Appendix 2

Durham Health and Wellbeing System Plan 2019-2020 Part A - Adults

Adults and Children's System Plans

This is Part A of a system plan which predominantly focuses on adults.

Part B – children's is being developed under the leadership of the Integrated Steering Group for Children and will be finalised and presented in May 2019. It will focus on some of the following key areas:

- Children and Young People's Strategy
- The Integrated Steering Group for Children governance and work programme
- Integrated commissioning approach for children's and the priorities linked to the inspection regimes in children's services.
- SEND
- Therapy services review
- Development of place based 0-19 services
- Maternity services
- Children's mental health
- Joint Autism Strategy

Partners within the Durham System Plan

- City Hospitals Sunderland NHS Foundation Trust - CHS
- County Durham and Darlington NHS Foundation Trust – CDDFT
- Durham County Council – DCC
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group – DDES CCG
- North Durham Clinical Commissioning Group – ND CCG
- North East Ambulance Service – NEAS
- North Tees and Hartlepool NHS Foundation Trust - NTFT
- Tees, Esk and Wear Valleys NHS Foundation Trust – TEWV

County Durham Integrated community care partnership

NHS North Tees and Hartlepool NHS Foundation Trust

City Hospitals Sunderland NHS Foundation Trust

Durham County Council

NHS County Durham and Darlington NHS Foundation Trust

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS North Durham Clinical Commissioning Group

Better health for the people of North Durham

NHS North East Ambulance Service NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Durham Village

If County Durham CCGs were a village of 100 people

6	x	Diabetes
5	x	Heart Disease
17	x	Raised Blood Pressure
3	x	Cancer
1	x	Dementia
1	x	Severe Mental Illness
7	x	Asthma
2	x	Stroke
22	x	Long Term Illness
27	x	Living in 'Most Deprived' Quintile

£1,477
Annual Cost Per Capita

1 Long Term Unemployed

24
Weekly Binge Drinkers

17 Smokers

14
Obese Adults

2
Persons (65+) Receiving Self Directed Support

7.7 years
Difference in Life Expectancy at Birth

7.1 years
Difference in Life Expectancy at Birth

Population Age Breakdown

Under 5s
5 - 18 years
19 - 65 years
66 - 80 years
81+ years

Actual Population: 547,163

Introducing the Taylor family

This is a fictional County Durham family – the Taylor family. However, they face some of the key challenges that a lot of our local communities face.

Supporting and working with the Taylor family to improve health and wellbeing in County Durham are a plethora of organisations. The County Durham Partnership is made up of key public, private and voluntary sector organisations that work together to improve the quality of life for the people of County Durham. The County Durham Partnership is made up of five thematic groups, altogether wealthier, altogether better for children and young people, altogether healthier, altogether safer and altogether greener. These groups work collectively in a range of partnerships including the County Durham Health and Wellbeing Board, the Safer Durham Partnership, County Durham Children and Families Partnership and the Area Action Partnerships. Improving the public's health can only happen by working with other partnerships in County Durham which are a key asset.


Good jobs and places to live, learn and play
Every child to have the best start in life
The Taylors
Mental health at scale
Seven strategic priorities to make a difference
Promoting positive behaviours
High quality drug and alcohol services
Better quality of life through integrated health and care services
Healthy workforce

Introduction

The County Durham Integrated Care Board (ICB) brings together partners in Health and Social Care commissioning and delivery. This forum was established as health and social care partners recognise the need to collaborate to achieve improved outcomes for the population within existing resources. This forum has been proven to be effective in co-ordinating commissioning and delivery activities across the County.

Historically each organisation has had their own delivery plan in line with their governance and assurance requirements. The organisations that are part of the ICB have separate local, regional and national policies, politics, regulators and stakeholders. However these policies and plans impact on the same people and communities in County Durham.

It is recognised by partners that our individual plans are interlinked and that the actions of one organisation will have an impact across the wider health and social care system. For the first time we are bringing together the key components of the separate organisational plans into a single County Durham Health and Wellbeing Plan. This will enable greater involvement from partners and greater oversight as we work to deliver our priorities in County Durham. The ICB doesn't replace governance arrangements within individual organisations, but allows us to have a common view of the issues and priorities across County Durham and ensure that we are joined up as we work to deliver improvements.

The development of a County Durham Health and Wellbeing Plan follows a strong track record of joint working and collaboration between health and social care. The development of a shared plan will strengthen that joint working, but also allow us to demonstrate how effective collaboration is in County Durham.

This plan sets out the key activities that we will be working on together across the next twelve months. The plan aims to set out the context that individual organisations are working in and how this effects that the areas that we need to work on in Durham. We recognise that the landscape in health and social care is rapidly changing and this plan will be need to be reviewed after six months and updated to reflect any emerging priorities.

Work is ongoing to develop a longer term plan that sets out to deliver the requirements of the Care Act, the NHS Long Term Plan and other relevant policy documents. This plan will demonstrate the journey towards greater system thinking in commissioning, delivery, performance monitoring, driving efficiency and improving outcomes for the people of County Durham.

The plan explains the key projects that we are working on together and should be read alongside individual organisational plans and also national policy which is covered later in this report. The plan also sets our how we will engage and consult where appropriate with the public and stakeholders if there are changes to services proposed.

There will be an opportunity in the summer to meet with the Overview and Scrutiny Committee and the Health and Wellbeing Board to examine the operating environment and the priorities set out in this and future plans in more depth.

National & Local Context

There is a wealth of national and local information that we use to form our plans

Many of the key deliverables are set out in national policy documents or in statute

Department of Health & Social Care

Prevention is better than cure

Our vision to help you live well for longer

Care Act 2014

NHS

The NHS Long Term Plan

County Durham Joint Health and Wellbeing Strategy

Director of Public Health Annual Report 2018

A new vision for 'The Taylors' Improving health in County Durham

NHS Operational Planning and Contracting Guidance 2019/20

County Durham Joint Strategic Needs Assessment

Durham Context

We recognise our place boundaries with others in the Integrated Care Partnership and the wider Integrated Care System of Cumbria and the North East, however our Health and Care plan relates to the place of County Durham. This plan helps us meet head on the challenge set for the Health and Wellbeing Board to be a more integrated system to protect the services for the people of Durham; we have strong foundations on which to build in the next 12 months.

The JSNA contains a range of information to help us understand the major health and wellbeing issues of importance locally. This information, when placed in context and linked to evidence, can provide intelligence and insight which, if communicated in the right way and to the right people can better inform decisions. It helps to inform the planning and improvement of local services, and guides us to make the best use of the funding. Durham Insight is an integral part of Durham County Council's Integrated Needs Assessment approach with the main aim of informing and supporting our joint Strategic Needs Assessment, and other assessments and strategies managed by the authority and its partners. Locally it has provided the evidence base for the JHWS and underpinned the development of the 7 priorities that have emerged from this that are reflected in the Taylor family.

Overall health and wellbeing has improved significantly in County Durham but it still remains worse than the England average. In addition, large health inequalities still remain across County Durham, especially with regards to breastfeeding, babies born to mothers who smoke, childhood obesity and premature deaths. The impact of this becomes obvious when looking at life expectancy; a child born today in the most deprived areas of County Durham could expect to live between 7 and 8 years less than one born in the least deprived areas.

Our ambition as a whole system is to work differently and collaboratively with partners across organisational boundaries to best meet the needs of the local population. We recognise there is still more to do, but great progress has been made in recent times with some specific examples below:

- A re-procured Community Services contract is now in place which has helped re-define service delivery and enable greater collaboration in particular to support integration and joint working between health and social care. The new structure reflects the arrangements of the CCGs and primary and social care being built up from the local TAPs (Teams around Patients), to locality and then countywide services. The NHS long term Plan has demonstrated Durham is ahead of the game with place based care

Durham Context

- Durham, Darlington and Teesside NHS mental health and learning disability partnership (formerly accountable care partnership) is now in place and is about improving outcomes for service users through partnership working. It makes sure funding set aside for mental health and learning disability services remains within those services and through the partnership we can provide a more streamlined system.
- We have worked closely with our Ambulance Service (NEAS) and acute provider Trust (CDDFT) to improve access to Urgent and Emergency care and Acute services.
- Work on the Troubled Families project, which encompasses a whole system, whole family approach to improve outcomes for children has achieved to the point where it has been given earned autonomy for the next funding allocation giving more freedom to innovate in this important area of work
- Based on the Blackpool model The Positive Lives initiative delivered through the DCC support and recovery team , funded by the CCGs works with the high intensity users of emergency services and is impacting on the demand on these services

Work is also now underway to develop an Integrated Commissioning approach with the Council and the CCGs to help us get the best quality services for our people through the most efficient use of resources available. Through stakeholder engagement we have started some transformation conversations and feedback from people across the system is they value the opportunities presented to work collectively in the future.

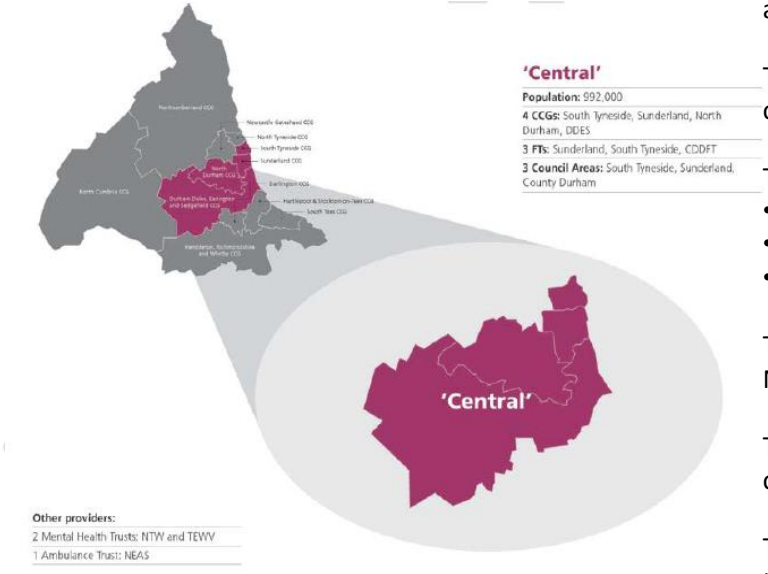
We recognise there is still more to do; we are on a journey and looking to the future, we will be having conversations with our stakeholders with workshops to further develop our thinking.

Boundary Relationships

County Durham sits in the centre of the North East and has relationships with a number of surrounding H&SC commissioners and providers. County Durham is part of the North East and North Cumbria Integrated Care System and is part of the 'Central' Integrated Care Partnership as shown in the diagram.

The NHS commission services based on their registered population i.e. those registered with one of the member GP practices whereas the LA commissions/provides services for the resident population. For people that live at the boundaries of the county this can sometimes cause complexities for H&SC services.

Changes to public health commissioning have meant that pathways have had to be in place for some patients living near the borders or perhaps attending a school in another county.



DCC commissions a number of services collaboratively with other North East local authorities as appropriate.

The two Durham CCGs work collaboratively with the Tees and Darlington CCGs to commission health services for the population.

The majority of County Durham residents receive acute care from three providers:

- County Durham & Darlington FT
- City Hospitals Sunderland FT
- North Tees & Hartlepool FT

There are also contracts in place with four other acute trusts including Gateshead, Northumberland, Newcastle and South Tees.

The majority of mental health care is delivered by Tees Esk Valleys NHS FT with some care provided by Northumberland Tyne and Wear FT.

These complexities can be challenging, but there are arrangements in place to ensure that dialogue takes place with neighbouring mental health and physical health providers, neighbouring local authorities and neighbouring commissioning organisations to ensure that pathway are smooth and effective.

Public Engagement and Consultations

Partners are committed to working together when engaging/consulting with the public and stakeholders in future wherever possible and we aim to develop a system plan that joins up engagement and consultation activities across County Durham.

The plan will focus on broad ongoing engagement activities for some of our key project areas such as access to services, improving care for frail and elderly care , primary care, outpatient care as opposed to issue specific engagement. We feel that this approach will help the public and stakeholders to have a greater understanding of the need for service development and improvement across the NHS and Local Authority.

This will not replace any of our formal duties to inform, engage or consult with stakeholders and the public, but will ensure that a broader range of patients views can be considered.

We will inform:

- When there is a temporary change that would only affect current users and they wouldn't be aware of the change i.e. short term/temporary change in hours of opening for a service

We will engage:

- When we are considering changing the way a service is delivered or when we want to develop alternative options for service delivery. We need to secure input before we develop the options to understand what users/carers/staff think about the services

- Where substantial development or variation changes are proposed

We will seek views of Health Overview and Scrutiny and ensure appropriate communication takes place in all circumstances

Public Engagement and Consultations

Quarter 1

- Learning disability commissioning Strategy
- Shotley Bridge Hospital - engagement
- Urgent treatment centre staffing model – engagement
- Stroke rehabilitation – engagement
- Ward 6 inpatient Services - engagement
- Pre consultation engagement Sunderland and South Tyneside Path to Excellence Phase 2
- Clinical Strategy – Hospital Services, South Integrated Care Partnership – engagement

Quarter 2

- Stroke rehabilitation
- Ward 6 inpatient Services
- Pre consultation engagement Sunderland and South Tyneside Path to Excellence Phase 2

Quarter 3

- Mental health rehabilitation and recovery services – engagement
- Shotley Bridge Hospital - consultation
- Sunderland and South Tyneside Path to Excellence Phase 2 - consultation

Quarter 4

- Mental health rehabilitation and recovery services – engagement

Shared Agenda

Finance

- The financial landscape across health, social care and public health is challenging with all partners experiencing increased costs and the need to ensure more effective and effective allocation of budgets through greater efficiencies.
- Some examples that contribute to this are:
  - Continued impact of austerity
  - Potential cut to the public health grant circa £19 million
  - Above inflation pay awards in the health sector
  - Efficiency targets set nationally for the NHS
  - Growing demand for services to meet the needs of the population, particularly in hospitals
- Partners are careful not to shunt costs to on another and work to achieve better outcomes from the County Durham health and social care £.
- Some examples of work programmes to support this are:
  - Ensuring the sustainability of hospital based services
  - Transforming community services around the health and social care needs of patients and to support the effective use of hospital services.
  - Reforming the out patient system to ensure a focus on clinical outcomes and improved
  - A focus on prevention and the longer term aim to improve outcomes
- A finance sub group of the Integrated Care Board is established to support a greater understanding of financial planning across health and social care.

Workforce

- There are significant workforce challenges across health and social care in Durham and across the country. There are shortages of GPs, social care staff, nursing, therapies and a number of medical specialities.

- Some key programmes are already in place to address some of the challenges:
  - GP and practice nurse career start scheme
  - Regional international GP recruitment scheme
  - Social care academy
  - Bid for a work programme to support organisational development across community health and social care
  - Mental health time to change workforce group.

- There is more to do regarding workforce. Partners are establishing a group in 2019/20 to ensure an even greater focus on plans to address shortages and the capacity and skills needed to support the long term plan and service transformation.

- In relation to NHS workforce planning Health Education North East is working with partners in County Durham to support plans regarding medical, nursing and therapy shortages.

Shared Agenda

Digital and Technology

- Digital and technology are key enablers to support delivery of the plan and longer term service transformation.

- Some examples of key schemes for 2019/20 across partners include:
  - Expansion of the digital programme in care homes to enable access to records by primary care and social workers, support for prescribing and remote monitoring of people with long term conditions.
  - Continued access through the roll out of the great north care record.
  - Roll out of e-consultations in primary care
  - Development of the replacement to the SIDD system
  - Development of the electronic patient record system business case for acute services
  - Liquid logic
  - Proposed re-procurement of the health record system in acute services

Estates

- An estates group has been established with all partners across health and social care. The purpose of the work is:
  - shared planning of estate utilisation
  - Ensuring effective use of current estate and reducing costs for all partners
  - Ensuing estate plans support the transformation of community and primary care services
- Continue to explore shared use estate developments, key examples implemented:
  - the Lavender Centre in Pelton
  - Lanchester Medical Centre
  - Care coordination centre
- In relation to the estate plan in 2019/20 some key projects include:
  - Engagement in early 2019 and consultation later in 2019 on options for Shortly Bridge Hospital
  - Planned closure of Crook Health Centre
  - Proposed closure of Kepier Clinic
  - Relocation of clinical services from Dr Piper House in Darlington for Darlington Memorial Hospital
  - Business case for UHND Emergency Care Centre

Shared Agenda

Quality

Quality and effectiveness of primary, community and secondary care in collaboration with our partners focussed on remains at the forefront of our priorities:

- Learning and sharing across the Durham System to support improvement
- Reducing the incidence of avoidable harm across the system
- Working with partners to achieve the best clinical outcomes for our population (for example, working with Local Authorities to support effective, efficient and high quality Continuing Health Care outcomes, supporting the implementation of the Enhanced Care in Care Homes strategy and reducing rates of Healthcare Acquired Infection (HCAI) across all provision
- Ensuring the best patient experience, supporting the implementation of patient experience forum
- Supporting the population in promoting patients to become actively involved in their own care and treatment

System Performance

As a system we will continue to focus on delivery of the constitutional targets and improve the health outcomes, against key standards, for our population.

There are some priority areas that we are focused on but not limited to as partners identified below:

- Cancer 62 day - will require a collaborative approach as the standard has not been consistently achieved by all provider organisations.
- Permanent admissions of older people (aged 65 years+) to residential/nursing care homes per 100,000 population.
- Non-Elective admissions/100,000 population
- Percentage of older people (aged 65yrs+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Delayed Transfers of Care (DToC) delayed days per 100,000 population
- Improving access to physiological therapies
- Improving mental wellbeing for people of all ages, including suicide prevention and reducing loneliness
- A&E 4 hour standard
- Ambulance performance standards

Key schemes across County Durham

Prevention

Promoting positive behaviours

Name of scheme: Embedding A Wellbeing Approach **Partner(s):** Whole system **Scheme dates:** January 2019 onwards

Need for the scheme: Taking a whole-system approach to population wellbeing reflects the need for coordinated collaborative delivery across a wide variety of sectors to create an environment that is consistent, interdependent and responsive to individual need; recognising people's life circumstances are not static and their support needs are often not singular or linear. This approach ensures provision is underpinned by population needs and not defined by service criteria, reflecting that key pillars of wellbeing such as self-efficacy, autonomy and health are not equally distributed across society.

Aim and benefits of scheme: The development of our wellbeing model will be guided by a set of principles. These will inform the review of relevant wellbeing services. They include the following:

1. Based on need, assets and evidence based interventions
2. Building empowerment, resilience and capital through community led and co-produced solutions
3. Reducing health inequalities through a life course approach that considers prevention and early intervention at every opportunity
4. Building on our successes
5. A Whole System Approach to population wellbeing
6. Value for money and collaborative commissioning
7. Aligned to our local health and wellbeing strategies.

Name of scheme: Children's mental health and resilience **Partner(s):** Whole system **Scheme dates:** April 2020

Need for the scheme: The County Durham CYP MH local transformation plan (LTP) takes a Thrive approach which ensures we start at the point of promoting good mental health and developing protective factors such as building resilience in children and families. There are currently good programmes of work in place across County Durham operating at an early help stage such as parent peer support and children's bereavement support but these are short term funded. Young people who experience a complex bereavement are known to be at greater risk of self harm and suicide. By ensuring effective bereavement support is in place for young people who are more vulnerable they can build their coping mechanism's to consider alternative coping strategies to self harm and can avoid suicidal ideation. If these lower level mental health support services are not in place the risk is that parents are less able to manage young people's mental health issues at home and needs are escalated to acute treatment services such as Child and adolescent mental health services . The LTP seeks sustainable funding for these two short term contracts. In addition to this County Durham will be submitting a wave two EOI for trailblazer funding when the call is announced which would provide additional investment for young people wrapped around school and FE settings..

Aim and benefits of scheme: Maintaining children's mental wellbeing, intervening early through evidence based interventions known to work, young people reporting improved wellbeing, fewer young people attempting to take their own lives

Prevention

Promoting positive behaviours

Name of scheme: Smoking in pregnancy **Partners**: Whole system **Scheme dates:** April 2020

Need for the scheme: At 18.4% across Durham we have higher than national numbers of women still smoking at time of delivery. This is unevenly distributed across County Durham with more women in deprived communities still smoking demonstrating significant inequalities. There has been great efforts made to reduce this % and the trend line is going in the right direction. However to achieve the national ambition of less that 6% of women still smoking at time of delivery by 2022 there is a significant amount of work to do across all partner agencies. County Durham has established a multi disciplinary steering group to drive an action plan forward to tackle the inequalities – working under the regional local maternity system (LMS). Work this next year includes improving ownership of the issue in maternity services, changing the narrative to a one of addiction and treatment, workforce development and better capturing of data to drive improvement.

The stop smoking services will also be reviewed during 2019/20 to ensure it reflects local need.

Aim and benefits of scheme: Fewer still births; fewer neonatal deaths; fewer low birth weight babies; better outcomes for mum

Name of scheme: Obesity / healthy weight **Partner(s):** Whole system **Scheme dates**: April 2020

Need for the scheme: County Durham has 23.7% reception age children and 36.2% of year 6 children with excess weight; at present these % are not reducing. We also have over two thirds of the adult population estimated to be overweight. The whole system healthy weight action plan sets out the work to be achieved which for the next year includes a focus and commitment to preventing children from becoming overweight in the first place through dedicated work during maternity and early years. Significant work is underway and must continue on changing the lived environment such as work on fast food takeaways, workplaces through health at work scheme, active travel and extensive work in schools such as the promotion of Active 10,20,30 (daily mile). Work is also linked to the County Durham child poverty plan and supporting out of school activities to include healthy food. Work with culture and sport is critical and aligning with the wellbeing approach and social prescribing will happen over the next year.

Aim and benefits of scheme: Excess weight and obesity have both short and long term impacts on the health and wellbeing of people but also impacts upon the economic outcomes of the County due to the known link between increased levels of absenteeism and obesity related ill health. Reducing obesity will in turn reduce the risk of type two diabetes, risk of cancer, risk of CVD and also risk of poor mental health as there is a strong association between obesity and depression.

Mental Health

Mental health at scale

Name of scheme: Recovery Approach **Partner(s)**: TEWV **Scheme dates**: April onwards

Need for the scheme: This is a TEWV-wide priority to change our processes and culture to support a personalised, well-being focussed approach to care. It will help service users find connectedness, hope, identify, meaning and empowerment. There is a need for this because traditional service delivery did not always focus on individual service user's goals were, or what would best sustainably support their wellbeing. We have also identified that care planning has in some cases become a bureaucratic exercise which is not assisting service user recovery nor informing the treatment and support offered by staff.

Aim and benefits of scheme: Outputs are continued increase in courses available at the Durham Recovery College and Recovery College Online, and service users become students at both of these. Increase in number of "expert by experience" roles in the Trust and peer workers. Delivery of a new way of developing and recording care plans. These outputs should lead to benefits such as an increase in patient satisfaction and improved clinical outcomes.

Name of scheme: Right Staffing **Partner(s)**: TEWV, Sunderland and Teesside Universities **Scheme dates**: April onwards

Need for the scheme: The NHS Long Term Plan will require an increase in the mental health workforce. However workforce supply is currently constricted and many mental health staff are reaching an age at which they can retire. Therefore we need to improve training, recruitment and retention while also improving the way we plan and roster to ensure the right number of staff, with the right skills are available at the right time in wards and community teams

Aim and benefits of scheme: Outputs include: Increased numbers of mental health and learning disability clinicians (including through increased places at Sunderland and Teesside universities); investment into apprenticeships, including degree apprenticeships to reduce liability for the Apprentice Levy; improvement in establishment and rostering practice, development of more varied clinical career pathways leading to improved staff retention. The aim is to be able to deliver high quality services that contribute to improving people's mental health and wellbeing by having the right staff in the right place with the right skills. Benefits will be consistency of staffing, safe levels of staffing, reduction in use of agency staffing, able to offer full range of therapeutic interventions to more people.

Mental Health

Mental health at scale

Name of scheme: Crisis Hub **Partner(s):** TEWV **Scheme dates**: 19/20 Q1 – Q3

Need for the scheme: Commissioner review and feedback from service users / stakeholders (including Durham Overview and Scrutiny) identified that the current crisis service offer is not consistent across the county, and there can be difficulties for service users regarding access. The existing Crisis House in Shildon does not clearly offer value for money or accessibility to all County Durham residents and the potential for a safe haven model will be explored.

Aim and benefits of scheme: Develop a single crisis team that works across the County, with more consistent quality and improved access arrangements for service uses. Benefits will be improved service user experience and reduced waiting time to access the service.

Name of scheme: Children & Young People (CYP) Neurodevelopmental pathway **Partner(s):** TEWV **Scheme dates:** 19/20 Q1 – Q3

Need for the scheme: To provide streamlined pathways for Children and Young People with autism, and / or with a learning disability to ensure they receive the right support promptly.

Aim and benefits of the Scheme: The output will be to complete an improvement event utilising TEWV's Quality Improvement Methodology to review current pathways and to agree streamlined processes to ensure children and young people receive the right support the first time. The benefits should be reduced waiting time for children and young people with autism or a learning disability to receive an assessment and signposting to appropriate post-assessment treatment or support.

Learning Disabilities

Name of scheme: Review of integrated community service **Partner(s):** Durham County Council **Scheme dates:** Q1-Q3

Need for the scheme: The changes to Learning Disability provision in line with the national Transforming Care agenda has achieved a reduced reliance on inpatient services. This is supported by investment in an enhanced community service and improvements to case management already developed across Durham, Darlington and Tees. A formal review of the integrated community team will be completed to identify any improvements to ensure the service model remains responsive to need..

Aim and benefits of scheme: To undertake a review of the integrated service in Durham to ensure it remains fit for purpose to meet current and future needs.

Name of scheme: Joint LD commissioning Strategy **Partner(s)**: whole system **Scheme dates**: Q1

Need for the scheme: The health and quality of lives of people with learning disability are often worse than other citizens. Therefore, it is often necessary to provide paid public support to address the inequalities people with learning disability experience.

Aim and benefits of scheme: Our shared vision is for all people with learning disability to have a good life in their community with the right support from the right people at the right time. We remain committed to driving up quality and value for money; making changes that result in positive outcomes; responding to local needs and meeting statutory requirements. For this to become a reality we must commission the right types of services from the right providers. Through effective procurement, monitoring, workforce development, partnership working and support, we must ensure that organisations that provide health and social care have sufficient capacity and high calibre staff to deliver the best outcomes for people who use these services and for their families and carers.

Primary Care

Better quality of life through integrated health and care services

Name of scheme: Improving Access to General Practice **Partner(s):** GP Practices, Federations, NHSE, NHS 111 (NEAS) **Scheme dates**: cont. 2019 onwards

Need for the scheme: Improving access to General Practice and Primary Medical Services is a key deliverable of the GP Forward View (2016). It is a key component due to public demand to access primary care services at a time convenient to all.
From July 2019, the Extended Access DES (not the above) requirements are to be introduced across every network, until 2021. The CCGs will support implementation. From 2021 both these access initiatives will be combined.

Aim and benefits of scheme: The aim of the service is to provide the population of County Durham with 7 day access to a GP or nurse appointment at a time and place that better suits individual need. Currently the 7 day services are being delivered from hubs in the community across both CCG areas, appointments are available with a GP, nurse or health care assistant, depending on patient need. This will also impact on the pressure of urgent and emergency care services. Following the independent report from the CCG public consultation on Improving 7 day access to Primary Care the CCG will work with partners to implement any changes identified to the current model. The Durham CCGs will continue to monitor the service to ensure utilisation rates continue to be high and agree actions with stakeholders should this change.

Name of scheme: Primary Care Networks **Partner(s)**: GP Practices, Federations, NHSE, providers **Scheme dates**: 2019 onwards

Need for the scheme: The NHS Long Term Plan describes Primary Care Networks (PCN) as the essential building blocks of an Integrated Care System. On 31 January 2019 NHSE published Investment and evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan. A key component of the framework is the introduction of the Network Contract Direct Enhanced Service (DES), general practice takes the lead role in every PCN. The framework sets out clear guidance to CCGs and practices on their roles in delivering on the PCN component.

Aim and benefits of scheme: The aim of PCNs is to support sustainability for GPs and Primary Care Services and to deliver a whole system Integrated Care System. DDES CCG and North Durham CCG have been supporting practices to work in an integrated way, with community and social care providers. DDES CCG practices have developed Primary Care Homes (PCH), 8 PCH teams working across the CCG and North Durham CCG has developed Teams Around Patients (TAPs), 5 TAPs teams working across the CCG.
During 2019 the CCG will support the current PCH and TAPs to transition to PCNs in line with the requirements of the NHSE framework.

Primary Care

Better quality of life through integrated health and care services

Name of scheme: Recruitment in General Practice **Partner(s):** GP Practices, Federations, NHSE, HEE **Scheme dates**: cont. 2019 onwards

Need for the scheme: Faced with an ageing population living with increasingly complex health needs and a chronic shortage of GPs and nursing staff, primary care is experiencing an unprecedented pressure, including recruitment and retention issues. Workforce transformation based around new models of care and skill mix is developing but not without challenges.

Aim and benefits of scheme: North Durham CCG and DDES CCG have developed a 5 point plan, specifically to deal with primary care workforce challenges;

- GP Career Start scheme – an initiative aimed at attracting GPs at an early point in their career and offers additional personal development for 2 years
- Federated Salaried GPs – CCGs continually work with federations to develop a role for a salaried GP who can work into practices, long or short term
- International Recruitment – in partnership with NHSE, aims to recruit over seas GPs into local practices
- GP Resilience – aims to deliver a menu of support to help practices become more sustainable
- GP Retention Scheme – a package of financial and educational support to help doctors who might otherwise leave the profession, remain in clinical practice

The new GP five year framework addresses workforce shortfall in a number of initiatives. Initiatives include reimbursement for additional roles which include clinical pharmacists, social prescribing link worker, physiotherapists, physician associates, community paramedics. Roles will be phased in starting with clinical pharmacists and social prescribing link workers in 2019. The CCG will support the development of these roles with local PCNs.

Name of scheme: GP Resilience/Quality **Partner(s)**: GP Practices, NHSE, LA, PPI groups **Scheme dates**: 2019 onwards

Need for the scheme: To offer support to practices and NHSE in responding to requests for changes to primary care medical service contracts.
To support sustainability of general practice to ensure patients are able to access save and equitable primary care services across County Durham.

Aims and benefits of the scheme: To follow a formal governance process to ensure the public is consulted on any changes which may result in changes to services whilst supporting sustainability of GP services. In early 2019 the follow requests for contract variations have been agreed or are in the process of consultation:

- Shotton Practice and Station Road Practice to merge and become Bevan Medical Group – approved
- Skerne Medical Practice request closure of branch sites at Fishburn and Trimdon Village – Trimdon Village approved, Fishburn not approved
- Phoenix Medical Practice to merge with East Durham Medical Group – still active
- New Seaham Medical Practice to move out of the main site at St Johns and conduct all services in the Easleigh building – still active
- Bowburn Practice and Belmont and Sherburn Practice, request for change in partnership – still active

In addition the CCG support practices with a programme of resilience initiatives (in addition to recruitment above) which include, support packages for mergers, GP resilience fund applications, vulnerability/sustainability indexing, peer support register. Adults Wellbeing and Health Overview and Scrutiny are chairing a cross party group to look at the resilience issues in General Practice and how the County Durham system can support the agenda.

Community Care

Better quality of life through integrated health and care services

Name of scheme: Intermediate Care Plus Crisis Response **Partner(s)**: DCC, CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The Intermediate Care Plus (IC+) service was developed in partnership with DCC, CCGs and CDDFT. The crisis response service provides a two hour response to patients who experience a health crisis and require fast access to physical health and/or social care services to either prevent admission to hospital/a care home, to support discharge and reablement and to support a return to independence. The model operates differently across County Durham. To support the updated specification and tender process for community services it was agreed that the crisis response element of the IC+ service would be reviewed.

Aim and benefits of scheme: The expected outcomes/benefits of the review are as follows:

- Service to be delivered within a consistent model across the whole of County Durham i.e. staffing structures etc.
- Operate with standardised approach and processes
- Provide absolute clarity on pathways in out of service and the customer/patient journey.
- Recipients of service to be broadened to include palliative care and Mental Health Services for Older People
- Incorporated Trusted Assessment and discharge to assess principles.
- Have sound budget management, including management of care package costs.
- Comply with the principles of the Community Services contract i.e. promote integration and the devolvement of resources to a TAP level wherever possible

Name of scheme: Teams Around Patients Implementation **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: To improve care for frail and elderly patients and to improve coordination of health and social care services. To reduce duplication in the provision of care and to devolve resources to local populations of c30,50,000 patients .

Aim and benefits of scheme: To promote much closer working across all disciplines so ensuring an effective approach that encourages relationships which work to support people who are at risk of losing their independence through ageing and/or frailty and disability. To provide appropriate support in the community to avoid admission to hospital or long term admission to nursing/residential care and to facilitate timely discharge from hospital or care wherever possible.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: Stroke rehabilitation services **Partner(s)**: CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: There is a need to improve health outcomes for those who have had a stroke within County Durham and to ensure that the model of care is standardised and improved across the local geography. NICE Guidance and the National Clinical guidance for stroke suggest that intensive stroke rehabilitation needs to occur in the Community at the earliest opportunity with patients having as few "hand-offs" of care as possible.

Aim and benefits of scheme: Recovery and patient experience will be improved for patients. Engagement with patients has highlighted that the following are priorities for improvement:

- Communication challenges various points in the patient pathway
- Emotional wellbeing and support, particularly post discharge
- Inconsistency of community rehabilitation provision
- People would appreciate a longer period of therapy once discharged from a hospital setting

Name of scheme: Ward 6 Inpatient Rehabilitation Services **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Ward 6 is an inpatient rehabilitation ward based in Bishop Auckland Hospital. Inpatient rehabilitation is delivered in a number of different ways across the acute and community hospital sites in County Durham. The current pathways in and out of ward 6 the inpatient rehabilitation ward are currently being reviewed to ensure that patient's needs are being met in the most appropriate way.

Aim and benefits of scheme: To engage with patients and stakeholders to understand views on current service provision and to develop options for future service provision. To develop a best practice model for inpatient rehabilitation that supports recovery following acute admission.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: Musculoskeletal (MSK) Integrated Model **Partner(s)**: CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Currently, around 20% of GP referrals into orthopaedic out patients are discharged with no procedure, suggesting that these patients could have been treated or assessed within MSK services without the need to attend hospital. Historically, there were two models of MSK services delivered across the county; Tier 1 Physio Hub model (North Durham and DDES) and the Tier 2 Pathway (North Durham only), which stopped short of a fully integrated MSK model by allowing direct non-red flag GP referrals to orthopaedics under a shortened criteria agreed with CDDFT clinicians and service leads. However, there were no contractual levers put in place to manage referrals into orthopaedics and waiting times in MSK have exceeded national standards.
Aim and benefits of scheme: An integrated MSK pathway will deliver a seamless pathway of care via a high quality integrated, multidisciplinary service for patients with MSK conditions. It will ensure that the service is efficient and cost effective by appropriately managing patients at all levels of the service, and provide a single point of entry for all patients with MSK problems . The service will be the only route to specialist care outside of acute trauma and emergencies, and will provide an MDT approach in the triage, assessment and treatment of patients, involving orthopaedics, rheumatology and chronic pain. The service will prevent patients bouncing around the system (fewer avoidable cross referrals) by providing the most appropriate service before an appointment is given – right clinic, first time.

Name of scheme: RightCare Respiratory Project Group **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Non-elective admissions to hospital for people with chronic lung conditions, such as COPD, are high within the county. Many admissions are avoidable if the person's condition was better managed at home and in the community through a range of measures from across the health and care system. Whilst rates of COPD are high due to legacy reasons they were still identified by NHS England as presenting an opportunity to reduce these.
Aim and benefits of scheme: A system-wide project group was established in 2017 from across Primary, Community and Secondary Care to consider what approaches could be undertaken to reduce the non-elective admissions. Since this time the group has expanded to included CDCC Public Health and British Lung Foundation patient representation. In 2019 the group will deliver a new model of diagnostic spirometry which will increase the positive diagnosis of those with COPD and reduce the likelihood of a receiving a 'false-positive' diagnosis. The group is also rolling out a smart-phone / tablet application for the self-management of COPD (MyCOPD) that promotes pulmonary rehabilitation, improved inhaler technique, and self-management through the monitoring of people's self-reported symptoms. The group is also promoting an approach to Shared Decision Making that places improved communication between health professionals and patients are the heart of decision making regarding treatment. The impact of the scheme has been a reduction in the number if non-elective admissions over 2018-19, and this is expected to continue into 2019-2020.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: RightCare Cardiovascular Disease Project **Partner(s)**: CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Atrial Fibrillation (AF) increases the risk of ischaemic stroke, and if left untreated more so. Within County Durham there are just over 13,000 people with AF, of whom approximately 1,300 (23%) are not receiving treatment, with a predicted risk of 89 strokes occurring within this group within the next year. A further 97 stroke admissions are expected by people with no diagnosis of AF, but with multiple stroke risk factors. Variance across Primary Care in the detection and management of AF is significant, with certain practices ensuring all patients diagnosed with AF are receiving optimal treatment, with others not performing as well. There is a clear need to ensure all County Durham residents with AF are diagnosed and afforded optimal treatment to reduce their risk of stroke.

Aim and benefits of scheme: The scheme will firstly focus on the detection of previously unknown AF within the community, and apply evidence based risk assessment scoring to enhance treatment of their AF. Work will also be undertaken to educate staff within Primary Care as to the importance of detection, risk assessment and treatment of AF in the avoidance of stroke. It is envisaged that by using high quality Primary Care data areas of poor compliance with best practice can be targeted to ensure equitable access to detection and treatment for the whole population.

Urgent & Emergency Care, and non-elective admissions

Name of scheme: Urgent Care Treatment Centre Review **Partner(s):** CCGs, CDDFT **Scheme dates: April 2019 onwards**

Need for the scheme: A review and implementation of a new model of staffing across the Urgent Treatment Centres in County Durham. These centres include Bishop Auckland, Shotley Bridge, University Hospital of North Durham, and Peterlee. Both CCG's are in support of the models which will match staffing levels to demand in off peak areas and times.

Aim and benefits of scheme: The scheme will ensure that the service continues to meet the 100% breach standard to feed in to the Trust 95% standard for breaches, and ensure all patients are seen and treated within 4 hours of arrival or within allocated disposition time to maintain patient quality and satisfaction. It will implement the new staffing model in the Urgent Treatment Centres which will generate cost savings and efficient working, whilst improving home visits, speaking to dispositions, booking 111 'face to face' consultations and ensuring the full service is providing more robust GP cover in peak times and meets Urgent Treatment Centre standards.

Name of scheme: Non elective admissions/bed occupancy **Partner(s)**: CCGs, CDDFT **Scheme dates: April 2019 onwards**

Need for the scheme: This is a joint project between CDDFT, CCGs and other partner organisations to look at reducing non elective attendances, admissions and bed occupancy at Darlington Memorial Hospital, University Hospital North Durham and Bishop Auckland General Hospital.

Aim and benefits of scheme: The project aims to reduce the number of patients attending A&E, as well as improve the number of beds available on each site, to ensure improved patient flow. The four main areas of consideration are;

- System-wide A&E Attends Avoidance
- System-wide Admission Avoidance
- CDDFT Internal Processes
- System-wide Facilitation of Discharges

Planned Care, including surgery & outpatients

Name of scheme: 7-day Diabetes Nurse Specialist Team **Partner(s): CCGs,** CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The National Diabetes Inpatient Audit suggested that 1 in 6 inpatients have diabetes. These patients are at an increased risk of prolonged hospital stays due to complications associated with their condition, however most are admitted for something other than their diabetes, i.e. receiving orthopaedic or general surgical care. Currently the Diabetes Specialist Nursing Team covers 5 days, with associated Consultant cover.

Aim and benefits of scheme: The service will extend to 7-day for both Specialist Nursing and Consultant access, and will be available to all departments within the Trust, including Accident and Emergency, and Medical Admissions. It is expected that 75% of all inpatients with a diagnosis of diabetes will be reviewed by the team, with an expected reduction in the average length of stay, and a reduction in avoidable non-elective admissions.

Name of scheme: Ophthalmology Outpatients **Partner(s):** CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Within County Durham there is an over reliance upon Secondary Care for the management of non-complex ophthalmology care, most notably post routine surgery and for patients with stable conditions. There has also been a variance in the clinical pathways that people have accessed for post routine cataract removal depending upon which part of the County they live in.

Aim and benefits of scheme: Community Optometry services are able to provide high level of care for patients with non-complex needs, and therefore a redesign of the clinical pathways for stable glaucoma and post-cataract removal to access these services provides care closer to home, and reduces demand on Secondary Care services to deliver more complex care. A redesign of the post cataract removal assessment pathway will also ensure that all patients are seen in a 1-stop service, thereby eliminating the variance in experience across the County.

Planned Care, including surgery & outpatients

Name of scheme: Dermatology Outpatients **Partner(s):** CCGs, CDDFT **Scheme dates: April** Q1 and 2

Need for the scheme: Demand for Dermatology services continues to grow, with particular use of the 2 week wait referral pathway for people who's needs are found not to be as urgent as first thought. This increasing demand impacts on the ability of the service to appropriately manage both urgent and non-urgent activity. It also impacts on CDDFTs ability to meet cancer standards.

Aim and benefits of scheme: The use of tele-triage prior to an outpatient appointment enables the correct use of the clinics available. This is facilitated by the use of dermatoscopes with smartphone cameras in Primary Care, and a programme of education on what constitutes an urgent referral. There is also the development of Community Dermatology Services and enhancing Primary Care provision that will move activity from Secondary Care to the most appropriate community setting, providing care closer to home.

Name of scheme: Orthopaedic Centre of Excellence – Bishop Auckland General Hospital **Partner(s):CDDFT** **Scheme dates:** Q1

Need for the scheme: The opportunity to better utilise the upgraded theatres within the Bishop Auckland General Hospital site has been an ambition for some time with the ultimate end of creating a true centre of Excellence in Orthopaedic Surgery performed from the site in the future. This in turn would be supported by appropriate rehabilitation services both in the hospital setting and the community setting helping to improve recovery times for patients.

Aim and benefits of scheme: Substantial improvement in Referral to Treatment (RTT) performance for orthopaedic activity; Improved utilisation of theatre capacity on BAGH site.

Planned Care, including surgery & outpatients

Name of scheme: RightCare Genitourinary (GU) Project **Partner(s):** CCGs, CDC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Non-elective admission for Urinary Tract Infection (UTI) within County Durham is higher than when compared with similar populations across the country. The reasons behind this are many with dehydration and misdiagnosis of delirium part of the picture, though any avoidable admission to hospital represents a poor patient experience and an outcome that could have been managed more appropriately. The RightCare GU project has brought together clinicians from across Primary, Community and Secondary Care to tackle this problem.
Aim and benefits of scheme: The project has multiple aspects including an education programme on the importance of hydration in care homes and by domiciliary care providers, the standardisation of catheter care across the health economy, and the appropriate assessment and treatment of delirium using the mnemonic PINCH-ME; **P**ain, **I**nfection, **N**utrition, **C**onstipation, **H**ydration, **M**edication and **E**nvironment which aims to reduce misdiagnosis and ensure optimal treatment is commenced.

Name of scheme: Operational Productivity Opportunities GIRFT / Model Hospital **Partner(s):** CCGs, CDC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The Model Hospital and Getting it Right First Time (GIRFT) are both generating Operational Productivity opportunities to improve patient pathways, for example improving the percentage of lap cholecystectomy which are performed as Day Cases instead of Inpatients.

Aim and benefits of scheme: The Model Hospital and GIRFT ambition is to identify areas of unwanted variation in clinical practice and/or divergence from the best evidence. The work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment.

End of Life

Name of scheme: 7 Day Community Nursing Service **Partner(s):** CDDFT **Scheme dates:** Q1-Q4

Need for the scheme: Previously the Community Palliative Care Nursing Team provided services Monday to Friday, 9-5. This meant that patients whose condition deteriorated at the weekend had very little option in terms of accessing appropriate specialist support, and often led to otherwise avoidable attendances at Accident and Emergency and subsequent non-elective admissions, in spite of patient choice not to be admitted to hospital.

Aim and benefits of scheme: By providing a 7–day service which now covers 9-5 at the weekend the Community Palliative Care Nursing Team are able to support patients at times of need, and where appropriate allow them to remain in their preferred place of residence. The result will allow for fewer unnecessary and avoidable attendance to Accident and Emergency over the weekend, and provides a significantly enhanced quality of service to patients.

Name of scheme: Six Steps for Care Homes **Partner(s):** DCC, CDDFT **Scheme dates:** TBC

Need for the scheme: Provision of training for End of Life care within residential and nursing care homes has been patchy and sporadic, and the resulting outcomes for residents has been poor. As the cohort of care home patients at End of Life grows there is a greater need for appropriately trained staff that are able to meet the needs of this patient group.

Aim and benefits of scheme: The Six Steps approach, which is a recognised best practice End of Life training programme for care homes, which has been undertaken elsewhere in the country, and is being considered by the Palliative Care Task and Finish Group. Data is currently being collated and steps are being made to resource the programme. Appropriate resourcing will allow for a consistent approach to delivery of End of Life care, which has been shown to significantly improve outcomes for care home residents. This includes improving conversations about conditions, fewer attendances at Accident and Emergency and associated avoidable non-elective admissions, and improved clinical skills in areas such as syringe driver administration.

Governance – leadership and accountability

The County Durham Integrated Care Board (ICB) works alongside the Health and Wellbeing Board. The ICB provides senior system wide leadership and accountability to support the vision and direction of travel set out in the County Durham Health and Care Plan. There is an Integrated Steering Group for Children that provides senior leadership across partners in respect of the priorities for children and young people.

There are a number of sub groups, set out in the overarching shared County Durham Partnership structure that support the work of the ICB and Integrated Steering Group for Children.

It is important to note that each partner as a statutory organisation retains accountability to its own governing body.

Within the ICB arrangements outlined, partners have agreed to plan together. A health, social care and prevention planning group has been established, reporting to IBC, with representatives from each organisation. The aim is to support the development of:

- an annual Durham Health and Wellbeing System Plan
- a long term plan taking account of Health and Wellbeing Board priorities and the recently published NHS long term plan.

Governance – delivery

To support and coordinate delivery of the Health and Wellbeing System Plan the following mechanisms have been established by partners. Their aim is to reduce duplication support partnership working:

- **Groups to support the Integrated Steering Group for Children -** with a focus on SEND and other priorities
- **System assurance group** – chief officer level responsible for assurance of delivery including performance.
- **Programme board** – oversight of the key programmes and escalation to the system assurance group.
- **System delivery group** – operational delivery and implementation of plans
- **Planning group** – supports the development of the annual Durham system plan and long term plans.
- **Local A & E delivery board** – oversight of the urgent and emergency care system for County Durham