County Durham
Care Partnership

The County Durham Commissioning and Delivery Plan 2020-2025 – 3rd edition, Autumn 2021

1. Introduction

This third edition of the County Durham Commissioning and Delivery Plan 2020-2025 ("the plan") sets out the health and care commissioning and delivery intentions across the life course from Starting Well, through Living Well, to Ageing Well, for the people of County Durham.

The plan is the health and care component of how the strategic aims within the County Durham Joint Health and Wellbeing Strategy will be delivered up to 2025, which in turn supports the delivery of the County Durham Vision 2035 ambitions of

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

The plan needs to be considered together with both strategic documents and therefore does not set out the case for change detailed within these.

This is a whole-system plan that encompasses health and care commissioning intentions from NHS County Durham Clinical Commissioning Group and Durham County Council, and the delivery aims of the County's health and care providers, be that statutory organisations (NHS Foundation Trusts), independent sector providers of health and care services (independent hospitals, nursing and care homes, supported living, day care, and domiciliary care providers), and the Voluntary and Community Sector. This County-wide approach to working collaboratively across health and care, commissioning and delivery, is formalised through the County Durham Care Partnership, and owned, governed and assured through the County Durham Care Partnership Executive.

Whilst it is recognised that individual organisations within the partnership continue to require separate operational plans due to distinct local, regional, and national policies, politics, regulators, and stakeholders, these all impact on the same people and communities in County Durham. Through collaborative planning it is envisaged that opportunities to address the health and care needs, and tackle the health inequalities experienced by our communities, will be enhanced.

This edition of the plan continues with the same format as before, highlighting cross cutting themes, whilst demonstrating an increasing maturity of integrated working between partners.

2. Alignment with the Joint Health and Wellbeing Strategy

The County Durham Joint Health and Wellbeing Strategy (JHWS) forms part of the delivery mechanism for the County Durham Vision, with the objectives contained under the vision ambition "People live long and independent lives" being the

responsibility of the Health and Wellbeing Board. This plan therefore forms the health and care component of meeting the aims within the JHWS, recognising that achieving the vision and JHWS aims is influenced by multiple factors, known as the wider determinants of health. Whilst most of the wider determinants of health are influenced by other strategic partnerships and strategies, including the Economic Partnership and the Environment and Climate Change Partnership, this plan sets out the health and care commissioning and delivery intentions to meet the following Joint Health and Wellbeing Strategic Objectives.

- To improve healthy life expectancy and reduce the gap within County Durham and between County Durham and England
- We will have a smoke free environment with over 95% of our residents not smoking and an ambition that pregnant women and mothers will not smoke
- Over 90% of our children aged 4-5 years, and 79% of children aged 10-11 years are of a healthy weight
- Improved mental health and wellbeing evidenced by increased self-reported wellbeing scores and reduced suicide rates

3. Covid-19 Pandemic

The impact of the pandemic has touched all our lives, our communities, and affected the delivery of our health and care services. Whilst sadly significant in terms of lives lost, families bereaved, and the emerging legacy of long-Covid and the direct/indirect consequences of lockdown, this period has seen health and care partners working collaboratively and dynamically across organisational and sectoral boundaries to meet the challenges bestowed by the pandemic. The plan reflects within each chapter how service provision has been impacted, and how we will recover through partnership working to become stronger, more resilient, and address the health inequalities that the pandemic has further exposed. Our health and care system continues to adapt to the changing nature of the pandemic, including responding at pace to changes in guidance and in restoring services, whilst keeping our communities safe.

The pandemic has enhanced collaborative working across the health and care system, from data sharing between health and social care to identify those at risk of untoward consequences of lockdown, through the successful roll out of the vaccination programme, to how we will support those experiencing longer waits for planned care. It is through this time of adversity that the strength of our partnerships has been shown to be founded in a common understanding that we work best for our communities when we plan, deliver, and align our efforts together as a single health and care system. Whilst there remain more opportunities to further integrate our teams, services and organisations, significant progress over this period has demonstrated that willingness to continue to do so.

4. Health Inequalities, Population Health, and Health Behaviours

Health inequalities within County Durham are known and documented within the Joint Strategic Needs Assessment, the summary of which is detailed within the JHWS. This plan sets out the steps required within each chapter to further our understanding of how these inequalities are experienced in our communities; be that in access to health and care, the experience of health and care, or in outcomes having been in receipt of health and care services. Increasingly our use of place-based data enables this understanding to improve, and through approaches defined by Population Health we will continue to identify where our resources are best placed to reduce the inequalities experienced.

Population Health is an approach that aims to improve physical and mental health outcomes, promote wellbeing, and reduce health inequalities across an entire population. It is founded upon 4 pillars.

- The **wider determinants of health** are the most important driver of health. In addition to income and wealth, these determinants include education, housing, transport, and leisure.
- **Our health behaviours and lifestyles** are the second most important driver of health. They include smoking, alcohol consumption, diet, and physical activity.
- **Places and communities** play a vital role in our health. For example, our local environment is an important influence on our health behaviours, while there is strong evidence of the impact of social relationships and community networks, including on mental health.
- Developing an **integrated health and care system**. This reflects the growing number of patients with multiple long-term conditions and the need to integrate health and care services around their needs rather than within organisational silos.

Each chapter within the plan details how health inequalities are to be identified and addressed, and what health behaviours influence the outcomes experienced. Through separating health inequalities and health behaviours in this iteration of the plan there is a recognition of the importance that these play in achieving the aims of the JHWS.

5. The County Durham Outcomes Framework

To support the work of the County Durham Care Partnership Executive an outcomes framework has been developed, based upon the Triple Aim of

- Improving the experience of health and care services
- Improving the outcomes of health and care services
- Ensuring a sustainable and resilient workforce

The framework marks a departure from traditional activity and organisational performance metrics, with each of the outcomes within the framework dependent upon whole system working. The framework continues to evolve as outcomes are identified that will support the work of the Executive, with a recognition that data does not currently exist for some of the outcomes. It will be for the Executive to agree which outcomes provide value in their decision making, and which do not. The framework provides bench-marking between County Durham and national indicators, and within the County between Primary Care Networks to identify health inequalities at a locality level.

The framework has been developed within RADIR, with the Executive to receive a 6-monthly analytical report that will highlight areas of both good and poor system performance.

6. The Approach to Wellbeing, Engagement and Co-production

In the second iteration of the plan each chapter detailed specific initiatives that were to align with the principles of the Approach to Wellbeing, however there is a recognition that this did not adequately reflect the model. The approach remains an important tool to ensure that the plan has people and places at its heart, recognises the importance of supporting systems, and uses an evidence based approach to what we know works. Through undertaking the self-assessment framework of the model, we know our plan requires further work in engaging our communities on its content, the identification of community assets and needs, and in continuing to identify those at greatest need.

The plan is however a good reflection of how we are working better together through aligning our strategies, our planning, and our governance. The plan is also a positive reflection of using an evidence base across all chapters, not least as a result of extensive participation of senior clinical and operational leaders from across the health and care system in developing each of these chapters.

The work on Population Health Management is one means by which the plan will progress on the principles of placing people and places at the heart of what we do. The plan will also be made available on the County Durham Care Partnership website in an accessible format, which will include the ability of interested third parties to engage with chapter leads on its content. The website will be promoted through working with Durham Community Action and other partners, to ensure that future iterations of the plan take into consideration those conversations that support co-production of how we plan and deliver our services with our communities.

7. Integration

Whilst progress continues to be made on integration of the system though planning, delivery and governance, integration also refers to ensuring that silo working within chapters is minimised. For example, children and young people, and people with mental health and learning disability needs, also experience other health and care needs. Therefore, each chapter reflects how these communities' needs are considered, whilst also having specific chapters of their own.

Each chapter also sets out how the integration agenda is being delivered on a subject specific basis, identifying opportunities where further integration of health and care can improve outcomes, experience and support our workforce.

8. Personalised Care

The Comprehensive Model of Personalised Care, as referenced within the NHS Long Term Plan, continues to be the framework within which the subject is considered within each chapter. The model establishes a whole-population approach to supporting people of all ages and their carers to manage physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes. Using personalised care approaches provides a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills, and confidence and to live well with their health condition. The model brings together six, evidence-based components;

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets

9. Next steps, future plans

This third iteration of the plan is the second written during the pandemic and reflects the lessons learnt from our experience to date. Whilst the pandemic placed, and continues to place, significant strain on the delivery of health and care services, it also reflects that through working collaboratively between commissioners and providers our health and care system can and will recover. Moreover, the plan is ambitious in setting out our intent to continue to evolve our health and care system to meet future challenges, address health inequalities, and further develop our strong

and resilient workforce who are skilled in meeting the health and care needs of our communities.

Plan Chapters (as PDF attachments)

Starting well
1. Maternity
2. Children and Young People

Living Well
3. Cancer
4. Cardiovascular Disease
5. Diabetes
6. Drugs and Alcohol
7. Respiratory
8. Sexual Health
9. Stroke

Aging Well
10. Dementia
11. Ageing Well
12. Palliative Care

Whole life course
13. Carers
14. Learning Disability and Autism
15. Mental Health
16. Oral Health
17. Primary Care Networks
18. Urgent and Emergency Care

Enablers
19. Digital
20. Personalised Care
21. Population Health and Prevention
22. Shorter waits