

Introduction to the new Director of Nursing for Quality

Update on Integrated Care Board priorities
Better Together Nursing Conference

Together
through change

Model ICB Blueprint

In summary

1. In support of the Darzi Review, a Model ICB Blueprint was published in May 2025 which outlined the future role and functions of ICBs. The Blueprint reaffirmed the importance of ICBs as strategic commissioners, with a focus on improving population health, reducing inequalities, developing long-term strategic plans, and ensuring the best possible value and outcomes from available resources.
2. At the time of publication, the Blueprint identified a number of functions that could potentially transfer to other parts of the health and care system over time, subject to further national development, readiness across the system, and, in some cases, legislative change. Subsequent national discussions and refinements to the operating model have provided greater clarity regarding the future role of ICBs. Whilst some functions continue to be reviewed nationally, a number of functions previously identified for potential transfer are now expected to remain within ICBs for the foreseeable future, with ICBs retaining responsibility for delivering their statutory duties and core strategic commissioning functions.
3. The developing national direction continues to emphasise the role of ICBs as strategic commissioners, system leaders and convenors of partnerships, whilst also recognising the need to retain the capabilities required to discharge statutory responsibilities and support delivery of national priorities. The future operating model remains subject to ongoing national development, and we will continue to review our structures and ways of working as further guidance becomes available.

The future of ICB's

What this means for the future ICB model

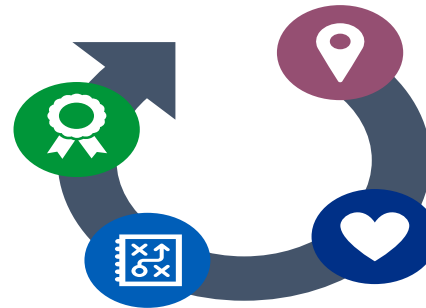
1. In practical terms, the Model ICB Blueprint (the 'blueprint') points to an ICB that is smaller and more strategic with less operational focus. This approach has been incorporated into our both our phase one and phase two structures. In line with the Blueprint, we see the commissioning cycle forming the basis of our cluster's design and operating model:

4. Evaluate impact

Day-to-day oversight of healthcare usage, user feedback and evaluation to ensure optimal, value-based resource user and improve outcomes

3. Deliver strategy through payer functions and resource allocation (deliver)

Oversight and assurance of what is purchased and whether it delivers outcomes required



1. Understand our peninsula context (discover)

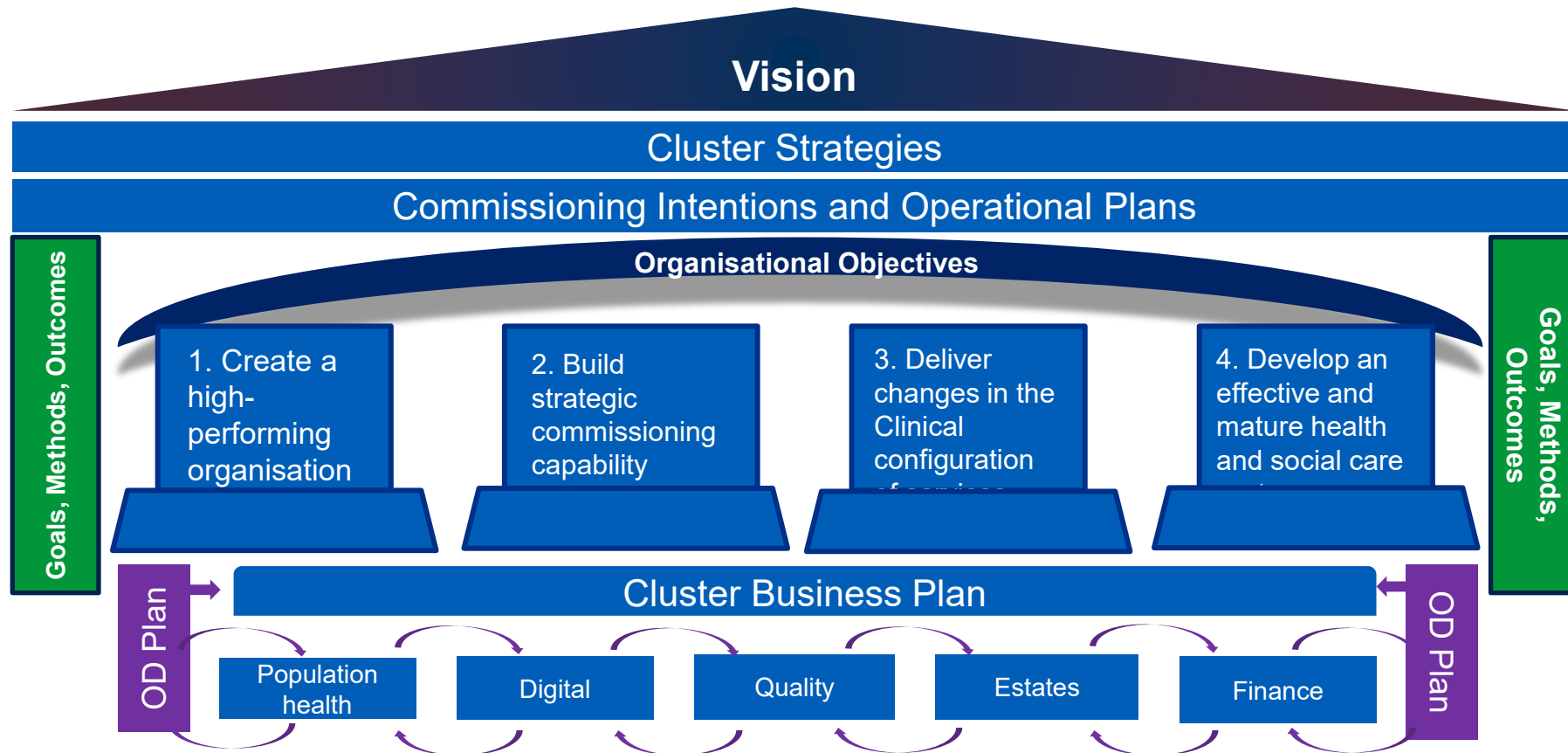
Accessing population needs now and in the future, identifying underserved and at-risk communities and assessing quality, performance and productivity of existing provision

2. Develop long-term population health strategies (design)

Long-term population health planning and strategy and service care pathway redesign to maximise value, based on evidence

ICB priorities

Four overarching organisational objectives have been agreed by the ICB Cluster Board to shape the 2026/27 Business Plan.



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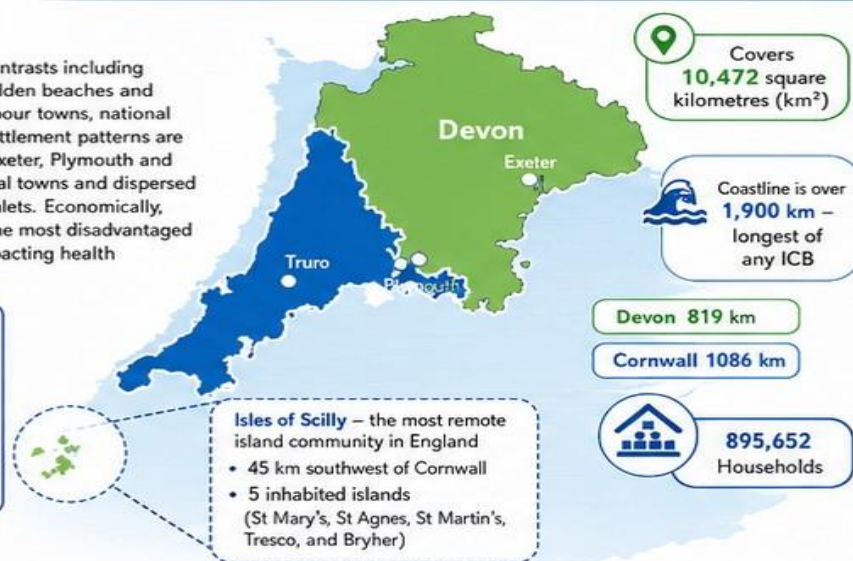
Cornwall, the Isles of Scilly and Devon: a Brief Description

1 Overview

The Cluster is an area of many contrasts including famed landscapes—expansive golden beaches and coastline, soaring fossil cliffs, harbour towns, national parks and other moorlands. Its settlement patterns are no less varied, from the cities of Exeter, Plymouth and Truro to historic market and coastal towns and dispersed rural and coastal villages and hamlets. Economically, affluence sits alongside some of the most disadvantaged areas of England, significantly impacting health outcomes for many.

Local Authorities

- 1 Cornwall Council
- 2 Council of the Isles of Scilly
- 3 Devon County Council
- 4 Plymouth City Council
- 5 Torbay Council



2 Population and Settlements

The population is growing but growth isn't consistent across the cluster.



Population in excess of **1.8m**

- 1 Cornwall – 583,289
- 2 Isles of Scilly – 2,366
- 3 Devon – 842,313
- 4 Torbay – 140,126
- 5 Plymouth – 272,067



2.21m by 2030 – increase of over **3.6%**

2.27m by 2035 – increase of over **6.5%**



Net migration is the leading driver of population growth but is predominantly for economic and lifestyle reasons, not retirement.

Our Cluster is older than the England average with fewer working age adults

	Cluster	England
Start Well (0–24)	26.0%	30.4%
Live Well (25–64)	48.8%	52.2%
Age Well (65+)	25.2%	17.5%

There is geographic variation at both small area geographies and Upper Tier LAs — Plymouth has the youngest population with over 30% aged 0–24 and Torbay the oldest with over 27% aged 65+.



Population density across Cornwall, the Isles of Scilly and Devon is among the lowest in the country

Cornwall **160.9** per km²

Devon **123.7** per km²

Isles of Scilly **125.9** per km²

3 Deprivation

Deprivation is a persistent problem. Whilst the cluster as a whole is not deprived, there are areas where there are very high levels of deprivation and this has not changed for some years.



Around **207,300** people (**11.2%** of the population of Cornwall and Devon) live in the 20% most deprived communities in England.



The proportion of the total population living in deprivation is higher in Plymouth (**26.2%**) and Torbay (**25.9%**).



Hidden rural deprivation is not identified by national measures due to the dispersed nature of rural populations. Rural disadvantage requires alternative measurement approaches that account for scattered settlement patterns, distance-dependent costs, and seasonal variations.



Nearly **94k** children live in relative poverty across the Cornwall and Devon cluster. Child poverty is higher in Cornwall **21.4%** (higher than the England average **19.8%**) and Devon **18.2%**.



In 2024, approximately **87,600 (10.6%)** of households in the cluster were calculated to be in fuel poverty.

4 Health and Wellbeing

Health inequalities continue in areas of deprivation — higher rates of obesity, and other risk factors contribute to earlier onset of comorbidity and disability.

Life Expectancy, Healthy Life Expectancy and Years Lived in Ill Health (2022–24)

Devon (2022–24)	Life Expectancy (years)	Healthy Life Expectancy (years)	Life Lived in Ill Health (years)
Male	80.0	61.7	18.3
Female	84.0	61.6	22.4
Cornwall (2022–24)	Life Expectancy (years)	Healthy Life Expectancy (years)	Life Lived in Ill Health (years)
Male	79.6	60.2	19.4
Female	83.6	60.0	23.6



In our most deprived Local Authority area men live **23.4** years in ill health and females **28.4** years, and both have shorter life expectancies than people living elsewhere in the cluster.

While inclusion health groups are a small proportion of our population as a whole, they experience disproportionately poorer health and opportunity.



People who experience homelessness



People with drug and alcohol dependence



Vulnerable migrants and refugees



Gypsy, Roma, and Traveller communities



People in contact with the justice system



Victims of modern slavery



Sex workers



People who experience Domestic Abuse and Sexual Violence

Our healthcare demands and costs of multimorbidity continue to rise as populations age.



More than **1 in 4** people has 2 or more long term conditions



More than **1 in 10** people aged 65+ have 7 or more long term conditions



Understanding co-occurring comorbidity and risk factors is key in driving prevention and reducing or delaying both conditions and healthcare utilisation. Obesity is a major challenge:

- Plymouth and Cornwall have some of the highest percentages of patients aged 18 or over living with obesity nationally
- **1 in 4** children in reception (aged 4–5) are overweight (including obese) — both Devon and Cornwall are national outliers
- Obesity is a co-occurring condition in over **40%** of all hypertension patients and nearly **20%** of all diabetes patients

Leading Causes of Death and Disease

Identifying key health challenges and disparities affecting the local population supports our focus on prevention, early diagnosis and effective management of chronic diseases, leading to improved outcomes and reduced health inequalities. Applying different lenses to the data shows consistency in our leading conditions.

10 Most Common Diagnosed Long-Term Conditions

- Hypertension
- Obesity
- Asthma
- Osteoarthritis
- Stress Related Disorders
- Diabetes
- Chronic Kidney Disease
- Cancer
- Ischemic Heart Disease
- Atrial Fibrillation

Most chronic diseases / long-term conditions increase with age.

Leading Disease Burden (DALYs)

Living longer but spending more years in ill-health. Main causes across Cornwall, Isles of Scilly and Devon:

- Neoplasms (Cancers)
- Cardiovascular diseases
- Musculoskeletal
- Respiratory infections
- Neurological disorders
- Mental disorders
- Chronic respiratory diseases
- Other non-communicable diseases
- Unintentional injury
- Diabetes and kidney diseases

Life Expectancy Gap

Gap between most and least deprived areas: 5.8 years male and 4.5 female. Devon: 6.7 male, 4.9 female. Over 50% driven by:

	C&IoS	Devon
Males		
Circulatory	23.8%	30.3%
Cancers	19.7%	18.6%
Respiratory	12.1%	14.1%
Females		
Circulatory	22.3%	32.0%
Cancers	10.9%	22.6%
Respiratory	10.5%	20.2%

Premature Mortality – Below 75

- Digestive organ cancers
- Ischemic heart diseases
- Respiratory / intrathoracic cancers
- Chronic lower respiratory diseases
- Accidents
- Diseases of liver
- Other heart diseases
- Cerebrovascular diseases
- Breast cancer
- Lymphoid / hematopoietic cancers

Leading Causes of Death – All Age

- Ischemic heart diseases
- Dementias
- Digestive organ cancers
- Other heart diseases
- Cerebrovascular diseases
- Respiratory / intrathoracic cancers
- Chronic lower respiratory diseases
- Other degenerative nervous system disease
- Influenza and pneumonia
- General symptoms and signs

Risk Factors

- Obesity
- Smoking
- Substance misuse
- Physical inactivity

Priorities for Prevention

Complex conditions, frailty, end of life needs, mental health, and urgent care all require joined-up working — not isolated initiatives. Neighbourhood care provides the shared framework to coordinate services around the individual with a holistic approach to health and wellbeing.

Priorities for Prevention

Priorities have been identified based on:

- Impact on activity & performance (cost)
- Potential interventions available
- Demonstrable impact on inequalities
- Impact on mortality, morbidity & healthy life expectancy

Falls and Frailty

Falls and frailty represent a major, preventable cause of harm, loss of independence and system pressure, with opportunities for impact across all levels of prevention. As people age, frailty and falls risk increases, making this a critical issue for population health and service sustainability. Frailty is a state of vulnerability arising from cumulative deficits.

The Medium-Term Planning Framework, Neighbourhood Health Framework and the 10 Year Health Plan for England all identify people living with frailty as a priority cohort.

As well as being key causes of death and disease across the system, the following also have high prevalence in our frail population:

CVD

Cardiovascular disease affects population health, inequalities and demand. Focus supports prevention, early intervention and improved outcomes.

Diabetes

High prevalence and strong links to inequalities; contributes to CVD, stroke, kidney failure and lower limb amputations.

Weight Management

A key contributor to disease and demand; linked to Type 2 diabetes, CVD, MSK conditions, cancers and poor mental health.

Respiratory

Major contributor to poor outcomes and emergency pressures. Most deprived 20% are 2.5x more likely to have COPD.

Shared prevention focus

The prevention priorities work together: early diagnosis, intervention and neighbourhood care can reduce inequalities, slow progression of long-term conditions and improve healthy life expectancy across local communities.

Prevention • Early diagnosis • Integrated care

How this applies to primary care in Cornwall, Devon and the IOS



The direction of travel

A smaller strategic commissioner, with more delivery through place and neighbourhood

Strategic commissioning

Set outcomes, use evidence and population health intelligence, align resources and assure delivery.

Place & neighbourhood

Integration around natural communities, with stronger local clinical leadership and partnership delivery.

Clinical leadership

Pathways and service change increasingly shaped through clinical leadership, not organisational boundaries.

The organisational change matters only if it enables better care.

For primary care, the opportunity is greater influence over pathway design, neighbourhood priorities and how resources are deployed closer to home.

Our priorities - through a clinical lens

Translating the 2026/27 Business Plan into what matters at the point of care



Prevention & inequalities

Earlier identification and intervention for people at greatest risk.



Neighbourhood health

Integrated teams organised around communities and population need.



Care closer to home

Redesigned pathways with more diagnostics, treatment and support outside hospital.



Avoidable demand

Reduce failure demand, admissions, bed days and unnecessary outpatient activity.



Quality & experience

Safe transitions, continuity, equity, safeguarding and patient experience through change.

Business Plan focus: quality • access • productivity • population health • financial sustainability

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Investing in neighbourhoods

Cornwall @ IoS

- Increase in investment over 3 years
- £6m - £12m - £18m
- Distributed via multi-neighbourhood accountable body

Devon

- 2026/27 £8m
- £3m for acute providers to support community provision
- £1.2m for VCSE assembly
- £3.8m for neighbourhood infrastructure and schemes

Primary care is at the heart of NHS delivery

Strong Foundations

GP appointment rates per 1,000 population exceed the national average across Devon and Cornwall, with strong access and patient-experience measures.

Innovation already happening

Same-day access models, Pharmacy First, population health tools, prevention/frailty programmes and stronger community partnerships

Pressure is real

Variation in resilience, workforce constraints and failure demand created by waits and interfaces elsewhere in the system.

Our job is not to ask primary care to absorb more work.
It is to redesign the system so that work happens in the right place, with the right capability and resource.

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Our population tells us where to focus

The conditions driving ill-health, inequality and avoidable system demand are familiar to primary care

Falls & frailty	Prevent harm, loss of independence and crisis-driven care.
Cardiovascular disease	Prevention, early detection and optimal management.
Diabetes	Strong links to inequalities, CVD, stroke and kidney disease.
Weight management	A major contributor to multimorbidity and future demand.
Respiratory disease	High emergency burden; COPD is strongly patterned by deprivation.

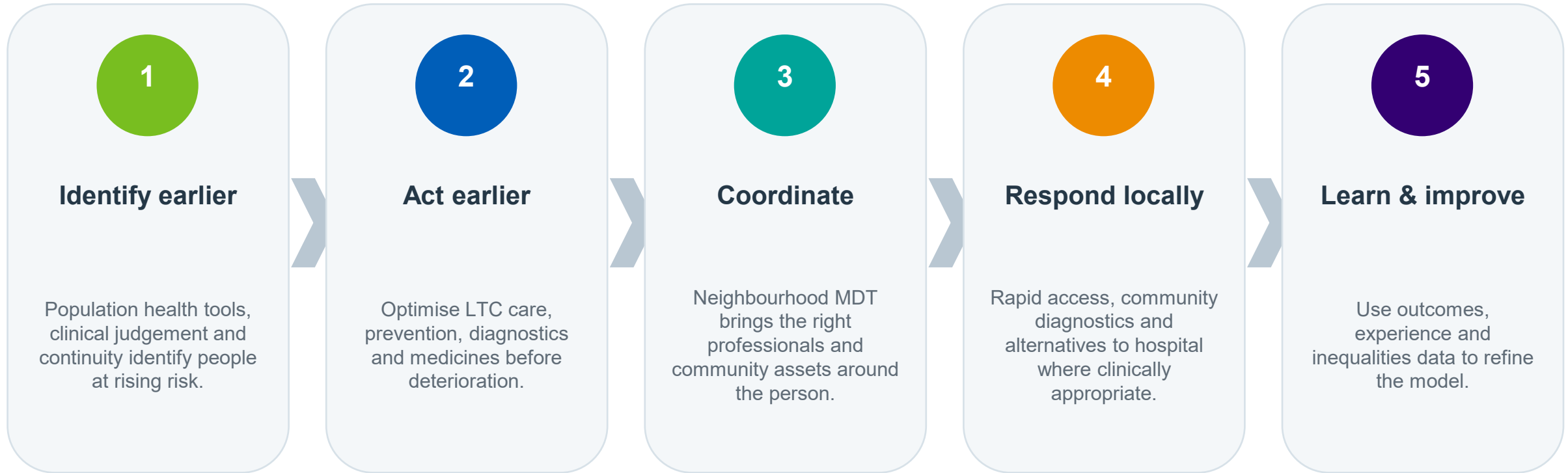
The common response

- Prevention
- Early diagnosis
- Integrated care
- Reduce inequity

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What could this look like in clinical practice?

A proactive pathway from risk identification to coordinated support



Examples already in development: frailty • CVD • respiratory • end of life • high-intensity users

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Right Place, First Time

Reducing avoidable demand must make care easier for patients and clinicians

Failure demand

Repeated contacts created by waits, unclear pathways and hand-offs.

Avoidable admission

Earlier intervention and community response where safe.

Unnecessary outpatient activity

Advice, guidance, SPoA and redesigned pathways.



What the system response needs to include

- Stronger clinical triage and Single Points of Access
- Same Day Emergency Care and community alternatives
- Proactive support for high-intensity users
- Referral optimisation and specialist advice
- Frailty, discharge and Home First pathways
- Capacity and capability following the work

“Left shift” should mean pathway redesign - not workload transfer.

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Clinical leadership: shaping the new model together

Primary care needs to be a co-designer, not a recipient, of transformation

Neighbourhood

Clinical leadership rooted in general practice and multidisciplinary neighbourhood teams.

Place

Collaborative Boards and partnerships bring a stronger, unified primary care voice.

Peninsula

Clinical Leadership Group and strategic commissioning connect pathway redesign to system priorities.

The design principle: decisions should be taken as close as possible to the communities and clinicians affected by them.

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Quality and safety through transformation

As care moves, quality must move with it

Safe transitions

Clear accountability, information flow and escalation across organisational boundaries.

Continuity

Protect relational continuity where it improves outcomes and experience.

Equity

Design for those experiencing the poorest access and outcomes — not the average patient.

Safeguarding & medicines

Build safeguarding, medicines optimisation and clinical governance into new pathways.

Experience & workforce

Measure what change feels like for patients, carers and staff — not just activity.

Quality is not a separate workstream - it is how we judge whether transformation has worked.

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What should primary care expect from us?

Four commitments as we move from strategy into delivery



Design with you

Clinical pathways and neighbourhood models shaped with primary care from the outset.



Remove barriers

Tackle duplication, failure demand and interfaces that consume clinical time without adding value.



Resource the shift

Care closer to home requires the right workforce, diagnostics, digital capability and infrastructure.



Protect quality

Use outcomes, experience, safety and inequalities - not activity alone to judge success.

More influence. More integration. More prevention. More care closer to home - but not simply more workload.

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How will we know if we have been successful?

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.

