NHS Devon

Health and Care Strategy

2026/2031

Shaping NHS services to improve the health of our communities and residents in Devon

Contents

Foreword

I am honoured to introduce our new, ambitious Health and Care Strategy for Devon. This strategy reflects our shared vision to transform the way health and care services are delivered across the county, ensuring that every individual receives the right care, at the right time, in the right place.

It is shaped by the priorities set out in the NHS 10 Year Health Plan: Fit for the Future, which sets a bold and clear roadmap for the future of healthcare across England over the next decade.

The NHS Plan challenges us to build a sustainable, person-centred health and care system that improves outcomes, reduces inequalities, and supports people to live healthier lives.

Our Devon-wide strategy aligns fully with these national ambitions and goes further by placing a strong emphasis on collaboration across health, social care, voluntary, and community sectors.

We know that the challenges facing Devon's population are complex. From an ageing population to rising demand for mental health services, and the ongoing need to tackle health inequalities, we must work smarter and more innovatively.

This strategy sets out clear priorities to improve prevention and early intervention, integrate services more effectively, and support people to manage their own health and wellbeing.

By focusing on personalised care, digital innovation, and workforce development, we aim to create a resilient and responsive system that delivers high-quality care close to home. As we set out our vision for the future of health and care, we remain firmly committed to delivering services that are not only high-quality and person-centred, but also financially sustainable. This strategy reflects our dedication to making responsible choices that ensure long-term value, resilience, and equity across our system. Through our new model of delivery, we aim to safeguard resources while continuing to meet the evolving needs of our communities.

Importantly, this strategy embodies our commitment to 'place-based' care, recognising the unique needs of communities across Devon—from urban centres to rural areas.

We are determined to break down traditional barriers between health and social care, working together in partnership with local authorities, voluntary organisations, and, crucially, the people we serve.

This is a pivotal moment for health and social care in Devon and together we will build a healthier, more connected Devon.

I look forward to working with all our partners and communities as we embark on this vital journey.

Libby Ryan-Davies
Chief Strategic Commissioning & Planning Officer

Personas

The Devon personas have been developed to bring to life the experiences of people across our communities, helping us to understand the impact of health and care services on real lives.

Personas are not statistical profiles, but carefully constructed stories that reflect the complex needs, circumstances, and aspirations of different groups in our population.

By grounding planning and engagement in these lived perspectives, we can design services that respond to what matters most to people, rather than to systems alone.

The use of AI has enabled these personas to be expanded and enriched, drawing on a wide range of local and national data, strategic priorities such as the NHS 10-Year Plan, and insights from local engagement.

This approach ensures that each persona remains dynamic, evidence-based, and sensitive to emerging challenges and opportunities.

By using personas, decision-makers can more clearly see how changes in policy or service delivery might be experienced by different people.

They provide a powerful way to test ideas, explore unintended consequences, and identify opportunities for prevention, integration, and innovation.

Most importantly, they help to ensure that patient and public insights are not only heard but actively shape the design of future health and care services in Devon. Some examples of how we can apply the personas with application of the model are described on the next page.

Margaret Plum, 84, Mid Devon

Margaret's healthcare can be fragmented, hospital-focused and she has several conditions including mild dementia, hypertension, osteoarthritis, mobility issues, and she is at risk of falls. She is heavily reliant on carers and rural transport, and experiences loneliness.

Under the NHS Devon strategy her experience shifts significantly. Care is delivered closer to home through **neighbourhood health hubs** and regular **frailty checks**, reducing the need for hospital travel.

Prevention becomes central: dementia-friendly programmes, falls-prevention groups, and personalised exercise support improve her independence.

Technology plays a supportive role, with a simple **wearable fall detector** linked to an appropriate responder, ensuring quick response and reassurance.

Social prescribing connects her to befriending groups and accessible transport, tackling loneliness and isolation. A **shared care record** prevents repetition and coordinates her support across services.

For Margaret, delivering the NHS Devon strategy means fewer crises, stronger community connections, and a system designed around prevention, independence, and dignity in later life.

Riley Rivers, 9, Exeter

Riley lives with his mum. He has epilepsy and is waiting for an attention deficit hyperactivity disorder (ADHD) assessment. At present, most of his care is hospital-based. His epilepsy requires multiple appointments, and he faces a lot of challenges with behaviour and stigma at school.

Under the NHS Devon strategy, Riley's experience becomes more joined-up and community-centred. His epilepsy reviews take place in his **neighbourhood community hub**, with results shared across health and care providers.

The NHS and schools work closer together to help manage his conditions, reducing stigma and improving his experiences at school.

Early intervention is prioritised: school-based mental health teams help Riley manage behaviour and anxiety before crises escalate, and his ADHD assessment is completed more quickly.

Technology, such as a **wearable seizure monitor**, provides reassurance and reduces unnecessary hospital visits.

Through **social prescribing**, Riley joins inclusive after-school activities, while his mum accesses peer and financial support.

His care shifts from fragmented hospital journeys to **integrated, preventative, community-focused support**, helping him thrive as a child.

Executive Summary

NHS Devon's Health and Care Strategy sets out a bold and necessary transformation to ensure the long-term financial sustainability of our health and care system. With a projected financial gap of £781 million by 2030/31 if we do nothing, the strategy recognises that maintaining current models of care is no longer viable.

Instead, we are committing to a fundamental shift in how services are commissioned, delivered, and measured—anchored in value, outcomes, and efficiency.

Central to this transformation is the adoption of a new three-tier model of delivery—Neighbourhoods, Place, and Specialist Settings—designed to integrate care around local populations and reduce reliance on acute services.

Neighbourhoods will become the default delivery point for non-specialist activity, supported by multidisciplinary teams and commissioned through lead provider frameworks. This approach enables proactive, personalised care and supports the strategic shift from treatment to prevention.

To deliver this model within a constrained financial envelope, NHS Devon is implementing a set of strategic commissioning intentions aligned with the Model ICB blueprint. These include a rigorous focus on productivity—both organisational and system-wide—using tools such as the Model Hospital and mutual aid arrangements.

Providers will be expected to harmonise quality and performance standards at the lowest sustainable cost and deliver a minimum 3% cost improvement programme (CIP) beyond baseline efficiencies.

Contracting protocols are also evolving to reflect this strategic direction. NHS Devon will move towards commissioning for outcomes rather than activity, with clear expectations and key performance indicators (KPIs) embedded in contract negotiation meetings commencing October 2025.

These meetings will ensure alignment between provider plans and the ICB's five-year commissioning roadmap, enabling a more accountable and transparent planning process.

To stimulate transformation, growth funding will be directed into a Neighbourhood Development Fund, supporting schemes that reduce acute activity and improve community-based care. Specialties such as dermatology, urology, orthopaedics, and cardiology will be commissioned through lead provider arrangements, with further transformation planned in urgent care, community hospitals, and midwifery-led units.

This strategy is not only a financial imperative—it is a commitment to delivering equitable, but high-quality care also that meets the needs of Devon's population now and into the future.

Through disciplined commissioning, innovative contracting, and system-wide collaboration, NHS Devon will build a health and care system that is both resilient and sustainable.

Introduction

NHS Devon Integrated Care Board (ICB), responsible for planning, funding, and overseeing services across the county, is leading a bold and necessary transformation. Our communities face rising demand, an ageing population with increasingly complex needs, entrenched health inequalities, and persistent financial pressures—all intensified by the ongoing recovery from the Covid-19 pandemic.

Despite the dedication of staff across NHS and care services, the system is under sustained strain. People in Devon continue to experience long waits for elective treatment, there is pressure on urgent and emergency care, and delays in accessing assessments, diagnosis, treatment and community-based support across a spectrum of services.

Services can feel fragmented and difficult to navigate, with care often arriving only at crisis point. Outcomes and access vary significantly depending on geography and circumstance, and the financial position across the system remains fragile, limiting the ability to invest in new models of care.

The current system is not designed to meet the modern, diverse needs of Devon's communities—whether that's rural and coastal populations with limited access, children and young people needing earlier mental health support, or older adults living with multiple long-term conditions who require more joined-up, personalised care.

Strategic and financial context

NHS Devon's core funding encompasses all commissioned services, including acute, mental health, and community care. Almost 80% of running costs are attributed to staffing, with the remainder covering estates and other non-pay expenses.

Despite receiving £163 million above its needs-based population allocation, the system remains financially fragile, requiring £54 million in deficit support to break even in 2025/26.

This financial imbalance limits the capacity to invest in innovation, respond to rising demand, and deliver sustainable improvements. However, the strategic redistribution of resources across Devon's four localities is beginning to correct historical inequities, bringing planned expenditure closer to fair share allocations and aligning with the principles of the Model ICB Blueprint.

Our population of around 1.3 million is ageing rapidly, with 24% aged 65 or older, well above the national average, and growth among those aged 75+ accelerating.

This demographic shift, combined with geographic and social inequalities, creates stark contrasts in health outcomes, with up to a 20-year difference in healthy life expectancy across the county.

Rising demand across all service areas, especially the delays in accessing assessments, diagnosis, treatment and community-based support is compounded by workforce shortages**,** fragmented care pathways, and infrastructure risks.

The system's IT and estates vary significantly in quality, with some facilities in urgent need of repair, posing risks to continuity and safety.

Nationally, policy frameworks such as the NHS Long Term Plan and the Fuller Stocktake have laid the foundation for the expectations for the NHS to deliver.

They call for a fundamental reconfiguration of services dissolving the long-standing divides between primary, community, and secondary care, and enabling more joined-up, person-centred approaches.

At the heart of this transformation is the emerging Neighbourhood model, a nationally endorsed delivery vehicle for integrated care.

This model envisions care being designed and delivered at a local level, tailored to the specific needs of neighbourhood populations, typically serving 30,000 to 50,000 people. It brings together general practice, community services, mental health, social care, the voluntary sector, and increasingly, public health and housing working as a single team around the individual.

The Neighbourhood model is not simply a structural change, it represents a paradigm shift in how care is conceptualised and delivered. It is the mechanism through which the three strategic shifts outlined by government are being operationalised.

This Strategy should be seen alongside the NHS Devon Strategic Commissioning Intentions and full Medium Term Financial Plan

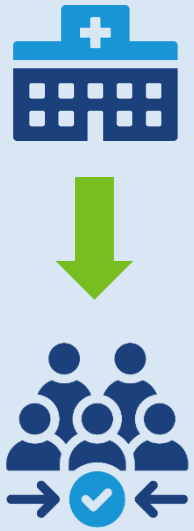
Our health and care strategy describes our future model and how we align services to deliver optimal outcomes for our population.

Our strategic commissioning intentions will describe how we will allocate resource to deliver the future service model within allocation.

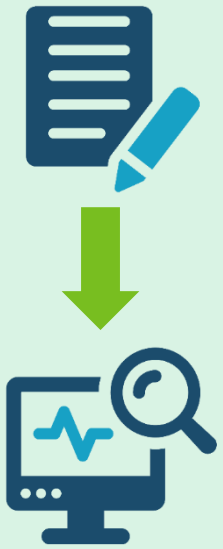
Our medium-term financial plan will describe the financial model the strategy will need to be delivered within and impact of commissioning intentions.

The three shifts

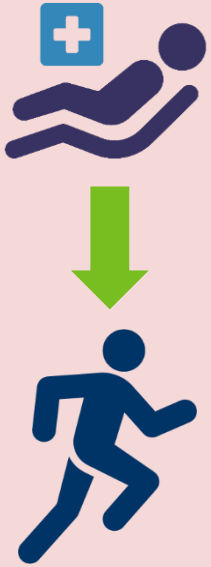
From hospitals to community and primary care: shifting the centre of gravity of the NHS closer to people's homes.



From analogue to digital: embedding digital tools to support access, coordination, and self-management.



From treatment to prevention: focusing on early intervention, population health, and reducing health inequalities.



This national direction is underpinned by growing evidence that locally integrated, neighbourhood-based care delivers better outcomes, improves patient and staff experience, and reduces unwarranted variation. It also enables more effective use of resources by aligning services around population need rather than organisational boundaries.

As Integrated Care Boards (ICBs), we are expected to lead the implementation of this model ensuring that neighbourhood teams are empowered, resourced, and supported to deliver care that is proactive, personalised, and equitable.

Our vision

“We imagine a Devon where everyone can live well—on their own terms, in communities that value equity, sustainability, and belonging.

This means recognising the rich complexity of people’s lives, identities, and experiences, and the many factors that shape health and wellbeing beyond traditional services.

By nurturing a culture of curiosity, care, and shared responsibility, we will work across boundaries to challenge injustice, reimagine support, and act boldly together.

Rooted in trust, lived experience, and community strengths, we are committed to lasting change—so that everyone, especially those historically underserved, can thrive now and for generations to come.”

A targeted strategic approach

In response, NHS Devon's strategic long-term approach will mark a seismic shift toward place-based, outcome-led delivery though a new model of care that is based around Neighbourhood Delivery.

This transformation is guided by the principles of the NHS 10-Year Plan and the NHS Medium Term Planning, which emphasizes earned autonomy, reduced duplication, and a relentless focus on productivity and value. We aim to fully embrace the greater financial flexibility, with fewer national priorities and more local discretion to tailor services to community needs.

Devon's strategy embraces this opportunity, aligning its financial planning, workforce development, digital innovation, and care redesign with the overarching goal of improving population health, reducing inequalities, and delivering consistently high-quality care.

This strategy is not just about recovery, it is about building a sustainable future and builds on existing work across the Integrated Care System, including the Joint Forward Plan, the Integrated Care Strategy, and local authority and provider plans.

It draws on national guidance such as the NHS 10-Year Plan and the Model ICB Blueprint, which advocate for earned autonomy, reduced duplication, and a sharper focus on productivity and value.

By aligning local priorities with national expectations, Devon is embracing the opportunity to tailor services to community needs, supported by greater financial flexibility and system-wide collaboration.

Structured around new model of delivery, the strategy sets out high-level commissioning intentions that reflect a shared ambition across all services directly commissioned by the ICB.

It aims to stabilise the system in the short term, while enabling long-term transformation through redesigned care pathways, digital innovation, a stronger focus on prevention and population health, and better use of workforce and estate resources.

Operating within a defined financial envelope, the strategy supports a shift from reactive and siloed approaches to proactive, preventative, and integrated models of care placing people at the centre and ensuring that care follows the individual, not the other way around.

Achieving this vision will require a phased, pathway-led, and coordinated effort, underpinned by strong leadership and alignment across the system.

The strategy is anchored by four core principles:

- sustainability, through financial, operational and environmental resilience
- quality and value, by delivering effective care that maximises impact
- person-centred care, designed around what matters to individuals and communities, and an
- accessibility, ensuring equitable access regardless of location, background, or circumstance.

By looking outward to national models and inward to local insights, Devon's strategy sets a clear direction for transformation—one that is grounded in collaboration, shaped by evidence, and focused on delivering better outcomes for all.

Our system

Progress has been made to improve services and outcomes, NHS Devon faces a range of long-term challenges that demand a major shift in how care is planned, delivered, and experienced.

Rising demand, an ageing population, increasing health inequalities, and financial and workforce pressures mean that continuing with our current models of care is not sustainable.

The NHS in Devon must remain attentive to the evolving national policy landscape, including changes to organisational structures and system footprints, while also recognising and responding to the expectations of our population.

Our population want to experience services that are easier to navigate, more joined-up, and more responsive to their individual needs. They wish to be supported to maintain their health, live independently for longer, and access care as close to home as possible.

Our population

Devon is undergoing a significant demographic transformation. Over the past decade, the population has grown by 9.7%. However, this growth is not evenly distributed across age groups. While the number of young people aged 0–19 has increased by less than 1%, the population aged 75–84 has surged by over 40%. This disproportionate growth in older age groups is reshaping the landscape of public service demand, particularly in health and social care.

Two primary factors are driving this shift. First, the legacy of the post-World War II baby boom continues to influence population structure. The birth rate in 1947 was approximately 50% higher than in 1937, and those born during this peak will turn 78 in 2025. This cohort is now entering the age range associated with higher health and care needs.

Second, Devon experiences consistent inward migration, particularly among individuals aged 35–70, drawn by the region's quality of life, environment, and retirement appeal.

This migration pattern results in a lower proportion of residents under the age of 53, except for a temporary spike in the 19–22 age group due to the presence of two major universities. Beyond age 53, Devon has a significantly older population profile compared to national averages.

Looking ahead, official projections indicate that Devon's population will continue to grow at a steady rate of approximately 0.7% per year, adding around 68,000 people over the next decade. Crucially, this growth will be concentrated among those aged 65 and over.

The baby boom generation will begin to enter the 85+ age bracket, while their children transition into later life, contributing to a substantial increase in the 65–74 age group. This demographic shift will have profound implications for the design, delivery, and sustainability of health and care services across the county.

Strategic implications for health and care services

As the population ages, we anticipate a corresponding rise in mortality rates and an increase in the intensity of health and care service usage. It is well established that the final years of life are associated with disproportionately high service demand. Previous estimates suggest that approximately one-third of a person's lifetime care costs are incurred in the last two years of life.

This underscores the urgency of strategic planning and resource allocation to ensure that services remain responsive, resilient, and financially sustainable.

To support this planning, the Devon System Demand Model has been developed. This model provides a comprehensive framework for understanding and forecasting service pressures, built around three interrelated components: health needs, demand, and supply.

- **Health Needs** are measured using Disability Adjusted Life Years (DALYs), a metric that captures both the prevalence and severity of illness, as well as premature mortality. Health needs increase significantly with age — a person aged 90 or older typically has health needs eight times greater than someone in their twenties.
- **Demand reflects the actual utilisation of health services** and the system's capacity to respond. It is shaped by population behaviour, accessibility of services, and system responsiveness.
- **Supply encompasses** the full spectrum of resources required to meet demand, including workforce, hospital beds, medications, equipment, and infrastructure.

Together, these components enable a strategic understanding of how demographic trends will impact service delivery and provide a foundation for evidence-based decision-making.

Changing patterns of health need

Analysis of DALYs over time reveals that health needs in Devon remained broadly stable between 2000 and 2015. However, since then, the system has entered a phase of accelerated growth in health needs, closely linked to the increasing number of people aged 75 and over. While demographic change is a key driver, other factors — including technological advances, evolving clinical practices, and non-demographic growth — also contribute to rising demand.

Conditions most affected by ageing show the highest annual growth rates. These include:

- respiratory infections (+3.4%)
- dementia (+3.3%)
- falls (+2.8%)
- diabetes (+2.7%), and
- stroke (+2.4%).

Additionally, in line with national statistics around 2.16% of the Devon population, approximately 26,000 people, are known to have a learning disability, with 8,000 registered in primary care. Since COVID-19, referrals for autism and ADHD support have quadrupled, driven by increased public awareness and demand. This surge has placed exceptional pressure on health services, highlighting a critical gap in capacity and access for neurodivergent populations.

Addressing deprivation and health inequality

Devon's demographic challenges are further compounded by persistent health inequalities and pockets of deprivation. Urban centres such as Plymouth, Torbay, and Ilfracombe experience the highest levels of deprivation, with additional hotspots in Exeter and Barnstaple.

Notably, Plymouth has more residents in the lowest deprivation quintile than the rest of Devon combined. Rural and coastal areas, particularly in North and West Devon, also face significant deprivation, driven by low wages, limited employment opportunities, and a high cost of living. These socioeconomic factors have a direct impact on health outcomes and service utilisation. Neurodivergent individuals, particularly autistic people, face significantly poorer health outcomes and higher risks of early mortality.

Analysis of acute hospital spending reveals clear variation by deprivation level, with differences evident across both urgent and planned care services. Addressing these inequalities is essential to delivering equitable care and ensuring that all communities across Devon benefit from strategic investment and service transformation. This will require a coordinated approach across health, social care, housing, and economic development sectors.

Protected characteristics

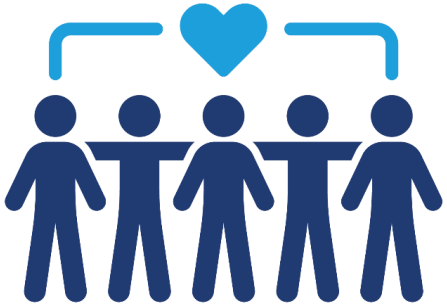
People with protected characteristics whether related to race, religion, sexuality, gender, or other aspects of identity often face distinct health needs and systemic barriers that result in poorer outcomes.

Tackling these disparities is a core commitment of NHS Devon and a fundamental principle of integrated care. All NHS-commissioned services will be expected to embed equity principles into their design and delivery. These include:

- **Proportionality**: Resources and interventions should be targeted according to need, recognising that some groups require more support to achieve equitable outcomes.
- **Accessibility**: Services must be physically, culturally, and linguistically accessible to all, removing barriers to entry and engagement.
- **Participation**: Communities must be actively involved in shaping the services they use, ensuring lived experience informs decision-making.
- **Transparency**: Data on outcomes must be collected, analysed, and shared to monitor progress and hold the system accountable.
- **Sustainability**: Equity efforts must be embedded into long-term planning, not treated as short-term initiatives.

Commissioned outcomes will be measured at Neighbourhood level, where care is delivered closest to communities, and monitored at Place, where strategic oversight ensures consistency and accountability.

To support this, NHS Devon has developed a nationally pioneering set of AI-generated personas realistic, data-driven profiles that reflect the lived experiences, demographics, and health conditions of diverse communities across Devon.



These personas are used to inform impact assessments, public engagement, and service design, helping to embed equity into every stage of planning and delivery.

By incorporating these personas into strategy development, service redesign, and Equality and Quality Impact Assessments (EQIAs), the system can better understand and respond to the needs of underrepresented groups. They will also be used iteratively in design workshops and decision-making processes to test service accessibility and equity.

Inclusion of health groups such as people experiencing homelessness face some of the most severe health inequalities. These individuals often experience multiple, compounding risk factors including stigma, poverty, trauma, and discrimination, leading to significantly poorer health outcomes and reduced life expectancy.

This strategy places equity, inclusion, and lived experience at the heart of system transformation. By embedding these principles into commissioning, service design, and workforce development, NHS Devon will build a health and care system that works for everyone, especially those who have historically been underserved.

Financial sustainability

In line with the Model ICB Blueprint, ICBs are now positioned as strategic commissioners, responsible for leading system-wide reform and optimising resource allocation. The Medium-Term Financial Plan (MTFP) plays a foundational role in this shift, supporting the development of leaner operating models and enabling ICBs to live within their means while delivering improved outcomes. It is a critical strategic tool for the ICB, designed to bridge the gap between long-term ambitions and short-term operational delivery.

Its core purpose is to provide a shared financial framework across system partners, enabling coordinated planning over a five-year horizon. This approach supports the delivery of the NHS 10-Year Plan by translating strategic goals into actionable financial trajectories, identifying the resources required to meet population health needs, and ensuring systems remain financially sustainable and together with our new contracting model, it will help rebalance system relationships.

It must be triangulated with workforce, activity, and quality plans, and co-produced with system partners to reflect shared priorities. This ensures that financial planning is not conducted in isolation but is embedded within broader strategic and operational frameworks.

The new operational planning guidance reinforces this alignment by setting out a focused set of national priorities, including improving access to timely care, increasing productivity, and addressing health inequalities.

Medium-term financial plan (MTFP) model in Devon

A Devon five-year Medium Term Financial Plan (MTFP) is being developed which fully aligns with the Health and Care Strategy. It will show how the financial challenge will be met across Devon as it drives towards achieving financial sustainability and sets the guard rails from within which the Devon Health and Care Strategy will be delivered.

The MTFP will set out investment strategies that allocate resources over time that are aligned with population needs. These investments will be focused on 'left shift' supported by equity analysis that will help ensure that resources are allocated towards improving equitable access, delivering care in the most appropriate setting and reducing health inequalities. They will be driven by data and population insights, with a strong focus on prevention, equity, and outcomes.

Current position

The Devon system is financially challenged and is both overspending and overfunded. This results in debt repayments being required annually to repay deficits and allocation reductions known as convergence being made to bring Devon back within the tolerance of the target needs-based population allocation. This, together with an underlying deficit in excess of £200m, leads to a challenging road to recovery.

	26/27 £m	27/28 £m	27/29 £m	29/30 £m	30/31 £m
Opening Underlying Posiion	-204.0	-305.4	-417.6	-536.1	-649.1
Convergence	-24.2	-24.7	-25.3	-15.3	-15.7
Allocation Growth	107.8	109.3	111.8	114.6	117.8
Demand Increases	-25.9	-29.9	-30.2	-29.0	-27.0
Inflation	-145.8	-153.0	-160.6	-168.7	-177.2
Minimum Uplift	-13.4	-13.8	-14.2	-14.6	-15.1
Exit ULP	-305.4	-417.6	-536.1	-649.1	-766.2
Debt Repayment	-14.2	-14.5	-14.8	-15.2	-15.6
	-319.7	**-432.1**	**-550.9**	**-664.3**	**-781.8**
ICB baseline	3,222.0	3,295.2	3,370.0	3,457.7	3,533.3
Savings required	-9.9%	-13.1%	-16.3%	-19.2%	-22.1%

Equity

Based on national funding formula, NHS Devon has reviewed its spend against programme area and locality to establish where inequity sits in funding of our services, this also identifies how our total overspend (or Distance from Target) is split.

Overall this shows an under-resourcing of Prescribing and Primary care whilst we spend £112m more than expected on community care, £66m more than expected on our Acute care and £30m more than expected on Mental Health.

The analysis also shows variation between locality with only one locality (Northern) showing as requiring a total spend below that which would be expected.

There should be a note of caution in interpreting these numbers as given current lack of Electronic Patient Records in Torbay and South Devon Hospital and University Hospital Plymouth there is a gap in current activity coded which will have implications for Devon's allocation of

resource based on the National Formula.

Devon providers will need to address coding issues to ensure the system receives its fair share of resources. In the meantime the equity analysis will be used as a directional tool alongside other benchmarking data to inform local allocation of resource as part of our commissioning plan and full MTFP.

Core ICB Funding						
	Eastern	Northern	Plymouth	Sth Devon & Torbay	Western	
25/26 plan expenditure	£m	£m	£m	£m	£m	
G&A and maternity	557.8	235.3	437.4	534.6	68.4	1
Community	133.0	49.6	93.9	121.2	16.5	
MH	113.5	43.2	83.9	91.1	11.5	
Prescribing	74.6	34.2	58.9	63.7	10.2	
Primary Care	14.2	5.9	11.3	10.9	1.7	
Total	**893.2**	**368.2**	**685.4**	**821.6**	**108.3**	**2**
25/26 expected expenditure						
G&A and maternity	568.6	251.1	412.5	470.3	65.0	1
Community	97.1	43.4	66.4	84.5	11.4	
MH	96.9	42.0	81.6	83.1	9.8	
Prescribing	77.3	33.8	59.0	65.9	9.5	
Primary Care	15.4	6.2	10.7	11.9	1.7	
Total	**855.3**	**376.4**	**630.1**	**715.7**	**97.3**	**2**
25/26 inequity						
G&A and maternity	-10.8	-15.7	24.9	64.3	3.4	
Community	36.0	6.1	27.5	36.8	5.2	
MH	16.7	1.2	2.3	8.1	1.7	
Prescribing	-2.7	0.4	0.0	-2.3	0.8	
Primary Care	-1.2	-0.2	0.6	-1.0	0.0	
Total	**37.9**	**-8.2**	**55.3**	**105.9**	**11.0**	

Future delivery

To deliver the medium-term financial plan (MTFP), financial sustainability and return on investment discipline will be at the core of our financial framework, underpinned by advanced population health management, value-based healthcare and a neighbourhood-first approach.

We will develop insights into cost behaviour and value achieved from commissioning services to inform healthcare planning and the better allocation of resources over time.

Productivity improvements will be required to achieve financial sustainability and free up funding for investment and service transformation.

Services will be reviewed to ascertain whether they can be stopped, shifted into a different service model or environment, or completely transformed but without the need for large capital investments, which will be limited. This will be supported by maximising digital transformation to reduce cost and improve productivity.

As the population ages, particularly with a sharp rise in those aged 65 and over, the burden of disease intensifies, leading to greater and more complex service demand. At the same time, the capacity to meet this demand through workforce, infrastructure, and clinical resources is limited, creating a mismatch that directly impacts financial sustainability.

We need to respond to the underlying inequity of spend on our population. The overall spend per person varies by 7.5% (£54 per person) from the lowest spend in the most deprived quintile to affluent quintile.

The highest spend in the 2nd most Urgent care spend per person is higher in more deprived areas, but planned care spend is higher in the more affluent areas. In the most deprived areas, urgent care makes up 47.5% of the total acute hospital tariff spend per person, but this reduced to 39.5% for the most affluent. Most of the higher urgent care tariff per person in the deprived communities is linked to higher type 1 ED attendances that are nearly double the rate seen in the most affluent areas (£53 compared to £28)

How the strategy was developed

The journey so far

We embarked on a journey to develop and deliver a comprehensive, inclusive, and future-focused strategy that ensures safe, effective, and sustainable health care for all people in Devon. This is aligned to national NHS direction and policy framework of focusing on population health, prevention, recovery of core NHS services, improving access, and reducing health inequalities though a lifecycle. It includes:

- Whole-population focus
- Care across the continuum
- Responding to system pressure and sustainability

The development of Devon's Health and Care Strategy has been guided by a structured Discover–Design–Deliver methodology. This approach ensures that transformation is not only evidence-based and strategically sound, but also inclusive and co-produced with the people who use and deliver services across the system.

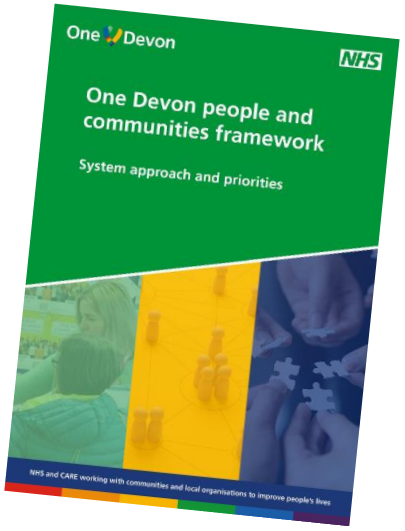
Discover phase: Building a shared understanding

The Discover phase focused on developing a rich understanding of the current health and care landscape in Devon, completed through:

- Reviewing existing intelligence through the system's insights library, which collates data on population health, service performance, and inequalities.
- Drawing on the 10-Year Plan engagement, which involved over 3,400 participants across Devon. This provided a robust evidence base, particularly around the three strategic shifts:
  - From hospitals to community and primary care
  - From treatment to prevention
  - From analogue to digital services

As part of the 10 Year Plan engagement, a committed cohort of over 200 individuals expressed interest in ongoing involvement were identified. This presents a valuable opportunity to establish a citizens' panel or bespoke reference groups to support continued co-design and accountability.

The One Devon People and Communities Framework demonstrates how we will work together across the One Devon System to widen engagement opportunities to the whole Devon population.



The Framework ensures that the voices of those who experience health inequalities, or those who live in rural, coastal or remote communities, have an equal chance to be heard and influence decision making.

The Devon 10 Year Plan Engagement programme proves the effectiveness of this approach. This was recognised by regional colleagues as a leading example.

To support the Framework, NHS Devon has developed a service change process. This has been agreed by leaders from across Devon to provide a consistent approach to managing service change.

Key findings from the Discover phase

The Discover phase has provided a rich understanding of the current position of the Devon Integrated Care System (ICS). Drawing on population data, system analysis, and extensive stakeholder engagement, we have identified the key pressures, opportunities, and priorities that ultimately shaped the development of NHS Devon's Health and Care Strategy.

While many of the findings may not be unexpected, they offer a clear and compelling evidence base from which the strategy can confidently move forward. They validate long-standing concerns, reinforce national policy direction, and highlight the areas where transformation is most urgently needed.

Demographic and population insights

Devon's population is undergoing significant demographic change, marked by an ageing population and increasing diversity in health and care needs. Older age groups are growing rapidly, driving demand for more complex and long-term care, including end-of-life support. Alongside this, there is a sharp rise in neurodiversity-related needs, particularly autism and ADHD, and Learning Disabilities with more individuals seeking diagnosis and support than ever before. This surge reflects growing public awareness and changing expectations around access to timely, personalised care.

Cultural attitudes and population expectations are also evolving, with people increasingly seeking proactive, inclusive, and responsive health services that reflect their lived experiences and identities. These shifts present a major challenge for the health and care system, which must adapt to meet rising demand, reduce inequalities, and deliver care that is both person-centred and culturally competent.

System pressures and infrastructure challenges

Devon is operating within a significantly challenged financial environment, having ended 2024/25 with a substantial deficit despite receiving support funding, and facing a much larger underlying financial gap that signals the need for strategic reform. Our unique geography adds further complexity, with remote rural and coastal communities facing persistent accessibility barriers.

Although deprivation levels are relatively low overall, health outcomes vary widely, with stark differences in healthy life expectancy across the county.

Infrastructure across IT and estates is inconsistent, with some facilities in good condition and others in urgent need of repair—posing risks to business continuity, safety, and service quality.

These pressures reflect a system that must evolve to meet growing and changing population needs, while ensuring resilience, equity, and sustainability.

Stakeholder engagement insights

Stakeholder engagement has been central to the Discover phase, ensuring that the strategy is shaped by the voices of our communities and professionals.

To support the Government's 10-Year Health Plan, NHS Devon led a comprehensive engagement programme involving staff, patients, the public, and partners across Devon.

Over 3,400 participants contributed to Devon's 10-Year Health Plan engagement, providing a robust evidence base for strategic development.

Described nationally as 'the biggest conversation about the future of the NHS since its inception,' this programme aimed to capture local voices on the three big shifts shaping healthcare.

NHS Devon tailored this engagement locally, ensuring the views of Devon's diverse communities informed both local priorities and the national plan.

Co-designed with Healthwatch Devon, Plymouth, and Torbay, and supported by the Devon Engagement Partnership (DEP), the programme aligned its questions with the national framework to maintain consistency.

The objectives were to:

- Reach the right people, in the right places, at the right time—especially those in Core20PLUS5 groups and seldom heard communities.
- Encourage ongoing public involvement in NHS transformation.
- Drive participation in the national 10 Year Plan survey.
- Maintain clarity and creativity in engagement to minimise confusion.
- Collaborate with neighbouring ICBs in Cornwall and Somerset.

The success of this approach relied on strong partnerships and using trusted networks across Devon to maximise reach and impact.

Three main engagement tools were used:

- An online survey for workforce and public (hosted on the One Devon website)
- A locally adapted “Workshop in a Box”
- Engagement postcards distributed at events

While survey and workshop questions mirrored the national programme, workshop content was adapted to resonate with Devon’s communities, making conversations meaningful and relevant. Though the survey was primarily online, phone responses were facilitated by Healthwatch and promoted in all communications.

Engagement postcards were also distributed at local events. NHS Devon’s communications and engagement team led the programme, supported by providers, local authorities, South Western Ambulance Service NHS Foundation Trust (SWASFT), Healthwatch, voluntary sector organisations, and other key partners. A communications toolkit helped partners promote the programme as trusted community voices.

Five engagement days across Devon raised awareness, encouraged survey completion, hosted workshops, and supported postcard responses—with strong backing from Healthwatch, voluntary sector groups, and provider colleagues.

To reach those most affected by health inequalities, NHS Devon invested in the voluntary, community and social enterprise (VCSE) sector through a small grants scheme. This enabled community organisations to hold targeted workshops, including:

- Yes Brixham (Homelessness)
- Adventure Therapy (Young People)
- Headway Devon (Learning Disability/Acquired Brain Injury)
- Age Concern (Carers and Older People)
- Hikmat Devon (Ethnically Diverse Communities)
- Citizens Advice (People with Physical Disabilities)
- Devon Communities Together (Coastal Communities)

Devon’s approach was recognised regionally as a model of best practice, with many other South West ICBs adopting similar methods.

Our thorough approach generated strong participation and broad representation:

- Over 3,400 individual feedback responses
- 2,353 survey completions
- 50 workshops (10% of all national workshops) with 358 attendees
- Over 700 written postcards completed
- More than 220 people signed up for ongoing engagement

Key themes

- Strong support for the NHS being free at the point of access
- The NHS workforce is seen as the system's most valuable but vulnerable asset
- Appreciation for the wide range of services and their personal impact
- Urgent need to improve access to primary care, mental health, A&E, and elective services
- Generally positive experiences when accessing care, despite low satisfaction with overall NHS management (reflecting national trends)
- Need for adequate NHS funding
- A call for better integration and communication between services
- Emphasis on prevention, diagnostics, and earlier intervention to reduce illness
- Desire for greater investment in frontline services and a reduction in management costs
- Recognition of technology's potential to improve efficiency and care coordination, balanced by concerns over AI, data privacy, and digital exclusion

Learning from local, national, international examples

Since its inception, the NHS has undergone numerous system-wide reorganisations in response to changing demographics, cultural shifts, advances in medical science, and the need for financial sustainability.

It continues to evolve to deliver care that is more personalised, effective, preventative, and sustainable—an imperative in today's complex healthcare environment and emerging policy landscape. In this section, we highlight examples of innovative and effective approaches to managing patients with complex needs and multiple long-term conditions.

These case studies illustrate how Primary Care, Community Services, and Acute Settings are working collaboratively to improve outcomes for our populations.

Local examples of good practice

Integrated care and health inequalities (including primary care)

Delivery of one-off hospital discharge Personal Health Budgets (PHB) as part of discharge planning have now been embedded with a centralised support model to simplify payment processes and minimise impact and workload forward-based staff. Leads in the local system are working with the Southwest Integrated Personalised Care Team to support to embed training offers centred on the 'what matters to you' conversation as part of the discharge planning process.

One Northern Devon' is a partnership of the NHS, social care, local housing authorities, police, fire service, local businesses and voluntary and community groups working together to reduce inequalities and improve health and well-being. The partnership has devised the 'Flow programme' to bring teams together to work in a more integrated way to support people with complex needs. Focussing on what matters to the person – which frequently relates to housing, finances and debt, it utilises a 'Team around the Person' and 'Community around the Person' approach. As well as the positive impact this has on people's lives, it has also been shown to reduce demand on the system. 'High Flow' focusses on the most frequent users of A&E and other emergency services and has resulted in a 60% reduction in A&E visits from these service users alongside reductions for SWAST, Police and Devon Partnership Trust. In one year, for 6 service users, this demand reduction equated to: £103,831.92.

Plymouth City Council has created the Creative Solutions Forum (CSF) to meet the needs of people who do not fit into standard care settings. Practitioners, managers and commissioners across public health, adult social care and mental health work together to provide integrated and bespoke offers for people and support workers. Staff report better risk management, less anxiety over high-risk cases and huge improvements in inter-service relationships, trust and co-operation. Around 70% of cases are resolved in one visit and almost all cases in 3 visits. Bespoke approaches have begun to replace standardised care, there are fewer inter-service hand-offs, better understanding of risk and inter-service co-operation has become the default, rather than the exception. Most importantly, culture right across the system has changed.

PCNs in Devon are also planning to deliver anticipatory care and personalised care more systematically and will be working to expand focus on CVD diagnosis and prevention to reduce demand on other community and hospital services.

National examples of good practice

Tackling Fuel Poverty in Cheshire and Merseyside: A Population Health Management Approach

Rising energy costs and wider cost-of-living pressures have driven more households into fuel poverty, which is strongly linked to worsening health outcomes. Cold homes increase the risk of respiratory and cardiovascular disease, poor mental health, and unintentional injury. The Institute of Health Equity estimates thousands of unplanned hospitalisations are directly associated with cold homes, while NICE suggests that preventative measures could avoid up to 28,000 deaths each year.

To address these risks, Cheshire and Merseyside Integrated Care Board (ICB), supported by NHS England's Innovation for Healthcare Inequalities Programme (Unhip), has adopted a population health management (PHM) approach. This involves using data to identify, engage, and support those most at risk, particularly people with respiratory illness living in fuel poverty.

Working with NHS, voluntary and community sector (VCS), and local authority partners, the ICB has launched several "trailblazer" projects across the integrated care system (ICS). These multidisciplinary initiatives use targeted interventions to improve health outcomes and reduce the wider impact of fuel poverty.

The trailblazers aim to:

- Rapidly identify and engage high-risk patients
- Reduce the number of exacerbations experienced
- Improve adherence and effectiveness of inhaler therapies
- Enable quicker eligibility checks for patients suitable for remote monitoring pathways
- Reduce fuel poverty debt by signposting sources of financial support

In the longer term, these interventions are expected to ease pressure on local health services by reducing GP visits, A&E attendances, unplanned admissions, and emergency calls linked to respiratory conditions aggravated by cold homes.

Bromley by Bow

The Bromley by Bow Centre, once described by former health minister Lord Mawhinney as “one of the most impressive displays of social entrepreneurship anywhere in Europe,” has grown from a small East End initiative into an internationally recognised charity. Based in Tower Hamlets, one of England’s most deprived areas—with nearly 40% of children in low-income households and a 10-year life expectancy gap between rich and poor men—the centre was founded in the 1980s by a local priest, his congregation, and volunteers to address deep social inequalities. Initially, it offered childcare, adult learning, welfare advice, a café, and community space.

By the 1990s, it was clear that conventional health and social care models were failing local residents. In response, the charity established its own GP practice, joined in 1997 by Dr Sam Everington and Dr Julia Davis, pioneering a model of care centred on the social determinants of health. Remarkably, this was the first British GP practice owned by patients and rented to the NHS. It later evolved into the Bromley by Bow Health Partnership, now employing 110 staff and serving more than 28,000 patients across three practices, including a walk-in clinic for 500 unregistered patients weekly.

The centre combines primary care with community services and research, empowering patients to engage actively in their health. Located in Bob’s Park, its design embraces green space and creativity, with projects like therapeutic horticulture for adults with disabilities and public art to foster community pride. Services extend beyond health into housing, welfare, employment, and money management, reflecting its philosophy of “health by stealth.” This holistic approach not only addresses immediate needs but also supports education, employment, and local enterprise development, contributing to the regeneration of East London.

A cornerstone of its work is “social prescribing,” enabling GPs to refer patients to non-clinical, in-house experts tackling root causes of poor health, from debt to isolation. This frees doctors to focus on clinical care while addressing wider health inequalities. Evidence of impact is strong: in 2014, Tower Hamlets ranked highest nationally for cholesterol and blood pressure control in patients with diabetes and heart disease.

The Bromley by Bow Centre demonstrates how integrated, community-led health and social services can transform lives and reduce inequalities at scale.

End of life care service for people with dementia living in care homes in Walsall

NHS Walsall Clinical Commissioning Group commissioned Dementia Support Workers (DSWs) to provide evidence-based advice, development sessions, and practical support to care home staff. Their aim is to promote best practice in dementia and end of life care, working closely with staff, residents, and families to identify improvements that enhance outcomes and quality of life.

This initiative was developed in collaboration with Pathways 4 Life (Accord Group and Age UK Walsall) and St Giles Walsall Hospice, responding to the pressing need for better dementia care, particularly at end of life. Many people with dementia continue to die in acute hospitals rather than in their care home, despite a preference to remain in familiar surroundings.

Two community-based DSWs work across Walsall, promoting person-centred care while fostering strong joint working with hospice teams, nursing case managers, ambulance staff, occupational therapists, voluntary organisations, and community groups.

Their engagement begins with observation studies in care homes, assessing person-centred practice, communication, and use of assistive technology. They deliver development sessions to build staff skills and create improvement plans with managers using **Care Fit for VIPS**. Recommendations often include better signage, orientation aids, and opportunities for socialisation and meaningful activity.

DSWs also support adoption of the **Namaste Care approach**, delivering tailored sessions to improve staff communication, understanding, and role modelling. Signs of pain or depression are escalated to GPs. The guiding principles of the service are to:

- make sure people with dementia are always at the centre of everything
- maximise partnership working
- utilise an evidence-based practice approach
- empower and engage volunteers, staff and families to maximise contribution
- Early evaluation has found the service has:
- decreased unnecessary hospital admissions
- increased resident engagement in activities
- improved staff confidence and skills
- strengthened links between Health and Social Care
- enhanced continuity of care through better communication

- improved staff understanding of what constitutes an emergency
- introduced more effective and efficient documentation
- This integrated, evidence-based model is helping to transform dementia and end of life care across Walsall.

International examples of good practice

How GRAND Mental Health reduced psychiatric inpatient hospitalisations by 93%

The organisation GRAND Mental Health is a Certified Community Behavioural Health Clinic (CCBHC) that offers behavioural health services in addition to support with diet, physical health, housing, and employment. The organization operates facilities in thirteen Oklahoma counties, including three crisis centres.

To reduce inpatient hospitalisations and create lower levels of care for people experiencing behavioural health crises, GRAND Mental Health created dedicated 24/7 crisis stabilisation services and extended virtual care access points into the community. The model changed the way crisis care in the region works.
With GRAND's new crisis care strategy, police can quickly and easily connect people with clinicians at the urgent recovery centre to assess patient need. Patients can also communicate directly with clinicians when in crisis or if they need support.

The result Compared to the baseline year of 2015, the model has shown the following results for GRAND's adult clients:

- Reduced inpatient hospitalizations at any Oklahoma psychiatric hospital by 93.1% (from 959 in 2015 to 66 in 2021)
- Reduced inpatient hospitalizations at Wagoner Hospital by 100% (from 841 in 2015 to 0 in 2021)
- Reduced inpatient bed days at Wagoner Hospital by 100% (from 1,115 in 2015 to 0 in 2021)
- Saved state and federal government $62 million dollars (from 2016-2021)
- Increased number of adult clients served by 163.5% (from 4,326 in 2015 to 11,401 in 2021)

When GRAND started the model, they were a fee-for-service (FFS) community mental health organization. Under FFS, GRAND was able to recoup the money spent from their general revenue budget by reducing the rate of no-show appointments. While GRAND eventually transitioned to a Certified Community Behavioural Health Clinic (CCBHC) business model, leadership believe this approach would have continued to bring a positive return on investment under FFS.

Buurtzorg: revolutionising home care in the Netherlands

Home care in the Netherlands supports the chronically ill, people with dementia, and those needing end-of-life care. It includes both medical services, such as wound care and injections, and personal support, such as bathing and help with daily living. By the mid-2000s, however, Dutch home

care faced serious challenges: declining quality, rising costs, lack of continuity, and a disillusioned nursing workforce.
Frustrated by this situation, nurse Jos de Blok left his job to found Buurtzorg ("neighbourhood care"), a radical alternative centred on patient needs and frontline autonomy. Rejecting centralised management, Buurtzorg empowered small nursing teams to integrate families and neighbourhood resources into holistic care solutions. This approach aimed to simplify the system, deliver higher quality care at lower cost, and improve job satisfaction among nurses.

- Buurtzorg's model consists of three key components:
- Self-governing teams of 10–12 nurses providing both medical and supportive home care
- An IT system to reduce administration and allow teams to self-monitor performance
- Regional coaches offering advice and promoting best practice without performance targets

Each neighbourhood-level team covers around 10,000 people and 40 patients. Nurses act as "health coaches", coordinating care with GPs, involving families, and mobilising community support. Objectives include:

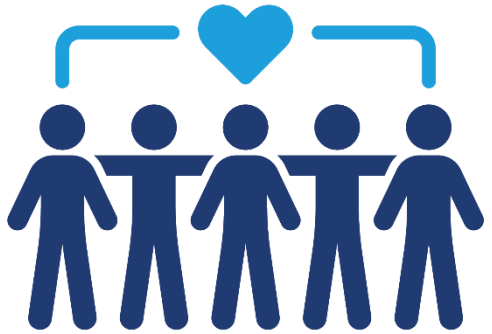
- Creating a financially sustainable, holistic model of care
- Boosting nurse satisfaction through autonomy
- Maintaining or restoring patients' independence
- Training patients and families in self-care
- Building neighbourhood networks of support

The outcomes have been notable:

- Patient satisfaction scores are 30% above the national average;
- between 2008–2013 the average rating was 9.1/10
- Patients stay in care for 5.5 months on average versus 7.5 months elsewhere, with 50% receiving care for less than three months – suggesting greater independence
- However, Buurtzorg patients are admitted to nursing homes at a younger age compared to others

By 2018, Buurtzorg had 10,000 nurses in 900 independent teams, caring for 70,000 patients annually. At its peak, 60% of Dutch community nurses worked for Buurtzorg, influencing national elderly care policy and inspiring competitors to adopt self-steering models.

While overall savings are debated, it is estimated that nationwide adoption of Buurtzorg could save the Dutch economy €2 billion annually. Its impact on patient satisfaction, independence, and nurse morale has been profound, offering a globally recognised model of sustainable, community-based care.



Design Phase: Co-creating the future

Building on the insights gathered, the Design phase focused on collaboratively shaping the strategy's content, priorities, and delivery models.

Key activities included:

- Ten targeted design workshops, each aligned to a chapter of the strategy, involving stakeholders from across the system—health, care, voluntary sector, and community representatives.
- Interactive and iterative engagement, where stakeholders tested ideas, refined options, and helped identify barriers and enablers to change through the Design Steering Group and engagement with localities.
- Validation of emerging models, ensuring that proposed solutions are grounded in lived experience and operational reality.

Over 125 individuals participated in one or more of the strategic workshops held to inform the development of this health and care strategy. These workshops were aligned with the following thematic chapters:

- Population health and prevention interventions
- Neighbourhood health services and primary care
- Community services and the bridging neighbourhood system
- Secondary and tertiary care
- Implementation via enabling plans

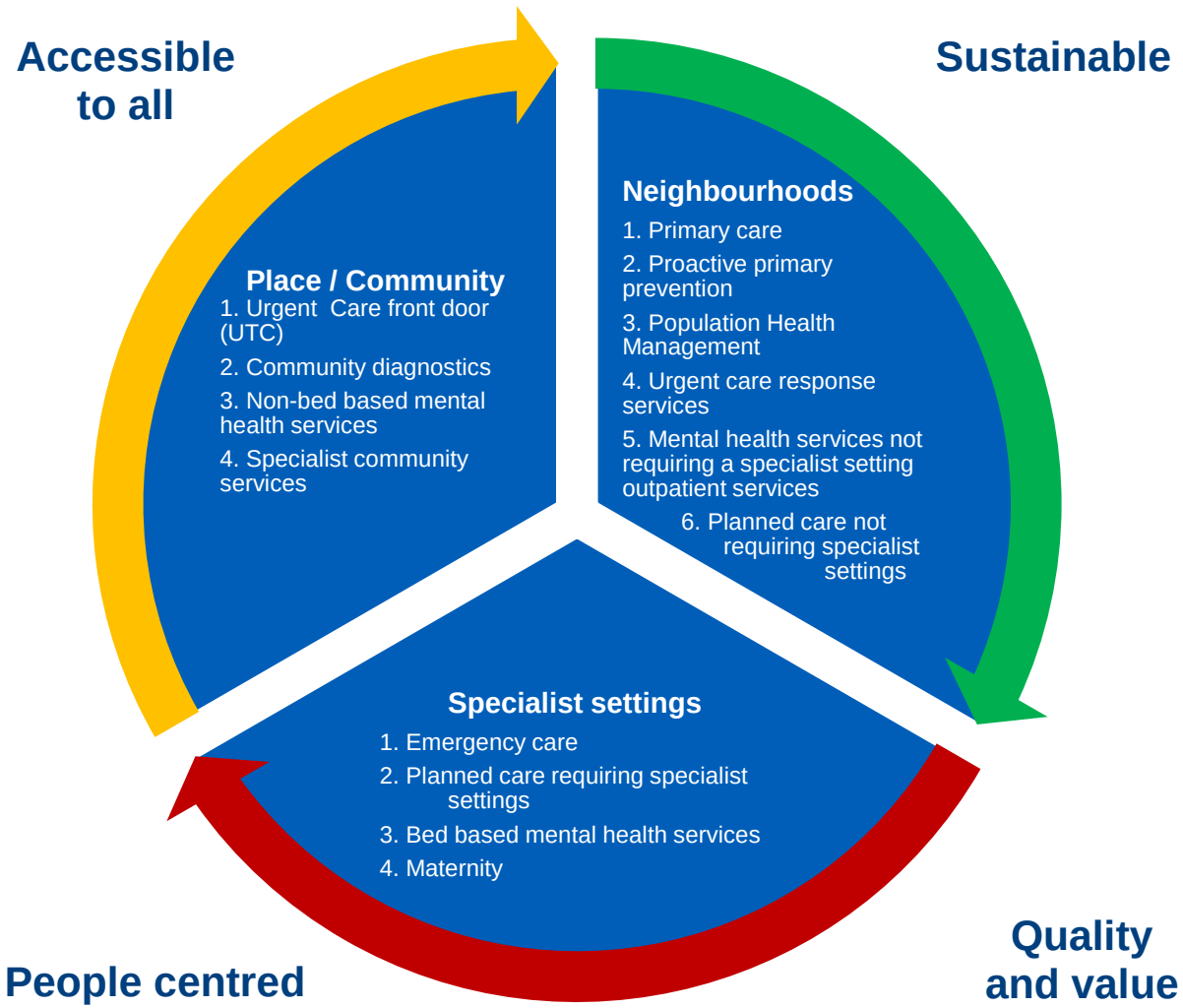
The workshops generated valuable insights and outputs. The initial round focused on assessing the current state, envisioning the future state, identifying system-wide gaps, and defining the necessary "bridges" to transition from the current to the desired future state. The second round of workshops built upon this foundation, using the identified bridges to shape detailed workplans, define intended outcomes, and establish measurable metrics. These contributions are reflected throughout this strategy document and will continue to inform future planning, development, and commissioning activity.

Design principles

Four core design principles serve as strategic guardrails for the development and implementation of our system-wide strategy. These principles have been rigorously tested and refined through extensive engagement during the Design phase. They underpin the delivery model and shape the anticipated impact of the transformational changes required to improve outcomes, enhance equity, and ensure sustainability across the Devon system.

Sustainable	Quality and value	People-centred	Accessible to all
• Sustainability means being able to live within our means and being conscious of the health system we leave to future generations. • Be deliverable within the financial resources available to us, eliminating the reliance on deficit support or funding above the fair shares allowance • Develop services that can be delivered using current estate • Deliverable with the projected available workforce • Support a shift from treatment to prevention to increase healthy life expectancy • Reduce the environmental impact of healthcare services • Deliver nationally and regionally agreed performance standards	• Quality and value means ensuring that we are balancing maximising the outcomes we get from our investment with delivering what is right. • Consider how it maximises outcomes: patient experience, financial, and patient and population health outcomes • Be honest about what cannot be delivered or where difficult decisions on resource allocation need to be made • Be considerate of its impact on all parts of our population, with clear impact assessments to help us understand any unintended consequences • Deliver on nationally and regionally agreed quality standards	• People-centred means being considerate of all the people impacted by our decisions. • Involve patients and the wider public in the design of their services • Involve patients and the wider public in the design of their services • Build services that cater for the needs of people and not the service • Enable the health workforce to deliver, and invest in them to retain and develop skills within the system • Involve partners from other organisations wherever there is an impact on them	• Accessible to all means ensuring ease of access to services and clear navigation through the health system. • Have clear access points that are understood by our population and partner organisations • Ensure a consistency of approach and service regardless of the access point to receive healthcare services • Minimise the number of handovers between organisations, and where they occur ensure that the patient journey is not affected by them • Navigate people to the right service for their needs as quickly as possible • Commission services which reduce health inequalities especially for the most disadvantaged groups

Our model of care



- **Neighbourhood** – Supporting integrated, community-based care tailored to local populations, with a strong focus on prevention, early intervention, and personalised support. This is community-based care across a population of between 30,000–50,000 people. Delivery is led by Integrated Neighbourhood Teams (INTs) that use combined resources to deliver joint outcomes. Outcomes are commissioned from a lead provider who will collaborate with other health services (including primary care), social care and VCSE organisations to deliver contracts.

- **Place** – Enabling coordination across services within localities, ensuring that care is joined-up across primary, community, mental health, social care, and voluntary sector partners.

- **Specialist settings** – Providing strategic oversight, specialist services, and infrastructure to support consistency, equity, and sustainability across Devon.

Building on this foundation, we have collaboratively developed a care Model for Devon that is tailored to our local context, responsive to population health needs, and aligned with our collective ambitions.

This model outlines a coherent framework for organising and delivering care across three integrated levels, ensuring consistency, coordination, and community relevance. There is however care that cannot be delivered in non-specialist settings and high-volume interventions that can benefit from economies of scale. Services should be commissioned to deliver national best practice to maximise cost and quality outcomes.

This layered approach will enable a shift toward more integrated, proactive, and person-centred care, ensuring that services are designed around people, not organisations, and that care follows the individual across settings and life stages.

The emerging model is not a fixed blueprint, it is a living framework for ongoing collaboration, innovation, and refinement. It will continue to evolve through engagement, testing, and learning, utilising the voices of our communities and the expertise of our workforce.

This approach ensures that Devon's health and care system remains responsive, resilient, and aligned to the needs of today's population and future generations.

Applying a population health management methodology – treatment to prevention

Our Delivery Model is dependent on the application of a Population Health Methodology for all service delivery. Population Health Management (PHM) is how we work collaboratively to understand and improve the health of people and communities, using joined-up data and intelligence. It goes beyond data analysis to include community engagement, clinical and financial input, evidence-based planning, and ongoing evaluation.

PHM enables us to identify and reduce health inequalities through proactive and preventative care, targeting resources where they will have the greatest impact. Techniques such as segmentation, risk stratification, and impact modelling help identify local 'at risk' cohorts, allowing us to design tailored interventions that prevent ill-health, improve care for those with long-term conditions, and reduce unwarranted variation in outcomes.

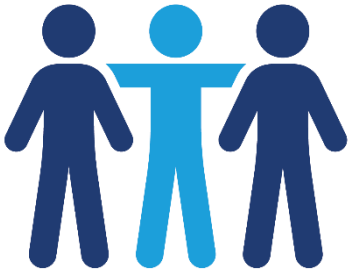
This approach is central to delivering more equitable, effective, and sustainable health and care services across Devon and will be central to transformation.

Devon's population is aging faster than the national average, leading to a rise in long-term conditions and increasing demand on secondary and urgent care services. Without a shift toward prevention and early intervention, the system will face growing pressure and financial strain.

A population health approach enables us to respond proactively supporting people to live healthier for longer and reducing the number of years lived in poor health.
This approach is especially critical in areas of deprivation, where life expectancy is shorter and poor health begins earlier. It also helps address the significant variation in healthy life expectancy and service demand across Devon.

Aligned with national PHM principles—including those set out in the NHS Long Term Plan, Core20PLUS5, and the ICB Model Blueprint, we are focusing on:

- **Reducing health inequalities** by targeting early intervention and prevention in communities with the greatest need.
- **Improving outcomes** through personalised care, healthy lifestyle promotion, and support for self-management.
- **Enhancing cost-efficiency** by reducing reliance on reactive, high-cost services through earlier, community-based support.
- **Increasing quality of life** by helping people maintain independence and wellbeing throughout their lives.
- **Supporting sustainability** by easing the burden of chronic disease and enabling better resource allocation.



This population health approach is embedded within our success measures framework, which tracks progress through a combination of quantitative indicators (e.g. waiting times, admission rates, workforce data), qualitative feedback (e.g. lived experience, staff and community engagement), and independent evaluation.

These measures will evolve as the strategy is implemented, ensuring we remain responsive to emerging needs.

Population health management in Devon

Using a learning cycle, Population Health Management (PHM) in Devon will enable us to work collaboratively across health, care, and community systems to better understand and improve the health of our population. By integrating joined-up data and intelligence, PHM helps us identify patterns in service use—highlighting where care is sub-optimal, where people are not accessing services in a timely way, and where there may be overuse or underuse. This insight

supports more effective service planning and resource allocation. This continuous cycle of learning ensures that PHM remains dynamic, responsive, and embedded in our wider strategy to create a healthier, fairer, and more sustainable Devon. A PHM methodology will help us in:

- **Identify patterns** – who is accessing services, where is care sub-optimal, who isn't accessing services in a timely manner
- **Risk stratify**, segment population, identify high risk cohorts and plan specific interventions, services and pathways
- **Shift from hospital to community** with earlier interventions and prevention
- **Population health** – role of wider determinants (e.g. through social prescribing) instead of, or as well as, healthcare

Digital transformation – analogue to digital

Digital transformation will be a central driver of change across Devon's Health and Care Strategy Delivery Model, and it is aligned to the ambitions set out in the national 10-Year Health Plan. We will harness digital innovation to respond to rising demand, an aging population, and increasing financial pressures delivering care that is more proactive, efficient, and resilient.

Through the implementation of integrated care records, virtual consultations, remote monitoring, and data-driven planning, we will reshape how services are delivered and accessed.

Our strategy commits to embedding digital solutions at scale, investing in infrastructure, building digital capability across the workforce, and ensuring inclusive access for all communities.

System-wide data-sharing	Standardised and Unified Infrastructure	Shared EPR and Operational Systems	Person centred care	Harnessing new technology
1. Shared patient data to support health and care across settings (NHS, care and community partners) 2. A quality-led approach to IG to resolve data-sharing barriers 3. Systems that enable a real-time linked data set 4. Optimisation of local instance of the Federated Data Platform 5. Dynamic System-wide Demand Management and Forecasting Capabilities	1. 'Staff Passport Technology' for cross-border team working and movement 2. Cyber secure infrastructure 3. Standardise and rationalise technology 4. Maximise economies of scale through converged contracts 5. Digital Collaborative Corporate Service 6. Single data architecture and consistent data management processes	1. Optimised single electronic patient record (EPR) across Devon acute hospital settings 2. Devon and Cornwall Care Record (DCCR) 3. A connected Devon and Cornwall Laboratory Information Management System 4. Medication optimisation capabilities 5. Automated end-to-end Pathway management for visibility and alerts 6. Converge systems to support corporate functions	1. NHS App 2. Single Patient Record to enable joined up care and patient engagement / activation 3. Personalised care plan 4. Digital inclusion strategy 5. Enabling easy navigation for patients, carers, teams 6. Safe adoption of virtual therapists, triage and remote monitoring in mental health 7. Neighbourhood health technology offers for wearables	1. AI to improve productivity and decision making through AI-enabled and AI-delivered health care 2. Wearables technology to support neighbourhood health and care 3. Surgical efficiency via Robotics 4. Digital decision-making based on patient outcomes and value to person and System

In a system under pressure, digital transformation will be a core part of how we deliver sustainable, high-quality care now and into the future. The following are principles of the digital innovation for Devon:

Quality in all we do

We will put quality at the heart of achieving best value in health and care. Delivering safe, effective, and person-centred services ensures that required outcomes are achieved and resources are used in the most impactful way. Our understanding of quality is shaped both by the voices of our population—who tell us what matters most to them in their care—and by the expertise of our clinicians, who bring evidence, professional standards, and frontline insight.

This partnership between clinical leadership and lived experience gives us a rounded view of what high-quality care truly means. By listening to patients and staff, and by embedding clinical judgement into our decision-making, we can design and deliver services that are responsive, viable, and represent the best value for our communities.

By building trusted relationships with clinical care and professional leaders we are able to create a unified approach to quality that is intelligence driven, clinical informed that drives innovation and transformation. We will use global best practice knowledge that can be adapted and adopted to drive high value commissioning and delivery.

We will lead a culture of continuous improvement, clinical excellence and evidence-based practice by using total quality management methodology and use of the national quality board frameworks.

With quality as our guiding principle, this strategy commits us to building a system that delivers:

- **Safe care** – risks are anticipated, and harm is minimised through strong clinical governance and leadership.
- **Effective care** – good outcomes are consistently achieved, informed by clinical evidence, clinical leadership, innovation, and research.
- **Positive patient experience** – people feel respected, listened to, and supported
- **High value** – resources are used responsibly to deliver the greatest possible benefit for patients, customers, communities, and taxpayers.

Neighbourhood health service and primary care - hospital to community

What is a neighbourhood?

Neighbourhoods are geographic areas with populations of 30-50,000 and are a way of working in which self-defined and often hyper-local, and statutory services, work together to improve the health and wellbeing of their population.

Neighbourhood working involves statutory and non-statutory stakeholders bringing their assets, capability, capacity and experience to a common goal.

Devon has not yet fully defined its Neighbourhoods, though work to do so is underway. Our Place arrangements in Devon, the five Locality Care Partnership's (LCPs), are being supported to define neighbourhood boundaries to ensure full coverage across the county. Within a Neighbourhood, Integrated Neighbourhood Teams (INTs) will be established to deliver health and care outcomes. Establishing our Neighbourhood footprints is essential, but we anticipate that our initial configuration will need to evolve over time. In some areas initial alignment with Devon's 31 Primary Care Networks (PCNs) will enable the development of services given their essential role as the clinical backbone of INTs, however it is essential that Neighbourhood footprints should be determined by local needs, local community demographics, and the existing assets in each area.

Aligning with PCN boundaries is a starting point, but INTs may need to work across them to provide effective, person-centred care. There are several essential foundations that our LCPs will take forward in order to establish our Neighbourhoods and foster a collaborative approach to successfully deliver our ambitions.

These include, ensuring the right representation and engagement with local stakeholders, strengthening the voice of the citizen, applying PHM methodology and risk stratification to understand local need, developing a clear local vision, and supporting system leadership development that will enable collaboration between partners to enable delivery.

Integrated Neighbourhood Teams (INTs)

Our Integrated Neighbourhood Teams (INTs) will become the primary interface for our population with health care services. Bringing together health, social care and VCSE partners, taking a multidisciplinary team approach using shared patient-level data, INTs will identify people at greatest risk, proactively reviewing and supporting interventions to keep them healthy.

Neighbourhood working is not just about the location of services but improving the population's health. Our neighbourhood teams will operate at the scale that makes the most sense for their populations.

Where it works most effectively, they will respond quickly to emerging needs, mobilise resources, and build strong, trusted relationships within their communities. Citizens and communities should be at the centre of

these teams, as active partners in the design and ongoing delivery of services.

Once established, INTs will be formally commissioned, via a lead provider, to deliver a wider range of physical and mental health services.

The commissioning arrangements will move away from paying for activity within these services, to paying for outcomes, allowing flexible use of resource to deliver the right interventions for the Neighbourhood population.

INTs will be encouraged to commit resource to reflect need, delivering more for those that have greatest need, rather than relying on delivering a standard, universal offer to all.

We will develop a risk stratification tool that can be used by the INTs to identify and understand local population need.

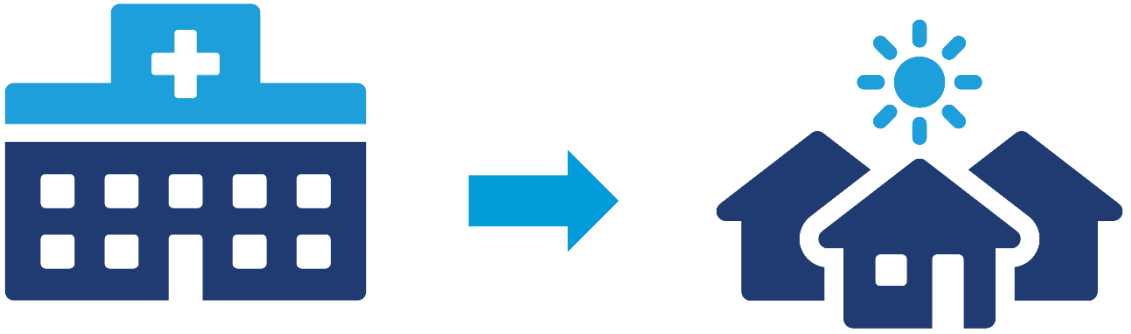
Applying a PHM approach, the INTs will initially focus on developing multidisciplinary team approaches to support the identification and supportive interventions for individuals with multiple long-term conditions in line with the national Neighbourhood guidance, making reasonable adjustments for individuals as required.

Through our Place arrangements, commissioning relationships will be further strengthened with local authority partners to align commissioning plans and give a clear steer on agreed outcomes to INTs. The commissioning approach will be permissive enough to allow INTs to use resources collectively, regardless of source. This will remain in place for as long as the INT is delivering commissioned outcomes.

INTs will also be supported to build relationships with private enterprise in order to develop income streams and outside investment that can be reinvested into health and social care services.

INTs will establish a physical hub for services to be co-located. While this may be within current NHS estate, where possible this should be within the heart of the neighbourhood, and consideration will be given to how partners collectively use their resource to support INTs.

INTs will be asked to take an all-age approach and will need to consider how to plan services around different groups, for example: services for children being delivered outside of school hours.



Moving activity from hospital to neighbourhood

Wherever services do not need to be delivered within a specialist setting, there will be consideration given to transferring to Neighbourhoods for delivery.

Primary care

Primary care will be central to the delivery of INTs. General practice and Primary Care Networks (PCNs) will expand to improve access for patients via telephone and digital means, in addition to face-to-face access. Patients can expect to receive clinically appropriate inputs from a variety of clinical and non-clinical staff delivered in an appropriate timeframe,

dependant on their needs. There will be greater promotion of self-management and use of community assets within their Neighbourhood.

INTs will continue to focus on improving the dental offer to our population, particularly for those with urgent needs, those requiring stabilisation of their oral health, and with a strong focus on prevention and ensuring lifelong good dental health.

Community pharmacy will further expand its service offer, often localising delivery for patients and supporting partner providers. Recognising pharmacy is not immune from delivery pressures, we will seek to commission a broader range of services on a longer timeframe, giving providers the confidence to grow their businesses and extend their offer.

Ophthalmic services will be required to ensure excluded groups are able to access the care and services they need. Initially this will be by ensuring that those within Special Educational Settings (SEND) have a robust and comprehensive offer, and where that is not readily accessed, work with SEND providers to identify and remove access barriers.

A problem-based approach to innovation will be established, using technology to help improve primary care. By understanding the challenges and through use of case studies, we will explore the best options to address these challenges at scale, which we know will include enabling safe, appropriate, and timely information exchange between system partners.

Urgent care response and virtual wards

INTs will be expected to develop a service that responds rapidly to those with an urgent care need (all age, physical or mental health) to support them to remain within the Neighbourhood, rather than need admission into a specialist setting. This should include ‘hospital at home’, which will replace the current virtual ward model.

Supporting discharge

INTs will be expected to deliver models to support early discharge from specialist settings. They will work with specialist providers to identify patients where support plans can be enacted to complete non-specialist treatment within a neighbourhood setting.

Outpatient services

INTs will deliver follow-up care to those that have had interventions in specialist settings.

This will be proportionate to the need of the individual and follow-up activity will be stopped where it is adding little to no clinical value.

Women's health

INTs will deliver integrated reproductive, preventative, and early-intervention services where these services do not require specialist settings. The aim is to improve women's health outcomes, reduce health inequalities, and prevent escalation to specialist gynaecological interventions wherever possible.

Mental health, learning disabilities, and neurodiversity

INTs will remove barriers between mental and physical health at a neighbourhood level, delivering primary prevention to their population based on totality of health need. INTs will work collaboratively to develop local support networks and peer-to-peer offers that will support those with mental health needs to avoid crisis. Support for patients and families

When individuals are escalated to more specialist services, either community or bed–based, neighbourhood teams will remain the primary care navigators for that patient, working with specialist services to revert to neighbourhood wherever possible, including for patients that have a Learning Disability and or neurodiversity.

Children and young people

INTs will deliver universal and preventative services that are embedded within the environments where children live, learn, and grow.

Neighbourhood delivery for children and young people will include strong alignment with schools, early years settings, and local authority locality structures. This integrated approach ensures that services are coordinated, equitable, and responsive to the diverse needs of children and families. It also enables early identification of health and developmental concerns, allowing for timely intervention and support.

The children's clinical workforce is highly specialised and often lacks the critical mass required for hyper-local delivery. As a result, while services must be accessible and community-based, they also need to be delivered at a scale that ensures quality and sustainability.

How will this feel different for our patients

- Those with greater need will be prioritised and interventions will be in place to keep people with long term conditions healthy.
- People will be able to have multiple needs met at once rather than making separate appointments with different agencies
- People will be able to access health services as part of their day-to-day routine instead of travelling to NHS settings
- People will only need to give their information once and not repeat this when using other local services
- People will need to access Hospital settings less and receive more care closer to their home
- When people have an urgent care crisis they will be supported to stay at home and have their needs met locally instead of travelling to other settings
- People with greatest need will receive a more "fair share" of available funding, increased outside investment in NHS services will mean more services available for all
- When services are not delivering for people the ICB will be able to intervene using contractual levers to support improvement

This necessitates close collaboration with services such as primary care, hospital-based care, and community health teams. The strategy adopts a whole-age approach, recognising the need for seamless transitions from childhood to adulthood—particularly for children and young people with special educational needs and disabilities (SEND), who may access services from birth up to the age of twenty-five.

At the heart of neighbourhood-level children and young people delivery is a commitment to prevention and health promotion. Health visitors and early years practitioners play a critical role in supporting families during the first 1,001 days (from conception to age two) laying the foundation for lifelong health and development.
School nurses will work in partnership with education settings to deliver immunisations, sexual health advice, and mental health screening. GPs will provide accessible care with strong links to paediatric expertise and multidisciplinary teams.

Community-based parenting programmes and peer support networks further strengthen protective

factors within families, promoting resilience and wellbeing. Digital tools are increasingly used to enhance early identification and access to support, offering families timely advice and resources through an online platform.

Place and Community

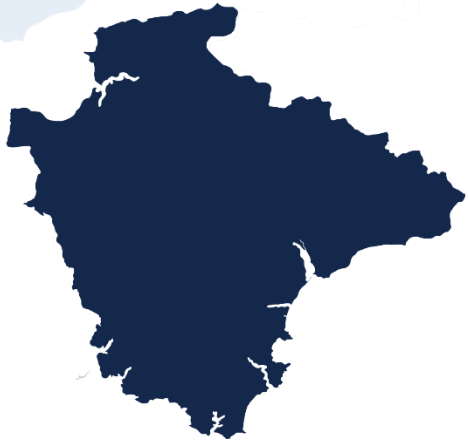
In the integrated care landscape, the concepts of Place and Community are central to delivering health and care services that are both strategically coordinated and locally responsive. These two dimensions operate across multiple neighbourhoods, each contributing uniquely to the design and delivery of care.

Place refers to a defined geographical footprint typically serving populations between 250,000 and 500,000 within which health and care organisations collaborate to plan, commission, and deliver services.

Place-based partnerships will align with Locality Care Partnerships (LCPs), and provide the infrastructure and governance needed to support neighbourhood development and delivery. They aim to enable coordination across neighbourhoods, particularly where services benefit from economies of scale, such as treatment centres, diagnostics, and workforce planning.

Place also plays a critical role in resource management, including estates, digital infrastructure, and innovation funding. Acting as the operational layer for Devon ICS, they will be pivotal in ensuring that neighbourhood teams are supported with the tools, investment, and strategic oversight required to deliver integrated care effectively.

Place is the structure that will support Neighbourhood development and delivery and sits across a geographical footprint that aligns with LCPs. Some services will be delivered across this footprint where there is benefit of economies of scale for this to be done across multiple neighbourhoods.



Community is defined not by geography, but by shared identity, experience or need, or protected

characteristics. Communities may be demographic (such as children and young people, older adults), clinical (such as people with mental health needs or neurodiversity), or experiential (such as carers, veterans, or LGBTQ+ individuals).

While communities often reside within a place, their boundaries are shaped by social connection and lived experience, rather than administrative borders.

Community-based approaches are essential for addressing health inequalities and ensuring that services are culturally competent, trauma-informed, and co-produced. By listening to and working with communities, the system can design care that reflects lived experience and builds trust.

Community is less structural, based around our people and their shared characteristics. While this may be around people who live in a similar geographical place, this will primarily be groups with similar demographic features or clinical needs.

Together, Place, Community and Neighbourhoods form a tri-level model that enables the health and care system to be both strategically coherent and locally responsive. This integrated approach ensures that services are designed around people, not organisations—delivering better outcomes, reducing inequalities, and building stronger relationships between services and the populations they serve.

How will we work at Place?

Locality Care Partnerships (LCPs) will serve as the primary delivery mechanism for neighbourhood-level health and care transformation.

Embedded within the broader framework of Integrated Care Systems (ICSs), LCPs are designed to bring together NHS organisations, local authorities, voluntary and community sector partners, and other stakeholders to co-design and deliver services that reflect the unique needs of local populations.

With support from NHS Devon, each LCP will be tasked with identifying and establishing core priorities at the neighbourhood level. These priorities will be informed by population health data, local intelligence, and community engagement.

Where appropriate, LCPs will collaborate across neighbourhoods to deliver services at scale—particularly in areas where specialist expertise, economies of scale, or infrastructure investment are required to ensure sustainability and equity of access.

To support this, a place-based estate register will be maintained, cataloguing available assets for neighbourhood use. This aligns with national ambitions to repurpose underutilised NHS estate and maximise value for money.

The 10-Year Health Plan highlights the need for neighbourhood teams to have access to appropriate facilities, technology, and working environments to deliver integrated care effectively. Strategic capital investment will be essential to modernise infrastructure and support the development of neighbourhood health centres.

Urgent care services will be coordinated through a dual-level approach. While urgent care response – such as community-based crisis teams and same-day access – will be delivered locally within neighbourhoods, the urgent care "front door", including Urgent Treatment Centres (UTCs) and walk-in hubs, will be strategically managed at the place level.

This ensures consistency, efficiency, and equitable access across the county, in line with NHS England's neighbourhood health guidelines. Innovation will be a cornerstone of neighbourhood transformation. Each place will hold Innovation Funds to support the piloting of new services, technologies, and models of care. These funds will be accessible through neighbourhood-led bids and will be governed by a clear framework of desired outcomes, including health equity, service integration, and sustainability.

Where pilot projects require longer-term evaluation or development, multi-year funding arrangements will be considered to ensure continuity and impact. National guidance encourages the use of innovation funding to support projects that are co-produced with communities, digitally enabled, and aligned with broader NHS priorities such as the Net Zero Carbon Plan and population health improvement.

Additionally, any national or regional pilot programmes with allocated resources will be channelled through these local innovation funds to ensure alignment with local strategies and continuity of funding. This approach reflects a broader shift in NHS policy from centralised service delivery to place-based, community-led transformation.

By empowering LCPs to lead at the neighbourhood level, supported by strategic coordination at place, we can build a health and care system that is agile, inclusive, and responsive to the needs of the people it serves.

Delivering for our communities

Mental health, learning disabilities, and neurodiversity

Mental health services across Devon will undergo a strategic shift—from a predominantly bed-based model to one that prioritises prevention, early intervention, and recovery. This transformation aligns with NHS England's national direction to move care from hospitals into communities, reduce reliance on inpatient beds, and embed mental health within broader integrated care systems.

At Place level, NHS Devon will commission a comprehensive suite of recovery and aftercare services designed to support individuals transitioning out of acute care.

These services will be co-produced with service users and community partners, ensuring they are responsive, trauma-informed, and focused on long-term wellbeing. The goal is to reduce readmissions, promote independence, and enable people to live well in their communities.
Mental health will be fully integrated into Neighbourhood services, alongside physical health, as part of a whole-person approach.

This includes both proactive prevention and urgent care response, ensuring that mental health needs are addressed in the same way as physical health—timely, locally, and holistically.

Clear and consistent access points to mental health services will be established across the county. These will be designed to reduce fragmentation, improve navigation, and ensure equitable access regardless of location or background.

Secondary prevention at Place-based delivery will also focus on secondary prevention, targeting early detection and timely intervention:

- Mental Health Support Teams (MHSTs) in schools will continue to expand, offering evidence-based interventions for mild-to-moderate mental health issues, supporting whole-school approaches, and linking education settings with specialist services. These teams are a cornerstone of the NHS Long Term Plan's ambition to improve access for children and young people.

- Annual health checks and physical health checks for people with Severe Mental Illness (SMI) will be commissioned and monitored at Place. These checks are vital for identifying preventable conditions early and addressing the significant health inequalities faced by people with SMI, whose life expectancy is 15–20 years shorter than the general population. Checks will include cardiovascular disease risk assessments, metabolic screening, and lifestyle support, with follow-up interventions embedded into personalised care plans.

Children and young people

At the community level, services are designed to support children and families through targeted, multi-agency coordination. This tier of delivery sits across multiple neighbourhoods and is aligned with local authority-defined localities and school clusters, enabling a joined-up approach to meeting complex needs.

Delivery at Place will focus on commissioning and sustaining integrated services that bring together education, social care, community health, and voluntary sector partners. These services are essential for children and young people who require more than universal support, including those with Special Educational Needs and Disabilities (SEND), mental health needs, and neurodiversity.

Multi-disciplinary teams comprising early help practitioners, school nurses, social workers, educational psychologists, therapists, and community nurses will work collaboratively to provide coordinated care. These teams will operate within locality-based structures to ensure consistency, reduce duplication, and improve access to support.

Community-level services will include:

- Targeted support for children with additional needs, including SEND and neurodevelopmental conditions.
- Community-based mental health and therapy services, designed to be accessible and responsive.
- Integrated locality teams, offering wraparound support for families through coordinated case management.
- School-based mental health interventions, including drop-in clinics and early access to psychological support.
- Data-sharing protocols to identify and support children at risk, such as those with poor attendance, safeguarding concerns, or emerging health issues.
- Partnerships with youth services and voluntary organisations, ensuring holistic development and continuity of care.

Services will be commissioned and monitored at Place, ensuring strategic alignment, equitable access, and consistent standards across Devon. The aim is to reduce escalation to statutory services, improve school attendance and mental wellbeing, and ensure early identification of issues.

By embedding targeted support within communities and aligning it with local systems, NHS Devon will reduce health inequalities and ensure that every child and family has access to the right help, at the right time, in the right setting.

Maternity

NHS Devon will commission perinatal services that reduce health inequalities, provide care within communities, manage social and medical complexity, and improve outcomes for the most vulnerable. Services designed to be holistic, accessible, and person-centred and recognise the profound impact of social determinants on maternal and infant health and work to address systemic barriers that disproportionately affect marginalised populations.

At their core, these services will be community-based and culturally responsive, ensuring care is delivered in local settings that are familiar and trusted by those who use them.

By co-locating services within community hubs, outreach centres, or via home visits, care will become more accessible to underserved groups, including ethnic minorities, refugees, young parents, and those experiencing poverty, trauma, or unstable housing.

To manage social and medical complexity, multidisciplinary teams; including midwives, obstetricians, mental health professionals, social workers, and community health advocates will collaborate seamlessly. These teams will identify and respond to multiple needs early, offering personalised care plans that integrate clinical treatment with social support, safeguarding, and mental health interventions.

Importantly, these services will adopt a data-driven approach to monitor disparities and evaluate outcomes, ensuring that interventions are tailored and targeted. Community voices, especially those with lived experience, will be embedded into service design and delivery, ensuring care is not only for communities, but with them.

Through these approaches, perinatal services will work to close the gap in health outcomes, improve maternal and infant wellbeing, and provide dignified, respectful care that empowers all families, especially those facing the greatest challenge.

How will this feel different for our patients

- People will receive the same level of service regardless of which urgent care centre they attend
- People with mental health needs will be supported to remain in their community instead of in inpatient services
- People will be able to access innovative services earlier without risk that funding gets pulled based on the annual funding cycle
- Children will be supported to maintain social and educational requirements alongside delivery of interventions for health needs

Care within specialist settings

Specialist settings deliver interventions that cannot be provided in the community. This includes physical and mental health hospitals delivering acute care such as:

- University Hospital Plymouth
- Royal Devon and Exeter Hospital
- North Devon District Hospital
- Torbay Hospital
- Mental health facilities provide a range of care from single-sex mental health hospitals, acute care and medium – low secure services:
  - Wonford House (Exeter)
  - Torbay Mental Health Unit (Torquay)
  - Glenbourne (Plymouth)
  - Langdon Hospital (Dawlish)
  - Lee Mill
  - Franklyn Hospital (Exeter)
  - The Moorings
  - Plymbridge House

Delivering care within specialist settings

Care within specialist settings is high costs and requires scarce clinical resource. Distribution of this resource too widely can risk reducing quality of care through unsustainable and inefficient services. Devon will embed not only the new model of delivery but also enable the shift from acute to community. Options for consolidating some services onto fewer sites where it is safe and makes sense to do so will also be considered.

The level of specialisation of staff within acute settings can lead to a false assumption of greater skill and that specialist centres are a better place to receive care.

In most cases, better outcomes can be achieved within Neighbourhoods. However, for those that need specialised resource and especially bedded care (for physical or mental health needs), the only place this can be delivered is within one of our acute hospitals and other bedded settings.

To establish what activity needs to be delivered within a specialist setting, a value-based commissioning review of all specialities will need to be undertaken to establish:

- Activity that can stop
- Activity that can be transferred to Neighbourhoods
- Activity for which there needs to be a transformed model

How will this feel different for our patients

- Stays in hospital will be shorter and more services will be provided closer to home.
- People may need to travel further to access services if they are delivered on fewer sites. The quality of the service will increase as specialist resource is consolidated, and people will wait less time for an intervention.
- Those who have an emergency care need will have this addressed sooner.
- People will experience a seamless handover between organisations
- People will be seen by the right service and professional for their need, irrespective of the hospital site that they are at

Making it happen

To deliver NHS Devon's Health and Care Strategy, we will establish a coordinated and outcome-driven delivery framework that aligns system leadership, operational planning, and local implementation.

The initial priority will be to embed the new model of delivery, with a particular focus on the development and mobilisation of Neighbourhood teams as the core delivery vehicle for integrated, person-centred care.

This will be supported by a robust success framework, which defines clear outcomes across strategic priorities such as improved population health, reduced inequalities, enhanced access and experience, and financial sustainability.

These outcomes will be tracked through a transparent performance dashboard, enabling continuous learning, accountability, and system-wide alignment.

Delivery will be enabled by a suite of supporting plans including organisational structure, culture, teams and partners, empowering patients and citizens, digital transformation, estates, finance, and ongoing engagement ensuring the system has the capacity, capability, and infrastructure to implement change.

We will adopt a life-course approach to service design, ensuring that care is responsive to the needs of people at every stage of life.

Governance will be streamlined to support agile decision-making, with neighbourhood teams, place-based partnerships, and system-level boards working in alignment.

Success measures framework

Devon's Health and Care Strategy will deliver meaningful and lasting change, and this change needs to be monitored through a clear set of outcomes and measures.

These will help us understand whether we are improving health and wellbeing, reducing inequalities, and building a more integrated, sustainable system. Aligned with the Model ICB Blueprint, NHS Devon will act as a system convenor, architect, and steward moving from transactional oversight to transformational, strategic leadership. This approach will guide the future development of healthcare services to meet the needs of our residents, which will be reflected in our commissioning intentions paving the way for the 'left shift' is service delivery and in how we allocate resources and measure success.

The success measures framework has been developed collaboratively through extensive engagement during the Design phase, ensuring it reflects the priorities, insights, and aspirations of all stakeholders involved.

This framework outlines the key outcomes we aim to achieve and the metrics by which progress will be measured. It serves not only as a tool for accountability, but also as a guide for continuous improvement, helping us to track impact, celebrate successes, and identify areas for further development.

Working with our partners, we will use Population Health Management approaches to establish a life-cycle delivery approach

Take a Neighbourhood-first approach
- Ensure an equal voice for decision, design and delivery for the voluntary sector, local authority and community partners in line with the shift '**From Hospital to Community'**
- Develop an inclusive approach to digitally enabled care to make sure it can expand neighbourhood capacity and enhance local capabilities
- Use patient access and demand insights to better plan specialist care across neighbourhood, place and secondary/tertiary for optimal outcomes

Embed a focus on equity and prevention
- Reduce inequity to narrow gaps in health outcomes between the most and least advantaged communities
- Improve access to care for underserved groups, including rural, coastal, and deprived populations
- Increase uptake of preventative services in areas of greatest need and focused on local disease profiles to shift 'From Sickness to Prevention'

Improve health and wellbeing outcomes
- Provide accessible and equitable universal services including vaccination and screening programmes
- Enable and evidence joined-up working across health, care and voluntary sectors to deliver 'whole person' care

Ensure financial and operational sustainability

Ensure Financial and Operational Sustainability
- Deliver care within the system's financial envelope
- Reduce unwarranted variation and duplication of services
- Improve productivity and value for money across the system
- Rebalance financials based on need and equity

Support workforce resilience and a shared culture

Support Workforce Resilience and a Shared Culture
- Take a deliberate and robust approach to shifting our culture, reducing organisational barriers, and placing patients at the heart of delivery
- Improve recruitment, retention, and staff wellbeing
- Expand roles and training to support new models of care
- Double down on collective leadership, collaboration, and organisational culture development

Innovate for digital and infrastructure transformation

Innovate for Digital and Infrastructure Transformation
- Increase use of digital tools to support access, self-management, and

Co-design and co-deliver accessible, joined care
- Increased delivery of care through a neighbourhood and place-based model to enable the shift 'From Hospital to Community'
- Drive up consistent use of personalised care plans and shared decision-making in line with national goals
- Improved navigation and continuity of care across services

Strong, consistent leadership
- Clearly define compassionate working and leadership/management process
- Develop a shared purpose that can underpin all planning, delivery and evaluation approaches
- Shift from transactional management to transformational leadership in line with the three shifts of the 10 Year Plan

A culture of collective responsibility
- Establish a positive culture; behaving, communicating, acting collaboratively for our communities
- Build a system-wide joint workforce plan to build the right competences within a health and social care setting
- Commit to a real 'no blame' transparent culture with 'bridge' relationships dedicated to fostering collaboration

Ensure quality across everything we do
- Embed a transparent and consistent impact assessment process in decision-making across and between system partners
- Support the most vulnerable in our populations with a robust system-wide safeguarding approach
- Define quantitative and qualitative outcomes and measures at the start of all service (re)design to enable honest evaluation

Embrace a value-based care approach
- Define and account for value through multiple lenses including person-centred and population health outcomes, financial balance, responsible resource and estate planning
- Develop an evidence-based framework that commits to changing or stopping investment when anticipated value is not realised

Clear governance and accountability
- Develop relationships built on strong foundations of trust to support the shift 'From Hospital to Community'
- Ensure clarity on where decisions are made, by whom, and how
- Establish risk management approaches to recognise and reward

Tracking progress and delivering outcomes

We have developed desired outcomes and associated metrics that form the foundation for how we monitor and evaluate progress throughout the lifecycle of the Strategy in line with our success framework. It not only identifies the key outcomes we aim to achieve but also sets out the metrics that will help us assess whether we are on track and delivering meaningful change.

Crucially, it enables us to monitor the impact of our new model of care delivery, ensuring that the changes we expect—across population health, service quality, equity, and system sustainability—are being realised.

To ensure these measures are both actionable and reflective of system-wide impact, we will adopt a balanced approach that includes:

- **Quantitative indicators** – such as waiting times, admission rates, and workforce data to provide a clear and objective view of system performance.
- **Qualitative feedback** – including lived experience, staff insights, and community engagement – to capture the human impact and ensure our work reflects what matters most to people.
- **Regular reporting** – to system partners, stakeholders, and the public, supporting transparency, shared accountability, and continuous dialogue.
- **Independent evaluation** – to validate outcomes, assess the effectiveness of our interventions, and inform ongoing learning and improvement.

These metrics are dynamic and will evolve as the Strategy is implemented, enabling us to remain responsive to emerging needs, challenges, and opportunities.

By embedding this monitoring framework into our governance and delivery structures, we are committing to a culture of openness, learning, and accountability—ensuring that our collective efforts lead to a healthier, fairer Devon for all.

This approach complements, rather than replaces, the system's ongoing responsibilities to meet national and local requirements under business-as-usual operations.

Alongside the transformative ambitions of the Strategy, providers are expected to continue delivering all mandated operating plan targets and pursue internal improvement programmes as part of their core functions. They should:

- Meet the requirements set out in the national operating planning guidance
- Meet the requirements set out in the national elective reform plan
- Meet the requirements set out in the national Urgent and Emergency Care plan
- Deliver within the context of the national 10 Year Health Plan
- Deliver within the context of the national neighbourhood health plan

Domain: Accessible to all

High level-outcomes	Metric
• **Take a Neighbourhood-first approach** • **Embed a focus on equity and prevention** • **Improve health and wellbeing outcomes**	• Access and navigation • % urgent care demand met same day • Digital triage success rate • Access equity for Core20PLUS5+ populations • Social prescribing uptake • Caseload coverage • Anticipatory care plan completion • Personalised Care Plan completion • Elective waiting times (referral to treatment (RTT) compliance) • A&E 4-hour target performance • Referral to treatment (RTT) metrics • Length of stay (LoS) • Bed occupancy rates

Domain: Sustainable

High Level-Outcomes	Metric
• **Ensure financial and operational sustainability** • **Support workforce resilience and a shared culture** • **Innovate for digital and infrastructure transformation**	• % of GP practices connected to Shared Care Record (SCR) • Digital maturity index scores • % of staff using integrated digital systems (e.g. Devon and Cornwall Care Record (DCCR) • Data sharing compliance (GDPR readiness) • Use of AI and advanced analytics in care pathways • Utilisation rate of estate (clinical and non-clinical) • % of estate meeting functional suitability standards • Carbon footprint and energy efficiency of estate • Staff survey results (engagement, morale, safety culture) • Sickness absence rates • Vacancy rates and turnover • Workforce equality metrics (e.g. WRES, WDES) • Training uptake and continued professional development (CPD) participation • Governance maturity assessments • Annual ICB statutory assessment results • Financial performance (surplus/deficit)

Domain: Quality and value

High level-outcomes	Metric
• **Ensure quality across everything we do** • **Embrace a value-based care approach** • **Develop clear governance and accountability processes**	• Cross-sector multidisciplinary team (MDT) participation • Rotational staff roles established • Referral response times across sector • % of contracts with outcome-based commissioning • % of pooled budgets across system partners

Domain: People-centred

Level-Outcomes	Metric
• **Co-design and co-deliver accessible, joined care** • **Enable a strong, consistent leadership** • **Create a culture of collective responsibility**	• Home discharge rate from recovery pathways • Readmission within 30 days • Friends and Family Test (FFT) scores • Patient experience survey results • Complaints and compliments data • Carer-reported experience measures • Patient Activation Measure (PAM) scores • Smoking prevalence, obesity rates, alcohol-related admissions • Vaccination coverage (e.g. flu, COVID-19) • Screening uptake (e.g. cervical, bowel, breast) • % of budget allocated to prevention • Population health management (PHM) indicators • Avoidable mortality rates • Health-related quality of life for people with long-term conditions • Emergency readmission rates within 30 days • Patient-reported outcome measures (PROMs) • Life expectancy at birth and at 75 • Early cancer diagnosis rates Hospital Standardised Mortality Ratio (HSMR

Enabling plans

Empowering patients and citizens

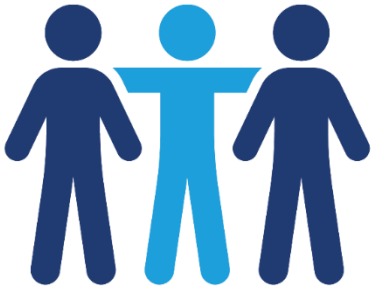
Through a focus on citizen and patient engagement, we will co-develop a community contract that clearly outlines mutual roles and responsibilities, fostering shared ownership of health outcomes.

A new system service change process aligned with the One Devon People and Communities Framework will be launched to strengthen how we listen, involve, and respond to our communities, supported by enhanced training for staff in patient communication and engagement.

We will also audit and improve our communication methods to ensure they are inclusive, accessible, and effective. In parallel, our Neighbourhood Shift approach will see the creation of a ‘Patient Partnership’ plan to guide the transition of services into community settings, ensuring that changes are co-designed and responsive to local needs.

A dedicated workforce transition plan will support staff through these changes, enabling a smooth and sustainable shift in how care is delivered.

- **Co-develop a Community Contract** Engage citizens and patients in structured dialogue to define mutual roles, responsibilities, and expectations around health and care.
- **Launch a new system service change process** Establish clear principles, processes, and tools for listening, involving, and responding to community voices across all service areas.
- **Develop a ‘Patient Partnership’ Plan** Co-design service transition plans with communities to ensure local relevance, responsiveness, and sustainability.
- **Implement a Workforce Transition Plan** Support staff through the shift to community-based care with tailored guidance, role clarity, and change management support.



Culture, teams and partners

Creating a thriving, collaborative culture across our health and care system is essential to delivering meaningful change.

Under the workforce planning strand, we will develop a system-wide, skills-based workforce plan with a five-year horizon, ensuring we have the right capabilities in place to meet future needs.

We will also reignite the Staff Passport initiative to enable greater cross-site mobility and flexibility, supporting integrated working.

Through a comprehensive review of organisational development (OD) and training, we will establish Strategic Education Groups to provide governance and oversight to create a unified training and leadership development plan that reflects shared priorities.

A collective training purchasing strategy will help maximise value and consistency across the system. At the leadership level, we will strengthen alignment and collaboration through the development of a Committee in Common across statutory and partner boards to deliver joint executive training with a focus on compassionate leadership, ensuring our leaders are equipped to guide transformation with empathy and purpose.

- **Develop a system-wide, skills-based workforce plan** Create a five-year roadmap that aligns workforce capabilities with future service needs across the health and care system.
- **Reignite the Staff Passport initiative**
- **Establish multi-agency agreements to enable this plan**
- **Create a Unified Training & Leadership Development Plan** Design a shared curriculum that reflects system-wide priorities and supports consistent professional growth.
- **Deliver Joint Executive Training in Compassionate Leadership** Equip senior leaders with the skills to lead transformation with empathy, purpose, and system-wide perspective.

Enabling functions

Digital and data

Harnessing the power of digital innovation and data intelligence is vital to transforming health and care delivery across our system.

We will enhance the Devon and Cornwall Shared Care Record (DCCR) to support outcomes-based planning and enable clustering across the Peninsula, laying the groundwork for a single Shared Care Record that facilitates seamless, person-centred care.

A unified Information Governance (IG) approach will be developed, including a sign-up strategy for GP practices and a shared policy and leadership structure across Devon and Cornwall, ensuring trust, transparency, and compliance.

Crucially, we will capture the patient voice to guide how data and digital tools are integrated into care.

Through the development of a Common Technical Infrastructure (CTI), we will enable cross-border working and interoperability across the Peninsula.

Our approach to Artificial Intelligence (AI) will prioritise staff engagement, training, and early evaluation of return on investment.

Finally, we will co-develop Digital Inclusion plans with VCSEs, local authorities, and ICS partners to address barriers to access and ensure that no one is left behind in the digital transformation.

- **System wide data sharing** Patient information will be shared with those who need access from different health, care and VCSE settings using a unified platform.
- **A unified Information Governance (IG) approach** will be developed, including a sign-up strategy for GP practices and a shared policy and leadership structure across Devon and Cornwall.
- **Standardised and unified infrastructure** Development of a single data management and reporting architecture by the system-wide business intelligence (BI) shared service.
- **Shared EPR and operational systems** The implementation of a single Electronic Patient Record (EPR) across all Devon acute hospitals and the Devon and Cornwall Care Record (DCCR) will continue to be the shared care record for sharing patient information across health and care settings.

Organisational structure

A coherent and agile organisational structure is essential to delivering integrated, neighbourhood-focused care.

We will begin with a comprehensive pan-system review of structures across NHS organisations and partners to identify opportunities for alignment, simplification, and improved collaboration.

Using business intelligence (BI) and Population Health Management (PHM) insights, we will support the strategic Neighbourhood 'Left Shift', enabling services to move closer to communities and better reflect local needs. This will be shaped in partnership with VCSE and community experts to define tailored neighbourhood offers.

To support understanding and engagement, a targeted Change Communications plan will be developed to clearly explain structural changes and their benefits to staff, partners, and the public.

Finally, we will establish a Whole System Planning approach, including a system-wide structure and training plan underpinned by co-designed metrics, ensuring that transformation is measurable, inclusive, and sustainable.

- **Leverage BI and PHM Insights to guide service shift** Use data-driven intelligence to support the strategic 'Left Shift' of services into community settings, tailored to local population needs.
- **Workforce plan.**
- **Incorporate a detailed system workforce plan** that support neighbourhood and place development.
- **Co-design metrics to measure transformation** Develop inclusive, meaningful indicators to track progress, impact, and sustainability of structural changes.

Estate and infrastructure

Modernising our estate and infrastructure is key to enabling care that is accessible, integrated, and future ready.

In community services, we will design place-based estate models that reflect local needs and support virtual care through mapped digital infrastructure. Asset consolidation will continue to ensure efficient use of resources, while a hub-and-spoke model will be developed around 5–6 strategically located community hubs to anchor neighbourhood care.

For primary care, we will review estate quality and develop a Primary Care Network (PCN) estate plan, alongside exploring new funding models and NHS ownership options to secure long-term sustainability.

Within acute services, we will maintain a steady-state approach to existing estate, while planning for service consolidation.

Future ward design—including virtual wards—will be co-led by digital and data teams to ensure alignment with technological capabilities.

A dedicated funding plan will be developed to support the reduction of outpatient activity, enabling a shift toward more proactive and community-based care.

- Design place-based estate models
- These models will inform the development and infrastructure to deliver services at place and in the most appropriate setting
- Map digital infrastructure for virtual estates planning
- Develop hub and spoke model
- Continue asset consolidation

Funding model

Transforming how we fund, and resource care is critical to enabling a shift from reactive to proactive, community-based services.

We will plan for a strategic resource shift from acute to community settings, addressing key challenges such as capital versus revenue funding to ensure financial sustainability.

We will develop delegated budgets for Integrated Neighbourhood Teams, empowering local decision-making and fostering accountability.

A comprehensive contract review will extend contract durations and embed outcomes-based commissioning, aligning incentives with population health goals.

In parallel, we will undertake a strategic commissioning review to assess statutory funding flows and evaluate the role of block contracts in supporting system-wide priorities.

We will create a Population Health Management (PHM)-informed funding

model for preventative care, ensuring that investment is targeted where it can have the greatest long-term impact on health and wellbeing.

The next phase of this work will focus on collaboration with relevant teams and stakeholders across the system to co-develop and implement each of the six enabling plans.

This will ensure that the plans are fully aligned with our overarching health and care strategy, grounded in operational realities, and shaped by the expertise and insight of those delivering and receiving care.

Through inclusive engagement, clear governance, and phased delivery, we will translate strategic intent into meaningful, system-wide change.
We will design a fair and equitable funding model that is:

- Fair
- Based on outcomes
- Provides equity
- Incorporates deprivation and protected characteristics
- Aligned to contractual models

Looking forward

As NHS Devon moves into the delivery phase of this strategy, we reaffirm our commitment to working in genuine partnership with our communities, providers, and system partners.

This is not just a principle it is a foundational approach embedded in our People and Communities Framework, which sets out a system-wide ambition to ensure that every voice, especially those from marginalised and Core20PLUS5 communities, is heard and influences decision-making.

Through the Devon Engagement Partnership (DEP), we will continue to nurture inclusive, coordinated, and transparent relationships. The DEP provides the governance and assurance that our system is meaningfully listening to and working with people and communities.

Engagement will be continuous, visible, and aligned to the four aims of the Integrated Care System—improving outcomes, tackling inequalities, enhancing value, and supporting broader social and economic development.

In parallel, we are implementing a renewed contract management framework, as outlined in our contract management approach blueprint. This framework introduces a structured, risk-based model for oversight and collaboration with NHS providers.

Key features include:

- Monthly contract review meetings (CRMs) chaired by senior ICB executives, providing a formal platform to monitor performance, quality, finance, and risk.
- Joint technical working groups (JTWGs) that underpin CRMs with detailed analysis of activity, referrals, waiting times, and financial impacts.
- A delivery management report (DMR) and Power BI dashboards to ensure a single version of the truth across the system.
- Clear governance and escalation routes to ensure accountability and alignment with strategic commissioning intentions.

This approach is designed to be proportionate, transparent, and focused on continuous improvement. It supports the development of commissioning intentions, service transformation, and financial sustainability, while ensuring that patient safety and experience remain central to all discussions.

Evaluation and learning will be embedded at every stage. We will use structured reporting, action tracking, and feedback loops to assess impact, adapt our approach, and ensure that our strategy remains responsive to the needs of our population. This includes formal reporting into NHS Devon's governance structures and assurance committees, and alignment with national planning and oversight frameworks.

Together, through inclusive engagement, robust contract oversight, and a culture of learning, we will deliver a strategy that is ambitious, accountable, and rooted in the lived experiences of the people we serve.