One Devon

Northern Neighbourhood Workshop

Background reading: Tuesday 28th April 2026

#OneDevon

Commissioning Plan Context: 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 authority 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

Neighbourhoods and Integrated Neighbourhood Teams

- Neighbourhood health sits at the heart of the 10-year health plan and is not a one-year programme.
- 2026/27 should be seen as a preparatory year to help plan and embed some of the change expected further into the delivery of the 10 Year Health Plan Neighbourhood health framework - GOV.UK
- The framework sets out the foundational steps local areas will need to take in 26/27 to develop local neighbourhood health plans for 27/28, delivered through joint working.
- Local Government and ICBs are encourages to consider how services can be reconfigured to focus more of prevention and early intervention, an approach that should be increasingly prominent within the local neighbourhood health plans over time.
- The framework seta out a minimum set of interventions from all ICBs to deliver over the next 3 years to establish the foundational building blocks of an effective, joined-up neighbourhood health service.
- Local systems will be supported by the National Neighbourhood Health Implementation Programme (NNHIP)

Working in partnership through health and wellbeing boards – in 26/27 – there is an ask of ICBS and LA to:

- *1. Agree neighbourhood footprints around natural communities for the future development of INT's*
- *2. Agree plan to establish INTS focussed on high priority cohorts, including how devolving care budgets could work in their area.*
- *3. Confirm intentions to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance.*
- *4. Confirm organisational ownership of planned deliverables*
- *5. Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification & evaluation.*

One Devon

Neighbourhoods and Integrated Neighbourhood Teams

From 27/28, ICB's and LA, working through Health and Wellbeing Boards will be asked to develop a local neighbourhood health plan:

- 1. Provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas outlined in the framework.
- 2. Set out how neighbourhood health will support wider local goals for improving health outcomes and reducing health inequalities.
- 3. Set out how local objectives are informed by the JSNA, and any other assessments by ICBs or LA's – as deemed necessary by the health and wellbeing board.
- 4. Confirm final geographies that partners will then work within
- 5. Confirm which organisations are responsible for different elements of delivery
- 6. Confirm the arrangements which will be in place to deliver this
- 7. Confirm how other relevant local services or initiatives will align with the strategy over time, such as Best Start Family Hubs, house, mental health hubs, Pride in Place, and employment support.

Commissioning for Population Health: NHS England » Fit for the future: towards population health delivery models

- As set out in the "Fit for the Future" model – delivering of the 10 Year Health Plan will require innovative population-based commissioning, led by ICB's.
- ICB's to set out how they will implement some outcomes-based contracts within 3 years, with a view to IHO contracts becoming the norm*
- General practice contracts (GMS, PMS, APMS, GDS, GOS) will continue to be determined nationally and commissioned locally.

Neighbourhood Health guidance shared: NHSE policy (January 2025) asked systems to focus on specific areas through 2025/26 in preparation for a move to Neighbourhood Health as defined in the 10YHP:

1. *Population Health Management*
2. *Modern General Practice*
3. *Standardising Community Health Services*
4. *Neighbourhood Multi-disciplinary teams (MDTs) for children and adults*
5. *Integrated Intermediate Care with a "Home First" approach*
6. *Urgent Neighbourhood Services*

**Integrated Health Organisation (IHO) contracts are a new, capitated, population-based contracting approach introduced in the UK's NHS 10 Year Health Plan to shift resources from hospitals to community settings. These contracts, expected to go live in 2027, involve awarding a "host provider" - a budget to manage the health outcomes of a geographically defined population*

One Devon

Government guidance for Neighbourhoods

NAPC

Neighbourhood health will only work as a **joint endeavour** between the NHS and local authorities, alongside wider partners.

Three principles of public sector reform:
- Integrated services around people's lives
- Improve outcomes, by focusing on prevention rather than crisis management
- Devolve power to local areas, which understand local needs, with services with and for people.

Measuring success of neighbourhood health

National minimum goals and objectives, plus locally developed aims and outcomes defined through neighbourhood health plans under the leadership of Health and Wellbeing Boards.

National NHS goals, objectives and metrics

1 Improve health outcomes

Targets include:
- reducing non-elective admissions
- improving outcomes for long-term conditions
- improving quality and access to care for children
- better end of life care

2 Improve access to general practice

Objectives include:
- 90% of clinically urgent patients seen the same day by March 2027
- faster access to routine GP care
- improved patient satisfaction

3 Improve experience of planned care

This will include:
- reducing variation in outpatient referrals
- improving coordination of outpatient care & reducing secondary care follow-up appointments

4 Improve urgent and emergency care
- Improving co-ordination of care for high priority cohorts (frailty, care homes, end of life)
- reducing emergency department attendances
- improving ambulance response times
- improving hospital discharge processes

5 Improve patient and staff satisfaction
- introducing patient-reported experience and outcome measures
- ensuring 95% of people with complex needs have an agreed care plan
- introducing neighbourhood staff experience measures

6 Local goals
- Health and Wellbeing boards recommended to consider the local outcomes framework for health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration
- Enabling those who receive long term support to live in their home
- Adults who needs are met by admission to residential and care homes
- Consider how neighbourhood plans align with wider public service reform

Aims
- Improve people's health and care outcomes
- Organise services around the person
- Reduce pressure on acute services
- Cut waste and duplication
- Help the NHS deliver against core targets

Delivering Neighbourhood Health

To deliver neighbourhood health, the NHS and local authorities must transform how they work together alongside wider partners including **voluntary, community and social enterprise organisations (VCSEs).** ICBs will ensure neighbourhood health becomes the default model of care

Reform agendas

1 Improve routine healthcare

The NHS will support GP access recovery by:
- improving GP access targets
- improving online access
- ensuring practices open during core hours, and reform out of hours
- providing faster access to care

GPs will be empowered to deliver better care through:
- proactive population health management
- reduced bureaucracy
- improved access to specialist advice

2 Improve proactive care
- Develop Integrated Neighbourhood teams to deliver better management of Long term conditions, frailty, children and young people and cancer
- Grow community services
- Reform outpatients, with closer working between GPs and specialists

3 Better alternatives to hospital care
- Expand urgent community response services
- Increase the capacity of virtual wards
- Increase intermediate care capacity
- Piloting 24/7 neighbourhood mental health centres

Read how NAPC helps partners implement neighbourhood health.

Contracting models

ICB → IHO → MNPs → SNPs

Single Neighbourhood Providers (SNPs): Deliver neighbourhood services through integrated teams within a defined area; allow primary care to offer services beyond core GP contracts.
Multi-Neighbourhood Providers (MNPs): Coordinate services across multiple neighbourhoods, supporting consistency, service design and shared risk for the registered population list.
Integrated Health Organisations (IHOs): Hold a whole-population budget, allocate resources across pathways, redesign services and invest in prevention. Initially likely led by high-performing NHS trusts, in partnership with primary and community providers.
All primary care contracts remain nationally contracted. PCNs might evolve into SNPs. More guidance to follow.

Changes for 2026/27
- Neighbourhood footprints considered in terms of local authority boundaries
- Reduce non-elective admissions
- GP access
- Establish integrated neighbourhood teams
- Improve outpatient pathways
- Confirm use of Better Care Funding (BCF)
- Improve primary secondary care interface
- Confirm organisational ownership of deliverables
- Improve data-sharing arrangements
- Plan for April 2027 to April 2029

Other headlines
- **Neighbourhood Health Centres (NHCs)**: 250 neighbourhood health centres by 2035, 120 by 2030
- **Workforce:** staff working differently rather than entirely new staff groups providing proactive, preventative personalised care, organisational boundaries
- **Finance:** ICBs prioritise funding for neighbourhood health services locally. National support will include: financial incentives encouraging the shifting care from hospital care to community, reforms to payment mechanisms, & support for outcome-based contracting

NAPC welcomes the continued focus on population health and prevention at a local level.
The national voice for primary and community care, NAPC is a not-for-profit membership organisation leading change, driving innovation and supporting partners across the health and care ecosystem.

Contact us: napc@napc.co.uk • www.napc.co.uk

Chris Reid
Chief Place and Transformation / Chief Medical Officer

NHS Cornwall and Isles of Scilly Integrated Care Board
NHS Devon Integrated Care Board

Cornwall's Neighbourhood Slides


A successful Neighbourhood Health & Wellbeing Model
1
Health Literate activated citizens
2
Trusted teams
3
Activated and resilient workforce
4
Improved Population Health metrics
5
Reduced Inequities of Health Outcomes
6
Reduced demand for Acute Services (primary & secondary)
7
Within financial envelope
8
Better Citizen Experience

NEIGHBOURHOOD HEALTH AND WELLBEING DELIVERY PLAN – KEY STEPS

Cornwall and Isles of Scilly Integrated Care System

The delivery plan is designed to provide a **common pathway for all Neighbourhoods**, while allowing for local variation in pace, starting point and emphasis. It does not prescribe a single operating model. Instead, it establishes a small number of core delivery steps that every Neighbourhood will be supported to progress through.

1. **Establish Neighbourhoods and develop plans** based around natural communities, agree the initial Leadership Team/Forum, understand baseline

2. **Continuous engagement with citizens and communities** and ask what matters to them

3. **Develop the Neighbourhood Leadership Team** define, single, empowered, and accountable

4. **Develop the Operational Neighbourhood Teams** activated, autonomous and motivated and develop deeper delivery partnerships

5. **Plan to deliver on the priorities** both system wide commissioning intentions and local priorities – with test and learn in some sites

6. **Integrate care** by removing the barriers that get in the way of delivery

7. **Support citizens** - to develop the skills, knowledge and confidence to take more control of their health and wellbeing

SUMMARY TIMELINE FOR A NEIGHBOURHOOD

Draft v1, 29th January 2026

	2025/26 Q4	2026/27 Q1	2026/27 Q2	2026/27 Q3	2026/27 Q4	2027/28 Q1	2027/28 Q2	2027/28 Q3	2027/28 Q4
1 Establish Neighbourhoods	Footprints & Leadership Team agreed	Baseline Maturity Framework Assessment	Neighbourhood Plans in place across all 16	Maturity Framework Refresh		Maturity Framework Refresh		Maturity Framework Refresh	
2 Continuous engagement with communities	Wave 1 Engagement Events	Wave 2 Engagement Events				Ongoing Continuous Engagement			
3 Develop the Leadership Team			Leadership Team Development Design	Wave 1 Leadership Team Development initial intervention	Wave 2 Leadership Development initial intervention				
4 Develop the Neighbourhood Teams		Staff Activation Baseline				Ongoing Staff Activation Assessment			
		Team Development Design				Wave 1 and 2 Team Development			
5 Plan to deliver on the priorities		Develop Plans to meet system and local priorities	Tracking impact through dashboards and evaluations			Develop Plans to meet system and local priorities	Tracking impact through dashboards and evaluations		
6 Integrate care		INTs work together to remove the barriers that get in the way and escalate those that require system resolution – measured through index of integration							
7 Support citizens		Citizen Activation Baseline – Wave 1			Ongoing Citizen Activation Measurement and nudging – Wave 1				
			Citizen Activation Baseline – Wave 2			Ongoing Citizen Activation Measurement and nudging – Wave 2			
Neighbourhood Events	◆	◆		◆	◆	◆		◆	◆

Cornwall and Isles of Scilly Integrated Care System

DELIVERY PLAN – SYSTEM ENABLERS

Alongside the delivery steps are a set of system enablers that must be put in place to make local delivery possible. These are the resources, partnerships, and infrastructure needed to support successful implementation.

1. **Workforce alignment towards neighbourhoods:** Phased alignment, testing models, clarity about decision-rights and accountability.

2. **Change and delivery support capacity:** Shared resource: change management and OD; leadership and team development; improvement capability; staff engagement

3. **Community and VCSE capacity and capability:** To enable meaningful partnership, co-production and delivery at neighbourhood level.

4. **Investment and sustainability:** Aligning resources and accountability over time. Enabling transitional investment

5. **Digital and technology:** Shared records and interoperability, population health data and analytics; digital tools

6. **Estates and physical infrastructure:** Towards a 'one public estate' approach for each Neighbourhood

7. **Governance and Quality:** Strong, trusted arrangements for quality, safety and clinical governance

8. **Impact evaluation and learning:** Metrics framework; mixed- methods evaluation; learning loops

BLUEPRINT ON A PAGE

Logic Drivers

1. Activated Staff
Motivated teams that feel they have greater **autonomy, common purpose, confidence and skills**.

2. Integrated Care
Removing the barriers to getting things done. Making the working lives of our teams easier while **enhancing the quality of care/experience**

3. Activated Citizens
Who have the **knowledge, skills, resources and confidence** to take more control of their own health and wellbeing.

4. Integrated Communities
Partners and **communities working together** to tackle the wider determinants and address inequalities.

Key Delivery Steps for Neighbourhoods

Step 1: Establish Neighbourhoods and develop plans based around natural communities

Step 2: Continuous engagement with citizens and communities and ask what matters to them

Step 3: Develop the Leadership Team define, single, empowered, and accountable

Step 4: Develop the Neighbourhood Teams activated, autonomous and motivated and develop deeper delivery partnerships

Step 5: Plan to deliver on the priorities both system wide commissioning intentions and local priorities

Step 6: Integrate care by removing the barriers that get in the way of delivery

Step 7: Support citizens - to develop the skills, knowledge and confidence to take more control of their health and wellbeing

System Enablers

Enabler 1. Workforce Alignment

Enabler 2. Change and Delivery Support Capacity

Enabler 3. Community and VCSE capacity and capability

Enabler 4. Investment and Sustainability

Enabler 5. Digital and technology

Enabler 6. Estates and physical infrastructure

Enabler 7. Governance and Quality

Enabler 8. Impact Evaluation and Learning

Success Outcomes

Health Literate activated citizens

Trusted teams

Activated and resilient workforce

Improved Population Health metrics

Reduced Inequities of Health Outcomes

Reduced demand

Within financial envelope

Better Citizen Experience

HOW WILL WE KNOW IF WE HAVE BEEN SUCCESSFUL?

Cornwall and Isles of Scilly Integrated Care System

1. **Health-literate, activated citizens** who have the confidence, knowledge and support to manage their health and wellbeing and make informed choices.
2. **Trusted, high-performing teams** working across organisational boundaries with shared purpose, clear roles and strong local relationships.
3. **An activated and resilient workforce** that feels valued, empowered and able to focus on what matters most for people and communities.
4. **Improved population health outcomes**, with measurable progress on prevention, long-term conditions and overall wellbeing.
5. **Reduced inequalities in health outcomes**, driven by targeted action on the needs of those experiencing the poorest health.
6. **Reduced demand for acute services**, as more needs are met earlier and closer to home through proactive, coordinated support.
7. **Delivery within a sustainable financial envelope**, demonstrating better value through smarter use of collective resources.
8. **A better citizen experience**, characterised by simpler access, joined-up support and care that feels personal, coordinated and respectful.

Draft v1, 29th January 2026

North & East Non-elective admissions by Neighbourhood Health area

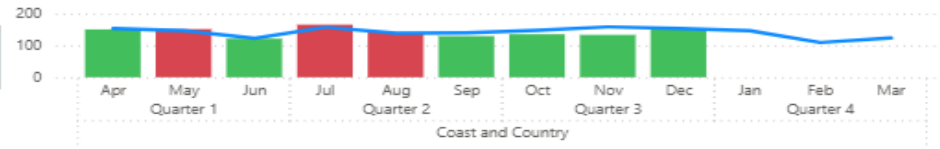
Cornwall and Isles of Scilly Integrated Care System

Information on the content of this page

Reduction in Non Elective Admissions at all main providers for FY 25/26 all age groups

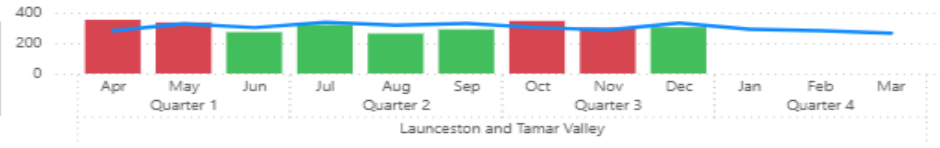
ICA: North and East Cornwall

Coast and Country



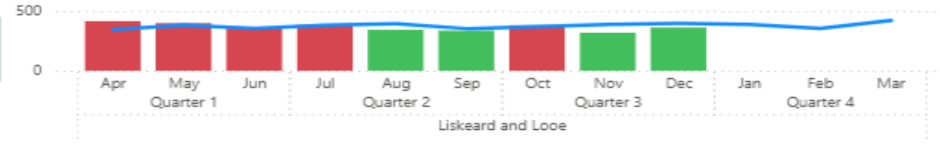
INT	24/25	25/26 Target	25/26 Actual
Coast and Country	1775	1691	1278
Apr	155	153	150
May	149	146	151
Jun	126	122	121
Jul	165	157	165
Total	1775	1691	1278

Launceston and Tamar Valley



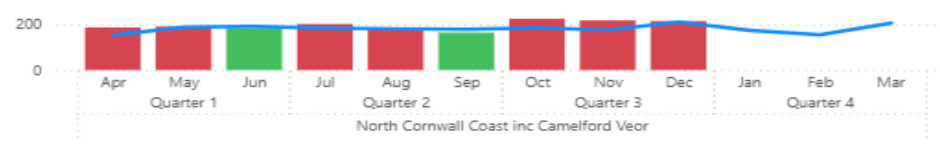
INT	24/25	25/26 Target	25/26 Actual
Launceston and Tamar Valley	3788	3653	2786
Apr	284	282	353
May	329	327	336
Jun	304	302	272
Jul	349	337	320
Total	3788	3653	2786

Liskeard and Looe



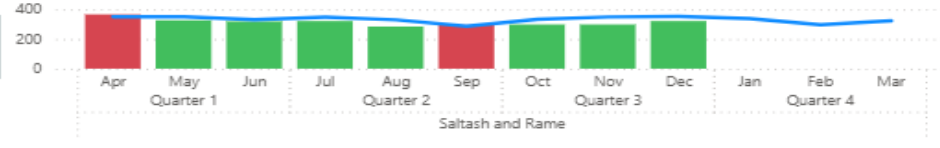
INT	24/25	25/26 Target	25/26 Actual
Liskeard and Looe	4641	4507	3291
Apr	344	343	414
May	380	379	397
Jun	355	354	364
Jul	391	379	382
Total	4641	4507	3291

North Cornwall Coast inc Camelford



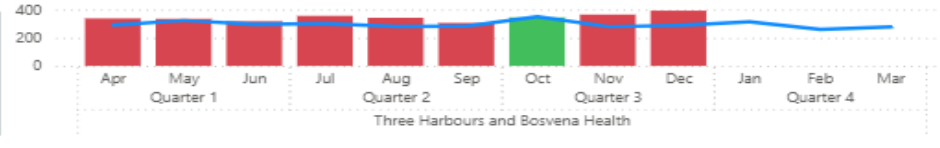
INT	24/25	25/26 Target	25/26 Actual
North Cornwall Coast inc Camelford Veor	2326	2205	1788
Apr	158	155	189
May	194	191	193
Jun	196	193	186
Jul	196	185	204
Total	2326	2205	1788

Saltash and Rame



INT	24/25	25/26 Target	25/26 Actual
Saltash and Rame	4138	4001	2837
Apr	353	352	367
May	353	352	327
Jun	333	331	320
Jul	361	349	322
Total	4138	4001	2837

Three Harbours and Bosvena Health



INT	24/25	25/26 Target	25/26 Actual
Three Harbours and Bosvena Health	3841	3542	3098
Apr	294	290	338
May	327	323	335
Jun	300	296	318
Jul	325	302	356
Total	3841	3542	3098

Neighbourhood Framework
Reporting Metric

March 2026

GOAL 01

Improve Health Outcomes

Deadline: March 2029

Cohort	National Metric/ Target	Deadline
mid–severe frailty, care home residents, and housebound	• 10% reduction in non-elective admissions & bed days	March 2029
End of life	• 10% increase in number of people identified as approaching end of life • 10% reduction in non elective admissions and bed days	March 2029
LTCs: CVD, Diabetes, COPD, MH, Dementia	• ≥10% improvement QOF outcomes • 10% increase in % of diabetes patients receiving all 8 care processes	March 2029
CYP	• 10% reduction in acute outpatient appointments for under 16s	March 2029

GOAL 02

Improve Access to General Practice

Deadline: March 2027

Cohort	National Metric/ Target	Deadline
GP Urgent Cases	• 90% of clinically urgent patients seen same day	March 2027

GOAL 03

Improve Experience of Planned Care

Deadline: March 2027

Cohort	National Metric/ Target	Deadline
Outpatient referrals	• At least 25% diversion rate via single points of access (10 specialties minimum)	March 2027
RTT	• 70% by March 2027 • 92% by March 2029	2027-29
Follow ups	• 10% reduction in follow up outpatient appointments	March 2027

GOAL 04

Better Urgent and Emergency Care Performance

Deadline: March 2029

Cohort	National Metric/ Target	Deadline
High-Priority Cohorts (frailty/end-of-life/ care homes)	• Keep non elective admission growth flat and move to overall reduction – by March 2029. • Support ED 4 hour standard: 82% by March 2027 85% overall trajectory • Reduce type 1 ED attendances for high priority cohorts.	2027-29
As above	• Reduce category 3 and 4 ambulance conveyances •	March 2029
As above	Improve: • % discharged on the discharge ready date (DRD). • Mean days between DRD and actual discharge.	March 2029

GOAL 05

Improve Patient and Staff Satisfaction

Deadline: March 2027

Cohort	National Metric/ Target	Deadline
Patient experience	• Introduce new PROMs/PREMs in 2026–27 with annual improvement trajectories.	March 2027
People with complex needs	• 95% of people with complex needs to have an agreed care plan – by 2027.	March 2027
Staff Experience	• New neighbourhood staff experience measures (from 2026–27) with yearly improvement trajectories.	March 2027

* The three circles indicate the three geographies, Cornwall and IoS, ICA and INT with **Green** representing data being ready to report, **Amber** – data available but needing adjustment to meet required metric and **Red** – either not captured or not currently available.

PHM – Principles from National Guidance

Neighbourhood health works as a joint endeavour between NHS and local authorities, emphasising upstream prevention, proactive care, understanding local needs, and reducing inequalities.

Population Health Priorities 26/27

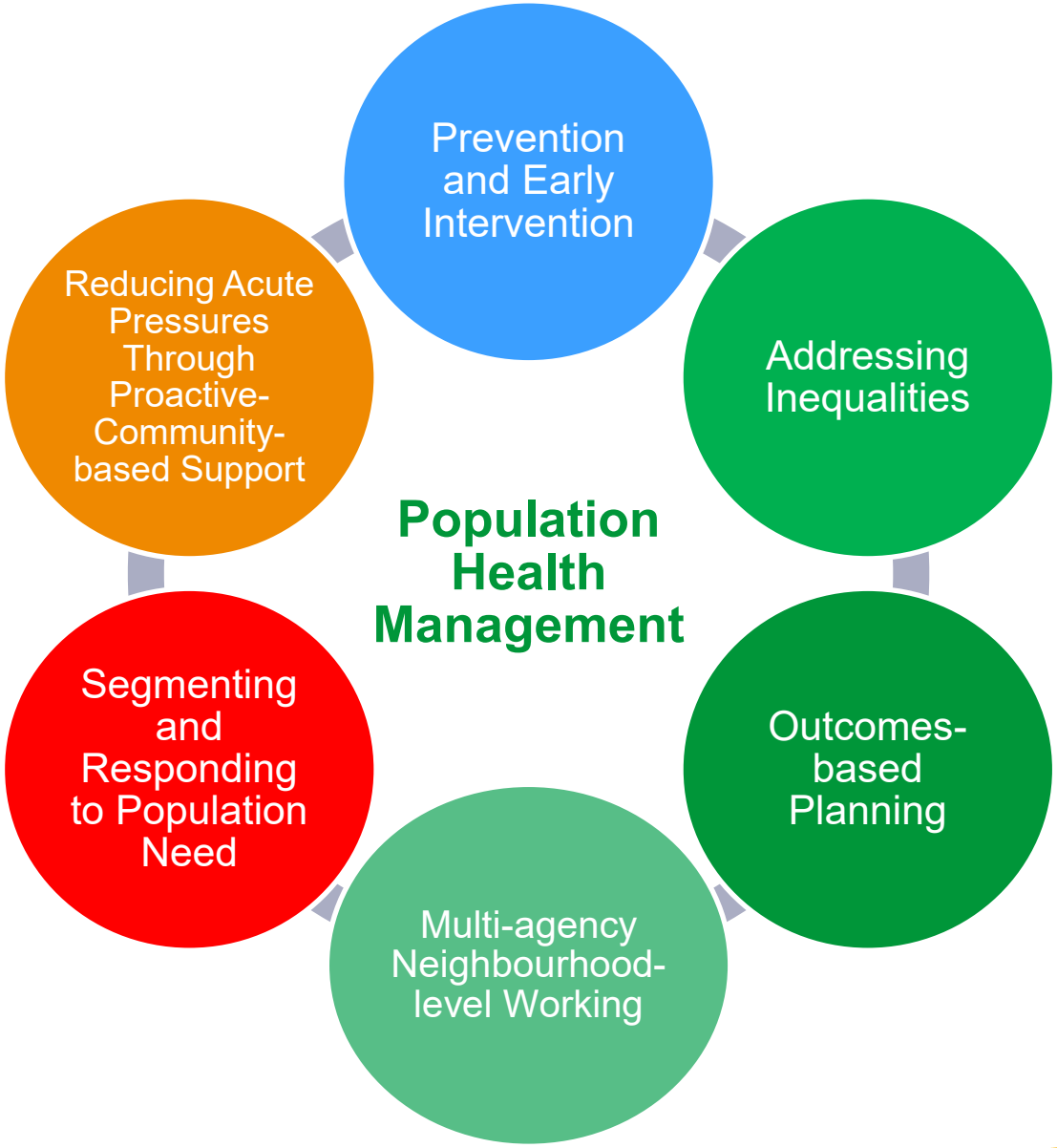
Shift to Prevention
- CVD
- Diabetes/ Weight Management
- Respiratory
- Falls and Frailty
- Smoking
- Oral Health

Enhance PHM approach
- ODD sign-up
- Data dashboard
- Population Segmentation
- Risk Stratification
- Training and development
- Integration with other sources of data

Support cultural change
- Organisational Development
- Anchor Organisation / Social Value
- VCSE development/social prescribing
- Support developing neighbourhoods
- Population Health Measurement Framework embedded and BAU
- Trauma informed Commissioning

Reduce Inequalities
- Core20+5 monitoring and reporting
- EQIA
- Digital Inclusion
- Inclusion Health Framework (incl ASR, GRT, Homeless + Veterans)
- Sharing and learning/ good practice

Population Health Management – Summary Diagram



PHM Enablers in Neighbourhood Health

One Devon Dataset Access (ODDA)

- Population segmentation
  - Supports neighbourhoods to understand the different needs of their population and tailor services and investment
- Risk stratification
  - Identifies individuals at risk of experiencing an adverse health outcome to support direct patient care interventions
- ODDA pulls data from across the Devon System - currently 82% of population covered and rising with primary care
- Introduction - PHM Dashboard - Power BI
- Email d-icb.onedevondataset@nhs.net to access

ODDA – One Devon Dataset Access

Introduction

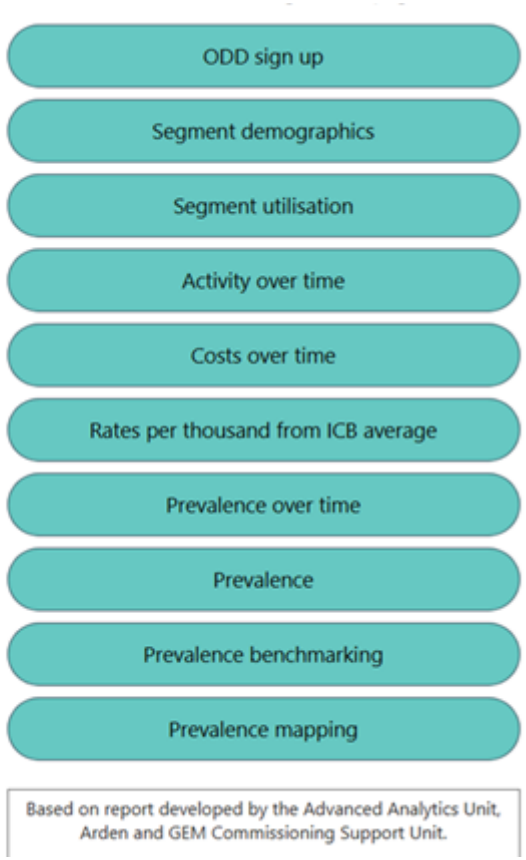
This report utilises a scalable population segmentation model and key data assets across the health and care system. Supporting geographies to understand their populations and proactively target initiatives. It allows local comparison across PCNs and GP Practices for specified cohorts.

The report includes 3 main components.

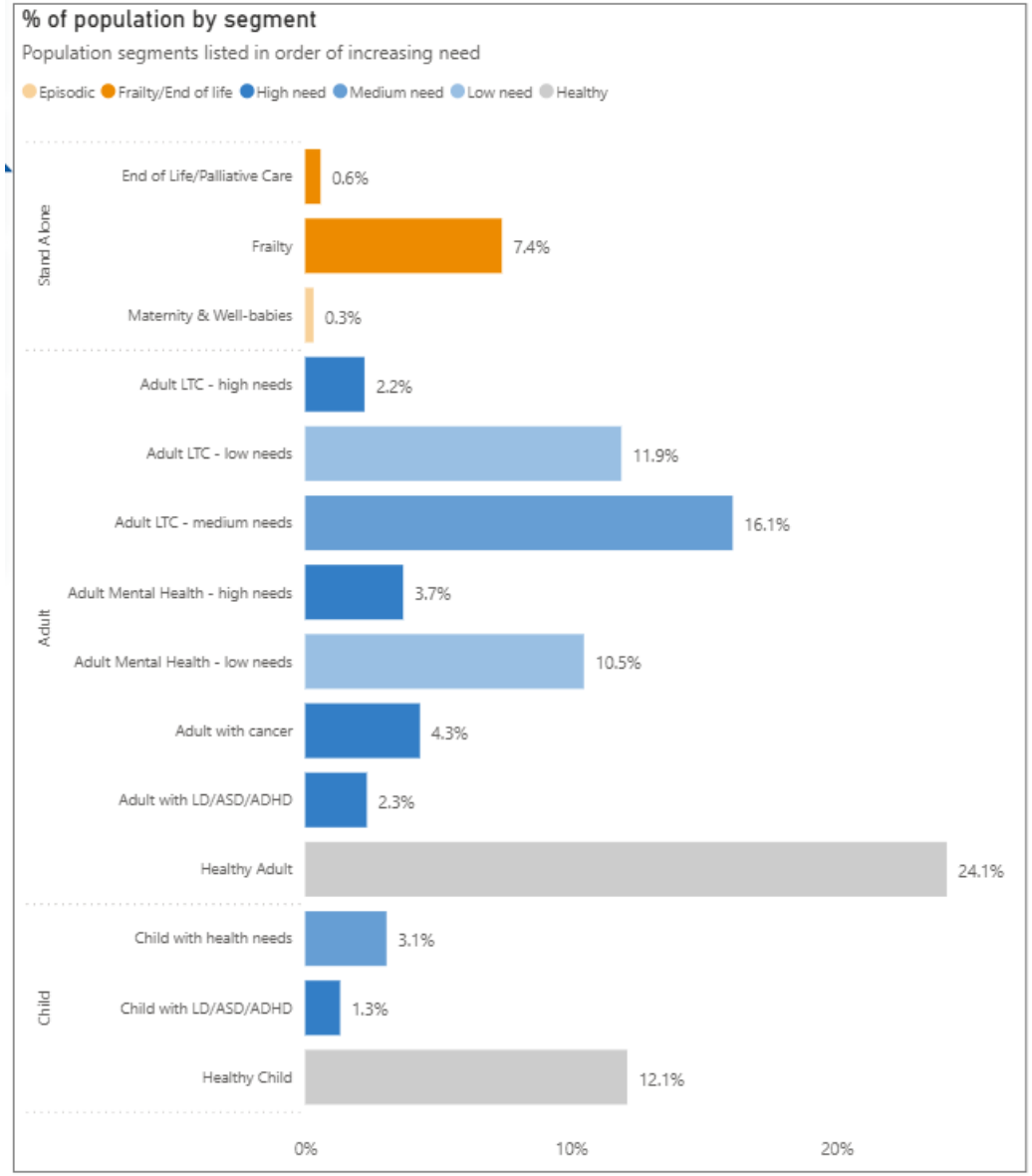
Population Segmentation
Understand how a population is split across segments of increasing health needs and complexity and how health care utilisation varies across these segments.

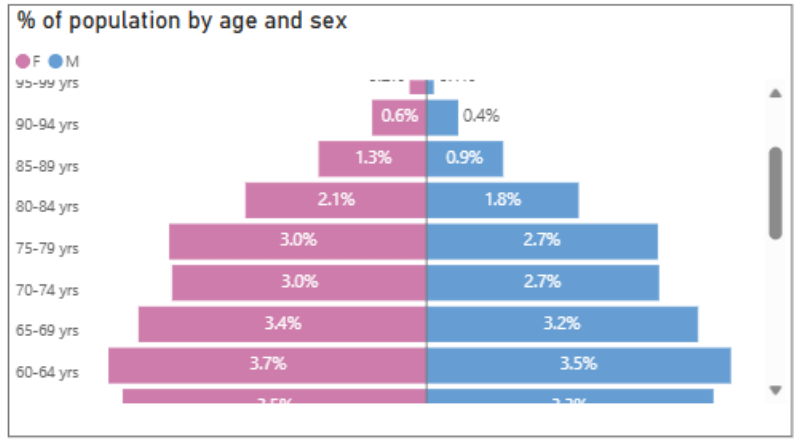
Long term condition and risk factor prevalence
Understand variation in long term condition and risk factor prevalence for specified populations. Understand the prevalence of comorbidities for people with a specific condition.

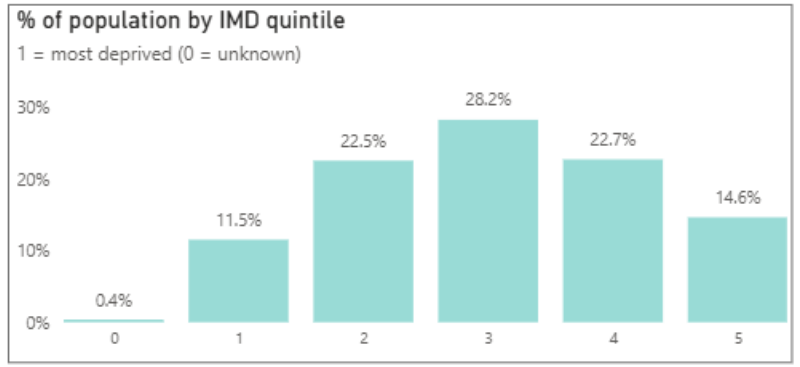
Health inequalities
Understand relative levels of inequality between population cohorts. Inequalities are measured for a range of activity, prevalence and outcome indicators.

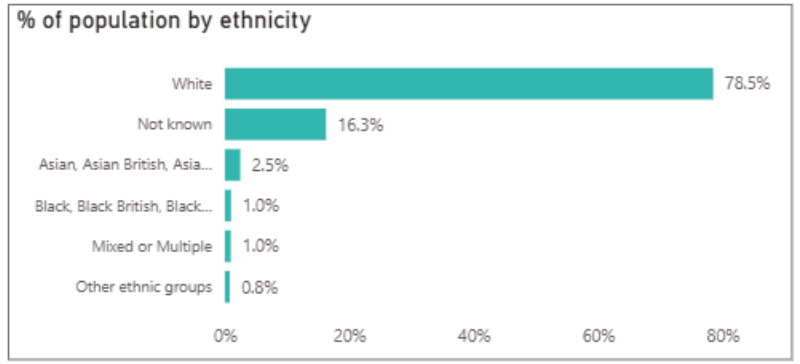


Segmentation









Reports Supporting Population Health Management

A neighbourhood-led approach to improving health equity: drivers

NHS 10-year plan's ambition for neighbourhood level working that empowers communities to lead local change

The wider determinants of health - housing, income, social connection etc are rooted in neighbourhoods, with communities being diverse and unique across DCIOS

Darzi review – communities must be meaningfully involved in shaping services and solutions for them

Shifting power – it's the right thing to do!

Goal to increase the chances of positive and sustainable impact, but also ensures continuity at a time when there is much change to come in the staffing of health services and local authority structures

A neighbourhood-led approach to improving health equity: the approach

A neighbourhood-led approach to improving health equity: the approach

SHINE community as the vehicle for this?

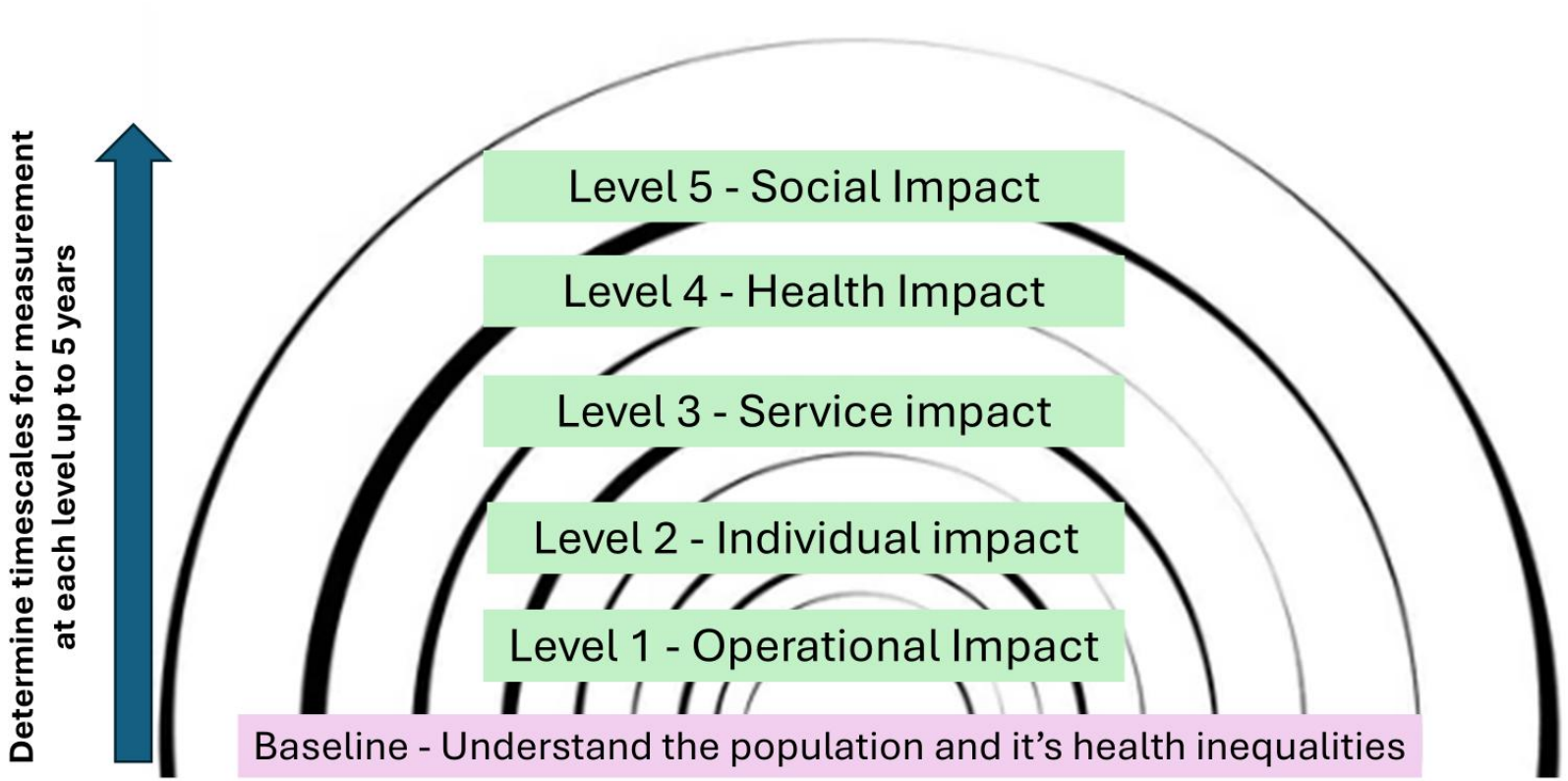
Finding our people: community ‘builders’, residents, professionals

Neighbourhoods and/or communities are the unit of change

Power in co-design and co-delivery: residents and professionals *together*

Celebrating and maximising what’s already available to improve access, experience and outcomes

Outcomes - Population Health Measurement Framework Supporting Long-Term Change



Funding and development

- Population Value Premium - PVP aims to embed prevention into all service development by requiring that at least 10% of any new or revised business case be allocated to prevention-focused interventions. Where direct prevention is not feasible, funds will be redirected to VCSE-led initiatives aligned with Devon's health priorities.

- Investment into Long Term Conditions - development of interconnected Local Enhanced Services

- Investment into training and education, culture and leadership - across primary care and VCSE, linked to LCP development

- Learning from other areas and sharing where change makes a positive difference

Funding and development

- Long Term Investment in VCSE Infrastructure via the Torbay, Plymouth and Devon VCSE Assembly (£6m over 5 years) to match a similar investment in CIOS ICB

- Development of a Devon and CIOS VCSE Brokerage Framework based on a model used by BNSSG ICB

- Development of an Anchor Plan with other large statutory sector providers. One of the aims within the plan is to keep commissioned services within Devon and Cornwall where possible.