Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Monday 2 October 2023**
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 Chair's agreement.

1. Apologies for Absence
2. Substitute Members
3. Minutes of the meeting held on 14 July 2023 (Pages 3 - 14)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. Shotley Bridge Hospital Update - Presentation by Richard Morris, Associate Director of Operations, County Durham and Darlington NHS Foundation Trust (Pages 15 - 22)
7. County Durham and Darlington NHS Foundation Trust Maternity Services CQC Inspection and Improvement Action Plan - Presentation by Sue Jacques, Chief Executive and Noel Scanlon, Director of Nursing, County Durham and Darlington NHS Foundation Trust (Pages 23 - 86)

   Copies of the CQC Inspection reports into Maternity Services at Darlington Memorial Hospital and University Hospital North Durham are attached for members information. (Appendices 1 and 2)

8. Adult Social Care update on the Introduction of Local Authority Assessment by the Care Quality Commission under the Health and Care Act 2022 - Report of the Corporate Director of Adult and Health Services (Pages 87 - 108)
9. Quarter 4 2022-23 Revenue and Capital Outturn and Quarter 1 2023-24 Revenue and Capital Outturn reports - Reports of the Corporate Director of Resources and presentation by Joanne Watson, Principal Accountant (Resources) (Pages 109 - 140)
10. Quarter 1 2023-24 Performance Management Report - Report of John Hewitt, Chief Executive (Pages 141 - 182)
11. Such other business as, in the opinion of the Chair of the meeting, is of sufficient urgency to warrant consideration

Helen Bradley
Head of Legal and Democratic Services

County Hall
Durham
22 September 2023

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

Councillor V Andrews (Chair)
Councillor M Johnson (Vice-Chair)

Councillors J Blakey, R Crute, K Earley, D Haney, K Hawley, J Higgins, L A Holmes, L Hovvels, J Howey, P Jopling, C Kay, C Lines, M McKeon, S Quinn, K Robson, A Savory, M Simmons, D Stoker and T Stubbs

Co-opted Members: Mrs R Gott and Ms A Stobbart

Co-opted Employees/Officers: Healthwatch County Durham

Contact: Paula Nicholson Tel: 03000 269710

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 1A , County Hall, Durham on **Friday 14 July 2023 at 9.30 am**

Present

Councillor V Andrews (Chair)

Members of the Committee
Councillors M Johnson, J Blakey, L Brown, R Crute, M Currah, J Higgins, L Hovvels, P Jopling, C Kay, C Lines, M McKeon, S Quinn, K Robson, M Simmons and T Stubbs

Co-opted Members
Mrs R Gott

Co-opted Employees/Officers
Project Lead G McGee, Healthwatch County Durham

Also Present
Councillors A Reed and C Varty

1 Apologies for Absence

Apologies for absence were received from Councillors K Earley, D Haney, L Holmes, J Howey, A Savory and Angela Stobbart.

2 Substitute Members

Councillor L Brown was present as substitute for Councillor D Haney.

3 Minutes

The minutes of the meeting held on 11 May 2023 were confirmed as a correct record and signed by the Chair.

Matters Arising

Councillor Quinn referred to the matter of oral health which had been raised at the meeting on 11 May 2023 and asked if a response had been received and asked if an officer from oral health could attend a future meeting of the Committee. S

Gwillym, Principal Overview and Scrutiny Officer advised that a written response had been received from the Integrated Care Board Chief Executive and he suggested that dentistry be considered as part of the work programme for 2023/24.

G McGee, Healthwatch asked if a response had been received regarding breast screening following the meeting on 11 May 2023. The Principal Overview and Scrutiny Officer advised that a response was outstanding from three separate trusts and agreed to follow this up.

4 Declarations of Interest

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

There were no items from co-opted members or interested parties.

6 Joint Health and Wellbeing Strategy 2023-2028

The Committee received a report of the Corporate Management Team which presented the Joint Local Health and Wellbeing Strategy (JLHWS) 2023-2028 (for copy see file of Minutes).

The JLHWS 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. The Health and Wellbeing Board has the responsibility to deliver the JLHWS, which is informed by the Joint Strategic Needs and Asset Assessment (JSNAA), 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.

A Healy, Director of Public Health gave a detailed presentation and explained that the joint strategic needs and assets assessment rooted in intelligence and wider evidence about what drove health and wellbeing across the county. She further explained the vision for the JLHWS *'County Durham is a healthy place, where people live well for longer'* and noted that the JLHWS focussed on areas that could prevent it from achieving this vision. The four priority areas were:

- Making smoking history
- Enabling healthy weight for all
- Improving mental health, resilience, and wellbeing
- Reducing alcohol health harms

Councillor Kay asked for further information regarding the strategy's ability to improve mental health. The Director of Public Health highlighted that this was a

priority area. She explained that the mental health strategic partnership had been refreshed to re-emphasise mental health as an important issue and included information on prevention and fair access to services. Councillor Kay expressed concern regarding the challenges experienced by service users in being referred to a specialist mental health team and requested that updates on the JLHWS be brought back to the Committee to keep members well informed on progress. The Director of Public Health advised that the purpose of bringing the JLHWS to the Committee was to allow members the opportunity to consider the strategy in greater depth and she advised that any concerns raised would be feedback.

Councillor Jopling expressed concern with youth vaping, stressing that the long term side effects of vaping were currently unknown and asked what schools were doing to prevent young people from vaping. The Director of Public Health advised that vaping was part of the work that was being done on tobacco. She explained that vaping was a safer option in comparison to cigarettes and was a great alternative for those trying to stop smoking but she stressed that vaping should not be promoted to young people. The Director of Public Health went on to advise that current legislation regarding vaping was challenging. She informed the Committee that a government consultation regarding youth vaping had recently launched and Durham had submitted a robust response seeking the prevention of advertisement to young people. The Principal Overview and Scrutiny Officer advised that youth vaping had been agreed as a topic on the workplan for Children and Young People's Overview and Scrutiny Committee (CYPOSC) for 2023/24 and assured members of the AWHOSC that they would be invited to meetings when this topic was to be discussed.

Councillor Brown commented that a study had recently been released which stated that vulnerable women in the North East were 1.7 times more likely to die as a result of suicide, addiction and domestic violence and asked how the JLHWS could improve these figures. The Director of Public Health advised that the strategy tackled inequalities and she informed the Committee that a conference was planned to take place locally which would discuss women's health and wellbeing. The Director of Public Health offered to share the outcome of the conference with members.

Councillor Hovvels noted the benefits of opening up community assets and stressed that this must be done in partnership, not in isolation. Councillor Hovvels went on to ask if gambling was included in the strategy as this had increased and whether water fluoridisation had been agreed. The Director of Public Health commented that with regards to community assets, local councillors knew their communities the best. In terms of gambling, the Director of Public Health explained that they had recently been successful for a bid which had led to specific posts being appointed by Middlesbrough Borough Council to target those people affected by gambling but stated that the level of need was currently unclear. With regards to water fluoridisation, the Director of Public Health advised that this was included in the oral health strategy and the responsibility for this was now with the Secretary of

State for Health. She advised that Durham was in a position to fluoridise water rapidly and agreed to keep the Committee updated on this matter.

Members agreed that gambling was a growing concern. Councillor Currah pointed out that most football teams were sponsored by gambling companies which targeted young males. He further stated that some young people chose to play video games rather than interact socially and drink alcohol and whilst this may decrease the level of alcohol consumption in young people, the impact of this lifestyle could lead to an increase in mental health. The Director of Public Health agreed that advertisements for gambling needed to be addressed and explained that the Local Authority were seeking action on gambling and agreed to provide an update to the Committee and to the CYPOSC. In terms of alcohol consumption, the Director of Public Health advised that there had been a reduction in young people but agreed that mental health in young males was a growing concern and explained that the campaign 'now you're talking' encouraged young males and adults to open up and talk.

R Gott, co-opted member expressed concern regarding mental health services at Tees, Esk and Wear Valley (TEWV) and felt that basic duties such as bloods were being missed by staff and explained that some patients did not have an identified case worker. The Director of Public Health agreed to feedback the concerns to TEWV.

With regards to the obesity strategy, Councillor McKeon explained there was growing evidence that mental health was the biggest factor in cases of obesity and in her opinion, mental health was not discussed enough within the obesity strategy. The Director of Public Health highlighted that mental health underpinned all of the priorities and explained that once the JLHWS was in place, members could challenge it and make improvements.

Councillor McKeon went on to state that it was more difficult for those living in villages to take part in active travel and improving the footpaths between villages would be beneficial. The Director of Public Health noted the Physical Activity Strategy and explained that a consultation on enabling active travel had recently taken place to identify what needed to change to allow active travel more easily.

Councillor Varty expressed her appreciation for being able to attend the meeting of the Adult, Wellbeing and Health Overview and Scrutiny Committee (AWHOSC). She advised that the waiting list for a diagnosis for autism and neurodivergent had increased to four years. She stressed that this was not progress and emphasised that long wait times for a diagnosis impacted on children's futures and their parent's mental health. S Burns, Joint Head of Integrated Strategic Commissioning, North East and North Cumbria Integrated Care Board accepted that waiting lists had increased since the COVID-19 pandemic but gave assurance that they were working hard to improve this and to provide the necessary support to patients who were waiting for a diagnosis and post diagnosis. The Principal Scrutiny Officer

informed the Committee that neurodivergency was planned to be on the agenda for a special meeting of the Children and Young People's OSC in October 2023 and members of the AWHOSC would be invited to attend.

Councillor Higgins commented that social workers previously had the power to make referrals to the mental health team directly, and in his opinion, this was a more efficient process than the current arrangement of a GP referral. The Joint Head of Integrated Strategic Commissioning explained that extensive work improving access to community mental health services had commenced to ensure that a broad range of support is available. She acknowledged Councillor Higgins comment regarding referrals by social workers and agreed to feed this back.

Councillor Crute noted the various strategies and asked how they all fit together locally and how the voice of the Local Authority could be heard on a regional and national level. The Director of Public Health explained that JLHWS was overseen by the Health and Wellbeing Board and one of the roles of the Board was to support partners to focus on the wider determinants of health. She advised that recently, the Health and Wellbeing Board had influenced a questionnaire for the Inclusive Economic Strategy and confirmed that they would continue to embed health and wellbeing with partners. The Director of Public Health explained that she worked closely with a group of directors on a regional and national level and these directors had the ability to influence relevant departments. Councillor Crute welcomed the work by the Local Authority but stressed it was vital to continually voice concerns with inequality regionally and nationally and to get services based on need.

Councillor Quinn commented that it was great to see the JLHWS and she welcomed the intervention by local shops with regards to vapes being ceased. Councillor Quinn went on to express concern in relation to energy drinks and highlighted that some of these drinks contained traces of alcohol. She expressed further concern regarding the cost of non alcoholic drinks in food and drink establishments explaining that there was no incentive for those choosing not to drink alcohol. The Director of Public Health advised that they worked with 'Balance' and agreed to feedback the concerns raised regarding the cost of non alcoholic drinks. In terms of energy drinks, the Director of Public Health confirmed that a great deal of work had been done on this area and advised that trading standards should be informed of any illegal sales.

Councillor Andrews, the Chair praised the great strategy and expressed her thanks to the Director of Public Health.

Resolved

That the Joint Local Health and Wellbeing Strategy 2023-28 be noted.

7 North East and North Cumbria ICB Joint Forward Plan 2023/24 to 2028/29

The Committee received a report of the Joint Head of Integrated Strategic Commissioning, North East and North Cumbria Integrated Care Board and Durham County Council which outlined the draft Joint Forward Plan received from the Integrated Care Board (ICB) on the 4 July 2023 (for copy see file of Minutes).

S Burns, Joint Head of Integrated Strategic Commissioning gave a detailed presentation and explained that the Joint Forward Plan was a national requirement for all ICBs and partner NHS Trusts covering the period 2023/24 –2028/29. The Joint Forward Plan is aligned to system ambitions, building on existing plans and is delivery focussed and demonstrates how ICBs and the NHS Trusts will:

- Arrange and/or provide NHS services to meet the population's physical and mental health needs
- Deliver the NHS Mandate and NHS Long Term Plan in the area
- Meet the legal requirements for ICBs

The Joint Head of Integrated Strategic Commissioning advised that there was an opportunity to provide feedback on the plan and members were therefore encouraged to review the Joint Forward Plan and provide comment on its content. The deadline for feedback was August 2023 with the final publication of the ICB Joint Forward Plan in September 2023. The Joint Head of Integrated Strategic Commissioning advised that an annual update would be issued each March beginning in 2024.

Councillor Stubbs noted the first review of the plan was scheduled for March 2024 and asked how members could monitor the success of the plan and if it was possible to view the report before it was submitted to ensure that members were satisfied with the content. The Joint Head of Integrated Strategic Commissioning explained that in terms of the local element of the plan, this could be brought back to the Committee for members consideration, but she explained that there would be challenges to do the same for the regional element of the plan.

The Principal Overview and Scrutiny Officer advised that a Joint Regional Committee existed which comprised all 13 Local Authorities in the region and noted the Chair of the AWHOSC was one of the representatives on the committee. He felt that the Joint Regional Committee were best placed to consider the content of the plan from a regional perspective. Councillor Stubbs agreed and stated that a local report would be the priority for local members.

Councillor Jopling emphasised that the plan must address the current issues with dentistry to ensure those requiring treatment could access it, particularly children. The Joint Head of Integrated Strategic Commissioning explained that dental services were previously commissioned by NHS England but were now the

responsibility of the ICB. She advised that the plan included a section on dentistry and explained that a group met regularly to consider actions that would help resolve the current problems. The Joint Head of Integrated Strategic Commissioning offered to attend a future meeting of the Committee along with an officer from the dental team to provide members with an update on progress but gave assurance that they were acutely aware of the impact dentistry was having on people in the community and on hospitals and they were doing their best to urgently address this.

R Gott asked if people on certain benefits would meet the criteria for free dentistry. The Joint Head of Integrated Strategic Commissioning advised that this needed to be explored further and agreed to raise this with colleagues in the ICB.

Councillor Crute asked if NHS England had transferred the responsibility for dentistry in its entirety to the ICB or if the role of the ICB was in a monitoring capacity. The Joint Head of Integrated Strategic Commissioning confirmed that the ICB was responsible for commissioning dentistry explaining that they held the funding, were responsible for the staff and for ensuring dentistry provision for the population. Councillor Crute commented that moving this responsibility to local communities was a positive step forward. The Joint Head of Integrated Strategic Commissioning explained that whilst there were challenges for the ICB, there was also an opportunity for her to influence and improve the position with dentistry at a local level.

G McGee, Healthwatch stressed that a lack of dentistry provision had impacted on several sectors including mental health, personal finances, antibiotic resistance and mouth cancer and asked if the plan considered the long term impacts of this. The Joint Head of Integrated Strategic Commissioning agreed with all points raised and stated that doctors and hospitals had seen an increase in people presenting with dentistry problems. With regards to mouth cancer, she agreed that this had the potential to increase and thanked G McGee for this helpful feedback.

Councillor McKeon asked if it was possible to have a roaming dentist and optometrist, particularly in rural areas as many families had to travel a considerable distance to attend appointments, and in some cases, this impacted on children's attendance at school. The Joint Head of Integrated Strategic Commissioning agreed to look at this locally but felt that it could be a challenge due to the current absence of dentists.

The Chair asked if all GPs treat dental problems. The Joint Head of Integrated Strategic Commissioning confirmed that whilst there had been an increase in people presenting at GPs with dentistry related problems, she was unsure whether all GPs treated this and agreed to obtain this information from the Local Medical Committee.

In response to a question from Councillor McKeon regarding engagement with schools, the Joint Head of Integrated Strategic Commissioning advised that family hubs performed a strong role in providing people with a range of support under one roof. With regards to mental health in schools, she advised that children's mental health was currently being reviewed and explained that the Starting Well Partnership had considered the children's commissioner report and Durham were doing well with investment and waiting times, but currently lacked the plurality of provision. She explained that all services were delivered by TEWV and at present there were not any alternatives to this. The Joint Head of Integrated Strategic Commissioning explained that consideration was being given on how to improve children's mental health provision and schools were at the heart of this.

Resolved

That the Draft Joint Forward Plan 2023/24 –2028/29 be noted and the comments made by members on the Plan be submitted to the ICB as a formal response from the Committee.

8 Health Protection Assurance Annual Report

The Committee received a report of the Director of Public Health which provided members with an update on the health protection assurance arrangements in County Durham and health protection activities over the course of the year (for copy see file of Minutes).

Councillor Crute thanked the Director of Public Health for the comprehensive report and commented that it was positive to see the recovery of screening programmes following the COVID-19 pandemic. He had heard that new screenings for lung cancer were going to be introduced and asked if this would be included in future annual reports and if this screening would be rolled out in County Durham. The Joint Head of Integrated Strategic Commissioning advised that a pilot for lung cancer screenings had taken place in the Bishop Auckland area and was to expand to the whole of the North East and Cumbria, she offered to provide a briefing note to the Committee to keep members updated.

Councillor Quinn believed that further education highlighting the benefits of vaccines was necessary to ensure that people did not become complacent. The Director of Public Health stated that it was important to understand why some people were complacent and make the vaccination process simple.

Resolved

That the content of the report be noted.

9 Adult Learning Disabilities across Durham Tees Valley Update

The Committee received a presentation of the General Manager (Interim), Adult Learning Disabilities which provided members with an update on Adult Learning Disabilities' Service across Durham Tees Valley (for copy see file of Minutes).

S Halpin, General Manager gave a detailed presentation. She explained that the Trust was commissioned to provide 21 assessment and treatment beds for adults with learning disabilities and was provided from two sites, Lanchester Road Hospital in Durham and Bankfields Court in Middlesbrough. The General Manager explained the pressures on the service and the Improvement Plan that had been developed following the Care Quality Commission (CQC) Inspection.

Councillor Johnson noted that Lanchester Road Hospital had not temporarily closed as planned and asked if it was an option for all services to be provided from Bankfields Court in Middlesbrough once admissions were ready to re-open. The General Manager confirmed that the decision not to close Lanchester Road Hospital in Durham was due to the complexity of need of the one remaining patient and advised that clinically this patient would not benefit from being transferred to the site at Bankfields Court. She agreed that it made sense to rationalise all services to one site until a full team could be recruited and stated that a model to re-open had been considered with the possibility of all services being sited at Lanchester Road Hospital.

In response to a further question from Councillor Johnson, the General Manager explained that many patients at Bankfields Court were ready to be discharged but there was not anywhere for them to move on to and this had contributed to the closure to new admissions.

Councillor Jopling advised that she had visited the site at Lanchester Road Hospital in Durham earlier in the year and was satisfied that the necessary improvements had been made. She further advised that she had been impressed with staff and their exceptional care and appreciated the pressures with recruitment in finding the right people. She noted that security at the site was good and described it as an uplifting place with beautiful grounds.

R Gott asked if there was an emergency strategy in place for unavoidable admissions. The General Manager explained that the priority would be for a member of the specialist health team to work with the person in their own home and keep them well at home and this would include supporting their families. If the person required hospital admission, she explained that they would be admitted to TEWV mental health services on a green light admission. As a last resort, an out of area placement would be considered if necessary.

Councillor Currah asked for clarification on the ratio of staff to patients. The General Manager advised that ratios were dependent on the patient's level of need

and stated that they currently had patients who required a high ratio, some being 7:1. She explained that once patients moved on, the service would have the opportunity to re-model and reasonable staffing levels should return.

In response to a question from Councillor Stubbs, the General Manager advised that the CQC had completed a full inspection of all TEWV Services in April 2023 and that follow up actions for the service would be identified in the final report, but she was hopeful that the report would confirm that the service rating had improved.

The Joint Head of Integrated Strategic Commissioning added that they worked closely with colleagues within TEWV and needed to assess what was required in terms of accommodation going forward including the possibility of self-contained flats for those in crisis. The General Manager advised that an event was soon to take place that would involve a range of professionals and one of the topics to be discussed was blockages and barriers with regards to discharge.

Resolved

That the content of the presentation be noted.

10 Q4 2022-23 Performance Management Report

The Committee received a report of the Chief Executive which presented members with an overview of progress towards achieving the key outcomes of the council's corporate performance framework and highlighted key messages to inform strategic priorities and work programmes. The report covered performance in and to the end of quarter four, 2022/23, January to March 2023 (for copy see file of Minutes).

Councillor Crute noted the reduction in the completion of care act assessments and stated that this needed to be monitored. With regards to social care, Councillor Crute advised that members of the CYPOSC had raised concerns with the volume of cases children's social workers were responsible for and suggested that caseloads for adult social workers may need to be monitored.

S Tracey, Corporate Equality and Strategy Manager explained that they had received feedback from services which indicated that engagement with the service user had been completed in a timely manner but complex elements around the social work process had taken longer to complete and this had been complicated further by the introduction of a new case management system. The Corporate Equality and Strategy Manager advised that children's social workers had a different model to adult social workers, noting that children social workers focussed more on safeguarding whereas adult social workers had more service users and focussed on consolidating care.

Councillor Jopling commented on safeguarding and wanted reassurance that users were not turned away despite the high case loads experienced by social workers. She also asked if recruitment had improved. The Corporate Equality and Strategy Manager explained that recruitment for adult social workers was improving but it was still difficult to fill some roles in the service.

Resolved

That Committee noted the following:

- The overall position and direction of travel in relation to quarter four performance
- The continuing impact of COVID-19 pandemic recovery and the external international factors driving inflation and cost-of-living on the council's performance
- The actions being taken to address areas of underperformance including the significant economic and well-being challenges because of the pandemic and other external factors.

11 NHS Foundation Trust Quality Accounts 2022/23

The Committee received a report of the Corporate Director of Resources which informed members of the Adults Wellbeing and Health Overview and Scrutiny Committee (AWHOSC) of the responses made on behalf of the Committee in respect of NHS Foundation Trust Draft Quality Accounts 2022/23 (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer advised that the AWHOSC had previously agreed responses to the draft Quality Accounts of County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust.

Upon receipt of the respective Quality Accounts, these were circulated to the AWHOSC membership for consideration and comment. A special meeting of the AWHOSC was held on 11 May 2023 where representatives of County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust presented information on the performance against the Quality Account priorities for 2022/23 and the proposed priorities for 2023/24.

In order to comply with the deadline for responding to the Quality Account documents, draft responses were produced and signed off by the Statutory Scrutiny Officer in consultation with the Chair of the Committee and sent to each Foundation Trust within the mandated timeframe for responses which was 30 days following receipt of the draft Quality Accounts.

Resolved

That the responses to the draft Quality Accounts of County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust be noted.

12 Refresh of the Adults Wellbeing and Health OSC Work Programme 2023/24

The Committee received a report of the Corporate Director of Resources which provided the Committee with a work programme for 2023/24.

AWHOSC review their work programme each year to reflect the objectives and associated outcomes and actions identified within the Council Plan and in the context of the County Durham Vision 2035.

The Principal Overview and Scrutiny Officer advised that the proposed work programme had been framed around the shared County Durham Vision 2035 and also reflected the 'long and independent lives' strategic ambition therein. The draft work programme also reflected NHS Partner strategies, priorities and actions that had been developed.

Overview and scrutiny work programmes are designed to be flexible to accommodate items which may arise throughout the year. Flexibility was particularly important as the work programme was extensive and needed to accommodate issues that may arise during the term of the work programme.

Councillor Crute suggested dentistry be added to the work programme for 2023/24 and agreed that it was helpful for the work programme to build in a level of capacity to deal with any emerging issues.

Councillor Jopling agreed that dentistry was a good topic for the forthcoming work programme.

Resolved

The Committee:

- Received and commented on the proposed Adults Wellbeing and Health OSC work programme for 2023/24
- Agreed the Adults Wellbeing and Health OSC work programme for 2023/2024 and the flexibility it offered to respond to emerging issues
- Agreed the addition of dentistry to the work programme

Shotley Bridge Redevelopment – Update

NHS
County Durham and Darlington
NHS Foundation Trust

Adult Health and Wellbeing Overview and Scrutiny Committee – 2nd October 2023

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www.cddft.nhs.uk

Project Principles

- Provide a modern, technologically mature, fit for purpose community healthcare facility serving population of Derwentside
- Transforming models of care and estate solutions
- Working as part of the County Durham and wider ICB healthcare system
- Continuity of existing services
- Ongoing stakeholder engagement
- A part of the local community

Progress Update

NHS
County Durham and Darlington
NHS Foundation Trust

- Clinical model and cost projections agreed with New Hospital programme (NHP) in October 2022
- OBC submitted January 2023
- Following advanced design stage of the new build, market testing exercise undertaken (March 2023)
- Costs returned fell significantly outside of the agreed funding allocation (hyper-inflation nationally)
- Consultation with NHP and CDDFT exec. on next steps
- Agreed a review of the scheme of accommodation and opportunities for value engineering
- Refresh of all activity data, engagement of healthcare planners to develop an affordable project scope
- Transformational plans to maintain current levels of activity and service availability in reduced floor area

Service Efficiency Measures

NHS
County Durham and Darlington
NHS Foundation Trust

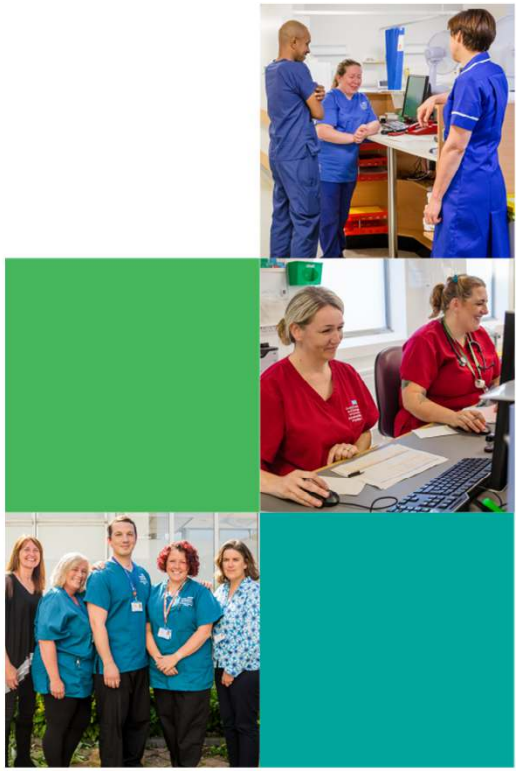
All clinical space operating at 85% utilisation

- Incorporate a live scheduling system for room utilisation – reduce unoccupied rooms due to cancelled clinics
- Maximise the use of virtual clinics/contacts in all areas
- Remove future expansion plans for services – review alternative estate options
- Reduce room sizes to HBN compliance minimum
- Multi-purpose rooms
- Shared department facilities
- Reduce or remove non-clinical areas
- Incorporate external plant to main build and roof area
- Review low volume services

Revised Timelines

- Cannot give definite timelines until we have a agreed and affordable scheme
- NHP, CDDFT and the ICB are committed to delivering the scheme
- Preferred option remains new build on Consett site
- Expect to have a revised scheme of accommodation costed by mid November 2023
- NHP will work closely with CDDFT to bring the scheme as close to the budget without compromising service levels
- Programme team will seek an acceleration through the business case assurance processes with NHSE and NHP

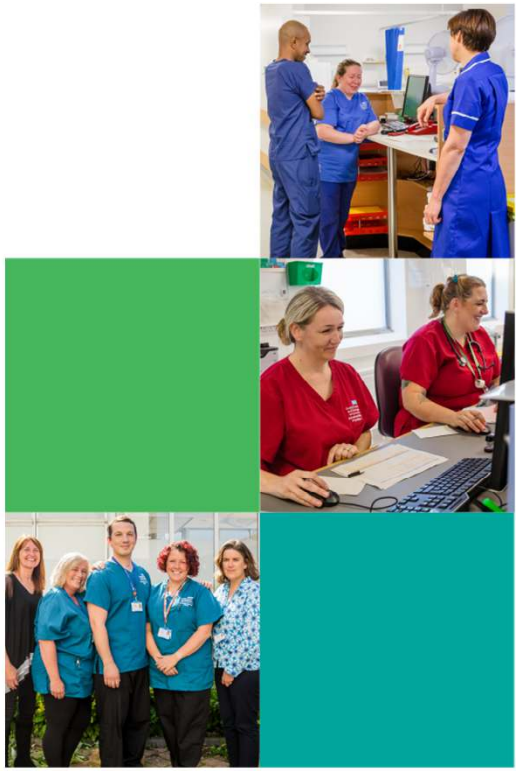
NHS
County Durham and Darlington
NHS Foundation Trust



Next Steps

- Revised floor plan agreed with NHP, CDDFT Clinical Directors and Execs to proceed to clinical review and impact assessment
- Each clinical area to work with the programme team to deliver area reductions whilst protecting, wherever possible, activity
- ALL opportunities to utilise technology, service transformation, innovation will be utilised with support of NHP and Trust systems
- Re-engage with architects and design team, produce revised scheme of accommodation
- Develop a revised cost plan and seek NHP approval to proceed
- Re-draft OBC

NHS
County Durham and Darlington
NHS Foundation Trust



Communication

NHS
County Durham and Darlington
NHS Foundation Trust

- Communication plan developed for ongoing engagement
- Met with local elected members and SBH support group 15th September to update on current position of scheme
- Plans to reinstate more regular meetings once we can agree a programme restart
- Staff drop in sessions weekly at SBH for any discussions/queries in the programme

NHS
County Durham and Darlington
NHS Foundation Trust

Thank You

Questions?

CQC Inspection - Maternity Services 28/29 March 2023

NHS
County Durham and Darlington
NHS Foundation Trust

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Ratings

County Durham and Darlington NHS Foundation Trust

	DMH		UHND	
SAFE	Requires Improvement		Requires Improvement	
WELL-LED	Requires Improvement		Requires Improvement	
MATERNITY				
SAFE	Inadequate		Inadequate	
WELL-LED	Inadequate		Inadequate	

Trust Rating

Care Quality Commission

Overall Rating 'Good'

Context

NHS
County Durham and Darlington
NHS Foundation Trust

- Around half of all units inspected by CQC have been downgraded
- Staffing and recruitment pressures are recognised at a national and regional level
- The service was rated ‘Good’ in 2019. Management arrangements had been stable and strengthened with the addition of senior clinical and non-clinical staff to help manage our response to the Ockenden recommendations
- In May 2022, the Maternity Quality Improvement Framework was introduced to support quality improvements in 5 key areas (workforce, screening, quality and safety, systems and Continuity of Carer)
- Throughout 2021/22 and 2022/23 the rollout of Continuity of Carer was modified, slowed and paused following staff feedback and staffing pressures
- The Trust is being supported by the ICB and Regional Chief Midwife in implementing action plans in response to CQC’s findings and providing oversight

Positives

NHS
County Durham and Darlington
NHS Foundation Trust

- **Courage, compassion, caring and resilience including sharing desire for improvement with CQC inspection team**
- **Patients at the heart of culture – recognising caring relationships**

- Safeguarding
- Equality and Diversity
- Domestic abuse
- Record keeping
- Children visiting
- Psychosocial assessments
- Mental health liaison
- Handover and huddles
- Transitional care

- Record keeping
- Medicines
- Dignity and respect clearly demonstrated
- Collaboration with universities, charities, research and innovation.

Themes identified for improvement

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- Disappointed with the ratings and take the concerns raised during the inspection very seriously
- Aware of many of the areas identified as requiring improvement and have already put changes in place and continue to make further improvements
- The report summarises the challenges we face with high demand and staffing pressures, like other NHS Trusts nationally, but also highlights that our colleagues promote a culture that places the patient at the heart of the service and recognises the power of caring relationships between people

- Staffing
- Incident Management
- Leadership
- Management of Risk
- Information Management
- Engagement

Actions taken since CQC's fieldwork in March to keep patients safe

NHS
County Durham and Darlington
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- Pregnancy Assessment Unit – triage and risk assessment
- CTG monitoring / foetal wellbeing
- Observations (mum and baby)
- Screening
- Training
- Staffing / Culture
- Duty of Candour / Involving patients and families following incidents
- Governance – risks, clinical audit, learning from incidents
- Equipment

Actions taken since CQC's fieldwork to keep patients safe

NHS
County Durham and Darlington
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- We have a consultation underway with the teams looking at the staffing model
- Nationally we know there is a shortage of midwives, however locally we have continued with our intensive recruitment programme – and have 30 midwives who have either already joined us in recent months or who will do so shortly, including five from oversees.
- We are absolutely committed to providing the best care and experience for all our birthing people and families.

- Every year we help to welcome more than 4,000 new babies and our teams are committed to providing a safe, compassionate and supported experience to each and every delivery
- Trust adopted an open and proactive approach to sharing information – conducted a series of interviews with media/press – social media activity – and a full update with FAQ and video resources made available on the Trust website: www.cddft.nhs.uk

Continuous improvement

NHS
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- Improvement actions continue with robust executive review and improved staff engagement
- Continuing our relationship and engagement with the Maternity and Neonatal Voice Partnership to listen and learn from patient experience and feedback
- Preparing for the opportunity of a full inspection expected before 7th December

You all do an amazing job and work very hard for women / birthing people, their babies and their families. As an MNVP we do hear good things and want to pass on to you all that many families say the midwives / doctors are kind and understanding of their wishes and they do feel cared for and safe.

'County Durham and Darlington MNVPs'

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We welcome your questions and comments.

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County Durham and Darlington NHS Foundation Trust

Darlington Memorial Hospital

Inspection report

Hollyhurst Road
Darlington
DL3 6HX
Tel: 01325380100
www.cddft.nhs.uk

Date of inspection visit: 28 to 29 March 2023
Date of publication: 15/09/2023

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Darlington Memorial Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Darlington Memorial Hospital (DMH).

We inspected the maternity services at County Durham and Darlington NHS Foundation Trust as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

Darlington Memorial Hospital is one of four sites for maternity services for the trust. Acute maternity services are also provided at University Hospital of North Durham. Outpatient maternity care is also provided at Bishop Auckland and Shotley Bridge Hospitals.

We carried out a short notice unannounced focused inspection of the maternity services at University Hospital of North Durham and Darlington Memorial Hospital, looking only at the safe and well-led key questions.

The inspection was carried out using a data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visits, we conducted interviews with specialist staff and senior leaders and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends. Feedback included 2 positive and 6 negative experiences. There were some negative comments about clinical decision making and delayed induction of labour.

The service at Darlington Memorial Hospital comprises of a labour ward with a maternity theatre, induction of labour beds and a recovery room. There are antenatal and postnatal wards. There is a separate pregnancy assessment unit. The service also has maternity services at University Hospital of North Durham and pregnancy assessment units at Bishop Auckland Hospital and Shotley Bridge Hospital which provide services to women and birthing people from across the County Durham area. Antenatal and postnatal clinics are also provided at this location.

The trust carried out 4500 deliveries between April 2021 to March 2022, of which about 3000 were carried out at University Hospital of North Durham and 1500 at Darlington Memorial Hospital.

A higher proportion of mothers were in the second (20%), third (16%) and fourth (17%) most deprived deciles at booking compared to the national averages (12% in the second most deprived, 11% in the third and 11% in the fourth).

A lower proportion of mothers were Asian or Asian British (3%) or Black or Black British (1%) compared to the national averages (14%) and (6%) respectively. More women were White, 86% at the trust compared to 67% nationally.

Our findings

Our rating of this hospital went down because:

Our rating of the maternity service impacted on the rating for the hospital location overall. As a result ratings for safe and well-led went down to requires improvement and services at Darlington Memorial Hospital are rated as requires improvement overall.

We also inspected the maternity service at University Hospital of North Durham run by County Durham and Darlington NHS Trust.

Following the Care Quality Commission (CQC) inspection of both County Durham Hospital and Darlington Memorial Hospital the CQC issued the Trust with a warning notice on 28/04/2023. This notice is served to the trust under Section 29A of the Health and Social Care Act 2008. Where it identified that the trust is required to make significant improvements.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Not all staff had training in key skills appropriate for their role.
- Staff did not always manage antenatal and intrapartum safety well. Including induction and risk assessment processes.
- Staff did not consistently assess risks to women and birthing people, nor act on them.
- Staff shortages increased risks to women and birthing people across the maternity service. Staffing levels did not always match the planned numbers putting the safety of women, birthing people and babies at risk.
- Women and birthing people could not always access the service when they needed it nor receive treatment within agreed timeframes and national targets. The trust did not audit or monitor time of arrival to triage or time of arrival to review.
- Staff did not always feel respected, supported and valued. They were not always able to focus on the needs of women and birthing people receiving care.
- The service did not always manage safety incidents well nor learn lessons from them.
- Leaders did not always have the skills and abilities to run the service for women and birthing people and staff.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services they did not always have the skills and resources to do so.
- Managers did not always ensure staff were competent.
- Staff had limited understanding of the service's vision and values, and how to apply them in their work.
- The service did not always engage well with women and birthing people and the community to plan and manage services.

However:

- Staff appraisal rates had recently improved to meet the Trust target.
- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse.
- The service maintained up to date cleaning records that demonstrated all areas were cleaned regularly.Staff kept good care records. They managed medicines well.
- Leaders used reliable information systems and supported staff to develop their skills.
- Staff were clear about their roles and accountabilities. They were focused on the needs of women and birthing people receiving care.

Maternity

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service did not make sure everyone completed mandatory training.

Staff were not up-to-date with their mandatory training. The service provided information that showed staff were required to complete mandatory training,clinical mandatory training, and local mandatory training. Following the inspection, the trust provided updated information on staff training compliance. Records showed compliance rates for individual mandatory training courses against a trust target of 95% for core statutory and mandatory essential training and 85% for role specific courses. New compliance rates showed the service across both sites was 87.7% compliant overall.

However, compliance for role specific courses for midwifery staff across the trust ranged between 50% for hand hygiene and 100% for preventing radicalisation. Midwifery staff achieved the trust target for 1 out of 5 core training and 22 out of 44 role specific courses. Compliance for medical staff ranged between 22% for hand hygiene and 100% for preventing radicalisation courses. Medical staff achieved the trust target for 0 out of 5 core training and 6 out of 30 role specific courses.

Managers did not always give staff time away from clinical duties to complete training. Staff said managers monitored mandatory training and alerted staff when they needed to update their training. However, they could not complete all the training because of staffing pressures. Staff reported it was a common occurrence of being pulled off internal study days. Staff said they had been advised by managers not to incident report this and it was corroborated by further evidence received.

Following our inspection, the trust provided information specific to Cardiotocographs (CTG) from 31 March 2023 to show compliance rates for staff across both sites had improved to 96% for midwives, 96% for doctors and 92% for consultants. In January to March 2022 compliance data had shown low rates of compliance: midwives 58%, doctors 65% and consultants 62%.

The service ensured all staff received multi-professional simulated obstetric emergency training. Staff could attended 3 study days a year which included simulated obstetric emergency training and life support training and this time was protected. The trust provided information from 31 March 2023 to show compliance rates had improved to 92% for midwives, 88% for doctors and 92% for consultants.

The service provided New-born Immediate Life Support Training Level 3. At the time of our inspection, the trust target was 95% and the compliance rate for medical staff was 83%. The annual local training in new-born resuscitation skills compliance rate for advanced nurses was 95% but only 81% for consultants. Compliance for neonatal nurses had improved from 80% to 94%, and the rate for junior doctors had improved from 88% to 100%.

Maternity

Staff were supported by practice development midwives to complete mandatory training. Staff told us specialist midwives could not always fulfil their specialist roles because they were often required to support staff shortages in the units.

Safeguarding

Staff understood how to protect women and birthing people 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 received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed safeguarding training at the level appropriate for their role. All medical staff (100%) and 96% of midwifery staff had completed safeguarding level 3 training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics. During handover we saw staff made adjustments to meet the needs of women and birthing people such as those living with mental health conditions or difficulties.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic patient records (EPR) system. We saw this recorded in records we reviewed. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence during our inspection that safeguarding concerns were discussed and escalated appropriately to the trust safeguarding team. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. However, the service had not practised what would happen if a baby was abducted within the 12 months before inspection as identified in the emergency skills and drills training schedule.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained, although staff told us wards had not been refurbished since the last inspection in 2018. Cleaning records were kept up-to-date, and staff could demonstrate all areas were cleaned regularly.

Maternity

The service had stopped offering water births because legionella had been identified within the water system in 2022. Staff reported there was a newly installed water system and processes to monitor the water supply for legionella. Staff would be informed when all testing had been completed. There were point of use (POU) filters fitted to taps and all water outlets. Water quality continued to be monitored and an agreed standard was being proposed via the Water Safety Group prior to removal of POU filters.

Domestics were available on the wards every day, and the environment appeared clean. The service generally performed well for cleanliness. Cleanliness audits for the 3 months prior to our inspection showed all areas met the compliance rate of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward managers completed regular Back to Basics IPC Audits that included infection prevention and control and hand hygiene checks.

In the last year compliance ranged from 71%, with some repeated issues regarding hand hygiene, to full compliance at 100%. Staff cleaned equipment after contact with women and birthing people and sometimes used labels to show when equipment was last cleaned, although these were not used consistently. We saw staff cleaned rooms thoroughly between use and notices were used to show when vacant rooms were clean and ready for use.

Environment and equipment

The service did not always have enough equipment to ensure safe care and treatment. However, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service did not always have enough suitable equipment to safely care for women and birthing people and babies. We found on inspection there was a lack of Dawes Redman specific cardiotocograph (CTG) machines and baby resuscitaire units. There was a mobile resuscitaire that was shared between labour ward and the antenatal ward/ pregnancy assessment unit (PAU), and another was stored in a corridor for use in the obstetric theatre.

We were not assured staff would be able to access appropriate resuscitation equipment in all areas. Each room on the labour ward had a fixed resuscitaire, suitable for single births. There were additional mobile resuscitaires for use with multiple births.

There was only one resuscitaire on the postnatal ward at DMH. This was fixed to the wall in the corridor so could not be taken to a baby suffering sudden clinical deterioration. The inspection team onsite escalated concerns and potential risks due to lack of resuscitation equipment to the Trust senior leadership team. The leadership team told us the next day that they had timed carrying a baby from the far end of the ward to the resuscitaire. The trust gave assurance that all their timings met the Resuscitation Council’s recommendation of commencing resuscitation in under 60 seconds as per the Resuscitation Councils 2021 national guidance. Following our concerns, senior managers told inspectors during the inspection that a second resuscitaire had been ordered.

Cardiotocography is usually called a 'CTG' by doctors and midwives. It can be used to monitor a baby's heart rate and a mother's contractions during pregnancy. There were CTG machines for each labour, delivery, recovery, and postnatal (LDRP) room. Not all CTGs were equipped with Dawes Redman monitoring, which did not meet Ockenden report 2020

requirements. Staff told us they were aware the equipment did not meet recommendations but had been told there were no funds available to replace existing CTG machines. There was central observation monitoring equipment at the nurses' station as well as computer access to CTGs. Immediately following the inspection, we raised this with trust leaders and they told us additional Dawes Redman equipped CTG machines had now been ordered.

Women and birthing people could reach call bells and staff mostly responded quickly when called. We saw midwives answered call bells on wards and labour ward.

Rooms on labour ward were designed and equipped for labour, delivery, recovery, and postnatal care (LDRP). The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

The service had completed self-harm and ligature risk assessments for labour wards. Staff told us any risks to vulnerable people would be mitigated by "cohorting with a birth partner or member of staff".

Staff carried out daily checks on emergency equipment. Resuscitaire checks were completed within labour room checks and there were no gaps in the checklist file between January and March 2023. Checklist audits showed staff checked 98% of resuscitaires at every shift.

There was a pool evacuation net and evacuation guidelines in the pool room. Staff told us the pool room had not been available for use for at least 12 months, and an evacuation drill had not been carried out in the last 12 months. However, managers said a skills drill was booked, although no date was provided to us.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support Staff aimed to use rooms close to the Midwives' station for women with additional needs.

At the time of the inspection, there were inappropriate bereavement facilities on both sites. Bereaved families stayed on labour ward in LDRP rooms. There was no designated bereavement room or facilities adequately equipped or soundproofed to meet the needs of families in meeting the National Bereavement Pathway recommendations.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and birthing person and staff did not always take action to remove or minimise risks. Therefore, staff were not always able to identify and quickly act upon women and birthing people at risk of deterioration.

Leaders did not monitor patient waiting times and could not be assured that women and birthing people could access maternity services when needed and receive treatment within agreed timeframes and national targets.

Pregnancy Assessment Unit (PAU) staff did not record the maternity triage waiting times. There was no review or audit to show how long women waited for triage or review.

Maternity

Staff told us all the information gathered from telephone triage and consultations would be entered onto the electronic patient record system (EPR). However, there were ineffective processes to ensure women and birthing people arriving in the (PAU) were assessed on arrival to the unit. Without an initial assessment, there was a risk the deterioration in women or birthing people would not be recognised and acted upon.

The trust had no standard process for documenting arrival times when women and pregnant people attended triage. The Trust did not have a formalised risk assessments to use in Pregnancy Assessment Unit (PAU) and no formal prioritisation tool was available to assist staff in providing timely care to those in most clinical need. Formalised and timely risk assessments were not carried out and the systems in place within the triage unit were not adequate to keep women, pregnant people, and babies safe. Not all clinical interactions were recorded,

Staff used a recognised tool known as the Modified Early Obstetric Warning Score (MEOWS) tool to monitor women and birthing people using maternity services. However, staff did not always carry out clinical observations in a timely way, record them, or escalate them appropriately. MEOWS audits from the 3 months between December 2022 and February 2023 showed 62.5% of women scoring above '0' on MEOWS indicating further action was required. Of those, 33% of observations were not taken in line with the appropriate frequency following local and national guidance. Also 47% of scores meeting the MEOWS trigger were not escalated according to trust policy. This meant there was a risk that deterioration of women, birthing people, and babies was not recognised and acted upon to provide safe care and treatment.

Staff did not always complete risk assessments prior to discharging women and birthing people and pregnant people into the community and did not always make sure third-party organisations were informed of the discharge.

We found there were delays to treatment including induction of labour. This meant some women and birthing people experienced delayed inductions and some did not receive induction of labour, although it had been planned for clinical reasons.

There were 93 incidents reporting delays in inductions of labour recorded by staff from both sites between 20 January 2022 and 20 January 2023. Patient records showed some women had waited for several days, and in one case, for over a week, or had no induction at all, even when records showed acknowledgement of clinical risk and trust guidance. We found evidence harm had occurred to mothers and babies when the trust did not act, and inductions were delayed or not carried out.

Cardiotocographs (CTG) were not always reviewed in line with local trust policy and not always interpreted correctly. 'Fresh eyes' CTG reviews were not always carried out at appropriate times during monitoring in line with local trust policy. Not, all CTGs with concerning features were escalated by midwives according to the trust protocol. This meant women, birthing people and babies were not risk assessed or managed appropriately to reduce the occurrence of harm.

During our inspection we found multiple examples of incident investigations where CTG protocols were not followed. Out of 17 investigations carried out by the Healthcare Safety Investigation Branch (HSIB), 5 cases were identified as having errors or care issues relating to CTG's.

Trust combined audit results showed CTG fresh eyes check compliance had decreased over the previous 3 months and results ranged from 85% in January to 74% in March 2023. Trust audit results showed for the Darlington site that CTG fresh eyes check compliance had fluctuated over the previous 3 months and results ranged from 77% in January, 73% in February to 83% in March 2023.

Maternity

There were missed opportunities for carrying out screening and for managing results of screening to safely manage care during pregnancies of women, birthing people and babies. There had been 76 incidents between January 2022 and January 2023 reported as 'near misses' or 'minor harm' that showed staff did not comply with guidance from pathology such as labelling protocols and guidance from national screening standards There were 6 of these that remained open or were awaiting a review in January 2023.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. In the records we reviewed these were completed by clinical staff via the electronic patient record system (EPR).

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection, we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, and recommendation for each patient.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. However, audit showed these were not always completed at appropriate times or according to trust policy. This sometimes meant some babies were readmitted to the unit or had prolonged stays in hospital. The trust did not provide evidence of plans to reduce "avoiding term admissions into neonatal units" (ATAIN).

The service provided transitional care for babies who required additional care. This enabled a mother or parent to stay with their baby together in hospital whilst they, with the team, cared for the baby. It meant the baby was well enough to stay in the postnatal ward, with support from the hospital staff.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

During the inspection, we found the service was consistently short of registered midwives across all areas. Board reports supported this information across several months' staffing submissions. Staff shared that it was a normal occurrence for inductions of labours to be delayed due to staffing issues.

The service did not use an acuity tool in all areas. Acuity was not measured in areas other than labour ward. Staffing records showed staffing levels in relation to the acuity was met in 47% of shifts on labour ward during January 2023 with two episodes not submitted. However, staff told us there were "many" occasions when there was only one midwife on the postnatal ward. During the inspection, we observed one midwife was present to run the pregnancy assessment unit with a health care support worker, with a second sonographer midwife present but she had a fully booked scanned clinic.

Maternity

The trust did not ensure there were enough senior, experienced midwives to ensure safe care and treatment for women, birthing people, and babies on labour wards. Skill mix was not always in line with national recommendations. There was not always senior midwifery supernumerary oversight on labour wards. Although labour ward coordinators were planned to be supernumerary staff told us this rarely occurred in practice, and coordinators took responsibility for direct care, especially out of hours. The Labour Ward co-ordinators should always remain as supernumerary for helicopter oversight of the service. However, the figures reported in the Integrated Quality and Performance Reports to Board added up to 214 occasions during the period from September 2022 and February 2023.

Staff told us they had raised concerns that Band 5 newly qualified midwives were working night shifts on labour ward to fill shifts. Staff used a staffing allocation tool to identify staffing numbers required on each area. Staff told us it was common practice to relocate the second midwife from the pregnancy assessment unit to the labour ward and sometimes staff from the Darlington Memorial Hospital were also relocated to work in the labour ward at University Hospital of North Durham. Staff shared that staff relocations should have been recorded on the staffing allocation tool. However, not all shifts were recorded accurately on the staffing allocation tool.

Staff told us that the pregnant women and birthing people did not always receive 1:1 care in labour due to staff shortages. However, the proportion of 1:1 care in labour achieved was not recorded in trust board papers or senior staff reports. Staff told us low numbers of staff made them feel unsafe. Staff had reported delayed inductions of labour through the incident reporting system and these included babies categorised as high risk. Between September 2022 and February 2023 there had been 144 delayed inductions of labour reported in trust board papers. The Maternity Safety Champions Meeting, January 2023 minutes stated “induction of labour queuing is deteriorating due to the challenges with staffing. Daytime staff are often hesitant to start induction to avoid pressure on the night staff.

During our inspection the ward manager did not have the resources to adjust staffing levels according to the needs of women and birthing people. Managers told us this happened daily, and they regularly moved staff according to the number of women and birthing people in clinical areas, Midwives told us this happened at short notice, and they were frequently expected to work in areas unfamiliar to them.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 (2015) ‘Safe midwifery staffing for maternity settings. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. During the inspection’ staff told us, and we found staff did not report staffing incidents that should have raised red flag indicators. These included delays to inductions of labour, delays with LSCS (lower segment caesarean section), delays of induction of labour for more than 2 hours or more between admission and beginning of the process. We found there was delayed recognition of, and action on, abnormal vital signs and lack of assurance that women were being seen for triage within 30 minutes of presentation.

Staff told us many issues relating to staffing were reported continually to managers and leaders, but these seemed to be ignored. Midwives had communicated their concerns to managers over the previous 12 months and had stated they found the unit was unsafe. However, staff told us nothing had changed. Staff told us they regularly missed breaks, worked late, and worked extra hours (both paid and unpaid) and midwife sickness levels were very high due to the increased pressure on staff because of shortages in staffing.

Staff told us they should be given their off-duty rota 4 weeks in advance but sometimes managers now provided these only 2 weeks in advance. Staff said this was insufficient time to plan for their shifts. However, NHS Improvement advises publishing rosters a minimum of six weeks in advance, ideally 12 weeks. (NHS Improvement, 2019).

Maternity

Midwifery staffing summary from open board meetings evidenced that the service had high vacancy rates, turnover rates, sickness rates, and high use of bank nurses. Despite the use of bank staff there remained 75 shifts unfilled September 2022 – February 2023.

The trust and service leads said they were actively recruiting locally, regionally, nationally, and internationally to meet their establishment and backfill using bank and agency staff. However, it was unclear as to what the trust correct staffing levels should be. Board papers from August 2022 showed an established acuity assessment tool was awaiting reassessment by a third party, and there was no evidence to show this had been completed by the time of the inspection.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service made sure all new staff completed competency assessments. Managers told us they supported staff to develop through yearly, constructive appraisals of their work. A practice development midwife supported multidisciplinary staff development.

The trust target for staff appraisals was 95%. Compliance data showed all medical staff (100%) and 96% of midwifery staff had completed an annual appraisal. This was a significant improvement from the maternity surveillance report from the maternity safety champions meeting in March 2023 which showed lower rates of compliance for January 2023 at 40%.

Staff said midwifes no longer received supervision but relied on the appraisal system to ensure competency. Staff told us they felt this was not as effective as supervision. The lack of supervision for midwifes should be separate from the appraisal process and this was not in line with national recommendations from Royal College of Midwives, Midwifery Standard 33: There must be a framework for effective and accessible clinical supervision. However, midwives told us they had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

Managers did not always make sure staff received specialist training for their role. Training provided included role specific training which showed a range of compliance for midwives, doctors and consultants as reported under mandatory training.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number and provided the required consultant hours for the service. The service had low vacancy, turnover and sickness rates for medical staff.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

Maternity

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular and constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Trainees in a GMC approved training post in the UK complete the 2022 General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received, support and wellbeing. Scores for this hospital were significantly below (worse) than the national average for the indicator 'Facilities', and significantly above (better) than the national average for the indicator 'Clinical Supervision' out of hours.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The patient care record was on a secure EPR system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used electronic patient records. We reviewed 12 electronic records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

Staff reviewed each woman or birthing person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records we reviewed were clear and up to date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely,. The clinical rooms where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature.

Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems at were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. These were shared in daily safety huddles, via emails and lessons learned were included in staff bulletins.

Incidents

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. However, managers did not always review incidents in a timely way and duty of candour was not always applied when things went wrong.

Staff could describe what incidents were reportable and how to use the electronic incident reporting system. Although managers reviewed incidents using the trust's root cause analyses tool (RCA), these reviews did not always recognise failings in care which may have had an impact on the outcome for babies, or for babies which sadly died. The trust did not have an open, accurate, effective, robust review of risk process and there was a lack of evidence lessons are learnt despite poor outcomes as reported in HSIB investigations and PMRT cases since 2019. PMRT reviews were not always completed and staff informed us this was because consent was not given. However, it is not necessary to obtain consent before carrying out internal reviews or PMRT.

Incidents reported were not always reviewed or acted upon in a timely manner. The potential for learning lessons from incidents, lack of immediate actions and further action planning meant opportunities were missed to prevent women, pregnant people, and babies being exposed to harm.

Managers did not always investigate incidents thoroughly.

Incidents were not always reviewed in a timely manner to monitor and manage risk, and identify opportunities for learning or changes in practice to reduce the recurrence of harm. We found 212 maternity incidents remaining open for over 60 days. Data regarding open incidents from 30 March 2023, showed there were incidents dating back to October 2021 that were awaiting review or closure. The trust provided evidence of Maternity Quality Improvement Forum (MQIF), Scope Actions and Outcomes". However, there was a lack of evidence of actions being completed to address themes, assess and manage risks and implement change. This was seen in recurrent findings and recommendations for example from HSIB reports. Following some reports HSIB action points were documented as completed. We found some of these actions remained outstanding and continued to put women, birthing people, and babies at risk. Reported incidents included; management of post-partum haemorrhage, delays in treatment, clearly documented information about allergies not being followed, and safety measures ignored. There was insufficient evidence that learning from these had been investigated and shared.

Maternity

The service did not always involve women and birthing people and their families in these investigations. We reviewed serious incident investigations and found staff had not always involved women and birthing people and their families in the investigations. Perinatal Mortality Review Tool (PMRT) review documents noted some families had provided feedback to show there was a lack of support and information provided, and a limited number of cases shared families' perspectives with staff.

Staff understood the duty of candour. However, they were not always open and transparent and did not always gave women and birthing people and families a full explanation if and when things went wrong. It was not clear duty of candour was always applied when it should have been. We reviewed serious incident investigations and found staff had not always involved women and birthing people and their families in the investigations. PMRT review documents noted families had provided feedback to show there was a lack of support and information provided, and a limited number of cases shared families' perspectives with staff. Maternity staff were not able to recall any instances where duty of candour had been carried out. We found serious incidents reviews that showed a lack of evidence Duty of Candour and PMRT had been carried out where the trust had identified care may have caused harm such as stillbirths, neonatal deaths, or brain injuries to babies. However, examples provided by the service of two serious incident records showed evidence that Duty of Candour had been carried out.

Managers did not always review incidents potentially related to health inequalities. One HSIB investigation noted a case where staff had not acknowledged a woman or birthing person's needs when antenatal records showed they lived with a learning disability.

Staff did not always receive feedback from investigation of incidents they had reported, or from reviews both internal and external to the service. Ward staff told us they did not always receive feedback from serious incidents, mainly because these were not reviewed by senior staff for several months.

Staff told us meetings had been set up in recent months to discuss cases of interest, and on some occasions, historic incidents or cases to look at improvements to the care of women and birthing people. Staff explained there was limited meaningful action and improvement following feedback.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. However, managers did not always review incidents in a timely way.

Staff could describe what incidents were reportable and how to use the electronic incident reporting system. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly. Staff reported postpartum haemorrhage (PPH) with more than 1.5 litres blood loss, and intrapartum perineal tears when these occurred. However, managers and leaders regularly graded these incidents inconsistently between "minor" and "no harm" during incident reviews.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff.

Local managers debriefed and supported staff after any serious incident.

Is the service well-led?

Inadequate

Maternity

Our rating of well-led went down. We rated it as inadequate.

Leadership

Local leaders did not always have the skills and abilities to run the service, they were not always visible and approachable in the service for women, birthing people and staff. Executive leaders did not always manage the priorities and issues the service faced. However, leaders supported staff to develop and take on more senior roles.

The service was led by a head of midwifery, clinical director and business operations manager. This triumvirate reported to the executive director of nursing and medical director. Leaders did not always have the skills and abilities to run the service. They understood the priorities and issues the service faced although these issues were not always addressed or shared with staff.

Staff told us that they felt their concerns were not listened to by the leadership team. Staff said responses from the leadership team appeared supportive. However, no tangible improvements were made, despite issues repeatedly being raised to the leadership team. Leaders for maternity services had been aware of patient safety risks and challenges throughout the service for a prolonged period of time. Leaders had not completed or taken all essential actions to ensure the safety, quality, and sustainability within the service.

Staff reported that leaders were not always visible and approachable for women, birthing people, and staff in the service. Leaders were not always respected, although some senior staff described them as approachable. Staff reported them lacking in providing supportive responses.

Staff told us they were supported by their line managers, ward managers and Matrons. They said the executive team visited wards and staff spoke of how they had been more accessible around the time of the inspection. The service was supported by maternity safety champions and non-executive directors.

Vision and Strategy

The service leaders had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, not all staff felt their views had been taken into consideration and could only give limited explanation of what it meant for the service and local women. Although leaders understood and knew how to apply them and monitor progress, staff did not understand the service strategy.

The trust leaders had developed a vision and strategy in relation to maternity continuity of carer (MCoC) model of care and had implemented this. This model is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwife through their pregnancy. However, ward staff could give limited explanation regarding the trust's vision and what it meant for women and birthing people and babies. Staff in the acute areas we visited told us they felt their views had not been considered. Leaders had carried out a staff consultation, but most staff told us they felt this had not been done fairly. Leaders provided survey results to staff and the trust board that showed most staff would have preferred to review the plans for implementing 'continuity of carer' as a group, but these responses were combined amongst other responses and not all had been considered. Although leaders stated the survey results had not been conclusive, the plans had gone ahead.

Staff reiterated they felt that 'continuity of carer' was the trust's main focus despite depleted safe staffing levels, skill mix, and staff being pulled in to cover acute areas on a frequent basis. The trust's implementation of 'maternity continuity of carer' (MCoC) was not in line with national recommendations as they could not demonstrate staffing levels

met safe minimum requirements on all shifts. These recommendations were shared nationally in September 2022. Senior leaders advised that the trust had considered these recommendations but had decided to continue with MCoC, albeit in a scaled back form compared to original plans. Staff told us, and incidents reported, showed there were inequalities and disadvantages for women not on the MCoC pathway. For example, when there were insufficient staff to provide induction of labour for women in the acute setting, one woman on the MCoC pathway had an induction carried out by her MCoC midwife. This meant one woman had an induction of labour based on availability of her midwife, before others at higher level of risk could have their planned induction of labour.

Culture

The service did not have an open culture where staff could raise concerns without fear.

Leaders were not responsive, staff had felt that leaders had been dismissive when issues had been raised with them. Staff reported feeling ‘frozen out’ or that their concerns were ignored by leaders as a recurrent issue with the leadership team since 2020. This was indicative of a “closed culture”. CQC defines a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture.

Staff told us that they felt their concerns were not listened to by the leadership team. Staff said responses from the leadership team appeared supportive. At the time of the inspection staff told us that although active recruitment was ongoing, they felt no tangible improvements were made despite issues repeatedly being raised to the leadership team. However, following the inspection and our feedback to the senior executive team, the service provided information to show they had begun new work, and continuing ongoing workstreams to address underlying service issues and challenges which sought to engage midwifery teams.

Staff promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Staff were focused on the needs of women and birthing people receiving care demonstrating kindness, compassion, and courage.

Dignity and respect for people accessing maternity services were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

We observed good working relationships throughout the multidisciplinary team. Staff felt there were good working consultant relationships and midwifery staff felt confident to challenge medical staff, although acknowledged that there were mixed approaches from the consultants who worked with differing styles and to “different protocols”. This included interpretation of the consultants using a standardised venous thromboembolism (VTE) risk assessment guidance.

The service promoted equality and diversity in daily work. Leaders understood and acknowledged how health inequalities affected treatment and outcomes in their local population. However, the service did not have effective systems to demonstrate how this was monitored or managed to improve maternity services.

Women, birthing people, and their families we spoke with said they knew how to complain or raise concerns and felt that they would be listened to. The service used the most informal approach applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Maternity

The trust provided complaints information that showed 4 formal complaints were received between January and March 2023. Of these, 1 had been partially founded and the others were awaiting outcomes. Managers investigated complaints and identified themes. However, staff said they did not receive feedback from cases other than newsletters and group emails. There was a lack of regular staff team meetings to communicate issues and feedback on outcomes and learning from complaints.

Governance

Leaders did not operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but they did not have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate an effective governance process throughout the maternity service. The service provided a clear governance structure and processes to support the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics although there was a lack of evidence of lessons learnt and subsequent improvements to practice. Therefore, there was not a comprehensive well-structured governance process embedded.

The trust had not met the “Ockenden 7 national immediate essential actions from December 2020”. The trust action plan from March 2022 in response to the Ockenden report statement “Women were not formally risk assessed at every antenatal contact to ensure continued access to care provision by the most appropriately trained professional” showed the trust were not yet compliant with this point and the head of midwifery would continue to monitor and maintain standards through audit. Audit results were provided by the service following the inspection. Leaders said they had considered the recommendations from the Ockenden 2020 and 2022 reports and said they planned to revise the vision and strategy to include these recommendations.

Key concerns identified from Ockenden 2020 and 2022 report recommendations were workforce, embedding twice daily ward rounds, implementation of PMRT, audits, and lack of risk assessments (to include place of birth). At the time of our inspection the service had no triage risk assessment tool and had not evidenced that they were compliant to Saving babies Lives version 2 (published March 2019). At the time of our inspection, actions in line with recommendations had not been implemented. However, the service provided an updated Ockenden Action Plan as presented to the Board in January 2023. This showed they were partially compliant with “A risk assessment must be completed and recorded at every contact".

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from October 2021 that continued to await review or closure. Leaders told us staff were encouraged to report incidents for understaffing. However, staff told us it was their perception they were advised by senior staff and discouraged from incident reporting relating to training being cancelled, staff being redeployed to alternative clinical areas, and understaffing.

Learning from serious incidents was not always embedded. We found there were 2 cases presented by the trust paediatric service to the trust board in 2023 which shared the same themes previously identified by HSIB and PMRT as evidenced in HSIB reports dating back to 2020 with repeated safety recommendations and actions required.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. However, information was not shared back to sub-committees and to all staff.

Maternity

Maternity service leaders were not always able to describe accurately the status of audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvement.

The service's governance and risk processes were not effective in identifying failings, learning from incidents, or evidencing changes to practice to prevent recurrence. Incidents reported were not reviewed or acted upon in a timely manner to monitor and manage risk and identify opportunities for learning or to implement changes in practice to reduce the risk of harm.

The Family Health Quality and Governance meeting minutes from February 2023 noted reports from the trust's 'Assurance Risk and Compliance report' (February 2023) and incident reporting minutes showed there had been 67 audits on a forward plan; 14 of which were complete, 18 were ongoing, 27 were behind schedule and 5 were abandoned. This included the audit to assess the adherence to the Saving Babies Lives recommendations for screening all that were part of the Maternity Incentive Scheme. However, the service told us following the inspection that no action plan had been developed for DMH due to resource issues.

We found reports relating to compliance with national guidance and report recommendations where the trust had assessed themselves as compliant, partially compliant, or actions had been met. These included external reports, and recent reviews including the Ockenden Trust Assurance Report and the Kirkup East Kent Hospitals report. However, we found instances where information contained within these was not correct and different information had been reported in board papers, in managers' meetings and in interviews with senior staff. For example: trust board papers from February 2023 showed the trust was not compliant with 2 of 10 actions under the Maternity Incentive Scheme 2022. This scheme is designed as a financial incentive to support the delivery of safer maternity care.

We reviewed data and figures from the service's maternity dashboard and found no recognition of "Babies Born Before Arrival" (BBA) in meeting minutes, action plans or in communications with staff.

Staff were clear about their roles and accountabilities, but they did not have regular opportunities to meet, discuss and learn from the performance of the service or incidents. For example, actions and lessons learned from PMRTs and HSIB investigation recommendations.

Management of risk, issues, and performance

The trust did not use effective systems to manage performance effectively and safely. They did not always identify and act to minimise risks and issues relating to safe care of women, pregnant people, and babies. The leaders did not complete and ensure changes in practice were made as agreed from action plans to improve safety and performance.

The service had a risk register to address service risks such as concerns around staffing and estate but not all risks discussed with the inspection team were included in the register such as escalation of clinical risk. Not all risks the service were aware of were effectively managed using this process. Therefore, the risk register could not provide assurance to the trust that it was fit for purpose. Leaders had presented risks through the board assurance framework which was recorded in the trust board open paper for 29 March 2023. These included risks regarding workforce, estate, and items raised during the inspection such as ligature risks.

Maternity

Leaders did not have an established clinical risk process and did not have full oversight of all risks to patient safety. Following reports and recommendations from investigations carried out by the Healthcare Safety Investigation Branch (HSIB) there was a lack of evidence to show effective tangible actions had been completed and lessons learnt.

Leaders did not always identify and escalate the relevant clinical risks, issues, and identified actions to reduce their impact. Staff told us not all risks were identified through the incident management system and identified risks were not always reviewed and recorded in meeting minutes of the monthly risk assurance meeting. The leadership team did not always take action to make changes where risks were identified.

Staff told us they were not aware of the service's stillbirth or neonatal death rates, or other key performance indicators because they had not seen the maternity dashboard.

Managers and staff did not complete a comprehensive programme of repeated audits to secure assurance of improvements over time. Leaders did not effectively share and make sure staff understood information from the audits and incidents. Maternity service leaders were not always able to provide audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvements. The service reported in February 2023 that there were 67 audits on a forward plan, 14 were complete, 18 only on going, 27 behind schedule and 5 were abandoned, which included the Saving Babies Lives audit. The service had not completed relevant clinical audits including the national perinatal mortality audit.

Results from a service modified early obstetric warning score (MEOWS) audit indicated staff did not always carry out clinical observations using MEOWS in a timely way, record the observations or escalate them appropriately. This meant that there was a risk to women, birthing people and babies coming to harm. The service's MEOWS audit results also indicated that observations were not being taken in line with appropriate frequency, and national and local guidance was not being followed. Significant numbers of MEOWS scores meeting a trigger point should have been escalated. However, this did not occur. Following the recommendations of a HSIB investigation in 2021 the trust had committed to an action plan but, at the time of the inspection, staff had not taken action to ensure MEOWS was used effectively, escalated in line with policy and associated risks were not mitigated.

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from as far back as October 2021 that continued to await review or closure. Delays in the trust completing incident reporting would not give the trust or its staff the opportunity to learn lessons or implement change. The trust had recorded its highest numbers of incidents remaining open in November 2022 at 216, and this had remained at over 190 on 1 February 2023. There was a significant lack of evidence and learning relating to the Healthcare Safety Investigation Branch (HSIB) and perinatal mortality review tool (PMRT) case action plans completed from cases from 2019, 2020, 2021 and 2022.

We reviewed the trust's HSIB cases aggregate report presented to the board dated March 2023. Recurrent identified themes included lack of MEOWS escalation, policies not being followed, lack of review and oversight of governance, lack of promotion of learning, and issues around the trust's safety culture. Although the reports marked the actions had been completed, the trust provided no evidence of actions taken, embedded, or shared.

Investigation reports from HSIB stated outcomes for women, birthing persons and babies may have been negatively impacted resulting from the lack of risk assessments, lack of learning from incidents, and lack of embedding national immediate essential actions. Senior staff provided assurance to the board that actions identified by HSIB had or would be completed. However, information provided by the trust showed these actions remained incomplete. Therefore, inhibiting the ability to improve the service and the experience and outcomes for women, birthing persons, and babies.

Maternity

The trust had not evidenced working collaboratively to ensure serious incidents were investigated thoroughly. The trust worked with the Local Maternity Neonatal Services, although there was a lack of learning by the trust, a lack of enhanced learning from incidents, and a lack of sharing of learning with the LMNS.

Partner agencies had previously reported risks to the trust regarding screening processes and incidents, and for managing results of screening to safely manage care during pregnancies of women and birthing people. Although this was included in the service risk register, screening incidents continued to be identified in some cases throughout all stages of pregnancy and intrapartum care, which provided a lack of assurance and risk process as lessons were not being learnt. The service reported an improving trend had been noted since Quarter 2 for 2022/2023, although some incidents reported as no harm had not been investigated regarding their impact on care. The review process had not been completed and incidents remained open.

The trust was reported nationally as being a statistical outlier of babies when born with a low Apgar score in 2022, continuing to the time of inspection. The Apgar scoring system is a recognised standardised assessment of a newborn baby following birth. This was recognised as being a higher (worse) than the national average and in the upper 25% of all organisations with a rate of 29 babies having high scores per 1000 births compared to the national average of 13 babies per 1000 births. The trust staff and leaders did not recognise or have an awareness regarding the trust being an outlier with this data. There were no audits or action plans to reduce future risks or improve the outcomes for women, pregnant people, and babies.

The national maternity dashboard showed trust information the period between March 2022 and February 2023. For 10 months the trust had a higher number of PPH than the national average, 1 month where they had the same number, and only 1 month where there were fewer. In April and May 2022 there were 45 in 1000 births, significantly higher compared to the national average of 29 per 1000.

The trust did not always use perinatal mortality review tool (PMRT) appropriately. They did not identify the cause of each baby's death by robustly and comprehensively reviewing each case and the quality of care provided. The service did not work through the care for each baby who died to identify contributory factors where issues were identified and assess whether different care may have made a difference to the outcome (grading of care). The service did not develop and complete action plans that addressed the contributory factors identified, achieve organisational change, or service improvements. The service did not recognise a 'just culture' of accountability for individuals and organisations.

The PMRT was found not to be shared with the trust board regularly, the themes and trends were not identified from these perinatal loss cases. The reports lacked full completion and meaningful action plans, and there was a lack of evidence that actions had been completed. We reviewed some completed PMRTs which lacked relevant information including the baby's birth weight centile. However, 'small for gestational age' was indicated as a theme from the HSIB and the PMRT cases reviewed. Staff reported that they had not had any 'Gap and Grow' training over the last 5 years. 'Gap and Grow' aims to increase the recognition of fetal growth restricted babies and improve outcomes. It includes a benchmarking missed case audit where clinicians undertake a 'standardised clinical outcome review and evaluation' (SCORE) of their small for gestational age (SGA) deliveries that were not recognised antenatally. Trusts and leads are encouraged to undertake this regularly on a proportion of cases to check for avoidable factors such a failure to follow risk assessments, inaccurate measurement or plotting, or lack of referral for investigation.

Following PMRT case reviews there was no evidence that the trust was providing parents with a robust explanation of why their baby had died, or accepting that in all instances, despite full clinical investigations, it is not always possible to determine this. Staff did not always explain any implications for future pregnancies.

Maternity

Information Management

The service did not always collect and analyse reliable data. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions, and improvements. Data or notifications were not consistently submitted to external organisations as required. However, the information systems were integrated and secure.

The service had a lack of processes, and systems for introducing and communicating new or amended trust policies. This meant staff did not have access to up-to-date local or national policies to plan and deliver high quality care according to evidence-based practice and national guidance. Not all policies and guidance were in date or reviewed every 3 years and not all staff could access the policies and guidance.

The service did not always collect and analyse reliable data**.** We requested a copy of the trust's maternity performance dashboard used by senior managers. The service provided a dashboard summary chart which showed key performance indicators and performance over time for some metrics. However, there were no measurable action plans put into place to address key metrics outside of targets. This dashboard showed live performance information which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Staff told us the maternity dashboard information was not shared with them.

There were errors in the Darlington Memorial Hospital maternity dashboard data with year-to-date figures being incorrect at times. For example, the maternity dashboard did not contain any data relating to the number of babies with Hypoxic-ischaemic encephalopathy (HIE) or numbers of cases referred to Healthcare Safety Inspection Branch (HSIB) or neonatal deaths. The maternity dashboard did not show metrics relating to the service's smoking rates at booking. However, the mandatory maternity data set data identified that these were higher (worse) than the national average. Smoking is a recognised risk factor and the trust had declared partial compliance with Saving Babies lives V2 in March 2022. However, although leaders stated that at the time of the inspection they were compliant, we found there was a lack of risk assessments and lack of audit to assess the adherence to the saving babies lives recommendations.

Staff could not always find the data they needed in easily accessible formats to understand performance, make decisions and improvements. National guidance and local policies were available for staff to access on the trust intranet for those who had access. However, not all midwives had their own login, so some staff were unable to access information which staff shared.

The PMRT summary report dated from 2022 to 2023 provided by the trust evidenced poor standards in the quality of the PMRT reviews with no external participation. In some reviews only 3 internal staff attended and did not include a member of the senior team. This summary report was not accurately reflected in risk, governance, or trust reports. Throughout both summary reports there was a lack of neonatology involvement.

A range of staff from the multidisciplinary team told us they experienced difficulty in accessing the range of information required to provide effective care. This was in part due to the fact that clinical information systems were not always integrated, with EPR systems being relatively newly introduced. However, the trust told us there was an interface between patient record systems.

Engagement

Leaders and staff did not always actively and openly engage with women, birthing people, and staff. There was a lack of collaboration with equality groups, the public and local organisations to plan and manage services.

Maternity

Leaders did not always work with the local Maternity Voices Partnership (MVP) in decisions about patient care. The MVP said they would have liked more active involvement with the service and stated they were not always included or invited to meetings with the service, which they would have welcomed. This was not a person centred approach to engagement. However, MVP representatives raised concerns with the inspection team about the trust's lack of engagement, in particular with ethnically diverse and vulnerable groups. Since the merge of two previous MVP groups into one, there had been some challenges with working across two sites of the maternity services in this trust.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

It was not evidenced that the senior leaders understood the needs of the local population outside the continuity of carer programme, despite there being other communities suffering social deprivation, an established community of Roma and Gypsy Travellers, persons seeking asylum, and refugees living in the Darlington area.

MVP voiced that they had a priority to reach out to the vulnerable and Black Asian and minority ethnic groups. MVP had asked for buy in from the trust and staff since the Ockenden recommendations but at the time of discussions the trust had not taken up this offer, and the MVP would continue to pursue this going forward.

MVP advised that the Continuity of Carer programmes targeted deprived areas. MVP had received feedback that was positive experience of the Continuity of Care model of care being provided. However, they stated the trust did not speak to the women and families from other deprived areas and felt that the trust did not engage in the MVP meetings, and these were too NHS focused.

MVP stated they had concerns regarding the lack of homebirths as they had recognised that there was an increased number of "freebirths". The trust was not offering home births and the service had been suspended for over a year. The MVP representative described feeling frustrated, that women had shared they planned to freebirth. MVP described communication regarding the lack of a homebirth service had been poor, and women and birthing people were not being given correct information about being able to attend another provider for their baby's birth.

The Local Maternity Neonatal Service (LMNS) were also involved with the MVP and involved with the maternity engagement group. These groups had identified ways to improve communication throughout the local communities and the top five languages had been shared. Staff told us the trust were engaged with the idea of using different languages. However, at the time of the inspection there was nothing yet in place.

Learning, continuous improvement and innovation

All staff were committed to improving services. However, staff did not always have the skills and resources to implement improvements to service and these were not always timely or evidenced as being implemented.

Staff were committed to learning and improving services. Quality improvement was routinely discussed at trust meetings including action plans such as those following HSIB investigations and PMRT reviews. However, staff had repeatedly reported the lack of acknowledgement of staff ideas and suggestions for improvements.

Leaders stated in reports they would promote change and improvement through training and innovation. However, staff said there had been nothing developed or shared.

Maternity

The trust had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.Staff did not always have an awareness of the trust's quality improvement methods and were not always given the time or skills to use them. The service was not committed to improving services by learning when things went well or there were lessons to be learned. However, there was a lack of action taken to follow up plans and learning.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support clinical research studies.

Outstanding practice

We found the following outstanding practice:

- The staff showed courage, compassion and demonstrated real caring for the women, people, and babies under their care, showing whilst demonstrating their own personal resilience. This included staff sharing information with the inspection team on how they would like the maternity service to improve.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives in order to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies. (Regulation 18 (1))
- The trust must ensure staff complete all maternity mandatory training, including role specific training modules. (Regulation 18 (2) (a))
- The trust must ensure staff are competent in carrying out CTGs, reviewing and escalating concerns appropriately. (Regulation 12 (2) (c))
- The trust must ensure there is sufficient equipment including CTGs to care for women, birthing people, and babies throughout the unit. Regulation 15 (1) (c) (f)
- The trust must ensure systems and processes for maternity triage are reviewed so to deliver a safe service in line with national guidance. (Regulation 17 (2) (a) (b) (c))
- The trust must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and escalated appropriately. (Regulation 12 (a) (b))
- The trust must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care. (Regulation 12 (a) (b))

Maternity

- The trust must ensure there are effective governance processes and systems to identify and manage incidents, risk, issues, and performance and to monitor progress through completion of audits, actions and improvements and reduce the recurrence of incidents and harm. (Regulation 17 (1) (2) (a) (b) (e) (f))
- The trust must ensure performance audit programmes are carried out, completed appropriately, and reported in line with national standards and guidance. (Regulation 17(2) (a) (b))
- The trust must ensure compliance with recommendations and reviews are carried out effectively to ensure actions and changes in practice are completed and performance is reported correctly. (17(2) (e) (f))
- The trust must ensure engagement with women, birthing people, and families to listen and involve them in investigations and reviews, and to include all local communities and groups. (Regulation 17 (2) (e))
- The trust must ensure Duty of Candour is carried out appropriately. (Regulation 20)

Action the trust SHOULD take to improve:

Maternity

- The trust should continue to ensure all staff complete regular multidisciplinary skills and drills training.
- The trust should ensure that there are appropriate facilities for use by bereaved families to meet national standards and guidance.
- The trust should ensure effective measurement of acuity in all areas to enable appropriate and sufficient staffing to provide safe care.
- The trust should ensure staff are encouraged and supported to report staffing problems and act upon them appropriately. Regulation 19 (1)
- The trust should ensure leaders are visible, approachable, acknowledge and manage the issues throughout the service.
- The trust should ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care.
- The trust should ensure the vision and values relate to the current model of care and all staff understand and apply them to their work.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

County Durham and Darlington NHS Foundation Trust

University Hospital North Durham

Inspection report

North Road
Durham
DH1 5TW
Tel: 01325380100
www.cddft.nhs.uk

Date of inspection visit: 28 to 29 March 2023
Date of publication: 15/09/2023

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at University Hospital North Durham

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at University Hospital of North Durham (UHND).

We inspected the maternity services at County Durham and Darlington NHS Foundation Trust as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

University Hospital of North Durham is one of four sites for maternity services for the trust. Acute maternity services are also provided at Darlington Memorial Hospital. Outpatient maternity care is also provided at Bishop Auckland and Shotley Bridge Hospitals, although we did not inspect these services.

We carried out a short notice unannounced focused inspection of the maternity services at University Hospital of North Durham and Darlington Memorial Hospital, looking only at the safe and well-led key questions.

The inspection was carried out using a data submission and an on-site inspection where we observed the environment, observed care, spoke with women and birthing people and their partners who used the services, and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visits, we conducted interviews with specialist staff and senior leaders and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends. Feedback included 8 positive and 12 negative experiences. There were some negative comments about staff attitude and long waiting in the pregnancy assessment unit (PAU).

The service at University Hospital of North Durham comprises of a labour ward with 16 labour, delivery, recovery and postnatal (LDRP) rooms, a maternity theatre, induction of labour beds and some enhanced recovery rooms. There is a 23 bed postnatal ward and an antenatal ward (ward 61) incorporating an early pregnancy assessment unit with some triage facilities. The service also has maternity services at Darlington Memorial Hospital and pregnancy assessment units at Bishop Auckland Hospital and Shotley Bridge Hospital which provide services to women and birthing people from across the County Durham area. Antenatal and postnatal clinics are also provided at this location.

The trust carried out 4500 deliveries between April 2021 to March 2022, of which about 3000 were carried out at University Hospital of North Durham and 1500 at Darlington Memorial Hospital.

A lower proportion of mothers were Asian or Asian British (3%) or Black or Black British (1%) compared to the national averages (14%) and (6%) respectively. More women and birthing people who used the service were White (86%) compared to 67% nationally.

Our findings

Our rating of this hospital went down because:

The service was last inspected in 2019 (as maternity as a standalone service) and rated as good in all five domains.

Our rating of the maternity service impacted on the rating for the hospital location overall. As a result ratings for safe and well-led went down to requires improvement and services at University Hospital North Durham are rated as requires improvement overall.

We also inspected the maternity service at Darlington Memorial Hospital run by County Durham and Darlington NHS Trust.

Following the Care Quality Commission (CQC) inspection of both County Durham Hospital and Darlington Memorial Hospital the CQC issued the Trust with a warning notice on 28/04/2023. This notice is served to the trust under Section 29A of the Health and Social Care Act 2008. Where it identified that the trust is required to make significant improvements.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Not all staff had training in key skills appropriate for their role.
- Staff did not always manage antenatal and intrapartum safety well. Including induction and risk assessment processes.
- The service maintained cleaning records, although these records were not always kept up to date. They did not always demonstrate that all areas were cleaned regularly or that secure areas were always locked.
- Staff did not consistently carry out checks on equipment.
- Staff did not consistently assess risks to women and birthing people, nor act on them.
- Staff shortages increased risks to women and birthing people across the maternity service. Staffing levels did not always match the planned numbers putting the safety of women, birthing people, and babies at risk.
- Women and birthing people could not always access the service when they needed it and sometimes had to wait for treatment. The trust did not audit or monitor time of arrival to triage or time of arrival to review.
- Staff did not always use the trust's systems and processes to safely record and store controlled drugs.
- Staff did not always feel respected, supported, and valued. They were not always able to focus on the needs of women and birthing people receiving care.
- The service did not always manage safety incidents well nor learn lessons from them.
- Leaders did not always have the skills and abilities to run the service for women and birthing people and staff.
- Leaders did not operate effective governance systems. They did not always manage risk, issues and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.
- Leaders did not always ensure staff were competent. Not all staff had received an annual appraisal and senior leaders did not always support staff to develop their skills.
- Staff did not always use electronic patient record systems consistently.
- Staff had limited awareness and understanding of the service's vision and values and staff were not always able to apply them in their work.
- The service did not always engage well with women and birthing people and the community to take all vulnerable people into consideration, plan and manage services.
- Leaders and managers were not always visible and approachable in the service.

However:

- Staff appraisal rates had recently improved to meet the Trust target.
- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse.
- Staff kept good care records. They administered and kept medicines prescription and administration records well.

Maternity

- Staff were clear about their roles and accountabilities. They were focused on the needs of women and birthing people receiving care.

Is the service safe?

Inadequate

Mandatory training

The service did not make sure everyone completed mandatory training.

Staff were not up to date with their mandatory training. The service provided information that showed staff were required to complete mandatory training, clinical mandatory training, and local mandatory training. Following the inspection the trust provided updated information on staff training compliance. Records showed compliance rates for individual mandatory training courses against a trust target of 95% for core statutory and mandatory essential training and 85% for role specific courses. New compliance rates showed the service across both sites was at 87.7% overall.

However, compliance for role specific courses for midwifery staff across the trust ranged between 50% for hand hygiene and 100% for preventing radicalisation. Midwifery staff achieved the trust target for 1 out of 5 core training and 22 out of 44 role specific courses. Compliance for medical staff ranged between 22% for hand hygiene and 100% for preventing radicalisation courses. Medical staff achieved the trust target for 0 out of 5 core training, and 6 out of 30 role specific courses.

Managers did not always give staff time away from clinical duties to complete training. Staff said managers monitored mandatory training and alerted staff when they needed to update their training. However, they could not complete all the training because of staffing pressures. Staff reported it was a common occurrence of being pulled off internal study days. Staff said they had been advised by managers not to incident report this and it was corroborated by further evidence received.

Following our inspection, the trust provided information specific to Cardiotocographs (CTG) from 31 March 2023 to show compliance rates for staff across both sites had improved to 96% for midwives, 96% for doctors and 92% for consultants. In January to March 2022 compliance data had shown low rates of compliance: midwives 58%, doctors 65% and consultants 62%.

The service ensured all staff received multi-professional simulated obstetric emergency training. Staff could attend 3 study days a year which included simulated obstetric emergency training and life support training and this time was protected. The trust provided information from 31 March 2023 to show compliance rates had improved from previous rates to 92% for midwives, 88% for doctors and 92% for consultants.

The service provided New-born Immediate Life Support Training Level 3. At the time of our inspection, the trust target was 95% and the compliance rate for medical staff was 83%. The annual local training in new-born resuscitation skills compliance rate for advanced nurses was 95% but only 81% for consultants. Compliance for neonatal nurses had improved from 80% to 94%, and junior doctors had improved from 88% to 100%.

Maternity

Staff were supported by practice development midwives to complete mandatory training. Staff told us specialist midwives could not always fulfil their specialist roles because they were often required to support staff shortages in the units.

Safeguarding

Staff understood how to protect women and birthing people 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 received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed safeguarding training at the level appropriate for their role. Ninety-four per cent of medical staff and 93% of midwifery staff had completed safeguarding level 3 training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics. During handover we saw staff made adjustments to meet the needs of women and birthing people such as those living with mental health conditions or difficulties.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic patient records (EPR) system. We saw this recorded in records we reviewed. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence during our inspection that safeguarding concerns were discussed and escalated appropriately to the trust safeguarding team. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the trust's baby abduction policy. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. However, staff said the service had not practised what would happen if a baby was abducted within the 12 months before inspection as identified in the emergency skills and drills training schedule.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment appropriately but did not always document control measures to protect women and birthing people, themselves, and others from infection. They kept most equipment and the premises visibly clean.

Maternity service areas were mostly clean and had suitable furnishings which were clean and well-maintained. Domestics were available on the wards every day, and the environment appeared clean. However, wards had not been refurbished to the latest national standards.

Cleaning records were not always kept up-to-date, and staff could not demonstrate that all areas were cleaned regularly. In the Pregnancy Assessment Unit (PAU) no cleaning records for equipment were available. One audit showed some items of equipment such as computer trolleys had been found to be dirty or dusty. During the inspection we found some equipment including the drug round trolley and resuscitation trolley in the antenatal ward were not clean. We found daily cleaning checklists for equipment that had not been completed for any of the first 21 days of March 2023.

Staff told us they used 'I am clean' stickers but we did not see these used in practice during the inspection.

Dirty utility rooms throughout the unit were not locked. There were keypads to enable locking of the doors, but staff explained these were left open for quick and easy access to the sluice areas. Cleaning chemicals were kept on worktops or in unlocked cupboards within the utility rooms. We found a cupboard containing cleaning items was locked but the keys had been left in the lock. These issues were escalated to ward staff during the inspection. Staff were unable to provide risk assessments to show these had been addressed.

The housekeeping area on the postnatal ward was cluttered with kitchen items.

The service generally performed well for cleanliness. Cleanliness audits for the 3 months prior to our inspection showed all areas met the compliance rate of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward managers completed regular Back to Basics IPC Audits that included infection prevention and control and hand hygiene checks.

In the last year IPC compliance ranged from 91% to 98%. Records showed rooms and equipment including mobile resuscitaires had been checked daily. Staff told us they cleaned everything immediately after use. However, checklists were not kept with equipment but stored in a folder at the nurses' station. It was not apparent how staff would know if a piece of equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment did not always keep people safe. The layout of the pregnancy assessment unit (PAU) was not an appropriate environment for women and birthing people to wait for clinical input. However, staff managed clinical waste well.

There was poor compliance with emergency equipment checks. For example, we found the PAU emergency resuscitation trolley top was dusty and the sepsis box had a loose lid. Records showed that the resuscitation trolley on labour ward was not checked every day and no checks were documented between 1 March and 21 March 2023.

Clutter and housekeeping issues on Ward 8 were identified and raised with staff during the inspection and we observed these were remedied immediately.

The inspection team found equipment was not always stored safely. The lists of contents for the Post-Partum Haemorrhage (PPH) trolley and eclampsia trolley were not dated to show when they were last reviewed. Daily checks for emergency trolleys throughout the unit were incomplete with gaps identified between December 2022 and March 2023, and in one case no check sheet was available for the whole of February 2023.

We found gaps in the flooring around the bed area in one of the labour rooms. Staff said it was “very difficult to clean this area, particularly after an instrumental delivery”. Other labour rooms had the same flooring but no gaps and these were filled with a solid sealant. The inspection team raised this with a senior midwife who advised that they would report the flooring issue to estates and ask for the gaps to be filled.

Women and birthing people could reach call bells and staff responded to the person's needs in a timely manner. We saw midwives answered call bells on wards and labour ward. However, we received feedback from women and birthing people following our inspection who told us they waited for lengthy periods for call bells to be answered at night. Staff aimed to use rooms close to the midwives’ station for women with additional needs.

There were CTG machines for each labour, delivery, recovery, and postnatal (LDRP) room. Not all CTGs were equipped with Dawes Redman monitoring which did not meet Ockenden report (2020) requirements. Cardiotocography is usually called a 'CTG' by doctors and midwives. It can be used to monitor a baby's heart rate and a mother's contractions during pregnancy. Staff told us they were aware the equipment did not meet recommendations but had been told there were no funds available to replace existing CTG machines. There was central observation monitoring equipment at the nurses’ station as well as computer access to CTGs. During and following the inspection we raised this with the trust. Trust leaders responded and told us additional CTG machines equipped with Dawes Redman monitoring had been ordered following the inspection.

There was a pool evacuation net and evacuation guidelines in the pool room. Staff told us there had not been an evacuation drill in the last 12 months. However, managers said a skills drill was booked.

The service had suitable facilities to meet the needs of women and birthing people's families. Rooms on labour ward were designed and equipped for labour, delivery, recovery, and postnatal care (LDRP). The birth partners of women and birthing people were supported to attend the birth and provide support.

At the time of the inspection, there were inappropriate bereavement facilities on both sites. Bereaved families stayed on labour ward in rooms that were not soundproofed or in an isolated area for privacy. However, staff told us refurbishment of a new bereavement room was underway and due to be completed within a few weeks of the inspection.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal. However, we found one pharmacy waste container which was overfilled. We informed a manager and the container was disposed of safely and replaced immediately.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and birthing person, and staff did not always take action to remove or minimise risks. Therefore, staff were not always able to identify and quickly act upon women, birthing people, or babies at risk of deterioration.

Leaders did not monitor patient waiting times and leaders could not be assured that women and birthing people could access maternity services when needed or receive treatment within agreed timeframes and national targets.

Maternity

During the inspections we found there was no standard process for documenting arrival times when women and pregnant people attended triage. Prior to February 2023, triage staff had recorded arrival times in a paper desk diary. However, staff told us due to pressures caused by shortages of qualified and experienced staff, they had been asked by managers to stop recording arrival times. There was no review or audit to show how long women waited for triage or review.

Staff told us all the information gathered from telephone triage and consultations would be entered onto the electronic patient record system (EPR). However, the staff in Pregnancy Assessment Unit (PAU) did not have full oversight of whom had telephoned or had been advised to come in, who was attending, and how long they were waiting for care.

At the time of the inspection there were ineffective processes to ensure women and birthing people arriving in the PAU were assessed on arrival to the unit. Trust board papers of May 2022 stated, “patients in Pregnancy Assessment Unit (PAU) will not have observations completed in the trust’s electronic system until admitted as an ‘in-patient’”. Staff told us, and records showed, patients attending triage during the inspection did not always have observations recorded during their time in triage. Without initial observations and an initial assessment, there was a risk that deterioration in women, birthing people, or babies would not be recognised and acted upon.

Staff used a recognised tool known as the Modified Early Obstetric Warning Score (MEOWS) tool to monitor women and birthing people using maternity services. However, staff did not always carry out clinical observations using the MEOWS tool in a timely way, record them, or escalate them appropriately. This meant that there was a risk of women, birthing people, and babies coming to harm. MEOWS audits from the 3 months between December 2022 and February 2023 showed 62.5% of women scored above ‘0’ on MEOWS indicating further action was required. Of those, 33% of observations were not taken in line with the appropriate frequency following local and national guidance. Also 47% of scores meeting the MEOWS trigger were not escalated according to trust policy.

Midwives completed records using the electronic patient record at booking and during antenatal care. Risk assessments were completed following prompts from the electronic record system. The service told us following the inspection an audit from February 2023 showed 99.5% completion. However, at the time of the inspection, there were no formalised risk assessments in line with national guidance to support staff to care for women and birthing people attending for triage at the Pregnancy Assessment Unit (PAU) . The systems used within the triage unit were not adequate to keep women, pregnant people and babies safe. Not all clinical interactions were recorded, and no formal prioritisation tool was available to assist staff in providing timely care to those in most clinical need. We told the trust they must ensure women and birthing people were appropriately monitored and timely risk assessments were carried out in triage. Following the inspection, the trust told us they had implemented a risk assessment process.

We observed women and birthing people in the PAU waiting area. Women and birthing people attending for triage or PAU sat out of sight of staff while they were waiting. This meant a deterioration of the women or birthing people may not be recognised and care and treatment could be delayed. We provided feedback about this to senior staff immediately after the inspection. The trust provided information on action taken to risk assess this and make improvements, including provision of additional staff and creating a formal waiting area with call bells installed.

Staff did not always complete risk assessments for each woman or birthing person during pregnancy or in the intrapartum period (around the time of labour and delivery of a baby), using a recognised tool, or review this regularly, including after any incident. There was no evidence-based, standardised risk assessment tool except for prompts provided through the electronic patient record (EPR). Staff explained the EPR was not always completed contemporaneously so any prompts provided were not always available to staff at the time of clinical need.

Maternity

Staff did not always complete risk assessments prior to discharging women and birthing people and pregnant people into the community and did not always make sure third-party organisations were informed of the discharge.

Newborn Infant Physical Examination (NIPE) was described as a “bone of contention” and babies' discharges could be delayed awaiting this examination as not all midwives could complete a NIPE and there was a reliance on the paediatricians to complete the these. Medical staff were not routinely rostered to ensure NIPE was carried out which meant there were delays.

Some women and birthing people experienced delayed inductions, and some did not receive induction of labour, although it had been planned for clinical reasons. As a result, women, birthing people, and babies were put at risk of harm. During the inspection we observed women and birthing people awaiting induction of labour were backlogged from the previous day, and further inductions were planned to attend that day as scheduled. Staff told us it was common for inductions of labour to be delayed. These delays regularly lasted 24 hours and sometimes lasted for 2-3 days. We observed safety huddles where staff discussed workload and acknowledged delays in inductions of labour.

There were 93 incidents reporting delays in inductions of labour recorded by staff from both sites between 20 January 2022 and 20 January 2023. Patient records showed some women had waited for several days, and in one case for over a week, or had no induction at all, even when records showed acknowledgement of clinical risk and trust guidance. We found evidence harm had occurred to mothers and babies when the trust did not take action and inductions were delayed or not carried out.

Staff did not always escalate concerning CTG features in line with trust policy or protocol. CTGs were not always reviewed in line with local trust policy and not always interpreted correctly. Staff did not always carry out second review (‘fresh eyes') at appropriate times during monitoring in line with local trust policy. Trust audit results showed CTG ‘fresh eyes’ check compliance had deteriorated in the 3 months prior to our inspection and ranged from 85% in January 2023 to 74% in March 2023. During our inspection we found multiple examples of incidents reported, and through audit where CTG findings had not been escalated and actions were not taken to avoid possible harm. Out of 17 investigations carried out by the Health Safety Investigation Branch (HSIB) 18th March 2019 – 14th March 2023, 5 cases were identified as having errors or care issues relating to CTGs. This meant women, birthing people and babies were not risk assessed or managed appropriately to reduce the occurrence of harm.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. In the records we reviewed these were completed by clinical staff via the electronic patient record system (EPR).

Staff shared key information to keep women and birthing people safe when handing over their care to others. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff held 2 safety huddles during each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, and recommendation for each patient.

Maternity

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. However, audit showed these were not always completed at appropriate times or according to trust policy. Some babies were readmitted to the unit or had prolonged stays in hospital. The trust did not provide evidence of plans to reduce "avoiding term admissions into neonatal units" (ATAIN).

The service provided transitional care for babies who required additional care.

We found there were missed opportunities for carrying out screening and for managing results of screening to safely manage care during pregnancies of women, birthing people and babies. There had been 76 incidents between January 2022 and January 2023 reported as 'near misses' or 'minor harm' that showed staff had not complied with guidance from pathology such as labelling protocols and guidance from national screening standards There were 6 of these that remained open or were awaiting a review in January 2023.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day we inspected the service, we observed there was 1 midwife in the pregnancy assessment unit when there should have been two registered midwives. During the inspection, 1 midwife was seen to care for 6 complex high-risk women and pregnant people in the antenatal area of pregnancy assessment unit (PAU) in addition to answering the triage telephone, booking scans and caring for women and pregnant people arriving and waiting in the PAU. Leaders advised that no acuity tool was being used in the PAU or ward areas.

Staffing establishment in relation to acuity was met at University Hospital North Durham for 68% of shifts during January 2023. However 30% of shifts showed the trust to be up to 2 midwives short on staffing establishment, and to be more than 2% short, with 16 episodes (90 hours) recorded of midwives being redeployed.

The service did not use an acuity tool in all areas. Acuity was not measured on the postnatal ward, however there were "many" occasions when there was 1 midwife allocated to the postnatal ward (Ward 10) and that midwife was responsible for caring for 13 mothers and babies. The trust had not identified how many registered midwives should be on shift but were using a staff allocation tool. However, however this tool was not specific to maternity care.

During the inspection we found the service was consistently short of registered midwives across all areas. Staff shared that it was a normal occurrence for inductions of labours to be delayed due to staffing issues.

There was not always senior midwifery supernumerary oversight on labour wards. Although labour ward coordinators were planned to be supernumerary staff told us this rarely occurred in practice, and coordinators took responsibility for direct care. The Maternity Surveillance Report for Maternity Safety Champions Meeting' (March 2023) recorded 10 occasions (6 in January and 4 in February) when the labour ward co-ordinator was not supernumerary.

Skill mix was not always in line with national recommendations. Staff told us they had raised concerns that Band 5 newly qualified midwives were working night shifts on labour ward to fill shifts. Staff told us it was common practice to

relocate the second midwife from the pregnancy assessment unit to the labour ward and sometimes staff from the Darlington Memorial Hospital were also relocated to work in the labour ward. Staff shared that staff relocations were to be recorded on the staffing allocation tool. However, not all shifts were recorded accurately on the staffing allocation tool.

Pregnant women and birthing people did not always receive 1:1 care during labour in line with national guidance National Institute for Health and Care Excellence: QS205 (2017). Incidents recorded showed staff had reported when women had not received 1:1 care and when treatment or procedures had been delayed due to shortage of registered midwives on shifts.

Leaders recognised the service was unable to offer home births due to staffing shortages. However, the trust website continued to list homebirth as an option for women. Staff told us they knew women who had been very disappointed this option could not be offered and anecdotally women were opting to have an unassisted or freebirth (unassisted birth is sometimes called 'free birth'. It means deciding to give birth at home or somewhere else without the help of a healthcare professional such as a midwife). Midwives and representatives from the local maternity voices partnership told us the number of women opting for freebirths was increasing, mainly because they could not have a midwife-assisted homebirth. The trust recorded numbers of babies “born before arrival” at hospital and these rates had steadily increased. Staff explained freebirths would be included in these figures.

Staff told us that the pregnant women and birthing people did not always receive 1:1 care in labour due to staffing. However, the proportion of 1:1 care in labour achieved was not recorded in trust board papers or senior staff reports. Staff told us low numbers of staff made them feel unsafe. Staff had reported delayed inductions of labour through the incident reporting system and these included babies categorised as high risk. Between September 2022 and February 2023 there had been 144 delayed inductions of labour reported in trust board papers. The service’s March 2023 Maternity Surveillance Report for Maternity Safety Champions Meeting reported in January 2023 documented examples of delayed inductions of labour and where staff identified clinical guidance had not been followed regarding appropriately timed inductions of labour.

During our inspection the ward manager did not have the resources to adjust staffing levels according to the needs of women and birthing people. Managers told us this happened daily, and they regularly moved staff according to the number of women and birthing people in clinical areas, Midwives told us this happened at short notice, and they were frequently expected to work in areas unfamiliar to them.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 (2015) ‘Safe midwifery staffing for maternity settings. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. During the inspection’ staff told us, and we found staff did not report staffing incidents that should have raised red flag indicators that included delays to inductions of labour, delays with LSCS (lower segment caesarean section), delays of induction of labour for 2 hours or more between admission and beginning of the process. We found there was delayed recognition of, and action on, abnormal vital signs and lack of assurance that women were being seen for triage within 30 minutes of presentation.

Staff told us many issues relating to staffing were reported continually to managers and leaders, but these seemed to be ignored. Midwives had communicated their concerns to managers over the previous 12 months and had stated they found the unit was unsafe. However, staff told us nothing had changed. Staff told us they regularly missed breaks, worked late, and worked extra hours (both paid and unpaid), and midwife sickness levels were very high due to the increased pressure on staff because of shortages in staffing.

Staff told us they should be given their off-duty rota 4 weeks in advance but sometimes managers now provided these only 2 weeks in advance. Staff said this was insufficient time to plan for their shifts. However, NHS Improvement advises publishing rosters a minimum of six weeks in advance, ideally 12 weeks. (NHS Improvement, 2019).

Midwifery staffing summary from open board meetings evidenced that the service had high vacancy rates, turnover rates, sickness rates, and high use of bank nurses. Despite the use of bank staff there remained 75 shifts unfilled between September 2022 and February 2023.

The trust and service leads said they were actively recruiting locally, regionally, nationally, and internationally to meet their establishment and backfill using bank and agency staff. However, it was unclear as to what the trust correct staffing levels should be. Board papers from August 2022 showed an established acuity assessment tool was awaiting reassessment and there was no evidence to show this had been completed by the time of the inspection.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service made sure all new staff completed competency assessments. Managers told us they supported staff to develop through yearly, constructive appraisals of their work. A practice development midwife supported multidisciplinary staff development.

The trust target for staff appraisals was 95%. Compliance data showed all medical staff (100%) and 96% of midwifery staff had completed an annual appraisal. This was a significant improvement from the maternity surveillance report from the maternity safety champions meeting in March 2023 which showed lower rates of compliance for January 2023 at 40%.

Staff said midwifes no longer received supervision but relied on the appraisal system to ensure competency. Staff told us they felt this was not as effective as supervision. The lack of supervision for midwifes should be separate from the appraisal process and this was not in line with national recommendations from Royal College of Midwives, Midwifery Standard 33: There must be a framework for effective and accessible clinical supervision. However, midwives told us they were supported in professional development and had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

Managers did not always make sure staff received specialist training for their role. Training provided included role specific training which showed a range of compliance for midwives, doctors and consultants as reported under the mandatory training section of this report.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number and provided the required consultant hours for the service. The service had low vacancy, turnover and sickness rates for medical staff.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locum doctors told us they were well supported and received a comprehensive induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular and constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Trainees in a GMC approved training post in the UK complete the 2022 General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received, support and wellbeing. Scores for this hospital were significantly below (worse) than the national average for the indicator Facilities, and significantly above (better) than the national average for the indicator Clinical supervision out of hours.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, patient records were not always completed contemporaneously.

In most clinical areas women and birthing people's notes were comprehensive, and all staff could access them easily. However, on PAU staff told us and records showed, not all clinical interactions were recorded at the time of activity. This included information required for each woman and birthing person on arrival, and no risk assessments were documented at this time.

The trust used electronic patient records. The patient care record was on a secure electronic patient record (EPR) system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

We reviewed 10 electronic records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service mostly used systems and processes to safely prescribe, administer, and record medicines. However, they did not always keep controlled drugs documentation in line with regulations or store all medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had completed them correctly.

Staff reviewed each woman or birthing person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed medicines and prescribing documents safely. The clinical rooms where the medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperatures.

There were gaps in documentation in the controlled drug register book on the labour ward between 25 December 2022 and1 March 2023. The controlled drug order book showed "received by" signatures were not always completed, indicating there was a poor medicines management process. Staff did not check controlled drug stocks daily.

The controlled drug register identified weekly stock checks had been completed. However, some patient identification details were missing. There were gaps for signatures and times when medicines were given. Start times for epidural fluids and dose information for epidural bags was not recorded. There was no evidence that a pharmacist had checked the ward stock and there were no checks or assurance entries entered.

We found some emergency trolleys and grab boxes contained insulin, adrenaline, or controlled drugs; (intravenous diazepam and rectal diazepam). But these had no tamperproof tags, so staff would not know if trolleys had been opened and contents used or taken. We raised this with ward managers at the time of the inspection.

Staff monitored and recorded most fridge temperatures and knew to take action if there was variation. However, there were gaps in the monitoring of the medicine fridge temperature checks on the antenatal ward. This fridge was used for storage of temperature sensitive medications for induction of labour. The daily checks identified a significant number of gaps, for example only 6 fridge checks were documented for the first 28 days of March 2023, of which only 1 minimum and maximum temperature check had been recorded. The February 2023 checklist identified only 7 checks had been recorded with minimum and maximum temperatures recorded on 6 of those occasions. No ambient room temperatures were recorded, and the fridge contained items and was very full giving concerns as to the effectiveness of the fridge's cold storage.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. These were shared in daily safety huddles, via emails and lessons learned were included in staff bulletins.

Incidents

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. However, managers did not always review incidents in a timely way and duty of candour was not always applied when things went wrong.

Maternity

Staff could describe what incidents were reportable and how to use the electronic incident reporting system. Although managers reviewed incidents using the trust's root cause analyses tool (RCA), these reviews did not always recognise failings in care which may have had an impact on the outcome for babies, or for babies which sadly died. The trust did not have an open, accurate, effective, robust review of risk process and there was a lack of evidence lessons are learnt despite poor outcomes as reported in HSBI investigations and PMRT cases since 2019. PMRT reviews were not always completed and trust staff cited "no consent" as the reason. However, consent is not necessary for internal reviews or PMRT to be carried out.

Incidents reported were not always reviewed or acted upon in a timely manner. The potential for learning lessons from incidents, lack of immediate actions, and further action planning meant opportunities were missed to prevent women, pregnant people, and babies being exposed to harm.

Managers did not always investigate incidents thoroughly. Incidents were not always reviewed in a timely manner to monitor and manage risk, and identify opportunities for learning or changes in practice to reduce the recurrence of harm. We found 212 maternity incidents remaining open for over 60 days. Data regarding open incidents from 30 March 2023, showed there were incidents dating back to October 2021 that were awaiting review or closure. There was a lack of evidence of actions being taken to address themes, assess and manage risks, and implement change. For example, reported incidents included management of post-partum haemorrhage, delays in treatment, clearly documented information about allergies not followed, and safety measures ignored. There was not always evidence to show learning from these had been investigated and shared. This was seen in recurrent findings and recommendations for example from HSIB reports. Following some reports, HSIB action points were documented as completed. However, some of these actions remained incomplete and continued to put women, birthing people, and babies at risk.

Staff understood the duty of candour. However, they were not always open and transparent and did not always give women and birthing people and families a full explanation if and when things went wrong. It was not clear duty of candour was always applied when it should have been. We reviewed serious incident investigations and found staff had not always involved women and birthing people and their families in the investigations. Perinatal Mortality Review Tool (PMRT) review documents noted families had provided feedback to show there was a lack of support and information provided, and a limited number of cases shared families' perspectives with staff. Maternity staff were not able to recall any instances where duty of candour had been carried out.

We found serious incident reviews that showed a lack of evidence Duty of Candour and PMRT had been carried out where the trust had identified care may have caused harm, such as stillbirths, neonatal deaths, or brain injuries to babies. However, examples provided by the service of two serious incident records showed evidence that Duty of Candour had been carried out.

Managers did not always review incidents potentially related to health inequalities. One HSIB investigation noted a case where staff had not acknowledged a woman or birthing person's needs when antenatal records showed they lived with a learning disability.

Local managers debriefed and supported staff after any serious incident. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. However, staff said they did not always receive feedback from investigations of incidents they had reported or from serious incidents, mainly because they were not reviewed for several months.

Managers met weekly to discuss the feedback and look at improvements to the care of women and birthing people. Staff explained, and incident reviews showed, there was limited meaningful action and improvement following feedback.

Maternity

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Local leaders did not always have the skills and abilities to run the service, they were not always visible and approachable in the service for women, birthing people and staff. Executive leaders did not always manage the priorities and issues the service faced. However, leaders supported staff to develop and take on more senior roles.

The service was led by a head of midwifery, clinical director and business operations manager. This triumvirate reported to the executive director of nursing and medical director. Leaders did not always have the skills and abilities to run the service. They understood the priorities and issues the service faced although these issues were not always addressed or shared with staff.

Leaders had been aware of patient safety risks and challenges throughout the service for a prolonged period of time. Leaders had not completed or taken all essential actions to ensure the safety, quality, and sustainability within the service.

Staff voiced concerns that they felt the unit midwifery staffing was 'unsafe' and this was repeated throughout the inspection. Although the trust had developed 'time to talk' sessions, staff told us these were affectionately known as 'time to listen' and that these were completed only as a tick box exercise.

Staff reported that leaders were not always visible and approachable for women, birthing people, and staff in the service. Leaders were not always respected, although some senior staff described them as approachable. Staff reported them lacking in providing supportive responses. Staff said leaders "appeared" supportive. However, no tangible improvements were made, despite issues repeatedly being raised to the leadership team.

Staff told us they were supported by their line managers, ward managers and matrons. They said the executive team visited wards and staff spoke of how they had been more accessible around the time of the inspection. The service was supported by maternity safety champions and non-executive directors.

Vision and Strategy

The service leaders had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, not all staff felt their views had been taken into consideration and could only give limited explanation of what it meant for the service and local women. Although leaders understood and knew how to apply them and monitor progress, staff did not understand the service strategy.

The trust leaders had developed a vision and strategy in relation to maternity continuity of carer (MCoC) model of care and had implemented this. This model is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwife throughout their pregnancy. However, ward staff could give limited explanations regarding the trust's vision, and what it meant for women and birthing people and babies. Staff in the

acute areas we visited told us they felt their views were not taken into consideration. Most ward staff told us they felt staff engagement had not been done fairly and they felt that not all staff views had been considered. Leaders had carried out a staff consultation, but most staff felt this had not been done fairly. Leaders provided survey results that showed most staff would have preferred to review the plans for implementing 'continuity of carer' as a group, but these responses were combined amongst other responses and not all had been considered. Although, leaders stated the survey results had not been conclusive, the plans had gone ahead.

Staff reiterated they felt that 'continuity of carer' was the trust's main focus, despite depleted safe staffing levels, skill mix, and staff being pulled in to cover acute areas on a frequent basis. The trust's implementation of 'maternity continuity of carer' (MCoC) was not in line with national recommendations as they could not demonstrate staffing levels met safe minimum requirements on all shifts. These recommendations were shared nationally in September 2022. Senior leaders advised that the trust had considered these recommendations, but had decided to continue with MCoC, albeit in a scaled back form compared to original plans. Staff told us and incidents reported showed there were inequalities and disadvantages for women not on the MCoC pathway. For example, when there were insufficient staff to provide induction of labour for women in the acute setting, one woman on the MCoC pathway had an induction carried out by her MCoC midwife. This meant one woman had an induction of labour based on availability of her midwife, before others at higher level of risk could have their planned induction of labour.

Culture

The service did not have an open culture where staff could raise concerns without fear.

Leaders were not responsive, staff said they felt leaders had been dismissive when issues had been raised with them. Staff reported feeling 'frozen out' or that their concerns were ignored by leaders, as a recurrent issue with the leadership team since 2020. This was indicative of a "closed culture". CQC defines a closed culture as "a poor culture that can lead to harm, including human rights breaches such as abuse". In these services, people are more likely to be at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture.

Staff told us they felt their concerns were not listened to by the leadership team. Staff said responses from the leadership team appeared supportive. At the time of the inspection staff told us that although active recruitment was ongoing, they felt no tangible improvements were made despite issues repeatedly being raised to the leadership team. However, following the inspection and our feedback to the senior executive team, the service provided information to show they had begun new work and continuing workstreams to address underlying service issues and challenges which sought to engage midwifery teams.

Staff promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Staff were focused on the needs of women and birthing people receiving care, demonstrating kindness, compassion, and courage.

Dignity and respect for people accessing maternity services were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

We observed good working relationships throughout the multidisciplinary team. Staff felt there were good working consultant relationships and midwifery staff felt confident to challenge medical staff, although acknowledged that there were mixed approaches from the consultants who worked with differing styles and to "different protocols". This included interpretation of the consultants using a standardised venous thromboembolism (VTE) risk assessment guidance.

Maternity

The service promoted equality and diversity in daily work. Leaders understood and acknowledged how health inequalities affected treatment and outcomes in their local population. However, the service did not have effective systems to demonstrate how this was monitored or managed to improve maternity services.

Women, birthing people, and their families we spoke with said they knew how to complain or raise concerns and felt that they would be listened to. The service used the most informal approach applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The trust provided complaints information that showed 3 formal complaints were received between January and March 2023. Of these, all were awaiting outcomes. Managers investigated complaints and identified themes. However, staff said they did not receive feedback from cases other than newsletters and group emails. There was a lack of regular staff team meetings to communicate issues and feedback on outcomes and learning from complaints.

Governance

Leaders did not always operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but they did not have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate an effective governance process throughout the maternity service. The service provided a clear governance structure and processes to support the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics although there was a lack of evidence of lessons learnt and subsequent improvements to practice. Therefore, there was not a comprehensive well-structured governance process embedded.

The trust had not met the “Ockenden 7 national immediate essential actions from December 2020”. The trust action plan from March 2022 in response to the Ockenden report statement “Women were not formally risk assessed at every antenatal contact to ensure continued access to care provision by the most appropriately trained professional” showed the trust were not yet compliant with this point and the head of midwifery would continue to monitor and maintain standards through audit. Audit results were provided by the service following the inspection. Leaders said they had considered the recommendations from the Ockenden 2020 and 2022 reports and said they planned to revise the vision and strategy to include these recommendations.

Key concerns identified from Ockenden 2020 and 2022 report recommendations were workforce, embedding twice daily ward rounds, implementation of PMRT, audits, and lack of risk assessments (to include place of birth). At the time of our inspection the service had no triage risk assessment tool and had not evidenced that they were compliant to Saving babies Lives version 2 (published March 2019). At the time of our inspection, not all actions in line with recommendations had been implemented. However, the service provided an updated Ockenden Action Plan as presented to the Board in January 2023. This showed they were partially compliant with “A risk assessment must be completed and recorded at every contact".

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from October 2021 that continued to await review or closure. Leaders told us staff were encouraged to report incidents for understaffing. However, staff told us it was their perception they were advised by senior staff and discouraged from incident reporting relating to training being cancelled, staff being redeployed to alternative clinical areas, and understaffing.

Maternity

Learning from serious incidents was not always embedded. We found there were 2 cases presented by the trust paediatric service to the trust board in 2023 which shared the same themes previously identified by HSIB and PMRT as evidenced in HSIB reports dating back to 2020 with repeated safety recommendations and actions required.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. However, information was not shared back to sub-committees or to all staff.

Maternity service leaders were not always able to describe accurately the status of audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvement.

The service's governance and risk processes were not effective in identifying failings, learning from incidents, or evidencing changes to practice to prevent recurrence. Incidents reported were not reviewed or acted upon in a timely manner to monitor and manage risk and identify opportunities for learning or to implement changes in practice to reduce the risk of harm.

We found reports relating to compliance with national guidance and report recommendations where the trust had assessed themselves as compliant, partially compliant, or actions had been met. These included external reports, national guidance, and recent reviews including the Ockenden Trust Assurance Report and the Kirkup East Kent Hospitals report. However, we found instances where information contained within these was not correct, and different information had been reported in board papers, in manager's meetings and through interviews with senior staff. For example: trust board papers from February 2023 showed the trust was not compliant with 2 of 10 actions under the Maternity Incentive Scheme 2022. This scheme is designed as a financial incentive to support the delivery of safer maternity care.

We reviewed data and figures from the service's maternity dashboard and found there were errors and inaccuracies in the calculations, totals, and omissions including months with missing information and data. Therefore, we were not assured that the correct data was being collated, recorded and reported within the service, and to the board. Dashboard information included the number of "Babies Born Before Arrival" (BBA). Following the inspection the service reported there had been 33 BBA cases in the 11 month period to February 2023. However, we found no recognition of BBAs in meeting minutes, action plans or communications with staff.

Staff were clear about their roles and accountabilities, but they did not have regular opportunities to meet, discuss and learn from the performance of the service or incidents. For example, actions and lessons learned from PMRTs and HSIB investigation recommendations.

Management of risk, issues, and performance

The trust did not use effective systems to manage performance effectively and safely. They did not always identify and act to minimise risks and issues relating to safe care of women, pregnant people, and babies. The leaders did not complete and ensure changes in practice were made as agreed from action plans to improve safety and performance.

The service had a risk register to address service risks such as concerns around staffing and estates but not all risks discussed with the inspection team were included in the register such as escalation of clinical risk. Not all risks the

service were aware of were effectively managed using this process. Therefore, the risk register could not provide assurance to the trust that it was fit for purpose. Leaders had presented risks through the board assurance framework including risks regarding workforce, estate, and items raised during the inspection such as ligature risks. This was recorded in the trust board open paper for 29 March 2023.

Leaders did not have an established clinical risk process and did not have full oversight of all risks to patient safety. Following reports and recommendations from investigations carried out by the Healthcare Safety Investigation Branch (HSIB) there was a lack of effective tangible actions evidenced and lessons learnt.

Leaders did not always identify and escalate relevant clinical risks, issues, or actions to reduce their impact. Staff told us not all risks were identified through the incident management system and risks were not always reviewed and recorded in meeting minutes of the monthly risk assurance meeting. The leadership team did not always take action to make changes where risks were identified.

Managers and staff did not complete a comprehensive programme of repeated audits to secure assurance of improvements over time. Leaders did not effectively share and make sure staff understood information from the audits and incidents. Maternity service leaders were not always able to provide audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvements. The service reported in the Family Health Quality and Governance meeting minutes in February 2023 that there were 67 audits on a forward plan, 14 were complete, 18 only on going, 27 behind schedule and 5 were abandoned, which included the Saving Babies Lives audit. The service had not completed relevant clinical audits including the national perinatal mortality audit.

Results from a service modified early obstetric warning score (MEOWS) audit indicated staff did not always carry out clinical observations using MEOWS in a timely way, record the observations, or escalate them appropriately. This meant that there was a risk to women, birthing people and babies coming to harm. The service's MEOWS audit results also indicated that observations were not being taken in line with appropriate frequency, and national and local guidance was not being followed. Significant numbers of MEOWS scores meeting a trigger point should have been escalated. However, this did not occur. Following the recommendations of a HSIB investigation in 2021, the trust had committed to an action plan but, at the time of the inspection, staff had not taken action to ensure MEOWS was used effectively, escalated in line with policy and associated risks were not mitigated.

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from as far back as October 2021 that continued to await review or closure. Delays in the trust completing incident reporting would not give the trust or its staff the opportunity to learn lessons or implement change. The trust had recorded its highest numbers of incidents remaining open in November 2022 at 216 and this had remained at over 190 on 1 February 2023. There was a significant lack of evidence of learning relating to the Healthcare Safety Investigation Branch (HSIB) and perinatal mortality review tool (PMRT) action plans completed from cases from 2019, 2020, 2021 and 2022.

We reviewed the trust's HSIB cases aggregate report presented to the board in March 2023. Recurrent identified themes included lack of MEOWS escalation, policies not being followed, lack of review and oversight of governance, lack of promotion of learning, and issues around the trust's safety culture. Although the reports marked the actions had been completed, the trust provided no evidence of actions taken, embedded, or shared.

Maternity

Investigation reports from HSIB stated outcomes for women, birthing people, and babies may have been negatively impacted as a result of the lack of risk assessments, lack of learning from incidents, and lack of embedding national immediate essential actions. Senior staff provided assurance to the board that actions identified by HSIB had, or would be completed. However, information provided by the trust showed these actions remained incomplete. Therefore, inhibiting the ability to improve the service and the experience and outcomes for women, birthing persons, and babies.

The trust had not evidenced working collaboratively to ensure serious incidents were investigated thoroughly. The trust worked with the Local Maternity Neonatal Services, although there was a lack of learning by the trust, a lack of enhanced learning from incidents, and a lack of sharing learning with the LMNS.

Partner agencies had previously reported risks to the trust regarding screening processes and incidents, and for managing results of screening to safely manage care during pregnancies of women and birthing people. Although this was included in the service risk register, screening incidents continued to be identified in some cases throughout all stages of pregnancy and intrapartum care, which provided a lack of assurance and risk process as lessons were not being learnt. The service reported an improving trend had been noted since Quarter 2 for 2022/2023, although some incidents reported as no harm had not been investigated regarding their impact on care. The review process had not been completed and incidents remained open.

The service was reported nationally as being a statistical outlier of babies when born with a low Apgar score in 2022, continuing to the time of the inspection. The Apgar scoring system is a recognised standardised assessment of a newborn baby following birth. This was recognised as being higher (worse) than the national average and in the upper 25% of all organisations with a rate of 29 babies having high scores per 1000 births compared to the national average of 13 babies per 1000 births. The trust staff and leaders did not recognise or have an awareness regarding the service being an outlier with this data. There were no audits or action plans to reduce future risks or improve the outcomes for women, pregnant people, and babies.

The national maternity dashboard showed trust information for the period between March 2022 and February 2023. For 10 months the trust had a higher number of post partum haemorrhages (PPH) than the national average, 1 month where they had the same number, and only 1 month where there were fewer. In April and May 2022 there were 45 in 1000 births, significantly higher (worse) compared to the national average of 29 per 1000.

Midwives told us they were not aware of the service's stillbirth or neonatal death rates, or other key performance indicators, because they not seen the maternity dashboard.

The trust did not always use perinatal mortality review tool (PMRT) appropriately. They did not identify the cause of each baby's death by robustly and comprehensively reviewing each case and the quality of care provided. The service did not work through the care for each baby who died to identify contributory factors where issues were identified and assess whether different care may have made a difference to the outcome (grading of care). The service did not develop and complete action plans that addressed the contributory factors identified, achieve organisational change, or service improvements. The service did not recognise a 'just culture' of accountability for individuals and organisations.

The PMRT was not shared with the trust board regularly. Themes and trends were not identified from these perinatal loss cases. The reports lacked full completion and meaningful action plans, and there was a lack of evidence that actions had been completed. We reviewed some completed PMRTs which lacked relevant information including the baby's birth weight centile. However, 'small for gestational age' was indicated as a theme from the HSIB and the PMRT cases reviewed. Staff reported that they had not had any 'Gap and Grow' training over the last 5 years. 'Gap and Grow' aims to increase the recognition of fetal growth restricted babies and improve outcomes. It includes a benchmarking missed

case audit, where clinicians undertake a 'standardised clinical outcome review and evaluation' (SCORE) of small for gestational age (SGA) deliveries that were not recognised antenatally. Trusts and maternity leads are encouraged to undertake this regularly on a proportion of cases to check for avoidable factors such a failure to follow risk assessments, inaccurate measurement or plotting, or lack of referral for investigation.

Following PMRT case reviews there was no evidence that the trust was providing parents with a robust explanation of why their baby had died, or accepting that in all instances, despite full clinical investigations, it is not always possible to determine this. Staff did not always explain any implications for future pregnancies.

Information Management

The service did not always collect and analyse reliable data. Staff could not always find the data they needed in easily accessible formats, to understand performance, make decisions, and improvements. Data or notifications were not consistently submitted to external organisations as required. However, the information systems were integrated and secure.

The service had a lack of processes, and systems for introducing and communicating new or amended trust policies. This meant staff did not have access to up-to-date local or national policies to plan and deliver high quality care according to evidence-based practice and national guidance. Not all policies and guidance were in date or reviewed every 3 years and not all staff could access the policies and guidance.

The service did not always collect and analyse reliable data**.** We requested a copy of the trust's maternity performance dashboard used by senior managers. The service provided a dashboard summary chart which showed key performance indicators and performance over time for some metrics. However, there were no measurable action plans put into place to address key metrics outside of targets. This dashboard showed live performance information which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Staff told us the maternity dashboard information was not shared with them.

There were errors in the University Hospital of North Durham maternity dashboard data with year-to-date figures being incorrect at times. For example, the maternity dashboard did not contain any data relating to the number of babies with hypoxic-ischaemic encephalopathy (HIE) or numbers of cases referred to Healthcare Safety Inspection Branch (HSIB), or neonatal deaths. The maternity dashboard did not show metrics relating to the service's smoking rates at booking. However, the mandatory maternity data set information identified that these were higher (worse) than the national average. Smoking is a recognised risk factor and the trust had declared partial compliance with Saving Babies lives V2 in March 2022. However, although leaders stated that at the time of the inspection they were compliant, we found there was a lack of risk assessments and audit to assess the adherence to the saving babies lives recommendations.

Staff could not always find the data they needed in easily accessible formats to understand performance, make decisions and improvements. National guidance and local policies were available for staff to access on the trust intranet for those who had access. However, not all Midwives had their own login, so some staff were unable to access information which staff shared.

The PMRT summary report dated from 2022 to 2023 provided by the trust evidenced poor standards in the quality of the PMRT reviews with no external participation. In some reviews only 3 internal staff attended and did not include a member of the senior team. This summary report was not accurately reflected in risk, governance, or trust reports. Throughout both summary reports there was a lack of neonatology involvement.

A range of staff from the multidisciplinary team told us they experienced difficulty in accessing the range of information required to provide effective care. This was in part due to the fact that clinical information systems were not always integrated, with EPR systems being relatively newly introduced. However, the trust told us there was an interface between patient record systems.

Engagement

Leaders and staff did not always actively and openly engage with women, birthing people, and staff. There was a lack of collaboration with equality groups, the public and local organisations to plan and manage services.

Leaders did not always work with the local Maternity Voices Partnership (MVP) in decisions about patient care. The MVP said they would have liked more active involvement with the service and stated they were not always included or invited to meetings with the service, which they would have welcomed. This was not a person centred approach to engagement. However, MVP representatives raised concerns with the inspection team about the trust's lack of engagement, in particular with ethnically diverse and vulnerable groups. Since the merge of two previous MVP groups into one, there had been some challenges with working across two sites of the maternity services in this trust.

The service made interpreting services available for women and birthing people and collected data on ethnicity.

It was not evidenced that the senior leaders understood the needs of the local population outside the continuity of carer programme, despite there being several other communities suffering social deprivation throughout the service's geographical area.

MVP voiced that they had a priority to reach out to the vulnerable and Black Asian and minority ethnic groups. MVP had asked for buy in from the trust and staff since the Ockenden recommendations but at the time of discussions the trust had not taken up this offer, and the MVP would continue to pursue this going forward.

MVP advised that the Continuity of Carer programmes targeted deprived areas. MVP had received feedback that was positive experience of the Continuity of Care model of care being provided. However, they stated the trust did not speak to the women and families from all deprived areas. They felt that the trust did not engage in the MVP meetings, and these were too NHS focused.

MVP stated they had concerns regarding the lack of homebirths as they had recognised that there was an increased number of "freebirths". The trust was not offering home births and the service had been suspended for over a year. The MVP described being frustrated, and women and birthing people had shared they planned to freebirth. MVP described communication re lack of homebirth service had been poor, and women were not being given correct information about being able to attend another provider for their baby's birth.

The Local Maternity Neonatal Service (LMNS) were also involved with the MVP and involved with the maternity engagement group. These groups had identified ways to improve communication throughout the local communities and the top five languages had been shared. Staff told us the trust were engaged with the idea of using different languages. However, at the time of the inspection there was nothing yet in place.

Learning, continuous improvement and innovation

Maternity

All staff were committed to continually learning and improving services. However, staff did not always have the skills and resources to implement improvements to services and these were not always timely or evidenced as being implemented.

Staff were committed to continually learning and improving services. Quality improvement was routinely discussed at trust meetings including action plans such as those following HSIB investigations and PMRT reviews. However, staff had repeatedly reported the lack of acknowledgement of staff ideas and suggestions for improvements.

Leaders stated in reports they would promote change and improvement through training and innovation. However, staff said there had been nothing developed or shared.

The trust had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives. Staff did not always have an awareness of the trust's quality improvement methods and were not always given the time or skills to use them. The service was not committed to improving services by learning when things went well or there were lessons to be learned and there was a lack of action taken to follow up plans and learning.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support clinical research studies.

Outstanding practice

We found the following outstanding practice:

- Staff showed courage and compassion, and demonstrated real caring for the women, people and babies under their care, whilst demonstrating their own personal resilience. This included staff sharing information with the inspection team on how they would like the maternity service to improve.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- The trust must ensure there are sufficient midwives. The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives in order to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies. Regulation 18 (1)
- The trust must ensure staff complete all maternity mandatory training including role specific training modules. Regulation 18 (2) (a)

Maternity

- The trust must ensure staff are competent in carrying out CTGs, reviewing and escalating concerns appropriately. Regulation 12 (2) (c)
- The trust must ensure there is sufficient equipment including CTGs to care for women, birthing people, and babies throughout the unit. Regulation 15 (1) (c) (f)
- The trust must ensure staff complete daily checks of emergency equipment. Regulation 15 (1) (e) (2)
- The trust must ensure systems and processes for maternity triage are reviewed so to deliver a safe service in line with national guidance. Regulation 17 (a) (b) (c)
- The trust must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and escalated appropriately. Regulation 12 (a) (b)
- The trust must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care. Regulation 12 (a) (b)
- The trust must ensure there are effective governance processes and systems to identify and manage incidents, risk, issues, and performance and to monitor progress through completion of audits, actions and improvements and reduce the recurrence of incidents and harm. Regulation 17 (1) (2) (a) (b) (e) (f)
- The trust must ensure performance audit programmes are carried out, completed appropriately, and reported in line with national standards and guidance. (Regulation 17(2) (a) (b)
- The trust must ensure compliance with recommendations and reviews are carried out effectively to ensure actions and changes in practice are completed and performance is reported correctly. 17(2) (e) (f)
- The trust must ensure engagement with women, birthing people, and families to listen and involve them in investigations and reviews, and to include all local communities and groups. Regulation 17 (2) (e)
- The trust must ensure Duty of Candour is carried out appropriately. (Regulation 20).

Action the trust SHOULD take to improve:

Maternity

- The trust should continue to ensure all staff complete multidisciplinary skills and drills training.
- The Trust should continue to ensure there is sufficient and accessible emergency resuscitation equipment to care for women, birthing people, and babies throughout the maternity unit.
- The trust should ensure that there are appropriate facilities for use by bereaved families to meet national standards and guidance.
- The trust should ensure effective measurement of acuity in all areas to enable appropriate and sufficient staffing to provide safe care.
- The trust should ensure staff are encouraged and supported to report staffing problems and act upon them appropriately. Regulation 18 (1)
- The trust should ensure leaders are visible, approachable, acknowledge and manage the issues throughout the service.
- The trust should ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care.

Maternity

- The trust should ensure the vision and values relate to the current model of care and all staff understand and apply them to their work.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Adult Wellbeing & Health Overview & Scrutiny Committee

2 October 2023

Adult Social Care update on the introduction of local authority assessment by the Care Quality Commission under the Health and Care Act 2022

Ordinary Decision

Jane Robinson, Corporate Director of Adult & Health Services

Electoral division(s) affected:

Countywide

Purpose of the Report

1 To provide AWHOSC with an update on the framework which the Care Quality Commission (CQC) began to use in April 2023 to assess how local authorities discharge their Adult Social Care duties under Part 1 of The Care Act 2014.

2 To provide AWHOSC with information relating to the update to the Government's plan for care and support reform, 'Next steps to Put People at the Heart of Care' April 2023.

Executive summary

3 In April 2022, the Health and Care Act 2022 came into force. It gave CQC regulatory powers to assess how local authorities discharge their Adult Social Care duties under Part 1 of The Care Act 2014. Using a similar approach, the CQC will also be assessing Integrated Care Systems (ICS) to establish how they are working to tackle health inequalities and improve outcomes for people.

4 In April 2023, CQC's regulatory powers to allow them to assess how local authorities discharge their Adult Social Care duties under Part 1 of The Care Act 2014 on behalf of the government came into effect.

5 Also in April 2023, the Government published its updated plan for care and support reform, 'Next steps to Put People at the Heart of Care'.

This confirmed the two-year plan for system reform for 2023-2024 and 2024-2025 and further implements the white paper ‘People at the Heart of Care' (December 2021).

6 This report outlines:

(a) the chronology leading up to the implementation of the white paper ‘People at the Heart of Care' (December 2021), the introduction of the Health and Care Act 2022, and the further update ‘Next steps to Put People at the Heart of Care’ (April 2023);

(b) the interim framework CQC will use when assessing how local authorities discharge their Adult Social Care duties under Part 1 of The Care Act 2014;

(c) CQC’s timeline to commence the assessment of the way local authorities discharge their Adult Social Care duties under Part 1 of The Care Act 2014;

(d) Durham County Council Adult and Health Services approach to the assessment as to how it discharges its Adult Social Care duties under Part 1 of The Care Act 2014 by CQC under their powers as outlined in the Health and Care Act 2022.

Recommendation(s)

7 Adult Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) note the contents of this report and that a further update will be received in six months;

(b) note that AWHOSC will be informed when CQC notifies Durham County Council that it will be undertaking the assurance process of the delivery of adult social care duties.

Background

8 Prior to March 2010, annual assessments of local authority Adult Social Care were undertaken by CQC on behalf of the government.

9 In March 2010, the powers which CQC had to carry out this independent assessment activity were stood down by the government of that time.

10 Since 2010, local authority Adult Social Care has not been subject to external assessment by an independent regulatory body. Local authorities have continued to carry out their own service led assurance activity within Adult Social Care, often working regionally to share information and improvement initiatives.

11 In December 2021, the government delivered the white paper ‘People at the Heart of Care', which announced plans for a reintroduction of external assessment by an independent, external, regulatory body, such as CQC.

12 In April 2022, the Health and Care Act 2022 came into force. It gave CQC regulatory powers from April 2023 to enable them to assess how local authorities and Integrated Care Systems (ICS) discharge their Adult Social Care duties under Part 1 of The Care Act 2014.

13 At the same time, the Health and Care Act 2022 established the forty-two statutory ICSs across England commencing from 1 July 2022. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Durham County Council is part of the ICS for the North-East and North Cumbria.

14 From July 2022 and throughout the development period, to support local authorities in preparing for the commencement of the assessment regime in April 2023, CQC carried out testing activity, consulted with all interested parties, and provided guidance documents and updates. This included:

(a) October 2022 - Disseminating an early draft of a proposed assessment framework to give local authorities an insight into the planned approach;

(b) December 2022 - Distributing an update so that local authorities would know that CQC’s planned work was progressing on schedule and sharing information relating to “Test and Learn” activities carried out in Manchester and Hampshire which further informed the development of their assessment framework approach;

(c) February to March 2023 – Publishing an interim approach to assessing local authorities with guidance, and a more finalised draft assessment framework for local authority assurance in adult social care;

(d) March to April 2023 – Delivering an ongoing webinar programme to provide updates to local authorities at which health and social care professionals can pose questions directly to CQC senior officers.

15 On 01 April 2023 and as planned, CQC's regulatory powers came into effect. When assessed, local authorities will be given a rating of outstanding, good, requires improvement, or inadequate.

16 On 04 April 2023, the Government published its update plan for care and support reform, 'Next steps to Put People at the Heart of Care'. This confirmed the two-year plan for system reform for 2023-2024 and 2024-2025 (see Appendix 4). This further implements the white paper 'People at the Heart of Care' (December 2021).

Introduction of CQCs interim assessment framework for local authority assurance

17 The assessment of the local authority made by CQC is based on a single assessment framework which is used to assess all types of services in all health and care sectors at all levels. This is currently in draft form, awaiting finalisation. The way that local authorities discharge their duties under Part 1 of The Care Act 2014 is assessed across four themes and nine quality statements which sit under each theme:

1. how local authorities work with people
    i. assessing needs;
    ii. supporting people to live healthier lives;
    iii. equity in experiences and outcomes;
2. how local authorities provide support
    i. care provision, integration, and continuity;
    ii. partnerships and communities;
3. how local authorities ensure safety within the system
    i. safe systems, pathways, and transitions;
    ii. safeguarding;
4. leadership
    i. governance, management, and sustainability;

ii. learning, improving and innovation.

18 These are aligned to “I” statements and “we” statements. “I” statements are based on what people expect and need and are used as a basis for gathering structured feedback. “We” statements are the standards against which CQC will hold local authorities and ICSs to account (Appendix 2).

19 The evidence used by CQC to support assessments of the local authority against these themes and quality statements is drawn from:

(a) information about people’s experience of adult social care;

(b) feedback from staff and leaders about adult social care;

(c) feedback from partners about adult social care;

(d) information about processes within adult social care;

(e) information about outcomes of adult social care.

20 Observation is not used as an evidence category for local authorities as it does not apply to the specific context of a local authority.

21 Data and information specific to the scope of the assessment, the delivery model and the local demographic is considered, alongside underpinning best practice standards and guidance.

22 Local authorities are expected to produce a self-assessment document on their current performance and this document will be requested by CQC as part of their assurance activity.

23 It is expected that CQC will expand upon and update this interim approach as they develop their draft model.

CQC’s timeline for commencing assessment of local authority delivery of adult social care

24 Between April and September 2023, CQC are reviewing published evidence and data from all local authorities to establish a baseline and inform the next phase of assessment activity. CQC is focusing on two quality statements only during this period:

(a) care provision, integration, and continuity;

(b) assessing needs.

25 CQC are looking mainly at evidence data which is already published, such as Market Position Statements, Joint Strategic Needs Assessments, and statutory returns.

26 CQC will draw out themes and insight on:

(a) access;

(b) commissioning;

(c) market shaping;

(d) workforce;

(e) personalisation.

27 This data and evidence will not be published at individual local authority level. Instead, CQC will publish it at an overall national level as a collection of evidence. For example, they may publish this information in the CQC annual statutory State of Care report to Parliament.

28 This national review is the first element towards full assessment of these two quality statements. It constitutes CQC's initial steps in developing judgements for individual authorities. It will also provide context and an opportunity to benchmark data.

29 Information which has been published about Durham County Council Adult Social Care will be scrutinised by CQC in this phase.

30 Additionally, between April and September 2023, CQC are carrying out five pilot assessments of local authorities to help to further develop and refine their approach. CQC is working with those pilot local authorities to determine the best way to publish their findings and will give the pilot local authorities an indicative rating, which will be in the public domain.

31 The authorities engaging in this pilot stage are Birmingham City Council, Nottingham City Council, Lincolnshire County Council, Suffolk County Council and North Lincolnshire Council.

32 From Autumn 2023, the formal assessment period of all local authorities will commence. CQC aims to complete twenty assessments initially and report these as published individual ratings from early 2024 onwards. A rating for all local authorities will be published over the next two years.

Durham County Council's preparation for the commencement of assessment of local authority delivery of adult social care

33 Durham County Council gains assurance regarding their Adult Social Care duties under Part 1 of The Care Act 2014 in several ways. These include but are not exclusive to:

(a) monitoring and oversight of assurance activity via the Adult and Health Services Quality Assurance Board (QAB) chaired by the Corporate Director of Adult and Health Services and the Adult and Health Services Oversight and Assurance Group chaired by the Chief Executive. See Appendix 3;

(b) participation in and learning from peer review and challenge, in the form of a regionally commissioned Annual Conversation (AC) which took place in October 2022. The key learning points from this are as follows:

Regionally

(i) activity has informed the North-East Association of Directors of Adults Services (ADASS) sector led improvement programme. DCC senior officers provide representation on the numerous regional groups covering areas such as commissioning, performance, workforce, digital, assurance and safeguarding. Findings from the outcome of Annual Conversations across the region are informing much of this work;

Locally

(ii) the need to improve corporate oversight and engagement was identified as an area for further development. An Oversight and Assurance Group and regular updates to Corporate Management Team and Cabinet were established in recognition of this prior to the annual conversation;

(iii) the need to strengthen feedback on our services and practices from a wide variety of stakeholders. This includes surveying key stakeholders such as wider DCC personnel, our partners, service users/carers and utilising the feedback to inform our self-assessment process;

(iv) Effective reablement and co-production framework were raised as examples of best practice in the regional feedback. Work is planned to further enhance co-production and our reablement model;

(v) the AHS workforce strategy was identified as an example of best practice;

(vi) the need to improve data quality to support decision making was also highlighted. AHS has enhanced its quality assurance processes and will achieve further gains following the implementation of new ‘business intelligence’ dashboards.

(c) the establishment of an Inspection Preparation Oversight Group. This meeting is chaired by the Head of Adult Care and adopts a program management approach for overseeing a work schedule;

(d) continuous development of our quality assurance framework. This is overseen by a Quality Assurance Board (QAB) chaired by the Corporate Director which provides further inspection preparation oversight;

(e) the development of a communication plan. This focuses on internal and external communications. The external communications include refreshing public facing web pages and keeping key partner organisations and the general public updated;

(f) analysing learning from other published peer review and challenge activity, such as the findings from the CQC “Test and Learn” activities held in Autumn 2022 and from the outcomes of the pilot activity which is taking place between April and September 2023;

(g) preparation of a self-assessment document on current performance which follows the guidance outlined in the Local Government Authority (LGA) and the Association of Directors of Adult Social Care (ADASS) publication “Getting Ready for Assurance: A guide to support the development of your Adult Social Care Self-Assessment” (October 2022);

(h) collation of a base of evidence which is published or statutorily returned and which CQC **will refer to** as part of their assurance activity, aligned to the “CQC Required Evidence list” (March 2023). This is described as evidence which CQC will “**have**;”

(i) collation of a base of evidence which CQC **will request** as part of their assurance activity, aligned to the “CQC Required Evidence list” (March 2023). This is described as evidence which CQC will “**request**;”

(j) the Adult and Health Service Annual Quality Schedule 2023 – 2024, which reports into QAB every quarter and includes a rolling programme of adult care case file audits.

34 Adult and Health Services will continue to monitor the assessment process which CQC is implementing from April 2023.

35 Adult and Health Services will continue to review and adapt the local authority response to and preparation for impending assessment of the way that Durham County Council discharges its adult social care duties under Part 1 of The Care Act 2014 within the powers that CQC has as part of the Health and Care Act (2022).

36 The feedback and outcomes of assurance activity which has been carried out within the local authority, locally with regional local authorities, and nationally, will continue to be analysed and used to inform service plans, and drive improvement and innovation.

Implementation of the white paper ‘People at the Heart of Care'

37 Adult and Health Services will continue to monitor, respond to, and implement the updated plan for care and support reform, ‘Next steps to Put People at the Heart of Care’ (April 2023). (See appendix 4).

38 Key points around the work that is being planned and is currently ongoing are stated below with regards to the areas raised appendix 4.

39 The two-year plan for system reform covered areas such as:

(a) charging reform

(i) continuing to monitor government updates on when this program might be restarted with an expected date of October 2024.

(b) capacity

(i) consideration of the funding allocation will be factored in as part of the current plan on updating the services market sustainability plan;

(ii) as part of our ongoing delivery of the BCF, plans are being put in place to meet the new request to report on capacity in our residential and community-based services;

(iii) the Care Academy supports independent sector care providers with recruitment, retention, training, and development. For example, since March 2021, 197 people

recruited into jobs by local care providers using the Care Friends app. More information can be found here.

(iv) we are sharing the work Durham Community Action are doing to encourage volunteering. More information can be found here.

(c) workforce

(i) the impact of the proposed changes relating to workforce development will be addressed through the review of the current AHS workforce strategy and developments relating to qualification opportunities utilising local investment via national funding referenced in appendix 4.

(d) digital and data

(i) the AHS digital board continues to oversee work plans and priorities in relation to digital developments to support the sector. We work closely with colleagues in performance and strategy service to utilise data to inform our service. improvement activity. The porting across of our data insight information to the corporate business intelligence system is being overseen by the AHS digital board.

(e) housing

(i) AHS is feeding into the consultation process of a new County Durham Housing Strategy 2024 which seeks to be inclusive and accessible of people with support needs.

(f) innovation and joined up working

(i) the Director of Integration oversees a program of integration covering a number of workstreams including community therapy support, hospital discharge, equipment in care homes;

(ii) we are currently working with our local mental health trust partners to strengthen our social care priorities in the delivery of integrated community mental health services.

Conclusion

40 Durham County Council's Adult and Health Service is undertaking ongoing service improvements which contribute to the preparation for CQC assessment of the local authority's delivery of its duties under part 1 of the Care Act 2014.

41 As outlined in this report, significant work is being undertaken in preparation for this assessment process. This includes working in conjunction with the other local authorities across the North East ADASS footprint, developing thought processes, sharing learning and providing mutual support.

42 The local authority is also undertaking a body of work to respond to the key themes in the government's new plan for social care reform 'People at the Heart of Care'.

Background papers

- None.

Other useful documents

- February 2021: NHS Reform White Paper
  Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)
- December 2021: People at the Heart of Care: adult social care reform white paper
  People at the Heart of Care: adult social care reform white paper
- December 2022: Update from CQC
  Our new single assessment framework - Care Quality Commission (cqc.org.uk)
- February 2023: Interim guidance from CQC
  Interim guidance for Local Authority Assessments (cqc.org.uk)
- March 2023: Draft guidance from CQC
  Assessment framework for local authority assurance - Care Quality Commission (cqc.org.uk)
- March 2023: Interim guidance from CQC
  Interim guidance on our approach to assessing integrated care systems
- April 2023: Adult social care system reform: next steps to put People at the Heart of Care
  Next steps to Put People at the Heart of Care

Contact: Lee Alexander Tel: 03000 268 180

Appendix 1: Implications

Legal Implications

This report responds to and covers the implications of the Department of Health and Social Care White Paper “Integration and innovation: working together to improve health and social care for all,” which set out legislative proposals for the Health and Care Act 2022.

Finance

Preparations and activity outlined in the report are being undertaken within existing budget arrangements.

Consultation

Where appropriate, consultation has taken place with internal and external colleagues and stakeholders and partners. Further consultation will be undertaken as required.

Equality and Diversity / Public Sector Equality Duty

The principles of equality and diversity have been considered.

Climate Change

N/A

Human Rights

The principles of equality and diversity have been considered.

Crime and Disorder

N/A

Staffing

Staff will be involved in any assurance activity and are required to adhere to relevant legislation and any professional regulatory or statutory requirements relating to their roles.

Accommodation

N/A

Risk

There is a reputational risk associated with the CQC assurance process. Assurance activity carried out by the organisation and the service, and

assessment of the local authority by an external independent organisation mitigates against risk by ensuring that the local authority adheres to relevant legislation and any professional regulatory or statutory requirements. Risk registers also held in the Adult and Health services, as well as for programmes of work.

Procurement

N/A

Appendix 2: CQC assessment framework for local authority assurance

Interim guidance for Local Authority Assessments (cqc.org.uk)

Theme 1: How local authorities work with people

'I' statements:

- I have care and support that is co-ordinated, and everyone works well together and with me.

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths, and goals.

- I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally, and emotionally.

- I am supported to plan ahead for important changes in my life that I can anticipate.

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths, and goals.

Quality statements:

- **Assessing needs:**

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing, and communication needs with them.

- **Supporting people to lead healthier lives:**

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support. Interim guidance on our approach to local authority assessments.

- **Equity in experience and outcomes:**

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support, and treatment in response.

Theme 2: How local authorities provide support

'I' statements:

- I have care and support that is co-ordinated, and everyone works well together and with me
- Leaders work proactively to support staff and collaborate with partners to deliver safe, integrated, person-centred and sustainable care and to reduce inequalities.

Quality statements:

- Care provision, integration, and continuity: We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- Partnerships and communities: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Theme 3: How local authorities ensure safety within the system

'I' statements:

- When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.
- I feel safe and am supported to understand and manage any risks.
- I feel safe and am supported to understand and manage any risks.

Quality statements:

- **Safe systems, pathways, and transitions:**

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored, and assured. We ensure continuity of care, including when people move between different services.

- **Safeguarding:**

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on

improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately.

Theme 4: Leadership

Quality statements:

- **Governance, management, and sustainability:**

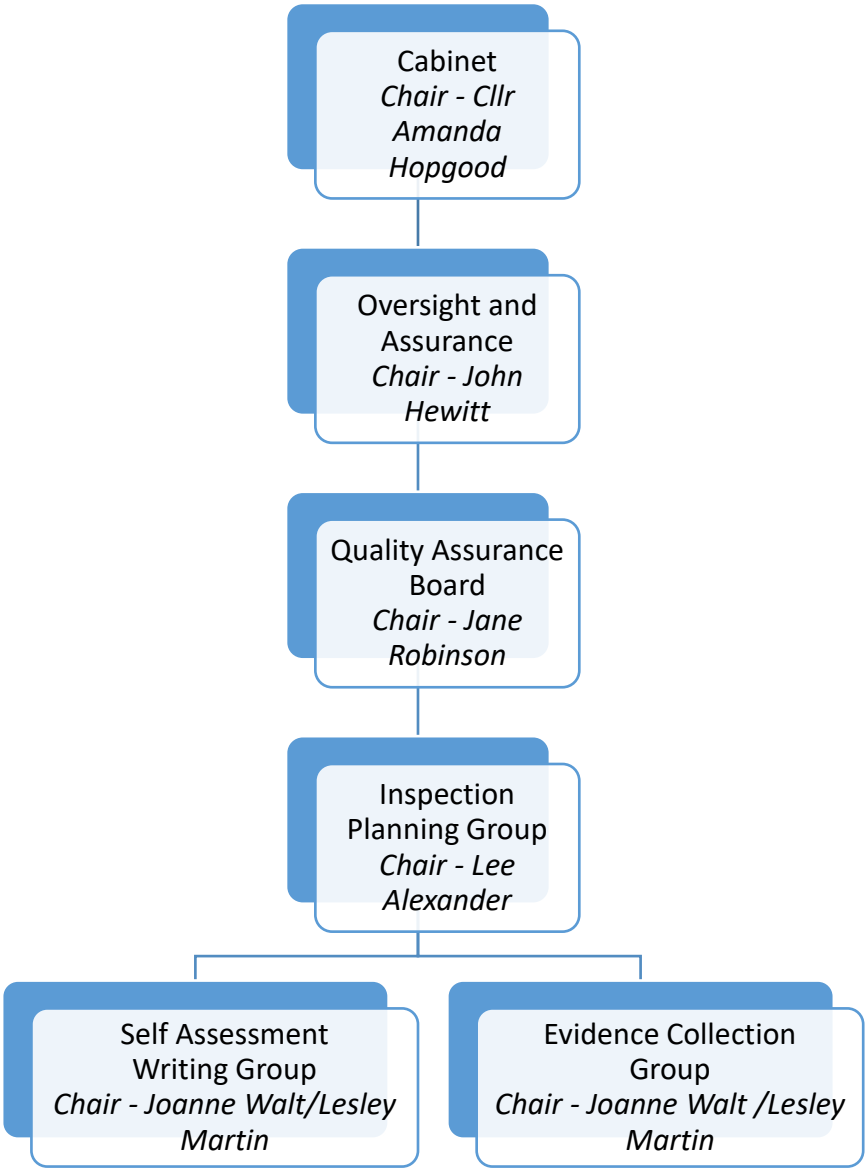
We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment, and support. We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate.

- **Learning, improvement, and innovation:**

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome, and quality of life for people. We actively contribute to safe, effective practice and research.

Appendix 3: Adult and Health Services Quality Assurance Governance Framework

Quality Assurance activity is managed via the Quality Assurance Governance Framework which follows the reporting line illustrated below. Assurance reports and presentations are made via this governance route. The relevant Chair for each meeting oversees the flow of activity between these groups and provides approval as appropriate, with Cabinet being the final decision maker.



Appendix 4: Implementation of the white paper ‘People at the Heart of Care'

1 On 4 April 2023, the Government published its update plan for care and support reform, ‘Next steps to Put People at the Heart of Care’. This confirmed the two-year plan for system reform for 2023-2024 and 2024-2025 and further implements the white paper ‘People at the Heart of Care' (December 2021).

2 The two-year plan for system reform covered areas such as:

(a) Charging reform

(b) Capacity

(c) Workforce

(d) Digital and data

(e) Housing

(f) Innovation and joined up working

3 The initial focus of the implementation of this vision was on the plans for charging reform. The focus has now shifted to the additional areas: capacity; workforce; digital and data; housing; and innovation and joined up working.

4 The latest published update to the two-year plan ‘Next steps to Put People at the Heart of Care’ outlines the following:

(a) Charging reform:

(i) This was paused for two years in October 2022 so that the allocated funding could be reallocated to address inflationary pressures on social care which local authorities are facing.

(b) Capacity:

(i) It has been confirmed that the Market Sustainability and Improvement Fund (MSIF) will be allocating £562m in 2023 - 2024 and £845m in 2024 - 2025 for local authorities to use flexibly. The grant conditions for MSIF have been published.

(ii) The new framework for the Better Care Fund (BCF) covering 2023-25 has been published, covering the conditions and allocations for the BCF over the next two years. Government will be asking local areas to report the capacity they will be putting in place to meet demand across all their residential and community-based services. This is the first time a request to report this information has been made.

(iii) £15m is being allocated to support care providers to access international recruitment. This will build upon the increased numbers of workers being drawn from overseas since the Health and Social Care Visa was added to the shortage occupation list in February 2022.

(iv) £3m is being invested to support an increase in volunteering within social care.

(c) Workforce:

(i) The strategy does cover career development but does not cover pay and conditions for the social care workforce.

(ii) It has been confirmed that £250m has been allocated for investment into this area over the next two years. The White Paper had originally allocated £500m for this work.

(iii) The Government will publish a new National Workforce Pathway in Autumn 2023. A consultation was launched in April 2023 to feed into the development of this pathway.

(iv) Investment will be made into providing additional training places. It is intended that a new Level 2 Care Certificate will be introduced and will become a 'baseline standard' for those working in social care. There will also be an emphasis on improving digital skills within the sector.

(d) Digital and Data:

(i) £150m will be invested in this area, as outlined in the original paper. The update confirms that £50m has been invested 2022 - 2023, with a further £100m investment planned to be spread over the next two years.

(ii) The £50m invested during 2022 – 2023 was focused predominantly on helping providers to institute digital care records and install falls technology. These areas were prescribed for this first allocation. The remaining allocation

will provide greater choice in identifying the right digital technologies for people drawing on their care and support services. It is intended this will be done by supporting ICSs to test and adopt care technologies that address local priorities, providing implementation and evaluation support to develop an evidence base to scale technologies where there are proven benefits.

(iii) The paper emphasises the importance of using data in social care delivery. Up to £50m will be invested in improving the sector's use of data. It is unclear whether this is additional funding or to be allocated out of the £150m mentioned in (i). This focus on improved data collection aligns to new and additional reporting requirements for local authorities, including those to CQC.

(e) Housing:

(i) The £300m outlined in the original White Paper to integrate housing into local health and care strategies is not mentioned in the update. It is suspected that this money will no longer be available.

(ii) There will be a £102m investment in the Disabled Facilities Grant over the next two years. This does appear to be additional to the £573m per year which was originally set out in the White Paper for this area.

(iii) A new and independently chaired Older People's Housing Taskforce will be established and jointly hosted by the Department for Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC). The aim is to provide recommendations on Retirement Housing (excluding care homes) to the Government by Spring 2024.

(f) Innovation and joined-up working:

(i) A new social care Innovation and Improvement Unit will be established by the Government, and £35m will be invested over the next two years to support local authorities, ICSs, and sector partners in developing innovative approaches to transform the quality of care.

(ii) £35m will be invested in supporting improved joined-up working between health and social care within local areas. This will cover:

1. Targeting support to local areas though the BCF support programme.

2. Developing a better understanding the impact of integrated support for carers.

3. Building leadership skills to support the better integration of services, particularly for those at ICS level.

5 Adult and Health Services will continue to monitor, respond to, and implement the updated plan for care and support reform, ‘Next steps to Put People at the Heart of Care’ (April 2023).

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Adults Wellbeing and Health Overview and Scrutiny Committee

2 October 2023

Revenue and Capital Outturn 2022/23

Report of Corporate Directors

Paul Darby, 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 2022/23 revenue and capital budget outturn position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget for the year.

Executive Summary

2 This report provides an overview of the 2022/23 revenue and capital outturn position. It provides an analysis of the budget outturn for the service areas falling under the remit of the Overview and Scrutiny Committee and complements reports considered by Cabinet on a quarterly basis.

3 The outturn shows that AHS has a cash limit underspend of £1.850 million at the year-end against a revised revenue budget of £137.989 million, which represents a 1.34% underspend. This compares with the previously forecast cash limit underspend, based on the position at 31 December 2022 of a £1.608 million cash limit underspend.

4 Based on the outturn position the Cash Limit balance for AHS as at 31 March 2023 is £5.329 million.

5 Details of the reasons for under and overspending against relevant budget heads is disclosed in the report.

6 The AHS capital budget for 2022/23 comprised a single scheme of £100,000. There has been capital expenditure incurred of £24,000.

Recommendation

7 It is recommended that the Adults Wellbeing and Health Overview and Scrutiny Committee note the financial position included in this report.

Background

8 County Council approved the Revenue and Capital budgets for 2022/23 at its meeting on 23 February 2022. 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 - £137.989 million (original £136.741 million)*
- *AHS Capital Programme – £0.100 million (original £1.170 million)*

9 The original AHS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

Reason for Adjustment	**£'000**
Original Budget	136,741
Budget Transfer to CYPS – Transitions	(923)
Budget Transfer to REG – Centralised repairs and maintenance	(24)
Budget Transfer to Resources – Business Support	(97)
Budget Transfer from Contingencies – Pay Award 2021/22	517
Use of (+)/contribution to Corporate Recovery Reserve (-)	128
Use of (+)/contribution to cash limit reserve (-)	1,399
Use of (+)/contribution to AHS reserves (-)	248
Revised Budget	**137,989**

10 The use of / (contribution) to AHS reserves consists of:

Reserve	**£'000**
Use of AHS - Social Care Reserve	148
Use of AHS – Integrated Reserve	11
Use of Public Health Reserve	89
Total	**248**

11 The summary financial statements contained in the report cover the financial year 2022/23 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 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 AHS service has a cash limit underspend of £1.850 million against a revised budget of *£137.989 million* which represents a 1.34% underspend. This compares with the forecast cash limit underspend at Quarter 3 of £1.608 million.

13 The tables below show the revised annual budget, actual expenditure in 2022/23 and the year end variance. 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	Actual £000	Variance £000	Items Outside Cash Limit £000	Cont. To / (From) Reserve £000	Cash Limit Variance £000	Memo-Forecast Position at QTR3 £000
Employees	39,001	37,957	(1,044)	(1,469)	0	(2,513)	(2,357)
Premises	1,182	1,914	732	(576)	0	156	131
Transport	2,166	2,346	180	(3)	0	177	47
Supplies & Services	5,815	6,964	1,149	(129)	0	1,020	569
Third Party Payments	319,583	326,991	7,408	0	0	7,408	9,355
Transfer Payments	10,811	11,223	412	0	0	412	(55)
Central Support & Capital	31,026	40,692	9,666	(2,596)	66	7,136	564
Income	(271,595)	(287,241)	(15,646)	0	0	(15,646)	(9,862)
Total	**137,989**	**140,846**	**2,857**	**(4,773)**	**66**	**(1,850)**	**(1,608)**

Analysis by Head of Service Area

	Revised Annual Budget £000	Actual £000	Variance £000	Items Outside Cash Limit £000	Cont. To / (From) Reserve £000	Cash Limit Variance £000	Memo-Forecast Position at QTR3 £000
Excluded Services	140	149	9	(9)	0	0	0
Central/Other	10,924	12,612	1,688	(1,373)	(26)	289	840
Commissioning	3,014	2,001	(1,013)	(204)	878	(339)	(104)
Head of Adults	121,961	120,230	(1,731)	(3,092)	3,023	(1,800)	(2,344)
Public Health	1,950	5,854	3,904	(95)	(3,809)	0	0
Total	**137,989**	**140,846**	**2,857**	**(4,773)**	**66**	**(1,850)**	**(1,608)**

14 The table below provides a brief commentary of the outturn 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	£840,000 under budget on employees due to staff turnover above budget. £588,000 over budget relating to transport. £34,000 over budget on premises. £106,000 over budget on supplies and services. £3,006,000 net over budget on direct care-related activity.	2,894
Safeguarding Adults and Practice Development	£156,000 under budget on employees due to staff turnover above budget. £14,000 under budget on transport. £53,000 over budget on supplies and services. £57,000 over recovery of income.	(174)
Ops Manager OP/PDSI Services	£619,000 under budget on employees due to staff turnover above budget. £212,000 under budget on transport. £370,000 over budget on supplies and services. £3,166,000 net under budget on direct care-related activity.	(3,627)
Ops Manager Provider Services	£491,000 under budget on employees due to staff turnover above budget. £17,000 under budget on transport. £75,000 over budget on supplies and services. £327,000 over recovery of income.	(760)
Operational Support	£89,000 under budget on employees due to staff turnover above budget. £44,000 under budget on supplies and services.	(133)
		(1,800)
Central/Other		
Central/ Other	£462,000 over budget on increased bad debt provision within cash limit. £173,000 under budget mainly in respect of uncommitted budgets to support future operational activity.	289
		289
Commissioning		
Commissioning	£91,000 under budget on employees due to staff turnover above budget. £248,000 under budget in respect of contracts.	(339)
		(339)

Service Area	Description	Cash limit Variance £000
Public Health		
County Durham Together	New Team – full year budget provided.	(99)
Protecting Health	New Team – full year budget provided pls additional income received from Integrated Care Board linked to vaccine inequalities carried forward to 23/24 in reserve.	(126)
General Prevention Activities	Under budget linked to Pharmacy contract for flu immunisation.	(50)
Healthy Communities Strategy and Assurance	Under budget and refund linked to water fluoridation.	(96)
Living and Ageing Well	Overbudget on supervised consumption £34,000, recovery centre premises £90,000, £39,000 over budget to cover reserve for VCS organisations to provide support/deliver programmes to reduce social isolation and risk of MH issues (CREES). Under budget on prescription charges £63,000. Over budget on nicotine replacement therapy vouchers £40,000 plus general net underspend £13,000.	127
Public Health Grant and Reserves	Amount to balance the cash limit variance (+£1,214,000) to Grant Reduction Reserve. £945,000 direct revenue funding to fund Newton Cap suicide prevention from unallocated budget of £1,393,000.	766
Public Health Team	£240,000 over budget to cover reserve contribution to AGE UK offset by £296,000 under budget on staffing – vacant posts within the Public Health Team. Unallocated budget of £301,000.	(357)
Starting Well and Social Determinants	£22,000 reserve to cover increase to Children's Wellbeing SLA and £35,000 to cover reserve linked to Domestic Abuse Counsellor and contribution to Safety of Women at Night £20,000 not drawn from reserve. Over budget on sexual health contract £26,000. Additional income received to be used in 23/24 of £227,000. Unallocated budget £41,000.	(165)
		0
AHS Total		**(1,850)**

15 The service grouping has maintained spending within its cash limit. The outturn position incorporates the MTFP savings built into the 2022/23 budgets, which for AHS in total amounted to £157,000.

16 Items treated as outside the cash limit (in £'000) are set out below:

• Contribution to Social Care Reserve	66
• Contribution to Community Discharge Reserve	350
• Contribution to County Durham Integrated Care Reserve	3,245
• Contribution to Adults Cash Limit Reserve	255
• Contribution to Public Health Reserves	1,369
• Transfer PH Regional Reserve to Balance Sheet	(5,287)
• Contribution to Corporate Recovery Support Reserve	72
• Use of Corporate Insurance Reserve	(4)
Total	**66**
• Outside Cash Limit (Central Support / Depreciation etc.)	(455)
• Increase in Bad Debt Provision	(2,407)
• Pay Award	(1,911)
Sub Total	**(4,773)**
Total	**(4,707)**

17 The cash limit reserve for Adult and Health Services is £5.329 million after incorporating the 2022/23 outturn.

Capital Programme

18 The AHS capital programme comprises one scheme, the development of Hawthorn House respite centre in Provider Services.

19 The capital budget at 31 March 2023 is £0.100 million and summary financial performance to the end of March is shown below.

Scheme	Actual Expenditure 31/03/2023 £000	Current 2022-23 Budget £000	(Under) / Over Spending £000
Provider Services – Hawthorn House	24	100	(76)
	24	**100**	**(76)**

Background Papers

20 Cabinet Reports 12 July 2023 – 2022/23 Final Outturn for the General and the Collection Fund.

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 spend against budgets agreed by the Council in February 2022 in relation to the 2022/23 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 implications included in the report.

Adults Wellbeing and Health Overview and Scrutiny Committee

2 October 2023

Quarter 1: Forecast of Revenue and Capital Outturn 2023/24

Report of Corporate Directors

Paul Darby, Corporate Director of Resources

Jane Robinson, Corporate Director of Adult and Health Services

Electoral division(s) affected:
Countywide

Purpose of the Report

1 To provide the Committee with details of the 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 June 2023.

Executive Summary

2 This report provides an overview of the forecast of outturn, based on the position to 30 June 2023. It provides an analysis of the forecast budget outturn for the service areas falling under the remit of the Overview and Scrutiny Committee and complements reports considered by Cabinet on a quarterly basis.

3 The forecast indicates that AHS will have a cash limit underspend of £85,000 at the year-end against a revenue budget of £156.296 million, which represents a 0.05% underspend.

4 Based on the forecasts, the Cash Limit balance for AHS as at 31 March 2024 will be £3.562 million.

5 Details of the reasons for under and overspending against relevant budget heads is disclosed in the report.

6 The AHS capital budget for 2023/24 comprises three schemes within Adult Care totalling £2.402 million. As at 30 June 2023 capital expenditure of £0.342 million has been incurred.

Recommendation

7 It is recommended that the Adults Wellbeing and Health Overview and Scrutiny Committee note the financial position included in this report.

Background

8 County Council approved the Revenue and Capital budgets for 2023/24 at its meeting on 22 February 2023. 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 - £156.296 million (original £156.296 million)*
- *AHS Capital Programme – £2.402 million (original £2.045 million)*

9 The original AHS revenue budget has not been revised at quarter 1. However, the original budget includes a number of budgeted use of reserves as summarised in the table below:

Budgeted Use of Reserves in Original Budget	**£'000**
Use of cash limit reserve at budget build	(699)
Use of AHS reserves at budget build	(2,072)

10 The use of AHS reserves consists of:

Reserve	**£'000**
Use of Social Care Reserve at budget build	(523)
Use of Integrated Reserve at budget build	(677)
Use of Public Health Reserve at budget build	(872)
Total	**(2,072)**

11 The summary financial statements contained in the report cover the financial year 2023/24 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 reporting a cash limit underspend of £85,000 against a budget of *£156.296 million* which represents a 0.05% underspend.

13 The tables below show the revised annual budget, actual expenditure to 30 June 2023 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	Items Outside Cash Limit £000	Forecast Use of Reserve £000	Cash Limit Variance QTR1 £000
Employees	40,360	9,504	40,217	(56)	0	(199)
Premises	1,283	169	1,256	22	0	(5)
Transport	2,147	311	2,661	0	0	514
Supplies & Services	4,500	1,401	4,956	0	0	456
Third Party Payments	351,544	67,519	351,465	3,500	0	3,421
Transfer Payments	11,838	1,833	12,083	0	0	245
Central Support & Capital	34,009	21,552	33,890	0	212	93
Income	(289,385)	(72,308)	(293,995)	0	0	(4,610)
Total	**156,296**	**29,981**	**152,533**	**3,466**	**212**	**(85)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Items Outside Cash Limit £000	Forecast Use of Reserve £000	Cash Limit Variance QTR1 £000
Excluded Services	122	(758)	122	0	0	0
Central/Other	10,828	(14)	10,838	3	0	13
Commissioning	354	(508)	915	(13)	(574)	(26)
Head of Adults	143,740	20,805	140,940	3,476	(748)	(72)
Public Health	1,252	10,456	(282)	0	1,534	0
Total	**156,296**	**29,981**	**152,533**	**3,466**	**212**	**(85)**

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	£231,000 under budget on employees due to staff turnover above budget. £10,000 over budget on premises. £487,000 over budget on transport. £78,000 over budget on supplies and services. £1,139,000 net over budget on direct care related activity.	1,483
Safeguarding Adults and Practice Development	£94,000 under budget on employees due to staff turnover above budget. £54,000 net over budget on supplies and recharges. £56,000 over recovery of income.	(96)
Ops Manager OP/PDSI Services	£180,000 under budget on employees due to staff turnover above budget. £37,000 over budget on transport. £81,000 over budget on supplies and services. £1,241,000 net under budget on direct care-related activity.	(1,303)
Ops Manager Provider Services	£104,000 under budget on employees due to staff turnover above budget. £54,000 net under budget on transport, premises, supplies & services.	(158)
Operational Support	No material variances.	2
		(72)
Central/Other		
Central/ Other	No material variances.	13
		13
Commissioning		
Commissioning	£65,000 under budget on employees due to staff turnover less than budget. £39,000 over budget on supplies and services.	(26)
		(26)
Public Health		
County Durham Together	Plans not yet in place for budget.	(65)

Service Area	Description	Cash limit Variance £000
Protecting Health	Plans not in place for budget of £50,000 offset by over budget on Infection Control not drawn from reserves £67,000	17
General Prevention Activities	Underbudget linked to pharmacy contract for flu immunisation.	(29)
Healthy Communities Strategy and Assurance	Under budget on water fluoridation £67,000 offset by over budget of £16,000 not drawn from reserves mainly linked to Let's Connect contract.	(51)
Living and Ageing Well	Under budget on Health Checks contract £126,000. IPD grant used to fund £16,000. Under budget on prescription charges £63,000. Over budget of £108,000 to cover reserve expenditure linked to Stamp it Out Hub, Tobacco (Serious Mental Illness) project, NRT additional allocation and diabetes project.	(97)
Public Health Grant and Reserves	Amount to balance the cash limit variance (£1,052,000) to Grant Reduction Reserve. Unallocated budget of £1,738,000 offset by forecast agenda for change costs of £366,000.	(320)
Public Health Team	£195,000 under budget on staffing – vacant posts within the Public Health Team. Over budget on projects linked to expenditure not drawn from reserves including contribution for CREES, Age UK, apprentice post, community champions post and Wellbeing Programme Manager.	260
Starting Well and Social Determinants	Under budget on sexual health contract £41,000. Underbudget on children's contracts £68,000. Underbudget on remain safe contribution £30,000. Over budget on projects linked to reserve expenditure £42,000 including GUM Out of area invoices, MapMe additional funding, HDFT Safeguarding Nurse, Glasses in Classes, Breastfeeding Insights work, projects linked to Domestic Abuse.	285
		0
AHS Total		**(85)**

15 The service grouping is on track to maintain spending within its cash limit. The forecast outturn position incorporates the MTFP savings built into the 2023/24 budgets, which for AHS in total amounted to £1.775 million.

16 The forecast outturn position excludes £3.466 million of expenditure outside the cash limit as follows; £56,000 in respect of the 2023/24 chief officers pay award, £3.500 million associated with a forecast underspend in adult care for future MTFP support and £22,000 in respect of a decrease in energy costs.

17 The Service has forecast £0.212 million net contribution to reserves at quarter 1 as outlined below and shown as outside the cash limit:

- Use of Social Care Reserve (42)
- Use of County Durham Integrated Care Reserve (192)

• Use of Adults Cash Limit Reserve	(1,088)
• Contribution to Public Health Reserves	1,534
Total	**212**

18 The cash limit reserve for Adult and Health Services is forecast to be circa £3.562 million after incorporating the 2023/24 forecast and transfers to other earmarked reserves.

Capital Programme

19 The AHS capital programme comprises three schemes, the upgrade of Hawthorn House respite centre, the development of complex needs provision at Harelaw and development of Positive Journeys at Chester le Street.

20 Further reports will be taken to MOWG during the year where revisions to the AHS capital programme are required. The capital budget currently totals £2.402 million.

21 Summary financial performance to 30 June 2023 is shown below.

Scheme	Actual Expenditure 30/06/2023 £000	Current 2023-24 Budget £000	(Under) / Over Spending £000
Hawthorn House Development	51	1,349	(1,298)
Complex Needs in the Community Harelaw	0	523	(523)
Positive Journeys Chester le Street	291	530	(239)
	342	**2,402**	**(2,060)**

22 Officers continue to carefully monitor capital expenditure on a monthly basis. There has been limited expenditure incurred to date. At year end the actual outturn performance will be compared against the revised budgets, and service and project managers will need to account for any budget variance.

Background Papers

23 Cabinet Report 14 September 2023 – Forecast Revenue and Capital Outturn 2023/24 – Period 30 June 2023.

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 2023 in relation to the 2023/24 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 - 2 October 2023

AHS Revenue and Capital – Outturn 2022/23 and Forecast 2023/24 Quarter 1

Joanne Watson – Principal Accountant

OVERVIEW

- 2022/23 Revenue Outturn and Variance Explanations
- 2022/23 Outturn Capital Position
- 2023/24 Quarter 1 Revenue Forecast Outturn and Variance Explanations
- 2023/24 Quarter 1 Capital Position

AHS 2022/23 Outturn
By Expenditure Type

	Revised Annual Budget £000	Actual 2022/23 £000	Variance £000	Items Outside Cash Limit £000	Cont. To / (From) Reserve £000	Cash Limit Variance £000	Memo-Forecast Position at QTR3 £000
Employees	39,001	37,957	(1,044)	(1,469)	0	(2,513)	(2,357)
Premises	1,182	1,914	732	(576)	0	156	131
Transport	2,166	2,346	180	(3)	0	177	47
Supplies & Services	5,815	6,964	1,149	(129)	0	1,020	569
Third Party Payments	319,583	326,991	7,408	0	0	7,408	9,355
Transfer Payments	10,811	11,223	412	0	0	412	(55)
Central Support & Capital	31,026	40,692	9,666	(2,596)	66	7,136	564
Income	(271,595)	(287,241)	(15,646)	0	0	(15,646)	(9,862)
Total	**137,989**	**140,846**	**2,857**	**(4,773)**	**66**	**(1,850)**	**(1,608)**

AHS 2022/23 Outturn
By Service Area

	Revised Annual Budget	Actual 2022/23	Variance	Items Outside Cash Limit	Cont. To / (From) Reserve	Cash Limit Variance	Memo-Forecast Position at QTR3
	£000	£000	£000	£000	£000	£000	£000
Excluded Services	140	149	9	(9)	0	0	0
Central/Other	10,924	12,612	1,688	(1,373)	(26)	289	840
Commissioning	3,014	2,001	(1,013)	(204)	878	(339)	(104)
Head of Adults	121,961	120,230	(1,731)	(3,092)	3,023	(1,800)	(2,344)
Public Health	1,950	5,854	3,904	(95)	(3,809)	0	0
Total	**137,989**	**140,846**	**2,857**	**(4,773)**	**66**	**(1,850)**	**(1,608)**

AHS Revenue Budget 2022/23

AHS budget position for 2022/23 is an under budget of £1.850 million, which equates to 1.3% of net budget

Key reasons for budget variances:

Head of Adult Care (under budget of £1.800 million)

- Net under budget on employee-related costs of circa £2.195 million mainly through the level of staff turnover being above budget.
- Net over budget on supplies and services, transport and other costs and over recovery of income £0.555 million.
- Net overall under budget on care-related activity of circa £0.160 million, this is mainly due to additional client contributions.

AHS Revenue Budget 2022/23

Key reasons for budget variances:

Central Costs / Other (over budget £0.289 million)

- Net effect of £0.173 million under budget on uncommitted budgets to support future operational activity and £0.462 million over budget in respect of increased bad debt provision.

Commissioning (under budget £0.339 million)

- Under budget in respect of management of vacancies and contract management.

AHS Revenue Budget 2022/23

Public Health (on target)

- This budget is funded mainly by Public Health Grant for 2022/23, and therefore shows nil net expenditure on the report.

- However, £1.214 million has been made available for future investment in Public Health projects from uncommitted budgets, savings from vacant posts and underspends against some contracts.

AHS – 2022/23 CAPITAL

AHS	Actual Expenditure 31/03/2023 £000	Current 2022/23 Budget £000	(Under) / Over Spending £000
Provider Services – Hawthorn House	24	100	(76)
	24	**100**	**(76)**

AHS Q1 2023/24 Forecast Outturn
By Expenditure Type

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Items Outside Cash Limit £000	Forecast Use of Reserve £000	Cash Limit Variance £000
Employees	40,360	9,504	40,217	(56)	0	(199)
Premises	1,283	169	1,256	22	0	(5)
Transport	2,147	311	2,661	0	0	514
Supplies & Services	4,500	1,401	4,956	0	0	456
Third Party Payments	351,544	67,519	351,465	3,500	0	3,421
Transfer Payments	11,838	1,833	12,083	0	0	245
Central Support & Capital	34,009	21,552	33,890	0	212	93
Income	(289,385)	(72,308)	(293,995)	0	0	(4,610)
Total	**156,296**	**29,981**	**152,533**	**3,466**	**212**	**(85)**

AHS Q1 2022/23 Forecast Outturn
By Service Area

	Revised Annual Budget	YTD Actual	Forecast Outturn	Items Outside Cash Limit	Forecast Use of Reserve	Cash Limit Variance
	£000	£000	£000	£000	£000	£000
Excluded Services	122	(758)	122	0	0	0
Central/Other	10,828	(14)	10,838	3	0	13
Commissioning	354	(508)	915	(13)	(574)	(26)
Head of Adults	143,740	20,805	140,940	3,476	(748)	(72)
Public Health	1,252	10,456	(282)	0	1,534	0
Total	**156,296**	**29,981**	**152,533**	**3,466**	**212**	**(85)**

AHS Revenue Budget 2023/24

AHS budget position for 2023/24 is a projected under budget of £0.085 million, which equates to 0.1% of net budget

Key reasons for budget variances:

Head of Adult Care (projected under budget of £72,000)

- Net under budget on employee related costs of circa £0.607 million mainly through the level of staff turnover being above budget.
- Net over budget on supplies and services, transport and other costs and over recovery of income circa £0.637 million.
- Net overall under budget on care related activity of circa £0.102 million.

AHS Revenue Budget 2023/24

Key reasons for budget variances:

Central Costs / Other (projected over budget £13,000)

- Slightly over budget due to an increase in central recharge costs.

Commissioning (projected under budget £26,000)

- Under budget in respect of management of vacancies and contract management.

AHS Revenue Budget 2023/24

Public Health (projected on target)

- This budget is funded mainly by Public Health Grant for 2023/24, and therefore shows nil net expenditure on the report.

- However, £1.052 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 – Q1 2023/24 CAPITAL

Scheme	Actual Expenditure 30/06/2023 £000	Current 2023/24 Budget £000	(Under) / Over Spending £000
Provider Services – Hawthorn House	51	1,349	(1,298)
Provider Services – Complex Needs in the Community: Harelaw	0	523	(523)
Provider Services – Positive Journeys: Chester le Street	291	530	(239)
	342	**2,402**	**(2,060)**

ANY QUESTIONS?

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Adults, Wellbeing and Health Overview and Scrutiny Committee

2 October 2023

Quarter One, 2023/24 Performance Management Report

Report of John Hewitt, Chief Executive

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 To present an overview of progress towards delivery of the key priorities within the Council Plan 2023-27 in line with the council's corporate performance framework.

2 The report covers performance in and to the end of quarter one, 2023/24, April to June 2023.

Executive Summary

3 The County Council is a key partner within the County Durham Together Partnership. Collectively partners work towards delivering a shared plan - the County Durham Vision 2035. The vision document was developed with partner organisations and the public. It sets out what we would like the county to be like over the next decade and beyond. The vision is for:

a place where there are more and better jobs, people live long, and independent lives and our communities are well connected and supportive.

4 We have set out how the council will operate effectively in the delivery of its services and its contribution to achieving this vision in our Council Plan[1]. The Council Plan[1] is structured around five thematic areas: our economy, our environment, our people, our communities, and our council. We monitor our success through a suite of Key Performance Indicators (our corporate performance framework), which forms the basis of this report.

5 In line with previous reports, we are continuing to report performance on an exception basis with key messages against the five thematic areas. In any given quarter, we will only include key performance indicators which have been updated during that quarter, for example, educational attainment will be updated annually in quarter three.

[1] The Council Plan is a rolling four-year plan, refreshed every year in line with the MTFP. Current version covers 2023 to 2027

6 However, to allow greater clarity of performance against our objectives, we have introduced a new easy-read report format (attached at appendix two).

7 The main difference in the new format, compared to the previous format, is the suite of dashboards (structured around specific service areas) which use greater data visualisation to provide more focus and greater transparency on trends, direction of travel, benchmarking and performance to target. The new report retains a summary highlighting 'things that are going well' and 'issues we are addressing' for each theme, and a new executive summary has been added.

8 To allow the reader, including members of Cabinet and Scrutiny Committees to compare the two formats and understand the changes made, we have also produced the quarter one report in the previous format (attached at appendix three). We are also seeking comments and suggestions on improvements to the new format which will be incorporated in quarter two.

9 We want to be a well-functioning local authority in relation to performance. Therefore, we are working to achieve the best practice model as set out in the Department for Levelling Up, Housing and Communities (DLUHC) recently published (July 2023) proposal for updating Best Value standards[2]. We will continue to develop the following through our performance management processes and the wider Corporate Business Intelligence Review:

(a) An organisational-wide approach to continuous improvement, with frequent monitoring, performance reporting and updating of the corporate and improvement plans.

(b) A corporate plan which is evidence based, current, realistic and enables the whole organisation's performance to be measured and held to account.

(c) Clear and effective mechanisms for scrutinising performance across all service areas. Performance is regularly reported to the public to ensure that citizens are informed of the quality of services being delivered.

Context

10 The council is a large organisation providing a broad range of services, and our operating environment can at times be challenging. However, we continue to show strong performance across our key outcomes.

(a) Across the county, inward investment continues, new infrastructure is being created and new business parks with the potential to create thousands of jobs are being developed. The promotion of the county as a year-round tourist destination continues (in 2022, tourism contributed more than £1 billion to our local economy for the first time).

(b) Demand for statutory children's social care and early help remains consistent overall, though the composition of needs and interventions are

[2] Best Value standards and intervention

increasingly complicated. Caseloads are improving and targeted recruitment is proving successful.

(c) Although health continues to be a challenging area, life expectancy is increasing, and life chances are improving. We are continuing to help households who are financially vulnerable through our financial support schemes.

(d) Environmental cleanliness remains good, and carbon emissions are reducing significantly from the 1990 baseline.

(e) We have increased lower cost, more accessible contact options for our customers through our digital work, and user satisfaction with our services remains high.

Recommendation

11 Adults, Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) Note the overall strong position and direction of travel in relation to quarter one performance, and the actions being taken to address areas of challenge.

(b) Note the changes and improvements to the new format performance report which will be used exclusively from quarter two 2023/24.

Background papers

- County Durham Vision (County Council, 23 October 2019) https://democracy.durham.gov.uk/documents/s115064/Draft%20Durham%20Vision%20v10.0.pdf

Other useful documents

- Council Plan 2023 to 2027 (current plan) https://www.durham.gov.uk/media/34954/Durham-County-Council-Plan-2023-2027/pdf/CouncilPlan2023-2027.pdf?m=638221688616370000
- Quarter Four, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s174900/Item%204%20Q4%202022-23%202%201.pdf
- Quarter Three, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s171720/Item%205%20Corporate%20Performance%20Report%20Q3%202022-23.pdf
- Quarter Two, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s166398/Corporate%20Performance%20Report%20Q2%202022-23%20v2.1.pdf
- Quarter One, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s161902/Corporate%20Performance%20Report%20Q1%202022-23%20Revised.pdf

Author

Steve Evans Contact: steve.evans@durham.gov.uk

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 change 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

Corporate Performance Report

Quarter One, 2023/24

Contents (blue text links to sections of the report)

Executive Summary

1 This performance report covers the first quarter of the 2023/24 financial year (April to June 2023). It sets out our progress towards delivering the key priorities set out within our Council Plan 2023-27.

2 Performance is reported on an exception basis with key messages structured around the five thematic areas of, our economy, our environment, our people, our communities, and our council.

3 In any given quarter, we will only include key performance indicators which have been updated during that quarter, for example, educational attainment will be updated annually in quarter three.

Our people

4 The priority aims to help our residents live long and independent lives and remain in good health for as long as possible. We will protect and improve health by tackling the leading causes of illness and early death, inequalities and the challenges around mental health. We will ensure a sustainable high-quality care market and will invest in a multi-million pound programme to transform our leisure centre venues.

Going Well

5 The rate of admissions to permanent residential and nursing care for adults aged 65+ is below the Better Care Fund (BCF) target (lower is better) and numbers entering permanent care continue to be lower than pre-pandemic levels. The percentage of older people still at home 91 days after discharge from hospital also continues to be high. Combined, these indicators demonstrate progress to meet our aim of maintaining the independence of people for longer. Work is also underway to examine the trends in admissions and reablement in order to understand changing demand for adult social care.

6 Over two thirds of adult social care service users have received an annual review or reassessment in the last 12 months. This is the highest for over a year and demonstrates the progress made since additional capacity was provided to target overdue reviews.

Issues we are addressing

7 The timeliness of the completion of Care Act assessments for adult social care service users continues to be low in comparison to levels seen prior to the pandemic. The Adult Social Care service is introducing new technology to support social workers to complete the assessments in a timely manner.

8 Work is being undertaken to examine referrals to adult social care. Analysis is examining source and outcome of referrals, and variations to take-up of services compared to prior to the pandemic to fully understand how demand is changing as this will inform service provision and commissioning priorities.

9 Our substantial leisure transformation programme continues to deliver upgraded and new facilities; however, this means a temporary drop in visits to our leisure centres, with almost 760,000 visits this quarter, which is 17% below target (-152,040). Visits

continue to be affected by transformation works at Spennymoor and Abbey leisure centres, a pool closure at Peterlee leisure centre, and the cost-of-living crisis.

10 Leisure centre memberships were 4% below target (-771). Ongoing cleansing of our third party income collection data identified a higher than expected number of cancelled memberships of which we were previously unaware. This is likely to continue into quarter two and possibly quarter three.

Our communities

11 The aim of this priority is to ensure our communities are well connected and supportive of each other, with vibrant and accessible towns and villages which are well-used, clean, attractive and safe. We will support our most vulnerable residents, particularly those isolated or financially vulnerable. We will maintain a strong focus on tackling poverty throughout the cost-of-living crisis.

Going Well

12 During quarter one, the warm space initiative was evaluated. An estimated 17,000 people attended a warm space between October 2022 and April 2023, and feedback confirmed that the initiative's primary purpose of helping people stay well through staying warm was realised. It also demonstrated other positive impacts which included connecting those attending to support services, creating social connections, and the formation of new groups in community venues, and different people connecting with local facilities.

13 The evaluation suggests an opportunity to build on the impact of the Warm Spaces Fund, perhaps under different branding to reflect the wider value of the activities beyond supporting people to keep warm in cold weather. Discussions will continue at the Poverty Action Steering Group in relation to plans for the forthcoming winter.

Risk Management

14 The government's statutory guidance for best value authorities sets out the characteristics of a well-functioning authority. This details the arrangements that councils should have in place for robust governance and scrutiny including how risk awareness and management should inform decision making. The latest risk management progress report can be found here.

Priority: Our People

County Durham is a place where people will enjoy fulfilling, long and independent lives. We aim to,

- ensure children and young people will enjoy the best start in life, good health and emotional wellbeing
- ensure children and young people with special educational needs and disabilities will achieve the best possible outcomes
- ensure all children and young people will have a safe childhood
- promote positive behaviours
- better integrate health and social care services
- tackle the stigma and discrimination of poor mental health and build resilient communities
- people will be supported to live independently for as long as possible by delivering more home to meet the neds of older and disabled people
- support people who circumstances make them vulnerable and protect adults with care and support needs from harm
- protect and improve the health of the local population, tackling leading causes of illness and death

National, Regional and Local Picture

15 A new national inspection regime of adult social care came into force from April 2023. CQC, the regulatory body, are undertaking a series of pilot inspections to ensure that their approach to local authority assessments is as meaningful and effective as possible. The full inspection process is planned to begin later in the year and the framework will cover four themes - Working with People, Providing Support, Ensuring Safety within the System and Leadership. Analysis in this and future performance reports with provide high level monitoring of key aspects of this framework.

16 The new Joint Local Health and Wellbeing Strategy 2023-28 (JLHWS) has recently been approved and focuses on tackling four priority areas. To assess performance of our key public health issues we are focusing on each of these JLHWS priority areas over the 12 month period. This quarter we have reviewed key measures relating to drug and alcohol use in County Durham. Wider Public Health issues will be raised by exception and escalated through the 'Going Well' / 'Issues we are addressing' sections.

Going Well

Adult Social Care

17 We continue to see a lower rate of adults aged 65+ per 100,000 population admitted on a permanent basis to residential or nursing care compared to the rate seen pre-COVID and, for quarter one, we are lower than the BCF target (lower is better). Whilst the average age of those entering permanent care has remained static over the last ten years (average age of 84.2 years), numbers entering continue to be lower than the average seen before the pandemic. This demonstrates progress to meet our strategic aim of maintaining the independence of people for longer. We are undertaking a data quality review to enable a greater understanding of the number of people entering

permanent care. This includes a review of the methodology used to calculate the indicator as well as recording processes.

18 The percentage of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services (85.5% in the latest quarter) remains high. Whilst reducing slightly from the previous quarter it is in line with the average seen over the last 5 years. Latest performance remains above our target of 84% and regional and national benchmarking. Latest data for the number of people discharged into reablement demonstrates a continued decline. The Commissioning Service are undertaking a review of reablement services to understand factors such as staff turnover, capacity of the service and changing demand.

19 Two thirds of service users (68.1%) have received an annual assessment or review in the last 12 months. This is the highest since quarter three 2021/22, improving from 59.1% at quarter four, 2022/23. Migration to a new case management system resulted in a deterioration in performance as transitional arrangements took unexpected amounts of capacity. The service responded by restructuring, creating dedicated capacity for reviews which is showing early signs of positive progress.

20 The percentage of individuals achieving their desired outcomes during the safeguarding process has increased to 93.6% across quarter one 2023/24, a 0.6% increase against the previous year. However, this remains lower than the regional (97.5%) and England (95.4%) averages for 2021/22.

21 The methodology for this indicator was reviewed and results re-calculated from 2021/22 to date, to ensure closer alignment to the national Safeguarding Adults Collection Return. Changes to the adult social care case management system are being implemented to ensure streamlined recording of outcomes against the national return.

22 During June and July 2023, workshops were held with front line staff, focusing on improving recording of key information across the safeguarding process and highlighting good practice. A comprehensive governance review is continuing across the Safeguarding service, focusing on areas of concern and good practice, with the aim of reviewing key strategic indicators and increasing assurance in reported results.

Public Health

23 County Durham has been awarded £3.5 million for 2023/24 to support the implementation of the new national drugs strategy. This supports a range of functions including increasing the mental health offer to all clients, and the implementation of an alcohol care team within Tees, Esk and Wear Valley NHS Foundation Trust. It will also increase activity around harm reduction linked to trends relating to substance misuse in our local communities.

Issues we are addressing

Adult Social Care

24 Referrals to adult social care have reduced since September 2022. The last three quarters have seen an average of 1,850 referrals received per month whilst the period July 2021-September 2022 saw an average of 2,324 per month. When comparing the latest quarter with the same period last year, we have seen a reduction of 16.7%.

Work is being undertaken examining source and outcome of referrals to better understand where demand is changing.

25 Timeliness of completion of Care Act assessments remains low with 53.6% of all Care Act assessments completed within 28 days in the latest quarter. This is similar to the timeliness seen 12 months ago; however, it is a reduction on levels seen prior to the pandemic. The Adult Social Care service is currently introducing new technology that should support staff to complete the assessments in a timely manner. The number of Care Act assessments completed by quarter has remained consistent over the last two years.

26 During the pandemic, home care hours increased as care homes were closed to new admissions. The number of service users receiving home care continues to be high, however, it has reduced over the last 12 months by approximately 700 service users (a reduction of 17%). This drop in home care hours is an expected change as our delivery model returns to being able to give the right kind of care at the right time.

Smoking

27 A quarterly increase in the percentage of mothers smoking at time of delivery has not affected our year-on-year percentage, which still demonstrates a consistent reduction. Smoking during pregnancy remains a key priority for public health and is reported to the Health and Wellbeing Board on a regular basis. The County Durham Tobacco Control Alliance continues to work collaboratively to drive towards the regional goal of reducing smoking at time of delivery to 5% or less by 2025 and a local ambition that all pregnant women and mothers will not smoke.

Disabled Facilities Grants

28 During quarter one, 68% of potential clients were contacted within three weeks of their initial referral for a Disabled Facilities Grant, which is 22pp below target, with staffing shortages contributing to not hitting target this quarter. New processes are being implemented to deal with the situation and recruitment underway to fill vacant posts. This is a new measure, and we are developing robust mechanisms for future monitoring.

Leisure Centres

29 Our substantial leisure transformation programme continues to deliver upgraded and new facilities; however, this means a temporary drop in visits to our leisure centres, with almost 760,000 visits this quarter, which is 17% below target (-152,040). Figures are slightly up on the same period last year (1%, 7,572 visits). Visits continue to be affected by transformation works at Spennymoor and Abbey leisure centres and a pool closure at Peterlee leisure centre. The current cost-of-living crisis continues to be a real challenge for our communities, and we have seen a trend in relation to timelines around energy charges and interest rate increases that have impacted visitor numbers.

Gym and Swim Members

30 Membership numbers for both gym and swim did not achieve target this quarter, with 16,106 (-4%, -684) and 1,707 (-5%, -87) respectively. Although profiled targets were set to take seasonal trends into account, data cleansing work is being undertaken to

better understand demand which has led to some corrections in historical data quality. This work is set to continue over the coming months.

Adult Social Care Dashboard

Primary KPIs
(same period last year)

5,746
referrals to adult social care
(6,891)

53.6%
Care Act assessments within 28 days
(53.8%)

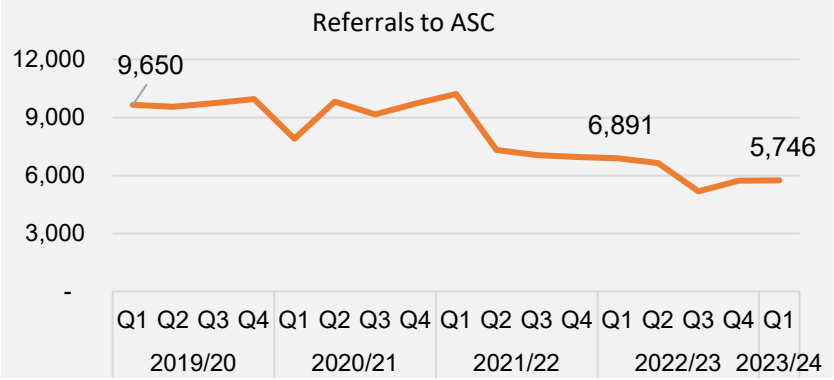
597
Care Act assessments completed in quarter
(610)

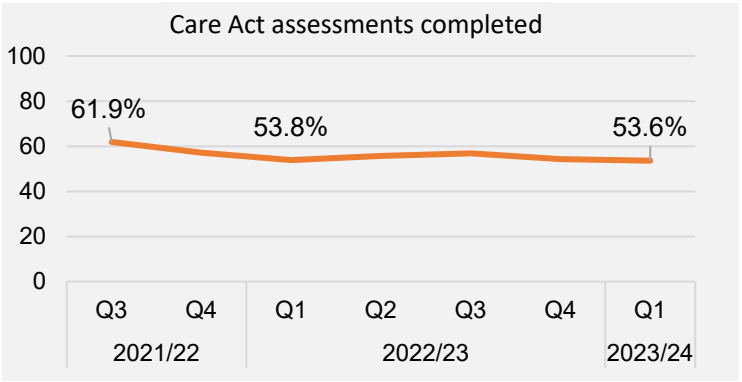
68.1%
service users receiving review or reassessment within 12 months
(59.1%)

Referrals

Work is being undertaken to examine the source and outcome of referrals to better understand the gradual reduction seen since Azeus was introduced in 2021/22 Q2.

Currently we only include 'general referrals' to the service. Work will review other sources including non-general referrals processed by Social Care Direct and internal referrals between services.





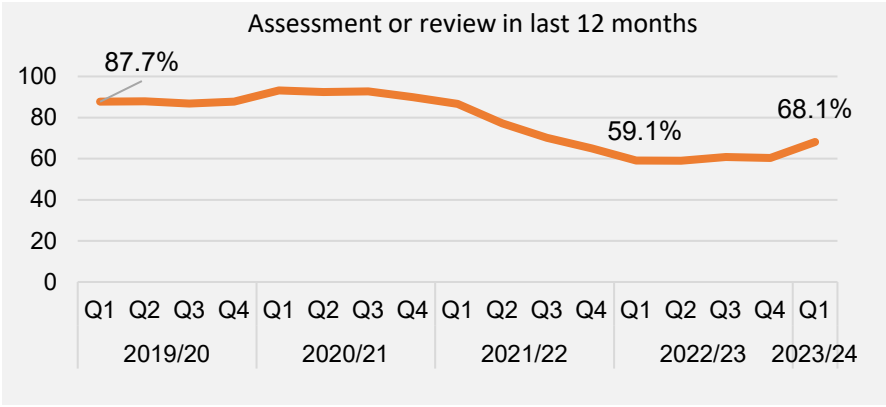
Care Act assessments complete

The Adult Social Care service is introducing new mobile technology to support staff to increase the number of Care Act assessments completed within the 28-day target timescale.

The number of Care Act assessments completed has remained consistent over the last 2 years.

Service users receiving an assessment or review in last 12 months

In quarter 4 2022/23 the Adult Care service established separate reviewing teams to tackle the issue of **overdue reviews**. Latest data demonstrates positive progress in addressing this issue.



Adult Social Care Dashboard

Primary KPIs
(same period last year)

153
adults 65+ admitted to permanent care (per 100,000) (100.4)

83.9 years
average age of admission to permanant care (84.6 years)

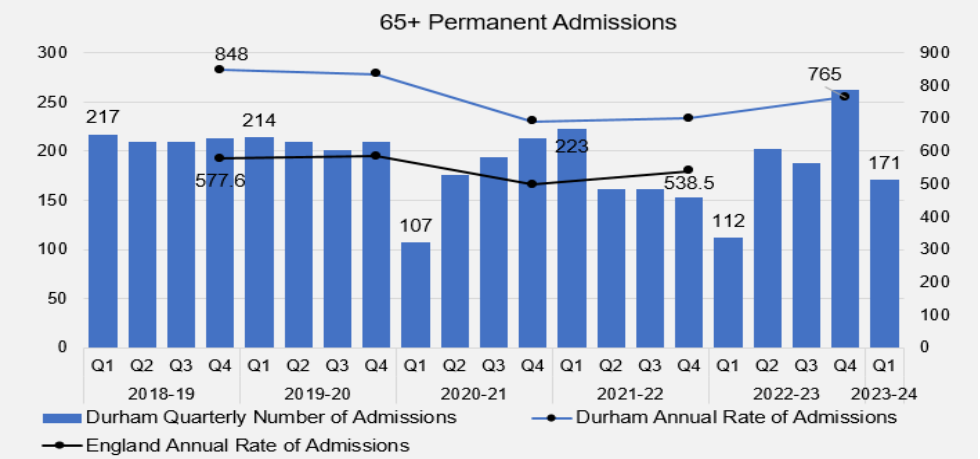
219
admissions under the Mental Health Act (225)

85.5%
older people still at home 91 days after discharge into reablement (89.2%)

Admissions to residential care

The quarterly number of admissions to residential care have fluctuated since 2020-21 Q1. We are undertaking a data quality review to ensure we are capturing residential admissions in the most accurate way possible.

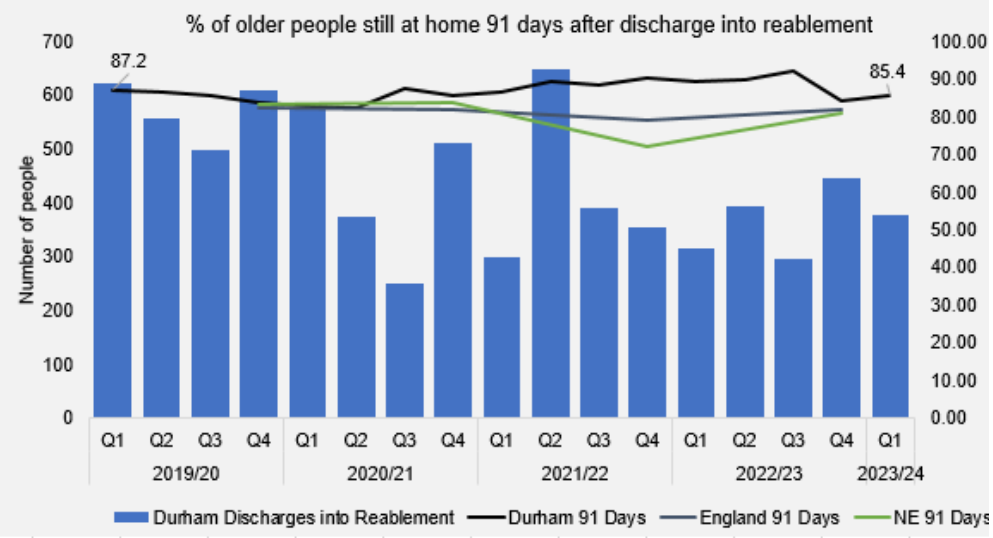
The **average age of admission** to permanent care continues to demonstrate very little change (fluctuating between 83.6 and 84.8) over the last 10 years.



Discharges into reablement

While the percentage of **older people still at home 91 days after discharge into reablement** services remains high, the last three years are based on fewer people discharged into reablement. Whilst the percentage of **older people still at home 91 days after discharge into reablement** services remains high, the last three years are based on fewer people being discharged into reablement.

The Commissioning Service are undertaking a review of reablement to understand staff turnover, provider capacity and changing demand for the service.



Adult Social Care Dashboard

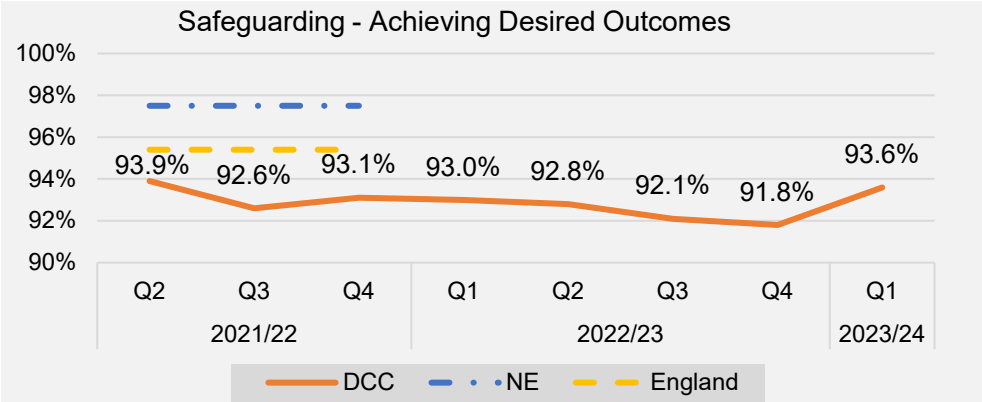
Primary KPIs
(same period last year)

- **93.6%** individuals achieving desired outcomes - safeguarding process (93.0%)
- **12.9%** service users receiving Direct Payments (10.7%)
- **679** service users receiving Direct Payments (638)

Safeguarding – Achieving Desired Outcomes

The methodology for this indicator has been reviewed and results re-calculated from 2021/22 to date to ensure alignment to the national Safeguarding Adults Collection Return.

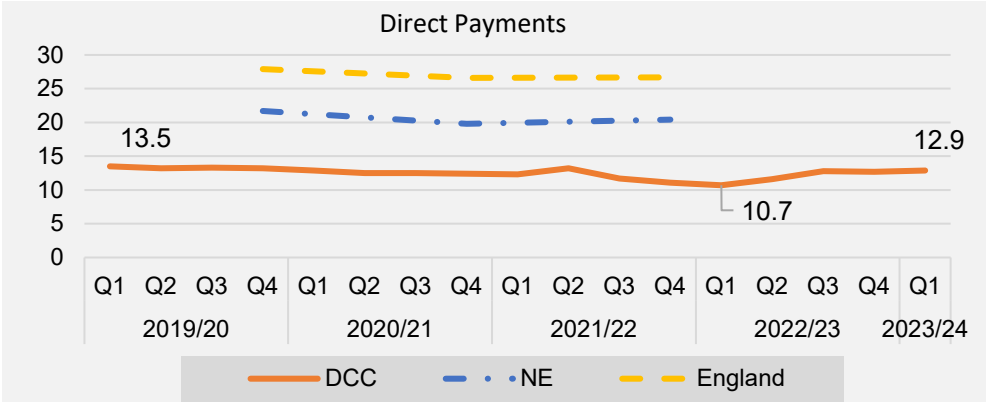
We are currently implementing changes in AzeusCare to streamline the recording of outcomes to the national return, followed by providing comprehensive practice guidance to front line staff to ensure these changes are communicated across the service.



Service users receiving Direct Payments

Durham has historically had low rates of Direct Payment take-up compared to regional and national averages.

An impact statement has examined factors affecting Direct Payment take-up in Durham. Whilst no evidence was found to suggest that Durham County Council's policy in relation to Direct Payments differs significantly from other local authorities, it was recommended that development work will seek to explore opportunities to further develop Direct Payment take-up. This is in addition to business-as usual promotion and development work.



Adult Social Care Dashboard

Primary KPIs
(same period last year)

3,232
service users receiving home care (3,903)

2,097
service users receiving Telecare (2,315)

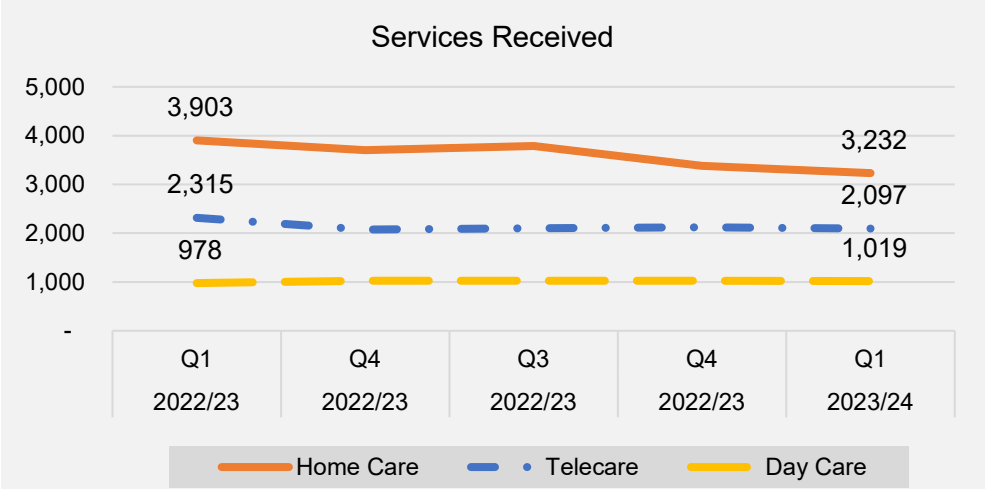
1,019
service users receiving day care (978)

Home Care

Home care continues to be the most used service, reflecting the aim for people to remain independent in their own home.

During the COVID-19 pandemic, home care hours increased as care homes were closed to new admissions.

The number of service users receiving home care continues to be high, however, it has reduced over the last 12 months by approximately 700 service users (a reduction of 17%). This drop in home care hours is an expected change as our delivery model returns to being able to give the right kind of care at the right time.



Telecare

Telecare supports people to remain safe in their home and is provided to approximately 2,000 service users.

Day Care

The number of service users receiving day care has remained static over the last 12 months.

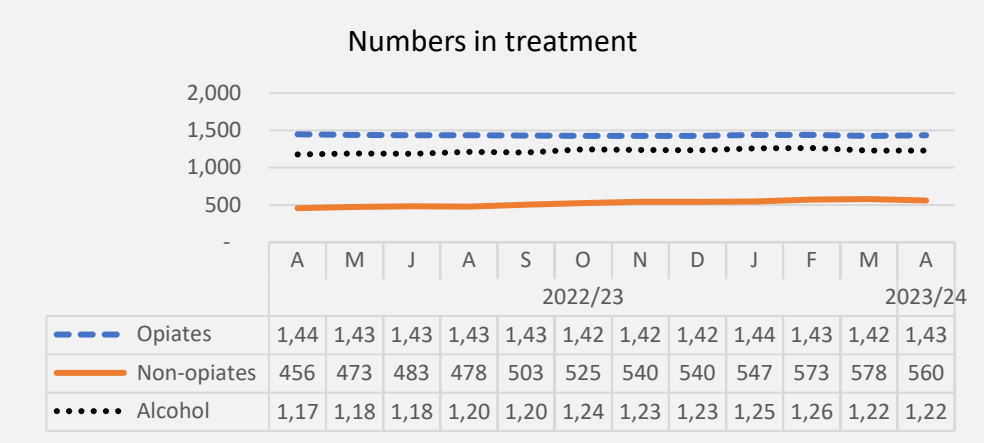
Public Health Focus – Drugs and Alcohol Dashboard

Primary KPIs
(same period last year)

- **30.7%** successful completions alcohol (34.1%)
- **5.1%** successful completions opiates (6.0%)
- **32.0%** successful completions non-opiates (34.7%)
- **1,288** in treatment alcohol (1,185)
- **1,433** in treatment opiates (1,432)
- **560** in treatment non-opiates (483)

Treatment

- Numbers for opiate treatment have largely remained static over the last year
- Treatment for non-opiate misuse has seen an increase of over 70 people during the year, an increase of 16%.
- The number of people in treatment for alcohol misuse has seen a small increase of 43.
- To support increased numbers in treatment County Durham has been awarded £2.3 million for 2023-24



	A	M	J	A	S	O	N	D	J	F	M	A
Opiates	1,44	1,43	1,43	1,43	1,43	1,42	1,42	1,42	1,44	1,43	1,42	1,43
Non-opiates	456	473	483	478	503	525	540	540	547	573	578	560
Alcohol	1,17	1,18	1,18	1,20	1,20	1,24	1,23	1,23	1,25	1,26	1,22	1,22

Successful completions

Completions for opiate treatment has reduced over the last 8 years. The national trend has also declined over the same period.

	% successful completions (12 months ending April 2023)		
	County Durham	North East	National
Alcohol	30.7%	29.1%	35.4%
Opiates	5.1%	4.0%	4.9%
Non-opiates	31.7%	27.1%	31.6%

Housing Vulnerable People Dashboard

Primary KPIs

10,727
Care Connect customers
(11,234, Q1 22/23)

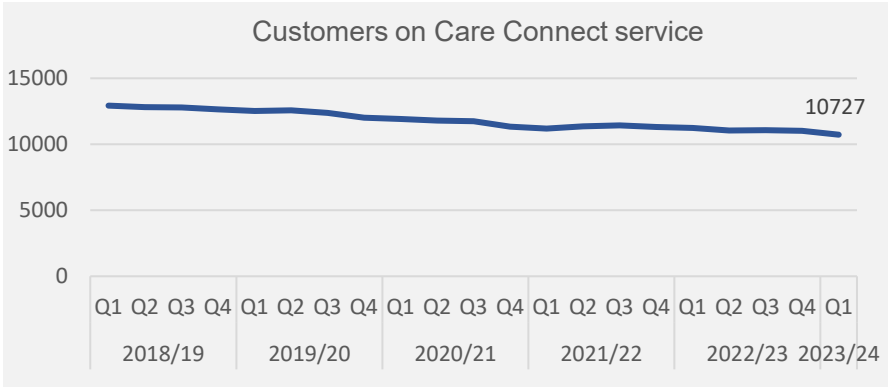
99.72%
Care Connect calls answered in 3 mins
(99%)

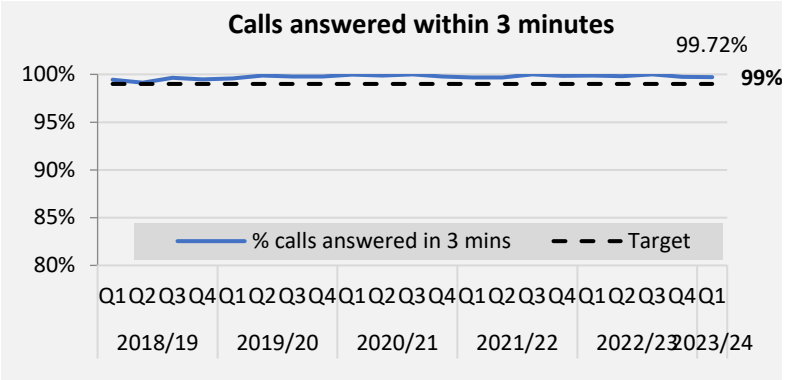
97.08%
Care Connect calls responded to in 45 mins
(90%)

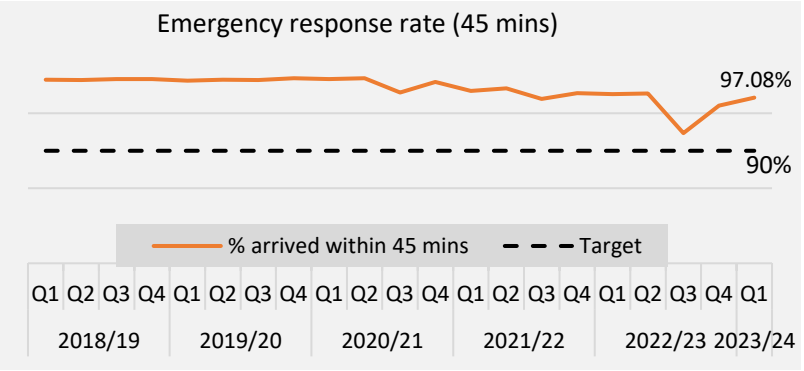
68%
potential clients contact in 3 wks of initial referral for DFG
(90%)

Care Connect

- Downward trend predicted largely due to the ongoing reduction in 'subsidised customers,' who have been leaving at an approx. rate of 300-400 per year. Despite having more 'full paying' customers than in 17/18, the loss of 'subsidised customers' is greater, giving the overall downward trend, which is likely to continue for 3-4 years.
- Other factors impacting general customer retention include patterns of behaviour, changing needs, the emergence of affordable consumer health technology, and the cost-of-living crisis.
- We continue to deliver our annual communications and marketing plan to attract new customers including sign up offers, targeted advertising, and online promotional videos.

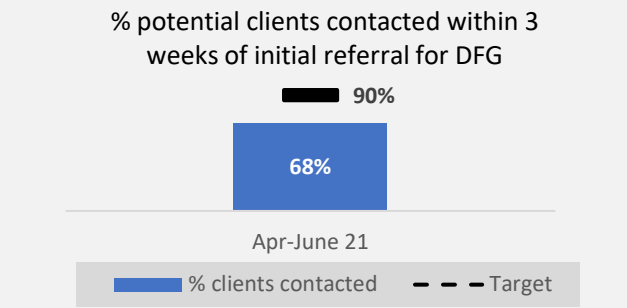






Disabled Facilities Grants (DFG)

- Currently performing below target due to staffing shortages, however backlog is now being addressed and recruitment underway to fill vacant posts.
- This is a new measure and back data is in the process of being collated.



Physical Activity Dashboard

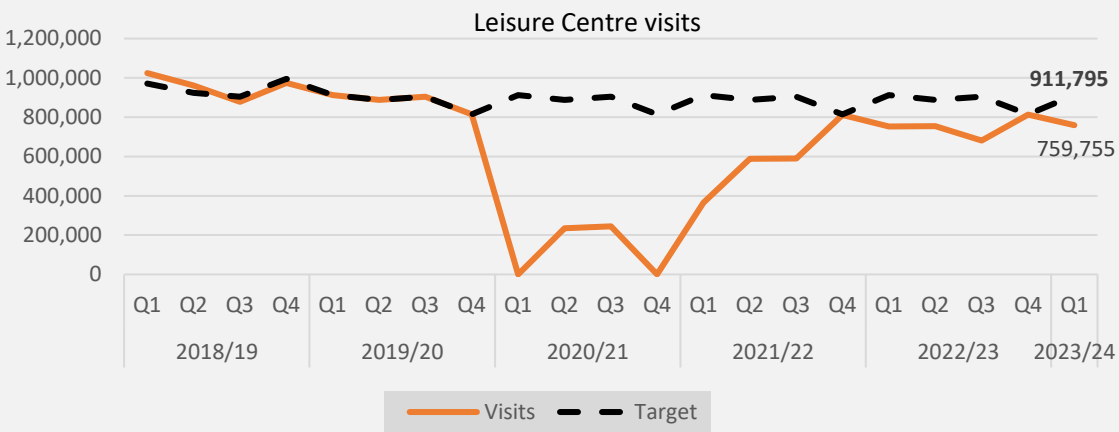
Primary KPIs
(compared to target)

759,755
visits to leisure centres
(911,795)

17,813
leisure memberships
(18,584)

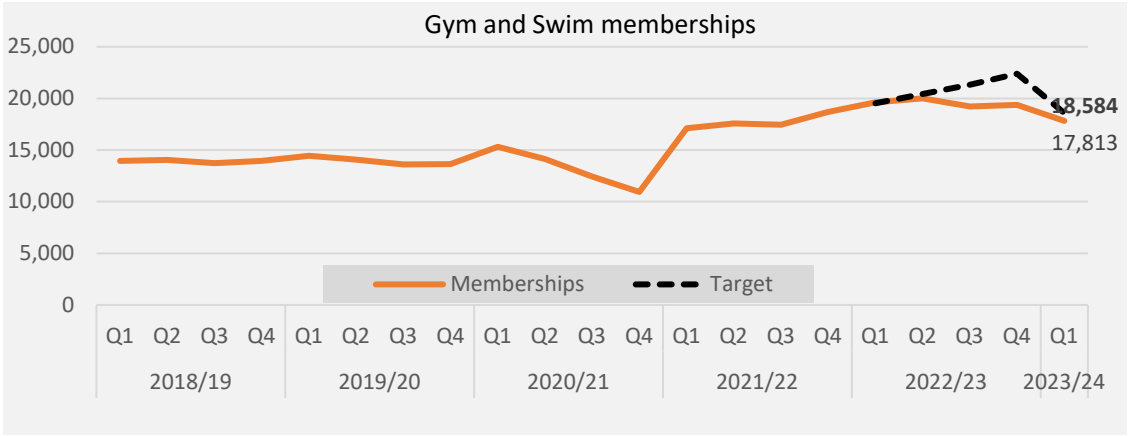
Leisure centre visits

Visits continue to be affected by transformation works in relation to Spennymoor and Abbey leisure centres and a pool closure at Peterlee leisure centre; as well as the cost-of-living crisis.



Leisure memberships (swim and gym)

Memberships have been impacted by a cleansing of our third-party income collection data, as part of ongoing system management processes which has inflated cancellations.



Priority: Our Communities

Durham is a great county in which to live, with flourishing communities which are connected and supportive of each other. We aim to,

- ensure standards will be maintained or improved across County Durham's housing stock
- have towns and villages which are vibrant, well-used, clean, attractive and safe
- ensure people will have good access to workplaces, services, retail and leisure opportunities
- ensure communities will be able to come together and support each other
- deliver new high-quality housing which is accessible and meets the needs of our residents
- ensure our rural communities will be sustainable whilst maintaining those characteristics which make them distinctive
- narrow the inequality gap between our communities
- build inclusive communities

Going Well

Warm Spaces

31 Between October 2022 and April 2023, a network of 175 Warm Spaces were in operation across the county including our 39 libraries. Supported by the Warm Spaces Fund and more than 1,000 volunteers, the network provided places where people could get warm, stay warm and enjoy a little company throughout the winter.

32 During quarter one, the warm space initiative was evaluated by the County Durham Community Foundation, our partner in delivering this initiative. We estimate that around 17,000 people attended a warm space and feedback confirmed that the initiative's primary purpose of helping people stay well through staying warm was realised. It also demonstrated that the positive impacts went far wider. Those attending were connected to support services, from financial advice to bereavement support, many people benefited significantly from the social connection found at the Warm Spaces, and there are indications that the impact of the initiative will continue through the formation of new groups in community venues, and different people connecting with local facilities.

33 The evaluation suggests an opportunity to build on the impact of the Warm Spaces Fund, perhaps under different branding to reflect the wider value of the activities beyond supporting people to keep warm in cold weather. Discussions will continue at the Poverty Action Steering Group in relation to plans for the forthcoming winter.

Data Tables

Key to Symbols

Performance against target and previous performance	
✓	meeting or exceeding
○	within 2%
×	more than 2% behind

Performance against comparable groups	
✓	Performance is better than national or North East
×	Performance is worse than national or North East
S	Performance is the same as national or North East

Types of indicators

There are two types of performance indicators throughout the report:

1. Key target indicators – targets are set as improvements can be measured regularly and can be actively influenced by the council and its partners; and
2. 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.

National Benchmarking (N)

We compare our performance to all English authorities. The number of authorities varies according to the performance indicator and functions of councils, e.g., educational attainment is compared to county and unitary councils, however waste disposal is compared to district and unitary councils.

North East Benchmarking (NE)

The North East comparator is the average performance from the authorities within the North East region - County Durham, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle upon Tyne, North Tyneside, Northumberland, Redcar and Cleveland, Stockton-on-Tees, South Tyneside, Sunderland.

More detail is available from the Strategy Team at performance@durham.gov.uk

Our Economy

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Increase the number of organisations involved in the Better Health at Work Award	105 (Jun 23)	Tracker -	87 ✓			Yes

Our Environment

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Raise cycling and walking levels in County Durham in line with national levels by 2035	67.7% (2020/21)	Tracker -	68% ○	71.2% ✗	69.5% ✗	No
% overall satisfaction with cycle routes & facilities *(confidence intervals +/-4pp)*	52% (2022)	Tracker -	54% ✓			No

Our People

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Reduce % point gap in breastfeeding at 6-8 weeks between County Durham and national average	18.7pp (2021/22)	Tracker -	17.4pp ✗		✗	No
% of mothers smoking at time of delivery	15.2.% (Jan-Mar 23)	0% ✗	14.8% ✗	✗	✗	Yes

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
% of smoking prevalence in adults (aged 18+)[3]	16.2% (2021)	5.0% ✗	16.5% ✓	✗	✗	No
Increase self-reported wellbeing (by reducing the proportion of people reporting a low happiness score) *Confidence intervals +/-2.4pp*	11.0% (2021/22)	Tracker -	8.8% ○	✗	✗	No
Reduce the overall suicide rate (per 100,000 population)	15.8% (2019-21)	Tracker -	14.3% ✗	✗	✗	No
No. of admissions under the Mental Health Act	219 (Apr-Jun 23)	Tracker -	225 -			Yes
Healthy life expectancy at birth – female	59.9 years (2018-20)	Tracker -	58.3 years ✓	✗	✓	No
Healthy life expectancy at 65 – female	10.2 years (2018-20)	Tracker -	9.0 years ✓	✗	✓	No
Reduce the gap between County Durham and England for healthy life expectancy at birth – female	4.0 years (2018-20)	Tracker -	5.2 years ✓		✓	No
Reduce the gap between County Durham and England for healthy life expectancy at 65 – female	1.1 years (2018-20)	Tracker -	2.1 years ✓		✓	No
Healthy life expectancy at birth – male	58.8 years (2018-20)	Tracker --	59.6 years ○	✗	✗	No
Healthy life expectancy at 65 – male	7.7 years (2018-20)	Tracker -	8.3 years ✗	✗	✗	No
Reduce the gap between County Durham and England for healthy life expectancy at birth – male	4.3 years (2018-20)	Tracker -	3.6 years ✗		✗	No
Reduce the gap between County Durham and England for healthy life expectancy at 65 – male	2.8 years (2018-20)	Tracker -	2.3 years ✗		✗	No

[3] Smoking prevalence: prior to COVID-19 this was collected via face-to-face interviews. In 2020, this moved to telephone interviews resulting in a potential bias in the sample and meaning that results were not comparable with previous years. To allow comparability the ONS have updated the weighting methodology to remove the effect of the mode change.

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
No. of visits to Leisure Centres	759,755 (Apr-Jun 23)	812,455 ✗	752,183 ✓			Yes
No. of leisure memberships	17,813 (Apr-Jun 23)	18,584 ✗	19,618 ✗			Yes
% of initial assessments for Adult Social Care service users completed within 28 days	53.6% (Apr-Jun 23)	Tracker -	53.8% ○			Yes
Number of Care Act assessments completed	597 (Apr-Jun 23)	Tracker -	610 -			Yes
% of service users receiving an assessment or review within the last 12 months	68.1% (Apr-Jun 23)	Tracker -	59.1% ✓			Yes
% of individuals who achieved their desired outcomes from the adult safeguarding process	93.6% (Apr-Jun 23)	Tracker -	93.0% ✓			Yes
Increase the satisfaction of people who use services with their care and support *Confidence intervals +/-4.3pp*	64.5% (2021/22)	Tracker -	69.6% ○	✓	✗	No
Increase the satisfaction of carers with the support and services they receive *Confidence intervals +/-5.1pp*	40.8% (2021/22)	Tracker -	51.2% ✗	✓	✗	No
Increase % of hospital discharges receiving reablement	2.2% (2021/22)	Tracker -	2.7% ✗	✗	✗	No
Increase % of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services	85.5% (2022/23)	84.0% ✓	89.2% ✗	82.7% ✓	81.6% ✓	Yes
Increase the average age whereby people are able to remain living independently in their own home	83.9 years (Jul 22-Jun 23)	Tracker -	84.6 years ○			Yes
Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	153.3 (Apr-Jun 23)	157.1 ✓	100.4 ✗			Yes
Increase the % of people aged 65+ with aids and assistive technologies in their homes	new PI	new PI	new PI			No

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
% of potential clients contacted within 3 weeks of initial referral for a Disabled Facilities Grant (DFG)	68% (Apr-Jun 23)	90% ✗	new PI			Yes
No. of Care Connect customers	10,727 (Apr-Jun 23)	Tracker -	10,757 ○			Yes
% of Care Connect calls answered within 3 minutes	99.72% (Apr-Jun 23)	99% ✓	99.87% ○			Yes
% of Care Connect calls arriving at the property within 45 minutes	97% (Apr-Jun 23)	90% ✓	97.54% ○			Yes
Ensure all new housing developments deliver at least 66% of their total units to meet accessible and adaptable standards (building Regulations requirement M4(2))	new PI	new PI	new PI			No
Ensure all new housing developments deliver at least 10% of their total units that are suitable for older persons	new PI	new PI	new PI			No

Our Communities

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
% of successful completions of those in alcohol treatment	30.7% (May 22-Apr 23)	Tracker -	34.1% ✗	35.4% ✗		Yes
% of successful completions of those in drug treatment – opiates	5.1% (May 22-Apr 23)	Tracker -	6.0% ○	4.9% ✓		Yes
% of successful completions of those in drug treatment – non-opiates	32.0% (May 22-Apr 23)	Tracker -	34.7% ✗	31.6% ✓		Yes

Other Relevant indicators

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Increase the % of children aged 4-5 who are of a healthy weight[4] *Confidence intervals +/-1.2pp*	75.5% (2021/22)	90% x	not reported	x	✓	No
Increase the % of children aged 10-11 who are of a healthy weight *Confidence intervals +/-1.2pp*	59.2% (2021/22)	79% x	not reported	x	✓	No

[4] National Child Measurement Programme ceased March 2020 when schools closed due to the pandemic, therefore, North East and nearest neighbour comparators should be treated with caution due to missing data from some LAs. Whilst the data for the academic year 2020/21 has been published, local authority data is not available as only a 10% sample of data was recorded.

Adults, Wellbeing and Health Overview and Scrutiny Committee

2 October 2023

Quarter One, 2023/24 Performance Management Report

Report of John Hewitt, Chief Executive

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 To present an overview of progress towards delivery of the key priorities within the Council Plan 2023-27 in line with the council's corporate performance framework.

2 The report covers performance in and to the end of quarter one, 2023/24, April to June 2023.

Executive Summary

3 The County Council is a key partner within the County Durham Together Partnership. Collectively partners work towards delivering a shared plan - the County Durham Vision 2035. The vision document was developed with partner organisations and the public. It sets out what we would like the county to be like over the next decade and beyond. The vision is for:

a place where there are more and better jobs, people live long, and independent lives and our communities are well connected and supportive.

4 We have set out how the council will operate effectively in the delivery of its services and its contribution to achieving this vision in our Council Plan[1]. The Council Plan[1] is structured around five thematic areas: our economy, our environment, our people, our communities, and our council. We monitor our success through a suite of Key Performance Indicators (our corporate performance framework), which forms the basis of this report.

5 In line with previous reports, we are continuing to report performance on an exception basis with key messages against the five thematic areas. In any given quarter, we will only include key performance indicators which have been updated during that quarter, for example, educational attainment will be updated annually in quarter three.

[1] The Council Plan is a rolling four-year plan and is refreshed every year in line with the Medium Term Financial Plan. The current version covers 2023 to 2027

Context

6 The council is a large organisation providing a broad range of services, and our operating environment can at times be challenging. However, we continue to show strong performance across our key outcomes.

(a) Across the county, inward investment continues, new infrastructure is being created and new business parks with the potential to create thousands of jobs are being developed. The promotion of the county as a year-round tourist destination continues (in 2022, tourism contributed more than £1 billion to our local economy for the first time).

(b) Demand for statutory children's social care and early help remains consistent overall, though the composition of needs and interventions are increasingly complicated. Caseloads are improving and targeted recruitment is proving successful.

(c) Although health continues to be a challenging area, life expectancy is increasing, and life chances are improving. We are continuing to help households who are financially vulnerable through our financial support schemes.

(d) Environmental cleanliness remains good, and carbon emissions are reducing significantly from the 1990 baseline.

(e) We have increased lower cost, more accessible contact options for our customers through our digital work, and user satisfaction with our services remains high.

Recommendation

7 Adults, Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) Note the overall strong position and direction of travel in relation to quarter one performance, and the actions being taken to address areas of challenge.

(b) Note the changes and improvements to the new format performance report which will be used exclusively from quarter two 2023/24.

Analysis of the Performance Report

8 The areas identified in this section are contributory indicators linked to the priorities of the Council Plan. Performance is reported on an exception basis with key messages against the five thematic areas within the Council Plan 2023-2027.

Our people

9 The aim of this priority is to help our residents live long and independent lives and remain in good health for as long as possible. We will protect and improve health by tackling the leading causes of illness and early death, inequalities and the challenges around mental health. We will ensure a sustainable high-quality care market and will invest in a multi-million pound programme to transform our leisure centre venues.

Going Well

10 The rate of admissions to permanent residential and nursing care is below the Better Care Fund (BCF) target (lower is better) and numbers entering permanent care continue to be lower than pre-pandemic levels. The percentage of older people still at home 91 days after discharge from hospital also continues to be high; these demonstrate progress to meet our aim of maintaining the independence of people for longer. Work is also underway to examine the trends in admissions and reablement in order to understand changing demand for adult social care.

11 Over two thirds of adult social care service users have received an annual review or reassessment in the last 12 months. This is the highest for over a year and demonstrates the progress made since additional capacity was provided to target overdue reviews.

Areas which require attention

12 The timeliness of the completion of Care Act assessments for adult social care service users continues to be low in comparison to levels seen prior to the pandemic. The Adult Social Care service is introducing new technology to support social workers to complete the assessments in a timely manner.

13 Work is being undertaken to examine referrals to adult social care and take-up of services including home care, day care and telecare. Analysis is examining source and outcome of referrals, and variations to take-up of services compared to prior to the pandemic to fully understand how demand is changing as this will inform provision and commissioning priorities.

14 Our substantial leisure transformation programme continues to deliver upgraded and new facilities; however, this means a temporary drop in visits to our leisure centres, with almost 760,000 visits this quarter, which is 17% below target (-152,040). Visits continue to be affected by transformation works at Spennymoor and Abbey leisure centres, a pool closure at Peterlee leisure centre, and the cost-of-living crisis.

15 Leisure centre memberships were below target by 4% (-771). Ongoing cleansing of our third party income collection data identified a higher than expected number of cancelled memberships which we were previously unaware of. This is likely to continue into quarter two and possibly quarter three.

Background papers

- County Durham Vision (County Council, 23 October 2019) https://democracy.durham.gov.uk/documents/s115064/Draft%20Durham%20Vision%20v10.0.pdf

Other useful documents

- Council Plan 2023 to 2027 (current plan) https://www.durham.gov.uk/media/34954/Durham-County-Council-Plan-2023-2027/pdf/CouncilPlan2023-2027.pdf?m=638221688616370000
- Quarter Four, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s174900/Item%204%20Q4%202022-23%202%201.pdf
- Quarter Three, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s171720/Item%205%20Corporate%20Performance%20Report%20Q3%202022-23.pdf
- Quarter Two, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s166398/Corporate%20Performance%20Report%20Q2%202022-23%20v2.1.pdf
- Quarter One, 2022/23 Performance Management Report https://democracy.durham.gov.uk/documents/s161902/Corporate%20Performance%20Report%20Q1%202022-23%20Revised.pdf

Author

Steve Evans Contact: steve.evans@durham.gov.uk

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 change 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.

Durham County Council Performance Management Report

Quarter One, 2023/24

1.0 Our People: National, Regional & Local Picture

1 A new national inspection regime of adult social care came into force from April 2023. CQC, the regulatory body, are undertaking a series of pilot inspections to ensure that their approach to local authority assessments is as meaningful and effective as possible. The full inspection process is planned to begin later in the year and the framework will cover four themes - Working with People, Providing Support, Ensuring Safety within the System and Leadership. Analysis in this and future performance reports with provide high level monitoring of key aspects of this framework.

1.1 Council Activity: Going Well

Adult Social Care

2 We continue to see a lower rate of adults aged 65+ per 100,000 population admitted on a permanent basis to residential or nursing care compared to the rate seen before Covid and, for quarter 1, we are lower than the BCF target (lower is better). Whilst the average age of those entering permanent care has remained static over the last ten years (average age of 84.2 years), numbers entering continue to be lower than the average seen before the pandemic. This demonstrates progress to meet our aim of maintaining the independence of people for longer. We are undertaking a data quality review to enable a greater understanding of the number of people entering permanent care. This includes a review of the methodology used to calculate the indicator.

3 The percentage of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services (85.5% in the latest quarter) remains high. Whilst reducing slightly from the previous quarter it is in line with the average seen over the last 5 years. Latest performance remains above our target of 84% and regional and national benchmarking. Latest data for the number of people discharged into reablement demonstrates a continued decline. The Commissioning Service are undertaking a review of reablement services to understand factors such as staff turnover, capacity of the service and changing demand.

4 Two thirds of service users (68.1%) have received an annual assessment or review in the last 12 months. This is the highest since quarter 3 2021/22, improving from 59.1% at quarter 4 2022/23. Migration to a new case management resulted in a deterioration in performance as transitional arrangements took unexpected amounts of capacity. The service responded by restructuring creating dedicated capacity for reviews which appears to be making positive progress.

5 The percentage of individuals achieving their desired outcomes during the Safeguarding process has increased to 93.6% across quarter one 2023/24, a 0.6% increase against the previous year. However, this remains lower than the regional (97.5%) and England (95.4%) averages for 2021/22.

6 The methodology for this indicator was reviewed and results re-calculated from 2021/22 to date to ensure closer alignment to the national Safeguarding Adults Collection Return. Changes to the Adult Social Care case management system are being implemented to ensure streamlined recording of outcomes against the national return.

7 During June and July 2023, workshops have been conducted with front line staff, focusing on improving recording of key information across the Safeguarding process and highlighting good practice. A comprehensive governance review is continuing across Safeguarding Service, focusing on areas of concern and good practice, with the aim of reviewing key strategic indicators and increasing assurance in reported results.

Public Health

8 County Durham has been awarded £3.5 million for 2023/24 to support the implementation of the new national drugs strategy. This supports a range of functions including increasing the mental health offer to all clients, and the implementation of an alcohol care team within TEWV. It will also increase activity around harm reduction linked to trends relating to substance misuse in our local communities.

1.2 Council Activity: Areas which require attention

Adult Social Care

9 Referrals to adult social care have reduced since September 2022. The last three quarters have seen an average of 1,850 referrals received per month whilst the period July 2021 – September 2022 saw an average of 2,324 per month. When comparing the latest quarter 1 with the same period last year, we have seen a reduction of 16.7%. Work is being undertaken to analyse the latest data to enable greater insight into this issue. Analysis is examining source and outcome of referrals to understand where demand is changing.

10 Timeliness of completion of Care Act assessments remains low with 53.6% of all Care Act assessments completed within 28 days in the latest quarter. This is similar to the timeliness seen 12 months ago, however, it is a reduction on levels seen prior to the pandemic. The Adult Social Care service are currently introducing new technology that should support staff to complete the assessments in a timely manner. The number of Care Act assessments completed by quarter has remained consistent over the last 2 years.

11 The number of service users receiving home care continues to be high, however, it has reduced over the last 12 months by approximately 700 service users (a reduction of 17%). This may be indicative of an observed reduction in the number of home care hours since the end of the pandemic when, during the Covid period, home care hours peaked at the expense of residential care. Work is being undertaken to examine these changes and to understand if service user numbers receiving a home care service are similar to those seen prior to the pandemic.

12 Whilst the number of service users receiving day care has remained static over the last 12 months (approximately 1,000 service users), work is being undertaken to examine the decrease in the number of commissioned day care sessions compared to pre-pandemic numbers.

Smoking

13 The percentage of mothers smoking at time of delivery has increased in the latest quarter compared to the same period last year. When reviewed by year the data demonstrates a consistent reduction. Smoking during pregnancy remains a key priority for Public Health and is reported to the Health and Wellbeing Board on a regular basis. The County Durham Tobacco Control Alliance continues to work collaboratively to drive towards the regional goal of reducing smoking at time of delivery to 5% or less by 2025 and a local ambition that all pregnant women and mothers will not smoke.

Disabled Facilities Grants

14 During quarter one, 68% of potential clients were contacted within three weeks of their initial referral for a Disabled Facilities Grant, which is 22pp below target. Due to staffing shortages, it has been necessary to put some cases on hold. New processes are being implemented to deal with the situation and recruitment underway to fill vacant posts. This is a new measure, and we are developing robust mechanisms for future monitoring.

Leisure Centres

15 Our substantial leisure transformation programme continues to deliver upgraded and new facilities; however, this means a temporary drop in visits to our leisure centres, with almost 760,000 visits this quarter, which is 17% below target (-152,040). Figures are slightly up on the same period last year (1%, 7,572 visits). Visits continue to be affected by transformation works at Spennymoor and Abbey leisure centres, a pool closure at Peterlee leisure centre. The current cost of living crisis continues to be a real challenge for our communities, and we have seen a trend in relation to timelines around energy charges and interest rate increases that have impacted visitor numbers.

Gym and Swim Members

16 Membership numbers for both gym and swim did not achieve target this quarter, with 16,106 (-4%, -684) and 1,707 (-5%, -87) respectively. Although profiled targets were set to take seasonal trends into account, data cleansing work is being undertaken to better understand demand which has led to some corrections in historical data quality. This work is set to continue over the coming months.

17 In addition to the overall memberships figures of 17,813 reported this quarter, we also provided 79 free Holiday Active Fitness (HAF) Young Lifestyle gym memberships[2] to targeted residents.

[2] Free Young Lifestyle gym memberships to young people (11-15) available in any leisure centre but targeted via specific organisations and groups we work with

6.0 Data Tables

Key to Symbols

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×	more than 2% behind

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More detail is available from the Strategy Team at performance@durham.gov.uk

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Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
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Our Environment

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		Period target	12 months earlier	N	NE	
Raise cycling and walking levels in County Durham in line with national levels by 2035	67.7% (2020/21)	Tracker -	68% ○	71.2% ✗	69.5% ✗	No
% overall satisfaction with cycle routes & facilities *(confidence intervals +/-4pp)*	52% (2022)	Tracker -	54% ✓			No

Our People

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
% of mothers smoking at time of delivery	15.2.% (Jan-Mar 23)	0% ✗	14.8% ✗	✗	✗	Yes
% of smoking prevalence in adults (aged 18+)[3]	16.2% (2021)	5.0% ✗	16.5% ✓	✗	✗	No
Increase self-reported wellbeing (by reducing the proportion of people reporting a low happiness score) *Confidence intervals +/-2.4pp*	11.0% (2021/22)	Tracker -	8.8% ○	✗	✗	No
Reduce the overall suicide rate (per 100,000 population)	15.8% (2019-21)	Tracker -	14.3% ✗	✗	✗	No

[3] Smoking prevalence: prior to COVID-19 this was collected via face-to-face interviews. In 2020, this moved to telephone interviews resulting in a potential bias in the sample and meaning that results were not comparable with previous years. To allow comparability the ONS have updated the weighting methodology to remove the effect of the mode change.

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
No. of admissions under the Mental Health Act	219 (Apr-Jun 23)	Tracker -	225 -			Yes
Healthy life expectancy at birth – female	59.9 years (2018-20)	Tracker -	58.3 years ✓	✗	✓	No
Healthy life expectancy at 65 – female	10.2 years (2018-20)	Tracker -	9.0 years ✓	✗	✓	No
Reduce the gap between County Durham and England for healthy life expectancy at birth – female	4.0 years (2018-20)	Tracker -	5.2 years ✓		✓	No
Reduce the gap between County Durham and England for healthy life expectancy at 65 – female	1.1 years (2018-20)	Tracker -	2.1 years ✓		✓	No
Healthy life expectancy at birth – male	58.8 years (2018-20)	Tracker --	59.6 years ○	✗	✗	No
Healthy life expectancy at 65 – male	7.7 years (2018-20)	Tracker -	8.3 years ✗	✗	✗	No
Reduce the gap between County Durham and England for healthy life expectancy at birth – male	4.3 years (2018-20)	Tracker -	3.6 years ✗		✗	No
Reduce the gap between County Durham and England for healthy life expectancy at 65 – male	2.8 years (2018-20)	Tracker -	2.3 years ✗		✗	No
No. of visits to Leisure Centres	759,755 (Apr-Jun 23)	812,455 ✗	752,183 ✓			Yes
No. of leisure memberships	17,813 (Apr-Jun 23)	18,584 ✗	19,618 ✗			Yes
% of initial assessments for Adult Social Care service users completed within 28 days	53.6% (Apr-Jun 23)	Tracker -	53.8% ○			Yes
Number of Care Act assessments completed	597 (Apr-Jun 23)	Tracker -	610 -			Yes

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
% of service users receiving an assessment or review within the last 12 months	68.1% (Apr-Jun 23)	Tracker -	59.1% ✓			Yes
% of individuals who achieved their desired outcomes from the adult safeguarding process	93.6% (Apr-Jun 23)	Tracker -	93.0% ✓			Yes
Increase the satisfaction of people who use services with their care and support *Confidence intervals +/-4.3pp*	64.5% (2021/22)	Tracker -	69.6% ○	✓	×	No
Increase the satisfaction of carers with the support and services they receive *Confidence intervals +/-5.1pp*	40.8% (2021/22)	Tracker -	51.2% ×	✓	×	No
Increase % of hospital discharges receiving reablement	2.2% (2021/22)	Tracker -	2.7% ×	×	×	No
Increase % of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services	85.5% (2022/23)	84.0% ✓	89.2% ×	82.7%	81.6% ✓	Yes
Increase the average age whereby people are able to remain living independently in their own home	83.9 years (Jul 22-Jun 23)	Tracker -	84.6 years ○			Yes
Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	153.3 (Apr-Jun 23)	157.1 ✓	100.4 ×			Yes
Increase the % of people aged 65+ with aids and assistive technologies in their homes	new PI	new PI	new PI			No
% of potential clients contacted within 3 weeks of initial referral for a Disabled Facilities Grant (DFG)	68% (Apr-Jun 23)	90% ×	new PI			Yes
No. of Care Connect customers	10,727 (Apr-Jun 23)	Tracker -	10,757 ○			Yes
% of Care Connect calls answered within 3 minutes	99.72% (Apr-Jun 23)	99% ✓	99.87% ○			Yes
% of Care Connect calls arriving at the property within 45 minutes	97% (Apr-Jun 23)	90% ✓	97.54% ○			Yes

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Ensure all new housing developments deliver at least 66% of their total units to meet accessible and adaptable standards (building Regulations requirement M4(2))	new PI	new PI	new PI			No
Ensure all new housing developments deliver at least 10% of their total units that are suitable for older persons	new PI	new PI	new PI			No

Other Relevant Indicators

Performance Indicator	Latest data (period covered)	Performance compared to:				Updated
		Period target	12 months earlier	N	NE	
Increase the % of children aged 4-5 who are of a healthy weight[4] *Confidence intervals +/-1.2pp*	75.5% (2021/22)	90% ×	Not reported	76.5% ×	74.3% ✓	No
Increase the % of children aged 10-11 who are of a healthy weight *Confidence intervals +/-1.2pp*	59.2% (2021/22)	79% ×	Not reported	60.8% ×	58.0% ✓	No

[4] National Child Measurement Programme ceased March 2020 when schools closed due to the pandemic, therefore, North East and nearest neighbour comparators should be treated with caution due to missing data from some LAs. Whilst the data for the academic year 2020/21 has been published, local authority data is not available as only a 10% sample of data was recorded.