Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Friday 17 January 2020**
Time **9.30 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

Items during which the Press and Public are welcome to attend. Members of the Public can ask questions with the Chairman's agreement.

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 9 December 2019 (Pages 3 - 6)
4. Declarations of Interest, if any
5. Media Issues (Pages 7 - 8)
6. Any Items from Co-opted Members or Interested Parties
7. Health and Social Care Integration - Joint Report of the Corporate Director Adult and Health Services, Durham County Council and the Director of Integration, Durham County Council/North Durham and DDES CCG (Pages 9 - 64)
8. Care Quality Commission Inspection Report - County Durham and Darlington NHS Foundation Trust - Presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust. (Pages 65 - 142)

   A copy of the CQC Inspection Report is attached for members information.

9. Draft Joint Health and Wellbeing Strategy 2020-2025 - Joint Report and presentation of the Corporate Director Adult and Health Services and the Director of Public Health Durham County Council. (Pages 143 - 192)
10. Quarter 2 2019/20 Performance Management report- Report of the Corporate Director of Resources. (Pages 193 - 210)
11. Budget Revenue and Capital Forecast Q2 2019/20 - Report and presentation of the Corporate Director of Resources. (Pages 211 - 228)
12. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
9 January 2020

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee**

Councillor J Robinson (Chair)
Councillor J Chaplow (Vice-Chair)

Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple and C Wilson

Co-opted Members: Mrs Hassoon

Co-opted Employees/Officers: Mr Cunnington Shore

Contact: Jackie Graham Tel: 03000 269704

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Monday 9 December 2019 at 9.30 am**

Present

Councillor R Crute (Chair)

Members of the Committee
Councillors A Batey, L Brown, S Quinn, H Smith, J Stephenson and O Temple

Co-opted Members
Mrs R Hassoon and Mr C Cunnington Shore

Also Present

Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors J Robinson, J Chaplow, R Bell, P Crathorne, J Grant, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, A Reed, A Savory, M Simmons and C Wilson

2 Substitute Members

There were no substitute members.

3 Minutes

The minutes of the meeting held on 15 November 2019 were agreed as a correct record and signed by the Chair.

4 Declarations of Interest

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

There were no items.

6 NHS Quality Accounts 2018/19: Progress against 2019/20 priorities

The Committee received information from Tees, Esk and Wear Valleys NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust that set out progress made against their Quality Accounts priorities for 2019/20 (for copy see file of minutes).

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

The Director of Quality Governance, Tees, Esk and Wear Valleys NHS Foundation Trust gave a brief update and highlighted the four priority areas for 2019/20 as:-

- Personalising care planning
- Reducing preventable deaths
- Improving child to adult service transitions
- Increasing the proportion of inpatients who feel safe on our wards

In referencing the Quality Improvement Metrics, members were informed that the average length of stay for patients in Mental Health Services for Older People Assessment and Treatment wards continued to be underperforming. The Director of Quality Governance indicated that this was often down to the lack of suitable alternative placements to enable transfers of care to be undertaken. Members also noted that the patient experience measures for the Trust were generally better for the Durham and Darlington locality than for other areas within the Trust.

North East Ambulance Service NHS Foundation Trust

The Assistant Director of Communications and Engagement gave a brief update and highlighted the three priority areas as:

- Continue to develop a Just and restorative Culture to improve patient safety
- To develop our mental health implementation plan, working in partnership with others to improve the experience and care provided to patients with mental health needs accessing our services
- To improve early intervention with patients in cardiac arrest

The Chair praised the service for delivering support and training for new community defibrillators and was pleased to learn of the new app ‘GoodSAM’ whereby a member of staff off duty could be called upon to deliver cardiac care until a paramedic arrived on scene. The Assistant Director of Communications offered to arrange a demonstration on the use of defibrillators and the Chair suggested that he could speak to the AAPs to get the message out to as many people as possible.

County Durham and Darlington NHS Foundation Trust (CDDFT)

The Associate Director of Nursing, County Durham and Darlington NHS Foundation Trust gave a brief update and highlighted the three priority areas as :-

- Safety including falls, dementia care, healthcare associated infections and pressure ulcers
- Experience including nutrition and hydration, end of life palliative care and the friends and family test
- Effectiveness including mortality ratio, reduction in readmissions to hospitals, reduction in length of time to assess and treat in A&E, paediatric care and excellence reporting.

The Associate Director of Nursing advised that the trust had received and outstanding judgement for their end of life care following the recent CQC inspection. She informed the committee that additional winter funding had been received to alleviate the pressure in the A&E assessments. She also went on to advise of two never events, both human factors and the patients were not harmed.

Referring to one of the never events Councillor Temple asked for an explanation as to whether it was private health care staff involved or another body using the facility. The Associate Director of Nursing advised that in this instance it was NHS staff from another facility who were involved.

Councillor Smith was aware of the long standing issues within the accident and emergency department and asked if they had a full complement of staff and if the trust had considered re-opening A&E at Bishop Auckland Hospital to alleviate some of the pressures. The Associate Director of Nursing responded that there was not a full complement of nursing or medical staff although the trust were actively recruiting and roles were being looked at. She was not in a position to answer the question about Bishop Auckland but went on to add that should the trust look at other venues they would also need to all other high level care settings including intensive care.

The Principal Overview and Scrutiny Officer referred to the recently announced CQC Re-section report for County Durham and Darlington NHS Foundation Trust and indicated that a report on this issue would be brought to the Committee's meeting in January 2020.

Resolved:
That the reports be received and noted.

7 Developing County Durham's Approach to Wellbeing

The Committee received a joint report of the Corporate Director of Adult and Health Services and the Director of Public Health, Durham County Council that provided an update on the development of the approach, highlighted examples of where and how the approach was being used and that outlined further areas to embed the approach (for copy see file of Minutes).

The Public Health Strategic Manager advised that the approach to wellbeing across County Durham was to improve physical and mental health with a community approach. There were significant challenges in health inequalities and a gap in some parts of the County with healthy life expectancy for women at 58.7 years and men at 58.9 years. Workshops had been held and 6 key principles had been agreed to support people, places and systems. Work was continuing with the Area Action Partnerships (AAPs) and all information was available through Durham Insight and supported by the Joint Strategic Needs Assessment, policies and plans.

Resolved:
That the contents of this report be noted and to actively support the continuing development of the County Durham Approach to Wellbeing be agreed.

Adults Wellbeing and Health OSC
17 January 2020 – Media Slide

CQC rate Darlington Memorial and Durham hospitals as good – Northern Echo 3 December 2019

Stroke reforms warning for Bishop Auckland Hospital – Northern Echo 7 January 2019

Why 2020 will be a crucial year for the NHS – BBC Website 19 December 2019

Strengthening services at County Durham community hospital – DCC Press Release 7 January 2020

Altogether better

Durham County Council

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Adults, Wellbeing and Health Overview and Scrutiny Committee

17 January 2020

Integration of Health and Social Care across County Durham

Ordinary Decision/Key Decision No.

Report of Lesley Jeavons, Director of Integrated Community Services and Jane Robinson, Corporate Director of Adults and Health Services

Electoral division(s) affected:

Countywide

Purpose of the Report

1 To update members of Adults, Wellbeing and Health Overview and Scrutiny Committee (OSC) on progress to date in relation to integration of health and social care across County Durham.

Executive summary

2 County Durham has a long tradition of strong partnership working. Additional opportunities to provide services in an integrated way have been successfully developed over the last 3 years. This has in the main involved the development of a new community service model, wrapped around primary care as well as an emerging integrated commissioning function.

3 The new community service model has resulted in improved outcomes for users of both NHS and adult social care services with a notable improvement in the interface between key stakeholders. This has in turn led to service reviews with the purpose of improving pathways and new investment in NHS services.

4 It is expected that further opportunities will arise in respect of greater levels of collaboration between the NHS and local government as well as the enhancement of services delivered within community settings.

5 Adults Wellbeing and Health Overview and Scrutiny committee is recommended to:

(a) Note the contents of this report.

(b) Support the direction of travel with regard to integration across County Durham.

Background

6 Integration has been a key policy driver for many years within health and social care. Most recently the Five-year Forward View and the Care Act 2014 outlined the need to design and implement services around individuals and their communities, to further enhance pathways and joint service provision across health and social care.

7 In County Durham, there is a strong track record of integrated working based on effective partnerships. This has led to the development of a number of examples of integrated services such as Intermediate Care plus, the 0-19 pathway and Mental Health and Learning Disability Services, which have been part of an integrated approach between Tees, Esk and Wear Valleys NHS Trust (TEWV) and Durham County Council for several years.

8 A new specification for the delivery of NHS community services was developed in 2017 which placed integration at its centre and this was supported by the council. This has required NHS community services to be managed alongside specific adult social care services. A combined Integrated Care Board (ICB) is in place and forms part of an established governance system. Direct service delivery of NHS community and adult social care services is being overseen by the Director of Integrated Community Services on behalf of all partners.

9 In relation to primary care, 13 Teams Around Patients (TAPs) have been established and are operational across County Durham and whilst the focus of activity has centred on the frail/elderly cohort, the longer-term ambition of the TAPs is to extend the remit to a wider group of patients, specifically to those with long term conditions. Furthermore, in line with the agreed direction of travel, work is ongoing to enhance the community offer with consideration being given to services transferring across to this service from an acute setting, e.g. the discharge management function.

10 Community services are seen as an essential partner in the provision of a safe and responsive service offer, the aim being to keep people at home and maintain their independence for as long as possible. Managing a safe and timely discharge process is also fundamental to the work of the service. Progress has been made in terms of integrating

senior management teams within adult care and the NHS community service with opportunities for joint working being progressed. Reviews have been taking place in relation to each service line within the community contract as part of an overarching “Transformation Plan”.

11 The new community service has been working hard to ensure its offer is responsive and customer focussed. Furthermore, the work to avoid hospital admission and facilitate discharge whilst providing more services closer to home has continued. More recently, focussed collaboration has taken place with care home and domiciliary care providers to drive improvements across the whole system, which recognises the need for improved interfaces between service providers.

12 We have already seen significant benefits of adopting an integrated delivery model in County Durham, including reductions in length of stay, improvements in rates of delayed discharge, reductions in admissions from care homes and reductions in falls related admissions. However there have also been improvements in outcomes which are not so easily measured i.e. feedback from frontline staff and colleagues in CCGs and primary care report much improved working relationships resulting in less duplication and more effective, targeted support for local people. A summary of key performance metrics is attached as appendix 2, 3 and 4 of this report along with inpatient activity utilised as part of the frailty pathway across community hospital provision and in-patient wards at Chester le Street, Bishop Auckland and Shotley Bridge. A case study and direct feedback from those using the service is also included in appendix 5.

13 The emergence of Primary Care Networks (PCNs) in 2019 was seen as a key building block of the NHS long term plan. They seek to bring general practices together in geographical networks covering populations of approximately 30-50,000 patients. The size is consistent with the size of the TAPs across County Durham and the work undertaken to date has provided an excellent platform to further build upon primary care infrastructure.

14 The aim of PCNs is to build upon the core of existing primary care services and enable greater provision of proactive, better co-ordinated care for local populations. Clinicians describe this as a change from reactively providing appointments to proactively caring for the people and communities they serve through better collaboration.

15 In addition to the above, work has been productive and effective in developing a model for the integration of commissioning functions between the Council and Durham Clinical Commissioning Groups (CCG). The model has been agreed by both Cabinet and the CCG governing bodies and will be implemented from April 2020. In

developing the model a number of principles were agreed which are attached as appendix 6.

16 A key principle was the joint management arrangements and a key joint appointment of Sarah Burns to the Head of Integrated Strategic Commissioning post to oversee the implementation and delivery of the new model was made in December 2019.

17 A more recent development has been that of the provision of an Integrated Business Unit (IBU) with dedicated support services to assist front line delivery. Elements of organisational development, performance management and communications and marketing will form part of the initial offer from the unit.

18 In line with these developments the ICB recently supported a recommendation to rename the partnership the “County Durham Care Partnership” and marketing material is currently being prepared to reflect this.

19 However, despite there being significant progress, the ambition in County Durham is to pursue integration further. There is a view, expressed by Chief Officers that establishing a substantial, system-wide integrated model would afford additional support and raise the profile of the local footprint which in turn could ensure attention would be focussed on the local development of services and protect investment of what has been referred to as “the Durham pound”.

20 The ICB is about to undertake work which identifies those services which should be delivered as core statutory health and adult social care services across the NHS and local government. Consideration has also been given to pathways and partnerships that should be delivered on a ***place*** - County Durham, ***system*** - Central Integrated Care Partnership (ICP) and ***regional*** - Integrated Care System (ICS) level.

21 Furthermore the ICB has made clear its commitment to see wherever possible, place based services devolved to the ICB for oversight and governance. Of course this will rely on such services lending themselves to an integrated approach with demonstrable benefits and outcomes that improve population health.

22 Consideration will be given therefore to identifying the services that are appropriate to deliver within an integrated model at the ICB’s next development session on the 7th February 2020.

23 There are a number of models operating in different parts of the country that could help support this way of working and these are to be considered further in due course. Key officers are planning a visit to Tameside in the near future to observe their integrated model at work.

24 What is clear across the current landscape is that partnership working is key to the continued success of delivering priorities that improve the service offer for local populations.

25 A key issue going forward will be the relationship in County Durham between the CCG/CDDFT and the Central ICP which is comprised of the NHS commissioning and provider functions of Durham, Sunderland and South Tyneside.

26 It is important to note Durham's position within that structure and the need to support the existing and future investment of Durham's financial resources. The development of sound governance structures and the ability to influence service development and delivery will also be an issue of concern for Chief Officers and elected members should County Durham become part of a larger operational geographical footprint.

27 It is pertinent however to also consider the position of ICP partners such as South Tyneside and Sunderland, who have their own integrated arrangements with similar concerns presumably, around the utilisation of finance and governance arrangements that support their own ambition and priorities.

28 Of course future developments could well enhance our local services. ICP working may strengthen our local hospital services by encouraging them to work together, therefore getting better quality for Durham residents. There is also the potential benefit of being able to release management resource to invest in front line services etc.

29 The adult social care service in County Durham is a prominent partner and there are strong, relationships between the council and colleagues in local NHS organisations. There is also LA representation on the ICP group from Durham/Sunderland/South Tyneside Local Authorities, with an acknowledgement from NHS leaders that Local Government are key to adopting a successful collaborative approach

30 In terms of the future, it is acknowledged that the merger of the two Durham CCGs creates scope for looking at other synergies between organisations and options for better connected delivery within partnership arrangements. Those options will be considered by the ICB in due course, as referenced earlier in this report.

31 The willingness to consider alternatives which forge stronger relationships is to be expected where healthy partnership working exists and is indicative of a mature and productive approach to integrated working. It is therefore timely to consider how further integration can be supported and how best to protect existing services and secure future investments for County Durham.

32 The potential content of a new Integrated Care Bill has recently been published and views have been sought on a country-wide basis. NHS Improvement (NHSI) and NHS England (NHSE) have a clear and strong consensus about what the bill should and should not contain and within their response they also make the following statements which contextually could help focus upon what the future partnership landscape could look like.

33 They recommend that the bill should be introduced in this session of Parliament. Its purpose would be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed implementation of the 10-year NHS long term plan.

34 Whilst supportive of integrated models, the bill is focussed in the main upon strengthening partnerships across the NHS, particularly between foundation trusts and commissioners i.e. CCGs. Although adult social care is referenced in the following context:

"The triple aim duty should reflect the need to engage local communities and build on the existing duties of local authorities and CCGs to engage patients and citizens, to collaborate in the performance of their functions, to integrate care delivery, and to improve the health and wellbeing of residents. Successful implementation of the NHS Long Term Plan requires the NHS to forge strong links with its communities, citizens and local government partners, not just to improve the planning and delivery of NHS services, but to promote physical and mental health and wellbeing, support the design of healthy communities, tackle inequalities, connect people better to relevant local community assets, and act as anchor institutions. We did not hear of specific NHS legislative barriers that hinder community co-production. Instead it may be possible to embed the principles of community co-production more clearly within the main text of the NHS Constitution".

Excerpt from: The NHS recommendations to Government and Parliament for an NHS Bill September 2019.

Conclusion

35 County Durham has a strong track record of delivering effective integrated models of care in County Durham.

36 Opportunities exist for further collaborative working and the County Durham Care Partnership is keen to pursue integration further and work is currently underway to establish which service could be delivered within an integrated approach.

Recommendations

37 Adults, Wellbeing and Health Overview and Scrutiny Committee is recommended to receive this report and note the progress made to date in respect of integrated working in County Durham.

38 Adults, Wellbeing and Health Overview and Scrutiny Committee is asked to receive an update report in May 2020.

Background papers

Report to Cabinet 16 October 2019 – Integrated Strategic Commissioning Function – Appendix 7

Other useful documents

Author(s)

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Appendix 1: Implications

Legal Implications

The existing partnership arrangements operate through a memorandum of understanding. Work is underway to further develop a partnership agreement.

Finance

Organisational budgets remain with partner agencies at present. The Better Care Fund is however a shared fund between DCC and County Durham NHS and it currently funds initiatives which support admission avoidance and hospital discharge.

Consultation

Not applicable within this report.

Equality and Diversity / Public Sector Equality Duty

Not applicable within this report.

Climate Change

Not applicable within this report.

Human Rights

Not applicable within this report.

Crime and Disorder

Not applicable within this report.

Staffing

A shared organisational development plan has been compiled and is in draft form. It underpins all of the partnerships support activity for staff.

Accommodation

The partnership supports the development of shared bases for staff whenever feasible.

Risk

Risk management registers exist in each partner agency. The Integrated Care Board as part of their future work programme will be formulating a shared risk register for issues pertinent to integration.

Procurement

Not applicable within this paper.

Appendix 2: Metrics – Bed Occupancy and Length of Stay

Attached as Separate Documents – (Appendix 2a) and (Appendix 2b)

Appendix 3: Metrics

Official Sensitive: Commercial

NHS North of England Commissioning Support Unit
Business Information Services Department
CDDFT Community Contract - Process Measures to September 2019
Summary

Summary - County Durham & Darlington

Selected display (drop down): County Durham & Darlington

Category		Measure	YTD 2018/19	YTD 2019/20	YTD Year on Year change	Previous month YTD Year on Year change
Emergency Admissions	All	All Emergency admissions	38,871	39,461	1.5% ↑	1.6% ↑
	By age	Aged 0-18 years	6,487	6,486	0.0% ↓	1.9% ↑
		Aged 19-64 years	16,176	16,279	0.6% ↑	0.5% ↑
		Aged 65-84 years	12,164	12,471	2.5% ↑	2.7% ↑
		Aged 85+ years	4,044	4,225	4.5% ↑	2.5% ↑
	By provider (65+)	CDDFT	28,876	28,783	-0.3% ↓	-0.2% ↓
		CHSFT / ST&S FT	3,370	3,773	12.0% ↑	12.5% ↑
		NT&HFT	3,156	3,062	-3.0% ↓	-3.8% ↓
		Other	3,469	3,843	10.8% ↑	11.6% ↑
Process Indicators (65+ years)		1.2 Care Home admissions	1,720	1,665	-3.2% ↓	-3.2% ↓
		1.3 Readmissions	2,277	2,382	4.6% ↑	3.3% ↑
		2.1 Preventable admissions	1,146	1,178	2.8% ↑	1.8% ↑
		2.2 Emergency admissions 65+	16,208	16,696	3.0% ↑	2.6% ↑
		2.3 Admissions on community caseload	0	0	0.0% →	0.0% →
		2.4 Timely discharge (bed days)	110,034	109,621	-0.4% ↓	1.7% ↑
		2.5 Emergency Admissions from Falls	1,429	1,428	-0.1% ↓	0.0% →
		2.6 Discharge to Chosen Place of Residence	83%	83%	-0.1% ↓	-0.2% ↓

Appendix 4: Delayed Transfers of Care Summary

Delayed Transfers of Care (DToC)

Progress in reducing DToC across the country remains a high priority and is subject to scrutiny by national partners. Fortunately for County Durham, performance in relation to DToC remains good largely due to a 'whole system' approach across health, social care and independent sector providers.

The latest available data on delayed transfers of care for County Durham in October 2019 is as follows:

- The overall DToC beds (average daily delays) per 100,000 adults was 2.6. This is significantly less than the rate for England which is 11.2 DToC beds per 100,000 adults.
- For County Durham the rate of delayed days per month was 79.8 per 100,000 adults, which is considerably less than the overall rate for England at 346.5 per 100,000 adults.
- During October 2019 there were 340 (83.2%) delayed 283 (83.2%) were attributable to the NHS and 57 (16.82) delayed days attributed to social care.
- The main reason for NHS delays was 'Housing' - patients not covered by the Care Act 2014 (23.7%), followed by 'Awaiting further non-acute care' (22.6%)
- The 57 delayed days (16.8%) attributed to social care occurred in the following NHS Trusts (Tees, Esk and Wear Valleys NHS Foundation Trust – 54.4%, South Tyneside and Sunderland NHS Foundation Trust – 29.8%, South Tees NHS Foundation Trust – 15.8%)
- The main reason for social care delays was 'Awaiting residential care home placement or availability' (54.4% of all social care delays)
- Out of 340 delayed days reported for County Durham patients in October 2019, County Durham and Darlington NHS Foundation Trust (CDDFT) accounted for 45 delayed days of (13.2% of the total).
- Between April – October 2019 County Durham, compared to all single tier and county councils was ranked 6 out of 15, on the overall rate of delayed days per 100,000 adults population across England.

Appendix 5: Case Study/Direct Feedback

Case Study

Gentleman referred to community nurses for assessment of wound. Patient is a previous stroke with resulting weakness to right side limbs and is profoundly deaf. On arrival at the patients home the nurses identified the gentleman was unkempt and his home was in a poor condition. Communication was difficult at first and they soon realised during this time the gentleman had very low income and was living with little to no furniture and sleeping on an old settee, he had very little food in the property and no bedding and limited amount of clothing.

The nurses contacted social care direct and spoke with the duty worker who identified the gentleman as having been closed to social services, they organised immediate assessment and allowed the nurses and social workers to source bedding/pillows, duvet and clothing for the patient and onward referral for support. The gentleman was referred to a social prescriber to assist with ongoing social exclusion issues, he will also be joining the residents of a local care home for his Christmas lunch arranged by the interactions of TAPS nurses, social workers and the Durham Dales health federation all working together to ensure a fully joined up service is in place in the Dales delivering compassionate care within the community.

Direct feedback from community services staff and service users

“My mother had been unwell for a long time and was unable to cope at home. I rang social services and within hours staff went out to see her and carers were put in place. “It all went so smoothly, it was obvious that all the different teams were talking to each other, knew each other well and it was clear they were identifying the best ways of dealing with things. This made such a difference. This made a difficult time much less stressful. It’s brilliant!” **Patient’s relative**

“It has achieved a lot, starting with understanding what we could each contribute, what our roles are and how to work better as a team (especially not passing work off). We all seem to be a lot closer. “The main benefit is practices coming together and talking, what we do and sharing new ideas. They agree on best ways forward and then try things out We are all talking to each other better such as more open, honest discussions with District Nurses and Social workers and we discuss patients who need lots of teams involved (to support/treat them).” **Primary Care Network lead**

“Since the implementation of the Virtual Ward the team has noted a marked improvement in the way we deliver and co-ordinate nursing care to the frail population. It enables effective communication for the patient between hospital and home and increases effective discharge planning, with the team promoting and signposting acute staff to the vast range of services available within the community, including equipment delivery, enabling the patient to return home much sooner.” **Community Sister, TAPS**

“I love my job - working in a truly integrated team, across health and social care which benefits patients and staff, easy communication, no barriers between teams and excellent working relationships across all parties – including primary care. I’m part of a highly dedicated, responsive and flexible team, who feel respected and valued. The range of different systems can be problematic, but generally overcome by co-location and good working relationships.” **District Nurse.**

“We’re all working together and we all know who each is and that accounts for a lot as we all understand what each other’s role is in the jigsaw which we probably didn’t know before, and we meet together regularly. In the Primary Care Network meetings we discuss how we can improve processes and in the practice meetings we discuss how we can help patients, so there’s a very big bunch of people who are keen to make a difference and change things for the better.” **GP**

“I was TUPEd across from North Tees and Hartlepool Trust in the Easington area under the new community contract. It’s been great - pretty much what I used to do before but I feel like I’m part of a team now because before I was more isolated and worked on my own. I even get a lunch break now!” **Podiatrist**

Appendix 6: Principles

The following principles are the basis upon which a new model for Integrated Commissioning has been developed and have been agreed by Cabinet and Governing Body:

- Function will capture all ages i.e. commissioning for Children and Adults across the whole life course.
- Whilst the initial focus is on Community Services it is acknowledged in line with national policy, that the direction of travel is for more hospital based services to be provided in the Community.
- Any model will need to work with existing and emerging elements on a potential Hub and Spoke model i.e. links with Primary Care Networks (including Teams Around Patients), the Mental Health and Learning Disability Partnership and the five CCGs operating across the Tees Valley.
- Joint Management arrangements will be required reporting to the Corporate Director of Adult and Health Services and the Chief Officer, Durham Dales, Easington and Sedgefield CCG.
- Any integrated team will follow the same approach adopted within the Community Services model where staff retain their employment status with their own organisation and associated Terms and Conditions.
- Durham County Council will host an Integrated Function giving opportunities to explore support to CCGs, for example in terms of legal support.
- Existing connections with Primary Care will be enhanced to ensure the local influence of clinical leads across the Primary Care Network is maximised.
- Both Durham County Council and the Clinical Commissioning Groups will retain their statutory responsibilities and decision-making processes

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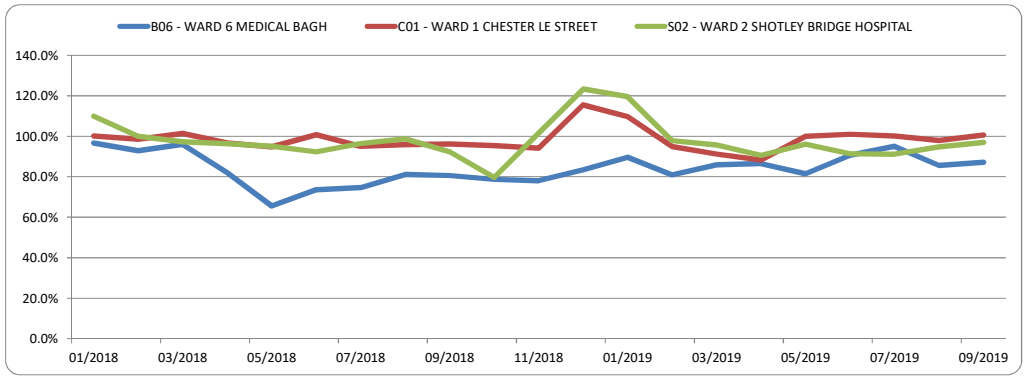
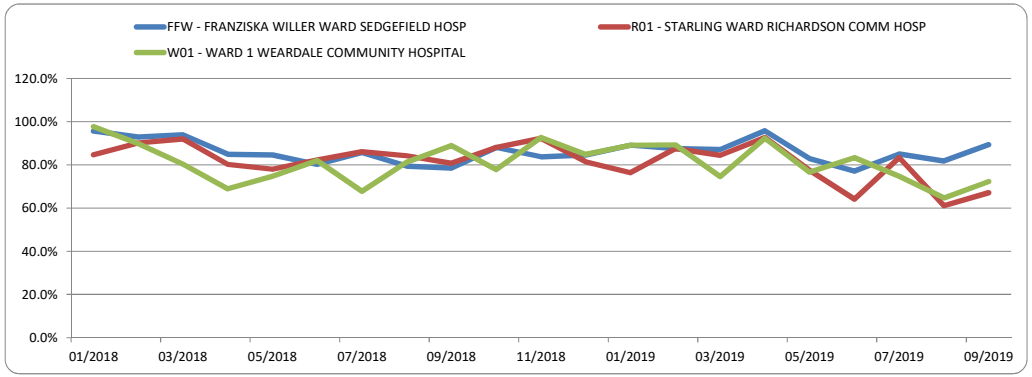
CDDFT - Community Hospitals - Midnight Bed Occupancy

Measure	Ward Name	01/2018	02/2018	03/2018	04/2018	05/2018	06/2018	07/2018	08/2018	09/2018	10/2018	11/2018	12/2018	01/2019	02/2019	03/2019	04/2019	05/2019	06/2019	07/2019	08/2019	09/2019	10/2019	11/2019	12/2019
Available	B06 - WARD 6 MEDICAL BAGH	744	672	744	720	744	816	868	852	840	752	720	744	744	672	744	720	744	720	744	744	720	744	720	744
	C01 - WARD 1 CHESTER LE STREET	552	496	544	543	554	650	713	713	690	503	494	496	543	560	594	549	496	481	512	496	480	580	600	620
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	534	448	528	480	496	480	496	496	480	496	480	496	496	448	496	476	496	480	496	496	480	460	480	496
	R01 - STARLING WARD RICHARDSON COMM HOSP	518	448	499	480	496	480	496	496	480	496	480	496	496	448	496	480	496	480	496	496	480	496	480	496
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	293	277	296	308	310	300	310	310	300	300	272	248	286	328	372	352	310	290	330	310	300	354	360	372
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	523	448	504	480	496	480	496	496	480	496	480	496	496	448	496	480	496	480	496	496	480	496	480	496
	Total available beds	**3,164**	**2,789**	**3,115**	**3,011**	**3,096**	**3,206**	**3,379**	**3,363**	**3,270**	**3,043**	**2,926**	**2,976**	**3,061**	**2,904**	**3,198**	**3,057**	**3,038**	**2,931**	**3,074**	**3,038**	**2,940**	**3,130**	**3,120**	**3,224**
Occupied	B06 - WARD 6 MEDICAL BAGH	719	624	714	591	488	601	648	691	677	592	562	621	667	544	639	623	606	653	707	637	628	659	632	633
	C01 - WARD 1 CHESTER LE STREET	553	489	552	525	525	655	678	683	664	480	465	573	596	532	542	485	496	486	513	486	483	498	512	604
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	511	416	496	408	420	385	425	394	377	437	402	420	442	392	432	456	411	370	422	406	429	446	440	420
	R01 - STARLING WARD RICHARDSON COMM HOSP	439	404	459	385	387	395	427	418	388	437	443	404	379	392	419	445	384	308	414	303	322	436	375	406
	Non IC Plus Patients	*432*	*348*	*380*	*311*	*302*	*376*	*367*	*355*	*361*	*386*	*396*	*358*	*338*	*383*	*357*	*413*	*366*	*297*	*405*	*295*	*306*	*415*	*342*	*377*
	IC Plus Patients	*7*	*56*	*79*	*74*	*85*	*19*	*60*	*63*	*27*	*51*	*47*	*46*	*41*	*9*	*62*	*32*	*18*	*11*	*9*	*8*	*16*	*21*	*33*	*29*
	IC Plus as % of Richardson Occupancy	*1.6%*	*13.9%*	*17.2%*	*19.2%*	*22.0%*	*4.8%*	*14.1%*	*15.1%*	*7.0%*	*11.7%*	*10.6%*	*11.4%*	*10.8%*	*2.3%*	*14.8%*	*7.2%*	*4.7%*	*3.6%*	*2.2%*	*2.6%*	*5.0%*	*4.8%*	*8.8%*	*7.1%*
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	322	277	288	297	295	277	299	306	277	239	276	306	342	321	356	319	298	265	301	294	291	315	325	361
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	511	403	405	331	371	394	336	403	427	386	445	421	442	400	370	443	380	400	371	321	347	414	395	426
	Non IC Plus Patients	*444*	*330*	*377*	*283*	*297*	*339*	*252*	*311*	*340*	*276*	*365*	*376*	*344*	*310*	*292*	*346*	*308*	*327*	*283*	*253*	*290*	*338*	*336*	*334*
	IC Plus Patients	*67*	*73*	*28*	*48*	*74*	*55*	*84*	*92*	*87*	*110*	*80*	*45*	*98*	*90*	*78*	*97*	*72*	*73*	*88*	*68*	*57*	*76*	*59*	*92*
	IC Plus as % of Weardale Occupancy	*13.1%*	*18.1%*	*6.9%*	*14.5%*	*19.9%*	*14.0%*	*25.0%*	*22.8%*	*20.4%*	*28.5%*	*18.0%*	*10.7%*	*22.2%*	*22.5%*	*21.1%*	*21.9%*	*18.9%*	*18.3%*	*23.7%*	*21.2%*	*16.4%*	*18.4%*	*14.9%*	*21.6%*
	Total occupied beds	**3,055**	**2,613**	**2,914**	**2,537**	**2,486**	**2,707**	**2,813**	**2,895**	**2,810**	**2,571**	**2,593**	**2,745**	**2,868**	**2,581**	**2,758**	**2,771**	**2,575**	**2,482**	**2,728**	**2,447**	**2,500**	**2,768**	**2,679**	**2,850**
% Occupied	B06 - WARD 6 MEDICAL BAGH	96.6%	92.9%	96.0%	82.1%	65.6%	73.7%	74.7%	81.1%	80.6%	78.7%	78.1%	83.5%	89.7%	81.0%	85.9%	86.5%	81.5%	90.7%	95.0%	85.6%	87.2%	88.6%	87.8%	85.1%
	C01 - WARD 1 CHESTER LE STREET	100.2%	98.6%	101.5%	96.7%	94.8%	100.8%	95.1%	95.8%	96.2%	95.4%	94.1%	115.5%	109.8%	95.0%	91.2%	88.3%	100.0%	101.0%	100.2%	98.0%	100.6%	85.9%	85.3%	97.4%
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	95.7%	92.9%	93.9%	85.0%	84.7%	80.2%	85.7%	79.4%	78.5%	88.1%	83.8%	84.7%	89.1%	87.5%	87.1%	95.8%	82.9%	77.1%	85.1%	81.9%	89.4%	97.0%	91.7%	84.7%
	R01 - STARLING WARD RICHARDSON COMM HOSP	84.7%	90.2%	92.0%	80.2%	78.0%	82.3%	86.1%	84.3%	80.8%	88.1%	92.3%	81.5%	76.4%	87.5%	84.5%	92.7%	77.4%	64.2%	83.5%	61.1%	67.1%	87.9%	78.1%	81.9%
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	109.9%	100.0%	97.3%	96.4%	95.2%	92.3%	96.5%	98.7%	92.3%	79.7%	101.5%	123.4%	119.6%	97.9%	95.7%	90.6%	96.1%	91.4%	91.2%	94.8%	97.0%	89.0%	90.3%	97.0%
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	97.7%	90.0%	80.4%	69.0%	74.8%	82.1%	67.7%	81.3%	89.0%	77.8%	92.7%	84.9%	89.1%	89.3%	74.6%	92.3%	76.6%	83.3%	74.8%	64.7%	72.3%	83.5%	82.3%	85.9%
	Total rate of occupancy	**96.6%**	**93.7%**	**93.5%**	**84.3%**	**80.3%**	**84.4%**	**83.2%**	**86.1%**	**85.9%**	**84.5%**	**88.6%**	**92.2%**	**93.7%**	**88.9%**	**86.2%**	**90.6%**	**84.8%**	**84.7%**	**88.7%**	**80.5%**	**85.0%**	**88.4%**	**85.9%**	**88.4%**





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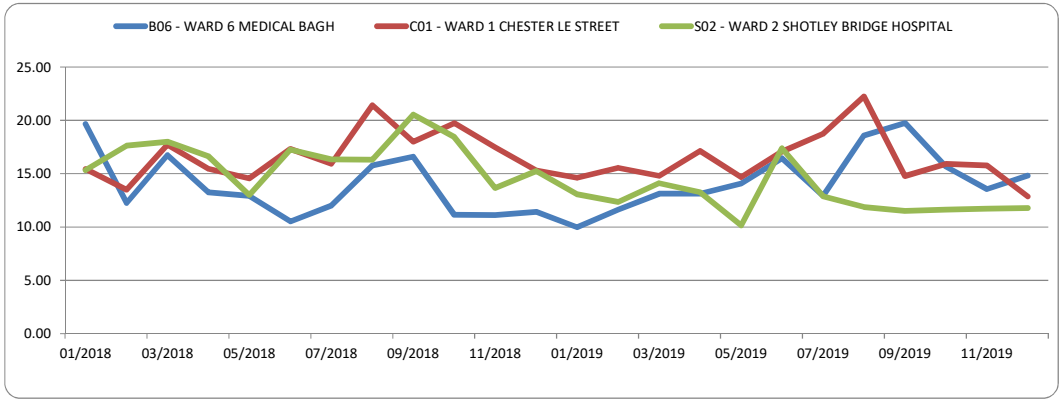
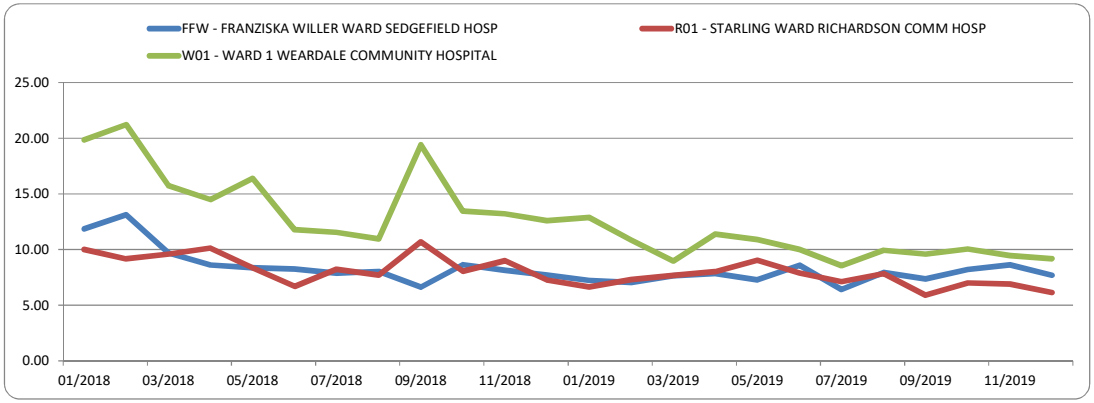
CDDFT - Community Hospitals - Average Length of Stay

Measure	Ward Name	01/2018	02/2018	03/2018	04/2018	05/2018	06/2018	07/2018	08/2018	09/2018	10/2018	11/2018	12/2018	01/2019	02/2019	03/2019	04/2019	05/2019	06/2019	07/2019	08/2019	09/2019	10/2019	11/2019	12/2019
Average Length of Stay	B06 - WARD 6 MEDICAL BAGH	19.66	12.26	16.75	13.24	12.92	10.52	12.02	15.78	16.60	11.14	11.12	11.43	9.98	11.64	13.13	13.13	14.08	16.47	12.94	18.58	19.76	15.67	13.56	14.82
	C01 - WARD 1 CHESTER LE STREET	15.44	13.51	17.72	15.45	14.57	17.32	15.94	21.43	18.00	19.74	17.48	15.31	14.62	15.56	14.81	17.15	14.69	17.07	18.74	22.25	14.79	15.91	15.77	12.87
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	11.85	13.13	9.70	8.61	8.36	8.25	7.88	8.03	6.62	8.65	8.13	7.71	7.23	7.06	7.65	7.86	7.28	8.60	6.41	7.94	7.36	8.21	8.62	7.69
	R01 - STARLING WARD RICHARDSON COMM HOSP	10.01	9.16	9.60	10.14	8.36	6.69	8.24	7.70	10.69	8.05	9.00	7.26	6.64	7.30	7.67	8.02	9.03	7.90	7.12	7.84	5.90	7.01	6.91	6.14
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	15.34	17.63	18.00	16.63	13.00	17.26	16.35	16.30	20.55	18.44	13.66	15.25	13.07	12.36	14.11	13.27	10.15	17.38	12.88	11.88	11.51	11.64	11.72	11.77
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	19.86	21.22	15.76	14.50	16.39	11.79	11.55	10.95	19.41	13.46	13.21	12.60	12.88	10.85	8.97	11.39	10.90	10.00	8.56	9.93	9.60	10.06	9.47	9.18
	Total rate of occupancy	**14.88**	**13.24**	**13.65**	**12.38**	**11.47**	**10.97**	**11.21**	**12.34**	**13.82**	**11.88**	**11.30**	**10.75**	**9.88**	**10.25**	**10.44**	**11.24**	**10.59**	**11.93**	**10.02**	**12.13**	**10.86**	**10.88**	**10.33**	**9.81**





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Cabinet

16 October 2019

County Durham Health and Social Care Plan –

Integrated Strategic Commissioning Function

Ordinary Decision

Report of Corporate Management Team

Jane Robinson, Corporate Director of Adult and Health Services

Councillor Lucy Hovvels, Cabinet Portfolio Holder for Adult and Health Services

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 To provide an update on the development of an Integrated Strategic Commissioning function for Health and Social Care Services across County Durham.

2 To seek agreement on the proposed model for the Integrated Strategic Commissioning function and to its implementation from April 2020 for Health and Social Care Services across the whole life course.

Executive summary

3 In April 2018 the proposed direction of travel in developing a Health and Social Care Plan for County Durham was approved. This was further developed and principles for the development of an Integrated Commissioning Model were agreed by Cabinet in March 2019.

4 This paper provides an update on the current national, regional and local context, with consideration of options for an Integrated Strategic Commissioning Function. This work is part of the continuum of work on integration across the county to provide improved services for our population.

5 A recommended option is put forward with a high level implementation plan and next steps suggested; this includes identification of potential

risks, how they may be mitigated, financial arrangements and a risk sharing approach.

Recommendation(s)

6 Cabinet is recommended to:

(a) Note the progress made since the previous report in March 2019;

(b) Note that this report is also being presented to the Governing Bodies of both North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups;

(c) Approve the progression of the joint management arrangements and associated delivery model as outlined in option 4.

(d) Recognise there is detail to work through before implementation and agree to the model being implemented from April 2020.

(e) Receive further reports on the Integrated Strategic Commissioning Function once operational.

Background

7 In April 2018, a joint report was presented to Cabinet and to the Governing Bodies of North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (CCGs) which outlined a proposed direction of travel in developing a Health and Social Care Plan for County Durham, building on a strong track record of joint working over many years.

8 There are recent examples where health and social care have commissioned services together, which have enabled partners to look at the whole pathway and holistic needs of patients/service users rather than look at these in isolation. An example of this is the development of the Integrated Care Plus (IC+) service which brought together funding and teams to deliver a seamless service for patients.

9 There are very few pathways for County Durham residents that do not involve elements of health and social care. Durham County Council (DCC) and CCG teams have been working together to commission pathways as opportunities arise, but to achieve maximum benefits a fully integrated approach to working is required.

10 Following the implementation of the SEND reforms from the Children and Families Act 2014 there is a requirement for local authorities and health partners to jointly commission services and ensure there is co-production with young people and their families. The legal framework since 2014 is that Local Authorities and Clinical Commissioning Groups must make joint commissioning arrangements for education, health and care provision for young people with SEND from 0-25 years.

11 Although there are a number of examples of this happening in Durham at service and individual level, this is an area which was significantly criticised in the SEND inspection of the Durham local area in November 2017 and is one of the areas requiring action through the Written Statement of Action resulting from the inspection.

12 The inspection findings at the time found that 'the local area's arrangements for joint commissioning services are at a very early stage of development. Leaders' current plan sets out how they intend to begin jointly commissioning services effectively. However, a lack of precision about intended outcomes in these plans means that, currently, they are not helpful. Until the local area has fully completed its extensive range of reviews it is unable to prioritise and plan appropriately'.

13 Variations in commissioning, integration across services and service performance were found in the inspection and the absence of an integrated commissioning function meant there was no co-ordinated overview across the system along with significant variations in practice across services and in different parts of Durham.

14 Since the inspection, significant strengthening of partnership governance and service reviews and has led to closer integration of work and more focus on co-production with families. Current work, however, still has to be done in an environment of different organisational structures with differing arrangements in place for elements of work including commissioning and contracting, finance, performance management and workforce development.

15 Having an integrated commissioning function with part of it dedicated to children's services from 0-25 will help us to develop our work to ensure that outcomes for vulnerable children and their families are central and services are more joined up and responsive to meet their needs.

16 Work is currently underway on the joint commissioning of integrated therapy services to improve support and outcomes for children and young people with SEND.

17 Following review work and the feedback, it is now being proposed to jointly commission all these children's therapies and further consultation on this and other SEND services is taking place as part of the work on High Needs Block funding for SEND discussed at Cabinet in July 2019. Jointly commissioning this work will require the CCGs and the local authority to work differently and this is an example that would work well from within an integrated commissioning function.

18 The intention is to build on this to define how we want all age health and social care services to be shaped and delivered across the County to further improve the outcomes for local people. This could be achieved by:

(a) Using collective resources more efficiently and maximising the impact of the Durham pound to benefit our communities

(b) Minimising duplication

(c) An improved focus on joined up solutions

(d) Maximising the skills available across the wider health and social care workforce

(e) Looking at all the issues that impact on resident's health and wellbeing building on the way that Public Health services have been developed since transferring to DCC in 2013

(f) A single method of evaluating the impact of the services we commission for our population that looks across the whole system which would ultimately provide a single version of the truth

19 Benefits for the residents of County Durham would include:

(a) Reduced duplication which would free up resources to invest in services to improve outcomes

(b) Improved services that are better tailored to their whole needs

20 An agreement in principle was reached that exploring a Joint Strategic Commissioning Function would make sense for County Durham. This could include the commissioning of community and acute services for all ages. However, any strategic reconfiguration of hospital services would fall under the remit of the wider integrated care system or integrated care partnership.

21 This was the preferred option because with an integrated fund this size, commissioners will be able to shape the provider market in County Durham and allow us to move resources from acute to community services. We recognise that acute reconfiguration should be undertaken by the CCGs at scale. This can be across a number of CCGs or for other more specialist areas at a North East level.

22 Commissioning has a key role to play in developing integrated services and the ongoing separation between Health & Social Care systems can be an obstacle to achieving better outcomes for local people. The detail of what is currently commissioned and by who is included within the financial summary as shown at **Appendix 2**.

23 The NHS locally has already begun to integrate their commissioning and delivery functions where that makes sense for example the five CCGs across Durham, Darlington and Teesside have a unique partnership with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) called the Mental Health Learning Disability Partnership, which

focusses on integrated NHS commissioning in relation to learning disability and mental health services;

24 Primary Care Networks (PCNs) now cover 100% of the population of Durham and maps are shown at **Appendix 3**. PCNs in Durham are already advanced organisations and should be thought of as a partnership between General Practice working at scale, community providers, mental health providers, social care, the voluntary sector and other primary care providers such as pharmacists, dentists and opticians.

25 Each PCN typically looks after a population of between 30 and 50 thousand people. In future they will be responsible for managing demand and delivering on the population health agenda. They will be responsible for driving up the quality of care their population receives and will be supported by the CCG to do this.

National Strategic Direction and Evidence

26 Integrated care has been shown to lead to improved clinical outcomes including a reduction in the use of acute and emergency care through better co-ordination with primary and community care. Improved service efficiencies can be shown through a reduction in duplication between services.

27 There is evidence[1] that integration of teams and services is more important than the integration of organisations. Success is dependent on shared purpose and clear vision and development of specific objectives. Integration is not an end in itself, more a means to better outcomes.

28 Health and Well Being Boards have a statutory duty to promote integration and the Better Care Fund has been a vehicle to get the NHS and local government to work more closely together and is an important step towards a single budget; this would enable financial decisions to be considered in a more co-ordinated way and make better use of the overall funding allocation.

29 The NHS is moving away from procurement to deliver better care and instead is being encouraged to integrate local providers to provide better joined up care for their population; this needs to be considered within the context of procurement legislation.

30 In order to support closer working, there is a move away from “Payment by Results” tariffs towards risk share agreements or block contracts between CCGs and Providers.

[1] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Options-integrated-commissioning-Kings-Fund-June-2015_0.pdf

31 The NHS Long Term Plan sets out how we might blend health and social care. This builds on the success of the Better Care Fund and suggests the following options.

(a) Voluntary Budget pooling between the council and the CCG for some or all their responsibilities

(b) Individual service user budget pooling through personal health or social care budgets

(c) The Salford model where the local authority has asked the NHS to oversee a pooled budget for all adult health and care services with a joint commissioning team

(d) A model where the CCG and local authority ask the chief executive of NHS England to designate the council chief executive or director of adult social care as the CCG accountable officer.

Learning from Elsewhere

32 In 2015 the Kings Fund published their options for Integrated Commissioning and suggested at that time examples of fully integrated commissioning were limited, with the nature and success of joint arrangements varying significantly depending on the area[2].

33 There has been progress in some areas of the country as shown below, however it is difficult to establish how much has been done on integrated commissioning specifically as a lot of the information and publicity relates to integrated care or services rather than commissioning.

(a) North East Lincolnshire - Historically, joint working has focused on a 'lead commissioner' model and Council and CCG have appointed a joint director of adult services with a broadened remit including oversight of some housing functions and the housing related support programme. They are employed by the Council, located within the CCG and have oversight of all adult services commissioning functions

(b) Sheffield – Integrated Commissioning Programme has 4 workstreams and focus seems to be on pooled budgets as part of the Better Care Fund.

(c) Devon and Plymouth – Health and Wellbeing Board have set the level of ambition and timeline for system integration. Have 4 commissioning strategies, pooled and aligned funds and a big

[2] https://www.kingsfund.org.uk/publications/options-integrated-commissioning

focus on bringing teams together, Organisational Development and Integrated Governance.

(d) Dorset, Bournemouth and Poole – appears to have more of a focus on integrated working rather than commissioning though some collaborative commissioning in place and joint work programmes.

(e) Greater Manchester – have a commissioning strategy with a focus in 2016/17 on specialised health services and primary care, with intention to broaden thereafter. They have recently undertaken a Commissioning review and created a 100-day plan, with task and finish groups taking forward some of the recommendations such as deciding on services to be commissioned at a Greater Manchester level.

(f) St Helens - have refreshed their Section 75 Partnership Agreement for 2019/20 following the establishment of an integrated commissioning function and are looking to establish an Integrated Commissioning fund. The Governing Body recently approved proposals to revise the agreement and embed the governance and decision-making processes to support the integration of St Helens CCG and St Helens Council through St Helens Integrated People's Services Department.

(g) Tameside and Glossop – a Strategic Commissioning Board was established by the CCG and Tameside MBC, to become the primary place where health and social care commissioning decisions are made. This followed the introduction of the Care Together programme and is intended to deliver improvements in health and social care. A recent Health Service Journal (HSJ) article suggests the shared leadership and commissioning function across the Council and CCG is a contributing factor to strong performance against the 4-hour A&E target.

(h) South Tyneside – an Alliance Leadership Team was established to develop integrated commissioning and has representation from across the Health and Social Care system. They have a Joint Commissioning Unit with a Head of Commissioning and a Joint Commissioning Manager. The unit is funded by the council and the CCG and has been in place almost 2 years. Commissioning has been set with two functions – transformational and transactional, though this is still developing.

Local Context

34 The North East and North Cumbria has recently been included in Wave 3 of the national rollout of Integrated Care Systems (ICS) and is now the largest of the ICS' covering more than three million people. The size of

the system may present some challenges, though may also present opportunities to work with partners across a wider geography.

35 As a subset to the ICS colleagues across Durham, Sunderland and South Tyneside are working more closely together as part of the Central Integrated Care Partnership (ICP). The interface between the ICS/ICP and County Durham will present opportunities and challenges. There is some uncertainty as the partnership is relatively new, however the Integrated Strategic Commissioning Function will put Durham in a strong position for other changes that may follow.

36 The two Durham CCGs have been working together more closely since April 2018 and were brought together under one management team across the five southern CCGs in April 2019.

37 In August 2019, an application was submitted for a formal merger of the 2 Durham CCGs and a separate merged arrangement for the 3 CCGs across the Tees Valley. This option was chosen as supported by partners and local population given the close relationships between the CCG and the Local Authorities, the configuration of clinical services and the patterns of service.

38 NHSE will consider plans submitted and if agreed, preparation for the merger would take place between October 2019 and April 2020.

39 Outcomes from inspections also contribute as one of the drivers for change; it has been identified there would be benefit to the population of Durham in working more collaboratively across the system. The SEND inspection identified Joint Commissioning as an area of focus.

40 Senior Leaders from across the County Durham system have undertaken a self-assessment against the LGA Integrated Commissioning for Better Outcomes Framework[3] to help identify focus areas for this work.

41 In March 2019 a further update report was presented to both Cabinet and the CCG governing bodies outlining progress as follows:

(a) Implementation of a new governance framework.

(b) Creation of the Integrated Senior Leadership Team for Community Services under the Director of Integrated Community Services.

(c) Delivery of the new Community Contract.

(d) Provision of proactive care through the Primary Care Networks and Teams Around Patients (TAPs) to support moving care out of the acute setting into communities where clinically safe to do so.

[3] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/commissioning-and-market-shaping/icbo

(e) Development of action plans and identification of opportunities to work together pending the implementation of an integrated strategic commissioning function.

(f) Proposed emerging principles for the development of the integrated commissioning model

42 Since March 2019 progress has been made in developing a model for Integrated Commissioning through a standard programme management approach as follows:

(a) An all ages System Plan for Durham has been developed with a supporting policy framework, which was shared with the Health and Wellbeing Board and the Adults, Well-Being and Health Overview and Scrutiny Committee at their development day on 13th June.

(b) The Memorandum of Understanding for the Integrated Community Care Partnership has been updated from the previous version (April 2017) to reflect current working arrangements and includes a schedule specifically outlining the arrangements for the development of the Strategic Integrated Commissioning Function (see **Appendix 4**).

(c) Joint Management Arrangements have been developed including the proposed new role of Head of Integrated Strategic Commissioning.

(d) A life course Commissioning Strategy is in development and options for the delivery of the commissioning function have been generated for consideration.

(e) The Financial Arrangements have been considered and refined to consider the total funding across Health and Social Care (**see Appendix 2**).

(f) A Risk Share Approach has been developed building on the existing Section 75 arrangements and suggests the pooling of budgets may be phased over specific timeframes (see **Appendix 5**). The current appetite for risk sharing focusses on risks remaining with 'owner' organisations, however, it is agreed this approach should be reviewed as integration progresses to ensure it keeps pace with the integrated commissioning agenda.

(g) A review of the 5-year digital plan for health has been undertaken and this is being coordinated with plans within the Council to develop a strategy for the County, whilst recognising Durham fits within the digital strategies for the regional Integrated Care System (ICS) and the more local Central and South Integrated Care Partnerships (ICPs).

(h) A Communication strategy has been developed and will be delivered through a joint plan to be led by the recently appointed integrated multi-media officer.

(i) A review of place-based services for Children and Young People is in progress and this is helping inform the development of local hubs through the repurposed Children and Families Place Based Development Group.

(j) The Durham System governance plan has been refreshed and this has fed into the development of future governance arrangements for the Strategic Integrated Commissioning function.

(k) A place was secured on the NHS Improvement (NHSI) Transformational Change programme and participation is allowing a group of senior representatives from across the County Durham System to access expert advice and experience from elsewhere to develop our system working.

Options considered

43 Locally a number of options have been developed and considered taking into account information available from other areas and organisations i.e. the King's Fund. These are detailed below;

(a) **Option 1** - to retain existing arrangements

Health and Social Care commissioning teams to continue to operate independently as they do now, recognising some services have already been jointly commissioned locally between the Council and Clinical Commissioning Groups (CCGs) i.e. Community Equipment, Carers' Services, Social Prescribing and the post diagnosis Autism Service.

(b) **Option 2** - to informally enhance current arrangements

Teams working more closely and taking opportunity to commission together should the occasion arise.

(c) **Option 3** – to create a separate entity

Set up of an independent "spin off" organisation that commissions across Health and Social Care.

(d) **Option 4** - To implement an Integrated Strategic Commissioning Function based on the principles agreed in March 2019, as set out below:

(i) Commissioning for Children and Adults across the whole life course.

(ii) With the initial focus on Community Services it is acknowledged in line with national policy, that the direction of travel is for more hospital based services to be provided in the Community and so the model for Durham should in time include all Acute, Community and MH services that relate to Durham.

(iii) Working with existing and emerging elements on a potential Hub and Spoke model i.e. links with Primary Care Networks (including Teams Around Patients), the Mental Health and Learning Disability Partnership and the five CCGs operating across the Tees Valley.

(iv) Joint Management arrangements reporting to the Corporate Director of Adult and Health Services and the Chief Officer, North Durham & Durham Dales, Easington and Sedgefield CCGs.

(v) In line with the Community Services model, staff will retain their employment status with their own organisation and associated Terms and Conditions.

(vi) The function will be hosted by Durham County Council giving opportunities to explore support to CCGs, for example in terms of legal advice.

(vii) Enhanced existing connections with Primary Care to ensure the local influence of clinical leads across the Primary Care Network is maximised

(viii) Both Durham County Council and the Clinical Commissioning Groups retain their statutory responsibilities and decision-making processes.

44 Potential impacts for each of the options are outlined below:

(a) **Option 1** – things would continue to operate across organisations as they do currently, however, this would not maximise opportunities for more efficient ways of working, retains duplication in the system and does not maximise the use of resources or optimise outcomes.

(b) **Option 2** – similar to the above, though there may be some instances where joint commissioning of services is possible should suitable occasions arise. Again, this would not necessitate significant change or reorganisation of work; however, this is a

reactive approach that does not facilitate broader development activity or cultural change.

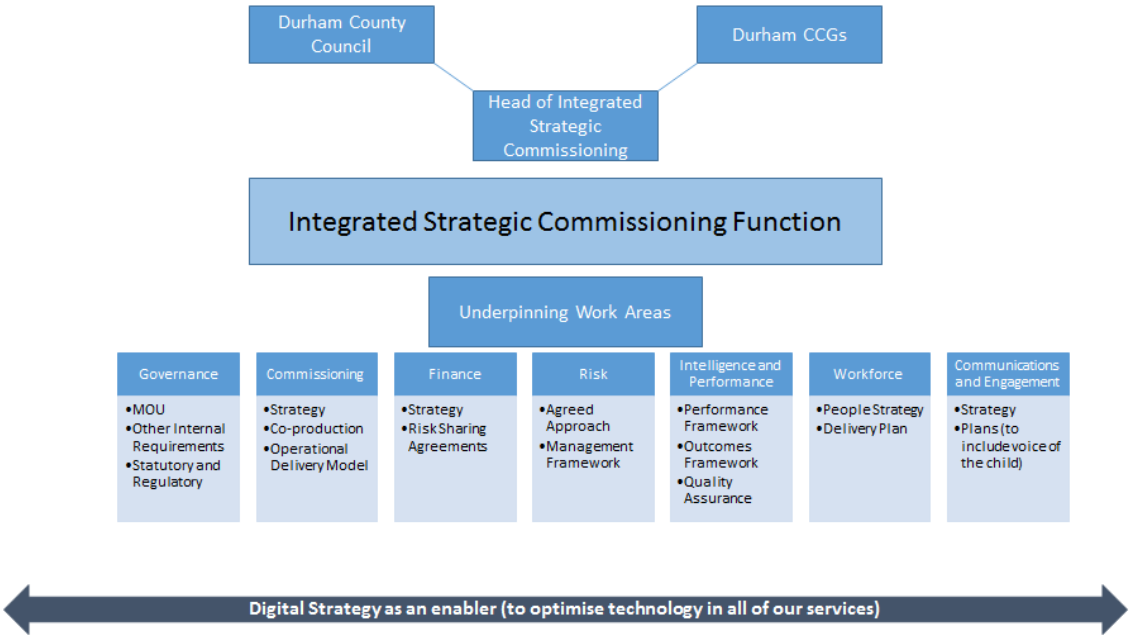
(c) **Option 3** – this would give a very clear identity to the integrated commissioning function and achieve similar benefits to option 4 but very little is understood about such an approach and this would require set up of a new organisational structure with associated governance mechanisms in place.

(d) **Option 4** – there are a number of potential benefits as shown below and this is a more proactive approach:

- Increased ability to influence the Children's Health agenda
- Resources could be managed more efficiently, maximising the impact of the Durham Pound
- Provider market could be shaped more in line with requirements of the Durham system
- Leadership strengthened and working alongside integrated Community Services
- Joint Contract monitoring introduced to enable improved quality of service provision
- Reduced duplication to improve efficiency and processes
- Most importantly, the aim of all the above would be to improve outcomes for the people of County Durham

There are some unknowns that will also need to be considered, particularly the uncertainty over the green paper for Social Care and the role of the Integrated Care Partnership; these will need to be managed irrespective of any changes or models proposed.

45 The diagram below provides an overview of the preferred option for an Integrated Strategic Commissioning Function.



46 The anticipated interfaces with other parts of the system can be seen in **Appendix 6.** Should additional stakeholder groups be identified as the model is further developed, they will be added to the interfaces diagram.

47 Part of the CCG Commissioning Management structure is in house and some is provided by North of England Commissioning Support (NECS) under a Service Level Agreement (SLA)

Risks

48 Some risks to the proposed approach have been identified as outlined below. These will be managed through the usual programme governance arrangements prior to implementation and then through operational risk management approaches thereafter.

a) Future ambitions and desired outcomes for integration may not be articulated as clearly as they could be. This is being progressed through joint system working on the Durham Plan, Vision and work underway as part of the NHSI Transformation Programme.

b) There may be insufficient capacity to meet the needs of the function, including suitable infrastructure to support joint working. The Integrated Care Board (ICB) is currently considering options to integrate the approach to support type services such as Organisational Development, Performance Management, Information Governance and Communications.

c) Organisations may not be able to move at the required pace for the change. There will be further development of the work on culture

which is already underway to help bring people together and share different ways of working.

d) The emerging Integrated Care System and Integrated Care Partnership may focus on more regional planning rather than County Durham; senior leader membership of the Integrated Care Partnership Executive will help mitigate this risk.

e) There may be differing financial objectives within each organisation which could create tensions and impact on the ability to deliver agreed services. There may also be a potential budgetary risk and uncertainty on control totals across the Integrated Care Partnership. This will be monitored via the finance group.

f) Providers may not be willing to work differently and there may be potential for market stability issues; close working with providers will help ensure stability and quality.

g) There is a potential risk to finance and capacity if the system carries on operating as it does currently and continues to commission in silos. The risk is that others regionally and nationally make decisions that impact on the Durham System. The setup of an Integrated Strategic Commissioning Function allows the Durham System to take control and do the best for the people of Durham.

h) Leadership will be critical to success so there is a risk by not putting Joint Management arrangements in place. Recruitment to the post and developing the structure beneath will help mitigate this risk.

i) The Memorandum of Understanding has already been reviewed by DCC lawyers and further legal advice will be sought as and when required as part of the implementation process, particularly when further developing risk share agreements.

Recommendations

49 The Integrated Commissioning group have developed an approach set out above that advances the direction of travel previously agreed by both Cabinet and the CCG governance bodies.

50 To build on the work already done, Option 4 would be the logical recommendation at this point in time.

51 An Integrated Management structure working in parallel with the Community Contract would enable us to maximise the use of the Durham Pound, reduce duplication and most importantly commission better outcomes for the people of County Durham.

Implementation Plan

52 A proposal to establish the post of Head of Integrated Strategic Commissioning is being submitted to full Council in October.

53 An implementation plan is in development; it is anticipated implementation can move at pace once joint management arrangements are in place.

54 The plan will cover:

a) Workforce implications as teams are brought together, this will include reviews related to staffing roles and responsibilities.

b) A review of team infrastructure and set up. This will include requirements for estates and access to IT systems for the function to be able to maximise effectiveness.

c) A review of governance arrangements for the new function to operate effectively and efficiently whilst ensuring decision making and assurance processes meet the requirements of the County Durham system.

d) The development of a Performance Framework for services across the current system. This will be further progressed to baseline the current commissioning service, evaluate the change and develop a benefits realisation plan.

Conclusion

55 The proposed model is in line with the central direction of integrating services to provide better care and more joined up working across the system.

56 Good progress been made so far with the preparation for the setup of the new function and we want to build on existing momentum to recruit to the new leadership post and aim for implementation from April 2020.

57 Whilst we will continue to work collaboratively with Integrated Care Partnership colleagues across South Tyneside and Sunderland, the setup of the new Integrated Commissioning Function will allow us to focus on doing the best for the people of County Durham.

58 It is recognised there will be detail to work through before implementation; we are working closely with colleagues across the system including legal and finance colleagues to ensure all aspects of the proposed approach are understood, risks can be mitigated, and comprehensive plans can be developed.

Background papers

- Cabinet report April 2018. Developing a Health and Social Care Plan for County Durham.
- Cabinet report March 2019. County Durham Health and Social Care Plan update

Other useful documents

- Previous Cabinet reports / None

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	Stewart Findlay	Tel: 0191 371 3222

Appendix 1: Implications

Legal Implications

In recent years, there have been a number of legislative and policy developments to assist the development of integrated health and social care. This report sets out how the local authority and CCGs are discharging their respective statutory duties to promote the integration of care under the Health and Social Care Act 2012 and the Care Act 2014.

Finance

There are no cost implications at this stage. Clearly, in progressing the development of options and given the size of budgets involved i.e. c. £1bn finance colleagues from both the Council and CCGs will continue to be involved.

Consultation

There are no consultation requirements at this stage.

Equality and Diversity / Public Sector Equality Duty

Equality and Diversity will be considered in the development of the options.

Human Rights

Human rights are not affected by the recommendations in this report.

Crime and Disorder

Not applicable.

Staffing

There are no specific staffing implications at this stage. The Principles outlined in the report describe joint management arrangements, which will be considered carefully with advice from HR in both the Council and CCGs.

Accommodation

No Issues at this stage.

Risk

Current risks link to uncertainty over future CCG configuration, which will need to be considered in detail as Options are developed. Any future model will need to include a detailed risk share agreement, further development of which will be part of the project plan.

Procurement

No issues at this stage but will form part of the consideration moving forward.

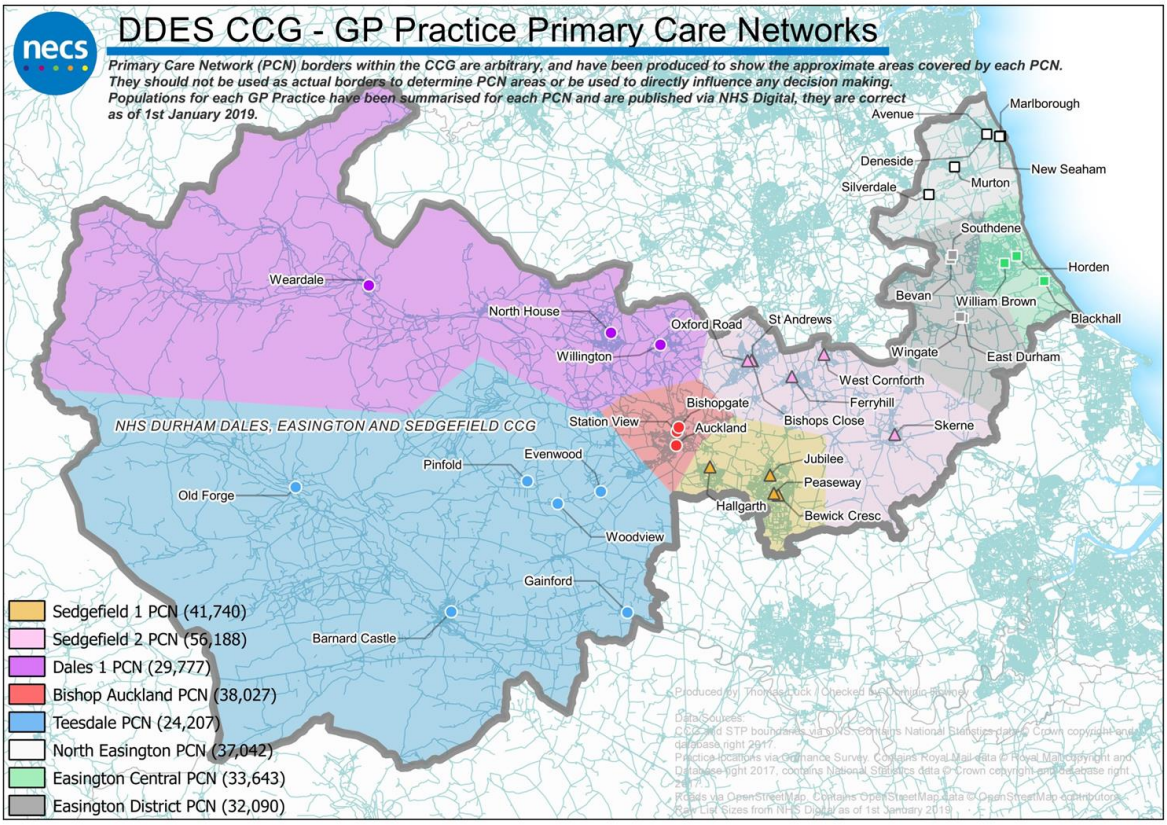
Appendix 2: Financial Arrangements

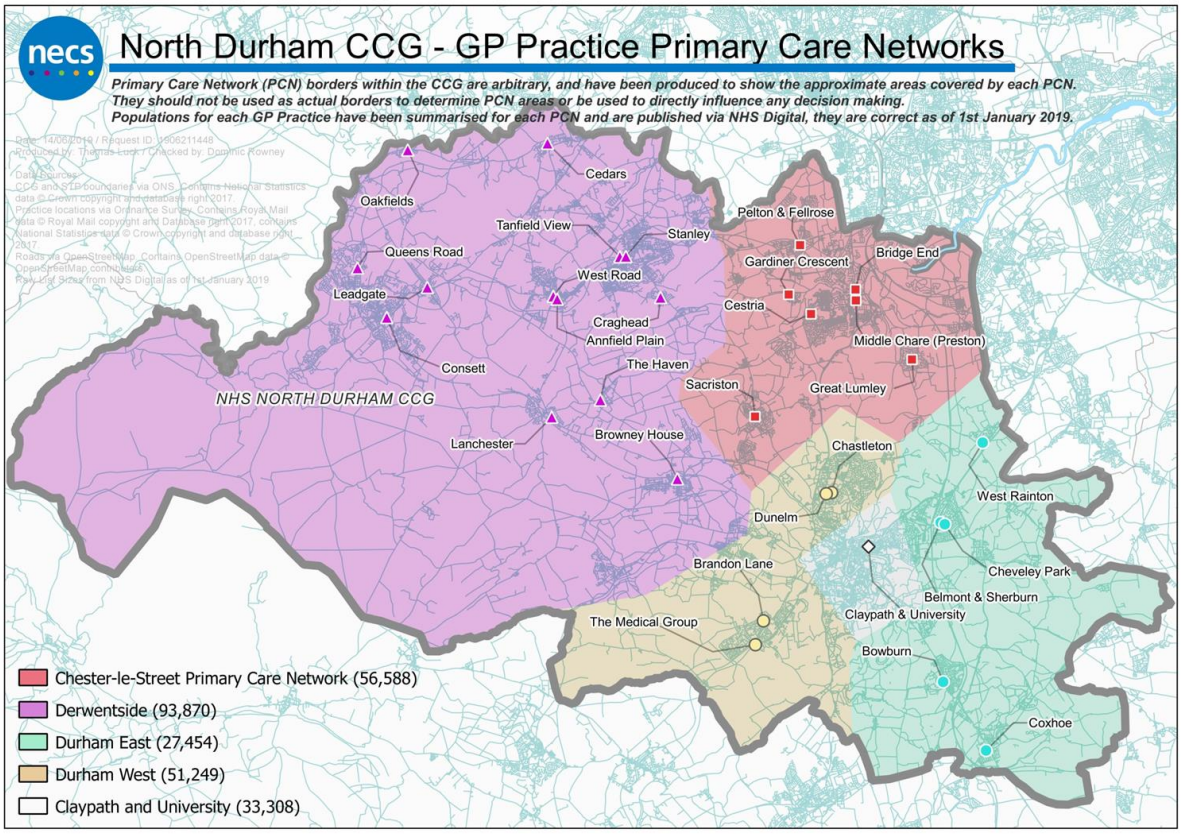
DCC and CCGs Integrated Budgets related Net Expenditure	2018/19 Outturn Net Expenditure			CCG split based on level of commissioning:					
	DCC	CCG	TOTAL		Sub-		Non-Core		
	£'000	£'000	£'000	Regional	Regional	Local	ACP	ACP	Total
CHILDRENS									
Childrens Social Care	74,755		74,755						0
Childrens Physical Health		31,797	31,797	3	11,736	20,058	0	0	31,797
Other Childrens		1,588	1,588	0	0	1,568	0	20	1,588
TOTAL CHILDRENS	**74,755**	**33,385**	**108,140**	**3**	**11,736**	**21,626**	**0**	**20**	**33,385**
ADULTS / OLDER PERSONS									
Physical Health / Support	33,641	360,103	393,744	37	127,980	232,086	0	0	360,103
Support with memory and cognition	16,562		16,562						0
Learning Disability Support	44,760	12,855	57,615	0	0	12,855	0	0	12,855
Mental Health	7,056	6,354	13,410	0	0	6,354	0	0	6,354
Adult Social Care / Support	19,671		19,671						0
Voluntary Sector and Other Services	7,731		7,731						0
TOTAL ADULTS / OLDER PERSONS	**129,421**	**379,311**	**508,732**	**37**	**127,980**	**251,294**	**0**	**0**	**379,311**
ALL AGE / UNABLE TO SPLIT									
Physical Health / Support		120,703	120,703	4,416	45,246	71,042	0	0	120,703
Mental Health		110,853	110,853	0	0	0	12,453	98,400	110,853
Assistive equipment and technology	3,748	2,813	6,561	0	0	2,813	0	0	2,813
Voluntary Sector and Other Services		4,605	4,605	0	0	3,910	0	695	4,605
TOTAL ALL AGE / UNABLE TO SPLIT	**3,748**	**238,974**	**242,722**	**4,416**	**45,246**	**77,765**	**12,453**	**99,095**	**238,974**
PUBLIC HEALTH	**48,361**		**48,361**						0
OTHER									
Ambulance / transport		23,872	23,872	21,998	25	1,849	0	0	23,872
Property		5,370	5,370	0	0	5,370	0	0	5,370
GPIT		1,801	1,801	0	0	1,801	0	0	1,801
Other		2,459	2,459	30	0	2,044	0	385	2,459
BCF/s256		34,759	34,759	0	0	33,044	0	1,714	34,759
TOTAL OTHER	**0**	**68,261**	**68,261**	**22,028**	**25**	**44,107**	**0**	**2,100**	**68,261**
TOTAL	**256,285**	**719,931**	**976,216**	**26,485**	**184,987**	**394,792**	**12,453**	**101,215**	**719,931**

The figures above reflect final outturn spend for DCC and CCGs for the year ended 31 March 2019

The allocation of CCG expenditure between Children's and Adults/Older person's physical health includes a number of estimates and apportionment across contracts and should therefore be treated with a degree of caution.

Appendix 3: County Durham Primary Care Networks





County Durham Integrated community care partnership

Memorandum of Understanding

The establishment of ICSs everywhere from 2021 will be built on strong and effective providers and commissioners, underpinned by clear accountabilities.

Trust boards are responsible for the quality of care they provide for patients and for the financial resources and staff they manage. Many initiatives will require cross-organisational actions, and it is only through working collaboratively that trusts and commissioners will agree the services that each organisation will provide and the cost they will reasonably incur in providing those services – ensuring these are affordable within the system's collective financial budgets.

(NHS England: The NHS Long term Plan)

MEMORANDUM OF UNDERSTANDING

Date: August 2019

Introduction

The purpose of this Memorandum of Understanding (MoU) is to establish a framework for collaboration between the following organisations with regard to integrated care in County Durham:

- Durham County Council (DCC)
- North Durham Clinical Commissioning Group (ND CCG)
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Harrogate and District NHS Foundation Trust (HDFT)
- Primary Care networks

Context

1. With the implementation of the Care Act 2014 and various government initiatives across the health and care system since 2013, there has been a commitment from statutory organisations in County Durham to progress the integrated care agenda.

2. It is now widely acknowledged that a new approach is needed to work towards greater levels of integration to bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

3. The aim of this MoU is to facilitate, develop and enhance collaborative working between the partner organisations to deliver the agreed vision for integrated care in County Durham.
4. This version of the MoU is an updated version of that agreed in April 2017 to reflect the changing landscape and the development of the Strategic Integrated Commissioning Approach across County Durham.
5. **Schedule 1** has been drafted to detail the specifics for the development of the Strategic Integrated Commissioning Function.

Shared Vison

6. Our vision for integrated care is:

   To bring together health and social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham

Our commitment to the people of County Durham is to:

- *Deliver the right care to you by teams working together*
- *Help you and those in your community lead a healthy life*
- *Build on existing teams already working together to help you stay well and remain independent*
- *Provide improved services closer to your home*
- *Offer a range of services working alongside GP practices which meet your needs*

Definitions

7. For the purpose of this MoU, the following definitions apply:

- Integrated Community Care Partnership (ICCP) – a local partnership of health and care commissioners and providers who respond to the diverse needs of a population by providing coordinated care, with an emphasis on quality as well as efficiency and with a financial incentive for providers to act holistically, collaboratively and flexibly in response to local circumstances and opportunities. This group focuses on all ages.

- Mental Health and Learning Disability Partnership (MHLDP) - A relationship exists between the Integrated Community Care Partnership and Mental Health and Learning Disability Partnership. The MHLDP is a partnership between Tees, Esk and Wear Valleys Foundation Trust, County Durham CCGs and other CCGs and Local Authorities across the southern ICP footprint. It is concerned with reviewing and commissioning high cost, specialist care packages for people with complex needs who have a learning disability and/or mental ill health. The County Durham Integrated Community Care Partnership will oversee such work for County Durham residents through the Integrated Care Board and the governance arrangements connected to it. This group focuses on all ages.

- Integrated Care Board (ICB) – comprises Chief Officers from the signatory organisations, who provide governance and feed back into their respective organisations – the ICB is a sub-group of the County Durham Health and Wellbeing Board. This group focuses on all ages.

- Integrated Senior Leadership Team - group of senior decision-makers, led by the Director of Integration for County Durham, which supports the ICB and the Integrated Community Care Partnership by implementing projects to deliver the shared vision for integrated care in the county. This group focuses on adults.

- Integrated Steering Group for Children - group of senior decision-makers, led by the Corporate Director for Children and Young People Services and CCG Director of Commissioning, Strategy and Delivery - Children & Young People. The group supports the ICB in delivery of projects most relevant to the younger population of the county. This group focuses on children.

- Partners – refers to the signatory organisations in this MoU, as well as other groups and organisations participant in delivering the vision for integrated care in the county

- Projects – local initiatives supported by the ICCP which contribute to the delivery of the shared vision for integrated care in County Durham (for example, Teams Around Patients).

Governance

8. The ICCP governance structure is shown in **Schedule 2**.

9. All MoU signatory organisations are an integral part of the governance structure and are represented at all levels of decision-making.

10. The governance structure is based on the principle that decisions will be taken by the relevant partner organisation(s) at the most appropriate level.

11. The Integrated Community Care Partnership (ICCP) will oversee the work of the Mental Health and Learning Disability Partnership (MHLDP) in respect of County Durham residents.

Guiding Principles

12. The following guiding principles underpin the work of the ICCP:

    - Partners are all of equal status and will work collaboratively and support each other in the spirit and intention of this MoU
    - Partners will be open and transparent and act in good faith towards each other
    - Partners will commit resources appropriately to support the delivery of the agreed objectives
    - Partners will demonstrate a willingness to put the needs of the public before the needs of individual organisations
    - All partners recognise and acknowledge that integration is an interactive and iterative process
    - The ICCP will review its progress at regular intervals with the aim of challenging the level of ambition to enhance the integrated offer further

Objectives

13. Partners agree the following objectives of development, commissioning and delivery of integrated care:

    - A whole system approach, moving from fragmented to integrated care, with a willingness to put the needs of the public before the needs of individual organisations
    - Person-focused to promote wellbeing, prevention and independence

- Providing the right care and support, in the right place, at the right time, by the right person
- Delivering a sustainable health and social care system within existing resources, using a multidisciplinary team approach
- A system built on trust, not only between leaders and organisations but also with local people and communities
- Supporting and developing staff to develop a shared culture, behaviours and ownership
- Everyone's contribution matters – from local people, frontline teams, healthcare practitioners, providers, voluntary and community sector leaders and board members
- The integrated model will be developed to link with the wider system including housing, employment, the environment, voluntary and community facilities, in order to align priorities for the benefit of local communities. This evolving partnership approach will involve primary care being at the centre of patient activity and taking a proactive role in the commissioning of both NHS and integrated service provision

14. Partners have agreed and developed a set of standards which represent the ambition to deliver the vision, based on four key principles:
    - Prevention
    - Proactive care
    - Responsive and accessible care
    - Coordinated approach
15. The anticipated outcomes of successful delivery of the vision are shown in **Schedule 3**.

Sharing information

16. The partners agree that they will share all information relevant to delivery of the vision for integrated care in an honest, open and timely manner.

17. The ICCP will agree an information-sharing agreement, which will allow the partners to manage their relationships and the flow of information between them in a confidential manner and with the best interest of the client (service user, patient, and carer) at its core.

18. The partners will develop an approach to risk sharing that will be documented and agreed with the group and form the basis of any future formal agreements. This will be reviewed as required once an Integrated Commissioning Function is in place.

Conflicts of Interest

19. The partners agree that they will:

- Disclose to each other the full particulars of any real or apparent conflict of interest which may arise in connection with this MoU

- Not allow themselves to be placed in a position of conflict of interest or duty with regard to any of their obligations under this MoU
- Use their best endeavours to ensure that all associated partners also comply with the guiding principles and aims when acting in connection with this MoU

Term and Termination

20. This MoU will commence on the date of signature of the partners and shall continue for an initial period of one year, to be reviewed at least annually.

21. This MoU, including the Schedules, may only be varied by written agreement of all the signatory organisations.

22. This MoU is not intended to be legally binding and no legal obligations or legal rights will arise between the partners from this MoU. The partners enter into the MoU intending to honour all their mutual obligations.

23. In the event of a partner leaving the ICCP, the following will apply:

    - The relevant partner will notify the other signatory organisations in writing
    - This MoU will be amended as appropriate
    - The annual review date for this MoU will be revised accordingly

Signatories

Signature _____

Date _____

Jane Robinson, Corporate Director Adults and Health Service, Durham County Council

Signature _____

Date _____

John Pearce, Corporate Director of Children and Young People's Services, Durham County Council

Signature _____

Date _____

Stewart Findlay, Chief Officer Durham CCGs

Signature _____

Date _____

Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust

Signature _____

Date _____

Colin Martin, Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust

Signature _____

Date _____

Steve Russell, Chief Executive, Harrogate and District NHS Foundation Trust

Signature _____

Date _____

Primary Care Network Lead, North Durham

Signature _____

Date _____

Primary Care Network Lead, DDES

Schedule 1

Development of the Strategic Integrated Commissioning Function

The inclusion of local government in integrated care systems represents a significant opportunity to include social care, public health and wider population health, bringing the relevant skills that they have. The NHS cannot do this alone. Generally, local government has a more direct relationship with its citizens and has a different understanding of insight. Bringing these skills together with the work already done in the NHS will only increase capacity, capability and understanding in the system overall.

https://www.kingsfund.org.uk/publications/joined-up-listening-integrated-care-and-patient-insight

Introduction

1. We have agreed to develop this annexe to the Memorandum of Understanding to help strengthen our joint working arrangements and to support the development of our Strategic Integrated Commissioning Function. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.
2. This is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between the Partners who have entered into this Memorandum intending to honour all their obligations under it.
3. It is based on an ethos that the partnership is for the people of County Durham; it does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Council. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

Background

4. The focus for partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.
5. Nationally the agenda is shifting to promote integrated commissioning across larger footprints, however, systems are being allowed to put forward local solutions, which align to this agenda and are being allowed to proceed if they can demonstrate they have a clear plan in place and are already in the process of implementation.
6. The proposed direction of travel to develop a Health and Social Care Plan for County Durham has been agreed, including the integration of commissioning functions; the Integrated Commissioning Group has been developing options for an Integrated Strategic Commissioning function
7. This is likely to include the commissioning of community-based services for children and adults across the County. Acute (hospital based) and other health care commissioning would sit outside of this model, being undertaken by CCGs at a regional/sub-regional level.

8. This will allow commissioners to shape the provider market in County Durham, whilst recognising that other health care and acute commissioning will best serve the local population if it is undertaken by the CCGs at scale. This can be across a number of CCGs or for other more specialist areas at a North East level.

    - All acute activity will be commissioned sub regionally except for that delivered by CDDFT where the CCGs are the lead commissioners, and this will be commissioned locally with the following exceptions:
        - Critical care – this will be commissioned regionally/sub regionally
        - Pathology and radiology – this will be commissioned regionally/sub regionally
        - Genetic testing – this will be commissioned regionally
    - Medical pathways will be largely commissioned locally or in some cases at an ICP level or with collaboration on the outcomes required across the ICP.
    - There will be collaboration between providers and commissioners on the commissioning of surgical pathways at an ICP or ICS level.
    - Emergency ambulances and PTS services will be commissioned at a regional level, but transport services specific to Durham will be commissioned locally.

Principles

9. The following have been proposed as working principles upon which a new model for Integrated Commissioning will be developed and have been agreed by Cabinet and Governing Body:
    - Function will capture all ages i.e. commissioning for Children and Adults across the whole life course.
    - Whilst the initial focus is on Community Services it is acknowledged in line with national policy, that the direction of travel is for more hospital based services to be provided in the Community.
    - Any model will need to work with existing and emerging elements on a potential Hub and Spoke model i.e. links with Primary Care Networks (including Teams Around Patients), the Mental Health and Learning Disability Partnership and the five CCGs operating across the Tees Valley.
    - Joint Management arrangements will be required reporting to the Corporate Director of Adult and Health Services and the Chief Officer, Durham CCGs.
    - Any integrated team will follow the same approach adopted within the Community Services model where staff retain their employment status with their own organisation and associated Terms and Conditions.
    - Durham County Council will host an Integrated Function giving opportunities to explore support to CCGs, for example in terms of legal support.
    - Existing connections with Primary Care will be enhanced to ensure the local influence of clinical leads across the Primary Care Network is maximised
    - Both Durham County Council and the Clinical Commissioning Groups will retain their statutory responsibilities and decision-making processes.

Local Place Based Partnerships

10. Local partnerships arrangements bring together the Council, voluntary and community groups, and NHS commissioners and providers (including Primary Care), to take responsibility for the cost and quality of care for the whole population.

11. These ways of working reflect local priorities and relationships and provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

12. Our partnership approach is geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice.

Governance

13. The Integrated Care Board (ICB) is the key decision-making authority and with membership including leaders from all organisations in the system, will be in a position to act as a forum where whole-system challenges can be addressed, and solutions identified and initiated.

14. Durham County Council is not subject to NHS financial controls and its associated arrangements for managing financial risk, however, through this Memorandum, they agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. Democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers

15. Partners understand no decision shall be made to make changes to services in County Durham or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

Financial Framework

16. All partners are ready to work together, manage risk together, and support each other when required. Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

17. Partners commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised in the event of the emergence of financial risk outside plans.

18. A set of financial principles have been agreed and confirm we will:

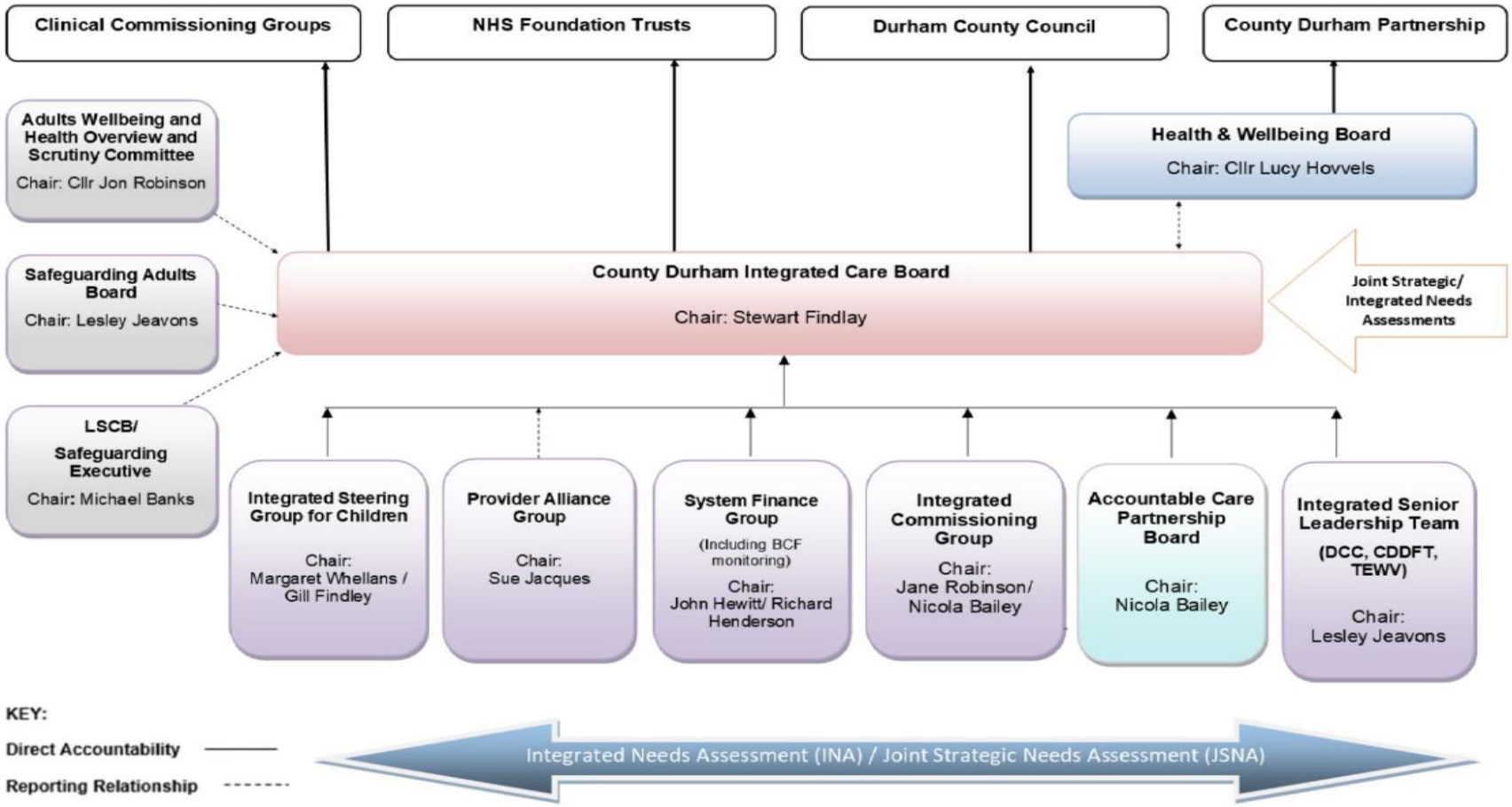
    - Aim to live within our means, i.e. the resources that we have available to provide services
    - Develop a County Durham system response to the financial challenges we face
    - Develop payment and risk share models that support a system response rather than work against it.

19. Partners agree to adopt an open-book approach to financial plans and risks leading to the agreement of fully aligned operational plans.

20. A detailed financial risk share agreement will be developed as part of the Strategic Integrated Commissioning Function and will be agreed by all partners.

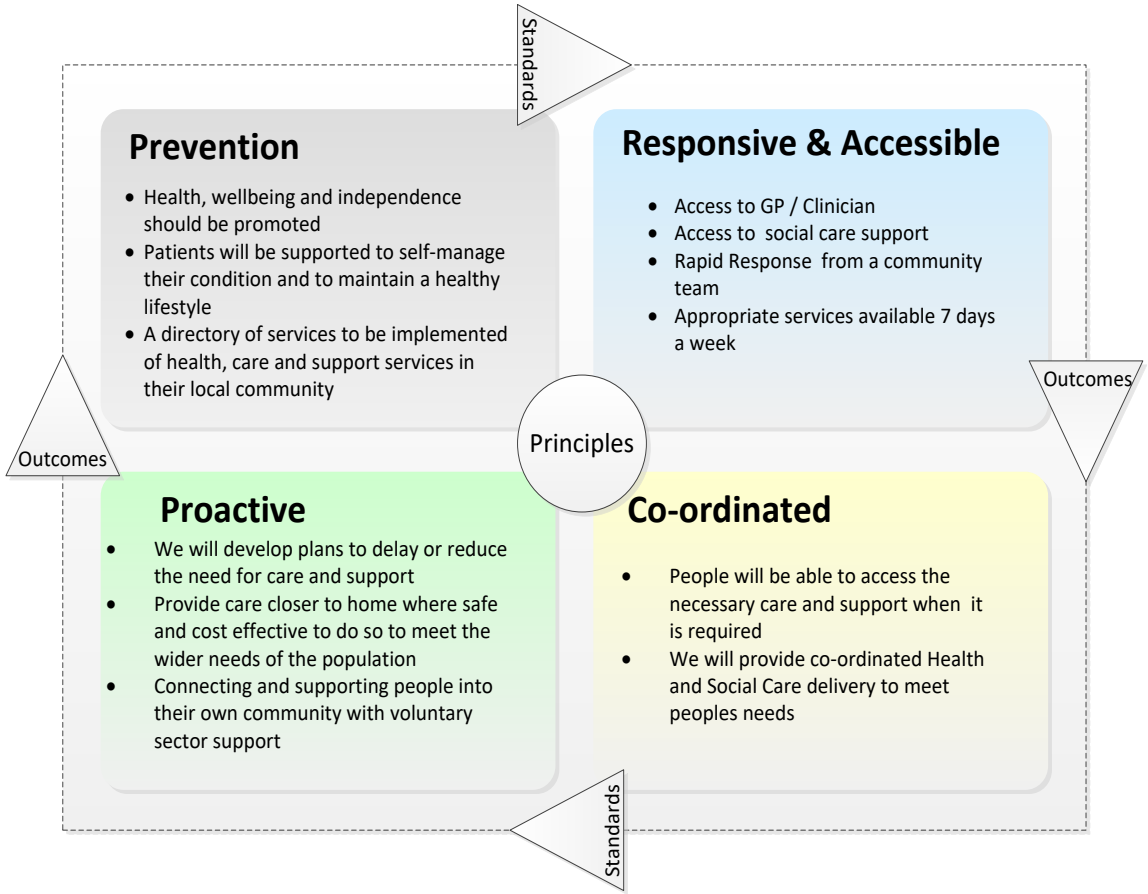
Schedule 2

Integrated Community Care Partnership Structure



Schedule 3

Outcomes of the shared vision for integrated care in County Durham



Appendix 5: Risk Share Approach

At the Integrated Commissioning Meeting in May 2019, a discussion paper was considered regarding appetite for financial risk sharing across integrated commissioning budgets.

The outcome of this discussion was a recognition that currently the appetite for risk sharing focussed upon risks remaining with 'owner' organisations, mirroring the current largely unintegrated commissioning / procurement arrangements that currently exist. However, it was agreed that the risk share approach should be reviewed as integration progresses to ensure it keeps pace with the integrated commissioning agenda.

Therefore, the current risk sharing approach is considered to be towards the left of the diagram below, with all risks to be managed in the organisation where they arise.

Risk Sharing Proposal for 2019/20 financial year – DCC / NDCCG / DDESCCG

If overspends cannot be resolved then the risk associated with a service line commissioned by the individual organisation will remain with that organisation, even if that service was procured by a partner organisation on their behalf, but jointly commissioned areas will be split proportional to the financial contribution from each party. Equally, efficiencies realised through commissioning of a service by an individual organisation will be retained by that organisation, with efficiencies from

jointly commissioned activity being realised by each party proportional to their investment in the service.

Opportunities to resolve the risk will include utilising flexibilities in reserves, opportunities to cease projects at short notice, or prudent commitment of non-recurring expenditure in-year.

It is recognised that the journey from the current position to full risk sharing arrangement will develop over time, in line with pooling of budgets and the move to more integrated and joint commissioning arrangements and will therefore be considered periodically as integrated commissioning continues to mature.

The recognition of risk and opportunities through pooled budgets and integrated commissioning arrangements should underpin decision-making linked to the whole integration agenda.

Scope of the budget

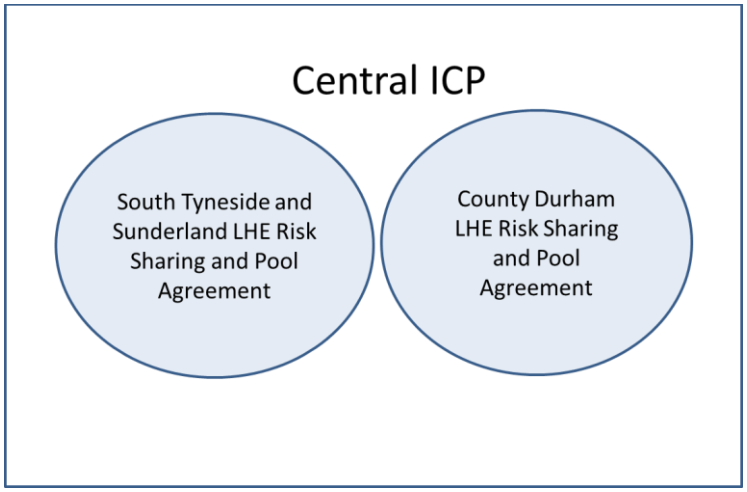
Since the Integrated Commissioning meeting in May 2019, further discussion regarding the scope of the budgets has been held amongst finance and commissioning colleagues, and the latest iteration of the relevant expenditure is shown in the 'Integrated Budget Spend' reports circulated for June's meeting. This captures the expenditure for 2018/19 financial year.

At present the responsibility for budgetary management and control rests with the 'owner' organisations of the budgets. Any changes to be proposed will need to be agreed through the respective governance processes of the affected organisations.

Links to other risk-sharing arrangements

The County Durham local health economy (LHE) has confirmed risk share principles which form part of the overarching approach for the Central Integrated Care Partnership.

The diagram below captures these arrangements, demonstrating how the two local health economies of County Durham, and South Tyneside and Sunderland work separately, but come together to form the Central ICP.

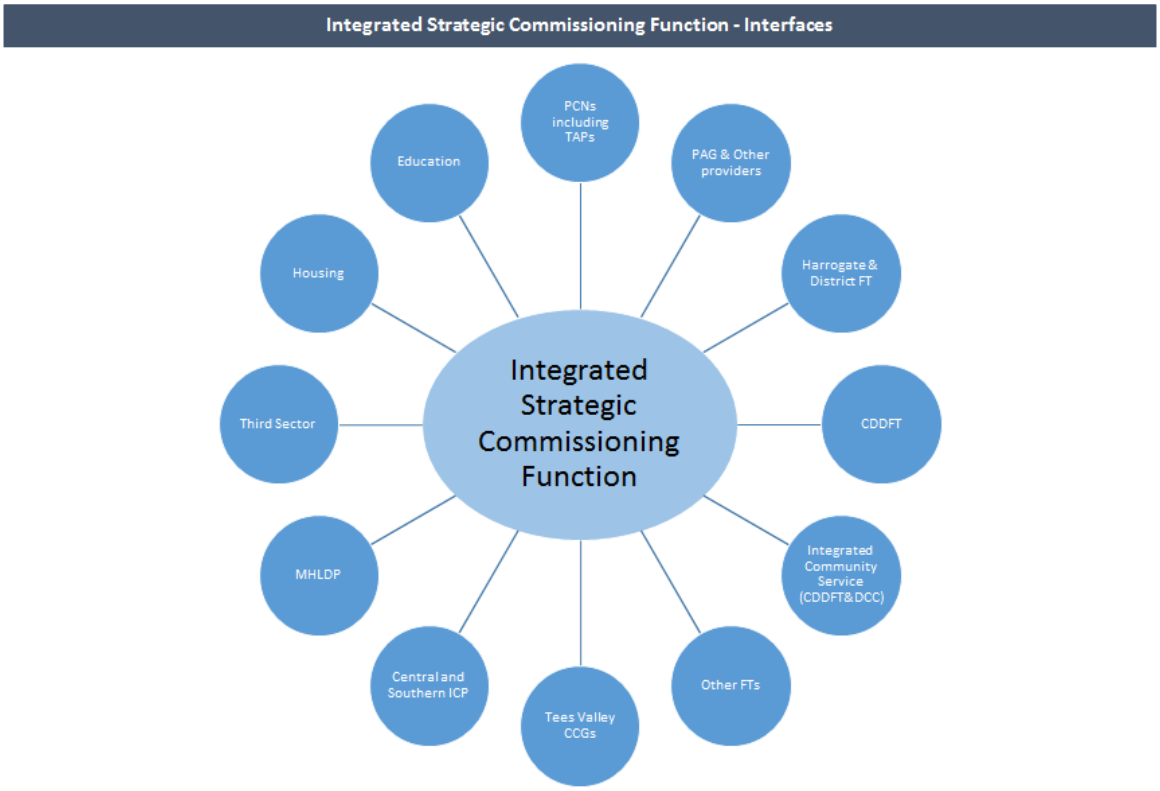


The process and principles are consistent between the two LHE's within the Central ICP and reflect the already established way of working and risk sharing approach in both Durham and South Tyneside/Sunderland.

In addition to the risk sharing approach above, the CCGs in County Durham are also part of a shared risk agreement with Tees, Esk and Wear Valleys NHS Foundation Trust to manage the risk associated with Mental Health and Learning Disabilities costs.

Mark Pickering
Chief Finance Officer – DDES CCG

Appendix 6: Interfaces with Integrated Strategic Commissioning Function



Abbreviations

CCG	Clinical Commissioning Group
CDDFT	County Durham and Darlington Foundation Trust
FT	Foundation Trust
ICP	Integrated Care Partnership
MHLDP	Mental Health and Learning Disabilities Partnership
PAG	Provider Alliance Group
PCNs	Primary Care Networks
TAPs	Teams Around Patients

County Durham and Darlington NHS Foundation Trust

Inspection report

Darlington Memorial Hospital
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Tel: 01325380100
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Date of inspection visit: 02 July to 04 Jul 2019
Date of publication: 03/12/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**
Are resources used productively?	**Good**

Summary of findings

Combined quality and resource rating

Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

A list of the acute hospitals at County Durham and Darlington NHS Foundation Trust is below.

County Durham and Darlington NHS Foundation Trust (CDDFT) is a member of a collaboration of Cumbria and North East NHS bodies working towards Integrated Care System status, and, at sub-regional level, a key member of the Integrated Care Partnerships for the Centre (Sunderland, South Tyneside, North Durham) and the South (rest of Durham, Darlington, Tees Valley, Hambleton and Richmondshire) of the trust's geography.

Trust services are organised into, and operations managed through five care groups: Integrated Medical Specialties (medical, emergency and urgent care including elderly care and stroke); County Durham Community Health Services (community services); Surgery (including critical care and anaesthetics); Family Health (acute obstetrics, gynaecology and paediatrics and community paediatrics); clinical specialist services (including pathology, radiology and other diagnostics, pharmacy and therapies).

The trust provides acute services at Darlington Memorial Hospital (DMH) and University Hospital North Durham (UHND), and elective inpatient and day case surgery at Bishop Auckland Hospital (BAH).

There are some smaller contracts with Public Health England for bowel screening, diabetic retinopathy, ante-natal and new-born (ANNB) and cervical screening and dental care; with specialist commissioners (mainly for drugs, intensive care and neonatal care) and Youth Justice.

(Source: Routine Provider Information Request (RPIR) – Sites tab / Acute context tab)

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good ↑

What this trust does

The trust runs services at University Hospital North Durham, Darlington Memorial Hospital, and a range of community services.

It provides the following acute core services:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology

Summary of findings

- Children and young people
- End of life care
- Outpatients and diagnostics.

The trust also provides the following community health services;

- Community Health inpatient services
- Community health services for adults
- Community health services for children, young people and families (school nursing and health visiting are provided by Harrogate and District NHS Foundation Trust).
- End of life care
- Community dental services
- Community urgent care services

The trust has a network of six community hospitals. Community services are delivered from a wide range of clinics and operating bases across the area.

We inspected only the two main hospital sites during this inspection.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 2 and 4 July 2019 we inspected urgent and emergency care, surgery and end of life care services provided by this trust at its two main hospitals because at our last inspection we rated the trust overall as requires improvement.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well- led key question at the trust level.

Our findings are in the section headed "is this organisation well-led?"

What we found

Overall trust

Our rating of the trust improved. We rated it as good because:

Summary of findings

- We rated safe as requires improvement and effective, caring, responsive and well led as good.
- We rated both University Hospital of North Durham and Darlington Memorial hospital as good.
- We rated well led at trust level as good. This was not an aggregation of the core service ratings for well led.
- In rating the trust, we took in to account the current ratings of the services that we did not inspect during this inspection but that we had rated in our previous inspection.
- Our full inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- We were concerned about staff safety in the reception area in the ED at University Hospital of North Durham as it was very accessible to the public. Staff voiced concerns over lone working and security, particularly at night.
- The service was not meeting elements of the Royal College of Paediatrics and Child Health (RCPCH) standards in the ED at University Hospital of North Durham.
- There were challenges in meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations due to consultant vacancies in the ED at University Hospital of North Durham.
- There wasn't a dedicated paediatric trained nurse in the recovery area which is best practice where children are being nursed at University Hospital of North Durham.
- On the day surgery unit at University Hospital of North Durham, the dirty utility room were unlocked with hazardous substances on display which should have been locked away in a cupboard. This was escalated to the senior nurse and resolved at the time of the inspection.
- Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication').
- Mandatory training for nursing and medical staff failed to meet the trust target in some core services.
- Process for prescribing oxygen post-surgery was not robust. The trust policy was to follow the British Thoracic Societies (BTS) guidance for the administration of oxygen. We observed during the inspection that oxygen was not prescribed or recorded in line with BTS guidance on all wards that we inspected.

However,

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.
- Improvements had been made to ensure the room for patients with Mental health needs met the required standards in ED. There were also plans to improve the environment for children attending the department.
- The concerns identified at the last inspection in relation to medicines had been addressed. We found systems and processes in place to safely prescribe, administer, record and store medicines.
- The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Summary of findings

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Are services effective?

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff monitored the effectiveness of care and treatment through clinical audit. Information from re-audit showed improvement, this suggested action plans were effective in improving care and treatment in the department.
- Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff of different kinds worked together as a team to benefit patients. They used these meetings to discuss any issues relating to patients and beds. Additionally, these meetings were used to relay information from senior management.
- Patient leaflets were available and displayed on the wards including preventing falls and alcohol awareness. There was also a poster labelled 'End PJ Paralysis' encouraging patients to get dressed and out of bed as evidence showed that such patients recovered quicker and felt better. All patients were asked about smoking and alcohol consumption as part of their pre-assessment.

However,

- Training compliance for Mental Capacity Act and Deprivation of Liberty training was significantly below the trust target for medical and nursing staff in some core services. However, we were provided with assurance this was being addressed.
- Pain relief was provided as prescribed and there were systems to make sure additional pain relief was accessed through medical staff. However, pain assessments were inconsistently documented. The service was aware of inconsistency and non-compliance and had a plan in place to address this within the digital platform.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Patients at the end of life said they knew the plan for their care and where appropriate, had spoken with staff about their preferred place of death. All patients said their care had been good.
- Porters told us they had received moving and handling training on how to sensitively transport a deceased patient to the mortuary.
- Feedback from people who used the service, those who were close to them, and stakeholders, was continually positive about the way staff treated people. People told us that staff went the extra mile and their care and support exceeded their expectations.
- Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.

Summary of findings

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Seven specialties were above the England average for referral to treatment (RTT) rates (percentage within 18 weeks) for admitted pathways within surgery.
- Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients with carers were allowed to bring their carer on to the wards to stay with the patient and offer the required support.
- The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting.
- Palliative care discharge coordinators had developed rapid palliative discharge guidance which enabled same day discharge. Staff were able to use this guidance for discharge even when the coordinators were not on duty.
- The trust was working with the local clinical commissioning group (CCG) to improve the creation and delivery of emergency health care plans as well as exploring the use of treatment escalation plans to support individualised care plans.
- There had been an increase in the involvement of end of life and palliative care from for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.
- The number of avoidable cardio pulmonary resuscitation (CPR) attempts had decreased through collaborative working between the cardiac arrest prevention (CAP) team and the palliative care consultant.
- Patients for end of life and palliative care were identified through a multidisciplinary discussion involving those involved in a patient's care on the ward, either directly with the specialist palliative care team or through the trust's electronic record system.

However,

- Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients.
- Whilst no patients waited more than 12 hours from the decision to admit until being admitted between May 2018 to April 2019; there were large number of patients waiting between four and 12 hours.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Summary of findings

- On our last inspection we found that there had been no formal attention to talent management or succession planning at a senior level. On this inspection we found that this had been strengthened and there was a focused talent management strategy in place. This was supported by an annual appraisal system and a more robust approach to succession planning.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- On our last inspection not all executives described the vision and strategy in the same way, at this inspection the senior team gave a unified view of plans for the trust.
- On our last inspection we were told that there was a lack of engagement from the trust with external stakeholders. On this inspection we saw evidence that the trust had worked alongside partners to plan strategy together.
- Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- As we saw at our last inspection, culture had been a challenge particularly in theatres and maternity. Staff told us that culture was improving, we heard examples where unacceptable behaviour had been addressed and working environments and plans had been improved based upon staff feedback. In theatres interventions had been put in place to address culture and safety such as Local Safety Standards for Invasive Procedures (LocSSIPs). Communication had improved between management and clinicians and this had led to less concerns being raised.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The Integrated Quality Assurance Committee (IQAC) had robust oversight of quality within the trust. It received assurance reports monthly on audits of all wards and teams against quality standards. The reports were generated from the electronic track and trigger system and were also used on the wards to drive improvement. These were triangulated with patient stories and discussions with ward or team leaders, who attended by invitation. Directors maintained regular interaction with wards and teams.
- Leaders and teams used systems to manage performance effectively. Teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- On our last inspection there had been several never events in theatres which the trust was addressing but processes to prevent and learn from issues were not embedded. On this inspection we saw an improvement in processes of monitoring issues and performance, and the sharing of learning within the organisation.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- On our last inspection we were told by external stakeholders that the trust could do more to engage with them and be more proactive. This was reiterated by external audit of the trust and the trust had worked to improve their routes of engagement with commissioners and partners across the region. Stakeholders told us that the trust engagement was improving and that concerns were taken on at board level

Summary of findings

- Staff were committed to continually learning and improving services. They had a growing understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- On our last inspection, role specific training compliance was at 55% which was below the target set by the trust. On this inspection the trust gave us broken down figures for role specific training. Out of 44 training modules across the trust, 31 met the target set by the trust. The trust also provided information on their decision making around trajectories and target setting and had an awareness of where they needed to improve.
- The trust had implemented its own continuous improvement methodology ('IMPS') and planned to have trained 400 staff in the 'novice' level by the end of November 2019. The trust reported strong engagement with this initiative, with non-executive directors (NEDs) and executive directors all acting as ambassadors.

However,

- The trust's employment checks for executive and non-executive board members were inconsistent in line with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) regulations 2014).
- Not all senior leaders had a good in-depth knowledge of risks to the organisation and at times deputies were relied upon to give detail which did not hold board members to account.
- We heard mixed views from staff on how well embedded the vision and strategy were and how it translated to frontline staff. Some care group leadership teams were more focused upon immediate operational issues than long term strategy.
- We heard concerns from areas of the trust around workload demands, lack of support for staff to take breaks and staffing shortages and that in some cases managers were unsympathetic to concerns and did not take action to improve staff experience. Some staff did feel supported when things went wrong and felt reprimanded by managers.
- On our last inspection we raised concerns about the capacity of the Freedom to Speak Up Guardian (FTSUG). While two champions had been recruited and working hours increased there was still work to do to increase capacity and raise the profile of the role within the trust.
- We saw limited evidence the trust communicates its financial plan and position throughout the organisation. Staff were not aware of the challenging financial position of the trust at ground level and the need to use resources wisely.
- The judgment of risk within the BAF was not always robust. We saw risks such as those related to staffing which were scored on tolerance despite ongoing staffing issues across the trust. Senior leaders could not give adequate explanation to us how the scores they arrived at, were robust and there was a risk that scores were too low and were not therefore reviewed at appropriate levels within the trust.
- The patient experience strategy was in the early stages and required more time to embed and develop to spread initiatives across more clinical services.
- Despite training compliance for mental capacity act (MCA) and deprivation of liberty safeguards (DoLs) training being within the trust's trajectory, compliance rates were low, at 34.29%.
- We saw evidence that improvement projects had begun to spread across the trust, the quality improvement (QI) approach was still at an early stage of implementation and needed embedding throughout the organisation. Not all senior leaders understood their sponsorship role and the need to support initiatives.

Summary of findings

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in End of Life care, Surgery and Urgent and Emergency care.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 11 breaches of legal requirements that the trust must put right. We found 25 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to trust wide breaches and breaches of legal requirements in End of Life care, Surgery and Urgent and Emergency care.

For more information on action we have taken, see the sections on Areas for improvement in this report.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

End of life care

- The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting.
- The mortuary management team had developed a multi-agency mortuary group including representatives of coroner's officers, funeral directors, the patient reference group, crematoria and the registry office.
- The trust had reduced the number and proportion of cardiac resuscitation attempts that could have been avoided.
- The trust provided the highest level of end of life and palliative care involvement to dying patients in the region.
- Patients for end of life and palliative care were identified either directly with the specialist palliative care team or through the trust's electronic record system.
- The specialist palliative care service had improved personalised care planning and supported preference for place of death for 95% of patients known to the service.

Summary of findings

- The number of avoidable cardio pulmonary resuscitation (CPR) attempts had decreased through collaborative working between the cardiac arrest prevention (CAP) team and the palliative care consultant.
- The trust had developed a specific dashboard for recording end of life and palliative care patient information and the content reflected preferred place of care (PPC) and preferred place of death (PPD).
- The trust had used the national VOICES postal questionnaire of bereaved relatives to understand about people's experience of end of life care and had conducted a local survey to provide more specific results.
- The acute intervention team is an innovative service providing assessment and input to critically ill patients in acute hospitals with the recognition that many of these patients will have palliative care needs

Surgery

- The surgical care group had instigated a bespoke surgical nursing preceptorship support programme. This was developed to be a national leader in support and preceptorship to help sustain and improve recruitment, retention and staff satisfaction.
- The trust had commenced roll out of a waste management system for offensive waste to reduce the cost and impact of waste on the environment, following a review of the use of the clinical waste streams. This was a key part of the trust's response to the collapse of healthcare environmental services, primarily because it enabled the trust to be more resilient by using companies outside of the clinical waste industry and because it had the potential to reduce the greatly escalating costs. Currently, the orange bags (clinical waste) were still being transported up to 250 miles for disposal whereas the offensive waste (tiger bags) were going to an energy incinerator in Stockton. Since March this had eliminated around 25 clinical waste truck journeys, which had saved around £50,000 and prevented around 20 tonnes of waste and carbon dioxide emissions.
- The Trust had a comprehensive LocSSIP development programme; this had been running for the last two years and was now supported by a programme of audit that was currently being rolled out.
- Getting it right first time (GIRFT) visits had commended elective orthopaedics and some aspects of the ophthalmology service. The national emergency laparotomy audit (NELA) results were ahead of average on a number of indicators and the Durham multi-disciplinary team functional bowel service was an award winning nationally recognised service
- The Trust was among the very best performers nationally for the NELA audit with respect to elderly care review.

Urgent and emergency care

- For quarters one to four in 2018/2019 the department had consistently achieved 100% for sepsis screening. The percentage of patients given antibiotics within an hour had increased from 55% to 93%.
- The department had developed the 'Silver Survey' to provide a framework for the management of elderly patients. The framework identified patients at risk and aimed to avoid the development of delirium.
- Significant work had been to implement the 'treat as one' agenda for patients presenting with mental health related risks. This included changes to triage to include assessment of mental health risk factors through training and close working with the mental health team. This initiative also provided staff with training on having richer relationships with patients in emotional crisis and for staff to feel more confident about their skills in working with very distressed or confused patients.
- The department had worked hard to improve knowledge and understanding around safeguarding for staff. Processes for children attending the department had been strengthened. Safeguarding supervision and safety huddles were

well established. Links with safeguarding teams had been strengthened. Link roles had been developed and additional roles such as Independent Domestic Violence Advocates (IDVA). An IDVA was present in the department twice a week. They were a useful resource in identifying domestic abuse and assisting patients through the referral process.

- The department had an alcohol nurse specialist. Initially this role focused on auditing, but the role had extended, and the nurse also saw patients in the department. The "Positive Lives" resource was utilised by the department. This offered coaching and training workshops to improve creativity, confidence, and communication skills for individuals, groups and teams.

Areas for improvement

Action the trust MUST take to improve:

Trust wide

- The trust must ensure that all board member appointment checks are in line with the Fit and Proper Persons Requirement (FPPR). **Regulation 5**
- The trust must ensure that adequate numbers of staff receive training for MCA and DoLs. **Regulation 12**

End of life care

- The service must ensure syringe driver safety checks are completed in accordance with trust policy and national guidance. **Regulation 12 (1)(2)**
- The service must ensure systems and processes to safely prescribe, administer, record and store medicines are consistently used. **Regulation 12 (1)(2)**
- The service must ensure pain care assessments and plans are completed consistently in all patient records. **Regulation 12 (1)(2)**

Urgent and Emergency care

- The department must ensure processes are put in place to ensure there are clinicians available with paediatric competencies to assess children who are streamed away from the emergency care setting. **Regulation 12**
- The department must work to improve medical staffing and paediatric nurse staffing. **Regulation 18**

Surgery

- The service must ensure that mandatory training compliance, including safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards training, meets the trust's target. Safe Care and Treatment **Regulation 12 (1)(2)(c**)
- The service must ensure oxygen for patients is prescribed, in line with national guidance. Safe Care and Treatment **Regulation 12 (1)(2)(g)**

Action the trust SHOULD take to improve:

Trustwide:

- Continue to develop the board's knowledge and oversight of risk to the organisation.
- Continue to improve compliance with role specific training targets and closely monitor this.

Summary of findings

- Work with care groups to embed the vision and strategy and make this meaningful for staff in frontline roles across the trust.
- Engage with staff to understand and resolve issues relating to demands wherever possible.
- Develop the capacity and visibility of the FTSUG further across the trust.
- Communicate the financial position more clearly with staff to aid understanding of pressures.
- Review the process of risk grading and consider if risks below and at tolerance are robustly scored.
- Continue to embed the patient experience strategy to more services in the trust and to wider patient groups.
- Continue to embed the QI approach and develop senior sponsorship and oversight mechanisms.

End of life:

- The trust should ensure syringe driver training and competence is monitored at ward level.
- The trust should review the completion of fluid balance records, specifically in relation to patients receiving IV fluids.

Surgery

- The service should continue to monitor and improve the data quality process and management surrounding medicines reconciliation and critical missed dose medications.
- The service should continue to monitor and improve the data quality surrounding the average length of stay for elective and non-elective patients, to improve performance standards measured against the England national average.
- The service should continue to monitor and improve the data quality surrounding referral to treatment times for ophthalmology patients.
- The service should ensure that the process surrounding obtaining patient consent for the storage of contemporaneous records at the patient's bedside is robust.
- The service should ensure pain care assessments and plans are completed consistently in all patient records as per the trust policy.
- The service should ensure that there are dedicated paediatric trained nurses in the recovery area which is best practice where children are being nursed.

Urgent and Emergency Care

- The department should review signage for patient's attending the 'see and treat' area.
- The department should consider a more robust system for evidencing daily checks of resuscitation equipment.
- The department should ensure that plans to improve the experience for children attending the department are implemented.
- The department should ensure MCA training is attended to improve training compliance for nursing and medical staff.
- The department should continue to work to reduce the number of patients waiting more than four hours from the decision to admit until being admitted.
- The department should ensure regular governance meetings are taking place.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

•Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

•On our last inspection we found that there had been no formal attention to talent management or succession planning at a senior level. On this inspection we found that this had been strengthened and there was a focused talent management strategy in place. This was supported by an annual appraisal system and a more robust approach to succession planning.

•The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

•On our last inspection not all executives described the vision and strategy in the same way, at this inspection the senior team gave a unified view of plans for the trust.

•On our last inspection we were told that there was a lack of engagement from the trust with external stakeholders. On this inspection we saw evidence that the trust had worked alongside partners to plan strategy together.

•Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

•As we saw at our last inspection, culture had been a challenge particularly in theatres and maternity. Staff told us that culture was improving, we heard examples where unacceptable behaviour had been addressed and working environments and plans had been improved based upon staff feedback. In theatres interventions had been put in place to address culture and safety such as Local Safety Standards for Invasive Procedures (LocSSIPs). Communication had improved between management and clinicians and this had led to less concerns being raised.

•Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

•The Integrated Quality Assurance Committee (IQAC) had robust oversight of quality within the trust. It received assurance reports monthly on audits of all wards and teams against quality standards. The reports were generated from the electronic track and trigger system and were also used on the wards to drive improvement. These were triangulated with patient stories and discussions with ward or team leaders, who attended by invitation. Directors maintained regular interaction with wards and teams.

•Leaders and teams used systems to manage performance effectively. Teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Summary of findings

•On our last inspection there had been several never events in theatres which the trust was addressing but processes to prevent and learn from issues were not embedded. On this inspection we saw an improvement in processes of monitoring issues and performance, and the sharing of learning within the organisation.

•The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

•Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

•On our last inspection we were told by external stakeholders that the trust could do more to engage with them and be more proactive. This was reiterated by external audit of the trust and the trust had worked to improve their routes of engagement with commissioners and partners across the region. Stakeholders told us that the trust engagement was improving and that concerns were taken on at board level

•Staff were committed to continually learning and improving services. They had a growing understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

•On our last inspection, role specific training compliance was at 55% which was below the target set by the trust. On this inspection the trust gave us broken down figures for role specific training. Out of 44 training modules across the trust, 31 met the target set by the trust. The trust also provided information on their decision making around trajectories and target setting and had an awareness of where they needed to improve.

•The trust had implemented its own continuous improvement methodology ('IMPS') and planned to have trained 400 staff in the 'novice' level by the end of November 2019. The trust reported strong engagement with this initiative, with non-executive directors (NEDs) and executive directors all acting as ambassadors.

However,

•The trust's employment checks for executive and non-executive board members were inconsistent in line with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) regulations 2014).

•Not all senior leaders had a good in-depth knowledge of risks to the organisation and at times deputies were relied upon to give detail which did not hold board members to account.

•We heard mixed views from staff on how well embedded the vision and strategy were and how it translated to frontline staff. Some care group leadership teams were more focused upon immediate operational issues than long term strategy.

•We heard concerns from areas of the trust around workload demands, lack of support for staff to take breaks and staffing shortages and that in some cases managers were unsympathetic to concerns and did not take action to improve staff experience. Some staff did feel supported when things went wrong and felt reprimanded by managers.

•On our last inspection we raised concerns about the capacity of the Freedom to Speak Up Guardian (FTSUG). While two champions had been recruited and working hours increased there was still work to do to increase capacity and raise the profile of the role within the trust.

•We saw limited evidence the trust communicates its financial plan and position throughout the organisation. Staff were not aware of the challenging financial position of the trust at ground level and the need to use resources wisely.

•The judgment of risk within the BAF was not always robust. We saw risks such as those related to staffing which were scored on tolerance despite ongoing staffing issues across the trust. Senior leaders could not give adequate explanation to us how the scores they arrived at, were robust and there was a risk that scores were too low and were not therefore reviewed at appropriate levels within the trust.

Summary of findings

•The patient experience strategy was in the early stages and required more time to embed and develop to spread initiatives across more clinical services.

•Despite training compliance for mental capacity act (MCA) and deprivation of liberty safeguards (DoLs) training being within the trust's trajectory, compliance rates were low, at 34.29%.

•We saw evidence that improvement projects had begun to spread across the trust, the quality improvement (QI) approach was still at an early stage of implementation and needed embedding throughout the organisation. Not all senior leaders understood their sponsorship role and the need to support initiatives.

Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating. The report is published on our website at www.cqc.org.uk/provider/RXP/Reports

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
University Hospital of North Durham	Requires improvement →← Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Darlington Memorial Hospital	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Overall trust	Requires improvement →← Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019
Community	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for University Hospital of North Durham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ➔➔ Oct 2019
Medical care (including older people's care)	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*						

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community end of life care	Good Sept 2015	Good Sept	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015
Community urgent care service	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

University Hospital North Durham

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Key facts and figures

University Hospital North Durham is an acute hospital site which is one of two forming the County Durham and Darlington NHS Foundation Trust.

Services provided at Durham are:

- urgent and emergency care
- medical care (including older peoples care)
- surgical care
- critical care
- maternity services (Midwifery led and consultant led)
- children's and young people's services;
- end of life care
- outpatient services and diagnostic imaging.

On this inspection, we inspected urgent and emergency care, surgery and end of life care.

Summary of services at University Hospital North Durham

Good ↑

Our rating of services improved. We rated it them as good because:

- We rated effective, caring, responsive and well led as good and safe as requires improvement.
- Urgent and emergency care services remained the same at requires improvement. Surgery improved by one rating to good and end of life care improved by two ratings to outstanding.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service had suitable premises and equipment and looked after them well. Staff kept themselves, equipment and premises clean. They used control measures to prevent the spread of infection.
- The service provided care and treatment based on national guidance and evidence of its effectiveness such as that issued by National Institute for Health and Care Excellence (NICE). Managers checked to make sure staff followed guidance.
- End of life care had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- End of life care had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.
- End of life care managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

However,

- There were challenges in meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations in relation to consultant staffing in the emergency department.
- There were challenges in meeting guidelines relating to the care of children in the department in terms of appropriately trained staff being available in the emergency department.
- Medical training compliance in Mental Capacity were below trust targets.
- There were some concerns over the general environment in terms of staff safety as areas had unrestricted access in the emergency department.
- Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication'). We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

Urgent and emergency services

Requires improvement 

Key facts and figures

The University Hospital of North Durham (UHND) is one of two emergency departments at County Durham and Darlington NHS Foundation Trust (CDDFT), the other is at Darlington Memorial Hospital (DMH). Both sites also had urgent treatment centres (UTC). UTC were also located at Bishop Auckland and Peterlee and Shotley Bridge.

The service provides emergency treatment for patients 24 hours a day, seven days a week. From February 2018 to January 2019 there were 222,185 attendances at the trust's urgent and emergency care services. Between July 2018 and June 2019 there were 12,364 paediatric attendances.

At the last inspection in September 2017, the domains of safe and responsive were rated as requires improvement. The other domains were rated good.

Our inspection in July 2019 was unannounced (staff did not know we were coming) to enable us to observe routine activity. Before the inspection, we reviewed the information about this service and information previously requested from the trust. We re-inspected all five key questions during this inspection.

During this inspection we visited the department on three separate occasions. We spoke with 12 patients and relatives and 54 members of staff. We observed staff delivering care, looked at 18 patient records and 18 prescription charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

•There were challenges in meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations in relation to consultant staffing.

•There were challenges in meeting guidelines relating to the care of children in the department in terms of appropriately trained staff being available.

•Medical training compliance in Mental Capacity were below trust targets.

•There were some concerns over the general environment in terms of staff safety as areas had unrestricted access.

•Concerns identified at the previous inspection regarding access and flow through the department remained a challenge.

•Whilst improvements had been seen there were still large number of patients staying in the department for longer than the recommended standard.

However;

•Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Urgent and emergency services

•Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

•Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

•The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

•Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

•There was also unrestricted access to all areas within the department. We requested a risk assessment, but this was not provided. We were particularly concerned about staff safety in the reception area as it was very accessible to the public. Staff voiced concerns over lone working and security, particularly at night.

•The service was not meeting elements of the Royal College of Paediatrics and Child Health (RCPCH) standards. Namely; the service did not always have staff with paediatric competencies available to see children who were streamed away from the emergency department. There was also no system in place for the prioritisation of children in the department if triage times exceeded 15 minutes.

•Two registered sick children's nurses were not available on each shift as per RCPCH guidelines.

•There were challenges in meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations due to consultant vacancies. Sixteen hours of consultant presence was not achieved which is considered best practice.

•The service did not have a dedicated paediatric emergency medicine (PEM) consultant as per RCPCH standards, however mitigating actions were in place.

However:

•Improvements had been made to ensure the room for patients with Mental health needs met the required standards. There were also plans to improve the environment for children attending the department.

•The concerns identified at the last inspection in relation to medicines had been addressed. We found systems and processes in place to safely prescribe, administer, record and store medicines.

•The service provided mandatory training in key skills including the highest level of life support training to all staff and had plans in place to meet end of years trajectory targets.

Urgent and emergency services

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were robust safeguarding processes in place for children and adults. Staff had training on how to recognise and report abuse, and they knew how to apply it.

•The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

•Triage and streaming processes supported early identification of any risks and staff quickly acted upon patients at risk of deterioration. Information was clearly and accurately recorded in patient records.

•The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Processes were in place to share learning from incidents.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

•The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

•Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

•Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

•Staff monitored the effectiveness of care and treatment through clinical audit. Information from re-audit showed improvement, this suggested action plans were effective in improving care and treatment in the department.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

•Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

•Key services were available seven days a week to support timely patient care.

•Staff gave patients practical support and advice to lead healthier lives.

•Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

•Training compliance for Mental Capacity Act and Deprivation of Liberty training was significantly below the trust target for medical and nursing staff. However, we were provided with assurance this was being addressed.

Is the service caring?

Good 

Urgent and emergency services

Our rating of caring stayed the same. We rated it as good because:

•Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

•Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

•Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

•Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients.

•The previous inspection highlighted the need for patients to be seen and transferred or discharged within four hours. From May 2018 to April 2019, the trust failed to meet the standard related to this, however, this was in line with the England average.

•From May 2018 to April 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. January 2019 saw the highest number of patients (1,177).

•Whilst no patients waited more than 12 hours from the decision to admit until being admitted between May 2018 to April 2019; there were large number of patients waiting between four and 12 hours.

However;

•The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

•The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

•It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

•Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

Urgent and emergency services

•The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

•Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

•Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

•Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

•Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

•Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

•All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

However;

•In 2019 governance meetings had only occurred twice.

Outstanding practice

See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Surgery

Good ↑

Key facts and figures

The service operated at three main sites, with elective and emergency surgery being undertaken at two main sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND), and elective (general surgery, orthopaedics, chronic pain, ophthalmology, dental, endoscopy, ear nose and throat/ head and neck, and dermatology) is undertaken at Bishop Auckland Hospital (BAH). In addition, day surgery, plastic surgery, general surgery and orthopaedics are undertaken at Shotley Bridge Hospital (SBH).

Surgery and ophthalmology services have close working relationships with other NHS Trusts within the North East.

The trust no longer provided a urology service and as of May 2019, there had been a disinvestment in the vascular service.

Our inspection was unannounced; that is, staff didn't know we were coming, until an hour prior to the inspection. We visited the surgical wards of North Durham University Hospital on 3 and 4 July 2019. During the inspection we spoke with 13 staff including nurses, medical staff, support workers and directors. We spoke with five patients and looked at 10 records. The inspection team consisted of two CQC inspectors who were supported by two specialist advisers who were experts in their field.

Summary of this service

Our rating of this service improved. We rated it as good because:

•The service provided mandatory training for staff and managers ensured staff completed this training. This ensured that the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

•Staff maintained appropriate records of care and treatment both electronically and on paper.

•The service had suitable premises and equipment and looked after them well. Staff kept themselves, equipment and premises clean. They used control measures to prevent the spread of infection.

•The service provided care and treatment based on national guidance and evidence of its effectiveness such as that issued by National Institute for Health and Care Excellence (NICE). Managers checked to make sure staff followed guidance.

•Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed staff interacting with patients in a professional manner during the inspection.

•Staff involved patients and those close to them in decisions about their care and treatment. This ensured that patients were able to make informed decisions about their care. The trust planned and provided services in a way that met the needs of local people.

•Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. They were visible and approachable for patients and staff.

•The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Surgery

•The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However,

•For nursing staff eligible for infection prevention and control training, only 52% had completed this training against the trust's completion target rate of 85%.

•Medical staff had not met the trust's target completion rates for six of the mandatory training courses.

•Nursing and medical staff had not met the trust's target completion rate for safeguarding children level 2.

•The management of obtaining patient consent for the storage of patient records at the patients' bedside was not robust.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

•The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. Nurse staffing was managed using daily monitoring, acuity tools and professional judgment. This was an improvement since the last inspection.

•The service had suitable premises and equipment and looked after them well. We saw that corridors were visibly clean and free from clutter. We found the hospital was accessible to wheelchair users, with clear signage.

•The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. There was an open culture around incident reporting. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

•The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

•The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

•There were dementia and learning disability link nurses in place. These link nurses supported patients living with dementia or having a learning disability.

•Nursing and therapy records were written in black ink and were legible. Each entry was signed and dated. This was an improvement from the previous inspection when the service was told they should ensure that patient records are complete and staff signatures legible.

•The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

•The service provided care and treatment based on national guidance and according to best practice. We observed staff in theatres and wards adhering to NICE guidance on infection control and preventing surgical site infections.

Surgery

•The trust participated in the 'Getting It Right First Time' (GIRFT) project, commissioned by the Department of Health. This is a national programme designed to improve the quality of care within the National Health Service by reduction of unwanted variations and or divergence from the best evidence. Senior leaders within surgery told us about GIRFT quality improvement projects in orthopaedics and general surgery.

However

•Patient's nursing and therapy records were stored at the end of each patient's bed. The service told us that patients' consent was taken prior to storing their records at the end of their beds. However, we did not see this consent in all of the records we examined.

•Oxygen was not prescribed or recorded in line with national guidance on all wards that we inspected. The service had an ongoing programme of improvement work within the digital platform with respect to oxygen therapy, being overseen by the clinical effectiveness committee.

•There wasn't a dedicated paediatric trained nurse in the recovery area which is best practice where children are being nursed.

•On the day surgery unit, the dirty utility rooms were unlocked with hazardous substances on display which should have been locked away in a cupboard. This was escalated to the senior nurse and resolved at the time of the inspection.

•For safeguarding training, both medical and nursing staff did not meet the trust's target for safeguarding children level 2.

•Overall mandatory training compliance for medical staff, did not meet the trust's target. Medical staff did not meet six of the 11 mandatory training compliance targets.

•There was no evidence to support that the anaesthetic machines were being checked daily; that is, the anaesthetic log book was not signed every day. The log book should be completed on a daily basis and recorded in the manufacturer's log as per the Association of Anaesthetists of Great Britain and Ireland (AAGBI 2012) recommendations. This was policy at other sites.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

•The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. The trust participated in a variety of audits; for example, bowel cancer. This audit showed that the risk-adjusted 90-day post-operative mortality rate was within the expected range when compared to other trusts. The trust had action plans in place to address issues identified in audits; for example, audit of fractured neck of femur resulted in pain scores being assessed within 15 minutes of patients arriving at the hospital.

•The service followed Venous Thromboembolism (VTE) procedures for patients at risk of developing blood clots and conducted risk assessments for such patients.

•Protected meal times were in place and during our inspection we observed that patients were provided with their meals on time. Staff completed a malnutrition screening tool to identity patients at risk of malnutrition. Patients had access to a dietician where required.

•Staff assessed and monitored patients regularly to see if they were in pain. Patients we spoke with were satisfied with the way staff responded quickly in dealing with their pain. Patients could be referred to the pain management team if needed as there was a pain link nurse on the wards.

•Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff of different kinds worked together as a team to benefit patients. They used these meetings to discuss any issues relating to patients and beds. Additionally, these meetings were used to relay information from senior management.

•Patient leaflets were available and displayed on the wards including preventing falls and alcohol awareness. There was also a poster labelled 'End PJ Paralysis' encouraging patients to get dressed and out of bed as evidence showed that such patients recovered quicker and felt better. All patients were asked about smoking and alcohol consumption as part of their pre-assessment.

•Staff clearly recorded consent in the patients' records. We examined eight care records and these showed that consent for treatment was clearly recorded, with the signature of the healthcare professional seeking consent clearly written in the records.

However;

•The service had a higher than expected risk of readmission for elective admissions in general surgery and a higher than expected risk of readmission for non-elective admissions in plastic surgery compared to the England average. The surgery care group recognised the inflated figures were due to a data quality cleansing issue rather than a practice issue and had agreed to address this moving forward.

•For medical staff, only 12% had completed Mental Capacity Act training against a trust completion target of 33%

•Pain relief was provided as prescribed and there were systems to make sure additional pain relief was accessed through medical staff. However, pain assessments were inconsistently documented. The service was aware of inconsistency and non-compliance and had a plan in place to address this within the digital platform.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

•Staff cared for patients with compassion. We observed staff treating patients with care and respect. Feedback from patients confirmed that staff treated them well and with kindness. They said their privacy and dignity was respected and maintained; for example, staff used the bed curtains when conducting medical examinations.

•Staff also involved patients in the planning of their care. Patients told us they knew what was happening with their surgery and what their treatment plans were and how long they were expected to stay in hospital.

•Staff took in to account people's social, cultural, religious and personal needs when delivering care; for example, patients could access the multi-faith chaplaincy team and the service provided halal and Kosher meals.

•A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. For the 12 months ending March 2019, the percentage of people who would recommend the ward for treatment was at least 93% and for some wards during some months it was 100%.

•Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a leaflet 'how to raise compliments, concerns, comments, complaints' displayed in corridors on the wards.

Surgery

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

•Seven specialties were above the England average for referral to treatment (RTT) rates (percentage within 18 weeks) for admitted pathways within surgery.

•The service met people's individual needs by planning and designing care to meet the individual needs of patients.

•The service ensured that there were sufficient staff on duty during each shift. We saw this on display boards which showed the planned and actual number of different grades of staff on each shift.

•Staff ensured that separate bays were allocated for patients of different sex. Staff we spoke with explained that they never allowed mix sex accommodation.

•Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients with carers were allowed to bring their carer on to the wards to stay with the patient and offer the required support.

•Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that interpreters could be booked through the hospital switchboard and they either attended the hospital or could provide interpretation through the telephone.

•The service treated concerns and complaints seriously, investigated them and lessons learned were shared with staff. The service involved patients in the investigation of their complaint.

However,

•The average length of stay for patients having elective general surgery at University Hospital North Durham was 5.4 days which was higher than the England average of 3.9 days.

•The average length of stay for patients having elective trauma and orthopaedics surgery at University Hospital North Durham was 5.4 days which was higher than the England average of 3.7 days.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

•Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff we spoke with felt supported by colleagues, managers, matrons and divisional managers.

•The service had a strategy in place which had been developed in consultation with staff. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

•Managers at service level promoted a positive culture through targeted intervention and action planning that supported and valued staff, creating a sense of common purpose based on shared values. Staff reported a positive culture, good team working, and various places in which to receive and share information and concerns. This was an improvement since the last inspection which had been an area of concern.

Surgery

•The trust had a governance handbook in place which described the governance structures, responsibilities, standards, behaviours and reporting requirements. This handbook described the different types of governance; for example, corporate, clinical and information. On a day to day basis, management of operations took place within care groups and corporate directorates.

•The service used the Board Assurance Framework (BAF) to capture and monitor action plans for board or executive-level risks. In addition, each directorate or care group had its own operational risk register. The trust did not maintain a separate 'corporate risk register'. All risks were managed by care groups and directorates on the electronic risk management system.

•We reviewed the risk register and saw that risks had mitigating factors with scores, risk owner, risk assessor and the next review date. The mitigating actions were appropriate, sufficient and effective.

•The service engaged well with patients, staff and the public to plan and manage appropriate services, and collaborated with partner organisations effectively. People using the service were encouraged to give their opinion on the quality of services they received. On the patient information board, we saw a leaflet 'how to raise compliments, concerns, comments, complaints' on the corridor in the wards. This leaflet explained how patients could make comments, complaints, concerns or compliments.

•The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The hospital encouraged staff to find innovative solutions to problems they encountered at work. To assist staff to bring their ideas to fruition, the trust had an innovation team.

However,

- The service was not meeting training targets for Mental capacity Act and Deprivation of Liberty Safeguards. Senior leadership were aware of this training non-compliance. We were provided with assurance of how the service would improve upon this.

Outstanding practice

See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

End of life care

Outstanding ☆ ↑↑

Key facts and figures

The trust provides end of life care at two sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND). End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death.

Ward staff were supported by the acute specialist palliative care team and acute intervention team across both hospital sites. Both teams also provided support to patients with a life limiting/progressive illness, not limited to those with cancer. Ward staff were able to refer to both teams using the electronic patient database or by telephone.

The trust had 2,032 deaths from February 2018 to January 2019.

This report focuses on the inspection of end of life and palliative care services (medical, nursing, mortuary, chaplaincy and bereavement).

We observed daily practice and viewed patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and also visited the mortuary and the hospital chapel. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke with members of staff, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

•The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

•The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

•The service provided care and treatment based on national guidance and evidence of its effectiveness.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

•The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

•Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

•The service had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

•Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

End of life care

•The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

However:

•Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication'). We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

•The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines. Pain care plans were not completed in all patient records.

•The results of the first round of the 'National Audit of Care at the End of Life' (2019) showed the trust scored lower when compared nationally for documented assessments of nutrition between recognition and time of death and hydration.

•Pain assessments were inconsistently documented for palliative and end of life care patients across wards visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

•Staff used infection control measures when visiting patients on wards and transporting patients after death.

•Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

•Staff kept detailed records of patients' care and treatment. Records were clear and easily available to all staff providing care.

•The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

However:

•Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication').

•We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

•The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines. Pain care plans were not completed in all patient records.

Is the service effective?

Good ↑

End of life care

Our rating of effective improved. We rated it as good because:

•The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

•Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

•Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

•Managers used information from audits to improve care and treatment. The palliative care annual report used the results of the national audit of Care at the End of Life (2019) to develop a robust action plan.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance; 100% of end of life staff at the hospital received an appraisal.

•Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

•Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

•The results of the first round of the 'National Audit of Care at the End of Life' (2019) showed the trust scored lower when compared nationally for documented assessments of nutrition between recognition and time of death and hydration.

•Pain assessments were inconsistently documented for palliative and end of life care patients across wards visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

•Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

•Patients said they knew the plan for their care and where appropriate, had spoken with staff about their preferred place of death. All patients said their care had been good.

•Porters told us they had received moving and handling training on how to sensitively transport a deceased patient to the mortuary.

•Bereavement services gave advice on obtaining a death certificate, funeral services, mortuary services and administration procedures.

•Staff always provided emotional support to patients, families and carers to minimise their distress. They always understand patient's personal, cultural and religious needs.

End of life care

•Renovation work in the mortuary resulted in sensitively decorated rooms and the room for the presentation of the deceased transformed into a welcoming and calming environment.

•Results from the bereaved relatives survey showed families felt that dignity and respect was always provided, they were supported after death and they had received support regarding feelings about illness and death.

However:

•Porters told us that they had not received specific end of life care to support bereaved relatives and carers.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

•The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

•The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting.

•Increased capacity through the appointment of training fellows had contributed to involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients.

•Palliative care discharge coordinators had developed rapid palliative discharge guidance which enabled same day discharge. Staff were able to use this guidance for discharge even when the coordinators were not on duty.

•The palliative care team was available five days a week and their role complemented by the acute intervention team in the evenings and at night. At weekends and out of hours a telephone service was available to provide consultant advice and support from a local hospice. Staff were aware of this service and we saw information leaflets on the wards we visited.

•The mortuary management team was accountable for securing services for the deceased throughout the trust and across agency boundaries and had developed a multi-agency mortuary group.

•The trust was working with the local clinical commissioning group (CCG) to improve the creation and delivery of emergency health care plans as well as exploring the use of treatment escalation plans to support individualised care plans.

•The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers

•The trust was continuing to reduce the number and proportion of cardiac resuscitation attempts that could have been avoided with better assessment and care planning.

•Palliative care training fellows were in post providing increased capacity in end of life and palliative medicine and developing future consultants in palliative care.

•There had been an increase in the involvement of end of life and palliative care from for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.

•The trust improved on 'death in usual place of residence' (DIUPR); each year fewer patients were dying in the hospital and better than the England average.

End of life care

•Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

•Palliative care discharge co-ordinators had developed rapid palliative discharge guidance which enabled staff to use available resources for discharge even when the co-ordinators were not on duty.

•The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge.

•Chaplaincy staff supported people's spiritual needs regardless of faith, including the needs of staff.

•The chapel had facilities for many faiths including, amongst others, Christian, Islam (Wuḍūʾ and ablution) and identified the Qibla (the direction that should be faced when a Muslim prays during ṣalāh).

•Patients for end of life and palliative care were identified through a multidisciplinary discussion involving those involved in a patient's care on the ward, either directly with the specialist palliative care team or through the trust's electronic record system.

•The trust 'Audit of Documentation of Care in the Last Hours and Days of Life for Expected Deaths in CDDFT' showed there were high levels of achievement of preferred place of death (PPD).

•The specialist palliative care service had improved personalised care planning and supported preference for place of death for 95% of patients known to the service.

•The number of avoidable cardio pulmonary resuscitation (CPR) attempts had decreased through collaborative working between the cardiac arrest prevention (CAP) team and the palliative care consultant.

•The trust took an average of 23.3 working days to investigate and close complaints in line with the trust complaints policy.

Is the service well-led?

Outstanding ☆ ↑↑

Our rating of well-led improved. We rated it as outstanding because:

•Leaders had the skills, knowledge, experience and integrity to run a service providing high-quality sustainable care.

•The palliative and end of life care team spoke positively about the impetus and motivation the restructuring of end of life care services within the trust had received since our last inspection.

•Staff were well supported in their roles and had a clear understanding of their responsibilities and told us leaders were visible and approachable. Ward staff told us that the specialist end of life and palliative care team were well known, accessible and provided expertise and advice when needed.

•Clinical leadership in the specialist palliative care service had been strengthened by the appointment of new consultants.

•Senior clinicians had engaged with other non-palliative teams (within and outside the organisation) to enhance the understanding of end of life and palliative care and supported improvements in the service for patients and families.

•The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement.

End of life care

•The service had a strategy in place for providing end of life care which aimed to implement improvements identified by national audit and recommendations from regulators to improve care for patients and families. The trust vision, strategy and work plan were based upon the national 'Palliative and End of Life Partnership' framework.

•All staff in palliative and end of life care services were positive about the leadership, strategy and organization of end of life and palliative care services at the hospital and throughout the trust. There was recognition that the trust had made improvements to end of life and palliative care since our previous inspection.

•Staff working in the mortuary and bereavement services had positive attitudes to their role and respected the service they gave to families and carers at a sensitive time.

•Porters had received training in moving and handling deceased patients and had developed good relationships with ward and mortuary staff to ensure the deceased patient was moved with respect and dignity.

•There was a governance structure in place with processes and systems of accountability to support a sustainable service.

•The trust had developed a specific dashboard for recording end of life and palliative care patient information and the content reflected preferred place of care (PPC) and preferred place of death (PPD).

•Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

•The trust had used the national VOICES postal questionnaire of bereaved relatives to understand about people's experience of end of life care and had conducted a local survey to provide more specific results.

•The palliative care service had made changes in response to patient and relatives' feedback.

•Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Outstanding practice

See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Darlington Memorial Hospital

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Key facts and figures

Darlington Memorial Hospital is an acute hospital site which is one of two forming the County Durham and Darlington NHS Foundation Trust.

Services provided at Darlington are:

- urgent and emergency care
- medical care (including older peoples care)
- surgical care
- critical care
- maternity services (Midwifery led and consultant led)
- children's and young people's services;
- end of life care
- outpatient services and diagnostic imaging.

On this inspection, we inspected urgent and emergency care, surgery and end of life care.

Summary of services at Darlington Memorial Hospital

Good ↑

Our rating of services improved. We rated it them as good because:

- We rated safe, effective, caring, responsive and well led as good.
- Urgent and emergency care and surgery core service ratings improved by one rating to good and end of life care improved by two ratings to outstanding.

Summary of findings

- At the previous inspection we found that the service did not have enough staff. At this inspection we saw that the service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Operating theatres were fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). This was an improvement since the last inspection.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Improvements in practice were effectively embedded with continuous development to support continued awareness and learning surrounding serious incidents and never events.
- End of life care had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

However,

- Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients.
- In surgery, mandatory training for nursing and medical staff failed to meet the trust target. In surgery, the targets were met for three of the nine mandatory training modules for which qualified nursing staff were eligible and three of the eleven mandatory training modules were met for which medical staff were eligible.
- In Surgery, medical and nursing staff failed to meet the trust target for safeguarding children training (level 2).
- In Surgery, medical staff failed to meet the trust target for Mental Capacity Act and Deprivation of Liberty Safeguards (level 2).
- Oxygen was not always prescribed or administered in line with national guidance.
- Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication'). We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

Urgent and emergency services

Good ↑

Key facts and figures

At County Durham and Darlington NHS Foundation Trust (CDDFT), there are Emergency Departments at Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND).

CDDFT manages five Urgent Treatment Centres (UTC):

- Darlington Memorial Hospital operate a 24/7 GP-led UTC, with GP provision at all times.
- Bishop Auckland and Peterlee UTC operate as a practitioner-led minor injuries unit 08:00-20:00 Monday to Friday and GP-led UTC at all other times.
- Shotley Bridge operates as a practitioner-led UTC service Monday to Friday 08:00-18:00 treating both minor injury and illness and revert to GP-led UTC at all other times.
- North Durham UTC operate 18:00-08:00 Monday to Friday as a GP-led UTC and 24/7 weekends and Bank Holidays.

(Source: Routine Provider Information Request (RPIR) – AC1 Context acute)

There are facilities for bariatric and dementia patients and internal decontamination facilities.

There are separate paediatric and adult waiting areas, and a chair-centric care area. X-ray facilities and a plaster room are within the department.

There is an out-of-hours GP service located in outpatients adjacent to the emergency department

Following inspection in September 2018 urgent and emergency care at Darlington Memorial hospital received an overall rating of requires improvement, with the key domains of safe and well led as requires improvement with ratings of good in effective, caring and responsive.

Following our inspection in 2018, the following issues were highlighted:

- The department was having difficulty meeting the four hour target. Between October 2016 and September 2017 the department had only met the monthly 95% four hour target once.
- The room used to assess patients with mental health needs, did not fully conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- The service did not always have enough staff of the right level to keep patients safe from avoidable harm.
- The service did not always manage medicines well.
- Clinicians did not update or review care pathways regularly.
- The access was blocked to the major incident store cupboard.
- The children's resuscitation room doors were not closed or locked allowing easy access from the main corridor, which could be a potential security risk.
- The layout of the main reception desk did not provide privacy as patients booked in.
- Staff did not always record patients' blood sugar levels when necessary
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

Urgent and emergency services

At our most recent unannounced inspection on 2 to 4 July 2019, we followed key lines of enquiry and rated all five key domains; safe, effective, caring, responsive and well led.

On this inspection we visited the emergency department at Darlington Memorial Hospital

We observed care and treatment, looked at 20 complete patient records, 20 medication prescription charts. We also interviewed key members of staff, medical staff, ambulance personnel and the senior management team who were responsible for leadership and oversight of the service. We spoke with 25 patients, five relatives and 42 members of staff.

We observed patient care, the environment within the department, handovers and safety briefings. We also reviewed the hospital's performance data in respect of the emergency department.

Summary of this service

Our rating of this service improved. We rated it as good because:

•At the previous inspection we found that the service did not have enough staff. At this inspection we saw that the service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

•Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

•Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

•The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

•Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However

•Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients.

Is the service safe?

Good ↑

Urgent and emergency services

Our rating of safe improved. We rated it as good because:

•At the previous inspection we found issues with security of the paediatric resuscitation room and accessibility of equipment. At this inspection we saw that all necessary security measures were taken and that all equipment was easily accessible.

•The service provided mandatory training in key skills including the highest level of life support training to all staff. Action plans had been introduced to ensure that all staff completed mandatory training.

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

•The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

•The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

•Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

•Following an incident prior to inspection we saw that there had been a robust response in the development and application of deteriorating patient pathways and with sepsis management. All staff were aware of their responsibilities and understood their roles.

•The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

•Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

•At the previous inspection we found that medicines were not managed appropriately. At this inspection the service used systems and processes to safely prescribe, administer, record and store medicines.

•The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

•The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

•The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

•Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

•Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

•Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

•Key services were available seven days a week to support timely patient care.

•Staff gave patients practical support and advice to lead healthier lives.

•Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

•Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

•Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

•Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

•Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

•Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients. The previous inspection highlighted the need for patients to be seen and transferred or discharged within four hours. From May 2018 to April 2019 the trust failed to meet the national standard related to this.

•From May 2018 to April 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

•No patients waited in excess of 12 hours from the decision to admit until being admitted between May 2018 to April 2019, however, there were large numbers of patients waiting between four and 12 hours.

However:

Urgent and emergency services

•The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

•The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

•It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

•At the previous inspection staff reported a low level of management engagement and did not feel valued. At this inspection staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. We spoke with 42 members of staff and there was a universally positive response in staff engagement and the improving culture within the department. The service had promoted an open culture where patients, their families and staff could raise concerns without fear.

•Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

•The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

•Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

•Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

•The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

•Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

•All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Outstanding practice

See the outstanding practice section above.

Urgent and emergency services

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Surgery

Good  

Key facts and figures

We inspected Darlington Memorial Hospital as part of the comprehensive inspection of Durham and Darlington NHS Foundation Trust which included this hospital and the University Hospital of North Durham. We inspected Darlington Memorial Hospital (DMH) between 2 and 4 July 2019.

At our last inspection, surgical services at Darlington Memorial Hospital received an overall rating of requires improvement, with the key domains rated as requires improvement in safe and well led and good in effective, caring and responsive.

Following our inspection of the service in 2017, requirement notices were issued for surgical services at Darlington Memorial Hospital.

Actions we said the trust MUST take to improve were;

- The trust must ensure that operating theatres are fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.
- The trust must continue to embed the theatres culture review action plan.
- Following never events the trust must ensure that improvements in practice are effectively embedded and maintained.
- The trust must ensure that checks of the difficult intubation trolley in recovery at UHND take place as per trust policy.
- The trust must ensure there is compliance with safeguarding adults and children training where staff are required to have this training.

Actions we said the hospital SHOULD consider taking to improve, were:

- The trust should ensure that equipment is stored in designated areas and boxes of equipment are stored off the floor where appropriate.
- The trust should ensure patient records are complete and staff signatures legible.
- The trust should ensure that protected time is available for theatre staff to attend regular training.
- The trust should assure themselves that relevant staff have access to sepsis training.
- The trust should ensure that patient's discharge plans are completed.
- The trust should ensure increased visibility of the executive team at University Hospital North Durham as staff feedback identified limited visibility on this site in surgery.
- The trust should ensure ongoing engagement from senior management with theatre staff.
- The trust should improve engagement with staff particularly those with protected characteristics.

Surgery

At this inspection we observed care and treatment, reviewed 16 complete patient records (and specific documentation in four others, including consent, mental capacity and deprivation of liberty safeguards documents). We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with nine patients, six relatives and 38 members of staff.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Several areas for improvement had been identified at our previous inspection in 2017. At this inspection we found these had been addressed in full or in part.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. This was an improvement since the last inspection.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Operating theatres were fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). This was an improvement since the last inspection.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Improvements in practice were effectively embedded with continuous development to support continued awareness and learning surrounding serious incidents and never events.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Nurse staffing was managed using recognised tools and professional judgment. To maintain safe staffing levels, the service monitored staffing levels and reviewed these daily using nationally recognised tools alongside clinical judgment.
- The service had enough nursing staff with the right qualifications and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The services were effective because processes were in place to ensure that guidance used by staff complied with national guidance, such as that issued by National Institute for Health and Care Excellence (NICE).
- Staff identified patients at risk of nutritional and dehydration risk or requiring extra assistance at pre-assessment stage. Patients were offered support when required.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed kind and caring interactions on the day units between staff and patients.
- The service had stable management structures in place, with clear lines of responsibility and accountability. We saw evidence of learning, continuous improvement and innovation within surgical services at the location.
- Patients we spoke to felt involved in their care and had been provided with information to allow them to make informed decisions.

Surgery

- The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement of staff, patients, and key groups representing the local community.

However,

- Mandatory training for nursing and medical staff failed to meet the trust target. In surgery, the targets were met for three of the nine mandatory training modules for which qualified nursing staff were eligible and three of the eleven mandatory training modules were met for which medical staff were eligible.
- Medical and nursing staff failed to meet the trust target for safeguarding children training (level 2).
- Medical staff failed to meet the trust target for Mental Capacity Act and Deprivation of Liberty Safeguards (level 2).
- Oxygen was not prescribed or administered in line with national guidance.
- Pain assessments were inconsistently documented for medical patients across the wards we visited. We saw documentation specific to pain assessments were used on some wards and on others we saw evidence of pain recorded within the digital platform.
- The management of obtaining patient consent for the storage of contemporaneous records at the patient's bedside was not robust.
- The service had a higher than expected risk of readmission for elective admissions in general surgery and ear nose and throat and a higher than expected risk of readmission for non-elective admissions in ear nose and throat surgery compared to the England average.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

•The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. Nurse staffing was managed using daily monitoring, acuity tools and professional judgment. This was an improvement since the last inspection.

•The service had suitable premises and equipment and looked after them well. We found the hospital was accessible to wheelchair users, with clear signage.

•The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

•Staff completed and updated risk assessments for each patient and removed or minimised risks.

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

•The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Surgery

•The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

•The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

However;

•Overall, mandatory training compliance did not meet the trust target for both medical and nursing staff. Nursing staff met three of the nine mandatory training modules and medical staff met three of the eleven mandatory training modules for which staff were eligible.

•Nursing and medical staff did not meet the trust target for safeguarding children level 2. Nursing staff achieved 37.7% and medical staff achieved 51% against the trust target of 85%. Although safeguard training was below the trust's internal targets at the time of inspection, the trust told us they had implemented a three-year plan to roll out training to all staff. This was in line with intercollege guidance.

•The service used systems and processes to prescribe, administer, record and store medicines. However, oxygen was not prescribed or recorded in line with national guidance on all wards that we inspected. The service had an ongoing programme of improvement work within the digital platform with respect to oxygen therapy, being overseen by the clinical effectiveness committee.

•The service used systems and processes to manage the storage of patient records. However, the management of obtaining patient consent for the storage of contemporaneous records at the patient's bedside was not consistent.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

•Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental health problems. They used agreed personalised measures that limited patients' liberty.

•Staff of different grades and professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

•Key services were available seven days a week to support timely patient care.

•Staff gave patients practical support and advice to lead healthier lives.

•Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

•Staff monitored the effectiveness of care and treatment through clinical audit. They used the findings to inform practice and improve outcomes for patients.

However;

Surgery

•The service had a higher than expected risk of readmission for elective admissions in general surgery and ear nose and throat and a higher than expected risk of readmission for non-elective admissions in ear nose and throat surgery compared to the England average. The surgery care group recognised the inflated figures were due to a data quality cleansing issue rather than a practice issue and had agreed to address this moving forward.

•Not all nursing staff received appraisals to assess their work performance and promote their professional development. Appraisal compliance for nursing staff did not meet the trust target of 95%. The service recognised that the appraisal rate for nursing staff within the theatre setting required further work; however, there was a detailed plan in place to ensure compliance within this area.

•Mental Capacity Act level 2 and Deprivation of Liberty Safeguards training compliance did not meet the trust target of 33% for medical staff where training compliance was 17%.

•Pain relief was provided as prescribed and there were systems to make sure additional pain relief was accessed through medical staff. Pain control was assessed and well managed and patients were referred to advanced nurse pain specialists if required. However, pain assessments were inconsistently documented. The service was aware of inconsistency and non-compliance and had a plan in place to address this within the digital platform.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

•People were treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.

•People who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with people. They supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

•Staff always empowered people who used the service to have a voice. They showed determination and creativity to overcome obstacles in delivering care. People's individual preferences and needs were reflected in how care was delivered.

•Feedback from people who used the service, those who were close to them, and stakeholders, was continually positive about the way staff treated people. People told us that staff went the extra mile and their care and support exceeded their expectations.

•Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.

•Staff recognised that people need to have access to, and links with, their advocacy and support networks in the community and they supported people to do this.

Is the service responsive?

Good ➔➔

Surgery

Our rating of responsive stayed the same. We rated it as good because:

•The trust planned and provided services in a way that met the needs of local people. Services were tailored to meet the needs of individual people and delivered in a way to ensure flexibility, choice and continuity of care.

•We saw that information leaflets and advice posters were available on the units we visited. These included discharge information, specialist services and general advice about nutrition and hydration.

•People could access the service when they needed it and received the right care promptly. Arrangements to admit, treat and discharge patients were in line with national standards.

•The service took account of patient's individual needs. The services had mechanisms in place to manage access and flow using various methods, including redesigning pathways or carrying out audits, to improve patient flow and working closely with commissioners.

•It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on their feedback.

•The average length of stay for elective and non-elective patients in surgery was lower than the England average.

•The percentage of cancelled operations at the trust showed a similar performance and trend to the England average.

However;

•One speciality was below the England average for admitted referral to treatment times within ophthalmology.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

•Leaders had the skills and ability to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Staff spoke positively about their leaders and felt respected.

•The service had a vision for what it wanted to achieve and a strategy to turn it into action. This had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

•Managers at service level promoted a positive culture through targeted intervention and action planning that supported and valued staff, creating a sense of common purpose based on shared values. Staff reported a positive culture, good team working, and various places in which to receive and share information and concerns. This was an improvement since the last inspection which had been an area of concern.

•The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care, by creating an environment in which excellence in clinical care would flourish. The governance structure was clear, and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports, to maintain quality.

Surgery

•The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

•The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Staff we spoke with felt valued by the service.

However;

•The service did not adhere to national guidance surrounding the prescribing of oxygen; however, the trust was aware of poor audit results and non-compliance and had a plan to address this.

Outstanding practice

See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

End of life care

Outstanding ☆ ↑↑

Key facts and figures

The trust provides end of life care at two sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND). End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death.

Ward staff were supported by the acute specialist palliative care team and acute intervention team across both hospital sites. Both teams also provided support to patients with a life limiting/progressive illness, not limited to those with cancer. Ward staff were able to refer to both teams using the electronic patient database or by telephone.

The trust had 2,032 deaths from February 2018 to January 2019.

This report focuses on the inspection of end of life and palliative care services (medical, nursing, mortuary, chaplaincy and bereavement).

We observed daily practice and viewed patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and also visited the mortuary and the hospital chapel. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke with members of staff, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

•The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

•The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

•The service provided care and treatment based on national guidance and evidence of its effectiveness.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

•The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

•Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

•The service had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

•Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

End of life care

•The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

However:

•Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication'). We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

•The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines. Pain care plans were not completed in all patient records.

•The results of the first round of the 'National Audit of Care at the End of Life' (2019) showed the trust scored lower when compared nationally for documented assessments of nutrition between recognition and time of death and hydration.

•Pain assessments were inconsistently documented for palliative and end of life care patients across wards visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment.

•The end of life and palliative care team did not hold its own risk register, and risks were held on the wider Community Services Risk Register.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

•The service provided mandatory training in key skills and ensured all staff had completed it. Targets were met for four of the five mandatory training modules for which staff were eligible.

•Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

•Mental capacity and best interest assessments were completed appropriately.

•Staff used infection control measures when visiting patients on wards and transporting patients after death.

•Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

•The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

However:

•Syringe driver safety checks were not completed in accordance with trust policy ('Policy for the administration of subcutaneous medication').

•We were not assured training in the specific syringe devices used throughout the trust was followed up or monitored at ward level.

•The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

•Records were not consistently clear and up to date up-to-date or easily available to all staff providing care.

End of life care

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

•The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

•Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

•Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

•Managers used information from audits to improve care and treatment. The palliative care annual report used the results of the national audit of Care at the End of Life (2019) to develop a robust action plan.

•The service made sure staff were competent for their roles. Managers appraised staff's work performance; 100% of end of life staff at the hospital received an appraisal.

•Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

•Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

•The results of the first round of the 'National Audit of Care at the End of Life' (2019) showed the trust scored lower when compared nationally for documented assessments of nutrition between recognition and time of death and hydration.

•Pain assessments were inconsistently documented for palliative and end of life care patients across wards visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment.

•Fluid balance charts were not appropriately completed for patients receiving IV fluids.

Is the service caring?

Good →←

Our rating of caring stayed the same. We rated it as good because:

•Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

•Patients said they knew the plan for their care and where appropriate, had spoken with staff about their preferred place of death. All patients said their care had been good.

•Porters told us they had received moving and handling training on how to sensitively transport a deceased patient to the mortuary.

End of life care

•Bereavement services gave advice on obtaining a death certificate, funeral services, mortuary services and administration procedures.

•Staff always provided emotional support to patients, families and carers to minimise their distress. They always understand patient's personal, cultural and religious needs.

•Renovation work in the mortuary resulted in sensitively decorated rooms and the room for the presentation of the deceased transformed into a welcoming and calming environment.

•Results from the bereaved relatives survey showed families felt that dignity and respect was always provided, they were supported after death and they had received support regarding feelings about illness and death.

However:

•Porters told us that they had not received specific end of life care to support bereaved relatives and carers.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

•The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

•The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting.

•The palliative care team was available five days a week and their role complemented by the acute intervention team in the evenings and at night. At weekends and out of hours a telephone service was available to provide consultant advice and support from a local hospice. Staff were aware of this service and we saw information leaflets on the wards we visited.

•The mortuary management team was accountable for securing services for the deceased throughout the trust and across agency boundaries and had developed a multi-agency mortuary group.

•The trust was working with the local clinical commissioning group (CCG) to improve the creation and delivery of emergency health care plans as well as exploring the use of treatment escalation plans to support individualised care plans.

•The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers

•The trust was continuing to reduce the number and proportion of cardiac resuscitation attempts that could have been avoided with better assessment and care planning.

•Palliative care training fellows were in post providing increased capacity in end of life and palliative medicine and developing future consultants in palliative care.

•There had been an increase in the involvement of end of life and palliative care from for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.

•The trust improved on 'death in usual place of residence' (DIUPR); each year fewer patients were dying in the hospital and better than the England average.

End of life care

•Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

•Palliative care discharge co-ordinators had developed rapid palliative discharge guidance which enabled staff to use available resources for discharge even when the co-ordinators were not on duty.

•The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge.

•Chaplaincy staff supported people's spiritual needs regardless of faith, including the needs of staff.

•The chapel had facilities for many faiths including, amongst others, Christian, Islam (Wuḍūʾ and ablution) and identified the Qibla (the direction that should be faced when a Muslim prays during ṣalāh).

•Patients for end of life and palliative care were identified through a multidisciplinary discussion involving those involved in a patient's care on the ward, either directly with the specialist palliative care team or through the trust's electronic record system.

•The trust 'Audit of Documentation of Care in the Last Hours and Days of Life for Expected Deaths in CDDFT' showed there were high levels of achievement of preferred place of death (PPD).

•The specialist palliative care service had improved personalised care planning and supported preference for place of death for 95% of patients known to the service.

•The number of avoidable cardio pulmonary resuscitation (CPR) attempts had decreased through collaborative working between the cardiac arrest prevention (CAP) team and the palliative care consultant.

•The trust took an average of 23.3 working days to investigate and close complaints in line with the trust complaints policy.

Is the service well-led?

Outstanding ☆ ↑↑

Our rating of well-led improved. We rated it as outstanding because:

•Leaders had the skills, knowledge, experience and integrity to run a service providing high-quality sustainable care.

•The palliative and end of life care team spoke positively about the impetus and motivation the restructuring of end of life care services within the trust had received since our last inspection.

•Staff were well supported in their roles and had a clear understanding of their responsibilities and told us leaders were visible and approachable. Ward staff told us that the specialist end of life and palliative care team were well known, accessible and provided expertise and advice when needed.

•Clinical leadership in the specialist palliative care service had been strengthened by the appointment of new consultants.

•Senior clinicians had engaged with other non-palliative teams (within and outside the organisation) to enhance the understanding of end of life and palliative care and supported improvements in the service for patients and families.

•The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement.

End of life care

•The service had a strategy in place for providing end of life care which aimed to implement improvements identified by national audit and recommendations from regulators to improve care for patients and families. The trust vision, strategy and work plan were based upon the national 'Palliative and End of Life Partnership' framework.

•All staff in palliative and end of life care services were positive about the leadership, strategy and organization of end of life and palliative care services at the hospital and throughout the trust. There was recognition that the trust had made improvements to end of life and palliative care since our previous inspection.

•Staff working in the mortuary and bereavement services had positive attitudes to their role and respected the service they gave to families and carers at a sensitive time.

•Porters had received training in moving and handling deceased patients and had developed good relationships with ward and mortuary staff to ensure the deceased patient was moved with respect and dignity.

•There was a governance structure in place with processes and systems of accountability to support a sustainable service.

•The trust had developed a specific dashboard for recording end of life and palliative care patient information and the content reflected preferred place of care (PPC) and preferred place of death (PPD).

•Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

•The trust had used the national VOICES postal questionnaire of bereaved relatives to understand about people's experience of end of life care and had conducted a local survey to provide more specific results.

•The palliative care service had made changes in response to patient and relatives' feedback.

•Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However:

•The end of life and palliative care team did not hold its own risk register, and risks were held on the wider patient services register.

Outstanding practice

See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Sarah Dronsfield, Head of Hospital Inspection chaired this inspection and Ruth Sadler, Inspection Manager led it. An executive reviewer, Rachel Charlton, supported our inspection of well-led for the trust overall.

The team included one further inspection manager, 10 inspectors, two assistant inspectors, one inspection planner and seven specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

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NHS
County Durham and Darlington
NHS Foundation Trust

CDDFT achieves 'Good' CQC rating

17th January 2019

Sue Jacques
Chief Executive

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Contents

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County Durham and Darlington
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- Inspection regime
- Previous position
- Inspection coverage 2019
- Outcomes
- Key actions & findings

Care Quality Commission

County Durham and Darlington NHS Foundation Trust

The CQC is the independent regulator of all health and social care services in England. They are given powers by the government to regulate, monitor and inspect all health and care services. The CQC inspect based on core services which for CDDFT are;

Acute

- Medical Care
- Surgery
- Critical Care
- Maternity
- Children and young people
- End of life Care
- Urgent and emergency care
- Outpatients

Community

- Community health services for adults
- Community health inpatient service
- Community health services for children and young people
- Community end of life care

Additional services

- Gynaecology
- Diagnostic Imaging

CQC 5 domains

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They inspect these services against five domains :

Domain	Summary objective
Safe	People are protected from abuse and avoidable harm
Effective	People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
Caring	The service involves and treats people with compassion, kindness, dignity and respect
Responsive	Services meet people's needs
Well led	Leadership, management and governance of the organisation assure the delivery of high-quality person centred care, support learning and innovation, and promote an open and fair culture.

Previous position

- Community Services rated Good
- DMH rated Requires Improvement
- UHND rated Requires Improvement
- Overall Trust rating 'Requires Improvement'

Ratings for University Hospital of North Durham

	Safe	Efective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement → ← Mar 2018	Good ↑ Mar 2018	Requires Improvement → ← Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Requires Improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good ↑ Mar 2018
Surgery	Requires Improvement ↓ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement ↓ Mar 2018	Requires Improvement ↓ Mar 2018
Critical care	Requires Improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires Improvement Sept 2015	Requires Improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires Improvement Sept 2015	Requires Improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires Improvement → ← Mar 2018	Requires Improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement → ← Mar 2018	Requires Improvement → ← Mar 2018

Ratings for Darlington Memorial Hospital

	Safe	Efective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement → ← Mar 2018	Good ↑ Mar 2018	Requires Improvement → ← Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018
Surgery	Requires Improvement ↓ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement ↓ Mar 2018	Requires Improvement ↓ Mar 2018
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires Improvement Sept 2015	Requires Improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires Improvement Sept 2015	Requires Improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires Improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires Improvement → ← Mar 2018	Requires Improvement → ← Mar 2018

Ratings for community health services

	Safe	Efective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community end of life care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires Improvement Sept 2015	Good Sept 2015
Urgent care	Requires Improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

Coverage - 2019

NHS
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- Unannounced inspections of:
  - End of Life Care
  - Urgent and Emergency Care (A&E)
  - Surgery

- Three day Trust-level 'Well-Led' assessment
- Separate 'Use of Resources' assessment

UHND

NHS
County Durham and Darlington
NHS Foundation Trust

Ratings for University Hospital of North Durham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019
Medical care (including older people's care)	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

1. All services good except A&E (same as 2017)
2. End of Life Care now Outstanding
3. Surgery now Good
4. Critical care and Medicine not inspected
5. **Overall rating for site = Good**

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Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

1. All services good
2. End of Life Care now Outstanding
3. Surgery now Good
4. **Overall rating for site = Good, same for all Domains**

Community Services

County Durham and Darlington NHS Foundation Trust

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community end of life care	Good Sept 2015	Good Sept	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015
Community urgent care service	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

1. Not inspected
2. Ratings as 2015
3. Trust self-assessment is that there is some outstanding practice to recognise here

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Sites and Trust ratings

County Durham and Darlington NHS Foundation Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
University Hospital of North Durham	Requires improvement ➔➔ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Darlington Memorial Hospital	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Overall trust	Requires improvement ➔➔ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019
Community	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Oct 2019	Good ↑ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ➔➔ Oct 2019	Good ↑ Oct 2019

1. Good at all levels
2. Safe Domain is RI because 1 out of 3 sites has RI (UHND)
3. Well-Led rating for the Trust is from the 3 day assessment not aggregated by sites
4. Use of resources rating (separate) is also Good

Thanking #TeamCDDFT

Other findings – Outstanding Practice

NHS
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NHS Foundation Trust

20 areas of outstanding practice

- End of Life Care
- Surgery
- Emergency Department

"The Trust provided the highest level of end of life and palliative care involvement to dying patients in the region."

"The acute intervention team is an innovative service proving assessment and input to critically ill patients in acute hospitals with the recognition that many of these patients will have palliative care needs."

"The specialist palliative care service has improved personalised care planning and supported preference for place of death for 95% of patients."

"For quarters one to four in 2018/19 the emergency department consistently achieved 100% for sepsis screening. The percentage of patients given antibiotics within an hour had increased from 55% to 93%."

Other findings – Outstanding Practice

NHS
County Durham and Darlington
NHS Foundation Trust

"The surgical nursing preceptorship support programme has developed to be a national leader in support and preceptorship to help sustain and improve recruitment, retention and staff satisfaction."

"Getting it right first time (GIRFT) visits commended elective orthopaedics and aspects of ophthalmology.

"The national emergency laparotomy audit (NELA) results were ahead of average on a number of indicators and the Durham multi-disciplinary team functional bowel service is an award winning nationally recognised service."

"The Trust was among the very best performers nationally for the NELA audit with respect to elderly care review."

Other findings

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- Nine ‘Must Do’ actions (improvement notices)
- 23 ‘Should Do’ actions (recommendations for improvement)

- Action Plans in place and work already in progress

Must Do Actions

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- Fit and Proper Persons Test to cover all statutory requirements
- Increase the coverage of training in MCA / DOLS
- Ensure compliance with training targets for the above
- Ensure consistent compliance with policy for syringe driver checks
- Ensure consistent compliance with policy for pain assessments / action (end of life care)
- Ensure safe and secure storage of medicines in all areas
- Continue to strengthen paediatric nursing and medical staffing in A&E Departments
- Ensure consistent compliance for Oxygen prescribing with BTS recommendations
- Ensure the availability of paediatrics-trained clinicians for children streamed away from the A&E Department

Questions

NHS
County Durham and Darlington
NHS Foundation Trust

Adults Wellbeing and Health Overview and Scrutiny Committee

17 January 2020

Draft Joint Health and Wellbeing Strategy 2020-2025

Ordinary Decision

Report of Jane Robinson, Corporate Director Adult and Health Services, Durham County Council and Amanda Healy, Director of Public Health, Durham County Council

Electoral division affected:

Countywide

Purpose of the Report

1 The purpose of this report is to present the draft Joint Health and Wellbeing Strategy (JHWS) 2020-2025 for comment and advise the committee that a presentation will be delivered at the meeting on 17 January 2020. The draft strategy is attached as Appendix 2.

Executive summary

2 The JHWS is a legal requirement under the Health and Social Care Act 2012, to ensure health and social care agencies work together to agree services and initiatives which should be prioritised.

3 The Health and Wellbeing Board has the responsibility to deliver the JHWS, which is informed by the Joint Strategic Needs Assessment (JSNA), as part of Durham Insight, which is an assessment of the current and future health, wellbeing and social care needs of residents in County Durham.

4 The current strategy runs until the end of 2019 and therefore a new strategy is required to meet this duty. An interim strategy will provide a holding position for a year while a strategic governance review of partnerships is undertaken, linked to the new County Durham Vision 2035 which was agreed by the County Durham Partnership as our shared vision for the next 15 years under the following three strategic ambitions:

(a) More and better jobs

(b) People live long and independent lives

(c) Connected communities.

5 The JHWS has also been aligned to the Director of Public Health Annual Report 2018, the developing Five Year Health and Care System Plan and the North East and North Cumbria Integrated Care System/Plan.

Recommendation(s)

6 Members of Adults Wellbeing and Health Overview and Scrutiny Committee are recommended to:

(a) Receive a presentation at the meeting 17 January 2020

(b) Provide comment on the draft Joint Health and Wellbeing Strategy to andrea.petty@durham.gov.uk or julie.bradbrook@durham.gov.uk by 14 February 2020.

Background

7 The development of the JHWS has been aligned to the new County Durham Vison 2035, which is a document developed with partners as a shared vision for the next 15 years with the following three strategic ambitions:

(a) More and better jobs

(b) People live long and independent lives

(c) Connected communities

8 The JHWS will take forward aspects of the vision that are focussed on the health and wellbeing of residents of County Durham and will contribute to other areas, working in partnership with other strategic partnership boards.

9 Work has taken place through a strategy development group (comprising of representatives from Durham County Council, Public Health and Culture and Leisure, Harrogate and District NHS Foundation Trust, Clinical Commissioning Groups, County Durham and Darlington Fire and Rescue service and Area Action Partnerships) to ensure that the JHWS is fit for purpose and reflects the work being undertaken in partnership by organisations across the county.

Joint Health and Wellbeing Strategy

10 The vision for the Health and Wellbeing Board is agreed as ***'County Durham is a healthy place, where people live well for longer'.***

11 Following discussion at the development session on 14 November 2019 and discussion at the HWB meeting on 27 November 2019 agreement has been made to reduce the strategic priorities to three.

12 As there are major differences in the health that people experience and differences between the health of local people and those across England, the Board will also ensure mental health and social determinants of health are cross cutting themes throughout the strategy, because of the impact they can have on people's health and wellbeing. These include the environment in which people live, access to a good education, housing, the food people eat, money and resources, family, friends and communities and good work.

13 The proposed three strategic priorities will be reframed as follows:

(a) Starting Well: This starts with a baby's mother being healthy before and during pregnancy as well as the experiences that children have early in their life, as these play a key part in their health as adults.

(b) Living Well: Having good jobs, health promoting environments, quality housing, active travel opportunities, and optimum mental health all have a positive influence on people's overall health and wellbeing and improve our chances of remining healthy and well during adulthood and into older adulthood.

(c) Ageing Well: The length of life of local people continues to rise, and we want to work to ensure that the number of years that people live healthy, independent lives increases too. We will also ensure that when the time comes, people receive good quality end of life care and have a good death.

14 Six objectives have also been chosen across the three strategic priorities, that are of importance given the impact they have on people's health and of where we want to be in 2025. It is recognised that these are challenging, but by working together across our partnerships and local communities we can make a difference:

(a) Improve healthy life expectancy and reduce the gap within County Durham and between County Durham and England

(b) We will have a smoke free environment with over 95% of our residents not smoking and an ambition that no child will be born to a mother who smokes

(c) Close the gap in the employment rate between those living with a long-term health condition, learning disability, in contact with secondary mental health services and the overall employment rate

(d) Over 90% of our children aged 4-5 years, and 79% of children aged 10-11 years are of a healthy weight

(e) Improved self-reported wellbeing

(f) Increase the number of organisations involved in Better Health at Work Award

15 In addition, a number of milestones are included in the JHWS to identify the changes we expect to see each year in a number of performance areas.

16 Work will take place with relevant performance leads as part of the strategy development group meetings to ensure that key performance indicators are identified to ensure realistic, but challenging measures are in place. The aim is to streamline the previous arrangements so there is focus for the Board on those performance issues that are the hardest to address. Regular updates will be provided to the Health and Wellbeing Board as part of its work programme.

17 An Equality Impact Assessment (EIA) is being undertaken alongside the development of the JHWS.

Consultation

18 Work has taken place with partners to develop the JHWS, and the draft strategy has been shared within individual partner organisations.

19 The following have, or will be utilised to provide comment, prior to sign off of the JHWS at the Health and Wellbeing Board in March 2020:

a) Wider consultation via the Durham County Council website from **17 December 2019 to 14 February 2020**. Consultation will take place with a number of groups and fora including the Area Action Partnerships, Better Together Forum, Armed Forces Forum, Local Councils Working Group, Investing in Children and the Learning Disabilities Parliament. Public Health colleagues will also be instrumental in this consultation work

b) Children and Young People's Overview and Scrutiny Committee **13 January 2020**

c) Final sign off of the JHWS will take place at the Health and Wellbeing Board's meeting on **11 March 2020.**

Conclusion

20 The development of the Joint Health and Wellbeing Strategy has been led by a partnership group. The Strategy has been informed by the Joint Strategic Needs Assessment which provides the evidence base on which the priorities have been developed. The JHWS is also aligned to the County Durham Vision 2035 and will be the delivery mechanism for some of the ambitions in the vision, particularly relating to living long and independent lives. Further work will take place with the Health and Wellbeing Board and with partners to develop the Strategy prior to agreement in March 2020.

Author(s)
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Appendix 1: Implications

Legal Implications
The Health and Social Care Act 2012 places clear duties on local authorities and Clinical Commissioning Groups (CCGs) to prepare a JHWS. The JHWS is based on evidence in the JSNA.

Finance
Ongoing pressure on the public services will challenge all agencies to consider how best to ensure effective services are delivered in the most efficient way. The demographic profile of the County in terms of both an ageing and projected increase in population will present future budget pressures to the County Council and NHS partners for the commissioning of health and social care services.

Consultation
Details of consultation are provided in the report.

Equality and Diversity / Public Sector Equality Duty
An EIA will be undertaken alongside the development of the JHWS

Climate Change
There are no climate change implications

Human Rights
There are no adverse implications

Crime and Disorder
The JHWS is aligned with and contributes to the current priorities within the Safe Durham Partnership Plan which focuses on crime and disorder.

Staffing
There are no staffing implications.

Accommodation
There are no accommodation implications

Risk
There are no risk implications

Procurement
The Health and Social Care Act 2012 outlines that commissioners should take regard of the JHWS when exercising their functions in relation to the commissioning of health and social care services.

Appendix 2: Draft Joint Health and Wellbeing Strategy

Attached as a separate document

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DRAFT
Joint Health and Wellbeing Strategy

2020 – 2025
(a review will take place in 2021)

Contents

Foreword

Welcome to the County Durham Health and Wellbeing Board's fifth Joint Health and Wellbeing Strategy.

The Health and Social Care Act 2012 required all upper tier local authorities to establish Health and Wellbeing Boards. The County Durham Health and Wellbeing Board was formally established as a committee of Durham County Council in April 2013.

As Chair and Vice Chair we are pleased to say that the Board have had a successful year, having worked to improve people's health and reduce health inequalities across the county. We have delivered on the six priorities in the JHWS 2016-19, and achievements aligned to these include:

- Increased number of businesses signing up to the county's Breastfeeding Friendly scheme
- Continuing downward trends in under 18 conceptions
- Introduction of the 'Active 30' programme in schools
- Delivery of the Youth Aware of Mental Health programme to secondary school pupils to help them cope with anxiety, depression and encourage them to make healthy lifestyle choices
- Delivering the Prevention at scale pilot, which focuses on mental health
- Significant reductions in smoking prevalence across the county
- Increased take up of screening for breast, cervical and bowel cancer
- Good performance in preventing delayed transfers of care from hospital
- Good proportion of people using social care saying that they have enough choice and control over the care and services they receive
- Further development of 'Dementia Friendly Communities'
- Development of the three-year Pharmaceutical Needs Assessment (PNA), which considers the health needs of the population and the provision of pharmaceutical services.

Moving forward, we continue to be supported by partners to deliver our vision to ensure County Durham is a healthy place, where people live well for longer.

Councillor Lucy Hovvels MBE

Chair of the Health and Wellbeing Board
Cabinet Portfolio Holder for Adult and Health Services

Dr Stewart Findlay

Vice Chair of the Health and Wellbeing Board
Chief Officer, North Durham and Durham Dales, Easington & Sedgefield Clinical Commissioning Group

What is the Health and Wellbeing Board?

Health and Wellbeing Boards were established under the Health and Social Care Act 2012. This legislation gives the County Durham Health and Wellbeing Board specific functions as follows:

- To develop a Joint Strategic Needs Assessment (JSNA), which provides an overview of the current and future health and wellbeing needs of the people of County Durham;
- To develop a Joint Health and Wellbeing Strategy (JHWS), which is based on evidence in the Joint Strategic Needs Assessment;
- A responsibility and duty to encourage integrated working between commissioners of health services, public health and social care services, for the purposes of advancing the health and wellbeing of the people in its area;
- Power to encourage those who provide services related to social determinants of health to work closely with the Health and Wellbeing Board;
- To produce a Pharmaceutical Needs Assessment which looks at the current provision of pharmacy services across County Durham, and whether there are any potential gaps to service delivery.

County Durham Vision 2035

The County Durham Vision 2035 is a document developed with partners to provide a shared understanding of what everyone wants our county to look like in 15 years' time. It provides strategic direction and enables us to work more closely together, removing organisational boundaries and co-delivering services for the benefit of our residents.

The County Durham Vision 2035 contains three strategic ambitions to develop County Durham over the next 15 years:

- More and Better jobs
- People live long and independent lives
- Connected communities

The Joint Health and Wellbeing Strategy priorities were developed ahead of the County Durham Vision. The JHWS will have a rapid review after a year to ensure full alignment with the County Durham Vision implementation and the partnership review. This will ensure that the priorities set out in the Joint Health and Wellbeing Strategy are fully embedded with the refreshed partnerships and delivery plan of the vision.

The Health and Wellbeing Board's vision is underpinned by the JSNA and is:

'County Durham is a healthy place, where people live well for longer'

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) helps to inform the planning and improvement of local services and guides us in making the best use of funding available. It builds a picture of current and future health and wellbeing needs of local people. This is used to shape joint commissioning priorities to improve health and wellbeing as well as reduce health inequalities in our communities. Over the last year our JSNA has been transformed to create a tool that is fit for the future and rooted in intelligence and wider evidence about what drives health and wellbeing across the county.

The development of assets within the JSNA is a key priority. By focussing only on the "needs" of local communities we do not acknowledge the importance of the assets or take account of the protective factors and strength within individuals and across communities. This should incorporate practical skills, capacity and knowledge of residents and the networks and connections in a community. In short it should cover:

- Where we live
- Our Services
- Our community

The JSNA is now part of Durham Insight which is a shared intelligence, research and knowledge base for County Durham, informing strategic planning across Durham County Council and its partners. This site includes in depth JSNA and Insight factsheets, health needs assessments, health equity audits and lots of topic-based intelligence including infographics, maps and story maps. New intelligence content is regularly added, and the site is continuously being developed and improved. www.durhaminsight.info

During 2019 recent additions to Durham Insight include JSNA factsheets on Special Educational Needs and Disabilities (SEND), and Children Looked After (CLA) plus the development of a vulnerable children's landing page and infographics to support our new Primary Care Networks (PCNs).

The JSNA, along with the use of evidence and local conversations, helps us to focus on the most important issues for our communities across County Durham.

Durham Insight
Insight & intelligence to inform

Building on our assets

County Durham has many assets that can support and protect health, some of these are set out below.

*A Cree is County Durham's version of Australia's Men's Shed. Crees aim to engage with those at risk of suicide by tackling social isolation and self-harm through skill-sharing and informal learning to promote social interaction. Although Crees were originally aimed at men, some have developed for women and young people.

Evidence for our strategic priorities

Data and intelligence had been coupled with the evidence base and knowledge of local circumstances to prioritise the key areas of focus in the strategy.

Where are we in 2020?

The key health and factors which impact on health have been drawn out from the JSNA and utilised to inform the priorities for the Joint Health and Wellbeing Strategy.

This has been coupled with the major policy drivers for improving health and reducing health inequalities:

- Marmot Fair Society Healthy Lives
- NHS Long Term Plan
- Prevention Green Paper
- Future in Mind

Our strategy follows a lifecourse approach and is focussed not only on extending the length of life, but quality of life and reducing differences in health outcomes for our local residents.

Across County Durham there are major differences in the health that people experience and there remains differences between the health of local people and those across England. The JHWS is seeking to work with people to change these outcomes. The solutions to these differences are not to be found within health and care services alone and many other factors have an influence on people's health and wellbeing. These include the environment in which people live, access to a good education, housing, the food people eat, money and resources, family, friends and communities and good work. These are often called the social determinants of health.

These differences are unjust and unfair, and the Health and Wellbeing Board is committed to making a difference. The Board recognises that many of the social determinants of health require close working with key partners across County Durham who have responsibility for housing, schools and of course with our local communities.

One in four adults experience at least one diagnosable mental health problem every year and mental health problems represent the largest single cause of disability in the UK.

Mental health can have an impact on the quality of life, ability to work and sickness levels at work. Good mental health can also be a protective factor for good health in general. The scale of the issue and its impact on individuals, communities, economy and services is why mental health is an important cross cutting issue for the Health and Wellbeing Board throughout all our priorities.

Achieving our objectives will rely on close working with a range of partners over the length of this strategy and beyond and in support of the County Durham Vision 2035.

Our Strategic Priorities

The Health and Wellbeing Board adopts a lifecourse approach to its priorities, recognising the importance of mental health and wellbeing and the social determinants of health cutting across all our priorities. These priorities are:

- Starting Well
- Living Well
- Ageing Well

Starting Well

The experiences that children have early in their life play a key part in their health as adults. In County Durham, it is estimated that 1 in 10 (over 10,000) children have a mental health disorder and that a quarter of adults will experience at least one diagnosable mental health problem in their lifetime.

While we have made progress in recent years in providing opportunities for our children including a good level of development by the end of reception, reduction in teenage conceptions and levels of smoking our overall outcomes for children should and can be improved. This is even more so for children facing significant disadvantage or challenge.

The Health and Wellbeing Board will work closely with children and young people to ensure they start well and reduce health inequalities for children and their families.

Living Well

We know that a good job, health promoting environment, quality housing and opportunities for active travel, as well as ensuring our communities have optimum mental health and wellbeing, have a positive influence on our overall health and wellbeing.

Good work is vital for people's health and wellbeing, impacting both directly and indirectly on the individual, their families and communities. Healthier, active and engaged employees are more productive and have lower levels of sickness absence. We know that almost 19% of sickness absence is due to mental health and over 15 million days are lost to depression every year nationally, and local people who have significant health issues need support to overcome the barriers they face to accessing and retaining work. The gap in the employment rate between those with a long-term health condition and the overall employment rate is 19.5% which is significantly worse than England and increasing over time.

Having access to a warm, comfortable place to live; our work and financial situation; and staying active make a difference to our chances of remaining healthy and well during this time of life and into older adulthood.

The Health and Wellbeing Board is committed to shaping a healthy place which is smoke free, supportive of a healthy weight and gives access to physical activity opportunities with good homes.

Health and Wellbeing

Starting Well

78.3 81.4

Life expectancy at birth

Boys and girls born today can expect to live to **59** years old in good health.

There is an **increasing** number of children who are overweight or obese.

1 in **4** reception children and **1** in **3** Year 6 children have excess weight.

Nearly **18%** of mothers smoke while they are pregnant.

That's around **900** babes are born to mothers who smoke.

Living Well

1 in **4** adults experiences at least one diagnosable mental health problem in their lifetime…

1 in **10** children have a mental health disorder.

…that's over **100,000** adults in County Durham.

47% of our population live in the 30% most deprived areas nationally..

For children this rises to **54%**.

Ageing Well

Over **17,000** people are supported by adult social care services provided by the Council

…and **90.1%** reported that their care and support services helped them have control over daily life.

1 in **20** people over 65 are recorded as having dementia.

The average age at which people are admitted to permanent residential care has **increased** by nearly **2** years over the last decade.

2 out of **3** social care users are satisfied with their care

There are fewer people than ever *smoking*, but *obesity* rates continue to rise.

2 in **3** adults are overweight or obese

Smoking prevalence has reduced to **15%**.

Ageing Well

While the length of life of local people continues to increase, the years that people can expect to live a healthy life sees significant differences across County Durham. The gap between the most deprived and least deprived areas within County Durham is 8.1 years for men and 6.9 years for women. This coupled with an ageing population and people living with a range of health conditions can affect people's ability to work and contribute to their communities and has an impact on our health and care services.

For some people, later life can be marked by disability, dependency and inequality rather than offering opportunities to continue leading a healthy and active life. The experience of later life is therefore deeply divided, especially along the lines of social class, relative deprivation, gender and ethnicity. These factors are strongly associated with the socio-economic conditions that shape earlier life, low income, or lack of supportive social networks. Long term ill health tends to be associated with later life and, as a result of population ageing, the need for health services is increasingly shifting from short-term, curative treatment to managing long-term conditions. The good news is that many of these conditions are preventable or at least can be delayed, through delivering on the priorities set out in this strategy, and by better shaping care and support around people and what matters to them.

We will also target approaches which enable our older people to remain independent and to lead lives with meaning and purpose and will ensure that when the time comes, people receive good quality end of life care and have a good death.

Alignment with other key strategic plans

The County Durham Health and Wellbeing Board takes a 'whole-system' approach to the health and wellbeing of our communities which requires coordination and collaboration across a wide variety of sectors. It is important that our priorities align to other plans to ensure our actions are delivered to meet the need of our local communities. Partners working across County Durham have developed a five-year County Durham Health and Wellbeing System Plan which identifies key programmes of work over the next five years for health and social care services. This provides the delivery plan for the health and care aspects of the JHWS

The County Durham 5-year Health and Wellbeing System plan is part of an Integrated Care Partnership which covers County Durham, Sunderland and South Tyneside which in turn is part of an Integrated Care System which covers the whole of the North East and Cumbria. This geography is shown at Figure 1.

An integrated health and social care system has an important role to play in terms of early intervention by preventing or reducing needs from deteriorating by providing the right care at the right time in the community and putting more people in control of their health; supporting the whole person, across mental and physical health and not just treating symptoms.

County Durham, our 'place', has primacy and will be where the majority of services will continue to be commissioned, planned and delivered, whilst also recognising that we will

work together with our neighbours at scale where this genuinely adds value. The JHWS is about long-term health improvement and reducing health inequalities including the social determinants.

Please refer to Appendix 1 to see how the Joint Health and Wellbeing Strategy aligns to other plans.

Figure 1: Geographies - Integrated Care System, Integrated Care Partnership, Place based and Primary Care Networks

Our objectives

We have chosen six objectives across our three strategic priorities, that are of importance given the impact they have on people's health and of where we want to be in 2025. We recognise these are challenging but by working together across our partnerships and local communities we can make a difference.

- Improve healthy life expectancy and reduce the gap within County Durham and between County Durham and England
- We will have a smoke free environment with over 95% of our residents not smoking and an ambition that no child will be born to a mother who smokes
- Close the gap in the employment rate between those living with a long-term health condition, learning disability, in contact with secondary mental health services and the overall employment rate
- Over 90% of our children aged 4-5 years, and 79% of children aged 10-11 years are of a healthy weight
- Improved self-reported wellbeing
- Increase the number of organisations involved in Better Health at Work Award

What changes can you expect to see?

Our ultimate goal is reducing the gap in healthy life expectancy within County Durham and between County Durham and England. This Strategy is focused on the foundations for achieving that goal. We have set out a number of changes you can expect to see throughout the course of this strategy to set the foundations for achieving this.

By 2022:

- Increase in breastfeeding friendly venues and organisational workplaces across County Durham that meet UNICEF Baby friendly Initiative Standards
- Increasing the equity of cancer screening programmes
- 10% reduction in suicides
- More businesses signing the Time to Change pledge to reduce mental health stigma and discrimination
- Increased referrals and adaptations done by the warm and healthy homes programme

By 2023:

- A reduction/downward trend in hospital admissions of children under 2 years of age, due to unintentional injuries
- Increase in patients seen with face to face second contact within 9 weeks of referral to CAMHS
- Fewer applications for takeaways near schools
- More businesses signing up to the Better Health at Work Award to improve health interventions at work
- More adult carers having carers assessments

By 2024:

- Child development outcomes at age 2 to 2.5 years will be 90%
- Increase in the number of physical health checks for those people with a mental health condition or a learning disability
- More mental health champions across workplaces
- Reduce the under 75 mortality rates from preventable cancers and a reduction in the size of the gap in preventable cancer mortality between County Durham and England

By 2025:

- Improve healthy life expectancy and reduce the gap within County Durham and between County Durham and England
- We will have a smoke free environment with over 95% of our residents not smoking and an ambition that no child will be born to a mother who smokes
- Close the gap in the employment rate between those living with a long-term health condition, learning disability, in contact with secondary mental health services and the overall employment rate
- Over 90% of our children aged 4-5 years, and 79% of children aged 10-11 years are of a healthy weight
- Improved Self-reported wellbeing
- Increase the number of organisations involved in the Better Health at Work Award

Approach to Wellbeing

There are many definitions of wellbeing, but in short it can be described as *'how well we are doing'* or *'how satisfied we are with our lives'*. As well as health, measures of wellbeing include our relationships; our work and finances; our levels of participation in sport, culture and community events, where we live and how safe we feel; and the services we can access. Wellbeing is starting to be an equivalent measure to economic growth, ensuring that we consider these important factors in people's lives alongside factors influencing economic development.

Wider influences such as finances, home, education, and environment can all have an impact on the health of our communities. However, communities also possess a number of assets available to them that help maintain and build their resilience and which in turn can protect challenges to their health or wellbeing.

Initiatives intended to encourage inclusive growth and improvements in wellbeing are founded on the engagement of communities and the devolution of power. County Durham has been at the vanguard in developing such approaches, engaging communities and sharing decision making through Area Action Partnerships. These have been operating since 2009, originally designed to give people a voice in how local services are provided. We know that this can make a difference and can build on these to close the gap and not leave people behind.

This approach to wellbeing is a key way of implementing the County Durham Vision and we will deliver this strategy together with our communities. We will operate to the following principles of working in order to improve the wellbeing of our residents:

- Solutions will be designed and produced together with service users
- We will work with communities and support their development and empowerment
- We will acknowledge the differing needs of our communities whilst acknowledging and building on their potential strengths
- We will direct our activities where they can make the biggest difference to those who are most vulnerable and help to build resilience
- We will make person centred interventions available, ensuring that they are empowering and not stigmatising
- We will align our related strategies, policies and services to reduce duplication and ensure greater impact.

Figure 2: Approach to Wellbeing

People and Places	Supporting Systems
Empowering communities working with communities to support their development and empowerment	**Working better together** working together across sectors to reduce duplication and ensure greater impact
Being asset focused acknowledging the different needs of communities and the potential of their assets	**Sharing decision making** designing and developing services with the people who need them
Building resilience helping the most disadvantaged and vulnerable, and building up their future resilience	**Doing with, not to** making our health and care interventions, empowering and centred around you as an individual.
Using what works: everything we do is supported by evidence informed by local conversations.	

Strategic priority 1: Starting Well

Why is this important?

Starting well begins with a baby's mother being healthy before and during pregnancy. There is a lasting impact in future years from what happens in the early years of a child's life.

Childhood is the springboard to a successful adulthood. It is the foundation on which our lives are built. We will provide the best support to expectant mothers and mothers of new born babies and their children. For our more vulnerable children and families we will provide a more targeted offer of support and reduce inequalities in outcomes. Our children and young people with Special Educational Needs and Disabilities will achieve the best possible outcomes.

Better outcomes for children cannot be achieved through health and social care service improvement in isolation. How children live, learn and play are all key drivers of healthy development. Parenting is critical to a child's development and evidence shows children who are exposed to adverse events such as domestic abuse or alcohol misuse can be affected negatively, both physically and mentally, throughout their adolescence and into adult life. Education, housing, community connections, employment and poverty all determine whether a child will be more likely to thrive and achieve their optimum potential in life.

We will improve health and wellbeing outcomes for all children and young people and help children and their families achieve and maintain their optimum mental health, resilience and wellbeing.

In addition to the direct feedback on health issues from young people to the Health and Wellbeing Board, we will look to coproduce work with young people and their families, for example in relation to mental health services.

The Children and Young People's Strategy provides focus and clarity on the priorities for improving services and life opportunities for children and young people. The Health and Wellbeing Board will provide strategic oversight to ensure that improved health and wellbeing outcomes of our children is delivered within this strategy, including reducing unacceptable inequalities, which our more vulnerable children encounter like unintentional injuries in the home or being an unhealthy weight.

Starting Well

People and Place

In 2018, an estimated population of just over **106,000** children

** 0-18*

140 Low birth weight babies.

4,868 live births

Around **900** babes are born to mothers who smoke.

Nearly **1 in 5** women were smoking at time of delivery.

78.3 81.4

Life expectancy at birth

Nearly **1 in 3** mums are breastfeeding at 6-8 weeks after birth.

Health and Wellbeing

3 in 4 5 year olds are free from tooth decay.

Hospital admissions caused by unintentional injuries in 0-4 year olds is ***significantly higher*** than England.

1 in 4 4 - 5 year olds are in excess weight.

The rate of teenage conceptions has decreased by **45%** since 2010.

Education

There are nearly 80,000 children of school age in County Durham.

** 5-18*

6% of 16-17 years are not in education, employment or training.

9 out of 10 children are achieving a good level of development at 2 -2 ½ years old.

7 out of 10 children are achieving a good evel of development at the end of reception

Vulnerable Children

As at March 2019 there were **800** children looked after in County Durham.

Nearly **1 in 5** children are living in the top *10% most deprived* areas nationally.

Hospital admissions (10-14 years) as a result of self-harm is *similar to England.*

1 in 10 children have a mental health disorder.

Starting Well: This priority covers the early years of life from conception to young adulthood and includes pregnancy, birth, and childhood

- Improve the quality, responsiveness and equity of access to our services to meet the needs of all children and young people, including those who have special educational needs and disabilities, by considering their family and community
- Identify perinatal mental health issues during the antenatal period and embedded pathways for support into practice
- Develop the national trailblazer for mental health support teams in identified schools
- Work within Education, Children's Services and universal health services to improve the workforce's ability to understand mental health, and where appropriate undertake a brief intervention and signpost or refer accordingly.
- Support women to achieve a smoke free pregnancy through whole system change and tackling tobacco dependency in pregnancy as an addiction not a lifestyle choice
- Support spatial policy and regeneration programmes which aim to improve health and reduce health inequalities
- Develop the Health and Wellbeing Framework for schools/settings to improve the health of children
- Increase the percentage of women who initiate breastfeeding and continue at 6-8 weeks through the County Durham 'Call to Action' to change the culture of breastfeeding in our county, whilst maintaining our Growing Healthy Service UNICEF Gold Baby Friendly Accreditation
- Develop a countywide offer around physical activity and good nutrition to address the issues of holiday activities specifically targeting vulnerable communities and health inequalities
- Reduce unintentional injuries in the 0-19 population, through the County Durham Prevention of Unintentional Injuries Framework 0-19
- Consider a range of population approaches to improving children's oral health across County Durham including community water fluoridation
- Increase the roll out in schools of 'poverty proofing the school day' which includes cutting the cost of the schools' day
- Support the effective transition of identified vulnerable young people aged 14+ towards adulthood and their transition to adult services where required

Delivery plan mechanisms:	1. Best Start in Life Steering Group action plan 2. County Durham Tobacco dependency in Pregnancy steering group action plan 3. Children and Young People Mental Health, Emotional Wellbeing and Resilience Local Transformation Plan	4. Special Educational Needs and Disabilities Strategic Partnership written statement of action 5. Oral Health Framework 6. Unintentional Injuries Framework 7. Healthy Weight Alliance Framework

Strategic priority 2: Living Well

Why is this important?

Good health is important at any age. While the length of life of local people continues to increase, the years that people can expect to live a high quality of life sees significant differences across County Durham. The gap between the most deprived and least deprived areas within County Durham is 8.1 years for men and 6.9 years for women. This coupled with an ageing population and people living with a range of health conditions can affect people's ability to work and contribute to their communities and has an impact on our health and care services.

We will work with businesses to help create a healthy community by offering employment and creating healthy workplaces to help ensure they retain their staff, attract new talent and help to keep the communities they work within, healthier. We will also support businesses to implement effective preventative strategies, not only to promote better mental health but also help avoid the costs of absenteeism and reduced productivity which are associated with poor mental health.

We will work with partners and communities to maximise the quality of our local environment and clean air, with opportunities to be physically active and achieve a healthy weight. We will encourage transport choices that are the most sustainable by improving the attractiveness of these modes of transport including cycling and walking for everyday journeys.

Housing conditions can influence our physical and mental health, for example, a warm and dry house can improve general health outcomes and specifically reduce respiratory conditions and good housing promotes positive mental health.

We will enable our local communities to increase people's skills, knowledge and confidence to look after their own health and wellbeing. We will encourage people to eat healthily by promoting the five a day message and increase their physical activity.

In County Durham, we recognise that for many people not smoking, having a healthy weight, being physically active, drinking moderate levels of alcohol and having good and supportive relationships is not a choice but shaped by the environment in which they live. We will adopt a 'settings' approach which creates an environment for healthy behaviours, including schools, workplaces, community centres and primary care so people can live well.

We will strive to shift the culture and influence policy and legislation to support improving people's health, for example, minimum unit pricing for alcohol.

The contribution of citizens, users and families to improving health outcomes is central to co-production. It values what works well in an area, it sees the potential of people's knowledge and moves away from a deficit approach to recognising the assets people already have and can contribute to their neighbourhood.

Living well

Our people and place

317,000 18-64 year olds

74.2% are in employment.

This has increased **7.5%** since 2016.

Nearly **50%** of our lower super output areas are in the top 30% most deprived areas nationally.

The gap in employment rate between those with a learning disability and the overall employment rate is **70** percentage points.

Risk taking behaviours

Around **3 in 5** adults are physically active.

… and **2** out of **3** adults are classed as overweight.

15% of adults are smokers.

12,500 people were admitted to hospital in 2017/18 for alcohol related conditions.

91.9 per 100,000 people aged 15-24 years admitted to hospital for substance misuse.

2,954 people were diagnosed with a sexually transmitted infection in 2018.

Living in poor health

An estimated **1 in 12** have diabetes.

Over **20,000** people have coronary heart disease.

1 in 5 people are diagnosed with high blood pressure.

Mental Health and Wellbeing

1 in 4 adults experience at least one diagnosable mental health problem in any given year.

Nearly **57,000** adults have been diagnosed with depression.

Less than **60** deaths a year from suicide.

1 in 5 people say they have high levels of anxiety.

1 in 10 people say they do not feel happy.

Living Well: This priority covers adulthood, from leaving school/university to retiring and includes our working life
• Work with a range of partners to deliver Making Every Contact Count to enable every contact to be a health contact • Ensure opportunities for service users and their carers to be involved in the development and co-production of services are maximised • Implement the approach to wellbeing which builds on the positive work in communities and involves communities in decisions about services • Develop our countywide approach to reducing stigma and discrimination across communities, workplaces and schools though working with the Time to Change hub • Develop a healthy settings approach to support health improvement and reduced health inequalities across a range of settings, including early years schools, workplaces, pharmacies, leisure facilities and voluntary and community sector organisations • Better identify the rate of self-harm and reduce the levels of suicide across County Durham • Reduce the prevalence of harm caused by smoking through tobacco control measures and redesigning the stop smoking service to improve the services to tackle tobacco-related ill health • Develop a Sexual Health Strategy for County Durham to ensure equitable access and a strategic focus on reducing sexually transmitted infections and good contraceptive health • Support the drive for a minimum unit price for alcohol to create a County Durham that has reduced harm from alcohol • Increase the use of active travel to encourage physical activity (including cycling and walking) to reduce traffic emissions related respiratory illness and carbon emissions • Increase the uptake of national/local screening programmes to reduce inequalities • Help people to manage their own long-term conditions including diabetes and respiratory conditions through self-management programmes through a range of methods, including digitally, to access advice, self-help in minor illnesses and health promotion • Attract more businesses and the voluntary and community sector to participate and achieve the Better Health at Work award including encouraging organisations to sign the Time to Change Employer pledge • Increase the number of organisations using the volunteering kite mark, which is managed by Durham Community Action • Implement strategies for vulnerable population groups, for example, those with learning disabilities and autism. • Develop initiatives for community home treatment as an alternative to crisis services • Ensure procurement processes encourage providers to have a focus on health within the workplace • Work with the Economic Partnership to maximise local opportunities for economic and job development, including apprenticeships, with a focus on closing the gap in employment opportunities for those with a long-term health condition or disability

• Contribute to the implementation of the Housing Strategy where this relates to housing and health include accommodation services for people with the most complex needs		
Delivery plan mechanisms:	**1. Tobacco Control Alliance Action Plan** **2. Healthy Weight Alliance Action Plan/Active Durham Partnership Framework**	**3. Resilient Communities Action Plan** **4. Sexual Health Strategy (when completed)** **5. County Durham Health and Social Care 5-year plan**

Strategic priority 3: Ageing Well

Why is this important?

Ageing well is something that happens throughout our lives, not just in old age: Starting and Living Well contribute as much if not more to ageing well as anything that happens later in life.

Older people in the county play a vital role in contributing to the life of their communities, and increasing numbers are continuing in paid employment well past State Pension age as well as volunteering and playing an active role in their local communities. However, with age comes the increased likelihood of living with one or more long term conditions and/or sensory impairment

We will integrate commissioning between health and social care for more effective integrated service delivery where is make sense to do so. We will seek to understand the opportunities at every stage of the development and delivery of joined up health and care services.

Older people have an increased risk to dementia and large numbers of older people suffer from depression and are also vulnerable to social isolation.

We will also target approaches which enable our older people to remain independent and to lead lives with meaning and purpose and will ensure that when the time comes, people receive good quality end of life care and have a good death.

Ageing Well

People and Place

110,000
people aged 65 and over.

The proportion of older people in the population is expected to increase.

By 2035…
31% *increase* for over 65's
82% *increase* for over 85's

Life Expectancy (LE) and Healthy Life Expectancy (HLE) is ***significantly lower*** for County Durham than England for men and women.

Women
LE is **81 years**... | HLE is **59 years**. | That's **22 years in poor health**

Men
LE is **78 years**... | HLE is **59 years**. | That's **19 years in poor health**

There is **inequality** in ***premature mortality*** across County Durham as rates are higher in the more deprived areas.

Health and Wellbeing

1 in 20 people over 65 are recorded as having dementia…
nearly **5,000** people

… this is predicted to ***double*** over the next 15 years.

Just over **72%** of over 65's had a flu vaccination in 2017/18.

The number of emergency admissions to hospital for falls is ***increasing***.

Nearly **2,500** in 2017/18

Contributing factors

4.3% of the county's over 60's are living in income deprived households.

Over **30,000** people over the age of 65 live alone.

In 2018/19, **94.6%** of the Durham residents reported that their care and support services helped them have a better quality of life.

Permanent admission rates to residential and nursing care homes for over 65's are ***significantly higher*** for County Durham than England.

Ageing Well: This priority covers the later life, from retirement to the end of life		
• Promote the uptake of the flu vaccination through marketing campaigns across County Durham, especially in target groups • Ensure dementia is identified and diagnosed at an early stage and families, carers and communities are helped to manage their condition • Following the success of early adopters, increase the number of communities across the County who are empowered to become dementia friendly communities, with support from Dementia Action alliance, Alzheimer's Society and AAP's where engaged • Work with partners and providers to reduce the incidence of falls and fractures in older people by training and digital technology • Develop housing and care options specifically to meet the needs of the older and disabled people within our communities • Increase the scale and integration of out of hospital services, based around communities and improve population health outcomes • Ensure the frail elderly are able to live well at home for as long as possible and receive high quality, consistent levels of service • Increase referrals and adaptations done by the warm and healthy homes programme • Carers are supported in their caring role are able to maintain their own health and wellbeing • Support community connectivity and the approach to wellbeing to help address social isolation and loneliness • Implement the approach to wellbeing which builds on the positive work in communities and involves communities in decisions about services • Work with Primary Care Networks to ensure social prescribing provides new opportunities for people to access the help they need • Improve the end of life pathway to ensure providers aspire to delivering support to people at the end of their life to deliver personal, bespoke care.		
Delivery plan mechanisms:	**1. County Durham Health and Social Care 5-year plan** **2. Housing Strategy**	**3. Dementia Strategy** **4. Palliative and End of Life Care Strategy**

Enabling factors

There are a number of enabling factors that are relevant to all actions in this strategy to ensure that it is delivered.

Leadership and Advocacy

- Make health and wellbeing everyone's business through cross-sector capacity building
- Promote key health messages through strategic influence, advocacy and PR

Whole System Approach

- Multiagency working across County Durham to achieve the best outcomes to address health and wellbeing needs in an efficient and sustainable way
- Commission and deliver high quality, safe and integrated health and wellbeing services
- Strong partnership governance arrangements
- Effective communications and information sharing across partners and communities

Strategic focus on prevention and early help

- Encourage a resource shift towards prevention and early intervention for people to remain as independent as possible making the best use of resources
- Adopt a whole family approach and recognising the roles played by carers and significant others

Performance management and intelligence

- Use Joint Strategic Needs Assessment and Durham Insight to support analytical view of priorities for health
- Use the best available evidence to address local needs including accessing data to identify areas where targeted intervention is required to inform commissioning decisions

Targeted Approach

- Appropriate, systematic, coordinated and targeted interventions to improve the health and wellbeing of the most and disadvantaged groups fastest

Community Engagement

- Meaningful engagement with local communities, patients, service users, carers and the public in commissioning and delivery of health and wellbeing services
- Empowering and enabling communities and individuals to take responsibility for their own health and wellbeing
- Utilise community assets

Workforce

- Ensure staff have the right knowledge, skills and competencies

Co-production

- Services are co-designed and co-produced with the people who need them, as well as their carers

Equitable access

- Everyone has the same opportunities to access health and social care services

Performance Management Framework

High level measures of success will be monitored through changes in life expectancy, healthy life expectancy and the life expectancy/healthy life expectancy gap between the most and least deprived communities.

The Health and Wellbeing Board will develop a set of performance indicators to measure the success of achieving the objectives and priorities in this strategy. Delivery of the actions in this strategy is by the Health and Wellbeing Board working with other partnership and the Health and Wellbeing Board sub groups who are responsible and accountable for the actions within this strategy.

Appendix 1: JHWS priorities and links to other strategic partnership plans

Joint Health and Wellbeing Strategy priorities and alignment to other Strategic Partnership Plans			
Joint Health and Wellbeing Strategy 2020 - 2025	**County Durham 5 Year System plan 2020 - 2025**	**Children and Young People's Strategy 2019 - 2022**	**Safe Durham Partnership Plan 2020 - 2025**
Starting well	Prevention Children and Young People's Strategy Children and Young People's mental health Learning disabilities	Young people gain the education, skills and experience to succeed in adulthood All children and young people have a safe childhood Children and Young People enjoy the best start in life, good health and emotional wellbeing Children and young people with SEND achieve the best possible outcomes	Supporting victims and protect vulnerable people from harm
Living well	Primary care Urgent care treatment centre review Development of place based 0-25 services Workforce Out of hospital care Urgent & emergency care Planned care		Promote being safe and feeling safe in your community Reduction of alcohol and substance misuse
Ageing well	End of Life		

Please ask us if you would like this document summarised in another language or format.

العربية (Arabic) (中文 (繁體字)) (Chinese) اردو (Urdu)
polski (Polish) ਪੰਜਾਬੀ (Punjabi) Español (Spanish)
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Adults Wellbeing and Health Overview and Scrutiny Committee 17 January 2020

Draft Joint Health and Wellbeing Strategy

Andrea Petty – Strategic Manager Partnerships
Julie Bradbrook – Partnerships Team Manager

County Durham Health & Wellbeing Board

Vision 2035

The Vision 2035 was developed with partners for the next 15 years with three strategic ambitions:

(a) More and Better jobs

(b) People live long and independent lives

(c) Connected communities

County Durham Health & Wellbeing Board

Health and Wellbeing Board's Vision

'County Durham is a healthy place, where people live well for longer'

County Durham Health & Wellbeing Board

JHWS – Strategic Priorities

The Health and Wellbeing Board has three strategic priorities which set out what we will focus on:

- Starting Well
- Living Well
- Ageing Well

County Durham Health & Wellbeing Board

Strategic Priority 1: Starting well

- A baby's mother being healthy before and during pregnancy
- Healthy development for children
- Targeted support for vulnerable children

Examples of key deliverables are:

- Support women to achieve a smoke free pregnancy
- Increase the percentage of women who initiate breastfeeding and continue at 6-8 weeks
- Reduce unintentional injuries in the 0-19 population
- Increase the roll out in schools of 'poverty proofing the school day' which includes cutting the cost of the schools' day

Starting Well

People and Place

In 2018, an estimated population of just over **106,000** children
** 0-18*

140 Low birth weight babies.

4,868 live births

Around **900** babes are born to mothers who smoke.

Nearly **1 in 5** women were smoking at time of delivery.

78.3 81.4
Life expectancy at birth

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Health and Wellbeing

3 in 4 5 year olds are free from tooth decay.

Hospital admissions caused by unintentional injuries in 0-4 year olds is ***significantly higher*** than England.

1 in 4 4 - 5 year olds are in excess weight.

The rate of teenage conceptions has decreased by **45%** since 2010.

Education

There are nearly 80,000 children of school age in County Durham.
** 5-18*

6% of 16-17 years are not in education, employment or training.

9 out of 10 children are achieving a good level of development at 2 -2 ½ years old.

7 out of 10 children are achieving a good evel of development at the end of reception

Vulnerable Children

As at March 2019 there were **800** children looked after in County Durham.

Nearly **1 in 5** children are living in the top *10% most deprived* areas nationally.

Hospital admissions (10-14 years) as a result of self-harm is *similar to England.*

1 in 10 children have a mental health disorder.

Strategic Priority 2: Living well

- Social determinants of health
- Improving mental health and wellbeing
- Positive behaviours
- Resilient communities

Examples of key deliverables are:

- Deliver Making Every Contact Count with partners to enable every contact to be a health contact
- Ensure procurement processes encourage providers to have a focus on health within the workplace
- Increase the uptake of national/local screening programmes to reduce inequalities
- Develop initiatives for community home treatment as an alternative to crisis services

County Durham Health & Wellbeing Board

Living well

Our people and place

317,000 18-64 year olds

74.2% are in employment.

This has increased **7.5%** since 2016.

Nearly **50%** of our lower super output areas are in the top 30% most deprived areas nationally.

The gap in employment rate between those with a learning disability and the overall employment rate is **70** percentage points.

Risk taking behaviours

Around **3 in 5** adults are physically active.

… and **2** out of **3** adults are classed as overweight.

15% of adults are smokers.

12,500 people were admitted to hospital in 2017/18 for alcohol related conditions.

91.9 per 100,000 people aged 15-24 years admitted to hospital for substance misuse.

2,954 people were diagnosed with a sexually transmitted infection in 2018.

Living in poor health

An estimated **1 in 12** have diabetes.

Over **20,000** people have coronary heart disease.

1 in 5 people are diagnosed with high blood pressure.

Mental Health and Wellbeing

1 in 4 adults experience at least one diagnosable mental health problem in any given year.

Nearly **57,000** adults have been diagnosed with depression.

Less than **60** deaths a year from suicide.

1 in 5 people say they have high levels of anxiety.

1 in 10 people say they do not feel happy.

Strategic Priority 3: Ageing well

- Approach to wellbeing
- Dementia friendly communities
- Support for carers
- Good quality end of life care

Examples of key deliverables are:

- Ensure dementia is identified and diagnosed at an early stage and families, carers and communities are helped to manage their condition
- Work with partners and providers to reduce the incidence of falls and fractures in older people by training and digital technology
- Carers are supported in their caring role are able to maintain their own health and wellbeing
- Ensure the frail elderly are able to live well at home for as receive high quality, consistent levels of service

County Durham Health & Wellbeing Board

Ageing Well

People and Place

110,000
people aged 65 and over.

The proportion of older people in the population is expected to increase.

By 2035…
31% *increase* for over 65's
82% *increase* for over 85's

Life Expectancy (LE) and Healthy Life Expectancy (HLE) is ***significantly lower*** for County Durham than England for men and women.

Women
LE is **78 years**… | HLE is **59 years**. | That's **19 years in poor health**

Men
LE is **81 years**… | HLE is **59 years**. | That's **22 years in poor health**

There is **inequality** in ***premature mortality*** across County Durham as rates are higher in the more deprived areas.

Health and Wellbeing

1 in 20 people over 65 are recorded as having dementia… nearly **5,000** people

… this is predicted to ***double*** over the next 15 years.

Just over **72%** of over 65's had a flu vaccination in 2017/18.

The number of emergency admissions to hospital for falls is ***increasing***.

Nearly **2,500** in 2017/18

Contributing factors

4.3% of the county's over 60's are living in income deprived households.

Over **30,000** people over the age of 65 live alone.

In 2018/19, **94.6%** of the Durham residents reported that their care and support services helped them have a better quality of life.

Permanent admission rates to residential and nursing care homes for over 65's are ***significantly higher*** for County Durham than England.

Consultation next steps

- Consultation will be live on Durham County Council website from **17 December 2019 to 14 February 2020**

The consultation will include the following groups:

- Area Action Partnerships
- Voluntary and Community Sector
- Armed Forces Forum
- Town and Parish Councils
- Investing in Children
- Learning Disabilities Parliament
- AWH and CYP Overview and Scrutiny Committees

Consultation questions

- Do you agree with each of the strategic priorities in the plan?
  - Are there any gaps?

- Do you agree with the strategic objectives in the plan?
  - Are there any gaps?

- Do you have any further comments about the Joint Health and Wellbeing Strategy

County Durham Health & Wellbeing Board

Adults, Wellbeing and Health Overview and Scrutiny Committee

17 January 2020

Quarter Two, 2019/20 Performance Management Report

Report of John Hewitt, Corporate Director of Resources

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 To present progress towards achieving those key outcomes of the council's corporate performance framework aligned to the Adults, Wellbeing and Health Overview and Scrutiny Committee.

2 The performance report which sets out progress to the council's corporate performance framework in its entirety can be found here.

Performance Reporting

3 Following an extensive public consultation programme, a shared vision for the county for the next 15 years has been developed with partners. This vision, agreed by Council on 23 October and formally launched at the County Durham Partnership event on 25 October, is structured around three externally focused results-based ambitions of 'more and better jobs', 'long and independent lives' and 'connected communities' (link).

4 As the Council has now adopted this vision, it is appropriate to modify the format of our performance reports to align to our new ambitions. This quarter, as a first step, existing performance information has been realigned to the three new ambitions plus a fourth 'better council' theme. Over the coming months, we will review the report to ensure it captures all elements of the new vision, as well as monitoring progress in improving how the council works.

Executive summary

5 Although the quarter two performance report for this committee (attached at Appendix 2) remains structured around the same set of key questions, they have been realigned to the ambitions of our new vision.

Long and Independent Lives

6 The ambition of 'long and independent lives' concentrates strongly on the health and wellbeing of the local population and the health inequalities across the county. Its focus includes giving children and young people the best start in life, as well as enabling people to live independently for longer through improved social care delivery and housing that meets the needs of older people.

7 Positive progress is being made to help people live long and independent lives. Smoking prevalence has fallen significantly to a position where we are on par with the rest of the country (although we have set ourselves a challenging target to reduce smoking much further and have particular challenges around smoking in pregnancy which is higher than North East and England average). We continue to perform extremely well in preventing delayed transfers of care from hospital (third best performing unitary authority in England).

8 Key challenges to improve life expectancy and quality of life include delivering the targeted reduction in smoking prevalence, supporting people to achieve a healthy weight and improving mental health and wellbeing. We are continuing to tackle these issues. Through the Tobacco Control Alliance, we influence regulation related to smoking, support people to stop smoking, reduce exposure to second-hand smoke and promote campaigns such as Stoptober. Our partnership approach to help people achieve a healthy weight focuses on the Best Start in Life, the physical and food environments, with actions to increase physical activity in schools (Active 30 programme), promote active travel and improve the regulation of hot food takeaways. We have implemented a full workforce mental health awareness programme (incorporating more Mental Health First Aiders and Time to Change Champions), established a workforce leads network to ensure a consistent approach to mental health training across partners, and are developing a tailored approach to mental health awareness across small-to-medium sized businesses

Risk Management

9 Effective risk management is a vital component of the council's agenda. The council's risk management process sits alongside our change programme and is incorporated into all significant change and improvement projects.

10 There are no key risks in delivering the objectives of this theme.

Recommendation

11 That the Adults, Wellbeing and Health Overview and Scrutiny Committee considers the overall position and direction of travel in relation to quarter two performance, and the actions being taken to address areas of underperformance.

Contact: Jenny Haworth, Head of Strategy Tel: 03000 268 071

Appendix 1: Implications

Legal Implications

Not applicable.

Finance

Latest performance information is being used to inform corporate, service and financial planning.

Consultation

Not applicable.

Equality and Diversity / Public Sector Equality Duty

Equality measures are monitored as part of the performance monitoring process.

Climate Change

We have declared a climate emergency and consider the implications of climate change in our reports and decision making.

Human Rights

Not applicable.

Crime and Disorder

A number of performance indicators and key actions relating to crime and disorder are continually monitored in partnership with Durham Constabulary.

Staffing

Performance against a number of relevant corporate health indicators has been included to monitor staffing issues.

Accommodation

Not applicable.

Risk

Reporting of significant risks and their interaction with performance is integrated into the quarterly performance management report.

Procurement

Not applicable.

Appendix 2

Altogether better

Durham County Council

Durham County Council

Performance Management Report

Quarter Two, 2019/20

Long and Independent Lives

1 The ambition of Long and Independent Lives is linked to the following key questions:

(a) Are our services improving the health of our residents?
(b) Are people needing adult social care supported to live safe, healthy and independent lives?

Are our services improving the health of our residents?

2 Reducing smoking continues to be one of the main priorities to be addressed by the council and partners. The annual County Durham Tobacco Control Alliance update, presented to the Health and Wellbeing Board in July 2019, highlighted future work of the alliance, including:

- Smoke-free homes, working with housing providers;
- Review of the council's No Smoking Policy;
- Progressing a vaping pilot;
- Reducing tobacco dependency in pregnancy.

3 The specialist Stop Smoking Service contract is in the process of re-procurement and a service review has been conducted. A number of recommendations are being considered to inform the new service specification. It is anticipated that a contract will be awarded prior to Christmas 2019.

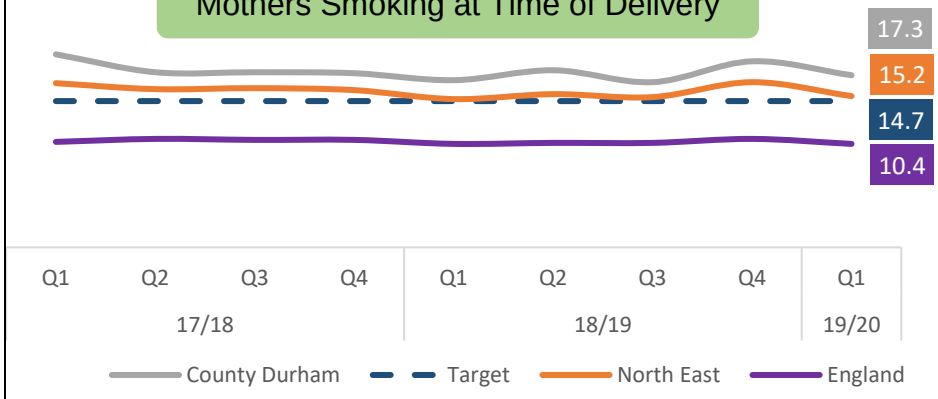
4 Four-week smoking quitter rates have reduced across the country, including rates for the North East and County Durham. A Health Equity Audit (conducted in August 2018) shows that the Stop Smoking Service successfully reaches those in the most deprived communities. However, challenges to changing smoking behaviour in such areas has led to a slowdown in quitter rates in Durham.

5 The method of recording the number of people setting a quit date and quitting at four weeks, through the Stop Smoking Service, has changed from 1 April 2019. Following these changes, it is anticipated that future data will show increases in the number of people setting quit dates, alongside a reduced percentage of overall smoking quitters. We will monitor how the change in recording affects service performance.

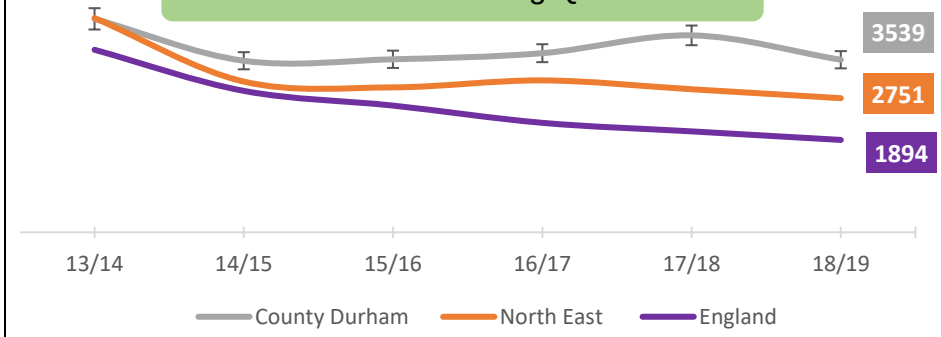
LONG AND INDEPENDENT LIVES

(a) Are our services improving the health of our residents?

Mothers Smoking at Time of Delivery



Four Week Smoking Quitters



Suicide Rate per 100,000 population (2016-18)

County Durham

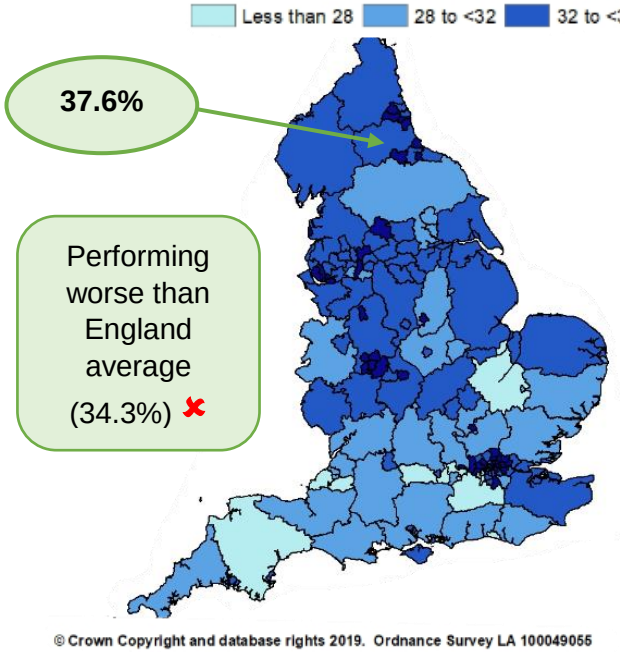
12.8

Increased since 2015-17 ⬆

Worse than England average (9.6) ✘

Worse than NE average (11.3) ✘

Prevalence of children aged 10-11 who are overweight and obese (18-19)



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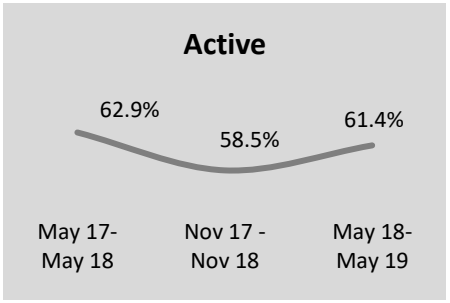
Performing worse than England average (34.3%) ✘

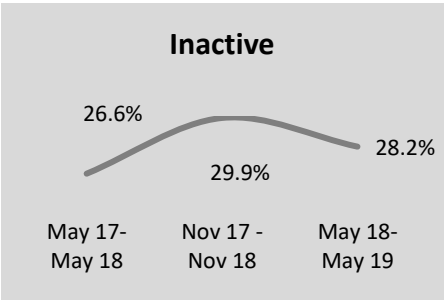
Of the other 10-11 year olds who participated in the National Child Measurement Programme this year:

61.2% healthy weight
1.2% underweight

Adult participation in sport and physical activity (May 18 to May 19)



England average 63.2%



England average 24.8%

6 There was significant planning for Stoptober 2019, with many partners within the Tobacco Control Alliance taking part in the promotion of the campaign. A photoshoot, attended by the Director of Public Health and the Portfolio Holder for Adult and Health Services, took place at the beginning of September for the local promotion of the campaign. Stoptober commenced on 1 October 2019.

7 County Durham and Darlington NHS Foundation Trust announced its smoke-free status on 1 October 2019. The move to smoke-free Trust status has seen the development of policies to treat tobacco dependency whilst admitted to hospital.

8 The reduction of smoking in pregnancy continues to be a key area of work. A multi-agency strategic plan tackling tobacco dependency in pregnancy has been implemented. Ongoing work also continues with the regional Local Maternity System, to ensure that links are in place between regional and local work.

9 Public Health has worked with the Stop Smoking Service to undertake focus groups with pregnant women who currently, or who have previously, smoked. This work has captured valuable insights into the journey of pregnant women who smoke.

10 E-cigarettes, also known as vapes, are the most commonly used quit-aid among smokers in England and there is growing evidence of their effectiveness. Leading health and public health organisations (including the Royal College of General Practitioners, British Medical Association, Cancer Research UK and the US National Academies of Sciences, Engineering and Medicine) agree that although not risk-free, e-cigarettes are far less harmful than smoking. We continue to monitor the latest advice and guidance from Public Health England.

11 A multi-agency action plan to improve breastfeeding has been developed which links into the regional work being taken forward by the Local Maternity System. As part of this, Public Health has worked with the Infant Feeding Team to ensure that Durham County Council venues and customer access points are scheduled to be re-accredited for the breastfeeding friendly County Durham scheme by December 2019.

12 The Mental Health Strategic Partnership has been involved in developing a system-wide approach to wellbeing across the county. The six principles underpinning the approach have been used to develop a tool which has been used to review the Housing Strategy and also to help inform the work of AAPs.

13 Activities supporting the Better Health at Work agenda included a focus on events for World Mental Health Day (10 October 2019). These included a focus on helping staff to develop a common language to support mental health and stamp out stigma and discrimination.

14 Funding from the Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby Integrated Care Partnership totalling £49,420 has been transferred to the County Durham Time To Change Hub, to continue development of anti-stigma work, with a focus on improving men's mental health.

15 Suicide rates for County Durham are significantly lower than the period 2013-15 and have almost returned to the levels seen in the early 2000s. As part of the continued work to tackle suicide, the Council undertook a feasibility study for alterations to Newton Cap Viaduct during the summer, with implementation planned for quarter three. Other work included setting up a station adoption scheme and community action group in Chester-le-Street in response to suicides in recent years. The Samaritans "Small Talk Saves Lives" and the Northern Rail "All Right?" campaign have been widely promoted in the town, including an event by Northern Rail at the train station on 3 July for the England vs New Zealand match during the ICC Cricket World Cup. Between April and August 2019, the If U Care Share Foundation (an organisation providing emotional support to young people and those affected by suicide) received 46 referrals. From these referrals, 36 people are now engaged with the service.

16 A strategic physical activity and cycling group has been established, to increase participation and improve cycle networks across the County. The first meeting took place in September 2019 and included colleagues from Access and Rights of Way, Road Safety, Sustainable Transport and Culture, Sport and Tourism.

17 Public Health facilitated a review of the council's Healthy and Sustainable Food Policy in September 2019 with key partners, to ensure it is in line with the current evidence base, as well as local and national policies. This will help to demonstrate our commitment to staff wellbeing, offering healthy and sustainable food when catering for public events and functions, as well as the promotion of local food supply chains wherever possible.

18 A new contract for the Health Check programme (for people between the ages of 40 and 74 who have not previously been diagnosed with CVD) is being implemented through the Derwentside Health Federation. This will increase the offer of lifestyle interventions, which will in turn increase the rate of referrals into behaviour change programmes. Between April and June 2019,

5,702 NHS Health Checks were offered, with 2,508 carried out. There were 219 offers of a referral to a lifestyle programme. Numbers accepting a referral remain low.

19 The 'Fit for Farming' project funded by AAPs will seek to increase engagement rates within the farming community with formal healthcare provision, in partnership with Public Health and Upper Teesdale Agricultural Support Services. This five-year initiative also aims to support outreach work with local GPs through undertaking health checks at local Farmer Auction Marts, to tackle gender and geographical health gaps in the rural communities.

20 Delivery of the Macmillan Joining the Dots service is progressing well. The service capacity continues to increase and after one year has now engaged with 403 clients - 284 clients with cancer, the remainder being carers, families or friends. DDES and North Durham CCGs have now agreed to continue this service indefinitely, which will allow continuing support to cancer patients and their families, friends and carers in County Durham.

21 Public Health has supported the Silverdale Project, a pilot undertaken by the Silverdale GP practice, to offer respiratory clients an opportunity to apply for a winter warmth package funded by Durham County Council. Boiler replacement, cavity wall insulation and support with utility payments are all potential interventions. An evaluation has been carried out and this pilot will inform the potential to extend the approach / interventions to identified vulnerable groups and locations and increase joint work with DDES and North Durham CCG colleagues.

Are people needing adult social care supported to live safe, healthy and independent lives?

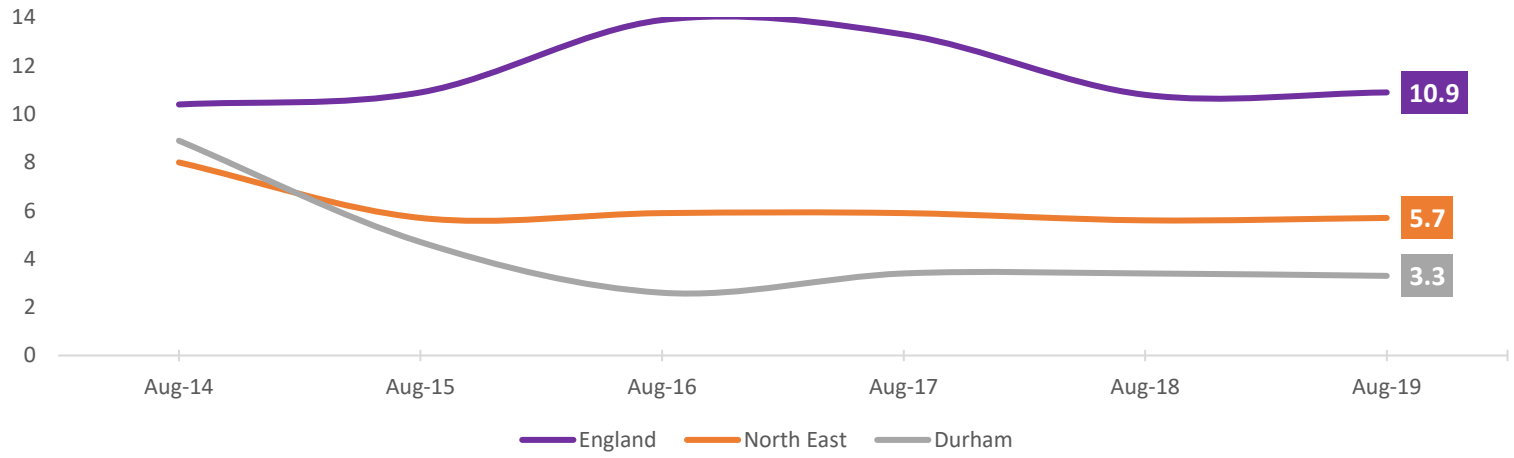
22 Nationally, Better Care Fund (BCF) planning submissions were submitted to NHS England by Health and Wellbeing Boards at the end of September 2019. Consequently, no national reporting has taken place for quarters one and two. It is anticipated that provisional targets will be made available in quarter three.

23 In the meantime, delayed transfers of care in County Durham continue to be one of the lowest in the country. The latest data for August 2019 show that we recorded an average of 3.3 daily delayed transfers per 100,000 population, which is better than the England (10.9) and North East (5.7) averages. Data for August show that Durham was the 9th best performing local authority in England.

LONG AND INDEPENDENT LIVES

(b) Are people needing adult social care supported to live safe, healthy and independent lives?

Daily delayed transfers of care (rate per 100,000 population)



384.5

adults aged 65+ per 100,000 population admitted to residential or nursing care on a permanent basis

(Apr-Sep 19)

⬇ compared to last year (391.6)

86.9%

of patients discharged into reablement / rehabilitation services still at home after 91 days

(Apr-Sep 19)

⬆ compared to last year (84.0)

87.9%

of service users receiving an assessment or review within the last 12 months

(Sep 18 – Sep 19)

⬆ compared to last year (86.6)

95.2%

of individuals achieved their desired outcomes from the adult safeguarding process

(Apr-Sep 19)

⬇ compared to last year (95.3)

24 Work to improve delayed transfers of care has included proactively monitoring the discharge of patients, an enhanced reablement offer, increasing the number of Continuing Health Care assessments outside of the hospital and extensive work with care home providers with regards to the brokerage service.

25 Durham continues to perform well in the Adult Social Care survey around overall satisfaction of those receiving care and support and those having enough choice over the services they receive.

Key Performance Indicators – Data Tables

There are two types of performance indicators throughout this document:

(a) Key target indicators – targets are set as improvements can be measured regularly and can be actively influenced by the council and its partners; and

(b) Key tracker indicators – performance is tracked but no targets are set as they are long-term and/or can only be partially influenced by the council and its partners.

A guide is available which provides full details of indicator definitions and data sources for the 2019/20 corporate indicator set. This is available to view either internally from the intranet or can be requested from the Strategy Team at performance@durham.gov.uk

KEY TO SYMBOLS

	Direction of travel	Benchmarking	Performance against target
GREEN	Same or better than comparable period	Same or better than comparable group	Meeting or exceeding target
AMBER	Worse than comparable period (within 2% tolerance)	Worse than comparable group (within 2% tolerance)	Performance within 2% of target
RED	Worse than comparable period (greater than 2%)	Worse than comparable group (greater than 2%)	Performance >2% behind target

National Benchmarking
We compare our performance to all English authorities. The number of authorities varies according to the performance indicator and functions of councils, for example educational attainment is compared to county and unitary councils however waste disposal is compared to district and unitary councils.

North East Benchmarking
The North East figure is the average performance from the authorities within the North East region, i.e. County Durham, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle upon Tyne, North Tyneside, Northumberland, Redcar and Cleveland, Stockton-On-Tees, South Tyneside, Sunderland, The number of authorities also varies according to the performance indicator and functions of councils.

More detail is available from the Strategy Team at performance@durham.gov.uk

LONG AND INDEPENDENT LIVES

Are our services improving the health of our residents?

Ref	Description	Latest data	Period covered	Comparison to						Data updated this quarter
				Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	
34	% of mothers smoking at time of delivery	17.3*	Apr-Jun 2019	14.7 RED	16.9 RED	10.4* RED	15.2* RED			Yes
35	Four week smoking quitters per 100,000 smoking population [number of quitters]	3,538 [2,313]	2018-19	Tracker N/a	4,038 [2,497] RED	2,750 GREEN	1,894 GREEN			Yes
36	Male life expectancy at birth (years)	78.3	2015-17	Tracker N/a	78.0 GREEN	79.6 AMBER	77.9 GREEN			No
37	Female life expectancy at birth (years)	81.4	2015-17	Tracker N/a	81.3 GREEN	83.1 RED	81.6 AMBER			No
38	Female healthy life expectancy at birth (years)	58.7	2015-17	Tracker N/a	59.0 AMBER	63.8 RED	60.4 RED			No
39	Male healthy life expectancy at birth (years)	58.9	2015-17	Tracker N/a	59.1 AMBER	63.4 RED	59.5 AMBER			No
40	Excess weight in adults (Proportion of adults classified as overweight or obese)	66.7	2017/18	Tracker N/a	67.7 GREEN	62.0 RED	66.5 AMBER			No
41	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population	12.8	2016-18	Tracker N/a	12.0 RED	9.6 RED	11.3 RED			Yes
42	Prevalence of breastfeeding at 6-8 weeks from birth	28.6	Jan-Mar 2019	Tracker N/a	29.2 RED	47.3 RED	33.8 RED			No
43	Estimated smoking prevalence of persons aged 18 and over	15.0	2018	Tracker N/a	14.3 RED	14.4 RED	16.0 GREEN			No

LONG AND INDEPENDENT LIVES

Are our services improving the health of our residents?

Ref	Description	Latest data	Period covered	Comparison to						Data updated this quarter
				Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	
44	Self-reported wellbeing - people with a low happiness score	8.9	2017/18	Tracker	6.9	8.2	9.1			No
				N/a	RED	RED	GREEN			
45	Participation in Sport and Physical Activity: active	61.4	May 18-May 19	Tracker	62.9	63.2				Yes
				N/a	RED	RED				
46	Participation in Sport and Physical Activity: inactive	28.2	May 18-May 19	Tracker	26.6	24.8				Yes
				N/a	RED	RED				

*provisional data

LONG AND INDEPENDENT LIVES

Are people needing adult social care supported to live safe, healthy and independent lives?

Ref	Description	Latest data	Period covered	Comparison to						Data updated this quarter
				Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	
47	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	384.5	Apr-Sep 2019	TBD	391.6					Yes
				N/a	GREEN					
48	% of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	86.9	Apr-Sep 2019	TBD	84.0	82.4	83.0	80.7*	2018/19	Yes
				N/a	GREEN	Not comparable	Not comparable	Not comparable		
49	% of individuals who achieved their desired outcomes from the adult safeguarding process	95.2	Apr-Sep 2019	Tracker	95.3	94.2		93.6*	2017/18	Yes
				N/a	AMBER	Not comparable		Not comparable		
50	% of service users receiving an assessment or review within the last 12 months	87.9	Sep 18-Sep 19	Tracker	86.6					Yes
				N/a	GREEN					

LONG AND INDEPENDENT LIVES

Are people needing adult social care supported to live safe, healthy and independent lives?

Ref	Description	Latest data	Period covered	Comparison to						Data updated this quarter
				Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	
51	Overall satisfaction of people who use services with their care and support	67.8	2018/19	Tracker	66.6	64.3	66.2	66.0*		Yes
				N/a	GREEN	GREEN	GREEN	GREEN		
52	Overall satisfaction of carers with the support and services they receive (Biennial survey)	51.2	2018/19	Tracker	43.3**	38.6	47.2	41.8*		No
				N/a	GREEN	GREEN	GREEN	GREEN		
53	Daily delayed transfers of care beds, all, per 100,000 population age 18+	3.3	Aug 2019	Tracker	3.4	10.9	5.7	9.9*		Yes
				N/a	GREEN	GREEN	GREEN	GREEN		
54	% of adult social care service users who report they have enough choice over the care and support services they receive	75.1	2018/19	Tracker	74.9	67.5	71.8	69.3*		Yes
				N/a	GREEN	GREEN	GREEN	GREEN		

*unitary authorities

** results from 2016/17 survey

Other Additional Relevant Indicators

LONG AND INDEPENDENT LIVES										
Are children, young people and families in receipt of universal services appropriately supported?										
Ref	**Description**	**Latest data**	**Period covered**	**Comparison to**						**Data updated this quarter**
				Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**	
24	% of all school pupils eligible for and claiming Free School Meals (FSM)	20.8	Jan 2019	Tracker	19.4	15.4	21			No
				N/a	RED	RED	GREEN			
25	Under-18 conception rate per 1,000 girls aged 15 to 17	25.0*	Jul 17-Jun 18	Tracker	22.3	16.9*	24.2*			Yes
				N/a	RED	RED	RED			
26	% of five year old children free from dental decay	74.2	2016/17	Tracker	64.9	76.7	76.1			No
				N/a	GREEN	RED	RED			
27	Alcohol specific hospital admissions for under 18s (rate per 100,000)	53.1	2015/16-2017/18	Tracker	56.2	32.9	62.7			No
				N/a	GREEN	RED	GREEN			
28	Young people aged 10-24 admitted to hospital as a result of self-harm (rate per 100,000)	350.1	2017/18	Tracker	400.8	421.2	458.0			No
				N/a	GREEN	GREEN	GREEN			
29	% of children aged 4 to 5 years classified as overweight or obese	23.9	2018/19	Tracker	25.0	22.6	24.3			Yes
				N/a	GREEN	RED	GREEN			
30	% of children aged 10 to 11 years classified as overweight or obese	37.6	2018/19	Tracker	37.1	34.3	37.5			Yes
				N/a	AMBER	RED	AMBER			

CONNECTED COMMUNITIES - SAFER											
How well do we reduce misuse of drugs and alcohol?											
Ref	**Description**	**Latest data**	**Period covered**	**Comparison to**						**Data updated this quarter**
				Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**	
85	% of successful completions of those in alcohol treatment	30	Mar 18-Feb 19 with rep to Aug 19	28 GREEN	32 RED	37.9 RED				Yes
86	% of successful completions of those in drug treatment - opiates	6.3	Mar 18-Feb 19 with rep to Aug 19	6 GREEN	5.5 GREEN	5.8 GREEN				Yes
87	% of successful completions of those in drug treatment - non-opiates	30.7	Mar 18-Feb 19 with rep to Aug 19	26.4 GREEN	29.2 GREEN	34.5 RED				Yes

Adult Wellbeing and Health Overview and Scrutiny Committee

17 January 2020

Adult and Health Services - Quarter 2: Forecast of Revenue and Capital Outturn 2019/20

Report of Corporate Directors
John Hewitt, Corporate Director of Resources

Jane Robinson, Corporate Director Adult and Health Services

Electoral division(s) affected:
Countywide

Purpose of the Report

1 To provide the Committee with details of the updated forecast outturn budget position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of September 2019.

Executive Summary

2 This report provides an overview of the updated forecast of outturn, based on the position to 30 September 2019. It provides an analysis of the budgets and forecast outturn for the service areas falling under the remit of this Overview and Scrutiny Committee and complements the reports considered and agreed by Cabinet on a quarterly basis,

3 The AHS service grouping is reporting a cash limit underspend of £2.438 million at the year-end against a revised budget of £116.782 million, which represents a 2.1% underspend. This compares with the previously forecast cash limit underspend, based on the position in June 2019, of a £2.650 million cash limit underspend

4 Based on the updated forecasts, the forecast Cash Limit balance for AHS as at 31 March 2020 is £10.041 million.

5 Details of the reasons for under and overspending against relevant budget heads is disclosed in the report.

6 The revised AHS capital budget for 2019/20 is nil.

Recommendation

7 It is recommended that the Adults Wellbeing and Health Committee note the financial forecasts included in this report.

Background

8 County Council approved the Revenue and Capital budgets for 2019/20 at its meeting on 20 February 2019. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

- *AHS Revenue Budget - £116.782 million (original £123.776 million)*
- *AHS Capital Programme – £Nil*

9 The original AHS revenue budget has been revised to incorporate budget adjustments as summarised in the table below:

Reason for Adjustment	**£'000**
Original Budget	123,776
Transfer to TAP of Business Support	(1,920)
Transfer from Contingencies – Pension Auto Enrolment	142
Transfer to Contingencies – Pension Deficit	(737)
Transfer to Resources – MFD Budget	(35)
Transfer to CYPS – Teenage Pregnancy	290
Use of (+)/contribution to Corporate reserves (-) (ERVR)	17
Use of (+)/contribution to AHS reserves (-)	(4,751)
Revised Budget	**116,782**

10 The use of / (contribution) to AHS reserves consists of:

Reserve	**£'000**
Contribution to AHS - Social Care Reserve	(6,059)
Use of Public Health Reserve	1,308
Total	**(4,751)**

11 The summary financial statements contained in the report cover the financial year 2019/20 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the forecast outturn;

- For the AHS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn

12 The updated forecasts show that the AHS service is now reporting a cash limit underspend of £2.438 million against a revised budget of *£116.782 million* which represents a 2.1% underspend.

13 The tables below show the revised annual budget, actual expenditure to 30 September 2019 and the updated forecast of outturn to the year end, including the variance forecast at year end. The first table is analysed by Subjective Analysis (i.e. type of expense) and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Cash Limit Variance £000	MEMO: QTR1 Cash Limit Variance £000
Employees	34,934	16,110	34,040	(894)	(889)
Premises	1,292	379	1,301	9	41
Transport	2,301	704	2,083	(218)	(69)
Supplies & Services	4,166	1,849	4,169	3	497
Third Party Payments	272,072	89,629	272,270	198	(1,361)
Transfer Payments	11,254	4,625	11,455	201	150
Central Support & Capital	26,726	19,859	27,200	474	415
Income	(235,963)	(76,937)	(238,174)	(2,211)	(1.434)
Total	**116,782**	**15,197**	**114,223**	**(2,438)**	**(2,650)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Cash Limit Variance £000	MEMO: QTR1 Cash Limit Variance £000
Central/Other	10,248	(28,628)	9,108	(1,140)	(1,120)
Commissioning	4,632	9,541	4,360	(272)	(279)
Head of Adults	100,369	67,973	99,343	(1,026)	(1,251)
Public Health	1,533	7,832	1,533	0	0
Total	**116,782**	**15,197**	**114,223**	**(2,438)**	**(2,650)**

14 The table below provides a brief commentary of the forecast cash limit variances against the revised budget, analysed by Head of Service. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. central admin recharges and capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£70,000 under budget on employees due to effective vacancy management. £10,000 under budget in respect of premises/transport/supplies and services. £161,000 net under budget on care provision.	(241)
Safeguarding Adults and Pract.Dev.	£80,000 under budget mainly across staffing together with supplies and services.	(80)
Ops Manager OP/PDSI Services	£39,000 over budget due to extension of temporary staffing contracts. £246,000 under budget in respect of premises/transport/supplies and services. £187,000 net under budget on direct care-related activity.	(394)
Ops Manager Provider Services	£311,000 net under budget mainly due to early achievement of MTFP savings.	(311)
		(1,026)
Central/Other		
Central/ Other	£1.140 million under budget mainly due to the early achievement of MTFP savings.	(1,140)
		(1,140)
Commissioning		
Commissioning	£272,000 under budget mainly in respect of employees and third party payments.	(272)
		(272)
Public Health		
General Prevention Activities	£10,000 under budget on health protection Emergency Response	(10)
Healthy Communities Strategy and Assurance	No Material Variance	(2)

Service Area	Description	Cash limit Variance £000
Living and Aging Well	£66,000 under budget Cancer Awareness project, £120,000 under budget NRT Voucher Scheme, £5,000 under budget Residential Detox, £5,000 under budget Supervised Consumption, £10,000 under budget DACT etc	(206)
Public Health Grant and Reserves	£482,000 Amount to balance the cash limit variance made up principally of the uncommitted budgets, savings from vacant posts and underspends on contracts.	482
Public Health Team	£59,000 under budget due to a vacant post and reduced hours, £8,000 under budget on training and staff travel, £110,000 uncommitted budget, £24,000 under budget due to technical adjustment relating to 2018/19.	(201)
Starting Well and Social Determinants	£53,000 Under budget on MARAC (domestic violence) contract that has now expired partially offset by a £13,000 over budget on next generation broadband costs, £18,000 savings on PH Young Adolescent Mental Health and £5,000 savings on rent at Greenfield Children's Health centre	(63)
		-
AHS Total		**(2,438)**

15 In summary, the service grouping is on track to maintain spending within its cash limit. It should also be noted that the forecast outturn position incorporates the MTFP savings built into the 2019/20 budgets, which for AHS in total amounted to £3.636 million.

16 Based on updated forecasts, the forecast Cash Limit balance at 31 March 2020 is £10.041 million.

Capital Programme

17 There is no capital programme in 2019/20 for AHS at present.

Background Papers

18 Cabinet Report 13 November 2019 – Forecast of Revenue and Capital Outturn Period to 30 September 2019.

Contact: Andrew Gilmore – Finance Manager **Tel: 03000 263 497**

Appendix 1: Implications

Legal Implications

The consideration of regular budgetary control reports is a key component of the Council's Corporate and Financial Governance arrangements. This report shows the forecast spend against budgets agreed by the Council in February 2019 in relation to the 2019/20 financial year.

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital outturn position alongside details of balance sheet items such as earmarked reserves held by the service grouping to support its priorities.

Consultation

Not applicable.

Equality and Diversity / Public Sector Equality Duty

Not applicable.

Human Rights

Not applicable.

Crime and Disorder

Not applicable.

Staffing

Not applicable.

Accommodation

Not applicable.

Risk

The consideration of regular budgetary control reports is a key component of the Councils Corporate and Financial Governance arrangements.

Procurement

The outcome of procurement activity is factored into the financial projections included in the report.

Overview and Scrutiny Committee -
Adults Wellbeing & Health – 17 January 2020

AHS Revenue and Capital - Forecast Outturn 2019/20 Quarter 2

Jo McMahon – Principal Accountant

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Durham County Council

OVERVIEW

- 2019/20 Quarter 2 Revenue Forecast Outturn and Variance Explanations
- 2019/20 Quarter 2 Capital Position

AHS 2019/20 Quarter 2 Forecast Outturn

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AHS Q2 2019/20 Forecast Outturn

By Expenditure Type

	Revised Annual Net Budget	YTD Actual	Forecast Outturn	Forecast Cash Limit Variance
	£000	£000	£000	£000
Employees	34,934	16,110	34,040	(894)
Premises	1,292	379	1,301	9
Transport	2,301	704	2,083	(218)
Supplies & Services	4,166	1,849	4,169	3
Third Party Payments	272,072	89,629	272,270	198
Transfer Payments	11,254	4,625	11,455	201
Central Support & Capital	26,726	19,859	27,200	474
Income	(235,963)	(76,937)	(238,174)	(2,211)
Total	**116,782**	**15,197**	**114,223**	**(2,438)**

AHS Q2 2019/20 Forecast Outturn

By Service Area

	Revised Annual Net Budget	YTD Actual	Forecast Outturn	Forecast Cash Limit Variance
	£000	£000	£000	£000
Central/Other	10,248	(28,628)	9,108	(1,140)
Commissioning	4,632	9,541	4,360	(272)
Head of Adults	100,369	67,973	99,343	(1,026)
Public Health	1,533	7,832	1,533	0
Total	**116,782**	**15,197**	**114,223**	**(2,438)**

Public Health Budgeted Expenditure

	Expenditure Budget
	£,000
Drug & Alcohol	6,163
Healthy Communities	4,405
Living and Ageing Well	9,193
Mental Health at Scale	238
Public Health Team (including Health Protection)	3,162
Starting Well	18,992
Vulnerable Groups	6,139
Grand Total	**48,292**

AHS Revenue Budget 2019/20

AHS budget position for 2019/20 is a projected under budget of £2.438 million, which equates to 2.1% of net budget

Key reasons for budget variances:

Adult Care (projected under budget of £1.026 million)

- Net under budget on employee-related costs of circa £0.371 million mainly through the careful management and control of vacancies and early achievement of MTFP savings across the service.
- Net under budget on supplies and services, transport and other costs of circa £0.307 million.
- Net overall under budget on care activity of circa £0.348 million.

AHS Revenue Budget 2019/20

Key reasons for budget variances:

Central Costs / Other (projected under budget of £1.14 million)

- Mainly due to early achievement of MTFP savings.

Commissioning (projected under budget of £272,000)

- Under budget in respect of staffing costs and third party payments.

AHS Revenue Budget 2019/20

Public Health (projected to be on target)

- This budget is funded in the main by Public Health Grant for 2019/20, and therefore shows nil net expenditure on the report.

- However £0.482 million is forecast to be made available for future investment in Public Health projects from uncommitted budgets, savings from vacant posts and underspends against some contracts.

AHS – Q2 2019/20
CAPITAL

- **No capital programme at present**

ANY QUESTIONS?

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