of dependency

Year 1 and 2 (operational plan detail)

Mental Health – Older Adults

Smart Objectives	Milestones – Year 1	How are you going to achieve – actions you are going to take	Impact

People will have a timely dementia diagnosis and planned onward care and support.	Devon will attain 63% of the required national standard of 66% dementia diagnosis rate
	
	A formal commissioning review of memory assessment provision will be completed to align capacity to demand alongside outlining any gaps in ability to meet demand
	
	Development of a system-wide Dementia plan to support people with dementia.
	
	Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care
	
	Review of commissioning arrangements for service delivery for 24/.25 operating planning
		• A formal commissioning review of Devon memory assessment provision will be completed to consider capacity needed to meet demand alongside outlining any gaps in ability to meet demand. The review will identify patterns in wait times, referrals and diagnosis rates. Outputs to feed into 24/25 operational planning and revised service specification
		• The ICS will develop a 5 year dementia plan that develops a partnership system approach for dementia, based on shared goals and ambitions with broad sign up
		• In year 2 implement the partnership approach
		• Supported by Local Care Partnerships:
		  • Promote and support the Dear GP support tool for care homes
		  • Direct engagement with target GP practices to support improved diagnosis rates
		• Older Persons mental health services will work with partners to consider all options to work collaboratively and integrate care where that is the right approach, in particular on hospital discharge pathways and joining up frailty and dementia care
		• Review of commissioning arrangements for service delivery for 24/.25 operating planning
			People with possible dementia receive a timely diagnosis that is supported by a personal plan for onward support
			
			Devon has a defined dementia strategy that provides a whole system integrated approach

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 2024 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 2024 (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, parents, carers and primary care to agree and co-produce a sustained promotional campaign to improve awareness and promote the uptake of AHC. Work underway with the PCN 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 gap 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

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 Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, 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 Understand relationship with LCPs and interface with other Provider Collaboratives	**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 and working in the context of LCPs and other Provider Collaboratives Integrated model of care co-designed and produced	**March 2028** Primary and Community Collaborative integrated and embedded within the Devon operating model, and recognised as high functioning Integrated model of care implemented in each of the five Local Care Partnership areas

One Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Integrated 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.	**March 2024** • Implement remote clinical support (Immedicare) to a further 60 care homes across Devon • Reduce Community Services waiting lists	**March 2025/26** • 100% PCNs and Community MDTs with defined integrated approach – cross organisational MDTs that include community health, social care and VCSE input • Evaluation of care home clinical support	**March 2028** • 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
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, by 2028	• 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%	• Increase 2 hour response target to 80% • Increase range and targets for services as set out as Intermediate Care nationally • Understand viable model for Devon to implement a single coordination centre	• Increase 2 hour response target to 90% • Digital maturity which enables coordinated activity across out of hospital services in Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention	**March 2024** • Implement CVD prevention plan, and those for Diabetes, Hypertension, Respiratory and other Long Term Conditions	**March 2025/26** • 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
Avoiding admissions 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 • Deliver 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

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
Personalised care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)	**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 • Frailty patients and those living with Dementia experience personalised care in all out of hospital services

One Devon

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Sustainable General Practice We will have sustainable and high quality general practice which operates within local and national Strategic Frameworks, and which has agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change.	• 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
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market - *quality* - *Price (funding)* - *Information, advice and signposting*	• Each LA completes their Market Sustainability Plans as required by the Market Sustainability and Improvement Fund • Market oversight compliant as per the CQC Assurance Framework • Review discharge model to ensure the market can support hospital flow	• Complex Care alternative models of care developed • Year 2 of market sustainability plans delivered	

Year 1- 5 Objectives and Milestones

Primary and Community Care

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes	• Tender for new Supported Living contract for Devon (first specification and pricing structure introduced) to improve choice, control and quality of tenancies through the separation of housing and support. • Make better use of Extra Care schemes across Devon. • Work with District/City Councils to ensure that local plans include supported housing in communities for people we support. • Make better use of Shared Lives schemes across Devon, particularly for young people age 16+. • Set out with the independent provider market the strategic objectives that we are working to achieve in Devon, including quality provision, sustainability and the training/skills required	• Work with independent providers to develop different models of Supported Living, including individual units in a hub and spoke model within communities. • Develop Extra Care schemes for people with dementia and for people with Learning Disabilities. • Increase supply of Shared Lives placements across Devon. • Continue work with District/City Councils to ensure that local plans include housing for people we support.	

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Collaborative working We will have a Primary and Community Care Collaborative which functions Devon-wide by 2026. This will enable the development of a model for further integration across Social Care, Mental Health and VCSE organisations, 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	• Devon Collaborative Board development sessions will support and inform the development of the GP Provider Collaborative • Assess the current position and the maturity of the GP Provider Collaborative against a recognised framework/process • Initiate and explore scope and remit of a Community Care Provider Collaborative, in the context of Local Care Partnerships • Adopt the Devon operating model for the Provider Collaborative and establish timeline for development and integration to form single function • Explore ways in which broader Primary Care – Pharmacy, Optometry and Dentistry will be incorporated	1. Primary Care Provider Collaborative will be able to represent the primary care voice and input in a more equitable way within the system 2. The Provider Collaborative will be able to contribute to decision making regarding service improvement and funding which will lead to improved patient access and more resilient services
Integrated 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.	**March 2024** • Implement remote clinical support (Immedicare) to a further 60 care homes across Devon • Reduce Community Services waiting lists	• 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 - 10% reduction in Community Services waiting list by 2024 - LTC 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

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Urgent Response We will develop Urgent Community Response services, which meet the 2-hour response target to avoid hospital admissions for 90% of referrals, and other services set out as Intermediate Care services nationally, 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%	• 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
Proactive Care Each PCN will identify the people that are most likely to benefit from, and apply an integrated proactive approach, with a focus on prevention and early intervention	**March 2024** • Implement CVD prevention plan, and those for Diabetes, Hypertension, Respiratory and other Long Term Conditions	• Implementation of Population Health Management across all areas where PCNs have signed up • Joint multi-disciplinary training sessions which develop the local model and offer • Delivery of long term condition plans for specific conditions across the ICB and Public Health teams	1. Population health management enables delivery to local population needs, addressing areas of health inequality 2. Improved management of long term conditions which leads to reduced unplanned care

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
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. Increase admission avoidance and increase hospital discharge ability 2. More people will experience supported care at home
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. Increase admission avoidance and increase hospital discharge ability 2. More people will experience supported care at home
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	• Ensure 75% of PCN's currently using Joy App are embedded in practice • Ensure 75% of VCSE based Social Prescribers are currently using Joy App • Negotiate with the remaining 25% of each to be onboarded by March 2024 • Deliver bespoke training sessions on how to use the Joy App for the remaining 25% • Link the Waiting Well programme led by Living Options Devon to the Joy App Marketplace	1. The number of people receiving Social Prescription and the impact of this is known and understood 2. An up to date Market place of community assets is maintained 3. Social Prescribers in PCN's and the VCSE are better supported

Year 1 and 2 (operational plan detail)

Primary and Community Care

SMART objective Year 1 & 2	Milestone	How are you going to achieve – actions you are going to take	Impact
Personalised care A personalised approach will be utilised across every integrated team, prioritising those population groups who will benefit most from the approach (end of life, frailty and dementia)	**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	• Personal health budget process already in place and has been extended to personalised discharge budgets to support those leaving hospital • End of Life commissioning review recommendations to be progressed • Each locality area developing a healthy ageing board or equivalent to oversee local delivery of the health ageing handbook • Population health management will inform local focus on their most vulnerable groups	1. Reduced unplanned care for those vulnerable groups who have a personalised approach 2. Improved patient and family experience for those experiencing personalised care 3. Increased numbers of people dying in their chosen place
Sustainable General Practice We will have Sustainable and high quality general practice operating within local and national Strategic Frameworks, with agreed standards at GP Practice and PCN level by 2028, with a planned approach to managing change.	• 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%)

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
Market Sustainability Local Authorities meet their Care Act Duties (section 5) by ensuring a sufficient care market - *quality* - *Price (funding)* - *Information, advice and signposting*	• Each LA completes their Market Sustainability Plans as required by the Market Sustainability and Improvement Fund • Market oversight compliant as per the CQC Assurance Framework • Review discharge model to ensure the market can support hospital flow	• To be developed	1. High quality social care provision available across Devon supported by a diverse range of resilient independent and voluntary sector providers
Independent Living Innovative Extra Care and Supported Living schemes will be developed to provide people with greater independence and support them to remain in their own homes	• Tender for new Supported Living contract for Devon (first specification and pricing structure introduced) to improve choice, control and quality of tenancies through the separation of housing and support. • Make better use of Extra Care schemes across Devon. • Work with District/City Councils to ensure that local plans include supported housing in communities for people we support. • Make better use of Shared Lives schemes across Devon, particularly for young people age 16+. • Set out with the independent provider market the strategic objectives that we are working to achieve in Devon, including quality provision, sustainability and the training/skills required	• To be developed	1. More people supported to live independently in their own homes

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 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)	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.
			• Reduction in waiting lists, with a focus of eliminating >65 by April 2024 and >52 week waits by April 2025.
			
			• Reduce outpatient follow-ups (OPFU) in line with national ambition of 25% against 2019/20 by March 2024.
			
			• Reduction in agency or locum costs (key deliverable for PASP – to be quantified).
			
			• Part of the all age target, to ensure 85% theatre utilisation for all elective procedures from April 2023 onwards.
			
			• Reduction in zero LOS for CYP with common childhood illness (to be quantified).

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 will result in the following impacts: • Waiting list for a neurodivergent diagnosis will have reduced to within NHS standard time frames (18 weeks) by 2025. • Requests for EHCPS will have decreased to bring Torbay, Devon and Plymouth in line with the national average. • We know that the baseline experience satisfaction for families who have neurodivergent is low and through the keyworker scheme we will see an incremental increase for parents / carers and CYP for the support they receive. • The number of children and young people on multiple waiting lists is reduced (target to be determined). • We are hoping to undertaken and economic evaluation of this benefits of this piece of work.
	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 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, which will have the following impact: • Greater confidence and capacity to support SLCN needs within the universal workforce (to be tested trough workforce survey). • Waiting list for a SLCN intervention will have reduced (95% CYP seen within the constitutional standard) to within NHS standard time frames (18 weeks) by 2025. • % of CYP requiring SEN support is moving towards national average rate per population for SLCN. • % of CYP requiring EHCP is moving towards national average rate per population for SLCN.

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:
	• System wide Maternal Mental Health offer including VCSE
	Enabled by:
	• Community outreach and engagement
		• 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
			CQC survey indicated areas for improvement:
			• There will be a 1 point increase in the post natal experience scores by 2024.
			• There will be a 0.1 point increase in experience of antenatal check-ups by March 2024.
			• There will be a 0.2 point increase in labour and birth experience by March 2024.
			
			For all maternity services to have full Baby Friendly Initiative (BFI) accreditation by 2025.
			
			Improved Outcomes
			• A 50% reduction by 2025 in:
			  • Stillbirth
			  • Neonatal Death
			  • Maternal Death
			  • Intrapartum Brain Injury
			• Reduction in preterm births from 8% to 6% (Nationally)
			• Increased breast milk at first feed to 78% by March 2024 (in line with regional value).
			• Increased breastfeeding at 6-8 weeks to 55% by March 2024 (in line with regional value).
			• Smoking at time of Delivery will be at 6% or less by 2024.

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.
			Increase the establishment (in post) vacancy & decrease sickness absence rates for Obstetricians, Neonatologists, Midwives, Maternity Support Workers and Neonatal Nurses (this should be in line with individual unit recommendations from BirthRate+ & Ockenden) - target to be confirmed once review has been undertaken to determine the accurate baseline.
			
			NHS staff survey questions on staff experience & morale (target to be confirmed once review has been undertaken to determine the baseline).
			
			Every newly registered midwife to have a preceptorship programme by 2025.

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.	**Year 1:** • Planning, monitoring and evaluation with a focus on health inequality groups. • Use data from national asthma dashboard (including deprivation data) and risk stratification tool to target support to PCNs and practises with children at high and very high risk. • Produce targeted communications with schools in most deprived areas. • Build relationships with SW CYP epilepsy team to support alignment of regional and national guidance and to local priorities, with consideration of priority groups. **Year 2:** • Deliver the priority service development improvement plans for asthma, diabetes and epilepsy with consideration of four priority groups. • Promote and share learning from eclipse tool to improve number of practises using the data.	**Asthma:** • To have a year on year reduction in emergency attendance and unplanned admissions due to asthma in secondary care. • 55% of GP practices within Devon have prescribed over 6.7 SABA inhalers within a year. Initial aim in the first 2 years is for 80% of GP practices to be prescribing 6.7 or less SABA inhalers per year for CYP. • To have jointly reviewed with primary care 90% of CYP identified as "Very High Risk" on eclipse in Devon by July 2024. • To have a remote review and recommendation with primary care - 80% of CYP identified on eclipse as "High Risk" and prescribed 3 or more SABA inhalers within a year by July 2024. **Diabetes:** • Identify Trusts with greatest disparity in uptake of rtCGM and insulin pumps based on deprivation and ethnicity. • Support Trusts where disparity has been identified to increase access to rtCGM and insulin pumps. • Increase proportion of CYP with Type 2 diabetes receiving NICE recommended care processes (all six health checks: HbA1C, Blood Pressure, BMI, Urinary Albumin, Foot exam & Thyroid). • Ensure CYP in Devon have equitable access to diabetes care and a reduction in variation across the three NHS Trusts, evidenced by a range of outcome measures in the National Paediatric Diabetes Audit (NPDA).

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.	

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.	Health input into EHCPs is provided within the statutory timeframe of 6 weeks – target 95% by 2024. There will be a reduction in the requests for EHCPs (due to appropriate help and support being received early). Individual targets for each Local Authority being set by the SEND programmes and will be confirmed. Parents report through Parent / Carer surveys that co-production is embedded within SEND improvement programmes. The percentage of children and young people absence from school with EHC Plans to reduce by 2025 to less than 10%. The percentage of new EHC Plans that meet the quality standard in the Quality Assurance framework greater than 70% by 2025.

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 2,956 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

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

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 management 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.	Achieving 96% bed occupancy by end of the financial year (31st March 2024)		

Year 1 and 2 (operational plan detail)

Acute Services Sustainability - Urgent and Emergency Care

SMART objective	Milestone	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	• We have seen a significant improvement in call answering performance in 111 as a result and an increase in clinical assessment service (CAS) resources. • Our priorities for next year are to grow the workforce across the service by better matching health advisor capacity to demand to improve call answering performance further and strengthening the clinical workforce out of hours to increase capacity and time to treatment. Additionally, we will be looking to embed digital development and dedicated end of life care out of hours.	Better outcomes for patients calling 111, and getting patients to the right place, first time.
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	• Partnership and system working to support standardisation of the UTCs across Devon. An ICB programme board will sit at the heart of this workstream to ensure this is delivered. • On-site UTC and GP streaming – support the contracting of these workstreams to ensure they are delivered efficiently and effectively.	Equity of community urgent care offer across Devon
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	A more consistent model will be in place by enabling more robust and visible pathways for any referring service. • Development of an ED based SDEC environment. • Development of paediatric SDEC services and palliative care support in ED. Further pathway development and frailty/paediatric SDEC will enable admission avoidance for patients being assessed for inclusion onto the VW without attending an acute site, which will release capacity within acute “front door” departments such as ED/SDEC/AMU. In addition, the opportunities of closer links with community pathways such as UCR 2hr response, falls teams, EHCH, 111 and 999 will continue to be explored to maximise the potential for acute admission avoidance.	Reduction in avoidable admissions and support our most vulnerable residents across Devon

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.	Achieving 96% bed occupancy by end of the financial year (31st March 2024)	The system is committed to increasing acute bed capacity and reducing bed occupancy through supressing growth in non-elective admissions to c2.5%, increasing bed capacity through escalation and community bed capacity and decreasing rates of no criteria to reside. Developments in same day emergency care will contribute to reductions in average length of stay. Block booking of P2 and P1 capacity will be important to ensure available support is in place to meet the NCTR target and to support in particular 92% G&A bed occupancy. Support from the VCSE will be a key priority for the next financial year in supporting pathway 0 and pathway 1 flow.	Improved patient flow through each acute site and more capacity for patients who need care the most

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 groups 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	Implement pathways in full for a defined vulnerable population
For the projected need for specialist housing, accommodation to meet the needs of older people, and affordable housing, to be recognised in Local Plans across Devon to support housing delivery	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; • reduced the number of households in temporary accommodation by 10% • reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0 • Increased the % of people sleeping rough who get an offer of accommodation to 100% • increased in the number of households successfully prevented from becoming homeless by 30%	**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 recognised in Local Plans across Devon to support housing delivery	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; • *reduced the number of households in temporary accommodation by 10%* • *reduced the number of families placed in temporary B&B accommodation for more than 6 week to 0* • *Increased the % of people sleeping rough who get an offer of accommodation to 100%* • *increased in the number of households successfully prevented from becoming homeless by 30%*	**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.
Unpaid carers will be supported to remain in or re-enter employment	Resources developed to support unpaid carers to remain in or re-enter employment.	Unpaid carers able to access additional support to remain in or re-enter employment.	Increase in the number of unpaid carers able to remain in and re-enter employment.
Build on resources developed across local authorities to support more people into employment.	Resources and services enhanced and developed to support people into employment.	People able to easily access resources to support them into employment.	Increase in the number of people being supported to find and retain employment.

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 being outcomes from 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 from individual impacts.

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
Unpaid carers will be supported to remain in or re-enter employment	Resources developed to support unpaid carers to remain in or re-enter employment.	Plan in development	More unpaid carers remaining in and re-entering employment.
Build on resources developed across the local authorities to support more people into employment.	Resources and services enhanced and developed to support people into employment.	Plan in development	More people being supported to find and retain employment.

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 based on the national strategy which sets local delivery priorities for the year	Action plans published and delivered	Action plans published and delivered	Action plans published and delivered
Our 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
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups	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 based on the national strategy which sets local delivery priorities 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.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be in line with or below the England average
Our 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.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be 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
Prioritise ongoing provision of suicide training programmes to continue to expand system knowledge of suicide and suicide prevention, coordinated by local Suicide Prevention Groups	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. Aiming for number?
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.	We will stabilise the suicide rate this year and reduce year on year so by 2028 our suicide rate in each local authority area to be in line with or below the England average

Year 1- 5 Objectives and Milestones

Health Protection

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Reduce occurrences of healthcare associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA)) *and* community onset community associated (COCA) occurrences of HCAIs	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10%	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% from Year 1	To have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 25% or more across a 5 year period
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 children and young people (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 Equality Diversity and Inclusion (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

One Devon

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 children and young people (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	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
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 Health care associated infections (HCAI) (Clostridium difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA)) *and* community onset community associated (COCA) occurrences of HCAIs	By Year 1, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by 10% By Year 2, to have reduced occurrences of HCAIs (C.diff, MRSA, gram negative organisms) by a further 10% 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

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
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
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

One Devon

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
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
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

Community Learning & Development

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
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)	By 2025: Local Care Partnerships will have co-produced a plan with local communities, including particularly disadvantaged groups, to empower and support groups to be more resilient (One-Devon-5-year-integrated-care-strategy) By 2025: Local Care Partnerships will have sequenced their support offer to communities based on level of deprivation and need By 2025: the role of communities and health will be fully recognised and local plans to invest in this as one of the four pillars of population health will have been created. (King's Fund)	By 2028: we will have directed our collective buying power to invest in and build for the longer term in local communities and businesses (One-Devon-5-year-integrated-care-strategy) By 2028: we will have supported the development of place-based partnerships that involve a wide range of partners to act on the full range of factors that influence health and wellbeing By 2028 communities will have a sense of purpose, hope, mastery and control over their own lives and immediate environment. (Health Creation Alliance, 2022) .

Year 1- 5 Objectives and Milestones

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, equipped and trained to agreed standards, 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 Local Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are 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
By 2028 local communities, and particularly disadvantaged groups, 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'	Milestones to be developed.	Milestones to be developed.	Milestones to be developed.

Year 1 (operational plan detail)

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 created 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)

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

One Devon

Year 1 (operational plan detail)

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 Care Partnerships will have integrated the role of community partnerships into their infrastructure and planning to ensure the communities of Devon are 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
By 2028 a Community Development workforce will be supported, equipped and trained to agreed standards, 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 occupat-ional standards (NOS) training • Identified wider CPD opportunities with local/regional providers	Best use of limited resource, shared engagement and development opportunities

One Devon

APPENDIX D
Enabling programme Milestones

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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, Innovation and Improvement

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
Build and strengthen networks at local, system, region and national level by March 2024	Map of stakeholders, strengths, assets and barriers	Networks in place across system and Peninsula	
Promote research and increase patient sign-up with demonstrable increase by end 2026	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 by having a ICB RII Team by April 2024	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 by end March 2025	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, Innovation and Improvement

SMART objective	Milestone – Year 1	How are you going to achieve – actions you are going to take	Impact
Build and strengthen networks at local, system, region and national level by March 2024	Map of stakeholders, strengths, assets and barriers	Establish RII network with COIS and provide ongoing support. Strengthen system networks and provide a point of co-ordination	There is routine evaluation, shared learning and roll-out of good practice
Promote research and increase patient sign-up with demonstrable increase by end 2026	Agreements in place with providers to promote Research and Innovation	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	All sections of Joint Forward Plan include 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. This will be demonstrated in planning documents
Develop capacity and capability by having a ICB RII Team by April 2024	Recruit to Joint Appointment with the AHSN	Agree Job description. Undertake recruitment. Induction and integration with posts in NHS Cornwall and Isles of Scilly (CIOS) and Somerset. Ensure support available within the ICB for this role	Increased capacity to support RII
Develop underpinning structure and governance mechanisms including evaluation and links to VBA principles by end March 2026	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	There will be increased activity in the areas targeted by the Regional Innovation Strategy

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 on an ongoing basis	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 Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement	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 including CVD, diabetes and respiratory	Co-ordinated programmes of work delivering on national targets with a particular focus on CVD, Respiratory and Diabetes	High Impact Interventions in place in line with national major conditions strategy	
Develop the ICB and NHS partners as Anchor Organisations by March 2026	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 2025	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	Milestone	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 on an ongoing basis	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 measurable improved outcomes
Ensure delivery of Core20PLUS5 deliverables (including adult and CYP) in line with national reporting requirement	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 including CVD, diabetes and respiratory	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 March 2026	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 2025	By April 25 People led change will be demonstrable throughout the ICS	Continue to support existing programmes of work and facilitate shared learning	Demonstrable changes in the way we approach commissioning for improved population health outcomes.

Year 1 - 5 objectives

Communications and Involvement

The communications and involvement mechanisms that will support delivery of the JFP include:
Support the use of the new ICS involvement platform ‘Let’s Talk’ the and citizens’ panel that programmes can utilise to support online involvement activities across the system
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.
Develop a system approach to communications and involvement, working with professionals from all system partners to support consistent communications, involvement, collaboration, sharing of best practice, and co-production.
Work with partner organisations such as Healthwatch Devon, Plymouth and Torbay and the wider VCSE sector, to deliver engagement on our behalf and to provide insights and connection to local populations
Support JFP programmes to work in partnership with diverse and vulnerable communities across the system, building a continued dialogue with communities
Provide expertise and guidance to those working on the JFP on how to consistently apply best practice principles for co-production, involvement and consultation.
Co-ordinate and support JFP leads to involve our 3 local overview and scrutiny committees addressing our statutory requirements under the Health and Social Care Act 2012, and also ensure we continue to build pro-active and meaningful relationships with all three Overview and Scrutiny Committees (OSC) in Devon, Plymouth and Torbay both individually and jointly as appropriate.

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.

Improve innovation, performance and efficiency through a diverse workforce

- 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.
- Consider race equality as part of all commissioning strategies.
- Support our leaders to champion the benefits of equality and diversity as means to improving Devon's financial and operational performance
- Support staff to feel safe, including listening and providing support to staff and managers.
- Improve data on equalities and ethnicity, including in the independent provider market.
- Include a clause in our social care contracts with acceptable standards that are monitored.

Ensure Devon's health and care services are inclusive and accessible to everyone

- 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.
- Work in partnership with the voluntary sector to understand needs and support people from diverse and vulnerable populations to have better access to health and care service.
- Support, empower and equip patient facing staff to take an inclusive approach to the accessibility and delivery of services

One Devon

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	• Detailed 5 year workforce plan in place for NHS providers. • Initial development of 'first cut' of Primary & Social Care workforce plan. • Build and launch of One Devon Strategic Workforce Planning tool for Acute and MH providers.	• Detailed 5 year workforce plan for Health, Primary & Social Care workforce. • Further development of One Devon Strategic Workforce Planning tool to roll out to Primary and Social Care workforce.	• 5 year workforce plan further developed with detailed data from VCSE sector included. • Further development of One Devon Strategic Workforce Planning tool to roll out to VCSE and other sectors.
System level attraction solutions in place that source new talent and position Devon System as an employer of choice.	• Development of a set of attraction strategy principles and a system recruitment event planner for 23-24 • Introduction of a Career Hub in schools to support youth engagement (work experience and career pathways) • Online Devon/SW attraction and careers page (one landing page to support recruitment, careers, apprenticeships, work experience, events etc) • System approach to simplifying recruitment and removing barriers to recruitment	• Multi-year System attraction strategy and event planning in place and securing new talent into Devon. • Development of a Devon talent pool to have a readily available pool of resources to fulfil requirements. • One Devon employer brand fully developed and utilised across all System partners to support recruitment of high calibre talent into Devon.	• One Devon recognised as employer of choice. • Talent pipelines developed for key roles across System partners.

Year 1- 5 Objectives and Milestones

Workforce

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
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	• Opportunities to develop new skills, knowledge and experience that support the needs of the population/community. • Our workforce will be built to meet the needs of the local population and embrace new roles built around skills, knowledge, experience and behaviours. • Staff have access to System-wide development opportunities for their personal and professional growth.	• Skill diversity of new workforce models & ways of working across One Devon recognised as adding significant value and fully embedded into service redesign across all System partners.
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future	• New roles and ways of working identified through strategic workforce planning with associated L&D and career pathway plans in development	• Opportunities to develop new skills, knowledge and experience that support the needs of the population/community. • Our workforce will be built to meet the needs of the local population and embrace new roles built around skills, knowledge, experience and behaviours. • Staff have access to System-wide development opportunities for their personal and professional growth.	• Skill diversity of new workforce models & ways of working across One Devon recognised as adding significant value and fully embedded into service redesign across all System partners.

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	• Detailed 5 year workforce plan in place for NHS providers (Yr1) and Primary & Social Care (Yr2) • Build and launch of One Devon Strategic Workforce Planning tool for Acute and MH providers.	• Roll-out of strategic workforce planning self-assessment tool across all sectors of the System to inform workforce plan numbers. • Development of Devon strategic workforce planning tool and methodology to standardise process and embed best practise across Devon partners. • Ongoing engagement with whole System stakeholders to inform Primary & Social Care workforce plan.	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.	• Development of a set of attraction strategy principles and a system recruitment event planner for 23-24 • Introduction of a Career Hub in schools to support youth engagement (work experience and career pathways) • Online Devon/SW attraction and careers page (one landing page to support recruitment, careers, apprenticeships, work experience, events etc) • System approach to simplifying recruitment and removing barriers to recruitment	Multiple workstreams in place under Attraction, Retention & Workforce Solutions 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 <1% of pay bill Workforce growth lower than activity growth in each of the next 5 years
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
We will promote employment opportunities that are rewarding, recognising the value of the ASC workforce and develop learning and career pathways fit for the future	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 Attraction, Retention & Workforce Solutions Pillar, Workforce Strategy and Learning & Education Pillars 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. • System level working to create new roles, increase the skill-diversity of our workforce (ie making greater use of our unregistered workforce).	Reduced turnover – target (tba) Reduced vacancy levels -target (tba)

One Devon

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	
Develop a commissioned offer for digital solutions and technology enabled care and support, including awareness raising and increasing diversity of prescribers (social care)	To be populated by social care		
Consider use of the Disabled Facilities Grant for technology solutions, including investigation of handyperson schemes focusing on ‘low-tech’ as well as ‘high-tech’ solutions	Complete feasibility work to understand the opportunity to use DFG to support tech and digital solutions	Implement plan to utilise DFG to increase the availability of technology solutions that support people to remain in, or return to, their own homes	

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

One Devon

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

Procurement

Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5
• development of improved collaborative working, intra system financial framework, contracting and risk sharing protocols	• commence pivot of funding upstream towards prevention and health inequalities	▪ continued recovery to sustainable financial balance by system and by organisation
• agreement of functions where a shared service arrangement should be pursued helping to inform the organisational restructure within reduced Running Cost Allowance	• take on formal delegation of Specialised Commissioning functions	
• development of Long term Financial Plan, trajectory to recover and sustainable financial balance over a 3-5 year scenario range	• corporate ICB right sized for RCA (Running Cost Allowance) allocations, emerging maturity of LCP's	
• development of system wide interpretation of the Drivers of the Deficit to underpin future recovery	• estates strategy finalised to underpin prioritised system wide capital allocations	
• delivery of 23/4 recovery and Cost Improvement Programmes both organisational, strategic collaborative, and structural		
• consolidate delegated of commissioning functions for extended primary care		

The Procurement 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 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
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

Green Plan

Smart Objectives	Milestones Year 1	Milestones Year 2-3	Milestones Year 4-5	Strategic Goal
More Devon ICB staff will make greener journeys to work.	10% increase in the number of staff making greener journeys to work	20% increase in the number of staff making greener journeys to work	40% increase in the number of staff making greener journeys to work	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities
Devon ICB will be a paper free organisation by 2028.	20% reduction in the use of paper across the ICB	40% reduction in the use of paper	Devon ICB is a paper free organisation.	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners.	Increase of 10% more products and services bought locally	Increase of 20% more products and services bought locally	Increase of 50% more products and services bought locally	We will create a greener, fairer and more environmentally sustainable health and care system in Devon, that adapts to and mitigates climate change and promotes actions to create healthier and more resilient communities

Year 1 and 2 (operational plan detail)

Green Plan

SMART objective (from previous slide)	Milestone (from previous slide)	How are you going to achieve – actions you are going to take	Impact
More Devon ICB staff will make greener journeys to work.	10% increase in the number of staff making greener journeys to work	Complete review of electric car charging points at ICB venues by March 24	Create a baseline for future improvement
		Explore the potential for subsidised public transport usage for staff by working with ICB HR teams to establish the current offer to staff	More staff are encouraged to reduce their reliance on petrol and diesel cars
		Further promote our EV Car buying scheme	
		Further promote NHS Devon's Cycle to Work scheme	
Devon ICB will be a paper free organisation by 2028	20% reduction in the use of paper across the ICB	Provide communications to staff on the cost of using paper	The reliance on paper is reduced
		Reduce the numbers of printers being made available across the ICB	
		Promote Ecosia as the preferred Internet Browser	
More products and services are bought locally promoting the concept of the Devon Pound across the ICS and its partners	Increase of 10% more products and services bought locally	Work with procurement colleagues to further develop the Social Value weightings on contract awards to include "buy local"	More things are bought locally to reduce our carbon footprint

APPENDIX E
Glossary

Glossary (A-C)

Abbreviation	Meaning
A&E	Accident and Emergency
A&G	Advice and Guidance
ABCD	Asset-based-community-development
ACE	Adverse Childhood Experience
ACS	Ambulatory Care Sensitive
A-EQUIP model	Advocating and Educating for Quality Improvement
AHC	Annual Health Checks
AHSN	Academic Health Science Network
AMR	Antimicrobial resistance
ARC	Applied Research Collaboration
ARRS	Additional Roles Reimbursement Scheme
ASC	Adult Social Care
B&B	Bed and Breakfast
BFI	Baby Friendly Initiative
BMI	Body Mass Index
BPTP	Best Practice Timed Pathway
C. diff	Clostridium difficile
C2C	Clinician to Clinician
CAS	Clinical Assessment Service
CFO	Chief Finance Officer
CHC	Continuing Healthcare
CIC	Community Interest Company
CIOS	NHS Cornwall and Isles of Scilly
CIP	Cost Improvement Programme
CLD	Community learning and development
CMO	Chief Medical officer
COCA	Community onset community associated
Core20PLUS5	The most deprived 20% of the national population PLUS the 5 ICS chosen population groups experiencing poorer than average health access, experience and/or outcomes that may not be captured in the core 20.
CPD	Continued Professional Development
CQC	Care Quality Commission
CRGs	Clinical Referral Guidelines
CRN	Clinical Research Network
CSDS	Community Services Data Set
CT	Computerised tomography
CTR	Care and Treatment review
CUC	Community Urgent Care
CVD	Cardiovascular disease
CYP	Children and Young People

Glossary (D-I)

Abbreviation	Meaning
DASV	Domestic abuse and sexual violence
DCCR	Devon and Cornwall Care Record
DDR	Dementia Diagnosis Rate
DMBC	Decision Making Business Case
DNA	Did Not Attend
DOS	Directory of Services
DPT	Devon Partnership Trust
DSR/C(E)TR Policy	Dynamic Support Register (DSR) and Care (Education) and Treatment Review C(E)TR policy
DWP	Department for Work and Pensions
EBI	Evidence Based Interventions
Ecosia	Search engine that uses the advertising revenue from searches to plant trees
ED	Emergency Department
EDI	Equality, diversity and inclusion
EHCP	Education, health and care plan
EHCS	Emergency Healthcare Plan
EPC	Energy Performance Certificate
ePHR	Electronic Patient Held Record
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EQIA	Equality and Quality Impact Assessment
ERF	Elective Recovery Fund
G&A	General and Acute
GIRFT	Getting it right first time national programme, designed to improve the treatment and care of patients through in-depth review of services
GRAIL	Healthcare company focused on saving lives and improving health by pioneering new technologies for early cancer detection
HbA1C	Haemoglobin A1c (HbA1c) test measures the amount of blood sugar (glucose) attached to your haemoglobin
HCAI	Healthcare associated infections
HEE	Health Education England
HEI	Higher Education Institution
HI	Health Inequalities
HR	Human Resources
HVLC	High Volume Low Complexity
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board (NHS Devon)
ICS	Integrated Care System (One Devon Partnership)
Immedicare	Telemedicine service providing 24/7 NHS video-enabled clinical support for care homes nationally
IPS	Individual Placement Support
IUCS	Integrated Urgent Care Service

Glossary (J-N)

Abbreviation	Meaning
JCP	Job Centre Plus
JFP	Joint Forward Plan
JLHWS	Joint Local Health and Wellbeing Strategy
JOY app	Real-time directory and case management tool that enables GPs and other health and social care professionals to easily refer into local services, helping to create a more joined-up system for service users.
JSNA	Joint Strategic needs Assessment
L&D	Learning and Development
LA	Local Authority
LCP	Local Care Partnership
LD	Learning Disability
LDA	Learning Disability and Autism
LDAP	Learning Disabilities and Autistic People
LeDer	Learning from Lives and Deaths (People with a Learning Disability and Autistic People)
LES	Local Enhanced Services
LGBTQ+	Lesbian, gay, bisexual, transgender, queer (sometimes questioning) plus other identities included under the LGBTQ+ umbrella
LIMS	Laboratory Information Management System
LMNS	Local maternity and neonatal system
LOS	Length of Stay
LPA	Local Planning Authorities
LTC	Long term condition
LTP	Long Term Plan
MD	Medical Director
MDT	Multi-disciplinary team
MECC	Making every contact count
MH	Mental Health
MHLDN	Mental Health, Learning Disability and Neurodiversity
MHST	Mental Health Support Teams in Schools model
MIS	Maternity Information System
MMR	Measles, mumps, and rubella
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MSW	Maternity Support Worker
NCTR	No criteria to reside
NEET	Not in employment, education, or training
NHP	New Hospitals Programme
NHSE	NHS England
NHSEI	NHS England & Improvement
NICE	National Institute for Health and Care Excellence
NOS	National Occupational Standards
NPA	National Partnership Agreement

Glossary (N-S)

Abbreviation	Meaning
NPDA	National Paediatric Diabetes Audit
NSS	Non-site specific
Ofsted	Office for Standards in Education, Children's Services and Skills
ONS	Office for National Statistics
OP	Outpatient
OPFU	Outpatient Follow Up
ORCHA	Organisation for the Review of Care and Health Apps
OSC	Overview and Scrutiny Committee
PACS	Picture Archiving and Communication System
PASP	Peninsular Acute Sustainability Programme
PAU/CAU	Paediatric/Children's assessment unit
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
PHE	Public Health England
PHM	Population Health Management
PIFU	Patient Initiated Follow-Up
PS	Property Service
PTL	Patient tracking list
RDUH	Royal Devon University Healthcare Foundation Trust
RII	Research, improvement and innovation
rtCGM	Real time continuous glucose monitoring
RTT	Referral to Treatment
SABA inhalers	Short-acting beta agonists
SAI	School-aged immunisation
SCORE Culture surveys	Anonymous, online tool that can be used to gain insight into a team's safety culture to help the team identify strengths and weaknesses and start to drive genuine improvement
SDEC	Same Day Emergency Care
SEMH	Social Emotional Mental Health
SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities
SET	Senior Executive Team
SIAG	System Improvement Assurance Group
SIC ODN	Surgery in Children Operational Delivery Network
SLCN	Speech and Language Communication Needs
SLT	Speech and Language Therapist
SMART objectives	Specific; Measurable; Achievable; Realist; Timebound
SOF	System Oversight Framework

Glossary (S-Z)

Abbreviation	Meaning
SOP	Standard Operating Procedure
SRM	Supplier Relationship Management
SRP	System Recovery Programme
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stopping overmedication of people with a learning disability, autism or both
SW	Southwest
SWAHSN	Southwest Academic Health Science Network
SWAST	South Western Ambulance Service NHS Foundation Trust
THRIVE	The THRIVE Framework for system change is an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and their families.
TIF	Tech Innovation Framework
TLHC	Targeted Lung Health Check Programme
TSDFT	Torbay and South Devon NHS Foundation Trust
UCR	Urgent Community Response
UDA	Unit of Dental Activity
UEC	Urgent and Emergency Care
UHP	University Hospital Plymouth NHS Trust
UKHSA	UK Health Security Agency
VBA	Value Based Approach
VCSE	Voluntary, Community and Social Enterprise
VW	Virtual Ward
WRES	Workforce Race Equality Standard