Health and Wellbeing Board

24 November 2021

County Durham Commissioning and Delivery Plan 2020-2025 (third edition)

Report of Sarah Burns, Head of Integrated Strategic Commissioning, Durham County Council and NHS County Durham Clinical Commissioning Group

Electoral division(s) affected:

None.

Purpose of the Report

1. To provide the County Durham Health and Wellbeing Board with an update on the third iteration of the County Durham Commissioning and Delivery Plan 2020-2025.

Executive summary

2. The County Durham Commissioning and Delivery Plan 2020-2025 (third edition) ("the plan") forms the health and care commissioning and delivery intentions of the system, to meet the objectives within the County Durham Joint Health and Wellbeing Strategy (JHWS). Now in its third iteration the plan continues to use the structure of the previous versions, namely 22 chapters that reflect the life course of

    - Starting Well
    - Living Well
    - Ageing Well

3. The plan is owned by the County Durham Care Partnership Executive (CDCPE), and therefore covers the commissioning intentions of the Integrated Commissioning Team (including Public Health) alongside the delivery intentions of NHS mental health, acute, community, and primary care services. The plan does not replace organisational operational planning, though does bring together partners across pathways of care within each chapter.

4. This third edition of the plan was due for publication in Spring 2021, however because of the pandemic a decision to delay this until the Autumn was taken.

Recommendation

5. The Health and Wellbeing Board is requested to review and approve the content of the plan.

OGIM structure

6. Each chapter, known as an OGIM (Objectives, Goals, Initiatives, Measures), provides a template to support read across between chapters, and to ensure that key lines of consideration are reflected within each. Changes in this edition include the removal of the Approach to Wellbeing under the initiative section, and the separation of health inequalities and prevention to a section dedicated to addressing health inequalities, and prevention being rebadged as health behaviours (alcohol, tobacco, nutrition, and physical activity).

7. The Approach to Wellbeing remains an important model to be applied within the plan, however it was acknowledged that in the previous editions of the plan the content under this heading did not reflect the model adequately, resulting in an inconsistency across chapters. The preface to the plan includes a section on how the plan is meeting the aims of the model.

8. The section on Covid-19 details how each subject area is to support the recovery of services from the pandemic and looks towards a post-pandemic future.

9. The chapter on Palliative Care and End of Life has not been updated due to staffing changes and the suspension of the Palliative Care and End of Life Group over recent months. A new lead for this chapter has been appointed and this chapter will follow in due course once updated with the new national guidance, and following consideration and approval of the group.

County Durham Outcomes Framework and the Triple Aim

10. Work has continued over the period since the last version of the plan was published on developing an outcomes framework based upon the Triple Aim (outcomes, experience, and workforce). Chapter leads have worked with colleagues within NECS to identify outcomes that reflect the triple aim for each subject area, and then the identification of sources of data that can support the reporting of these.

11. A dashboard has been developed within RADIR (Rapid Actionable Insight Driving Reform), a health intelligence tool, that will enable the CDCPE to benchmark these outcomes both nationally, and within the county. This will enable CDCPE to highlight areas of inequality at a county-wide level, and between Primary Care Networks (PCNs). It is expected that the CDCPE will receive a twice yearly report, including an

analyst's narrative report, to ensure that areas of concern regarding outcomes are highlighted. An example of this can be seen in the attachment folder. It is expected that the framework will support investment decision making over time.

Assurance and Approval Processes

12. Each chapter within the plan has been led by a chapter lead, who has worked across organisational boundaries to ensure that the content of each OGIM reflects those working within the subject area (see Appendix 2). This has included extensive clinical leadership engagement, both from within the County, and wider where regional networks have provided support.

13. Chapter leads have also provided an internal assurance process between draft and final submission of the OGIMs, that is, the chapter leads for mental health, children and young people, and personalised care have reviewed each OGIM and suggested amendments and re-wording to ensure read across between chapters.

14. External assurance has been sought from the County Durham Public Health Team to ensure that the section on healthy behaviours reflects current practice and plans, and County Durham Sport has reviewed and provided feedback for each chapter from a physical activity perspective.

15. Approval processes for the plan have been modelled on the new County Durham governance structure, therefore each of the four Partnership Boards considered the chapters relevant to their remit, as seen below.

Board	**OGIMs**
Children, Young People and Families Partnership Board	Maternity, Children and Young People
Mental Health and Learning Disabilities Partnership Board	Learning Disability and Autism, Mental Health
Acute Care Partnership Board	Cancer, Cardiovascular Disease, Respiratory, Stroke, Palliative Care, Urgent and Emergency Care, Shorter Waits
Primary, Community and Social Care Partnership Board	Diabetes, Drugs and Alcohol, Sexual Health, Dementia, Ageing Well (frailty), Carers, Oral Health, Primary Care Networks
County Durham Care Partnership Executive	(enablers) Digital, Personalised Care, Population Health Management.

Patient, Public and Carer engagement

16. It has been recognised that previous versions of the plan have been technical in nature and effectively inaccessible to the public and interested Voluntary and Community Sector (VCS) partners. Whilst the plan is the health and care delivery component of the JHWS and is therefore likely to remain heavy on detail, this should not prevent engagement with the wider public.

17. To support the move towards a co-production model in the future each chapter will be summarised on the County Durham Partnership website, with a page dedicated to the plan. Through promotion of the website by chapter leads within their networks, and working with Durham Community Action, the website will enable interested parties to provide feedback on content. It is hoped that this engagement will facilitate improvements in participation and co-production from non-statutory partners in future editions of the plan.

Governance

18. Governance of the plan between iterations has been sporadic with the monitoring of progress in-year down to individual chapters utilising their existing arrangements, for example, progress against the aims within the diabetes chapter have been managed through the Diabetes Governance Board. However, such arrangements are not in place for each chapter.

19. To support in-year governance of the plan each chapter lead has been asked to identify their top three priorities for delivery by March 2022 (see appendix 3). Assurance will be provided to the relevant Partnership Board on a three-month basis using a highlight report. This will enable the Partnership Boards to have oversight of progress, address any risks and issues to delivery, and provide a forum for requests to change in-year.

Conclusion

20. The third iteration of the plan reflects an increasing maturity of the health and care system in County Durham to collaboratively plan, measure, and deliver integrated services, whilst tacking the health inequalities within the county, and addressing the legacy of Covid-19.

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Appendix 1: Implications

Legal Implications

The 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

Finance

The financial implications of the plan are not considered within the report.

Consultation

Consultation with Senior Clinical Leads, Commissioners, and Operational Managers within the County Durham health and care system.

Equality and Diversity / Public Sector Equality Duty

The principles of equality and diversity are embedded within each chapter.

Climate Change

No impact.

Human Rights

The principles of human rights are embedded within each chapter within the plan.

Crime and Disorder

Not applicable.

Staffing

The consideration of workforce outcomes supports the identification of service vulnerabilities due to workforce issues.

Accommodation

Not applicable.

Risk

All initiatives within the plan are designed to reduced risk of harm from ill-health and improve outcomes and experience.

Procurement

Specific procurements are not outlined within the plan.

Appendix 2: Chapter Leads

Chapter	Chapter Leads
Starting well	
1. Maternity	Kathleen Berry
2. Children & Young People	Alison Ayres
Living Well	
3. Cancer	Sarah Lee
4. Cardiovascular Disease	Mathew Thomas
5. Diabetes	Joanna Dunbar
6. Drugs and Alcohol	Jane Sunter
7. Respiratory	Helen Stoker
8. Sexual Health	Michelle Baldwin
9. Stroke	Rachel Rooney
Aging Well	
10. Dementia	Lucile Blight
11. Ageing Well	Jen Steel
12. Palliative Care	Sarah Lee
Whole life course	
13. Carers	Rachael Mawston
14. Learning Disability & Autism	Claire Kerr
15. Mental Health	Steven Bramwell
16. Oral Health	Michelle Baldwin
17. Primary Care Networks	Nicole Theobald
18. Urgent and Emergency Care	Clair White
Enablers	
19. Digital	Nicola Murray
20. Personalised Care	Jon Quine
21. Population Health and Prevention	Jon Quine
22. Shorter waits	Kathryn Kirkby / Vicky Blunsdon

Appendix 3: Top three priorities September 2021 to March 2022

Chapter	Priority 1	Priority 2	Priority 3
1. Maternity	Deliver on the agreed plan for continuity of carer model	Deliver the agreed actions in response to Ockenden	As a system scope out the pre-birth and under one pathway of care and make recommendations for improvement including early help making recommendations back to Best Start in Life and the Strategic Delivery Group for Vulnerable Pre-Birth and under 1-year olds in County Durham.
2. Children and Young People	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.	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.
3. Cancer	Implement Survival Follow Up in prostate and one other tumour group	Finalise Lynch testing pathway	Implement social marketing campaign in key tumour groups to target most at-risk communities/cohorts
4. Cardiovascular Disease	Atrial Fibrillation Optimisation and Detection Programme	Implementation of shared decision making within NHS Healthchecks to include patient activation, behaviour change and self-management measures.	Reduce variation of practice in the identification and management of high-risk conditions and audit & clean-up registers to ensure people are coded properly.

5. Diabetes	Continue to deliver and evaluate the County Durham Integrated diabetes model of care programme to determine its impact on health benefits and outcomes for patients with type 2 diabetes.	Continue the work to reduce variation in diabetes care (9 key care processes), outcomes and treatment targets across County Durham.	Introduce a Multi-Dimensional Family Therapy & 7-day Diabetic Impatient Specialist Nurse service using the 2020-24 NHS E Diabetes Treatment & Care programme funding to help reduce hospital length of stay and amputation rates for diabetes patients across County Durham.
6. Drugs and Alcohol	Drug crime and harm reduction funding to support a whole systems approach.	Reduce prescribing rates of potentially addictive medication within primary care.	Integrated approach to referring those identified with substance misuse into Drug and Alcohol Recovery Services.
7. Respiratory	Spirometry: Development of a diagnostic spirometry service across County Durham, either to be delivered by CDDFT alone or with support from PCNs. Address the backlog of patients who are waiting for diagnostic spirometry testing for those without a confirmed Chronic Obstructive Pulmonary Disease (COPD) or Asthma diagnosis.	Long Covid: Continue to meet the needs of people with Covid-19 through the integration of Personalised Care approaches are supporting people within the Post / Long Covid pathway.	Covid Virtual Ward: Explore extending the covid virtual ward – need to address how to support patients out of hours and on weekends. Funding for More staffing resource required would be required.
8. Sexual Health	Develop and implement a 3-year Sexual Health Strategy which includes clear actions to deliver strategic recommendations	Better understanding of the risk-taking behaviour of high-risk groups which informs more impactful delivery	Review the local multi-agency action plan for sexual health improvement to deliver age-appropriate relationship and sex education and reduce the conception rates in those under 18.

9. Stroke	Finalise plans to enhance hospital-based specialist rehabilitation	Review contract with stroke association to ensure a more integrated approach to the management of stroke	Ensure integration of health and social care processes have a positive impact on patient outcomes i.e. discharge planning
10. Dementia	Countywide Dementia Advisor Service commissioned on a long-term basis with sustainable funding in place	Work in partnership to ensure the Dementia Advisor Service is fully integrated within Primary Care ensuring those with a diagnosis of dementia are supported from the onset	People with dementia are supported to live at home for as long as possible, however those that require long term care in a community setting are cared for by appropriately skilled staff who have access to the required training. Technology, carer support and commissioner activity relating to care home staff all contribute effectively to this goal
11. Ageing Well - Frailty	Development of a community frailty model including Urgent Community Response and Same Day Emergency Care for frailty, to support the evolving Frailty Front of House and complex frailty unit for patients at Darlington Memorial Hospital, University Hospital North Durham & Bishop Ausckland General Hospital.	Recommissioning of Community Hospital/Intermediate Care/ Designated Setting Discharge Beds to ensure care as close to home as possible as soon as this is appropriate.	Ensure that crisis response whether this is predominantly a health, mental health or social care issue is coordinated in a timely personalised fashion being cognisant of the two hour response for health and four hours for mental health crisis.
	Priority 4 - Ensure the evolving IT systems within different organisation supporting older people are able to share key information to enable the person to tell their story once.	Priority 5 - Embed integrated working between physical health, mental health and social care with mental health within the Teams Around Patients framework and wider community assets, including VCSE.	Priority 6 - Improved working between hospital and community teams including developing a multi-disciplinary approach to the Discharge Management Team.

	Priority 7 - 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.		
12. Palliative Care	On hold	On hold	On hold
13. Carers	Continue to provide and improve robust mental health support for carers, particularly in light of pandemic pressures. Increase the number of carers accessing carer breaks to prevent carer breakdowns.	Increase the number of carers accessing employment support initiatives and raise awareness of the issues carers face in the workplace. Development of a working carers wellbeing app.	Improve information for carers and the accessibility of the information. Focus on the digital skills of carers and training opportunities available to support with this.
14. Learning Disability and Autism	Roll out, as part of new PCN arrangements the STOMP-STAMP programmes. STOMP: Stop the over-medication of children and young people with a learning disability, autism or both STAMP: Supporting treatment and appropriate medication in paediatrics.	Review data and identify service gaps to improve understanding of community support options available in County Durham to meet the needs of people with Learning Disabilities and their family/carers as they grow older including improved planning and end of life care.	Increase the number of learning disability residential homes who are using Health Call technology to detect early signs of deteriorating health.

15. Mental Health	Start Well; Implement I-Thrive model	Live Well: Increase the number of people with severe mental illness receiving annual physical health checks.	Age Well; Through a system-wide Ageing Well Strategy, reduce social isolation to prevent mental ill health and future frailty
16. Oral Health	Plain drinking water in public sector and community venues is the main drink available.	Provide a choice of sugar free foods –including vending machines	Inclusion of oral health promotion and guidance into the healthy schools' framework for education settings.
17. Primary Care Networks (PCNs)	Utilisation of Population Health Management in conjunction with Public Health and other relevant partners to inform PCN's understanding of population health needs.	Maximise use of Additional Roles Reimbursement Scheme	Primary Care Workforce plan including training and development of expanded multi-disciplinary team working.
18. Urgent and Emergency Care	Continue to support all aspects of County Durham and Darlington Local A&E Delivery Board in time of escalation including; leading on elements of the Emergency Department (ED) recovery plan, improvement plan, implementing the winter plans and providing the continuous improvement role in ED. Continue to provide Integrated Care Provider link role.	Develop and implement a Day Time Durham Urgent Care Service / GP extended access service to support the unprecedented demand in ED. In addition, provide a GP front of house model.	Develop an Urgent & Emergency Care strategy for CDDFT linked to this OGIM.
19. Digital	Improve the transfers of care process using functionality such as Fast Healthcare Interoperability Resource (FHIR) and Emergency Referral System (ERS).	Develop and expand electronic systems to support signposting for patients away from emergency departments	Work with Acute Trusts and neighbouring CCGs to develop the Little Orange Book App to support families with young children to access the most appropriate health care at the right time.

20. Personalised Care	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.	Develop and implement a proactive NHS@home pathway for hypertension/blood pressure @home, pulse oximetry @home, and heart failure @home, ensuring personalised care is embedded within the pathway.	Develop a process for approval of Personal Health Budgets for children and young people who have an Education, Health and Care Plan.
21. Population Health and Prevention	Development of the County Durham Outcomes Framework–a system-wide performance framework that is based upon the Triple Aim of 1) Health Outcomes 2) Patient Experience 3) Workforce, with a RADIR dashboard and associated analytical reporting.	Integration of the Durham Wellbeing Model in all system planning and operational delivery.	To develop and implement the Population Health Management (PHM) approach for all PCNs building on the learning from the Wave 2 National programme and the local PCN PHM support.
22. Shorter waits	Recovery up to the nationally set thresholds.	Development of Elective Plus Initiative to tackle backlogs at a system wide level - starting with the specialities Trauma & Orthopaedics and Ophthalmology.	Develop Health Inequalities Dashboard for the Patient Treatment List to inform targeting of any work.