County Durham Joint Health and Wellbeing Strategy 2016-2019

Delivery Plan

"Improve the health and wellbeing of the people of County Durham and reduce health inequalities"

JOINT HEALTH & WELLBEING STRATEGY – DELIVERY PLAN 2016-2019

STRATEGIC OBJECTIVE 1: CHILDREN AND YOUNG PEOPLE MAKE HEALTHY CHOICES AND HAVE THE BEST START IN LIFE

Outcome: Reduced Childhood Obesity

	Strategic Actions/Sub-Actions	Lead	Timescale
1.	**Improve support to women to start and continue to breastfeed their babies** • Undertaking a breastfeeding health equity audit to better understand the population which is choosing to take up breastfeeding compared to those who are not. • Provide targeted programmes and interventions to support women to start and continue to breastfeed their babies.	Healthy Weight Alliance	July 2016 September 2016
2.	**Improve support to families and children to develop healthy weight** • Review the Family Initiative Supporting Children's Health to help tackle childhood obesity in the county. • Continue the roll out of Wellbeing for Life Service to target individuals who are overweight or obese to deliver healthy weight initiatives to individuals and families.	Healthy Weight Alliance	December 2016 March 2017

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Outcome: Improved early health intervention services for children and young people

	Strategic Actions/Sub-Actions	Lead	Timescale
3.	**Support children and young people to achieve their optimum mental health and emotional wellbeing by transforming the quality and availability of services from prevention and early intervention through to specialist care and recovery, delivered closer to home** • Implement the County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience 2015 – 2020; • Continue to develop the CAMHS Crisis service to ensure access to mental health crisis support and intervention in order to reduce rates of self-harm by young people. • Develop the Community Eating Disorder Service and pathway to ensure compliance with recently published access and waiting time standards for Children and Young People.	Children and Young People's Mental Health and Emotional Wellbeing Group	March 2020 March 2017 March 2017

4.	**Support the reduction of teenage pregnancies (under 18 conceptions) in County Durham by delivering interventions that are in line with evidence and best practice**
	• Complete the Teenage Pregnancy and Teen Parent Health Needs Assessment for County Durham.
	• Develop the County Durham Teenage Pregnancy and Teen Parent delivery plan 2016-2018 to reduce teenage pregnancies and provide support young parents.
	• Implement the County Durham Teenage Pregnancy and Teen Parent delivery plan 2016-18 by:
	  • Increasing the capacity within the school system to support young people who are at increased risk of teenage pregnancy by embedding primary mental health nurses via the 0-19 service in order to increase young people's confidence in accessing support.
	  • Increasing the resilience of children and young people to help protect them against engagement in risky health behaviours by implementing the Young Minds resilience programme to schools.
	  • Undertaking consultations with young people who are Looked after Children and Care Leavers to identify their SRE needs in order to ensure they receive suitable SRE information and support.
	  • Delivering the commissioned Sex and Relationships Education (SRE) project to improve the quality of SRE in secondary schools, focussing on schools in locations with persistently high teenage conception rates.
	• Review the integrated sexual health service and re-procure for October 2017 to improve public sexual health, including reduction in Blood Borne Virus rates.
		Teenage Pregnancy and Sexual Health Steering Group	March 2017
			March 2017
			September 2016
			December 2016
			December 2016
			March 2017
			October 2017

5.	**Support the reduction in oral health inequalities faced by children within County Durham** • Complete public consultation regarding priorities for an Oral Health Strategy for County Durham. • Develop an Oral Health Strategy for County Durham. • Implement actions in the Oral Health Strategy for County Durham to reduce tooth decay in targeted areas of the county including working in partnership with NHS Oral Health Promotion Teams and local providers, dentists and Children's Centres.	Oral Health Strategy Group	November 2016 December 2016 December 2018

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	Strategic Actions/Sub-Actions	Lead	Timescale
	• Work proactively with families through the One Point service and health visitors, to increase dental registrations.		December 2019
6.	**Deliver an integrated 0-19 model to include universal mandated services plus targeted services for vulnerable groups** • As part of the integrated model for 5-19 year olds, deliver a core offer programme to mainstream schools regarding physical and mental health improvement as part of the curriculum, to include topics such as relationships and sexual health, mental health, life skills and preparing for more independent living, to help children achieve and succeed. • Work with the provider to deliver a health visitor service for those aged 0-5 year olds. • Work with the provider to deliver an enhanced school nursing service for those aged 5-19 year olds	Harrogate and District NHS Foundation Trust/DCC Public Health	March 2018 April 2018 April 2018

7.	**Implement the Early Help and Neglect Strategy to better support families who have additional needs at an earlier point**
	• Develop a Third Sector Alliance, as part of the Innovation Programme, to enhance the resources available to families in the county and improve the engagement of the Third Sector in multi-agency family plans and support, through closer links with the Families First and One Point teams, by:
	  • Coordinating a 'Friend of the Family' volunteer programme to provide support to vulnerable families during and after statutory intervention
	  • Seeking out additional funding and resources to complement and add value to services to meet local need
	  • Promoting the voice of young people in developing and changing services
		DCC Children's Services	April 2016
			
			September 2016
			
			September 2016
			
			September 2016

8.	**Work together to reduce rates of self-harm by young people** • Undertake a strategic review of preventative mental health and suicide prevention services and re-procure where necessary. • Provide School Staff, Children's Home Staff, and Youth Services Staff who come into contact with young people on a regular basis, basic mental health and emotional wellbeing awareness training. • Place restrictions to limit internet access on personal computers in Council run buildings including libraries to ensure that sites which glorify self-harm and relevant social chat sites are prohibited access and improve internet safety. • Develop specific web pages for parents/carers giving information on preventing self-harm and how to support their children. These pages are to be designed by, or with direct involvement of, young people who have knowledge of self-harm and emotional health and wellbeing such as help4teens.co.uk. • Develop parental peer support group which includes parents with experience of managing self-harm in the home	Children and Young People's Mental Health and Emotional Wellbeing Group	December 2016 December 2016 December 2016 December 2016 March 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale

	• Refresh the multi-agency Public Mental Health Action Plan for County Durham including the self-harm and suicide plan.
	• Identify evidence based interventions for those at high risk including:
	  ◦ Looked after children and care leavers
	  ◦ Young carers
	  ◦ Those engaged with criminal justice system
	  ◦ Those who have experienced violence and abuse
	  ◦ Children, young people and families from Gypsy Roma Traveller communities
	  ◦ Preventing suicide among trans young people
	• Ensure children and young people have access to post vention and general bereavement support
	• Implement the County Durham Managing Self Harm protocol including training in managing self-harm
	• Develop in partnership with children, young people and their families, a mental health crisis service based on a 24/7 model of care and provided in their local communities based ensuring care is provided as close to home as possible or within their own homes.
	• Develop the model for intensive home treatment for children and young people with complex needs.
		Children and Young People's Mental Health and Emotional Wellbeing Group	March 2017
			March 2017
			March 2017
			March 2017
			March 2017

9.	**Deliver the Strategy for Children and Young People with Special Educational Needs and Disability 2016-2018 and support schools to improve outcomes relating to achievement, independence and preparation for adulthood** • Following the establishment in April 2016 of a new Integrated Transitions Team for 14-25 year olds moving from children's services into adult social care services, agree a joint performance framework. • Secure improved transition arrangements between traditional children's and adult services to support service user satisfaction by reviewing the way in which we provide support between the services. • Support CCGs to review delivery models for therapies in educational settings to improve service user satisfaction. • Support schools and settings to implement the SEND Code of Practice 2014, which provides guidance on outcomes relating to achievement, independence, and preparation for adulthood. • Deliver training to schools to support their duties relating to children with additional medical needs. • Deliver training to schools and local authority staff to enable services to identify SEND at the earliest point, so that children, young people and their families and carers are fully involved in decisions about their support and what they want to achieve.	DCC SEND and Inclusion Strategy Group	July 2016 March 2017 March 2017 July 2017 July 2017 July 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale
10.	**Ensure health, social care and third sector organisations work together to identify and support young carers** • Implement the Young Carers Strategy to ensure that young carers are not disadvantaged by their caring role and responsibilities and have the best possible chance of achieving the five Every Child Matters outcomes, which are to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing.	All partners of the Health and Wellbeing Board	March 2017
11.	**Support young people to manage their risk taking behaviours by building resilience and creating a culture that encourages young people to choose not to drink** • Continue to support schools and colleges and youth settings to provide effective education on alcohol to children and young people as part of the resilience framework. • Promote alcohol free schools, play areas and soft play areas to ensure that areas where our children and young people routinely go should be alcohol free. • Provide the children and families workforce with the tools to identify and provide early interventions among parents with alcohol problems and pathways of support • Continue to promote positive social norms which highlight the opportunity of either not drinking alcohol or to drink within the recommended daily limits, in all areas retaliating to alcohol harm reduction. • Continue to support the liaison work of Durham Constabulary with the Drug and Alcohol Service provider when under-aged young people are found in the possession of alcohol.	DCC Public Health	 March 2017 March 2017 March 2017 March 2017 March 2017
12.	**Reduce the negative impact alcohol has on the lives of children, young people and their families through parental alcohol use** • Develop support pathways for children and young people and for parents/carers who have alcohol problems. • Monitor the uptake of support services for children and young people and parents/carers. • Provide the children and families workforce with the tools to identify and provide early interventions among parents with alcohol problems and pathways of support.	DCC Public Health	 March 2017 March 2017 March 2017

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Breastfeeding initiation	Tracker indicator - no target required		
Prevalence of breastfeeding at 6-8 weeks from birth	Tracker indicator - no target required		
Percentage of children aged 4-5 classified as overweight or obese	Tracker indicator - no target required		
Percentage of children aged 10-11 classified as overweight or obese	Tracker indicator - no target required		
Number of young people referred to CAMHS who are seen within 9 weeks	Tracker indicator - no target required		
Alcohol specific hospital admissions for under 18's (per 100,000 under 18 years population)	Tracker indicator - no target required		
Percentage of exits from young person's substance misuse treatment that are planned discharges	80%	No Set	Not set
Under 16 conception rate	Tracker indicator - no target required		
Under 18 conception rate	Tracker indicator - no target required		
Percentage of mothers smoking at time of delivery	17.2%	16.6%	Not yet set
Infant mortality rate	Tracker indicator - no target required		
Emotional and behavioural health of Looked After Children	Tracker indicator - no target required		
Young people aged 10-24 admitted to hospital as a result of self-harm per 100,000 population	Tracker indicator - no target required		
Tooth decay in under 5	Tracker indicator – no target required		
Percentage of Community Eating Disorder Service cases receiving NICE compliant treatment in line with the new access and waiting time standards	Tracker indicator – no target to be set		
Emergency admission rate for children with asthma per 100,000 population aged 0–18 years (North Durham CCG)	4.8% reduction on baseline of 239.4		
Emergency admission rate for children with asthma per 100,000 population aged 0–18 years (DDES CCG)	4.7% reduction on baseline of 234.5		

STRATEGIC OBJECTIVE 2: REDUCE HEALTH INEQUALITIES AND EARLY DEATHS

Outcome: Reduced levels of tobacco related ill health

	Strategic Actions/Sub-Actions	Lead	Timescale
13.	**Support an infrastructure that delivers a comprehensive partnership approach to wider tobacco control actions to reduce exposure to second hand smoke, help people to stop smoking, reduce availability (including illicit trade), reduce promotion of tobacco, engage in media and education and support tighter regulation on tobacco** • Review the impact of the 'Fresh' North East campaign office and develop the working model for 2017-18 to contribute to the reduction of smoking prevalence. • Roll out the new commissioned Stop Smoking Service to ensure that service delivery is targeted at smokers / smoking quitters from deprived communities and vulnerable groups. • Support and encourage intelligence reporting of sales of illicit tobacco and the supply of tobacco products to children which will be actioned through Trading Standards. • Carry out a health equity audit of the Stop Smoking service in 2018.	Tobacco Control Alliance	December 2016 March 2017 March 2017 March 2019
14.	**Support the local vision statement that "a child born in any part of County Durham will reach adulthood breathing smokefree air, being free from tobacco addiction and living in a community where to smoke is unusual"** • Develop a new Tobacco Alliance action plan for 2017-2021, to support the vision statement that "a child born in any part of County Durham will reach adulthood breathing smoke free air, being free from tobacco addiction and living in a community where to smoke is unusual". • Support pregnant women to stop smoking by the implementation of the babyClear Pathway and referrals by maternity services to the Stop Smoking Service. • Implement local awareness-raising campaigns to support the Smokefree Families Initiative, to reduce exposure to second hand smoke, particularly to children in our most deprived communities. • Help people to stop smoking in our most deprived communities and most vulnerable groups by ensuring our Stop Smoking Service target groups most in need.	Tobacco Control Alliance	March 2017 March 2017 March 2018 March 2018

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Outcome: Reduced obesity levels

	Strategic Actions/Sub-Actions	Lead	Timescale
15.	**Implement the Healthy Weight Strategic Framework to develop and promote evidence based multi-agency working and strengthen local capacity and capability** • As part of the Physical Activity Framework for County Durham, develop school food growing clubs to raise awareness of healthy eating and to help local people to achieve and maintain a healthy weight. • Raise awareness of healthy eating and to help local people to achieve and maintain a healthy weight through the delivery of healthy weight interventions by Wellbeing for Life Health Trainers. • Enable networks to be developed through the Community Growing sub group of Sustainable Food Partnership.	Healthy Weight Alliance	 March 2017 March 2017 March 2017

Outcome: Reduced levels of alcohol and drug related ill health

	Strategic Actions/Sub-Actions	Lead	Timescale
16.	**Reduce health inequalities and reduce early deaths in County Durham by reducing alcohol consumption across the population** • Support delivery of the Alcohol Harm Reduction Strategy 2015-20. • Facilitate Rapid Process Improvement Workshops for pathways to integrate robust referral pathways into recovery services for adults, young people, families and carers. • Identify and train key staff in Alcohol Identification and Brief Advice. • Review the impact of the Balance North East campaign office and develop the working model for 2017-18 to contribute to the reduction of alcohol related hospital admissions.	DCC Public Health	 March 2017 March 2017 March 2017 March 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale
17.	**Implement the Drugs Strategy to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life, whilst minimising the impact of drugs on communities and families** • Refresh the County Durham Drugs Strategy (2016/17) and retain connectivity into the Alcohol Harm Reduction Strategy (2016/20). • Provide specific targeted training and education to support individuals, professionals, communities and families to address the harm caused by drugs and sustain a future for individuals to live a drug-free and healthy life. • Work with Durham Constabulary Harm Reduction Unit to raise awareness of new legislation relating to Novel Psychoactive Substances (legal highs) through training and media engagement. • Continue to deliver an Integrated Drug and Alcohol Service for adults, young people, families and carers across County Durham. • Provide on-going support for the independent Recovery Forum to facilitate and support the development of visible, supportive recovery communities in County Durham.	DCC Public Health	 March 2017 March 2017 March 2017 March 2017 March 2017

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Outcome: Reduced mortality from cancers and circulatory diseases

	Strategic Actions/Sub-Actions	Lead	Timescale

18.	**Work in partnership to develop effective pathways for cancers covering prevention, screening, diagnosis, treatment and survivorship**
	• Complete the Health Equity Audit for cancer and implement refreshed actions which are identified in this process.
	• Review and streamline key pathways including diagnosis and referral to treatment pathways to reduce unnecessary delays.
	• Review education and communication pathways to reduce the number of two week wait appointments which are not attended. This includes Primary Care Macmillan Nurses in the DDES area working with GP practices to make contact with those patients who did not attend appointments.
	• Re-commission the Health Check Programme in County Durham, to:
	    • Improve the quality of health checks and increase coverage of the programme throughout the county
	    • Develop a new model for delivering health checks to improve recording and reduce the wide variation in coverage between GP practices.
	• Work together to plan the development of the Macmillan Joining the Dots Service, to provide everyone affected by cancer (people diagnosed with cancer, their carers' and families) with the opportunity of a holistic needs assessment, from the point of a cancer diagnosis. The assessment will identify practical, physical, emotional, lifestyle, information, relationship needs and Macmillan Joining the Dots will connect people to the services best suited to address their identified needs.
		DCC Public Health /CCGs	
			September 2016
			March 2017
			March 2017
			April 2017
			April 2017

19.	**Work in partnership to develop and implement an effective preventative and treatment programme for people with and at risk of diabetes through the delivery of Integrated Diabetes Model with Consultants and GP Practices working together to deliver improved health outcomes for people with diabetes** • Develop a local Diabetes Strategy, based on the strategic framework model for cardiovascular disease, to target those people in County Durham who are most at risk by working with Consultants and GP Practices to deliver improved health outcomes for people with diabetes. • Work collaboratively with the Clinical Commissioning Groups in County Durham on the diabetes prevention programme, with a focus on reducing obesity as part of the overall approach.	DCC Public Health / CCGs	 August 2016 April 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale
20.	**Deliver an integrated and holistic Wellbeing Service to improve health and wellbeing and tackle health inequalities in County Durham** • Develop and implement a baseline survey to capture housing and health activity/programmes undertaken by Register Social Landlords and use the feedback to inform future developments. • Pilot two initial programmes focused on Making Every Contact Count (MECC) with the Registered Social Landlords workforce and self-care/management working with Registered Social Landlord tenants who have a diagnosed health condition. • As part of the Wellbeing for Life service, develop closer links with housing providers in the county to ensure a two-way signposting process for customers and service users to improve their quality of life	Community Wellbeing Partnership	September 2016 April 2017 April 2017
21.	**Reduce the inequalities between people with learning disabilities and the general population** • Undertake two engagement forums events per year to connect with people with a learning disability and their carers to provide updates and seek their views on developments which may have an impact on their life and the lives of those who support them. • Ensure the views of people with a learning disability, their carers and their community are considered as services commissioned by the Council and their partners are reviewed and or re-shaped.	Learning Disabilities Engagement Forum	March 2017 March 2017
	• Reduce premature mortality in people with learning disabilities who are at greater risk of poor physical health ensuring access to prevention and screening programmes including primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.	CCG's	March 2017
	• Through the Transforming Care fast track programme and the Durham and Darlington locality plan, develop three specialist accommodation-based services in the county for people with learning disability and mental health needs, shifting resources from hospitals to community settings. • Through the Transforming Care fast track programme, implement relevant elements of the Durham and Darlington locality plan, once funding and financial allocations have been agreed, to improve health outcomes and quality of life for people with learning disabilities and/or autism.	Learning Disabilities Transforming Care Programme Board	March 2017 March 2019

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	Strategic Actions/Sub-Actions	Lead	Timescale
22.	**Work together to reduce the health inequalities between the Gypsy Roma Traveller community and other BME Groups and the general population** • Commission an evaluation of work with the Gypsy Roma Traveller community to inform future interventions. • Undertake welfare checks for all individuals/households on Unauthorised Encampments (UE) and Temporary Stop Over Areas (TSOAs) on Durham County Council owned land. • Commission a specialist Wellbeing intervention for the Gypsy Roma Traveller community. • Include Specialist Health Visitor provision for the Gypsy Roma Traveller community in 0-19 commissioned activity.	DCC Public Health	 March 2017 March 2017 March 2018 March 2018

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Outcome: Reduced Excess Winter Deaths

	Strategic Actions/Sub-Actions	Lead	Timescale

23.	**Integrate and roll out interventions to address the impact of fuel poverty on excess mortality and morbidity**
	• Refresh the Cold Weather Plan, integrating it with the NHS Winter Resilience Plan, to ensure that any identified vulnerable individuals receive the necessary advice, guidance and support they need to enable them to maintain their independence.
	
	• Deliver a Warm and Healthy Homes Programme to target those individuals with long-term health conditions exposed to the dangers of living in a cold, damp home by ensuring that front-line health and social care practitioners know to refer them as appropriate to a central point of contact where they can be offered a menu of options:
	  ◦ 300 frontline health and social care professionals offered training
	  ◦ A minimum of 100 referrals made
	  ◦ Capture the range of interventions achieved.
	• Target GP surgeries with the highest number of COPD patients, offering patients the range of Warm and Healthy Homes interventions and monitor the impact on their health and wellbeing.
	• Develop a Housing and Health Matrix to target localities with the worst housing conditions and highest levels of health issues, this matrix to then be used to inform the work with GP surgeries
		DCC Public Health / CCG's
		
		DCC Public Health
		
		DCC Public Health
		DCC Public Health
			November 2016
			
			March 2017
			
			March 2017
			
			July 2016

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Mortality rate from all causes for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from all cancers for persons aged under 75	Tracker indicator - no target required		
Percentage of eligible people who receive an NHS health check	8%	8%	Not yet set
Mortality rate from liver disease for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from respiratory diseases for persons aged under 75 years	Tracker indicator - no target required		
Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis	96%	96%	96%
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85%	85%	85%
Male life expectancy at birth	Tracker indicator - no target required		
Female life expectancy at birth	Tracker indicator - no target required		
Successful completions as a percentage of total number in drug treatment – Opiates	Within top quartile of similar LAs	Targets to be agreed as part of the review of Drug & Alcohol Provider Contract	
Successful completions as a percentage of total number in drug treatment – Non Opiates	Within top quartile of similar LAs	Targets to be agreed as part of the review of Drug & Alcohol Provider Contract	
Alcohol-related admissions to hospital per 100,000 population	Tracker indicator - no target required		
Successful completions as a percentage of total number in treatment – Alcohol	Within top quartile of similar LAs	Targets to be agreed as part of the review of Drug & Alcohol Provider Contract	

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Four week smoking quitters per 100,000 smokers aged 16+	2,311	Not yet set – will be reviewed as part of the Stop Smoking Service Contract	
Estimated smoking prevalence of persons aged 18 and over	Tracker indicator - no target required		
Proportion of physically active adults	Tracker indicator - no target required		
Excess weight in adults	Tracker indicator - no target required		
Percentage of women eligible for breast screening who were screened adequately within a specified period	70%	70%	70%
Percentage of women eligible for cervical screening who were screened adequately within a specified period	80%	80%	80%
Percentage of people eligible for bowel screening who were screened adequately within a specified period	60%	60%	60%
Excess winter deaths	Tracker indicator - no target required		
Percentage of people with learning disabilities that have had a health check	Tracker indicator - no target required		
Prevalence of Diabetes	Tracker indicator – no target required		

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STRATEGIC OBJECTIVE 3: IMPROVE THE QUALITY OF LIFE INDEPENDENCE AND CARE AND SUPPORT FOR PEOPLE WITH LONG TERM CONDITIONS

Outcome: Adult care services are commissioned for those people most in need

	Strategic Actions/Sub-Actions	Lead	Timescale
24.	**Provide better support to people with caring responsibilities by reviewing the service delivery model and increasing access to personal budgets for carers** • Review and monitor service specification for NHS Personalised Carer Support Fund to include services for carers such as gardening, ironing and cleaning services.	DCC / CCG's	March 2017

Outcome: Increased choice and control through a range of personalised services

	Strategic Actions/Sub-Actions	Lead	Timescale
25.	**Work together to give people greater choice and control over the services they purchase and the care that they receive** • Further develop the functionality and services within the LOCATE website, which provides details of locally available services, to support greater self-service of needs by the public. • Consider ways to develop integrated personalised commissioning through working with the Integrated Transitions Team and focusing on children and young people eligible for education, health and care plans, to allow them greater involvement in their care and support.	DCC DCC / CCGs	March 2017 March 2017

Outcome: Improved independence and rehabilitation

	Strategic Actions/Sub-Actions	Lead	Timescale
26.	**Continue to progress the model for Frail Elderly which incorporates a whole system review that cuts across health, housing, social care and the third sector providing safe, high quality seven day integrated services; delivering person centred care, and places early identification, timely intervention and prevention at its core.** • Continue the implementation of the Frail Elderly Model. • Review the model of community services to support independence, integration and care co-ordination for patients.	CCGs CCGs	March 2017 March 2017
27.	**Improve people's ability to reach their best possible level of independence by evaluating the Intermediate Care Plus Service, Reablement Service and any other effective alternatives to hospital and residential care admission** • Help people to manage their own long term conditions through self-management programmes. • Following the evaluation of the Intermediate Care+ service, develop a robust and streamlined performance framework to monitor the effectiveness of service delivery.	DCC / CCGs	April 2016 March 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale
	• Deliver a sustainable service to people in care homes, hospitals and supported living are cared for in the right way to regarding to ensure Deprivation of Liberty Safeguards are met.		March 2017
28.	**Provide safe, high quality seven day integrated services across the health and social care economy** • Complete a scoping exercise of the standards required for successful implementation of seven day services to identify any gaps in relation to the time to complete consultant reviews, access to diagnostics, access to consultant-directed interventions and standards regarding on-going reviews. • Develop an action plan to remedy any gaps identified as part of the scoping exercise.	CCGs	March 2017 March 2017
29.	**Implement the Urgent Care Strategy to ensure patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most effective way providing the best outcome for the patient** • Review and re-procure GP Out of Hours Service and review extended access in primary care. • Review DDES urgent care services (in hours) and minor injuries services to develop a model that is patient centred.	CCGs	March 2017 April 2017

Outcome: Improved joint commissioning of integrated health and social care

	Strategic Actions/Sub-Actions	Lead	Timescale
30.	**Implement the agreed framework and policies for Clinical Commissioning Groups and partners in relation to continuing health care and integrated packages in mental health and learning disability, including personal health budgets** • Monitor uptake of the local offer for personal health budgets and refine where necessary. • Develop a regional approach to Continuing Health Care commissioning and fee setting.	CCGs	March 2017 March 2017
31.	**Develop a vision and new model of integration for County Durham to maximise the use of resources and improve outcomes for local people with regard to health and social care** • Develop with partners a vision and new model of integration for County Durham, working with a commissioned external organisation, to maximise the use of resources and improve outcomes for local people with regard to health and social care.	DCC / CCGs	March 2017
32.	**Work together to consider the implications of the key clinical quality standards and potential models of care across the Durham, Darlington and Tees area within the resources available** • Undertake a public engagement scoping exercise on what the future of NHS Services should look like through the Better Health Programme. • Develop a Better Health Programme Strategy.	CCGs	October 2016 March 2017

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Carer reported quality of life	Tracker indicator - no target required		
Overall satisfaction of carers with support and services they receive	48-53%	Not set	Not set
Percentage of service users reporting that the help and support they receive has made their quality of life better	Tracker indicator – no target required		
Proportion of people using social care who receive self-directed support	90%	90%	90%
Adults aged 65+ admitted on a permanent basis in the year to residential or nursing care per 100,000 population	710.4	Not set	Not set
Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	85.7%	Not set	Not set
Emergency readmissions within 30 days of discharge from hospital	Tracker indicator - no target required		
Delayed transfers of care from hospital per 100,000 population	Tracker indicator - no target required		
Falls and injuries in the over 65s	Tracker indicator - no target required		
Hip fractures in the over 65s	Tracker indicator - no target required		
Proportion of people feeling supported to manage their condition	Tracker indicator - no target required		
Avoidable emergency admissions per 100,000 population	2,811 (Apr-Jun16) 2,861 (Jul-Sep16)	2,958 (Oct-Dec16) 2,846 (Jan-Mar17)	
Number of people in receipt of Telecare per 100,000	225	Not set	Not set
Number of residential / nursing care beds for people aged 65 and over commissioned by Durham County Council	Tracker indicator – no target required		
Reduction in prescribing rates (typically prescribed for self-limiting acute conditions) in primary care	QPI target not yet set		

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STRATEGIC OBJECTIVE 4: IMPROVE THE MENTAL AND PHYSICAL WELLBEING OF THE POPULATION

Outcome: Increased physical activity and participation in sport and leisure

	Strategic Actions/Sub-Actions	Lead	Timescale
33.	**Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles through the development of the Physical Activity Framework for County Durham** • Develop and support a robust and cross cutting partnership to enable a coordinated approach to the framework, and to reap the wide ranging benefits of physical activity. • Establish a coordinated and county wide approach to data and insight for tackling inactivity', to ensure an intelligent led approach. • Establish an agreed metric approach to large scale campaigns, maximising technology and encouraging all partners to commission and apply the metric. • Work with National agencies to develop single behavioural change messages on recommended levels of activity. • Develop a county wide approach to large scale active campaigns, joint marketing and measurement • Establish a partnership approach to attracting external resource to the County to support the framework	Active Durham Partnership	May 2017 May 2017 May 2017 May 2017 May 2017 May 2017

Outcome: Maximised independence

	Strategic Actions/Sub-Actions	Lead	Timescale

34.	**Work together to improve timely diagnosis and support for people with dementia and their family and carers**
	• Following the dementia health needs assessment, refresh the Dementia Strategy 2014/17 to:
	    • Focus on prevention and promote the benefits of healthy lifestyle programmes
	    • Review opportunities for promoting dementia awareness through all possible contacts, such as substance misuse and alcohol teams
	    • Ensure that local people have the best possible services in place for those who have dementia, their carers and families, as well as those who have not yet been diagnosed with dementia
	    • Carry out a review of the Dementia Care Advisory Service to inform future commissioning activities
	• Support people with dementia to live in their own home for as long as possible.
	• Carry out the accreditation process for dementia friendly communities in both the identified pilot sites – Barnard Castle and Chester-le-Street.
		Mental Health Partnership Board	March 2017
			March 2017
			March 2017
			March 2017
			March 2017
			March 2017

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	Strategic Actions/Sub-Actions	Lead	Timescale
35.	**Improve access and availability of suitable accommodation and services to support recovery for people with a range of needs including learning disabilities, mental health problems and autism to enable them to live as independently as possible in the community** • Develop a new recovery-focused mental health service in Meadowfield, to provide an accommodation advice and resource centre for people with mental health needs	DCC	April 2017

Outcome: Improved mental health for the population of County Durham

	Strategic Actions/Sub-Actions	Lead	Timescale

36.	**Improve access to evidence based programmes which improve mental health, wellbeing and resilience**
	• Implement the Dual Needs action plan including adults, children and young people, families and carers with needs arising from multiple factors which may be a combination of:
	  • Substance misuse issue
	  • Mental and behavioural diagnosis
	  • Dementia
	  • Learning disability
	• Work with partners to refresh the County Durham 'No health without mental health' implementation plan incorporating the recommendations in Mental Health Taskforce report ' Five year forward view for mental health'
	• Refresh the County Durham Public Mental Health action plan including the Self-Harm and Suicide Plan.
	• Establish task and finish groups to lead key work areas for Dual Needs including pathway development, informing commissioning, acting as a forum for arbitration, workforce development and developing practice from lessons learnt.
		Mental Health Partnership Board	January 2017
			
			March 2017
			
			March 2017
			March 2017

37.	**Work together to find ways that will support the armed services community who have poor mental or physical health** • Hold a workshop that brings together organisations that provide specific services which support the Armed Forces Community and other Mental Health service providers within County Durham to develop understanding, connectivity and foster relationships between services. • Invite representatives from key organisations and services to the biannual County Durham Armed Forces Network to share research and information about their activities and services and take forward any identified recommendations as required. • Encourage GP services to identify armed services community.	DCC / CCGs DCC (Public Health) CCGs	September 2016 March 2017 March 2018

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	Strategic Actions/Sub-Actions	Lead	Timescale
38.	**Ensure people with poor mental health are supported to stay in work and gain employment** • Deliver Mental Health Trailblazer dedicated employment support with psychological therapy to those adults with have a 'common mental health' condition (principally anxiety and depression) as primary reason for unemployment. • Improve access to integrated evidence based psychological therapies for people with anxiety and depression, with a focus on people living with long term physical health conditions and supporting people into employment.	Mental Health Partnership Board	March 2018 March 2018
39.	**Continue to improve access to psychological therapies** • Implement new specification for Counselling Services regarding service improvements including information governance and data capture. • Work with partners to expand the training programme for staff from the Child and Mental Health Services (CAMHS) Children and Young People's Improving Access to Psychological Therapies programme in order to respond to the needs of children, young people and their families.	CCGs DCC Public Health / CCGs	March 2017 March 2017
40.	**Develop a more integrated response for people with both mental and physical health problems, in particular supporting people with common mental health problems (such as depression or anxiety) and improve the physical health of people with secondary mental health problems** • Prioritise people with mental health problems who are at greater risk of poor physical health ensuring access to prevention and screening programmes including primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • Improve the physical health care of people with severe mental health problems including psychosis, bipolar disorder and personality disorder through primary care. • Reduce premature mortality among people with severe mental illness ensuring that people with living with severe mental illness have their physical health needs met by increasing early detection and expanding evidence- based physical care and assessment. • Provide training with competencies for Health and social care staff involved in care and support of people with mental health problems, should receive training with competencies in dealing with common physical health problems, mental health prevention (including suicide), and empowering people to understand their own strengths and carer involvement.	Mental Health Partnership Board	March 2017 March 2018 March 2018 March 2018

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Outcome: Increased social inclusion

	Strategic Actions/Sub-Actions	Lead	Timescale
41.	**Work in partnership to identify those who are, or who are at potential risk of becoming socially isolated to support people at a local level and to build resilience and social capital in their communities** • Agree a contract which focuses on the social care needs of prisoners, to include screening and assessment processes, through the Durham Prisons and Social Care Forum and working in partnership with the four prisons in County Durham, the local community rehabilitation company and the national offender management service. • Provide individuals and groups with volunteering and community health development opportunities, to support local communities to adopt healthier behaviours through the delivery of an integrated and holistic Wellbeing for Life Service	DCC Community Wellbeing Partnership	March 2017 April 2017

Outcome: Reduced self-harm and suicides

	Strategic Actions/Sub-Actions	Lead	Timescale

42.	**Refresh the Public Mental Health Action Plan including the suicide prevention framework**
	• Address the following priority areas arising from the Mental Health Needs Assessment:
	    • Suicide prevention including self-harm
	    • Stigma and discrimination
	    • Physical activity and mental health
	    • Workplace mental health
	    • Recovery
	    • Mental health and welfare change.
	• Learn from deaths by suicide process to identify what steps services should take to ensure that there is learning from all deaths by suicide to prevent repeat events.
		Mental Health Partnership Board	March 2017
			
			March 2017

43.	**Work in partnership through the Crisis Care Concordat action plan to improve outcomes for people experiencing mental health crisis in the community and in custody**
	• Initiate task and finish groups to deliver specific projects to improve the experience of patients experiencing a mental health crisis including:
	    • Improving ambulance waiting times for transportation of mental health patients to hospital
	    • Investigating options such as Street Triage and Crisis Assessment suites.
	• Review the recommendations from the review of Crisis Services and consider whether the recommendations need to be revised and/or implemented.
	• Consider introduction of pre-crisis services by reviewing community and statutory services to prevent crisis.
		Mental Health Partnership Board	March 2017
			
			March 2017
			
			March 2017

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Gap between the employment rate for those with long term health conditions and the overall employment rate	Tracker indicator - no target required		
Health related quality of life for people with a long term mental health condition	QPI target not yet set		
Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population	Tracker indicator - no target required		
Hospital admissions as a result of self-harm	Tracker indicator - no target required		
Excess under 75 mortality rate in adults with serious mental illness	Tracker indicator - no target required		
Percentage of people who use adult social care services who have as much social contact as they want with people they like	Tracker indicator – no target required		
Estimated diagnosis rate for people with dementia	Tracker indicator - no target required		
Access to Improving Access to Psychological Therapies (IAPT) Services – North Durham CCG	15	-	-
Access to Improving Access to Psychological Therapies (IAPT) Services – DDES CCG	15	-	-

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STRATEGIC OBJECTIVE 5: PROTECT VULNERABLE PEOPLE FROM HARM

Outcome: Prevent domestic abuse and sexual violence and reduce the associated harm

	Strategic Actions/Sub-Actions	Lead	Timescale
44.	**Ensure all victims of domestic abuse and sexual violence have access to the right help and support and services are available to address their needs** • Embed the domestic abuse referral pathway across relevant statutory, voluntary and community organisations in County Durham by promoting the pathway through the Safe Durham Partnership, Local Safeguarding Children Board and Safeguarding Adults Board in order to ensure that victims, perpetrators and children access appropriate support services. • Review the existing county wide domestic abuse service and remodel the service specification to inform the commissioning process taking into consideration possible duplication and gaps in provision and opportunities for pooled funding. • Coordinate the delivery of the Domestic Abuse and Sexual Violence Action Plan 2015-2018.	Domestic Abuse and Sexual Violence Executive Group (Safe Durham Partnership)	September 2016 March 2017 March 2018

Outcome: Safeguarding children and adults whose circumstances make them vulnerable and protect them from avoidable harm

	Strategic Actions/Sub-Actions	Lead	Timescale
45.	**Work with partners to help families facing multiple and complex challenges, ensuring children are safeguarded and protected from harm and early intervention and prevention services are in place to support Phase 2 of the Stronger Families Programme in County Durham** • Deliver the Phase 2 Stronger Families Programme to 4,330 families in County Durham to help them address the complex issues they face and reduce the problems they cause to the community around them.	DCC Children's Services	May 2020
46.	**Develop the practice of adult protection lead officers and frontline teams to improve safeguarding for individuals and to involve them in the process;** • Take a more creative approach to responding to safeguarding concerns in order to enhance individuals' involvement, choice and control as well as improving their quality of life, wellbeing and safety	DCC	March 2017

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Percentage of repeat incidents of domestic violence	Less than 25%	Less than 25%	Less than 25%
Proportion of people who use services who say that those services have made them feel safe and secure	Tracker indicator no target required		
Number of children's assessments where risk factor of parental domestic violence is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental mental health is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental alcohol misuse is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental drug misuse is identified	Tracker indicator - no target required		
Number of children with a Child Protection Plan per 10,000 population	Tracker indicator - no target required		
The percentage of individuals who achieved their desired outcomes from the adult safeguarding process	Tracker indicator - no target required		

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STRATEGIC OBJECTIVE 6: SUPPORT PEOPLE TO DIE IN THE PLACE OF THEIR CHOICE WITH THE CARE AND SUPPORT THAT THEY NEED

Outcome: Improved End of Life Pathway

	Strategic Actions/Sub-Actions	Lead	Timescale
47.	**Ensure providers deliver support to people at the end of their life based on the Five Priorities for Care that will deliver personal, bespoke care** • Offer Emergency Health Care Plans (EHCP) and the opportunity of an Advance Care Plan to all eligible patients and reviewed annually or whenever relevant. • Provide a 24/7 patient and carer support through a single point of access to address the limited access to advice and support. • Improve the quality of practice palliative care registers ensuring that a preferred place of death is recorded for all patients on end of life pathways.	End of Life Care	 March 2017 March 2017 March 2017

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PERFORMANCE INDICATORS

Indicator	2016/17 Target	2017/18 Target	2018/19 Target
Proportion of deaths in usual place of residence	Tracker indicator - no target required		
Percentage of hospital admissions ending in death (terminal admissions) that are emergencies	Tracker indicator - no target required		
Number and percentage of patients on GP practice palliative care registers	1%	1%	1%
Proportion of people who state their preferred place of death and achieve it	Tracker indicator – no target required		
Reduce the number of palliative care emergency admissions	Tracker indicator – no target required		

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GLOSSARY

ABBREVIATION	DESCRIPTION
CCG	**Clinical Commissioning Groups** are clinically-led groups that include all of the GP groups in their geographical area The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients
CDYOS	**County Durham Youth Offending Service** works with young people and partner agencies to prevent re-offending
COPD	**Chronic Obstructive Pulmonary Disease** (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
DCC	**Durham County Council** Local Authority performs all council functions in the County Durham area
DDES CCG	**Durham Dales, Easington and Sedgefield.** The name of the Clinical Commissioning Group operating in the South and East and West of the County
GP	**General Practitioner** is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients
IAPT	**Improving Access to Psychological Therapies** (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders
ND CCG	**North Durham** The name of the Clinical Commissioning Group operating in the North of the County
NICE	**National Institute for Health and Care Excellence** (NICE) provides national guidance and advice to improve health and social care
SEND	**Special Educational Needs and Disability.** Children who have needs or disabilities that affect their ability to learn, for example: • Behavioural/social (e.g. difficulty making friends) • Reading and writing (eg dyslexia) • Understanding things • Concentrating (eg Attention Deficit Hyperactivity Disorder) • Physical needs or impairments
TSOA	**Temporary Stop Over Areas.** Pieces of land in temporary use as authorised short-term (less than 28 days) stopping places for all travelling communities. They may not require planning permission if they are in use for fewer than 28 days. The requirements for emergency stopping places reflect the fact that the site will only be used for a proportion of the year and that individual households will normally only stay on the site for a few days.
UE	**Unauthorised Encampments.** Encampments of caravans and/or other vehicles on land without the landowner or occupier's consent and constituting trespass.

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North Durham Clinical Commissioning Group

Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

healthwatch
County Durham

May 2016
Published by Durham County Council
On behalf of the County Durham Health and Wellbeing Board
Available online at www.durham.gov.uk/jhws

Produced in collaboration with:
Durham County Council, North Durham Clinical Commissioning Group, Durham Dales, Easington and Sedgefield Clinical Commissioning Group, NHS County Durham, County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust, Healthwatch County Durham.

County Durham Joint Health and Wellbeing Strategy

2016-2019

Delivery Plan

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CAS18416 Children and Adults Services, CMI Team 2015