Appendix 2: Draft County Durham Plan 23/24

NHS
North East & North Cumbria

Place plan for County Durham:

Submitted by: Sarah Burns, Director of Place

Date: 15 March 2023

Summary Statement:

The Plan for County Durham has been developed by key leads working across health and social care. The system delivery plan for County Durham was first introduced in 2019 and has been refreshed on a regular basis. This latest version of the plan captures all the key activities for partners in health and social care in County Durham, sets out the difference the plan will make and how we will measure that difference.

Health and care providers and commissioners have a long track record of working in partnership for the benefit of the people in County Durham. As a system there is shared understanding and ownership of the challenges that County Durham faces.

The Joint Strategy Needs and Assets Assessment is updated on an ongoing basis and clearly illustrates areas of good practice, but also areas for improvement (https://www.durhaminsight.info/#/view-report/5f6e69673588409bae5d58e537a1c5bf/E06000047). Many of the key deliverables set out in the plan are underpinned by evidence of the need for improvement highlighted by the JSNAA.

This plan sets out the key activities in four key areas which mirror the Partnership Governance of the County Durham Care Partnership which has three Partnership Board responsible for delivery across the life course. They are:

- Starting Well – Children Young People and Families Partnership;
- Living Well Partnership Board and
- Ageing Well Partnership Board

The partnership groups are broad and inclusive. They work together on an ongoing basis to identify priorities and challenges that require collaboration between partners and in most cases integration of services to deliver improvements. Partners work together to identify how resource can be used to best effect in the County best on jointly agreed criteria.

Summary Statement:

The partnership structure mirrors the priorities set out in the Northeast and North Cumbria Integrated Care Strategy as shown below:

NENC ICS Strategy	County Durham System Governance
Giving children and young people the best start in life	Starting well – Children Young People and Families Partnership Board
Better health and care services	Living Well and Ageing Well Partnership Boards
Fairer outcomes for all	
Longer and healthier lives	

The latest Joint Local Health and Wellbeing Strategy for County Durham sets out the four key priorities of the Health and Well Being Board, namely:

- Tobacco
- Obesity
- Drugs and alcohol
- Mental health

The HWBB has chosen this reduced number of key priorities as it is recognised that addressing these four ley challenges will have the greatest impact on Health and Wellbeing in County Durham.

This plan sets out deliverables for each of the three partnership boards plus some of the enabling actions that support the whole system but are required to ensure the plan is deliverable.

The County Durham plan focusses on what we can deliver locally, but we are proud to be part of an Integrated Care System across a broader geography and work at scale with our partners where we need to collaborate.

Governance and partnership working –

The County Durham Care Partnership brings together NHS organisations, Durham County Council and other health and care providers in a true collaboration, driving our ambition to further develop system-wide integrated models of care. We have a shared vision across the Partnership, and we live by it, delivering everyday by collaborating and driving our ambition to develop even more system wide integrated models of care through all the organisations involved.

Our health and social care staff work closer to patients in their homes wherever possible, improving access to care and making it available at the right time, while reducing unnecessary hospital admissions, avoiding duplication and promoting independence.

The Care Partnership is about putting the people at the centre of everything we do, moving away from a hospital/residential care-based model of care to a new way of working, based on collaboration and partnership, to provide more care in people's homes and their community at the same time breaking down barriers between services.

This means joining up the work of general practices, community services, care providers, hospitals (both acute and mental health) and community-based support.

The proposed principles to guide the work of the Partnership are to:

- put the patient and service user first,
- ensure that the right person is in the right place at the right time delivering care to reduce handoffs, delays and duplication,
- promote integration between primary, community and social care,
- deliver care closer to home preferring primary and community settings to acute,
- engage, share and develop our workforce together,
- share the benefits and successes,
- encourage leadership at all levels,
- ensure the best value from the resources available,
- innovate, evaluate and make the most of opportunities together,
- acknowledge and respect our differences and promote a culture of integrated working.

The principles complement the overall aims of the County Durham Care Partnership and will be used to guide and assess our work to improve outcomes and agree priorities.

Key stakeholders

Durham County Council	North East and North Cumbria Integrated Care Board	Tees Esk and Wear Valleys NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust	Clinical Leaders	North East Ambulance Service NHS Foundation Trust
HealthWatch	Primary Care Networks	Patient, public and carer engagement groups
Harrogate Foundation Trust	Voluntary Sector	Health and Wellbeing Board
Overview and Scrutiny Committee	Local Councillors	Local MPs
County Durham Area Action Partnerships	County Durham Fire and Rescue Service	Durham Constabulary
Criminal Justice Partners - to include YJS, Probation and Prisons	North Tees and Hartlepool Foundation Trust	Sunderland and South Tyneside Foundation Trust
Police, Crime and Victims Commissioner's office		

Priority Area 1: Starting Well

Why is change needed?

There are 115,000 children and young people (aged 0-19) in County Durham

- 7 out of 10 children achieve a good level of development at the end of reception year in school
- 10,400 school age children have special educational needs
- 91% of 16–17-year-olds are in education or training
- The county's care leavers are more likely to be in education, employment and training than in other areas both regionally and nationally

• Poverty: 1 in 4 children live in a household which cannot afford all the basics they need such as their food and fuel bills

• Impact of Covid-19:

- A 20% increase in demand for children and young people's mental health services is projected over next 5 years
- 1 in 6 children, aged 5-16 years, identified as having a probable mental health disorder (an increase from 1 in 9 in 2017)

• Healthy start to life:

- There are almost 4,800 live births annually o 1 in 6 women smoke at time of baby's delivery
- 1 in 3 are breastfeeding 6-8 weeks after birth
- 1 in 4 of reception and more than 1 in 3 year 6 pupils are overweight o 1 in 4 5-year-olds have tooth decay
- The number of babies, toddlers and school age children vaccinated is significantly better than the England average

Objectives and Goals –

Best Start in Life
7 Priorities from Children Young People & Families Partnership Board sub-group

Early help and prevention
- Increase uptake of flu vaccinations for 2-3 year olds
- Support the delivery of the Oral Health Promotion Strategy 2023 - 2028

Family Hubs
- develop a network of 15 family hubs which can support the delivery of a range of local community support and services to children, young people and families.

Special Educational Needs
- Develop a short breaks and respite offer that meets both universal and specialist needs for children with SEND and their families
- Meeting Health needs in schools
- Equipment, Aids and Adaptations in schools
- Roll out of integrated therapies pilot

Children in care
- Delivery of the Sufficiency Strategy for children looked after and care leavers
- Secure long-term approach for Pause
- Ensure continued delivery of CDDFT statutory obligations relating to adoption and children coming into care.

Transition into Adulthood
- Review transition sub-group workplan to inform joint funding of services to ensure improvement of transition from child to adult services across physical and mental health and social care.

Objectives and Goals –

Acute care

- Support acute paediatric and neonatal service development
- Core20Plus5 – Asthma, Diabetes, Epilepsy
- End of life & palliative care – implement statutory guidance for ICBs
- Review dietetics & therapy services delivered to paediatrics wards

Mental Health and Learning Disabilities

- Review of support and services offered around eating disorders
- Increase uptake of flu vaccinations for those with a learning disability
- Development of a needs-led neurodevelopmental offer
- Healthcheck uptake for those aged under 18 with a learning disability
- Development, agreement, and implementation of Peri Natal mental health strategy
- Needs analysis to inform commissioning priorities for complex packages of care
- Continue improving access to mental health support for children and young people in line with the Long Term Plan ambition, across community and through education for earlier evidence-based interventions; building on the MHST offer, while ensuring MHST support is responsive to individual schools' and colleges' needs, not 'one size fits all'.
- Ensure coordination and take up of the Trainee CWP role and education Mental Health Practitioner (EMHP) roles are supported and sustainable funding is agreed through the ICB, so that these roles can support earlier evidence-based support for CYP and Parents as and when difficulties arise.
- Gather support requirements for CYP and families wanting to access support for trauma - ie adverse childhood experiences and the role with co-morbidity across MH Teams

Primary and Community Care

- Implement service for Paediatric diagnostic spirometry

Maternity

- Follow anticipated national maternity plan.

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
Best Start in Life										
1.	Support the implementation of the Maternity Planning Guidance due to be released April 2023	■	■	■						
2.	Review perinatal mental health services and implement the strategy agreed by BSIL	■	■	■						
3.	Pause - review service and seek agreement for ongoing funding	■	■	■						
4.	Deliver the BSIL workplan which includes targets to increase breastfeeding and decrease smoking at time of delivery		■	■	■					
Early help and prevention										
5.	Increase uptake of flu vaccinations for 2-3 year olds	■	■	■	■					
Family Hubs										
6.	Develop a network of 15 family hubs which can support the delivery of a range of local community support and services to children, young people and families.	■	■	■	■					
Special Educational Needs										
7.	Re commission the Short Break Offer for County Durham to secure a 50% reduction in the numbers of families waiting over 1 month for a Short Break from 42 (March 2023) to 21 during 2023-2024	■	■	■	■					
8.	Build upon the findings from the Integrated Therapies pilot to roll out integrated therapies model for County Durham by March 2024.	■	■	■	■	■				
Children in care										
9.	Increase the number of local independent children's homes who are willing to adopt a 'Durham First' approach from 6 to 12 during 2023-2024.		■	■	■					
10.	Develop and register the 6 additional Children's Homes identified within the local Sufficiency Strategy for Children Looked After and Care Leavers to support accommodation options during 2023-2024	■	■	■	■					
Transition into Adulthood										
11.	Review transition sub-group workplan to inform joint funding of services to ensure improvement of transition from child to adult services across physical and mental health and social care.	■	■	■						
Acute care										
12.	Development of robust pathways for UEC for CYP	■	■	■	■					
13.	Support CDDFT with agreed acute paediatric service development	■	■	■	■					

Mental Health and Learning Disabilities										
14.	Eating disorders - review current pathway									
15.	Increase uptake of flu vaccinations for those with LD									
16.	Development of a needs-led neurodevelopmental pathway including considering support for autism (pre and post diagnosis)									
Primary and Community Care										
17.	Propose a model for Paediatric diagnostic spirometry and implement if approved									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
Best Start in Life	Reduction in the proportion of mothers smoking at time of delivery	In 2021-22 there were 4710 live births in County Durham. Of those giving birth 14.6% were documented to be smokers at the time of delivering their baby – around 1 in 6 women	5% or less women smoking in pregnancy at birth by 2025	2025
	Reduction in the number of children who are overweight or obese.	County Durham 21/22 •Around three quarters of reception children were healthy weight (75.5%). In year 6, 58.8% of children were a healthy weight.		
	Increase in the number of children who are ready for school when they start reception.			
Early Help & Prevention	Increase in the number of physically active children, young people and adults			
Acute Care	Reduce numbers of children and young people attending hospital for asthma, diabetes and epilepsy			
Children in Care	Increase the children looked after with health assessments delivered within statutory timescales.			
Mental Health, Autism and Learning Disabilities	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact 12-month rolling			
	Number of women accessing specialist community PMH and MMHS services in the reporting period YTD cumulative			
	Waiting times for CYP waiting for a neurodevelopmental disorder assessment (including autism and ADHD)			
	Reliance on inpatient care for people with a learning disability and/or autism - Care for children			

Priority Area 2: Living Well

Why is change needed?

With increasing system-wide demand and associated pressures there is a need to ensure ongoing service development to ensure appropriate pathways which meet the needs of our local communities are in place. To ensure high quality, safe and appropriate service provision which promotes prevention and self-care close to home wherever possible. Access to general practice is a key challenge which needs to be addressed as part of the overall aim of improving health and social care for local communities.

Care pathways need to be integrated and cross -sector, with support form the voluntary sector to ensure people stay well and independent for longer. Due to the COVID-19 pandemic health and care inequalities have widened, resulting in poorer outcomes for those more deprived populations within our locality.

The Joint Strategic Needs and Assets Assessment should be used to determine areas of development and allocation of resource, using quantitative and qualitative data as well as the views of those with lived experience to co-produce health and care transformation.

Objectives and Goals

Urgent and Emergency Care

- Support urgent and emergency care services by filtering patients and reducing the number of inappropriate attendees at A&E / Urgent Treatment Centres and managing the treatment of those patients in primary care services.

Planned Care

- Support the County Durham population through the continued development of planned care services.

Primary Care

- Improve access to General Practice in primary care by reducing appointment delays and working with practices to reduce inefficiency.

Community Care

- Develop the range and complexity of community care services on offer so that patients can be better managed outside of hospital and closer to their homes.

Mental Health

- Develop effective approaches to support better early intervention/mental health promotion across the County, including better ways to address the wider determinants of mental ill health and support to develop resilient communities
- Continue and build on existing robust approaches to suicide prevention
- Deliver and embed new transformed models of care for adults with serious mental health issues, achieving a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Ensure those in immediate crisis and most in need of mental health support can access those services in a timely and appropriate way.
- Increase the number of adults accessing Talking Therapies for anxiety and depression, aiming for at least 50% moving to recovery.
- Work towards eliminating inappropriate adult acute out of area placements
- Reduction in the use of inpatient services and length of stay in hospital settings; ensuring that those with more complex needs are able to live and be supported in the community.
- Increase access to perinatal mental health services, offering support and intervention at the earliest opportunity.
- Through personalisation and effective co-production, make effective improvements in reducing health inequalities across our local population

LD and Autism

- Ensure the needs of those with a learning disability and / or autism diagnosis receive the appropriate support and care through the continued development of wrap-around services in the community.

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
Urgent and Emergency Care										
1.	Ongoing development of UEC model of care through system-wide partner (LADB County Durham). This will include people with MH problems and LD, ensuring that all UEC pathways meet the needs of those with SMI and LD.									
2.	Improve organisational data sets for A&E / GP access.									
3.	Development of 24/7 Urgent Treatment Centre at UHND									
4.	Emergency Department patient filter to primary care Same Day Access Hubs / 24/7 UTC at UHND									
5.	Ongoing commissioning of County Durham Same Day Urgent Care Hubs									
Planned Care										
6.	Dermatology service review Review of CDDFTs dermatology/skin service, identifying opportunities to make improvements quickly to the service Consider implementing a SPA for all dermatology and skin services Support 2WW telederm issues Standardise dermatology/skin services across the county ensuring equity of service and VFM									
7.	Diabetes service review Review of previous service evaluation to inform decisions around future service model									
8.	Patient Initiated Follow Up (PIFU) Seeking assurance that PIFU is standardised as normal practice									
9.	Gynaecology service review									
10.	Increased capacity for planned surgery Working with partners and seeking assurance sufficient capacity to meet demand									
11.	Tuberculosis service review Ensure service is meeting NICE Guidance and review service model and current workforce									
Primary Care										
12.	Developing Integrated Neighbourhood Teams models (Fuller Stocktake)									
13.	Improving access to general practice									

14.	Acute Respiratory Infections (ARI) Hubs. Commissioning beyond 22-23.									
15.	Extended access (DES), lack of provision of appointments and Sunday and Bank Holiday.									
16.	Increase in Health Checks, Alcohol IBA, Tobacco BI and L2 provision.									
17.	Delivery of Impact & Investment Fund / Quality Outcomes Framework Indicators, LIAISE (Local Incentive Scheme)									
18.	Embedding POD (Community Pharmacy, Opticians and Dentistry) into NENC ICB. Four true pillars of primary care									
19.	Screening and Immunisation (Flu and Covid vaccination)									
Community Care										
20.	Respiratory and frailty hospital at home.									
21.	Increase referrals into the DARS for alcohol unmet need – 81% for those who are alcohol dependant.									
22.	Increase in weight loss management									
23.	Wellbeing services – review taking place to increase uptake on health behaviours and wider determinants.									
24.	Promoting financial resilience									
25.	Implementation of the Health Squad model to address needs in those who are at risk of homelessness, probation services, DARS clients, BAME – including GRT. Domestic Abuse services.									
26.	Dementia – HNA being undertaken to help reassess need.									
27.	Carers									
28.	Access to information – linked to County Durham Together and the Wellbeing Approach									
29.	Workforce development									
30.	Voice of Lived Experience/co production/ consultation.									
31.	Pharmacy services									
Mental Health										
32.	Create a system of support across the County which maximises opportunities for early MH intervention and prevention									
33.	Develop population and place-based approaches to MH provision which enable support to be tailored to community needs, and available as close to home as possible									

34.	Ensure those with the most complex needs, and those who are most vulnerable, get the right support at the right time									
35.	Deliver effective interventions to understand and address the wider determinants of mental ill health across the life course									
36.	Have a skilled workforce across the County who can Make Every Contact Count (MECC) and feel confident in talking to people about, and supporting them to get help for, their mental health problems									
37.	Live Well; Improving Access to Psychological Therapies (IAPT), focus for this period will be Long-Term-Conditions, ensuring those with LTCS can receive support in line with national targets.									
38.	Live Well and Age Well; agree and implement effective housing strategies for people with mental health problems (all ages, including targeted support for young people moving into adulthood).									
Learning Disabilities / Autism										
39.	Refresh the Think Autism Strategy for 2024-26, which incorporates above (and is all age)									
40.	People can lead fulfilling lives and more people with a learning disability will have a greater say and be able to decide for themselves the way they live their lives and choose how they are supported.									
41.	Reduce health inequalities that people with a learning disability and autistic people experience.									
42.	Young people and their families will be supported and prepared effectively to move into adulthood.									
43.	More people with a learning disability and autistic people will have health concerns or unmet health needs identified early and treated effectively.									
44.	Autistic people can access mental health interventions that meet their needs in line with the Autism framework and Autism Act.									
45.	More people will be supported to live independently and safely within their own homes and community for as long as possible, having their own tenancies - or even have the opportunity to own a home.									
46.	We will also see a reduction in the number of people cared for 'out of area' and a reduction in the use of inpatient services and length of stay in hospital settings; ensuring that those with more complex needs are able to live, and be supported, locally.									
47.	A reduction in waiting times and a more holistic approach to the autism assessment.									
48.	To learn from the reviews of deaths for people with a learning disability and/or autism in accordance with Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021 and progress service improvement plans accordingly.									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
UEC	See and treat within four hours of presenting at Accident and Emergency.		< 4 hours	
Planned Care	Reduction in diabetes prevalence rates			
Primary Care	Increase in the number of Additional Roles Reimbursement Scheme.			
Primary Care	<two week wait for GP appointment			
Community Care	Reduction in the rate of non-elective hospital admission			
Mental Health	Reduction in the rate of suicide			
Learning Disabilities	Reduction in number of Learning Disability beds as per trajectory			
Mental Health	Reduction in the rate of suicide Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider in period activity			
	Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period in period activity			
	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses 12-month rolling			
	Percentage of patients who have been seen by the crisis team within 4 hours of referral			
Learning Disabilities	Learning disability registers and annual health checks delivered by GPs Reduction in number of LD beds as per trajectory			

Priority Area 3: Ageing Well

Why is change needed?

People are now living far longer, but extra years of life are not always spent in good health. They are more likely to live with multiple long-term conditions, or live into old age with frailty or dementia, so that on average older men now spend 2.4 years and women spend three years with 'substantial' care needs. To ensure older people are able to live happy, healthy and upright at home for as long as possible and receive high quality, consistent levels of service we need to take a preventative population approach to care, utilising early recognition and intervention with short-term support, and signposting in delivery models to ensure an enabling approach, positive individual outcomes with a focus on wellbeing and sustainable budgets.

Despite significant progress in cancer survivorship over recent decades, detecting cancer earlier remains a top priority in the NHS Long Term Plan. Patients diagnosed early, at stages I and II, have the best chance of curative treatment and long-term survival. In County Durham, existing health inequalities result in poorer outcomes for cancer patients when compared to the England average, and also when comparing communities within the county. Health inequalities also impede access to screening and prevention services. Performance within treatment pathways and in quality measures varies geographically and by tumour group and is impacted by staffing capacity pressures in key clinical areas such as specialist nursing, oncology, and radiology

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 and Goals –

To work across all parts of the health and social care system to support care of the individual in order to:

- Proactively identify those who are at risk of or who are living with frailty..
- Promote preventative, short-term approaches for example Intermediate Care and reablement to provide a progression approach to care delivery. Achieve an invest to save solution to delivery, promoting reablement and independence and avoiding as far as possible costly long-term care.
- To support people living in Care Homes to receive the same level of support as if living in their own home, as apart of system support
- Changing culture to ensure that all involved in delivering care focus on maximising a personalised approach to wellbeing, independence and quality of life pertinent to the individual.
- Continue and further develop discharge and post discharge support following an in-hospital stay
- Continue to deliver the Community Mental Health Transformation Plan, including development of sustainable support for community infrastructure.
- agree and implement effective housing strategies for people with mental health problems (all ages, including targeted support for young people moving into adulthood)
- Support the delivery of the County's Ageing Well Strategy
- Develop a new, system wide Dementia Strategy for Durham and ensure the dementia diagnosis rate achieves the national ambition of 66.7% as a minimum
- Reduce unnecessary Hospitals Admissions
- Safe and timely discharges, to enhance patient experience and embed personalised care and reduce risk of harm.
- Older People with a learning disability and/or autism are supported to live safe and healthy lives in their community.
- Older People with a learning disability and/or autism are not subject to health inequalities
- Domiciliary care availability, coverage and quality is maintained and able to deliver a supportive approach through appropriate workforce development ensuring consistent staffing with appropriate skills and knowledge, with opportunities for career progression and flexibility. The County
- A Multidisciplinary Discharge Team coordinates the personalised approach for complex discharges reducing errors and improving patient and carer experience. Durham Care Academy to continue to focus on this area of work.
- 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 and Local Authority services that supports the quality of their care, with the County Durham Care Academy supporting this coordination of partner training.

  Diagnosis cancers sooner at Stage 1& 2
- To meet the six National Ambitions for patients on end of Life, including adapted approaches for people with dementia
-

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
Community Care										
1.	Fully deliver Enhanced Heath In Care Homes national framework	■	■	■	■					
2.	Community contract review	■	■	■	■					
3.	Bed bureau	■	■	■	■					
4.	Additional acute bed capacity	■	■	■	■					
5.	Recovery unit	■	■	■	■					
6.	Discharge System Co-ordinator and Transfer of Care Hub	■	■	■	■					
7.	Frailty hospital at home	■	■	■	■					
8.	Urgent Community Response	■	■	■	■					
9.	Health Call - CDDFT Telehealth Team and Health Call Solutions MDM support for Care Providers	■	■	■	■					
10.	Care Home Connectivity Improvements – for the 11 Care Homes Identified					■				
Needs-Led Accommodation										
11.	Commissioning and delivery of suitable and sustainable care provision for older people, ensuring a needs-led approach to develop the provider marketing including market and shaping as appropriate	■	■	■	■	■				
12.	Diversify extra offer within County durham working with developers, registered social land lords and care providers to develop additional services by 2028								■	
13.	Review approach to Dom Care and reablement commissioning to determine optimum service model					■				
Cancer										
14.	Prehabilitation	■	■	■	■					
15.	SNSS	■	■	■	■					
16.	Macmillan Care	■	■	■	■					
17.	Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway)	■	■	■	■					
18.	Continue to develop Joining the Dots, delivering Holistic Needs Assessments, Support Plans and Follow-up support and develop a new Macmillan Programme including Right By You	■	■	■	■					

19.	Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand. This will include local ongoing delivery of the Lung Case Finding Pilot in x3 PCN areas launched in 2022									
20.	Commission key services which will underpin progress on early diagnosis, including non-specific symptoms pathways (to provide 100% population coverage by March 2024), surveillance services for Lynch syndrome, BRCA and liver; and work with regional public health commissioners to increase 12 | 2023/24 priorities and operational planning guidance colonoscopy capacity to accommodate the extension of the NHS bowel screening programme to 54 year olds.									
21.	Further develop partnership working with PCNs, Public Health, Macmillan and CRUK to support schemes aimed at earlier diagnosis, quality of referrals and improved patient experience – such as QOF, PCN DES. This will include development and delivery of the new PCN Early Diagnosis Facilitator Role									
End of Life										
22.	End of life strategy development									
23.	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.									
24.	Develop effective systems to reach people who are approaching the end of life, and ensure effective assessment, care coordination, care planning and care delivery.									
25.	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.									
26.	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.									
27.	Ensure that all those who provide palliative, and end of life care understand and comply with legislation that seeks to ensure an individualised approach.									
28.	Ensure unpaid carers receive the support, training, and education they need to effectively care for their loved ones.									
Dementia and MH										
29.	Developing dementia care across health and social care									
30.	Develop a new, system wide Dementia Strategy for County Durham, including early onset dementia									
31.	Continue to develop and implement comprehensive approaches with care home staff and primary care/community teams to support the needs of people with dementia in 24/7 care, including roll out of Namaste approaches and other non -pharmacological interventions									
32.	Improve capacity across the County to ensure people who could benefit from Cognitive Stimulation Therapy at the early stages of illness are able to access this									
33.	Continue to implement new community MH models to ensure that older people with severe mental illness receive the support they need as close to home as possible, and in as timely a way as possible									
34.	Build on learning from the Care Home Wellbeing Service (developed in response to the COVID-19 pandemic) to better support staff working within care homes to be resilient and to support patient flow across the system/prevent placement breakdown									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
End of Life	Continued reduction of smoking related deaths			
Planned Care	Improvement in self-reported wellbeing			
UEC	Rate of re-admissions to hospital (within 30 days of index admission discharge)			
	Number of attendances at Care Home by NEAS			
Primary Care	% of health care plan (by primary care) in place			
	% of structured meds reviews completed annually for eligible patients			
	% of eligible residents who have had an annual health check completed (last 12 months)			

Priority Area 4: Cross Cutting Transformation

Why is change needed?

Partners in the County Durham system recognise that we need to work together and share our skills wherever possible. There are a number of joint appointments as well as functions that operate across the County Durham system on behalf of all partners. This includes engagement and involvement, digital, workforce, integration, and strategic estates.

The partnership intends to grow collaboration across these supporting functions and do things once across the system wherever possible. This will allow partners to deliver efficiencies and work together at pace.

Objectives and Goals

- Develop a well led skilled and valued health and social care workforce
- Supporting the provider market to facilitate stability and sustainability to deliver quality services
- Support unpaid carers in their role to have a life outside of their caring role
- Identify opportunities to transform the way services are delivered to facilitate efficient and effective digital provision
- To ensure County Durham has fit for purpose buildings to support the delivery of modern services
- To facilitate client/patient needs for the present and future
- To provide an accessible and effective transport facility for people to enhance flow and access
- To improve access to personalised care services for local people to facilitate choice and control

Initiatives – Key deliverables

Item	Deliverable description	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25	25/26	27/28	28/29	Measure Reference
Workforce										
1.	Supporting the further rollout of ARRS roles									
2.	Development of neighbourhood teams as per Fuller Report									
3.	Development of a joint clinical training programme for care homes									
4.	Development of commissioning workforce strategy for social care for all ages									
5.	Pilot NHS overnight workforce provision for care homes (OP and specialist)									
6.	Continuation of Care Academy and recruiting social care workforce and exploring expansion into NHS recruitment									
7.	Developing joint NHS/Social care home care roles									
8.	Upskilling care staff to undertake delegated duties on behalf of the NHS									
9.	Continue to develop the commissioning workforce in line with the Integrated Commissioning Workforce Strategy									
10.	Pilot digital solutions and telecare to support care workforce pressures									
Carers										
11.	Develop support for younger adults in a caring role									
12.	Evaluate effectiveness of Mobilise platform which supports carers									
13.	Refresh carers strategy for County Durham									
14.	Review of advocacy services									
15.	Re-procure carers services for County Durham									
16.	Review arrangements with Employers for Carers who support carers that are in employment									
Digital Transformation										
17.	Review of Healthcall digital care homes service and identify new opportunities for Healthcall developments									
18.	Continued roll out of the Care Academy job site to support digital methods of recruitment for social care staff									

19.	Pilot and evaluate technology for falls prevention (Vitalerter)									
20.	Pilot and evaluate the Kraydel system to support delivery of remote care visits									
21.	Pilot and evaluate RITA in older persons care settings									
22.	Pilot and evaluate use of the Happiness Programme digital system in special care and children's services									
23.	NHS App promotion, highlighting the free messaging functionality.									
24.	Optimising social media communications.									
25.	Improvements in Wi-Fi connection in residential homes to support visiting clinicians' access to patient records.									
26.	Encrypted, secure communication between schools and health care professionals.									
27.	Expansion of the Durham care home project across NENC to ensure access to primary care patient records by residential home staff and use of secure emails.									
28.	Electronic communication methods used between primary care and CDDFT including all hospital discharge notifications.									
29.	Development of the clinical systems used in Durham hospices.									
30.	Expansion of social prescribing veteran support across NENC.									
31.	Procurement of the COIN									
32.	Procurement of SMS system provider.									
33.	Clinical System procurement.									
34.	Digital speech recognition pilot.									
35.	Digitising Lloyd George paper notes.									
36.	Expansion of GPAD data collection to include PCN appointment information									
Estates										
37.	Development of a new community hospital to replace Shotley Bridge									
38.	New Emergency Department at University Hospital of North Durham									
39.	UHND mortuary build									
40.	Develop specialist accommodation for people with complex Leaning Disabilities and or Autism at Whitebeam Gardens									

41.	Expand provision at Hawthorn House for step up and step-down care									
42.	Development of specialist step up/step down provision for complex young people									
Transport										
43.	Review of hospital discharge transport services									
44.	Ongoing development of PTS services to ensure all community delivery sites are accessible									
45.	Ensuring robust emergency transport in place including inter-hospital transfers and taxi frameworks									
46.	Consider expansion of the volunteer driver scheme and ensure ongoing promotion of the service									
Personalisation										
47.	Development of process and governance structures to support PHB/DP across health and social care									
48.	Understand the barriers to uptake of PHB/DP									
49.	Grow and develop the personal Assistant market, particularly in areas where there are gaps e.g. rural areas									
50.	Develop a Person Centred Care Training offer via the Care Academy									
Communications, Engagement and Co-production										
51.	Recruit a lay member for involvement and engagement for the County Durham Care Partnership									
52.	Ensure the County Durham Approach to Wellbeing is adopted wherever possible and integrated in the approach to commissioning services									
53.	Undertake engagement with the populations to understand preferences for care in later life									
54.	Continue the County Durham Care Provider Panel to engage providers in service developments and changes									
55.	Undertake engagement with people with Learning Disabilities and Autism in partnership with Inclusion North									
56.	Undertake review of engagement and involvement with Children and young people									
57.	Publishing commissioning plans including Market Position Statement and Accommodation Plans									

Key performance metrics to track delivery

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
Recruitment and retention	Number of ARRS roles recruited			
	ASC workforce numbers			
	Health staff numbers			
	Care staff recruited via Care Academy			
	NHS staff recruited by Care Academy			
	Joint NHS/Social Care staff recruited			
	Care home supported by NHS nursing staff			
	Number of care homes de-registering			
	Home care pending list			
Training	Number of learning opportunities delivered via Care Academy			
Workforce	Strategy developed and implemented			
Carers	Number of carers supported by CDCS and Mobilise			
Digital	Number of providers using HealthCall			
	Admissions to hospital from care homes			
	Reduction in number of falls per population			
	Number of users supported by Kraydel/RITA/Happiness Programme and outcomes achieved			

Reference	What is being measured?	Where are you now?	What is the target?	When do you aim to get there?
Estates	Increasing capacity in the LDA residential market			
	Increasing capacity in the CYP residential market			
Transport	Increase access to most appropriate services			
	Reduce delayed discharge relating to transport			
	Increase volunteers working for the Volunteer Driver Service			
	Increase uptake of the Volunteer Driver Service			
Personalisation	Development of governance processes for PHB/DP			
	Increase uptake for PHB/DP/PA			
Engagement	Increase occasions when a full co-production methodology is used			
	Number of people involved in engagement involvement exercises			
	Increase the number of people that volunteer in County Durham			

Enablers –

1. Process – operational models that will require change as a result of this plan being delivered.

Continue to develop and deliver in an integrated way to ensure joined up care pathways which meet need in the most appropriate way, reducing duplication and adding value to improve outcomes for the local population.

2. Workforce

See priority area 4

3. Research and Innovation

4. Digital technology and Data.

See priority area 4

5. Estates.

See priority area 4

Enablers –

6. Finance

Financial plans for 2023/24 are being developed in the context of continuing constrained financial conditions for all organisations operating across County Durham. There is also uncertainty about longer term funding and the impact of cost pressures, but the aim to work together will be important to our ability to deliver improved outcomes for the people of County Durham.

Further information to add

Risks

Risks	Mitigations
Limited/no growth funding	System prioritisation process and governance to ensure statutory provision and where possible invest to save proposals to fund subsequent must do's
Limited resource to deliver plan	Prioritisation of workplans and integrated approach to delivery
Additional in-year directives/policy change	Ongoing review of must do's and realignment of resource to deliver
Workforce limitations within provider organisations to recruit and retain staff e.g. social workers, health visitors, specialist roles	Workforce strategies in place
Commissioning reorganisation and clarity on roles and responsibilities as well as ensuring sufficient clinical leadership and Network involvement.	Work ongoing to ensure appropriate clinical leadership throughout commissioning at place and region