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2024 Update

May 2024

Contents

H&S Care

Devon Integrated Care Board
Royal Devon University Healthcare Trust
Devon County Council Social Care
Devon Partnership Trust
North Devon Primary Care Collaborative

Local Authorities

North Devon Council
Torridge District Council
Devon County Council

Emergency Services

Devon & Cornwall Police
South West Ambulance Service

Not-for-profit

NDVS
TTVS
Active Devon
North Devon Homes

Business

North Devon Plus
South West Business Council

Education

Petroc

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VISION

People in Northern Devon live happy and healthy lives in safe, clean and connected communities where people are supportive of one another and aspirations are achieved through equal access to the best education & employment, whilst living in decent homes and enjoying our world-class natural environment.

AIM

Improve health outcomes and reduce health inequalities, through prevention and addressing the wider determinants of health.

OBJECTIVES

1. Enable strong, resilient and healthy communities working in partnership (One Communities)
2. Support people with complex needs to improve health outcomes (Flow)
3. Assist people to age healthily (HAND)
4. Reduce health inequalities (Partnership)
5. Increase years spent in good health through increased physical activity and engagement with nature and arts (Prevention)
6. Improving the mental health of all in North Devon (Mental Health Partnership)

PRINCIPLES

PERSON-CENTRED

WHOLE PLACE

CONSIDERS PERSON'S WIDER CONTEXT

THINK LONGER TERM

CO-PRODUCED

BUILD ON GOOD PRACTICE

TARGET RESOURCES WHERE THEY WILL HAVE MOST IMPACT

COMMUNICATE

JOIN FORCES & PROMOTE SHARED LEADERSHIP

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DRAFT

Devon

- Devon partnerships
- Team Devon
- Devon Integrated Care Partnership (ICP)
- Devon Integrated Care Board (ICB)
- Devon Health & Wellbeing Board

One Northern Devon Local Care Partnership

One Northern Devon LCP Board

CHAIR: Lou Higgins, VICE CHAIR: Dr Kay Brennan

- OND Planning Group

OND LCP Programme Group

CHAIR: Andrea Beacham

Development Groups

Community Learning & Development	Person-Centred Support (Flow)	Health Ageing North Devon (HAND)	Health Inequalities	Active Travel	Tackling Health Inequalities with Physical Activity (THIPA)	Mental Health Partnership
CHAIR: John Womersley, Op Lead: James Lander	SROs: Spt Toby Davies, Dr David Richardson, Op Lead: Simon Rapsey	CHAIR: Dr Kay Brennan Op Lead: Jeni Watts	CHAIR: Andrea Beacham Clinical Lead: Dr Oliver Hassall	CHAIR: Dr Kay Brennan	CHAIR: Gareth Dix, Dr Kay Brennan	CHAIR: Phil Harris

Projects

- Poverty Truth Commission
- Anticipatory Care Pilots
- One Communities
- High Flow
- CVD Prevention
- Community Flow
- FAME
- Secondary Care Flow
- Live Longer Better
- Lower Limb Therapy Service Flow
- Ilfracombe Task Force
- Housing Flow Pilot Ilfracombe
- InHIP Primary Care Outreach
- InHIP CVD Remote Monitoring

Connects with...

- Northern Devon Community Safety Partnership
- Northern Devon Futures
- System Operations Group
- Devon and North & East Unscheduled Care Boards
- Northern Devon Primary Care Collaborative Board
- Planned care
- Peninsula Acute Provider Collaborative
- Mental Health, Learning Disability and Neurodiversity (MHLDN) Provider Collaborative

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Health Inequalities Strategy Development

2020 Health Inequalities Strategy

OND published its Health Inequalities Strategy in 2020 just before the pandemic and in 2022 decided to revisit it to make sure it was relevant to the new challenges being faced by those most at risk of health inequalities in the population and make use of new opportunities.

Health Equity stakeholder workshop #1

OND held the first Health Equity Stakeholder Workshop on 29th June 2022. It brought together the qualitative and quantitative data and participants agreed current priorities as well as the different ways in which we'd need to work in order to stop the increasing inequalities.

Data collection

the OND team collated the latest public health data for Northern Devon which highlighted the current picture of inequalities in Northern Devon and emerging population health management tools.

Community & stakeholder engagement

OND commissioned a report based on community and stakeholder engagement and research to ensure insights were included based on people's experiences of health inequalities, either in a personal or professional capacity

Health Equity stakeholder workshop #2

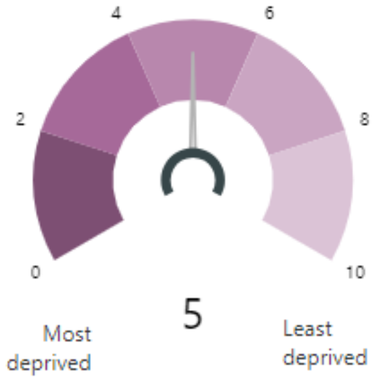
OND held the second Health Equity Stakeholder Workshop on 8th November 2022.

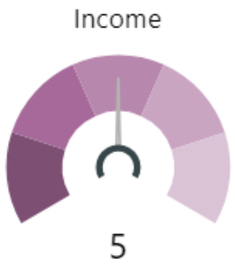
Co-designed:

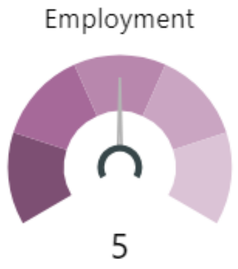
- **Principles for equity**
- **Barriers**
- **investment priorities**

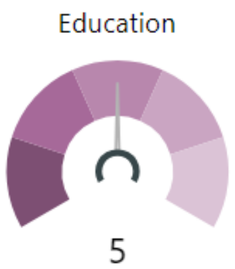
Northern Local Care Partnership: Selected data

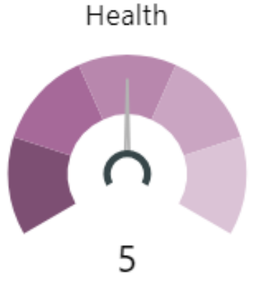
IMD Decile





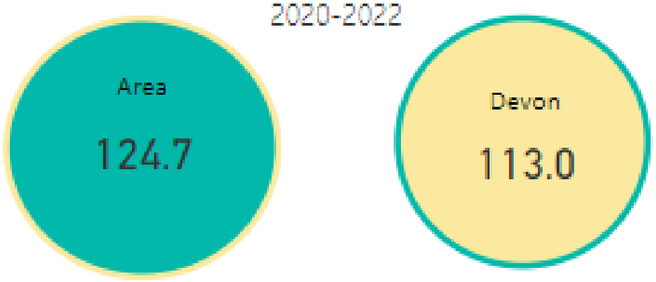






Preventable deaths

2020-2022



Child poverty

2018/19

Area %

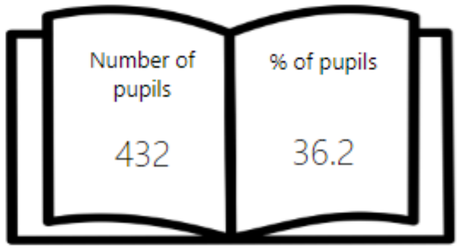
15.5

Devon %

12.2

GCSE Attainment

2018

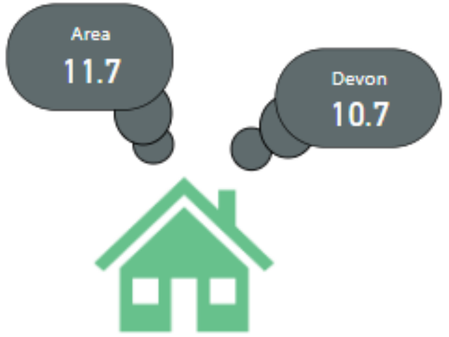


Devon %

40.9

Houses classed as fuel poor %

2019



Percentage of population

Lifestyle behaviours %

2018

Physical Inactivity	Alcohol Use	Smoking	Excess Weight
27.5	23.5	15.0	30.4

Percentage of population

Themes from public health data

- **Housing**
  - Poorer housing conditions in deprived rural areas
  - Low housing affordability (low wages, high house prices)
  - High rate of second homes, park homes, private sector renting
- **Rural and coastal challenges**
  - Hotspots of rural & coastal deprivation amongst the highest in the country
  - Higher rates of fuel poverty in villages and towns in sparse settings
  - Small coastal tourist towns have higher alcohol-related admission rates (independent of deprivation)
  - Highest rates of people killed & seriously injured in road traffic accidents in deprived rural areas &
  - Occupational risks with industries such as farming or fishing
- **Mental health and wellbeing**
  - Significantly higher self-harm admission rates in North Devon and Torridge
  - Rural pockets of high rates of mood & anxiety disorders but lower levels of referrals to IAPT
  - Loneliness risk higher than average in sparsely populated areas & deprived rural areas
  - Interaction of social & physical isolation can make rural loneliness more severe
  - Higher levels of suicide with some high risk rural occupations including farming and vets;
- **Geographical setting**
  - Communities located in sparse settings have more people with long-term health problems
  - Distance from services & access to primary & secondary care is an issue in rural areas
  - Lower use of preventive & treatment services in places further away from them

Themes from engagement

- Poor **transport** infrastructure
- Lack of affordable **housing**
- **Poverty** including food and fuel poverty and the cost of living crisis
- **Mental health, trauma, loneliness and isolation**
- Geographical **remoteness, rurality and lack of local support**

OND Health Equity Workshop #1

HEALTH INEQUALITIES STAKEHOLDER WORKSHOP - 29 JUNE 2022

FACILITATORS: DAVID RELPH & ANDREA BEACHAM

Four challenges that One Northern Devon had opportunities to test interventions in the short-term:

#1 Poor health outcomes in rural, deprived and coastal communities

#2 Large geographical footprint

#3 Pockets of high levels of poverty

#4 Poor Mental health

Challenge #1 Poor health outcomes in rural, deprived & coastal communities

The data

Life expectancy difference of 10 years between deprived coastal communities and the most affluent and a 14 year difference in healthy life expectancy. 12.5% of Ilfracombe Central's working age population have multiple long-term conditions and Barnstaple has the highest rate of alcohol-related hospital admissions in the county. Lifestyle behaviours aligned to deprivation – 27.5% inactive, 23.5% harmful alcohol use, 15% smoking, 30,4% excessive weight (2018 figures, so likely worse post-pandemic). Alcohol related admissions – top 95% in England. Diabetes rates are top 95%. Dementia diagnosis rate (65y +) ranked in top 95% nationally.

Our approach

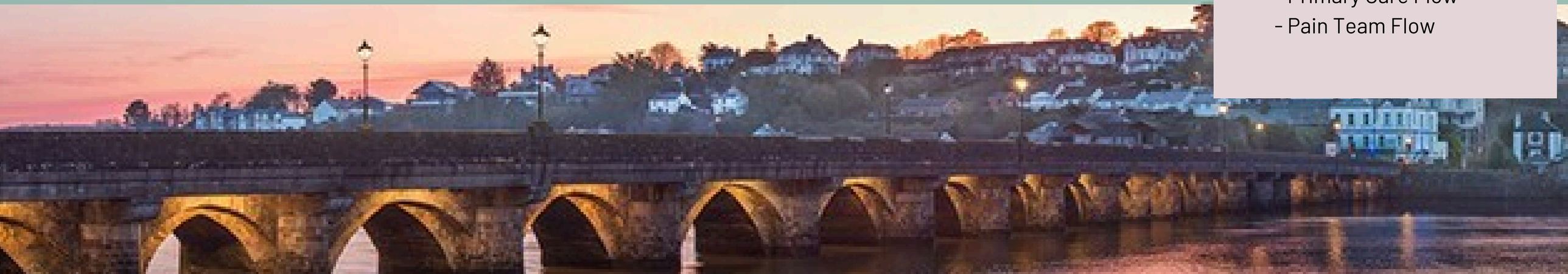
We tested approaches that tackle poor health with interventions targeted at prevention as well as those that support people in crisis or at risk of crisis.

At community prevention level we funded local community physical activity providers to offer free sessions for people at risk of poor and worsening health; working with community providers to offer older people greater access to outdoor activities and activities that reduce social isolation which is associated with poor health outcomes.

We developed a new approach that is improving how services respond to people that have been identified as most vulnerable, in particular people discharged from hospital and those who frequently use emergency services.

Projects or Programmes

- Tackling Health Inequalities with Physical Activity (THIPA)
- Healthy Ageing in Northern Devon (HAND)
- Person-centred support for people with multiple or complex needs
  - High Flow
  - Community Flow
  - Mental Health Flow
  - Primary Care Flow
  - Pain Team Flow



Challenge #2 Our large geographical footprint

The data

2,071 KM2, Population size: 164,253

-Our large (bigger than Greater Manchester or Greater London) but sparsely populated geography brings particular challenges in relation to access to services. Distance and poor transport infrastructure mean that people on low incomes or with inflexible jobs find it difficult to access services located in the urban centres such as the acute hospital.

Our approach

We have tested approaches to address this in a number of ways – through outreach and remote services. Communities become even more important when you have this type of geography, and to that end, OND has invested for a number of years in community partnership infrastructure (One Communities) that enables the full capacity and energy of citizens, the VCSE sector, local services and local businesses to work together to strengthen the resilience and health of their local community.

Projects or Programmes

- Primary Care Outreach for vulnerable population
- Steady on Your Feet
- Remote monitoring for people with Heart Failure
- Community Partnership development
  - One Ilfracombe
  - One Atlantic
  - One Barnstaple
  - Torrington 100
  - One South Molton
  - Holsworthy & DCF
  - Live Well in Braunton

Challenge #3 Pockets of high levels of poverty

The data

38.9% of children in Ilfracombe Central ward are living in poverty. This compares to 1.5% of children in Exeter Chard Road area. Homelessness is significantly higher in North Devon (worst in the South West.) There is a high proportion of older houses which are harder to insulate. £5,827 lower annual wage than UK. 91% of households in East & West Ilfracombe, and 73% in Bideofrd are in the 4th quartile of fuel poverty. 34% of fuel poor households also have an EPC rating of E-G. The regional average for fuel poverty is 15% which is worse than national but masks how clustered the impact of fuel poverty is on certain communities.

Our approach

We have worked with our communities to tackle the cost of living crisis (taking learning from the Covid Community Support programme); and have provided interventions aimed at reducing fuel poverty and food poverty. We have launched a Poverty Truth Commission that seeks to challenge inevitability and create alternatives to current ways of addressing poverty by involving those with experience of struggling to make ends meet.

Projects or Programmes

- Cost of living crisis support
- Fuel poverty
- One Communities Food Insecurity Research
- Poverty Truth Commission

Challenge #4 Poor Mental health

The data

Mood and anxiety disorders are significantly greater in North Devon & Torridge compared to other localities in Devon (highest in urban areas in sparse settings with Ilfracombe, Barnstaple, Bideford and Holsworthy as high ranking towns). There is a higher rate of admissions to hospital for self-harm that the rest of Devon. Emergency admissions for YP injuries (15-24yo), for intentional self harm is significantly higher.

Our approach

We have developed alternative options for people suffering from mental health issues and anxiety by developing Arts on Prescription and Nature on Prescription offers. We have also explored how we might make transport easier to access to social prescribing activities by including transport in the offer.

Projects or Programmes

- Arts on Prescription
- Nature on Prescription
- Tackling Loneliness with Transport
- HAND Building Community Connection activities

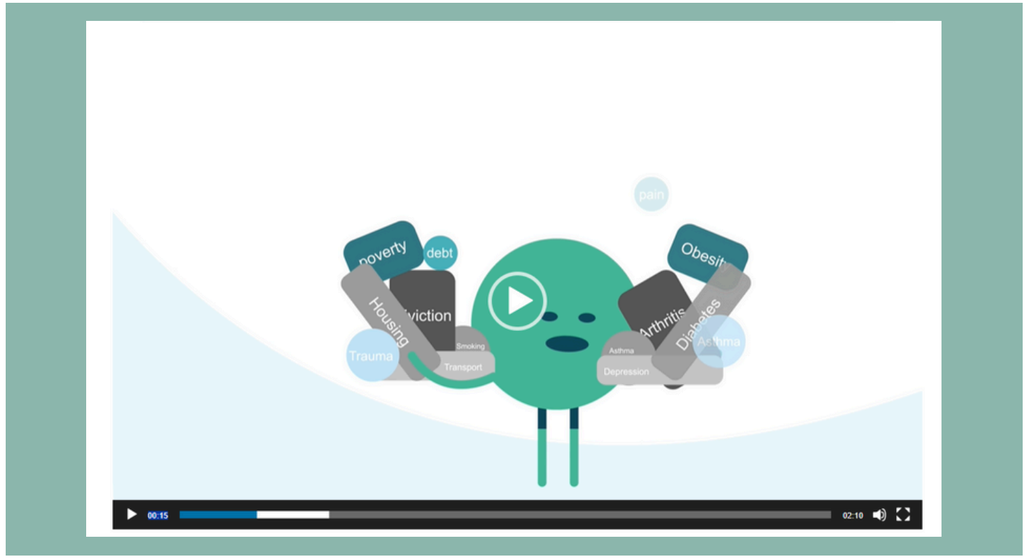
Project snapshot

Person-centred support for people with multiple or complex needs (Flow)

Overall aim

One Northern Devon's 'Flow' Programme helps organisations and practitioners provide person-centred care and support. It is particularly helpful for people with multiple or complex needs

It focusses on 'What Matters' to the person and bringing services together in a Team around the Person approach so that support 'flows' around the person rather than the person bouncing around the system, often seeing multiple services frequently without addressing their real needs.



Why needed?

People most in need of support are least likely to receive it.
They describe feeling 'bounced around' services repeating their story, which can be distressing, particularly for people who have experienced trauma. People feel distanced from the professionals that support them as they get referred to various providers for more specialised support.

What if people told their story once and the practitioner listened, understood and built a team around them?

FLOW
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2024

- High Flow
- Community Flow
- Pain Team Flow
- Leg Team Flow
- Housing Team Flow

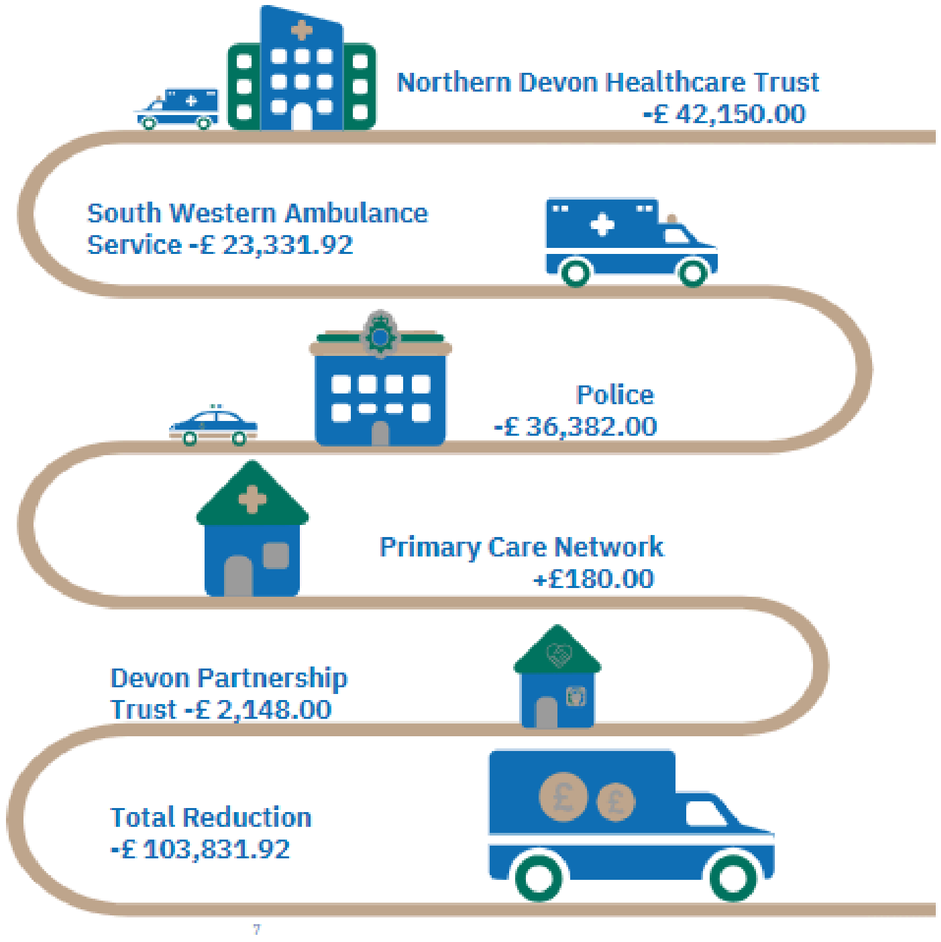
Flow Case Studies

Original High Flow

Project Objectives High Flow:

- To improve the wellbeing of individuals with multiple & complex needs
- To reduce the demand these individuals have on multiple system partners including Police, SWAST, Housing, DPT, Primary Care.

Decreases in average demand pre and post intervention					
DPT	POLICE	SWASFT	NDHT	PCN	TOTAL
During/Pre	During/Pre	During/Pre	During/Pre	During/Pre	During/ Pre
26%	62%	78%	24%	-1%	66%
Post/Pre	Post/Pre	Post/Pre	Post/Pre	Post/Pre	Post/Pr e
96%	83%	70%	80%	-11%	78%



In 23/24 there was one High Flow caseworker who worked with the most intensive service users across the system plus up to 200 wider beneficiaries. High Flow clients were supported to achieve 1,028 individual outcomes ranging from improved motivation to improved emotional or physical health, debt management, improved living conditions and increased independence.

High Flow Safer Streets

High Flow Safer Streets Barnstaple

- To support rough sleepers and street attached individuals to access meaningful occupation
- To support rough sleepers to access housing
- To reduce the level of anti-social behaviour in Barnstaple Town.

Outcomes

- 33 people supported through Safer Streets
- 8 received intensive 1:1 support
- 1 entrenched rough sleeper successfully housed and thriving
- 4 people had their living conditions improved
- 1 person moved into employment
- 2 people were supported on pathway to employment
- 23 reported improved motivation
- 20 were supported to try meaningful activities such as surfing and attending walking groups
- 10 people had welfare benefits advice leading to income maximization
- 10 felt confident enough to take their own action to deal with issues
- 2 people secured financial grants to support their recovery and independence
- 1 person was supported through a court process with a successful outcome

Community Flow

The key aims of Community Flow are to enable faster, safer and sustainable discharges, avoid readmission and reduce reliance on health and social care services.

Desired system outcomes:

- Reduce likelihood of unnecessary re-admissions to hospital
- Enable faster and safer discharges for people medically fit
- Contribute to more efficient hospital flow by freeing up capacity
- Support community teams to be able to efficiently focus on clinical needs
- Support sustainability of clinical health interventions
- Join up and improve efficiency of multiple healthcare interventions
- Reduce the cost burden of health inequalities
- Reduces likelihood of ongoing care costs

In the year 2023/2024, 377 people were supported by community flow, resulting in an estimated minimum saving of £276,272 to the health and social care system:

- Discharge expedited: **54 times**
- Crisis re-admission prevented within first six weeks of discharge: **136 times**
- Potential future admission avoided: **196 times**
- **1072 positive outcomes** for people were achieved in the areas of housing; physical & mental health; relationships with family and friends; meals, diet and nutrition; money and finance; community connection and independence.

New Service: High Intensity User Flow

Objectives : High Intensity User Flow – Started January 2024

- To sustainably improve the overall health and wellbeing of the individuals repeatedly using ED.
- To reduce the impact of high intensity users on the NDDH Emergency Department
- To reduce the impact of these high intensity users on wider system partners by utilising the established system partnerships and learning developed through the OND flow programme
- To align the One Northern Devon High Flow programme with the NHSE HIU programme

So far we have seen a total reduction in activity equivalent to £44,407 when compared to the previous quarter

Table 1. HIU KPI Data since January 2024

KPIs (NHSE/One Devon/OND LCP)	Target	Jan-March 2024 Northern	Cost savings
New clients per quarter (Jan-Apr)	15	19 (126.6%)	n/a
Number of ED attendances in previous 3 months	n/a	156	n/a
Reduction in ED attendances	40%	57%	£10,156
Reduction in non-elective admissions	40%	94%	£28,875
Reduction in ambulance conveys	40%	55%	£5376

Flow recognition

Integrated Care NHSE case study

High Flow was used as a case study on NHS England's website under Resources for Integrated Care in 2019 – which had a wide reach nationally.

South West Integrated Personalised Care Award 2023/2024:

The Flow programme and team were nominated for the NHS South West Integrated Personalised Care Team (SWIPC) awards in October, and won the award for the 'What Matters' category.

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"The dedication and perseverance demonstrated by your team have played a crucial role in making personalised care a reality for the individuals in your local community. The judging panel, in particular, took note of the team's exemplary use of personalised care to support individuals of all ages and diverse needs, contributing to the improvement of mental and physical health, wellbeing, and confidence.

In the face of numerous challenges within the health and care sector in recent years, the inspiration provided by every member of your organisation instils hope that, through our collective humanity, we will overcome these difficult times. I am confident that together, we will collaboratively shape a more sustainable health and care system where individuals are at the forefront of our efforts.

I extend my sincere thanks and gratitude to you for your leadership and to your entire teams for their outstanding commitment to incorporating personalised care as a core element of their work."

Frances Tippett
Head, South West Integrated Personalised Care, NHSE

"We need to demonstrate to everyone - not least the critical minds of the Treasury - where improvements are taking place and how they are delivering efficiencies as well as improving health outcomes. The good news is that much is already happening up and down the country.

Take for example the **High Flow project in Northern Devon** which has brought agencies together to reduce A&E demand among those with complex and multiple needs."

Matthew Taylor (Chief executive)
NHS Confed Conference June 2021

Healthy Ageing in Northern Devon (HAND)

Who: Older people at risk of frailty or loneliness

AIM: Work with the One Communities to test activities that help keep older people well & reduce loneliness. We hoped to learn what communities can offer; the costs & benefits & whether those benefits could be scaled up with ongoing funding

What happened: 191 older people took part in community activities over 12 weeks including:

Straw Patch in Ilfracombe which offered nature, allotment & countryside activities) & Dementia support in South Molton which also provided 40 hours of carer respite. Other activities included guided walks, Tai Chi, volunteer 'buddies', & pub 'lunch & chat' sessions.

"This is much better than popping pills any day of the week"

"Lovely to have company as I live on my own and things can get out of perspective"

"Its been super, I like the company. I don't go out, so it's nice that you come to see me."

"I struggled to find local groups. It helped me to meet people since finding myself alone in an area I don't know well. Made new friends to hopefully meet up for future walks."

"So glad we came. Mum hasn't stopped smiling since she got here"

"I didn't think my husband would like it as he's never been one for groups but he recognised an old colleague from his farming days & they've been chatting ever since. And he's talking about coming again."

"I lost confidence in going out after falling and breaking a leg, I felt very depressed. I feel I can do anything now, I never thought I'd get this far"

"Provided calm into a frantic world. Loneliness can be a terrible thing."

"This is the first time I've been out of my house in 3 years, I'll be coming again too - thank you."

Healthy Ageing in Northern Devon (HAND)

Straw Patch

Dementia support

Guided Walks

Go North Devon

Memory Cafe

Tai Chi

Age Concern buddies

Coffee & Chats

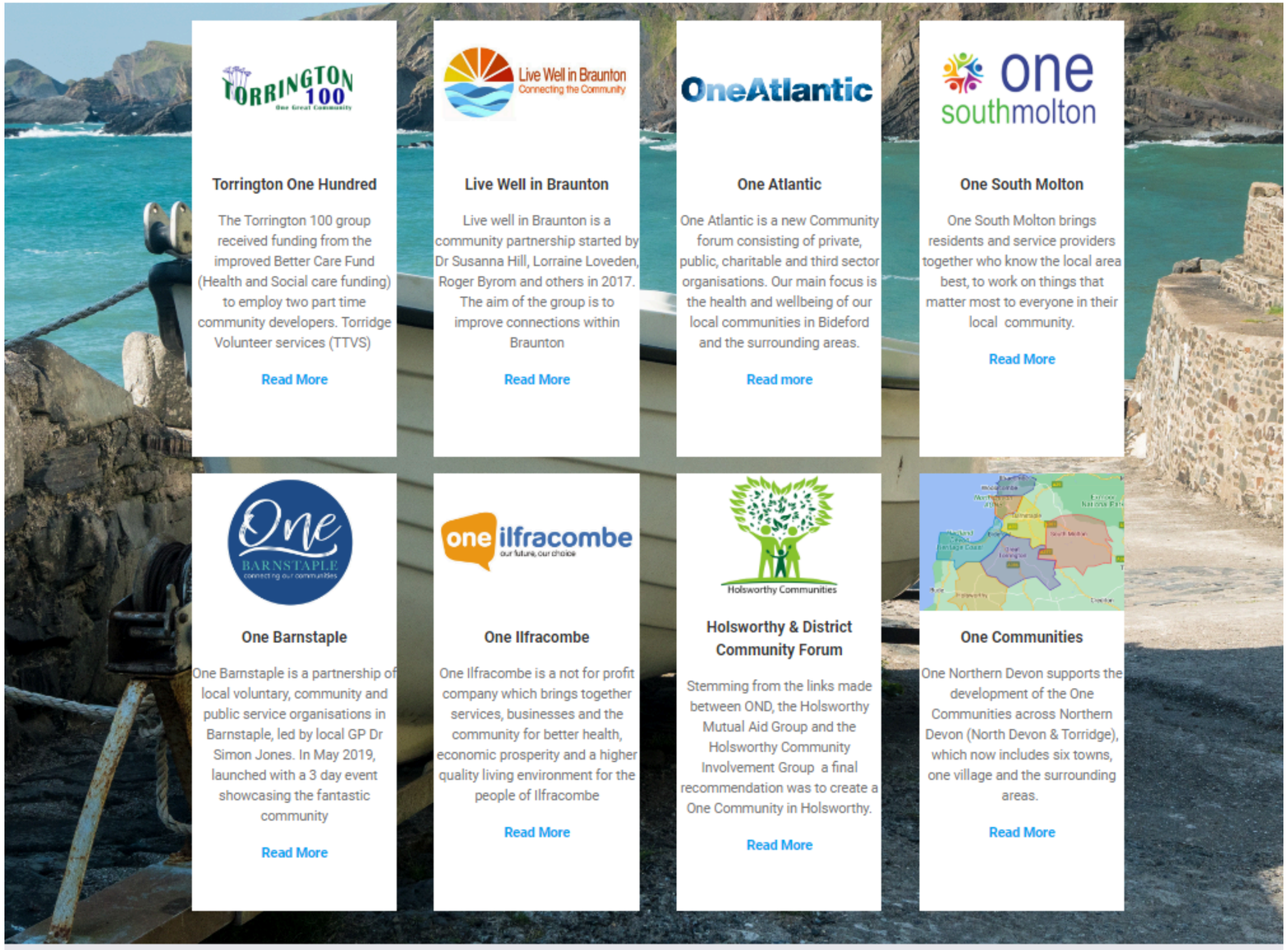
One Northern Devon co-designing care and support for older people living with frailty

Healthy Ageing Community Prevention Evaluation Report here

Community Partnership Development

ONE COMMUNITIES

- Community power – local communities should have much greater influence over the decisions of public services
- Community partnerships - “doing with and alongside”
- Community partnership infrastructure investment in Community Developer workforce
- Community-level system working
- Staff embedded in local organisations (town council/VCSE/PCN etc)
- Local needs and priorities addressed in partnership with NHS, Councils, Police etc and using local assets



APRIL 2024 ONE COMMUNITIES HIGHLIGHT REPORT CAN BE FOUND HERE

One Communities timeline

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2013

2017

2018

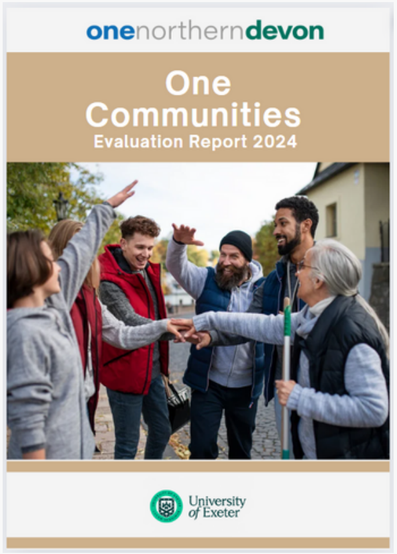
2019

2020

2021

2024

NDVS & TTVS successful Lottery Bid enabling expansion into hinterlands...



Exeter University Draft Evaluation of One Communities Report 2024

Multiple initiatives and projects led by OND and the One Communities... emphasise not only the considerable focus on partnership working, but the added value of working in partnership with other organisations. Specific impacts evidenced include a more diverse and wider group of community members being reached and engaged, combating loneliness, reducing social isolation, reaching elderly members of the community, increasing awareness of community services for residents, reducing antisocial behaviour, and increasing opportunities for funding at the community level.

There is evidence of a number of clear positive outcomes stemming from this approach, including projects benefitting from local expertise with lived experience, making sure individual voices are heard and that projects reflect these voices, skill sharing, connectedness, empowerment, reported improvements in mental health and wellbeing, and improved confidence and direction.

“Overall, the extent and impact of person-centred approaches and partnership working in the One Communities project is clearly significant and positive”

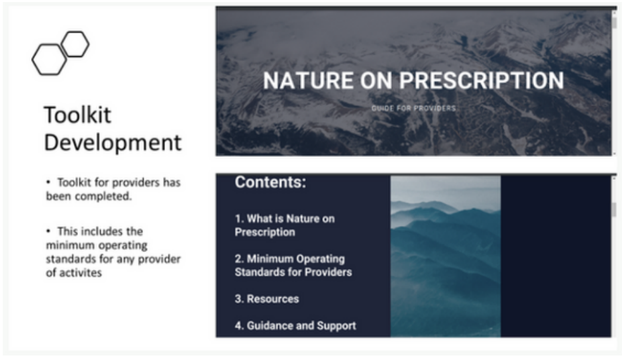
Case study of the One Communities Covid 19 response was written up by South West Academic Health Science Network - Learning from the South West during COVID-19

Communities role in health & wellbeing

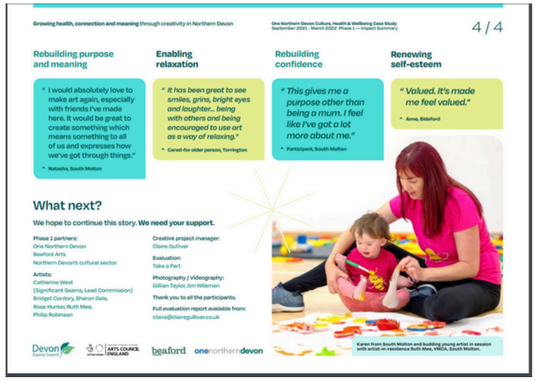
Working with our One Communities to access health promoting activities:

- Arts on Prescription
- Nature on Prescription
- Physical Activity on Prescription

Nature on Prescription



Arts on Prescription



SWAHSN Social Prescribing Test Bed report featuring One Communities

Physical activity on prescription

Fuel Poverty

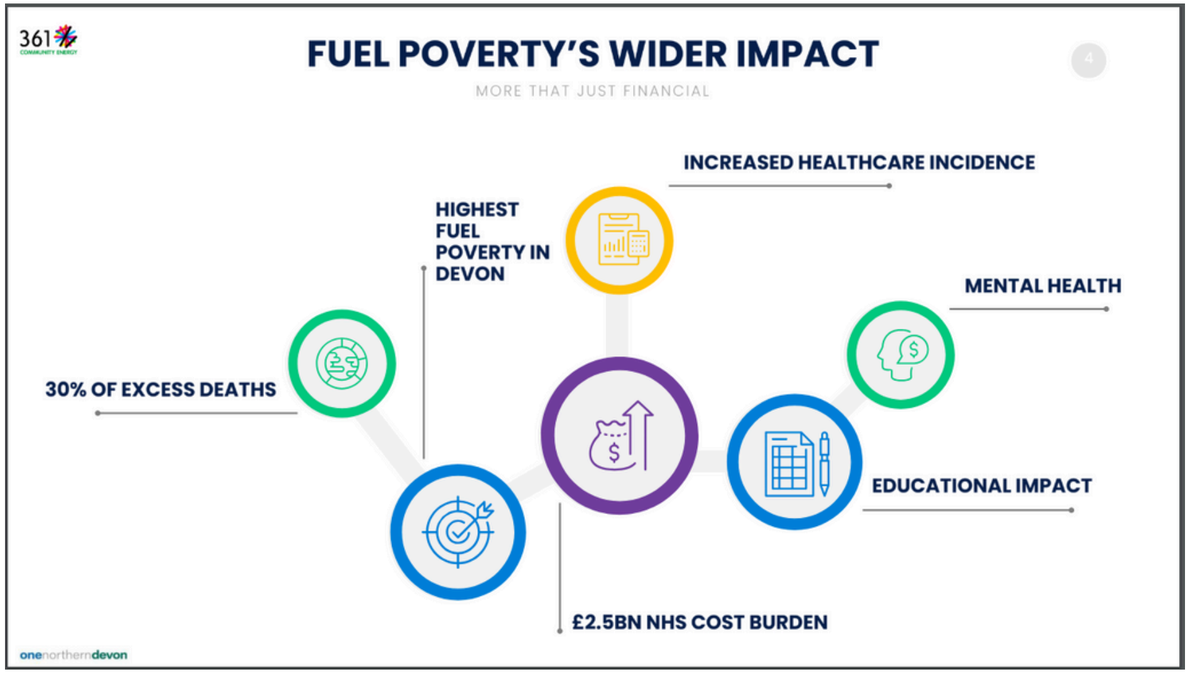
1. Develop multi-sector strategy

Included both District Councils, Social Housing, Community Engergy Charity and Healthcare

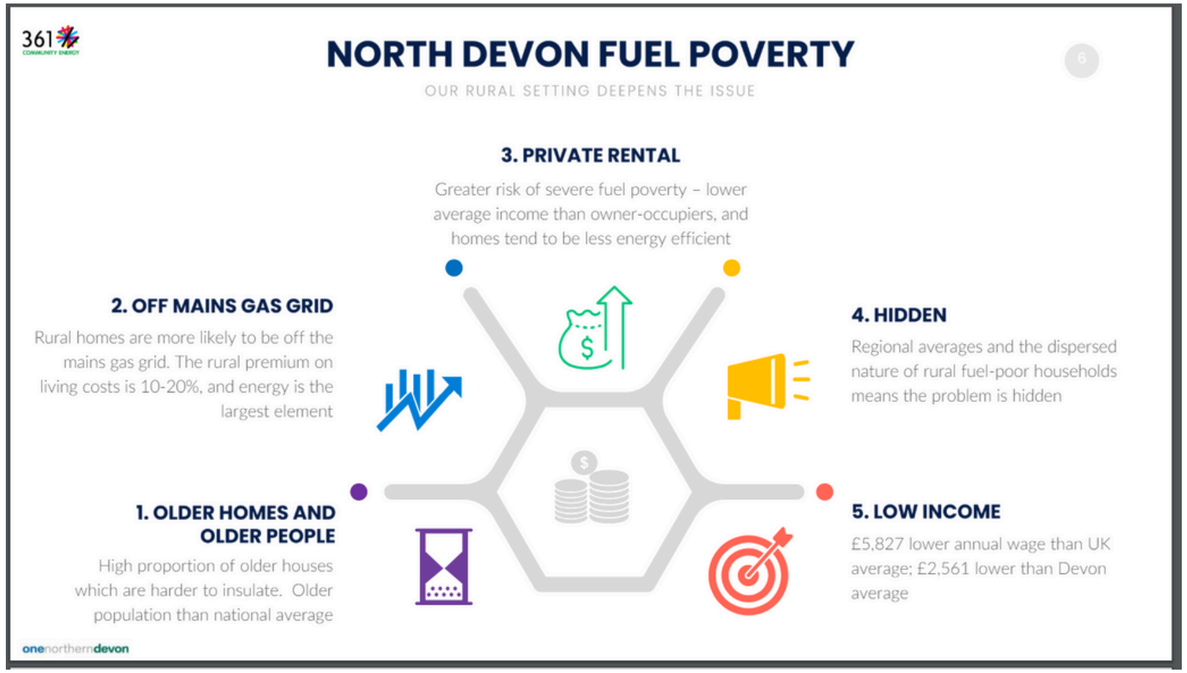
2. Define fuel poverty

FUEL POVERTY DEFINITION	Households that have required fuel costs that are above average (the national median level) and were they to spend that amount, they would be left with a residual income below the official poverty line
ON THE GROUND MEANING	Residents need to make day-to-day decisions about heating their homes adequately OR paying rent, feed their families and other basic needs

3. Understand its impact

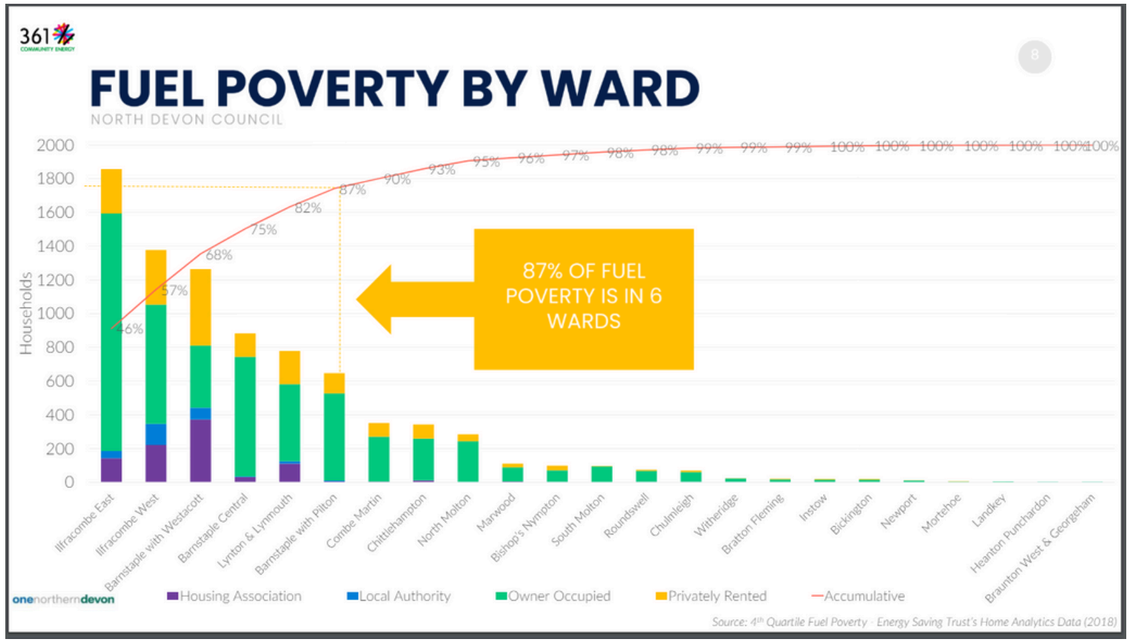


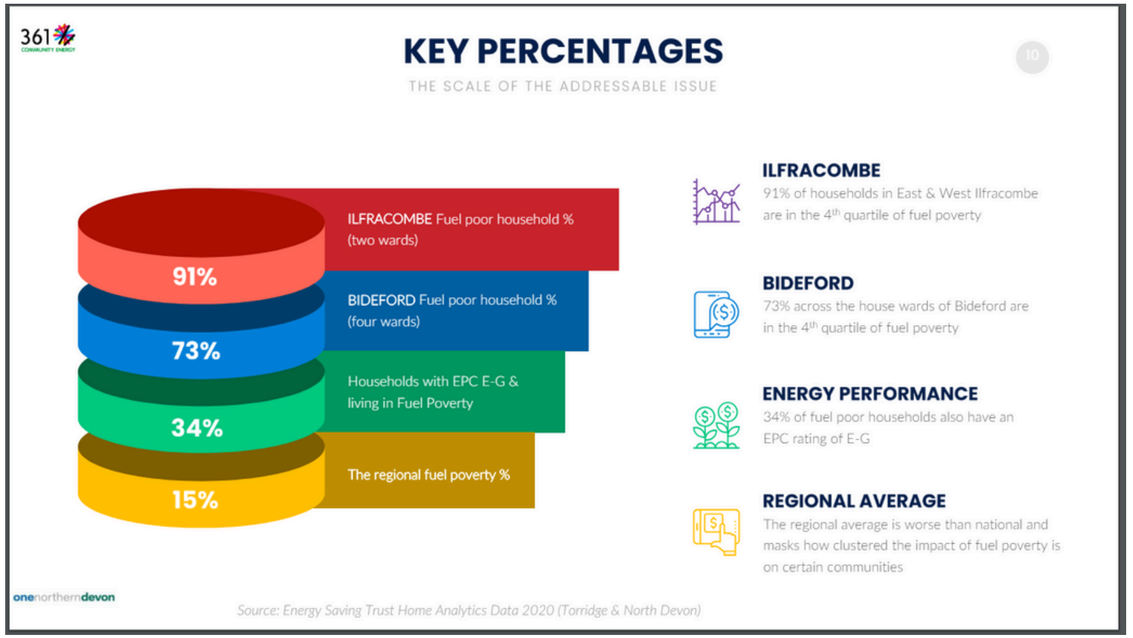
4. Understand the local situation

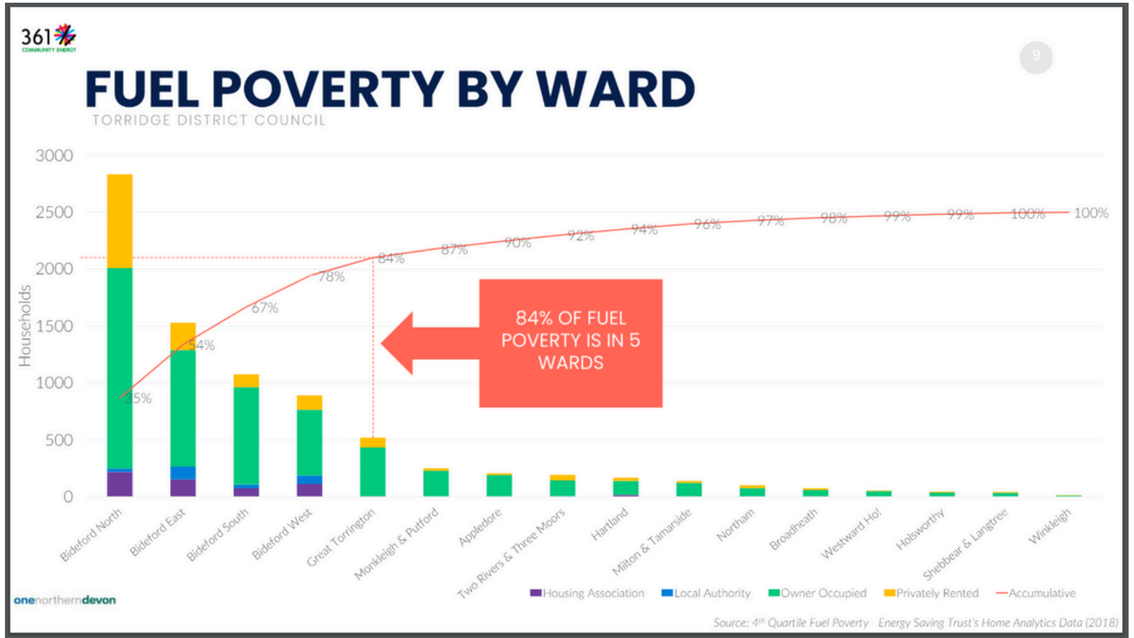


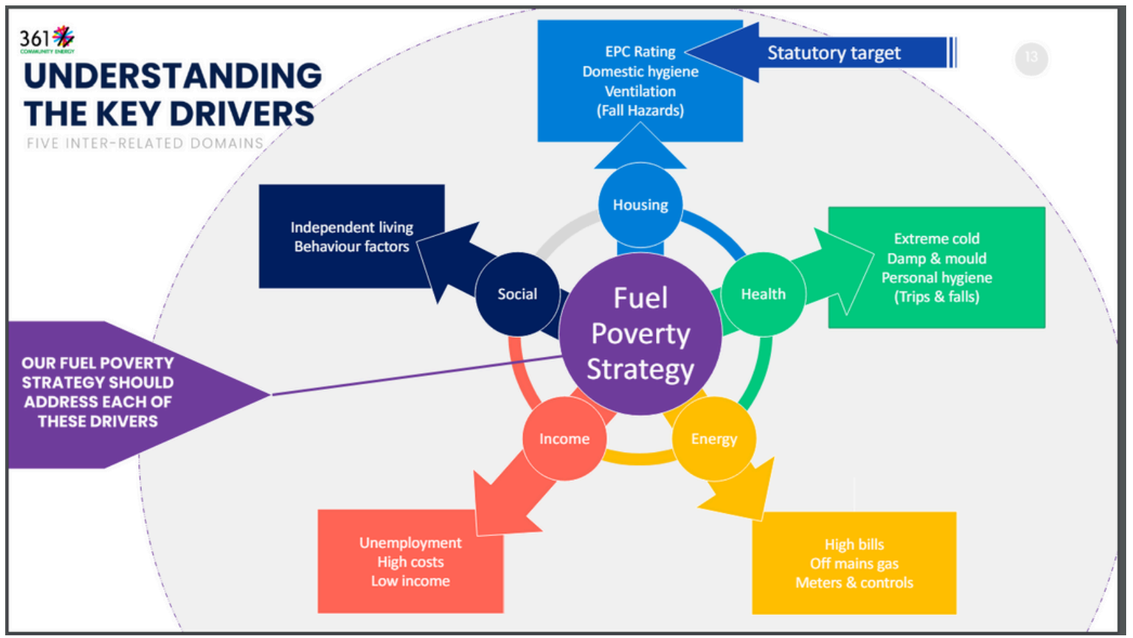
5. Local risk stratification - North & Torridge

Fuel Poverty cont'd...



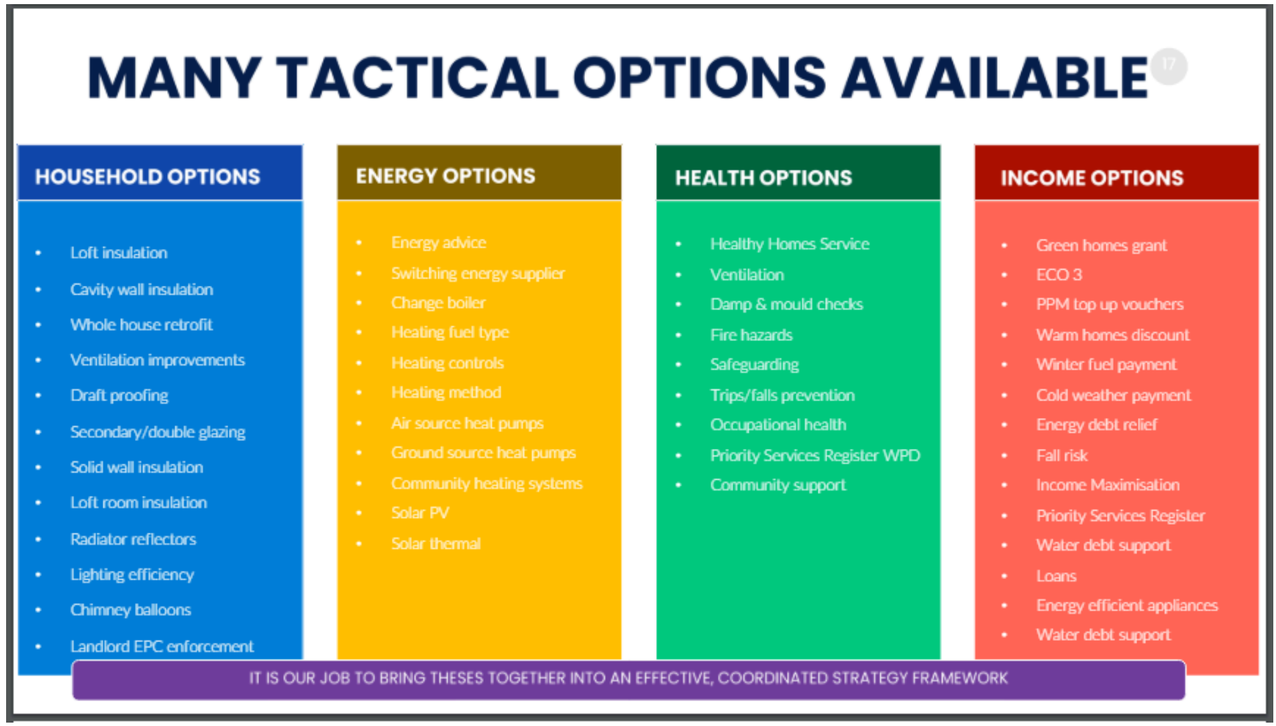






6.Create strategy

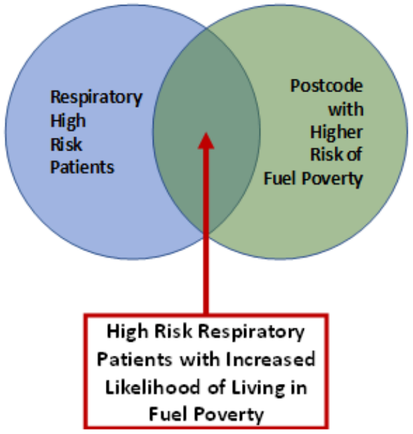
Fuel Poverty cont'd...



Multi-sector strategy document can be found here

7.Take action

Aim: To identify people vulnerable to health problems associated with a cold home (NICE QS117, 2016)



One Devon

8.Results

Fuel Poverty cont'd...

Did we reach our target group?

Primary Care Network (PCN)	Allocation of home energy visits based on PCN pt list size	No of patients contacted	No of patients referred to 361 energy	Unable to contact	Conversion rate from PCN to energy organisation	Completed Home Energy Visits (Sept 23)	Home energy visits to be booked or completed (Sept 23)	Home energy visits declined or not home when visited (Sept 23)
Barnstaple Alliance	88	170	114	17%	67%	95	2	17
Coast and Country	38	78	47	8%	60%	35	0	12
North Devon Coastal	89	178	97	28%	54%	69	4	24
Torridge	100	148	95	13%	64%	75	1	19
Totals/Averages	**315**	**557**	**353**	**16.5%**	**61%**	**274**	**7**	**72**

- The programme reached 87% of the planned home visits
- On average 61% of initial calls by the GP surgery resulted in a referral to the Community Energy Organisation

Financial benefits

Behavioural changes e.g. One less minute in shower each day, Turning off lights, Appliances put in standby mode

- 217 (82%) people benefited from behavioural change support from the programme.
- The main behavioural change interventions were Wash at 30 and Shower.
- The median financial gain for those benefiting was £516 and the mean benefit was £574.

This equates to a mean benefit of £468 per person.

Income Maximisation e.g. Tax allowances, Grants from charities, Fuel, health or food vouchers, Council tax reductions

- 117 (44%) people benefited from income maximisation and debt advice support from the programme.
- The main income maximisation and debt advice interventions were Fuel/water discount and New benefits check/application.
- The median financial gain for those benefiting was £140 and the mean benefit was £508.9, across the entire programme.

This equates to a mean benefit of £224 per person.

Energy Efficiency e.g. Electric throw, Thermostats, Draught proofing, Led bulbs, Smart meters, Boiler replacement

- 150 (56%) people benefited from energy efficiency support from the programme.
- The main energy efficiency interventions were LED Bulbs and Radiator foils.
- The median financial gain for those benefiting was £75 and the mean benefit was £126.

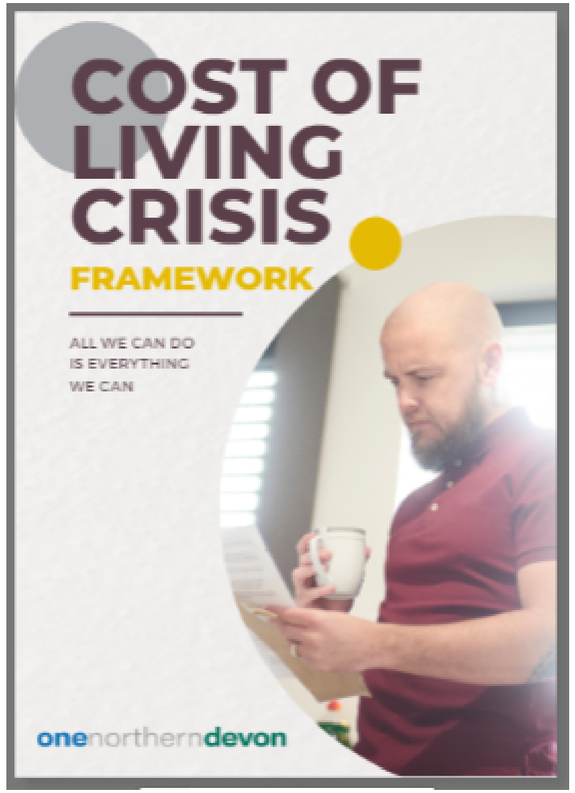
This equates to a mean benefit of £71 per person.

SMART e.g. Solar electricity panels, Tariff review, Smart meters, Smart lighting

- 120 (45%) people benefited from SMART support from the programme.
- The main SMART interventions were Energy monitor and Time of Day Tariffs.
- The median financial gain for those benefiting was £70 and the mean benefit was £108.

This equates to a mean benefit of £49 per person.

Cost of living crisis



We developed a framework with 4 points of action:

1. Identify key areas of support
2. Identify what's already available to meet that need
3. Identify gaps and consider how local partners could fill those gaps
4. Ensure those who need it can access the support

One Communities engaged their residents & created:

- Warm spaces
- Drop-in help hubs
- Warm clothing bank
- Community fridge/larder
- Coffee and cake vouchers with local businesses
- Free/reduced dental and vet fees
- Community food network
- Promotion of support available such as free school dinners which were being under-utilised

OND Cost of Living Full Report here

Find out more about some of our other projects

- Sustainable, healthy and fair: how the principles of ‘active travel’ can shape northern Devon.
- Poverty Truth Commission March 2024 Highlight Report and Presentation
- One Communities – food insecurity participatory research connecting local people with local food producers
- High Flow - Quarterly Report
- High Flow pilot Case Studies
- HAND Steady on Your Feet pilot
- Arts on Prescription
- Nature on Prescription

External comms

- Readers’ Digest March 2024 Print Edition on rural health inequalities featuring work of OND
- InHIP Remote Monitoring project featured in The Guardian
- One Communities presented at King’s Fund Delivering Effective Place-Based Care Conference
- InHIP Primary Care outreach project presented at the Royal Society of Medicine’s Tackling Inequalities through Innovation and Entrepreneurship conference
- Health Innovation South West blog about the InHIP primary care outreach project
- OND Flow team winners of the What Matters Award at the South West Personalised Care Awards