NHS Devon

NHS Devon Five Year Commissioning Plan 2026/31

SUMMARY

Executive summary

NHS Devon is entering a critical period of transformation.

Rising demand, an ageing population with more complex needs, persistent health inequalities, and sustained financial pressure mean the current model of care is no longer sustainable.

There are long waits, pressure across urgent and emergency care, fragmented pathways, variation in outcomes, and limited capacity to invest in change due to historic deficits and rising costs.

This Five-Year Commissioning Plan (2026–2031) sets out how NHS Devon will respond by shifting to a more proactive, integrated, and financially sustainable model of care.

It translates the Devon Health and Care Strategy into commissioning intentions and a delivery framework aligned to national priorities.

The plan is underpinned by population health insight, demand modelling, productivity intelligence, and engagement with communities and partners.

Our Five-Year Plan

Our system is aligning strategy, commissioning and delivery to provide a single, coherent route from ambition to outcomes. The Health and Care Strategy sets the long-term vision and measurable outcomes for population health and equity. The Five-Year Commissioning Plan translates that vision into prioritised, funded programmes and contracts.

Our Five-Year Plan recognises that Devon's current model of care is not keeping pace with population need. Demand is rising as people live longer with more complex conditions; access and experience remain inconsistent; and cost and workforce pressures continue to challenge the system.

The plan focuses on **three major shifts** that will be delivered through neighbourhood and place-based transformation, systemwide pathway improvement, productivity gains, clinically led service configuration, and stronger contract management.

Our commissioning intentions translate the strategy into specific outcomes, activity changes and milestones, supported by the levers of contracts, payment, workforce, digital and estates.

We build on these intentions by setting out the performance, quality, digital, workforce and financial requirements we expect providers to meet. Where appropriate, the expectations will be built into contracts and overseen through a strengthened contract-management approach.

If we are successful, the benefits will include shorter waits, fewer avoidable admissions, better outcomes, reduced inequalities, improved productivity and a more sustainable financial position for the system.

Our three major shifts

1. Moving care from hospital to neighbourhoods
2. Shifting from treatment to prevention
3. Modernising services from analogue to digital

Introduction and purpose

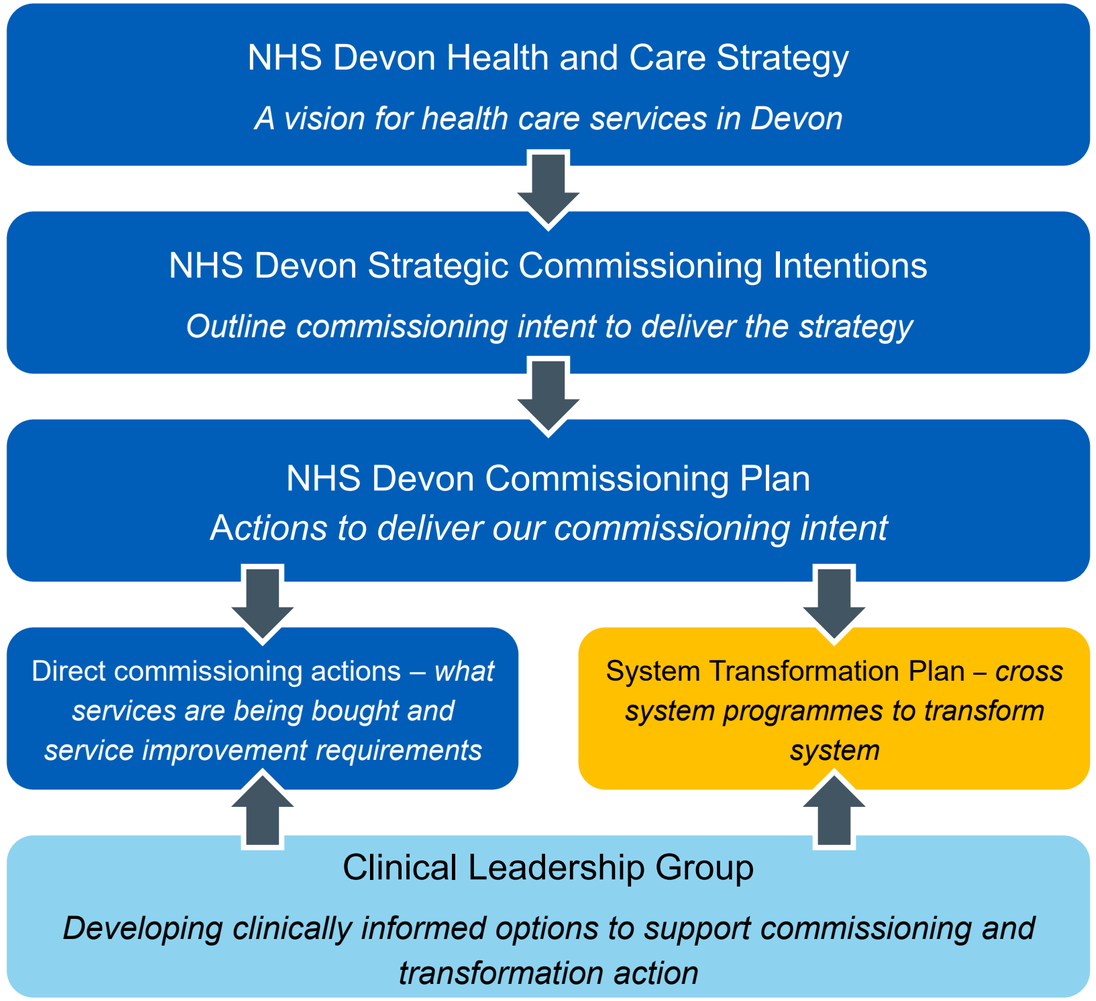
The Five-Year Plan sets the commissioning route to deliver Devon's Health and Care Strategy between 2026 and 2031.

NHS Devon's ambition is a system that is simpler to navigate, more consistent across the county, and financially sustainable.

Specialist services remain essential, but more care will be delivered closer to home through stronger neighbourhood, community, and preventative services, supported by digital innovation and redesigned pathways.

The purpose of the Five-Year Commissioning Plan is to set out how NHS Devon will commission services to improve population health outcomes, reduce inequalities, and ensure high-quality sustainable care.

It is both strategic and practical—supporting coordinated system decisions, targeted investment, and collective delivery over 2026–2031.



Structure and what is included in the document

1. Why change is needed
The evidence base (demography, inequalities, finance, workforce, quality, public insight).

2. Opportunity and productivity
Where transformation, redesign and efficiency initiatives will have the biggest impact.

3. Strategy
The Devon care model across neighbourhood, place and specialist settings; PHM; digital; quality.

4. Commissioning intentions
What we are commissioning, the outcomes we aim to achieve, and the activity shifts we expect to see as a result.

5. Commissioner expectations
Performance, quality, digital, workforce and finance expectations for providers, in addition to commissioning intentions that focus on service models. Some will be incorporated into contracts.

6. Transformation
Sets out transformation programmes and early priorities we will progress; supporting governance and delivery.

7. Enabling plans
Workforce and culture, digital and data, estates and infrastructure, contracting and payment, people and communities support delivery of the commissioning intentions, commissioner expectations and transformation.

8. Governance
One joined-up model that enables collective leadership, clear decisions and disciplined delivery, and respects sovereign accountabilities.

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1. Why change is needed

The key evidence, insights and system pressures that underpin the need for significant transformation across health and care in Devon.

This section sets out the core challenges facing our population, services and workforce, and provides the rationale for the strategic commissioning intentions and commissioner expectations outlined later in this plan.

Why change is needed

This section brings together the key evidence, insights and system pressures that underpin the need for significant transformation in Devon. It sets out the core challenges facing our population, services and workforce, and provides the rationale for the strategic commissioning intentions and commissioner expectations outlined later in this plan.

NHS Devon faces a decisive period of transformation. Demographic growth, rapid population ageing, rising multi-morbidity, persistent inequalities and sustained financial pressure mean the current model of care is no longer sustainable.

Although emergency department attendance rates are relatively low compared to national averages, Devon experiences higher-than-average non-elective admissions, long lengths of stay in the very old, and high average costs per elective spell.

These patterns point to gaps in intermediate care, discharge coordination, community alternatives and pathway productivity rather than excessive front-door demand.

At the same time, national productivity benchmarking shows that Devon's acute providers and the Devon system overall have seen a deterioration in productivity since 2019/20, driven by real-terms cost growth outpacing activity growth.

The total health needs of the Devon population is expected to grow by an average of 1.52% per year over the next five years. The aging effect of the population is the largest component of that growth at an average of 0.93% per year. Population growth on its own will add an average of 0.75%.

The model assumes that there is a small reduction in the health needs per person (-0.16% per year) which can be viewed as a measure of improved prevention.

Population health need and drivers of demand

NHS Devon serves a **population** of around 1.3 million people with a significantly older age profile in comparison to the national average, with almost a quarter of the population (24.3%) aged 65 or over compared with the rest of England (17.4%) The population of Devon is growing at a rate that exceeds the national average (c.0.7% per annum vs c.0.4% per annum) with the greatest growth being seen in those aged over 75

The Devon Integrated Care System's (ICS) **financial** position remains challenged, with the system financial plan for 2025/26 requiring deficit support funding of £54m to deliver breakeven against resources that are £163m more than our needs-based population fair share

Devon shows a mixed picture: urban areas contrast with remote rural and coastal communities that face poor accessibility. While **deprivation and affluence** both exist in pockets, most of the population falls near the national average with only around 12% in the bottom two deprivation deciles. Yet health outcomes vary sharply, with up to a 20-year difference in healthy life

Demand for services across all age group is growing across primary, community, acute and mental health services, with a particular increase for children and young people's services.

Our **workforce** is challenged to meet the increasing demand for services, financial pressures, supply challenges such as recruitment and retention and the need for education and training programmes to expand the scope of professional practice

Our system is not currently **co-ordinated** sufficiently to help people to not need acute services in the first place, with multiple services and pathways across the system, often layered rather than designed in a person-centred way.

Devon's **IT and estates infrastructure** requires upgrading, including the varied estate profile ranging from some excellent facilities to some in dire need of repair, which brings with it high-risk, there is a business continuity risk that our buildings could fail, impacting on the safety and quality of services that we are able to provide.

Engagement overview

Comprehensive engagement has been central to 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 an inclusive 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.

Engagement key themes and findings

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

Why change is needed – key messages

Demographics	A rapidly ageing population driving higher health need, multi-morbidity and end-of-life demand
Inequalities	Deprivation and rurality shape outcomes and access; inclusion health groups face persistent barriers
Finance	Underlying fragility and limited investment headroom require productivity improvement and value by design
Workforce	Supply, retention and skill-mix pressures; productivity below pre-COVID; variable culture and digital readiness
Quality and access	Sustained urgent and emergency care (UEC) pressure, diagnostics constraints, variable experience, and long waits in some pathways
Performance	Significant pressure across urgent, elective, cancer and mental health pathways, with front-door congestion, diagnostic backlogs and delayed discharge continuing to pull key standards off trajectory
Digital	Devon has significant room to strengthen digital capability, with priorities around leadership, workforce, citizen access and a single digital front door
Public insight	Consistent support for preventative, local, digitally-enabled care that is easier to navigate

Conclusion: change is unavoidable. The system must shift delivery into neighbourhoods, design for prevention, standardise specialist services, tackle variation and incorporate best practice — with productivity and equity built in from the start — and the public are generally supportive of the direction of travel

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2. Opportunity analysis

The opportunity analysis brings together a wide range of intelligence sources, including local activity and cost data, national benchmarking, Model Health System indicators, productivity packs and population health insights.

It provides an objective assessment of Devon's current performance across planned care, urgent and emergency care, outpatient services, community pathways and specialist services.

It highlights areas where Devon performs well, where performance differs from national comparators, and where there are clear opportunities to improve productivity, outcomes and financial sustainability.

Opportunity analysis

Non-elective care

Devon undertakes around **111,000 non-elective spells** per year at a cost of **£299m**.

Standardised non-elective activity is **6.4% above** the national average and **15.9% above** lowest-quartile ICBs.

Average tariff per spell is **below national average**, but interpretation is limited by known coding issues.

Length of stay is in the **lowest quartile nationally overall**, but closer to average for people aged 85+, indicating scope to improve complex discharge and intermediate care.

Aligning activity and tariff to national averages could release around **£7m**.

Emergency department

Type 1 emergency department ED attendance rates are in the **lowest quartile nationally** and 20% below the national median. The challenge is therefore less about front-door demand and more about admission avoidance, same-day care, and flow once patients reach hospital.

Productivity

The size of the opportunity is significant: three-year productivity opportunity analysis totals £314m.

NHS Devon cost per weighted activity unit (WAU) is **above national median**.

Acute providers show **high real-terms cost growth** since 2019/20, contributing to financial pressure.

Recent year-on-year **productivity has improved**, demonstrating that change is possible when focus and grip are applied.

The primary opportunity is not “doing less care” but **doing care differently**—earlier, closer to home, and through standardised, high-value pathways.

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3. Health and Care Strategy 2026/2031

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

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Our strategic vision

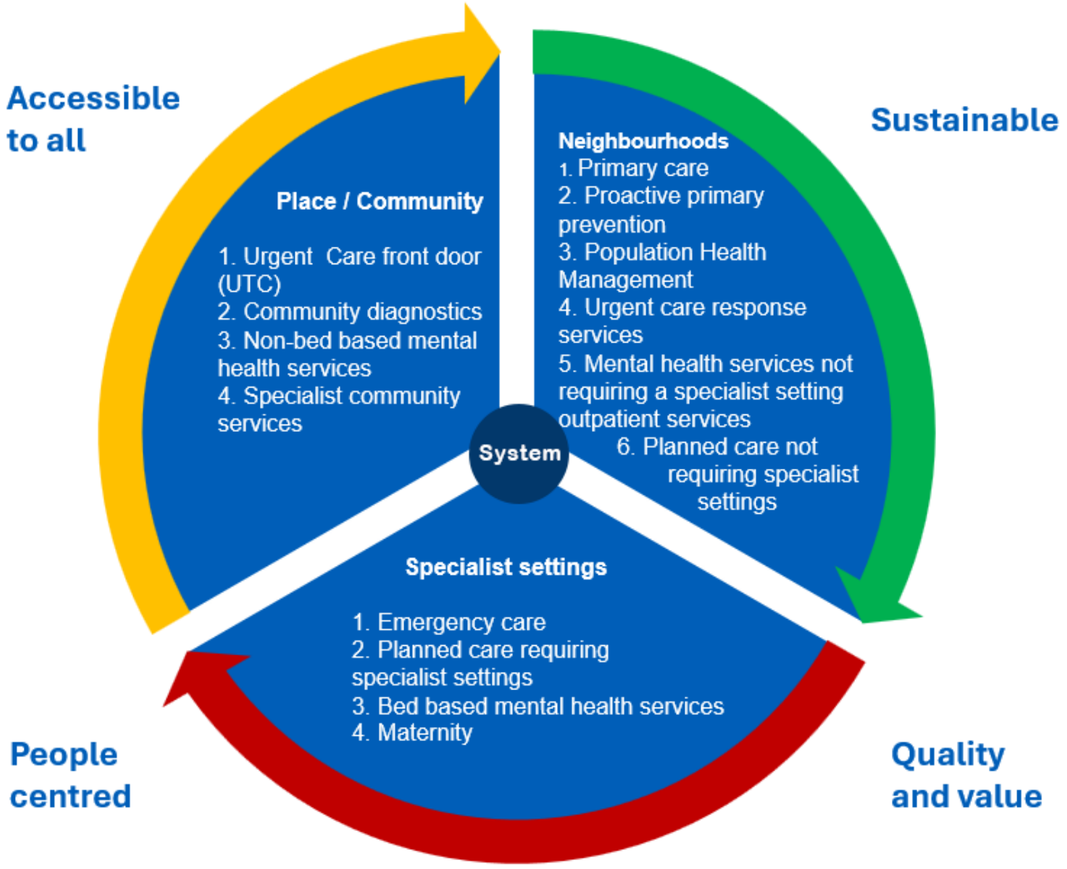
“We imagine a Devon where everyone can live well – on their own terms, in communities that value equity, sustainability, and belonging.

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.”

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 the community-based care across a population of c. 30,000 – 50,000. Delivery is led by Integrated Neighbourhood teams that use combined resources to deliver joint outcomes.

Outcomes are commissioned from a lead provider who will collaborate with other Health (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.

Acute 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.

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4. Strategic Commissioning Intentions

NHS Devon is transitioning towards a strategic commissioning model that places outcomes at the heart of service design and investment. The Strategic Commissioning Intentions outline commissioning intent to deliver the strategy.

Historically, commissioning has focused on funding services or activities and retrospectively assessing their impact. While this approach has delivered some improvements, it has also led to fragmented care and limited scope for innovation.

Our new model redefines commissioning as a proactive, collaborative process that pays directly for outcomes, enabling providers to design services that are both creative and responsive to local needs.

Strategic commissioning intentions

Keeping people safe and well in their neighbourhood	Shifting traditional acute care and treatment into our communities	Timely and responsive specialist care and treatment when needed	Prevention and inequalities focussed initiatives co-commissioned with our local system partners	Specific areas of health improvement focussed on our population need
Our neighbourhood services will work in partnership to keep our population healthy and enable them to live fulfilling lives in their own home. We will fully establish Integrated Neighbourhood teams that will bring together Health and Social Care and voluntary, community and social enterprise (VCSE) partners to take a multi-disciplinary team approach to: • Identify people at greatest risk, proactively reviewing and supporting interventions to keep them healthy. • Empower individuals to manage their health. • Integrate care around the individual and what matters to them. • Ensure people can access same day urgent care services • Reduce health inequalities and long-term care dependency. • Simplify and streamline care using digital tools, AI, and shared digital records.	Large acute hospitals have become the default in delivery of our health services. As we move towards the new model described within our Health and Care Strategy, we will move care away from our acute providers and into neighbourhood and place settings We will shift any care that does not need a specialist setting into the community through recommissioning of our pathways to align with our new model of delivery. This will see the delivery of specialist services outside of specialist settings We expect the majority of our care to be delivered outside of hospitals.	Even within a model that prioritises care within the community there will remain needs that require specialist response and treatment. Whether this is unplanned (emergency) care or planned (elective) care the response will need to be timely and proportionate to the level of need. In order to deliver safe and timely care all specialist pathways will be expected to be as productive and efficient as possible, offered advice and guidance to our neighbourhood services. Where services need to be provided in a specialist setting, we expect that this will be managed across our specialist sites as single services. This will likely result in changes to where services are delivered.	Linked to our ambitions within Neighbourhoods, the NHS is not alone in driving improvements in the health of its population. We will be looking to work closely in partnership with public health, adult and children's social care teams, and others within local authorities to maximise the use of our collective resource to deliver for our population. Over five years, we will build on our already strong relationships, working across organisational boundaries to deliver collective outcomes. This work will focus on market development and shaping and ensuring we work together to improve the health of the population particularly regarding diabetes, respiratory illness, cardiovascular disease and weight management.	Through the development of our Health and Care strategy and engagement across the system, there are a number of areas of Health care delivery that have been identified as requiring targeted support beyond the approach to deliver in our first four strategic commissioning priorities. These are: a. Diagnostics b. Birthing c. Mental health, learning disabilities and neurodiversity: d. Dementia e. Cardiovascular disease f. Continuing healthcare and individual placements

Evidence-base underpinning our commissioning intentions

Our commissioning intentions are strongly supported by national policy and a robust UK evidence base.

- **Neighbourhood models** – Integrated teams and continuity of care improve access, equity and outcomes when locally co-designed and aligned to Fuller.
- **Rapid access and flow** – single point of access (SPoA), urgent community response (UCR), urgent treatment centres (UTCs) and same day emergency care (SDEC) reduce avoidable admissions when core components and national standards are in place.
- **Frailty and intermediate care** – Comprehensive Geriatric Assessment and NICE NG74-aligned intermediate care have some of the strongest evidence for improving outcomes and supporting timely discharge.
- **Virtual wards, outpatients and diagnostics** – Proven national models delivering better experience, earlier decisions, increased capacity and reduced unwarranted variation.

Our commissioning approach will also seek to mitigate known implementation risks (workforce, digital, operational variation) through clear service specifications, being consistent with national standards, equity-focused development and disciplined management measurement.

Underpinned by national guidance (Fuller Stocktake; NICE NG74; BGS Silver Book II; NHSE Virtual Ward Framework; Outpatient Transformation Guidance; Community Diagnostic Centres) and leading systematic reviews (CGA; Hospital at Home; continuity of care)

Strategic commissioning intentions: Executive assurance overview

Our initial equality and quality impact assessment (EQIA) indicates that our strategic commissioning intentions present a coherent and achievable framework for improving outcomes across Devon, with clear potential to strengthen prevention, enhance access to care, and deliver more personalised, community centred services.

Purpose and direction:

- Strategic Commissioning Intentions: Clear, deliverable framework to improve outcomes, strengthen prevention, and expand personalised, community-centred care.

Assurance position:

- High-level EQIA review undertaken in line with both legal and statutory requirements, following approved local EQIA process.
- Strategic Commissioning Intentions are beneficial and achievable, with mitigations applied consistently.

Key system risks:

- Neighbourhood capacity variation
- Rural access challenges
- Specialist workforce constraints
- Gaps in protected characteristic data
- Addressing these risks proactively will be essential to ensuring that the benefits of the commissioning intentions are realised equitably across all communities, including those who may be at greater risk of exclusion or poorer outcomes.

Oversight and governance:

- ICS Finance, Performance and Quality Committee: quality, safety, patient experience
- ICS equality, diversity and inclusion (EDI) governance: statutory equality duties, equality actions
- Continuous learning, data-driven monitoring, community co-production to reduce inequalities and maintain quality

Equality, Quality Impact Assessment (EQIA) findings

Strategic Commissioning Intention	Potential Positive Impacts	Potential Negative Impacts	Potential Neutral Impacts	Mitigation Actions
1. Supporting people to stay safe and well in their neighbourhoods	▪ Improved access for older adults and disabled people through localised care. ▪ Stronger relationships with minority groups via neighbourhood engagement. ▪ Better continuity for carers and families.	▪ Variation in neighbourhood capacity may disadvantage rural and coastal communities. ▪ Minority ethnic and LGBTQ+ groups may be overlooked in low-diversity areas. ▪ Limited specialist knowledge in neighbourhood teams.	▪ No direct impact on marriage/civil partnership status. ▪ Limited direct impact on religion or belief where neighbourhood teams already reflect local demographics. ▪ Neutral impact on sex where services are universally accessible.	▪ Standardised neighbourhood operating model ▪ Equity audits and targeted outreach. ▪ Cultural competence and disability inclusion training ▪ Mobile/outreach services for rural areas.
2. Delivering more care traditionally provided in acute settings within community environments	▪ Reduced travel burden for older adults, disabled people, and pregnant people. ▪ More personalised care closer to home. ▪ Improved early intervention for long-term conditions.	▪ Community settings may lack specialist equipment or clinical capability. ▪ Risk of fragmented transitions between acute and community care. ▪ Digital-first models may disadvantage some disabled people.	▪ Neutral impact on sexual orientation where community services are inclusive ▪ No direct impact on marriage/civil partnership ▪ Neutral impact on religion or belief where community sites already accommodate cultural needs	▪ Phased transition plan with workforce modelling ▪ Strengthened clinical governance and escalation pathways ▪ Community diagnostics and remote monitoring ▪ Multiple access routes (digital, phone, face-to-face) ▪
3. Ensuring timely and responsive access to specialist care when required	▪ Faster diagnosis and treatment for complex conditions ▪ Standardised pathways reduce variation for protected groups ▪ Improved outcomes for paediatrics, maternity, cancer, cardiovascular disease	▪ Travel barriers for rural residents and older adults ▪ Limited local provision for gender identity care and some paediatric sub-specialties ▪ Referral bottlenecks may disproportionately affect minority groups	▪ Neutral impact on marriage/civil partnership ▪ Neutral impact on religion or belief where specialist pathways are clinically driven. ▪ No direct impact on sexual orientation unless linked to specific clinical pathways	▪ Streamlined referral pathways and digital triage ▪ Outreach/satellite specialist clinics ▪ Transport support and virtual specialist consultations ▪ Regional collaboration for low-volume specialist services
4. Focusing on prevention and reducing health inequalities	▪ Targeted prevention for high-risk groups (e.g., ethnic minorities, disabled people, LGBTQ+ communities) ▪ Supports healthy ageing and maternal health ▪ Reduces long-term inequalities	▪ Small minority groups may be statistically invisible in datasets ▪ Prevention messaging may not be accessible to disabled people or culturally appropriate ▪ Short-term funding cycles undermine long-term impact	▪ Neutral impact on marriage/civil partnership ▪ Neutral impact on sex where prevention programmes are universally targeted ▪ No direct impact on religion or belief unless programmes intersect with cultural practices	▪ Multi-year prevention investment ▪ Improved protected characteristic data recording ▪ Co-design with minority and faith groups ▪ Accessible formats for all prevention materials
5. Improving outcomes in specific areas of health based on population need	▪ Strong alignment with Devon's older population (dementia, frailty, cardiovascular disease) ▪ Better pathways for neurodiversity, mental health, and long-term conditions ▪ Opportunity to reduce diagnostic inequalities.	▪ High demand may exceed specialist capacity ▪ Risk of siloed services and poor transitions (e.g., CAMHS to adult) ▪ Diagnostic tools may not be culturally adapted	▪ Neutral impact on marriage/civil partnership ▪ Neutral impact on sexual orientation unless linked to specific mental health pathways ▪ No direct impact on religion or belief where clinical pathways are standardised	▪ Integrated pathways across life stages ▪ Workforce development and advanced practitioner roles ▪ Standardised diagnostic frameworks ▪ Population health analytics to target highest-need groups

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5. Commissioner expectations

Headline expectations for providers to guide planning and contract negotiations. Where appropriate, national requirements and commissioner priorities will be built into local contracts. This ensures NHS Devon has the contractual levers needed to address performance and quality issues and to drive improvements in population health outcomes through its role as a strategic commissioner.

Commissioner expectations

In addition to our commissioning intentions, NHS Devon has set out headline expectations for providers to guide planning and contract negotiations. Where appropriate, national requirements and commissioner priorities will be built into local contracts. This ensures the ICB has the contractual levers needed to address performance and quality issues and to drive improvements in population health outcomes through its role as a strategic commissioner.

Performance

- trajectories to restore constitutional standards across elective, cancer, diagnostics, urgent and emergency care (UEC) and primary care access; transparent reporting.

Quality

- strong governance, Patient Safety Incident Response Framework (PSIRF) embedded, reduction in unwarranted variation, equality and quality impact assessment by default, and maternity safety focus.

Workforce

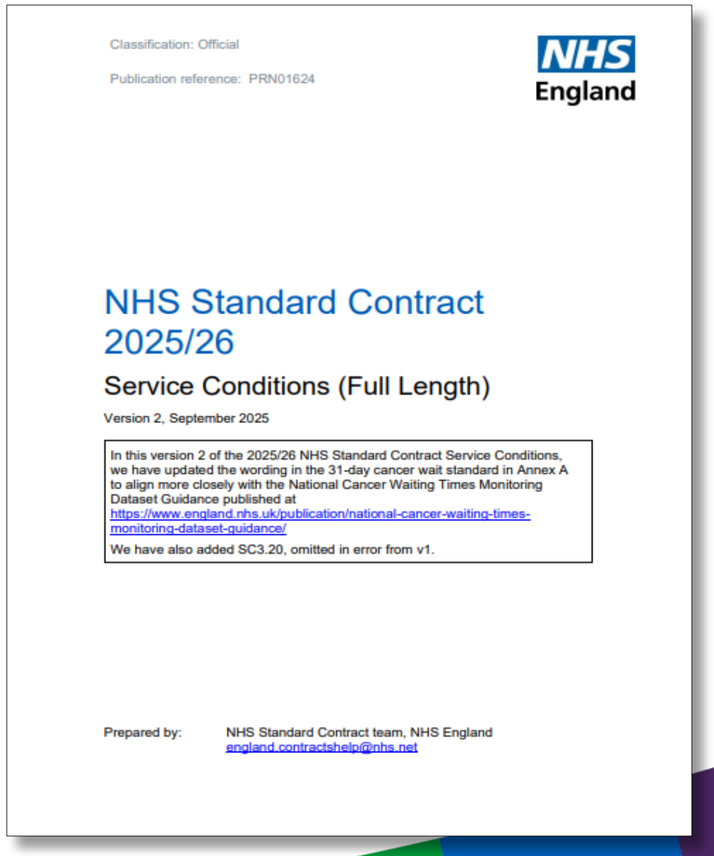
- deliver productivity, reduce agency to zero by 2029, plan within envelope, redesign skill-mix, improve retention and culture.

Digital & data

- NHS App as front door; shared records and care plans; FDP utilisation; standardised comms via NHS Notify; AI-assisted triage; improved data quality

Finance

- minimum 2% annual productivity improvement; year-1 5% efficiency for trusts; 3% cash-out for ICB & move to outcomes-based payment over time, with tighter contract management in the shorter term.



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NHS England

NHS Standard Contract 2025/26

Service Conditions (Full Length)

Version 2, September 2025

In this version 2 of the 2025/26 NHS Standard Contract Service Conditions, we have updated the wording in the 31-day cancer wait standard in Annex A to align more closely with the National Cancer Waiting Times Monitoring Dataset Guidance published at https://www.england.nhs.uk/publication/national-cancer-waiting-times-monitoring-dataset-guidance/

We have also added SC3.20, omitted in error from v1.

Prepared by: NHS Standard Contract team, NHS England
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6. Commissioning plans

The Commissioning Plans outline the actions we intend to take to deliver our commissioning intent.

A whole-system approach to transformation is essential if we are to deliver our strategy and respond to the considerable challenges facing Devon's health and care system.

Commissioning plans (1 of 2)

The Commissioning Plans outline the actions we intend to take to deliver our commissioning intent.

Delivering sustainability across the Devon system will not be possible without significant transformation.

NHS Devon will work with partners across the system to achieve this.

Guided by the Health and Care Strategy, and co-owned by system Chief Executives, the system will focus on key high-impact areas of transformation over the next five years.

A whole-system approach to transformation is essential to deliver our strategy and respond to the considerable challenges facing Devon’s health and care system.

Commissioning plans (2 of 2)

The transformation portfolio will cover a small number of high-impact programmes, supported by cross-cutting enablers – digital and data, workforce, estates, finance and analytics.

Service improvement projects will plug into the programmes, so effort is joined-up, benefits are shared, and delivery is consistent for patients, clinicians and communities.

The ambition for neighbourhood transformation is to deliver cohesive, integrated teams across physical and mental health, working together to care for all ages of our population as close to home as possible with a radical shift of care from specialist settings into neighbourhoods.

System wide improvement and pathway transformation will deliver whole scale transformation of pathways to move care into neighbourhoods and ensure all care provided meets the highest level of best practice, productivity and performance.

As neighbourhoods develop to their full potential with a shift of care from specialist settings into the community and we increase standardisation, consistency and productivity across clinical pathways, we need to consider the implications for our more specialist services.

We need to ensure that these services are configured to deliver to the right footprint and are supported by the right organisational structures.

We need to ensure that services that sit between neighbourhood and specialist services are in the right place offering the right services to support neighbourhoods and avoid unnecessary use of specialist services, we then need to configure our specialist services in a way that offers safe and sustainable care using our workforce in the most effective way possible.

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Priority 1

Keeping people safe and well in their neighbourhoods

Priority 1: Keeping people safe and well in their neighbourhoods

Key objectives	
• Establish single, point of access so people are directed to the right service first time. • Establish and commission Integrated Neighbourhood Teams (INTs) across all areas, supported by a development fund to build capability and capacity. • Define and implement a consistent core neighbourhood service offer across the life course (physical health, mental health, children and young people, and perinatal). • Expand same-day care in neighbourhoods, including offers for children and young people and rapid support for people in mental health crisis. • Strengthen intermediate care (step-up and step-down, including short-stay beds) to avoid admissions and speed up safe discharge. • Improve continuity and proactive care for people with long-term conditions and complex needs.	• Embed fully co-commissioned prevention services within INTs. • Recommission children's community services to deliver a consistent, neighbourhood-based offer. • Develop and roll out a community perinatal model aligned to neighbourhood teams. • Design, engage on and procure a modern end-of-life care model delivered close to home. • Implement the outcomes of community services and intermediate care reviews at scale, ensuring delivery of services that do not require specialist settings. • Establish single, point of access so people are directed to the right service first time.

Expected impact – How will this feel different to people?	Expected impact – Activity Changes	Outcomes we will commission to deliver
• People are more confident to self-care and more activated to do so, becoming more independent and less dependent on long-term care • People will be able access a local neighbourhood hub to address a wide range of health and social care needs • People feel listened to, respected and included regardless of background • People will report more confidence and trust in services • People will experience a more joined up system of support	• Reduction in ED attendances: (8am–6pm, 7 days; 12-month effect) • Increased same-day urgent demand met in primary care and community services • Increased discharges to usual place of residence and on the discharge-ready date • Reduction in unplanned admissions and length of stay; reduction in 7-day readmissions (CYP readmissions: TBC) • Fewer referrals to secondary care for conditions that can be managed in the community • Improved management of non-emergency urgent care demand in primary and community settings.	• Reduction in 999/111 calls. • Reduced numbers of hospital attendances and admissions. • Reduced length of stay in hospital with reduced rates of no criteria to reside. • Reduced escalation to specialist and emergency services and fewer people at high risk of hospital admission. • Clearance of community long waits. • Increased proportion of people dying in their place of choice. • Improved long term health outcomes. • Fewer people require long term residential care. • Increase in people discharged from hospital to their usual place of residence.

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Priority 2

Shifting traditional acute care into communities

Priority 2: Shifting traditional acute care into communities

Key objectives	
• Shift appropriate acute care and treatment into community settings, scaling Hospital at Home and proactive support for frequent users. • Move paediatric outpatient pathways into neighbourhood models and fully implement them at scale. • Redesign and implement a consistent community urgent care (Type 3) model to divert demand from ED and reduce multi-day admissions. • Commission and expand community assessment and treatment services—starting with long-term conditions and extending to all-age pathways where appropriate.	• Develop and deliver a community frailty model focused on falls prevention and supporting independence. • Embed digital consultation options across community assessment and treatment services. • Fully integrate community services with community diagnostics hubs, proactive case finding and specialist outreach to create seamless pathways. • Improve access, prevention and planned care in neighbourhoods to reduce avoidable hospital attendances and admissions.

Expected impact – How will this feel different to people?	Expected impact – Activity Changes	Outcomes we will commission to deliver
• People will be able to access care closer to home rather than travel to hospital for routine needs. • People will experience clearer, simpler pathways with fewer hand-offs between services. • People with long-term conditions will feel more confident in managing their health with local support.	• Hospital at Home / Virtual Ward: average length of stay reduced ~85% occupancy; 75% of beds used for admission avoidance (multi-day); 25% used to support flow. • Long-term conditions: reduction in multi-day non-elective admissions for diabetes, respiratory and CVD. • Outpatients: increase in outpatient activity delivered in community settings. • Fewer avoidable hospital attendances and non-elective admissions as more patients are safely managed in community or hospital-at-home models. • Frailty model impacts reflected in Same Day Emergency Care (SDEC) modelling	• Reduced numbers of hospital attendances and admissions. • Reduced length of stay in hospital. • Improved long term health outcomes. • Reduced health inequalities. • Reduced escalation to specialist and emergency services and fewer people at high risk of hospital admission. • Fewer people require long term residential care. • Increase in people discharged from hospital to their usual place of residence

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Priority 3

Timely and responsive specialist care when needed

Priority 3: Timely and responsive specialist care when needed

Key objectives	
• Reduce non-interventional outpatient appointments and embed patient-initiated follow-up (PIFU) where appropriate. • Standardise all surgical services to best practice pathways (GIRFT (Getting It Right Fist Time-aligned). • Establish a robust, system-wide Advice and Guidance (A&G) and Single Point of Access (SPoA) model to support neighbourhood teams and manage elective demand. • Ensure hospitals deliver consistent SDEC to manage urgent demand into specialist services. • Move to a single managed service model across key medical and surgical specialties (Stroke, Urology, Orthopaedics, Ophthalmology, Oral and Maxilllofacial Surgery (OMFS)/ Ear Nose and Throat (ENT), Dermatology, Gynaecology, Surgery in Children).	• Define and implement the paediatric specialist medical offer and pathways. • Review and strengthen specialist end-of-life provision. • Redesign the urgent and emergency care (UEC) front door model and implement the agreed solution. • Improve early cancer diagnosis and outcomes by developing faster, clearer and more consistent cancer pathways, including increased direct access diagnostics and streamlined referral processes. • Reduce inequalities in cancer outcomes through targeted action based on population health data, screening uptake and tailored interventions. • Strengthen personalised care and support for people living with and beyond cancer, ensuring holistic, locally delivered support across providers and neighbourhood teams.

Expected impact – How will this feel different to people?	Expected impact – Activity Changes	Outcomes we will commission to deliver
• Faster access for first appointments, fewer unnecessary hospital trips, and greater use of remote support • Patient health outcomes will improve through faster access to care • More reliable, safer specialist care within consistent access to senior decision makers. • Shorter waits and fewer delays due to improved service resilience • Some people may have to travel further for specialist care but will benefit from higher quality and safer services. • Better patient experience	• SDEC: increase the percentage of non-elective admissions supported via SDEC (reducing multi-day admissions). • Follow-ups and A&G/PIFU: • Surgical follow-ups: reduction in surgical and non-surgical follow-ups • Increase use of PIFU for appropriate patient groups • A&G diversion: pre-referral 36%; post-referral 14.1% • Reduction in new outpatients across 10 specialties with benefits • Single managed medical and surgical services: pathway standardisation and potential consolidation to improve productivity and financial sustainability	• Reduced outpatient attendances • Reduced hospital admissions • Streamlined patient flows • Reduced elective waiting lists • Reduced variation in service • Improved theatre utilisation • Reduction in length of stay for elective patients • Faster, more consistent cancer pathways, ensuring earlier diagnosis and quicker access to tests and treatment • Reduced inequalities in cancer outcomes, targeted to populations with the greatest need screening uptake to support prevention. • Personalised and integrated cancer care, with holistic support available closer to home

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Priority 4

Prevention and inequalities (with local authorities and VCSE)

Priority 4: Prevention and inequalities (with local authorities and VCSE)

Key objectives	
• Co-commission prevention and inequalities initiatives with local authority partners, embedding them in neighbourhoods. • Strengthen and standardise the care market: complete key procurements, launch a competitive framework, and maintain ongoing performance and contract management with an open framework for new providers. • Introduce a standardised 1-to-1 care home policy with consistent pricing to reduce reliance on 1-to-1 support and remove unwarranted variation. • Develop single-point-of-access pathways for weight management and improve early diagnosis and treatment for respiratory disease and diabetes.	• Deliver the suicide prevention strategy in partnership with local authorities. • Expand suitable, adapted housing for people with learning disability and neurodiversity, with a fair access mechanism and strong engagement with people with lived experience; evaluate impact over time. • Embed neighbourhood-based prevention models and support integrated approaches for people with multiple long-term conditions.

Expected impact – How will this feel different to people?	Expected impact – Activity Changes	Outcomes we will commission to deliver
• People able to live independently in community in an area of choice closer to family and support network in accommodation that meets their needs • Improved health outcomes • Increased opportunity to find employment and contribute in the community • Prevention of escalations • Reduction in contacts with health and social care. • Greater healthy life expectancy	• Reduced ED attendances, admissions and length of stay through prevention (diabetes, respiratory, weight management, suicide prevention) • Improved workforce sustainability linked to a consistent Community Urgent Care (Type 3) model	• Increase in patients accessing weight management services. Better uptake of national programmes, notably diabetes • Reduced ED attendances and admissions • Reduced Length of Stay

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Priority 5

Targeted improvement areas

Priority 5: Targeted improvement areas (1 of 2)

Key objectives	
Diagnostics • Build an integrated, community-first diagnostics network with faster access closer to home. • Standardise triage and prioritisation; enable GP direct access and clear links with PCNs. • Improve acute turnaround times (extended hours, optimised scheduling) and deliver 7-day access for priority diagnostics. • Fully integrate across CDCs and acute sites with single referral/reporting, EPR integration and digital/AI-enabled triage. • Develop peninsula links with Cornwall where beneficial. **Birthing (Maternity)** • Decide the future model for stand-alone midwifery-led units and implement the outcome. • Redesign and implement the hospital-based birthing service model. **Dementia** • Increase diagnostic capacity, improve early diagnosis and develop a neighbourhood model of post-diagnostic support. • Ensure everyone with a diagnosis has a personalised care plan; strengthen prevention to delay onset. • Embed the neighbourhood support model. **Cardiovascular Disease (CVD)** • Develop community cardiology for lower-complexity patients and scale primary care case finding and treatment. • Deliver a CVD prevention action plan focused on high-impact interventions. • Commission a sustainable cardiology model and integrate pathways into Long Term Conditions (LTC) management.	**Mental Health, Learning Disability and Neurodiversity (MH/LD/ND)** • Expand crisis alternatives, embed MH within the ED pathway and move liaison psychiatry towards 24/7. • Redesign community MH models (including ARMS) and implement integrated shared-care services. • Ensure appropriate use of beds through demand/capacity analysis and clear commissioning statements. • Develop and procure a community ND diagnostic and aftercare pathway; publish an adult neurodivergence strategy. • Evaluate LD inpatient provision (e.g. Kingfisher) and implement learning. • Progress delegation of Individual Patient Placements (IPP) and Section 117 commissioning responsibilities. • Establish continuous evaluation and a five-year review to set the long-term commissioning strategy. **All-age Continuing Healthcare (CHC) and IPP** • Reduce unwarranted variation across locality hubs with shared practice and joint training. • Implement a digital case management system and progress towards a patient portal. • Establish brokerage hubs/functions (pilot then full implementation) aligned to local demand. • Maintain ongoing monitoring and review.

Priority 5: Targeted improvement areas (2 of 2)

Expected impact – How will this feel different to people?	Expected impact – Activity Changes	Outcomes we will commission to deliver
• Reduction in health inequalities and improvements in health outcomes through timely access to diagnostics and a reduction in repeat diagnostics. • Faster and more convenient access to diagnostics closer to home. • Earlier detection of disease and improved outcomes through timely intervention. • Women and birthing people will have clearer information and confidence in their choices about place of birth. • Families may need to travel further, but will see improved safety, facilities, and outcomes. • Improved continuity of care, with smoother integration between community midwives and obstetric units. • Improved maternal and neonatal safety outcomes, with fewer avoidable complications and safer transfers. • Sustainable maternity system able to meet national standards and workforce challenges. • People with mental health needs cared for in dedicated, safe environments with appropriately qualified and empathetic staff. • Better access to the appropriate mental health support with a focus on recovery. • Person centred care with people feeling more empowered to manage their mental health in a way that suits them. • Better access to joined up lifestyle services. • Local delivery access to a variety of professions appropriate to need with more proactive support. • Fewer heart attacks and strokes. • Shorter waits for All Age Continuing Healthcare assessments and eligibility decisions with improved experience and reduced stress and uncertainty for patients and families. • Clear timely decision, by 12 weeks, on the long-term funding arrangement for an individual's placement (CHC, Adult Social Care ASC, self funding).	• Diagnostics (CDCs): increase activity to plan to reach performance targets; maximise CDC utilisation; enable direct GP ordering; standardise triage/booking. • Cancer: deliver GIRFT best practice and improved performance through optimised pathways. • Birthing: potential consolidation of activity currently in stand-alone units to improve quality, performance and financial sustainability. • CVD: pathway changes reflected in outpatients/LTC shift (community management of lower-complexity patients). • MH/LD/ND/Dementia: fewer avoidable ED attendances, crisis presentations, admissions/readmissions; shorter LoS; reduced demand for inappropriate out-of-area placements.	• Shorter waits for elective and cancer pathways. • Improvement of diagnostic reporting turnaround times (e.g., imaging reports within 48 hours) and increase in diagnosis rates. • Utilisation rates of >85% for diagnostic equipment. • Improved performance against national maternity indicators (continuity of care, choice of birth setting, outcomes). • Stronger compliance with national maternity safety standards and Care Quality Commission (CQC) expectations. • Reduced ED attendances and length of stay. • Improved patient experience. • Reduced waiting lists and improved access to services when required. • Reduction in unplanned mental health crisis interventions. • Reduction in elective care waiting times.

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7. Enabling plans

A set of interdependent enabling plans that create the conditions for sustainable, integrated, person-centred care.

Enabling plans

Our plan is underpinned by a set of interdependent enabling plans that together create the conditions for sustainable, integrated, person-centred care. These enablers will drive the core shifts in our Health and Care Strategy: from hospital to community, from treatment to prevention, and from organisational silos to neighbourhood-based delivery.

Workforce and culture	• system workforce strategy aligned to INTs; new roles and skill-mix; leadership and culture programme; digital skills uplift
Digital and data	• single digital front door; DCCR-enabled shared records and care plans; FDP products; PHM analytics; cyber and infrastructure convergence
Estates and infrastructure	• community hubs and co-location for INTs; primary care estates planning; acute steady-state with targeted optimisation; Net Zero trajectory
Contracting and payment	• incomes-based approaches; strong CRM/JTWG model; full use of NHS Payment Scheme levers; movement to fair-shares over time
People and communities:	• co-design embedded via Devon Service Change Process; patient partnership plans for transitions; single engagement and insight platform

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