Findings from Devon 10 Year Plan Engagement and development of Integrated Neighbourhood team development

October 2025

National 10 Year Health Plan

- 10 Year Health Plan published on 3 July
- Built around the government's three key shifts (community, digital and prevention)
- Aims to reduce waiting lists, deliver more convenient care, tackle inequalities, and more preventative care
- Sets out a new operating model – including "making ICBs strategic commissioners" and delivering the running cost reductions
- Plan says workforce is key and that "staff will be better treated, more motivated, have better training and more scope to develop their careers"

Devon 10 Year Health Plan engagement

- One Devon partners (including Healthwatch) led a bespoke engagement programme to capture the views of the Devon population to inform local priorities and strategy
- The approach was considered as a leading example by regional colleagues

More than 3,400 pieces of feedback

2,353 survey responses

50 workshops hosted across Devon

358 people attended a workshop

More than 700 written feedback postcards completed

More than 220 people recruited for continuous engagement

Devon 10 Year Health Plan findings

Overarching themes

People valued the NHS being free at the point of access

NHS workforce is seen as the most valuable, but most vulnerable, asset

People valued the wide range of services available and how they have helped personally

Address access to primary care and mental health, and reduce waiting times

Satisfaction levels of how the NHS Is run is low (aligned to the national picture)

Funding the NHS sufficiently should be a priority

Devon 10 Year Health Plan findings

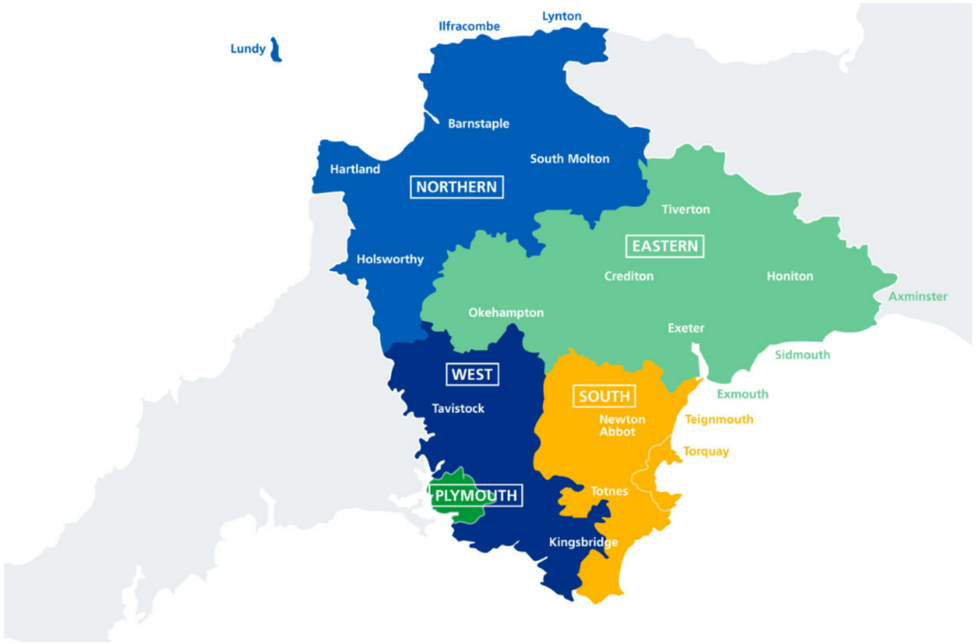
Themes related to the three key shifts

Hospital to community	Sickness to prevention	Analogue to digital
• More investment in front line services and a reduction in management costs • When people access services – their experience is generally positive	• Better access to diagnostic and preventative services • More education and strategies to improve people's confidence in taking ownership for their own health and wellbeing	• Advances in technology will support efficiency, help join up services and improve care • Mistrust in AI and data safety, aligned to concerns about reliability and increasing health inequalities • More joined up approach across health and care needed

Integrated Neighbourhood Team Development

Development of INT - Devon

- Devon is on a development journey to embed Integrated Neighbourhood Teams (INT) across our system in line with national guidance, the 10-year plan and our emerging Health and Care Strategy
- Devon has a range of strong assets and community integrated team models (including examples operating across frailty services) that act as a grounding for this work
- Devon is coordinating work pan Devon through an INT steering group, but driving local discussions through our Local Care Partnership (place level arrangements)



National Neighbourhood Health Implementation Programme – Plymouth Application

Drafting Process

- Huge collaborative effort in Plymouth to pull bid together – daily drafting sessions with multiple partners took place over a 3-week period
- 25 signatures of support received across key stakeholders
- *ICB & PCC, all PCN CD's, Eldertree, POP, Improving Lives Plymouth, St Lukes, Marie Curie, Plymouth Community Homes, Community Pharmacy, HIN, DCC, UHP, Livewell, DPT & Devon LOC*

Bid Overview

- Place: Plymouth
- Population: 290,000; 7 Primary Care Networks & 28 practices (inclusive of areas beyond Plymouth LA Boundary to cover Mewstone & Beacon PCN footprints)
- Aim: to reduce health inequalities and improve outcomes through integrated, neighbourhood-based care.

Key Strengths & Assets

- **Integrated System:** Strong history of collaboration across health, social care, and VCSE sectors.
- **12 Health & Wellbeing Hubs**
- Unique in having a **single integrated community health, mental health, and social care provider**, Livewell Southwest CIC.
- **Data infrastructure:** One Devon Dataset (ODD), risk stratification tools, and shared digital records.

Challenges addressed

- High levels of deprivation (20% most deprived nationally; Stonehouse & Devonport in bottom 1%).
- Significant health inequalities and early onset of frailty.
- Rising demand due to ageing population.
- Homelessness and social isolation.

Programme Goals

- Develop **neighbourhood footprints** aligned with natural patient flows.
- Deliver **joined-up, person-centred** care through Integrated Neighbourhood Teams (INTs).
- Shift care from acute to community settings.
- Improve outcomes for people with **long-term conditions (LTCs)** and complex needs.
- Tackle **social isolation** and promote community resilience.

Commitments & Contributions

- Share learning nationally (e.g. Deep End, VCSE models, digital tools).
- Recruit a full-time **Place Coach and project lead.**
- Use **co-production** and trauma-informed approaches.
- Focus on **digital innovation**, estates planning, and workforce development.

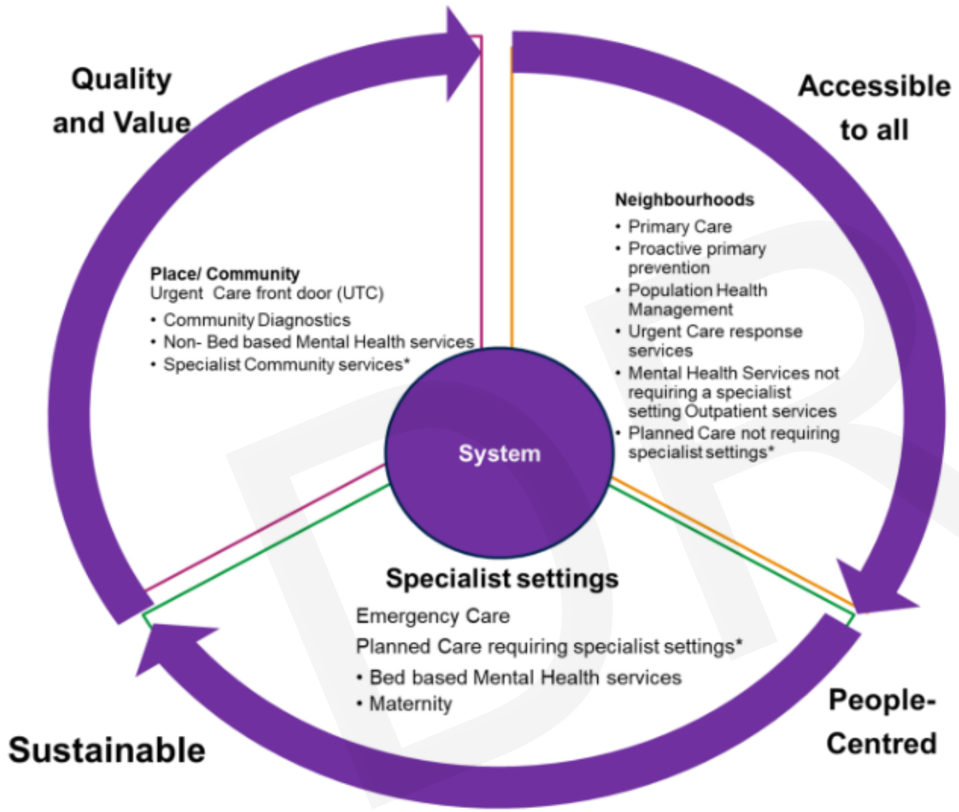
Existing Integrated Working

- **Gateway Hub:** Single point of access for admission avoidance.
- **Community Frailty Virtual Ward:** Proactive, multi-agency support.
- **Deep End Movement:** Targeted support in most deprived areas.
- **Age Positive:** VCSE-led frailty prevention programme

Next Steps

- **Revisit the Foundations** - Clarify and define key milestones to ensure alignment and shared understanding across the programme.
- **Re-engage Stakeholders** - Initiate a structured re-engagement process with all stakeholders involved in the original bid, identifying and addressing any gaps.
- **Facilitate In-Person Collaboration** - Organise face-to-face events to accelerate progress, strengthen relationships, and **co-define neighbourhood footprints.**
- **Identify Pilot Sites** - Select and mobilise pilot neighbourhoods to begin implementing and testing the Neighbourhood Health model in practice.

Devon Health & Care Strategy – Operating Model



- **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 contract.
- **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

Slide contents subject to Devon Health & Care Strategy sign off

Integrated Neighbourhood Timeline - Indicative

2025/26	2026/27	2027/28	2028/29	2029/30
Formation	Commissioning	Delivery	Enhancement	
Development of Place Development of Neighbourhood Working Defined Neighbourhood Footprints Risk Stratification Tool in place	Q1 – Neighbourhood pilots Q3 – Core Neighbourhood Spec Q3 – Procurement Process for Lead Neighbourhood Provider Transfer of some outpatient services to Neighbourhood / place models	Q1 – INT's formally commissioned Q1 – Community Urgent Care and Outpatients (subject to sequencing) delivered through INT's	Q1 – 40% of health activity delivered through INT's	Q1 – INT's commissioned to deliver any activity that doesn't require a specialist site

Next steps 2025/26

- Place maturity assessment / development plans (aligned to current LCP's)
- Developing a clear 'place vision' for INT development – responding to local pressure / population need, but aligned to delivery ambitions and priorities set out in the Health & Care strategy
- Clear development plan for each area
- Agreed Neighbourhood footprints
- Pilots – aligned to guidance ambitions around Long Term Conditions and ambitions to support community urgent care
- Risk stratification tool in place
- Personalised Care & Support Planning – next steps