County Durham Care Partnership

County Durham Place Based Commissioning and Delivery Plan 2020-2025 | September 2020 update

County Durham and Darlington NHS Foundation Trust

County Durham Clinical Commissioning Group

Durham County Council

Harrogate and District NHS Foundation Trust

North of England Commissioning Support Unit

Tees, Esk and Wear Valley NHS Foundation Trust

Contents

Introduction

The County Durham Partnership has agreed the Vision for 2035 with the following ambitions:

- More and better jobs
- People live long and independent lives
- Connected Communities

One of the objectives under 'people live long and independent lives' focuses on better integration of health and social care services.

The Health and Wellbeing Board brings together key statutory services who have a role to reduce health inequalities in County Durham and support people to live well for longer. The Joint Health and Wellbeing Strategy 2020-25 includes a life course approach to its priorities, recognising the importance of mental health and wellbeing and the social determinants of health cutting across all our priorities. These priorities are:

- Starting Well
- Living Well
- Ageing Well

Aligned to the Health and Wellbeing Board, 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 making best use of the resources available. This forum is proving effective in co-ordinating commissioning and delivery activities across the County.

Historically each organisation has had its own commissioning and 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, they all 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. We are bringing together the key components of the separate organisational commissioning and delivery plans into a single system plan which will become embedded within the Joint Health & Wellbeing Strategy. This will enable greater involvement from partners and greater oversight as we work to deliver our priorities in County Durham. The ICB allows us to have a common view of the issues and priorities for health and social care across County Durham and ensure that we are joined up as we work to deliver improvements, as one element of the Health & Wellbeing Board's work.

The development of this plan is possible because of the strong track record of joint working and collaboration between health and social care. The development of our

shared plan will strengthen the joint working and also allow us to demonstrate how effective collaboration is in County Durham.

The Joint Strategic Needs Assessment (JSNA) helps inform the planning and improvement of local services and guides us in making the best use of funding available. It builds a picture of current and future health and wellbeing needs of local people. This plan is underpinned by evidence from the JSNA to shape the joint commissioning priorities to improve health and wellbeing as well as reduce health inequalities in our communities.

Following the development of a one year system delivery plan in the summer of 2019, partners have been working together to develop this five year system delivery plan to inform integrated commissioning and implementation for County Durham. This sets out the key activities that we will be working on together across the next five years. We recognise that the landscape in health and social care is rapidly changing and this plan will need to be reviewed annually and updated to reflect any emerging priorities within the wider context of the Joint Health & Wellbeing Strategy.

This plan sets out to deliver the requirements of the Children and Social Work Act 2017, Children and Families Act 2014, Care Act 2014, the NHS Long Term Plan and other relevant policy documents. It will demonstrate the journey towards greater system thinking in commissioning, delivery, performance monitoring, driving efficiency and improving outcomes for the people of County Durham. It does not however replace or deprioritise any of the statutory responsibilities for inspection that any of the partner organisations currently have, for example in regards to safeguarding or SEND.

It is recognised this plan is an internal document that is being used to hold partners to account on delivery of our priorities over the next five years; however a shortened brochure for the public and wider stakeholders will be developed to more effectively communicate its aims.

This single system plan is structured around the life course, reflecting the spirit and content of the Joint Health and Wellbeing Strategy and the Approach to Wellbeing; this also ensures that prevention is prominent in both the structure and content of our planning. It explains the key commissioning and delivery projects that we are working on together and can be read alongside individual organisational plans and national policy.

This version of the plan (September 2020) is the first update since its approval by the Health and Wellbeing Board in April 2020, and fulfils the commitment of the ICB to provide the Health and Wellbeing Board with a twice yearly update.

Each chapter has been updated with 3 ‘asks’ requested over the summer.

The first is in relation to Covid-19 as since April the country has been in the midst of the pandemic which has impacted on all aspects of our lives, and not least in the health and care services that we all rely upon. Each of the chapters within the plan has included a new section detailing how it is to manage recovery from Covid in the short, medium and longer term.

Secondly, each chapter has 'BRAG' rated each of the schemes and initiatives set out over the coming 4 and a half years using the following definitions:

- Blue – complete
- Red – not started
- Amber – delivery concerns
- Green – on track.

Not surprisingly the pandemic has impacted on some of timings of the schemes and initiatives, and further detail on how can be found within each chapter.

Finally, each of the chapters has identified a number of metrics that will support the development of the County Durham Outcomes Framework which will enable the ICB to monitor and understand the performance of the system.

The framework is based upon the Triple Aim of Outcomes, Experience and Workforce, recognising that these are key factors in the delivery of high quality, safe, effective and sustainable health and care services.

The framework is in its infancy and further work is required to develop the suite of system (rather than organisational) outcomes, however great progress has been made by system partners in identifying outcomes that reflect the interdependence of health and care services.

The plan identifies nine cross cutting themes which are described in more detail in the following sections.

1. Health inequalities and Prevention

The health and wellbeing of the people in County Durham has improved significantly over recent years but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than the England average, with too many of our population suffering from avoidable ill-health or dying prematurely.

The factors that underpin health inequalities are known as the social determinants of health. These include educational attainment, employment, housing, and financial security. If people do not have good educational attainment, they are less likely to find good employment and are then less likely to have good housing. These factors are all interlinked and are considered in the broader Joint Health & Wellbeing Strategy.

As well as understanding health and wellbeing needs and health inequalities we also want to increase the focus on our community assets and how we can use them to help people to remain healthy, both physically and mentally, and to remain independent for as long as possible. This is why a wellbeing approach is being adopted in County Durham.

The aim for our population's health is to have the best start in life and to maintain health as people progress through the life course. To prevent ill health is a major theme within the NHS long term plan. To do this there must be concerted effort in maintaining people's health and wellbeing and prioritizing protective factors. In addition to ensuring the social determinants of health are considered across County Durham, there are also positive health behaviours that will reduce the risk of developing long term conditions such as heart disease, respiratory disease and cancers. The health behaviours that can impact negatively on longer term health which must be addressed through the five year system delivery plan include:

- stopping people from starting to smoke and supporting those who do smoke to stop
- maintaining a healthy weight and supporting those who are overweight or obese to lose weight
- encouraging an active lifestyle and increasing physical activity levels
- encouraging people to drink alcohol within recommended levels and supporting those who are high risk or dependent drinkers to reduce or stop
- promoting good sexual health, and
- the foundation for all of this is promoting good mental health

To ensure County Durham is a health promoting environment, the health and social care infrastructure must commission and deliver effective evidence based programmes which empower people and enable the heathier choice to be the easier choice. This is only possible through the wellbeing approach and to start all health and social care pathways with prevention first. As a County Durham Place Based Commissioning and Delivery Plan, both medical and non-medical approaches to prevention and treatment will be considered.

The social prescribing infrastructure will be developed to provide sufficient reach into all communities. All health and care staff working in County Durham will be trained in making every contact count and will understand the importance of starting from the point of prevention and appreciating the assets in local communities which are complementary to medical interventions. All commissioned services will adhere to these principles.

The ongoing Covid-19 pandemic has impacted disproportionately on certain segments of our population, namely our older population; those with existing underlying health conditions such as diabetes and obesity; our BAME population and those living/working in more disadvantaged circumstances.

The mental wellbeing impact of the pandemic has impacted the whole of society across the life course. Covid-19 has widened health, social and economic inequalities and the County Durham health inequalities impact assessment provides a comprehensive review with key recommendations which will be interwoven into this plan. Recovery will take years and all chapters of this NHS system plan must consider how it has impacted on health and wellbeing and work to prevent inequalities widening further.

2. Approach to Wellbeing

The County Durham Approach to Wellbeing has been adopted by the Health and Wellbeing Board as a means of ensuring all organisations and services consider wellbeing as a common currency; it includes everything that is important to people and their lives. It is designed to promote whole system change and to invoke a culture where the wellbeing of the County's residents is considered in every decision that is made, whether this is regarding decisions about people or places or the systems designed to support them. It is aligned to the County Durham Vision and its 3 aims of More and Better Jobs; People Live Long and Independent Lives; and Connected Communities.

Our approach has six guiding principles which are all underpinned by a strong evidence base. These principles affirm the key role communities can play in supporting their residents and the significant improvements in health and wellbeing outcomes that can result from involving them more in decisions that affect them. A community can be a geographical community or one based on interest such as people living with dementia or asylum seekers.

Our approach has people and places at its heart, supporting the positive development of neighbourhoods, fostering resilience and empowerment through the support offered to everyone, and importantly to those who are most vulnerable.

Our approach highlights the importance of supporting systems – encouraging alignment across agencies and sectors, ensuring services are commissioned and delivered in a way that is collaborative and supportive.

For those requiring more formal interventions or treatment, our approach supports person-centred interventions that are empowering rather than stigmatising. Through commissioners and providers of services across the sectors the model helps to

provide a framework against which we can address the needs of people, communities and neighbourhoods whilst working towards a cultural change. This means ensuring all services self-assess against the model using the structured framework that helps to reflect on current practice and will inform future decisions about how local work and activities can support the wellbeing of people living in communities. Over time it is aimed that the model will be integrated into commissioning decisions, supporting providers to deliver services that place improving wellbeing at the centre of service delivery.

Finally, and most importantly, all our actions need to be informed by local conversations with people and communities – using and building on their knowledge and learning from their own experiences of knowing what they need, what is right and what works for them. In doing this we will also ensure that the model is dynamic, adapting, changing and that it is shaped and developed over time by County Durham residents.

3. Personalised Care

The Comprehensive Model of Personalised Care remains at the forefront of service transformation and health and care delivery within County Durham, ensuring that people have the same choice and control over their mental and physical health that they have come to expect in every other part of their life.

Key to delivering personalised care is moving the conversation with our patients, residents and communities from 'What's the matter with you?' to 'What matters to you?'

It is expected that people's knowledge, skills and confidence in managing their long-term condition is greatly improved by ensuring that supportive conversations allow people to make informed choices and reduce treatment decision regrets.

Whilst there is a specific chapter on personalised care which details some of the goals stipulated within the NHS Long Term Plan, each chapter is required to demonstrate how it is adapting to deliver personalised care. This work is supported by a multi-agency group from across the system and will evolve to include an equal or greater number of members of the public within its membership.

The components of the model remain:

1. Choice
2. Shared decision making
3. Social prescribing
4. Personalised care and support planning
5. Patient activation
6. Personal health budgets

Over the pandemic period, the capacity to reform services in light of personalised care aims has been limited. However, with the restoration of services comes an opportunity to use the tools within the model to advance and sustain change.

Developments within personalised care since the last version of the plan include:

- The appointment of a project lead to work across County Durham and Darlington Foundation Trust (CDDFT) and South Tyneside and Sunderland Foundation Trust (STSFT) to integrate Patient Activation Measures within outpatient settings. This project will reduce avoidable face to face outpatient appointments by adopting new ways such as telephone or video conferencing appointments, and shift resources from providing a one-size fits all model of outpatient care to supporting people to develop the skills, confidence and knowledge on how to self-care and manage their long-term condition
- The rolling out of Personal Wheelchair Budgets to support people in choosing options that suit their needs, rather than being provided with standard issue equipment
- Embedding Social Prescribing Link Workers within every Primary Care Network to support people to access community based services to meet their individual non-medical needs.

4. Mental Health and Learning Disabilities

There are specific chapters in this plan that relate to patients with mental health issues or a learning disability and targeted actions to make improvements in these areas. However, the needs of people with mental health needs and/or learning disabilities cross all aspects of this plan, therefore we will be considering the broader approach to wellbeing and any additional actions we need to take to ensure that the needs of people with mental health issues, learning disabilities and/or autism are addressed when looking at particular areas of service improvement.

The actions within this plan support the aims and objectives of a wide range of local and national strategies, including:

- NHS Long Term Plan and associated guidance, including:
  - Transforming Care which aims to reshape services to ensure more services are provided in the community and closer to home rather than in hospital settings
  - Community Mental Health Framework for adults and older people

- Durham Mental Health Strategic Partnership Board priorities delivered through multiagency workstreams:
  - Dementia strategy implementation
  - Children and young people' mental health
  - Suicide prevention,
  - Resilient Communities
  - Crisis Care Concordat.

- County Durham Commissioning Strategy for People with Learning Disabilities. This strategy has a focus on adults and young people aged 14+, and sets out how the system will work together to deliver better outcomes for people with learning disabilities, increasing choice and control and supporting them to remain living in their communities. The shared vision is for all people with learning disabilities to have a good life in their community with the right support from the right people at the right time.

- Think Autism Strategy. This all-age strategy aims to ensure children, young people and adults in County Durham who are on the autism spectrum live fulfilling and rewarding lives within a society that accepts and understands them.

- Integrated Care System priorities relating to mental health and learning disabilities

For the September 2020 update we have incorporated planning to meet the expected surge of additional mental health demand over the coming months and years that has resulted from Covid-19. Within County Durham a specific Health Impact Assessment, supported by detailed forecasting and modelling work has given a helpful, system-wide picture of the possible impact of the pandemic and lockdown on County Durham over the next 5 years. Broadly speaking we anticipate this will come from:

- New Covid-19 related demand - Mental health support for Covid-19 survivors; mental health impact of lockdown on vulnerable groups ; moral injury amongst frontline staff (all key workers)

- Backlog of clinical activity – work that was not possible due to restrictions (e.g. autism and dementia assessments); increased referrals and demand as a result of referring agencies getting back to normality (schools, GPs, social care etc); delayed diagnosis and access to treatment for more routine/non urgent cases resulting in increasing complexity of case loads

- Exacerbation and relapse of mental health conditions - due to impact of Covid-19 on mental health, continuity of care, bereavement, changes to social conditions,

- Long term impact of the socioeconomic consequences - impact of unemployment, reduced finances, ‘austerity’ and relationship breakdown

Following the undertaking of health impact assessments and modelling of possible demand our plans have necessarily been refreshed and revised. Solutions to meeting this demand continue to be worked upon to ensure we are able to meet these needs.

5. Children

A life course approach to all health and social care must be considered. All children are in the context of family and their educational environment and home setting. The children's strategy for County Durham sets out the vision for children and young people and the priorities for improvement. There are specific chapters in this five year system delivery plan that relate to children with specific and targeted actions to make improvements via commissioning and delivery activities.

The evidence for health and wellbeing improvement for children and young people is sound and commences with the first 1001 critical days which place maternity and health visiting services as central planks of support from a universal perspective. A graded response of support is then required pending the needs of the child and the vulnerability's or health conditions they are living with.

The plan recognises the cross-cutting nature of vulnerability and how the conditions and family circumstances, into which children are born, grow, learn and develop can significantly affect their lives and determine variations in health, wellbeing, attainment and social mobility. These can be further compounded for children and young people with a disability, ill health or developmental difficulties – including mental ill health and special educational needs; children who are vulnerable or of concern by virtue of their identity or nationality or children who care for others.

All chapters of the plan consider the impact on children to ensure pathways and services are life course in approach.

6. Digital

A digital strategy for the North East and Cumbria integrated care system has been published. This document outlines how as a system we will improve how we use Information & Technology Services to meet the needs of care providers, patients and the public, helping care professionals to share information and our patients to manage their health and care. The key priorities for health and social care are to enable people to improve their wellbeing and maintain their independence for as long as possible. Our digital ambition is to use technology to achieve these goals and to provide the best possible experience for people when using health and care services in County Durham.

A cross agency digital group is in place enabling collaboration and development of joint priorities and action planning. The benefit of this approach is being seen in the joint working on the implementation of the Great North Care Record within the County, as well as the joint development of an approach to technology enabled care. We also need to consider the environment and look at ways to reduce unnecessary travel associated with health and care provision where we can and where it is appropriate to do so. We will be considering how we do this in our commissioning and delivery activities to support delivery of sustainable health and care in County Durham.

7. **Finance**

Covid-19 has had, and continues to have, a significant financial impact for all partners in the County Durham system, both in respect of the additional costs of responding to the pandemic as well as the impact of lost income/funding.

From an NHS perspective, temporary financial arrangements have been implemented which are intended to fund additional costs and deliver a breakeven overall position for organisations although at present there continues to be uncertainty around funding arrangements for the remainder of the financial year and beyond. From a Local Authority perspective, whilst some additional Government funding has been provided, the impact of Covid-19 has resulted in significant financial pressures which continue to grow.

This presents a substantial challenge both in managing the immediate financial pressures in the short term as well as the potential longer term impact including additional efficiency requirements and uncertainty around future funding. Managing these pressures will be critical to the sustainability of the Durham system and may involve difficult decisions around funding priorities and efficiency measures.

As we develop and implement integrated commissioning arrangements we will look to achieve the best possible service delivery and improvement for our population, whilst dealing with the significant financial pressures arising from Covid-19 and collectively agreeing efficiency plans as necessary. This will include focussing on reducing duplication and joining up services wherever possible. Where this frees up resources we will consider together the most appropriate areas for investment based on the priorities set out in this plan, including the pressures arising from Covid-19.

There will be a strong focus on delivering services within our available resources and achieving and maintaining financial balance.

There will be deliberate and concerted focus on reducing hospital based treatment and permanent care home admissions, and increasing spend on prevention, primary and community based care and non-medical interventions.

As a partnership of commissioners and providers, there will also be a focus on ensuring the financial sustainability of our provider organisations and working with them to deliver the best possible services within the available funding.

We will also ensure we meet our obligations under the relevant legislation including:

- The need to facilitate markets that offer a diverse range of high quality and appropriate care and support services, to enable genuine choice for people in meeting their needs.
- The need to make joint arrangements to plan and commission education, health and social care provision for children and young people with SEN or a disability.
- The need to secure sufficient accommodation for looked after children within their local authority area.

The Care Act 2014 represents the most significant changes to adult social care in recent times, it provided fundamental reforms in how the law on adult social care will work, placing a stronger emphasis on advice and information, prevention and market shaping. The Act introduced new challenges for commissioners and providers which may also realise opportunities for service development. The Care Act places statutory duties on the local authority to facilitate markets that offer a diverse range of high quality and appropriate care and support services, to enable genuine choice to people in meeting their needs.

Similarly, the Children and Families Act 2014 aims to improve services for children and young people and their families. The Act requires local authorities, clinical commissioning groups and, where relevant, NHS Commissioning Boards to make joint arrangements to plan and commission education, health and social care provision for children and young people with SEN or a disability.

The council also has a duty, as stated in section 22G of the Children Act 1989, to take steps to secure, as far a reasonably practicable, sufficient accommodation for looked after children within their local authority area. The 2010 guidance on the 'sufficiency duty' states that local authorities should have embedded plans, as part of their commissioning processes and through partnership working, to meet the duty.

8. **Integration**

This plan is built on bringing together services and commissioning across County Durham with all of our system partners and stakeholders. We are building on the good start we have made with our Community Contract and the work of our Teams Around the Patient and the development of Primary Care Networks. Commissioning services together will enable us to look at the whole pathway and holistic needs of population rather than look at these in isolation and so further improve the outcomes for local people. By using our collective resources more efficiently we can maximise the impact of the Durham pound to benefit our communities

As would be expected from a strategic integrated commissioning function, we will be seeking to understand the opportunities at every stage of the development and delivery of joined up health and care services. We will be ensuring that we look at a whole person's needs when redesigning or commissioning/delivering new services, removing the boundaries between health and care. We will be commissioning across the full life course and part of the function will be dedicated to children's services from 0-25; this will help us to develop our work to ensure that outcomes for vulnerable children and their families are central and services are more joined up and responsive to meet their needs.

The Health and Social Care commissioning teams came together formally in April 2020 under new senior leadership, just as the pandemic was taking grip. Transformational change may not have started as quickly as intended, however, there has been enormous value in the teams working closely together during times of crisis and the learning from all parts of the team will be invaluable in developing services for the future.

9. Cultural Change

There is no denying system working can be hard, yet across County Durham we have strong foundations on which to build. The successful delivery of this plan will be dependent on a change in ways of working and also the mind set of our commissioners and providers. This may be challenging due to the years of ingrained behaviours and previous ways of working. We will be considering the culture change that will be required to make this successful as we develop new commissioning and delivery initiatives.

We are proud of the dedicated individuals in all of our organisations; they want to do the best for the people of County Durham. We will be maximising the skills available across the wider health and social care workforce, learning from each other and be looking to our leaders to demonstrate positive collaboration from the top.

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

In future there will be an even greater focus on plans to address shortages and the capacity and skills needed to support the long term plan and service transformation. We will also consider the development of new hybrid roles to support development of Health & Social Care in a more joined up way to help reduce duplication.

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 and the development of new roles.

Estates

Work has been ongoing for a number of years between the partners that have developed this plan to ensure:

- Shared planning of estate utilisation
- Effective use of current estate and reducing costs for all partners
- Estate plans support the transformation of community and primary care services
- Support to enable integrated working between health and social care teams

This work will continue across the duration of this plan to achieve the objectives listed above.

Next steps, future plans.

This is the first update to the plan and has been undertaken whilst in the midst of the pandemic. Needless to say this has had a significant bearing on each of the separate plans within each chapter. However, the pandemic has also shown that collaborative working across the County Durham health and care system continues to support service reform, sometimes as a direct result of the pandemic, and at other times in spite of it.

As the new integrated commissioning team continues to evolve, and collaborates jointly with partners in Public Health and provider organisations it is expected that the plan will become increasingly embedded and reflects the system thinking at that time. It is therefore a reflection of a point in time and will evolve and develop between updates.

Next steps include the development of the County Durham Outcomes Framework from that presented here in the 'Triple Aim' section of each chapter, into a meaningful performance framework to assist the Integrated Care Board in supporting effective and efficient services to provide a positive experience for patients and residents of County Durham.

The next iteration of the plan will be submitted to the Health and Wellbeing Board in Spring 2021.

Contributors

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- DCC – Durham County Council
- HDFT – Harrogate and District NHS Foundation Trust
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- NTHFT – North Tees and Hartlepool NHS Foundation Trust
- STSFT – South Tyneside and Sunderland NHS Foundation Trust
- TEWV – Tees, Esk and Wear Valley NHS Foundation Trust

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Maternity

Why is change needed?

This narrative has been updated since the last OGIM in 2019 to update the maturing system and the closer working relationships that have been developed since October 2019

- Better Births (2016), report of the national maternity review found that despite the increase in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade. However, the quality of clinical and emotional outcomes for pregnant women and their families in the UK continues to lag behind those seen in many other developed countries.
    - Stillbirths and / or neonatal deaths are less common than previously, but the need for further improvements to the quality of maternity care has been highlighted by studies showing that:
    - Deficiencies in care are present in at least half of term, singleton normally formed antepartum stillbirths.
    - 76% of babies experiencing major adverse outcomes during labour at term might have had a different outcome with higher quality care
    - There is clear evidence of unwarranted variation in stillbirth rates across the country even when controlling for deprivation and other confounding factors
    - While perinatal and maternal mortality rates appear to have fallen over the last decade, the rates of improvement have 'stalled' over the last 2-3 years
- The population has significant widening health inequalities which have been highlighted in the Due North Health Inequality report (Whitehead, 2014) and are reflected in the maps of English deprivation (https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015) and Public Health England (PHE) statistics (PHE, 2018). Disadvantaged groups are disproportionately affected by health inequalities, with economically deprived and socially vulnerable groups being at higher risk. 7% of women booking in pregnancy are recorded as having complex social circumstances, for example, the North East has a higher than average teenage pregnancy rate and has the highest rates of smoking in pregnancy (16.1% opposed to 10.7% in England) (PHE, 2018). Pregnancy provides an excellent opportunity to support women and their families to make and sustain better health choices which will positively impact on pregnancy outcome, and the current and future health of the mother.
- Breastfeeding is a major contributor to public health. It has an important role in the prevention of illness and reducing health inequalities. If sustained for the first six months of life, breastfeeding can make a major contribution to an infant's health, wellbeing and development and is also associated with better health outcomes for the mother. Improving breastfeeding rates forms part of key national drivers in child health and is highlighted in numerous government policy documents, supported by the evidence (UNICEF, 2018). Across the region 59% of women initiate breastfeeding following delivery compared to 74.5% in other parts of England. Breastfeeding rates reduce quickly up to 6 weeks post-delivery. Supporting women to Breastfeed for longer will have a positive impact on health and well-being across County Durham and Darlington.

Objectives

By 2021

- We will work to ensure 35% of women are booked on a continuity of carer pathway.
- We will ensure women are provided a choice of place of birth including a midwifery led unit / pathway.
- We will launch a digital solution for the service and its users.
- We will roll out SBLCB v2 with the aim to reduce still birth, neonatal and maternal death by 20%.
- We will build on the existing maternity voices partnership and other engagement avenues to drive a co - produced service.
- We will continue to work to reduce health inequalities through supporting safe maternity care and the prevention work wrapped around this

By 2025

- Support enhanced Continuity of carer for 75% vulnerable women and women from BME groups.
- Continue to support Trusts to reduce still birth, neonatal and maternal death by 50% ensuring all elements of SBLCBv2 are in place.
- We will continue to address new health inequalities and transformation challenges as the present to maximise the service for our local families.

COVID – 19

- Short Term
    - The maternity service has made adaptions that have delivered less face to face community care, but utilised technology to connect at some points in pregnancy. However the team have maintained significant contact with women.
    - Home birth was phased but has restarted and the community team are driving an increase in home birth action group.
    - The antenatal education has discontinued but plans to alternatively deliver in development
    - Visiting on the postnatal ward and partners being present at scan has ceased, develop plan to reintroduce.
    - CO monitoring discontinued; scope alternative methodology.
    - All Health visitors face to face contacts to be reinstated by the 1st of September and vaccination programmes in line with national guidance and to continue to safeguard children as the top priority.
    - LMS team has supported vulnerable women in a variety of ways to access help and support online

- Medium Term
    - Develop a value added outpatient community pathway that has removed waste and added value
    - Reintroduce Co monitoring and drive smoking cessation.
    - Reintroduce visitors with reference to the feedback from women and their families and IPC advice.
    - Reintroduce education that is supported by technology and women's needs
    - Develop a business case to introduce a digital platform for data collection, a patient portal and full end to end EPR.

- Long Term
    - Provide a coproduced value added maternity service that removed wastes and improves outcomes.
    - Moving forward, the LMS prevention team will consider the health inequalities and unintended consequences as we progress to the later phases and recovery.

Goals

Implementing the Better Births Vision, especially for vulnerable groups of women in our region, will improve pregnancy outcomes. Providers and commissioners operating as Local Maternity Systems, with the aim of ensuring that women, babies and families are able to access the services they need as close to home as possible, provides the opportunity to bridge the widening health inequality gap.

The quality of care and clinical/emotional outcomes for women and their families in County Durham and Darlington will be at least equivalent to, or even better than, those seen in the rest of the UK. The maternity service will collaborate with women and their families to continuously improve maternity services by supporting and further developing the voice of women via the Maternity Voices Partnership (MVP).

The maternity service will deliver a robust governance framework including working closely with the clinical networks to allow for shared learning following serious incidents, working closely with HSIB and striving to improve clinical outcomes from acute and community care. Key performance indicators will be met in all areas including screening and child health to ensure quality assurance.

The maternity service will support, develop and empower a workforce; that is in readiness for a safe, quality, objective and proactive service of the future.

As the provider and commissioners of the maternity service we will work collaboratively to deliver the maternity transformation programme including striving to book the majority of women onto a Continuity of Carer pathway which will allow women and their families to establish a trusting relationship with their healthcare professional who will have effective oversight of their care. This will improve safety, clinical outcomes as well as better experience of their pregnancy journey.

In addition to the drive for continuity of carer the organisation will meet the majority of the digital challenges by procuring and empowering staff and users to utilise an electronic end to end patient record.

Better Births recognise that care in the postnatal period is equally important as during pregnancy and birth and we improve this service to ensure a personalised plan for women which transfers smoothly between other disciplines. It is important to ensure the mothers return to physical health is supported appropriately and that clear pathways for referral are in place if follow up is required. By 2024 postnatal physiotherapy will be offered to all women if physical complications because of birth are experienced within County Durham and Darlington.

The providers and commissioners will collaborate to fully implement the SBLCB v2 care bundle which will work towards halving stillbirths, neonatal and maternal deaths.

The maternity service has pledged to improve the health of the population by setting the following public health ambitions for women of County Durham and Darlington;

1. Reduce tobacco dependency in pregnancy
2. Increase vaccination uptake in pregnancy
3. Improve perinatal mental health; including mental health assessment, recognition of antenatal anxieties, fulminating deterioration and acute events and in collaboration with the region present pathways to support all levels of mental health needs
4. Reduce alcohol consumption in pregnancy
5. Increase breastfeeding at initiation and at 6-8 weeks, have an accredited Infant feeding strategy (Baby Friendly Initiative).
6. Improve management of obesity and promote healthy weight in pregnancy
7. Increase in Making Every Contact Count

Triple Aim Outcome Measures

Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Reduction in stillbirth and unplanned neonatal admissions	1. Women feel safe and supported by maternity services both during and in the immediate postnatal period and this is reflected in feedback	1.Continuty of care team engagement and staff satisfaction overall
2.Reduction in smoking at point of delivery and increasing breastfeeding rates at 6-8 weeks	2.Women are involved in the co-production of services that the maternity team provide	2.Turnover rate
3. Number of women on a continuity of care pathway increasing	3. Women are given a choice of place of birth and are supported to get this choice as far as possible	3.Sickness absence rates

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Implement an enhanced and targeted continuity of carer model, ensuring that by 2024, 75% of women from Black/Black British, Asian/Asian British communities and women from the most deprived areas or vulnerable groups will receive continuity of care						
Increase breastfeeding rates to achieve greater or equivalent to rest of England by 2025						
Less than 5% of pregnant mothers smoking by 2025						
Increase the offer of flu and pertussis vaccinations in the acute settings to achieve 95% uptake by 2025						
Less than 5% of pregnant mothers drinking alcohol by 2025						
100% of pregnant women with a BMI 30 or greater are supported by using NICE guidance recommendations by 2025						
100% women with BMI 30 and above at the postnatal review (6-8weeks) are signposted to a structured weight management programme by 2025						
2. Approach to Wellbeing						
Reduce rates of neonatal, death and maternal death and brain injury during birth by 20% by end of 2020/21						
Reduce rates of neonatal, death and maternal death and brain injury during birth by 50% by end of 2025						
Fully implement Saving Babies Lives care bundle (version 2) by March 2020						
Establish Maternal Medicines Networks to further ensure women with acute and chronic medical problems have timely access to specialist care and advice at all stages of pregnancy, by March 2024						
Postnatal physiotherapy is offered to women with physical complications because of birth by March 2024						
3. Personalised Care						
Most women (>51%) receive continuity of person caring for them during pregnancy, birth and postnatally by 2021						
4. Mental Health and Learning Disabilities						
Establish maternity outreach which integrate maternity, reproductive health, and psychological therapy for women who experience mental health difficulties arising from, or related to, the pregnancy or birth experience						
66,000 women across the UK with moderate to severe perinatal mental health difficulties will have access to specialist community care from preconception up to 2 years after birth						
5. Children						
By April 2020 ODNs and LMS to produce local plans to implement the neonatal critical care review						
6. Digital						
All women can access their electronic maternity personal health record by 2024						
Maternity, Neonatal and Perinatal mental health workforce can access the information that they need to provide safe and high quality care through the Health Information Exchange of the Great North Care Record by 2024						
7. Finance						
Work as part of the ICP to look at where training can be shared across the system and areas where staff can be upskilled closer to the patient						
Work with LMS to access any central funding in a targeted manner						
8. Integration						
Continue to work across the system on the prevention agenda looking at where organisations can work together to deliver the same messages with regards breastfeeding, obesity and smoking at time of delivery and where we can benefit from working together on an improvement project						
9. Cultural Change						
All maternity units to be accredited at UNICEF level 3 by 2025						

Children & Young People

Why change is needed

We recognise that variations in health and wellbeing outcomes can be significantly impacted by the cross-cutting nature of vulnerability and the conditions and family circumstances into which children are born, grow, learn and develop.

Best Start in Life

- We need to ensure that children have the best start in life and prevent ill health wherever possible and reduce health inequalities by prioritising protective factors and provide help and support as early as possible.

Prevention and Early Help

- The current healthcare system for children and young people can often feel disjointed.
- The CYP Workforce across the wider system needs to review training and development approaches to be intelligence led, remove organisational barriers, avoid duplication, and provide efficient and sustainable integrated approaches
- To embed a trauma informed" Think Family" approach to ensure services consider the impact of adverse childhood experiences on their health and wellbeing with earlier identification and provision of appropriate support for vulnerable CYP and their families.
- Reduce levels of risk and build on protective factors using a strength based approach to mental health and emotional wellbeing in County Durham.

Integration

- To provide a sustainable integrated approach to service support and delivery which involves communities, voluntary organisations and the wider health and care system which will support Children and Young people and families from birth and as they move into adulthood.

Transitions to Adulthood

- Children and Young people and their families have outlined that they need better transition planning at all transition points with more integrated pathways and approaches to their care that prioritises continuity.

Objectives

- To embed an integrated, child and family centred approach to the delivery of high quality services which delivers optimal outcomes, reduces health inequalities and is responsive and reflective to changes.

Goals

Best Start in Life

- Ensure that every child has the best start in life:
  - Increasing Breastfeeding Rates and deliver targeted community approaches to increase both breast feeding initiation and continuation to reduce the gap between County Durham and England breast feeding rates and reduce inequality
  - To have a significant and sustained reduction of A&E attendances and hospital admissions caused by unintentional Injuries by embedding the unintentional injuries framework for County Durham
- Improving Speech and Language and Communication through the provision of evidence based assessment, early intervention and therapies and the development of integrated pathways
- To embed the "Think Family approach" into all relevant assessment processes for children and families and apply professional curiosity that considers life through the eyes and voice of the child

Prevention and Early Intervention

- Children and Young People will be able to access high quality, age appropriate, support, advice and care that meets their physical and mental health and emotional wellbeing needs (right practitioner, right place, right time) including those children with additional needs and vulnerabilities.
- To provide innovative access to support and deliver services through the enhancement of a digital offer to reflect learning from new approaches during Covid.
- Ensure Children, Young People and vulnerable adults are safeguarded and protected from harm
- Ensure Children and Young People, their families and their carers are engaged in the development and co-production of services.

Transitions to Adulthood

- Children and Young People will be supported throughout their transition process into adulthood
- Pathways will support young people to have a planned, informed, coordinated and safe transition into adult services

COVID – 19

The below identifies the overall Covid recovery system plans. Detailed plans for individual services are available.

Short Term

- In the short term services have made changes to delivery where required to use appropriate virtual technology to deliver services safely.
- Face to face visits maintained where clinically indicated and to safeguard CYP
- Services have interpreted national and local guidance to deliver services in a safe and appropriate manner
- In accordance with the above point this has involved the use of RAG ratings on individual cases where appropriate in some services.

Medium Term

- In the Medium Term services will seek to apply face to face meetings where it is safe and appropriate to do so with National Guidance. It is recognised that not all services need to be delivered in that way and accordingly service reviews will seek to apply the most appropriate delivery methods on a service by service basis.
- Service reviews (including the use of Covid High Impact Assessments) will seek to ensure that any changes to service delivery will deliver equity of access to all children and their families, and to ensure a move towards a more virtual approach for some elements does not lead to a lack of provision for those children and families who do not have access to the requisite technology or for whom such an approach is not appropriate.
- Services will work in an integrated and joined up way and for those services who are able to provide face to face delivery a "Make Every Contact Count " approach will ensure that appropriate sharing of information with other services is undertaken.
- All services will continue to work in an integrated way as potential Covid related disruption to services (local lockdown or school closures) occurs.

Long Term

- The long term plan, 2022+ will be to have full service provision, as per pre Covid-19, but elements may be delivered differently when the learnings from the short and medium term have taken place.
- Services will deliver a co-produced approach to as well as ensuring equity of access through robust service reviews and data analysis. In this way we will deliver services that are child and family centred.

Triple Aim Outcome Measures

Title of the accountable governance group Children and Young Peoples Integrated Board		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Best Start in Life Reduction in the number of children who are very overweight through the delivery of a system wide approach focusing on achieving a Healthy weight for Children and Young People by Reception	**1. Best Start in Life** Promoting bonding and attachment through the delivery of the Solihull programme and approaches to improve short and long term outcomes, with improved relationships within families and with service providers	**1. Best Start in Life** Training all relevant multi-agency staff in the delivery of Trauma informed care
2. Prevention and Early Intervention Children who have speech language and communication needs are identified at the earliest opportunity and supported appropriately to promote school readiness and a good level of development (GLD) as they enter Key Stage 1 and beyond.	**2. Prevention and Early Intervention** Empowering and increasing confidence and resilience for parents and carers to support their children's health and wellbeing including managing childhood illnesses and mental health and emotional wellbeing needs.	**2 Prevention and Early Intervention** Upskilling all staff and Skills Matrix in the Making Every Contact Count Agenda
3. Transition to Adulthood Children with vulnerabilities including children who are looked after, care leavers and those children with special educational needs have continuity of care that meets their needs.	**3. Transition to Adulthood** Transition pathways are co-produced and co-designed with young people in accordance with their needs.	**3. Integration** To identify a core suite of workforce training needs and establish an agreed multi-agency training programme.

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Reduce unwarranted variation in the uptake of the Childhood Immunisation Programme						
All organisations to prioritise reducing tobacco dependency in pregnancy. Trusts to include as a clinical priority and all organisations to change the narrative to a one of addiction.						
Changing the social norm of breastfeeding by implementing the call to action. Including County Durham to become BF friendly.						
Increase breast feeding rates (up to 64.8%) in mothers initiating breast feeding & sustaining at 6-8 week by 2020/21						
Deliver a whole system unintentional injuries strategy to reduce accidents in the home and to see a significant and sustained reduction in the hospital admission rate for injuries in children 0-14						
Implement the whole system approach to obesity as laid out in the County Durham healthy weight framework						
Oral health • Roll out targeted tooth brushing schemes to early years settings and reception classes • Continue to explore the feasibility of expanding community water fluoridation across County Durham						
2. Approach to Wellbeing						
Review and redesign CYP pathways to consider a whole system approach to meet the CYP needs which are empowering						
Ensure shared decision making that involves CYP in the design and development of services that recognise the different needs of geographical communities						
Communication and engagement strategies are established that reflect the needs of CYP including those up to the age of 25 yrs old in line with the NHS plan						
3. Personalised Care						
Working with families and young people to deliver appropriate and timely person centred approaches to meet individual needs and considers a think family and trauma informed approach						
Promote the Signs of Safety approach to ensure everyone involved in a child's life has the same understanding of the strengths and the worries, and agrees the goals that need to be reached to make sure that CYP are safe and well at all times						
Ensure young people have choice, control and freedom over their lives and their voice is heard and reflected in their education health care plan where appropriate (SEND)						
4. Mental Health and Learning Disabilities						
Review the Education Health and Care opportunities for children and their families on the autistic spectrum and implement recommendations to improve outcomes						
Develop a transition pathway for young people with mental health issues including CYP with complex issues including autism and learning difficulties.						
Increase resilience of young people by promoting protective factors for MHEWB as reflected in the CYP local transformation plan and mental health OGIM						
5. Children						
That Children and Young Peoples Voice / through the eyes of the child is included in all service KPIs						
There are sufficient support and accommodation options to ensure that the placement of all children looked after are the most appropriate available to meet the child's needs						
6. Digital						
Review service provision to provide a menu of digital options to access services that meets the needs of CYP (consider learning from Covid business continuity)						
Ensure high quality data and intelligence is shared across Education, Health and Care to inform and improve services with joint KPIs where appropriate						
7. Finance						
Work as part of the integrated care partnership to scope shared resources to improve quality, efficiencies and better outcomes for CYP						
8. Integration						
Identify opportunities to further strengthen and integrate children's therapies services across the County and implement those opportunities						
Review children's equipment processes to improve current pathways and review the potential of joint commissioning/pooled budgets for children's equipment						
Develop and implement the early help and think family place-based approach to better connect community and public resources.						
Embed and maintain a joint commissioning cycle that improves access to integrated support in Education, Health and Care (SEND)						
Scoping exercise to be carried out to clarify cohorts, review transitions arrangements and build a multi-agency offer (Transitions)						
9. Cultural Change						
Improve engagement with children and young people, parents and carers to inform policy and service quality of all services including SEND.						
All services encouraged to empower communities to improve their own health and wellbeing through the application of the County Durham approach to wellbeing principles						

Cancer

Why change is needed

- Despite more cancer patients being diagnosed earlier and overall survivorship increasing year on year, the gap has been steadily widening between County Durham and the England average in One-Year Survivorship since 2003.
- Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival, but there are significant inequalities in our most deprived communities
- There is a significant gap between life expectancy across the ICP footprint and that of England
- There is a significant inequality gap within communities across our localities, more people from our deprived communities die from cancer or their quality of life post cancer treatment is worse than what it should be when compared to the local, regional and English averages.

What has changed since March 2020?

- The pandemic will delay progress on many of our 20/21 initiatives and these have been BRAG rated AMBER. However, these will remain a priority over the next 4-5 years and new timescales will be reset following LTP revised guidelines being published this Autumn
- Some of the initiatives under Integration are rated Green, but may need re-wording in light of RDC development
- The one Red rated initiative (lung case finding pilot) is most uncertain given radiology capacity concerns – however, lung is highlighted as a priority tumour group for RDC development in our ICP

Objectives

- Our ambition is by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients – early diagnosis improves patient outcomes, survivorship and quality of life

Goals

- More people each year will survive their cancer for at least five years after diagnosis
- Raise greater awareness of symptoms of cancer
- Maximise the number of cancers that we identify through screening
- Closer working with all partners to support delivery of world-class cancer care and aim to increase cancer survival levels to match or exceed that of England as a whole
- Making best use of new emerging primary care networks and strong existing links with our Public Health partners to reduce health inequalities, improve overall cancer outcomes and deliver the best possible patient experience
- Faster Diagnosis Standard (28 days)
- Focus on quality of life, not just length of life
- Collaborative focus on key prevention initiatives such as smoking cessation and reducing alcohol harm

COVID – 19

- **Short Term** – our short term priorities are to restart and restore all cancer screening and immunisation, diagnostic and treatment services as safely as possible as well as to measure and model impact of the backlog of patients now waiting for services. Work will continue to reassure the public about coming forward with symptoms in order to restore levels of suspected cancer referrals. Some pathway redesign is also being developed/implemented immediately and PCN-level initiatives as part of the Cancer DES.

- **Medium Term** – continued multi-agency remedial action to achieve constitutional cancer targets where possible, recognising that the backlog is unlikely to be cleared in 2020. Greater focus on ICP-level pathway redesign and further development of the Rapid Diagnostic Centre (RDC) model as well as work towards Personalised Care objectives, Stratified Follow-Up (SFU) and addressing cancer health inequalities.

- **Longer Term** – by 2022 and beyond our objectives will continue to be on the RDC model as this is a four-year transformational programme aimed at delivering sustainable cancer services and improved outcomes in the context of limited clinical resources.

Triple Aim Outcome Measures

County Durham & Darlington Cancer Locality Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Early Diagnosis: The proportion (%) of cancers diagnosed at Stage I and II	1. Proportion of patients giving a high score to patient involvement question in the Five for Five (or CPES)	1. Vacancy rates in radiology, oncology and CNS
2. Rapid Diagnosis: the proportion (%) of suspected cancer referrals meeting the new 28 Day Faster Diagnosis Standard	2. Proportion of suspected cancer referrals achieving the 2ww standard	2. Staff satisfaction scores in the Five for Five Survey
3. The rates of cancer incidence across the Durham population	3. Proportion of patients able to self-manage their condition	

In order to achieve the above it is recognised that targeted work in areas of high deprivation and across hard to reach communities (such as LD, BAME, vulnerable groups, poor digital access, etc.) will take greater priority in order to reduce health inequalities in cancer

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Target prevention, awareness and screening activities in most deprived communities and adapt to specific needs of those communities and vulnerable groups e.g. offenders, care leavers, drug/alcohol users, BME, etc.						
Ensure robust links with secondary care prevention and pre-habilitation						
Fund and implement services and initiatives around the modifiable risk factors of cancer including tobacco control, healthy weight, alcohol harm and sexual health						
Following Cervical Screening Engagement Event: adopt a standardised approach to improving uptake with the support of practice cancer champions and sustained awareness campaigns						
Explore potential lung cancer case finding pilot to screen at-risk cohorts of patients and promote earlier diagnosis, taking learning from pilots across neighbouring cancer localities						
Continue to develop practice Cancer Champions, further training around signs and symptoms & local campaigns						
Undertake health equity audits of cancer screening programmes and act on the findings						
Explore potential for Lynch Syndrome Testing of all colorectal patients and family members						
Continue to implement, raise awareness and monitor impact of FIT (Faecal Immunochemical Test)						
Carry out audit to investigate and address widening gap in one-year survival rates for breast/bowel/lung/upper GI cancers and develop mitigation plan to close the gap						
Carry out clinical audit of late/emergency lung cancer presentation to investigate and address barriers to earlier diagnosis and develop mitigation plan to reduce ratio of emergency admissions						
2. Approach to Wellbeing						
Roll out of We Are Undefeatable - PHE Sport England campaign to launch in September 2019 linked to increasing physical activity in people with cancer						
GP and patient education/awareness to ensure 2WW and 62 day targets are met and support local implementation of new 28 day faster diagnosis target when introduced in 2020						
Renovate a new, modern chemotherapy department at UHND supported by a new staffing structure						
Embed End of Treatment Summaries key tumour groups and share content with patients and other care providers (initially breast and colorectal with all others to follow)						
Increase access to information and support for people affected by cancer across all settings						
Completion of Cancer Care Reviews within 6 months of diagnosis						
Continually improve patient/family/carer experience by acting upon feedback from surveys and continue to engage service users in service re-design and improvement across whole pathway including primary care						
3. Personalised Care						
Continue to develop Joining the Dots, delivering Holistic Needs Assessments, Support Plans and Follow-up support						
Work with relevant charities, voluntary and community sector organisations to establish support groups in areas or around cancer types where there are currently gaps						
Collaborative working between primary and secondary care to deliver necessary support to patients who are stratified to a self-managed pathway						
Utilise Care Navigator resource to support patients through the complexities of medical appointments and ensure target timescales are met across the pathway, including transfers of care between providers						
All patients diagnosed with cancer to be offered a Holistic Needs Assessment and where appropriate, a personalised care plan						
Develop and implement stratified pathways of care, including self-managed follow-up in all tumour groups (initially breast and colorectal)						
Implement Macmillan Right By You to support the integration of cancer services across all settings (particularly primary and community) so HNA, care and support is seamless from the patient perspective FUNDING PULLED DUE TO PANDEMIC						
4. Mental Health and Learning Disabilities						
Train IAPT services and ensure pathways are developed to ensure people with cancer have access to knowledgeable and empathetic mental health services						
Target prevention, awareness and screening activities in most deprived communities and adapt to specific needs of those communities and vulnerable groups e.g. people with learning disabilities						
5. Children						
Continue to provide specialist cancer care for teenagers and young adults aged 16 to 24 years and children aged 0-15 (paediatric oncology), to improve cancer treatment outcomes, reduce morbidity arising from treatment and support the patient and family throughout their cancer journey and beyond. NB these services are commissioned by NHS Specialist Commissioning.						
6. Digital						
Quality requirement within Practice funding schemes to use approved Cancer Care Review templates						
Introduction of treatment summaries to inform the Cancer Care Review						
Develop the use of digital technology and remote monitoring solutions to enhance patient experience						
7. Finance						
Northern Cancer Alliance (NCA) have announced an indicative 4-year budget for transformational initiatives and this will be begin to be allocated from April 2020						
8. Integration						
Work with neighbouring CCGs and Trusts to build sustainable radiology capacity						
Collaborate with neighbouring CCGs and Trusts to implementation national optimal pathways in main tumour groups						
Collaborate with neighbouring CCGs and Trusts to review demand/capacity and build sustainable oncology services across boundaries						
Build relationships with Primary Care Networks to enhance and develop primary care role across whole treatment pathway, from prevention and screening to diagnosis and follow-up care and utilising nursing teams and GPSIs						
9. Cultural Change						
Ensure that prevention and addressing health inequalities are prioritised in the cancer strategy, not just the constitutional diagnosis and treatment targets						
Work collaboratively with neighbouring cancer localities (commissioners, providers and public health) in new ways and across all boundaries to address universal challenges such as capacity and						

Cardiovasular Disease

Why change is needed

- Prevention, early detection and treatment of CVD can help patients live longer, healthier lives. Too many people are still living with undetected, high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation (AF). We must utilise all opportunities to work with partners to ensure that people are able to access services that will allow them to prevent and detect health conditions, and upon diagnosis ensure that conditions are managed and optimised effectively. In primary care networks we will support all clinical staff including pharmacists to case find and manage people with the 3 key high-risk conditions described above (AF, Hypertension, and FH). In tackling the CVD agenda, there is an ambition to Prevent 150,000 heart attacks and strokes.
- Behavioural risk factors such as poor diet, smoking and low physical activity, along with high blood pressure, high body mass index and high cholesterol are the main risk factors for cardiovascular disease. A large proportion of premature deaths in County Durham from CVD are preventable. An awareness raising of the impact public health interventions can have on CVD is important; whilst people are living longer, they are not necessarily living well and living with CVD contributes to this.

REMOVED from Gantt Chart: PH Commission BP and Pulse Checks in pharmacy - under 40 and over 75. No longer funded by public health.

Objectives

- AF
  - 30% reduction in No. of patients who have not been appropriately treated
  - 80% reduction in No. of patients who have not been risk assessed
  - 50% reduction in No. of patients who are inadequately anti-coagulated when required
- Hypertension
  - Increase in the number of patients detected with hypertension and to increase the number treated to bring blood pressure within safe parameters
- Hypercholesterolemia
  - Increase in the number of patients detected and appropriately managed. In Familial Hypercholesterolemia, we currently have a 7% detection rate –need to increase to 25%

Goals

- Continue to work closely with Public Health Partners on the CVD prevention agenda (smoking, obesity and healthy living) and implementation of effective and equitable NHS Health Checks
- Continue to work with partners to detect and medically optimise patients with AF to prevent stroke
- Continue to work with partners to detect and medically optimise patients with hypertension to prevent CVD events
- Continue to work with partners to detect and manage Hypercholesterolemia, and to undertake cascade testing of family members to identify and medically optimise those with Familial Hypercholesterolemia.

COVID - 19

- Short Term

The pandemic has meant that projects have been paused and anticipated end points have now been extended. Projects that were due to yield results in 20/21 will now likely only see results in 21/22 at the earliest. It is hopeful that projects that required data cleansing as their primary goal may still be achieved in year but this will be dependent on whether or not there is a second wave, and its impact, and therefore could be subject to change. The negative impact on cardiovascular health as a side effect of lockdown, and the substantially worse prognosis of a person that contracts COVID-19 that has CVD as a comorbidity, puts greater importance on the need for these lists to be cleansed and correct to enable targeted intervention. People remain concerned about utilisation of NHS resources and work will be required with people to ensure they know it is safe to go to the doctors for preventative purposes (engagement with VCSE could help here). People who may have had CVD episode during COVID may have been concerned about seeking treatment and therefore there may be additional morbidity.

- Medium Term

As described above the plan for the medium term is to complete projects that were put on hold during the initial grip of the pandemic and aim to get back on track. To accommodate this, dates for completion for several projects have been put back to 2021/22 for completion.

- Long Term

The long term goal for recovery is to get back on track to achieve the goals of the NHS Long Term Plan. This is outlined within the Cardiovascular Disease section of the document. The projects outlined in the Gantt Chart are specifically designed to meet these aims and objectives and is anticipated they can be achieved in the long term.

Triple Aim Outcome Measures

Cardiovascular Disease Strategy Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Reduction in the rate of AF related stroke admissions	1. Increased proportion of patients referred to cardiac rehabilitation.	1. Increased pharmacist presence in primary care management of CVD.
2. Increase in the proportion of patients treated to have BP within safe parameters therefore reducing admission for CVD conditions.	2. Attendance at the lipid clinic for more controlled cholesterol if Familial Hypercholesterolemia is identified; for patient and their future generations.	2. Increased self-management activity (e.g. know your numbers, BP home check etc.) on primary care to monitor and measure identified metrics.
3. Reduce prevalence of CVD particularly in younger adult age groups through improved detection of Familial Hypercholesterolemia	3. Improved quality of life for users with severe mental health with increased uptake of use of the Lester Tool 2014.	3. Increased measurement and capture of identified metrics in wider health community.

Risks to delivery / mitigation proposed

The primary risk to delivery is the impact that COVID-19 may have; not only in terms of a second wave that would delay timescales further, but if finances that had been attached to various areas of work from different sources e.g. pharmaceutical industry/AHSN, is reprioritised as a result of the pandemic. There is no indication that this will happen at this time but should be considered. To mitigate, timelines may have to be extended to achieve intended outcomes, and potentially other sources of funding identified and pursued, should the need arise.

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
CCG league tables for hypertension – level/ treated/ untreated						
Reduce variation of practice in the identification and management of high-risk conditions and audit & clean-up registers to ensure people are coded properly. Root cause analysis						
Bespoke Data packs with updated info showing current recent position. Healthy Hearts website to promote prevention in local areas						
AF Optimisation and Detection Programme – Pharmacist delivered project across all GP practices in the Southern Collaborative to include; identification of patients from clinical systems, Pharmacist led appointment to risk assess, educate and prescribe optimal medication, and an educational programme for Primary and Secondary care clinicians. CVDPREVENT audit will also be used in 2020. AliveCor rolled out to 12 practices.						
NHS Healthchecks - targeted at people with estimated high CVD risk						
NEW: Develop a program to address CVD outside of people that attend primary care						
Hypertension Detection and Optimisation Programme – Data analysis, audit and education programme. Although slightly different versions, this will be replicated across the Southern Collaborative						
Hypercholesterolemia Programme – Data analysis and communication plan with all Primary Care to ensure patients are detected and are referred into a specialist Lipids clinic if found to have a cholesterol of 7.5mmol or more. These patients will be risk assessed and cascade testing offered to ensure this is prevented in future generations. This will be replicated across the Southern Collaborative						
2. Approach to Wellbeing						
Review of Cardiac Rehabilitation services and aim to increase referral and uptake of cardiac rehabilitation during 2021/22.						
In 2023/24, funding for wider roll out will be included in fair shares allocations to systems. This links to community for longer term rehabilitation following on from specialist services						
MOVED: NHS Healthchecks check for hypercholesterolemia						
3. Personalised Care						
Further development and utilisation of referral pathways for people at risk of CVD to Ways to Wellbeing / Wellbeing for Life Services commissioned by Public Health link with PCNs.						
NEW: Implementation of referral pathways with Smokefree County Durham for people who are identified in general practice and secondary care as smokers.						
NEW: Implementation of shared decision making within NHS Healthchecks to include patent activation, behaviour change and self-management measures						
4. Mental Health and Learning Disabilities						
NEW: Ensure educational materials around CVD prevention and risk are developed with and for people with learning disabilities						
Lester Tool 2014 wider uptake for mental health services						
5. Children						
Preventative measures for C&YP to address ACE's by utilising trauma informed care						
NEW: Active 30, Healthy Weight Alliance, Quality Standards Framework in Schools (potential to link to poverty agenda)						
6. Digital						
AliveCor has been nationally supported to help local partners identify AF. Investigation is ongoing to potentially roll this out further. Other schemes such as including a 'suspected AF' box on the diabetic podiatry screening sheet are being investigated. Use of a digital tool for the AF Optimisation and Detection Programme for patient stratification and identification.						
NEW: Promotion of Heart Age Tool						
7. Finance						
We will detect and medically optimise patients with AF to prevent stroke leading to savings via fewer AF related admissions and stroke episodes which can be re-invested into stroke and CVD services.						
NEW: prevention programmes and health checks commissioned by DCC, plus the public health stop smoking service, wellbeing for life and ways to wellbeing services all contribute to the prevention agenda and will reduce admissions.						
8. Integration						
Pilot extended in pharmacies and re-modelled with formal GP feedback. Primary care led/paid for pulse checks to detect people with hypertension						
9. Cultural Change						
Public and health care professional awareness work re: BP/Pulse/NHS health checks/ Wellbeing for Life/ Ways to Wellbeing/ Specialist Stop Smoking Service/ Whole System Approach to Obesity/ CVD Prevention Self-Assessment with work done on links to employment, housing, pollution and poverty.						
NEW: Implementation of Making Every Contact Count across the health care system by health care professionals						
NEW: Recognition and understanding of wider determinants of CVD including protecting people from traumatic events, increasing physical activity, improving diet/nutrition, access to green spaces, reducing air pollution and working as a system to address these risk factors.						

Diabetes

Why change is needed

- There is variation in the care people receive
- Opportunities for patients to be supported to manage their own condition aren't widely available
- High reliance on hospital based care

Objectives

- To support people living with diabetes to manage their own health through an enhanced support offer and reducing variation in care

Goals

- Increased identification and improved management of patients at risk of developing diabetes or those with Non Diabetic Hyperglycaemia (NDH) /pre diabetes
- All patients have access to NHS Diabetes Prevention Programme
- Access to structured education and digital self-management tools have been expanded
- All eligible patients have access to flash glucose monitors
- Reduced variation in achievement of diabetes treatment targets
- Reduction in length of stay and readmission rates for diabetes related admissions

COVID - 19

Short Term

- ❖ Diabetes service restart plans agreed (see summary below) and consultation completed with GP practices in all localities.
- ❖ Diabetes Governance Board meetings restarting 28th July 2020. Diabetes Clinical Advisory Group meetings to restart September 2020
- ❖ Diabetes Locality Group meetings restarting in August 2020 and will pick up the work around the Integrated Model. Meetings to be held every month in order to gain momentum following COVID.

Acute

- ❖ Diabetes outpatient services re-opened on ERS – 1st July 2020.
- ❖ Backlog - All Consultant/DSN outpatient appointments that were cancelled over the last 3 months being triaged by Consultant /DSNs and rearranged into telephone review, virtual, face to face or discharged.
- ❖ Face to face appointments limited to a maximum of 4 patients per clinic due to social distancing measures.

Integrated Diabetes Model – Consultant and DSN practice based clinics

- ❖ Backlog - Consultants/DSNs triaging patients cancelled during COVID. Telephone reviews or face to face consultations being offered.
- ❖ Support for Integrated model to restart September 2020 -dependant on *DSNs being released from the wards & no second wave of the virus.*
- ❖ Plan to move to virtual Consultant/DSN clinics with GPs/PNs and patients as much as possible, using AccuRX. Demos of AccuRX held for consultants/DSNs and tests completed with practices.
- ❖ Proposed to have 1 in 4 consultant clinics face to face, remaining clinics virtually, based on the support individual practices need.
- ❖ DSNs contacting practices they support in July & August to establish support required with priority being given to "care basic" practices and those that have employed new nurses.

Structured education – MyDesmond app and virtual X-Pert sessions being offered until face to face group sessions restart.

Medium Term – Virtual clinics and meetings to continue. Face to face consultations offered based on patient and/or practice need. Integrated model to continue as per service specification

Long Term – If successful, mixture of virtual clinics and face to face to continue in the longer term. Integrated model to continue as per service specification

Triple Aim Outcome Measures

Diabetes Governance Board		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Reduction in obesity and diabetes prevalence: Increase in number of referrals and attendance for the NHS Diabetes Prevention programme (NDPP)	**1. Improved patient care in the community** • Increase in % of people with type 2 diabetes who have had a medication review in the last 12 months. • Increase in % of people with diabetes achieving the 3 treatment care targets (BP, Chol & HbA1c) • Increase in % of people with diabetes receiving the 9 care processes.	**1. More skilled primary care workforce** • % of GPs, nurses and HCAs with training needs that have completed training. • Increase in number of GP practices delivering at Care ++ level (*based on care level criteria).*
2. Less diabetes related complications Reduction in number of hypo and hyper admissions per 1000 people with diabetes	**2 Better informed patients** Increase in the number people referred to and attend type 2 diabetes structured education sessions.	

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
We will continue to lobby the Government nationally on the introduction of legislation that will support diabetes prevention – *Progress update: through ICS Diabetes Steering Group and ICS NDPP Operational Group*						
We will continue to lobby locally for responsible licensing which may impact on obesity/diabetes prevention including responsible local planning and licensing for food outlets etc.						
We want to increase our use of primary care data to identify and target patients who are at risk of diabetes and other diseases and develop a strengthened approach to management and support for these people – *Progress update: NDDP in place. Patient searches in use. NDPP and referral numbers standing agenda item for Diabetes locality group and Diabetes Governance Board meetings*						
We want to continue to use the National Diabetes Prevention Programme (NDPP) wherever possible, but we recognise that we need to offer a range of programmes/ interventions to support people to stay healthy – *Progress update: NDPP in place (WW provider)*						
We will consider any barriers to participation and work with people to enable them to participate in the NDPP or any locally developed programmes- *Progress update: through Diabetes Locality groups and ICS NDPP Operational Group*						
We will ensure that the PCN social prescribing link workers have a focus on supporting patients who at risk of developing diabetes *Progress update: through Diabetes Locality groups.*						
We will consider how we use real time primary care data to support case finding for those patients who are risk of developing Diabetes or other conditions *Progress update: through Diabetes Locality groups.*						
We will consider the role that a primary care weight management service can play in supporting patients who are at risk of diabetes (and other health conditions)						
We will continue work to reduce variation in outcomes and treatment targets across County Durham. We know there is variation in outcomes by age with older people achieving the best outcomes in terms of the NICE recommended treatment targets currently – *Progress update: working to reduce variation through diabetes locality groups*						
We plan to undertake a health needs assessment for diabetes to identify if there are sections of the population where outcomes are not improving in line with the general population. We will use the HNA to identify if we need to target or adapt our diabetes offer for prevention, education or treatment						
2. Approach to Wellbeing						
We will continue to work to improve management of blood glucose, but will also expand our focus to a broader range of targets such as lipids, hypertension, diabetic renal disease and micro albuminuria. We will work to increase the areas that we focus on incrementally. *Progress update: through Diabetes Locality groups and Diabetes Governance Board*						
We will engage with community pharmacies to understand the role they could play in diabetes management						
We will review the pilots that have taken place to reduce hospital length of stay for diabetes patients and identify a way of making sustainable improvements. We will work to narrow the gap in length of stay for patients with diabetes compared to the rest of the population – *Progress update: 7 day DISN service introduced at CDDFT but problems recruiting due to short term funding. Evaluation report and business case to be considered by Diabetes Governance Board with potential to reinstate the service through 2020-24 NHS E Diabetes treatment & care programme funding*						
We will continue to offer a single point of contact for diabetes structured education with a range of packages available *–Progress update: in place (DIET service), recurrent funding agreed.*						
We will develop a directory of the range of diabetes education packages that are available and identify any gaps in provision *Progress update: Virtual & face to face courses and digital app options currently being offered.*						
We will work to identify any barriers to accessing structured education and identify how we can address this. *Progress update: through Diabetes Locality groups and Diabetes Governance Board*						
We will continue to use the Wellbeing for Life service to support people to improve their health, wellbeing and quality of life. *Progress update: Currently in place*						
3. Personalised Care						
We will use Patient Activation Measures to identify those who are able to self-manage their own condition with fast track access back into primary and secondary care services where required.						
4. Mental Health and Learning Disabilities						
We will ensure that there is a focus on people with Severe Mental Illness or people with a Learning Disability as part of the Health Needs Assessment focussing on prevention, education and treatment						
We will review the bespoke education package for patients with Learning Disability that has been developed in North Tyneside to consider implementation in County Durham *– Progress update: pilot delayed due to COVID. Liaising with colleagues in North Tyneside.*						
5. Children						
We will work with schools and families to increase exercise, healthy behaviours and reduce childhood obesity						
We will work to reduce the number of children diagnosed with type 2 diabetes						
We will improve outcomes for children with type 1 diabetes and ensure compliance with the best practice pathway for paediatric diabetes						
6. Digital						
We will recommend digital applications for diabetes structured education following the current trials that are ongoing - *Pilot delayed due to COVID – NHS E app offer available from Autumn 2020*						
We will review processes for responding to the data that is generated from Flash glucose monitors to ensure that we have safe and effective systems for managing patients who use those devices						
We will develop a pilot initiative to use a digital photography application to enable review of potential diabetic foot ulcers and identify patients that need to be seen in an urgent clinic						
7. Finance						
We will reduce admissions for complications of diabetes and reinvest funding in prevention and the rising cost of diabetes related drugs.						
8. Integration						
We will continue to have an integrated model of care for diabetes across County Durham which includes primary, community and secondary care. The model of care is overseen by a Diabetes Governance Board which includes representatives from the voluntary sector (Diabetes UK) – *This is for Type 2 Diabetes and is in place*						
Our specialists (who were previously hospital based) will continue to work in our GP practices training and upskilling primary care staff – *This is for Type 2 Diabetes and is in place*						
9. Cultural Change						
We will work with clinicians to increase awareness of the wellbeing approach and of the alternatives to medical treatment for diabetes						

Drugs and Alcohol

Why change is needed

- To reduce the burden of disease and inequality caused by alcohol and drug harms by addressing the physical, mental and social impact of addiction on individuals, families and local communities.
- The percentage of adults drinking above the recommended weekly consumption rate is significantly higher in the north east than national average.
- Local prevalence estimates indicate that drug treatment penetration rates leave an unmet need of 45% for opiate and crack users.
- Hospital admissions for alcohol-related conditions have risen nationally over the past 8 years. In 2018 to 2019, there were over 1.2 million admissions related to alcohol, of which alcohol was the main reason for admission for about 336,000 cases.
- Deaths from drug misuse are increasing nationally but are significantly higher both regionally and locally. Addiction problems disproportionally effect those from disadvantaged groups and areas of social deprivation widening health inequalities.
- Tackling intergenerational drug taking is essential and an important element in the Think Family approach.

Objectives

- To improve upstream prevention initiatives for the reduction of harm caused by alcohol and drugs
- To optimise the care setting of drug and alcohol services
- To manage long-term conditions for those in treatment
- To reduce the impact on the wider family using the Think Family approach

Goals

Maintenance of the County Durham Alcohol and Drug Harm Reduction Strategy and Action Plan

- Primary prevention – provide a systematic approach for Audit C screening for alcohol within a range of settings. Increase referrals rates for alcohol from Health Checks and secondary care into Alcohol and Drug Recovery Services based on Identification and Brief Advice (IBA) for alcohol. Reduce primary care prescribing rates for prescription medication. Maintenance of harm reduction services including screening for BBV's and overdose prevention.
- Secondary Prevention – delivery of comprehensive Alcohol and Drug Recovery Services providing an optimal care package for young people, adults and families suffering with substance misuse. Develop integrated care pathways to build recovery capital, including clinical interventions, trauma-informed care, mental health and wellbeing, criminal justice, social care, housing, poverty reduction, domestic abuse and smoking cessation.
- Tertiary Prevention – target the aging population of substance misusers to address long term conditions including respiratory care, CVD, complex needs.

COVID - 19

- Awareness raising of the prevention and early identification of drug and alcohol misuse as a coping mechanism to effects of covid-19.
- Ensure system wide links are maintained to promote mental wellbeing and reduce increases in alcohol consumption.
- Increased virtual support for those already in treatment unable to access psycho-social intervention and supervised consumption due to lockdown.
- Risk management of chaotic clients via a multi-agency approach with increased support.
- Close monitoring of substance misuse related deaths in order to react quickly to prevent further.
- Support for easy access to testing for the vulnerable aging population of substance misusers with LTC. As well as support for physical health e.g. flu vaccinations. Support for outbreak control in services.
- Developing further opportunities for partnership working to address complex need.

Triple Aim Outcome Measures

Alcohol and Drug Harm Reduction Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Reduce levels of alcohol consumption	1. Increase opportunities for prevention and early intervention	1. Access to training for prevention and early intervention (IBA)
2. Numbers in treatment	2. Ease of access into recovery services based within local communities	2. Accessibility for discreet and confidential access for any members of the system workforce into DARS
3. Successful Completions	3. Client satisfaction with the service	3. Ensure a recognised standard DARS workforce, trained to deliver within a quality standard framework

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Develop integrated care pathways for substance misusers with long term conditions including respiratory health and CVD						
Provision of women-only services						
Maintain primary prevention initiatives including IBA and extended IBA in primary care.						
2. Approach to Wellbeing						
Increase systematic referrals from Health Checks into Alcohol and Drug Recovery Services.						
Reduce prescribing rates of potentially addictive medication within primary care.						
Develop Alcohol Care Teams based in secondary care						
Develop optimal care pathways from secondary care into Alcohol and Drug Recovery Services						
Alcohol and drug education for secondary care staff to support identification, IBA and onward referral						
Provision of holistic Alcohol and Drug Recovery Services utilising a life course approach to address the needs of individuals, families and local communities (Current contract runs until 21/22)						
Develop pilot outreach clinics from the hospital based respiratory service into one or more of the drug treatment centres and evaluate the impact this has on the health of this vulnerable group.						
Administer influenza and pneumococcal vaccinations within drug and alcohol services						
Consider opportunities to develop addiction services to include problematic gambling						
3. Personalised Care						
n/a						
4. Mental Health and Learning Disabilities						
Further develop and imbed provision of pathways for patients with co-occurring mental health and alcohol/drug use *conditions.* *(NB All OGIM workstreams will be working closely with each other to ensure we have a consistent and coherent approach across the system to addressing mental ill health)*						
5. Children						
Provision of Drug and Alcohol Recovery Service for CYP and families (current contract runs until 2021/22)						
6. Digital						
Improve data collation in A&E for regular attenders and cross reference with criminal justice partners, primary care and Alcohol and Drug Recovery Services.						
7. Finance						
Local Authority Budget allocation secured until 2021/22.						
8. Integration						
Improve recovery capital in individuals by working with partners to address need including clinical interventions, trauma-informed care, mental health and wellbeing, criminal justice, social care, housing, poverty reduction, domestic abuse and smoking cessation						
Support attrition between services by ensuring plans are put in place to prevent patients dropping out of the pathway						
9. Cultural Change						
Integrated approach to referring those identified with substance misuse into Drug and Alcohol Recovery Services.						

Respiratory

Why change is needed

- Lung conditions, including lung cancer, are estimated to cost wider society around £9.9 billion each year. Respiratory disease affects one in five people in England, and is the third biggest cause of death. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in the winter pressures faced by the NHS. Over the next ten years we will be targeting investment in improved treatment and support for those with respiratory disease, with an ambition to transform our outcomes to equal, or better, our international counterparts.
- Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation, where there is often higher smoking incidence, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

Objectives

- Improved services and outcomes for respiratory disease.
- Provide an integrated approach to delivery which involves communities, voluntary organisations and the health and care system.
- Focus on prevention, early detection and diagnosis and optimal treatment options, concentrating interventions initially on populations at greater risk.

Goals

- Early and accurate diagnosis: to increase early and accurate diagnosis for people with respiratory disease.
- Medicines management: to promote appropriate prescribing of respiratory medication and inhaler use to promote better compliance and prevent avoidable acute admissions and deaths from poor self-management.
- Flexible learning: to develop an accredited education programme for individuals diagnosed with common respiratory diseases such as COPD, asthma and bronchiectasis.
- Expansion of pulmonary rehabilitation: to increase the number of patients who would benefit from Pulmonary Rehabilitation and are referred to and complete a good quality programme.
- Community-acquired pneumonia: to reduce avoidable admissions and bed days for patients with community acquired pneumonia, achieved through implementation of risk stratification tools and ambulatory care services such as nurse-led supported discharge services.
- Breathlessness models: A model of care for breathlessness management is designed for patients who have either cardiac or pulmonary disease and have symptoms of breathlessness in common, to include the diagnostic pathway and joint rehabilitation models

Triple Aim Outcome Measures

Respiratory Clinical Advisory Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Non-elective admissions for COPD	1. Proportion of patients who report being confident in being able to self-manage (Patient Activation Measure level 3 & 4)	1. Number of nurses trained and competent in delivering diagnostic spirometry treatment
2. Non-elective admission for asthma		2. Staff vacancy rates in respiratory specific roles
3. Community steroid prescribing rates		

COVID-19

Short Term

- A new cohort of patients affected by COVID-19; who have a plethora of physical and psychological symptoms that require an integrated approach (including respiratory)
- Our existing patient groups, many who have multi-comorbidities (including respiratory); they may also have now suffered an episode of COVID-19
    - Develop a working group across the Health and Care System – involving public health, DCC and voluntary services to develop community pathways for respiratory, pulmonary, cardiac with the medium term plan of including other LTCs
    - Support our workforce to work differently, ensuring they have the skills required (understand the training needs)
    - Develop new roles to support innovative pathways

Medium Term

Focus on the four key points to ensure interventions are evidence based, integrated and community focused.

I. Redesigned evidence based trans-diagnostic pathways

a. Current single diagnostic pathways, will not adequately meet the physical, psychological and social needs of patients.
b. A trans-diagnostic pathway would enable allow a wider cohort of people to access appropriate rehabilitation. This is of particularly important during the current pandemic due to anticipated escalating rehabilitation demands with multiple presenting symptoms.

II. **the development of integrated and cross-organisational roles**

a. to address patient specific trans-diagnostic needs including:
    - Redesigning current roles for qualified clinicians (e.g. nurses, physiotherapists)
    - Working with Public Health and County Council (e.g. Wellbeing for Life)
    - Working with Mental Health Organisations (TEWV)

III. the use of the Patient Activation Measure (PAM) [1]

a. Targeting appropriate people/ care
b. Shared decision making
c. enablement to self-management approach

IV. A programme of training for upskilling the current and future workforce for psychologically informed care.

a. CBT training already embedded within Respiratory Team
b. Workshops and training which could enhance

- Patient Activation Measure
- Acceptance and Commitment Therapy
- "Fear of recurrence"
- Introduction to CBT skills
- Motivational Interviewing

Long Term

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Respiratory CAG reviewing local treatment guidelines and standard exacerbation plans						
Ensure adequate provision of Pulmonary Rehabilitation is commissioned and funded by CCGs, and that pathways into community physical activity provision ensure this element is sustained.						
Increasing flu vaccine uptake.						
Awareness of signs and symptoms and risk factors for respiratory disease. Discussions from primary care physicians about second hand smoke where children are diagnosed. Preventative measures for Smokefree homes						
Feasibility of pulmonary clinics in drug and alcohol recovery services.						
Smoking cessation in the home identified as part of HIA on Housing and to be integrated into the Housing licensing scheme for landlords.						
Extend the Silverdale pilot as part of the warm homes initiative						
Respiratory Health Equity Audit to be undertaken and outcomes reflected in future commissioning plans						
2. Approach to Wellbeing						
ARTP standard spirometery reversibility performance with accurate interpretation and an education programme targeting GPs re interpretation.						
Development of a diagnostic spirometry service delivered via a hub and spoke method e.g. at PCN level based on regional model across the county. Need to rationalise who does this, consider online interpretation after HCA ARTP equivalent trained test performed. Needs to have clear screening guidelines/referral criteria into the service and consideration of staffing required/skill mix.						
Roll out of the education programme across the County and include practice nurses, community nursing and ANP/VAWAS teams.						
Hospice Support/ end of life/palliative support						
Commitment from acute Trust and CCG colleagues to adhere to guidance to ensure best possible prescribing						
Holistic assessment for patients with pneumonia required where housing conditions, movement, hydration and nutrition are taken into account and in acute emergency services						
On-going education of acute admitting teams on the importance of CURB and early intervention in pneumonia						
Launch of PHE/Sport England WeAreUndefeatable campaign to keep people physically active in September 2019						
In order to develop generic breathlessness services to their full potential there needs to be recruitment to vacant cardiology and respiratory posts to full establishment. This will provide the long-term continuity needed for successful attainment						
3. Personalised Care						
Education plan for patients at point of diagnosis, including education on correct inhaler techniques						
Consider patient folders to be used to hold all plans/documents to be used by all clinicians						
4. Mental Health and Learning Disabilities						
Pilot for nurses to provide CBT to respiratory patients suffering with anxiety						
Access to CBT for patients with breathlessness with history, examination & investigation to be completed prior to referral						
5. Children						
Education programme for children and young people and their parents/carers						
Encourage use of the Child Health app for parents						
6. Digital						
MyCOPD training for PNs to be delivered. Consider giving MyCOPD license to all new COPD patients						
Consider alternatives for current Pulmonary Rehabilitation classes, such as myCOPD App/videos at home, days & times of sessions and venues. Engagement with patients						
Improved use of the CURB score within primary care for pneumonia						
7. Finance						
Review/intervention of over/under use of patients inhaler prescriptions						
Work with Meds Ops and Local Pharmacy committee						
8. Integration						
Increased use of community resources for people who are unable to commit to the intensity of pulmonary rehabilitation, or because of days & times of sessions and venues. Review issues surrounding transport						
On COPD template in GP's , patients with COPD screened prior to leaving hospital and referred, outpatient consultant and nurse referrals made / Ways to Wellbeing provision of community physical activity/social activity						
9. Cultural Change						
Increase focus on preventing respiratory ill health including smoking cessation or switching to vaping						

Sexual Health

Why change is needed

- Sexual and reproductive health is fundamental to health and wellbeing. It is a national priority and matters to both individuals and communities. Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. Achieving good sexual health is complex, and there are variations in need for services and interventions for different individuals and groups. It is essential that there is collaboration and integration between a broad range of organisations, in order to achieve desired outcomes.
- Unplanned teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Despite significant progress over the last 18 years, with a reduction of almost 62% in the under-18 conception rate, a continued focus is needed as this remains significantly higher than the national average and the gaps remains static
- The statutory requirement for educational setting to provide age-appropriate Relationships and sex education (RSE), and health education
- The requirement of an integrated, graded approach for support and services that covers prevention through to health intervention

Objectives

- All residents of County Durham have access to high quality integrated sexual health services, information advice and guidance,
- Children and young people have access to appropriate relationship and sex education (RSE), and health education that addresses inequalities and reduces the number of sexually transmitted infections and unplanned pregnancies.

Goals

- Improvement in chlamydia screening rates aged 15-24
- Improvement in HIV late diagnosis rate
- Reduction of under 18 conception rate
- Co-production of services with service users, including young people, to inform service delivery
- High quality age appropriate relationship and sex education (RSE) is delivered to children and young people.
- Improvements to data sharing between stakeholders
- Better use of service level data to inform service planning to improve outcomes and tackle inequalities
- Improved access to Long Acting Reversible Contraception (LARC) based upon informed choice.
- Have a clear understanding the needs of vulnerable groups, and respond accordingly
- The voice of the young person to inform service delivery
- Improve the whole system digital offer

COVID - 19

Short Term

- Identify suitable alternative site for the ISHS community hubs
- Understanding the impact of COVID 19 on system wide delivery model's – what positive innovations have been made
- How to address any clinical backlogs within the ISHS e.g. LARC through phased return to face to face contacts
- Focus on targeting vulnerable groups by all agencies including young people
- Develop a system wide communications plan that supports short/medium/long term recovery

Medium Term

- Identify/implement appropriate activity to ensure that the ISHS has 2 community hubs in specified locations
- All partners/services move to restore face to face contacts where possible
- Explore how to capture the voice of all service users including children and young people across the system to inform future service delivery plans
- Review the digital offer in line with multi agency comms plan considering all vulnerable groups and potential inequalities

Long Term

- The ISHS will be delivered through 2 main community hubs will have moved to suitable locations in Durham City and Bishop Auckland
- Revised delivery models will be in place ensuring that innovation/best practice developed through COVID 19 has been incorporated
- Improved quality framework in place based on service user feedback etc

Triple Aim Outcome Measures

Teenage Pregnancy and Sexual Health Steering Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Young people will will have the ability to make informed healthy relationship choices, they will know where to go if they need information, advice and/or guidance resulting in a reduction in unplanned teenage conceptions	1. Ensure that the voice of all service users including children and young people is captured and used to inform system design and/or improvements	1. All relevant staff/agencies will have a workforce that is trained to support young people to make healthy relationship choices
2. All residents of County Durham will have access to high quality sexual health services accessed through a range of community-based hubs and spokes	2. Identify and consider all vulnerable groups in system planning to ensure a reduction in inequalities	2. The workforce will be upskilled and supported to ensure that they can effectlivy support vulnerable groups to access relevant support
3. A multi-agency quality framework will be in place that ensures data is robustly used to inform service delivery	3. Ensure that all services are developed considering the impact of adverse childhood experiences(ACE's) and trauma informed practice	3. The system workforce will have an understanding of ACE's and apply a trauma informed approach

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Better understanding of the risk-taking behaviour of high-risk groups which informs more impactful delivery						
Reduce inequalities in sexual health and under 18 conceptions through the integrated sexual health service providing both universal and targeted services provision and support						
Continue to sustain low STI rates locally and reduced inequalities						
2. Approach to Wellbeing						
Develop and implement a 3-year Sexual Health Strategy which includes clear actions to deliver strategic recommendations						
3. Personalised Care						
Ensure that Personalised Care approaches are embedded within service delivery, including the use of shared decision making and choice are included within the offer						
4. Mental Health and Learning Disabilities						
Ensure that people with learning disabilities and other vulnerable groups are supported to make appropriate choices regarding their sexual health and relationships						
5. Children						
Develop a local multi-agency action plan based on the national framework for sexual health improvement to reduce the conception rates in those under 18						
6. Digital						
As part of the development of the strategy to ensure that the digital offer supports the sexual wellbeing of the people of County Durham, including advice and guidance, and signposting.						
7. Finance						
Through the development of the strategy ensure a whole system approach to financial management is undertaken						
8. Integration						
To support the further development of integrated services across pathways of care as part of the strategy, including Primacy Care Networks, and the Voluntary and Community Sector.						
9. Cultural Change						
To ensure that leaders within the system are identified from partner organisations to support the cultural change that will ensure positive experience and outcomes for the people of County Durham.- what do you mean by this / what will it look like and how will it be measured?						

Stroke

Why change is needed

- Due to changing demographics, the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability will increase by a third by 2035
- Advances in treatment are not universally available
- Changes to the hyperacute elements of the pathway have improved patient outcomes however these gains are not being realised due to the fact that rehabilitation is not standardised for all patients across County Durham
- The current model of care does not provide adequate levels of therapy input as ort of the overall stroke pathway
- Inequality exists within the current model of care, accessibility into services is disparate and requires bolstering of community and inpatient based therapy provision

Objectives

- To provide high quality specialist care to all patients, improving quality of life following a stroke
- Ensure that supported discharge and high quality, consistent rehabilitation is embedded into pathways.

Goals

- All patients who can benefit from mechanical thrombectomy and thrombolysis receive it
- Services are configured to ensure that high quality specialist care is the norm for all patients
- The stroke workforce are well equipped to deliver specialist interventions and high quality rehabilitation
- To develop a person-centred model of care that delivers care closer to home
- To minimise variation, reduce inequalities and maximise the health outcomes of our local population
- To develop a service which retains and attracts an excellent workforce
- To ensure care is accessible and responsive to people's needs

COVID - 19

- Short Term – emergency stroke services maintained in light of COVID to ensure resilience. Services have adapted pathways to ensure patient needs are met whilst also following latest Government guidelines. Remote technology has been used particularly in relation to ongoing review appointments

- Medium Term – understanding any impact that the COVID pandemic has had on known stroke cases and the way in which services have and continue to be accessed

- Long Term – ensuring all future plans for service transformation are quality assured in line with COVID guidance

Triple Aim Outcome Measures

Stroke Improvement Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Adults having stroke rehabilitation in hospital or in the community are offered at least 45 minutes of each relevant therapy for a minimum of 5 days a week.	1. Patients and their families are involved in rehabilitation goal setting which is documented and reviewed in a standardised way across acute and community	1. Ring-fenced funding in place for inpatient stroke specialist therapy input
2. Reduced length of stay across inpatient stroke units	2. All eligible patients to receive opportunity for 6 month review	2. Implementation of a skill mixed therapy model which meets NICE clinical guideline (CG162)
3. Patients to receive a swallow screening assessment within four hours of arrival at hospital	3. Personalised care plans in place with a MDT approach to goal setting, intervention and care management – across all settings	3. To develop and implement a stroke-specific staff survey to be used as a measure of success with community and acute based teams

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Ensure standardised model of care is rolled out across CDD for Atrial Fibrillation						
To utilise existing commissioned services focussed on prevention across NHS, social care and voluntary sector organisations to identify opportunities for AF screening						
To review equity of access to stroke services following potential change in model of care						
2. Approach to Wellbeing						
Continue to actively use the SSNAP data to review any service improvements and best practice. Active stroke consultant recruitment						
Finalise plans to enhance hospital based specialist rehabilitation						
Implement community based stroke service and measure improvements against baseline information as part of 6 month review of service						
Mobilise future model of care for inpatient rehabilitation across County Durham and Darlington						
Review future model of care for inpatient rehabilitation against baseline measures						
3. Personalised Care						
To review the utilisation of the shared decision making model throughout the pathway						
4. Mental Health and Learning Disabilities						
To review and continue to develop acute and community based stroke rehabilitation to include access to psychological therapies as per NICE guidance						
To ensure there are reasonable adjustments made to ensure equity of access as part of the pathway						
5. Children						
6. Digital						
To ensure all clinical and performance systems interact with one another, particularly in relation to the Stroke Association and their delivery of the 6 month review service						
7. Finance						
To review appropriate use of resources ensuring that any savings are reinvested in workforce and additional investment in community services realises benefits.						
8. Integration						
Review contracts with stroke association as an integrated approach						
Ensure integration of health and social care processes have a positive impact on patient outcomes i.e. ensure discharge planning and implementation is done holistically						
9. Cultural Change						
To review effectiveness of new model of care and change in culture of working practice by comparing quality and performance against baseline. In particular to assess average length of stay to ensure a more seamless pathway and early discharge.						
To work with teams across acute and community as well as social care to create a culture of “one team” to ensure seamless transitions for patients and their families						

Dementia

Why change is needed

- To ensure people living with dementia and their carers are supported and receive a high quality, consistent level of service. Appropriate support, services and signposting are in place to ensure that people can live as well as possible with dementia. This encompasses people living in the community and in care homes.

Objectives

- People with dementia live in their own home / community for as long as possible
- Appropriate support, signposting and services are available to people with dementia and their carers.
- Communities, public services and providers are supported to achieve dementia friendly status

Goals

- People with dementia are able to live at home for as long as possible, avoiding as far as practicable the requirement for long-term care placements and hospital admissions. Technology, carer support and environmental factors all contribute effectively to this goal
- Countywide Dementia Advisor Service commissioned on a long-term basis with sustainable funding in place
- Dementia Advisors fully integrated within Primary Care ensuring those with a diagnosis of dementia are supported from the onset
- Dementia Advisors working across prisons in County Durham supporting prisoners with dementia and assisting rollout of dementia friends training in prisons
- Ensure appropriate, specialised services are in place to support those with dementia including early onset dementia
- Market dementia services and ensure, simple, effective communication to those living with dementia and their carers.
- Continue to Support the development of Dementia Friendly Communities across the County, including dementia friendly organisations, providers, employers and services.

COVID - 19

- Short Term - Ensure that dementia support services are robust during / post pandemic, including availability of voluntary sector support and domiciliary / personal assistant offer; and care home dementia specialist provision.

- Medium Term – Increased urgency to test new ways of working and, in particular, digital solutions for people living with dementia, given the need to improve outcomes but also increase the pace of invest to save initiatives, taking into account funding pressures. In addition, focus on wider system change such as improved diagnosis and integrated working with primary cares can open up opportunities to bring forward initiatives at a time when increased partnership working with the voluntary and independent sector has become more prevalent due to the pandemic

- Long Term – Recognition that dementia services may change in the longer term, both in terms of strategic aims, desired outcomes and methods of service delivery. For example, increased focus on digital services and service delivery in post-pandemic environment and acknowledgement of a shift in terms of funding pressures. New ways of working may lead to invest to save initiatives and improved future outcomes for some individuals, e.g. a focus on rehab and rehabilitation for dementia rather than an approach of 'management of decline'. Careful monitoring of OGIM and associated action plans as live documents and ability to change focus to address emerging or changing pressures.

Triple Aim Outcome Measures

Dementia Strategy Implementation Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Improved diagnosis rates and access to specific support post diagnosis	1. Increased availability of services for people with early onset dementia	1. Sustainable funding secured for dementia advisor service
2. Improved recognition of early onset dementia across the system, with aim that diagnosis is achieved as early as possible and support identified	2. Improved information and access to information for people living with dementia and their carers	2. Increased availability of personal assistants for people living with dementia and their carers
3. Further integration with primary care to ensure joined up approach to dementia services and seamless, quality services to individuals	3. Embed new / improved digital solutions and new ways of working with people with dementia. Reduce demand on statutory services	3. Increased co-production with people living with dementia / carers and the wider system – including dementia alliance and voluntary sector

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Community Services available for older people with dementia and their carers across the County. Address gaps in service provision around early onset dementia (under 65)						
2. Approach to Wellbeing						
Long-term funding is secured for the Dementia Advisor Service						
Continue to review / improve information for people with dementia and their carers and the accessibility of the information. Increased focus on digital solutions for provision of information, where this suits the needs of people living with dementia and their carers						
Consider alternative options to residential / nursing care for people living with dementia, e.g. specialist supported housing, extra care, use of technology; provider training and support (NB cost considerations are crucial to this). Review of care home commissioning strategy to consider options to meet dementia needs in alternative provision, particularly extra care						
3. Personalised Care						
Promote personal health and social care budgets, including direct payments (DP), for people living with dementia and their carers. Investigate ways of increasing take up of such opportunities for more self-directed care. Increase availability of personal assistants, through improved pay rates and Care Academy initiative, to facilitate more opportunity and choice. Plans in place for improvement in DP pay rates. Explore opportunities to quicken the pace of this work given the economic impact of the pandemic and possibility of attracting more people to a career in care						
4. Mental Health and Learning Disabilities						
Improve service availability for people with learning disabilities and dementia, identified as an increasing national trend. Through both access to existing OP services, where suitable, and possible new / specific services. Consideration of the role of specialist residential care as part of specific review process.						
5. Children						
6. Digital						
Improve technology and telecare options for people living with dementia, including investigation of new / innovative solutions, e.g. sensors, tracking technology, health / interactions analysis etc.						
7. Finance						
Dementia advisors core contract funding in budget until March 2021 – identification of long-term funding required. Acknowledged that this is likely to be a budget pressure given increased financial pressure on the system Additional primary care dementia advisor service extension to be considered, including identification and agreement of budget. Potential funding required for Dementia Friendly Co-Ordinator, as below						
8. Integration						
Improve services / support for people with dementia / carers including integration with primary care (including dementia advisor service); hospital offer; investigation and adoption of new ways of working and new technology solutions						
Working with all the dementia groups e.g. Dementia Action Alliance, Strategy Group and ADASS Dementia Leads to align priorities to achieve best outcomes for people with dementia and their carers and identify gaps in service provision. This promotes a co-production approach to dementia strategy and services. Refresh and reinvigorate strategic approach. Consider whether desired outcomes, needs and risks have changed due to the pandemic						
Dementia Advisor Service to be granted access to prisons in County Durham (currently Frankland only) to support prisoners with dementia and promote dementia friends approach. Acknowledge need to consider COVID-19 risks in this work						
9. Cultural Change						
Potential funding to be sourced for Dementia Friendly Co-ordinator to support communities across the County in becoming dementia friendly.						

Living well with frailty / Older People – Community Care

Why change is needed

- To ensure frail elderly are able to live well at home for as long as possible and receive high quality, consistent levels of service. To take a preventative, progression approach to care, utilising short-term support, preventative services and signposting in delivery models to ensure an enabling approach, positive individual outcomes and sustainable budgets

Objectives

- Promote preventative, short-term approaches and a progression approach to care delivery
- Appropriate services, signposting and VCS resources are available to service users / carers.
- Achieve an invest to save solution to delivery, promoting reablement and independence and avoiding as far as possible costly long-term care
- Changing culture to ensure that all involved in delivering care focus on maximising wellbeing, independence and quality of life pertinent to the individual

Goals

- Short-term, preventative and rehab / reablement services are the first option for care delivery. People are able to live at home / in the local community for as long as possible. VCS and provider markets are able to support this goal. Where long-term care is required, stakeholders retain a progression approach to ensure that service users are enabled to maintain independence and develop skills, rather than being 'maintained' in terms of care
- Technology, carer support and environmental factors are able to contribute effectively to this goal
- Reablement and intermediate care / hospital discharge services continue to deliver high quality outcomes and sustain capacity across the Durham geographical footprint
- Equipment provision is available to support reablement, progression and sustainable outcomes, including community equipment and provision in care homes
- Domiciliary care availability, coverage and quality is maintained and able to deliver a progressive approach through appropriate staffing and skills
- Day services are commissioned for all specialisms and function appropriate to the needs of the user groups
- Integration between adult social care and community health services delivers improvements in quality and efficiency. A multidisciplinary Discharge Team coordinates the pathway for complex discharges reducing errors and improving patient experience
- There is a coordinated approach to the provision of training and support to care home and domiciliary care provider staff from the range of community health services that supports the quality of their care
- People with a learning disability and/or autism are supported to live safe and healthy lives in the community
- People with a learning disability and/or autism are not subject to health inequalities
- Integration between adult social care and community health services delivers improvements in quality and efficiency. A multidisciplinary Discharge Team coordinates the pathway for complex discharges reducing errors and improving patient experience
- There is a coordinated approach to the provision of training and support to care home and domiciliary care provider staff from the range of community health services that supports the quality of their care

COVID - 19

- Short Term – Ensure that critical services, including reablement and domiciliary care, are robust in terms of service delivery and able to function during the winter period and / or during an increase in COVID-19 cases. Contingency planning and system support in place, including continued focus on Care Academy opportunities for people not in employment who may be willing to change career and work in care
- Medium Term – Increased urgency to test new ways of working and, in particular, reablement approaches in wider services, given the need to improve outcomes but also increase the pace of invest to save initiatives, given funding pressures. In addition, focus on wider system change such as improved discharge pathways and opportunities to bring forward initiatives at a time when increased partnership working with the voluntary and independent sector has become more prevalent due to the pandemic
- Long Term – Recognition that services may change in the longer term, both in terms of strategic aims, desired outcomes and methods of service delivery. For example, day services may be less in demand and / or delivered in a different way, including virtual support, while learning disability services or those for people with dementia may have an increased reablement focus which has been thought to be to challenging in the past. Increased focus on digital services and service delivery in post-pandemic environment and acknowledgement of increase in funding pressures and greater urgency to transform services. Careful monitoring of OGIM and associated action plans as live documents and ability to change focus to address emerging or changing pressures.

Triple Aim Outcome Measures

Durham Frailty Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Episodes of falls in older people	1. Proportion of over 65s in care homes	1. Vacancy rates in community nursing
2. Rates of loneliness in older people	2. Hospital admission rates for older people	2. Morale in community services
3. Rates of depression in older people	3. Long hospital stays endured by older people	3. Vacancy rates in community therapy services

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Continued investment in VCS infrastructure and services to enable preventative approaches. Includes Public Health commissioning and interventions						
Preventing loneliness and social isolation						
Increasing participation in exercise in older people including building strength and balance. Focus on improving 'activity' provision in care homes						
Enhancing falls services to support falls prevention. Pilot new falls prevention approaches, potentially using extra care services initially						
2. Approach to Wellbeing						
Changes to commissioning models / specifications to ensure a focus on outcomes. Embed reablement and outcome focussed intervention approaches across the system. Increased financial pressures due to pandemic mean need to embed improved long-term outcomes and 'invest to save' approaches are more urgent						
Identify sustainable funding for reablement service, to ensure reablement can be offered to all with potential to benefit. Ensure reablement national target of package start times continues to be met across Durham footprint. Reablement / rehab approach to be embedded to wider services – so this becomes an ongoing system aim						
Recommissioning of IC / Hospital Discharge Beds to ensure continued effectiveness of model and system developments are reflected in delivery. Continued promotion and work with providers to sign up to spot provision, to ensure rising demand is met.						
Development of a community frailty model including Same Day Emergency Care for frailty						
Developing in reach model to support discharge from hospital and supporting the Home First community collaborative						
Development of the existing community lymphedema service to include non-complex patients						
Implementing the extended community delivery model for intravenous antibiotic treatment						
Implementing the improved stroke rehabilitation model						
Reviews of SALT dietetics, cardiac rehabilitation, ISC Catheter and osteoporosis services to support improved patient outcomes						
3. Personalised Care						
Implementation of Personal Health Budgets for wheelchairs (including powered chairs)						
Increased uptake of PHBs for continuing care patients						
Increase in personalised care and shared decision making						
Implementation of Social Prescribing Link Workers targeting people with long term conditions						
4. Mental Health and Learning Disabilities						
As work takes place to reduce the gap in life expectancy for people with a learning disability we will review the community models of care and support to enable people with a learning disability to age well						
We will continue to develop flagging systems to ensure adjustments are made for those people who have a learning disability. Include consideration of reablement approaches for people with a learning disability						
Ensure that the two hour response for mental health crisis is linked to the wider frailty crisis response						
5. Children						
6. Digital						
Implementation of digital technology in care homes to support better patient care and outcomes, including Health Call, NHS mail roll out and electronic care plan sharing						
Improvement and electronic sharing of Emergency Health Care Plans						
Development of Local Directory of Service to ensure that all involved in care provision are aware of local services that are available						
Re-launch of mobile working for NHS community teams						
Review technology offer through strategic system groups, including review of care connect service and potential new delivery models						
Implementation of digital technology in care homes to support better patient care and outcomes						
7. Finance						
Ensuring that there is continued growth in funding for community based services to support prevention, support in crisis and returning to independence after a period of ill health						
Community equipment contract to be reviewed / recommissioned, multi-disciplinary approach across all stakeholders. To include review of care home equipment policy						
Review / recommission other equipment contracts, e.g. ceiling track hoists / slings						
Review options for future commissioning of domiciliary care in terms of basing delivery / payment on tasks / outcomes. Potential for new AZEUS system to facilitate new ways of commissioning, when implemented						
Day Services review and remodelling to promote employment, volunteering, training as an alternative to traditional day service delivery. Potential Invest to Save model; outcome focussed provider interventions to promote service users moving into meaningful activity / employment and avoid long-term costs. Reablement type approach of specific service before access to any long-term provision. Need to factor in effects of pandemic on wider economy and employment opportunities						
8. Integration						
Integrated commissioning model for domiciliary care; initially spot provision but moving to framework contracts also. Includes piloting joint care facilitation and payment processes through AZEUS						
Further development of integrated working between health and social care and mental health and physical health within the Teams Around patients framework						
Improved working between hospital and community teams including developing a multi-disciplinary approach to the Discharge Management Team						
Development of integrated commissioning of nursing and residential care across health and social care; potential for new ways of commissioning care home services to ensure they are on a sustainable footing and able to deliver the quality needed within budgets for the longer term						
9. Cultural Change						
Recruitment and Training support to community providers (particularly domiciliary care / reablement) through supporting the Provider Market project Care Academy. Aim to increase / sustain capacity and quality and enable workforce is able to shift to progression / outcomes based model						
Developing understanding of the services available in the community and their ability to manage patients safely and effectively. This is vitally important for both relationships between clinicians and also between H&SC staff and the public						

Palliative Care and End of Life

Why change is needed

- Death and dying are inevitable. The quality and accessibility of this care will affect all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities, must be addressed, taking into account their priorities, preferences and wishes. Personalised care at end of life will result in a better experience, tailored around what really matters to the person, and more sustainable NHS and social care services. In County Durham the National Ambitions Framework for Palliative and End of Life Care forms an effective basis for action. There are perceived inequalities in access to palliative and end of life care which need to be identified and actions to reduce inequity developed.

Objectives

- "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

Goals

- I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. Those who care for me know that and work with me to do what's possible.
- I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.
- My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.
- I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond.
- Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.
- I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

COVID - 19

- Short Term – palliative and end of life care has no doubt been affected by COVID-19 – family are unable to be there for people during their last weeks, days and hours if in hospital; people dying with COVID discharging home risks transmission of the virus into the community so people are not able to die in the place of their choice; bereavement has been difficult for families where they are unable to be in close proximity to each other for support - this will continue even as society restarts.

- Medium Term – as we live with COVID-19 there may be additional increases in death numbers – as long as there remains transmission in the community – palliative and end of life care staff will need to be mindful of the additional risks in their roles.

- Long Term – will need to get back to a more compassionate and holistic view of palliative and end of life care.

Triple Aim Outcome Measures

County Durham and Darlington End of Life and Palliative Care Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. People are able to die in their usual place of residence (measured by Public Health Outcomes Framework indicator *Percentage of deaths in usual place of residence (DiUPR) (All ages*))	1. Quality of service is rated as good or excellent by informal carers (measured by Voices survey)	1. Nursing and consultant staff to be working at optimal capacity (measured by vacancy rates).
	2. Families' and others' experience of care is rated as good, excellent or outstanding (measured by National Audit of Care at the End of Life)	

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
The Health and Wellbeing Board will lead the development of population-based needs assessment and Health Equity Audit (HEA) for palliative and end of life care services						
Development of End of End of Life and Palliative Care Strategy, informed by needs assessment and HEA.						
2. Approach to Wellbeing						
Patients and families/carers are engaged in the co-production of EoL and palliative care action plans locally and in the design/delivery of future services.						
Ensure patients have access to Specialist Palliative Care when needed, including a clear understanding of how to access medicines and equipment as part of the rapid response to changing needs.						
Every organisation will have clear governance at Board level for high quality palliative and end of life care and environments in which all staff can provide the best of their professionalism and humanity.						
3. Personalised Care						
Develop effective systems to reach people who are approaching the end of life, and ensure effective assessment, care coordination, care planning and care delivery.						
Work with the voluntary and hospice sector to ensure paid carers and clinicians at every level are trained, supported and encouraged to bring a professional ethos and awareness of a personalised care approach to care.						
Ensure that all those who provide palliative and end of life care understand and comply with legislation that seeks to ensure an individualised approach.						
Ensure care records encompass patients' needs and their preferences as they approach the end of life, using Decide It Right and 'Everything in its place'. With the person's consent, these records should be shared with all those involved in their care.						
Ensure unpaid carers receive the support, training and education they need to effectively care for their loved ones.						
4. Mental Health and Learning Disabilities						
Work to be undertaken with clinical leads across the system to ensure appropriate adjustments are made to pathways to support people with Significant Mental Illness and Learning Disabilities.						
Continued meeting of the multiagency LD Service Improvement group (chaired by the County Durham CCG Director of Nursing), where the thematic tool will be discussed and future areas of work agreed						
5. Children						
6. Digital						
The End of Life and Palliative Care Steering Group will ensure that Individual organisations and local systems of care engage with initiatives to generate much more robust and useful data.						
7. Finance						
8. Integration						
Develop a better system-wide response to dying people, using a full range of coordinated services deployed in the community. Informed by the Health Equity Audit, improve equity of access to EoL and palliative care services across County Durham, taking into account rurality, deprivation and other socio-economic and health factors.						
9. Cultural Change						
Maintain an End of Life Steering Group/commit to Integrated Care Partnership level steering group whilst keeping links with Darlington and Tees Valley.						
To achieve our ambition more should be done locally and nationally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their families and communities.						

Carers

Why change is needed

- To ensure unpaid carers are recognised across the system and receive appropriate support, services and signposting to ensure they can manage their own wellbeing and maintain their caring role

Objectives

- Carers are supported in their caring role
- Carers are able to maintain their own health & wellbeing
- Carers are able to maintain unpaid care, to support the health and social care system (invest to save basis)

Goals

- Unpaid carers across all sectors and specialisms are able to self-identify and recognise that they have a caring role and may require support, including young carers / BME groups. Carers receive a consistent quality of service, no matter the care needs of the person they care for and whether they are an adult or child (acknowledging that the focus of young carer services is to protect from inappropriate caring and give YC's similar opportunities to their peers, whereas adult carers is focused on maintaining caring role).

- Carers continue to be able to access appropriate practical and emotional support to maintain their caring role and own wellbeing and are recognised and valued by all parts of the system; with professionals having knowledge of carer services and where to signpost, as well as knowledge of adjustments required for carers and how to recognise their knowledge / experience

- Health & Social Care system is able to manage increase in volume of carers, including investment in services and potential new ways of working / new technology to mitigate demand on resources. Increased complexity of caring roles is recognised and supported, e.g. services for 'sandwich carers' who are dealing with often competing caring roles for individuals of different generations.

- Carers are able to maintain employment and are supported to do so, including engagement with employers across work sectors. Carers are no longer discontinuing their employment in order to care, affecting their own wellbeing, financial status and the local economy. Closer / stronger working with employers, Job Centre Plus, Adult Learning & Skills service etc.

COVID - 19

- Short Term – increased focus on carer breaks and identifying risks of carer breakdown; in recognition that the pandemic has increased pressures on many carers as services the person they care for stood down and they were in lockdown. Specific actions have been developed to address this and funding has been provided to the Carers Support Service. "Keeping in Touch with Carers" project has been set up to maintain contact and offer support to unpaid carers affected by the pandemic in the most high-risk groups.
- Medium Term – Employment support and aiming to get more carers into employment is a significant outcome focus for Durham. This contributes to several of our strategic aims in terms of wellbeing, financial security, cultural change etc. We are aware that this work will need to be adapted considering the affects of the pandemic, both in terms of the overall economy and the potentially increased demand on carers as a result of COVID-19. This will involve potentially longer timescales and changes to approaches. Carers services are also working with employers under DCC's umbrella membership of Employers for Carers to raise awareness of issues carers face and how best to work with carers to achieve outcomes satisfactory for all.
- Long Term – Recognition that services for carers may change in the longer term, both in terms of strategic aims, desired outcomes and methods of service delivery. For example, increased focus on digital services and service delivery in post-pandemic environment and acknowledgement of a shift in terms of funding pressures. Careful monitoring of OGIM and associated action plans as live documents and ability to change focus to address emerging or changing pressures.

Triple Aim Outcome Measures

Durham Carers		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Reduce instances of carer breakdown leading to emergency service provision being required	1. No of carers applying for / accessing carer breaks	1. No of carers accessing employment support initiatives
2. Carers outcomes reported in the national Survey of Adult Carers remain above NE and England averages	2. No of carers assisted to claim / retain benefits	2. Development of carers self-assessment tool / RAS, incorporating personal budgets for both health and social care where applicable
3. Robust mental health support is available for carers, particularly in light of pandemic pressures	3. Parent carer services to be consolidated and long-term funding identified	3. Successful re-launch of carers card / carers discount schemes including no of carers issued with this support

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
County Durham continuing to improve outcomes and operate at higher standard than both north east and national targets in the Survey of Adult Carers in England (based on baseline from 18-19 survey						
2. Approach to Wellbeing						
Carer breaks and continued training / development of carers through DCC Supporting the Provider Market Care Academy project						
Development of plan for further employment support, with event for employers (including health / social care and SME's) in 20-21 and 21-22. This will be delivered virtually if required and adapted to take into account pandemic pressures in the employment market. Focus on carers maximising benefit opportunities where needed, e.g. those who have lost their jobs						
Parent carer resources to be developed and funded. Particular resource pressure as previous provider grant funding no longer available.						
Potential short-term funding availability to Q3/4 20-21 and long-term funding to be identified, with appropriate specifications, thereafter						
3. Personalised Care						
Revisit and explore the possibility of a carer's self-assessment tool and resource allocation system leading to carers receiving their own personal budget. NB: Would involve consideration of services delivered under current contracts. Explore use of carers personal health budgets						
Continue to deliver personalised carer breaks to prevent carer breakdown.						
4. Mental Health and Learning Disabilities						
Contracts for carers deliver a universal offer irrespective of the needs of the cared for. Opportunities are in place for carers, e.g. training to safeguard their own mental health and wellbeing.						
5. Children						
Continue to work with CYPS to identify hidden young carers and to ensure delivery of the right services to this carer group (including carer breaks). Particular focus on schools as services return post pandemic.						
Monitor the services provided to Parent Carers currently delivered from adults non-recurrent funding as a short-term solution. Carer services provider to continue to seek more longer-term funding for this group of carers with specific needs; commissioners to also consider funding options if required. Acknowledge that funding pressures may be more acute in post-pandemic system						
6. Digital						
Continue to improve information for carers and the accessibility of the information. Increased importance to delivery of information, services, and support virtually in pandemic and post pandemic environment						
Improve services for carers on a practical level – marketing approaches; improved recognition; signposting to services such as Wellbeing for Life; support for carers in hospitals; investigation and adoption of new ways of working and new technology solution						
7. Finance						
Carer breaks funding built into contract; STPM funding currently to end 20/21						
8. Integration						
Carers provider, Durham County Carers Support (DCCS) working into employers to offer assistance and support to carers and employers						
Re-launch Carers Discount scheme and carers card initiatives – including marketing and joint working with retail and services sector through DCCS						
9. Cultural Change						
To continue to reverse the national trend of decreasing satisfaction of carers – this is not being seen in Co Durham						

Learning Disability & Autism

Why change is needed

- People with lived experience tell us they are unable to access health services the same way as other people
- Some people with learning disability die prematurely of preventable and treatable causes
- People with a learning disability, autism, or both tell us they want to live safe lives in their own community, with friends and family and have the same rights and choices as everyone else.
- For more information, please see:
  Joint Commissioning Strategy for People with Learning Disabilities and Durham insight Learning Disability Factsheet
  Think Autism in County Durham Strategy

Objectives

- For all people with a Learning Disability, Autism, or both in County Durham to have a good life in their community with the right support from the right people at the right time.
- To learn from Learning Disability mortality reviews and prevent premature mortality

Goals

- Develop keyworkers for children and young people with the most complex needs and their carers/families
- Reduced numbers of people in specialist learning disability or autism inpatient settings
- The 7 keys of Citizenship are fully embedded increasing outcomes such as independence, wellbeing, choice, control and community resilience
- Increased focus on preventative support, early help and timely intervention, with the right information, advocacy, advice and support to help prevent/manage a crisis
- More people with a learning disability and/or autism living in their own homes receiving personalised care and support, which helps them make choices, maximise independence and reach their personal goals
- More people with a learning disability and/or, autism in paid employment as well as meaningful activity, education and training
- More children, young people and adults with a learning disability each year will have an annual health check and better access to health and social care
- To raise greater awareness of the appropriate use of psychotropic medication
- To reduce the number of people with a learning disability and /or autism who die prematurely unnecessarily.
- Equity of access to community-based specialist mental health, learning disability and autism services, which includes the best care, the right accommodation and good provision of assistive technology and equipment
- To complete a mortality review within 6 months of notification of death for all people with a learning disability over the age of 4 years who have died using LeDeR methodology
- To share the learning from Leder reviews with partners across health and social care

COVID - 19

Short Term

- Keeping people safe- people with learning disabilities are at higher risk from Covid 19 due to levels of respiratory related mortality); workforce being able to support people safely and practice infection control where people lack capacity, have increased anxiety/distress or have behaviours which challenge
- Keeping people connected and providing mental health support- increased vulnerability, loneliness & isolation during the pandemic emergency; post trauma among frontline staff (key workers)
- Address backlog of clinical activity/health checks due to restrictions (e.g. health checks, autism assessments)
- Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities.

Medium Term

- Respond to impact of Covid19 on mental health and wellbeing, continuity of care, bereavement, relationship management, financial resilience, changes to social conditions.
- Impact on the most vulnerable communities and need to ensure equitable access to support and advice

Long Term

- Long term impact of the socioeconomic consequences - Impact of unemployment, reduced finances, ‘austerity’, relationship breakdown
- Long term impact of the pandemic/lockdown/social distancing on mental health and behaviours, anxiety and fear, pressure on family carers and on the workforce
- Delays due to the pandemic in developing new services for people with learning disabilities and/or autism with complex needs; impact on the market, design of and financial impact on services to take into account infection control measures

Triple Aim Outcome Measures

Durham Learning Disability and Autism Strategy Delivery Groups		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. We will Improve health and wellbeing by reducing health inequalities, improving healthy life expectancy and preventing illness and avoidable death	1. We will work collaboratively with people and their families to develop new ways to deliver services and support to achieve better outcomes and improve their lives	1. We will support **workforce development** and **culture change** to ensure that alternative options and new ways of working are actively promoted and considered as positive alternatives.
2. People experience good physical and mental health and a sense of wellbeing in spite of any underlying health issues related to their disability/condition and are helped to be as independent as possible.	2. People are helped to achieve what is important for them, ensuring their needs are met in their community and helping to reduce loneliness and isolation.	2. People who provide support will have the necessary knowledge and skills to meet needs and also understand any reasonable adjustments required (e.g. due to autism/sensory/communication and learning difficulties)
3.. People's physical and health needs are addressed in a timely manner	3. All factors that impact on people's lives are considered in plans to meet health and social care needs to improve broader wellbeing	3. People who provide support in whichever setting understand the importance of people getting their physical and mental health needs addressed

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Eye, hearing and dental services examinations in residential schools						
Promotion of screening and prevention programmes : Cancer, Flu, Annual Health Checks across primary care and the community						
Ensure Medication is used appropriately where there is a diagnosed through greater awareness of the appropriate use of psychotropic medication.						
Continue the work supported by the Autism in Schools Project to increase support and preventative strategies to maintain children and young people in education						
Further develop the Learning Disability training programme within Primary Care, covering mental capacity act, communication, alternative approaches to medication and equality in health care for the learning disability population						
2. Approach to Wellbeing						
Roll out, as part of new PCN arrangements the STOMP-STAMP programmes						
Continue to promote and deliver Building the Right Support by reducing further the number of people in inpatient setting whose needs can be met in the community in their own homes						
3. Personalised Care						
Implement and embed the 7 key principles of Citizenship; As part of the Transforming Care Delivery Network, Support the development of a coproduced focused programme of initiatives, which addresses: Housing, Employment, Personalised care and support and advocacy						
4. Mental Health and Learning Disabilities						
5. Children						
Robust Child Death process is in place within the Trust						
6**. Digital**						
Work with Network partners to explore further developments to improve digital flagging and optimal use of assistive technology						
7. Finance						
Work across our Integrated Health and Social Care system to further ensure value for money and cost effective commissioning frameworks in line with the Durham Joint Health and Social Care Learning Disability Commissioning Strategy and Autism Strategy						
8. Integration						
Deliver the Joint Health and Social Care Learning Disability and Autism Strategy across Durham - establishing new supported accommodation services for people with the most complex needs						
Jointly review the support commissioned for people living in specialist residential care including out of county placements.						
9. Cultural Change						
Implement and embed the 7 key principles of Citizenship; As part of the Transforming Care Delivery Network, Support the development of a coproduced focused programme of initiatives, which addresses: Housing, Employment, Personalised care and support and advocacy						

Mental Health

Why change is needed

- **Start well**
- Half of mental health problems are established by the age of 14, 75% by 24 years
- While the County has a good range of resources to support re know that not all systems are joint up meaning families don't know where to first seek support.

- **Live well**
- 1 in 4 adults are diagnosed with mental ill health at some stage in their life. Due to the Covid we predict this number will increase as a direct result of the pandemic, result of lockdown and further economic challenges in the future as a result. Other factors like rise in domestic abuse and its impact on mental health are expected to rise.
- Economic factors are a factor to emotional mental health; only 8% of people on Care Programme Approach (CPA) are in employment and predicted to rise as a result of economic downturn and increased deprivation.
- Use of alcohol and prevalence of substance misuse is higher in those presenting with a mental health diagnosis and learning disability.

- **Age well**
- There is an ageing population in North East and North Cumbria - in people over 65 years 7% have dementia, 28% have depression - the rate of depression is higher than the England average.
- Loneliness and isolation are felt to be key factors in emotional wellbeing need in the older population, further exacerbated by covid19/lockdown
- The life expectancy of mental health service users is 20-30% less, in terms of years lived, for mental health service users than the rest of the population. The gap in the North East and North Cumbria is higher than the national average.

- **Full life cycle**
- The North East has some of the highest rates of mental illness in England and demand is increasing, Need predicted to accelerate due to covid19/lockdown impact on emotional wellbeing.
- Health inequalities exist; mental health impact for those with autism, vulnerable groups such as LGBTQ+, BAME have some different needs to be supported.

What has changed from the last plan?

Easy read healthy lifestyle booklets have been created and will be distributed via learning disability partnership – reason not strategic enough.

Objectives

Our objectives are set out within the **Mental Health Strategic partnership** covering 5 key objective areas;

1. Children and young people's Mental Health and Emotional Resilience Transformation Plan
2. Suicide prevention alliance
3. Crisis care concordat
4. Dementia strategy implementation group
5. Resilient Communities

The Living Well Alliance as three key objectives;

1. Recovery and staying well
2. Own choice
3. Participation

The Heath Impact Assessment has key objective areas;

Using a system wide approach to address:

1. Socio-economic factors linking to County Durham Poverty Reduction Strategy and Poverty Reduction Plan
2. Improving mental health and emotional wellbeing via County Durham Mental Health Strategic Partnership
3. Build resilience in community assets and community networks
4. Promote inclusion for marginalised groups

Key **cross theme** objectives are;

- **Start well**
- Ensure all young people and their families have the best start in life. Mental health services designed to support at point of need with open door.
- **Live well**
- Connected communities rich in community assets to support
- **Age well**
- Maximise the support offer to reduce loneliness and social isolation

Goals

- **Start well,**
- Maternity and Paediatrics – allowing evidence- based treatment and interventions to be provided closer to home
- Child Health - Implementation and evaluation of multiagency, co-produced plans to transform children and young people's services in order to improve children and young peoples' mental and physical health and wellbeing. This includes supporting family around any child/young person.
- Services are commissioned to ensure those who work, live with, and support children and young people receive the support they need in order to continue to care while maintaining their own well-being.

- **Live well**
- Promoting prevention and early intervention and connectivity into VCSE to increase mental health and wellbeing within local communities and build resilience by delivering the right support and care in the right place at the right time. This will include wrapping service around Primary Care Networks as appropriate.
- Empowering the system-wide workforce to feel confident in addressing mental health and wellbeing through MECC training, mental health first aid and suicide prevention.
- Reduce the premature mortality of people living with severe mental illness and autism by enabling more people to have their physical health needs met through increased early detection and access to evidence based physical care, assessment and intervention.
- Improving the physical health of people in receipt of treatment or support for a mental health condition and/or autism–– Reduce the premature mortality of people living with severe mental illness by enabling more people to have their physical health needs met through increased early detection and access to evidence based physical care, assessment and intervention.
- Urgent Care and Crisis –enhance the full pathway so people with mental health needs can access the right care at the right time from the right person/team/service
- Community Framework – maximise the mental wellbeing and resilience of our population by delivering the right support/care in the right place at the right time. This will include wrapping service around Primary Care Networks as appropriate, delivery of enhanced community based, early intervention support and stabilised specialist provision
- Maternity and Paediatrics – allowing evidence based treatment and interventions to be provided closer to home
- Suicide Prevention and Bereavement Support – Implementation of the North East North Cumbria Integrated Care Sector regional Zero Ambition for suicide.
- Psychological Wellbeing Therapy– Develop a more integrated IAPT model with Primary Care Networks to increase IAPT workforce within primary care

- **Age well**
- Ensuring a skilled workforce to meet the needs of the communities they support in a place based setting.
- People's choice will be supported in order to meet their needs.
- People with dementia and their carers will have the support they need, when they need it.

- **Full lifecycle**
- The strategic partnership will ensure services are recovery / wellbeing focussed
- Ensure positive patient outcomes from all services provided and ensure high levels of patient satisfaction
- Optimising Mental Health Services and mental health outcomes across the full system. This will include development of Resilience Hubs providing a range of specific interventions (from community based to highly specialist) to support the key worker workforce and wider community (across the life course) address covid-specific mental health/emotion needs

COVID – 19

Prevention at scale is a key theme that runs through short, medium and long term. Ensuring support at a population level and ensuring that every contact counts is a key element to the Covid recovery plan for mental health.

- **Short Term**
- Understanding predicted demand.
- Accepting New Covid19 related demand - Mental health support for Covid19 survivors; mental health impact of lockdown on vulnerable groups ; post trauma amongst frontline staff (*all* key workers)
- Address backlog of clinical activity due to restrictions (eg autism assessments, dementia assessments);
- Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities.

- **Medium Term**
- Exacerbation and relapse of mental health conditions - relapse due to impact of Covid19 on mental health, continuity of care, bereavement, relationship management, financial resilience, changes to social conditions.
- Medium term economic impact due to social restrictions/ reduction in income/job losses.
- Impact on the most vulnerable communities and need to ensure equitable offer

- **Long Term**
- Long term impact of the socioeconomic consequences - Impact of unemployment, reduced finances, 'austerity' , relationship breakdown

Triple Aim Outcome Measures

Due to the challenge of Covid this section is all related to Covid 19

Mental Health Strategic Partnership Board		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
Start well In the community I know where I can get support e.g. mental health and emotional wellbeing services for myself or my child via my school, local area, or where I can self-refer or access digital support like Kooth.	**Start well** People who support me help me to achieve what is important for me	**Start well** People who support me (workforce) help increase my access to low level early mental health support pathways within educational and community settings. They offer a graded response and trauma informed support. Consideration given for most vulnerable in my community such as LGBTQ+ and BAME
Live well In the community I have knowledge of the Resilience hubs and what they can offer me. I can easily access these and they help me with issues specific to COVID. I am able to easily access good mental health services for all other needs I might have	**Live well** People who support me ensure that my needs are locally met in my community. This might be from a range of providers.	**Live well** People who support me understand financial welfare support and the impact money worries can have on my health and wellbeing They have the necessary knowledge and skills to meet my needs and also understand any reasonable adjustments I may need (e.g. due to autism/sensory/communication and learning difficulties)
Age well People who support me have been part of the age well strategy and are able to understand my support needs and give me better outcomes.	**Age well** People who support me consider all factors that impact on my life and ensure my health and social care needs are met. Helping to reducing loneliness and isolation supports my broader wellbeing	**Age well** People who support me in whichever setting, including my care home/care sector support my physical and mental health needs.

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Start Well – Schools have a graded and robust offer to support children, young people and their families via a cross system response. This offer support teachers and school based staff						
Live Well - Aim to prevent all suicides, and to reduce the suicide rates by a minimum of 10% by 2021.						
Age Well – Through new Ageing Well Strategy, reduce social isolation across the County to improve wellbeing and prevent mental ill health with a particular focus on those who are clinically vulnerable						
COMPLETE Implementation of IPS - Increase in education, training, volunteering and employment opportunities for people with mental ill health						
COMPLETE Promote, increase and maintain screening rates prevention programmes: Cancer, Flu, Annual Health Checks for those with a learning disability and a severe mental illness.						
2. Approach to Wellbeing						
Start Well – Perinatal services meet 4% target in order to support the best start in life, and supporting parents at the first opportunity.						
Live Well - Development and delivery of implementation plan for new community based models of care, in line with national framework for community mental health services (5 year programme) and improved pathways of care. Improve capacity for early intervention and prevention services, and develop community assets across Durham in line with DCC Approaches to wellbeing						
Age Well – Through new Ageing Well Strategy, reduce social isolation across the County to improve wellbeing and prevent mental ill health for all adults.						
COMPLETE “Make Every Contact Count” – a brief interventions toolkit paper – has been developed to support patient-facing services in engaging with clients around depression, generalised anxiety disorder, social anxiety disorder, alcohol use disorder, smoking cessation and gambling awareness						
COMPLETE Increasing staffing resource within urgent care and crisis bids investing to support; frequent users of services (High intensity users), trauma informed care post within crisis teams, a happiness hub fund to support VCS organisations to establish new alternatives to crisis, establishing new 111 (option 2) services and an older peoples team						
3. Personalised Care						
Start Well – Ensure all services can support personalised care for children and young people, ensuring they can express what is important to them and their needs.						
Live Well – Everyone accessing specialist services feels involved in their care and has co-produced their care plan						
Age Well – Ensuring everyone has a say in a co-produced care plan that best meets their needs						
COMPLETE Social prescribing funded navigator posts will be available to Primary Care Networks						
4. Mental Health and Learning Disabilities						
Start Well – Ensuring resilience approaches are available to all young people to prevent MH needs.						
Live Well – Implement mental health support line for people in crisis, including those with substance use needs (dual diagnosis)						
Age Well - Mental Health Services for Older People (including dementia services) improvement plan						
COMPLETE Continued delivery of Core 24 standard Liaison Psychiatry Service and build on offer to include HIU and discharge support						
COMPLETE Improved access, recovery and waiting times to IAPT accredited interventions and therapists – Implementation of a new service model from 1st of April 2019, including a single point of assessment undertaken by suitably qualified staff and a wellbeing offer. Recruitment ongoing to increase capacity within the service to offer the full range of NICE approved, evidence based interventions; including trainee PWP and HIT.						

Oral Health

Why change is needed

- Despite being largely preventable, tooth decay remains a significant health problem amongst young children in England; a quarter of 5-year olds and 12% of 3-year olds have experienced tooth decay, and alongside the risks of pain and infection, this can have a wider impact on children's nutrition, school-readiness, development and well-being. Tooth decay is the leading cause of hospital admission for children aged 5-9 years, contributing to an NHS spend on hospital-based tooth extractions for children in excess of £35m per year.

Objectives

- Improve the oral health of County Durham through population wide and targeted approaches.
- Help improve dietary habits, dental hygiene and use of dental services.
- The proportion of 5 year old children free from dental decay continues to rise (measured by PHE)

Goals

- An increase in dental access and attendance for children aged 0-2 years;
- A reduction in hospital-based tooth extraction for children, with associated economic benefits;
- A reduction in restorative and emergency dental treatment for children attending NHS primary care dental services, with associated economic benefits;
- A reduction in Emergency Department attendances, a decrease in NHS 111 use and unscheduled dental care appointments, and a decrease in antibiotic and analgesia prescribing - for young children, with associated economic benefits; and
- A decrease in the number of missed school days associated with poor oral health, and a decrease in the number of days taken off work by parents or carers due to caring for children with poor oral health.

COVID - 19

Since developing the OGIMS the covid-19 pandemic has affected the whole of society. All OGIMS are now required to be considered through the lens of recovery over three phases: short term (restarting society – 2020), medium term (living with covid – 2021), longer term (recovering – 2022). Please provide a brief narrative of how you have adapted the detail below to take this into account.

- Short Term – dentists closed during lockdown. School based programmes, early years also paused.
- Medium Term – covid-19 diet studies are highlighting an increased calorie intake. Plausible impact on food consumption. Community based interventions will need to consider how they function within social distancing guidelines. However, covid-19 highlighted the health risk of obesity and obesity strategy may begin to tackle food manufacture.
- Long Term – lockdown suspended the public consultation on community water fluoridation, which may have a long term impact for the process.

Triple Aim Outcome Measures

Oral Health Strategy Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Improved dmft for children age 5.	1. Satisfaction with NHS dentistry	1. Integration into early years settings
2. Reduction in extractions	2. Tooth brushing schemes core business County Durham Health settings (part of Early Years Healthy Settings)	2. Component of better health at work
3. Reduction in 111 usage	3. Support for community water fluoridation	3. Drinking water and sugar free foods seen across public sector settings

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Increase in families accessing the dentist in 30% most deprived MSOAs						
Increase breast feeding initiation by 5%						
Increase breastfeeding at 6 – 8 weeks by 5%						
Training on oral health promotion given to front line practitioners						
Collaborate to deliver community water fluoridation and consider appropriate approaches to revenue costs.						
2. Approach to Wellbeing						
Plain drinking water in public sector and community venues is the main drink available						
Provide a choice of sugar free foods – including vending machines						
Increase number of schools following national school food plan; ensure plain drinking water available and sugar free snacks						
Explore feasibility of minimum set of standards for oral health within care home contracts, and those in receipt of adult social care e.g. oral health assessment on admission to care home, oral health care plan established and regularly reviewed – quality metrics						
3. Personalised Care						
Implementation of labelling dentures to reduce loss and cost of replacement						
4. Mental Health and Learning Disabilities						
Ensure that the new County Durham Oral Health Strategy considers the specific needs of people with Learning Disabilities and those with Mental Health needs.						
5. Children						
Targeted oral health promotion work for vulnerable groups; SEND and vulnerable parent pathway; training sessions delivered to special school support staff on oral hygiene and health promotion						
Encourage schools to include oral health as part of the curriculum – PSHE resources easily available						
School Nurses to promote dental access at parent sessions and to assist with dental practices regularly visiting schools to facilitate the uptake of dental care in targeted communities						
6. Digital						
Ensure that the new County Durham Oral Health Strategy considers opportunities to utilise digital approaches to support good oral health						
7. Finance						
Include training and support in residential care homes on importance of oral hygiene and dual training on dementia care as part of contract						
8. Integration						
Align dental practices to children centre cluster areas in targeted communities, and dental practices to each residential care home to ensure a general dentist is available for advice/guidance						
9. Cultural Change						
Breastfeeding friendly venues – UNICEF accreditation maintain status						
Consider lobbying for national policy change, but also local implementation on tackling the promotion of less healthy food and drink by place and policy and introducing calorie labelling in the out of home sector. Consider extending the current soft drinks levy, with a local levy to the foods popular with children (and adults) that are high in sugar such as sugary drinks, breakfast cereals, biscuits, ice cream, chocolate confectionery, cakes, puddings and sweet confectionery.						

Please note the Oral Health Strategy was due to be published in April 2020 which would have updated the content of this chart, however due to Covid has not occurred to date. Once available this will be updated to reflect the new strategy, including new timescales.

Primary Care Networks

Why change is needed

- It is estimated that around 90% of NHS contacts take place in primary care, with approximately 8,700 patient contacts per day (over 3 million per year) in general practices across County Durham.
- In County Durham, it is estimated that 23.6% of over 65s are living with a limiting long term illness or disability.
- In January 2019, NHS England published the NHS Long Term Plan setting out the overarching long term goals for the NHS and specific changes for Primary Care through dissolving the divide between primary care and community based health services. Building on the ambitions set out in the NHS Five Year Forward View and The General Practice Forward View, the plan emphasises a shift of focus away from hospitals and towards community and primary care and acknowledges the challenges currently being faced in General Practice such as
    - Increase in an aging population with multiple Long Term Conditions and Health Inequalities
    - Workforce demands including challenges with recruitment and retention of GPs, Practice Nurses and Practice Managers
    - Increase in the number of financially vulnerable practices
    - Demands in Secondary Care with expectations of more specialist care delivered closer to home

Objectives

- Increase the scale and integration of out of hospital services, based around communities and improve population health outcomes

Goals

1. To improve access to primary care services for people living in County Durham, both in hours or within extended services (during evening and weekends), through a range of methods, including digital solutions and the ability to share electronic care records for better continuity of care.
2. By ensuring good access to primary care seven days a week, we will offer better support for patients, while reducing urgent demand at our hospitals to enable them to care for acutely unwell patients.
3. Through Primary Care Networks, we will increase the scale of multi-agency integration to reduce health inequalities and improve our population health outcomes. We will also support better health through prevention and develop a culture that promotes self-care.
4. Ongoing development of new models of proactive, co-ordinated and personalised care that promote shared decision making to ensure high quality care is delivered closer to home. This approach will ensure hospital stays are seen as part of a continuing relationship with care services and not an isolated episode.
5. Patients will continue to have a named GP who is accountable for their care, but may be supported and treated by another member of the extended multi-disciplinary team who can best meet their needs.
6. Work in collaboration with wider health and care partners to provide a fully integrated health and social care system without visible boundaries.
7. To build capacity, skills and capability into the extended primary care team. The team will include a range of clinical and non-clinical roles, to meet the health and social care needs of the local population. We will continue our focus on both recruitment of additional roles and retention of our existing workforce to help improve workforce satisfaction.
8. Following national direction, we will aim to reduce unnecessary bureaucracy to release more time to care.
9. To help practices to become more resilient and sustainable we will continue to identify and support vulnerable practices. We will implement initiatives aimed at reducing workload pressures resulting from increased demand and/or workforce shortages. We recognise that PCNs provide an opportunity for practices to work together to improve their collective resilience and sustainability.

COVID - 19

The COVID-19 outbreak is arguably one of the greatest public health challenges of our time, not least for general practice.

Data on primary care activity suggests that activity has returned to pre COVID-19 levels although there has been a huge shift to telephone or video consultations.
PCNs were required to deliver on the newly developed COVID-19 Care Home Support requirements in May 2020 and are now refocusing once again on the Network Contract Direct Enhanced Service (DES) and have reinstated the Extended Hours Access DES.
Primary care is focused on re-start, understanding patient's views of new ways of accessing services and collaboration with secondary care on service delivery such as out-patient support.
Our programme of work, over the next six months, will focus digital technology to help patients to access primary care services in different ways and support new ways of working. We will also give priority to re-starting primary care services and supporting early cancer diagnosis.
To ensure that the positive transformative changes are not lost, we must take steps to lock-in these improvements moving forward. As part of our refreshed primary care strategy and recovery planning we need to take into consideration three dimensions:

- Embedding COVID driven transformation.
    - Guidance has been shared with practices originally developed by 'The Maltings Surgery', around the use of face to face and remote consultations, linked to the COVID-19 risk level. Practices will be able to review and adapt these policies based on their individual circumstances.
    - The CCG has undertaken a review of the LIS to identify indicators that are no longer viable or deliverable given the pandemic. These are to be replaced by indicators that support pathways between primary and secondary care as part of COVID-19 recovery planning.
- Managing the backlog of non-COVID patients, whose treatments have been delayed during the crisis.
    - One of the key Network DES priorities during recovery is Early Cancer Diagnosis.
    - We will continue to work with partners to support system recovery. This will include understanding demand already in the system and the re-establishment of GP referrals to acute hospitals and mental health services.
- Restart service development and redesign which was planned pre COVID-19
    - Practices have restarted many nurse clinics where safe to do so.
    - PCNs are to fully implement the requirements of the Enhanced Health in Care Homes (EHiCH) service model as part of the Network Contract DES.
- Building resilience for future COVID waves, embedding the lessons learned into ways of working, business continuity plans, and future pandemic response.
- Health inequalities
    - There is a risk that recovery of services could cause confusion and lead to increasing health inequalities for our population. Future work plans will aim to recover services in ways which address population differences which have been exacerbated by COVID-19.

Triple Aim Outcome Measures

Primary Care Networks Clinical Directors Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Proportion of people with a learning disability on the GP register receiving an annual health check	1. National GP survey (annual)	1. Number of GPs employed by NHS (CCG level data)
2. Increase uptake of screening programmes (breast, bowel and cervical)	2. GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*	2. Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme
3. Delivery of structured medication reviews	3. Patients whose care has been discussed as part of shared decision making	3. Proportion of providers with an outstanding or good rating from the CQC for the "well led" domain

Project Gantt Chart	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**	**BRAG**
1. Health Inequalities and Prevention						
Implementation of DES service specification – Early Cancer Diagnosis						
Implementation of DES service specification – Structured Medication Review and Medicines Optimisation						
Flu preparedness						
Population Health Management in conjunction with Public Health to inform PCN's understanding of population health needs						
Implementation of DES service specification – CVD diagnosis and prevention						
Implementation of DES service specification – Tackling health inequalities						
Implementation of Diabetes Prevention Model (interdependency with Diabetes OGIM)						
2. Approach to Wellbeing						
Extended Access – potential development of new model post COVID-19						
Extend Social Prescribing Link Workers model						
Helping staff working in primary care stay safe during the Pandemic						
3. Personalised Care						
Implementation of DES service specification – personalised care						
Implementation of DES service specification – anticipatory care						
4. Mental Health and Learning Disabilities						
Community Mental Health – practice based mental health workers (Interdependency with MH OGIM)						
Promote annual health checks with people living with learning disabilities – increase to 75% and health checks for patients with autism to be piloted (Interdependency with MH OGIM)						
PCN workforce additional role – new Mental Health practitioners						
5. Children						
Support PCNs with any specific improvement projects						
6. Digital						
Virtual Consultation – embedding of digital solutions in line with the regional strategy						
7. Finance						
Co-commissioning activity which may include management of arising contract issues, practice mergers and branch closures and overall sustainability particularly in relation to vulnerable practices						
Local Improvement Scheme (LIS) - refreshed annually to reflect local needs and national priorities						
IIF - Support primary care on implementation of work to support indicators						
8. Integration						
Primary Care Workforce plan including training and development of expanded multi-disciplinary team working						
Additional Roles Reimbursement Scheme						
Fuller joining up with urgent care services and NHS 111 Direct booking						
Ongoing PCN development as part of an integrated system approach						
Implementation of the DES service specification – Enhanced Health in Care Homes						
Review of VAWAS and CSP role in the context of PCN development and integration						
Primary Care input into system wide planning for recovery and preparing for future COVID waves						
9. Cultural Change						
Total Triage – embedding transformation post COVID						
Care Navigation – understanding how this will fit with total triage and post COVID transformation						
Continue to support the cultural shift from separate primary, community and social care services towards integrated Primary Care Networks through the organisational development programme						

Urgent and Emergency Care

Why change is needed

- Urgent and Emergency Care demand has increased year on year and for services to meet the needs for those who most need it changes to the current system must be made. To ensure that we continue to meet the needs of our most unwell patients, we must ensure that patients are treated in the most appropriate setting and in the most appropriate timeframes, reducing pressure on our most stretched services. Staffing remains a challenge, with large gaps in most sectors, due to difficulties in increasing staff numbers within limited financial budgets, we must reduce activity in order to need the most urgent needs of the population.

What has changed since March 2020?

- During the peak of the Covid-19 pandemic, the level of patients attending Urgent and Emergency Care reduced significantly, with approx. 30% less attendances that pre Covid-19. These levels have increased again, but still remain approx. 10% lower, if this could be maintained would mean that the Trust has sufficient capacity to manage both the emergency demand and the standing up of the elective demand.

Objectives

- To reduce demand on Urgent and Emergency Care Services, improving patient flow experience and performance.
- Reducing unwarranted variation across the Region standardising services and delivery

Goals

Highly responsive 24/7 seamless urgent and emergency care including:

- Pre-Hospital Care - a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services, ensuring patients receive the most appropriate clinical advice and direction to the most appropriate services.
- Timely and accurate data flowing through the ECDS for all EDs, UTCs and CDES from 2020 and the National Ambulance Dataset to be implemented.
- Adults, children and young people experiencing mental health crisis will be able to access the support they need – single point of access through NHS 111, access to crisis care 24/7 and intensive follow-on to reduce future use.
- The Urgent Treatment Centre model universally implemented by autumn 2020.
- Ambulance services, at the heart of urgent and emergency care system, providing timely responses and patients treated at home or in more appropriate care settings outside of hospital. Ambulance staff will also be trained and equipped to respond effectively to mental health crisis, including mental health transport, mental health nurses available for ambulance EOC, and mental health training for front-line crews.
- Improved responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines.
- All parts of the country delivering reablement care within two days of referral.
- Enhanced health in care homes – upgrade NHS support to all care home residents who would benefit by 2023/24.
- Evening and weekend GP appointments in place through Extended Access Services.
- All hospitals with a major A&E department will have a comprehensive model of Same Day Emergency Care at least 12 hours a day, every day, in both medical and surgical specialties; and provide an acute frailty service for at least 70 hours a week achieving clinical frailty assessment within 30 minutes of arrival.
- Implement the findings of the Clinical Standards Review to focus on patients with the most serious illness and injury.
- Extending digital services beyond care homes to vulnerable patients in their own homes

COVID - 19

Since developing the OGIMS the covid-19 pandemic has affected the whole of society. All OGIMS are now required to be considered through the lens of recovery over three phases: short term (restarting society – 2020), medium term (living with covid – 2021), longer term (recovering – 2022). Please provide a brief narrative of how you have adapted the detail below to take this into account.

- **Short Term** – to continue to manage the ongoing Covid-19 demand via segregated emergency streams, both in the Emergency Department and the Acute Medical Units, as well as managing other emergency demand.
- **Medium Term** – to manage the level of emergency demand (both Covid-19 and non Covid-19) to ensure that we have sufficient capacity to cope with the emergency demand, as well as the elective demand. If levels of emergency demand increase back to pre Covid-19 levels, we won't have enough capacity to fully stand up our elective services. Emergency demand needs to be contained at 85-90% of pre Covid-19 levels.
- **Long Term** – to actively work across the system to manage emergency demand for patients with chronic / long term conditions, and to ensure that patients are

Triple Aim Outcome Measures

Local Accident and Emergency Delivery Board (LADB)		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Improved management of Long Term Conditions	1. See and Treatment Standards (95% within 4hrs)	1. Senior Decision Makers at the Front Door
2. Multi-disciplinary management of complex patients	2. Short Lengths of Stay - linked to Same Day Emergency Care (SDEC)	2. Enhanced Clinical Model in the Emergency Departments
3. Improved management of frail patients	3. Improved pathways for frail patients – linked to acute and complex frailty units	3. Improved vacancy rate across all professions

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Continue to utilise local and national data to understand local variation in use of hospital based services and access to treatment						
Work with Primary Care Networks to understand variation in their population's use of health services						
2. Approach to Wellbeing						
NEAS pathfinder to be rolled out to County Durham utilising the single point of access. Requires ongoing training of staff within NEAS						
There is an expectation that once the findings of the Clinical Standards review are finalised, any required changes to reporting and monitoring will be implemented. Shadow monitoring to be agreed and introduced.						
Increase the proportion of people that are treated and discharged on the same day by meeting the new national guidelines for same day emergency care						
Increase the focus on wellness and prevention						
3. Personalised Care						
Appropriate approaches to self-management to be considered by the Personalised Care Steering Group that may positively impact on UEC services						
4. Mental Health and Learning Disabilities						
Continued delivery of Core 24 standard Liaison Psychiatry Service and build on offer to include High Intensity User and discharge support						
5. Children						
Ongoing implementation of the poorly child pathway						
6. Digital						
Development and implementation of a solution to enable compliance with the Emergency Care Data Set database. Approval agreed to progress with IT solution during Quarter 3 to be in place for 2020/21 which will help the urgent and emergency care system to understand capacity and demand which will in turn improve patient care						
Support continues use of the Child Health app						
7. Finance						
Continue to focus on increasing planned care and decreasing use of unplanned care wherever possible to ensure most efficient use of resources						
8. Integration						
Implementation of Consultant Advice Line to provide urgent advice to GPs						
Clinical Assessment Service support NHS111 to provide a clinically backed service which now includes GPs 24/7. This works alongside GP out of hours services across all County Durham and Darlington with direct booking access is in place.						
Supporting streaming from A&E to primary care where appropriate to ensure people are seen in the most appropriate service to meet their needs						
Services are in place with facilities/services in A&E and also in the community. NHS111 profiles ensure these patients are profiled to the correct services. This work is being progressed following the recent System Summit.						
All TAPs and the overnight services together ensure that in a crisis response service is accessible for adults experiencing a sudden change in their physical health condition to prevent avoidable hospital admission. The service is accessed through a single point of access (C3) and includes patients presenting in the ED department at UHND. This service is to be expanded to NEAS, starting in quarter 2 of 2020/21.						
9. Cultural Change						
Continued engagement with the public regarding accessing appropriate services suitable to meet needs, including use of 111						

Digital, Data and Technology

Why change is needed

- Data: The NHS is made up of hundreds of separate but linked organisations, and the burden of managing complex interactions and data flows between trusts, systems and individuals is vastly time consuming. Investing in data interoperability gives the opportunity to release time and resources to focus on clinical care and health promotion.
- Technology: is a significant part of our everyday lives improving the way we socialise, shop and work. It also has great potential to improve how the NHS delivers its services in a new and modern way; providing faster, safer and more convenient care.

Objectives

- To enable the delivery of high quality, easily accessible and efficient health and care services to local population through digital solutions.

Goals

- Flow of data between provider and commissioning organisations for the provision of better patient care and population health management and to support research.
- Providers must submit Emergency Care datasets on a daily basis (as currently mandated)
- Secondary care provides will be fully digitised including clinical and operational process across all settings, locations and departments
- Increase the digital maturity of all health and care organisations.
- Digital solutions are robust and adhere to core standards set across interoperability, accessibility, cyber security and key quality standards achieved in collaboration with our partners
- Patients are empowered to manage their health, access services and view their clinical information using digital solutions. These solutions are provided in addition to the current methods of accessing health and care services.
- Timely information to ensure seamless transfers of care for patients
- Improve access to contemporaneous medical records at the point of care by providing mobile devices and digital services to clinicians

COVID - 19

- Short Term
  - Adoption of the 100% triage first model in primary care with the use of remote consultation software and equipment including online and video solutions
  - Creation of hot and cold sites within individual GP Practices and cross PCN
  - Adoption of video consultation software for the use in MDT meetings in all settings
  - Accelerated roll out of Health Call
  - Expansion of Locate as resource platform in response to Covid 19 for people and for the community hubs

- Medium Term
  - Continuation of the triage first model in primary care with an increase of face to face appointments where clinically necessary.
  - Continuation of the use of hot and cold areas within GP Practices with the ability to step up cross PCN working if necessary
  - Continuation of the use of video software to support MDT meetings as appropriate
  - Strategy for assistive technology being developed

- Long Term
  - Continuation of the triage first model in primary care as part of a blended approach with face to face consultations
  - Video and online consultations remain in place as part of future ways of working
  - Continuation of the use of video software to support MDT meetings as appropriate

Triple Aim Outcome Measures

County Durham Digital Integration Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Information held by partners more efficiently shared, resulting in professionals being enabled to make more informed decision making	1.Improved information provision enabling more self-resilience and ownership of own health and care.	1. Staff efficiency improved due to utilisation of digital platforms and equipment

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Rollout of telehealth solutions including Healthcall / Digital Care Homes						
2. Approach to Wellbeing						
Delivery of the Veteran Health Armed Forces Directory						
Development of the role of social prescribers working within PCNs						
Review of community directory information provision to ensure that people have access to robust advice/information to enable them to live healthy and independent live in their local community						
3. Personalised Care						
Continued development of an digital shared care record through the implementation of a Health Information Exchange and Patient Engagement Platform						
4. Mental Health and Learning Disabilities						
Expansion of the ERS system to include mental health referrals						
Develop a community based mental health patient record system (SystmOne) for use across County Durham and Darlington which integrates with local systems						
5. Children						
Use digital functionality to improve the sharing of child protection information across health and care settings						
6. Digital						
Continuing to identify additional opportunities within the Global Digital Exemplar expansion programme either to obtain GDE status or identify a fast follower arrangement						
The NHS App, online consultations and GP Online, will provide a secure way for citizens to access digital NHS services such as 111 and GP record, book appointments and register for organ donation.						
Mobile devices with remote access software installed will be available to primary care clinicians						
Ensure that the implementation of all digital solutions meet current standards and requirements with regards to interoperability and DSPT						
Deployment of ophthalmology software to allow patient information flow between community ophthalmologists and secondary care clinicians						
7. Finance						
Digitisation of primary Lloyd George care records						
8. Integration						
Ensure that the implementation of all digital solutions meet current standards and requirements with regards to interoperability, accessibility and cyber security						
Further develop the digital solutions available to all care home staff and their residents including secure correspondence						
Improve the transfers of care process using functionality such as FHIR and ERS						
9. Cultural Change						
Develop a communications strategy to support the engagement of patients in the use of digital solutions						
Offer support to care providers in the use of digital solutions that interface with health and social care						

Personalised Care

Why change is needed

- Whilst the health and care system has been changing, the population itself has also changed. People are living for longer with more complex health and care needs. The focus on hospital-based, disease-based and self-contained "silo" curative care models undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care. People are often unable to make appropriate decisions about their own health and health care, or exercise control over decisions about their health and that of their communities.

Objectives

- People have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences.
- Personalised Care will benefit up to 2.5 million people by 2024, giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life
-

Goals

- Empowering people, integrating care and reducing unplanned service use through Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.
- Supporting people to build knowledge, skills and confidence and to live well with their health conditions through proactive case finding and personalised care and support planning through General Practice. Also ensuring support to self-manage by increasing patient activation through access to health coaching, peer support and self-management education.
- Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes through 1) Shared Decision Making, 2) Enabling choice, 3) Social prescribing and link worker roles, 4)Community-based support.

COVID - 19

- Short Term
  The role of the Social Prescribing Link Worker (SPLW) has been (and will continue to be) a key element of both the proactive calls to support those who are shielded and clinically and/or socially vulnerable, identified via the County Durham population health management approach, and reactive response provided by the County Durham Together Community Hub. The inclusion of the SPLWs in this programme has reduced duplication and has facilitated the provision of a wide range of support including welfare calls, mental health support, linking with community groups including food provision, support engagement with stop smoking services etc.

- Medium Term
  The response to the pandemic resulted in the suspension of all non-urgent services, including outpatient clinics. As these are being restored work is underway to incorporate Patient Activation Measures as a means to identify those cohorts of patients who, due to their knowledge, skills and confidence in managing their long term condition. The statement from National Voices regarding the next stages of the pandemic response adopted within the Phase 3 letter from Simon Stevens and Amanda Pritchard places the adoption of personalised care as one of the 5 principles to the restoration of services whilst living with Covid

- Long Term
  Embedding the principles of Personalised Care in all aspects of commissioning and delivery intentions across all clinical pathways and services delivery

Triple Aim Outcome Measures

County Durham Personalised Care Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Improvement in the Short Warwick Edinburgh Wellbeing Scale (SWEMWBS) scores of people using the SPLW service	1. Reduction in the number of avoidable outpatient appointments	1. Number of staff within the County Durham health and care system trained in Shared Decision Making and Personalised Care and Support Planning through the Institute of Personalised Care
		2. Number of staff within the County Durham health and care system trained in the use of the Patient Activation Measure

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Integration of Shared Decision Making approaches within the renewal of the NHS Health Check service, including use of evidenced based decision support tools						
2. Approach to Wellbeing						
Recruitment of Social Prescribing Link Workers in each Primary Care Network by April 2021						
14,500 referrals to Social Prescribing by 2023/24						
12,000 people, including those with long term conditions and people at the end of life and pregnant women supported by personalised care and support planning by 2023/24						
3. Personalised Care						
Full compliance with The NHS Choice Framework						
Shared Decision Making embedded in 30 high-value clinical situations in primary and secondary care, and at the interface between these, by 2023/24						
Patient Activation Measures (PAM) to be incorporated into outpatient setting for a minimum of 5 clinical specialities with staff trained in the administration of PAM, supported by a project lead working across the County Durham, South Tyneside and Sunderland ICP and into the both CDDFT and STSFT						
Proactive and personalised care planning undertaken for everyone identified as being in their last year of life						
By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.						
People who are off work for more than four weeks will receive personalised care plans to manage their condition in work, with reasonable adjustments where needed.						
4. Mental Health and Learning Disabilities						
To ensure that all approaches to personalised care consider the needs of people with learning disabilities and mental health needs.						
5. Children						
To ensure that appropriate use of personalised care approaches are applied in services for children and young people						
6. Digital						
100% of elective referrals exercising choice through e-RS by 2023/24						
7. Finance						
1,600 Personal Health Budgets in place in County Durham by April 2021						
1,600 Personal Maternity Care Budgets by April 2022						
All wheelchair provision to include a Personal Wheelchair Budget offer						
All people receiving home-based Continuing Health Care by April 2020 will have a Personal Health Budget (approx.320)						
8. Integration						
1,200 staff within the County Durham health and care economy undertaken professional skills training in Shared Decision Making and Personalised Care and support planning by 23/24						
Train a minimum of 8 people with lived experience to become system leaders in conjunction with the Peer Leadership Academy by 2023/24						
9. Cultural Change						
All transformational schemes to consider opportunities for integration of Shared Decision Making approaches within the scope of the project, whilst also rolling out the ‘Ask 3 Questions’ or ‘BRAN’ across the health and care sector within County Durham						
All transformation schemes to consider opportunities for integration of Patient Activation Measures (PAM) approaches within the scope of the project, whilst all commissioning staff to undergo awareness training of PAMs						

Population Health and Prevention

Why change is needed

- Delivering service transformation of the scale set out in the NHS Long Term Plan requires a well-developed system and effective underpinning infrastructures. Over the next five and ten years the NHS will progressively increase its focus on prevention and closing the gap in inequalities in health and unwarranted variation in care is at the centre of all our plans

Objectives

- An integrated local system, with population health management capabilities which support the design of new integrated care models for different patient groups.
- Improved incidence and prevalence of key protective factors including smoke-free lungs and living environments, active living and healthy diets; effective and equitable uptake of screening and immunisations; appropriate use of medicines.

Goals

- Strong Primary Care Networks and integrated teams with clear plans to deliver the service changes set out in the Long Term Plan;
  - Reduced inequalities and unwarranted variation in health outcomes through stronger action by the NHS working with Durham County Council and key stakeholders
  - Developed system architecture, with clear arrangements for working effectively with all partners and involving communities as well as strong system financial management and planning (including a way forward for streamlining commissioning, and clear plans to meet the agreed system control total moving towards system financial balance)
  - A move from reactive care towards a model of NHS and Social Care services that embody active population health management, through the Durham Wellbeing Model

COVID - 19

- **Short Term**

  In March 2020 at the early stages of the Covid 19 global pandemic, Durham Council partnered with NECS to adopt a Population Health Management (PHM) approach to support the Covid19 response. The challenge was to use PHM to:

  • Identify patient cohorts by level of vulnerability and risk of severe Covid19 disease and complications, as well as the indirect impacts of the social distancing and lock down measures.

  • Utilise insight and intelligence to target the most vulnerable with a range of care, welfare and well-being support through the local community hub.

  The approach was supported by the North East & North Cumbria Integrated Care System (NENC ICS) Population Health Management steering group. The PHM approach combined medical and social vulnerability intelligence to identify patients and residents who had a greater risk of severe Covid19 disease and ensure they were provided with the right support. The support arrangements included the implementation of the Government advice on social distancing, isolation and shielding. This work is ongoing within the gradual restart of services

  The County Durham and Darlington Health, Welfare and Communities Recovery Group have initiated a rapid Health Impact Assessment (HIA) on health inequalities to provide a 'snapshot' insight into the impact of Covid lockdown during the recovery and restoration phase of the pandemic. An HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population and the distribution of those effects within the population. The Assessment's recommendations support all sectors in ensuring community voices and assets are considered in organisational recovery plans.

- **Medium Term**

  The PHM approach has enabled the Durham Health System to explore other opportunities where integrating data and developing deeper intelligence and insights into the population can support the development and delivery of integrated interventions. These include the following:

  a. Using the PHM approach and population stratification to inform reset of services as well as the development of the local Covid19 recovery plans across the system,
  b. Modelling of the mental health impact of covid19 by applying planning scenarios to the different vulnerable populations (including recognising multiple vulnerabilities) and using this to inform the identification and delivery of targeted early intervention
  c. Using PHM to understand the health and well-being issues for children and young people as part of the Growing Up In Durham programme
  d. Exploring the use of PHM to help inform the NHS and wider health system operational reset and winter plans for the coming year
  e. Using PHM to further understand the mortality profile for Covid19 and non-Covid19 deaths during the pandemic and using the information for future planning for subsequent waves of the pandemic.
  f. Using PHM approach to understand flu immunisation uptake and to inform plans for improving uptake for the coming winter as well as prepare for the covid19 vaccination programme

  In the medium term the County Durham Outcomes Framework will provide the Integrated Care Board with a suite of metrics framed within the Triple Aim that enables a greater understanding of system performance and the interdependence

- **Long Term**

  Work will continue to support the development of PMH approaches that support geographical populations via Primary Care Networks, age related cohorts aligned to the life cycle, and communities of interest (BAME, LGBTQ, etc.)

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
PCNs provided with Health Analytics from NECS to identify unwanted variation at a locality level, drawing upon multiple data sources including NHS RightCare						
Triangulation and alignment of DCC Business Intelligence (including Durham Insight) and NHSE/I & RightCare data to address health inequality and wider determinates of health						
PCN strategic and operational plans to address health inequality						
2. Approach to Wellbeing						
Integration of the Durham Wellbeing Model in all system planning and operational delivery						
3. Personalised Care						
All initiatives identified as a result of addressing health inequalities to consider and implement appropriate Personalised Care strategies including population segmentation and shared decision making to address unhealthy behaviours and						
4. Mental Health and Learning Disabilities						
See MH & LD OGIM						
5. Children						
See Children and Young People OGIM						
6. Digital						
Development of a system-wide performance framework that includes operational performance (including waiting times, non-elective care, service outcomes, etc.) and wider determinates of health (including housing, employment, healthy life expectancy, activity, smoking, etc.) whilst incorporating the Triple Aim						
7. Finance						
Integrated Governance arrangements further developed to support integrated working across the system that supports strong system financial management and planning						
8. Integration						
Single PCN / TAP operational plans and governance frameworks						
Integrated Commissioning Team established between Durham CCG and Durham County Council						
9. Cultural Change						
Use of population health approaches to shift cultural thinking in health and social care provision from a reactive illness model of care to a proactive and targeted preventative model						

Shorter Waits

Why change is needed

- Receiving timely care is important to patients when they are referred to hospital for treatment
- In some cases care could be provided differently rather than a face to face appointment which would improve patient experience and efficiency of care delivery
- The waiting list position has been deteriorating and the number of people waiting for treatment has increased.
- There is a requirement to implement the recommendations of the Clinical Standards Review (2019) regarding patient access and choice.
- There is no agreed system in place to offer all patients waiting more than 6 months an alternative provider.

Objectives

- Reduce the number of people waiting for hospital treatment to March 18 levels and achieve Referral to Treatment (RTT) targets.
- No patients waiting more than 52 weeks for treatment
- To offer every patient waiting 6 months or longer the choice of receiving treatment from an alternative provider.
- To implement the outcome of the Clinical Standards Review.
- All referrals triaged on receipt
- Implement MSK First Contact Practitioner.

Goals

- All referrals triaged on receipt to identify the most appropriate pathway of treatment
- Achieving 92% Referral to Treatment Incomplete Pathway target.
- Achieving waiting list requirements of the Long Term Plan whereby waiting lists are below March 18 levels and no patient is waiting 52 weeks or more for treatment.
- All patients waiting more than 6 months are offered an alternative provider through an agreed system in place.
- All recommendations of the Clinical Standards Review are implemented.
- A range of alternative pathways are developed as an alternative to face to face appointments (where appropriate)

COVID - 19

- **Short Term**
  - Demand Management - Development and implementation of advice and guidance, digital consultation, shared decision making and prioritisation.
- **Medium Term**
  - Return to pre Covid levels of performance
- **Long Term**
  - Fundamental changes embedded and the achievement of the objectives set

Triple Aim Outcome Measures

System Assurance Group		
Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Waiting list mortality	1. Reduction in 18 & 52 week waits for CDDFT & CCG	1. Consultancy vacancy rates / no of fragile services
2. Waiting list morbidity	2. Advice & Guidance	2. Staff competent and confident utilising A & G
3. Effective system of patient prioritisation	3. Patient experience of remote consultation	3. Staff competent and confident in digital consultations

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities and Prevention						
Continue to utilise local and national data to understand local variation in use of hospital based services and access to treatment						
Work with Primary Care Networks to understand variation in their population's use of health services						
Undertake respiratory health equity audit						
2. Approach to Wellbeing						
Increase the focus on wellness and prevention						
Implementation of Clinical Review Standards – to be published Spring 2020						
3. Personalised Care						
Develop a process to offer choice of an alternative provider where patients have been waiting more than 26 weeks for treatment						
Consider implementation of a Patient Activation Measures (PAMs) approach across a number of specialties to support people to self-manage their condition where appropriate						
Improving elective capacity at Bishop Auckland and choice of hospital for surgery						
4. Mental Health and Learning Disabilities						
Ensure that appropriate adjustments to pathways continue to be in place for patients with a Learning Disability and that their effectiveness is monitored						
5. Children						
Implementation of a community based level 2 and 3 continence service as an alternative to hospital based treatment						
6. Digital						
Continue to implement a range of pathways as an alternative to face to face appointments building on the successful implementation of virtual fracture clinics and tele-dermatology						
7. Finance						
On-going delivery of the Outpatient Transformation programme						
Continuation of the MSK First Contact pilot to support evaluation and a decision on full roll out across the county						
Introducing triage of referrals on receipt to ensure that people are booked into the most appropriate service						
8. Integration						
Reduce Demand - Additional impact will be realised with ongoing focus on the joint OP Efficiency Programme to reduce secondary care demand e.g. Virtual fracture clinics and tele-dermatology						
9. Cultural Change						
Communicate the benefits of alternative models for delivery of outpatient care						
Develop partnerships between primary, community and acute care to support joined up service delivery and care close to home wherever possible						